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Future meetings

Clinical Congress
2006 Chicago, IL,
October 8-12
2007 New Orleans, LA,
October 7-11
2008 San Francisco, CA,
October 12-16

Spring Meeting
2007 Las Vegas, NV,
April 21-24
2008 To be announced
2009 To be announced
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Rhonda Peebles
An outstanding educational opportunity
and one of the largest international surgical meetings of the year
is just ONE MONTH AWAY

American College of Surgeons

Clinical Congress
92nd Annual

The American College of Surgeons invites you to attend its 2006 Clinical Congress, “Working Together Toward Humanitarian Ideals,” in Chicago, IL, October 8–12.

The Congress will afford you with a prime opportunity, regardless of your specialty area, to advance your knowledge in the traditional surgical areas as well as learn about the latest innovations in surgery. The entire program, complete with online registration, can be viewed online at:

http://www.facs.org/clincon2006/index.html

Register today!

Accreditation. The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

CME Credit. The American College of Surgeons designates this educational activity for a maximum of 50.75* AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

*A maximum of 37.25 AMA PRA Category 1 Credits™ for general sessions only, including evening video sessions.
From my perspective

As reimbursement levels stagnate or decline, and practice expenses continue to rise, surgeons are experiencing new financial strains. On the personal financial side, many young members of the profession worry that they will have difficulty paying their children’s college tuition, while late-career surgeons are beginning to wonder if they will be able to retire comfortably.

The leadership of the American College of Surgeons understands and appreciates the increasingly complex financial challenges that its members are experiencing. Hence, we are working to provide surgeons with the investment knowledge and services that we believe they need to ease those concerns.

In the near future, we will be launching one of those services—the Surgeons Diversified Investment Fund (SDIF). This diversified mutual fund uses fundamental investing principles—asset allocation, diversification, and rebalancing—that we believe are the necessary ingredients for a successful investment program, and that are used by the College’s endowment fund. All members of the College are invited to participate in this new opportunity, which is designed to alleviate some of the stress associated with financial planning.

In addition to launching SDIF, the College is sponsoring several investment seminars at the 2006 Clinical Congress. The seminars on investing are designed to aid surgeons in understanding fundamental investing principles as they relate to practice management. (For more information on these courses, see page 28.)

Finally, toward the effort to begin to improve your investing knowledge, I urge you to read the article on page 21 by George Pendergast, investment consultant with Cambridge Associates, the consulting firm that the College used to develop its endowment funds.

Financial challenges

Surgeons at all stages of their careers are facing new and complex financial challenges. Most physicians leave medical school deeply in debt, and the low wages paid during lengthy surgical residencies forestall repayment on loans that continue to accrue interest.

Meanwhile, practicing surgeons continually see their Medicare and Medicaid reimbursement levels drop because of flaws in the formula used to calculate fees. While the American College of Surgeons and other medical organizations continue to work with Congress and the Centers for Medicare & Medicaid Services to develop a more rational and equitable payment methodology, the realization of this objective will take some time. In addition, other payors are offering lower payment amounts and negotiating more restrictive contracts, adding another layer of financial distress to many practices. Compounding the effects of these new realities are rising liability insurance and business costs. Furthermore, the rigors of surgical training and practice leave scant time to concentrate on business affairs or the stock market.

As a result, many surgeons today simply have less discretionary income than past generations enjoyed and run the risk of saving too little to ultimately be able to experience a rewarding retirement. Most surgeons would like to lead lives that are free of money worries, both for themselves and their children.

The College responds

To reclaim a sense of stability, surgeons need access to resources that enable them to be better businesspeople and investors. They need to know
how to code and bill for maximum return, how to run cost-effective practices, and how to negotiate contracts. The American College of Surgeons has offered a number of programs to help surgeons manage their practices efficiently. In addition, the College offers reliable life, disability, and other insurance coverage through a program underwritten by New York Life Insurance Co.

These programs and services are described in greater detail in the “From my perspective” column on page 3 of the February 2006 Bulletin (available at www.facs.org/fellows_info/bulletin/2006/feb06russell.pdf). In that column, I also noted that we were working to develop a proprietary investment vehicle, or mutual fund, as a benefit of College membership. The launch of SDIF represents the culmination of that effort.

The mutual fund

The College believes that SDIF provides a unique investment opportunity for members of this organization, their families, employees, and affiliate groups. SDIF is managed by Surgeons Asset Management, LLC (SAM), and I serve as that organization’s Chief Executive Officer and Director. Other members of the SAM Board of Directors are identified on page 27.

SDIF uses the fundamental investing principles of asset allocation, diversification, and rebalancing. SDIF is designed to meet the needs of surgeons at any given career stage and for a portion of their portfolio. More specifically, SDIF invests in what are known as exchange-traded funds (ETFs) in a variety of asset classes. ETFs typically track a stock-market index and trade on an exchange like a regular stock. Under normal market conditions, approximately 70 percent of SDIF’s net assets will be invested in equities, and the other 30 percent will be invested in fixed-income securities. The equities include both domestic and foreign stocks, as well as energy and real estate investments. Furthermore, SDIF’s assets will be rebalanced periodically to maintain this target allocation.

SDIF is available to help surgeons manage their assets and fulfill their needs based on where they are in their careers. For example, medical students typically have very little discretionary spending money and even less time to think about saving for the future, while residents primarily want to reduce their debt. Mid-career surgeons generally want to be able to put aside enough money to ensure their families’ well-being and happiness, while late-career professionals want to protect their assets and plan for retirement. We believe SDIF is a good place to start and continue building your healthy financial future.

You should be receiving a mailing about SDIF in the coming weeks. An investor should consider the fund’s investment objectives, risks, charges, and expenses carefully before investing. SDIF’s prospectus contains this and other information about the fund. The prospectus is available by visiting www.surgeonsfund.com or by calling 800/208-6070. Before investing, read the prospectus carefully.

I hope that many of you will explore this new investment opportunity that the College is providing to members. We anticipate that this service will be of assistance in alleviating some of the financial pressures that surgeons now face.

The information contained in the fund’s current registration statement (prospectus and statement of additional information) is not complete and may be changed. The fund is not currently available for purchase and will not be available until the registration statement filed with the Securities and Exchange Commission is deemed effective. The fund’s current registration statement is not an offer to sell the fund and is not soliciting an offer to buy the fund in any state where the offer or sales is not permitted.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
ACS comments on hospital and GME payments

On June 12, the American College of Surgeons submitted comments to the Centers for Medicare & Medicaid Services (CMS) on a proposed rule that would reduce hospital reimbursement for many surgical procedures and alter graduate medical education (GME) payments. The proposal responds to a report issued last year by the Medicare Payment Advisory Committee (MedPAC), which called on CMS to adjust its methodology for determining hospital payments. MedPAC concluded that specialty hospitals often have an unfair advantage because they treat less severely ill patients but are paid at the same rate as other hospitals. As a result, CMS’ proposed rule would largely increase hospital payments for medical cases and reduce reimbursement for surgical services, especially cardiac and spine operations. The College questions CMS’ approach and calls for a delay and phase-in of the changes, because such a dramatic shift may move resources away from the operating room.

CMS also clarified in the rule that hospitals cannot count didactic time, including lectures and morbidity and mortality conferences, for purposes of calculating direct and indirect GME payments. The College objected to this proposal on the principle that these activities are critically important to resident training and urged CMS to withdraw this clarification. To review the College’s comments on these and other provisions in the proposed rule, go to http://www.facs.org/ahp/views/hospitalpayment.html.

Proposed rule on RVUs issued

On June 21, CMS released a proposed rule that implements changes for both the five-year review of work relative value units (RVUs) and an update to the practice expense RVUs in the physician fee schedule. In total, the rule would shift more than $4 billion from some codes in the Medicare physician fee schedule to others. For general surgery, some codes would experience slight increases, whereas others would undergo slight cuts. According to CMS, the changes to the work values are expected to result in a net zero gain for general surgery, while the practice expense changes would yield a 1 percent increase in reimbursement. Some surgical specialties—including neurosurgery, orthopaedic surgery, and ophthalmology—would face total cuts of 4 percent to 6 percent, whereas many nonsurgical specialties, including primary care, emergency medicine, and dermatology, would see increases of 5 percent to 7 percent.

The work RVU changes are scheduled to become effective January 1, 2007, and the changes to practice expense RVUs are set for phase-in between 2007 and 2010. At press time, the College was drafting detailed comments for submission to CMS. To download the proposed rule, go to http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage, and click on regulation number CMS-1512-PN at the bottom of the page.

MedPAC report focuses on value

MedPAC released a report to Congress on June 15 that focuses on improving the value of Medicare services. In the report, MedPAC examines the practice expense component of the fee schedule and concludes that CMS is using outmoded data in its calculations.
MedPAC recommends that Congress provide CMS with the resources necessary to collect new data and update calculations for the practice expense component of the payment formula. Consistent with concerns the College has raised, MedPAC notes that distorted practice expense payments threaten patient access to care by creating perverse incentives for physicians to limit the range of services they provide and by providing disincentives for physicians to pursue certain specialties.

The report also presents information gathered through MedPAC’s ongoing study of efforts to measure quality of care and specifically looks at variations in physician use of resources, or “efficiency,” and in quality across different regions. The report highlights some of the shortcomings associated with using claims data to link efficiency and quality and recommends that Medicare develop broader clinical measures not tied to resource use. MedPAC also suggests the possibility of measuring resource use at the individual physician level and discusses the potential difficulties of obtaining and using such measurements. Specific challenges identified include determining the minimum number of episodes or indicators needed to qualify a physician for analysis, implementing patient risk adjustments, and accounting for variations in practice patterns across certain regions. For a copy of the report, go to http://www.medpac.gov/ and click on the first link under “recent products.”

The Medicare program will not make payments on any claims during the period of September 22 through September 30, the end of the federal government’s fiscal year. Payments that would have been made during that nine-day period will be made on October 2, the first business day of the new fiscal year. No interest will be paid on the delayed payments.

The Deficit Reduction Act, which was enacted earlier this year and which repealed the 4.4 percent cut in the payment rate that went into effect January 1, provides for this delay in payments. For more information, visit the CMS Web site at http://cms.hhs.gov, and type MM5047 in the search box.

To help provide more timely service to patients seeking disability benefits and, ultimately, Medicare and Medicaid coverage, the Social Security Administration (SSA) asks that physicians and other medical providers submit medical records electronically. Physicians may do so via any of the following methods: faxing, using the Internet to submit individual patient records to the SSA’s secure Web site, or scanning and sending batched files to the Web site. To register to use the SSA’s secure Web site to send medical records or for more information, contact the SSA via e-mail at electronic-records-express@ssa.gov or by phone at 866/691-3061.
State legislatures wrap it up for 2006

by
Melinda Baker,
State Affairs Associate,
Division of Advocacy and Health Policy
In the first half of 2006, there were more than 3,000 bills introduced in Congress, compared with the more than 90,000 bills introduced in state legislatures during that same time period. From this statistic alone, it is easy to see the impact that state governments have on the practice of medicine. Most states adjourned their legislative sessions by early summer and six states were not scheduled to hold regular legislative sessions in 2006. In addition, during election years, state legislators tend to be hesitant to attempt any large legislative battles so close to Election Day—resulting in legislative sessions that, for the most part, avoid controversy.

Because there are so many bills introduced in state legislatures, it is important to focus the College's state affairs resources. In order to do this, the Health Policy Steering Committee has directed State Affairs staff to focus on the following five broad categories:

- Medical liability reform
- Provider taxes
- Scope of practice
- Trauma system funding and development
- Regulation of office-based surgery utilizing moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia

**Medical liability reform**

Medical liability reform remains the largest single issue for the College. More than 40 percent of the bills being monitored by ACS dealt with medical liability reform, although few of these were reforms crafted fully in the style of the Medical Injury Compensation Reform Act.

In 2005, the Wisconsin Supreme Court declared unconstitutional the $350,000 cap on noneconomic damages (which was adjustable for inflation) in medical liability suits. The justices ruled four to three that the cap violated the equal protection guarantees of the state's constitution. In its opinion, the majority was quick to point out that “just because caps on noneconomic damages are not unconstitutional per se does not mean that a particular cap is constitutional” and in March of this year, Gov. Jim Doyle (D) signed a bill instituting a $750,000 cap on noneconomic damages that is expected to meet constitutional muster.

Florida’s legislature has addressed other reform measures in past years, and this year physicians in Florida scored another victory when, in April, Gov. Jeb Bush (R) signed H.B. 145, eliminating joint and several liability.

Six states passed legislation allowing health care professionals to say “I'm sorry” without it being presented as evidence against them at trial—Iowa, Idaho, Indiana, South Carolina, Utah, and Vermont became a part of the recent trend among state legislatures to adopt this commonsense medical liability reform.

In February, Michigan’s Gov. Jennifer Granholm (D) signed H.B. 4670 and H.B. 5375, which create a special volunteer license for retired physicians who provide medical care for the needy and grant civil immunity provided that the physician does not accept compensation and “the care is provided at a health facility or agency that provides at least 75% of its care annually to medically indigent individuals.” Civil immunity would not apply in cases of gross negligence, which is defined as “conduct so reckless as to demonstrate a substantial lack of concern for whether an injury resulted.”

However, not all liability bills had such happy endings. In May, Arizona’s Gov. Janet Napolitano (D) vetoed a bill (H.B. 2315) that would have raised the burden of proof from “a preponderance of evidence” to “clear and convincing evidence” in order to win a lawsuit against emergency room personnel.

In her veto message, Governor Napolitano wrote, “There is no disagreement that the unfunded federal mandates of EMTALA [Emergency Medical Treatment and Active Labor Act], coupled with the decrease in reimbursement rates and the rise of specialty surgery centers, have led to shortages of on-call specialists in our emergency rooms. No data has been supplied to me, however, to suggest that raising the burden of proof would, alone, cure these problems.” Governor Napolitano also expressed her belief that the bill might be unconstitutional. In addition, the Governor indicated that the bill was unnecessary because she had created a task force to study the issue. (Critics have remarked on the timing of the creation of the task force, as it was created on the same day she vetoed H.B. 2315.)

Florida’s S.B. 2686 was defeated in committee on a tie (four to four) vote. It would have required out-of-state physicians who are providing expert

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testimony in malpractice cases to obtain a certificate from the Florida Board of Medicine and provided for disciplinary action for false testimony.

Provider taxes

In 2004, New Jersey passed a 6 percent tax on cosmetic medical and dental procedures. Although 2005 saw a rash of proposals in other states to do the same, they all failed largely because of the dismal returns that New Jersey was experiencing. Original projections had been that the tax would bring in $24 million in the first year, yet only $7.8 million was actually collected.

In March, State Assemblyman Joseph Cryan (D-NJ), the same legislator who sponsored this tax in 2004, introduced a bill to repeal the tax, saying that it was “an untested revenue stream that ultimately hasn’t delivered.” On June 23, the repeal bill was unanimously released from the Appropriations Committee with expectations for quick passage in both the Assembly and the Senate. The Stop Medical Taxes Coalition, of which the College is a member, distributed grassroots advocacy kits to more than 7,000 New Jersey surgeons to help them educate their patients on this issue, greatly helping to support this repeal effort.

Scope of practice

Dozens of the bills being monitored by the ACS pertained to scope of practice issues. The range of scope issues is broad and deals with a variety of specialties.

In June, Connecticut Gov. M. Jodi Rell (R) signed S.B. 164 to allow physical therapists with a master’s degree (or those who earned a bachelor’s degree before January 1, 1998) to treat patients without a physician referral. The bill allows them to provide treatment for 30 days or six visits (whichever occurs first), provided they meet the following criteria:

- The patient discloses the name of his or her primary care physician
- The therapist provides information regarding the need for consultation with a physician
- The therapist refers the patient to a physician if the patient does not demonstrate objective, measurable, functional improvement

Physical therapists will not be allowed to provide direct access on any case involving an injury.

The following additional scope issues have also occurred:

- Florida and Illinois passed legislation requiring that a circulating nurse be a registered nurse
- Florida’s Governor Bush signed a bill that “requires all health care practitioners to inform patients of their licensure either orally or through wearing a nametag and will help ensure that patients know who is treating them.”
- Louisiana Gov. Kathleen Blanco (D) signed S.B. 418 on June 23. This bill alters optometrists’ scope of practice partly by removing the term “incision” from the current statute as it pertains to “the eyes and its adnexa.”

Diagnostic imaging

Recent years have seen a wave of legislation attempting to restrict imaging services by non-radiologists. Although these attempts are often seen as scope of practice issues, these restrictions are usually attempted through legislation governing certificate of need or reimbursement.

In 2005, more than half the states saw some type of (unsuccessful) legislation introduced to restrict imaging procedures. Partly because of the failure of this legislative strategy, proponents of these restrictions tried a new strategy: adoption of guidelines by private payors. Several states—including Idaho, Connecticut, Illinois, and Pennsylvania—have already seen attempts by private payors to restrict usage in this fashion.

In Louisiana, S.B. 570 would prohibit independent diagnostic testing facilities and ambulatory surgical centers in rural areas from performing all imaging services (including ultrasounds). Exempt from this ban are physician offices and physician group practices, provided they are owned exclusively by physicians and are not leased or owned by nonphysicians or are not licensed as rural health clinics. The Governor signed the bill on July 5.
Trauma

Helping state Committees on Trauma implement grassroots advocacy activities related to trauma-focused legislation is an important part of State Affairs. The College monitors the following four categories pertaining to state trauma legislation:

• Trauma system development
• Trauma system funding
• Injury prevention
• Repeal of the Uniform Accident Sickness and Policy Provision Law (UPPL)

Indiana was successful in passing legislation directing the Department of Public Health to develop a statewide trauma system (S.B. 284). The Kentucky trauma community introduced H.B. 724 to create a similar system, but it was held in committee at the sponsor’s request.

Many states—including California, Georgia, Florida, Hawaii, and New Mexico—had proposed bills that would increase funding for their trauma systems through a variety of mechanisms, such as increasing fines on moving violations and increasing penalties for drug charges. The bill also calls for the creation of a grant program in the state’s budget to fund trauma care.

Florida and Maryland both saw adjustments to their trauma funding formulas. Maryland’s H.B. 1164 increased the reimbursement rate for costs incurred by level II and III trauma centers—Gov. Robert Ehrlich (R) signed the legislation in early May—whereas Florida’s H.B. 7141 changed the trauma funding formula by using the International Classification Injury Severity Score (ICISS) instead of the Injury Severity Score (ISS) instead of the Injury Severity Score (ISS) and by defining the terms “trauma caseload volume,” “trauma patient,” and “local funding contribution.” H.B. 7141 also created a trauma center start-up grant program. Governor Bush signed the bill in early June.

Kansas Gov. Kathleen Sebelius (D) signed H.B. 2611 in March. This legislation requires that children aged four to seven years (or those who weigh less than 80 pounds or are shorter than 4’9”) be restrained in child seats while in a moving vehicle.

In 2006, six states introduced legislation to repeal the UPPL, which allows insurers to deny patients for costs incurred when an accident is a result of “the insured’s being intoxicated or under the influence of any narcotic.” Only eight states (Colorado, Connecticut, Massachusetts, Michigan, New Mexico, New Hampshire, Utah, and Wisconsin) never officially enacted the UPPL; however, courts have ruled that insurance companies may still deny payment because state law does not specifically prohibit such denials.

Both Connecticut and Colorado were successful in passing legislation to specifically prohibit these denials and although Hawaii’s S.B. 2364 passed both chambers with no opposition, the chambers were unable to come to an agreement and the bill died in conference committee.

Regulation of office-based surgery

After a flurry of activity between 1999 and 2003, the issue of regulations of office-based surgery seemed to settle down somewhat, with little legislative activity taking place. This year, Illinois Gov. Rod Blagojevich (D) signed legislation allowing for registered nurses to administer conscious sedation when ordered by a physician. In Tennessee, H.B. 1288 would have made performing surgery under general anesthesia or conscious sedation outside of a hospital or ambulatory surgical center grounds for disciplinary action against a physician; fortunately, this bill died in committee. Of note is that Tennessee’s Board of Medical Examiners had adopted regulations effective November 6, 2005, for office-based surgery permitting level III offices to use general anesthesia, provided the office is accredited.

Miscellaneous legislation

Among the bills the College is currently monitoring, 20 percent do not fall into the five categories identified by the Health Policy Steering Committee. Health system reform initiatives, insurance coverage of bariatric surgery, and insurance for attorneys were just some of the additional bills that the College was monitoring.

Several legislatures in 2006 took an interest in legislation pertaining specifically to bariatric medicine/surgery. Most of these bills were attempts to study and/or mandate insurance coverage of bariatric procedures. However, Indiana’s S.B. 266 amended some onerous legislation passed in 2005. The new bill made commonsense statutory changes, including the reduction of the 18-consecutive-month, preoperative, nonsurgical, physician-supervised weight loss period to only
six months and the protection of the physician in cases where patients cannot be located for tracking purposes (the law required monitoring of the patient for five years following the operation).

Malpractice insurance for attorneys was debated in a number of states. New Jersey saw proposed legislation to require attorneys to carry malpractice insurance, whereas Tennessee’s H.B. 2877 went a step further and would have required any attorney “who advertises as permitted by the supreme court to include a statement of whether attorney has malpractice insurance and if so the limits of such insurance in such advertisement.”9 Although both bills died in committee, Virginia’s House of Delegates passed Resolution 6, which “encourages the Supreme Court of Virginia and the Virginia State Bar to consider some form of mandatory insurance for attorneys or an uninsured attorneys fund for client/victim compensation for malpractice committed by uninsured attorneys in the Commonwealth.”9

Much was made in the media of Massachusetts’ H.B. 4850, which mandates that all residents who can afford to do so must purchase health insurance. Although Gov. Mitt Romney (R) vetoed the high-profile “fair-share” assessment, which included a $295 assessment on noncontributing employers with more than 10 employees, the legislature overrode the veto and the assessment stands as passed.

States are eagerly awaiting the outcome of this groundbreaking legislation, which, should it prove successful, promises to be repeated in other states.

Ongoing state advocacy

Monitoring and tracking state legislation is just one component of the College’s State Affairs program. In 2006, the College’s State Affairs staff continued to publish ACS Cross Country, a monthly newsletter dedicated to state legislative efforts (http://www.facs.org/sslac/index.html) and has participated in several issue-based coalitions. In addition, staff helped ACS chapters use the Surgery State Legislative Action Center, a Web-based advocacy tool (http://www.facs.org/sslac/index.html) that is cosponsored by 12 surgical specialty societies and provides surgeons a quick and easy way to send prewritten letters to their state legislators or other elected officials.

State Affairs staff spoke at several chapter and special interest groups meetings and promoted the College’s state legislative agenda at the annual meeting of the National Conference of State Legislatures.

Staff also continued the “StAR” (state advocacy representative) program. StARS act as liaisons between the College and their state legislatures. Quarterly conference calls are held to discuss ACS state legislative activities and to provide an opportunity for “StARS” to share state legislative information regarding their own state with both the College and their colleagues in surrounding states. Because many legislative “ideas” often cross state borders, the calls can serve as an early warning system for contiguous states.

For more information on state legislative issues or to become a StAR, please contact Melinda Baker at 312/202-5363 or e-mail mbaker@facs.org.

References

Rank and file weighs in on trauma and general surgery issues:

Results from a survey of ACS Fellows

by Thomas J. Esposito, MD, MPH, FACS, Chicago, IL
Topics currently generating great discussion and debate both within and outside the “house of surgery” include the future of general and trauma surgery training and practice, the concept of an acute care surgeon, and surgical workforce issues.1-7 Surveys of ACS Fellows and academic trauma surgeons have been conducted previously to seek opinions on some of these issues. One survey offered a profile of surgical practice among ACS Fellows but did not specifically broach many pressing issues related to trauma care.8 The other survey included a sample of ACS Fellows and non-Fellows, which was admittedly biased toward surgeons whose practice predominantly involves trauma and critical care based at academic centers.9 Although both surveys are informative and useful in their own right, neither speaks to the opinions of rank-and-file surgeons who practice general surgery and trauma care in the community. To that end, the ACS Committee on Trauma recently conducted a survey of 710 Fellows. Participation in the survey was solicited through three separate requests posted in the ACS NewsScope electronic newsletter over three months. Selected results obtained from this convenience sample follow.

Demographic and practice information

The average age of respondents was 49 years and 89 percent were male. Among participants, 44 percent indicated that they practice in an urban environment, 32 percent in a suburban environment, and 24 percent in a rural environment. Regarding practice settings, 37 percent responded that their practice setting was private/solo, group, or health maintenance organization, and 29 percent specified they were in academic practices. For those in a group practice, the reported average group size was eight physicians. Responses showed that 17 percent described themselves as trauma surgeons with some degree of involvement in other general surgery, 69.3 percent described themselves as a career general surgeon with some degree of involvement in trauma care, and 14 percent described themselves as a

![Figure 1](image-url)
ing duties, administrative activities, research and consulting, or volunteer work. Of the time spent in clinical practice, respondents reported that 59 percent is spent doing elective surgery, 16 percent doing emergency surgery, 15 percent doing trauma care, and 10 percent doing critical care (see Figure 3, this page). Of the time spent in elective practice, 51 percent is reportedly spent doing basic general surgery.

Table 1 on page 16 outlines the percentage of surgeons performing procedures of a given category of general surgery and, of those, the percentage reported performing a specific type of procedure within that category. The most commonly practiced procedures cluster into routine abdominal and laparoscopic categories focusing on bowel and the biliary tree. A large number of respondents also perform tracheostomies. Fewer respondents include breast, soft tissue, vascular, endocrine, and chest surgery in their scope of practice. A moderately large number reported engaging in surgical critical care, endoscopy, and ultrasonography. Very few perform angiography, and those procedures are almost exclusively limited to the extremities. Overall, 85 percent responded that they were satisfied with their career choice as a surgeon.

The majority (2%) report performing between 200 and 500 major nontrauma cases per year. Coding using the International Classification of Diseases, Ninth Version, Clinical Modification, is done predominately (42%) by office staff, with 30 percent of respondents reporting that they perform this function themselves (see Table 2, page 17). Coding with Current Procedural Terminology and evaluation and management codes is reportedly done by the office staff of 33 percent of respondents and 42 percent of respondents themselves. Surprisingly, 58 percent of respondents did not know their charge capture rate, 64 percent did not know their rate of charge denials, and 71 percent reported not knowing their claim denial profiles (see Table 3, page 18).

Current trauma practice and issues

Currently, 57 percent of respondents reported being satisfied with the trauma care aspect of their practice. However, 35 percent strongly agreed and 15 percent agreed that, given their
Table 1
Percentage of surgeons performing procedures within given categories of general surgery

<table>
<thead>
<tr>
<th>Category/procedure</th>
<th>% performing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>Abdominal Surgery</td>
<td>93</td>
</tr>
<tr>
<td>Conventional hernia</td>
<td>97</td>
</tr>
<tr>
<td>Routine pancreaticobiliary</td>
<td>84</td>
</tr>
<tr>
<td>Complex pancreaticobiliary</td>
<td>38</td>
</tr>
<tr>
<td>Routine foregut</td>
<td>96</td>
</tr>
<tr>
<td>Complex foregut</td>
<td>60</td>
</tr>
<tr>
<td>Routine colorectal</td>
<td>98</td>
</tr>
<tr>
<td>Complex colorectal</td>
<td>50</td>
</tr>
<tr>
<td><strong>Laparoscopy</strong></td>
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<td>Cholecystectomy</td>
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<td>Split thickness skin graft</td>
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<td>Upper for</td>
<td>96</td>
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<tr>
<td>Lower for</td>
<td>98</td>
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<td>Endoscopic retrograde cholangiopancreatography for</td>
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<td>Bronchoscopy for</td>
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<tr>
<td>Thoracoscopy for</td>
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<tr>
<td><strong>Ultrasound Imaging</strong></td>
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<tr>
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<td>53.9</td>
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<tr>
<td>Biliary</td>
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<tr>
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<td>Focused abdominal sonography for trauma</td>
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<td><strong>Soft Tissue</strong></td>
<td>52</td>
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<tr>
<td>Soft Tissue</td>
<td></td>
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<tr>
<td>Sarcoma resection</td>
<td>92.6</td>
</tr>
<tr>
<td>Other</td>
<td>15.6</td>
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<tr>
<td><strong>Vascular Surgery</strong></td>
<td>40</td>
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<td>Vascular Surgery</td>
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<tr>
<td>Routine vascular</td>
<td>79</td>
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<tr>
<td>Complex vascular</td>
<td>35.6</td>
</tr>
<tr>
<td>Inferior vena cava filter placement</td>
<td>59.4</td>
</tr>
<tr>
<td><strong>Thoracic Surgery</strong></td>
<td>39</td>
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<tr>
<td>Thoracic Surgery</td>
<td></td>
</tr>
<tr>
<td>Routine thoracic</td>
<td>76.1</td>
</tr>
<tr>
<td>Complex thoracic</td>
<td>19.9</td>
</tr>
<tr>
<td>Retroperitoneal spine exposure</td>
<td>51.5</td>
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<tr>
<td><strong>Angiographic Imaging</strong></td>
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<td>Extremities</td>
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<td>Pelvis</td>
<td>29.2</td>
</tr>
<tr>
<td>Aorta</td>
<td>33.3</td>
</tr>
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</table>

*Diagnosis
†Treatment
current practice, they would prefer not to care for trauma patients; 27 percent report having given up the practice of trauma surgery. Common reasons given for this decision were impact on professional or personal lifestyle and lack of subspecialty and/or hospital administrative support. Few cited malpractice premium, litigation, or reimbursement issues.

Of those who continue to take trauma call, 22 percent stay in-house per mandate, 9 percent generally stay in-house, and 67 percent generally take call from home. Among respondents, 31.7 percent report that they receive a stipend for taking call. These stipends reportedly range from less than $500 to more than $2,500 (see Figure 4, this page). Commonly cited reasons for continuing to participate in trauma care were service to the community and society along with hospital mandates in order to maintain staff privileges. Among respondents, 81 percent agreed or strongly agreed with the statement that the trauma surgeon is undervalued by society.

Trauma surgery comprises up to 24 percent of practice activity for 74 percent of respondents. Among respondents, 88 percent estimate doing fewer than 100 major trauma cases annually. Current qualifications for Advanced Trauma Life Support® were reported by 59 percent of participants, and 20 percent report having a current certificate of added qualifications in surgical critical care. The majority of respondents (75%) feel very confident with resuscitation and diagnosis. Fewer (65%) feel very confident with operative care, and 47 percent report feeling very confident with critical care.

Trauma surgery is felt to represent a distinct

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Diagnosis and procedure coding practices of respondents</th>
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</thead>
<tbody>
<tr>
<td>“Who does your ICD-9* coding?”</td>
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<tr>
<td>Respondent</td>
<td>29.7</td>
</tr>
<tr>
<td>Respondent’s office staff</td>
<td>42.2</td>
</tr>
<tr>
<td>Hospital medical records staff</td>
<td>10.1</td>
</tr>
<tr>
<td>Department of surgery/trauma program/physician foundation staff</td>
<td>10.3</td>
</tr>
<tr>
<td>Independent billing service</td>
<td>4.7</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
</tr>
<tr>
<td>“Who does your CPT†/E/M‡ coding?”</td>
<td></td>
</tr>
<tr>
<td>Respondent</td>
<td>44.8</td>
</tr>
<tr>
<td>Respondent’s office staff</td>
<td>33.4</td>
</tr>
<tr>
<td>Hospital administration staff</td>
<td>7.6</td>
</tr>
<tr>
<td>Department of surgery/trauma program/physician foundation staff</td>
<td>8.3</td>
</tr>
<tr>
<td>Private vendor</td>
<td>3.2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2.7</td>
</tr>
</tbody>
</table>

*ICD-9 = International Classification of Diseases, Ninth Revision
†CPT = Current Procedural Terminology
‡E/M = Evaluation and management codes

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Business acumen</th>
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</thead>
<tbody>
<tr>
<td>Charge capture rate</td>
<td>Known 42% Unknown 58%</td>
</tr>
<tr>
<td>Rate of charge denials</td>
<td>36 64</td>
</tr>
<tr>
<td>Profile of claim denials</td>
<td>29 71</td>
</tr>
</tbody>
</table>

Figure 4

Payment of on-call stipends
body of knowledge that is part of, but distinct from, general surgery by 56 percent of respondents. Among respondents, 79 percent disagree or strongly disagree that general surgeons should not do trauma surgery and critical care; 82 percent disagree or strongly disagree that trauma/critical care surgeons should not do general surgery, and 64 percent believe a general surgery practice is essential for the trauma surgeon to maintain. Furthermore, 76 percent agree or strongly agree a low-volume operative practice is detrimental to the practice of trauma surgery.

Despite the perceived importance of maintaining a general surgery practice, 82 percent of respondents also believe that trauma practice is inherently disruptive to an elective general surgery practice. At the same time, 40 percent disagree that they personally find it difficult to engage in both trauma and elective general surgery practices whereas 49 percent agree that such a dual practice is difficult to maintain. Among respondents, 70 percent disagreed or strongly disagreed that the broad practice of general surgery by “trauma surgeons” is currently restricted at their hospitals. More than 80 percent believe that both general surgeons and trauma surgeons should perform emergency general surgery. Only 5 percent believed that such emergency operations should be performed exclusively by specialty-trained acute care surgeons.

The future of trauma surgery

Changing the field of trauma surgery is endorsed by 60 percent of respondents, whereas 27 percent believe the status quo should be maintained and 13 percent believe the field is not sustainable and no effort should be made to promote, expand, or support it. The majority (64%) support a change in the practice model to one resembling that of emergency medicine—for example, large group, hospital based, broad practice scope, shift work, reliable and adequate compensation, and so on. In-house call for these surgeons is favored by 43 percent of respondents, with 37 percent disagreeing. Work-hour restrictions regulating practice are favored by 29 percent whereas 50 percent disagree. A mandated post-call day off is favored by 45 percent with 29 percent disagreeing. Half of respondents support the inclusion of limited neurosurgical procedures in the scope of training and practice for future trauma surgeons whereas 35 percent are not in favor. A favorable inclination to including selected orthopaedic procedures was expressed by 56 percent of respondents, whereas 38 percent do not support such an expansion of practice scope. The majority (62%) agrees that these specialty surgeons and the centers where they are based should be funded by municipalities (local, county, state, federal), much the same as fire, police, emergency medical services, and public health department services. Only 16 percent disagree with this concept.

Currently, only 23 percent of respondents report transferring the majority of trauma patients they are called about to another facility. However, 67 percent favor regionalization of trauma care in order to accomplish the type of practice model previously alluded to, which mimics the emergency medicine physician practice model. Among respondents, 40 percent agree or strongly agree that initial care of trauma patients at community hospitals should be rendered by emergency

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Ideal characteristics of surgical practice with a major trauma component by priority rank</th>
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<tbody>
<tr>
<td></td>
<td>Guaranteed appropriate salary</td>
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<tr>
<td></td>
<td>Guaranteed time away from practice</td>
</tr>
<tr>
<td></td>
<td>Subsidized ancillary benefits</td>
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<tr>
<td></td>
<td>More general surgery</td>
</tr>
<tr>
<td></td>
<td>Less night call with increasing age</td>
</tr>
<tr>
<td></td>
<td>Subsidized reliable coding and billing</td>
</tr>
<tr>
<td></td>
<td>Addition of physician extenders</td>
</tr>
<tr>
<td></td>
<td>Less critical care</td>
</tr>
<tr>
<td></td>
<td>Stipend for on call services</td>
</tr>
<tr>
<td></td>
<td>Large group centralized diversified practice (emergency medicine practice model)</td>
</tr>
<tr>
<td></td>
<td>Addition of selected orthopedic and neurosurgical procedures</td>
</tr>
</tbody>
</table>
medicine physicians with rapid transfer to regional centers with acute care surgeons on staff; 42 percent disagree or strongly disagree and 18 percent are neutral. Curiously, at the same time, 84 percent of respondents disagree that trauma surgeons do not need to evaluate patients in the emergency department if an emergency medicine physician is already there.

The modifications to current surgical practice that are perceived as making the practice ideal from a trauma surgery standpoint are noted in Table 4 (on page 18). Those viewed as most important by the majority of respondents seem to revolve around reimbursement and lifestyle. Of note, 65 percent responded that on-call stipends are regarded as an important and beneficial modification. The most important characteristic believed to reflect an ideal general surgical practice with a major trauma component were guaranteed appropriate salary, guaranteed time away from practice, and subsidized ancillary benefits (health insurance, financial planning, malpractice coverage, and so forth). Of intermediate importance were less critical care, more general surgery, less night call with increasing seniority, use of physician extenders, and billing and coding support. Of least importance were large group practice and addition of neurosurgical and orthopaedic procedures.

Reflections on the findings

These findings are similar to, and thus corroborate, the findings of others who conducted similar surveys. These collective data validate results of the individual studies that are subject to criticisms of poor response rates and selection bias such as trauma surgeons only versus general surgeons only and responders versus nonresponders.

This study shows that the majority of general surgical practice appears rooted in routine abdominal and biliary surgery with a fair amount of endoscopy and laparoscopy supplementing more invasive procedures. Although results are not stratified accordingly, one would speculate the majority of complex procedures are being performed predominantly in urban academic centers speaking to de facto regionalization.

Of surprise and concern is the lack of business practice and savvy reflected by the information on knowledge of charge capture rates, claim denials, and profile of denials. Although it seems that many respondents are concerned with reimbursement and look externally for the solution, perhaps a modicum of introspection and assessment of practice business factors might be equally in order. The American College of Surgeons has ample resources and established educational programs devoted to this vital, nonclinical aspect of practice. Perhaps increased emphasis on the importance of the billing, coding, and collection processes and further marketing of education in business tactics would be beneficial.

The issue of on-call stipends continues to be controversial and vexing. It appears that approximately one-third of responding general surgeons receive stipends for taking call. Of more interest is the number who believe these stipends would give them incentive to provide essential services. This may be in reaction to the stipends currently being extracted by others and a desire for parity. No matter what the reason for seeking stipends, such practices may publicly call into question professional values and motives.

There appears to be advancing support for the metamorphosis of trauma surgery into the discipline of acute care surgery. The findings of this survey echo the sentiments conveyed in a survey of predominantly academic trauma surgeons on this paradigm shift.9

Among with attention to the scope of practice and training, equally, if not more important, are the issues of lifestyle and practice model for both groups surveyed. Furthermore, this sample of predominantly general surgeons supports regionalization of services to achieve the goals of broad practice scope, hospital-based practice, and controllable lifestyles. They also endorse the concept of funding such regionalized services through the public tax base. Although overall regionalization seems to be supported, there is some perceived ambivalence with regard to the role of the surgeon versus the emergency medicine physician in the initial care of trauma patients. These system and interdisciplinary issues will need to be further explored and resolved.

These findings also suggest emergency and elective general surgery are currently not restricted in most practice settings. It appears that
performance of such cases by trauma surgeons would not only be supported but is seen as essential by most rank-and-file general surgeons.

Finally, although quite contentious, inclusion of limited orthopaedic and neurosurgical procedures in the scope of training and practice is supported. This support is offered by those surgeons categorizing themselves as primarily general surgeons to much the same degree as those who categorize themselves as primarily trauma surgeons. The specifics of exactly what is included in future curricula and practice, and how competence is monitored and assured, remains to be negotiated. Given the level of support from general surgeons, the findings suggest these changes in tradition are not merely the self-serving wants of a special-interest group of trauma surgeons. This broad support for such changes in scope of practice warrant that they should not be neglected or omitted.

In summary, there is a growing body of evidence indicating why and how trauma surgery and, perhaps, general surgery training and practice should change. This survey adds to that bank of information. Though change is difficult, it appears that it must occur if the “House of Surgery” is to weather the future and stand strong so it can continue to offer sound protection to those patients who seek refuge within its walls.

References

Fundamentals of Prudent Investing

by
George Pendergast
and
Beth Rabbitt.
Boston, MA

George Pendergast, a managing director at Cambridge Associates, and Beth Rabbitt discuss in the following article the fundamentals of prudent investing, including asset allocation, diversification of investments, and rebalancing of investment portfolios. Since 1999, the American College of Surgeons has engaged Cambridge Associates as its investment consultant in the management of its endowment funds. Using the fundamentals presented here, surgeons can apply this investment knowledge and simple strategies to the management of their practice. How? By understanding how asset allocation drives investment returns, which will prove critical when planning for expansions, purchasing equipment, and budgeting for future expenses in your practice.

Mr. Pendergast will also be presenting this topic at this year’s Clinical Congress in Chicago, IL. Because this information will lay the foundation for improving your investment knowledge, it will be offered twice, one session on Sunday (GS112) and one on Monday (GS113), at times the College hopes will be most convenient for meeting attendees.

—Thomas R. Russell, MD, FACS,
ACS Executive Director

SEPTEMBER 2006 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
When thinking about successful investing practices and asset management, many harbor the stereotypical Wall Street Week mentality—with a broker on speed dial and a gazillion megabytes of Internet analysis and information on hand, you can operate with the certainty that there are endless opportunities out there to buy unfollowed stocks at $5 and sell at $300, achieving amazing day-trading profits and a portfolio that always beats the market.

Although this notion is romantic, it is hardly practical for the rest of us. Picking individual investments is a risky and time-consuming proposition and the whole process of personal investing in this fashion can be intimidating and overwhelming. However, as will be discussed in this article, successful, prudent personal investing does not require preternatural short-term abilities, but rather long-term focus, discipline, and perspective. Using the right tools in your own portfolio can simplify the process and help ensure that you meet your goals. To use a tired Boston investing adage, “It’s a marathon, not a sprint.”

What is investing for long-term success?

Although it is tempting to focus on the short-term results of investments (for example, my portfolio is up 4% this month, down 2% the next), it is more important to think about your goals with a long-term perspective. When preparing for future retirement, we are often talking about time periods of 10 years or more, not days or months. The strategy needed to have investment gains over the long haul is very different from that of choosing an individual investment and measuring its performance on a day-to-day basis. Most stocks perform well at some point in their history. When investing for your future, what you want is more than incredibly good returns at one point in time. What is needed in this case is a consistent pattern of long-term performance.

What really matters in long-term investing?

Most people point to individual stock selection and market timing as the number-one factor in success.* However, the findings of several researchers are powerful reminders that what people think does not necessarily translate to reality. (See Figure 1, this page.)

It turns out that what is most important is not the specific stocks you pick but the overall composition of your investment portfolio or asset allocation. This crucial composition accounts for 90 percent of your investment results over time.

The bottom line is that, although it is tempting to think that investment success is mostly about being great at picking individual stocks—a myth many day-traders take to the extreme—in the long run, it is the allocation of your assets that really drives performance. The impact of market timing and individual stock selection pales in comparison to the impact of getting your allocation right. Once you have put the time into creating an asset allocation policy that is right for you, given your timeline and objectives, what is really required is staying focused and being disciplined in implementing your investment plan.

Creating an appropriate personal asset allocation policy

All investments share two common characteristics: return, or how much an asset increases in value over time, and risk, or how volatile the value of the asset can be on a short-term basis (in the investment world, risk is often measured in standard deviation). Generally these two characteristics have a positive relationship—as expected return increases, so does risk.

Creating a personal asset allocation therefore starts with one simple decision: How much return do you want and how much risk are you willing to accept to get it? This fundamental tradeoff should form the basis for any investment decision you make.

The choices people make usually are dependent on their investment horizon (when they plan to retire or will need to tap into their funds) and their own affinity for risk. A highly risk-averse investor—for example, a surgeon who plans to retire in a few years—will most likely decide to choose an allocation with lower return in exchange for the security of knowing that the chance of losing a portion of his or her assets is slim. Conversely, recent medical school graduates with 40 years before retirement can invest more aggressively because they have a longer time to both see the returns on their investment as well as recoup any losses in down periods.

Figure 2

Average Annual Compound Returns (%):
- Equities: 6.61
- Bonds: 2.39
- Cash: 1.11

Tools of the trade: Equities, bonds, and cash

Given that inflation averages approximately 3 percent a year, you need to seek a return of greater than that to merely preserve your personal wealth. When it comes down to it, most amateur market watchers have three choices for investing assets: stocks, bonds, and cash. Stocks (or “equities”) offer the highest potential for return. However, they are generally the most volatile. Bonds offer a safer bet, but in most markets, you can expect a significantly lower return. Cash and

<table>
<thead>
<tr>
<th>Percent invested in U.S. stocks</th>
<th>Investor 1</th>
<th>Investor 2</th>
<th>Investor 3</th>
<th>Investor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>50%</td>
<td>70%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Percent invested in U.S. bond</td>
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<td>50</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Expected real return after inflation</td>
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<td>3.4</td>
<td>4.3</td>
<td>5.8</td>
</tr>
<tr>
<td>Expected risk (standard deviation)</td>
<td>7</td>
<td>9.9</td>
<td>12.3</td>
<td>16.5</td>
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</table>

These data use the S&P 500 Index as the basis for a U.S. equity investment and the Lehman Brothers Aggregate Bond Index as the basis of a U.S. bond investment.
its equivalents, such as money markets, are a safe bet for short-term use, but you can incur a higher opportunity cost (or loss of benefits from investing those funds elsewhere) for holding on to too much of it.

Figure 2 on page 23 shows the cumulative real gain of a dollar invested in the three asset classes since 1900. As you will see, stocks clearly beat bonds and cash in the long run, providing the highest return over time.

However, what also is clear is the fact that stocks are more volatile, and the variability of the peaks and valleys in the return line in Figure 2 shows this fact. If you invested 100 percent of your assets in stocks at the wrong time, you could risk losing a significant portion of your assets in one year alone. In order to hedge against this downside risk, you need to use an asset allocation that is appropriately diversified. Diversification is a powerful tool for reducing overall risk and increasing the probability of achieving a consistent pattern of returns.

The case for diversification

Despite the fact that it is a cliché, the old saying that you should not put all of your eggs in one basket is particularly true when it comes to personal investing. The more diversified you are, the better return you can get for any given amount of risk.

The Table on page 24 shows the risk and return profiles of four investors with four different personal asset allocations. Investor 1 is highly conservative, investing all his assets in a U.S. bond fund. Investor 4, on the opposite end, is highly aggressive, putting all her cash into the U.S. stock market fund. Investors 2 and 3 take a more moderate approach, investing their assets in a mixture of U.S. stocks and bonds.

If each of these investors invested $100 dollars in their respective allocations, rebalancing their portfolios back to their targets over a 10-year period, where would they be now? Figure 3 (page 24) simulates the returns of the four portfolios.

Despite the fact that Investor 4 does end up in a marginally wealthier position at the end of the 10-year period, this investor experienced a much higher level of risk and endured a roller-coaster ride in the market. Depending on when she needed to retire, the probability of being able to predict her financial position would be low. Conversely, through diversification, Investors 2 and 3 experienced a much smoother ride with less risk and more certainty and enjoy returns in the end that are fairly comparable to the more aggressive position.

Obviously, this scenario simplifies the story a bit. As an investor today, you have many options beyond just investing in U.S. stocks and bonds. Mutual funds offer an opportunity to access a more diverse group of investments through a pool of funds than you would on your own. Global investments also offer a way to diversify into different markets. Finally, investing in specific sectors such as real estate or energy can also tap into new opportunities for return and tend to be less correlated with one another, which is another way of diversifying your risk.

What now?

Meeting with a financial advisor can be a great way to start the process of creating a diversified asset allocation that fits your time horizon and objectives. Many mutual fund companies will offer free assessments online or in person. Once you have figured out an allocation that works for you, stick with it. Consistent rebalancing back to your targets on a regular basis (such as annually) will lower your risk and help you meet your goals. Rebalancing requires diligent discipline, primarily because it often means selling your most successful investments and adding to your underperforming ones. It is the opposite of “momentum” or “market-timing” investing, which, in the long run, is a good thing. By staying focused, you will have a greater potential of achieving your investment objectives prudently.

Mr. Pendergast is a managing director at Cambridge Associates, Boston, MA.

Ms. Rabbitt is a business development associate at Cambridge Associates, Boston, MA.
Finance update

by Gay L. Vincent, CPA, ACS Comptroller, Chicago, IL

The American College of Surgeons Endowment Fund consists of funds designated by the ACS Board of Regents, affiliate organization funds, and donor-restricted funds. As of June 30, 2005, the donor-restricted and affiliate organization funds composed less than 10 percent of the total fund.

The College’s endowment funds are managed by the Investment Subcommittee of the Board of Regents’ Finance Committee. In 1999, the Board hired Cambridge Associates to provide consulting services to the endowment fund. The investment returns for the endowment fund have been above the total fund’s benchmark as reflected in the chart on this page.

The benchmark is based on the endowment fund’s allocation between equity (70% using the S&P 500 Index) and fixed income (30% using the Lehman Brothers Aggregate Bond Index). This generalized benchmark has been used for the total investment fund. Individual benchmarks are used to measure and compare performance for each individual money manager (for example, NAREIT Equity Index, MSCI EAFE Index, MSCI Emerging Markets Index, and so on). The endowment fund employs a simple strategy of asset allocation, diversification, and rebalancing.

The Board of Regents adopted the concept of a spending rate for the endowment fund that allows up to 5 percent of the fund to be used by the College to cover new programs and initiatives and to help cover the costs of programs that are supported by membership dues. The endowment fund’s returns have helped the College maintain its existing dues structure, provided funds for new programs and initiatives, and provided continual funding for annual scholarship awards of more than $1.5 million.

This year, for the first time, the College will sponsor continuing medical education programs at the Clinical Congress designed to provide surgeons with investment knowledge and simple strategies they can apply to the management of their practice. (See page 28 for more information on these programs.) Understanding how asset allocation drives investment returns will prove critical when planning for expansions, purchasing equipment, and budgeting for future expenses in the surgeon’s medical practice. The programs will incorporate the endowment fund’s simple strategy of asset allocation, diversification, and rebalancing.
The Surgeons Asset Management, LLC (SAM) Board of Directors held its organizational meeting on June 8 in Chicago, IL. SAM was constituted to manage and advise the Surgeons Diversified Investment Fund (SDIF), a new mutual fund sponsored by the American College of Surgeons.

SDIF is available to U.S. citizen members of the College and their families and their employees; and to affiliated retirement plans, physician practice plans, and U.S. medical societies and associations that include members of the College in their organization. SDIF seeks to provide investors with long-term capital appreciation and income by investing in a variety of ETFs (exchange traded funds) among several asset classes.

SDIF is intended to provide an opportunity for its shareholders to invest their assets and benefit from asset allocation, diversification, and rebalancing.
George Pendergast, a managing director of Cambridge Associates, will discuss the fundamentals of investing, including asset allocation, diversification, and rebalancing. Surgeons need to plan early in their careers in order to build a solid financial future for their medical practices and themselves. The task sounds daunting; however, with a little fundamental knowledge and by following a few simple strategies, any surgeon can gain considerable investment savvy. This luncheon session will be beneficial for both members of the College and their spouses.

Because this session will lay the foundation for improving your investment knowledge, it will be offered again on Monday, October 9, from 9:30 to 10:30 am. (Monday’s session is not a luncheon.)

Panel Discussion:
**Equity Investments vs. Fixed Income Investments**
*Tuesday, October 10, 2006 | 1:30-3:00 pm*

*Introduction:*  
John L. Cameron, MD, FACS, Baltimore, MD, Treasurer, American College of Surgeons

The panel will include four nationally recognized money managers from leading investment management firms who will discuss investment options, risk tolerances, and the advantages and disadvantages of equity versus fixed income. This session is sponsored by the Finance Liaison Committee of the Board of Regents as a continuing effort to assist members in need of new ideas and innovative resources to enhance their ability to manage money now and in the future.

Surgeons’ Roundtable:
**An Open Discussion of Investment Experiences**
*Tuesday, October 10, 2006 | 4:00-5:00 pm*

College leaders will share investment experiences, mistakes, and lessons learned. The goal of this session is to increase participants’ investment savvy so they can become smarter money managers. This high tea event will be held at the Hilton Chicago. Participants include Charles D. Mabry, MD, FACS, Pine Bluff, AR; Thomas R. Russell, MD, FACS, Executive Director, American College of Surgeons, Chicago, IL; Josef E. Fischer, MD, FACS, Boston, MA; and John L. Cameron, MD, FACS, Baltimore, MD.

To register for these Sessions of Special Interest, use the Social Program Registration form, which is available online at [www.facs.org/clincon2006/social/socialregform.pdf](http://www.facs.org/clincon2006/social/socialregform.pdf).
The following statement was developed in order to assist trauma centers in identifying problem drinkers and in providing interventions for drinkers who are at risk to harm themselves and others. Brief interventions for problem drinkers have been shown to decrease recidivism among trauma patients, thus serving as an excellent prevention measure. However, although most trauma surgeons support such activity, in the majority of states, it is legal for an insurer to withhold payment to a treating physician or hospital if information demonstrates that the patient was intoxicated at the time of the injury. These states enacted their version of the Uniform Accident and Sickness Policy Provision Law in 1950.1 In 2001, the National Association of Insurance Commissioners voted unanimously to correct this law in favor of providing payment for injured patients, irrespective of drug or alcohol involvement. However, such legislative change must be accomplished at the state level and, to date, only eight states have done so. This statement was developed to assist trauma surgeons and trauma centers in understanding this legislation and to encourage support for changes in insurance laws so that the hospital and treating physicians will not be penalized for providing an intervention that decreases the risk of future injury and death.

Alcohol is involved in some way in 30 percent to 50 percent of all traumatic injuries, and screening and interventions for problem drinkers have been shown to decrease recidivism at trauma centers.2 In 1950, the insurance codes of 38 states incorporated the Uniform Accident and Sickness Policy Provision Law (Model 180, UPPL), which states that the insurer would not be liable for any loss sustained or contracted as a consequence of the insured’s being intoxicated or under the influence of any narcotic unless administered on the advice of a physician. Some insurance companies have invoked this law as a reason to discriminate against patients who are injured while intoxi-
cated. More recently, the National Association of Insurance Commissioners voted unanimously for an amendment to Model 180 that states that this provision may not be used with respect to hospital, medical, or surgical coverage for an accident or sickness. However, adoption of this amendment requires approval at each state legislature.

The American College of Surgeons recognizes the following facts:

- 30 percent to 50 percent of injured patients have a positive blood alcohol concentration at the time of trauma center admission
- 83 percent of trauma surgeons believe that the trauma center is the appropriate place to provide interventions for injured patients who test positive for alcohol
- Identifying patients with underlying substance use disorders provides trauma centers with an opportunity to perform interventions to motivate patients to accept treatment and counseling
- Alcohol interventions provided in trauma centers reduce the patient’s risk of reinjury by nearly 50 percent and are cost-effective, saving $4 for every $1 invested
- Many trauma centers and trauma surgeons are reluctant to measure alcohol levels in states where the UPPL is upheld

In consideration of these facts, the National Association of Insurance Commissioners (NAIC) unanimously passed a new model law in 2001, which would prohibit insurers from denying coverage at trauma centers on the basis of patient intoxication. To date, eight states have adopted this model law.

Therefore, the American College of Surgeons strongly supports the new 2001 NAIC model law and encourages adoption of this legislation in all states. This action will enable trauma centers to fulfill their obligation to provide alcohol screening and interventions for problem drinkers as part of their program to prevent injuries and will ensure that access to needed care will not be denied on the basis of the UPPL.

References

Medicare changes
by the Division of Advocacy and Health Policy

The federal government typically implements changes to Medicare at the beginning of the final quarter of each fiscal year; the last quarter of 2006, which starts October 1, is no exception.

However, this year surgeons should be prepared for one big difference at the end of the third quarter—a nine-day delay in payments at the end of September. Details about this change are provided in “Dateline: Washington” on page 6 of this issue. This article discusses the other modifications to Medicare coding and billing that surgeons should anticipate in September and October.

Diagnostic codes
Physicians must use updated International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnostic codes for claims related to services provided on or after October 1. A complete list of the more than 200 codes that have been revised is available at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage. To view and download the codes, click on “New Diagnosis Codes-Effective 10/01/2006 [PDF 120KB]-Updated 6/1/06 (final version).” Additional information is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5142.pdf.

Screening mammography
Currently, claims for screening mammography may not include codes for other services. This policy changes on October 1, when physicians may start using the same claim to bill for both a screening mammography and other services provided.

To do so, use diagnosis codes V76.11 (Screening mammogram for high-risk patient) or V76.12 (Other screening mammogram) as the secondary diagnosis on claims that include other services. Additional information is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5050.pdf.

Around the corner
September
• No Medicare payments will be made from September 22 through 30. Payments that were to be made during that time will be made October 2.
• ACS-sponsored basic and advanced coding workshops for surgeons and their office staff will be held September 21 and 22 in Boston, MA. To register, visit the ACS coding workshop Web page at http://www.facs.org/ahp/workshops/index.html.
• Economedix will hold a teleconference, Dealing with Difficult People, on September 13 and another, Maximizing Patient Collections, on September 27. For more information and to register, visit http://yourmedpractice.com/ACS or phone 877/401-9655.

October
• Medicare requires updated ICD-9-CM diagnostic coding on claims with dates of service on and after October 1.
• Medicare will implement the Correct Coding Initiative, version 12.3, on October 1.
• ACS-sponsored basic and advanced coding workshops for surgeons and their office staff will be held October 9 and 11 at the Clinical Congress in Chicago, IL. Advanced registration has closed but spaces may still be available for on-site registration.
• Economedix will hold a teleconference, ICD-9-CM Coding and Changes for 2007, on October 25. For more information and to register, visit http://yourmedpractice.com/ACS or phone 877/401-9655.

Claims status indicators
Practices that bill Medicare electronically and use health care claim status transactions will experience a change on October 2. On that date, carriers will begin using a revised list of claim status categories and codes. To view and download a complete list of the codes, go to http://www.wpc-edl.com/codes and click on Claim Status Codes or Claim Status Category Codes. Additional information is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5137.pdf.

continued on page 64
The ACS Leadership Conference for Chapter Leaders and Young Surgeons took place June 11–13 in Washington, DC. Highlights of the program, coordinated by the College’s Division of Advocacy and Health Policy and Division of Member Services, included presentations by political analysts and physician members of the U.S. House of Representatives. Surgeon conferees also had opportunities to meet with their legislators and congressional staff. Approximately 150 individuals attended the meeting, including surgeons, residents, speakers, and College staff.

**General sessions**
Kicking off the program was a day of concurrent sessions for chapter leaders/administrators and for young surgeons, which focused largely on their daily needs as organizations and surgeons. For example, chapter leaders/administrators participated in sessions on young surgeon membership needs and expectations and on the ACS National Surgical Quality Improvement Program (NSQIP).

Paul Pomerantz, executive vice-president of the American Society of Plastic Surgery (ASPS), explained how that organization used market research to launch a series of initiatives to attract, retain, and engage young members. In addition, Mr. Pomerantz led a discussion on generational differences and how organizations can serve surgeons at each stage of their careers.

In addition, Kathy Rowell, executive vice-president of QCMetrix, spoke about the NSQIP. Ms. Rowell explained the program’s purposes and functions and examined NSQIP effects on surgeons and their institutions, including its potential use in determining pay for performance (P4P).

Meanwhile, young surgeons learned about contracting and leadership skills. The session on contracting included a discussion of the pros and cons of Medicare participation, led by Frank G. Opelka, MD, FACS. Dr. Opelka, associate dean for health care quality and safety at Louisiana State University, New Orleans, and a member of the College’s General Surgery Coding and Reimbursement Committee, also talked about contract provisions as they relate to career progression. Mark Rust, JD, an attorney with Barnes & Thornburg, LLP, reviewed the important components of surgeons’ employment contracts.

Meanwhile, young surgeon attendees sharpened their leadership skills in a session mod-
erated by Terry Buchmiller, MD, FACS, Chair of the ACS Committee on Young Surgeons. During this panel discussion, John M. Daly, MD, FACS, dean of Temple University School of Medicine, spoke about conflict resolution in the office, operating room, and other business settings. Bruce Gewertz, MD, FACS, chair of the department of surgery at the University of Chicago, outlined strategies for running a safe and successful operating room. ACS Executive Director Thomas R. Russell, MD, FACS, responded to young surgeons’ queries.

**Welcoming/opening remarks**

ACS President Kathryn D. Anderson, MD, FACS, welcomed the meeting participants and spoke about the College’s efforts to promote an optimal and ethical practical environment. Dr. Anderson explained how the humanitarian ideals that she has sought to advance during her presidential year support this mission. “Our humanity demands that we provide the best care to patients,” Dr. Anderson said.

In the meeting’s opening remarks, Thomas Ault, principal at Health Policy Alternatives, Inc., a consulting firm, addressed Medicare physician payment updates. He noted that, under the current reimbursement system, surgeons will receive negative annual updates in fiscal years 2007 to 2015.

Mr. Ault said that these payment cuts are the result of Medicare’s use of the sustainable growth rate (SGR) in setting spending targets for physician services. According to Mr. Ault, unless Congress enacts legislation eliminating the SGR from the formula used to calculate Medicare payment, “Physicians really are facing a cliff.”

Options for payment reform include establishing individualized spending targets based on the unique nature of the services surgeons and other specialists provide, a concept the College endorses, Mr. Ault noted. He added that the Medicare Payment Advisory Commission (MedPAC), which recommends changes in reimbursement policies to Congress, has suggested that Medicare adopt a P4P methodology.

If Congress continues to avoid passing major changes in the Medicare fee schedule because of the high costs associated with such reforms, the Centers for Medicare & Medicaid Services (CMS) could make some administrative adjustments, according to Mr. Ault. These fixes, however, would result in increased beneficiary copayments and premiums.

Although all physicians have experienced payment reductions in recent years, surgeons have been particularly hard hit. “The American College of Physicians says that primary care is on the verge of collapse. Isn’t it time to think about the collapse of surgery?” Mr. Ault concluded.

**Outside influences**

Dr. Russell moderated a session featuring representatives from several national organizations that are interested in linking Medicare payment to quality.
Janet Corrigan, PhD, MBA, president and chief executive officer of the National Quality Forum (NQF), explained that the NQF was created in 1998 for purposes of improving quality measures. NQF became operational in 2000 and this year began a strategic repositioning process. NQF membership is open to the range of stakeholders and includes public and private purchasers of care, as well as medical organizations, such as the College, Dr. Corrigan said.

Because gaps in quality measures are prevalent at this time, the NQF would like national goals set to guide measure selection, Dr. Corrigan said. She noted that the Institute of Medicine (IOM) has called for more rapid development of measurement sets that reflect shared accountability for outcomes. The IOM also is seeking longitudinal measures of resource use, she said.

In addition, the NQF is attempting to develop a smoother process for moving quality measures into the marketplace and is looking forward to greater collaboration with all member groups in the future. “We really are embarking on a period of rapid and fundamental change in both the environment of care and the health care setting,” Dr. Corrigan noted.

Carmella Bocchino, executive vice-president of America’s Health Insurance Plans, spoke on behalf of the Ambulatory Care Quality Alliance (AQA). Ms. Bocchino noted that the IOM has released reports on medical errors, quality, and access and that a RAND study shows that evidence-based care is used in only approximately half the cases.

P4P actually was developed in response to these problems, Ms. Bocchino said. The current system encourages misuse of resources, and employers who offer health insurance benefits complain about the cost associated with wasteful efforts, such as redundant testing. P4P developed from the premise that the health care providers and professionals should reward quality, not quantity, of care, she added.

The major function of the AQA is to introduce quality measures to the marketplace. “AQA does not develop quality measures. AQA brings them into the public sector,” Ms. Bocchino said.

Michael Rapp, MD, JD, FACEP, director of Quality Development Measurement and Health Assessment Group, Office of Clinical Standards and Quality at CMS, noted that Medicare and Medicaid pay for approximately half of all the health services delivered in the U.S. Like employers, these public payors are looking to reimburse participating providers on the basis of quality, not volume, of care.

Another major initiative for CMS is encouraging “transparency” in the system through quality and cost reporting. A voluntary program for physicians just started this year, Dr. Rapp noted.

As the government and other stakeholders attempt to reform the health care system, the focus must be on the needs of patients. “Some of us in this room are physicians, but all of us are patients,” Dr. Rapp observed. Hence, a primary goal is to make the system more patient-centered.
**View from Capitol Hill**

Brett Loper, chief of staff to Rep. Jim McCrery (R-LA), Chair of the House Ways and Means Subcommittee on Health, offered a political and legislative outlook. (Representative McCrery was scheduled to speak but cancelled because of health problems.)

“It’s not a great environment for Republicans right now, primarily because of Iraq,” Mr. Loper said. “The anxiety it creates seeps into other areas as well.” He noted that political dynamics are particularly acute in election years, such as this one. "Less gets done because no one wants to offend his or her constituencies.

Nonetheless, Congress is making progress on a few fronts, Mr. Loper said. A supplemental spending bill was near completion at the time of the meeting. Congress intends to address the physician payment issue in the near future because, as Mr. Loper added, “The path we’ve been on is unsustainable.”

Representative McCrery is in a good position to replace retiring Rep. Bill Thomas (R-CA) as Chair of the Ways and Means Committee if the Republicans retain control of the House next year, Mr. Loper said. If he attains that post, the congressman is likely to ensure that the committee addresses Medicare, Social Security, and tax reforms.

More general health care reforms are also likely as the result of concerns that “American business cannot compete worldwide because of health care costs,” Mr. Loper said. He noted that national legislation similar to the Massachusetts law requiring everyone to have some form of health insurance may be introduced with bipartisan support.

Also speaking on Representative McCrery’s behalf was Laura Bozell, his health legislative assistant. Issues that the Ways and Means Health Subcommittee is set to address include liability reform, health information technology, and voluntary outcome reporting and measures, Ms. Bozell said, applauding the College’s contributions to the quality discussion.

**Quality improvement efforts**

Information about how the College is tackling the quality issue was provided during a panel discussion that Dr. Russell moderated.

According to R. Scott Jones, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, the practice of medicine has become “an adversarial enterprise that is driven by money.” As a result, the system pits hospital against hospital, physician against physician, against hospital, and so on, he said.

Dr. Jones called upon surgeons to put aside their financial grievances and focus on improving the quality and safety of patient care. “We need to promote the interests of the sick and the public. We need to earn and keep the public’s trust,” he said.

“Quality surgical care is easy to define,” Dr. Jones added. It’s about making the correct diagnosis and providing the proper outcome. The bigger question is, “What processes need to be in place to ensure quality care is offered?” he said.

The College is engaged in several activities that examine processes of care, including the ACS NSQIP. Dr. Jones said. In addition, the College’s National Cancer Data Base is undergoing a major overhaul and information collected through this repository is being submitted to the NQF for approval. So far, the NQF has approved quality of care measures for breast and colon cancers that the College has submitted.

Furthermore, the College is examining the 1,700 guidelines for surgery in existence to determine their scientific validity. Dr. Jones said it is likely that surgical residents and other young surgeons will be involved in this process.

Dr. Jones encouraged the meeting participants to “live by the scientific method and do what we went into surgery to do,” which is to provide safe, quality care to patients.

“Quality problems are everywhere,” Dr. Opelka added. Hence, recent efforts to reform the health care system are “all about value.” “Currently, we operate in a zero-sum value system” mired in “dysfunctional competition,” he added.

Dr. Opelka chairs the surgical panel for the AQA. “Our common purpose [on this subgroup] is to create patient value. It is critically important that we develop surgical quality measures,” he said.
Election outlook

Charlie Cook, editor and publisher of The Cook Political Report, provided insights into current political trends and the upcoming congressional elections.

“The macro way of looking at elections would suggest that it’s going to be really bad for Republicans,” Mr. Cook said. According to recent polls, 61 percent of Americans believe the nation is on the wrong track, and Congress’ job approval rating is approximately 27 percent to 32 percent. As a result, Mr. Cook added, “Republicans will probably lose seats in the Senate but will retain control” because the Democrats don’t have any strong challengers. Republicans may lose their majority in the House, however.

With regard to possible Republican presidential candidates in 2008, Mr. Cook named the following individuals: Arizona Sen. John McCain; former New York City Mayor Rudolph Giuliani; Tennessee Sen. Bill Frist, MD, FACS; former Speaker of the House Newt Gingrich of Georgia; and New York Gov. George Pataki. However, most of these individuals cannot bridge the gap between “secular Republicans” (fiscal conservatives) and “sacred Republicans” (social conservatives). Republicans who may have crossover appeal include Virginia Sen. George Allen and Massachusetts Gov. Mitt Romney, Mr. Cook said.

Leading the list of contenders for the Democrats are New York Sen. Hilary Clinton and former vice-presidential candidate John Edwards of North Carolina. However, because most Democrats believe Senator Clinton would lose a general election, the odds of her receiving the party’s nomination are limited, Mr. Cook said. He noted that most of the Democrats elected president have been from the South because voters, most of whom are centrists with a slight lean to the right, tend to assume that southern Democrats are more moderate than their northern counterparts.

Communicating with officials

Ilona Nickels, congressional scholar for the Center on Congress at Indiana University, instructed participants in effective communication with representatives and senators.

“The most important thing is to be timely,” Ms. Nickels said. “It’s really hard for them to focus on anything for more than a week at a time,” she added. Hence, surgeons should meet with legislators in Washington when issues of concern are on Congress’ radar screen. Surgeons seeking to build a relationship with a legislator or to provide a more comprehensive overview of a topic should visit the individual’s home office, where he or she is less likely to be distracted.

Ms. Nickels said it is important that individuals who are trying to influence members of Congress understand their elected officials’ perspectives and to create two-way communication. She also advised surgeon advocates to “local-ize the issue” to every extent possible. “Every member of Congress knows who drives elections. They answer to the majority of those who vote,” she said.

In addition, Ms. Nickels offered her perspective on the upcoming elections. “Democrats have raised 85 percent of what the Republicans have in campaign contributions,” she said, noting that this financial disparity puts them at a disadvantage. She also noted that despite concerns about the way President Bush and congressional Republicans have handled both domestic and foreign policy issues, including the war in Iraq, voters still believe they are better able to protect the U.S. from attack. “9/11 created the poli-
tics of fear. National security became the dominant issue, particularly for women,” Ms. Nickels noted.

**ACSPA SurgeonsPAC**

The organization that is helping surgeons gain more influence in Washington, DC, is the American College of Surgeons Professional Association political action committee (ACSPA SurgeonsPAC). Andrew Warshaw, MD, FACS, PAC Chair, provided an update on the group’s activities.

Topping the list of issues that the ACSPA SurgeonsPAC is addressing is reimbursement. “Physician payment was threatened and will continue to be threatened” until the SGR is changed, Dr. Warshaw said. Increasing the likelihood that the Medicare payment system will be reformed in a way that ensures surgeons will be treated equitably is the fact that two Fellows of the College have been appointed to the Medicare Payment Advisory Commission, Dr. Warshaw said, adding that progress on this battle front is “little by little, hill by hill.”

In addition to seeking payment reform, the ACSPA SurgeonsPAC is attempting to secure the passage of tort reform legislation. “Access is the message” in this effort, which poses the question, “Will a surgeon be there?” Dr. Warshaw said.

Although the PAC is making progress, “We are underperforming,” Dr. Warshaw said. “Unless you act, nothing’s going to happen. You have to be part of the process,” he added, encouraging surgeons to contribute to the PAC.

**State Affairs**

This year’s Arthur Ellenberger Award for Excellence in State Advocacy was presented to Thomas R. Gadacz, MD, FACS, of the Georgia Chapter. Dr. Gadacz was honored for his efforts to change the state’s certificate of need program to recognize general surgery as an individual specialty. “It’s somewhat surprising that someone would get an award for stirring up trouble,” Dr. Gadacz said. He noted that the fight in Georgia to modify the certificate of need language continues, and he believes “we’re taking the high ground on this.”

Melinda Baker, State Affairs Associate, ACS Division of Advocacy and Health Policy, updated participants on state-level activities. She explained that the College’s Health Policy Steering Committee has directed State Affairs staff to monitor specific issues, including regulation of office-based surgery, trauma planning and development, provider taxes, liability reform, and scope of practice.

Ms. Baker noted that approximately 90,000 bills are introduced at the state level within a six-month period, making it difficult for a two-person staff to monitor every bill and determine its relevance to surgery. Therefore, she asked the meeting participants to keep her informed about the issues of concern in their states.

**Briefings**

The College’s Washington Office staff provided details about several issues that surgeons should consider addressing during their visits to Capitol Hill.
during a session moderated by Christian Shalgian, Manager of Legislative Affairs, Division of Advocacy and Health Policy.

More specifically, Shawn Friesen, Government Affairs Associate, spoke about the problems with Medicare physician payment and the potential development of a P4P approach to reform. Mr. Shalgian spoke about the medical liability crisis and its effects on access to care. Adrienne Roberts, Government Affairs Associate, spoke about cuts in trauma systems development and financing programs, and Geoffrey Werth, Government Affairs Associate, spoke about health information technology and quality issues.

Physician congressmen

Physician members of the House of Representatives addressed the meeting participants before their Capitol Hill visits. Rep. Mike Burgess, MD (R-TX), noted that legislation authorizing trauma systems development is “actually about two or three years overdue” and should be a high-priority item, given that “trauma is one of the leading causes of death” in this country.

Nonetheless, “The most vexing problem on Capitol Hill is physician payment,” the congressman said. Representative Burgess said he believes the most sensible approach would be to move away from use of the sustainable growth rate and toward the Medicare Economic Index as a measure of spending. In addition, the representative said Medicare should consider reinstating balanced billing for some services. If some steps aren’t taken to fix the system, he added, “People at the peak of their skills...are going to drop out.”

Rep. Charles Boustany, MD, FACS (R-LA), addressed some of the lessons learned about emergency response in the aftermath of Hurricane Katrina. “The hurricanes unmasked problems with disaster preparedness,” he said, adding that a major reason for the delays in response was that initiating any action required cutting through layers of bureaucracy at the state and federal levels.

The initiatives that did prove successful, such as the relocation of evacuees to the congressman’s hometown of Lafayette, were the result of “individuals pulling together and building from the ground up. We had no plan. We had to do it all on the fly,” Representative Boustany said.

Rep. Tom Price, MD, FACS (R-GA), agreed with Representative Boustany’s sentiments, adding, “If you think government is the answer, then you’re in trouble.” He went on to state that “the only thing holding the [health care] system together is the altruism of physicians” who are willing to put their patients ahead of their incomes.

To help alleviate some of the problems, “We need to put patients in charge of their health care,” Representative Price said. Noting that approximately 45 million Americans are without health insurance, he said, “We need to move to a system where everyone has insurance.”

Rep. Phil Gingrey, MD (R-GA), talked about medical liability reform and electronic medical records: “I’ll be honest, I’m sick of talking about tort reform... I’m not giving up on tort reform.
I think eventually it will pass,” but physicians will have to accept some compromises, he said. Electronic medical records will have a significant effect on health care spending by eliminating duplication and preventing misprescribing, according to Representative Gingrey. He noted that President Bush wants the nation to completely switch to electronic recordkeeping by 2014.

**Hill visits**
The conference concluded with opportunities for participants to meet with their elected officials and their health policy staffs. Most of the surgeons rated this experience and the rest of the meeting as very good to excellent, according to surveys conducted by the ACS divisions that presented the program.

At press time, details regarding next year’s ACS Leadership Conference were still being negotiated.

## Register for the 2006 Clinical Congress in Chicago

Register today for the 2006 Clinical Congress, to be held October 8–12, in Chicago, IL. The registration form is available in your Program Planner, which you should have received in the mail. You may also go to the College’s Web site, www.facs.org, to register.

Registration is open to all physicians and individuals in the health care field. Registration includes a name badge, program, and entrance to the exhibits and all sessions other than postgraduate courses. Registered attendees may purchase postgraduate tickets based on availability. Advance registration is strongly encouraged.

The advance registration deadlines for international, U.S., and Canadian registrants have passed. Registrations received and postmarked after the deadlines will be billed according to the pricing structure on the registration form. Attendees may also register on-site in Chicago.
The annual meeting of the American Medical Association (AMA) House of Delegates (HOD) was held June 10–14 in Chicago, IL, and the College’s delegation participated in numerous activities to represent the interests of surgery. Through the course of eight reference committee hearings, recommendations from 66 AMA Council/Board of Trustees reports and 209 resolutions were debated, discussed, analyzed, and dispensed by the HOD.

Issue highlights from the meeting include the following:

• A resolution authored by the College and cosponsored by a number of surgical specialty societies was referred for consideration by the Council on Medical Education in the context of the AMA’s Initiative to Transform Medical Education. The resolution asked for support for a number of policies, most notably the development of a prerequisite curriculum that is disease-based, focusing on a multidisciplinary style of medical practice to facilitate the transition from medical student to resident.

• A report from the Council on Medical Education, addressing the impact of increasing specialization and declining generalism in the medical profession, contained one recommendation that created considerable debate. This recommendation would have the AMA encourage physician reimbursement changes that would make a generalist physician practice more appealing. The reference committee took into account testimony from the College and specialty societies that the term “generalist physicians” could be interpreted to refer only to primary care physicians and to support financial differences among the specialties, and the committee made a number of revisions to clarify this. However, delegates from primary care organizations were not willing to concede on this issue and amended the recommendation on the floor of the HOD to return to the original language, thereby reinforcing the interpretation that the AMA should support reimbursement changes for primary care physicians. The vote to keep the original language was extremely close, and this issue will likely come up for further review at the November 2006 interim HOD meeting.

• The Council on Ethical and Judicial Affairs (CEJA) presented a report detailing ethical obligations of physicians when working with manufacturer representatives. Because of a need for clarification of some of the guidelines, the report was referred back to the CEJA for additional work. However, the reference committee noted that the College has a statement with useful guidelines on this subject and that it should be widely disseminated and used by CEJA to assist it in its work. (The Statement on Health Care Industry Representatives in the Operating Room is available at http://www.facs.org/fellows_info/statements/st-33.html.)

ACS Delegates/Alternates

Richard Reiling, MD, FACS, Charlotte, NC (delegation chair)
Charles Logan, MD, FACS, Little Rock, AR
Amilu Rothhammer, MD, FACS, Colorado Springs, CO
Thomas Whalen, MD, FACS, New Brunswick, NJ
Chad Rubin, MD, FACS (alternate), Columbia, SC
Patricia Turner, MD (YPS delegate), Washington, DC
Jacob Moalem, MD (RFS delegate), North Brunswick, NJ

Surgical caucus education session

In a departure from tradition, the Surgical Caucus of the AMA sponsored an educational program outside of its usual Saturday afternoon meeting. The
program, A Surgical Approach to Disaster Preparedness, was held Monday morning as part of the general educational component of the HOD. More than 70 surgeons and other interested physicians attended this session to hear about lessons learned from responses to recent hurricanes, participation by the ACS Committee on Trauma in various disaster preparedness and response activities, and practical suggestions on how individual physicians can get involved in disaster preparedness at the local level.

**Elections**

Several surgeons were elected to AMA offices: William Plested III, MD, FACS, a cardiothoracic surgeon from Los Angeles, CA, was inducted as the 161st President of the AMA; a neurosurgeon from Newark, NJ, Peter Carmel, MD, FACS, was reelected to the AMA Board of Trustees; Charles Hickey, MD, FACS, an ophthalmologist from Dublin, OH, was elected to the AMA Council on Constitution and Bylaws; and Lee Morisy, MD, FACS, a general surgeon from Memphis, TN, was elected to the Council on Science and Public Health. Patricia Turner, MD, of Baltimore, MD, the College’s Delegate to the AMA Young Physicians Section (YPS), was elected by the YPS to be its Alternate Delegate to the AMA HOD.

For more information on the AMA HOD meeting, contact jsutton@facs.org or visit the AMA Web site at [http://www.ama-assn.org/ama/pub/category/15931.html](http://www.ama-assn.org/ama/pub/category/15931.html).

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**Fellow honored with 2006 Surgical Volunteerism Award**

Immediately following the 2005 Clinical Congress, the Governors’ Committee on Socioeconomic Issues put out a call seeking nominations for the 2006 ACS/PMHI Surgical Volunteerism Award in association with Pfizer Medical Humanities Initiative. A great number of College members submitted nominations for the award. The committee had a challenging time in scoring the excellent candidates.

For his service in the international arena, the committee nominated John L. Tarpley, MD, FACS, of Nashville, TN. Dr. Tarpley began his volunteerism in Nigeria in 1978. He devoted a full-time effort to improving the inequalities of health care and health care training from 1978 to 1993. Since 1993, he has continued his efforts on a two- to three-week trip each year, at which time he teaches and leads a team in performing specialized work.

Dr. Tarpley will receive his award at the annual Board of Governors dinner on Tuesday, October 10, during the Clinical Congress.

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Dr. Tarpley
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.

**Now available on CD-ROM**

<table>
<thead>
<tr>
<th>Category</th>
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<tr>
<td>Fellows of the American College of Surgeons:</td>
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<td>Non-Fellow:</td>
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<td>RAS member:</td>
<td>$75</td>
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<tr>
<td>Surgical Resident, not a RAS member*:</td>
<td>$95</td>
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*Non-RAS residents must supply a letter confirming status as a resident from a program director or administrator, and are limited to one CD-ROM.
(Additional $16 for shipping and handling of international orders.)

Orders may be placed through ACS Customer Service at 312/202-5474 or via the College’s Web site at: www.acs-resource.org
For more information contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354
Philosophical society calls for award and fellowship nominations

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

The Judson Daland Prize
The Judson Daland Prize recognizes outstanding achievement in patient-oriented research. The recipient will be awarded the $20,000 prize at the meeting of the American Philosophical Society in November 2007. The Society reserves the right to award a shared prize.

Eligibility
Although candidates need not be U.S. citizens, the work must have been performed at an institution in the U.S. Nominees should be no more than 15 years beyond receipt of their medical (MD) degree.

Nomination process
Candidates must be nominated by the chair of a clinical department of a medical school or hospital located in the U.S. The nominator must submit an abstract of the work to be honored, together with the curriculum vitae and bibliography of the nominee (see details that follow). A letter from the nominator must make clear the patient-oriented nature of the investigation.

The following list provides the order in which materials should be submitted.

- Cover page that provides the following information:
  - Daland Prize 2007 nomination submitted on [date]
  - Full name of nominee, last name in capital letters
  - Address, telephone number, and e-mail address of nominee
  - Date MD degree was conferred
  - Name of institution where work was performed
  - Brief title, with an indication of the discipline (for example, pediatrics, internal medicine, and so on)
  - Name, address, and telephone number of nominator
  - A 50-word summary of the major achievements of the nominee
    - Abstract of the work to be honored, not to exceed two typed pages (500 words)
    - Provide last name of nominee in upper left corner of each page
    - CV of no more than three pages that includes a list of 10 publications by the nominee; provide last name in upper left of each page
    - Letter from nominator, stating the patient-oriented nature of the investigation
    - Three additional letters of support for the nominee should be sent separately to the society. No more than one of these three supporting letters should be from a person at the same institution as the nominee.

Nominations and all three letters of support must be received by March 15, 2007.

Daland Fellowships in Clinical Investigation
The American Philosophical Society awards a limited number of Daland Fellowships in Clinical Investigation for research in the several branches of clinical medicine, including internal medicine, neurology, pediatrics, psychiatry, and surgery, with an emphasis on patient-oriented research.

This is a one-year fellowship with possible renewal, if satisfactory progress is demonstrated. The stipend for the fellowship is $50,000 (for each year). The society provides no funds for institutional overhead.

The fellow is expected to devote 100 percent of his or her time to research; the fellowship will constitute salary support. Limited teaching or clinical service is permitted, and a small portion of the fellowship may be used for supplies. The committee reserves final decisions until it has a clear understanding of the fellow’s financial support for the project, whether in the form of additional salary granted by the institution at which the fellow is located or from other fellowships.

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

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

Deadline, notification
Applications for first-year fellowships are due no later than September 1, 2006. A complete application includes all materials requested on the form, in the correct number of copies, and the three confidential letters supporting the application.

For more information on the Daland Fellowships in Clinical Investigation or the Judson Daland Prize, contact Linda Musumeci, research administrator, at LMusumeci@amphilsoc.org, or call 212/440-3429. Application forms and more details about these prizes are available at www.amphilsoc.org/grants/daland.htm.

Ongoing, urgent need for surgeons to aid hurricane victims

A medical clinic run by the Operation Blessing/International Medical Alliance in New Orleans, LA, has a continuing urgent need for surgeons in all specialties to assist victims of last year’s hurricanes. Provisional Louisiana medical licenses are available for volunteers. To read more about this opportunity, visit the College’s Operation Giving Back Web site at www.operationgivingback.facs.org, or call Kathleen Casey, MD, FACS, at 312/202-5359.

New grant program supplements awards

The American College of Surgeons and the Triological Society announce a competitive grant program to provide supplemental funding to otolaryngologists–head and neck surgeons who receive a new Mentored Clinical Scientist Development Award (K08/K23) from the National Institute on Deafness and Other Communication Disorders (NIDCD), beginning in 2007.

This award is being offered as a means to facilitate the research career development of otolaryngologists–head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal before the conclusion of the K award.

These awards will provide financial support in the amount of $80,000 per year for up to five years to supplement the NIDCD K08/K23 awards. Funds are available for one award at this time with additional awards considered as funds become available. Funding is dependent on receipt of meritorious applications.

The first application deadline is October 1. For further details, please go to http://www.facs.org/memberservices/research.html or contact the ACS Scholarships Administrator at Kearly@facs.org, or call 312/202-5281. This information is also posted on the Triological Society’s Web site, at http://www.triological.org/researchgrants.htm.
Robert W. Hobson II, MD, FACS

Fellow of the American College of Surgeons since 1975. ACS Governor-at-Large from New Jersey and Past-President of the New Jersey Chapter of the ACS.

“The American College of Surgeons’ great asset is its planning of superior educational opportunities for surgeons of all specialties. Coupled with the College’s professional activism during recent years, the organization is to be complimented for its exemplary track record, which merits our support.

“Fellowship in the College has defined many activities for me during my academic career. These opportunities included participation as a candidate member, submission of abstracts as a younger surgeon to the Surgical Forum, gaining ACS Fellowship, and participation in Clinical Congress programs and postgraduate courses. Participation in the annual meeting and leadership in the New Jersey Chapter of the ACS has also been a satisfying opportunity and experience.

“A gift to the ACS Foundation in the form of a charitable trust or other contribution should be considered by surgeons as part of a program of estate planning. Benefits are apparent for the individual surgeon and his or her family and the Foundation in its efforts to expand opportunities for ACS scholarships, and basic and clinical research programs.”

Dr. Hobson supports the College financially through active membership in the Fellows Leadership Society.

For information about joining the Fellows Leadership Society, please contact the Foundation via telephone at 312/202-5376, via e-mail at fholzrichter@facs.org, or by visiting the ACS Web site at www.facs.org.
Tours of historic College properties available during Congress

At this year’s Clinical Congress, the American College of Surgeons will provide tours of the College headquarters building at 633 N. Saint Clair St. and the newly restored historic John B. Murphy Memorial Building at 50 E. Erie St. At the last Clinical Congress in Chicago in 2003, the Murphy was only in the beginning stages of its restoration, so Fellows were unable to view it at that time. This year, those registering for tours will be able to see the exquisite detail in which the preservation architect managed to bring the Murphy back to its original glory.

The Murphy Memorial Building was built in honor of John B. Murphy (1857-1916), a College founder and widely recognized master surgeon of his day. Modeled after the Chapelle de Notre-Dame de Consolation in Paris, its construction was completed in 1926, and for many years it served as the College headquarters. Over the years and until the mid-1990s, it was used for the College library, office space, meeting rooms, and banquet hall for various College activities. The space was frequently rented out to other organizations as well.

The current College headquarters, a modern and lovely blue-green and silver glass building, is located about two blocks east of the old headquarters at 55 E. Erie, which

The College’s headquarters (left), and the Murphy Memorial Building.
An exciting on-site program tailored especially for the children of attendees at the Clinical Congress has been arranged for this year’s meeting in Chicago, IL.

The College will once again be partnering with ACCENT on Children’s Arrangements, Inc., a nationally recognized professional child care company organized to provide on-site children’s activities in a nurturing, safe, and educational environment.

From Sunday, October 8, through Wednesday, October 11, your child(ren) can participate in activities such as arts and crafts, active games, movies, and much, much more. It is ACCENT’s goal to entertain your child(ren) in a safe environment so you can attend the Clinical Congress with the peace of mind that they are being taken care of and having a great time too. Children aged six months to 12 years are welcome to participate in Camp ACS.

For additional information, contact ACCENT at 504/524-0188 or visit http://www.facs.org/clincon2006/social/campacs.html.

College properties

Murphy Memorial Building (50 East Erie):

—Monday, October 9, 8:30 am
—Wednesday, October 11, 10:30 am

Headquarters Building (633 N. Saint Clair St.):

—Monday, October 9, 9:30 am
—Tuesday, October 10, 11:30 am
—Wednesday, October 11, 11:30 am

Children can attend Camp ACS during Clinical Congress

was sold and subsequently razed for a new high-rise condominium. The College completed negotiations for the new building in March 1996 and staff completed the move by January 1998. Currently, the College leases floors 1 through 22 to the Wyndham Hotel and Draft Consulting and the ACS office staff members are housed on floors 23 through 28, with offices for various surgical societies—such as the Society of Vascular Surgeons, the Society of Thoracic Surgeons, the American Board of Thoracic Surgeons, the Pacific Coast Surgical Association, and the American Association for the Surgery of Trauma—occupying offices on sections of floors 23, 24, 26, and 27.

College staff will direct tours of both the ACS headquarters building and the Murphy, back to back. The tours will be approximately 45 minutes each and will be conducted according to the schedule listed on this page. For those interested in registering for both tours, please note that the buildings are a short, 10-minute walk apart on Erie Street.

Preregistration is required for the headquarters tours and sign-up sheets and more information will be available at the Hilton Chicago Hotel and Towers ACS Registration Desk, Social Program Counter, and at the McCormick Place Lakeside Center in the Member Services area. If you are interested in participating in any of these tours, please complete the tour registration form and indicate your preferred date and time for the tour of your choice.

Murphy Memorial Building tours will begin gathering outside the Murphy and headquarters building tours will commence in the ground floor lobby of the headquarters building. Transportation to the College headquarters from McCormick Place will be provided by the orange bus line (Route 5). The bus will unload at the Wyndham Hotel, which adjoins the College, and access to the College can be gained through its main entrance on St. Clair Street.

SEPTEMBER 2006 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
Collaboration to bring information about clinical trials to women

The Gynecologic Cancer Foundation (GCF) and the Gynecologic Oncology Group (GOG) are partnering to provide timely information to women about GOG phase III clinical trials. Now the Women’s Cancer Network (www.wcn.org)—GCF’s award-winning Web site featuring up-to-date information on reproductive cancers, a risk-assessment tool, and a “find-a-doctor” section—has a clinical trials section that provides details about current GOG phase III trials.

In addition to a Frequently Asked Questions section, the clinical trials section provides detailed information about phase III trials currently open for enrollment. The information is presented in a manner to allow women to determine if they are eligible for participation. Should a woman decide she wants more information about enrolling in a particular trial, she is asked to call GOG’s toll-free number, 800/22-303. There she can speak with a specially trained staffperson who can provide her with the name and the telephone number of the individual responsible for trial enrollment at the institution or practice setting most convenient for her.

To review this information, log onto the Women’s Cancer Network at www.wcn.org and click on “Clinical Trials” on the home page.

2006 State of the State of Gynecologic Cancers: A Report to the Women of America now available

In its fourth year of publication by the Gynecologic Cancer Foundation (GCF), the 2006 State of the State of Gynecologic Cancers: A Report to the Women of America is available through the Foundation. The special section for this year’s addition is “The Importance of the Role of Clinical Trials” by Larry J. Copeland, MD, FACS, chair of the department of obstetrics and gynecology at The Ohio State University, James Cancer Hospital, and president of the Society of Gynecologic Oncologists.

Each major gynecologic cancer is described, and advances that occurred in the past year are detailed. Each annual edition is released in September, which is Gynecologic Cancer Awareness Month.

The report is edited by Bobbie S. Gostout, chair of the Gynecologic Cancer Foundations’ Communications Committee and associate professor at the Mayo Clinic. Along with Dr. Copeland, David Gershenson, Benjamin Greer, Patricia Judson, David Miller, and Gregory Sutton contributed their time and expertise to the 2006 edition.

To obtain copies of this report and other GCF educational materials, call 312/578-1439 or e-mail info@thegcf.org.

Visit the College’s Web portal!

View surgical news, interact with surgical communities, update CME credits, enter case log information, track resident hours, and more—all at e-facs.org
Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings

June 9–10, 2006

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

American College of Surgeons Professional Association (ACSPA)

From December 1, 2005, the beginning of the current election cycle, to May 15, 2006, the College’s political action committee (ACSPA-SurgeonsPAC) raised $760,181. The telephone fundraising campaign also continues to remain productive.

Of the 216 U.S. members of the Board of Governors, 91 (42%) have contributed to the PAC. The names of all leaders who contributed to the PAC, and those who donated $1,000 or more in 2006, will be listed at the PAC booth during this year’s Clinical Congress.

Contributions have been made to 123 candidate and leadership PAC committees. The ACSPA-SurgeonsPAC has organized 12 political fundraiser events.

The Executive Committee of the Board of Regents agreed to continue membership in Doctors for Medical Liability Reform (DMLR). The recent Senate debate on medical liability reform provided DMLR with an opportunity to further its objectives for 2006. Highlights of DMLR’s efforts include the following.

• In an effort to support the Senate leadership, DMLR ran print and radio ads in target states. These ads ran during the April recess and highlighted access-to-care issues. Listeners and readers were directed to contact specific senators to ask them to support medical liability reform.

• DMLR spokespersons participated in radio tours and/or recorded radio news releases that were broadcast 7,503 times on 5,613 stations nationally and in DMLR’s target states. This resulted in approximately 45 million people who learned about the Senate vote, patient access-to-care problems, and DMLR’s Protect Patients Now campaign.

• Washington think tank American Enterprise Institute hosted a panel discussion with DMLR spokespersons as follow-up to a media roundtable discussion in October. The event was attended by 34 people, including representatives from the White House, senior Senate staff, and the media.
• DMLR has built a grassroots network of 135,298 physicians, patients, and concerned citizens.

• Increased Web site traffic (protectpatientnow.org) in April and May resulted in 29,437 actions taken that were facilitated by DMLR’s Action Center.

• DMLR Internet advertising resulted in 139,900 additional visits to the site.

• DMLR developed a petition to support comprehensive federal medical liability reform that has been signed by more than 37,708 physicians, patients, and concerned citizens. More than 21,000 of these signatures were added since April 1.

• 7,206 letters were sent to U.S. senators via the DMLR Web site from April 1 through May 8.

ACS Foundation

The Board of Regents approved the nomination of C. Rollins Hanlon, MD, FACS, of Chicago, IL, to serve on the Board of Directors of the ACS Foundation to fill the unexpired term of the late Oliver H. Beahrs, MD, FACS.

American College of Surgeons (ACS)

ACS Institute for Health Policy Research

The Board of Regents approved a business plan to establish an ACS Institute for Health Policy Research. In its advocacy efforts, the College is frequently hampered by a lack of high-quality data on the health care system as it affects surgical patients, as well as on socio-economic issues and trends affecting surgeons. Policy research foundations and government agencies tend to focus their research efforts on primary care and epidemiological issues, and scant attention is devoted to surgery.

The College’s Health Policy Steering Committee (HPSC) appointed a working group to investigate the concept of creating a health policy research institute for surgery. Upon the conclusion of the group’s investigation, the HPSC concluded that the College, its Fellows, and the surgical specialty societies would all benefit from establishing such an institute. The HPSC proposed that the College establish an American College of Surgeons Institute for Health Policy Research as an independent program housed in the Washington Office. The institute’s work will encompass all surgical disciplines and include surveys, in-depth case studies, data analysis, and so forth. Its work products will include peer-reviewed journal articles, reports, symposia, testimony, press statements, and participation in policy conferences sponsored by other organizations.

MedPAC. The appointment of a surgeon to the Medicare Payment Advisory Commission (MedPAC) has been a top priority in 2006 for the Washington Office. General surgeon Karen R. Borman, MD, FACS, was appointed to MedPAC along with urologist Ronald D. Castellanos, MD, FACS. Dr. Borman’s nomination was supported by national health care organizations, state medical societies, the governor of Mississippi (her home state), and members of Congress.

SQA. The Surgical Quality Alliance (SQA), formed by the College as a resource for all surgical specialties struggling with development and implementation of physician performance measurement systems, has made significant progress. A number of educational sessions were held, and jointly sponsored comment letters were submitted to various quality-related organizations, particularly with respect to inpatient care. Plans are under way to begin a comprehensive review of issues related to outpatient surgical procedures. The SQA continues to grow and now includes 16 surgical specialty societies.

Emergency care workforce issues. The Division of Advocacy and Health Policy worked with the Regental Task Force on Emergency Care Workforce Issues to develop a report outlining the problem; its underlying causes; relevant efforts by the College; and potential legislative, regulatory, and private sector remedies. The paper was formally released on June 14 in conjunction with the Institute of Medicine’s (IOM) reports. A. Brent Eastman, MD, FACS, who participated in the IOM press conference, will participate in regional workshop events that will follow. The
College is a sponsoring organization for the regional workshops.

**Bariatric surgery.** The Centers for Medicare and Medicaid Services announced on February 21 that Medicare will cover bariatric procedures only when they are performed in facilities that are certified by the College or by the American Society for Bariatric Surgery.

**Medicare physician payment.** The estimated 2007 fee schedule update is –4.7 percent. Members of Congress have stated publicly that they expect to pass another one-year “fix” to the problem, and there remains a potential for combining this relief with some kind of pay-for-performance scheme.

**Closed Claims Project.** The Board of Regents reviewed the final report on the ACS Closed Claims Project. For this project, 40 surgeon-reviewers, five insurance companies, and eight site visits were required to complete reviews of 460 closed claims with indemnity or loss experience greater than $25,000. F. Dean Griffen, MD, FACS, Chair of the Patient Safety and Professional Liability Committee, is working with the University of Washington in Seattle to prepare the project results for journal publication.

### National Approvals Program for Breast Care

The Board of Regents approved a business plan for a National Approvals Program for Breast Care. In 2005, a proposal was made to establish a multidisciplinary accreditation process for breast centers in the U.S. In 2006, an estimated 212,920 new cases of invasive breast cancer are expected to occur in the U.S. Increased use of screening mammography has led to increased detection of breast cancer. Along with increased detection, the size and stage of breast cancer have changed. With these changes, the treatment of breast cancer has become more complex. The heterogeneity of breast cancer becomes much more important when dealing with cancers smaller than 1.5 cm. As the size of breast cancer decreases, the complexity of decision making increases, as does the number of people involved with patient care.

The program is a consortium of national, professional organizations dedicated to the improvement of the quality of care and outcomes of women with diseases of the breast. This mission is pursued through standard-setting, scientific validation, and patient and professional education.

The program will recognize certain levels of breast centers eligible for participation. There is considerable overlap in the levels for many breast centers in the U.S. Specific criteria will be developed to support each level. It is anticipated that a pilot program will launch in mid-2007 with the criteria for a level I center. Following the launch, criteria for the additional levels will be developed, pilot tested, and released.

### Rural Trauma Team Development Course

The Board of Regents approved a business plan for a Rural Trauma Team Development Course. The Rural Trauma Subcommittee of the Committee on Trauma identified a need for education of trauma personnel in rural areas of the U.S. and subsequently developed a course that can be taken to rural facilities. The course can be given in one day with a minimum of expenses and equipment. The goal of this effort is to bring rural centers into trauma systems, thereby improving the care of injured patients in rural settings. In addition, a study is under way to determine the efficacy of the course by measuring changes in care patterns as well as patient outcomes.

### Business plan update: ACS NSQIP

The Board of Regents reviewed an updated business plan for the ACS National Surgical Quality Improvement Program (NSQIP). The ACS NSQIP roll-out to private sector hospitals began in the fall of 2004. The overall goal of the ACS NSQIP is to improve the surgical care of patients throughout the U.S. through the collection and usage of risk-adjusted outcomes. The ACS NSQIP, which to date has experienced a 100 percent contract renewal rate, is the first nationally validated, risk-adjusted, outcomes-
based program to measure and improve the quality of surgical care.

The ACS NSQIP has been working closely with the Centers for Medicare and Medicaid Services on the Surgical Care Improvement Project (SCIP) and is planning to release a SCIP data-collection module this summer. This module will be released to ACS NSQIP participants free of charge and will allow hospitals the ability to enter both sets of data in one location. A few of the new objectives of the program over the next two years are as follows:

- Develop in a cost-effective manner additional ACS NSQIP modules that meet market needs
- Train and support surgical clinical nurse reviewers at each of the participating institutions
- Provide data analysis and feedback to the participating hospitals

New ACS standing committee

The Board of Regents approved the dissolution of the Communications Committee of the Board of Regents and the Public Profile and Visibility Steering Committee and approved the establishment of the Public Profile and Communications Steering Committee (PPCSC). Initially, the PPCSC will focus on the mid-June IOM press conference at which A. Brent Eastman, MD, FACS, will be a major presenter; he will identify himself as a representative of the College and present its views on emergency and trauma care in the U.S. The PPCSC will meet in July to discuss the results of the IOM press conference.

Coverage of IOM Report

The College has contracted with a public relations/communications management firm. Principals of the firm are working with the College to use the IOM press conference as a platform to bring attention to the issues related to emergency and trauma care. The desired outcome is to achieve solid, broad-based system reform that corrects payment, liability, and reimbursement disincentives that currently penalize surgeons for participating in emergency, hospital, and uninsured care and increasingly inhibits their participation in that care.

The short-term objectives are as follows:
- Increase public awareness of patient safety risk when trauma centers and emergency departments are inadequately staffed
- Increase public understanding of the American College of Surgeons’ lead role in the development of state-of-the-art trauma systems
- Introduce the larger problem of surgeon shortage by focusing on trauma centers and emergency departments

The key messages for the short-term objectives including the following:
- Our nation’s trauma system—the best hope for anyone who is seriously injured or who experiences an acute life-threatening event—is in serious jeopardy.
- The alarming news is that patients are increasingly at risk because the current health care system discourages surgeon participation in trauma centers and emergency departments.
- Policymakers must correct the inequities in the system to encourage surgeon participation in trauma centers and to ensure that vitally important trauma patient services are not lost.

Statement on Insurance, Alcohol-Related Injuries, and Trauma Centers

The Board of Regents approved a Statement on Insurance, Alcohol-Related Injuries, and Trauma Centers. The statement was developed by the Committee on Trauma Subcommittee on Injury Prevention and Control in order to assist trauma centers that identify problem drinkers and to provide interventions for drinkers who are at risk to harm themselves and others. Brief interventions for problem drinkers have been shown to decrease recidivism among trauma patients, thus serving as an excellent prevention measure. Most trauma surgeons support such activity.

In a majority of states, however, it is legal for an insurer to withhold payment to a treating physician or hospital if information dem-
onstrates that the patient was intoxicated or under the influence of any narcotic, unless administered on the advice of a physician, at the time of the injury. The National Association of Insurance Commissioners (NAIC) developed this law—Uniform Accident and Sickness Policy Provision Law (UPPL)—in 1950. In 2001, the NAIC voted unanimously to correct the law in favor of providing payment to a treating physician or hospital, irrespective of drug or alcohol involvement. Such legislative change, however, must be accomplished at the state level. To date, only eight states have enacted the 2001 amendment.

The statement emphasizes the College’s strong support of the new 2001 NAIC law and encouragement of adoption of this legislation in all states. Doing so will enable trauma centers to fulfill their obligation to provide alcohol screening and intervention for problem drinkers as part of their program to prevent injuries. (The statement appears on page 29 of this issue.)

**Statement on Principles of Patient Education**

The Board of Regents approved a Statement on Principles of Patient Education. Developed by the Patient Education Advisory Committee, the statement summarizes the critical role of patients and their significant others as integral members of the surgical team and as being essential to delivering optimum and safe surgical care. Active involvement of patients as partners in care can increase compliance and decrease complications through early identification of risks. Patients need to possess the requisite knowledge and skills to contribute effectively to their care, and patient education is key in this regard. (The statement appeared on page 30 of the August Bulletin.)

**Clinical Congress.** The major theme of the Clinical Congress is “Working Together Toward Humanitarian Ideals” and is designed to address contemporary topics in surgery related to the core competencies, patient safety, new procedures, emerging technologies, and nonclinical topics related to the practice of surgery. The program includes 112 general sessions, 13 didactic postgraduate courses, and 21 skills-oriented postgraduate courses.

Implementation of a five-level program for verification of knowledge and skills of individuals following participation in the College’s educational programs is under way. Each of the didactic and skills-oriented postgraduate courses to be offered during the 2006 Clinical Congress has been reviewed and assigned a verification level.

A new course on ultrasound for surgical residents is being developed by the National Ultrasound Faculty. The course will be offered during the 2006 Clinical Congress.

**New DVD. Disclosing Surgical Error: Vignettes for Discussion** was recently released. The vignettes demonstrate two approaches used by a surgeon to disclose to the patient’s family a major technical error that occurred in the operating room. The vignettes demonstrate a number of effective disclosure techniques, along with certain approaches that need improvement. The vignettes may be used as free-standing trigger tapes for small group discussions between surgeons, surgical residents, and medical students, or they may be incorporated into a comprehensive curriculum on communication skills.

**Accreditation.** The Model for Accreditation of Education Institutes by the College was formally approved by the Board of Regents in June 2005. It involves two levels of accreditation: Level I, Comprehensive; Level II, Basic, based on three standards: Learners, Curriculum, and Technical Support and Resources. The program was formally launched in October 2005.

**New shared scholarship**

The Board of Regents granted conditional approval of a request for a new shared faculty career development award. The award is to be jointly sponsored with the Neurosurgery Research and Education Foundation (NREF) of the American Association of Neurological Surgeons. Regent approval is contingent upon equal funding by the NREF and the College. The two-year award is to assist a surgeon in the establishment of a new and independent research program in an area of neurological surgery.
Committee on Diversity Issues—Revised Mission Statement

The Board of Regents approved a revised mission statement for the College’s Committee on Diversity Issues. The revised mission statement reads as follows:

The primary mission of the Committee on Diversity Issues is to study the educational and professional needs of minority surgeons, including minority groups defined by race or gender, in an effort to optimize the opportunities for these surgeons to achieve professional success and satisfaction.

Secondly, the mission of the Committee is to study the impact of diversity on delivery of surgical care and to work to optimize equitable delivery of surgical care to all population groups.

Commission on Cancer (CoC)

The following CoC activities have taken place or have been initiated since the February 2006 Board of Regents meeting.

- Grant activities: The Patient Safety in Surgery Study and the ACS/Anesthesia Patient Safety Foundation Proposal
- Education activities: The Young Surgical Investigators Conference, the Outcomes Research Course, and the Clinical Trials Methodology Course.
- Other activities: The Surgical Research Committee, the Committee on Perioperative Care, and various accreditation efforts.

e-FACS.org

Since the College’s Web portal e-FACS.org was launched earlier this year, new content and resources have been added, and existing features have been made more robust and easier to use. During the first four months of operation, more than 3,000 members of the College have visited e-FACS.org, generating more than 70,000 hits.

George F. Sheldon, MD, FACS, Editor-in-Chief, continues to develop the Editorial Board for e-FACS.org. There are now 16 at-large members, 45 community editors, 154 associate community editors, and 40 communities, of which 12 are specialty communities and nine are subspecialty communities under the category “general surgery.” The remaining communities are special interest communities.

Dr. Sheldon sent letters to all general surgery department heads, asking them to consider putting a link to the College’s portal on their home page. He will also send letters to the heads of departments for all of the surgical specialties in the U.S.

The ACS Web portal provides a highly effective mechanism to disseminate and enhance access to educational programs and products, offer individually tailored education, and provide opportunities to earn Category 1 continuing medical education credits and maintain a record of these credits.

Journal of the American College of Surgeons (JACS)

Statistics for 2006 online usage show total monthly downloads of 54,940 versus 38,333 for the same time in 2005, a 30 percent increase. As of May 15, JACS provided 84,788 CME Category

Continuous Quality Improvement

Major activities in the area of Continuous Quality Improvement are as follows:
1 credits to Fellows of the College at no cost.

*JACS* has taken on a new program. One of the important functions of the College’s Committee on Trauma (COT) is to support and develop interest in trauma among residents. The committee sponsors an annual resident paper competition and receives some outstanding papers. At the COT Executive Committee meeting, discussion centered on the possibility of publishing the winning Basic Science and the winning Clinical Paper in *JACS*. *JACS* is very pleased to welcome this addition.

Again this year, *JACS* is pleased to publish the abstracts from the Surgical Forum presentations held during the Clinical Congress. On Monday, October 9, the Surgical Forum will announce its dedicatee and present awards to the outstanding abstracts authors. This year, 241 abstracts are contained in the *JACS* supplement. Of these, 11 will receive awards for excellence.

**Communications update**

Name mentions for the College and its programs continue to appear in national and community publications and on various Web sites. Topics covered most frequently in recent weeks were the Cancer Approvals Program, various issues related to Medicare coverage for surgical services, and issues related to trauma centers and trauma systems.

A newspaper-based print advertising campaign was developed in an effort to highlight the CoC approvals program. The intent of the campaign is to help consumers find a CoC-approved program that “provides the best in cancer care close to home.”

Lazar J. Greenfield, MD, FACS, and the editorial staff members of the International Medical News Group and the College continue to focus on the main goal of providing useful and current information to *Surgery News* readers. A recent readership survey indicates that this newspaper is very well received.

**Board of Governors**

The Governors’ Committee on Socioeconomic Issues solicited the ACS membership for nominations for the 2006 ACS/PMHI Surgical Volunteerism Award in association with the Pfizer Medical Humanities Initiative. This award is offered annually in recognition of individuals who make significant contributions to surgical care through organized volunteer activities. The committee reviewed all the nominations submitted and selected John L. Tarpley, MD, FACS, of Nashville, TN, as this year’s recipient. Final approval came from the Executive Committee of the Board of Governors during its interim meeting on May 15. (See article on page 41.)

At its February 2006 meeting, the Board of Regents deferred action on a proposed Statement on Sharps Safety that was developed by the Committee on Perioperative Care (CPC). The Board of Regents requested that the members of the Board of Governors review this statement. The Governors’ Committee on Blood-Borne Infection and Environmental Risk reviewed the statement, suggested minor changes, and, after these changes were received and discussed by the Executive Committee of the Board of Governors, submitted them to the CPC. Mark A. Malangoni, MD, FACS, Chair of the Board of Governors, relayed this information to the Board of Regents at the June meeting.

**Operation Giving Back (OGB)**

The database of volunteer opportunities within the U.S. continues to be augmented. As of May 15, 36 opportunities were posted, 52 agencies had been contacted and were in the pipeline, an additional 40 agencies had been identified that were potentially appropriate for inclusion, and seven domestic volunteer opportunities had been added.

Ongoing efforts continue to be devoted to expanding the database of international volunteer opportunities. As of May 15, 18 agencies were represented on the OGB Web site, translating to 40 opportunities for surgical volunteers. An additional 39 volunteer agencies had been contacted and were in the process of being incorporated into the OGB database, and 12 agencies had been added to the database.

As of May 15, hits to the OGB Web site ex-
ceeded 850,000 since its launch on September 1, 2005. Ongoing efforts include the following:

- Collaborative discussions regarding an appropriate mechanism for the College to respond to disasters
- The 2006 volunteerism panel at the Clinical Congress will include residents’ perspectives on volunteerism and international surgical care
- The 2006 ACS/PMHI surgical volunteerism award winner will be highlighted during the volunteerism panel

**Advisory Councils**

Standard items for review, discussion, and action by all of the College’s Advisory Councils included the College’s Web portal; ACS public profile and visibility; continuous quality improvement; and recommendations for the Jacobson Innovation Award, Sheen Award, and Honorary Fellowship. Other projects included the following:

- Health policy scholarships
- Spring Meeting
- Clinical Congress

The Advisory Council for General Surgery, chaired by Mark A. Malangoni, MD, FACS, presented a proposed position statement on acute care surgery to the Board of Regents for approval. The Board did not approve the proposed statement but requested that it be reviewed by all of the Advisory Councils for further development and refinement. Marshall Z. Schwartz, MD, FACS, Chair of the Advisory Councils’ Chairs, will facilitate this request.

**Young Surgeons**

The 2006 Leadership Conference was held at the Washington Court Hotel in Washington, DC. Planned programs focused on practice management and on leadership skills for young surgeons. (For a summary of the conference, see page 32 of this issue.)

**Resident and Associate Society (RAS)**

The RAS recognizes its position as an organization of the future Fellows of the College and continues to work to ensure that it represents the voices, views, and concerns of the young surgeons to the leaders of the College. The following activities are just a few of the ongoing efforts of the RAS.

- The Communications Committee continues to publish the bimonthly RAS-ACS newsletter
- The Issues Committee has put together a panel discussion for the annual symposium during the Clinical Congress
- The Education Committee is developing Web-based guides for a career in academic surgery and how to apply for fellowships in subspecialties of surgery

Last year, a new RAS-ACS Leadership Scholarship was introduced, and three recipients were awarded paid travel and expenses for ACS educational courses. The RAS-ACS petitioned for—and received—additional funding in order to offer the scholarship program on an annual basis.

**HealthCareers**

As of May 15, there were 668 active jobs listed on the site with 62 posted resumes. The site receives approximately 100 hits per day.

**Archives**

Plans are under way for providing tours of the College’s Archives Room, as well as the College’s headquarters building, during the upcoming Clinical Congress. Tours of the J. B. Murphy Memorial Auditorium are also planned. (See article, page 46.)

**Convocation**

The 2006 Convocation will be held at the Hilton Chicago rather than the McCormick Place Convention Center.
Gastrointestinal stromal tumor (GIST) is a relatively uncommon tumor that affects approximately 5,000 people annually in the U.S. GIST develops in the stomach or intestinal tract and can metastasize to the abdomen or liver. Until the development of Gleevec™ (imatinib), there has been no therapy other than surgery for GIST. Surgical resection includes either a gastrectomy or intestinal resection, depending on tumor location. Recurrence is related to tumor size (greater than 3 cm in diameter) and tumor rupture at the time of surgical resection.

There is considerable interest in Gleevec, an antineoplastic drug that blocks a specific growth factor in GIST. There is relatively low toxicity associated with this targeted agent. Gleevec has been approved for the treatment of metastatic GIST, but it is not known if Gleevec is effective in a postoperative adjuvant setting in patients who have had a completely resected GIST. ACOSOG Z9001 is a trial designed to answer this question.

Z9001 is a phase III, double-blind, randomized trial in which patients who have had their GIST completely resected receive either Gleevec or placebo for one year. Primary endpoint is disease-free survival, and if a patient relapses with disease, unblinding occurs and the patient is treated appropriately. There are no drug costs to the patients during protocol treatment. More than 620 patients have been enrolled in this trial, which has a target accrual of 803 patients. ACOSOG is interested in completing patient accrual by 2007.

ACOSOG needs your assistance to enroll patients in this trial. Eligible patients include those who have had an R0 or R1 resection of a GIST greater than 3 cm in diameter. There are more than 460 hospitals with approval from the Institutional Review Board (IRB) for this trial. A list of sites and investigators with IRB approval can be found at www.clinicaltrials.gov. Run a search query for Z9001. Eligibility criteria are listed on this Web page. If you have an eligible patient and do not have IRB approval at your hospital, please consider referring your patient to a nearby IRB-approved site listed on the Clinical Trials Web page.

Z9001 is an important trial for a rare but treatable malignancy. We strongly encourage you to consider this trial for your patients.

Disclosure: Dr. Ota has served on the Novartis Femara Surgical Advisory Board and is principal investigator of a Novartis grant for Z9001.

Dr. Ota and Dr. Nelson are ACOSOG Group Co-Chairs.
Summer is winding down and fall is approaching. Once September 21 arrives, the leaves on the trees are not the only things falling. Those with some role in the care and treatment of the injured are well aware of the seasonal variation in trauma center admissions. The relatively cooler weather—coupled with the return to school and regular work routines that coincide with the end of the summer season—appear to have an impact on trauma volume.

A few articles studying this weather-related seasonal trend have been published in the past five years, and they have concluded that trauma volume was greater in warmer weather. However, these studies evaluated trauma volume at the individual trauma center level. One study took place in the northeast, whereas the other involved a trauma center in the south. Working in the other two census regions (midwest and west), we have our own anecdotal experience with this phenomenon.

In order to examine if this seasonal trend occurs throughout the country, we examined the National Trauma Data Bank® Dataset 5.0 and found more than 1 million records from 2000 through 2004 available for seasonal analysis. The records for level I and level II trauma centers were then examined,
resulting in more than 820,000 records for review. These records represent 259 facilities and include 788 years worth of data. The month of admission was tallied at the trauma center level, and trauma centers were divided into one of the four census regions. The monthly average number of admissions per facility in each region was calculated and appears on the graph on this page.

According to the graph, it is clear that there is a greater number of trauma admissions in the middle of summer when compared with the middle of winter. Chicago has below-zero wind chills in the winter and 90-plus degree, high-humidity days in the summer. It is easy to rationalize that more activity and therefore more traumas will occur during the lazy, hazy, crazy days of summer. But this trend is universal, so whether the weather in winter for you means temperatures of 70 degrees above or below zero, you will still see an increase volume when your summer trauma season comes.

Throughout the year, we will be highlighting these data through brief 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.

A look at the Joint Commission

The International Center for Patient Safety

The Joint Commission International Center for Patient Safety works to collect and distribute patient safety information and solutions to patients, families, and health care professionals and organizations all over the world.

The Center provides resources and solutions through its Web site, www.JCIpatientsafety.org. Surgeons can use the site to obtain patient safety plans and focused solutions, such as the Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™. Complimentary patient safety resources on the Center’s Web site include tools such as a sample outline for a patient safety plan, a listing of award recipients and nomination forms for future awards, case studies, good practices, and articles and newsletters.

With these resources, surgeons have a veritable arsenal of proven strategies and evidence-based practices to solve real-life problems and, in the process, provide better care to their patients. Surgeons can also subscribe to the Center’s free electronic newsletter, Patient Safety Link, by going to www.JCIpatientsafety.org/PatientSafetyLink.

In addition to serving as a clearinghouse for patient safety solutions, the center also forges collaborations and partnerships around the globe with other leading patient-safety organizations and experts, ministries of health, patient/consumer groups, and others. These activities support the center’s role as the World Health Organization’s only official collaborating center for patient safety solutions.

The Joint Commission launched the center in 2005 with its affiliate Joint Commission Resources.

Each month, this column focuses on activities of the Joint Commission that are relevant to surgeons. For more information on the Joint Commission, and to sign up for Joint Commission e-mail newsletters and announcements, visit www.JointCommission.org.
NEW: DISCLOSING SURGICAL ERROR: VIGNETTES FOR DISCUSSION: This DVD demonstrates two approaches used by a surgeon to disclose to the patient’s family a major technical error that occurred in the operating room. The vignettes demonstrate effective disclosure techniques, as well as approaches that need improvement. This project was supported by a grant from the Agency for Healthcare Research and Quality and is available at no cost.

SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM.

BASIC ULTRASOUND COURSE: This course has been developed 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 at the Clinical Congress and is available for CME credit.

PROFESSIONALISM IN SURGERY: CHALLENGES AND CHOICES: This CD presents 12 case vignettes, each including a scenario followed by multiple-choice questions related to professional responsibilities of the surgeon within the context of the case. The program provides a printable CME certificate upon successful completion.

PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons: This CD uses an interactive/lecture format to equip residents and young surgeons with the knowledge to manage their personal financial future, including debt management and financial planning for surgical practice. This program provides a printable CME certificate upon successful completion.

PRACTICE MANAGEMENT for Residents and Young Surgeons: This CD uses an interactive/lecture format to equip residents and young surgeons with the knowledge to manage their 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. This program provides a printable CME certificate upon successful completion.

BARIATRIC SURGERY PRIMER: This CD addresses various aspects of bariatric surgery, including the biochemistry and physiology of obesity, appropriate candidates, basic bariatric procedures, comorbidity and outcomes, and surgical training, as well as facilities, managed care, liability issues, and ethics.

ONLINE CME: Courses from the ACS’ Clinical Congresses are available online for surgeons. Each online course features a video introduction, slideshow presentations with synchronized audio of session, printable written transcripts, and printable CME certificate upon successful completion. The courses are accessible at www.acs-resource.org.

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

For more information contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.
To report your chapter’s news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Alabama hosts residents and guests
The 54th annual meeting of the Alabama Chapter was held May 18–20 in Destin, FL. The education program included presentations by guest faculty and residents. The faculty included William S. Eubanks, MD, FACS, professor and chair, department of surgery, University of Missouri Health Care System, Columbia; Andrew Peitzman, MD, FACS, professor, department of surgery, University of Pittsburgh School of Medicine, Pittsburgh, PA; David Ota, MD, FACS, Co-Chair, ACS Oncology Group, Durham, NC; Gary D. Meyers, MD, FACS, representing Medicins Sans Frontieres, New York, NY; Donald J. Palmisano, MD, JD, FACS, Past-President of the American Medical Association and clinical professor at Tulane University, New Orleans, LA; and C. Alden Sweatman, Jr., MD, FACS, clinical associate professor, University of South Carolina School of Medicine, Columbia (see photo, this page).

Maine Chapter examines surgical practice issues
The Maine Chapter held its 56th annual meeting at the Asticou Inn in Northeast Harbor, ME, June 2–4. Tom McHugh, MD, FACS, Governor-at-Large, and Chapter President Robert Hawkins, MD, FACS, presided over a special session, Challenges Facing Maine Surgeons, as well as the scientific meeting. Topics presented included quality metrics, the ACS Web portal, surgical call coverage, and surgeon recruitment and retention.

Guests from the College included Frank Opelka, MD, FACS; George Sheldon, MD, FACS; and Thomas R. Russell, MD, FACS, the College’s Executive Director. Drs. Opelka and Russell received honorary Maine Chapter membership certificates in appreciation of their third visit to the Maine Chapter in recent years (see photos, this page).
Illinois conducts annual meeting

The Illinois Chapter held its 2006 annual meeting May 21–22 at Starved Rock State Park. The Annual Residents Competition was held; the winning residents were from University of Illinois College of Medicine in Peoria.

First place: Jennifer Ash, MD,* The Value of Resident Teaching to Improve Student Perception of the Surgery Clerkship and Surgery Career Choice

Second place: Arthur Rawlings, MD,* Surgical Residents Research Ethics Course: Preliminary Results

Third place: Jay Woodland, MD,* Robotic vs. Laparoscopic Colectomy

In addition, the Illinois Chapter presented the Philip T. Siegert, MD, FACS, Distinguished Service Award to Lorin D. Whittaker, Jr., MD, FACS (see photo, this page). The Siegert Award was created in 2005 to recognize the volunteer services of Illinois Chapter members.

Belgium Chapter participates in Week of Surgery

In conjunction with the Royal Belgian Society of Surgery, the Belgium Chapter participated in the annual Week of Surgery, which was held May 4–6 in Ostend. Paul E. Collicott, MD, FACS, Director of the Division of Member Services, represented the College at the education program (see photo, this page).

In addition to presenting an update on College activities, Dr. Collicott is working with the Belgium Chapter leadership to increase the number of Fellows from Belgium.

Ohio Chapter installs officers

During the 51st annual meeting, the new Ohio Chapter officers were installed for the coming year. The new officers include William C. Sternfeld, MD, FACS, President; Linda M. Barney, MD, FACS, President-Elect; John A. Howington, MD, FACS, Secretary; and Chris R. McHenry, MD, FACS, Treasurer. On May 9, following an afternoon of visits with state legislators, the Ohio Chapter held a legislative reception at the Statehouse Atrium.

Each year, residents statewide have the opportunity to compete in the Research Forum and

*Denotes Resident membership in the College.
## Chapter meetings

For a complete listing of all of the ACS chapter education programs and meetings, please visit the ACS Web site at [http://www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html). (CS) following the chapter name indicates a program cosponsored with the College for Category 1 CME credit.

<table>
<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
<th>Location/contact information</th>
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<tbody>
<tr>
<td>September 2006</td>
<td></td>
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<tr>
<td>September 6–8</td>
<td>New Mexico</td>
<td>Location: Albuquerque Hilton, Albuquerque, NM</td>
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<td>Contact: Sharon Wehrle, 505/272-4152</td>
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<tr>
<td>September 8–9</td>
<td>Italy</td>
<td>Location: Livorno, Italy</td>
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<td>Contact: Emanuele Lezoche, MD, FACS, 39-06-4997-8852</td>
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<td>September 9–10</td>
<td>Kansas (CS)</td>
<td>Location: Hyatt Hotel, Wichita, KS</td>
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<td>Contact: Chip Wheelan, 785/234-3319</td>
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<td>September 9</td>
<td>Arkansas (CS)</td>
<td>Location: Embassy Suites, Little Rock, AR</td>
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<td>Contact: Linda Clayton, 501/526-7053</td>
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<tr>
<td>September 14–17</td>
<td>Georgia (CS)</td>
<td>Location: The Cloister, Sea Island, GA</td>
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<td>Contact: Lois Shinall, 912/925-8969</td>
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<td>September 14–16</td>
<td>Kentucky</td>
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<td>October 2006</td>
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<td>October 21</td>
<td>Delaware (CS)</td>
<td>Location: DuPont Country Club, Wilmington, DE</td>
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<td>Contact: Diana Garvey, 302/658-7596</td>
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<td>Connecticut (CS)</td>
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<td>Contact: Christopher Tasik, 203/674-0747</td>
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<td>November 3–4</td>
<td>Keystone (CS)</td>
<td>Location: Crown Plaza Hotel, Valley Forge, PA</td>
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<td>Contact: Leslie Howell, 717/558-7750</td>
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<td>November 4–5</td>
<td>Arizona (CS)</td>
<td>Location: Omni Tucson National Golf Resort &amp; Spa, Tucson, AZ</td>
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<td>Contact: Joni Bowers, 602/246-8901</td>
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<td>November 18</td>
<td>Manitoba (CS)</td>
<td>Location: St. Boniface General Hospital, Winnipeg, MB</td>
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<td>November 18</td>
<td>Massachusetts (CS)</td>
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<td>Contact: Lindsay Rappa, 978/927-8330</td>
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Clinical science, second place: Elias Darido, MD,* Good Samaritan Hospital, Cincinnati. Gender Differences in Diabetic Patients Following Coronary Artery Bypass Graft Surgery

Basic science, first place: Mubeen Jafri, MD, Cincinnati Children’s Hospital Medical Center. Cholangiocyte Injury Mediates Temporal Dependence of Experimental Biliary Atresia

Basic science, second place: Lynn Huffman, MD,* University of Cincinnati. STAT-3 Activation Mediates Ischemic Preconditioning in Pressure-Overload Hypertrophy

Peter J. Minton Award for Oncology: Ryan Thomas, MD,* University of Cincinnati. The RON Tyrosine Kinase Receptor and Its Role As a Novel Mediator of Pancreatic Cancer

New orientation program for chapter leaders

During the Clinical Congress, a new orientation program for chapter leaders will be held at the McCormick Place Lakeside Center on Tuesday, October 10, 3:00–5:00 pm. The orientation program will be preceded by Chapter Showcase, which is a “how-we-do-it” session featuring chapters’ special and/or unique programs, services, and management tools. All chapter leaders—new and experienced—are invited to attend.

Chapter anniversaries

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<tr>
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<td>New Jersey 55</td>
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<td>Keystone (PA) 54</td>
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<td>West Virginia 56</td>
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<td>August</td>
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<td>Hawaii 55</td>
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<td>Northwest Pennsylvania 56</td>
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<td>Rhode Island 54</td>
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*Denotes Resident membership in the College.

SOCIOECONOMIC TIPS, from page 31

MREP update

Last October, the Centers for Medicare & Medicaid Services released Medicare remit east print (MREP) software that billing personnel may use to read and print a remittance advice at their computer. The software may be used to manually reconcile accounts receivable and to create paper documents for inclusion with claim submissions to secondary payors. Carriers are expected to post notices on their Web sites when the third revision of the MREP software is available for downloading, which will be on or shortly after October 2. In the future, the software will only be released annually. Additional information is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5032.pdf.

Revised claim form

Those surgeons and billing personnel who submit paper claims should know that the CMS-1500 has been revised to accommodate the National Provider Identifier (NPI). They may begin using the revised form anytime between October 1, 2006, and January 31, 2007. All claims that carriers receive beginning February 1, 2007, must use the revised form in order to be accepted. (Note that acceptance is contingent upon when the claim is received, not on when the service is provided.) Additional information is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf.