

# BULLETIN

AMERICAN COLLEGE OF SURGEONS



April 2007  
Volume 92, Number 4

Surgery's  
**2007**  
federal advocacy agenda



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APRIL 2007  
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## FEATURES

<b>Surgery's 2007 federal advocacy agenda</b> <i>Cynthia A. Brown</i>	<b>11</b>
<b>Staying safe: Simple tools for safe surgery</b> <i>Richard C. Karl, MD, FACS</i>	<b>16</b>
<b>Surgical lifestyles: Retired surgeon is now a "clock doctor"</b> <i>Diane S. Schneidman</i>	<b>23</b>
<b>The economics of managed care reimbursement: A rationale for nonparticipation</b> <i>Robert DeGroot, MD, FACS</i>	<b>28</b>
<b>Statement on surgery using lasers, pulsed light, radiofrequency devices, or other techniques</b>	<b>37</b>

## DEPARTMENTS

<b>From my perspective</b> <i>Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director</i>	<b>4</b>
<b>Dateline: Washington</b> <i>Division of Advocacy and Health Policy</i>	<b>6</b>
<b>What surgeons should know about...</b> <i>The EMTALA TAG</i> <i>Adrienne Roberts</i>	<b>8</b>
<b>Socioeconomic tips</b> <i>Getting ready for Medicare's new quality reporting program</i> <i>Division of Advocacy and Health Policy</i>	<b>39</b>

**On the cover:** As the 110th U.S. Congress convenes, the College's Division of Advocacy and Health Policy continues to work with policymakers to address issues of priority to surgeons. Photo courtesy of Punchstock.

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## Future meetings

### Clinical Congress

- 2007** New Orleans, LA,  
October 7-11
- 2008** San Francisco, CA,  
October 12-16
- 2009** Chicago, IL,  
October 11-15

### Spring Meeting

- 2007** Las Vegas, NV,  
April 22-25

Bulletin of the American College of Surgeons (ISSN 0002-8045) is published monthly by the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. It is distributed without charge to Fellows, to Associate Fellows, to participants in the Candidate Group of the American College of Surgeons, and to medical libraries. Periodicals postage paid at Chicago, IL, and additional mailing offices. POSTMASTER: Send address changes to Bulletin of the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211. Canadian Publications Mail Agreement No. 40035010. Canada returns to: Station A, PO Box 54, Windsor, ON N9A 6J5.

The American College of Surgeons' headquarters is located at 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5000; toll-free: 800/621-4111; fax: 312/202-5001; e-mail: postmaster@facs.org; Web site: www.facs.org. Washington, DC, office is located at 1640 Wisconsin Ave., NW, Washington, DC 20007; tel. 202/337-2701, fax 202/337-4271.

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Library of Congress number 45-49454. Printed in the USA. Publications Agreement No. 1564382.

## NEWS

<b>Dr. Ko appointed to ACS leadership post</b>	<b>41</b>
<b>Trauma meetings calendar</b>	<b>41</b>
<b>A look at The Joint Commission: ACS Fellow named chair of board of commissioners</b>	<b>43</b>
<b>Letters</b>	<b>44</b>
<b>NTDB® data points: May Day Richard J. Fantus, MD, FACS, and Frank L. Mitchell III, MD, FACS</b>	<b>50</b>
<b>Operation Giving Back: Volunteer opportunities available</b>	<b>51</b>
<b>Specialty board reports to be published on Web portal</b>	<b>51</b>
<b>Chapter news Rhonda Peebles</b>	<b>53</b>

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



# AMERICAN COLLEGE OF SURGEONS

## • DIVISION OF EDUCATION •



### □ **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.

□ **BIARIATRIC 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](http://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](http://www.acs-resource.org)

For more information contact Linda Stewart at [lstewart@facs.org](mailto:lstewart@facs.org), or tel. 312/202-5354.



# From my perspective

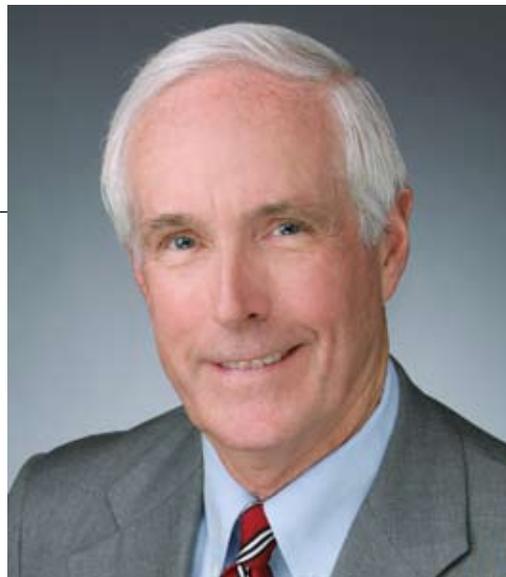
Since it became operational during the 2005 Clinical Congress, the ACS Case Log System has accumulated more than 100,000 cases. Such intense interest in this resource clearly illustrates that surgeon and resident members of the American College of Surgeons recognize the value of having a single repository for tracking the patient care they provide.

## *How it works*

To participate in this robust program, surgeons enter case information either via a personal digital assistant (PDA) or via computer through the College's Web portal at [http://efacs.org/portal/page/portal/ACS\\_Content/ACSSvcs/MEMBERBENEFITS](http://efacs.org/portal/page/portal/ACS_Content/ACSSvcs/MEMBERBENEFITS). This system allows members of the College to gather practice data in an ongoing and systematic way. They then use this information to monitor their practice patterns, identify their strengths and weaknesses, and choose educational programs that will enable them to improve the clinical or cognitive skills needed to offer their patients high-quality care.

The ACS Case Log System also provides participants with masses of deidentified data that they may use to determine how their outcomes compare with those of other surgeons in the pooled database. More specifically, the Case Log System captures information on a surgeon's patients and uploads it into his or her own private data store. The data are then stripped of any information that could be used to identify the patient or the surgeon and placed in a central database that can be accessed by all users.

In addition, the system streamlines the process of case log reporting by generating simple reports about mortality and complication rates, including the percentage of deaths or cases that incurred complications. This information is organized by procedure. Surgeons also may compare their caseloads against national trends and use the data to determine the effects educational programs have on their performance. In other words, they can assess how they were doing before they took a course, see if the program helped them to improve their outcomes, and compare themselves with other surgeons who are performing the same procedure.



**“The College believes its Case Log System is an invaluable instrument for surgeons who are concerned about maintaining their board certification and hospital privileges.”**

## *Credentialing purposes*

The College believes its Case Log System is an invaluable instrument for surgeons who are concerned about maintaining their board certification and hospital privileges.

As most surgeons know, a few years ago, the American Board of Medical Specialties identified practice-based learning and improvement as a core competency. Hence, in order to attain and maintain board certification, surgeons in all specialties must offer evidence that they are tracking their practice patterns, evaluating their own skills, and engaging in lifelong learning.

Indeed, it is quite possible that practice-based learning and improvement will be the key aspect of maintenance of certification in the near future. As surgeons' practices become more specialized and as our emphasis as professionals continues to center on patient safety and quality care, the boards are finding that the traditional, broad-based recertification examination process is no longer an accurate method of determining whether surgeons are competent. Today, results speak louder than test scores.

Furthermore, it will no longer be enough for surgeons to spend a specific number of hours

in continuing medical education programs. The boards are going to want know how those courses affect performance and how they relate to an individual's practice patterns.

Similarly, hospitals will likely narrow the range of services they provide, focusing on the types of care they are best able to provide. That is to say, some medical centers will strive to build a reputation in cardiovascular treatment, whereas others will become leaders in cancer care, and so on. To help them create and sustain their identities, hospitals are likely to become more selective about the physicians they privilege and credential. Surgeons will need to keep and provide evidence of the number of specific procedures they have performed and their outcomes, and the ACS Case Log System certainly will be useful to those ends.

### *Relevance to payment*

In their efforts to develop a more equitable, efficient, and effective health care delivery system, federal policy experts and lawmakers have demonstrated significant interest in linking reimbursement to outcomes. For its part, the College has been working steadfastly to bring the ACS National Surgical Quality Improvement Program (ACS NSQIP) into the private sector and arrive at a methodology that will appropriately measure surgical outcomes. The Case Log System will also allow the surgeon to compare outcomes with the data collected from the NSQIP program. We believe that ultimately the data collected and reported through these systems will be useful to the government and insurers as they attempt to develop a value-based, consumer-driven reimbursement system. To test this theory, the ACS NSQIP has partnered with the Centers for Medicare & Medicaid Services and Blue Cross Blue Shield of Michigan to have NSQIP data incorporated into their quality assessment programs.

Furthermore, although pay for performance is still in the conceptual stage, the government already is making progress in establishing the protocols for pay for reporting. On December 20, 2006, President Bush signed legislation that provided for additional payment by Medicare if a physician voluntarily reports quality information in the last half of 2007. (Surgeons who are interested in learning more about how this system will work and its potential benefits and pitfalls for their

The Case Log System Web page.

practices are encouraged to read this month's "Socioeconomic tips" column on page 39.)

### *Reducing the hassle factor*

Unquestionably, surgeons are now expected to provide more documentation about their performance than has ever before been required, and it's probably safe to assume that this trend will only expand in the coming years. The College recognizes that many of our members have concerns about trying to balance their time in the operating room with the time they expend documenting what they have done. We anticipate that surgeons will find the Case Log System to be an effective means of quickly and accurately maintaining their records.

If you have suggestions regarding additional services or resources we might offer our members, please let us know. The College wants to provide services that will assist our members as we move into a new era of surgical care and accreditation.

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](mailto:fmp@facs.org).

# Dateline Washington

prepared by the Division of Advocacy and Health Policy

## President's budget cuts health care

On February 5, President Bush unveiled a \$2.9 trillion budget proposal for fiscal year (FY) 2008 that includes significant cuts in federal health care programs. For example, the proposed budget reduces Medicare funding by \$66 billion and Medicaid funding by \$25 billion by cutting payments to providers and implementing policy changes over the next five years. The President's budget also allocates \$5 billion to the State Children's Health Insurance Program (SCHIP), which is approximately half the amount needed to maintain current coverage. In total, the President's plan will cut more than \$8 trillion in health care entitlement spending over the next 75 years in an effort to keep the Part A trust fund active until at least 2018. Whereas Part B physician payment is spared from the chopping block, no funds are provided to prevent the 10 percent reimbursement cuts scheduled to take effect January 1, 2008.

In addition, add-on payments—including graduate medical education and disproportionate share funding, as well as policies related to bad debt—are poised for reductions. Graduate medical education may take a double hit because of a provision that would expressly prohibit Medicaid funds from being used to subsidize physician training, a change that would cost residency programs more than \$2 billion. In addition, the budget would cut all Medicare provider payments, including physician payments, by 0.4 percent when more than 45 percent of Medicare spending comes from general revenues, a milestone that probably will be reached in several years. Finally, physicians who fail to participate in pay-for-performance and transparency programs would face further cuts.

Other provisions in the budget would expand health care coverage through tax credits and association health plans, freeze funding for the National Institutes of Health at 2007 levels, reduce spending for several health professional training programs, and cut funding for the Health Resource and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC). Slated for elimination are the HRSA's Trauma-Emergency Medical Services (EMS), children's EMS, and traumatic brain injury programs, as well as the CDC's Preventive Health and Health Services Block Grant. The CDC's National Center for Injury Prevention and Control is funded at the same level as in 2007: \$138,410,000. For details about the budget, go to <http://www.whitehouse.gov/omb/budget/fy2008/>.

## Trauma funding bills introduced

Just before the President released his budget proposal, Congress introduced legislation that would reauthorize the Trauma-EMS program. The Trauma Care Systems Planning and Development Act, H.R. 727, was introduced in the House of Representatives on January 29, by Reps. Gene Green (D-TX) and Mike Burgess, MD (R-TX). On February 16, the Senate followed suit, with Sens. Jack Reed (D-RI) and Pat Roberts (R-KS) introducing the companion bill, S.657. This legislation would provide funding for the program through FY 2012, with authorization levels of \$12 million in FY 2008, \$10 million in 2009, and \$8 million in 2010–2012. The bills also create a competitive grant program for states that have already

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## **Health Partnership Act introduced**

begun the process of establishing a trauma system using national standards and protocols. Log on to the College's Legislative Action Center at <http://www.capitolconnect.com/acspa/> to send a letter to your legislators asking them to cosponsor these bills. For more information, contact Adrienne Roberts, Government Affairs Associate, Division of Advocacy and Health Policy, at [aroberts@facs.org](mailto:aroberts@facs.org).

On January 17, Sens. Jeff Bingaman (D-NM) and George Voinovich (R-OH) and Reps. Tom Price, MD, FACS (R-GA), Tammy Baldwin (D-WI), and John Tierney (D-MA) introduced the Health Partnership Act, S. 325 and H.R. 506, respectively. This legislation would authorize grants to states, regional entities, and others to pursue innovative strategies for increasing access to health insurance coverage, ensuring that patients receive high-quality and appropriate care, improving efficiency, and using information technology to enhance infrastructures.

The legislation also calls for establishing a bipartisan state health innovation commission that would be responsible for approving a variety of reform options, including institution of tax credits; expansion of Medicaid or SCHIP; creation of pooling arrangements, single-payor systems, or health savings accounts; or a combination of these and other options. The American College of Surgeons supports the legislation. For more information, go to <http://www.facs.org/ahp/views/hpact.html>.

## **Resubmit Aetna E/M claims with modifier -57**

Surgeons have until April 30 to resubmit Aetna claims for evaluation and management (E/M) visits billed with a modifier -57. Aetna will pay the resubmitted claims in compliance with an agreement the insurer reached with the state medical societies to make payment for E/M claims with modifier -57, indicating that the decision with regard to a surgical procedure was made during the visit, when billed with major (global, 90-day) procedures. The agreement applies to claims for services provided between January 1, 2005, and February 11, 2006. After seeking input from medical societies and the independent Physician Advisory Board, Aetna decided to change its policy and began paying these claims effective February 12, 2006. For further information, including detailed instructions and forms required to ensure timely and accurate processing of resubmitted claims, visit the Aetna Web site at <http://www.aetna.com/>.

## **New Jersey governor vetoes cosmetic surgery tax repeal**

Weeks after the state legislature unanimously passed legislation to repeal the state's tax on cosmetic surgery, New Jersey Gov. John Corzine (D) vetoed A-2282 on January 26. The governor did not issue a statement explaining his rationale for the veto, and supporters of the legislation are now considering their options. As part of advocacy efforts in support of the tax repeal, more than 60 New Jersey surgeons used the Surgery State Legislative Action Center to contact the governor's office. For further information, contact Melinda Baker, State Affairs Associate, Division of Advocacy and Health Policy, at [mbaker@facs.org](mailto:mbaker@facs.org).

# What surgeons should know about...

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## The EMTALA TAG

by Adrienne Roberts, Government Affairs Associate, Division of Advocacy and Health Policy

The Emergency Medical Treatment and Active Labor Act (EMTALA) was signed into law in April 1986 by Pres. Ronald Reagan as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 to address the problem of “patient dumping” by hospital emergency departments. Since then, EMTALA has undergone many changes. As a result of one of these transformations, the EMTALA Technical Advisory Group (EMTALA TAG) was created in 2003. Unless Congress reauthorizes it, the TAG is scheduled to expire in June.

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### When was the EMTALA TAG created, and what is its purpose?

The EMTALA TAG was created as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and signed into law by Pres. George W. Bush in December 2003. This law required the Secretary of the U.S. Department of Health and Human Services (HHS) to establish the TAG to review EMTALA regulations and to provide advice and recommendations to the Centers for Medicare & Medicaid Services (CMS) concerning these regulations and their effect on hospitals and physicians. The TAG also is required to solicit comments and recommendations from hospitals, physicians, and the public and to disseminate information concerning the application of the regulations. CMS staffs and administers the TAG, and since its inaugural meeting in March 2005, the TAG has met five times, most recently in November 2006.

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### Who serves on the TAG?

The TAG is composed of 19 members, including the CMS Administrator, the Inspector General of HHS, and individuals in each of the following categories:

- Four representatives of hospitals—including at least one public hospital—that have experience with the application of EMTALA and

at least two hospitals that have not been cited for EMTALA violations

- Seven practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopaedic surgery, neurosurgery, pediatrics or a pediatric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field

- Two patient representatives
- Two CMS staff members from a regional office who are involved in EMTALA investigations

- One representative from a state survey agency involved in EMTALA investigations and one representative from a quality improvement organization, both of whom shall be from areas other than the regions represented by the CMS regional offices

Currently, four College Fellows serve on the TAG: Richard Perry, MD, FACS, a general surgeon from Phoenix, AZ; David Tuggle, MD, FACS, a pediatric surgeon from Oklahoma City, OK; James Nepola, MD, FACS, an orthopaedic trauma surgeon from Iowa City, IA; and John Kusske, MD, FACS, a neurosurgeon from Orange, CA.

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### What has the TAG recommended in regard to physician on-call requirements?

In 2005, the group met on three occasions to examine issues related to EMTALA’s physician on-call requirements. In comments submitted to the TAG, the College strongly urged the advisory committee to reject any legislative or regulatory efforts to require surgeons to take call as a condition of Medicare participation or as a stipulation for obtaining hospital privileges. Most of the panel members concurred with the College, believing such a proposal would lead to a dramatic reduction in physicians participating in the Medicare program and result in an access to care problem for seniors and people with disabilities. Hence, the TAG recommended that

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CMS *not* require physicians to serve on call as a condition of Medicare participation.

### **What changes to the EMTALA Interpretive Guidelines has the TAG recommended?**

In 2006, the TAG discussed physician communication and the appropriateness of contact with a patient's personal physician to determine medical history, physician response time to the emergency department, selective call, and follow-up care requirements.

Because the EMTALA Interpretive Guidelines do not contain any explanation regarding physician communication, at a May 2006 meeting the TAG recommended adding language that stated that "at any time a treating physician or qualified medical person is not precluded from contacting the patient's physician to seek advice regarding the patient's medical history and needs that may be relevant to the medical treatment and screening of the patient."

The TAG also recommended that physician-to-physician communication in a patient transfer situation should be encouraged but not required, and that a "range of minutes" should be required for a physician to respond to the emergency department if he or she is on call, which would apply only to the initial response. The initial response may occur by phone.

With regard to selective call, the TAG recommended that CMS clarify that when a physician takes call for patients with whom he or she has a preexisting medical relationship, it is *not* considered "selective call." The TAG also suggested that when a physician is not on the on-call roster, he or she is not obligated to provide call coverage (for instance, when in the hospital seeing patients).

When discussing shared or community call, the TAG recommended that CMS clarify its position, such that shared or community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as back-up plans.

The TAG also recommended that CMS incorporate into the Interpretive Guidelines that "the presence of a specialty physician on the on-call roster is not, by itself, sufficient to be considered a specialized capability" and that all hospitals,

including specialty hospitals, should maintain an on-call list.

### **What discussions and recommendations has the TAG made regarding specialty hospitals?**

In preparation for the October 2005 meeting, the TAG looked at three issues: (1) whether there should be a federal requirement for specialty hospitals to maintain emergency departments and, if so, whether this is best achieved by amending EMTALA or through some other means; (2) whether specialty hospitals, irrespective of whether they have emergency departments, are subject to the EMTALA requirement under which a Medicare-participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual; and (3) whether additional or different on-call requirements should be established for specialty hospitals (for example, whether specialty hospitals should be required to participate in community protocols).

In its submitted comments, the College stated that the issue of whether specialty hospitals should have their own dedicated emergency rooms is, and should remain, a matter of state law and community need. Irrespective of whether a specialty hospital has an emergency department, it should be required to accept the appropriate transfer of an individual who requires a treatment that the facility provides. However, it is also important to recognize that, by their nature, specialty hospitals can only treat patients with specific medical needs. Patients with underlying conditions beyond a specialty hospital's capabilities must be referred to a more comprehensive facility. In addition, specialty hospitals should accept all patients to whom they can provide appropriate care, without regard to source of payment. Patient selection should be based on medical criteria and facility capabilities.

The ACS also supported the expansion of statutory language requiring hospitals "to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency

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medical condition” to include specialty hospitals after an appropriate transfer. After hearing testimony from several groups and much discussion of this issue, the TAG voted to recommend that: (1) hospitals with specialized capabilities *not* be required to maintain dedicated emergency departments (DEDs), and (2) hospitals with specialized capabilities that do not have DEDs be bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have DEDs. In the fiscal year (FY) 2007 Hospital Inpatient Prospective Payment System (HIPPS) final rule, CMS accepted this TAG recommendation. CMS also announced that it did not intend to require that all hospitals have DEDs as a condition of Medicare participation.

The FY 2007 HIPPS also included the definition of “labor,” as advocated by the American College of Nurse-Midwives and supported by the American College of Obstetricians and Gynecologists (ACOG), which the TAG recommended. As a result, the definition of “labor” has been amended to permit certified nurse-midwives and other qualified medical personnel to certify false labor.

### **Do physicians have obligations beyond EMTALA?**

Focusing on just exactly when an emergency medical condition ends has been discussed at several meetings. TAG members have stressed that EMTALA obligations end once a patient has been discharged. But the question of how to handle needed follow-up care and appropriate discharge instructions has been raised. Therefore, TAG recommended that CMS amend its interpretive guidelines to clarify that once a patient has been stabilized, the hospital and physician have no further obligation to provide follow-up care.

### **What other documents are the TAG working to develop?**

The TAG is developing two white papers regarding the effects of physician reimbursement levels and medical liability on the availability of on-call physicians. The College has submitted comments to TAG for its review, and TAG is expected to continue working on these papers in 2007.

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### **What are the issues TAG is scheduled to review in 2007?**

At its November 2006 meeting, TAG identified several important issues that are scheduled to be addressed in 2007, including the following: (1) the definition of “specialized capacity” and the requirements of hospitals with specialized capacity, (2) regional call sharing, (3) continuous call, (4) the requirement that hospitals maintain lists of on-call physicians and the definition of “best meets the needs” of the community, (5) physician response time, (6) ambulance “parking” of emergency patients, (7) waiver of EMTALA during natural disasters or other emergencies, (8) follow-up care requirements, and (9) applicability of EMTALA to inpatients in need of services that the hospital cannot provide. TAG will also likely issue several recommendations to CMS regarding suggested changes to the EMTALA regulations and interpretive guidelines. TAG is slated to assemble for its sixth meeting May 3–4 in Washington, DC.

### **How can Fellows keep informed of EMTALA TAG activities?**

The EMTALA TAG has its own Web site, which can be accessed at [http://www.cms.hhs.gov/FACA/07\\_emptalatag.asp](http://www.cms.hhs.gov/FACA/07_emptalatag.asp). 

A ceramic figurine of a classical building with a dome and a clock face. The building has a portico with columns and a pediment. The clock face is on the right side, showing the time as approximately 10:10. The entire scene is set against a light, neutral background.

# Surgery's 2007 federal advocacy agenda

by  
Cynthia A. Brown,  
Director,  
Division of Advocacy and Health Policy

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**N**ow that the 110th Congress has convened and more is known about the priorities and goals of its new leadership, it seems appropriate to review some of the legislative challenges and opportunities facing surgeons and their patients. Many of the high-priority issues remain the same, but in some cases, the potential solutions and partnerships that evolve to address them may be slightly different today than during the 109th Congress.

### Medicare physician payment

Some issues never seem to go away. Once again, physicians are confronting a significant reduction in the Medicare fee schedule conversion factor in the coming year. In fact, because the budgetary device used to finance this year's freeze in the conversion factor expires at the end of 2007, physician services will be subjected to what essentially amounts to two payment reductions at once, totaling approximately 10 percent in 2008, unless Congress intervenes.

At the heart of the issue is a statutory formula that makes reforming the physician payment system very expensive under federal budgetary rules. The current estimated cost to the federal government of eliminating the sustainable growth rate (SGR) system that is producing the annual payment cuts is approximately \$250 billion over 10 years, with beneficiaries bearing an additional 25 percent of the total of the outlays through annual premium increases. Beneficiary outcries, along with a self-imposed "pay-go" rule that requires Congress to offset spending increases by reductions in other areas, means that politically difficult choices will have to be made before the problem truly can be resolved.

Not surprisingly, many policymakers and advisors are searching for innovative, less expensive approaches to at least partially address the problem. On March 1, 2006, the Medicare Payment Advisory Commission (MedPAC) issued a congressionally mandated report on ways to reform the SGR system. In addition to restating its long-held view that the SGR ought to be eliminated, MedPAC described an alternative that would involve establishing local expenditure targets that embrace all health care providers.

Organizations representing primary care physi-

cians have been promoting an advanced medical home (AMH) concept, under which Medicare beneficiaries would identify a physician practice to serve as the coordinator for all their health care services. In return, the physician practice would receive a monthly, risk-adjusted, capitated payment in addition to any fee-for-service payments made for individual office visits or other services. Primary care organizations argue that improved care coordination will produce system-wide cost savings by eliminating redundant or unnecessary testing and reducing rates of complication and hospitalizations.

From surgery's perspective, the MedPAC proposal to expand a SGR-type system would be enormously complex and, by imposing a flawed mechanism for constraining costs to an even broader array of services, it holds serious potential for making a bad situation worse. The AMH proposal also raises administrative and financial concerns. For example, it seems unlikely that federal budget authorities will predict sufficient Medicare savings from better coordinated services to avoid another round of fee schedule payment redistributions among specialties.

Like MedPAC, the College appreciates that an alternative to completely eliminating the SGR must be developed in order to overcome the budget-induced inertia. Last year, the College and a number of surgical specialty societies, together with the American Osteopathic Association, jointly supported a proposal to establish separate SGRs for four physician service categories—primary care, major procedures, minor procedures, and diagnostic and laboratory tests. Because these service categories have dramatically different rates of Medicare volume and expenditure growth, a system of separate targets would lend more focus to cost-containment efforts. And, because both major procedures and primary care have relatively low rates of spending growth, the separate targets and conversion factor updates would protect these services from continued payment cuts that offset spending increases in other service areas. Although this proposal still carries a significant price tag, it drew favorable responses from many Capitol Hill policymakers, and the College is continuing these discussions in 2007.

Although it remains questionable that either

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comprehensive or incremental Medicare payment reforms can be achieved this year, lawmakers certainly understand the disruptions that would occur if a 10 percent conversion factor cut is allowed to take effect January 1, 2008. At minimum, we can expect legislative intervention that will continue the past practice of providing a short-term freeze or modest payment increase for one or two years.

### Quality improvement and reporting

In December 2006, Congress established a new program of payment incentives for physicians to report quality measures. Between July 1 and December 31, 2007, physicians who participate in the Physician Quality Reporting Initiative, or PQRI (formerly known as the Physician Voluntary Reporting Program, or PVRP), will be eligible for a 1.5 percent payment bonus on all Medicare claims submitted during this period. The bonus will take the form of a one-time payment, which will be made early in 2008. (Details of the program are still being finalized and will be provided in a future issue of the *Bulletin*. This month's "Socioeconomic tips" column on page 39 also addresses the subject.) As the specific mandate and funding for the PQRI expire at the end of the year, the legislation sets the stage for the Secretary of the U.S. Department of Health and Human Services to conduct an unspecified quality reporting program in 2008.

Many questions surround the PQRI, as well as any future quality-measurement program. The questions include doubts about the utility and validity of some of the process measures involved, fears that superficial measures of quality will be used someday to publicly rank physicians, concerns about the feasibility of accurately reporting quality on claims forms, suspicions that specialties with few or no measures will eventually finance the incentive bonuses paid to others, and worries that specialties with many measures will suffer from a disproportionate and unsustainable reporting burden.

The new congressional leadership includes both supporters and critics of the PQRI, so it is difficult to predict its future. However, both Medicare administrators and private sector health plans are unquestionably determined to implement some

program that will differentiate between physicians and other providers based on the quality and effectiveness of the care they provide.

For surgeons, particularly those who operate in hospitals and ambulatory surgical centers, a patient-centered evaluation of quality of care is complex, encompassing many individuals, facility attributes, and patient characteristics. So, although PQRI may represent a starting point for quality measurement and improvement efforts, it cannot serve as an accurate measure of a surgeon's skill or the quality of care he or she provides. The College is working with other specialty societies and with public and private sector payors to develop more useful tools for measuring and improving the quality of care provided to surgical patients.

### Medical liability reform

Despite acknowledgment of the problems that the liability system causes our health care system, the new leadership in Congress is unlikely to pass comprehensive reforms that include a cap on noneconomic damages. For the traditional package of tort reforms, the College and its allies must turn their attention to state legislatures.

However, key members of Congress have signaled genuine interest in considering non-traditional liability reforms. For example, Sen. Michael Enzi (R-WY) introduced the Fair and Reliable Medical Justice Act in 2005. Cosponsored by Sen. Max Baucus (D-MT), this legislation would establish state demonstration projects to evaluate alternatives to current medical tort litigation. Most notably, the bill would allow for the creation of health courts as a method of adjudicating medical liability cases. Although the College did have some concerns with a few technical areas of the bill, it has been supportive of these demonstration projects, and Senators Enzi and Baucus are expected to reintroduce the legislation this year.

### Covering the uninsured

The issue of ensuring access to care for uninsured Americans has once again risen to prominence on the congressional health care agenda, and most medical associations have already started weighing in. On January 11, a coalition

## Principles for reform of the U.S. health care system

**Preamble:** Health care coverage for all is needed to facilitate access to quality health care, which will in turn improve the individual and collective health of society.

Health care coverage for all is needed to ensure quality of care and to improve the health status of Americans.

- The health care system in the U.S. must provide appropriate health care to all people within the U.S. borders, without unreasonable financial barriers to care.
- Individuals and families must have catastrophic health coverage to provide protection from financial ruin.
- Improvement of health care quality and safety must be the goal of all health interventions, so that we can assure optimal outcomes for the resources expended.
- In reforming the health care system, we as a society must respect the ethical imperative of providing health care to individuals, responsible stewardship of community resources, and the importance of personal health responsibility.
- Access to and financing for appropriate health services must be a shared public/private cooperative effort, and a system that will allow individuals/employers to purchase additional services or insurance.
- Cost management by all stakeholders, consistent with achieving quality health care, is critical to attaining a workable, affordable, and sustainable health care system.
- Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services.
- Sufficient funds must be available for research (basic, clinical, translational, and health services), medical education, and comprehensive health information technology infrastructure and implementation.
- Sufficient funds must be available for public health and other essential medical services to include, but not be limited to, preventive services, trauma care, and mental health services.
- Comprehensive medical liability reform is essential to ensure access to quality health care.

of 10 physician organizations\* released a list of guiding principles for health care reform (see box, left). One week later, a group of 15 broadly representative stakeholder organizations† announced a more specific agreement, outlining steps that may reduce the number of uninsured individuals. Both documents stress the need for a combination of public and private sector solutions.

In Congress, Sens. Jeff Bingaman (D-NM) and George Voinovich (R-OH) and Reps. Tom Price, MD, FACS (R-GA), Tammy Baldwin (D-WI), and John Tierney (D-MA), introduced the Health Partnership Act, S. 325 and H.R. 506, respectively. This legislation would authorize grants to states, regional entities, and others to pursue innovative strategies for increasing access to health insurance coverage, ensuring that patients receive high-quality and appropriate care, improving efficiency, and using information technology to enhance infrastructures.

Common to these and most other approaches that have been circulating is a commitment to both public and private sector solutions. For example, there is general commitment to maintain the State Children's Health Insurance Programs. Favorable tax treatment for health insurance premiums paid by individuals for private insurance also enjoys broad support.

### Emergency and trauma care

Surgical specialists—especially those who provide on-call coverage in their communities' emergency departments—are among the physicians who bear the greatest burden of caring for the uninsured. In fact, the Institute of

\*American College of Surgeons, American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American College of Cardiology, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Osteopathic Family Physicians, and American Osteopathic Association.

†AARP, American Academy of Family Physicians, American Hospital Association, American Medical Association, American Public Health Association, America's Health Insurance Plans, Blue Cross and Blue Shield Association, Catholic Health Association, Families USA, Federation of American Hospitals, Healthcare Leadership Council, Johnson & Johnson, Kaiser Permanente, Pfizer Inc., United Health Foundation, and U.S. Chamber of Commerce.

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Medicine recently released a series of reports on the future of emergency care in the U.S., which found that hospital emergency departments and trauma centers across the country are severely overcrowded and that emergency care is highly fragmented.<sup>3</sup> Furthermore, heightened liability exposure and a large number of patients needing uncompensated care are combining to reduce the availability of critical surgical specialists who will participate in emergency on-call panels.

The College and other surgical societies believe that emerging specialty shortages in emergency care serve as the “canary in the coal mine,” signaling that forces are combining to place unsustainable stress on surgical practices. The College and the surgical specialty groups are making a concerted effort to educate policymakers on this threat to the health care safety net, and to promote a series of short- and long-term solutions to the underlying causes.

## Other developments

Of course, the College’s legislative agenda includes a variety of other issues, including patient safety, trauma system development, scope of practice, antitrust reform, federal provider credentialing, graduate medical education financing, and funding for biomedical research. Indeed, as the scope of the federal government’s interest in health care expands, surgery’s agenda has grown much broader.

The College is committed to representing its membership’s interest in Washington and is providing important new tools for conducting surgery’s advocacy efforts. For example, at its meeting in February, the ACS Board of Regents took the following steps toward strengthening the College’s presence in Washington:

- A business plan was approved to conduct a comprehensive study of the surgical workforce, including an assessment of the impact that public policies and marketplace trends are having on the supply of and demand for surgical care.
- Funds were designated in the coming fiscal

year to establish an ACS Institute for Health Policy Research, which will be charged with data collection and analysis of trends affecting surgeons and patients.

- A final decision was made to purchase property and construct a new building on Capitol Hill to house the College’s Washington office, with ample room for other surgical specialty societies that want to join in.

To be truly effective, however, the College relies on the support of its membership. Fellows are encouraged to take advantage of opportunities to educate themselves about the many socioeconomic issues confronting surgery today and to participate in the College’s grassroots advocacy efforts. □

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<sup>3</sup>Institute of Medicine of the National Academies, Future of Emergency Care series: *Hospital-Based Emergency Care: At the Breaking Point*, *Emergency Medical Services: At the Crossroads*, and *Emergency Care for Children: Growing Pains*. Washington, DC: National Academies Press; 2006.



**STAYING SAFE:**  
*Simple tools for safe surgery*

by **RICHARD C. KARL, MD, FACS,**  
*Tampa, FL*



y operating team was closing the third case of the day and the sponge count wouldn't come out right. We had searched the drapes and the large, red, biological waste disposal bags. There was a delay getting the X-ray

technician into the room. I was frustrated, and so was everybody else. I sensed we would all agree that there must be a better way. Two thoughts came into mind, almost colliding: It never seems this disorganized when I fly airplanes, and this extra anesthesia time was not good for this patient.

My own lifelong interest in surgery and in flying has led to some rather obvious comparisons between the two. Others, too, have started to draw the similarities. There is now a growing awareness in medicine that hospitals can be dangerous places and that medical error can contribute to death and harm. Many point to the expected, almost routine, safety of commercial flying as way to look for cues that may be useful in medicine. Is there a problem with medical error? How big is the problem? Will lessons learned in other dangerous industries like aviation, nuclear power, and the Navy submarine service be helpful in decreasing harm and death caused by medical error?

### ***The problem and its size***

In 1999, the Institute of Medicine (IOM) published *To Err Is Human*.<sup>1</sup> In this book, data were extrapolated from studies done in the early 1990s that indicated that as many as 100,000 lives a year are lost in U.S. hospitals because of medical error. Though most surgeons were aware of occasional events that were harmful to patients, the common conclusion among my colleagues at that time was that these events were occurring elsewhere, in some other hospital. After all, most U.S. doctors pride themselves on being highly trained professionals delivering high-quality, thoughtful care. But, as my own awareness grew, I began seeing and hearing about incidents that made me wonder if 100,000 lives a year was an underestimate. I'd hear about the liver resection

patient who died on the table at one hospital, probably because of unappreciated blood loss by the surgeon, underresuscitation by the anesthesiologist, and poor communication between the two. I'd been told of the transhiatal esophagectomy with the unrecognized tracheal laceration at another institution and the young surgeon who was reluctant to ask for help. In discussion with friends around the country, I almost always was briefed on another horror story. I began to think that if we could cut the death rate from error in half, it would be the equivalent of curing breast cancer, which kills approximately 42,000 people a year.

Around the same time, I began to sense a number of less dramatic consequences of medical error. The patient didn't die but did end up with a wound infection, an avoidable colostomy, or a reoperation for a retained foreign body. Then, in December 2006, the Institute for Healthcare Improvement released data estimating that there are 15,000,000 incidents of harm "resulting from or contributed to by medical care."<sup>2</sup> When I saw this figure, I thought, what is going on here?

A lot is going on, it turns out. Though evidence for ways to practice safer surgery is accumulating, many surgeons are reluctant to adopt new ways of doing things. Papers detailing the consequences of mild hypothermia (threefold increase in surgical site infection rate, prolonged hospitalization) are well documented and published in our best journals,<sup>3,4</sup> but the thermostat in most operating rooms where I work is still set for my comfort and, until recently, my anesthesia colleagues and I rarely discussed the matter of temperature during an operation.

Tight glucose control has been shown in several studies to be associated with lower surgical site infection rates and, in critically ill patients, a 34 percent decrease in mortality.<sup>5-7</sup> Yet, glucose control is still managed with imprecise sliding scales for insulin administration in most hospitals.

Consider the gratuitous number of units of blood often administered in operating rooms where communication between the surgeon and the anesthesia team is limited or nonexistent.

Until recently, I'd be only vaguely aware of a transfusion during a case. I'd hear a nurse whispering the unit number and blood type to an

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anesthesia resident. Not uncommonly, it would turn out the patient had been hypotensive for a while and that pressors had been given. Though no blood had been lost, a transfusion had been ordered. Yet, it is now well documented that the immunosuppressive effects of a transfusion of packed cells more than triples the risk of nosocomial infection.<sup>8,9</sup> In cancer patients, blood transfusion has been linked to an increased recurrence rate in almost every primary site studied.<sup>10,11</sup> In the case I mention here, the cause of hypotension was a retractor pressing on the heart.

### ***The possible solutions to the problem***

Human factors studies have proven the adage of the IOM book: to err is human. In aviation, this assumption underlies the systems designed to detect potential errors, to “trap” them and, if they still occur, to correct them before harm occurs. In medicine, the surgeon is the “captain of the ship,” and all responsibility rests on his or her shoulders. Our culture is more punitive than supportive, and likely most surgeons have witnessed the hostile behaviors associated with a surgeon’s sense of insecurity. Many physician executives who participated in a survey reported encountering disruptive or dangerous physician behaviors on a regular basis.<sup>12</sup>

The airline captain used to be the captain of the ship too. But the investigation of multiple accidents attributed to pilot error revealed that often another member of the team in the cockpit was well aware of the danger but was not assertive enough to let it be known, and, ultimately, the crew was unable to avoid a fatal accident.<sup>13</sup> Gradually, aviation began to see pilots and flight engineers as crews, with the captain as the leader, though not the supreme being. In this model, sometimes called “crew resource management” (CRM), the leader seeks input from several sources but doesn’t abdicate the ultimate responsibility for a safe flight.\* I am reminded of the wisdom of this approach when I watch a young faculty member struggle with a laparoscopic cholecystectomy. Often the nurse

standing next to the surgeon has seen a thousand such operations and has a clear idea as to what is the cystic duct and what isn’t. Yet, the young surgeon does not ask her advice and she does not proffer it. In such cases, likely neither had been trained in CRM.

Checklists are also ubiquitous in aviation. Most serious aviators wouldn’t consider a flight without strict adherence to the order and cadence of a well-written checklist. These are essentially reminders, not instructions, that require one pilot to respond to a challenge read by another. “Gear down?” will query the pilot. “Down with three green [lights],” comes the response from the other pilot. Such patterned responses are wonderful to listen to; they sound like the litany of a religious service.

Forcing functions are designed into airliners. Speed brakes—those slats on top of the wing—will not automatically deploy on landing until a certain tire speed is reached, assuring that the airplane is in fact on the ground. There are some forcing functions in medicine as well. Computerized physician order entry systems require the physician ordering a medicine to respond to questions about allergies and renal and hepatic function before the order will be fulfilled. These systems have resulted in a markedly decreased rate of harm from inappropriate orders.<sup>14,15</sup> Nonetheless, the use of checklists and forcing functions in medicine is primitive compared with other high-reliability systems. When it comes to checklist violations, imagine if you were the surgeon sewing in the heart-lung transplant in a young patient, only to hear that there is a blood type mismatch. Such a sinking feeling cannot be described.

When an emergency occurs in flight, pilots turn to emergency checklists and the Quick Reference Handbook (QRH), where carefully written algorithms guide anxious pilots to the safest course of action. Compare this approach with the common chaos in an operating room when an airway is lost or the patient’s blood doesn’t clot.

We have a long way to go in medicine, both substantively and culturally. Though the universal protocol was mandated in 2004, there were even more wrong site operations in 2005. In 2005, in Florida, there were 88 operations to remove a

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\*See related articles on the subject of error reduction and CRM by Gerald B. Healy, MD, FACS; Jack Barker, PhD; and Capt. Gregory Madonna in the February, June, and November 2006 issues of the *Bulletin*.

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foreign body from a surgical procedure; 31 wrong site operations; and, in five instances, operations performed on the wrong patient.<sup>16</sup> I sometimes think the term “timeout” is antithetical to the concept of safety woven into the fabric of what we do. It implies that safety is an exception, not a practice, and it is a term commonly used for disciplining errant children.

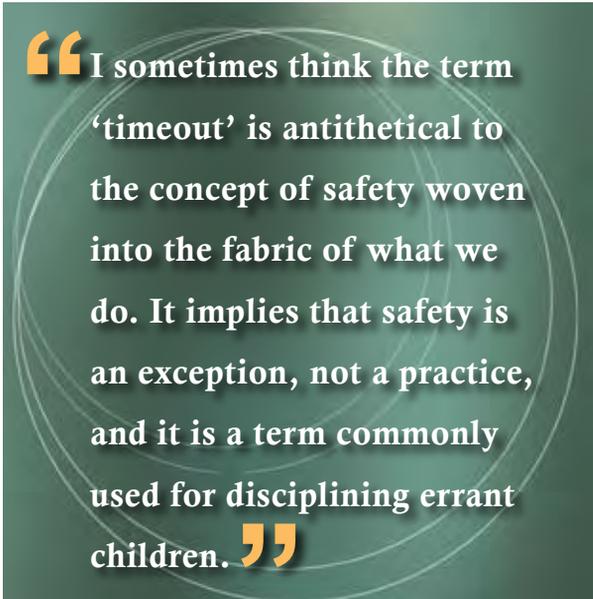
Almost every surgeon involved with a wrong site procedure reports doing a timeout and carefully marking the site. But marks get washed off and patients get repositioned and wrong site operations, as hard as they are to comprehend, do occur. Many states still hold the surgeon alone, rather than the entire team, responsible and punish them with fines and reprimands, as if they sought to do harm. We have yet to realize that these errors occur because of the systems we use in medicine, because people are fallible and because we have a culture of punishment or condescending disregard that inhibits many from speaking out about an impending mistake that may lead to harm or, worse, take a life.

### ***Types of error***

It is helpful to see how errors occur so that systems can be designed to minimize their occurrence and catch those inevitable mistakes that do fall through the cracks.

Latent errors are those caused by the background of the workplace. Hospitals that allow fatigued surgeons to operate, cultures that prohibit a nurse from alerting a surgeon to an impending mistake, and organizations that don’t address issues of maintenance are all breeding grounds for latent error.

Active errors are the type common to surgeons—for example, the common duct is severed or the portal vein is torn by rough hands. These errors can be attributed to knowledge, where the surgeon just doesn’t know where the portal vein lies. Or the error can be related to experience, where the surgeon has studied the anatomy but has little actual experience developing that plane between the superior mesenteric vein and the neck of the pancreas. Finally, there are execution errors, where the surgeon knows and has experience, but for some reason—perhaps a distraction, lack of attentiveness, bravado, ennuï, fatigue—the vein is still torn.

A quote by a surgeon about the term 'timeout'. The text is white with a drop shadow, set against a dark green background with faint circular patterns. The quote is enclosed in large, stylized orange quotation marks.

**“I sometimes think the term ‘timeout’ is antithetical to the concept of safety woven into the fabric of what we do. It implies that safety is an exception, not a practice, and it is a term commonly used for disciplining errant children.”**

Planning errors are just that: the plan is bad. An example would be a recent case where a young surgeon divided the right branch of the bile duct and the right hepatic artery before recognizing what was obvious on the computed tomography scan: that the hepatic lesion was unresectable because of portal vein involvement.<sup>17</sup> The plan was poor because of lack of experience and lack of appropriate supervision.

### ***When things go wrong***

Most medical adverse events caused by error are the result of poor communication, checklist violations, loss of situational awareness, and latent error. Often caregivers aren’t “on the same page,” leading to miscommunication.

To address miscommunication in the submarine service, a simple way of transferring information, called “SBAR,” has been developed. When telling another person about a situation, this patterned way of speaking—S=situation, B=background, A=assessment, and R=recommendation—is powerful. In medicine, rather than a phone call from hospital staff to a surgeon in the middle of the night with poorly organized data and no clear sense of expectation on the part of the

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person who has placed the call, a cogent, concise conversation can be constructed. As opposed to “Mrs. Smith doesn’t look right,” a call can be worded—using SBAR—like this: “Mrs. Smith has developed atrial fibrillation [S]. She had an uncomplicated esophagectomy two days ago [B]. Her heart rate is 160 and her systolic pressure is 100 [A]. I think we should move her to the unit and control her heart rate [R].”

### ***The role of culture***

The airplane cockpit and the operating room have a lot in common as well as some obvious differences. Airlines and hospitals have different cultures too. To expect that some CRM training alone will change the harm rate in medicine is an overly simplistic concept. Profound inherent differences, including the following, are obvious:

- In airline accidents, several people die at once, likely guaranteeing mention on the front page of the newspaper. Yet, 100,000 deaths a year in hospitals is the equivalent number of lives lost in four jumbo jet fatal crashes per week.

- Airline pilots work for the airline. If they deviate from the airline’s training and standards, they are fired. Patients come to hospitals to be treated by surgeons, and as a result, surgeons exert considerable financial force on the institution’s profit.

- Pilots are first at the scene of the crash. They are highly motivated to avoid an accident.

- Flights are cancelled when the airplane has a mechanical problem. Operations are undertaken precisely because there is a mechanical problem.

Additional differences are related to history and culture of these institutions, and some of these principles are ripe for adoption in medicine.

- Airline pilots are required to successfully pass recurrent simulator-based training and evaluation. Though surgery is moving toward a more robust assessment of competencies, these efforts are just beginning.

- Airline pilots have strict duty hour regulations, whereas surgeons do not.

- There is a “no fault” reporting system for aviation near-misses that is administered by the National Aeronautics and Space Administration

(not the Federal Aviation Administration).

- New airline hires and new captains fly with check airmen during their initial operating experience. Newly appointed surgeons rarely operate with another surgeon experienced in hospital policy and culture.

- Below 10,000 feet, airlines maintain a “sterile cockpit,” where no discussion is allowed unless it regards matters pertaining to the safe conduct of the flight.<sup>†</sup>

- Airlines constantly review safety with line-oriented safety audits. Observations are made of several flights and safety trends are observed. No interdiction with the crews occurs—the object is to review the process and not those particular pilots.

- Airlines learned long ago that there are certain weather conditions in which a safe landing is unlikely. Thus, an instrument approach cannot be initiated unless certain minimum conditions exist. Yet, a surgeon can operate on anybody he or she wants to, regardless of cardiac or pulmonary function or the likelihood that the operation will benefit the patient.

- Simulators are much more advanced in aviation than in medicine and in surgery.

- Pilots are hired after an exhaustive line-oriented interview, where interpersonal skills and collaborative abilities are assessed. Surgeons meeting a hospital’s eligibility criteria are appointed and given operating room privileges without much consideration of emotional intelligence.

There is one more difference between these two systems: Without intending to diminish either glorious profession, as a pilot type-rated in the Boeing 737 and as a surgical oncologist, I can say unequivocally that surgery is much harder than flying.

### ***Does any of this work?***

All surgeons are data driven and we expect evidence to support the concept that aviation techniques can help reduce error. There is early evidence that these practices are effective. In a

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<sup>†</sup>I am reminded of my own experience several years ago, when a fine surgical oncology fellow and I had just resected a large retroperitoneal tumor. In relief that we hadn’t violated the inferior vena cava, we started talking about his children and, in a moment of inattention, injured the patient’s ureter.

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Kaiser Permanente hospital that instituted a briefing period before a procedure was performed, it was found that unexpected delays were cut in half and that nursing turnover, a major concern for hospital administrators and surgeons, decreased from 19 percent to zero. Furthermore, whereas three wrong site procedures had been reported before this briefing system was implemented, there was none afterwards.<sup>18</sup>

#### ***What can you and I do?***

There are several simple things we can do to reduce harm in our work. Start by recognizing that the people we work with are, almost without exception, bright, altruistic, and hardworking. They believe in the Hippocratic Oath, “Primum non nocere.”

One way to increase safety is to put a white board in the operating room. On it, write the name of the patient, his or her age, and the medications that will affect the safe conduct of the operation. Include the site of the problem (for example, “left knee,” or “esophageal adenocarcinoma at 35 cm”), and the names of everybody in the room. Use this simple tool as the centerpiece for a preoperative briefing. Make sure you, the nurses and technicians, and anesthesia staff have a shared view of the case. Discuss fluid administration, proposed length of the operation, and the possible difficulties. (I’ll admit that when I started using a white board, my anesthesia colleagues looked at me as if I’d had a small stroke. They ultimately realized that this communication was helpful.)

Invite everyone in the room to speak up if they see something unusual or dangerous. This seems like an obvious thing to do, but saying these words out loud has a profound effect on the atmosphere in the room. I benefited recently when an alert technician reminded me that clos-



Dr. Karl in the cockpit.

ing the chest without chest tubes was a deviation from our usual routine.

This preoperative briefing more than meets The Joint Commission’s preoperative verification process requirements, and it sets a tone that is characterized by a relaxed, professional demeanor. Consider also operating without music. It is possible and it makes it easier to hear each other.

Require callouts from anesthesia every 30 minutes. This is a great chance to compare the progress of the surgeon to the progress of the patient. Blood pressure, pulse, urine output, temperature, and oxygenation can easily be discussed. It is a good time to let the anesthesia team know if you’re having trouble or might run into bleeding.

Do a debrief at the end of the procedure. Review what might have been done differently. Share any special concerns with the post-anesthesia team. Communicate. Make a solid

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handoff of the patient. Be the leader. Support change to a safer environment.

### Conclusion

Flying and operating are two of the most rewarding challenges in life. Both are exhilarating, sometimes frightening, always riveting. Both are more fun when things are organized to reduce surprises. I enjoy surgery more than ever, now that I've been using these simple tools. 

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*Surgical lifestyles*

## Retired surgeon is now a “clock doctor”



*by Diane S. Schneidman,  
Manager, Special Projects, Communications*

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**D**avid G. Murray, MD, FACS, Past-Chair of the ACS Board of Regents and Past-President of the American College of Surgeons, may have retired from orthopaedic surgery six years ago, but he never shook the urge to get patients moving again. Today, however, his patients tend to have wood or brass components instead of bones and ligaments. He now runs a small clock repair business—Doc’s Clocks—out of the workshop adjacent to his home in Syracuse, NY.

“My barber suggested the name,” Dr. Murray said. “I was getting a haircut, and I told him I was trying to decide what to call my clock repair shop, and he said, ‘Why don’t you call it Doc’s Clocks?’” Dr. Murray liked the suggestion, and, so, the name has stuck.

Opening a clock repair shop wasn’t simply a novel way for Dr. Murray to spend his retirement. He has had a particular interest in grandfather clocks—their inner mechanisms, the materials from which they are crafted, and their personal histories—since he was a young man. But during his years as professor and chair of the department of orthopaedic surgery at the State University of New York (SUNY) Health Science Center in Syracuse, Dr. Murray was too busy operating on patients and training residents to devote much attention to his avocation. He did manage to gather a collection of about 10 grandfather clocks from the 18th and 19th centuries, but he rarely even tinkered with them.

### ***Back to school***

Once he retired from surgical practice and education, however, he had some time on his hands and decided to pursue his outside interests. As a first step, Dr. Murray enrolled at the National Association of Watch and Clock Collectors School of Horology in Columbia, PA. The school offers training in either clock or watch repair, each of which requires an entirely different set of skills, he said.

“I signed up for clock repair. It was a 30- to 35-week program, which was divided into seg-

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Overleaf: Dr. Murray repairing a cuckoo clock. “Cuckoo clocks are not my favorite but I seem to get a lot of them!” he said.



Dr. Murray pointed out that “even my own clocks need attention from time to time.”

ments, each centered on a different type of clock,” Dr. Murray said. “So the duration of my training depended on how many types of clocks I wanted to learn how to repair. I completed the segments individually, spread out over as long as I wanted. Each section was devoted to a certain type of clock. I got through the entire program, including the portion on grandfather clocks, in 2003,” he noted.

After administering a final exam, the school issued a “certificate of satisfactory completion” to him, and Dr. Murray was ready to hang his shingle. No license is needed to enter the clock repair business in New York State, just a state sales tax identification number.

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### ***His “patients”***

Since opening Doc’s Clocks, Dr. Murray finds himself repairing approximately 50 to 70 clocks annually. Dr. Murray provides his services to the owners of all types of clocks—mantel, anniversary, cuckoo, and, of course, grandfather clocks—and he relies solely on word-of-mouth to market the business. “I have all of the work I want to handle,” he said.

The clock repair business and orthopaedic surgery have certain similarities, Dr. Murray said. “In many ways, clocks are just like people. They have personalities and they get worn out and stop running. Sometimes they can be fixed and continue to function, and other times there’s just nothing you can do.”

And like people, clocks can be moody and affected by their environment. Sometimes clocks won’t keep time properly because of where they are located. An uneven floor or unstable mantel,

for example, can easily knock a clock off kilter, Dr. Murray noted. In some instances, the clock itself is unsteady. When this situation arises, Dr. Murray sometimes finds it necessary to amputate a portion of the clock’s feet or legs.

One clock that Dr. Murray “treated” was malfunctioning because the owners had hung it parallel to the roof. Once it was moved to a more desirable location, it worked well. Other clocks simply have collected too much dust over the years and just need a good cleaning or perhaps new mainsprings.

Still others have problems with their gears. Clocks from different eras have different types of gears, Dr. Murray explained. Older clocks are more likely to have wooden gears, whereas clocks from the last two centuries tend to have brass movements. If the gears are particularly distressed, they need to be replaced or rebuilt, processes that require precision and patience.



The works of a grandfather clock on a stand in the shop. According to Dr. Murray, “Grandfather clocks are dismantled in the owner’s home and set up on a stand in the shop to work on. The case stays home.”

The repairer sometimes must carve new teeth for wooden gears or replace the small spindles in the ones with brass movements. Dr. Murray has done both procedures—cutting, filing, and sizing intricate wood prongs and immersing brass fittings into ultrasound baths.

Dr. Murray doesn't typically perform outpatient surgery on the clocks he repairs. "I usually keep them two or three weeks to make sure they're working all right," he said. However, he does make house calls. "I pick up and deliver all of the clocks, so I can observe their surroundings and so clients don't have to come to the house," he added.

The owners of clocks often behave in a way that is similar to the behavior of patients' families—fretting about their timepiece's condition and chances of recovery, Dr. Murray noted. Monetarily, most of the clocks he repairs are of moderate value—typically in the \$400 to \$500 range—although some very unusual pieces or those crafted by famous makers can be worth \$5,000 to \$10,000. But the financial aspect is a secondary concern for many clock owners.

People can grow very sentimentally attached to clocks, either because they've been passed down for generations or simply because they've become trusted fixtures in the household. Hence, sometimes clock owners "can be more grateful than some patients' families," he said.

Despite the gratitude that most of his customers express, he still carries malpractice insurance, just in case someone is dissatisfied. So far, no one has sued, but the premiums are much lower—only \$325 per year.

### ***Before Doc's Clocks***

When Dr. Murray was still at the SUNY Health Science Center, he served as the 77th President of the American College of Surgeons, 1996–1997, and as Chair of the Board of Regents, 1993–1994.

He completed his undergraduate studies at Cornell University in Ithaca, NY, and earned a medical degree from Washington University School of Medicine, St. Louis, MO, in 1955. Dr. Murray completed a rotating internship at Vancouver (BC) General Hospital before serving as



### *Clock trivia*

**D**uring the course of his career as a clock doctor, Dr. Murray has learned other interesting facts about timepieces. For example, "Oftentimes, clocks had two makers—one who constructed the inner workings and their housings and another who made the faces or the cases of the clocks." It's important to know who worked on each separate part to determine wherein a problem may lie.

He's also noted that clock dials have undergone evolutionary changes. "In the 1800s, it became popular to have painted dials instead of the brass that was used previously," Dr. Murray noted. A more recent addition to grandfather clocks was a window at the top of the dial, showing suns, moons, and other images historically associated with time.

Left: Dr. Murray pointed out that "Repair might be difficult but, as in surgery, diagnosis can be the most challenging."

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a lieutenant, MC, in the U.S. Navy from 1956 to 1958. He then served as assistant resident in general surgery at SUNY Health Science Center from 1958 to 1959, going on to pursue a residency in orthopaedics at the State University of Iowa, Iowa City, from 1959 to 1962. He attained certification from the National Board of Medical Examiners in 1956 and was named a diplomate of the American Board of Orthopaedic Surgery in 1965. Dr. Murray joined the faculty at SUNY and assumed the position of chair of the department of orthopaedic surgery in 1966, continuing to serve in that capacity until his retirement in 2001.

Dr. Murray became a Fellow of the American College of Surgeons in 1966 and played leadership roles on numerous ACS committees prior to being named Chair of the Board of Regents and elected President. In addition, Dr. Murray served as president of the American Academy of Orthopaedic Surgeons from 1982 to 1983 and as president of the Orthopaedic Research and Education Foundation from 1988 to 1991.

### ***Interesting case***

Old grandfather clocks are Dr. Murray's favorite to repair because they are the most complex and have the most distinct personalities, especially when compared with the mass-produced timekeepers of post-industrialized eras. "I really like working on the old grandfather clocks, where the repair can be challenging, but I also get to learn their histories and how they were made," Dr. Murray said.

The oldest clock he's worked on was built circa 1780. To get the clock running properly again, he first did some research on the maker because the owner wasn't certain when or where the clock was made. According to Dr. Murray, grandfather clock craftsmen of that period often wrote their names inside the door of the casing or on the dial itself, leaving one clue as to where and when the timepiece was made. This particular clock was signed by Thomas Harben. A father and son with the same name were clockmakers but, obviously, were practicing their crafts in different eras. The elder Thomas Harben was constructing clocks in England from the early 18th century until his death in 1760. His son, on the other hand, produced timepieces under

the Harben name until 1810. The junior Thomas Harben was the craftsman in this instance.

The clock had a continuous rope drive, which regulates the strike and movement mechanisms. The rope was roughly worn, so Dr. Murray had to figure out how to weave the rope together to get it to run, he explained. This task required skill, accuracy, and patience—just like most operations. Even so, the process was somewhat hit or miss, an element of clock repair that would be unacceptable in the operating room. "When you're working on people, you have to be more precise," Dr. Murray said. If a clock mender makes a misdiagnosis or chooses a less than perfect approach to treating a condition, he or she can always start over again and test alternatives. With people, you've got to get it right the first time. Ω

# THE ECONOMICS OF MANAGED CARE REIMBURSEMENT: A rationale for nonparticipation

BY ROBERT DeGROOTE, MD, FACS, HACKENSACK, NJ



Physicians and patients have seen the reality that managed care has changed the landscape of medical practice both professionally and financially. Any surgeon who practiced in the era that preceded health maintenance organizations (HMO) can attest to this. Financial, clinical, and ethical problems that arose as a result of the managed care environment have wreaked havoc on the surgical community. Most physicians have let themselves be held hostage by the managed care companies because of fear—that is, fear of professional and financial ruin through the loss of market share. The perception that nonparticipation in these plans would lead to financial suicide became the mantra through which these companies have kept physicians in line. The subsequent demoralization of the profession has further lowered surgeons' self-esteem and self-confidence and taken away our self-respect collectively, allowing an even tighter control of physicians by the insurance industry.

As a practicing general and vascular surgeon for the last 20 years, I watched the development of a sad scenario that I never thought possible: A once proud, respected, trustworthy, and noble profession brought to its knees by those not trained in the honorable art and science of medicine and whose only motivation is profit.

Four years ago, my office manager informed my partners and me that there were not sufficient funds in the business checking account after all expenses to pay physician salaries. I was stunned, to say the least—we all were! I am part of a very busy general and vascular surgical practice (2,650 cases/year) in an affluent suburb in the New York metropolitan area. The vast majority of patients here have insurance and we participated in every major HMO at the time. Examination of the books revealed a cash flow problem because of payment denials, down-coding, and the insurers delaying payments. Does this sound familiar? It should, because the same thing has probably happened to you.

I became very angry and I quickly began educating myself in the business aspects of a surgical practice. I took a course sponsored by the Medical Society of New Jersey, which taught me how to use the resource-based relative value scale (RBRVS) to analyze our business and determine if a particular insurance contract was profitable as well as how to determine the profitability of specific procedures we performed. The results were utterly shocking and that analysis is the basis for this paper.

The main problem facing surgeons in dealing with managed care companies from a business perspective is that many surgeons do not know what are the costs to provide surgical services. These costs can vary widely by surgeon, depending on how high is his or her salary and by how well he or she can control practice expenses.

Furthermore, managed care companies do not provide physicians with a full fee schedule or, in many instances, any fee schedule. The surgeon does not know what are the costs and does not know what he or she will be paid. This is a recipe for certain financial suicide. Do you know of any business that would sell a product without knowing what it costs? The only business I know of that operates in this manner is medicine, and this is one of the main reasons that the profession is in financial jeopardy.

This analysis relies on the principle of converting all of our payments, expenses, and profits into unit values using the same relative value units (RVUs), which payors use to develop base procedural reimbursements. This allows us to compare apples to apples and to better

understand the expense relationship associated with a particular procedure, something I had never thought of doing before taking this course.

Each Current Procedural Terminology\* code that is billed has a specific number of RVUs assigned to it. For example, in 2002, code 49505 (inguinal herniorrhaphy) had 12.38 RVUs assigned to it. Medicare and insurers use a conversion factor per RVU in dollars and then multiply the conversion factor by the RVUs to calculate the payments for a particular CPT code.<sup>1</sup> Each payor uses a different conversion factor, thereby yielding different reimbursements for the same procedure.

The first step in doing the analysis is to find the total number of RVUs of service provided over a given time period. The RVU becomes the basic unit of measure. All services rendered by our practice for 2002 were entered into the analysis. Each CPT code billed for that year was entered by the number of times the procedure was performed or the patient encounter occurred. This was then multiplied by the amount of RVUs specific to each CPT code. The total number of RVUs of service provided for that year was calculated. This was done as shown in the following abbreviated example:

<b>CPT code</b>	<b>Procedure</b>	<b>Number performed</b>	<b>x</b>	<b>RVU/CPT code</b>	<b>=</b>	<b>RVU total</b>
49505	Hernia	75	x	12.38	=	928.50
47562	Laparoscopic cholecystectomy	75	x	17.37	=	1,302.50
35301	Carotid	100	x	29.32	=	2,932.00
44140	Colon	50	x	32.36	=	<u>1,618.00</u>
				RVU total=		6,781.25

We then totaled the collections specific only for those services rendered during that year. This was done as shown in the following example:

49505	75 hernias paid	\$ 33,611.70
47562	75 laparoscopic cholecystectomies paid	47,159.55
35301	100 carotids paid	106,138.40
44140	50 colons paid	<u>58,571.60</u>
	Total reimbursement	\$245,481.25

\*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2006 American Medical Association. All rights reserved.

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Dividing the total collections by the total number of RVUs of service provided during that year left us with a global (that is, all payors) conversion factor specific to our practice. This figure was calculated as follows:

$$\begin{aligned}\text{Conversion factor} &= \text{Total reimbursement/RVU total} \\ &= \$245,481.25/6,781.25 \\ &= \$36.20 \text{ per RVU of service provided}\end{aligned}$$

The conversion factor for our practice was actually \$36.17 in the year 2002. The conversion factor for Medicare for that year was \$36.20. Since the Medicare conversion factor is uniform and applicable to all, and not really different from ours, we used \$36.20 as the global conversion factor for the calculations that ensued.

The next step in the analysis is to analyze our costs. This was done by totaling all practice expenses for 2002. Everything it cost to run our practice was included, including salaries but not bonuses (as this is an analysis of a business, not an analysis of personal income). The total expense dollar amount was divided by the number of RVUs of service we provided for that year. The resultant figure is the cost conversion factor for each RVU of service provided. This was calculated as follows:

$$\begin{aligned}\text{Total expenses for the practice} &= \$200,860.62 \\ \text{Total RVUs of service provided} &= 6,781.25 \\ \text{CCF} &= \text{Total expenses / RVU total} \\ &= \$200,860.62 / 6,781.25 \\ &= \$29.61\end{aligned}$$

This CCF (\$29.61) is what it cost our practice to perform one RVU of service in 2002.

The last step in the analysis was to analyze our profits for the year. By subtracting the CCF from the conversion factor, we are left with our profit per RVU of service provided. This was calculated as follows:

$$\begin{aligned}\text{Profit} &= \text{Revenue} - \text{Expense} \\ \text{Revenue for each RVU of service (conversion factor)} &= 36.20 \\ \text{Expense for each RVU of service provided (CCF)} &= \$29.61 \\ \text{Profit} &= \$36.20 - \$29.61 = \$6.59\end{aligned}$$

This amount of \$6.59 was the profit to our practice for providing one RVU of service to the patient. This profit was the global profit to our

practice encompassing all payors.

We then completed the same analysis individually for the three HMOs that composed the bulk of our managed care patient population: Aetna, United Health Care, and Oxford. These three separate analyses were compared to the global analysis, which essentially is Medicare. The profit from Aetna was \$4.89/RVU, Oxford was \$4.76, and United was \$5.63. Clearly, this total profit was far less than what was received for Medicare.

Tables 1 and 2 on page 31 show the figures from our practice analysis using the profit formula discussed in this article. Table 1 shows the global profits for our practice for some of the common CPT codes used in general surgery as well as for some of the more complex procedures performed for 2002. Table 2 compares the profits for these same procedures among different payors.

A Whipple operation is the single most complex operation in terms of RVUs that a general surgeon performs (73.72 RVUs for 2002). This translates into a profit of \$485.81 for a Medicare patient, \$360.49 for an Aetna patient, \$350.90 for an Oxford patient, and \$415.04 for a United patient. For a ruptured abdominal aortic aneurysm (66.66 RVUs), this translates into a \$439.28 profit for a Medicare patient, \$325.96 for an Aetna patient, \$317.30 for an Oxford patient, and \$375.29 for a United patient. For a three vessel coronary artery bypass graft (CABG), this translates into a \$343.66 profit for Medicare, \$255.01 for an Aetna patient, \$248.23 for an Oxford patient, and \$293.60 for a United patient. Do you know of any surgeon who would knowingly do a CABG with all its attendant morbidity and malpractice risk for such a cursory fee?

We found these results shocking. If my malpractice insurance increased by \$10,000 the next year (something that is very probable in New Jersey), I would need to perform 100 extra laparoscopic cholecystectomies (at approximately \$100 profit per laparoscopic cholecystectomy) just to be able to pay the increase alone without lowering my salary.

We secured a copy of the 1992 Medicare fee schedule (the year Medicare enacted the RBRVS payment system) and compared the fee differences from the 2002 fee schedule. The results are shown in Table 3 on page 32. The fees in 1992 were already cut from the previous year. We did

**TABLE 1: Global profits for general surgery CPT codes**

CPT#	Procedure	RVU/CPT	x	Profit/RVU	=	Profit per Procedure
19160	Breast biopsy	11.22	x	\$6.59	=	\$73.93
27590	Amputation	26.05	x	6.59	=	171.66
33512	Coronary artery bypass graft	52.15	x	6.59	=	343.66
35092	Ruptured abdominal aortic aneurysm	66.66	x	6.59	=	439.28
35301	Carotid	29.32	x	6.59	=	193.21
35566	Femoral tibial bypass	41.71	x	6.59	=	274.86
44120	Small bowel resection	26.13	x	6.59	=	172.19
44005	Lysis adhesions	25.02	x	6.59	=	164.88
44140	Colon resection	32.36	x	6.59	=	220.04
44950	Appendectomy	16.19	x	6.59	=	106.69
47562	Laparoscopic cholecystectomy	17.37	x	6.59	=	114.46
48150	Whipple procedure	73.72	x	6.59	=	485.81
49505	Inguinal hernia	12.38	x	6.59	=	81.58
99213	Level 3 office visit	1.39	x	6.59	=	9.16
99254	Level 4 hospital consult	3.78	x	6.59	=	24.91

**TABLE 2: Profits for procedures among different payors**

CPT#	Procedure	Medicare	Aetna	Oxford	United
19160	Breast biopsy	\$ 73.93	\$ 54.86	\$ 53.40	\$ 63.16
27590	Amputation	171.66	127.38	123.99	146.66
33512	Coronary artery bypass graft	343.66	255.01	248.23	293.60
35301	Carotid	193.21	143.37	139.56	165.07
35092	Abdominal aortic aneurysm	439.28	325.96	317.30	375.29
35566	Femoral tibial bypass	274.86	203.96	198.53	234.82
44005	Lysis adhesions	164.88	122.34	119.09	140.86
44120	Small bowel resection	172.19	127.77	124.37	147.11
44140	Colon resection	220.04	158.24	154.03	182.18
44950	Appendectomy	106.69	79.16	77.06	91.14
47562	Laparoscopic cholecystectomy	114.46	84.93	82.68	97.79
48150	Whipple procedure	485.81	360.49	350.90	415.04
49505	Inguinal hernia	81.58	60.58	58.92	69.69
99213	Level 3 office visit	9.16	6.79	6.61	7.82
99254	Level 4 hospital consult	24.91	18.48	17.99	21.28

not have any Medicare fee schedules from previous years, but it is my recollection that the fees were cut by some 25 percent to 30 percent in 1992.

We then located a 1993 Usual and Customary Fee Schedule for the zip code 07601 (Hackensack, NJ) from McGraw Hill,<sup>2</sup> whose 50th percentile fees were as follows:

CPT	Procedure	50th percentile 1993 fee
19160	Partial mastectomy	\$ 731
33512	Three vessel CABG	6,109
35092	Ruptured abdominal aortic aneurysm	5,394
35301	Carotid endarterectomy	3,628
35566	Femoral tibial bypass	3,895
44005	Lysis of adhesions	1,914
44120	Small bowel resection	2,518
44140	Colon resection	2,647
44950	Appendectomy	1,448
48150	Whipple procedure	4,332
49505	Inguinal herniorrhaphy	1,184
99213	Level 3 office visit	63
99254	Level 4 hospital consult	230

The conversion factor calculated for the 50th percentile usual and customary fee in 1993 was \$86. The conversion factor for Aetna, Oxford, and United is 60 percent less than this. The consumer price index (CPI) for medical care services (taken from the U.S. Department of Labor) had risen 55 percent from 1993 to 2003. If we increased our usual and customary fees by this amount as any other business would, the conversion factor for our 1993 50th percentile usual and customary fee adjusted by the increase in CPI for medical care services would be \$133.30. Comparing the conversion factors for Aetna, Oxford, and United to the CPI adjusted usual and customary fee results in a decrease of 75 percent. The actual conversion factor comparison is as follows:

Payor	Conversion factor
Medicare (2002)	\$36.20
Aetna	34.50
Oxford	34.37
United	35.24
1993 usual/customary	86.00
1993 usual /customary (adjusted by CPI for health care services)	133.30

**TABLE 3: Medicare fee changes**

CPT#	1992	2002	% change
19160	\$415.76	\$406.16	-3
27590	1,033.80	943.01	-9
33512	3,427.48	1,887.83	-45
35092	3,566.24	2,413.09	-33
35301	1,491.32	1,061.38	-29
35566	2321.93	1509.90	-35
44005	1047.98	905.72	-14
44140	1212.92	1,171.43	-4
44950	519.70	586.07	12
48150	3087.78	2,668.66	-14
49505	474.13	448.15	-6
99213	38.14	50.31	31
99254	140.18	136.83	-3

Source: 1992 and 2002 Medicare fee schedules.

**TABLE 4: Veterinary pet insurance (VPI) sample benefit schedule<sup>3</sup>**

Condition	VPI Superior Plan
Gastritis	\$ 347
Gastric torsion	1,993
Intestinal foreign body	1,363
Pancreatitis	593
Neoplasia pancreas	2,265
Liver disease	409
Lacerations	501
Abscess	378
Neoplasia thorax	2,558
Pneumonia	588
Neoplasia prostate	2,022
Laminectomy	2,338
Fracture-plate	1,852
Diabetes mellitus	568

If we now use the profits/RVU from HMO revenues and compare them to the 1993 usual and customary fee profits adjusted by the CPI for medical care services, our profits are down 95 percent. The calculation is shown in the following:

**TABLE 5: Reimbursement for procedures: Veterinary versus human<sup>6</sup>**

Procedure	Medicare	Aetna	Oxford	United	Veterinary
Gastric torsion (Gastrectomy CPT 43631)	\$1,241	\$1,183	\$1,178	\$1,208	\$1,993
Intestinal foreign body (CPT 44010)	725	691	689	706	1,363
Neoplasia pancreas (CPT 48140)	1,297	1,236	1,231	1,263	2,265
Neoplasia thorax (CPT 32480)	1,403	1,337	1,332	1,366	2,558

CPI adjusted 1993 usual/customary conversion factor  
= \$133.30/RVU  
Cost conversion factor (CCF) = 29.61/RVU  
CPI adjusted usual/customary profit/RVU = 103.69/RVU

Aetna profit = \$4.89/RVU (-95%)  
Oxford profit = \$4.76/RVU (-95%)  
United profit = \$5.63/RVU (-94%)

If we used the 1993 50th percentile fees and adjusted them by the 55 percent CPI increase in health care services, our profit would be \$103.69/RVU.

I don't know of any business whose profits could decrease by such a margin and still survive.

An operating nurse on our staff with veterinary insurance for her collies provided us with a veterinary fee schedule for canine medical and surgical services (Table 4, page 32).<sup>3</sup> In Table 5 (this page), a comparison of veterinary surgical services with analogous surgical procedures in humans shows that this veterinary insurance plan pays providers almost twice what Medicare pays.

Table 6 on this page shows the hourly wages for health care professionals as published in the *AMA News*.<sup>4</sup> Note that a nurse at my hospital working weekends (with no benefits) is paid more per hour than a family practitioner and almost as much as an internist. While I don't begrudge the nurses what they earn, it seems that physicians are being placed in an economic strata that in some cases is less than a registered nurse; it is the poor reimbursements from the insurers that are responsible for this scenario.

More significantly, the sum total of compensation for the 10 major managed care chief executive officers (CEOs) exceeds \$1 billion. That is 1/1,500 of the entire national expenditure for health care in 2001 (\$1.5 trillion). (See sidebar on page 34 for more specific information about

**TABLE 6: Estimate of hourly wages for selected specialties and nonphysicians<sup>3</sup>**

Family practice	\$47.28
Internal medicine	51.38
Neurology	63.00
Obstetrics/gynecology	79.58
General surgery	83.74
Otolaryngology	84.99
Cardiology	96.31
Managed care CEOs	1,423
Weekend nurse at HUMC	50

the profits and compensation levels of the managed care industry.)

As you can well imagine, the salary data presented here outraged my partners and me. As a result we began dropping managed care plans and had resigned from all of them as of January 2003. We were frightened but determined that we were no longer going to support a system that denies care to patients, that rewards middlemen with enormous sums of money for essentially no risk, that relies on fear of professional and financial ruin to keep doctors in line, and that reimburses physicians a pittance for the care that they render and the risks that they take. Our monthly collections (see Figure, page 35) show a significant increase beginning approximately eight months after resigning from managed care plans. Statistical analysis using analysis of variance (ANOVA) shows a highly significant difference between collections after dropping out of managed care ( $P = .001$ ). Initially, our caseload decreased. That has since reversed itself. Our offices are no longer crammed with managed

## Managed care profits and compensation

Please note the average hourly wage of a managed care chief executive officer (CEO). Table 1 at right shows the salaries, bonuses, and unexercised stock options of the 10 highest paid health care executives from for-profit health plans in 2001.<sup>5</sup>

Table 2, bottom right, shows the net income (profit) of some of the larger health plans for the year 2003.<sup>6</sup> HMOs in the U.S. saw profits increase by 86 percent in 2003 according to a survey by Weiss Ratings Inc. Earnings for the 502 health plans soared from \$5.5 billion to \$10.2 billion in 2003. Blue Cross/Blue Shield plans taken together had a 63 percent increase in profits.<sup>7</sup> In 2005, United Health Care reported a net profit of \$3.3 billion. The CEO of United Health Care had accumulated more than \$2 billion in stock options during his 14-year tenure, \$488 million of which has been exercised. He had \$1.7 billion in unexercised options remaining when his employment was terminated late this year. This is in addition to the \$124 million he received last year. The personal compensation in stock options alone for this one individual is 1/900 of the entire national expenditures for health care in 2004 (\$1.8 trillion).

It amazes me that these staggering profits continue to rise while the physicians' fees continue to fall. After all, it is the physicians whose services are sought and it is the physicians who are taking the responsibility for all that happens to the patient while the insurance industry is afforded certain protections under the law for any untoward events related to their decision making.

It also amazes me that health insurance premiums are rising by double-digit percentage increases annually when the health plans have so much profit to report. A possible reason was given recently by the *Wall Street Journal* in a discussion of United's acquisition of Oxford: "But much of the merger rationale happens behind the scenes, where the behemoths can use their mounting pricing power to force down rates charged by hospitals, doctors, and other health suppliers."<sup>8</sup>

These huge profits for insurers represent money that is being taken away from patient care, from hospitals, doctors, allied health care professionals, and graduate medical education. It is money that is not put back into the health care system. Medical care providers need to wake up to the economics of health care so we can correct this imbalance.

**TABLE 1: Highest executive compensation packages, excluding stock options in for-profit health plans<sup>5</sup>**

Name	Company	Compensation
W. McGuire	United	\$54,129,501
W. Taylor	Cigna	24,741,578
R. Williams	Wellpoint	13,205,631
W. Donaldson	Aetna	12,650,393
L. Schaeffer	Wellpoint	11,127,465
H. Hanway	Cigna	9,478,634
D. Weinberg	Wellpoint	8,957,410
R. Huber	Aetna	6,988,987
W. Pastore	Cigna	6,779,028
T. Jones	Cigna	6,055,314

**Highest executive unexercised stock options in for-profit health plans<sup>5</sup>**

Name	Company	Compensation
W. McGuire	United	\$357,865,646
S. Hemsley	United	144,928,886
N. Payson	Oxford	115,375,414
W. Taylor	Cigna	66,141,372
L. Schaeffer	Wellpoint	64,610,759
H. Hanway	Cigna	43,385,939
J. Stewart	Cigna	41,049,922
J. Rivet	United	39,450,395
R. Wheeler	United	32,506,870
J. Rowe	Aetna	25,026,549

**TABLE 2: Health plans: Revenue gains in 2003<sup>6</sup>**

Company	Net income	% change from 2002
Aetna	\$967,000,000	137
Anthem	774,000,000	41
Cigna	668,000,000	268
HealthNet	324,000,000	16.5
Humana	229,000,000	60
Oxford	352,000,000	58.5
PacifiCare	243,000,000	132
United	1,800,000,000	35
WellPoint	935,000,000	33

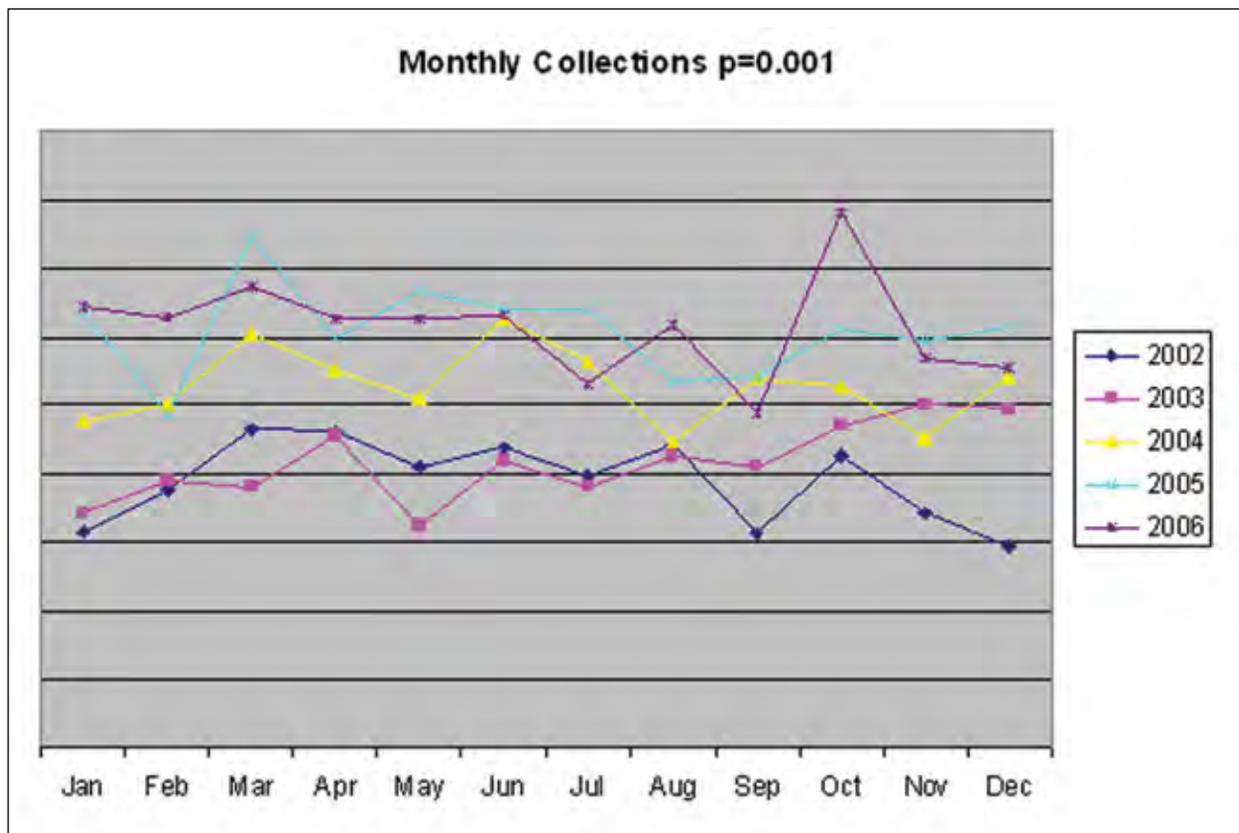
care patients demanding immediate appointments and wanting the latest tests that they have seen on television. We have more time to spend with patients and no longer feel that we are on an ever-speeding treadmill that is impossible to dismount. Our fixed office overhead is less as there is no longer a need for extra staff in dealing with managed care plans and there is much less time spent arguing with insurance clerks. However, because of increased malpractice premiums, which affected all physicians in New Jersey, our overall costs have risen slightly. We see all patients, whether they are insured or not, whether they have Medicaid or they are from the clinic.

We feel like physicians again and are happy to go to work doing what we love, unencumbered by the managed care bureaucracy. Our fear at initially resigning from these plans has turned to

joy now that we can practice surgery the way we were trained to. As of this writing, many general surgeons practicing at hospitals in our area decided on their own to take similar steps and have dropped major managed care plans because of restrictive patient care algorithms and insulting reimbursement rates. We are aggressively taking back our profession, regaining our self-respect, and we are better off for it!

We have evaluated our practice yearly since 2002. As some HMOs required up to one year before our resignations took effect, 2003 was a hybrid year of collections, a mixture of HMO and non-HMO reimbursements. The first year of purely out-of-network reimbursements was 2004. There was no statistical difference between the collections from 2002 compared to collections from 2003.

FIGURE



The subsequent collections from 2004, 2005, and 2006, however, were compared using ANOVA and found to be highly significant when compared to 2002 ( $P=.001$ ). A yearly reevaluation of our practice revealed the following:

	<u>2002</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>
Conversion factor =	\$36.20	\$45.51	\$54.41	\$57.53
CCF =	29.61	29.71	30.56	33.45
Profit =	6.59	15.80	23.85	24.08

As shown in the preceding paragraph, our profit per RVU has increased more than 360 percent since 2002.

It is my hope that after reading this, you will analyze your practices and see what we have seen. Just looking at our figures isn't enough. Our analysis is based on a \$200,000 yearly salary per surgeon and a total overhead of 38 percent of gross receipts exclusive of salary and bonuses. Fiscal prudence is a cornerstone of our practice and neither the salaries nor the expenses are excessive for our area. There are many practices that I believe will not be able to match our numbers. Performing these calculations on your own practice may have a gut-wrenching impact on you.

Do these numbers make you angry? They should. They reflect just how little self-respect we have for ourselves in allowing those not trained in the art and science of medicine to literally hijack an entire profession and control it. The outrageous compensation packages were paid to managed care executives with our hard-earned dollars and thanks to the denials of care to those who need it. If you do the analyses of your practices, there is only one conclusion you can come to in order to survive. I hope all have the courage to do so. Q

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# Statement on surgery using lasers, pulsed light, radiofrequency devices, or other techniques

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*Recognizing the increased usage of laser surgery and to provide professional guidance to state and federal regulatory bodies addressing laser and other surgery issues, the American College of Surgeons wishes to make the following revised statement regarding these operative techniques. The original statement was published in the March 1991 issue of the Bulletin, and this revised statement was approved by the Board of Regents at its February 2007 meeting.*

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is a part of the practice of medicine. Surgery is also the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be surgery (this does not include administration by nursing personnel of some injections, such as subcutaneous, intramuscular, and intravenous when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical intervention are not eliminated by using a light knife or laser in place of a metal knife or scalpel.

In recent years, technological advances have made it possible to perform cosmetic surgical procedures of the skin using a variety of devices and techniques. Lasers, pulsed light, and radiofrequency devices are often used for ablative and nonablative treatments. An ablative treatment is expected to excise, burn, or vaporize the skin below the dermo-epidermal junction. Nonablative treatments are those that are not expected or intended to excise, burn, or vaporize the epidermal surface of the skin. Any procedures that can damage the eye (cornea to retina) are ablative and should only be performed by a licensed physician.

The American College of Surgeons believes that surgery using lasers, pulsed light, radiofrequency devices, or other means is part of the practice of medicine and constitutes standard forms of surgical intervention. It is subject to the same regulations that govern the performance of all surgical procedures, including those that are ablative or nonabla-

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tive, regardless of site of service (that is, hospital, ambulatory surgery center, physician's office, or other locations). Patient safety and quality of care are paramount, and the College therefore believes that patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. This is evidenced by comprehensive surgical training and experience, including the management of complications, and the acquisition and maintenance of credentials in the appropriate surgical specialties (that is, board certification) and in the use of lasers, pulsed light, radiofrequency devices, or other similar techniques.

However, the College also recognizes that the use of ablative lasers may be delegated to non-physician advanced health care practitioners (defined as nurse practitioners or physician assistants) who are appropriately trained and licensed by the state in which they practice. Ablative treatments or procedures performed by nonphysician advanced health care practitioners should fall within the statutory and/or regulatory scope of the practitioner's profession. The physician may delegate the performance of ablative treatments through the use of written protocols to an advanced health care practitioner. Direct supervision should be provided by the physician whenever performance of ablative treatments has been delegated to an advanced health practitioner, unless specific state regulations allow for lesser amounts of supervision. The physician is responsible for doing the initial review of the patient and for authorizing the treatment plan. This should be appropriately noted in the patient's chart prior to any initial ablative treatment.

Physicians may also delegate the performance

of nonablative treatments to nonphysician health practitioners (defined as registered nurses, cosmetologists, aestheticians, and medical assistants or other qualified personnel), provided the treatments are performed under direct supervision by the physician consistent with state laws and regulations in the state where they practice. The physician must also assure that these practitioners are appropriately trained, licensed by the state in which they practice, practicing within the scope of their licensure, and provided with written protocols. Similar to ablative treatments, the physician is responsible for doing the initial review of the patient and for authorizing the treatment plan, and this should be appropriately noted in the patient's chart prior to any initial nonablative treatment.

In those cases where the surgeon may utilize the services of a nonphysician advanced health practitioner or nonphysician health practitioner as an assistant during the performance of laser surgery (including ablative or nonablative procedures), the assistant must meet the following requirements:

- Be properly licensed, certified, and/or credentialed to practice his or her profession
- Have appropriate education and training for assisting the surgeon in laser surgery procedures
- Complete assigned duties under the direct supervision of the surgeon performing the procedure

Individuals who perform laser surgery utilizing lasers, pulsed light, radiofrequency devices, or other techniques should meet the principles of the College in all respects (see [http://www.facs.org/fellows\\_info/statements/stonprin.html](http://www.facs.org/fellows_info/statements/stonprin.html)), to include the avoidance of any misrepresentations to the public regarding unfounded advantages of the laser compared with traditional operative techniques.

# Socioeconomic tips

## Getting ready for Medicare's new quality reporting program

by the Division of Advocacy and Health Policy

On December 20, 2006, President Bush signed legislation that provided for additional Medicare payment to physicians who voluntarily report quality information in the last half of 2007. As a result, the opportunities for surgeons to provide quality information will change fairly dramatically. Hence, this article describes how the program will work and how it will affect office workflow. Please note, however, that the Centers for Medicare & Medicaid Service (CMS) has yet to release final instructions regarding this program, so some information in the article is preliminary and may change.

The Physician Quality Reporting Initiative (PQRI) will work as follows:

- The physician reports on quality measures for procedures performed during the period from July 1 through December 31, 2007. The College developed quality measures that most surgeons can use, and some surgical specialties will have additional procedure-specific measures.

- The physician reports the clinical quality information on the same claim as the procedure itself using five-digit, alpha-numeric codes to report quality measures as though they were procedure codes.

- A bonus payment of up to 1.5 percent of the physician's allowed charges for all services performed during that same six-month period will be made. The payment for 2007, which will be made sometime after March 1, 2008, will be a single, consolidated payment for all physicians covered by a taxpayer identification number.

### Quality measures

Physicians will be able to report on 74 measures. The final list of measures is posted on the CMS Web site at [www.cms.hhs.gov/PQRI](http://www.cms.hhs.gov/PQRI). Well before July 1, this posting will include a description of the measure and instructions for reporting, including the applicable codes from Current Procedural Terminology (CPT)\* and diagnosis codes from

### Around the corner

#### April 2007

Economedix will hold two teleconferences this month. The first, on April 11, is Effective Governance and Management of Your Practice. The second, on April 25, is ICD-9 Diagnosis Coding for Physicians and Surgeons. For more information and to register, go to <http://yourmedpractice.com/ACS/>.

#### May 2007

- Economedix will hold two teleconferences this month. The first, on May 9, is Benchmarking Practice Productivity and Profitability. The second, on May 23, is Appealing Third-Party Insurance Claims. For more information and to register, go to <http://yourmedpractice.com/ACS/>.

- ACS-sponsored basic and advanced coding workshops for surgeons will be held May 3-4 in Baltimore, MD. To register, visit the ACS coding workshop Web page at <http://www.facs.org/ahp/workshops/index.html>, or call Stephanie Flynn at 312/202-5244.

the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) to which the measures apply. Although no changes can be made in the basic quality measures, minor refinements, such as changes in the codes, may be made until the beginning of the reporting period on July 1.

Most surgeons will be able to report on selection of antibiotic prophylaxis, timing of the start of antibiotic prophylaxis, timing of the discontinuation of antibiotic prophylaxis, and whether venous thromboembolism prophylaxis occurred. Those measures may be used for approximately 400 procedures. As noted previously, some surgical

\*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2006 American Medical Association. All rights reserved.

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specialists may use other measures. For example, ophthalmologists may use measures related to cataracts and diabetic retinopathy, and neurologists may apply consideration of rehabilitation services in cases of stroke.

The surgeon selects the quality measures on which he or she wishes to report. However, the reporting must meet certain criteria to qualify for the bonus. If one, two, or three measures are selected, the surgeon's reporting is considered satisfactory if each measure is reported 80 percent of the time. If more than three measures are selected, the surgeon must report on three of the measures 80 percent of the time. If the surgeon does not meet whichever 80 percent rule applies, he or she is ineligible for the bonus payment.

### ***Reporting quality information***

CMS is making it very clear that it expects quality information to be reported on the claim when the substantive procedure code is presented for payment. It does not want to process two claims—one for payment and another to report quality information.

CMS is still working out the details of what information in addition to the five digit "procedure" code is to be reported on the same line item. It is very clear, though, that if any money amount is shown for the quality information, it is to be zero.

CPT codes will exist for the quality measures developed by the College. Those codes will be added to CPT July 1 and may be referenced on the Web sites of the American Medical Association and CMS. Note that if the quality measure is not given because of the patient's condition, a modifier is used.

Although the purpose of this new program is to begin to gather *reported* quality information, CMS is going to issue confidential reports to physicians telling them how they are doing in comparison with their peers. CMS sees this as a first step toward public reporting of quality information, although Congress must act to change the law before that can actually happen.

### ***The bonus payment***

For 2007, the bonus payment is made to the tax identification number. Surgeons should check the appropriate documents for their practice to be sure they are clear about how any further redis-

tribution will be made. (The statute gives CMS considerably more flexibility in identifying billing units in future years.)

There is a cap on the amount that can be paid as a bonus, which is intended to limit the payment a physician with a low volume of performance measure gets. Unfortunately, this cap cannot be calculated in advance for 2007.

### ***To report or not***

For surgeons, the workflow changes are substantial because they have to remember a large number of CPT codes to which a given measure applies. Furthermore, in many instances, the quality measure is documented in the hospital's chart but the claim is prepared in the surgeon's office. Surgeons and their staffs must come up with some methods of tracking additional pieces of data.

Now is the time for surgeons to begin thinking about whether to take part in this voluntary program and, if so, what work flow changes they will have to make. Because of the 80 percent rule for satisfactory reporting, practices need to be ready to report the quality measures effective with surgeries performed on July 1. (Even the practices that are very good at reporting quality information will miss a few quality measures.) Factors to consider in making a decision about taking part in the program include the frequency of reporting quality information, the size and cost of workflow changes, the value of the feedback that CMS is planning to give, and how much a bonus payment will be.

The College is planning to make a variety of training media available to both surgeons and their office staff, including a feature article in the June issue of the *Bulletin*. However, we will not be able to cover the PQRI in any depth in the College's coding workshops because most of them are given after July 1. □

## Dr. Ko appointed to ACS leadership post

Clifford Ko, MD, FACS, a colorectal surgeon from Los Angeles, CA, has been named Acting Director of the Division of Research and Optimal Patient Care.

Dr. Ko's appointment follows the retirement of R. Scott Jones, MD, FACS, who will continue to work with the division as a consultant.

A Fellow since 2003, Dr. Ko had previously served as the division's associate director. He is also the medical director of the ACS National Cancer Data Base.

Dr. Ko has been an associate professor of surgery at the University of California-Los Angeles (UCLA) School of Medicine since 2004, in the department of health services at UCLA School of Public Health since 2005, and vice-chair of clinical research for the department of surgery since 2006. In addition, he is the director of the Center for Surgical Outcomes and Quality, a collaboration between UCLA, the West Los Angeles Veterans Administration (WLAVA), and the RAND corporation; associate director of the Robert Wood Johnson Clinical Scholars Program of UCLA-RAND; and chief of the section of colorectal surgery at the WLAVA.

In 1987, Dr. Ko received his bachelor's degree in biology from the University of Chicago, IL, followed by a master of science in biological and medical ethics (as



Dr. Ko

part of the Arts and Sciences Basic to Human Biology program) in 1989, and his medical degree in 1991. His clinical and research training continued at UCLA with a general surgery residency in 1998, surgery junior residency from 1991 to 1993, research fellow in microsurgery and tissue engineering from 1993 to 1995, and surgery senior/chief

residency from 1995 to 1998. His colorectal surgery fellowship was at The Lahey Clinic in Burlington, MA, in 1999, but he returned to UCLA and in 2001 was a Robert Wood Johnson Foundation clinical scholar and earned a master of science in health sciences degree in health services research.

In addition to being a reviewer for multiple medical journals, Dr. Ko has coauthored more than 100 scientific articles. The awards and honors he has received throughout his career have included the Wyeth-Ayerst/ACS Resident Award in 1996, the Lahey Clinic Postgraduate Research Award in 1999, the UCLA department of surgery's Golden Scalpel Award for Excellence in Teaching in 2003 and 2004, the Piedmont Award for Best Clinical Study from the American Society of Colon and Rectal Surgeons (ASCRS) in 2005, and a health policy and management scholarship from ACS/ASCRS in 2006.

### Trauma meetings calendar

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

- **Trauma, Critical Care, & Acute Care Surgery 2007—Point/Counterpoint XXVI**, June 4–6, Atlantic City, NJ.

- **Advances in Trauma**, December 7–8, Kansas City, MO.

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

# Postgraduate Courses you can take anywhere



## —Nine Courses —for Surgeons on the Go

The American College of Surgeons' Division of Education is pleased to make available the content of nine postgraduate courses on a CD-ROM, Syllabi Select 2006. This CD-ROM is able to run in the PC and Mac environments and offers you the ability to word-search throughout the CD, along with the convenience of accessing any of the courses when you want and where you want.

These syllabi can be purchased by calling 312/202-5474 or through the College's Web site at [www.facs.org](http://www.facs.org).

\$69 for Fellows of the American College of Surgeons;  
\$45 for Resident or Associate Members;  
\$99 for nonmembers; \$60 for surgical resident nonmembers\*  
(Additional \$16 shipping and handling charge for international orders.)

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

## SYLLABI SELECT

- PG 22:** Principles of Cancer Surgery
- PG 23:** The Hernia Course (Parts I & II)
- PG 24:** Update on Mechanical Ventilation
- PG 25:** Unresolved Issues in Trauma and Critical Care
- PG 27:** Minimally Invasive Esophageal Surgery
- PG 28:** Benign Disease of the Gastrointestinal Tract (Parts I & II)
- PG 29:** Surgery of the Pancreas
- PG 32:** What's New in Vascular Surgery 2006: Update on Management of Common Vascular Problems
- PG 33:** Minimally Invasive Surgery: The Next Steps



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## A look at The Joint Commission

# ACS Fellow named chair of board of commissioners

The board of commissioners of The Joint Commission appointed health care educator and surgeon David L. Nahrwold, MD, FACS, as its chairman in 2007 and 2008.

Dr. Nahrwold is emeritus professor of surgery at the Feinberg School of Medicine, Northwestern University, Chicago, IL. He has served on The Joint Commission's board of commissioners since 2003.

Dr. Nahrwold was the American College of Surgeons' Interim Director from 1999 to 2000. In addition, he was on the Board of Regents from 1998 to 2001 and the Board of Governors from 1992 to 1998. He is currently the First Vice-President of the College.

"Dr. Nahrwold's experience as a leader, educator, and practitioner will be invaluable in helping the board realize the near-term and long-term strategic goals for The Joint Commission," says Dennis S. O'Leary, MD, president of The Joint Commission. "David Nahrwold is also the right person to guide The Joint Commission through its leadership transition this year."

"Chairing The Joint Commission's board presents a special opportunity to help forge and expand partnerships with health care organizations and stakeholders to create a more effective health care system that truly meets the needs of those it



Dr. Nahrwold

serves," Dr. Nahrwold said.

In addition to Dr. Nahrwold, the following officers and Executive Committee members-at-large were selected for 2007:

- Vice-chairman: David A. Whiston, DDS, a practicing oral and maxillofacial surgeon from Falls Church, VA, and former president of the American Dental Association

- Treasurer: J. James Rohack, MD, a senior staff cardiologist at Scott & White Clinic in Temple, TX, and former chair of the American Medical Association Board of Trustees

- Secretary: Mary T. Herald, MD, an internist and endocrinologist from Summit, NJ, and

former chair of the board of regents of the American College of Physicians

- Executive committee member-at-large: Gerald M. Shea, assistant to the president for government affairs at the AFL-CIO; a public member of the board

- Executive committee member-at-large: Fred Brown, founding president and chief executive officer of BJC Healthcare, St. Louis, MO, and a past chairman of The Joint Commission board of commissioners, the American Hospital Association, and the National Kidney Foundation

The American College of Surgeons is represented on The Joint Commission board of commissioners by Dr. Nahrwold; Kurt Newman, MD, FACS; and LaMar McGinnis, Jr., MD, FACS.

The board of commissioners serves as The Joint Commission's governing body. Its membership includes representatives from each of The Joint Commission's five corporate member organizations, as well as six public members, one at-large representative of the nursing profession, and The Joint Commission president. The board also includes three nonvoting positions for representatives of the home care, behavioral health care, and long-term care fields, respectively.



# Letters

The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the "From my perspective" columns written by Executive Director Thomas R. Russell, MD, FACS.

## Access to emergency care

Dr. Trunkey concludes that access to emergency care in the U.S. cannot be improved by addressing issues in the current delivery process without creating a whole new system (A growing crisis in patient access to emergency care: A different interpretation and alternative solution. *Bull Am Coll Surg.* 2006;91[11]:12-22). This is a provocative concept, radical enough that the data upon which the conclusion is made should be accurate. Unfortunately, the neurosurgical information Dr. Trunkey provided is not accurate.

In the article, Dr. Trunkey makes the statement that the number of medical students interested in surgical specialty areas such as neurosurgery is flat or declining. In fact, there is not a reduction but an increase in the number of medical students who wish to pursue a career in neurosurgery. There are many more applicants for first-year neurosurgical residency positions than there are available slots. Currently, 866 physicians (including the PGY-1 year) are tracking toward board certification in neurosurgical residencies. In 2006, 165 applicants matched with a neurosurgical program. The percentage of matched applicants who had attained Alpha Omega Alpha honors continues to be high at 22 percent. A minority of 15 international medical graduates (IMG) matched in 2006. The number of available first-year training positions has increased from 140 in 1996 to 172 in 2006 and is carefully monitored by the Accreditation Council for Graduate Medical Education through the Residency

Review Committee. See the Society of Neurological Surgeons-sponsored match report below.

### Comparative data for neurosurgery match (from Neurosurgery Residency Matching Program)

	1996	2006
Registrants	263	291
Matched	140	165
U.S. seniors	120 (86%)	141 (85%)
U.S. all	137 (98%)	150 (91%)
IMG	3	15
Positions offered	140	172
Positions filled	140	165
USMLE step	226	235

Although organized neurosurgery certainly agrees there are problems with the delivery of emergency care, the statement that there is declining interest by U.S. medical students in the specialty of neurosurgery is incorrect.

**Clarence B. Watridge, MD, FACS,  
Chair, ACS Advisory Council  
for Neurological Surgery**

**Robert A. Solomon, MD, FACS,  
Chairman, American Board of  
Neurological Surgery**

**M. Sean Grady, MD, FACS,  
Secretary, American Board of  
Neurological Surgery**

**A. John Popp, MD, FACS,  
President, Society of Neuro-  
logical Surgeons**

**Donald O. Quest, MD, FACS,  
President, American Associa-  
tion of Neurological Surgery**

**Douglas Kondziolka, MD, MSc,  
FACS, FRCS, President,  
Congress of Neurological  
Surgeons**

**Steven L. Giannotta, MD, FACS,  
Chairman, Residency Review  
Committee for Neurological  
Surgery**

## Dr. Trunkey responds

In response to the letter from the various presidents, chairs, and secretaries of the neurological professional societies, I offer the following: The authors take issue with my statement that "the number of medical students interested in a surgical specialty area such as neurosurgery is flat or declining." This statement is taken out of context.

In preparation for my talk to the Congress of Neurosurgery in October 2006, I went to the National Residency Matching Program (NRMP) Web site for information on trends in application to surgery, neurosurgery, and orthopaedics. I was interested not so much in the absolute numbers, but the trends. My secondary objective was to find how many residencies were filled as a percentage of the total and whether women were represented in a proportional amount to medical school enrollment. I was also interested in how many positions are being filled by international medical graduates. The data in the NRMP data bank did not seem quite right, as there are slightly more than 100 neurosurgical training programs. I attempted to find out the same information from the American Board of Neurological Surgery but the organization did not have data on the specific trends nor the sex or IMG positions. I thus went with the NRMP data. My contention that surgery was flat or declining was based primarily on the article by Bland and Isaacs (Contemporary trends in student selection of medical specialties: The potential impact on general surgery. *Arch Surg.* 2002;137:259-267).

More importantly, my contention was based on the original white paper by the Division of Advocacy and Health Policy (DAHP) of the American College of Surgeons. Specifically, the DAHP cited a study by the Lewin Group and the American College of Emergency Physicians

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that showed nearly three-fourths of emergency department medical directors believe they have inadequate on-call specialist coverage. Specifically, the white paper mentioned orthopaedics, plastic surgery, and neurology.

In the same white paper, the DAHP states the following:

Another important but overlooked factor is the small number of specialists produced by training programs each year. As an example, approximately 130 neurosurgery residency training positions are offered each year, far fewer than the largest medical specialty, internal medicine, which offers more than 4,700 positions. In addition, recent studies have found that a number of operative cases has generally and significantly decreased for neurosurgery residents because of compliance with the 80 hour workweek constrictions. Considering the small number of neurosurgeons practicing in the U.S today (approximately 3,200), a large proportion of whom are older than 55 years (34%) and the time it takes to train a neurosurgeon (about 7 years), it will be difficult to safely and adequately replace the shrinking pool of neurosurgeons participating in on-call panels.

These problems are compounded further by another finding of the DAHP, as stated in the white paper: "For example, a recent survey of neurosurgeons revealed that 38% now limit the types of procedures that they perform. Of those, 7% have eliminated pediatrics, 13% no longer provide services related to trauma, and 11% no longer perform cranial procedures."

I apologize for any perceived misinformation in my article that resulted from using the NRMP data. I wish to emphasize that I was not interested in absolute numbers but trends, the number of women involved in the various

surgical specialties, and the number of IMGs. I am sure that my article was perceived by some to be contentious. However, I concluded by making certain recommendations to solve some of these issues. I would hope that all organizations would take these recommendations as a starting point, and it will require all surgical organizations to participate in solving the crisis in emergency surgical care.

**Donald Trunkey, MD, FACS  
Portland, OR**

Dr. Trunkey's article in the *Bulletin* is praiseworthy and long overdue. It applies to all medical care as well.

It should be acknowledged and stressed, however, that all of corporate medicine—health maintenance organizations, insurance physician panels, "physician practice groups," call centers, pharmaceutical fraud and bribery, Current Procedural Terminology code fraud, insurance and third-party billing, exorbitant "on call pay," the rationalizations for hiring poor or marginally trained graduates to fill residency slots—requires physician compliance. Indeed, none of these things I mention could occur without physicians' help, which is given mostly for the promise of more money.

The primacy of "lifestyle" considerations is another negative trait. Perhaps we just need a better class of physicians.

**S. Angier Wills, MD, FACS  
Jasper, GA**

With respect to the cost of procedures in other countries as discussed in Dr. Trunkey's fine article about a growing crisis in emergency care, these are amazing statistics. It will be a miracle if all elective U.S. surgery isn't outsourced very soon, given the rates in Thailand, India, and Singapore as compared with the rates in the U.S. Certainly patients requiring emergency surgery may be required to travel hundreds

of miles for this type of care since no one will want to subsidize American surgeons' income.

However, some data are missing from Dr. Trunkey's report. My initial perusal of economic information about of the countries listed shows a per capita income of approximately \$41,000 in the U.S., \$750 in India, and \$1,500 in Thailand. When you compare fees in this way, they look really huge for the average Indian or Thai. What is left out of the picture is the lack of support systems overseas when complications occur. (Will the family be able to visit overseas? How about local rehabilitation facilities?) Furthermore, there is the issue of how an American patient might seek legal redress for complications caused by negligence.

I suspect that these are matters the average human resources officer doesn't consider very strongly when looking at the bottom line of health care costs. Based on what I was able to find on short notice, we might just as well move overseas for the lower fees—and live better than we do here. Of course, I'm given to wonder why we have so many international medical graduates here—now approximately 25 percent of U.S. physicians and 17 percent of physicians in Georgia (my state). We'd better make very sure about which side of the fence has the greenest grass—and what has been used to fertilize it.

**Harold Kent, MD, FACS  
Brunswick, GA**

I would like to thank Dr. Trunkey for a timely and well-written summation of our current problems with access to emergency care. He has correctly identified many of the major impediments to developing a workable solution to the current crisis. I disagree with the proposed solutions, however.

From my point of view, the crux of the problem is human behavior. A multitude of solutions have been

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proposed throughout the ages as to how best to motivate people to perform certain tasks. In general, the most successful solutions have been to motivate individuals with appealing rewards. Constructs that involve the expectation of high-level performance—particularly sustained throughout one's career—in the absence of substantial reward are a recipe for failure, as people will choose other pathways to success. Such is the nature of surgery today.

Unfortunately, over the past several decades, surgery—along with medicine in general—has allowed “outsiders” to define our mission. I believe we capitulated long ago to well-meaning but ill-informed overseers whose agenda was not always what was best to deliver care. Surgery itself has been run like a traditional medieval guild up to this day, hardly befitting the multibillion-dollar industry that it is. Antiquated ethical constructs have forced many of us into roles that even the most dedicated individual cannot actually live up to. Try as we might to avoid it, every one of us has probably violated some regulation, statute, directive, or bylaw on an almost daily basis.

I believe that the only real solution to this crisis is a two-tiered system. Public clinics and hospitals, owned and operated by the government, would be staffed by employed physicians and nurses, similar to the VA system, and would provide care to anyone who cared to come by the facility. This would provide a social safety net of appropriate care without respect to remuneration from the individual patient. It would be funded out of the public treasury for the public good, just like a public school.

Patients who choose to use the private system would be free to contract with a provider of choice for a negotiated price, as they are now free to do, with essentially every other commodity in this coun-

try, much like a private school.

I believe there is an opportunity to provide competent, appropriate care to everyone in a way that is not onerous for physicians and nurses. It will indeed call for a substantial change in how we do things. We, as surgeons, can start making that happen now. Or, we can just wait for the next great idea from a government policy wonk.

**Daniel T. McDevitt, MD, FACS  
Riverdale, GA**

### **October Bulletin**

I am a neurosurgeon and a Fellow who practiced for more than 30 years in Redwood City, CA, and then retired to the Palm Springs area. Now I finally have time to enjoy what I read, including the *Bulletin*. I want to compliment everyone on the October 2006 *Bulletin*.

For example, Barbara Peck's article on Medicare reimbursement (What surgeons should know about... Trends in Medicare reimbursement. *Bull Am Coll Surg*. 2006;91[10]:8-12) was as clear as the subject can be made. It amazes me how many physicians—and, for that matter, Congress—do not and will never understand how the reimbursement is calculated. Some years ago, I spent almost an hour explaining practice expense relative value units to Rep. Anna Eshoo (D-CA), who represents my congressional district. When I checked back with her some months later, I found the information had gone in one ear and out the other. I asked her what the sources were for her health care information, and she said it was the American Medical Association (AMA) and the Congressional Budget Office.

As a former chairman of the California Medical Association political action committee (PAC) and the national neurosurgery PAC, I especially enjoyed the article by Adrienne Roberts (Surgeons on the move: “All politics is local”: The importance of grassroots ad-

vocacy. 2006;91[10]:16-18). Her advice was excellent and should be made mandatory reading for anyone interested in visiting a legislator. Physicians sometimes put forth misguided attempts at advocacy in legislators' offices. Unfortunately, the symposium chaired by Sen. Daniel Foster at the Clinical Congress in San Francisco in 2005—Surgeons and Politics Do Mix—was lightly attended and I don't have a solution except to ask Ms. Roberts to keep plugging. Her advice was excellent.

When I retired in 2003, I also resigned as delegate to the AMA House of Delegates representing the American Association of Neurological Surgeons, feeling that the war should be fought by those in the trenches and not by retirees. I think I enjoyed the HOD but it certainly was a long walk for a short ride. Your efforts to build bridges with the AMA have been recognized before and you again discussed nicely the issue.

I appreciate the opportunity to send this to you. Your leadership is widely appreciated and it remains an honor to be a Fellow.

**George H. Koenig, MD, FACS  
La Quinta, CA**

I have enjoyed Dr. Russell's monthly *Bulletin* column, “From my perspective.” In the January column, I thought Dr. Russell's line that patient safety organizations “are writing the libretto for the next health care system” was excellent (*Bull Am Coll Surg*. 2007;92[1]:3-5). Unfortunately for the Fellows of the College, such a comment is untimely because neither the College, nor other medical organizations, have fostered open discussion.

I made the same observation that you did several years ago (Application of administrative law to health care reform: The realpolitik of *Crossing the Quality Chasm*. *J Law Health*. 2001-2002;16[1]:65-

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76). Unfortunately, whether it is my paper or that of others, if a paper on the American health care system does not ratify, adopt, or pay homage to the political position of the College or the American Medical Association, the story never reaches the rank and file physician. It is amazing to me that organized medicine now encourages physicians to get advanced degrees outside the medical arena and then stifles the voice of these enlightened physicians. From my perspective, this is because of a lack of leadership in the College and elsewhere. The leadership in the College is extremely insular and unchanging. If the College really wanted to improve, it would accept advice from more Fellows who are not members of a College committee appointed because they have passed the litmus test for blind College loyalty.

Yes, I know that Dr. Russell is good about going to local College meetings and listening to Fellows' comments. His people and communication skills are excellent, and I think he genuinely listens and gives truthful answers. Having been an anonymous surgeon in the audience who has asked him questions on several occasions, I believe my observations are not wrong. Unfortunately, I think Dr. Russell also filters out many of the comments of the rank-and-file after these sessions and that perhaps he does this because of political pressure to preserve the status quo—even if many of his monthly columns point out the world is changing and the status quo cannot be preserved.

True leadership should lead and not react to this change. Opening the College's publications to surgeons who would respectfully assert opinions not cherished by the College would go a long way toward avoiding the need to react to pay-for-performance concerns, which is what the College appears to be

doing. Similarly, true debate at the College meeting, rather than having a consensus panel espouse the traditional doctrine, would demonstrate leadership strong enough to tolerate opinion not consistent with the status quo.

Bottom line: The College has a lot of Fellows with expertise in business and law and who have no political agenda. I encourage the College to seek these members out.

**Thomas McLean, MD, JD, FACS  
Shawnee, KS**

### **Reimbursement**

I have read with great interest the recent articles "Surgery's future under Medicare? The College proposes effort to reform Medicare payment structure" by Shawn Friesen (*Bull Am Coll Surg.* 2006;91[12]:14-17) and "What surgeons should know about... Trends in Medicare reimbursement" by Barbara Peck, and I believe certain extremely important concepts have been overlooked. I think we are viewing the "trees" and not the "forest."

As surgeons, we can talk about the sustainable growth rate, the Medical Economic Index, the resource-based relative value scale, and our proposed service category growth rate until the cows come home, but it's not going to change the fundamental societal rules under which we are currently playing.

Surgeons need to clearly understand that the government has promised too much to the people and it simply cannot pay for it. The demands are going to increase over time, and the relative income of physicians will continue to decrease. We are one of the more vulnerable targets as decreased payments continue to bolster the unreasonable promises of our government and attempt to hold expenditures down.

Quite honestly, I would not respect the bureaucrats running

the Medicare system if they did not continue to decrease the reimbursement of all physicians. That is their job. What we all need to understand is the "cuts" will continue to occur until something happens to demonstrate our fundamental dissatisfaction with our economic enslavement.

The College is actively supporting the pay-for-performance initiative whereas those of us with previous experience realize that this is just another government scheme to decrease the cost of the Medicare system while attempting to pay for promises on the backs of surgeons and other providers.

Indeed, the overall outlook for surgery's future under Medicare is dismal unless we begin to deliver to Congress the message that the system lacks the fundamental integrity and honesty that will inspire excellence in the delivery of medical care in the future.

The real challenge for the future of this country is how we can provide a basic level of medical care to our citizens without the economic and intellectual oppression of providers that the current system embodies. If we do not answer this question, our current obsession with quality care will be nothing more than a cruel joke.

**James P. Weaver, MD, FACS  
Durham, NC**

### **Office-based surgical facilities**

I enjoyed the recent article that recommended accreditation for office-based surgical (OBS) facilities (A look at The Joint Commission: Improve performance with office-based surgery accreditation. 2007;92[1]:71), but I would like to see more interest on the state and federal levels regarding reimbursement for the costs associated with the use of an OBS facility. In New York, we had an amicable relationship for years with the payors for coverage of OBS facilities, but recently some of them have

been denying that component of the surgical cost.

This has happened even in the case of breast reconstruction, for which coverage is a federal mandate. The accrediting agencies (The Joint Commission, the American Association for the Accreditation of Ambulatory Surgical Facilities, and others) seem to take the position that all they do is “accredit” and have no role in pursuing or even recommending reimbursement. Why bother to be accredited if you can’t recoup the cost of the build out, supplies, dressings, maintenance, equipment—and, of course, the cost of accreditation?

I think it is an issue of national importance that the College and the AMA get involved to see that these accredited facilities are properly reimbursed for the costs incurred.

Health care is a constantly evolving process and years ago all surgery was performed in a hospital. Patients were admitted the night before to be sure they had nothing to drink in the morning, and they were then admitted after their surgery for another night (at

a substantial cost to the insurer).

In 1969, the first-ever ambulatory surgical center (ASC) was developed in Arizona to improve patient care and to provide that care at a better price. The concept of a license for an ASC was a later development, and the first ASC was described as a “surgical office.” The number of procedures that are now done on an outpatient basis has continued to rise precipitously. This has been a substantial cost savings to the payors.

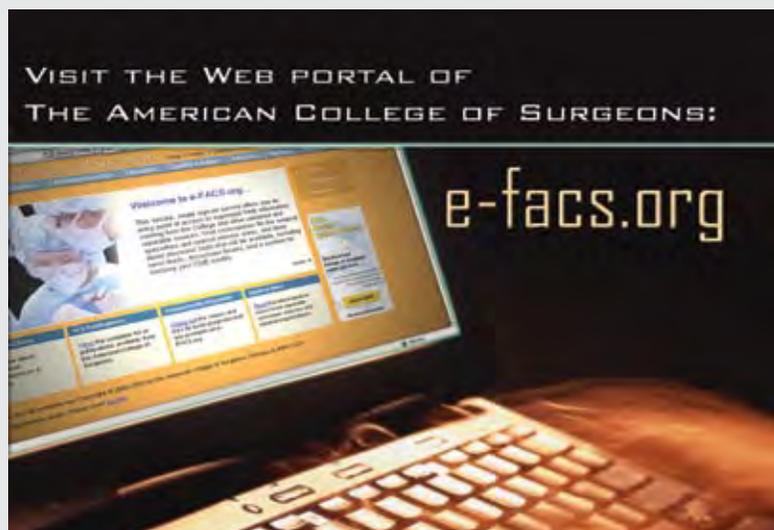
More recently, surgery has migrated to office-based surgery (OBS) facilities. OBSs are typically licensed under the umbrella of the individual physician’s medical license, as opposed to ASCs, where many physicians operate in a clinic-like setting, which may require a separate state license to monitor the activity of the group. State licenses are a way for the state to monitor these facilities, as opposed to accreditation, which payors recognize for reimbursement. Indeed, in approximately 15 states, accreditation is viewed as equivalent to state licensure. The standard of care in this community

is to perform surgery in an operating room, and there are costs incurred for the use of the operating room, whether it is a hospital, an ASC, or an OBS facility.

In an ongoing effort to provide better care at a better price, surgeons have built private accredited facilities at great expense. These facilities are simply the natural evolution of superior, cost-effective health care. OBS facilities also offer Health Insurance Portability and Accountability Act privacy at a level difficult to achieve in other settings.

May I please suggest that the College develop a position statement—similar to one that the American Society of Plastic Surgeons developed in 1987—supporting the concept of reimbursement for OBS facilities. I would further suggest that the College aggressively pursue those payors who avoid their financial responsibility to the patient for coverage of the facility fee, especially in the area of breast reconstruction.

**Darrick E. Antell, MD, FACS**  
New York, NY



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## NTDB® data points

# May Day

by Richard J. Fantus, MD, FACS, Chicago, IL,  
and Frank L. Mitchell III, MD, FACS, Kansas City, MO

At the 2006 Clinical Congress in Chicago, IL, the fifth edition of *Resources for Optimal Care of the Injured Patient*\* was introduced. The name of this document has evolved since its introduction in 1976. Once a hospital-centered optimal resource guide, it has been revised to focus on optimal care with available resources. This subtle change in emphasis highlights the move toward an inclusive trauma system. An inclusive trauma system encompasses all the components associated with optimal care, such as prevention, access, acute hospital care, rehabilitation, and research.

Over the past 30 years, trauma care and trauma systems have evolved. This publication has had a significant impact on that process. The authors have volunteered countless hours with each revision. Many are members of the American College of Surgeons Committee on Trauma (COT). Input has also been provided by other groups such as the American Burn Association, the American College of Emergency Physicians, the American College of Radiology, the Orthopaedic Trauma Association, and from representatives

\*American College of Surgeons Committee on Trauma. *Resources for Optimal Care of the Injured Patient 2006*. Chicago, IL: American College of Surgeons; 2006.



from the fields of neurosurgery and pediatric surgery.

The mission of the ACS COT is to develop and implement meaningful programs for trauma care. An outgrowth of this document was the development of a process of verification to assess if hospitals were meeting the ACS criteria. The verification process started in 1987 and more than 1,800 verification and consultation visits have been completed to date. This edition of the resources guide was developed to aid in the verification/consultation process and better defines many of the areas assessed within hospitals. In keeping with the ACS COT mission, the National Trauma Data Bank® (NTDB) is committed to being the principal national repository for trauma center registry data.

One of the new requirements of this edition of the resources document is that all level I, II, and III trauma centers must submit their trauma registry data to the NTDB.

May Day is just around the corner. The requirements listed in the “green book” take effect on May 1 (see graphic on this page). A new edition with new definitions and criteria leads to new questions. A comprehensive Web site ([http://www.facs.org/trauma/faq\\_answers.html](http://www.facs.org/trauma/faq_answers.html)) has frequently asked questions to assist with this transition. Come May 1, there is no need to call out “Mayday!”, as we are here to help you. We will provide assistance and guidance so you will be able to participate in the largest aggregation of trauma data in the world.

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Throughout the year, this column will provide brief monthly reports. The full NTDB *Annual Report Version 6.0* 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 sub-

mitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at [mneal@facs.org](mailto:mneal@facs.org).

## Operation Giving Back

# Volunteer opportunities available

The Operation Giving Back (OGB) database is continually expanding with new volunteer opportunities, including the following agencies:

- Since 2001, Esperanca has been sending surgical teams to Bolivia in an attempt to address the unmet surgical needs of Bolivia's poor. General surgeons typically care for patients for two weeks: one week in Tarija and one week in an outlying hospital. Obstetricians/gynecologists; urologists; ophthalmologists; and orthopaedic, pediatric, and plastic (burn reconstruction) surgeons participate for one week in Tarija. In addition to performing surgery, volunteers

are asked to participate in educational programs for local physicians and medical students.

- Project Access has established a system of coordinating donated medical care and services provided by physicians, hospitals, pharmacies, and ancillary services for low-income and uninsured patients. The American Project Access Network (APAN) represents and supports those communities that use the Project Access model. Currently listed on the OGB Web site are 23 APAN affiliates, spanning 15 states, that use surgeon volunteers. For those interested in establishing Project Access in their commu-

nity, more information is available on the OGB Web site as to how to contact APAN.

OGB provides surgical volunteers with a wealth of information, including a collection of personal accounts of surgical volunteer experiences that have been featured in the *Bulletin* over the years. OGB's *Bulletin* Archives Web page (<http://www.operationgivingback.facs.org/portfolio/bulletin.php>) provides real insights into what takes place when members of the College embark on volunteer outreach and highlights their contributions to those in need.

## Specialty board reports to be published on Web portal

Each year, the boards of the 10 surgical specialties recognized by the American Board of Medical Specialties compose reports that are presented to the ACS Board of Regents. For several years, a condensed version of these reports have been published in the *Bulletin*—typically in the March and April issues—to

keep Fellows and other interested readers informed of the changes and developments occurring within these groups, specifically the boards of colon and rectal surgery, neurological surgery, obstetrics and gynecology, ophthalmology, orthopaedic surgery, otolaryngology, plastic surgery, surgery, thoracic surgery, and urology.

Beginning with the 2007 volume, however, these reports will no longer appear in the *Bulletin*. Instead, at the recommendation of the Advisory Council Chairs, the reports will be accessible via the Web portal at [www.efacs.org](http://www.efacs.org) within the specialty communities.

*Announcing the ACS Foundation*

# The future of patient safety just got even brighter.



The new ACS Foundation will underscore the vital role that surgeons play in benefiting society by enhancing and extending life for patients of all nationalities, creeds, and economic levels. It will help surgery continue to advance and make a positive difference in people's lives for many generations to come.

The American College of Surgeons Foundation invites you to take an active and visible role in

continuing to expand research, increasing efforts to enhance patient safety, and doubling scholarship and fellowship funding. We have initiated a program for recognizing significant gifts either publicly or privately. More importantly, there will be no administrative overhead applied to gifts to our Foundation. So, 100% of your donation will actually go to the support of our programs.

*Leading the Challenge to Meet the Need*

To learn more about the American College of Surgeons Foundation, programs it supports, and opportunities for recognizing your commitment to the advancement of surgery, please call Fred W. Holzrichter, Chief Development Officer, at 312.202.5376 or visit our Web site at [www.facs.org](http://www.facs.org).



# Chapter news

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by Rhonda Peebles, Division of Member Services

To report your chapter's news, please contact Rhonda Peebles at 888/857-7545 or [rpeebles@facs.org](mailto:rpeebles@facs.org).

## Louisiana Chapter convenes in New Orleans

The Louisiana Chapter convened in New Orleans January 12–14 at the Ritz Carlton Hotel. During the education program, various clinical and specialty topics, as well as health policy-related topics, were addressed, including pay for performance and electronic medical records.

During the annual business meeting, honorary memberships were presented to Thomas R. Russell, MD, FACS, ACS Executive Director, and Rhonda Peebles of the Division of Member Services (see photo, this page).

In addition, the following officers were elected to lead the Chapter in 2007–2008 (all MD, FACS): Gustavo A. Colon, President; Robert Pleasant Marshall, President-Elect; Daniel J. Frey, Vice-President; Benjamin DunLop Li, Secretary; and Mark Gabriel Hausmann, Secretary.

## New York Chapter helps lead workforce review

As a result of changes in the legislature, physician groups' requests for an evaluation of the state's physician workforce are being addressed by a state-level commission. Since December 2006, a new report on the status of the physician workforce in New York has been released; significant conclusions include the following:

- Nearly 30 percent of New York physicians are women, 10 percent were underrepresented minorities, and 35 percent were international medical graduates
- Between 2001 and 2005, the number of New York general surgeons per capita declined by 14 percent

The New York Chapter has been working to convene leaders from the state-level surgical specialty societies to ensure that surgery's concerns are presented to the study commission. For more information or assistance, contact Amy Clinton, Executive Director, at 518/283-1601, or [NYCofACS@yahoo.com](mailto:NYCofACS@yahoo.com).



Louisiana Chapter: Dr. Colon (left) presents Kevin Sittig, MD, FACS, Immediate Past-President, with an award for his volunteer service to the LA Chapter.



Louisiana Chapter: J. Patrick O'Leary, MD, FACS (right), with Rhonda Peebles and her honorary membership award.

## 2007 Leadership Conference

The 2007 Leadership Conference will be held June 3–6 at the Washington Court Hotel in Washington, DC. The College's Committee on Young Surgeons has arranged to present the following sessions on June 4:

- Pay-for-Performance: How Will Surgeons Be Affected? Moderator: Frank G. Opelka, MD, FACS, Louisiana State University, New Orleans
- From Imus to Oprah to Katie. Presenter: Patricia A. Clark, Communication Strategies, Ogden Dunes, IN
- Preparing Surgeons for the Practice of Leadership. Presenter: Wiley Souba, MD, ScD, FACS, Ohio State University, Columbus
- Engaging Young Members of the Profession—Generational Concerns for Surgical Societies. Presenters: Mary Maniscalco-Theberge, MD, FACS, Reston, VA, and John Armstrong, MD, FACS, Shands at the University of Florida, Gainesville

- How Does Capitol Hill Really Work? Presenter: Judy Schneider, Congressional Research Service, Washington, DC

Also on June 4, a separate networking luncheon will be held for the Young Surgeon Representatives from the chapters; Young Surgeons will need to register for this event. Current health policy issues will be presented and reviewed on June 5, and Capitol Hill visits, which will be arranged by the College's Washington, DC, office, will be conducted June 6. For more information and to register, go to <http://www.facs.org/about/chapters/chapleadership2007.html>. The deadline to register is May 22.

*continued on page 56*

## Chapter meetings

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

(CS) following the chapter name indicates that the ACS is providing *AMA PRA Category 1 Credit*<sup>™</sup> for this activity.

Date/time	Event	Location/contact information
<b>April 2007</b>		
April 12–14	Alabama	Location: University of Alabama at Birmingham, Birmingham, AL Contact: John Hooton, 205/776-2106, <a href="mailto:jh@surgicalassociates.com">jh@surgicalassociates.com</a>
April 13	Japan	Location: Rihga Royal Hotel in Osaka, Japan Contact: Susumu Eguchi, MD, 81-95-849-7316, <a href="mailto:sueguchi@net.nagasaki-u.ac.jp">sueguchi@net.nagasaki-u.ac.jp</a>
April 13	New York (CS)	Location: Sagamore Resort on Lake George, Bolton Landing, NY Contact: Amy Clinton, 518/283-1601, <a href="mailto:NYCofACS@yahoo.com">NYCofACS@yahoo.com</a> ACS representative: Edward Copeland III, MD, FACS
April 20–21	North and South Dakota (CS)	Location: Holiday Inn, Fargo, ND Contact: Leann Tschider, 701/223-9475, <a href="mailto:leann@ndmed.com">leann@ndmed.com</a>
<b>May 2007</b>		
May 2–5	Chile	Location: Hotel Sheraton, Santiago, Chile Contact: Carlos Lizana, MD, FACS, 562/264-1878, <a href="mailto:c_lizana@hotmail.com">c_lizana@hotmail.com</a>
May 2	Jacksonville	Location: Epping Forest Yacht Club, Jacksonville, FL Contact: John Isaacs, Jr., MD, FACS, 904/244-3498, <a href="mailto:john.isaacs@jax.ufl.edu">john.isaacs@jax.ufl.edu</a> ACS representative: J. Patrick O'Leary, MD, FACS
May 4–6	Virginia (CS)	Location: Homestead Resort, Hot Springs, VA Contact: Susan McConnell, 804/643-6631, <a href="mailto:smcconnell@ramdocs.org">smcconnell@ramdocs.org</a> ACS representative: Cynthia Brown

*continued on next page*

## Chapter meetings (continued)

Date	Event	Location/contact information
May 6–11	Australia & New Zealand	Location: Christchurch, New Zealand Contact: Lindy Moffat, (03) 9249-1224, lindy.moffat@surgeons.org
May 10	Vermont (CS)	Location: Middlebury Inn, Middlebury, VT Contact: Jeanne Jackson, 802/847-9440, jeanne.jackson@vtmednet.org
May 10–12	Indiana (CS)	Location: South Bend Marriott Contact: Carolyn Downing, 800/257-4762, cdowning@ismanet.org ACS representative: David L. Nahrwold, MD, FACS
May 10–12	South Carolina (CS)	Location: Marriott Hotel, Myrtle Beach, SC Contact: Heather Black, 803/798-6207, heather@scmanet.org
May 10–12	West Virginia (CS)	Location: The Greenbrier, White Sulphur Springs, WV Contact: Sharon Bartholomew, 304/598-3710, wvacs@labs.net ACS representatives: Ajit K. Sachdeva, MD, FACS, FRCS; Julie Freischlag, MD, FACS
May 11–12	Ohio (CS)	Location: Westin Great Southern Hotel, Columbus, OH Contact: Brad Feldman, 877/677-3227, jacak@qconline.com ACS representative: Frank G. Opelka, MD, FACS
May 12	Northern California (CS)	Location: Marine Memorial Hotel, San Francisco, CA Contact: Annette Bronstein, 650/992-1387, ABronst230@aol.com ACS representative: Thomas R. Russell, MD, FACS
May 14	Metropolitan Philadelphia (CS)	Location: Union League of Philadelphia, Philadelphia, PA Contact: Jennifer Keeler, 717/558-7850, jkeeler@pamedsoc.org ACS representative: Shukri F. Khuri, MD, FACS
May 17–19	Illinois (CS)	Location: Hilton Hotel, Springfield, IL Contact: Carolyn Koch, 309/786-4227, jacak@qconline.com
May 24–27	Florida (CS)	Location: The Breakers, West Palm Beach, FL Contact: Bob Harvey, 904/384-8239, bharvey@hgmnet.com ACS representatives: Thomas R. Russell, MD, FACS; Edward Copeland III, MD, FACS; Gerald Healy, MD, FACS
May 24	Brooklyn & Long Island (CS)	Location: Garden City Hotel, Garden City, NY Contact: Teresa Barzyz, 516/741-3887, acsteresa@aol.com ACS representative: Martin B. Camins, MD, FACS
<b>June 2007</b>		
June 1–3	Maine (CS)	Location: Bar Harbor Regency Hotel, Bar Harbor, ME Contact: Joel Lafleur, MD, FACS, 207/593-5723, jlafleurmd@gmail.com
June 1–3	Turkey	Location: Istanbul, Turkey Contact: Cemalettin Topuzlu, MD, FACS, 90-212-347-6300, ctopuzlu@istanbul.edu.tr
June 14–17	Washington State (CS)	Location: Campbell's Resort, Chelan, WA Contact: Susan Lentz, 206/794-7022, sclentz@aol.com
June 14–17	Missouri (CS)	Location: Lodge of the Four Seasons, Lake Ozark, MO Contact: John Adams, Jr., MD, FACS, 573/443-8773, jgadamsjr@aol.com

## Ohio Chapter redesigns Web site

The Ohio Chapter recently announced that its newly redesigned Web site was online at *www.ohiofacs.org*. In addition, the Ohio Chapter has begun online collection of dues and registration for meetings and programs. The new Ohio Chapter Web site includes a link to the Surgery State Legislative Action Center so that Ohio members can contact their legislators via e-mail. For more information or assistance, contact Brad Feldman, Executive Director, at *ocacs@ohiofacs.org*, or 877/677-3227.

## Philippine Chapter announces new leaders

The Philippine Chapter has announced new volunteers for various leadership positions (all MD, FACS): President and Governor, Bienvenido Gaddi; Vice-President and Chair of Continu-

ing Medical Education, Fernando L. Lopez; Secretary-Treasurer, Rey Melchor Santos; Chair, Ways & Means, Menandro V. Siozon.

## Chapter anniversaries

Month	Chapter	Years
March	Brazil	55
	Southern California	55
	Massachusetts	53
	Nevada	42
	New Hampshire	55
	Puerto Rico	57
April	South Dakota	55
	Metropolitan Chicago	52
	Mississippi	54
	Oklahoma	57

RESIDENCY ASSIST PAGE

RAD



American College of Surgeons

Division of Education

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

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

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

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