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A proposal for
a military medical think tank
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DEPARTMENTS

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

Dateline: Washington  
Division of Advocacy and Health Policy

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Division of Advocacy and Health Policy

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

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
It behooves me to explain what the College is doing to represent the interests of surgeons in the policymaking arena and to remind our members that they each play an important role in attempting to effect change.

Payment concerns
Since its inception, the Medicare payment system has evoked visceral reactions from many surgeons, and rightly so. The resource-based relative value scale (RBRVS) for calculating physician payment was designed purely to control costs by targeting physician fees. In recent years, efforts to improve the payment system have had perversely negative effects. The use of the sustainable growth rate to calculate payment has proven particularly ill-conceived and has resulted in the threat of significant physician pay cuts for several years.

Some people argue that the College has accepted these hits lying down. These same people assert that the College lacks the leadership needed to address this issue. Indeed, one surgeon wrote to me earlier this year, saying that the College was caving in to “blackmail” on the part of the federal government. This surgeon went on to describe our ongoing negotiations with Congress and the Centers for Medicare & Medicaid Services (CMS) to enact true Medicare payment reforms as akin to “serfs asking their lord for a living wage.” The author proceeded to ask, “When is the ACS going to accept its responsibility and really represent surgeons by doing something economically significant?”

ACS response
I empathize with this individual’s frustration. Achieving the types of true reform that are necessary to improve the Medicare reimbursement system is a difficult and arduous process. However, anyone who assumes that all of our problems with payment reductions and expense hikes would vanish if the College would just adopt a tougher stance is taking a rather simplistic view of a very complex situation.

The fact of the matter is that this organization has aggressively pointed out the defects in the RBRVS since it was first proposed. Over the years, the College’s leadership has repeatedly offered testimony to Congress and participated in meetings with high-ranking officials at CMS to educate them about how existing payment policies affect surgeons’ ability to continue to provide services to Medicare beneficiaries.

We recognize that this strategy has had limited effectiveness in today’s highly politicized climate. To that end, we formed the American College of Surgeons Professional Association (ACSPA),
which, because of its tax exemption status, has been able to form a political action committee (PAC). The ACSPA Surgeons PAC contributes to the election campaigns of legislators who understand the socioeconomic pressures on surgeons and on their ability to practice.

Moreover, we are leading and participating in groups of stakeholders who are working to develop a more sensible approach to payment. More specifically, we are leading efforts to ensure that if Congress replaces the reimbursement system with a pay-for-performance model, which seems likely, surgical outcomes will be measured in a risk-adjusted and rational way. And, finally, members of our General Surgery Coding and Reimbursement Committee recently met with leaders at CMS to discuss payment and quality issues.

**We need you**

Of course, legislators listen only up to a point to representatives of organized medicine. They are more attentive to their constituents. Hence, each of us must play an active role in the political process if we want to ensure that the payment system recognizes surgeons’ unique concerns and allows us to provide appropriate care to our patients.

The College really pushed our members to get involved in averting the payment cut for this year, and many of you stepped up to the plate. Unfortunately, a surprising number of our members were apathetic and did not get involved.

Here’s what I mean: The College sent two electronic alerts, calling upon our Fellows to write their legislators and urge Congress to address the Medicare pay cut before adjourning last December. These alerts were sent to the 21,000 members who have given us their e-mail addresses for our electronic database. Thus, a total of 42,000 messages were sent. Only 5,408 (less than 8%) of those 42,000 messages were opened, and just 468 Fellows used the link provided to write to their legislators. Particularly disturbing is the fact that no letters were sent from surgeons in several states that have senators and representatives who serve on key congressional committees that are responsible for Medicare issues.

In addition, we ran multiple items about this subject in ACS NewsScope, our weekly electronic newsletter, in our monthly Bulletin, and in our monthly newspaper, Surgery News. All of those articles encouraged the Fellows to contact their members of Congress.

Our lobbyists in Washington, our communications professionals, and I all realize that surgeons who are busy running their practices and caring for patients have very limited time to devote to outside activities. Therefore, we have tried to keep our messages brief and to make it as easy as possible for surgeons to contact their elected officials. Through our online Legislative Action Center (http://www.capitolconnect.com/acspa/), surgeons can contact their senators and representatives with just a few clicks of the mouse. The whole process literally takes only a matter of minutes.

The College cannot wage this battle alone. Therefore, I encourage every surgeon who truly cares about the legislative issues that affect his or her ability to provide quality care to their patients to become educated about the issues by reading the alerts and publications I have mentioned. Surgeons also should consider participating in the health policy leadership programs that we offer to learn about the realities of the legislative process. In addition, I want to emphasize the importance of contacting your legislators to voice your opinions. When they hear from enough constituents, they listen.

If you have suggestions as to how the College can improve its advocacy efforts, please contact me at the e-mail address below or our Washington Office at ahp@facs.org. We value your input and want to include you in our efforts to bring about real and positive change.

Thomas R. Russell, MD, FACS
The Centers for Medicare & Medicaid Services (CMS) announced February 21 that it is expanding Medicare coverage of bariatric surgery to beneficiaries of all ages. As a caveat, because the agency determined that the health benefits of bariatric surgery can only be assured in facilities where large numbers of these procedures are performed by highly qualified surgeons, those patients must seek care in Level 1 facilities certified by the American College of Surgeons or the American Society for Bariatric Surgery (ASBS).

After considering recommendations from the College and other experts in the field, CMS determined that the evidence supports providing Medicare coverage for three bariatric procedures: open and laparoscopic Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding, and open and laparoscopic biliopancreatic diversion with duodenal switch.

To qualify for Medicare coverage for bariatric procedures, patients must be diagnosed with other health problems associated with obesity, such as type 2 diabetes, coronary heart disease, and certain types of cancer.

Some surgeons continued to perform operations on the younger than 65 population in facilities not yet certified soon after the announcement because they were unfamiliar with the new mandate. Many of those claims were denied, but CMS has agreed that those denials may be appealed. For more information, go to http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1786, or contact bpeck@facs.org.

On March 1, the Medicare Payment Advisory Commission (MedPAC) released its first 2006 report, and the House Ways and Means Committee’s Health Subcommittee heard testimony regarding the report’s recommendations. In the report, MedPAC calls for a 2.8 percent increase in Medicare physician payments for 2007. However, unless Congress passes related legislation, physician reimbursement will be cut an estimated 4.6 percent in 2007. The reduction is a result of the universal target on volume and physician spending imposed by the sustainable growth rate methodology used to determine Medicare physician payments.

In addition, the commission suggested the development of an advisory expert panel to identify overvalued services, review recommendations from the Resource-Based Relative Value Scale Update Committee, and consult with the Secretary of Health and Human Services to review values for recently introduced services.

Although MedPAC has yet to propose broader payment reforms, the commission is studying volume growth in physician services and considering possible solutions, including separate volume targets for different geographic regions or types of services. To access the MedPAC report, go to http://medpac.gov/publications/other_reports/Mar06_WholeReport.pdf?CFID=2401389&CPTOKEN=19872535. For more information regarding the hearing and the testimony presented, go to http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=464.
ACS Executive Director Thomas R. Russell, MD, FACS, participated in a congressional briefing on March 7 in an effort to educate legislative staff about the College’s ongoing programs to promote high-quality surgical care. In his talk, Dr. Russell described the ways in which programs designed to improve quality in surgical care may differ from those targeted at improving chronic medical conditions. In particular, he noted the importance of collecting risk-adjusted outcomes data for high-risk surgical services so that surgeons can gain greater insights into their own performance and, thereby, engage in practice-based learning.

Also participating in the briefing were representatives of the American Medical Association, the American Academy of Family Physicians, and the American College of Cardiology. Each of those groups highlighted its own quality initiatives and described the promises and challenges associated with efforts to implement value-based purchasing programs for Medicare physician services. For more information, contact ahp@facs.org.

The CMS Office of the Actuary released a report on February 22, which projects that health care spending in the U.S. grew 7.4 percent in 2005 and will increase 7.3 percent in 2006, surpassing the $2 trillion mark. The 7.4 percent growth rate is 0.5 percentage points less than the growth observed in 2004 and represents the third consecutive year of decelerating growth. Nonetheless, given the aging population and changes in medical technology and use, national health expenditures are expected to double in the coming decade, growing at an average rate of 7.2 percent a year. Hence, health care’s share of the gross domestic product, 16 percent in 2004, is expected to climb to 20 percent by 2015.

The health care spending projection data are accessible at http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp.

According to a recent report from CMS, more Medicare beneficiaries are participating in Medicare Advantage plans this year, following approval of 163 new and expanded plans in 2005. Beneficiaries in every state now have access to Medicare Advantage plans, with 74 percent of enrollees having the option of participating in health maintenance organizations, 52 percent with access to preferred provider organizations, and 98 percent able to select private fee-for-service plans.

As required by statute, CMS also issued a preliminary 45-day notice on February 17, regarding the methods that will be used to calculate Medicare Advantage payment rates for 2007. This notice included a preliminary estimate of a 6.9 percent increase in the national per capita Medicare Advantage growth percentage, which will be used to determine the minimum annual percentage increase in capitation rates for Medicare Advantage plans in all counties for Part A and B. At press time, the preliminary estimate was scheduled for update before final 2007 capitation rates for all counties were announced in April. Further information is available at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1783.
TIME TO LEND A HAND:

A proposal for a military medical think tank

by

Ben Eiseman, MD, FACS,
and
James G. Chandler, MD, FACS,
Denver, CO
The Revolution in Military Affairs, where-in overlapping wars are fought with unequal and often stateless antagonists in widely disparate terrains, is in the process of overrunning the three U.S. military medical departments. They are stretched thin; tightly budgeted; and facing novel, critical operational and planning decisions for evolving responsibilities at home as well as abroad.

The disaster wrought by Hurricane Katrina brought two operational issues into sharp focus: Federal force has to take charge when states flounder, and military and civilian critical care and trauma surgeons work well together in tough situations, as exemplified by the displaced Charity Hospital trauma surgeons working side-by-side with Navy surgeons on active duty on the naval ship USNS Comfort. The disarray and disconnect between real need and well-equipped, expert help that kept North Carolina’s State Medical Assistance Team and its mobile surgical hospital wandering about Louisiana until they found work in Mississippi could have been avoided if they simply could have reported for duty to a coordinated command.

As the world’s only current superpower, the U.S. has effectively become the “world’s sheriff.” The sheriff is often criticized as being too rough, too self-interested, and sometimes capricious, but detractors and admirers alike look to the sheriff to maintain world order and hunt down the bad guys. Inextricably, by training and professional intent, we are the sheriff’s surgeons, as the College has recognized through its Operation Giving Back program and, on an individual basis, through Fellows’ participation in religious and secular humanitarian private organizations.

The bad news is that many civilian trauma surgeons are underemployed and undercompensated. But the good news is twofold: (1) the military medical services need to develop a limited-term, trauma-care, surge capacity, and (2) several auspicious events are conspiring to bring us all together for the common good. The Walter Reed Army Medical Center is going to be rebuilt near the National Naval Medical Center in Bethesda, MD, which is likely to be an engulfing merger of unequals but also a substantial step toward triservice medical care. The Uniformed Services University (USU) is on the same campus and headed by a Fellow, a trauma surgeon and a former active duty naval medical officer, Charles L. (Chip) Rice, MD, FACS.

We believe the time is right for the College’s Committee on Trauma (COT) and others to step up and get behind the sheriff. To facilitate this, we have proposed that a military medical think tank be incorporated into USU’s postgraduate division to provide a structured framework for the best minds in trauma, critical care, health care management, and military medicine to formulate new ideas and forge new paths. This think tank will be modeled after the Rand Corporation and the Brookings Institute, within the structure of the university, to provide evidence-based staff support to the Surgeons General and the Assistant Secretary of Defense for Health Affairs through the Senior Military Medical Advisory Council (SMMC).

The SMMC was established within the U.S. Department of Defense (DoD) in 2002 to systematize DoD health care decisions and is the ideal command structure to task such a think tank and to receive its work product. USU’s dual credibility within both the Department of Defense health care and the civilian academic community uniquely qualifies the school as the ideal academic administration to oversee the think tank and facilitate its work. The scope of the think tank should encompass both policy and operational issues, with a primary focus on improved care of the sick and injured in both instances.

There are many issues appropriate for think tank deliberations, but the general tenor can be illustrated by considering options for developing a trauma care surge capacity, absent committing to a permanent expansion of the military medical services or putting more burden on the Reserves and National Guard as they are currently constituted. In order of progressive discomfort for the establishment, the options are as follows:

- Integration of military medical personnel from allied nations as individuals or, perhaps more effectively, as a medical battalion or companies into the U.S. Medical Corps as noncombatants, subject to the U.S. military medical command structure. It may be necessary, or even desirable, to limit the activities of an allied nation’s medical unit to humanitarian care of the
local population, as this workload component has proven to be substantial in Iraq.

- The DoD sponsors surgical residents and Fellows in both military and civilian training programs. These surgeons are already ranked in the military and have eventual active duty commitments. Temporary assignment to a combat zone or civilian disaster, particularly if mentor pairing were included, would be a valuable part of their training—but to be real contributors, they would need to be of senior rank and activated on short notice, which is unlikely to be popular with their program directors.

- Special trauma/critical care reserve units have always had a certain appeal, as they imply built-in camaraderie and coworker confidence. Surgeons might sign up through a multidisciplinary umbrella in the model of university units of World Wars I and II. Today’s health care structure offers several alternatives, including Level 1 trauma centers; individual Veterans Administration (VA) Medical Centers or VA centers of an entire region; or large civilian health maintenance organizations—which could serve as contracting units and manage the added obligation by rotating personnel assignments to the on-call reserve military unit, assuming all substitutions would be in kind; and annual training commitments. Academic trauma departments, in particular, could offer considerable flexibility in return for DoD funding of a cadre of Fellows rotating between clinical care and research.

- Private military firms could easily adapt to provide a trauma/critical care surge capacity.

“As the world’s only current superpower, the U.S. has effectively become the ‘world’s sheriff.’ Inextricably, by training and professional intent, we are the sheriff’s surgeons.”

**Dr. Eiseman** is VA Distinguished Physician and emeritus professor of surgery, University of Colorado Health Sciences Center, Denver, CO.
They are traditional, for-profit businesses that provided special-forces-type combat units in Afghanistan and in pre-invasion Iraq and are now major suppliers of foodservice, bulk transport, housing construction, and interpreter resources in U.S. combat and peacekeeping efforts. Trauma/critical care specialists from other countries, as well as those in the U.S., would be likely participants in a medical private military firm, attracted by very competitive salaries and being free of the fetters imposed by the political stance of various countries and the military bureaucracy. The principal issues are quality control (the COT and ACS’s National Surgical Quality Improvement Program), integration, and intelligence security.

This proposal is meant to proselytize. We already see steps in the right direction: the COT’s appointment of David Hoyt, MD, FACS, to coordinate its efforts with the military medical departments and the Association for the Surgery of Trauma’s Military Medical Liaison Committee, led by C. William Schwab, MD, FACS, another trauma surgeon and former active duty naval medical officer. These appointments suggest that these could be preliminary events leading to the establishment of a regular, productive working relationship.

In the past, military medical leaders—such as Walter Reed, Leonard Heaton, Robert Brown, and Basil Pruitt—freely sought help from their civilian counterparts, and the likes of Evarts Graham, Edward Churchill, Isidore Ravdin, Michael DeBakey, and Tom Shires regularly responded with helpful largess. However, this fruitful civilian–military, collegial medical relationship eventually eroded—not by design, but by simple neglect. This is a propitious moment for both parties to renew the spirit of the past and harvest their joint potential for meeting the widely varying demands that all know are a part of the game, and the think tank should be an ideal venue for restoring this relationship. The issues that merit “out of the box” thinking have been given just a light touch here. Each potential solution has substantive pros and cons that require in-depth and expeditious exploration for the immediate need, but the nature of the issues is such that they will also engender worthy clinical research projects. We are convinced that the collective knowledge is available and up to the task, and will flourish within the academic framework of the USU.

**References**


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**Dr. Chandler** is clinical professor of surgery, University of Colorado Health Sciences Center, Denver, CO.
America needs a new system of MEDICAL JUSTICE

by Philip K. Howard, JD,
New York, NY

Common Good is a bipartisan coalition dedicated to restoring common sense to American law. Advisory groups of experts research, establish, and promulgate public policy guidelines that can bring reliability and balance to the legal system. In health care, these visionaries have concluded that special health courts are the answer.

Philip K. Howard, founder and chair of Common Good, has participated in past years on panels at ACS Clinical Congresses. Since then, much progress has been made, and policymakers and government agencies are increasingly interested in health courts. The ACS Patient Safety and Professional Liability Committee has solicited the following article to bring Fellows up-to-date on Common Good’s efforts to improve the quality of surgical care and the environment in which we work.

As potential advocates for health courts, you should visit www.cgood.org for additional insight.

F. Dean Griffen, MD, FACS
Chair, Patient Safety and Professional Liability Committee
The American Bar Association (ABA) recently adopted—without addressing serious concerns raised by members of its Health Law Committee—a resolution opposing the creation of special health courts. In doing so, the ABA put itself in direct conflict with a broad coalition of medical associations, patient advocates, consumer groups, and think tanks that are calling for pilot projects of special health courts as a way to begin to restore reliability to medical justice.

It’s disappointing that the ABA would oppose this consumer-oriented reform but not surprising, given that 60 percent of the cost of the medical liability system goes to lawyers and court costs. More money now goes to lawyers’ fees and administrative costs than to patients who have been harmed by medical malpractice.

**How health courts work**

The hallmark of health courts would be judges dedicated full-time to resolving health care disputes. They would make written rulings in every case to provide guidance on proper standards of care. Their rulings would set precedents on which both physicians and patients could rely. As with similar administrative courts that exist in other areas of law—for tax disputes, workers’ compensation, and vaccine liability, among others—there would be no juries. To ensure uniformity and predictability, each ruling could be appealed to a new medical appellate court.

The fundamental concept behind health courts is that restoring trust in medical justice requires creating a system that no longer tolerates wildly inconsistent verdicts. According to the landmark Harvard Medical Practice Study and subsequent major studies, most people don’t sue under the current system when there has been a medical mistake, but a substantial percentage (as much as 80%) of claims are made against physicians who were not negligent.

**Health cases in today’s courts**

Under the current system, most patients who are harmed by medical errors get no compensation at all, yet the nearly universal distrust of justice drives up costs—billions of dollars are spent in defensive medicine alone—and drives down quality, killing the open professional interaction needed for effective care. The current system is unpredictable, emotionally wrenching, and staggeringly inefficient. The lawyers are compensated to a greater extent than injured patients and the lawsuits go on for years.

There is virtual unanimity among organizations concerned with health care that the current system is a failure, as evidenced by the following quotes:

- The Institute of Medicine: “The legal liability system does not adequately fulfill either of its two main objectives—to encourage enhanced safety and quality and to provide timely and fair compensation to injured patients.”
- The Progressive Policy Institute: “It does not give most injured patients access to justice, and it does not send clear signals about standards of care that would help healthcare providers avoid medical mistakes.”
- The Joint Commission on Accreditation of Healthcare Organizations: The current system is “…not a ‘real system,’ but rather a patchwork of disjointed and inconsistent decisions with a limited ability to inform the development of improved healthcare practices.”

The current system pits physicians and patients against each other, when the two are not, of course, natural enemies. Both groups need what justice today is not providing: reliability. Patients need a system that will reliably hold physicians accountable when there’s a mistake, and physicians need a system that will reliably protect them when unfairly charged.

Restoring reliability to health care justice, however, requires questioning the one assumption that, until recently, no one dared even discuss: the role of the jury.

The core flaw with justice today is that no one’s in charge—all-important decisions are made by juries that come and go with each case. Juries can’t set precedent; every jury is different, and decisions are often inconsistent. One jury may grant a huge award in a particular case, and another, in a similar case, may grant no award at all.

**The jury**

In American law, the role of juries in civil cases is to decide disputed issues of fact, and the role of judges is to rule on the law. Decisions on proper standards of care should fall with the judges as matters of the law, not with juries.

Popular confusion over the jury’s role probably
stems from the distinction between civil and criminal cases. Under the Sixth Amendment, only a jury has the power to convict. Juries in a criminal case are our protection against abuses of state power. But a private lawsuit is a use of state power against another private citizen. A lawsuit is just like indicting someone—it’s just an indictment for money. That’s why the jury has the more limited role of deciding disputed facts.

The role of the jury in a particular lawsuit depends not on constitutional rights but on whether the case turns on a question of law. Does the case hinge on a factual dispute specific to the parties—say, who ran the red light? Or does the issue implicate the functioning of society—say, the standard of care appropriate in a particular medical case?

Questions of broader impact are ones that the judge has the authority to decide as a matter of law. That, in turn, provides the consistency that physicians, for instance, need in order to know what’s expected of them.

The point is not that the judge is necessarily wiser than a jury, but that the jury can’t make a ruling with binding effect. Trial lawyers typically argue that the jury system is the way our society regulates wrongful behavior. If that’s the case, where’s the regulation where we can find the guidelines of right and wrong? It doesn’t exist, because the “regulation” varies from jury to jury.

The point is not that the judge is necessarily wiser than a jury, but that the jury can’t make a ruling with binding effect. Trial lawyers typically argue that the jury system is the way our society regulates wrongful behavior. If that’s the case, where’s the regulation where we can find the guidelines of right and wrong? It doesn’t exist, because the “regulation” varies from jury to jury.

Today, partly as a result of the increasing complexity of medical science, no one working on behalf of society is making binding rulings about what is good care and what is not. No one is deciding when a test is needed and when it is not. Established standards of care are missing. It’s difficult to improve the current system when no one has the authority to make the choices needed to bring health care under control. The way to create reliability, and to make the deliberate choices needed to improve care, is to create specialized health courts, with trained judges relying on neutral experts to make decisions about the standard of care in medical injury cases.

**Benefits of a health court**

Common Good, the bipartisan legal reform coalition, is currently developing a prototype for a health court pilot project, in partnership with the Harvard School of Public Health and with funding from The Robert Wood Johnson Foundation. The outlines of a health court could vary, but the basic components are very straightforward: Health courts would be staffed by judges with medical training. The judges would have the authority to hire neutral experts, instead of experts-for-hire who now confuse and prolong liability cases. To reduce legal fees and the emotional toil, proceedings would be expedited so that injured patients would keep more of any award.

Along with reliable decisions about standards of care, which would set precedent from one case to another, health court judges could award non-economic damages (over and above medical costs and lost wages) in accordance with a schedule of benefits that would provide predetermined amounts for specific types of injuries.

With special health courts, recovery for patients is expedited for injuries out of range of expected results. Patients would still have their own lawyers, but the fees would be a fraction of what they are today, because the cases would take months, not years.

A primary goal of a specialized health court should be patient safety. This requires reviving or inducing a culture of open communication. With an expert health court, doctors could have the confidence that they would not be penalized for admitting uncertainty or error in the candid back-and-forth in hospital corridors and exam rooms. Rulings from a health court could also provide affirmative incentives for doctors and hospitals to improve the quality of care.

As Margaret O’Kane, president of the National Committee for Quality Assurance, has said: “The current legal system presents real barriers to improving the quality of American health care. A special health court could provide powerful incentives for honest reporting and analysis of errors, and to elevate standards of care.”

Reliable accountability is critical to overcoming the distrust that infects daily choices and the physician-patient relationship. Patients injured by medical mistakes should be compensated fairly. Physicians who are unjustly charged should be protected. Physicians who are not competent should lose their licenses. An expert court can make these types of decisions reliably and consistently.

Creating a new health court may seem like a
Philip K. Howard, a lawyer, is chair of Common Good, the bipartisan legal reform coalition, and the author of The Death of Common Sense and The Collapse of the Common Good.

radical proposal. But health care in America is in meltdown, and the benefits of health courts are clear:

• Quicker, more reliable justice
• Improved patient safety
• Lower costs
• An open, trusting relationship with physicians
• Liberalized compensation to cover avoidable injuries without the requirement of proving negligence

As noted, specialized courts are common in other areas of law, and expert courts or tribunals have long been recognized as the sensible solution in situations where there is a crisis of distrust.

The concept of health courts has been endorsed by U.S. Senate Majority Leader Bill Frist (R-TN) and by the Progressive Policy Institute, a major Democratic think tank. A bipartisan bill is pending in the U.S. Senate to authorize pilot projects for special health courts. The bill was introduced by Sens. Mike Enzi (R-WY) and Max Baucus (D-MT), and hearings are expected shortly. A similar bill has been introduced in the House by U.S. Rep. Mac Thornberry (R-TX). In addition, several of America’s most prominent hospitals, including Johns Hopkins and New York–Presbyterian, have indicated an interest in participating in a pilot project.

Support for the health court concept is broad and growing. Scores of the nation’s most prominent leaders in health care and the law have called for the creation of special health courts, including university presidents, medical school deans, former high-ranking government officials from both political parties, and current or former heads of health care policy, health care quality, or patient safety organizations.

Joining Common Good in advocating the creation of pilot projects for health courts are leading organizations such as the AARP, the Joint Commission on Accreditation of Healthcare Organizations, the American College of Obstetricians and Gynecologists, the American Association of Family Physicians, and the American College of Emergency Physicians, among others, as well as the state medical societies in Maryland, Mississippi, New Jersey, New York, Pennsylvania, Rhode Island, and Virginia.

Support from major news publications includes an editorial in USA Today stating, “Health courts could show the way for quicker and fairer compensation to the deserving.”

The time for a new approach is now. William Sage, a health care expert at Columbia Law School, recently observed that it would be a shame to waste the current crisis. American health care finds itself in a “perfect storm”—of needless errors, unaffordable cost increases, declining access, inadequate accountability, and fearful and frustrated professionals. Those who care passionately about improving health care must seize this moment to do what’s needed—create a solid foundation of law, reliable for patients and providers alike, upon which we can begin to make the deliberate choices needed to improve quality and access of health care for all Americans.

Creating special health courts is an ambitious undertaking, but it’s essential to strengthen one of the oldest and most basic principles of the American system of justice: that like cases be decided alike. There isn’t really a choice: the distrust that is eating away like a cancer at American health care cannot be cured until justice in health care is made reliable.

The time has come to move ahead with special health courts and put the public interest ahead of special interests.

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Retirement is more than work coming to a close. A person’s livelihood might be more than a job, as a career can shape his or her identity and relationships. In the following articles, two surgeons consider their own retirement and how it has had an impact on the whole of their careers: James C. Neely, MD, FACS, provides a narrative of a most unexpected experience on what was supposed to be the first day of his retirement, and C. Barber Mueller, MD, FACS, discusses his knowledge and experience at the retirement stage of his career in the form of an open letter to medical students.
A surgeon must have
The eye of an eagle
The heart of a lion
And the hand of a lady

—Jessie Ternberg, MD*

I believe every real surgeon is like me. That surgeon wonders all his or her life how it will feel—how he or she will act—when putting in that final stitch and leaving the operating room (OR) for the last time, never to return. After all, surgery for us is an amazing love affair, and our nature cries out for its magnificent obsession. It is a glorious addiction. But addiction, we all know, can breed withdrawal. We have seen our respective forebears preternaturally gray, thrombose good coronaries, and even put an end to themselves, all right after they retire. The worst of these retirees are lounge lizards, dour presences sipping coffee every day in the doctors’ room, talking nonsense about the bad old days over outdated newspapers. I swore this was not going to happen to me.

There are only two ways to do this retirement thing. You either cut back on your practice, or you choose a date and you quit. I didn’t believe there was such a thing as cutting back on practice. How does one do that anyway? Just care for the patients one wants to and avoid the rest? The late, great chairman Victor Richards, MD, said either a person is or is not in the practice of surgery—there is no in-between. It’s really that simple.

So, at age 72, after 40 years in a big, tough, liability-ridden metropolis, I gave six months until retirement and gave everyone the date I’d chosen. On June 15, 1998, I would put in my last stitch and walk away. There would not be a bang, nary a whimper, and that way I wouldn’t have to orient a whole new batch of residents—all fresh and new as if acute appendicitis was just happening for the first time—who would be coming on service July 1.

The “last” day
June 15 was an ordinary day. I wanted it that way. I had done a lap chole and two or three simple hernias. At home in the evening, my wife served me my favorite meal and excitedly told me about my forthcoming grandchildren. I retired to my study with a little bit of Mozart and the poems of my friend, W. S. Merwin. His breathtaking poem “Ashes” brought me to tears:

O you with no
beginning that we can conceive of
no end that we can foresee
you of whom once we were made
before we knew ourselves
in this season of our own

It was a beautiful poem about each of our lives, what it comes to in the end for all of us. I fell asleep in my deep, black leather chair until my wife came to put me properly to bed at 11:00 pm. It was 1:45 am when the intensive care unit called to tell me I was on emergency room (ER) call and they had a gastrointestinal bleeder for me to see. “The gastroenterologist says come right away,” the nurse said. “No questions, he doesn’t have time to talk to you.” I could tell—a surgeon always can—that this was serious. I told my wife as I woke her for the thousandth time in our marriage, as I rolled out of bed, that I had no idea I was on ER call and not to expect me until the morning.

The patient
The patient had been hospitalized on medicine for four hours with a dropping hemoglobin from 10 to 8.3 to 7.5 to 6.8, despite five units of blood. He had been scoped fore and aft, been worked up

*Surgical lifestyles
My last stitch
by James C. Neely, MD, FACS, Napa, CA

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for blood dyscrasias, had a chemical panel, received X rays of the chest and abdomen, and two electrocardiograms. All tests were normal. The one thing that had been noticed was progressive swelling in his abdomen, for which a computed tomography (CT) scan had been completed. I went down to X ray to review the films while the patient was settled back in bed. I alerted the senior resident to come in from home and told the operating room to stand by for an emergency laparotomy. The radiologist, by modern computer miracle, was able to read the CT scan data at home while I reviewed the original films. One by one, he described the findings to me over the telephone. We confirmed a normal liver and spleen, a completely normal aorta, no free air, normal bowel pattern, and no soft tissue trauma—nothing. The X rays were no help. Yes, there was massive bleeding intraperitoneally, but there was no evidence as to where it might be coming from.

At the patient’s bedside, I spoke with his wife. They were traveling from Scotland and had been in San Francisco for four days when they went out to dinner and her husband, who was 55 years of age, collapsed with abdominal pain. He was always healthy, his wife said. His annual physical—just two weeks ago—was normal. No trauma, no vomiting, no alcohol. When the resident finally appeared, I pointed out the tense, distended abdomen and, especially, the purple, flank discoloration only seen with massive peritoneal bleeding. I asked the resident what he thought we should do. He considered more tests, then suggested a laparoscopic approach. I picked up the telephone and told surgery we were wheeling a patient with massive peritoneal bleeding from unknown source for a crash laparotomy. I told the staff to warn the anesthetist and to get eight units of O-positive blood for starters if they couldn’t provide matched blood. I told the wife that her husband was dying from internal bleeding and we couldn’t determine where. The eighth unit of blood was running as we entered the OR. Blood pressure was 78 systolic.

The surgery

My hospital has the best residents in the world, with incomparable brio and brightness. They are modern in every sense of the word, and when they are called in from their bed at home, they expect to be allowed to do the case. I love to teach, and it was natural for me to allow the senior resident his earned position on the patient’s right side to do this case.

When he asked me where I wanted him to make the incision, I said urgently, “From outside in,” as I outlined a generous xiphoid to pubis incision. The resident did this, and suddenly there was blood and huge rubbery clots everywhere—a volcanic faucet bled somewhere down deep. The patient’s blood pressure dropped to zero, and visibility was zero. I dove for the aorta with my dominant right hand, felt it, and crushed it against the vertebrae just beneath the diaphragm. I didn’t know what else to do.

Surgery is not an intellectual pursuit. Rocket physics, the permutations and combinations of the deoxyribonucleic acid helix, and the decussations of Plato’s Republic are infinitely more difficult for the mind. All surgery requires of the mind is average superior intelligence. Nothing special. But there is something else, something that is seldom mentioned anymore, let alone emphasized, that is required: In a day and age when time away from work is mandated for youth, when home life is valued above all else, when efforts are afoot to shorten residency years, it is not de rigueur to proclaim to the world that surgery is essentially an emotional discipline. But the fact is that one can learn the 12 cranial nerves in a night, but it takes a lifetime to understand and control feelings. Where I received my training, only the psychology residents who underwent Freudian analysis were committed for as long as the surgeons. A person cannot control feelings in surgery in three or four years—it takes six or seven, followed by a lifetime. And when I dove for that aorta and crushed it against the vertebrae to save a life—something I had done because, 30 years earlier, someone had showed me that that’s what to do automatically in a case like this—I was suddenly alone, without an assistant. The cool head of the trained surgeon is nothing more. It is that same surgeon who just now feels alone in the middle of the night on the wrong side of the table with a third-year resident and only a free left hand to work with.

With my left hand, I continued to scoop blood and huge clots from the abdomen. The bleeding seemed to be coming from a tense lesser sac, which I urged the resident to enter quickly. He did this, though much too slow for me, as my right hand was rapidly tiring as the anesthetist poured unit after
unit of blood against my aortic pressure to bring the patient’s blood pressure to 60. If I relaxed even slightly, the blood immediately welled up in the mid-abdominal area and obscured the field. I asked for a Satinsky clamp and knew I would have to place it blind across the infradiaphragmatic aorta. This I did, with only partial results. The belly filled up with blood again, so I replaced the Satinsky, hoping to get a more complete cross-clamp. I quickly helped the resident enter the lesser sac, but the exam was negative for any bleeding source. And once again, the abdomen filled with blood. Once more, the anesthesiologist was without a pressure. I began to feel helpless and hopeless. I looked at the liver and the spleen, in case the CT had been wrong.

Desperate, I recalled a case from my early days of a metastatic chorioepithelioma to the liver that had spontaneously bled into the peritoneum. I fantasized that that case had returned to haunt me. Then I suddenly realized I might be losing it. We had now replaced the patient’s total blood volume twice over and had begun our third. The Satinsky was not holding, and the resident was fading fast.

At 3:00 am, I decided that if this patient was going to die, I wanted the chair of the department by my side to witness what I had done. When the nurse asked what she should tell him, I said to only tell him I needed him right away, which was something I never did.

I crushed my numb right hand against the aorta again, as it was the only thing that was having any effect. It seemed like an hour, but help arrived within minutes, and I can’t think of a time I was ever so happy to see a person in my entire life. I replaced my hand with the resident’s hand, and together the department chair and I were able to lift up the fatty apron of omentum and begin our exploration up along the aorta. As we came to the root of the midcolic artery and traced it out, there was an apparently large A-V formation in the right colic area that had ruptured. When pinched off with release of aortic pressure, the gushing bleeding was controlled. The department chair backed away, and as I held pressure, I invited the resident to oversee this area and we’d see if a right colectomy was necessary. He oversaw the area and in doing so, his spirits perked up a bit, as my own anxiety over a completely new experience had been hard on him.

Together, the resident and I watched the bowel for a long time and saw that it was viable. The resident closed the abdomen with aplomb, as all good residents do. As he put the serial steristrips in place to approximate the skin edges from below upward, I suddenly made him stop in the epigastrium so that I could place the last one.

**The last stitch**

I do believe a surgeon has only so many cases like this in him. Yet, despite everything that had gone wrong with this patient, with his multiple near-death experiences, we surgeons had done it right. This patient was my postoperative lifetime miracle. I expected disseminated intravascular coagulation, acute respiratory distress syndrome, renal shutdown, paraplegia, sepsis, hepatitis, atelectasis, pneumonia, dead bowel, evisceration, blood dyscrasias, and so on. But this patient never turned a hair. He returned to Scotland after two weeks, and his wife sent me a reassuring card three weeks later with understated thanks and appreciation as if nothing had happened in the U.S. that night.

“It was expected,” she said, and that’s all I ever got—but that was enough, more than enough, because I was able to put in that last stitch, a steristrip, all by myself.

I have never returned to the OR since that night. But somehow I think that if I had to, there’s a part of me that could do it again. Sometimes I wonder why I still feel that way, but in my heart I know. I’m a surgeon.

**Dr. Neely is a retired clinical professor of surgery at the University of California, San Francisco. He is a published author and poet.**
At the dawn of your medical career and the twilight of mine, I feel obliged to reflect on the unusual privileges that society accords to our very special profession.

After your time in medical school has introduced you to the world of the sick, you will enter an elite and fascinating world. By surviving thus far, you have not only demonstrated an interest in medical science but also have shown that you are intent on a serious career in caring. A long history of many traditional medical guidelines to help you give this care and practice judiciously in your chosen field are contained in several codes of ethical conduct that have been fashioned by the profession and are now supported in courts of law. Short and cryptic, these statements on ethics are worth reading, understanding, contemplating, and remembering, for they underpin our heritage and though they don’t govern what is done, they specify the goals of doing and the reasons for our being. Medical misconduct usually occurs in the area of social behavior and reflects an ignorance or abjuration of decent, upright, and honest interpersonal views. Rarely is ignorance of medical knowledge considered misconduct.

Although these words may seem to come lightly, they carry a heavy message about you and your chosen field, which will shape you as you are shaped by it. As a member of the health/medical profession, you will receive many privileges from a society that expects you to serve it with trust and confidence. The grocer, shopkeeper, police officer, teacher, and acquaintances outside of the profession will defer to you and grant special favors just because you are a physician.

Most of you will be in clinical practice—that is, you will care for patients, young and old, sick and not so sick, or those who make up the worried well. As clinicians, you will touch, feel, and give care to others as you tend to their illnesses and assuage their sorrows. Some of you will be in clinical laboratories or in research on the periphery of direct patient care; but all of you will be members of the health profession, one of the four noble professions alongside justice (law), truth (education), and virtue (religion). The health profession is different from these other three professions, in that it involves the touching of human beings, bodies and minds.

For the truly caring physician, this many be an uplifting experience and a rewarding way of life, as society will trust you with its collective bodies—and to some extent, its collective minds—and does this with extremely high and often unreasonable expectations for process and outcome.

Benefits in this profession are bilateral—you, the giver, and the patient, the receiver, both receive the benefits. At first thought, the benefits may seem to be for the patient, but they also become yours for your caring. You will be judged more on how well you care than on how well you cure. The well-being of others must always be the objective of the effort. Remember that well-being to a patient is personal, physical, and emotional—as well as medical—and should always come before the well-being of the self. Chiefly, benefits are measured by the quality of life of others—a difficult thing to measure—and they are not to be found in your personal bank account, your material possessions, or in the academic or research honors you may accrue. You will experience your benefits from the sense of satisfaction that comes from caring for others, from your membership in an elite group, and from your association with like-minded people who are curious, well-educated, articulate, and informed. However, these benefits
carry risks—you may become rigid, opinionated, and dogmatic, as in the eyes of a patient it is a physician’s obligation to be correct, certain, and up-to-date. These expectations carry a burden for which you must be prepared by being secure in yourself and accepting your errors—often the result of inadequate information—that will inevitably occur when making decisions regarding ill patients. And others, not you, will feel the effects of these errors. Recognizing, acknowledging, and being comfortable with your errors require thoughtful insight; critical analysis of the self; and a great deal of personal, emotional security.

After the degree

As a neophyte physician in the process of requiring your particular set of skills, knowledge, and attitudes that will reflect the responsibility resting on your shoulders, you will finally receive your doctor of medicine degree and later become licensed to practice medicine. Once licensed, you will be permitted to stick people with a needle, cut them with a knife, poke, punch, and probe into their body orifices. You will be permitted to enter the homes of strangers—their bedrooms and bathrooms—and to touch the unclothed and the unwashed. You will be given permission to administer drugs that by law are prohibited to others and you may explore personal habits and lifestyles as you probe into family and social interactions. You may even delve into another’s thoughts of suicide or murder.

All of these actions constitute assault and battery, the invasion of privacy, and violation of the body or mind of another; and these would be criminal offenses if committed by someone unlicensed or uncertified and could lead to prosecution and jail as felonious acts. Through its governing agencies at the state or provincial level, our society has developed license and certification laws that authorize, support, and defend you in these activities and these statutes go so far as to permit you to perform these activities in secret under the rubric of patient-physician confidentiality. In addition, there is a tolerant accountability system that is built on trust of physicians—in other words, trust in you. However, accidents do happen, misadventures do occur, and patients do suffer or may even die from misjudgments; yet, all of these actions are outside the criminal code. The law protects you, the doer, when you act with anticipated benefit to the patient and when you are so trustworthy that you recognize the true measure of your capability and do not attempt to exceed it.

The privilege of practicing medicine

These are very special privileges. Do not see them as a burden, but be aware of the heavy responsibility that comes with the special role you play in exercising them. Society sets you and your colleagues apart from everyone else. Please do not let the practice of medicine become such an obsession, so commonplace and commercialized, that you forget the origin of these privileges—occasionally someone is tempted to use these privileges for self-gain and, if this happens, it may bring legal troubles. However, the greatest penalty occurs when a physician loses the purpose in life that comes with helping others less fortunate. Money is not an equivalent that can make up for this lost purpose.

As you enter this world of the privileged few, you will be honored so long as you uphold the highest traditions of our profession. It is not a business; it is a calling and a life of caring. I am pleased to have been a part of this life and a member of this class of privileged people in the special world of caring for others. I can only hope that you may become as enriched and fulfilled as I have been. Keep your aspirations high, your vision clear, and your eyes on the stars. But, above all, keep the faith.

Dr. Mueller is a retired general surgeon in Hamilton, ON, and a Past-Second-Vice-President of the College.
For many years, the American College of Surgeons has had an active presence in Washington, DC, to allow the organization to effectively deal with important federal issues. More recently, state advocacy has become an increasing priority as chapters and Fellows have come to recognize that federal solutions are not readily forthcoming for issues such as medical liability reform.

Indeed, most surgeons are affected to a greater extent by what goes on in their state legislatures than on Capitol Hill. Licensing requirements, medical liability and managed care reform, Medicare and Medicaid reimbursement levels, small business taxes, and office surgery regulations are just a few of the direct-impact issues addressed at the state level.

In the College’s Division of Advocacy and Health Policy in Chicago, IL, two people compose the State Affairs staff. They are dedicated to assisting chapters and Fellows with state advocacy activities. These staff members monitor 50 state legislatures and the DC Council, and although the predominant focus is on legislative issues, State Affairs also monitors ballot initiatives and regulatory proposals from state agencies.

**Common state issues**

With so many legislatures to monitor, the Health Policy Steering Committee has suggested that the College’s state advocacy efforts focus on five broad issues—medical liability reform, provider taxes, allied health professional scope of practice, office-based surgery regulation, and trauma system funding and development. State Affairs monitors state legislative activity to pro-
tect Fellows from unwanted legislation and to identify issues and develop strategies that ACS chapters may use to make the best use of their resources. The College is only interested in bills that fall into these five categories; however, ultimately, each chapter is free to pursue the issues most critical to its members and to the state’s physician community at large.

Medical liability reform

Surgeons and other physicians in high-risk specialties have experienced substantial medical liability insurance premium increases over the past few years, especially in those states lacking comprehensive medical liability reforms. The gold standard for state liability reform is California’s Medical Injury Compensation Reform Act (MICRA) of 1975. These reforms include a $250,000 cap on noneconomic damages, modifications to the collateral source rule, mandatory periodic payments of future damages, and a sliding scale for plaintiff attorneys’ contingency fees. The College supports MICRA-type reforms in those states where reforms have yet to pass, as well as implementing expert witness qualifications and modifying joint and several liability so that defendants are liable only for their own portion of noneconomic and punitive damages.

Other state legislation relating to medical liability reform includes alternative dispute resolutions, “I’m Sorry” provisions, and even “Good Samaritan” exemptions. Where appropriate, the College weighs in with grassroots activities, letters, and testimonies on these state legislative proposals.

Provider taxes

Over the past few years, state budgets have experienced revenue shortfalls. In a few instances, legislatures have seen surgical care as an easy target for increasing tax revenue by assessing a tax on cosmetic surgery (for procedures defined as medically unnecessary), surgical services provided in ambulatory surgery centers, or for physician services overall. Not only is it ethically questionable for the state to tax patients for medical care, but provider taxes could require that physicians take on the responsibilities of tax collectors. In turn, it adds one more bureaucratic burden for medical professionals who should be devoting their time to patient care. In addition, physicians already pay personal income taxes, regular business taxes, and local and state sales taxes on supplies and utilities.

Estimates of the amount of tax revenue that may be generated by provider taxes are often overstated. In fact, New Jersey’s recent imposition of a cosmetic surgery tax (the only state that has legislated such a tax) has resulted in such minimal additional tax revenues—compared with the cost of implementation—that the original sponsor of the legislation has introduced a bill to repeal that tax during the 2006 legislative session.

Scope of practice

It is a common occurrence in state legislatures for one group of licensed health care professionals to seek expansion of their scope of practice. Some practitioners within these professions have the education, training, and experience needed to gain additional practice privileges. However, more frequently, these practitioners lack the proper background. For example, some nonphysicians are now seeking permission to perform surgical procedures on the eye, face, neck, and other parts of the body without the training and experience that surgeons attain during medical school, residency training, and specialty fellowships. The College supports surgical specialty societies in their efforts to stop single-degree dentists from seeking to perform cosmetic plastic surgery of the head and neck and optometrists from performing surgery with lasers and scalpels on the eye and surrounding areas. Although these nonphysicians may be well trained to practice dentistry and optometry, respectively, they lack the education and

Trivia question

Although State Affairs tracks legislation in 50 states, this office only monitors 49 state houses. Why? (Answer at end of article.)

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training necessary to perform complex surgical procedures. It is vitally important that patient safety and quality of care be the top concerns when legislators consider proposals to expand scope of practice.

**Office-based surgery**

In 2003, the College and other national societies representing surgeons, anesthesiologists, and accreditation organizations collaborated to develop and adopt a set of 10 patient safety principles for office-based surgery involving moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia. (For more information, visit [http://www.facs.org/fellows_info/statements/st-46.html](http://www.facs.org/fellows_info/statements/st-46.html).) The College has been publishing its own *Guidelines for Optimal Ambulatory Surgical Care and Office-Based Surgery* since 1994.

At least 19 states have adopted regulations pertaining to office-based surgery, with Arizona, Indiana, Kansas, and Oregon considering doing so in 2006. The College encourages states in the process of implementing regulations or guidelines for office-based surgery involving moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia to consider using the College’s published principles as a basis for these regulatory efforts.

**Trauma**

Trauma centers and emergency departments have been negatively affected by a lack of specialists resulting from medical liability problems, uncompensated care for uninsured or underinsured patients, federal regulations requiring the provision of care for all patients, and the ever-increasing cost of providing emergency care. The College supports efforts by its state chapters, state Committees on Trauma, and other stakeholders to raise revenues to alleviate some of the funding problems. States and counties have addressed this problem through the following activities: increasing the tobacco tax and allocating some or all of the increase to the trauma system; assessing a surcharge on driver’s licenses or renewal of automobile license tags; adding extra fines on motor vehicle violations, including driving under the influence; and permitting voters to decide to increase the county sales tax (as happened in Los Angeles) with these funds exclusively allocated to trauma care.

Other trauma-related issues include the repeal of alcohol exclusion laws (also known as Uniform Accident and Policy Provisions) and development and implementation of state trauma systems.

**Supporting chapters**

The State Affairs staff at the College is always available to provide support and advocacy resources to interested surgeons and chapters. Some chapters have chosen to focus their efforts on physician reimbursement, whereas some state Committees on Trauma have taken an active role in attempting to pass legislation regarding motorcycle helmet laws or motor vehicle child safety restraints. No matter what the issue, the staff at the ACS can help in a variety of ways, including the following:

- Hosting chapter advocacy activities, such as advocacy training workshops, issue and legislative briefings, and lobby days at the state capitol.
- Assisting in chapter legislative strategy and development by identifying trends, drafting legislation/model legislation, analyzing bills, providing testimony for committee hearings, and mobilizing the grassroots activities.

**SSLAC**

The College sponsors the Surgery State Legislative Action Center (SSLAC), a Web-based advocacy site supported by more than a dozen surgical specialty societies. The SSLAC ([http://capwiz.com/sslac/home/](http://capwiz.com/sslac/home/)) enables these societies to send action alerts to their members, directing them and their colleagues to send targeted e-mails, make coordinated calls, or send faxes to state legislators to encourage action (or nonaction) on a bill. The Web site can even be configured to send letters to the editors of local newspapers for a media campaign. Use of the SSLAC increased from 682 users in 2004 to 1,534 users in 2005, with more than 3,000 letters sent to state legislators. The SSLAC also allows surgeons to identify their elected officials.

**ACS Cross Country**

A monthly newsletter devoted to state issues, *ACS Cross Country*, is published on the College’s Web site. Chapters may submit story ideas or photos, and a variety of state legisla-
tive and regulatory issues are highlighted in an easy-to-read format. To access the current issue and back issues, visit http://www.facs.org/ahp/crosscountry.html.

**StAR program**

The State Advocacy Representative (StAR) program is open to any Fellow or chapter administrator with an interest in state legislative activities. StARs serve as the “eyes and ears” of the College at the state level and are often involved in state advocacy efforts through their chapters, state specialty societies, or state medical associations. At this time, there is at least one StAR in each state.

Ultimately, the StAR program is about information sharing. StARs participate in conference calls several times a year to exchange information with the College and their counterparts. The StAR regions are organized using the same regional structure as the Committee on Trauma, with multiple regions sharing a conference call. StARs may participate in any call but are encouraged to call in during their region’s specified time.

**Coalition participation**

Participation in national and multispecialty coalitions is another way the College stays on top of national trends in state legislation. Two coalitions were formed in 2005 in response to state legislative trends. The state-level Coalition for Patient-Centered Imaging is a group that was developed when several specialty organizations noticed an onslaught of bills attempting to restrict surgeons from performing magnetic resonance imaging, computed tomography scans, or positron emission tomography scans, “except for a radiologist group practice or an office consisting solely of one or more radiologists.” Another coalition focuses on combating provider taxes and includes corporate partners as well as state medical society representatives.

Not all coalitions focus on a single issue. The Chicago area is home not only to the American College of Surgeons and the American Medical Association but many other national specialty societies. Chicago Area State Affairs Staff, for example, meets each quarter to trade information, discuss successful legislative strategies, and learn about the issues facing other medical specialty organizations.

**State advocacy success**

Although the College strongly supports state advocacy activities and provides numerous resources to assist chapters and Fellows in these efforts, state advocacy only works when individual surgeons get involved. Constituents talking to legislators, writing letters, visiting the state capitol, attending hearings on proposed rules and regulations, and participating in local elections are the tried and true activities.

Surgeons interested in getting involved in advocacy efforts in their states, finding out about current legislative issues, or wanting to alert the College’s State Affairs staff about potential issues should contact Melinda Baker, State Affairs Associate, in the College’s Chicago office, at 312/202-5363, or e-mail mbaker@facs.org.

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**Trivia answer**

The Nebraska legislature is unicameral and nonpartisan and, therefore, only has a state senate.
Generations of graduating medical students have been drawn to a career in surgery for various reasons: a love of the operating room, the privilege of a patient’s trust, an appreciation for immediate and tangible results in patient care, a reliance on the laying on of hands in a time when great technological advance has physically distanced most medical professionals from their patients, and the opportunity to engineer and translate advances in basic science to the bedside.

Although these motivations have really not changed significantly over time, the world landscape is shifting on an unprecedented scale. We live in a continuously globalizing world that is integrating across a wide range of disciplines, from expansion of trade in goods and services to the related interconnectedness of the international economy and the increasing movement of people across borders. Moreover, the ongoing revolution in information technology is eliminating preexisting barriers of distance in sharing knowledge.

The fruits of this globalization, however, have not been equally shared. In the health care field, there have been significant improvements in life expectancy and infant mortality rates in indus-

Surgery and global health:
The perspective of UCSF residents on training, research, and service
by Doruk Ozgediz, MD, MSc; Kayvan Roayaie, MD, PhD; and Jennifer Wang, MD, San Francisco, CA
triaized countries in the last 50 years—but the gap between the quality of life of the world’s rich and poor populations grows in a largely unabated fashion. This is true both between countries and, perhaps to an even greater degree, within countries.

In this shifting and integrating global context, many of us as surgeons and health professionals were drawn to the surgical field for reasons other than the factors cited above. Mindful and disturbed by the growing gap in global health equity, we wanted to develop portable skills that could be used in a wide range of settings to help directly improve access to medical and surgical care to underserved populations in the world community. A survey of all residents in our program at the University of California, San Francisco (UCSF), showed that 90 percent of residents have a strong interest in a surgical experience in a developing country during residency. More than 40 percent of entering interns already have some international experience during medical school. This rate is not surprising, given the proliferation of international opportunities offered to students in medical schools across the country and the expanding role of international health in undergraduate medical curricula around the world.

Despite this great interest, until recently our residency program, as in most other programs, had no structured overseas opportunities for residents or faculty members. Those faculty members who do participate in international activities largely do this on a voluntary basis outside the auspices of their formal academic responsibilities. For residents wishing to pursue a career or develop the required skills to integrate surgery and global health, public health, or aspects of health policy, there are few mentors available. But these activities should no longer be sidelined as part of the training process—they should be an essential element of the mission of the leading academic surgical training institutions in this country. These activities directly complement the academic mission of education, research, and service.

**Benefits to surgical education**

The multifaceted educational benefits of clinical work in developing countries have been well-documented in surveys of trainees who participate in these activities, including previous reports in the *Bulletin*. First, in these settings with limited resources, there is an increased emphasis on precise history-taking and physical examination. In U.S. hospitals, we take for granted advanced technological diagnostic aids such as computed tomography scan and magnetic resonance imaging in patient management, luxuries unavailable in most environments with only basic resources. As residents, we have endured a host of cases in our weekly morbidity and mortality conferences, which have exhorted the simple principles of closer patient contact and more exact physical exams, and spoken against unnecessary diagnostic tests that have sometimes delayed surgery or misdirected therapy. A limited resource environment fosters creativity in treatment and challenges decision making, and in return makes us more cost-conscious clinicians.

Training in what is called general surgery in the U.S. has been gradually reduced to an increasingly narrow range of surgical conditions, with ongoing debates about the actual viability of the discipline. But a wider perspective that includes the developing world reveals that surgeons still perform a broad scope of truly “general” operations. Indeed, because of limitations in surgical manpower, most of the surgical care provided in developing countries is done not by surgical specialists, but by general medical doctors or paramedical cadres. But work in underdeveloped environments hones our adaptability across surgical disciplines and challenges the notion that we must train to be super-specialist surgeons to care for patients in the modern era. We are also exposed to surgical conditions that we simply do not see in the U.S., such as tropical surgery, and more varied surgical infectious diseases. How many of us are familiar with the presentation and management of buruli ulcer, noma, or obstetric fistula? These surgical conditions all preferentially affect impoverished patients in developing countries.

Work in these settings also cultivates our cultural sensitivity as we care for patients and families with dynamics, relationships, and competing priorities that are considerably different from our own and learn from the overall context of poverty and public health in developing countries.

Enrollment in general surgery programs has steadily been in decline across the country, and this has been under great scrutiny over the past
The role of surgery and public health

Surgery has typically been sidelined as a part of the global public health agenda, largely because of the emphasis on primary prevention and community health promotion programs since the 1976 Alma Alta Declaration and because of the notion that in the spectrum of health interventions, surgery is at the curative, “high-tech,” cost-ineffective, individually focused end. Research in the global health community is currently focused on the significant morbidity and mortality imposed by infectious diseases such as human immunodeficiency virus (HIV), tuberculosis, and malaria. Although this focus is warranted, recent evidence shows that surgical conditions account for up to half of the global burden of disease. This burden can only be expected to grow, especially with the increasing share of injury, obstetric conditions, and noncommunicable diseases in developing countries.

By 2020, injury is projected to rank third behind ischemic heart disease and depression in the global burden of disease as developing countries rapidly urbanize and motorize. Only one-third of severely injured patients in rural areas of developing countries ever reach medical care. The Essential Trauma Care guidelines developed by the World Health Organization provide a promising blueprint for trauma systems development in resource-constrained settings and suggest that much can be done at low cost. These guidelines are currently being piloted in Ghana, Mexico, and Vietnam. The substantial burden imposed by perinatal and obstetric emergencies has also been recognized and the reduction of maternal mortality is one of the eight health-related development goals set by the United Nations in 2000.

Disease trends in developing countries also show an increasing trend in noncommunicable diseases such as neoplasms and cardiovascular diseases, particularly in heavily populated countries in developmental transition such as India and China. These countries and others in epidemiologic transition face the challenge of a “double burden” of disease, of coexisting early childhood mortality, and of chronic disease. Contrary to what might be expected, a number of studies suggest that surgery may be as cost-effective as other population-based public health interventions.

Although surgery is an essential part of health systems worldwide, there are minimal standards for the organization and delivery of surgical services in developing countries. This is partially because of the neglect of the hospital sector in developing countries, even though it consumes 50 percent to 70 percent of the health care budget in most countries. The surgical manpower shortage is only part of the increasingly recognized gap in human resources in health. Even for emergency operations such as cesarean section (10% of those in need do not receive one) and strangulated hernia (30% of patients go without surgical treatment), there is tremendous unmet need for surgery. Over the years, this lack has been met through various strategies such as overseas volunteers, intermittent outreach programs to rural areas of developing countries, and through training of paramedical cadres to perform surgery. It is still unclear how to determine which strategy is most appropriate in various settings or how more sustainable services can be provided.

Even with the significant burden of disease imposed by surgical conditions, very little is known about the epidemiology and natural history of surgical conditions in developing countries, the efficacy and cost-effectiveness of treatment in various settings, or the development of sustainable surgical services within the health systems of developing countries. The research agenda in global public health is still essentially set by major donor organizations from wealthy countries, as reflected in what is called the “10-90 gap,” which shows that 90 percent of global health research concerns conditions that affect only 10 percent of the world’s population. This also affects incentives for drug development and innovations in medical technologies, which are preferentially geared to diseases that affect industrialized countries. Furthermore, available evidence is published mostly in journals based in northern countries that are often pro-
hibitively expensive for many academic centers in the developing world, even with Internet access. The nascent movement in open access publishing and an associated focus on developing drugs and technologies for neglected diseases is a promising first step in attempting to right this imbalance.25,26

Leading academic institutions should support the generation of this knowledge, and skills in epidemiology and the core disciplines of global public health such as health policy, health systems, and economic evaluation should be regarded in the same Halstedian tradition as the requisite skills required in developing surgical scientists. “Translating” the bench to the bedside is a frequent discussion; translating our surgical innovations in the other direction—to population-level interventions that must be creatively adapted in various settings around the world—must also be considered. In many developing countries, surgical research is considered a luxury—U.S. surgeons have the opportunity to share resources and ensure that this is no longer the case.

Service
A wide range of international nonprofit organizations focus on providing essential surgical services to populations in need. Historically, the typical model for these organizations has been short-term volunteer missions—though this has been gradually changing with a greater consciousness of incorporating training and capacity building to promote sustainable service delivery.27 When most surgeons consider international health, the general focus is still on volunteerism, though there is a need to move beyond this to consider training and skills development. Perhaps most importantly, there is currently minimal coordination between all of these
organizations and no consensus on where the greatest needs are (globally) and how these can be met. The academic surgical community should be an integral part of this discussion.

**Development programs abroad**

Most other industrialized countries have established programs—both through their national surgical associations and through the efforts of individual academic institutions—to prioritize collaborative programs with developing countries to promote global surgical development. The University of Toronto provides an excellent example of what is possible through its office of international surgery and its close collaboration with the Canadian Network for International Surgery. The University of Toronto hosts the annual Bethune Round Table Conference in International Surgery, which focuses on collaboration and surgical development in developing countries, and runs the Ptolemy project, which has provided free online access to the university’s electronic library for surgeons in East Africa. The Canadian Surgical Association has also taken a leadership role in working with the College of Surgeons of East, Central, and Southern Africa in determining priorities in development and in supporting the *East and Central African Journal of Surgery*. The Royal College of Surgeons of England has had a long-standing overseas doctors training scheme, which allows training opportunities for surgeons from developing countries. Increasingly, some surgical training programs in the U.K. are considering mandating overseas work for their postgraduate students; the effect of the work-hour limitations on reducing their breadth of training has also played a part in this. There are similar overseas opportunities for trainees in Scotland, Australia, and New Zealand.

Currently, the College has active international programs through the Committee on Trauma, and the recently reported delivery of the Advanced Trauma Operative Management course in West Africa was encouraging. In addition, the launch of Operation Giving Back provides American surgeons with a comprehensive database for volunteering abroad. Nonetheless, although the focus on volunteerism is important, there is much more that can be done in terms of systematic collaboration with other national surgical societies and academic institutions abroad. Our colleagues in orthopaedics provide a promising example of what is possible through the American Academy of Orthopaedic Surgeons (AAOS). The AAOS has partnered with the not-for-profit organization Health Volunteers Overseas (HVO), which focuses preferentially on training through short-term volunteer missions. The HVO is sponsored by 12 national societies (including Anesthesia Overseas) and has established sites and infrastructure to promote volunteerism in 25 developing countries. The AAOS runs annual courses in orthopaedic surgery in developing countries for interested volunteers.

**Surgical collaboration with Uganda**

The evolving surgery and global health program at UCSF was spurred through aforementioned resident and faculty interest. There is already substantial interdisciplinary work in global health at UCSF through the Institute for Global Health and UCSF Global Health Sciences, in hopes of bridging basic science, clinical service, and public health through international partnerships. Almost all of the UCSF senior residents in orthopaedics volunteer for a month of clinical service in South Africa, and more than half of the senior medical residents volunteer at a HIV outreach program in Uganda. In both programs, participating residents report these experiences as the “best” of their residency. Early studies of the orthopaedic elective also show that participants continue to volunteer abroad after completion of their residency.

Building on the preexisting relationships across disciplines, the department of surgery at UCSF initiated a discussion with the surgery department at Makerere University in Uganda to discuss potential collaboration in training and research. To date, we have pilot a visiting clinical experience for several UCSF residents and have developed multiple promising research collaborations. In addition, UCSF is beginning a Cross-Residency Area of Concentration Program in Global Health to foster a community of residents who will study global health issues and conduct a project overseas.

**Context of health care in Uganda**

Uganda has a population of 25 million and is one of the least urbanized countries in sub-Saharan Africa with an 80 percent to 90 percent rural population. Life expectancy still lags at 48...
years for men and 51 years for women, and overall, Uganda ranks 147 of 175 in the United Nations Human Development Index, a composite aggregated measure of development. Uganda gained independence from Britain in 1962 and had one of the best functioning health systems in Africa until the civil conflict of the 1970s and 1980s. In the international public health community, Uganda has been praised for its progress in controlling HIV and acquired immune deficiency syndrome (AIDS), with a decline in prevalence rates from 32 percent in 1992 to the current 6 percent reported rate, though there is regional variation.

**Surgical services/training**

The hospital system in Uganda, like most others in Africa, is based on national, regional referral, and district hospitals. There are approximately 100 specialty-trained surgeons in the country, predominantly concentrated in Kampala, the site of Mulago Hospital, the 1,200-bed national hospital. Uganda produces approximately 150 physicians a year through the medical schools at Makerere University in Kampala and Mbarara University in western Uganda. Makerere University has a rich academic tradition as one of the leading institutions in East Africa, and physicians enter the postgraduate program in surgery usually after several years of independent practice in rural areas. The postgraduate (master’s degree) program lasts three years, with one year of didactics and two years of clinical work culminating in a master’s thesis. The surgery department encompasses all specialties except orthopaedics, which has its own training program and has produced approximately 10 specialty-trained orthopaedic surgeons. There are no other subspecialty training programs in
this program, so graduates go abroad to acquire further training. For example, Uganda has three pediatric surgeons and two neurosurgeons for the whole country. This proportion is actually greater than exists in most of Uganda’s immediate neighbors and counterparts in sub-Saharan Africa.\textsuperscript{38,39}

In an effort to improve access to emergency surgery, the Ugandan Ministry of Health is attempting to bring surgical care closer to the rural poor by building operating rooms at the sub-district level. Part of the impetus for this new policy is Uganda’s high maternal mortality rate, at 500 per 100,000 births, and the associated need for improved access to emergency obstetric care, including cesarean sections.\textsuperscript{40}

**Voluntary clinical experience**

At the kind invitation of the department of surgery at Makerere University, several UCSF residents have visited in a clinical capacity, spending a month at Mulago hospital working with our Ugandan postgraduate counterparts, and two weeks at Nsambya Hospital, a 300-bed mission hospital in Kampala. Nsambya is one of several mission hospitals of similar size in Kampala. Residents participating in the program did so during their two years of research, which usually occurs after three years of clinical training in the U.S. Besides assisting in patient care and working with the residents, UCSF residents also conducted medical student teaching sessions in the classroom setting and at the bedside.

At Mulago Hospital, trauma accounts for more than 70 percent of emergent admissions and operations, and injuries resulting from road traffic crashes predominate; furthermore, there is a heavy burden of head trauma resulting from motorcycle taxi drivers and their clients traveling without helmets.\textsuperscript{41} Burns in children exact high morbidity and mortality rates and are challenging to manage without the benefit

All anesthesia in the operating suites was performed by hand-ventilation.

Buruli ulcer
of a sterile environment. Patients presenting with abdominal pain and peritoneal signs may turn out to have a small bowel perforation from typhoid fever, tuberculous peritonitis, or bowel obstruction—conditions rarely encountered in the U.S. Postoperative fevers are often caused by malaria. Among patients on the surgical wards, 30 percent suffer from HIV, often unmanaged because of the limited availability of antiretroviral medications, though this is slowly changing. In women, cervical and breast cancer are leading causes of cancer death, and it was alarming to see many young women presenting with advanced stages of both, as there is no screening program for either disease. There are only two mammography units in the country and limited capacity in personnel and equipment for cytology departments to develop pap smears. In addition, Uganda also has a high incidence of lymphoma. Furthermore, endemic and AIDS-related Kaposi sarcoma present frequently and require surgical intervention.

Patients often arrive at a significant delay after their injury or their first symptoms because of barriers in transport and the lack of any prehospital care system. Visitors from UCSF witnessed several patients die of appendicitis resulting from extremely advanced presentation and sepsis. Generally, diagnostic radiologic studies are limited to plain films, if film is available, and laboratory studies may similarly not be dependable. Though there is a computed tomography scanner at Mulago, it cannot always be used because of issues of cost and function. Therefore, decisions to operate on patients are often based largely on history and physical examination alone.

Resources in the operating room are austere, particularly in terms of anesthesia. Cases are completed without cardiopulmonary monitoring and pulse oximetry, and patients are hand-ventilated through operations, with halothane used most frequently. Suction and cautery, which we depend on heavily in the U.S., are often not functional and surgical instruments are of the most basic variety. Bowel staplers, which are taken for granted in surgical training, are not available, and all anastomoses must be hand-sewn. We visitors were reminded of the wise words of one of our surgical attendings at home who still sews all bowel anastomoses to provide residents an experience they may otherwise not encounter in the course of residency training: Don’t always depend on technology, and be proficient in basic surgical skills. Economy must always be considered through the sparing use of all supplies generally taken for granted, such as suture. It was important to observe that patients can still have positive outcomes without the dense overlay of technology to which surgeons are accustomed in the U.S.

During the pilot clinical experience, we benefited greatly from the relationships with our Ugandan resident counterparts. We debated dilemmas in patient management and developed strategies around issues of broader collaboration. We were extraordinarily struck by the discipline and commitment of the postgraduate students and other health care staff, especially in the context of extreme resource constraints. In addition, the devotion of families, who assume much of the responsibility of patient care at the bedside on crowded wards, was inspiring.

Ethics and reciprocity
Working in an environment with limited resources, representative of the surgical resources available to the majority of the world’s population, we were forced to revisit fundamental questions about the extreme global imbalance in resource allocation. The most basic emergency surgical care is still not available in most of the world, where undernutrition contributes to millions of childhood deaths worldwide. If access to basic medical and surgical care is a fundamental
human right, then how can these disparities be allowed to persist? A broader view of the world’s surgical needs and sharing of resources through partnerships is a mandatory part of what should be done to correct this gap.

With regard to the UCSF program, it will be critical to develop reciprocity to meet the collaborative needs of the surgery department at Makerere University. We aim to provide similar clinical and research opportunities for the Ugandan trainees in the U.S., and more structured opportunities for faculty exchange. Challenges we face to make this happen currently include funding, legal issues, and licensure. We have already embarked on several areas of collaborative research and training, including training in research for injury prevention and trauma care, as well as another program in breast cancer prevention, diagnosis, and treatment. These programs must be designed carefully with the shared objective of capacity building to avoid exacerbating the “brain drain”—the migration by the highly trained “best and brightest” to more developed countries—that already plagues many developing countries.

Conclusion

This initiative from UCSF, although in its infancy, is gradually evolving, and the collaboration is met with great enthusiasm from faculty and residents in both the U.S. and Uganda. It is the kind of partnership that should be forged by all leading academic institutions and surgical associations to promote global surgical development. The results of such an initiative will only be apparent with time.

As specialists in health care and also as American citizens, surgeons cannot lose track of the current world political climate. The time is ripe for an emphasis on more positive forms of collaboration and sharing of resources with our partners abroad. Our current generation of surgical trainees must take a leadership role to promote a broader perspective in ensuring a more cohesive global community.

References


Dr. Roayaie is a resident in general surgery at UCSF.


42. Personal communication with Keith McAdam, director of Infectious Disease Institute, Kampala, Uganda, regarding preliminary data from Mulago hospital study; April 2005.
Is it possible to justify introduction of a new, innovative, international component into the surgical curriculum at a time when vast—or “cataclysmic,” as some say—changes are occurring in American postgraduate surgical education? Is there value—educational, professional, or otherwise—in assigning an American surgical resident to an international training milieu in which clinical facilities generally lack ancillary support, modern equipment, and adequate staffing, given that U.S. programs adhere to strictly limited resident work hours, have access to sophisticated technology, practice early tracking to narrow subspecialties, and socialize residents as employees of large health care systems? Residents at the University of California, San Francisco (UCSF), have answered affirmatively, adamant in their demand for exposure to international health as a critical element of their training.

Senior surgery faculty members have focused their attention elsewhere: responding to the 80-hour workweek, evaluating the extent to which the six areas of competency are fulfilled within the framework of our training program, and addressing the problem of steadily declining revenues threatening the viability of academic programs; but our residents have independently identified areas and venues of training that will enhance their surgical education and, more importantly, that they believe are essential to it. In particular, residents perceive the inevitability and existence of globalization and the resulting distressing inequity that exists between industrialized and developing nations. This polarization is particularly underscored by the disparate access to health care and consequently the tremendous economic burden and stress that surgical disease places on less modernized countries. Recognizing the potential multifaceted impact globalization has on residents’ surgical training and professional careers, our residents forged ahead and defined opportunities for mutually beneficial educational programs, specifically with the department of surgery at Makerere University in Uganda. Although initially reluctant to support such a program, our senior faculty members were finally convinced of its merits. We applaud our residents for their tenacity and credit them with being the architects and pioneers of a well-received pilot exchange program.

Why did our residents invest significant effort to develop this program and bring it to fruition? A simple explanation is that it was merely the creative élan inherent of youth and their fresh, unencumbered vision of the world. But, in fact, the explanation is far more complex. Our leaders in academic surgery may be guilty of selling this generation of surgical residents short: We have
repeatedly opined at national meetings and in publications of a generation of residents more concerned with improving their lifestyle than advancing medicine. Under mandate, we enforce work hour rules that extract residents from the operating room in the midst of complex procedures, with obvious consequence to time spent teaching and learning, and we have essentially eliminated them from direct patient care responsibility. The emphasis of residency instruction has strayed from teaching our trainees to go beyond parochial barriers to serve the sick and has been eclipsed by a honing of their ability to record work hours. But our residents are deeply motivated to participate and define the type of training they receive, transcend the rigidity of bureaucratic regulation, and embrace the practice of their profession with passion, and we applaud and support them in these efforts. Rather than only passively participating in lectures on professionalism, these young surgeons intend to live a life of professionalism.

How does an international rotation help trainees achieve their goals and strengthen our department’s curriculum? As the effectiveness of a surgery program is now judged by qualitative success in six specific areas of competency, following is a brief, somewhat subjective, analysis of the potential impact an international program may have on these components.

**Medical knowledge**

An international experience will challenge surgical trainees with diseases rarely seen in the U.S., broadening their breadth of medical/surgical knowledge, actual experience, and ability to treat the more unfamiliar clinical problems. As communities in the U.S. and abroad reflect increasingly ethnically diverse populations, and in light of the exposure and mobility offered by recreational travel, the additional knowledge and skill trainees acquire will undoubtedly prove particularly useful.

**Patient care**

As sophisticated technology and equipment are often unavailable in developing countries, trainees will likely rely far more on the history and physical examination for diagnosis and management decisions. In effect, the focus of care shifts back to the patient as careful attention is given to what the patient says and physically presents with, which the physician/surgeon must interpret. Trainees, thus, will nurture and improve the scope, flexibility, and creativity of their response to clinical problems as they explore alternate solutions to therapeutic and technical problems.

**Professionalism**

Perhaps there is no better way to develop and heighten professionalism than exposure and firsthand experience in underserved areas void of adequate facilities, advanced technology, and presence of sufficient numbers of health care workers. By participating in an international training program, trainees, in all likelihood, will provide...
care to an underserved population. By directly witnessing the day-to-day and lifelong hardship confronting underserved populations—coupled with the frustration of their own limitations in this setting—trainees will be imbued with an appreciation of the scope of the human condition. It will instill in them sincere compassion for those they serve, well after and beyond the context of this experience. At the same time, they will develop an inevitable admiration and respect for their colleagues who have chosen to dedicate their practices to serving these communities. If the values system of our society as a whole remains intact, then we would hope these experiences and their inherent message of respect, dignity, and service will emerge as components of the trainees’ professional credo.

**Interpersonal and communication skills**

Cross-cultural communication can prove challenging. Language barriers and culturally specific perspectives and behaviors can contribute to misunderstandings and delay in delivery of patient care. Still, however difficult a learning curve this area may present, there is no doubt that training in a cross-cultural environment is likely to improve trainees’ overall communication skills, including their ability to effectively work cooperatively. The effort to address, develop, and improve this area of competency would be well invested.

**Practice-based learning and improvement**

An international program admittedly would be unlikely to have a major effect on the practice-based learning and improvement competency, other than to provide exposure to vastly different practice modes and environments. Residents would be involved in practice-based learning and improvement regardless of the venue of training.

**Systems practice**

The addition of an international component to the curriculum will involve the residents directly with globalization. It may be that, as the impact of events on either a national or international level blurs boundaries, trainees will conclude that a philosophy of professional and personal distance and detachment is simply no longer a realistic posture. Their participation and contributions will be concrete among an increasing interdependence of national and worldwide health systems and problems.

Finally, this program could serve as the blueprint from which other institutions model similar programs. In addition, as this international rotation matures, it may significantly expand basic science and clinical research, providing a gateway for collaborative opportunities between our institution, Makerere University, and other academic programs in Uganda and other regions in Africa. Certainly the potential to conduct public health and epidemiologic studies is a considerable benefit.

Convinced of this pilot program’s promise of enhancing our residents’ surgical training, our faculty looks forward with excitement and enthusiasm to collaboration with our colleagues at the Makerere University and our respective residents. Our goals are an improved educational experience for the residents of both institutions, closer academic and clinical ties between our two universities, and increased research opportunities aimed at relieving the burden of surgical diseases in the developing world.

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Dr. Farmer is professor of surgery, pediatrics, and obstetrics; gynecology; and reproductive sciences in the department of surgery at UCSF, and surgeon-in-chief at the UCSF Children’s Hospital.
Socioeconomic tips

Two pesky CPT modifiers: –25 and –59

by the Division of Advocacy and Health Policy

The Current Procedural Terminology (CPT)* modifiers for a distinct procedural service (modifier –59) and for a significant, separately identifiable evaluation and management (E/M) service (modifier –25) are two troublesome modifiers, known by experts to be subject to misuse. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has recently performed audits of the use of these two modifiers in the Medicare program; the results shed some new light on exactly how these modifiers are misused.

The OIG randomly selected a sample of claims using modifier –59 or modifier –25 from a complete file of all Medicare claims submitted during a 12-month period. The OIG requested, and almost always received, medical records to support the use of the modifier and had certified coders review the records to see whether they met the standards for the use of the modifier. This article reports on the OIG’s findings and offers some tips on the use of the modifiers.

Distinct procedural service (modifier –59)

A surgeon may need to indicate that a service was distinct from another service that he or she did on the same date. To quote from the CPT, “This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries)....” In the case of Medicare, which uses Correct Coding Initiative (CCI) edits, and some other payors, which use similar types of edits, use of a –59 modifier bypasses the edits and both line items on a claim are paid. For the 12-month period ending September 30, 2003, Medicare allowed $245 million for services with a –59 modifier.

The OIG found that in 15 percent of the claims that used modifier –59, the services were not distinct from each other because they were performed at the same session, at the same anatomical site, and/or through the same incision. In another 25 percent of the claims, there were documentation deficiencies. Either one or both services were not documented in the medical record, or the documentation was insufficient to make a determination that the correct code was selected. In a few instances, the documentation showed that a different code should have been used for one or both of the services. Finally, in 11 percent of cases, the modifier was not attached to the code.

CPT modifiers –25 and –59

–25, Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

–59, Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier –59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician [emphasis added]. However, when another already established modifier is appropriate it should be used rather than modifier –59. Only if no more descriptive modifier is available, and the use of modifier –59 best explains the circumstances, should modifier –59 be used.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.
in the pair that had the lower price or lower total relative values.

Follow these tips to use modifier –59 correctly:
• Be sure a modifier is needed on the claim by reviewing the list of reasons a modifier –59 can be used. (See CPT definitions in text box, previous page.)
• Be sure a more specific modifier does not exist. The Medicare program recognizes modifiers in the Healthcare Common Procedure Coding System that are anatomically more specific than –59. These are useful when designating the side of the body or the digit that was involved in the operation.
• Check for the presence of an edit if you are billing Medicare. The CCI edits are widely available as part of billing or coding software packages. They also are available on the Web at http://cms.hhs.gov/NationalCorrectCodInitEd/.
• If separate diagnosis codes are appropriate, use them and link the diagnosis codes to the appropriate procedure code.
• Attach the –59 to the service with the lower price or lower total relative values.

Significant separately identifiable E/M service (modifier –25)
A physician may be scheduled to perform a surgical procedure but when the patient arrives, he or she says, “I have another problem.” The physician then provides an E/M service to address the new problem. Assuming the other problem is unrelated to the surgical procedure, CPT rules allow the surgeon to bill for both the procedure and the E/M service as long as the modifier –25 is appended to the code for the E/M service. In 2002, Medicare reimbursed $1.96 billion for approximately 29 million E/M claims using modifier –25.

The OIG reported that 31 percent of the claims were not properly documented and another 2 percent failed to meet the basic requirement for the modifier—that the visit and procedure were indeed separate. The –25 modifier may be used if the E/M service is separately identifiable or beyond the usual preoperative or postoperative care associated with the procedure.

There were also technical problems with the use of the modifier. One was that the modifier was placed on a service but only one service was billed on that day. On claims that did show two services on the claim, 28 percent of the providers using the –25 modifier attached it to the procedure code rather than the E/M code.

Follow these tips to use modifier –25 correctly:
• Be sure both a procedure code and an E/M code are being reported.
• Be certain the ground rules for the –25 modifier are met. (See text box, previous page.)
• Attach the –25 modifier to the E/M code.
• Use appropriate diagnosis code(s) on the claim and link them appropriately to the procedure code and the E/M code. Different diagnosis codes may be appropriate for some situations, but there will be other situations where the same diagnosis code is used for both the procedure and the E/M service.
• Be sure that the surgeon documented both the procedure and the E/M service. The documentation for the two should be clearly separated.
• Know whether your payor requires that you submit the documentation with the claim or submit the documentation only if the claim is reviewed. Even in the latter situation, it is important to have good documentation because you never know when you will have to supply it.

Conclusion
Documentation was a big problem with the use of both modifiers, with errors accounting for 25 percent of all claims for modifier –59 and 31 percent of all claims for modifier –25. It is so easy to give short shrift to documentation in a busy surgeon’s office, but the importance of good documentation cannot be underestimated. Payors have no choice but to take the attitude that “if it wasn’t documented, it wasn’t done.”

Herbert Chen, MD, FACS, assistant professor of surgery and chief of endocrine surgery, University of Wisconsin, Madison, was selected as the Year 2007 Australia and New Zealand (ANZ) Chapter of the ACS Travelling Fellow.

As the Travelling Fellow, Dr. Chen will participate in the Annual Scientific Congress of the Royal Australasian College of Surgeons in Christchurch, New Zealand, May 6–11, 2007. He will attend the ANZ Chapter meeting during that congress and will travel to several surgical centres in Australia and New Zealand.

Dr. Chen has previously been honored with a College award—in 2004, he was chosen to receive the Clowes Career Development Award.

The application deadline for the Year 2008 ANZ Travelling Fellowship is November 15, 2006. The requirements for the Year 2008 Travelling Fellowship will appear in the Bulletin and will be posted on the College’s Web site, www.facs.org, later this year.

David M. Lingle, MD, FACS, a general surgeon from Nas-sawadox, VA, has been selected to receive the 2006 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees. The purpose of the Oweida Scholarship is to help young surgeons practicing in rural communities attend the Clinical Congress and benefit from the educational experiences it provides.

The Oweida Scholarship is awarded each year by the Executive Committee of the Board of Governors.

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

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

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
The third Faculty Career Development Award for Oncology of the Head and Neck—jointly sponsored by the American College of Surgeons and the American Head & Neck Society—was announced to the Board of Regents in February 2006. Stephen Y. Lai, MD, PhD, assistant professor at the Eye & Ear Institute, University of Pittsburgh, PA, has been given the 2006-2008 award for his research project, Tumor Microenvironment Regulation of HIF-1 in Head and Neck Cancer Invasion and Metastasis.

This career development award is intended to provide support for clinical basic science or translational research in the study of neoplastic disease of the head and neck. The awardee receives support at a level of $40,000 per year for each of two years.

Dr. Lai

The ACS and AAST are offering this award jointly with the NIGMS as a means to facilitate the career development of individuals pursuing a career in surgical research. This award will provide financial support over and above that offered by the NIGMS K08/K23 mechanism. The application deadline is June 1.

For further details, please see the College’s scholarships Web page, http://www.facs.org/memberservices/research.html, or contact Kate Early, ACS Scholarships Administrator, at kearly@facs.org; tel. 312/202-5281.

MEDICAL JUSTICE, from page 15

ACS Traveling Fellowship to Japan available

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

**Purpose**

The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese 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 Japan, pursuing the following goals:

- To attend and participate in the annual meeting of the Japan Surgical Society, which will be held in Osaka, Japan, April 11–13, 2007
- To attend the ACS Japan Chapter meeting during that congress
- To visit at least two medical centers (other than the annual meeting city) in Japan before or after the annual meeting of the Japan 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 Japan Surgical Society and the Japan 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 Japan.

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 $7,500 U.S. to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society.

The selected Traveling Fellow must meet all travel and living expenses. Senior Japan Surgical Society and Japan Chapter representatives will consult with the Fellow about the centers to be visited in Japan, 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 Japan.

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 the final selection.

Applications for this traveling fellowship may be obtained at [http://www.facs.org/memberservices/acsjapan.html](http://www.facs.org/memberservices/acsjapan.html), 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 June 1, 2006.

The successful applicant and an alternate will be selected and notified by November 1, 2006.
International Guest Scholarships available for 2007

The American College of Surgeons offers International Guest Scholarships to competent young surgeons from countries other than the U.S. or Canada who have demonstrated strong interests in teaching and research. The scholarships—in the amount of $8,000 each—provide the scholars with an opportunity to visit clinical, teaching, and research activities in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons’ Clinical Congress.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS(Hon), former College Director. More recently, a bequest from the family of Abdol Islami, MD, FACS, and gifts from others to the International Guest Scholarship endowment have enabled the College to expand the number of scholarship awards.

The scholarship requirements are as follows:

• Applicants must be graduates of schools of medicine.
• Applicants must be at least 35 years of age, but no older than 44 years, on the date that the completed application is filed.
• Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
• Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of the applicant’s country.
• Applicants whose careers are in the developing stage are deemed more suitable than those who are serving in senior academic appointments.
• Applicants must submit a fully completed application form provided by the College on its Web site. The application and accompanying materials must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.
• Applicants must provide a list of all of their publications and must submit, in addition, three complete publications (reprints or manuscripts) of their choice from that list.
• Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment or a Fellow of the American College of Surgeons residing in their country. The chair’s or the Fellow’s letter is to include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes sealed by the recommenders. These letters are to be submitted with the completed application form.
• Applicants are required to submit a curriculum vitae of no more than 10 pages.
• Applicants may submit a photograph. (Passport size is preferable.)
• The International Guest Scholarships must be used in the year for which they are designated. They cannot be postponed.
• Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.
• An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

The scholarships provide successful applicants with the privilege of participating in the College’s annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses plus admission to all lectures,
demonstrations, and exhibits, which are an integral part of the Clinical Congress. Assistance will be provided in arranging visits, following the Clinical Congress, to various clinics and universities of their choice.

In order to qualify for consideration by the selection committee, all of the requirements listed previously must be fulfilled.

Formal American College of Surgeons International Guest Scholar application forms may be obtained from the College’s Web site (http://www.facs.org/memberservices/research.html) or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211 USA; fax: 312/202-5021.

Completed applications for the 2007 International Guest Scholarships and all supporting documentation must be received at the office of the International Liaison Section before July 1, 2006, to receive consideration by the selection committee. All applicants will be notified of the selection committee’s decision in November. Applicants are urged to submit their completed applications and supporting documents as early as possible in order to provide sufficient time for processing.

A look at the Joint Commission

Tracer methodology

The Joint Commission’s new accreditation process changes not only the way surveyors evaluate a health care organization, but also the way they interact with surgeons during the survey.

Surgeons can expect to play an integral role in the Joint Commission’s new tracer methodology, which guides the new survey process. Surveyors select patients to use their medical records as a roadmap to assess and evaluate standards compliance and the interaction and functions between departments and services. The number of “tracers” completed depends on the length of the survey. The average three-day hospital survey with a team of three surveyors typically allows for completion of approximately 11 tracers.

As part of the tracer activity, the surveyor will focus the questions to staff on the tracer patient. For example, a patient, “Mr. Smith,” has a surgical wound. The surveyor might say, “What steps did you take to reduce infection control risk?” Perhaps there were several health care professionals caring for Mr. Smith. The surveyor might ask the surgeon and nurses, “How did you communicate with each other while you cared for Mr. Smith, specifically regarding verbal orders?”

The Joint Commission’s new approach focuses on clinical care and how the organization prepares for the next patient, not the next survey. The tracer methodology also provides several opportunities for surveyors, surgeons, other staff, and leaders to share best practices.

Health care organizations will also use the tracer methodology as a management tool in their continuous operational improvement efforts, such as the annual periodic performance review, or PPR. This column will explore the PPR in the June issue.

Each month, this column will focus on activities of the Joint Commission that are relevant to surgeons. For more information on the Joint Commission, and to sign up for Joint Commission e-mail newsletters and announcements, visit www.jcaho.org.
Most practicing surgeons seem to believe that now is a bad time to be a surgeon. Concerns about physician autonomy, reimbursement, liability, and fragmentation of surgery have filled the surgical environment with pessimism. There are further concerns that this atmosphere might make surgery a less attractive field for students entering postgraduate training. It is at times like these that one must look to surgeons of the past to understand how they managed to get through difficult times and carry on the tradition of caring for others.

In 2002, Massachusetts General Hospital (MGH) completed renovation of the conference rooms in the department of surgery, including the Hurlbut Room—a conference room for residents. To discover how an unknown surgeon came to have a conference room named after him, I looked into his history and how his life made a difference in surgery. Although Dr. Hurlbut died before he was eligible for College Fellowship, I believe he provides a symbol of what a surgeon should be, and knowing his story can help present-day surgeons become recharged in our goal to accomplish the best we can.

The early years
Robert Satterlee Hurlbut, MD, was born in Cambridge, MA, in 1912. His father was the dean of Harvard College, and he spent his childhood attending Belmont Hill School. Unfortunately, there are not many records of Dr. Hurlbut’s childhood years.

Dr. Hurlbut attended Harvard College. Upon graduation, he married Sally Drew, of Newton, MA, and entered Harvard’s Medical School. He applied for the house officer examination at MGH in 1937, using as references his instructors Thomas Lanman, MD, FACS; Robert Zollinger, MD, FACS; and Henry Jackson, MD.

Dr. Lanman described Dr. Hurlbut as “one of the outstanding men of his class from the point of view of his qualifications for internship...well above average in the school and is outstanding in his ability to apply his knowledge.... I should place Hurlbut [sic] first on the list with Burbank a close second.” In full, Dr. Zollinger’s letter read as follows: “This chap is a nice appearing fellow with an excellent personality. He worked his cases up well and did not shirk. I can recommend him as a very desirable intern material.” Jackson’s letter cannot be found.

The intern examination
Dr. Hurlbut’s summary sheet for intern examination suggests he was in the middle third of his class and had a nice appearance. One person rated him as good to excellent, another said he was “OK,” and another said, in all capital letters, that he was “A-1 in every particular.”

Dr. Hurlbut endured the traditional intern examination. On the written exam, he answered a question that described the management of a patient with small bowel obstruction. He accurately and succinctly described the contraction alkalosis with consequent serum and urine electrolyte abnormalities to be found. His recommendation of administering 5 L saline might be a little generous by
today’s standards, as was his recommendation of giving 1 to 2 L saline as a clysis to “keep the fluid in.” But in his description of this case, the fictional patient never got past fluid resuscitation before time was called.

Also on the written exam, he described his attraction to the field of surgery, tracing it to an elementary course in anatomy taught at Belmont Hill School by R. Heben Rowe, MD, who he called “a most stimulating and interesting man.” He described having worked with Sir Wilfred Grenfell, MD, in Labrador, caring for various surgical problems and performing simple operative procedures. He describes his fondness for operative manipulation as follows: “The feel of instruments gives me a keen sense of pleasure. The cleanliness, skill, speed, and technique of an operation seem to be the height of what one can do manually.” He summarized his reasons for pursuing a career in surgery with the following statements:

- “Because I love to use my hands.”
- “Because you are doing something definite for the patient.”
- “I do not expect to be any great figure in the surgical field, but I should like to have the reputation of being a good doctor to whom any man would be willing to entrust his case. My plans for the future are that if it is humanly possible, I should like to practice in Boston. Surgery in Boston is difficult for there are so many good men in the field, but I sincerely hope that the old adage of ‘Where there is a will, there is a way’ will hold true.”

Dr. Hurlbut also indicated he expected to be in training for five to six years—at that time, there was no set period for surgical training, though records of MGH residents at that time suggest that the average was four to five years. Of course, when speaking of his future, Dr. Hurlbut could not have known that the world was soon to enter a war that would change his plans.

Dr. Hurlbut received a grade of A— for the written exam and A— for the oral exam, and in 1939 he was admitted to East Service as a pup from January to March. He then served in the urology, outpatient department and emergency ward and junior ward for the remainder of the year. In 1940, he served as third assistant resident from January through mid-June, and then, at his request, was named second assistant resident in pathology (without stipend) from the end of June through February. Following this residency was a five-month stint on Baker/Phillips House, five months in the outpatient department, a two-week vacation (the only of his entire residency), and four months on the male and female wards.

Dr. Hurlbut’s performance as a resident is not widely documented, as the evaluations of the day were not as extensive as today’s. However, there are two performance evaluations available. Maurius Smith-Peterson, MD, FACS, had stated that Dr. Hurlbut made an excellent impression on the entire orthopaedic staff: “His presentation of cases is done with great accuracy and emphasis of important points and apparently with the greatest of ease. He has a fine mind: we hope his hands will function as well as his brain when he gains more surgical experience.” And A.W. Reggio, MD, stated, “Dr. Hurlbut handles the patients very well. Absolutely satisfactory.”

World War II

After his residency assignments, Dr. Hurlbut was released for availability to the Armed Forces in July 1942. Though he had hoped for assignment to sea duty—he had experience sailing the Atlantic Coast—his first two months of active duty were spent at Chelsea Naval Hospital. Nearly half the physicians had trained at MGH, so Chelsea functioned essentially as an annex to MGH. Dr. Hurlbut was satisfied with this assignment, as there were plenty of opportunities for performing surgery.

He was soon transferred to the Naval Aviation Cadet Selection Board, First Naval District Headquarters, better known as the “USS Concrete.” He spent five miserable months performing physical examinations on prospective aviators while campaigning for reassignment. He was so obsessed with performing active duty in the war that he threatened to resign his medical commission and take a commission as a line officer (which he was entitled to do because of his Navy Reserve Officers’ Training Corps experience). He spent a month at Harvard as a physician of the V-12 program, a shortened medical
school course to provide physicians for the war effort. He was also assigned as a medical officer to the USS Halligan, DD-584, a 376-foot, 2,100-ton Fletcher-class destroyer, which had been built in four months in the Boston Navy Yard. Dr. Hurlbut had watched the ship being built and took great pleasure in outfitting the sick bay. Francis Moore, MD, FACS, said in his obituary of Dr. Hurlbut that he “…spent many days collecting the right equipment for sick bay with all the same loving care with which he would have outfitted the cabin of his schooner in days of peace, or his new office had he been going into practice.”

**Exploits of the Halligan**

After a shakedown cruise, the Halligan spent a five-month deployment in the Atlantic, the highlight being an escort ship for Roosevelt to the Teheran conference, and several months of anti-submarine warfare off the coast of North Africa. The ship was then sent to the Pacific, transiting the Panama Canal in January 1944. Dr. Hurlbut described medicine on a destroyer as being limited but varied. He believed he was “a general practitioner in every sense of the word. He reported that “the ‘worm’ has been extracted more than once” and that all seven cases of tendon repair had healed uneventfully. Dermatology was his biggest challenge, with what he called “bizarre eruptions which I defy some of the most eminent men in the field to diagnose.” When in port, Dr. Hurlbut would take sick call in the base hospitals as a method to keep up with advances, and he found that the surgeons at base hospitals were always glad to have him scrub in on surgical cases.

In addition to his medical duties, Dr. Hurlbut served as morale officer on the Halligan. Much of his free time was spent as an assistant navigator and standing deck watches at sea or working in the communication department. During general quarters, he was
armed with a movie camera to take official pictures of the action. He also carried with him his accordion—his “belly Baldwin”—with which he entertained frequently.

The Halligan was involved in the invasion of the Philippines, entering Leyte Gulf in late October. The ship survived numerous air attacks, including an instance when two bombs passed between her stacks and struck the water without exploding. The next assignment was the invasion of Luzon, where the shipmates downed numerous fighters and kamikaze planes, and then Iwo Jima. During one of these battles, Lt. Terry E. Lilly, Jr., MC, another physician, reported that Dr. Hurlbut had made a startling discovery: a sailor who had been standing on the deck of his ship was injured when there was an explosion on a nearby ship, and “In the operating room, while irrigating a deep shrapnel wound of the buttock, Dr. Hurlbut found there and removed unharmed a fish, two and one half inches long—weight unknown!!!” There are numerous references to other humorous accounts in Dr. Hurlbut’s letters, but these letters have not been put forth for public use. But it has been said that Dr. Hurlbut’s letters were marked by positive attitude and good humor, as were all his interactions with others, and expressed an intense desire to return to Boston to practice and raise his family in the peace that all were confident would follow the defeat of Japan.

The Halligan arrived off the coast of southwestern Okinawa on March 25, covering mine sweepers patrolling waters heavily mined in irregular patterns. The ship was at general quarters, with some officers and men having an informal dinner, when, at 18:35, a tremendous explosion rocked the ship, sending smoke and debris 20 feet into the air. The ship had hit a mine head-on, exploding the forward magazine and blowing off the front section of the ship, including the bridge and back to the forward stack.

It is unknown where Dr. Hurlbut had been at the time of the explosion, but it can be assumed he was having dinner in the officers’ mess hall two decks above the forward magazine or standing on the bridge. Based on the naval inquiry, it seems he was killed instantly.
with the explosion; his body was never recovered. Ensign R.L. Gardners, the senior surviving officer, organized search and rescue parties and gave the final orders to abandon ship.

The Halligan lost half its 300-man crew and all but two of the 21 officers. The ship drifted aground on Tokashiki, a small island west of Okinawa, and its hulk was donated to the Ryukyu Islands government in 1957.

In addition to his wife, Dr. Hurlbut had been survived by four children—Robert Jr., Sally, Patricia, and Caroline, ranging in age from eight years to 17 months. Dr. Moore, who had been a residency colleague of Dr. Hurlbut and a junior member of the MGH faculty at that time, wrote the following in an obituary in the MGH News in June 1945: “The characteristic vim and vigor with which Bob did everything and the light-hearted mannerisms which were so much a part of his character will be sorely missed in the life of the MGH in the years of peace to come.”

Dr. Moore started to work with Dr. Hurlbut’s widow, Sally, and his mother, Edna Woolson Hurlbut, to create a memorial library. At the same time, Butch Donaldson, MD, FACS, had begun exploring the possibility of some type of memorial. In November 1945, the two groups collaborated on a plan for a memorial library to be located on MGH surgical floor White 3 or 3A.

Work on building the Hurlbut Room was tedious. Dr. Moore’s voluminous records from planning the room and the subsequent committee meetings show his interest in detail and documentation. His correspondence with Sally Hurlbut; Dr. Donaldson; general director Nathaniel Faxon, MD; and department chairman Edward D. Churchill, MD, FACS, covered everything from the pipes running across the ceiling to the placement of the blackboard. The controversy over the nautical motif went on for quite awhile, with Dr. Donaldson arguing until the bitter end for a picture of the Halligan. There was a running controversy about whether to move a door, which level of argument was surpassed only by that regarding the location of the computer outlets in the present Hurlbut Room. The book plate required several modifications before it was found satisfactory to all involved. The room opened in November 1947.

Current lessons

There are several things we can learn from Dr. Hurlbut, but the most important is that we as individuals reach our best when we do what we know is right. From the research, it can be argued that Dr. Hurlbut was a modest, earnest, and honest young man who had hoped to be a well-respected surgeon trusted by his colleagues.

A portrait of Dr. Hurlbut in uniform; he was reported missing in action.
this end, he was quite successful, though perhaps not in ways success is usually measured. He could have sat out the war, performing physical examinations on aviators and perhaps working in some capacity at MGH, thus helping to launch his future practice. But he chose instead to serve his country and his fellow man while placing himself in danger. Given his education and training, perhaps Dr. Hurlbut could have obtained a post in a major naval hospital and furthered his education. Instead, he chose to do what he knew how to do—to practice surgery (at an admittedly simpler level, compared with today’s residency graduate)—for those at the front lines of war.

This is an example of true selfless service. To serve in this fashion is not easy, for it places those who are served ahead of oneself. It requires a subjugation of self-interest in the interest of others. It is free of the need for recognition and does not calculate the results of service. It does not discriminate who will be served but serves all. This type of service is difficult, but it is the highest calling of humanity. This type of service is what we should all strive for in our lives as surgeons.

Acknowledgments

I would like to express my appreciation to all who made this interesting exploration possible: to Dr. Richard Hodin, for asking the question, “Who was Hurlbut?”; to Francis Brooks, a patient of mine who knew Dr. Hurlbut as a child and young man; to the National Naval Historical Center and Bureau of Ships for information on the Halligan; to Leslie Ottinger, MD, FACS, former gunnery officer on a Fletcher class destroyer; to the staff of Charlestown Navy Yard National Park for free access to the Cassin Young; and, most importantly, to all who have served the MGH surgical residency for preserving all the records necessary for this review.

Dr. Ferguson is associate professor of surgery, Harvard Medical School, and surgical residency program director, Massachusetts General Hospital, Boston, MA.
ACOSOG news

ACOSOG announces new statistical leadership

The scientific leadership of the American College of Surgeons Oncology Group (ACOSOG) is pleased to announce the transition of statistical leadership from Dr. Stephen George to Karla Ballman, PhD, and Daniel Sargent, PhD, effective March-June 2006.

Dr. Stephen George, professor of biostatistics in the department of biostatistics and bio-informatics at Duke University Medical Center, assumed the role of the statistical leader of ACOSOG following the October 2004 site visit. Dr. George has been the long-time leader of the Cancer and Leukemia Group B Cooperative Group. After a highly successful and regarded career in the cooperative groups, he announced his plans to transition out of the cooperative group leadership role and move toward a focused effort at the Duke Comprehensive Cancer Center. We are grateful for his leadership and wish to thank him for his many important contributions to ACOSOG, including the drafting of our Data Monitoring Committee charter and the mentorship of that newly formed committee. We will also be bidding farewell to Dr. James Herndon and Dr. Kouros Ozwar, staff statisticians, who will also be focusing future efforts at the Duke Comprehensive Cancer Center. A sincere thanks to Steve, Jim, and Kouros for their past contributions to ACOSOG.

Linda McCall, MS, has been an ACOSOG statistician for the last five years and we are delighted that Linda will be staying on with ACOSOG.

We are pleased to introduce Dr. Karla Ballman, Dr. Dan Sargent, and Shauna Hillman as the new statistical leadership for ACOSOG. Dr. Ballman will be a co-director of the ACOSOG Statistical Center and will transition to sole director of the center over the period 2006-2008. Dr. Ballman has been the lead statistician for the North Central Cancer Treatment Group’s (NCCTG) neuro-oncology committee, is

Dr. George

Dr. Ballman

Dr. Sargent
the director of Biostatistics Core for the Mayo Brain Cancer Specialized Programs of Research Excellence, has experience initiating and leading a disease committee research effort (subject of a 2005 American Society of Clinical Oncology oral presentation), has served as an ad hoc reviewer on several National Cancer Institute (NCI) study sections, and is actively engaged in statistical methodology research for data from high-throughput genomics technology. Dr. Ballman will assume primary responsibility for the oversight of the majority of the ACOSOG statistical activities with counseling, support, and mentorship provided by Dr. Sargent.

Dr. Sargent is an established cooperative group statistician leader, with past accomplishments including chair of Subcommittee H, co-chair of a joint NCI-European Organization for Research and Treatment of Cancer committee on tumor markers, director of the Mayo Clinic Cancer Center (MCCC) Biostatistics Shared Resource, director of the NCCTG Statistical and Data Center, member of the NCI’s Program for the Assessment of Cancer Clinical Tests strategy group, first author or co-author of numerous statistical and clinical publications, and invited lecturer at numerous national and international medical and statistical conferences. In the last five years, Dr. Sargent has successfully recruited junior statisticians with genomics expertise to the MCCC, led the successful implementation of remote data capture in the NCCTG, spearheaded a new membership evaluation policy within the NCCTG, overseen the successful conversion of the NCCTG data editing process from paper to electronic databases, and actively engaged the NCCTG and the MCCC in the cancer Biomedical Informatics Grid process.

Drs. Ballman and Sargent would like to convey their excitement and delight with the prospect of becoming part of the ACOSOG team.

ACOSOG semi-annual meeting

When: June 22–24, 2006
Where: Wyndham Hotel, Chicago, IL

Preliminary program

Thursday, June 22, 12:00 noon–8:30 pm
Data and safety monitoring
Executive Committee
Scientific direction committees
Breast, gastrointestinal, sarcoma, thoracic, basic science, diagnostic imaging, radiation oncology, medical oncology, nursing/clinical research associate
Individual administrative committees

Friday, June 23, 8:00 am–9:00 pm
Plenary session
Opening remarks
Scientific Committee presentations (breast, gastrointestinal, thoracic, sarcoma)
Accrual campaign
Community outreach
“How I do it”
“What we should do it”
“What it takes to do it”
Questions and answers to common trial questions
Disease committees
General session/protocol team breakout sessions
Executive Committee

Saturday, June 24, 8:00 am–2:00 pm
Plenary session
Closing remarks
Educational forum (continuing medical education credits)
Nursing/clinical research associate training
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, comorbidities 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.
NTDB® data points

What I learned in school

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

High school graduation is just around the corner for more than 3 million senior students throughout the U.S. As parents of graduating seniors prepare for that milestone, what lessons have our children learned beyond the classroom?

Alcohol and drugs are prevalent in our society and our children are not immune from exposure to them. According to the National Center on Addiction and Substance Abuse, more than 5 million high school students binge-drink at least once a month. Adolescents who begin drinking before age 15 are four times more likely to develop alcohol dependence than those who begin at age 21. Teenagers who drink alcohol are five times more likely to smoke cigarettes, four times more likely to smoke marijuana, and three times more likely to use an illicit drug.

The National Institute on Alcohol Abuse and Alcoholism reported in 2003 that almost 50 percent of 12th graders have consumed alcohol within the last 30 days whereas 30 percent have engaged in binge drinking (having at least five or more drinks on one occasion) within the past two weeks. Aside from the obvious health problems posed by early alcohol consumption, it is associated with increased sexual assaults, high-risk sex, suicide, homicide, and an increase in fatal motor vehicle crashes.

There are 75,382 records for hospital patients aged 15 to 19 years contained in the National Trauma Data Bank® Dataset 5.0, and among those tested for alcohol, more than one in four tested positive. When looking at the subset among these data of drivers of motor vehicles, there were 17,875 records. Of these drivers, 7,463 were tested for alcohol and 2,114, or 28 percent, tested positive (see graph on this page). Considering that the legal age for drinking anywhere in the U.S. is 21, we are losing the battle for zero tolerance when our children are under the influence of alcohol and behind the wheel. Adolescent drivers have limited experience to start with and adding alcohol to the situation impairs motor skills, judgment, and reaction times. The net result is a preponderance of fatal crashes for this age group.

When tests were administered, alcohol was shown to be involved in more than one-fourth of all injuries in this data set. What is the answer to this public health problem? Obviously, the answer is multifactorial, but let us start at home. Education and awareness are key elements. Children who were warned about alcohol by their parents and children who reported having a closer relationship with their parents...
were less likely to start drinking. Then, when parents think about what their children are learning at school, they will not worry that these lessons include how to consume alcoholic beverages.

Throughout the year, we will be highlighting these data through brief monthly reports in the Bulletin. The full NTDB Annual Report Version 5.0 is available on the ACS Web site as a PDF file and a PowerPoint presentation at http://www.ntdb.org.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

### ACS Career Opportunities

**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.
- Track your current and past activity, with toll-free access to personal assistance.

**Employers:**
- Nationwide market of qualified surgical candidates.
- Resume Alert automatically e-mails notices of potential candidate postings.
- Exceptional customer service and consultation.
- Online tracking.

**Questions?**
Contact HealtheCareers Network at 888/884-8242 or candidates@healthecareers.com for more information.