

BULLETIN

AMERICAN COLLEGE OF SURGEONS



February 2007
Volume 92, Number 2

RURAL SURGERY: *A personal perspective*



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AMERICAN COLLEGE OF SURGEONS



FEBRUARY 2007
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On the cover: A rural surgeon reflects on both the big picture and the daily aspects of rural surgical practice (see article, page 12). Background photos courtesy of Punchstock; surgical scrub photo courtesy of Charles D. Mabry, MD, FACS.

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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

NEWS

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



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.

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



From my perspective

The government and the private sector are slowly and incrementally developing a new and, hopefully, improved health care system. As difficult as it may be for many surgeons to accept, what is evolving is, in many respects, similar to a single-payor construct. I realize use of this term is verboten in many circles, but it would be foolhardy to view the situation in any other way.

If we defiantly turn away from this reality, we will only harm our profession and the patients we serve. Without the medical community's participation, the government will continue to assume this responsibility, and we may wind up with a system that is centered on what's best for the economy rather than on what is best for the American people.

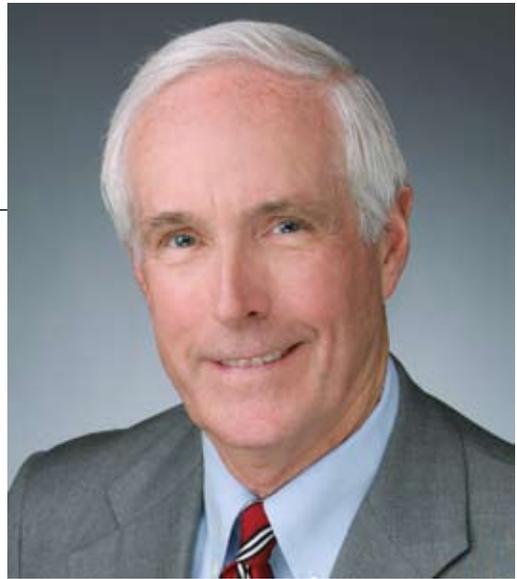
Ongoing government involvement

Multiple societal changes that have transpired over the last several decades have expanded the government's role in administering the health care delivery system. For example, more people are meeting the age requirements for Medicare eligibility. In 2005, Medicare served 35.6 million elderly Americans, and this number will soar as the Baby Boomers begin seeking benefits.

Enrollment in other government-sponsored programs has grown as well; as of 2005, Medicare, Medicaid, and military health programs provided coverage to 45.5 million working-age individuals and their dependents. An additional 18.2 million had jobs in the public sector, which includes state, federal, and local governments, as well as public schools and state universities. They, too, receive health care coverage through government-supported health plans.

In addition, the government provides tax incentives to businesses that provide health insurance coverage to their employees. According to the Agency for Healthcare Research and Quality, the tax subsidy cost the federal government approximately \$208.6 billion in 2006.

As Daniel Gross wrote in a recent issue of the *New York Times*, "By various measures, the United States is about halfway toward a system in which the government and tax payers fully fund health care. And trends are pushing



“Our objective should be to ensure that surgeons and other health care professionals are key players in the design of our health care system.”

the government to become more involved each year.”*

Clearly, the existing system is economically unsustainable. As a result, the government has continued to institute policies aimed at controlling the health care cost behemoth—first through methods to control prices such as the resource-based relative value scale; then by controlling the use of resources through managed care in the private sector; and, more recently, through efforts to promote competition among providers and link payment with performance.

New government involvement

In order to develop the pay-for-performance model, the government is incrementally implementing steps to encourage physicians to abide by set standards and to participate in the quality measurement system. As acknowledged previously in this column, pay for performance or some other manifestation of value-based purchasing is seemingly inevitable.

And, of course, we should bear in mind that

*Gross D. Economic view: National health care? We're halfway there. *New York Times*. December 3, 2006; Section 3, Page 4.

approximately 46.6 million Americans lacked health insurance in 2005—slightly more than the number of Americans who are covered by state and federal health insurance programs. When these individuals fall ill, they often land in our overstressed emergency rooms or receive uncompensated care. In other words, all patients get care, but not all are served. As the Democrats take control of Congress this year, we are likely to see renewed emphasis on providing health insurance coverage to the uninsured.

The Administration has repeatedly opposed efforts to resolve this problem through government-sponsored programs. However, the continued push from the Centers for Medicare & Medicaid Services toward pay for performance is in many respects a move toward a single-payor model. Indeed, one of the driving concepts behind value-based purchasing is that consumers, employers, and private insurers will use a common set of outcomes data generated through pay for reporting and pay for performance to determine which physicians and other providers offer high-quality, cost-effective care. So, in essence, we will have at minimum a single point of reference for determining who is in a position to offer value-based care.

The College's role

Ideally, however, this single point of reference will be based on analysis of information from the most knowledgeable and experienced sources. As you know, the College is striving to participate in this process and provide risk-adjusted outcomes data on surgical procedures through its ongoing ACS National Surgical Quality Improvement Program.

In addition, the American College of Surgeons intends to play an active role in the government's attempts to address the inaccessibility of health insurance coverage for so many citizens. Our Health Policy Steering Committee continues to analyze potential proposals. Moreover, we intend to increase our visibility in the nation's capital by moving the Washington Office closer to Capitol Hill and into a facility that will allow for greater collaboration among the surgical specialty societies. We also anticipate creating a Health Policy Institute within the Washington Office, which will be charged with studying the issues and

offering scholarly recommendations on how the health care delivery system can best be improved. Our goal in all these endeavors is to ensure that surgeons—not MBAs or economists—are the ones determining how surgical care is delivered to our patients.

Again, I realize that the term “single-payor” carries negative connotations for many surgeons. Typically, it conjures images of government controls that disrupt the timely delivery of care. In many countries that have government-run national health insurance systems, these problems are prevalent. Perhaps the U.S. should more carefully examine these systems and determine the causes of the pitfalls. It is quite possible that government is not necessarily the best manager of health care and that an independent board would be a more competent administrator.

In any event, the reality is that we are slowly inching our way toward a single-payor system. Our objective, therefore, should be to ensure that surgeons and other health care professionals are key players in the design of our health care system, so that our patients receive timely, effective, professional care centered on meeting patient needs.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

Dateline|Washington

prepared by the Division of Advocacy and Health Policy

Senate passes Medicare relief package

As noted in the January *Bulletin's* Dateline: Washington column, on December 9, 2006, the Senate passed a Medicare relief package that blocks a 5 percent cut in the physician fee schedule conversion factor for 2007. The legislation passed just before Congress' adjournment and was produced during a week of intense negotiations between House and Senate leaders. At press time, the President was expected to sign the law, which encompasses a range of issues not related to Medicare.

In addition to freezing the conversion factor at the 2006 level of \$37.8975, the bill establishes a pay-for-reporting quality incentive program. Between July 1 and December 31, 2007, physicians who report specific quality measures on Medicare claim forms for a sufficient number of eligible services will receive an additional 1.5 percent bonus payment for all of their covered Medicare services. Although still subject to some refinement, the measures that will be used are those that the Centers for Medicare & Medicaid Services (CMS) develops for the Physicians Voluntary Reporting Program (PVRP). (Visit www.cms.gov/PVRP for the current list of measures and other information about PVRP.) The 1.5 percent bonus will be paid as a lump sum in early 2008 to each reporting physician who qualifies.

Other provisions in the bill include a one-year extension of the "floor," or minimum, on geographic payment adjustments that benefit physicians in rural areas and a one-year moratorium on payment caps for physical therapy. In addition, the Office of the Inspector General will conduct a study regarding the prevalence of and payment for major medical and surgical errors in the Medicare program, and the recovery audit contractor program under the Medicare Integrity Program will be expanded in an effort to reduce Medicare overpayments.

Although the legislation offers some much-needed relief, many surgeons will nonetheless experience payment reductions as a result of the outcome of the five-year review of relative work values currently included in the physician fee schedule. In addition, the legislation falls far short of the long-term comprehensive reforms needed to eliminate annual across-the-board Medicare payment reductions projected to occur through 2014. In fact, the freeze essentially takes the form of a 5 percent "bonus" adjustment to the conversion factor; technically, the 5 percent reduction will still take place in 2007. Consequently, when the 2007 adjustment expires at the end of 2007, calculation of the 2008 conversion factor will begin with the lower number (approximately \$35.98) that would have taken effect in 2007 if Congress had failed to intervene. The combined impact will be an estimated 10 percent conversion factor reduction in 2008, unless Congress acts once again.

In addition, Senate leaders agreed on a separate measure providing short-term relief from the 2007 funding shortfall that would have jeopardized 17 state children's health insurance programs (SCHIPs). That bill redirects unspent SCHIP dollars from states that experienced a surplus in funds in fiscal years 2004 and 2005 to those states with deficits. As a result, 2007 shortfalls should be deferred until early May, buying time for further congressional action. The legislation also

Heritage Foundation calls for reform

provides Medicaid matching funds to cover populations other than children and pregnant women. The SCHIP language was attached to a larger National Institutes of Health funding-extension bill.

Just before Congress took action on Medicare payment, The Heritage Foundation had released a report urging lawmakers to avert the 5 percent reduction in Medicare physician payments and to implement long-term reimbursement reforms. According to the report, the payment update reduction would have forced many physicians to stop accepting new Medicare patients, to defer investments in new equipment and technology, or both. Hence, The Heritage Foundation called on Congress to reform Medicare by replacing the existing payment system with value-based purchasing. Specifically, this conservative think tank said that Congress should promote transparency of price and outcomes and reward superior performance and results. The group also asserted that Congress should reject pay-for-performance proposals that would force physicians to comply with government guidelines and instead call on the medical profession to set standards of care. Furthermore, the report advised moving new Medicare beneficiaries to an entirely new system based on defined contributions and powered by the free-market principles of choice, competition, price transparency, and information availability.

The report cited the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), originally developed within the Department of Veterans Affairs, as an outcomes reporting mechanism that has significantly reduced postoperative mortality and morbidity, shortened length of stay, and increased patient satisfaction. Currently the College is enrolling private sector hospitals in ACS NSQIP.

John S. O'Shea, MD, FACS, Health Policy Fellow in the Center for Health Policy Studies at The Heritage Foundation, wrote the background information for the report. To view the text, go to <http://www.heritage.org/Research/HealthCare/bg1986.cfm>.

Medicare posts outpatient cost data

On November 20, CMS began posting Medicare payment information for physicians and hospital outpatient departments on its Web site. The purpose of this effort is to help patients, providers, and payors make more informed health care decisions and to complement the inpatient hospital and ambulatory surgery center data already available on the site. Included in this latest data release is information on services commonly provided in physicians' offices and in hospital outpatient departments. An executive order that President Bush signed August 22, 2006, directed that more data be made available to all Americans as part of a commitment to make health care more affordable and accessible by making costs more "transparent"—the Administration anticipates that patients will review the data to compare the costs of procedures performed in the various sites of service and use that information to select the most appropriate and desirable setting for their care. These data may be viewed on the CMS Web site, at www.cms.hhs.gov/HealthCareConInit/.

What surgeons should know about...

Responding to reductions in Medicare payment—What’s legal, what’s not

by Barbara Peck, JD, Senior Regulatory Associate, Division of Advocacy and Health Policy

As surgeons begin receiving their first Medicare reimbursement checks for 2007, many are starting to learn first-hand the impact of a variety of policy changes implemented January 1. Since the inception of the Medicare fee schedule, surgeons have often found themselves on the losing end of policy changes and 2007 should be no exception. The results of the third five-year review of work shifted more than \$4 billion to evaluation and management codes and reduced all work relative value units (RVUs) by 10 percent in the process, the Deficit Reduction Act of 2006 drastically reduced reimbursement for many codes that have a technical component, and the Medicare conversion factor remained frozen for the second year in a row while expenses and professional liability costs continued to creep higher and higher. In March, the Medicare Payment Advisory Commission (MedPAC) will release a report on possible alternatives to the sustainable growth rate (SGR) formula that will likely call for strict monitoring of physician costs; expansion of pay for performance; coordination of care between primary care physicians, specialists, and hospitals; geographic spending targets; and greater bundling of payments, including bundling hospital and surgeon payments. Lastly, on July 1, Medicare will begin implementing a voluntary pay-for-reporting program that has not been popular with many surgeons. As frustration and anger in the surgical community continue to rise, physicians frequently ask themselves—and the College—what actions can be taken in response to these pressures.

Can physicians go on strike to protest Medicare physician payment rates?

A strike to protest Medicare payment rates is not an option. The Sherman Antitrust Act prohibits concerted activities that restrain trade;

the organization of a strike is undoubtedly a “concerted activity” and demanding higher reimbursement, or price fixing, is a per se violation. In the mid-1970s, the Supreme Court rejected the argument that professionals such as physicians were not subject to antitrust laws because they did not engage in what is typically thought of as trade. Since that landmark decision, numerous cases have been brought against physicians for violating antitrust laws.

If physicians unionized, could they strike?

Generally speaking, physicians could not unionize and then go on strike. There is an organized labor exception to the antitrust laws and this exception allows unionized employees to strike against their employers. If a group of unionized physicians wanted to strike against their employer, such as a hospital or health maintenance organization, this exception could apply. However, when dealing with third-party payors, including Medicare, courts have ruled repeatedly that physicians are independent contractors, not employees, and that negotiations concerning reimbursement terms are not the equivalent of labor negotiations over terms of employment.

What happens if physicians strike anyway?

The Federal Trade Commission (FTC) would likely seek injunctive relief (that is, a court order) directing physicians to immediately cease and desist. A court would grant the injunctive relief and anyone who did not follow it would be in contempt of court and could go to jail. In addition, the court would also issue substantial fines. In 1996, physicians in Puerto Rico, which is governed by U.S. antitrust laws, organized a strike of the Puerto Rican version of Medicaid

in an effort to demand higher prices. The strike lasted eight days and was focused exclusively on nonemergency care. The FTC was not only granted injunctive relief to stop the strike, but the College of Physicians–Surgeons of Puerto Rico and the island’s three largest physician practices were fined \$300,000.

Didn’t some physicians go on strike because of medical malpractice?

In the past several years, physicians have taken strike-like actions in Nevada, New Jersey, and West Virginia over the professional liability crisis. There are several distinguishing factors, however. First, these actions did not involve reimbursement levels and, although they still may have restrained trade, it is not a clear-cut per se violation. Second, there is an exception to antitrust law called the Noerr-Pennington doctrine, which states actors do not violate antitrust laws when they act solely to elicit legislative, judicial, or administrative agency action. In the professional liability events, the aim was legislative action—passage of a tort reform bill—and not an increase in payment rates. Finally, several scholars did view these types of activities as a violation of antitrust law and the FTC and states’ attorney generals involved chose to look the other way. Please note, however, that just because no one prosecuted physicians taking strike-like actions to protest the professional liability crisis, this does not mean what they were doing was legal. A strike against the Medicare program would not likely receive the same response from the FTC.

Can physicians collectively boycott Medicare?

Physicians cannot boycott Medicare. Under antitrust law, a boycott is considered a “restraint of trade.” State and federal governments have prosecuted a number of provider boycotts of Medicare, Medicaid, and other government payment programs. These cases involved concerted activity by physicians, pharmacists, nursing homes, dentists, and optometrists, aimed at exerting collective pressure to achieve higher reimbursement. For example, in an action against the

Michigan State Medical Society, the FTC prosecuted physicians over their agreement to coerce payors into increasing fee-for-service payment levels through threats of nonparticipation.

Why can’t a physician strike or boycott of Medicare fall under the Noerr-Pennington doctrine?

Several provider groups have attempted to use this doctrine to argue their boycott-related actions should be labeled as lobbying, because the ultimate goal was the passage of legislation. But this argument has been rejected by the courts. The Noerr-Pennington doctrine does not protect defendants from liability for concerted price fixing or boycott activities aimed at governmental payors. This doctrine shields collective action by provider associations to secure anticompetitive legislation, such as a price increase, or other governmental actions favorable to their members, but it does not afford protection in boycott cases involving coercive refusals to deal with Medicare, Medicaid, or other government entities. The Supreme Court has made this point clear, holding that the doctrine has no applicability where conduct crosses the line from advocating for government action and becomes a collective boycott designed to evoke change in governmental policy.

Can the American College of Surgeons or another group tell its physicians not to participate in Medicare or other payment system?

Neither the College nor any other organization can take any action that would have the effect of restraining trade. Under antitrust law, there is a concept called “signaling” that prohibits organizations from taking an action or not taking an action that signals its members to individually engage in anticompetitive behavior.

What recourse do physicians have?

There are three general options available to physicians fed up with the system: (1) Become politically involved through lobbying and political donations; (2) participate in the regulatory

framework for payment by responding to information and survey requests, working with local Medicare carriers, and participating in committees; and (3) evaluate the individual practice business plan and make payor and case mix changes that will enhance revenue.

As explained previously, the Noerr-Pennington doctrine creates an antitrust exception for lobbying activities. Each year for the past five years, Congress has had to take action to prevent a cut to the Medicare conversion factor. And, each year, the College and other organizations have asked members to call, write, or e-mail their elected officials and tell them how the payment cuts are affecting practices and ask them to support specific legislation. And, each year, the response falls far short of its potential for a membership as large and well informed as the College's. In the coming year, Congress will once again be faced with tough decisions on how to respond to the impending Medicare physician payment cuts and they must hear from their constituents—including members of the College—on this issue. Physicians can also ask their patients to get involved by signing petitions, sending letters, and calling their elected officials.

Congress is not the only player in the physician payment arena, however. The College is constantly working with the Centers for Medicare & Medicaid Services (CMS) to ensure services are adequately covered and valued. Much of this work involves requesting data from members. For example, over the next year, a new multi-specialty practice expense survey will be sent for data collection from members that will be used to adjust the practice expense RVUs. However, the response rate for these types of activities is typically low and jeopardizes the College's ability to provide credible evidence to CMS on the value of services.

If I am a Medicare-participating physician, do I have to treat Medicare beneficiaries?

Being a “participating physician” under the Medicare program does not mean that you have to treat Medicare patients when they are

referred to you or call for an appointment. The “participating provider” status means that if a physician chooses to see a Medicare patient, he or she agrees to accept the Medicare fee schedule rate as the full reimbursement and will not bill beneficiaries for any additional charges beyond allowable copayments (this process is referred to as “accepting assignment”). Practices are free to close their practices to new Medicare patients or to limit the number of Medicare appointments. However, if a practice is going to stop scheduling appointments for those patients with whom it already has a preexisting physician-patient relationship, it must follow proper bioethical procedures related to notice, request for charts, and so on.

What is Medicare nonparticipation status?

If a physician elects to be a nonparticipating provider, he or she chooses on a claim-by-claim basis whether to accept Medicare assignment. If a nonparticipating provider decides to accept assignment for a particular service, he or she will submit the claim to Medicare and will receive 95 percent of the Medicare fee schedule amount for the service. If the decision is made not to accept assignment, the physician will be permitted to bill the beneficiary up to the limiting charge, which is 115 percent of the 95 percent of the fee schedule amount. Under this arrangement, Medicare will send the beneficiary reimbursement for its portion (80% of the 95% of the fee schedule amount) and the beneficiary will be responsible for the remaining amount.

For example, if the Medicare fee schedule amount for a service is \$100, Medicare charges are based on 95 percent of that figure (\$95). The limiting charge—the total amount the physician may bill the beneficiary—is \$109.25 (115% of \$95). Medicare pays 80 percent of the \$95 and the beneficiary pays 20 percent as a copay. In this example, Medicare would pay \$76, the beneficiary would pay \$33.25 (\$19 of which is the copay and \$14.25 of which is related to the limiting charge), and the physician would receive \$109.25 for this service. It is important to note that the physician would have to collect the full \$109.25 from the beneficiary because Medicare

would reimburse the beneficiary, not the physician, for its \$76 share. If the physician chose to accept assignment on this particular case, he or she would receive the \$76 directly from Medicare and \$19 from the beneficiary.

How does the Medicare opt-out option work?

A third participation option for physicians is to opt out of Medicare altogether. Contrary to popular myth, opting out is not the same as being excluded from the program. Under the opt-out plan, the physician and Medicare beneficiary agree to a private contract amount for the physician's services. There is no limit on the amount the physician can charge the beneficiary, and the beneficiary is financially responsible for the full amount. It is important to note that the physician and beneficiary are only contracting for the cost of the physician's services, and Medicare will continue to pay for any inpatient charges, laboratory or imaging work, and services billed by other physicians such as anesthesiologists. In addition, physicians may not privately contract with beneficiaries in need of emergency medical services. For example, if a physician who has opted out is on-call and a Medicare beneficiary comes to the emergency room in need of an emergency appendectomy, the physician cannot privately contract with the beneficiary for a fee amount. In this instance, the physician would instead bill Medicare as a nonparticipating provider and would receive 95 percent of the Medicare fee schedule amount for his or her services. It is also possible for a practice to employ some physicians who have opted out and others who are still participating providers. Finally, if a physician chooses to opt out, he or she must do so for a period of two years. After the two-year period, the physician can elect to rejoin the Medicare program as a participating or nonparticipating physician.

When can I change my participation status?

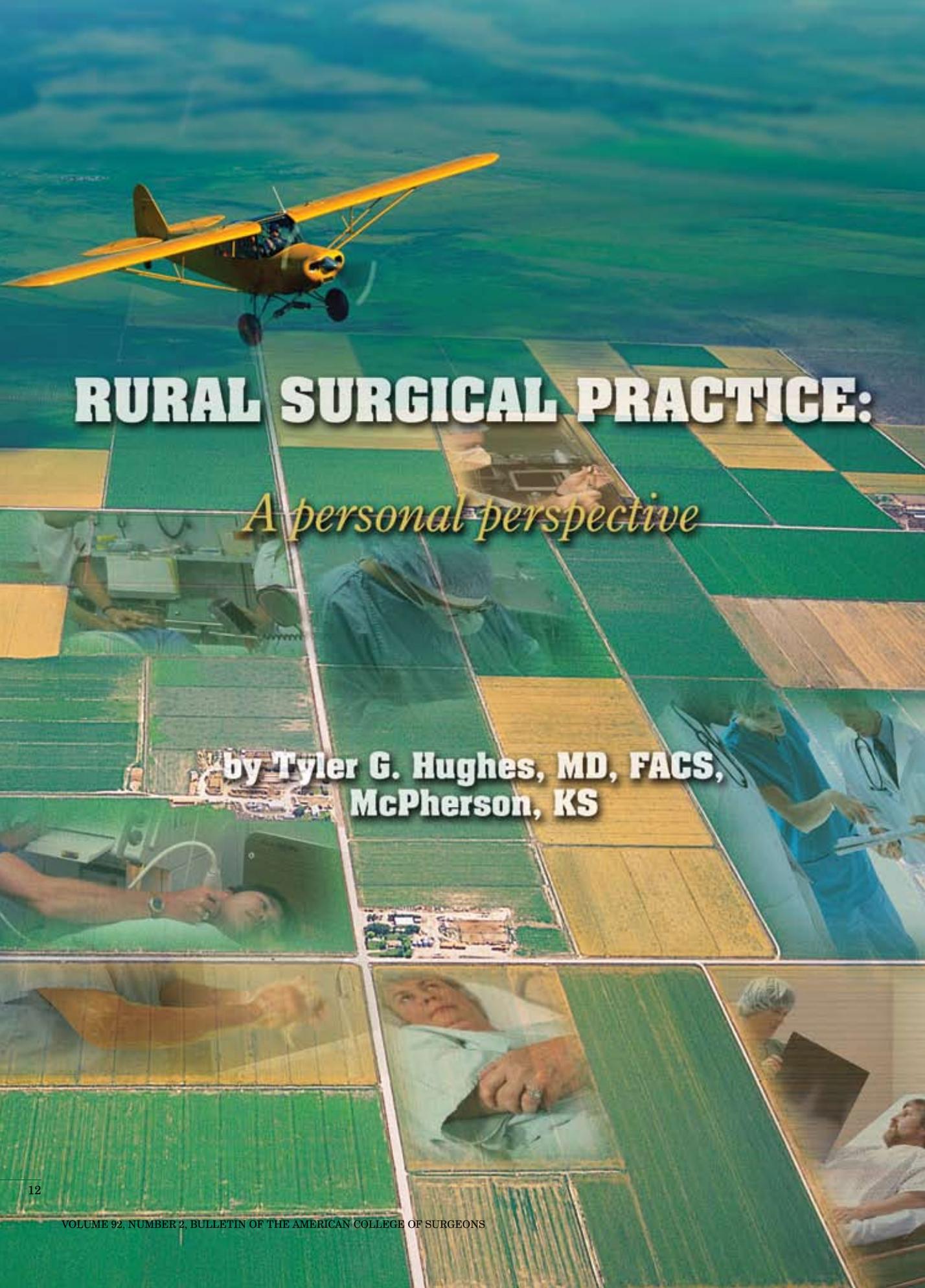
Physicians can change their participation status during open enrollment, which typically runs from mid-November to the end of Decem-

ber. Although this date may seem like a long way off, it is strongly suggested that physicians seek both legal and financial advice well in advance of changing their participation status in order to ensure they are making the best decision for their practice.

What else can I do to respond to changes in Medicare reimbursement levels?

Many practices are taking two approaches to respond to Medicare reimbursement changes: (1) Maximizing physician time for providing services, and (2) generating other sources of revenue. In order to maximize physician time, practices need to evaluate how physicians are currently spending their time and where changes can be made by either increasing use of physician extenders or nonsurgeon physicians or dropping some services altogether and marketing other services. For example, some practices have found it beneficial to increase the number of physician assistants or to add additional partners who are not surgeons, including radiologists, neurologists, cardiologists, and gastroenterologists. Multispecialty practices tend to better cope with marketplace changes. In addition, other practices have stopped performing certain poorly reimbursed services in order to concentrate on other services.

At the same time, many surgeons have explored other sources of revenue completely, including on-call stipends, medical directorships, consulting arrangements, medical chart review, and boutique services. As always, physicians should carefully evaluate such arrangements to ensure they are not running askew of the anti-kickback or Stark laws. The College offers practice management teleconferences twice monthly that may be beneficial to maximizing practice efficiency and output. Information on these teleconferences can be found at: <http://www.facs.org/ahp/workshops/teleconferences.html>. Q



RURAL SURGICAL PRACTICE:

A personal perspective

by **Tyler G. Hughes, MD, FACS,**
McPherson, KS

Editor's note: This article is adapted from a presentation (GS11) at the 2006 Clinical Congress in Chicago, IL.

My chief during training, Ernest Poulos, MD, FACS, said more times than I can count that surgery is a difficult business. In the 23 years since I left his tutelage, I have had the honor of practicing in a teaching environment, a private urban practice, and, for the last 11 years, in a rural practice. I have no illusions regarding my importance to the field of surgery (none of you will have to learn the “Hughes criteria” for a major illness or read chapters by me in textbooks); however, I am joined in my love of rural surgery by real surgical giants like Carl Moyer, MD, FACS, and Ben Wilson, MD, FACS. Both of these men were university department chairmen who left the “rat race” of urban practice to work in smaller venues, doing the sort of variegated practice that matched their skill and intellectual abilities.

When flying over the U.S., one might notice vast expanses of seemingly empty terrain. Through the haze are blurry images of what is classified as rural America. This is land from whence came amazing men and women like Pres. Dwight Eisenhower and Amelia Earhart (both Kansans). The view, though, of this land from 35,000 feet and 400 nautical miles per hour is inadequate in helping one understand what life and medicine are like far down below. Our government uses the Metropolitan Statistical Analysis method to define demographically what is rural. Unfortunately, like the airplane flying high above, the human nature of rural living is lost in such statistical examination.

Every year, residents of McPherson, KS, celebrate All Schools Day. This local event is highlighted by a parade that features dozens of bands, floats, horses, antique cars, Shriner clowns, and much more. When I look upon the crowd during the parade, I see the panoply of rural surgery. Looking at the teenagers, I remember a recent splenic injury to a student during a football game. A young baby held in the arms of her mother represents the child who may come in with a strangulated hernia or intussusception. The proud grandparent is reminiscent of all the

advanced procedures I must do from time to time, from ruptured aortic aneurysms to colon resections. These people are my friends and neighbors, vulnerable to all the ailments that flesh is heir to. These people and the range of cases they represent are the width and breadth of practice for a rural surgeon. I would not trade it for any other kind of practice.

Challenges of rural practice

Charles Rinker II, MD, FACS, reports a practical definition of rural surgical practice by D.C. Lynge: More than 50,000 people is urban, whereas a population of 50,000 down to 10,000 is large rural and fewer than 10,000 is small rural.¹ I live on the cusp between small and large rural in a town of 13,000 people. These towns with fewer than 50,000 residents represent approximately 25 percent of the American populace, but only 9 percent to 12 percent of the entire surgical workforce serves that population.^{1,2} This demographic fact dominates the nature and challenges of working in rural America. Other issues include geographic and intellectual isolation as well as an increased number of on-call nights and the absence of immediately available subspecialty care. In addition, rural patients are generally older and sicker, and they smoke more and receive less medical care than their urban counterparts.^{2,3}

Several times a year, I fly to Smith Center, KS, to assist Pamela Steinle, MD, FACS, in her OR. One morning as I approached the airfield there, I was struck by how small the town appeared from the air and what resources were not available. There was no blood bank with many units of blood available in Smith Center. The large white building that composed the “skyline” of Smith Center was not a professional building full of cardiologists and intensivists—rather, it was a grain elevator. Dr. Steinle serves a population that represents the fifth oldest per capita in the U.S. Not long ago, while trying to log one of her cases in the ACS Case Log System, she found she could not enter the complete data on her patient because the system would not accept a birth date 107 years in the past.

Despite these and similar “impediments,” that morning she and I excised a colon cancer in a gi-



McPherson, KS, on All Schools Day.

ant incarcerated inguinal hernia in a 70-year-old man. The operation took less than two hours, and the patient left the hospital a few days later. The social implications of attempting this operation in a regional center were simply untenable: This elderly man—with very few monetary resources; a significant speech defect; an elderly, frail wife; and marginal coping mechanisms to wend his way through a large tertiary care facility—would have been emotionally and physically unable to endure an operation away from his familiar and supportive home. I flew home proud to be a rural surgeon.

Fewer resources equals greater variety

When I practiced in Dallas, TX, I took up flying as a hobby. At that time, perhaps it seemed frivolous, but now, as a rural surgeon, I realize how important general aviation is to rural patients and practitioners. Helicopters and fixed-wing aircraft get sick patients where they need to be fast. Access to general aviation allows the rural surgeon to travel quickly to conferences and short holidays, which is so essential to maintaining both clinical competence and a certain sanity and respite from the constant pressure of caring for

an entire community. I certainly do not believe that a rural surgeon must be a pilot, but I can vouch to the reader that it is practical.

The rural surgeon has limited resources. My hospital, which is licensed for 49 beds but usually runs a census of 20, maintains an intensive care unit every day of each year with only 10 registered nurses, one licensed practical nurse, and four monitor technicians. Our operating room handles more than 1,800 cases a year with a total staff of 10. Despite this challenge, we supply quality care to patients ranging from newborns to nonagenarians. Rural people are hardly the hicks that stereotypes make them out to be: Their values are sometimes portrayed as unsophisticated, but they accomplish a great deal with very few resources.

I am often asked what kind of cases I do in such a “small” place. The answer is “everything I need to.” According to my ACS Case Log, I performed 531 procedures in the last year. The most frequent cases were endoscopic (279, all types), cholecystectomy (43), inguinal hernias (11), carpal tunnel releases (11), and appendectomies (8). The remaining 187 procedures ran the gamut of surgery. I never know what condition a person who walks through the door might have.



Downtown Smith Center, KS.

One of my favorite cases was that of a man who appeared at my office complaining of a stingray injury—an unusual injury in central Kansas. He had been hit by the ray's barb earlier in the day and flew home from Florida to be treated locally. The patient recovered uneventfully thanks to research via the Internet and advice from surgical friends outside my region.

Developing human resources

Key to being a successful and safe surgeon in such an environment is attitude. I often say that I have no desire to be a small-town physician, but rather a big-town physician who happens to work in a small town. The rural American surgeon does not have excuses for inferior results that perhaps surgeons of developing nations or combat surgeons might. Rural surgery must have results comparable to those in more major centers. To that end, a network of resources is required. For me, the support of those working at the Wichita, KS, surgery residency is important. Through knowing the faculty of that program, I have benefited greatly. Equally important is the rotation of third- and fourth-year medical students from Kansas University Medical Center in Kansas City.

Teaching these young men and women requires me to know my subject and stimulates me to constantly study. Since trauma is so common in surgical practice, an association with a level 1 trauma center is essential. Rural surgeons must not abdicate the care of the injured to others. By being part of a trauma system, rural surgeons limit mortality and morbidity of these patients. Emergency medical systems and the rural surgeon should work in concert. The night I assisted paramedics in extracting an impaled patient from his overturned tanker truck—while fire hoses were aimed at us in case of explosion—instilled in me a real-life understanding of prehospital care.

I am fortunate to have two associates—Erik Rieger, MD, FACS, who has been with me for 10 years, and Clayton Fetsch, MD, who joined the practice this year—who help share the load of call work and allow me the luxury of immediate technical and cognitive support with difficult cases. Would that more rural surgeons could have partners to ease their sometimes lonely burdens. I've also benefited from the experience of William Collier, MD, FACS, who served McPherson for 35 years before his retirement. His sage guidance in acclimating me to rural surgery from an urban practice was invaluable.



Small-town aviation.

Surgeons in small towns are relatively big fish in small ponds. We are regarded as a key resource in the community and through that are often involved with local, state, and national officials. This situation gives the rural surgeon significant influence in policymaking if he or she chooses to put forth the effort: by actively interacting with officials, government entities will better understand the needs of the surgical community. In the long run, this understanding is returned to the community in the form of better patient care through support from government officials.

The last, but by far not the least, important network for me is the Kansas Chapter of the American College of Surgeons. Through the chapter, I've come to know those throughout my state who are practicing in all sorts of specialties. My chapter colleagues are among my best sources of support in patient care and intellectual development.

Planning is essential

The following case encapsulates the implications of the rural surgical environment. Two days after Christmas in 2004, a single-engine aircraft suffered an engine failure during a night flight at low altitude. The pilot crash-landed in a field

in South Texas. He was air-evacuated to a level 2 trauma center in Brownsville. He walked away from that crash with a broken finger and three nondisplaced rib fractures. That pilot was my brother. I later asked him at what point he made the various decisions in landing his plane. He told me that he had actually made those decisions years previously. He always knew it was possible that his engine might fail. He knew that should that happen, he needed a plan for survival based on data accrued before the moment of crisis. From predisaster planning, he knew he needed to land with wheels up, that the fuel valves to the engine must be closed to minimize the chance of fire, and that he had to maintain the lowest safe airspeed all the way to the ground to reduce energies at the moment of impact. My brother never saw the ground before impact that night, yet his planning saved his life.

This case represents not only the type of trauma that can literally fall out of the sky onto a rural surgeon, but the type of thinking the rural surgeon must exhibit. One must plan for the types of cases that may occur before they drop into the office or emergency room. Then, the surgeon must develop contingency plans to follow rather than rely on improvisation or, worse, luck. The rural

surgeon knows his or her resources are limited and that transfer may not be possible. The rural surgeon must play chess better. He or she must realize that resources may be overwhelmed and must consider many questions. Where is the blood? How much is there? How long will it take to get blood? What is the weather? Is there a capable assistant always within reach? What maintenance is being done in the hospital that might limit one's ability to respond? To whom can one turn when STAT transfer must occur, and how will the patient be transported? Finally, the rural surgeon must know his or her personal and facility limitations so that appropriate transfer to tertiary care is done in a timely and safe fashion.

Meeting real human needs

Some dissenters proclaim that there is no need for rural surgeons. These critics of rural surgery observe that there is a major center within an average of 50 miles of any place in the U.S. Factually, there is also an airport approximately every 50 miles in this country. But as in the case of my brother, the safe harbor of an airport or major hospital may be too far away. Imagine the plight of my cohorts in Colorado, Montana, or West Virginia. The most able pilots in the world and bravest ambulance personnel often cannot fly over or drive in mountainous terrain in severe winter weather. Such efforts put both the patient and the air crews in danger. For many of us in far-flung territories, 50 miles is an infinite distance. Critics of rural surgery bring to mind what surgical legend I.S. Ravdin, MD, FACS, said regarding criticism of his treatment of President Eisenhower's Crohn's disease: The severity of the criticism rose with the square of the distance from the operating table. Those wishing to limit rural surgery need to first spend time doing it.

Averages do not satisfy real, human needs. Actual emergencies happen in small towns. Without local surgical expertise, people will suffer mortality or disability. Transfer dislocates family from the patient and is especially hard on the elderly. Pain is a real issue during transport. Lastly, continuity of care is lost by relocating the patient. Although large centers often complain of poor communication by smaller centers, the same can be said of the reverse.

An old saying is that "nothing ever happens in a small town." I would disagree. In August 2006, along with my routine cases, I dealt with a paraesophageal hernia with organoaxial torsion, a newborn with imperforate anus, an inflammatory breast cancer, a gastrinoma, a massive upper gastrointestinal bleed from a lymphoma, a massive lower gastrointestinal bleed from a colon cancer, and one case each of brucellosis and tularemia.

Without question, rural surgery—like all of surgery—faces an uncertain and challenging future. For those individuals who wish to take the challenge, rural surgical practice is highly rewarding. New opportunities and challenges present themselves daily. Rural medical access is essential to the economic viability of a town. Every day, in the grocery store, on Main Street, and in the faces of the people in our community, I get to see the results of my life's work. I know not what path others might take—but, as for me, there is no place like my small town home and practice. □

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**2006
MIDTERM ELECTIONS
BRING DRAMATIC CHANGE**



by Patricia Weir, Manager of ACSPA–SurgeonsPAC

T

he November midterm elections brought about the most change in the nation's capital since Republicans took control of both chambers of Congress in 1994. Now, 12 years later, it is the Democrats that will hold the majority. The swing in party control comes after Democrats gained 29 seats in the House and six in the Senate. In the weeks leading up to the elections, the phrase "all politics is local" was heard repeatedly from Republicans encouraged by their prospects of holding off a Democratic takeover. However, Democrats were able to nationalize the election by focusing voters' attention on national and international issues rather than local concerns. Exit polling showed that the war in Iraq, President Bush's declining approval rating, and a desire for new leadership all played vital roles in the Democrats' victory.

In the U.S. House of Representatives, where all 435 members were up for reelection, Democrats needed to win a minimum of 15 seats to regain control. The member breakdown before the elections was 230 Republicans, 201 Democrats, one Independent, and three vacancies. Democrats exceeded the minimum number of victories by more than two-dozen seats, ensuring their majority status in the 110th Congress. When the 110th Congress convened in January, it was composed of 234 Democrats and 201 Republicans in the House of Representatives.

There were a number of prominent House Republican upsets in the November election, including Rep. Nancy Johnson (R-CT), a 12-term incumbent and outgoing Chair of the Ways and Means Health Subcommittee. Representative Johnson's defeat is indicative of the gains made by Democrats in most areas of the country, particularly

in Connecticut, New Hampshire, and Pennsylvania.

Two Fellows of the American College of Surgeons won reelection to the House of Representatives: Tom Price, MD, FACS (R-GA), and Charles Boustany, MD, FACS (R-LA). In addition to supporting these two Fellows, the American College of Surgeons Professional Association's surgeons' political action committee (ACSPA-SurgeonsPAC) supported a significant number of candidates. Among those candidates, 85 percent were successfully elected to the House or Senate.

On the other side of the Capitol, there were 33 contested seats in the U.S. Senate, with Democrats occupying 18 and Republicans holding 15. Conventional wisdom suggested that it would be extremely difficult for Democrats to regain control of the Senate as well. However, Democrats proved many pollsters wrong by retaining 18 seats and gaining an additional six. Among the six seats gained, key victories included the following: State Treasurer Bob Casey (D) defeated incumbent Sen. Rick Santorum (R) in Pennsylvania; Rep. Sherrod Brown (D) defeated incumbent Sen. Mike DeWine (R) in Ohio; and former Navy Secretary Jim Webb (D) ousted incumbent Sen. George Allen (R) in Virginia. One key Senate win for Republicans occurred in Tennessee, where former Chattanooga Mayor Bob Corker (R) overcame a challenging opponent in Rep. Harold Ford, Jr. (D), to replace Sen. Bill Frist, MD, FACS, the retiring Majority Leader.

The Democrats' newfound majority comes with many powerful leadership posts. California Democrat Nancy Pelosi will become the first woman Speaker of the House in U.S. history, with Rep. Steny Hoyer (D) of Maryland serving as Majority Leader and Rep. James Clyburn (D) of South Carolina as Majority Whip. In the Senate, former Minority Whip Harry Reid (D) of Nevada will start the new session as Majority Leader and Sen. Richard Durbin (D) of Illinois will serve as Senate Majority Whip.

On the Republican side of the aisle, former House Speaker Dennis Hastert (R-IL) declined to seek a minority leadership position. Former House Majority Leader John Boehner (R-OH) will return as Minority Leader and Rep. Roy

HOUSE OF REPRESENTATIVES		
COMMITTEE	CHAIR (D)	RANKING MEMBER (R)
Appropriations	David Obey (WI)	Jerry Lewis (CA)
Energy & Commerce	John Dingell (MI)	Joe Barton (TX)
Ways & Means	Charles Rangel (NY)	Jim McCrery (LA)
SENATE		
COMMITTEE	CHAIR (D)	RANKING MEMBER (R)
Appropriations	Robert Byrd (WV)	Thad Cochran (MS)
Finance	Max Baucus (MT)	Charles Grassley (IA)
HELP	Edward Kennedy (MA)	Mike Enzi (WY)

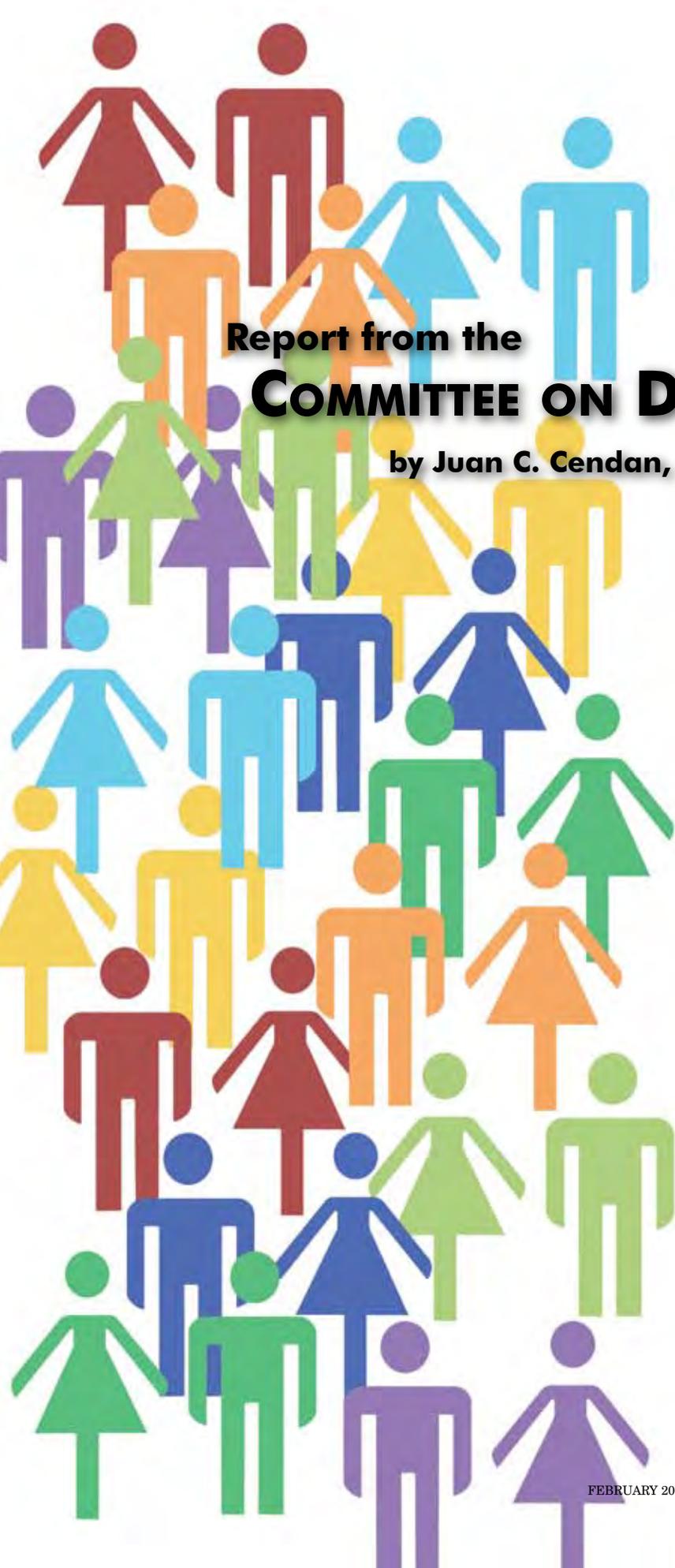
Blunt (R-MO) as Minority Whip. In the Senate, former Majority Whip Mitch McConnell (R-KY) has been elected to serve as Minority Leader and Sen. Trent Lott (R-MS) has been reinstated in his party's leadership and will serve as Senate Minority Whip.

In addition to new congressional leadership, the outcome of November's election also means the switching of both Chairmen and Ranking Members of all committees. The table on this page illustrates the new committee leadership, highlighting those that will affect ACS and its committees of jurisdiction.

The first order of business for the new Congress will be the completion of numerous fiscal year (FY) 2007 appropriation bills that are now part of a continuing resolution expiring in mid-February. Upon completion of the FY07 appropriation bills, it will prove to be a busy spring with numerous issues on the horizon such as the war in Iraq, minimum wage, and ethics reform, among others. Given that Democrats have a reputation for being committed to health care, various issues that are important to surgeons and their patients are also likely to take center stage on Capitol Hill this year. Among them are modifications to the Medicare prescription drug program, health care coverage for the uninsured, and greater oversight of the Medicare program. In addition, although the

chances for federal medical liability reform may have diminished, the new congressional chairs are already indicating that they would like to have action on the Medicare physician payment issue early in 2007.

During the 110th Congress, the College will be actively advocating a number of important issues. With 61 new representatives and senators, the College will be developing new relationships while also enhancing established relationships with returning members. Fellows are encouraged to use the College's Legislative Action Center (<http://www.capitolconnect.com/acspa>) in order to stay in touch with their members of Congress. Ω



Report from the

COMMITTEE ON DIVERSITY ISSUES

by Juan C. Cendan, MD, FACS, Gainesville, FL

The American College of Surgeons Committee on Diversity Issues (CDI) was created in 2002 to study the educational and professional needs of underrepresented surgeons and surgical trainees and the impact that its work may have on the elimination of health disparities among diverse population groups. The CDI has sponsored a number of symposia at the annual Clinical Congress and in October 2006 in Chicago, IL, cosponsored (with the Committee on Surgical Research) a session entitled Understanding and Reducing Disparities in Surgical Care.

The CDI identified the need to understand the membership of the ACS from the standpoint of diversity. We considered several possible methods of evaluation and concluded that the most efficient initial mechanism would be through an electronic mail questionnaire. Fellows of the ACS who are within our listserv were invited to participate. The questionnaire was developed in two parts. The initial questionnaire was presented in a manner that mirrors the data maintained by the American Medical Association. A second questionnaire was then developed, given the findings of the initial survey.

Initial questionnaire results

We received 421 responses to the first questionnaire. The data demonstrate that a majority of respon-

dents were male (73%); most were non-Hispanic (87%), and specifically 67.7 percent were white. The figure on this page provides a more detailed breakdown of the race of survey respondents.

The final question on the initial questionnaire investigated whether respondents believed that their race or gender had negatively affected their training in or practice of surgery; in that survey, the majority (69%) did not believe that race or gender had a negative impact, but 31 percent agreed. Based on this initial survey, we constructed a second questionnaire to try to further delineate this issue.

Second survey

Those responding to the initial questionnaire were asked if they would respond to the second survey. Among respondents, 51 percent had been in practice more than 20 years; 28.5 percent had been in practice between 11 to 20 years, and 20.5 percent had been in practice less than 10 years.

1. *Race and gender in career choice.* The second survey data demonstrate that race did not affect the choice of surgery as a specialty as often as did gender. Respondents noted that race

either “pulled me toward surgery” or “pulled me away from surgery” equally (9.5% and 8%, respectively). However, gender had a larger impact, with 51 percent responding that “gender pulled me toward surgery” and 40 percent responding that “gender pushed me away from surgery.”

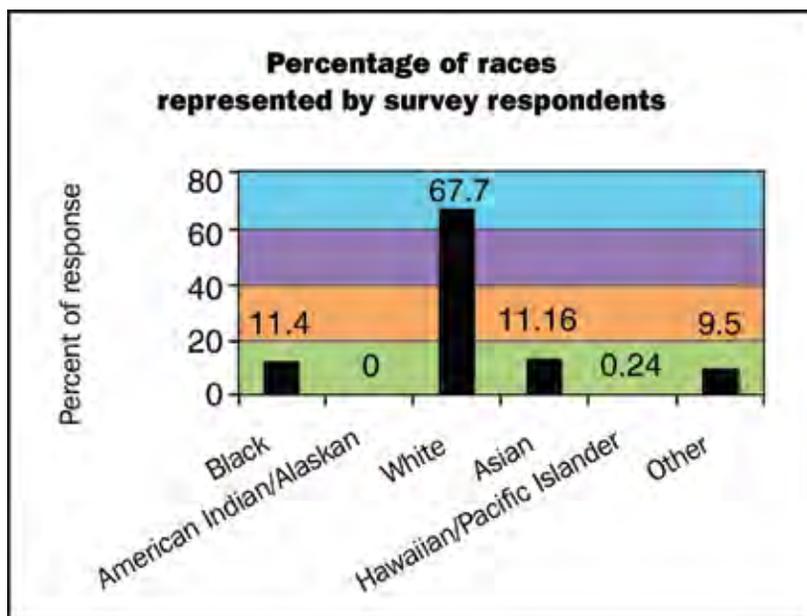
2. *Race and gender in training.* The majority (68%) believed that race did not affect their training either positively or negatively. A smaller number reported a negative effect (9.3%), and fewer noted a positive effect of race during training (4.6%). Gender had more apparent implications, with 13.3 percent reporting a positive effect on training and 23.2 percent reporting a negative effect on training. Approximately half (52%) reported no impact on training due to gender.

3. *The practice environment.* Approximately half of respondents are in a private practice environment, and one-quarter practice in an academic environment. The remaining quartile did not specify work environment. Once in practice, the majority identified no effect in their ability to develop a clinical clientele because of their gender (56.6%) or their race (62.8%). Race did not appear to have a perceived negative effect in either a positive (13.8%) or negative dimension (10.3%). Gender was frequently considered to be a positive factor in the building of clientele (27.6%) and not frequently a detractor (12.4%).

4. *Academic practice promotion.* Race and gender were seen to have no effect on promotion and tenure by 60.8 percent and 62.75 percent of responders, respectively. In this case, few believed that race (2%) or gender (10%) had a positive effect. A negative effect was reported for race in 21.6 percent and gender for 19.6 percent.

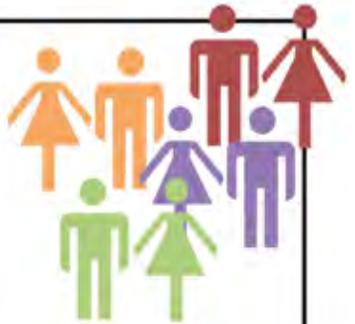
5. *Private practice partnership.* The effect of race and gender on advancement to partnership was reported as not significant by 74.3 percent and 76.3 percent, respectively. Race and gender were more

continued on page 24



Addressing disparities in surgical care

by Juan C. Cendan, MD, FACS, Gainesville, FL,
and John D. Birkmeyer, MD, FACS, Ann Arbor, MI



The Surgical Research and Diversity Issues Committees cosponsored a provocative general session (GS110) on disparities in surgical care during the 2006 Clinical Congress in Chicago, IL. At this session—Understanding and Reducing Disparities in Surgical Care, which was comoderated by Juan C. Cendan, MD, FACS, and John D. Birkmeyer, MD, FACS—five national leaders in the field addressed the reasons underlying such disparities and strategies for reducing them.

Harold Freeman, MD, FACS—medical director of The Ralph Lauren Center for Cancer Care and Prevention in New York, NY, and associate director of the National Cancer Institute (NCI) and director of the NCI Center to Reduce Cancer Health Disparities—presented data documenting relationships between race, poverty, and diminished life expectancy in the U.S. Potential mechanisms underlying such disparities include substandard housing; inadequate information and knowledge; risk-promoting lifestyles, attitudes, and behaviors; and diminished access to high-quality health care. He presented data from Bach and colleagues revealing that 80 percent of black patients receive care from one-fifth of all physicians, that black patients were less likely to have access to board-certified specialists, and that blacks faced obstacles in accessing tertiary treatment centers. He then presented a comprehensive plan for reducing racial disparities in health care, suggesting that this problem should receive the same orchestrated response as would a natural catastrophe. Selwyn Rogers, Jr., MD, FACS, director of the Brigham and Women's Center for Surgery and Public Health, presented further evidence about the scope of racial disparities in surgical care. For example, angioplasty, coronary artery bypass grafting, and mammography are systematically underused in black patients relative to whites.

Brian Smedley, PhD, who was instrumental in the seminal Institute of Medicine report *Unequal Treatment*, emphasized the importance of separating patient and health care system factors underlying disparities. Relative to the health care system factors, he pointed to problems with cultural and linguistic barriers between patients and

their physicians, the lack of stable relationships with primary caregivers, geographic inequalities, and fragmentation of the U.S. health care financing system. Dr. Smedley proposed that health care workers' awareness of disparities should be increased and that cross-cultural education should be incorporated into

health care professional training. Furthermore, he argued for implementation of evidence-based guidelines for reducing disparities resulting from physician bias.

Arden Morris, MD, MPH, assistant professor at the University of Michigan in Ann Arbor, presented evidence that minority patients have poorer outcomes because they are treated in lower-quality hospitals. As an example, she pointed to data demonstrating higher operative mortality rates among black patients undergoing cardiovascular and cancer surgery. Blacks tend to receive their care at centers with lower volume and hospitals with higher overall mortality rates, independent of race, she said.

In closing, John Ayanian, MD, MPH, associate professor of Medicine and Health Care Policy at Harvard Medical School, presented research and policy strategies for reducing disparities in surgical care. He proposed that future research should focus on the reasons for unequal outcomes by race and ethnicity: Delayed referrals, communications issues between surgeons and patients, technical quality of operations, perioperative care, and care-team coordination. He also stressed the need for a broad system for monitoring hospital performance by race and ethnicity.

This session will be available in its entirety via Web cast in the near future, at www.acs-resource.org.



Committee on Diversity Issues

CHAIR: Joseph Espot, MD, FACS, *Chicago, IL*
VICE-CHAIR: Kevin J. Mitchell, MD, FACS, *Marysville, CA*

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surgical training more often than race. Once in training, the gender issue persists with negative implications. However, noteworthy is the fact that once in practice, gender may be seen positively and reportedly has a positive effect on ascension to partnership and building of clientele more often than a negative effect. However, all too frequently gender and race appear to affect the relationship that surgeons enjoy with their patients (between 20% and 30%, according to the survey), and gender appears to have a role in the eventual career changes.

The members of the CDI realize that this was a biased series of surveys because absolute responses were low. Of the nearly 36,000 e-mails that were sent, only 421 responses were received. Those who have not already filled out the questionnaire are encouraged to do so by going to http://www.facs.org/surveys/diversity_survey.html. It is with this kind of information that the CDI can develop sessions and formulate programs to assist members of the College. 

often viewed positively (7.2% and 11.3%, respectively) than as negatively (4.1% and 8.3%, respectively).

6. *Acceptance of surgeon by the patient.* The majority did not believe that their race or gender had created a problem of acceptance by the patient according to, respectively, 61.8 percent and 62.5 percent of respondents. Gender appeared to have a negative impact more frequently (31.6%) than race (21.7%) in this particular topic.

7. *Career changes.* When asked if race and gender had possibly influenced the surgeon to change career paths, the majority responded that gender (85.2%) and race (81.9%) did not influence a career change. In those responding positively, however, gender was more frequently cited (9.4%) than race (2.7%) as a direct career change precipitant.

Conclusions

The ACS, through the CDI, is attempting to identify problems faced by our Fellows during training and in practice. These initial data reveal that gender is perceived as a barrier to

Dr. Cendan is assistant professor of surgery, University of Florida. He was the 2004–2006 Chair of the ACS Committee on Diversity Issues.



In compliance...

...with hospital CoP and medically unbelievable edits

by the Division of Advocacy and Health Policy

The Centers for Medicare & Medicaid Services (CMS) has revised the hospital Conditions of Participation (CoP), making significant changes in the admission history and physical examination (H&P), verbal and written orders, medication storage, and anesthesia services. The revised CoP was effective January 26. On a completely different front, all Medicare claims are being subjected to new Medically Unlikely Edits (MUE), beginning with claims submitted on January 1, 2007. These edits—which limit the number of times a service may be delivered to a patient on a given day—are designed to catch data entry errors, not to limit care. This article will explore the CoP revisions and the MUE.

Hospital CoP

Major changes were made to the rules for timing of the admission H&P. The new requirement is that the H&P must be conducted no more than 30 days before or 24 hours after admission. Previously the H&P had to be conducted no more than seven days before or 48 hours after admission. The existing language requiring a H&P before all nonemergency procedures has not changed.

Under the new rules, if a H&P is conducted before an admission, it must be updated within 24 hours of admission. In the preamble, or background information that precedes the CoP, the Centers for Medicare & Medicaid Services (CMS) explains that if there are no changes to the original H&P as written, the physician doing the update can simply write a note stating the original H&P has been reviewed, a physical examination performed, and the physician concurs with the findings of the H&P completed on a specified date. The CoP requires that the H&P (and update, if necessary) be placed in the patient's medical record within 24 hours of admission.

Around the corner

February

- Economedix will hold two teleconferences this month. The first, on February 14, is Medicare Update for 2007. The second, on February 28, is Advanced CPT Coding. For more information and to register, go to <http://yourmedpractice.com/ACS/>.

March

- Economedix will hold two teleconferences this month. The first, on March 14, is E & M Coding... From an Auditor's Perspective. The second, on March 28, is Annual Review of the HIPAA Privacy and Security Rules. For more information and to register, go to <http://yourmedpractice.com/ACS/>.

A significant change also was made to the qualifications of the person performing an H&P before admission. The CoP recognizes that the H&P may be performed by someone who does not have privileges at the hospital where the admission is to take place. Therefore, it is required that the person be qualified by state law and the admitting hospital's policy to conduct H&Ps. That H&P will have to be updated within 24 hours of admission by someone who has privileges at the admitting hospital.

In the preamble to the CoP, CMS explains that the physician who authenticates the H&P can delegate parts of it to someone else but remains responsible for ensuring that it is complete and for its integrity.

The revised CoP also extended the categories of providers that could authenticate orders by including practitioners who are responsible for the care of the patient and are authorized by state law and hospital policy to write orders. In the preamble to the CoP, CMS points out that the hospital may continue to have a more restrictive

policy on who can authenticate orders.

The extension of authentication is only effective for five years. In the preamble, CMS says that during the five-year period, there is enough time for two very disparate things to occur: Permit an evaluation of the revised policy regarding who can authenticate orders and allow electronic health technology to be adopted by hospitals. CMS states that it is aware of the potential for a gap between the expiration of the extension of the authentication provision and the publication of a revised CoP, if that is necessary.

The revised CoPs also place a restriction on the time frame for authentication of verbal orders. The hospital should first look to state law for a time frame, but if there is no state statute regarding authentication of verbal orders, the order must be authenticated within 48 hours. In the preamble to the CoP, CMS points out that hospitals have more flexibility in who can authenticate orders under the revised CoP.

Significant revisions were made regarding securing medications, stating that drugs and biologicals must be in a secure area and locked when appropriate. This means that hospitals have the authority to determine which nonscheduled drugs and biologicals need to be stored in locked areas and which can be stored in areas that are secured and available only to authorized hospital personnel. In the preamble to the CoP, CMS specifically says operating suites are considered secure areas when they are operational and staff is engaged in providing patient care. The preamble goes on to say that when the suite is not in use, drugs and biologicals must be locked and suggests a number of ways this can be accomplished. The CoP is consistent with the policy statement of the October 2003 American Society of Anesthesiologists, "Security of Medications in the Operating Room." (The publication is available at <http://222.asahq.org/clinical/LockedCartPolicyFinalOct2003.pdf>.) The preamble specifically says medications such as nitroglycerine tablets and inhalers may be kept at the patient's bedside.

Finally, a change was made in the post-anesthesia evaluation for hospital inpatients. More flexibility is allowed by having the post-anesthesia evaluation conducted by anyone who is qualified to administer anesthesia. Previ-

ously, the CoP required that the post-anesthesia evaluation be conducted by the person who had administered the anesthesia.

At press time, revised interpretive guidelines had not yet been released. However, it is expected that much of the material in the preamble will be repeated in the interpretive guidelines.

To view the complete CoP and the related preamble, go to <http://www.gpoaccess.gov/fr/> and click "Browse" on the left side of the page; next, make sure the pull-down menu for back issues is set to 2006 and click the "Go" button; click on the link to Monday, November 27, 2006, and scroll to the Centers for Medicare and Medicaid Services; locate the hospital Conditions of Participation.

New Medicare edits

Medicare has developed MUEs designed to notice claims that have been prepared with a keying error in the number of times or units a service was given in a day. The claims processing system will pay for services up to the predetermined maximum number of times a procedure may be performed and automatically deny units in excess of the maximum. For example, if a cholecystectomy was listed in a claim as having been performed 11 times, payment would be made for one cholecystectomy and the remaining 10 would be denied. No modifier bypasses the edits. However, claims that are partially denied by the edits may be appealed. The new edits are effective for claims processed on or after January 2. Approximately 2,800 procedure codes will be subject to the new edits, with more being added in April. □

Surgical advocacy at the AMA

by Jon Sutton, Manager of State Affairs, Division of Advocacy and Health Policy

The interim meeting of the American Medical Association's (AMA) House of Delegates (HOD) took place November 11–14, 2006, in Las Vegas, NV. Numerous surgical issues were discussed, with College delegates advocating on behalf of surgeons with regard to such matters as the emergency and trauma workforce and policies on postoperative care, itinerant surgery, and fee splitting. Not unexpectedly, reimbursement and quality improvement were two critical concerns, with the HOD holding to a steady course of supporting advocacy efforts during Congress' lame-duck session to address the proposed physician payment cut.

Surgical issues

With dozens of thoughtful reports and more than 100 resolutions typically on the agenda for meetings of the HOD, it can be a daunting challenge to address every issue up for debate. The College's delegation

reviews all the submissions to identify those items of greatest concern to surgery and focuses its efforts on responding to them. The reports and resolutions that received most of the College's attention during the November meeting are summarized as follows.

Postoperative care

The Council on Medical Service Report 3, *Postoperative Care of Surgical Patients*, was hotly debated in reference committee hearings and on the floor of the HOD. To address the College's concerns about postoperative care, itinerant surgery, and fee splitting, the reference committee recommended strengthening current AMA policy. However, some delegates are concerned that the committee inadequately addressed the coding issue in the original resolution from June 2006. As a result, the entire report has been referred to the AMA Board of Trustees (BOT).

BOT Report 14

The BOT Report 14, *The Future of Emergency and Trauma Care*, was the initial product of a workgroup composed of the AMA, ACS, and various surgical and medical specialty societies. The workgroup was created as part of a 2005 ACS-authored resolution calling for the development of comprehensive, long-term legislative and regulatory proposals to address the undersupply of specialist physicians and the future of emergency and trauma care.

During the course of the workgroup's meetings, the Institute of Medicine released a series of reports on the emergency workforce, and the College issued a report on the growing crisis in patient access to emergency surgical care. These two reports and the recommendations published in them were major sources for the BOT report, and the HOD responded by issuing the following calls for action:

- The AMA should expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology, and other advanced technologies to improve the efficiency of care.

ACS delegation

Richard Reiling, MD, FACS (Delegation Chair)
Charles Logan, MD, FACS
Amilu Rothhammer, MD, FACS
Thomas Whalen, MD, FACS
John Armstrong, MD, FACS (Alternate Delegate)
Chad Rubin, MD, FACS (Alternate Delegate)
Patricia Turner, MD, FACS (Young Physician Section Delegate)
Jacob Moalem, MD (Resident and Fellow Section Delegate)

- With the advice of specific specialty societies, the AMA should advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties.

In addition, the report directs the AMA to advocate for the following: insurer payment to physicians who have delivered care mandated under the Emergency Medical Treatment and Active Labor Act (EMTALA), regardless of in-network or out-of-network patient status; financial support for providing EMTALA-mandated care to uninsured patients; bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service; and federal and state liability protections for physicians providing EMTALA-mandated care. Because there is further work to be done for this issue, the workgroup intends to expand its membership and continue to meet over the course of the next year.

Resolution 820

The development of a report on certificate of need (CON) laws is critical to states where legislative efforts may be undertaken to amend or repeal them. This is the case especially for Georgia, which brought this resolution forward and expects a lively battle in its state legislature in 2007.

(See related article, "Health care competition in Georgia: Still restricted for general surgeons," in the November 2006 *Bulletin*.) The HOD agreed that the AMA BOT should prepare a report—*AMA Advocacy Report on the Advantages of Elimination of Certificate of Need to the Business and Employer Communities*—addressing the benefits and risks to physicians and patients as well as the business and employer communities by eliminating CON laws and regulations that restrict the development of physician-owned ambulatory surgery centers, procedural and imaging centers, and laboratories and ancillary services. This report also should include an analysis of the major components of arguments used to support the maintenance of CON laws and regulations.

Resolution 909

The College, along with eight surgical specialty societies, asked in Resolution 909, *Addressing the Impending Surgical Workforce Crisis*, that the AMA recognize that the aging of the physician population is a serious problem for many specialties, including surgical specialties, and that the organization support policies to make specialties that are experiencing shortages more attractive to medical students and residents. This effort includes support for legislative and regulatory efforts to reduce the bias against specialty care in programs that are designed to support workforce needs (for example, loan repayment programs and bonus payments

in physician scarcity areas), so that workforce shortages in non-primary care specialties may also be addressed.

In light of the recommendations in BOT Report 14 (noted previously) and current AMA policy, the HOD unanimously accepted Resolution 909 as a reaffirmation of current AMA policy.

Surgical Caucus

The Surgical Caucus of the AMA sponsored an educational program entitled *The Emergency Surgical Workforce—Crisis in the Emergency Department*. More than 130 surgeons and other interested physicians attended the session, which included presentations by John Fildes, MD, FACS, Chair of the ACS Committee on Trauma, and Brian Keaton, MD, FACEP, president of the American College of Emergency Physicians. Both spoke about the workforce/on-call problems in the nation's emergency departments and trauma centers while offering their respective organizations' perspectives on possible solutions. The College's report, *A Growing Crisis in Patient Access to Emergency Surgical Care*, was distributed to program participants, and copies may be downloaded from the College's Web site at <http://www.facs.org/>.

For further information on the College's involvement in the AMA HOD, contact Jon Sutton at jsutton@facs.org.

Operation Giving Back

Volunteer opportunities available

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

- Omni Med works to raise the standard of medical care through health education and other innovative program ventures. Omni Med's programs work with otolaryngologists; ophthalmologists; urologists; obstetricians/gynecologists; neurosurgeons; and maxillofacial, plastic, and general surgeons in Belize, Guyana, and Kenya for short-term teaching missions.
- Since 1993, Operation

Access has been mobilizing a network of medical volunteers, hospitals, and community clinics to provide donated outpatient operations and procedures to uninsured persons. This organization—currently operating in 19 hospitals—encourages interested, actively practicing surgeons in the greater San Francisco, CA, area to give of their time and talents to help this effort. Urologists, otolaryngologists, ophthalmologists, and orthopaedic and general surgeons are sought for participation in the Operation Access program.

OGB provides surgical volunteers with a wealth of information, including tailored resources for each of the countries that our partner agencies serve. Located in the lower right-hand corner of the OGB home page, the "Volunteer Toolkit" provides travel advisories and country-specific information, including culture, health-related issues, and more. A toolkit specific for the country of note is also included with each opportunity match delivered through an OGB database search. To learn more, visit www.operationgivingback.facs.org.

Nominations sought for ACGS Member-at-Large

The Membership Committee of the Advisory Council for General Surgery (ACGS) is soliciting nominations for a Member-at-Large. The following guidelines will be used by the ACGS Membership Committee during discussion of potential nominees and during the subsequent approval process by the Board of Regents:

- Nominees should be Fellows of the ACS and members of their state or local chapter.
- Nominees should be in active surgical practice.
- Nominees should recognize the importance of representing all who practice general surgery.

- Geographic representation and type of practice will be considered.

- The College encourages consideration of women and other underrepresented minorities.

- Nominees should be loyal members of the College who have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

The functions performed by the ACGS are as follows: To advise the Board of Regents on policy matters and formula-

tions; to discuss matters that the Council believes appropriate to be brought to the attention of the Board of Regents and/or other organizations; to serve as a liaison in the communication of information to and from general surgery organizations to the Board of Regents; to nominate individuals from general surgery to serve on College committees and other bodies; and to aid in the development of programs for the annual Clinical Congress.

Nominations may be submitted to ms@facs.org through **April 1**.

Postgraduate Courses you can take anywhere



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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.

\$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



Jacobson investigator award nominations sought

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

Award criteria are as follows:

- Candidate must be board-certified in a surgical specialty and must have completed surgical training in the last three to six years.
- Candidate must be a Fellow or an Associate Fellow of the American College of Surgeons.
- Candidate must hold a fac-

ulty appointment at a research-based academic medical center (including military service positions).

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

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

- Only one application per surgical department will be accepted.

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

- Nominee must submit a one-page essay to the committee, explaining why he or she

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

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

Nominations are accepted at any time. To be considered for the award in 2007, submissions must be e-mailed or sent via postal service, postmarked no later than **March 16**. Submit all application materials via e-mail to mfitzgerald@facs.org or by mailing to Mary T. Fitzgerald, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Applicants are encouraged to verify that all necessary documentation has been received before the March 16 deadline. For additional information, e-mail mfitzgerald@facs.org or call 312/202-5319.

AMA and ACS conduct physician practice survey

The American Medical Association (AMA), with the support of the American College of Surgeons and more than 60 other medical specialty societies, will begin a multispecialty survey of America's physician practices this year. The purpose of the study is to compile up-to-date information on physician practice characteristics in order to develop and redefine

organized medicine's policies. Data related to professional practice expenses also will be collected.

The AMA and the College plan to survey thousands of physicians from virtually all specialties to ensure accurate and fair representation for all physicians and their patients. As a result, it is likely that the Gallup Organization will be

asking Fellows to participate in the survey. The College encourages surgeons to participate in this study because the information derived from it will be a critically important in shaping the positions we present to policymakers on behalf of surgeons and their patients. For more information, contact the Division of Advocacy and Health Policy at ahp@facs.org.

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**Physician
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Systems**

Disciplinary actions taken

During the meeting of the Board of Regents on October 7, 2006, the following disciplinary actions were taken:

- A thoracic surgeon from Bellflower, CA, was censured for providing expert witness testimony that was found to be in violation of ACS Statement 8: Statement on the Physician Acting As an Expert Witness, in that the surgeon did not hold current privileges to perform the procedures he was testifying about and was not actively involved in the clinical practice of the specialty or subject matter of the case during the time the testimony was provided.

- Donald E. Rogers, MD, FACS, an ophthalmic surgeon from Albuquerque, NM, had his Fellowship with the College placed on probation. He had been charged with violation of the ACS *Bylaws* Article VII, Section 1(b), after his license to practice medicine in the State of New Mexico was placed on probation following a finding of incompetence and negligence.

- Gary J. Lustgarten, MD, FACS, a neurosurgeon from North Miami Beach, FL, had his full Fellowship privileges restored. His Fellowship was suspended in February 2004 after he was found to be in violation of ACS *Bylaws* Article VII, Section 1(b). Dr. Lustgarten's license to practice medicine in the State of North Carolina had been limited. After those limitations were removed, the suspension of his Fellowship with the College was lifted.

Definition of terms

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

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

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

Probation: A punitive action for a stated period of time, during which the member (a) loses the rights to hold office and to participate as a leader in College programs; (b) retains other privileges and obligations of membership; (c) will be reconsidered by the Central Judiciary Committee periodically and at the end of the stated term.

Suspension: A severe punitive action for a period of time, during which the Fellow or member, according to the membership status, (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker,

or panelist in College programs; (b) is subject to the removal of the member's name from the Yearbook and from the mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor's registration fee when attending College programs; (e) is not subject to the payment of annual dues.

When the suspension is lifted, the Fellow or member is returned to full privileges and obligations of Fellowship.

Expulsion: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.



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CALL FOR SUBMISSIONS

for the 2007 Clinical Congress of the American College of Surgeons

The American College
of Surgeons Division of
Education welcomes
your submissions
to the following programs
to be considered
for presentation at

the

93rd annual

Clinical Congress,

October 7–11, 2007,

New Orleans, LA



Oral presentations

- *Surgical Forum*

Program Coordinator: Kathryn L. Matousek,
312/202-5336, kmatousek@facs.org

- *Papers Session*

Program Coordinator: Beth Cherry,
312/202-5325, echerry@facs.org

Poster presentation

- *Scientific Exhibits*

Program Coordinator: Mary Kate Colbert,
312/202-5385, mcolbert@facs.org

Video presentation

- *Video-Based Education*

Program Coordinator: GayLynn Dykman,
312/202-5262, gdykman@facs.org

Submission information

- Abstracts are to be submitted online only
- Submission period begins November 1, 2006
- Deadline: 5:00 pm (CST), March 1, 2007
- Late submissions are not permitted
- Abstract specifications and requirements will be posted on the ACS Web site at www.facs.org
- Duplicate submissions (one abstract submitted to more than one program) are not permitted.

A look at The Joint Commission

The Joint Commission's new brand

In early January, the Joint Commission on Accreditation of Healthcare Organizations refreshed its identity by officially changing its name to The Joint Commission and adopting a new logo and tagline: "Helping health care organizations help patients."

The move to a shorter name is intended to both make the name more memorable and reflect current common practice in the health care arena. The simplification acknowledges the broad recognition The Joint Commission now enjoys in the health care arena. It also reflects that The Joint Commission's quality and safety improvement efforts now extend well beyond the basic conduct of an accreditation process.

These changes are part of The Joint Commission's continuing efforts to improve the value of accreditation and its utility as a mechanism for improving the quality and safety of patient care.

The Joint Commission hired



a design firm to create a fresh logo (see above) and visual identity system for the organization and its affiliate, Joint Commission Resources. Over the past year, The Joint Commission has engaged many of the organizations it accredits in a reassessment of their perceptions of The Joint Commission in order to determine their specific views about how The Joint Commission could improve its approach to accreditation.

To enter into direct dialog with hospital senior leaders, The Joint Commission has conducted town hall meetings around the country and met with each of its various program-specific advisory councils. This outreach is part of The Joint Commission's commitment to continuously seek input

from accredited organizations and other key stakeholders on ways The Joint Commission can improve the value and relevance of the accreditation and performance improvement services it offers.

The Joint Commission's mission statement, as follows, continues to reflect the fundamental purposes set forth by the American College of Surgeons when it created its Hospital Standardization Program in 1917: "The mission of the Joint Commission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations."

Trauma meetings calendar

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

- **Trauma, Critical Care, & Acute Care Surgery—2007,**

March 26–28, 2007, Las Vegas, NV.

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

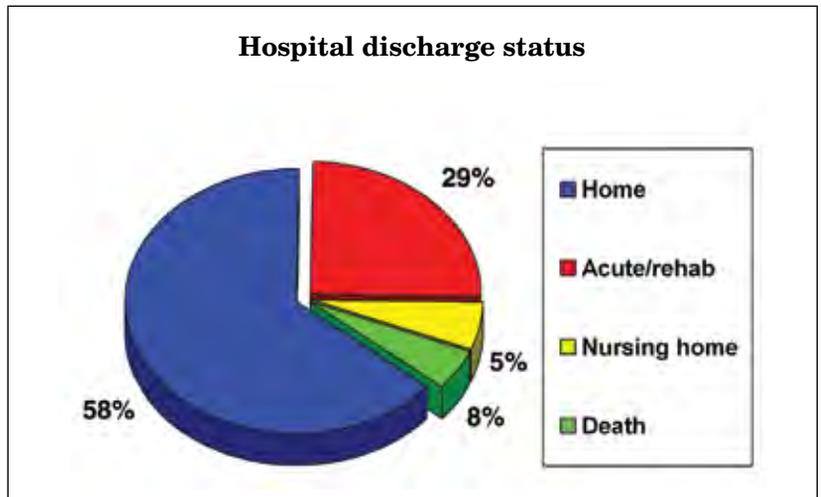
NTDB® data points

The river runs through it

by Richard J. Fantus, MD, FACS, Chicago, IL

Fractures to the pelvic ring occur as the result of high-energy mechanisms of injury such as motor vehicle crashes, pedestrians struck by vehicles, and falls. Three main vectors of force—anteroposterior compression, lateral compression, and vertical shear—result in pelvic ring fractures. Each force produces a characteristic fracture pattern. These injuries carry a significant morbidity and mortality related not only to complications of the pelvic fracture but also the commonly associated injuries. In addition to injury to the usual organs—that is, liver, spleen, and kidney—injuries to the mesentery, diaphragm, and gastrointestinal tract occur. Structures of the genitourinary system that are in close proximity to the pelvic ring are also susceptible to injury. Bladder injury can occur as an associated injury or as a complication of the pelvic ring fracture. Extraperitoneal bladder rupture occurs more commonly, whereas intraperitoneal rupture tends to occur in patients who are injured when the bladder is full. Urethral injuries result from the same type of shearing forces that lead to extraperitoneal bladder rupture.

In order to examine the occurrence of these injuries in the National Trauma Data Bank® Dataset 6.0, the *International*



Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes for pelvic fractures 808.0 through 808.5, 808.8, and 808.9 were used. There were 62,755 records containing 87,504 pelvic bone fractures as a result of blunt force trauma. Among the patients in these records, 33,208 were discharged to home; 16,451 to acute care/rehabilitation; and 2,580 to nursing homes; there were 4,564 deaths. These data are depicted in the figure on this page. This group of patients was nearly equally distributed between male and female, on average 44 years of age, with an average length of stay of 9.8 days and an average injury severity score of 17.28.

Pelvic fractures carry signifi-

cant morbidity and mortality as evidenced by more than one-fourth requiring further acute care or rehabilitation. With the proximity of genitourinary structures and the propensity for their injury, it would be wise to empty the river that runs through it before getting into a motor vehicle for a long car ride and putting your pelvis at risk.

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 submitting your trauma center's data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

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.



Chapter news

by Rhonda Peebles, Division of Member Services

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

Chapters support the College's funds

In 2006, 17 chapters contributed a total of \$21,150 to the College's endowment funds. The chapters' commitments to the various funds support the College's pledge to surgical research and education. Chapters can contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. The chapters that contributed in 2006 include the following:

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

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



Connecticut Chapter leaders present Dr. MacArthur with the Distinguished Service Award. Left to right (all MD, FACS): Philip Corvo, Vice-President; Dr. MacArthur; Kathleen LaVorgna, Councilor; and Scott Kurtzman, President.



Connecticut Chapter: The winners of the chapter's 2006 residents' competition included (not in order) Charles Bakhos, MD**; Brian Kelly; Syed O. Ali, MD; Khaled Zreik, MD**; Bridget Nibler, PA-C, MHS; Tabatha Groff, PA-C, MPAS; Arun A Mavanur, MD**; Souheil Adra, MD; Scott M Cinelli, DO**; C. Van Cott, MD**; Lynsey Biondi, MD**; Jeremiah T Martin, MD**; Shaher Khan, MD**; Peter Abrams, MD**; and Tracy S. Wang, MD**. The winner of the Residents' Jeopardy was the team from Yale University (also pictured).

**Denotes Resident Member.

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*[™] for this activity.

Date	Event	Location/contact information
February 2007		
February 15–17	Puerto Rico	Location: San Juan Hotel and Casino, San Juan, PR Contact: Aixa Velez-Silva, 787/277-0674, genteinc@prtc.net ACS Representatives: Paul Collicott, MD, FACS; Mary McGrath, MD, FACS
February 17	Alberta	Location: Rimrock Resort Hotel, Banff, Alberta, MB Contact: Sean McFadden, MD, FACS, 403/944-4279, sean.mcfadden@calgaryhealthregion.ca
February 22–24	South Texas (CS)	Omni Houston Hotel, Houston, TX Contact: Janna Pecquet, 504/733-3275, janna@southtexasacs.org
February 23–24	North Texas (CS)	Location: City Place Conference Center, Dallas, TX Contact: Mark Watson, MD, FACS, 214/645-0500, mark.watson@utsouthwestern.edu
February 24	Metropolitan Washington (CS)	Location: Georgetown University Conference Center, Washington, DC Contact: Ebony Harris, 202/337-2701, eharris@facs.org
March 2007		
March 22–24	Northeast Mexico	Location: Convention Center, Monterrey, NL, Mexico Contact: Hector Marroquin Garza, MD, FACS, 011-52-8183-186900, hmarroquinfacs@prodigy.net.mx
April 2007		
April 12–14	Alabama	Location: University of Alabama at Birmingham, Birmingham Contact: John Hooton, 205/776-2106, jh@surgicalassociates.com
April 13	Japan	Location: Rihga Royal Hotel, Osaka, Japan Contact: Susumu Eguchi, MD, 81-95-849-7316, sueguchi@net.nagasaki-u.ac.jp
April 13	New York (CS)	Location: Sagamore Resort on Lake George, Bolton Landing, NY Contact: Amy Clinton, 518/283-1601, NYCofACS@yahoo.com ACS Representative: Edward Copeland III, MD, FACS
May 2007		
May 2–5	Chile	Location: Hotel Sheraton, Santiago, Chile Contact: Carlos Lizana, MD, FACS, 562/264-1878, c_lizana@hotmail.com
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 Sachdeva, MD, FACS, FRCS; Julie Freischlag, MD, FACS

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

Annual Members of the Fellows Leadership Society: Alabama, Georgia, Japan, Maine, Metropolitan Philadelphia, North Dakota, South Dakota, South Florida, and Virginia

Contributors: Southwest Missouri

Connecticut Chapter recognizes distinguished service

During its annual meeting on November 6, 2006, the Connecticut Chapter presented its first Distinguished Service Award to John MacArthur, MD, FACS (see photo, page 38). Dr. MacArthur has served the Connecticut Chapter in all leadership capacities, including the Board of Governors. Currently, Dr. MacArthur is semi-retired and working in Massachusetts.

In addition, the Connecticut Chapter conducted an extensive paper and case-report competition that included various categories, including bariatric surgery, plastic/reconstructive surgery, general surgery, and oncology, as well as Residents' Jeopardy, which concluded the day-long education program (see photo, page 38).

Manitoba observes 50th anniversary

The Manitoba Chapter celebrated its 50th anniversary at its 2006 annual meeting at the St. Boniface Research Centre in Winnipeg in November. Richard J. Finley, MD, FACS, a Regent of the College, presented the Manitoba Chapter with its 50th anniversary commemorative charter. Jacob Langer, MD, FACS, from Toronto, ON, served as the keynote speaker. After the education program concluded, a special dinner was held at the Manitoba Club (see photo, this page).

2007 Leadership Conference

The 2007 Leadership Conference will be held June 3–6 at the Washington (DC) Court Hotel. Chapters are encouraged to send their chapter officers, two to three young surgeons (age 45 or



Manitoba Chapter: Leaders and guests of the chapter included the following: From left to right (all MD, FACS): B.J. Hancock; Dr. Langer; James Ross, Governor; Mark Taylor; Iona Bratu, Secretary; and Dr. Finley.

younger), and their chapter administrator or executive director to the meeting. The College's Washington, DC, Office will schedule Capitol Hill visits—to be conducted Tuesday afternoon—for all the chapters that participate.

Chapter anniversaries

Month	Chapter	Years
January	Northern California	55
	Louisiana	55
February	Arizona	55
	Australia–New Zealand	22
	South Florida	53
	Iowa	39
	Italy	21
	Lebanon	44
	Montana–Wyoming	42
	Eastern Long Island, NY	39
Peru	30	
South Korea	20	
Washington State	55	

[†]The Fellows Leadership Society is the distinguished donor organization of the College. Chapters that contribute at least \$1,000 annually are members. Chapters that have contributed \$25,000 are Life Members.