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FEATURES

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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
The surgeons who take the time away from active duty or civilian practice to care for our nation’s troops deserve our utmost respect and gratitude.

From my perspective

This past June, I had the opportunity to visit Landstuhl Regional Medical Center (LRMC) in Germany, which provides trauma and critical care to U.S. military troops and contractors who experience severe injury or illness while serving in Iraq and Afghanistan. Unquestionably, meeting the wounded soldiers as well as the civilian and military medical and surgical professionals caring for them was one of the most emotional and educational experiences of my surgical career.

“Wounded warriors”

Landstuhl is actually the last stop for trauma and critical care patients before they are sent to stateside hospitals for tertiary care. These individuals have already been treated in the battle zone by medics, undergone emergency surgical treatment at mobile field hospitals, and received “damage control” services at combat support facilities. Patients who have sustained injuries or acquired illnesses requiring more intensive care are evacuated via air transport to LRMC.

The trauma patients who are admitted to LRMC typically have injuries of a severity rarely seen, such as multiple penetrating wounds to the brain, lungs, viscera, and extremities. Invasive materials lodged in their bodies may include not only shrapnel from grenades and mortar shells typically associated with military conflict, but also rocks, bolts, nails, and other sharp objects embedded in improvised explosives. Severe burns covering more than half of a soldier’s body are common.

In addition to treating trauma patients, LRMC provides services to critical care patients. These individuals present with such life-threatening conditions as heat stroke, near-drowning, pneumonia, malaria, and diabetic ketoacidosis.

The courage and dedication to duty demonstrated by the troops I had the privilege of meeting was extraordinary. Not one of these “wounded warriors” expressed any self-pity, and they were all anxious to get well enough to rejoin their friends and comrades still battling it out in the war zone. Regardless of one’s personal views about our nation’s military activities in the Middle East, we can all be proud of the young men and women who are completing their tours of duty with fearlessness and determination.

Team-based, certified trauma care

Injured patients, who account for 85 percent of the admissions at LRMC, receive care through the hospital’s efficient and efficacious trauma service. This department comprises a multidisciplinary team working in an open intensive care unit (ICU). Core members of the team include fellowship-trained surgical, medical, and pulmonary physicians; critical care nurses; respiratory therapists; nutritionists; an infectious disease specialist; and a pharmacist. Specialists in neurosurgery, ophthalmology, and orthopedics are available for consultation.

Military medical students, residents, and fellows frequently complete an elective rotation at LRMC. In addition, civilians provide volunteer services through the Senior Visiting Surgeon Combat Casualty Program, which the College’s Committee on Trauma (COT) cosponsors with the American Association for the Surgery of Trauma. Based on the clinical information available before the patients’ arrival, a surgical intensivist at LRMC triages all casualties and surgical patients to inpatient versus outpatient status, ward versus ICU admission, and primary admitting service. I was amazed to see how quickly and accurately a soldier’s complete medical chart
can be electronically transferred from military hospital to military hospital.

As noted in other recent Bulletin articles about LRMC, this facility is the only military hospital outside the continental U.S. to achieve ACS verification as a level II trauma center.* That a military hospital was capable of meeting all of the ACS COT’s rigorous criteria for level II trauma center certification is an impressive achievement, particularly in light of the large number of patients the facility receives each day.

**Transfer to the U.S.**

The average length of stay at Landstuhl is less than 72 hours. Once they are stabilized, troops are triaged to one of the military’s stateside tertiary care hospitals, such as Walter Reed Army Medical Center, Washington, DC; National Naval Medical Center, Bethesda, MD; Brooke Army Medical Center Burn Unit, San Antonio, TX; or San Diego (CA) Naval Hospital. They are

transported via C-17, C-130, and other aircraft large enough to transport many patients and the equipment and medical personnel necessary to care for them on the long flight to the U.S.

Physicians and surgeons with critical care certification lead the in-flight medical team, which also includes critical care nurses and a respiratory therapist. Patients requiring mechanical ventilation are placed on gurneys along the interior walls of the aircraft, which have access to systems that can power state-of-the-art ventilators and other life-support mechanisms. To the crews’ credit, it is highly unusual for a patient to die during transfer.

Of course, some of the patients at LRMC are too weak to withstand hours of air travel. In these cases, the military contacts the families and arranges for inhospital visits and lodging.

**Program worthy of our pride**

It has been said that the only victor in war is medicine. Without a doubt, the selfless military and civilian surgeons who provide care at LRMC are learning some very important lessons that they will be able to apply at trauma centers back home.

The ACS and the American Association for the Surgery of Trauma can be very proud of the Senior Visiting Surgeon Combat Casualty Program at LRMC. To show the College’s respect for this effort, ACS Regent A. Brent Eastman, MD, FACS, participated in this program last summer and delivered a Certificate of Appreciation to the surgical teams at the LRMC. Indeed, the surgeons who take the time away from active duty or civilian practice to care for our nation’s troops deserve our utmost respect and gratitude.

I would encourage interested trauma, neurological, vascular, and orthopedic surgeons as well as career surgeons to get involved in this very worthwhile program.

I will be forever appreciative of the opportunity to visit LRMC. It’s almost impossible to put into words how moving and inspiring this experience was. Perhaps the photographs that accompany this column will help to tell the story more completely.

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

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Thomas R. Russell, MD, FACS
Dateline Washington

prepared by the Division of Advocacy and Health Policy

Senate fails to pass Medicare fix

After passing in the House of Representatives by a large margin (355–59) on June 24, the Medicare Improvements for Patients and Providers Act of 2008 fell one vote short of approval in the Senate on June 26. This legislation would have stopped the 10.6 percent cut in Medicare reimbursement that went into effect July 1. The bill also would have stopped the 5.4 percent cut scheduled for January 1, 2009, and provided a positive 1.1 percent update for 2009. Nearly every physician organization (including the College), AARP, and countless other patient and provider groups supported this legislation, but the health plans and the President opposed it. In the end, 39 senators voted with the health plans and the President.

Thousands of Fellows called their legislators in the weeks preceding congressional action, urging them to support this bill. The response from the Fellows to this campaign was substantially larger than ever. Passage of this legislation has been the number-one priority for the College, and an active advocacy effort by surgeons and ACS staff continued into July to ensure that Congress would pass legislation to retroactively stop the 10.6 percent cut upon returning from their Fourth of July recess.

ACS comments on hospital payment rules

On June 12, the College submitted comments to the Centers for Medicare & Medicaid Services (CMS) regarding proposed regulations for inpatient prospective payment in fiscal year 2009. Among the College’s concerns is proposed expansion of the hospital-acquired conditions rules, which prevent a hospital from coding patients into a higher-paying diagnosis-related group for specified complications if these conditions were absent upon admission. Most of the nine new conditions proposed either are not accurately detectable upon admission or are not reasonably preventable through existing evidence-based guidelines. In addition, the College expressed concern about CMS’ proposal to add another 43 quality measures that hospitals must report to receive the full payment update for 2009. Other worrisome provisions call for changes in the Emergency Medical Treatment and Active Labor Act rules and proposed changes to the Stark III rules. To view the College’s letter, go to http://www.facs.org/ahp/acs_comments_ipps_fy09.pdf.

PQRI feedback reports available

CMS has announced that final feedback reports on the 2007 Physician Quality Reporting Initiative (PQRI) are now available on a secure Web site. Reports are accessible to each practice that has at least one eligible health care professional who submitted 2007 PQRI quality measures data. Information in the documents includes individual reporting rates, clinical performance, and incentive payments, as well as summary information at the practice level. If they haven’t already done so, CMS recommends that practices set up an online account so they can retrieve their reports immediately. Physicians, other health care professionals, and appropriate staff can register for access through CMS’ new “Individuals Authorized Access to CMS Computer Services-Provider Community” (IACS-PC). For more information about the IACS-PC, go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf or http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf. Details also are posted at http://www.cms.hhs.gov/PQRI.
For many years, surgeons and other physicians have been regularly frustrated in dealing with third-party payors when it comes to contracts. These contracts may contain various types of clauses that could be problematic to a surgeon. Many times, a fee schedule is not even provided, so surgeons do not know what they will be paid but are expected to sign the contract without that knowledge.

Unless legal review is sought before signing a contract with a payor, all kinds of problems may crop up. The American College of Surgeons hears from surgeons when certain provisions negatively affect their practice; however, very little can be done if the contract has been signed and complies with state law.

The purpose of this article is not to provide legal advice or counsel regarding third-party payor contracts. Surgeons with legal or other contractual questions should contact their attorneys. Rather, this article provides general information to surgeons about problematic contractual issues and discusses some recent state legislative approaches to encouraging fairness and transparency in contracts.

What do the terms “fairness” and “transparency” mean in contracts?

These terms are used in many situations whether they relate to contracts or not. Certainly there is a great emphasis in our society on transparency with regard to government and politics. Media coverage of transparency in medicine often pertains to patient safety and quality issues, as well as health care budgets and spending, disciplinary action by medical boards, and commercial support for continuing medical education programs and other activities.

In contracts for physicians, however, fairness and transparency may refer to availability of the fee schedule before signing a contract, the use of plain language in contracts, a clear description of contractual requirements for both parties, or payment policies and guidelines; however, this list of potential meanings is not exhaustive.

What are some problem clauses in third-party payor contracts?

According to the fourth edition of the American Medical Association’s (AMA) Model Managed Care Contract, a number of common problematic clauses can be found in contracts. Some of these clauses include the following*

- “All products or future products,” which would force physicians to participate in all current or future products
- Definition of payor, making it easy to sell or rent the provider network
- Termination without cause, which may have strings attached and keep the physician on the panel for up to a year after termination
- Noninterference with members—for example, a gag clause on physician-patient communication
- Comparable provider rate, a “most favored nation” provision requiring the physician to give the contracting insurer the benefit of the lowest rate negotiated with any insurer

How can third-party payors get away with including such unreasonable clauses in contracts?

State law dictates what clauses a payor may legally include in a contract, and state legislatures have been slow to jump on the fairness and transparency bandwagon when it comes to dealing with managed care organizations and other third-party payors. Not surprisingly, the insurance industry has a great deal of influence in state legislatures, so it can be an uphill battle when physicians advocate for fairness and transparency in their states.

*If you want more information regarding these clauses and you are an AMA member, you may download a copy of Model Managed Care Contract at [http://www.ama-assn.org/ama/pub/category/9559.html](http://www.ama-assn.org/ama/pub/category/9559.html).
Part of the problem is that state legislators are unclear about how the system works. Their knowledge of these matters is often quite limited unless they have a personal interest in them. Furthermore, many physicians are not committed to grassroots advocacy and educating legislators about the problems they experience in their surgical practices, and state medical and specialty societies can only do so much on their own. Ultimately, legislators want to hear from their constituents, not just an organization in a state with paid lobbyists and an agenda to advance. If all surgeons reading this article decided to commit to regularly talking with their state legislators over the next 12 months about the problems faced in contracting with third-party payors, the foundation would be laid for enacting contract fairness and transparency reforms all over the country.

Have any states enacted laws to provide fairness and transparency in contracting?

A few states have responded to legislative proposals that medical societies and physicians have developed, and two states serve as recent examples of what can happen when physicians unite in grassroots advocacy.

Last year, Colorado enacted S.B. 79, a bill concerning contractual agreements with health care providers. This legislation made the language in contracts more transparent by requiring health insurers to use a standard managed care contract when negotiating with physicians. The standard contract must disclose payment and compensation terms (including fee schedules, methodology used to calculate fee schedules, internal processing and edits used, and so on) and incorporates a number of contract requirements regarding termination for cause by either party, utilization review, rental network preferred provider organizations (PPO), binding arbitration, and physicians’ rights to a private cause of action.1

Earlier this year, the Ohio State Medical Association, with the active support of the Ohio Chapter of the ACS and other state specialty societies, capped a comprehensive multi-year advocacy effort to pass the Healthcare Simplification Act. This legislation, signed into law by Gov. Ted Strickland (D) on March 25, addresses three important areas:

- **Transparency in contracting:** complete copy of the fee schedule, summary disclosure form outlining important contractual terms, restrictions on silent PPOs and rental networks, 90 days’ notice of all material contractual amendments
- **Standardized credentialing:** adopts the Council on Affordable Quality Healthcare credentialing form, 90-day time frame for processing credentialing applications, penalties for not credentialing within 90 days
- **Fairness in contracting:** prohibits “most favored nation” clauses, prohibits unilateral contractual amendments, restricts “all products” and “future products” clauses, prohibits repricing of claims and sale of contracted rate, improves eligibility inquiries²

It should be noted that, at press time, Florida’s governor had not yet acted on S.B. 1012. This legislation would impose clear and reasonable guidelines on resolving overpayment or underpayment of physician services and enforcing assignment of benefits declarations by patients. The rules also prohibit silent PPOs unless the contract expressly authorizes this arrangement.

What should surgeons do to protect themselves in the contracting process?

1. Have legal counsel review all contracts. Spending a few dollars on the front end will save a lot of time, money, and anger on the back end.

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1 American Medical Association Advocacy Resource Center. *Advancing a Counterattack on Managed Care Payment Practices, 2007 Legislative Summary Managed Care Payment Issue.* Chicago, IL: American Medical Association; 2007.


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Internet resources

ACS Practice Management: [http://www.facs.org/ahp/practmanagement.html](http://www.facs.org/ahp/practmanagement.html)

The surgical workforce crisis in Africa:

A call to action

by Doruk Ozgediz, MD, MSc; Robert Riviello, MD, MPH; and Selwyn O. Rogers, MD, MPH, FACS
It is hard to imagine a more pressing issue facing the global surgical community than ensuring the training and education of an adequate and equitably distributed surgical workforce. Currently, the World Health Organization (WHO) estimates that there is a global shortage of 4.3 million health workers, with an estimated shortage of 1 million in Africa alone. Africa bears 25 percent of the global burden of disease with only 2 percent of the world’s workforce—and an even smaller proportion of this workforce is represented by surgeons. Africa may have less than 1 percent of the number of surgeons in the U.S., despite having three times the population. Furthermore, because of the lack of rigorous data, these figures are merely estimates that may significantly underestimate the gap between the burden of surgical disease and the health workforce to address that need. The world’s anesthesiology and nursing workforce is similarly insufficient and maldistributed, contributing to limited access to surgical care and compromising the availability, safety, and quality of perioperative services.

The surgical consequences of this limited workforce are readily apparent to clinicians who have volunteered or worked in Africa. Most patients with surgical problems routinely treatable in the U.S. fail to reach a health facility or reach a facility without the capacity—either in staff or infrastructure—to care for their problems. The consequence is unparalleled morbidity and mortality that is unfathomable to clinicians who have not worked in these settings. As surgeons in an increasingly interconnected world, we must be aware of the complex factors affecting the overall global health workforce and, specifically, our potential role to improve its quantity and equitable distribution. Nonetheless, there currently seems to be relatively little individual or concerted action on the part of developed countries to tackle this problem in a coordinated, robust, and thoughtful manner.

Global forum

These issues were the focus of the first Global Forum on Human Resources for Health in Kampala, Uganda, which convened in March. The forum was hosted by the Global Health Workforce Alliance, a group formed by WHO to tackle the current crisis in human resources for health. During the meeting, the “Kampala Declaration” was adopted with a 12-point call to the world community to develop the world’s health workforce, especially in the poorest countries. As surgeons, we are calling to arms the U.S. surgical community to confront this crisis.

Though an integral part of health systems, essential surgical services have been sidelined as a luxury by public health efforts in developing nations. Overwhelmingly, the major donor organizations that set the global health agenda support programs exclusively related to infectious diseases. As a result, the already limited numbers of health workers in poor countries are more interested in working with these organizations than pursuing careers in surgery and anesthesia, where there are fewer profitable opportunities. It is generally unrecognized that surgical conditions account for an estimated 11 percent of the total global burden of disease, led by traumatic conditions. Africa, in particular, has the world’s highest concentration of surgical disease burden. Some researchers have estimated that 90 percent of the global surgical need is in the developing world. However, current spending on human immunodeficiency virus research is almost 200 times that of injury research when controlled for relative disease burden. To create better balance in donor focus, there is an urgent need for surgeons to document the unmet global surgical need, to advocate for patients and local clinicians abroad, and to affirm the role of surgery within global public health.

Surgical workforce migration

The migration of health workers from poor countries is under particular recent scrutiny because of the added burden this effect places on already strained health systems. Overall, global migration is growing inexorably, and professionals and nonprofessionals alike will continue to migrate for better opportunities. It is estimated that 25 million people migrate every year.

Opposite: There is a limited supply of physicians in Africa, and most do not choose a career in surgical and perioperative disciplines for a multitude of reasons. Jane Fualal, MD, MMed (Surgery) (right), a senior faculty general and endocrine surgeon at Makerere University, Uganda, teaches senior medical students in the outpatient surgical clinic. The two medical schools in Uganda produce a combined total of 140 medical students each year. (Photo by Dr. Ozgediz.)
A small percentage of these are from sub-Saharan Africa, given the very small source pool, this is a significant number. In general surgery residency programs, 10 percent of first-year postgraduate posts are held by IMGs, though there are little data on the distribution of source country. Many more IMGs from low-income countries who have migrated have yet to obtain licenses to practice in recipient countries. They may outnumber those currently practicing and very little is known about the characteristics of this group. With surgeons in particular, because of the length and intensity of training, the costs borne by the host country that has invested in
the education of a surgeon are likely to be very significant. Some experts have proposed bonding trainees to periods of service in low-income countries that have invested in their training, whereas others have called for reparations from recipient countries to reimburse low-income countries for these training costs. Although based on ethically sound principles, these policies are practically very difficult to implement.

The promise of working in a better system with more opportunities for learning and advancement, with corresponding compensation, pulls some of the brightest physicians-in-training from developing countries to the U.S., even despite the significant cost and toil associated with such a move. As the increase in U.S. residency positions is projected to outstrip growth in the U.S. medical student production, this pull effect will predictably increase the number of IMGs who seek training positions in the U.S. This effect will exacerbate the already inequitable distribution of surgical manpower worldwide.

The push factors that drive emigration must also be recognized. The factors most frequently cited are poor compensation and family opportunities, occupational risk of infectious diseases, and dilapidated health systems and hospital conditions that lead to low morale among health workers who may have skills that transcend local capacity. Another underappreciated factor is the ironic coexistence of a human resource shortage with unemployment of trained workers as a result of limited job opportunities. This outcome is partially a consequence of mandatory debt repayments and limits on health spending imposed by the International Monetary Fund to protect against inflation and ensure payment of domestic debt. Recent analyses suggest that there is insufficient macroeconomic evidence to support these policies, which may further cripple health services.

Although locally derived solutions to these problems are critical, creative approaches by developed countries can also have a significant impact. The Norwegian government, for example, has committed to directly support the compensation of health workers in poor countries and to produce more of its own physicians—thus addressing both push and pull factors. The International Council of Nurses, the Health Worker Migration Global Policy Council, and other bodies have issued guidelines for ethical recruitment in low-income countries to avoid poaching. Meanwhile, the U.K.-South Africa memorandum of understanding on the health workforce also outlines key principles to strengthen the South African health system, to increase U.K. health worker self-sufficiency, and to guide ethical recruitment to stem the unchecked flow of South African health workers to the U.K. However, these examples are of current practices—very little is known about which policies work because of a lack of systematic research on effective policies in human resources for global health.

A great opportunity

Training institutions and associations in the U.S.—the most surgically resourced country in the world—have an opportunity to take a leadership role in facing the global surgical workforce...
crisis. For example, partnerships, or “twinning” programs between U.S. training institutions and their counterparts in low-income countries, have the potential for great impact. There is an unprecedented enthusiasm and energy among U.S. surgical trainees toward global health care, part of a greater acknowledgment of its role in medical training.\textsuperscript{20,21} Harnessing this momentum in a thoughtful fashion can help build greater surgical capacity globally. Mutually beneficial partnerships between American overseas partner institutions can share knowledge, skills, and resources. This collaboration can increase local capacity to train surgical providers, and improving local working conditions can then increase recruitment, training, and retention of surgeons in poor countries. Such partnerships have been identified as one tactic among several key strategies for scaling up education and training of health workers worldwide.\textsuperscript{22}

By providing a supportive work environment—the material resources necessary to deliver patient care according to one’s training, collegial camaraderie, and intellectual stimulation—we believe that professional migration can be mitigated. If this outcome proves to be true, then such twinning programs will be vital to addressing the surgical workforce shortage. They must, however, be carefully designed to avoid paradoxically exacerbating the “brain drain” instead of fostering capacity building.\textsuperscript{23}

Some may believe that this work is reserved for the community of international humanitarian organizations. Undoubtedly, volunteerism plays an important role as a stopgap measure to meet workforce shortages in low-income countries. The College’s Operation Giving Back program has been a leader in coordinating such voluntary missions, and many nongovernmental and private volunteer organizations provide essential surgical services to vulnerable populations in low-income countries.\textsuperscript{24} Much can be learned from the experiences of these organizations in providing high-quality care in austere medical environments. However, only through a systematic, coordinated response from training institutions and associations can the human resource problem be truly confronted.\textsuperscript{25}

To have a sustainable impact on patient care, we must also work closely with anesthesia and nursing training programs and associations, the same as we do in the operating room for each individual patient. At the most basic level, we believe in the essential human right to the “highest attainable standard of health care,” as promoted by the WHO, which is inclusive of surgical care. We have an opportunity to move toward greater equity in surgery and elimination of disparities in surgical care worldwide. It is an urgently shared responsibility that transcends borders. The lessons learned in this process may,
in turn, inform how we approach local disparities in access to surgical care in the U.S.

March’s Global Forum on Human Resources for Health demonstrated increasing global recognition of the central role of the health workforce to improve health in poor countries. There is also an increasing awareness, even among nonsurgeons, that surgical conditions in low-income countries exact an enormous and heretofore neglected health and economic burden.26 Finally, the global health community is beginning to emphasize the overall improvement of health systems rather than solely focusing on disease-specific interventions.27 Certainly, developing surgical delivery requires investing in infrastructure and addressing barriers to care in addition to training surgical providers. Given these factors, U.S. surgical associations and training programs now face a critical opportunity to explore what we can do to help meet global training needs, to partner with other associations around the world, and to declare as surgeons what contribution we will make to solving the world’s health workforce crisis.

Many injured patients do not have expeditious care of fractures and emergency trauma care, leading to complications and long-term morbidity. This man sustained complex open femur and tibia/fibula fractures when thrown from a truck in rural Angola. (Photo by Dr. Riviello.)

References

reactions to unmet expectations can range from mild disappointment to extreme anger. Knowing the expectations of your patients can help avoid these reactions, improve their health care experience, and reduce your exposure to liability.

Each patient enters the physician’s office with specific expectations. Those expectations may be uppermost in their minds or merely representative of a comfortable familiarity with a routine they have come to know. Understanding and managing patient expectations not only improves patient satisfaction but it can be an important technique in reducing risk of liability. An additional benefit will be smoother operations in your office.

One of the pitfalls of ignoring patient expectations may be a lawsuit. Studies have shown that as much as 70 percent of litigation relates to real or perceived problems involving physician communication, which influences patient expectations. Not meeting expectations may bog down office staff with excessive complaints and result in suboptimal patient compliance; it also could affect a physician’s reputation in the community. Research has consistently shown a dissatisfied patient will tell other people, and as the word spreads, this dissatisfaction could be indirectly communicated to many more individuals.* Another troubling scenario is that patients with unmet expectations may never complain to the physician directly—they just won’t return for ongoing care.

To understand patients’ expectations, a physician must be aware of how they may have been formed. Personal experiences, or those of friends or relatives with a similar problem, can be important factors. Today patients are increasingly exposed to information from the media or the Internet. Drug companies promote their products in magazines and television advertisements, occasionally using celebrity testimonials. The number of Web sites with health information continues to expand.

The patient who brings information from these sources to his or her doctor visit believes it is valuable and expects the physician’s interest. This occurrence provides an ideal opportunity to discuss their questions and to advise them that not all information available on the Internet is accurate. However, physicians must be sure to express appreciation for what patients have shared. Enhance this approach to pointing patients in the right direction on the Internet. Include in office brochures or post on the bulletin board a valuable health information Web site. These actions further encourages active patient participation in their care.

What are some of the general expectations patients may have? Literature suggests that most patients expect to be listened to by the physician, to receive clear explanations about their condition, and to be cared about by the physician and staff. Although patients certainly come to the office

primarily for diagnosis and treatment of their symptoms, research shows that they want physicians and their staff to like them. Patients, on a conscious or subconscious level, believe that if their physicians like them, they will ultimately receive better care.

They also expect a physician and his or her staff to look professional. For many patients, staff members are the key reason they return to the physician’s practice. If they look less than professional, that may suggest to the patient that they are less qualified.

Uncovering patient expectations

Techniques for uncovering expectations can be varied. One way to manage the patients who may think they can address all complaints during a single visit is to ask upfront the nature of their visit. If they are asked at the beginning of the visit if there are any other complaints besides what was stated when the appointment was made, the physician may be able to better control expectations for the visit. It will also help to more easily direct them to make an additional appointment, if necessary, to handle the other symptoms or complaints. It lets the patient know at the onset what can realistically be addressed during the current appointment and gives direction about the need to schedule additional time for other complaints. Another approach is to have the office staff give the patients a short form when they arrive to state the purpose of the visit and to probe for other problems they may wish to present.

Showing care for patients is one of the more important expectations. How can it be communicated to them? Taking good notes during each visit will help with remembering names and issues they mentioned during that visit. For example, if the patient was leaving for a vacation after the previous visit, the physician might inquire if he or she had an enjoyable time. Another gesture might be to inquire about a member of the patient’s family. Employ the listening skills of leaning forward, sitting down to communicate, keeping eye contact, and using facial expressions to indicate engagement.

Communicating in a way that helps patients to understand the medical information provided also indicates that the physician cares about them and their concerns.

Some approaches to providing effective explanations to patients include the following:
- Using similes or analogies
- Using statistics
- Providing patient handouts
- Using visual aids such as models
- Dictating reports in the patient’s presence

Requesting feedback to test how much a patient understood what was communicated to him or her is important as well. However, it is important to clarify why this question is being asked. To ask, “Tell me how you will care for this wound,” is less effective than, “I want to be certain my explanation was clear, so let’s review your wound care plan before you leave.”

Information expectations

Managing patient expectations also entails providing complete medication information and instructions. A cursory review of current literature from the pharmaceutical industry stresses the importance of complete and understandable information for patients about how to take medications—for example, don’t chew, crush, or divide tablets; take with or without food; how to respond to missed doses, and so on. In addition, they emphasize how important it is that patients understand the possible side effects. The information identified by the drug companies is important for a physician to include in his or her patient instructions so the patient knows what to expect with the treatment regimen. Although a patient receiving medications from a pharmacy will be given an information sheet to meet his or her needs, those receiving sample drugs or injections in the physician office have the same requirement for complete information about the drug.

Clear communication of expectations of the patient, as well as a better understanding of the patient’s expectations, pave the way for a more successful health care relationship. Establishing a health care relationship with new patients is most effective by starting with communicating clearly the “rules” and practices of the physician office. Patients are more comfortable if they know what to expect from physicians and staff. Most often, new patients want to know the following details:
- The hours the practice is open
- Billing practices
• How to reach the physicians after hours
• How to most efficiently handle a prescription refill
• What they should bring with them to the appointment

A useful tool to communicate the initial information is through a patient brochure or fact sheet. This tool encourages a consistent message from the office staff, who can emphasize key points by referring to the brochure. Patients may be unsure with whom to discuss various aspects of care or billing because they are uncertain of the role of various members of the office staff. An example of how to assist the patient is to have staff wear nametags with first name, credentials, and job title listed. It assists the patients in directing their clinical questions to appropriate clinical staff and the billing questions or administrative information to the person responsible for each function.

Unrealistic expectations
Dealing with unreasonable or unrealistic expectations can be very difficult. From a risk perspective, however, it is critical. The most challenging is the patient who expects a cure when his or her condition/diagnosis does not favor that result. The physician’s role is to explain the reality of the patient’s situation but still allow him or her a more optimistic view by making clear that everything available to assist with symptomatic relief to preserve the quality of life will be employed. Clear communication and gestures of caring—not just by the physician but also by staff—help these situations enormously. Physicians should guard against being evasive for the benefit of the patient or to reduce the risk of being sued. Often plaintiffs will state that a lawsuit was the only means to really find out what happened.

Sometimes the patient has unrealistic expectations of obtaining medication or a surgical procedure he or she has seen on TV or read about in the popular press. It is important to validate their right to request a certain treatment. However, it is prudent for the physician to explain that the best treatment for the patient’s particular problem is being recommended, based on knowledge and experience. The physician should include his or her reasoning and the benefits seen in a particular approach to diagnosis. Ending with a comment such as, “How does that approach seem to you?” demonstrates a partnership in care so patients feel empowered to contribute to the decision making. One of the most difficult aspects of illness for patients is the loss of control. By partnering with them, a measure of control has been restored to them.

If patients who cling to unrealistic expectations are encountered, recommending that they pursue a second opinion might be worth considering. If that consultant does not confirm the original recommendations, it might be best for the patient to seek out another practitioner. Continuing to treat a patient whose expectations are beyond the reality of the situation may place a physician at an increased risk for an eventual lawsuit.

Set expectations
It is helpful to examine practices that are followed by one’s organization to develop strategies for setting expectations and to make sure that patient expectations are taken into consideration and there is response to their needs.

Conclusion
Patient expectations may not seem like a big deal but they are a real issue. Even physicians themselves have expectations of the care provided to patients. If a physician is able to see his or her practice through the eyes of patients, that will increase the level of everyone’s satisfaction.

For more information, refer to Preventing Medical Malpractice Suits, by James E. Schutte (Seattle, WA: Hogrefe & Huber Publishers; 1995).

Ms. Murray is a registered health information administrator, a certified professional in health care risk management, and a patient safety/risk management account executive with OHIC Insurance/The Doctors Company in Columbus, OH.
PAGING ALL DOCTORS:

by Andrew L. Warshaw, MD, FACS; and Sara Morse, Manager of Political Affairs, Division of Advocacy and Health Policy
Earlier this summer, your e-mail inbox was, no doubt, filled with urgent requests from Thomas R. Russell, MD, FACS, Executive Director of the American College of Surgeons, and the ACS Washington Office, asking you to contact your senators regarding the pending legislation to stop the cuts to Medicare physician payments scheduled for implementation over the next two years (a 10.6 percent cut on July 1 and a 5.4 percent cut in 2009).

At first glance, the response was encouraging. As of the Senate vote on June 12, more than 2,000 Fellows contacted their senators, urging their vote for cloture. (At the time this article was written, the fate of the legislation remained uncertain.) Clearly, this is a significant number. A closer look, however, reveals that we are falling far short of our potential. Based on our membership numbers alone, the American College of Surgeons should be leading the charge for the House of Medicine.

Currently, the College counts roughly 45,000 U.S. residents among its members. College databases contain the e-mail addresses for only 35,000 of these members.*

If all 45,000 members not only opened and read these alerts but subsequently took action, the impact would be immediate and impressive. Each Senate office, for example, would receive approximately 900 phone calls from ACS surgeons from their home state. That call would take three minutes of your time, but would contribute to a combined total of approximately 45 hours of live telephone lobbying to each senator from concerned, active constituents.

Rep. Pete Sessions (R) from the 32nd district of Texas (which includes Dallas) explains that communication from constituent advocates is critical to the formation and advancement of legislation: “The voice of constituents is a powerful tool of democracy that influences the halls of Congress on a daily basis. Members of Congress and congressional staff rely on the real-world experience and perspective of constituents in developing and advancing policy initiatives, and every phone call is an important contribution to this process. Through power in numbers, physicians and their patients can bring an issue to the forefront of Congress’ attention and help bring change for the good of the nation.”

Members of the College have intermittently contacted the Washington Office to express dismay over these requests for action. After all, you went through medical school, training, and residency to practice medicine, not to lobby Congress. In fact, you may have joined the College specifically to be represented and protected by the advocacy staff and ACS leadership. Although the staff of the Washington Office does work tirelessly to educate members of Congress and their staff and promote the legislative agenda of surgeons and their patients on Capitol Hill, their work cannot stand alone. No lobbyist can ever be as powerful as the voices of constituent voters raised in unison around an issue.

Providing members with the tools to use their numbers, expertise, and commitment to the betterment of health care and to shape the legislative and regulatory measures taken by the government is the cornerstone of ACS’ advocacy efforts. The strength of any effective advocacy program is derived from the activism of the membership as a whole.

It is an absolute reality that Congress plays an active role in the way you practice on a daily basis. The decisions that are made on Capitol Hill directly affect how you treat your patients, the method and rates of compensation for the care you provide, the technology you use, and even the way you manage your office. With the acceptance of this truth must come the determination that you cannot afford to passively allow these decisions to be made without your input. Your understanding of what it means to be a surgeon must change. Providing the finest health care absolutely requires you to be equipped with the latest innovations, superior staff, cutting-edge technology, and best practices; but dedication to passionate and ongoing grassroots advocacy is every bit as essential. Will Rogers put it best in his oft-quoted quip: “Even if you are on the right track, you will get run over if you just sit there.”

What can you do?

Respond to alerts. Dr. Russell and the Washington Office staff are sensitive to the preciousness of a surgeon’s time and only activate an urgent grassroots alert when issues critical to surgery

*If you do not receive electronic communications and would like to provide your e-mail address, please contact the Division of Member Services at ms@facs.org.
face imminent action in Congress. The louder surgery’s voice becomes, the greater the chance for substantive and positive reform.

Attend the Joint Surgical Advocacy Conference. Be on the watch for information on the Joint Surgical Advocacy Conference in Spring 2009. Join hundreds of your fellow surgeons at a three-day conference designed to promote and educate constituent physician advocates. In March of this year, approximately 330 surgeons participated in the conference in Washington, DC, and listened to presentations by six members of Congress, including Rep. Fortney “Pete” Stark (D-CA), Chairman of the Ways and Means Subcommittee on Health; Rep. Bart Gordon (D-TN), Chairman of the Energy and Commerce Subcommittee on Health; Rep. Michael Burgess, MD (R-TX); Rep. Shelley Moore Capito (R-WV); Representative Sessions; and Rep. Tom Price, MD, FACS (R-GA). The conference features sessions where participants learn the details of how Congress works, hear from key members of Congress and congressional staff on the status of legislation important to surgery, learn what major changes are on the horizon for health care in the U.S. and how individuals can affect them, and more.

Visit the ACS Federal Action Center. You can learn about and take action on issues pertinent to surgery, read about key legislation that the ACS is working on, find your legislators, and more by visiting http://www.capitolconnect.com/acspa/.

Get to know your representatives and senators. The following activities can help a person to get to know his or her congressional representatives:

• Communicate with their offices on a regular basis, not just when you “need something.”
• Employ the five-minute advocacy rule each week by spending five minutes calling the health care staff of either your representative or one of your senators, rotating each week so that every year you call each of the three offices 17 times. Note that 50 calls per year multiplied by 45,000 American College of Surgeons Professional Association (ACSPA) members results in 2,250,000 calls to Congress each year!
• Set up in-district delivery of ACSPA-SurgeonsPAC (political action committee) checks (a great way for you to get to know your member of Congress or to help foster your existing relationship).
• Schedule a time for your member of Congress and/or his or her staff to tour your office or your hospital to learn more about what surgeons do and how Congress directly affects your practice and your patients.
• Host an in-district fundraiser for fellow surgeons and the greater physician community benefiting your member of Congress.

Individual relationships with members of Congress and their staff are critical to the success of surgery’s advocacy efforts on Capitol Hill.

Get involved with your PAC. For more information on the ACSPA-SurgeonsPAC, visit http://www.facs.org/acspa/index.html or contact Sara Morse at smorse@facs.org.

Dr. Warshaw is the W. Gerald Austen Professor of Surgery at Harvard Medical School and surgeon-in-chief and chairman of the department of surgery at Massachusetts General Hospital, Boston. He is Treasurer of the College.
Stand up for patients

When patient health is at risk, doctors would do well to follow the example of their California peers

by SreyRam Kuy, MD

Editor’s note: The following is one of an ongoing series of articles written by members of the Resident and Associate Society of the American College of Surgeons. The series will provide a forum for the concerns and needs of residents and young surgeons in all surgical specialties.

Dr. Kuy’s article was published in the February 28, 2008, Los Angeles Times. This adaptation is printed here with her permission.

Recently The Times disclosed that Blue Cross of California was asking physicians to report patient conditions that could be used to cancel medical coverage. Amid the furor of physicians all over California, the leadership of the California Medical Association responded with a letter to state regulators protesting this practice. Blue Cross has since halted its solicitation of physician policing.

This demonstrates the urgent need for physicians all over the U.S. to practice leadership in our individual practices, in our hospitals, in our health care organizations, and in the political process. Physicians hold a trust to protect the health of our patients. We cannot abdicate this sacred trust.

A 2006 poll by the American College of Physician Executives showed that 60 percent of physicians are considering leaving medicine due to low morale and lack of autonomy and status. We practice medicine in the context of Medicare reimbursements that don’t keep pace with the rate of inflation, a mountain of medical school debt (over $200,000 for some of my colleagues), the constant threat of litigation, and years of delayed gratification. (In my case, 17 years of higher education: four years of college, four years of medical school, seven years of general surgery training, and two years of fellowship.) We’re feeling harried, hassled, and harassed, and it can be tempting to fall into
pledged “to consecrate my life to the service of humanity” and that “the health of my patient will be my first consideration” and that “I will respect the secrets that are confided in me.” I believed I was joining a profession empowered with a sacred duty. I still believe this. When patients are ill, they are at their most vulnerable. That a person would allow me to take a scalpel and slice into his body to extirpate disease is such an extraordinary act of trust. It places me, the surgeon, in an enormous position of both privilege and responsibility. The patients entrust their health to the physician with the confidence that the physician will advocate first for the patient’s health, not her pocketbook. When physicians place the health of our patients as our first consideration, we reclaim our autonomy, our morale, and ultimately, our dignity as a profession.

So I applaud the California Medical Association and the physicians in California who protested when asked to look for patient conditions that could be used to cancel their medical coverage. At the same time, to my colleagues who bemoan our profession’s fall, I say, remember how you started: with a pledge that the health of our patients will be our first consideration. Now is the time to stand up for our patients.

Dr. Kuy is a general surgery resident at the University of Texas Health Science Center at San Antonio. She researches health care disparities and access as a Robert Wood Johnson Clinical Scholar at the Yale School of Medicine.
This statement was originally published in the June 2000 issue of the Bulletin. This revised statement incorporates revisions recommended by the College’s Central Judiciary Committee and was approved by the Board of Regents at its June 2008 meeting.

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hysicians understand that they have an obligation to testify in court as expert witnesses on behalf of the plaintiff or defendant as appropriate. The physician who acts as an expert witness is one of the most important figures in malpractice litigation. In response to the need to define the recommended qualifications for the physician expert witness and the guidelines for his or her behavior, the Patient Safety and Professional Liability Committee of the American College of Surgeons has issued the following statement.

**Recommended qualifications for the physician who acts as an expert witness:**

- The physician expert witness must have had a current, valid, and unrestricted state license to practice medicine at the time of the alleged occurrence.
- The physician expert witness should have been a diplomate of a specialty board recognized by the American Board of Medical Specialties at the time of the alleged occurrence and should be qualified by experience or demonstrated competence in the subject of the case.
- The specialty of the physician expert witness should be appropriate to the subject matter in the case.
- The physician expert witness who provides testimony for a plaintiff or a defendant in a case involving a specific surgical procedure (or procedures) should have held, at the time of the alleged occurrence, privileges to perform those same or similar procedures in a hospital accredited by The Joint Commission or the American Osteopathic Association.
- The physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should have been actively involved in the clinical practice of the specialty or the subject matter of the case at the time of the alleged occurrence.
- The physician expert witness should be able to demonstrate evidence of continuing medical education relevant to the specialty or the subject matter of the case.
- The physician expert witness should be prepared to
document the percentage of time that is involved in serving as an expert witness. In addition, the physician expert witness should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times he or she has testified for the plaintiff or defendant.

**Recommended guidelines for behavior of the physician acting as an expert witness:**

- Physicians have an obligation to testify in court as expert witnesses when appropriate. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.
- The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.
- The physician expert witness should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complications occurring as a result of medical uncertainty).
- The physician expert witness should review the standards of practice prevailing at the time and under the circumstances of the alleged occurrence.
- The physician expert witness should be prepared to state the basis of his or her testimony or opinion and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty. The physician expert witness should be prepared to discuss important alternate methods and views.
- Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of a case.
- The physician expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records and subject to independent peer reviews. Moreover, the physician expert witness should willingly provide transcripts and other documents pertaining to the expert testimony to independent peer review if requested by his or her professional organization. The physician expert witness should be aware that failure to provide truthful testimony exposes the physician expert witness to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license.
On June 17, the College dedicated the new Nora Institute for Surgical Patient Safety at its headquarters. The Institute has been established to further the College’s efforts to ensure the safety and quality of surgical care by informing and educating patients and surgeons about issues related to surgical patient safety and by monitoring the legislative process as it relates to the issue at both the federal and state level.

“We are very pleased that the Nora Institute for Surgical Patient Safety is housed at the American College of Surgeons. The College has a long history in leading patient safety efforts in the U.S. and around the world, so we will become great partners in efforts undertaken by the Nora Institute,” ACS Executive Director Thomas R. Russell, MD, FACS, said. “Surgeons are keenly aware that their fundamental responsibility is to be their patients’ quality care advocates and providers, and the work of the Nora Institute will be instrumental in providing surgeons with the resources they need to safeguard patient safety and utilize best practices,” he said.

Paul F. Nora, MD, FACS, Institute Founder and Director, is a general surgeon and professor of clinical surgery at Northwestern University Medical School, Chicago, IL. He has a long affiliation
with the College and has lent his expertise to the College’s many surgical patient safety efforts. Dr. Nora has served as a consultant to (2006–present) and member of (2001–2007) the Committee on Patient Safety and Quality Improvement; Chair (1975–1977) and consultant to the Committee on Operating Room Environment (1981–1988); and Vice-Chair (1983–1986) and member (1980–1986) of the Medical Devices Committee. Furthermore, Dr. Nora served as Director of the College’s Professional Liability Program from 1986 to 1999. He is co-editor of ACS Surgical Patient Safety: Essential Information for Surgeons in Today’s Environment and editor of two editions of the College’s Professional Liability/Risk Management: A Manual for Surgeons.

In speaking of the Institute, Dr. Nora explained, “The Institute has been founded to assist the American College of Surgeons in achieving its overriding goal of ensuring surgical patient safety in the U.S. and in countries around the world. Furthermore, we anticipate that the Institute will be a valuable resource for all surgeons, policymakers, patients, and other stakeholders who are concerned about the quality of health care in the U.S.”

**Fellows in the news**

**Edmond C. Cabbabe, MD, FACS**, clinical professor of plastic surgery at St. Louis (MO) University School of Medicine and chief of plastic surgery at De Paul Health Center, was elected to a three-year term (2008–2011) on the American Medical Association Board of Trustees.

**C. Rollins Hanlon, MD, FACS**, ACS Executive Consultant, wrote the preface to Michael E. DeBakey, MD: Selected Publications, 1934–2006, a book containing many published scientific articles Dr. DeBakey authored or co-authored throughout his career. The book was published by the Baylor College of Medicine and presented to attendees at the sixth Current Trends in Cardiothoracic Joint Session with the Michael E. DeBakey International Surgical Society’s 17th Congress in Houston, TX, April 30–May 3.

In his preface, Dr. Hanlon said, “Younger surgeons who
currently debate the merits of conventional versus endovascular approaches to cardiovascular lesions may find in these publications some intimation of the excitement engendered by reports from Houston in the middle of the twentieth century. Such reports laid the foundation on which the current complex structure of cardiovascular therapy stands firm. Surgically impressive as they are, they are merely a segment of the variegated professional and personal career that has immensely benefited a world touched by the genius of Michael E. DeBakey.”

Warren F. Muth, MD, FACS, a general and vascular surgeon from Dayton, OH, who also serves as the medical director of the Kettering Medical Center Surgery Network, was elected president of the Ohio State Medical Association at its annual meeting.

In May, husband-and-wife cancer patients of David P. Winchester, MD, FACS—professor of surgery at Northwestern University in Evanston, IL, and ACS Medical Director of Cancer Programs—donated $1.5 million to establish the Evanston Northwestern Hospital (ENH) Board of Directors/ David P. Winchester, MD, Chair of Surgical Oncology. Dr. Winchester’s son, David J. Winchester, MD, FACS, professor of surgery at Northwestern University Feinberg School of Medicine, was appointed to be the first chair holder by Mark Talamonti, MD, FACS, chairman of the ENH department of surgery. (See photo, page 28.)

Jacobson Award recipient honored

Donald L. Morton, MD, FACS (right), was presented with the fourteenth Jacobson Innovation Award of the American College of Surgeons during a dinner ceremony held June 13 in the College’s John B. Murphy Memorial Auditorium in Chicago, IL. Pictured with Dr. Morton are Julius H. Jacobson III, MD, FACS, and Joan L. Jacobson, who sponsor the award. (See full story in the July 2008 issue, page 88.)
Sleeve gastrectomy approved as standard procedure for ACS BSCN accreditation

On April 9, the Advisory Committee of the American College of Surgeons Bariatric Surgery Center Network (ACS BSCN) Accreditation Program updated the criteria in the Bariatric Accreditation Manual regarding standard surgical procedures. The committee voted to approve adding sleeve gastrectomy and revisional surgery to its list of standard bariatric surgery procedures. Committee members also clarified that the only gastric bypass procedure (open or laparoscopic) that is acceptable as a standard procedure is the Roux-en-Y.

For the purposes of obtaining and maintaining status as an Accredited Bariatric Center in the ACS BSCN, the following operations are defined as ACS BSCN standard surgical procedures when performed by an open or laparoscopic approach:
- Roux-en-Y gastric bypass
- Laparoscopic adjustable gastric band
- Vertical banded gastoplasty
- Biliopancreatic diversion with duodenal switch
- Biliopancreatic diversion without duodenal switch
- Sleeve gastrectomy

In another important accreditation decision, the ACS BSCN Advisory Committee approved a new criterion that nonstandard surgical procedures may be considered when determining a center’s annual volume requirements. The ACS BSCN will recognize nonstandard surgical procedures, provided that a center receives and presents to the ACS Institutional Review Board approval for each type of nonstandard procedure that will be included in its annual volume requirement.

The ACS has a strong commitment to improving safe surgical care within the context of evidence-based knowledge. This decision was made in an effort to support, strengthen, and expand the evidence base of new and emerging surgical procedures while ensuring the delivery of high-quality patient care.

To learn more about the ACS BSCN Accreditation Program, visit www.acsbscn.org.

ACS field-tests surgical CAHPS survey: General surgeons needed

The American College of Surgeons is sponsoring the development of a cross-surgical specialty version of the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey. CAHPS is the standard instrument for measuring patients’ health care experience and is used in public reporting and quality improvement efforts. It also has been endorsed by the American Board of Medical Specialties for purposes of Maintenance of Certification.

The College has contracted with the American Institutes for Research and Westat to develop and field-test a Surgical CAHPS survey and is actively recruiting general surgeons for participation. Practices participating in field testing will submit a list of eligible patients to Westat. All information collected will remain confidential, and no identifying information about the patient or the practice will be linked to the results. Patient information will be collected in a manner that complies with federal privacy standards. Upon completion of the study, interested participants will receive a brief report and comparative data.

To learn more about the Surgical CAHPS survey or to enroll in the field test, contact Caitlin Burley at cburley@facs.org or 202/672-1517.
2008 Japan and Germany Exchange Travelers announced

The International Relations Committee of the College has established an exchange program with the Japan Surgical Society and the ACS Japan Chapter. Earlier this year, Sam Wiseman, MD, FACS, FRSCS, of University of British Columbia, attended the annual meeting of the Japan Surgical Society in Nagasaki and visited several other Japanese surgical centers. The Japan Exchange Traveler, Tomoharu Yoshizumi, MD, PhD, of Saiseikai Fukuoka General Hospital, has been selected to attend the College’s Clinical Congress in San Francisco, CA, in October. He will give a presentation at the Congress and will tour several surgical institutions in North America. Dr. Yoshizumi specializes in living donor liver transplantation.

The German Surgical Society and the ACS Germany Chapter have also developed a similar exchange program with the College. ACS Fellow John F. Renz, MD, FACS, of University of Arizona, Tucson, attended the German Surgical Society’s annual meeting in Berlin in April and will visit additional surgical sites throughout Germany later this year. His German counterpart, Tobias Keck, MD, PhD, of University of Freiburg, will attend Clinical Congress and choose several surgical sites to visit with the guidance of his mentors at home and in the U.S. Dr. Keck’s research focuses on pancreatitis.
SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available online at www.acs-resource.org or on CD-ROM.

BASIC ULTRASOUND COURSE: This CD provides a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications and is available for CME credit.

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

DISCLOSING SURGICAL ERROR: This DVD demonstrates two approaches used to disclose to a patient’s family a major technical error. This project was supported by a grant from the Agency for Healthcare Research and Quality and is available at no cost.

COMMUNICATING WITH PATIENTS: This DVD addresses the essential principles of communicating with patients about surgical errors and adverse outcomes. Three vignettes demonstrate critical concepts for understanding and approaching these conversations. This project was supported by a grant from the Agency for Healthcare Research and Quality and is available at no cost.

PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons: This interactive CD provides a debt management and financial planning for surgical practice. This program provides a printable CME certificate upon successful completion.

PRACTICE MANAGEMENT for Residents and Young Surgeons: This series of three CDs covers important topics such as mechanics of setting up or running a private practice, essentials of an academic practice and career pathways, and basics of surgical coding. This program provides a printable CME certificate upon successful completion.

BARIATRIC SURGERY PRIMER: This CD addresses various aspects of bariatric surgery, including the biochemistry and physiology of obesity, appropriate candidates, and basic bariatric procedures.

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

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

For more information, contact Olivier Petinaux, MS, at elearning@facs.org, or 866/475-4696.
Richard J. Bold, MD, FACS, medical director of the University of California–Davis Cancer Center Clinics, Sacramento, has been selected as the 2009 Australia and New Zealand (ANZ) Chapter of the ACS Travelling Fellow.

As the Travelling Fellow, Dr. Bold will participate in the annual Scientific Congress of the Royal Australasian College of Surgeons in Brisbane, Australia, May 6–9, 2009. He will attend the ANZ Chapter meeting during that congress and will then travel to several other surgical centers in Australia and New Zealand. Dr. Bold has published on the basic science aspect of pancreatic cancer, investigating the molecular mechanisms of resistance to chemotherapy-induced cell death.

The application deadline for the 2010 ANZ Travelling Fellowship is November 15, 2008. The requirements for the 2010 Travelling Fellowship will appear in a future issue of the Bulletin and will be posted on the College’s Scholarships Web page, [http://www.facs.org/memberservices/research.html](http://www.facs.org/memberservices/research.html).

Fundamentals of Laparoscopic Surgery (FLS)—a joint educational program of the Society of American Gastrointestinal and Endoscopic Surgeons and the American College of Surgeons—has received a $1.8 million grant from Covidien to launch the Covidien Educational Fund. The fund will be used to support surgical residency and fellowship training by providing an opportunity for surgeons-in-training to use the FLS program to study and validate their basic skills in laparoscopy before going into clinical practice. A comprehensive and validated educational module, the FLS program is designed to teach the physiology, fundamental knowledge, and technical skills required in basic laparoscopy that allow practice in a safe environment without putting patients at risk. The Covidien Educational Fund will allow the FLS program to be provided to more than 250 surgical residency programs in the U.S. and Canada, reaching thousands of surgeons-in-training. Recipient programs will receive the didactic content, a FLS trainer box with manual skills training accessories, and test vouchers with access to regional or on-site FLS-proctored testing. For more information, visit [http://www.flsprogram.org](http://www.flsprogram.org) or call 310/437-0544, ext. 130.

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The Executive Committee on Video-Based Education and Ciné-Med have developed the interactive *Multimedia Atlas of Surgery*. Each volume presents a comprehensive list of surgical procedures, featuring:

- Narrated surgical video
- Didactic presentations
- Medical illustrations
- Expert commentary
- Foreword by Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, American College of Surgeons

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- Individual chapters: $35 each (CD-ROM) $20 each (1-year online subscription)
ACS resident research scholarships available

The American College of Surgeons is offering two-year resident research scholarships for July 2009 through June 2011. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty. American College of Surgeons’ Resident Research Scholarships are supported by the generosity of Fellows, chapters, and friends of the College to encourage residents to pursue careers in academic surgery.

The Ethicon Scholarship of the American College of Surgeons for the Study of Surgical Wound Healing is funded by a grant from Ethicon Inc. to encourage residents to pursue careers in academic surgery. The scholarship is intended primarily to stimulate interest in the healing of soft tissue and minimally invasive surgery. Proposals may include the biology of wound repair, complications of wound repair, or the application of new technologies to clinical problems.

Wyeth Pharmaceuticals has provided an unrestricted educational grant to the ACS to fund a Resident Research Scholarship. The purpose of the scholarship is provide two years of laboratory experience to residents performing surgical research related to biological and physiological aspects of inflammation.

General policies

The policies for granting of the American College of Surgeons Resident Research Scholarships are as follows:

- The applicant must be a Resident Member of the College who has completed two postdoctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarship is awarded (July 1, 2009) and shall not complete formal residency training before June 2011. Scholarships do not support research after completion of the chief residency year.
- The scholarship is awarded for two years, and acceptance of it requires commitment for the two-year period. The award is to support a research plan for the two years of the scholarship, July 2009 through June 2011. Priority will be given to the projects of residents involved in full-time laboratory investigation. Study outside the U.S. or Canada is permissible. Renewal of the scholarship for the second year is required and is contingent on the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Section of the College by May 1, 2010.

Application for these scholarships may be submitted even if comparable application to other organizations has been made. If the recipient accepts a scholarship/fellowship from another agency or organization, the ACS Resident Research Scholarship will be withdrawn. It is the responsibility of the applicant to notify the Scholarships Section of competing awards.

- The scholarship is $30,000 per year; the total amount is to support the research of the recipient and is not to diminish or replace the usual or expected compensation or benefits of the recipient. Indirect costs are not paid to the recipient or to the recipient’s institution.
- The scholar is expected to attend the Clinical Congress of the American College of Surgeons in 2011 to present a report on the research as part of the Forum on Fundamental Surgical Problems and to receive a certificate at the annual meeting of the Scholarships Committee.
- Approval of the application is required from the administration (dean or fiscal officer) of the institution. Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor who will be supervising the applicant’s research should be submitted. Only in exceptional circumstances will more than one scholarship be granted in a single year to applicants from the same institution.

The closing date for receipt of completed applications and all supporting documents is September 1.

Application forms may be obtained
The Triological (TRIO) Society and the American College of Surgeons announce a call for proposals. The TRIO/ACS competitive grant program will provide supplemental funding to otolaryngologists–head and neck surgeons who receive a new Mentored Clinical Scientist Development Award (K08/K23) from the National Institutes of Health (NIH) in 2009. Previously submitted applications and previously granted awards are not eligible for consideration.

**Purpose:** The ACS and TRIO are offering these awards as a means to facilitate the research career development of otolaryngologists–head and neck surgeons, with the expectation that awardees will have sufficient pilot data to submit a competitive R01 proposal before the conclusion of the K awards.

**Eligibility requirements:** Each applicant must be a MD otolaryngologist–head and neck surgeon and a Fellow or Associate Fellow of the ACS. Applicants must meet all requirements set forth in the NIH K08 and K23 application criteria and must be recipients of a new K08 or K23 award effective 2009.

**Mechanism of support:** Awards will use the K08 or K23 mechanisms. Planning, direction, and execution of the program will be the responsibility of the candidate and his or her mentor on behalf of the applicant institution. The project duration will be for a minimum of three years and no more than five years. Awards are not renewable.

**Research objectives**

**Environment:** The institution must have a well-established research and clinical career development program and qualified faculty in clinical and basic research to serve as mentors. The institution must be able to demonstrate a commitment to the development of the awardee as a productive, independent investigator. The awardee, mentor, and institution must be able to describe a multidisciplinary career development program that will maximize the use of relevant research and educational resources.

**Program:** The award provides three to five consecutive 12-month awards. At least 75% of the recipient’s full-time professional effort must be devoted to the program and the remainder devoted to other clinical and teaching pursuits consistent with the objectives of the award.

**Mentors:** The recipient must receive appropriate mentoring throughout the program.

**Allowable costs**

**Salary support:** The ACS, in conjunction with TRIO, will provide salary and fringe benefits for the NIH K08/K23 recipient. The sponsoring institutions will award a combined total of up to $80,000 per year in direct costs to the institution of the awardee.

The institution may supplement the salary of the recipient up to a level that is consistent with the institution’s salary scale. Institutional supplementation of salary must not require extra duties or responsibilities that would interfere with the purpose of the Mentored Clinical Scientist Development Award.

The ACS and TRIO will not reimburse indirect costs or institutional overhead.

**Application procedures:** Applications should conform to the guidelines published for the NIH Mentored Clinical Scientist Development Award (K08) or Mentored Patient-Oriented Research Career Development Award (K23). Visit [http://grants.nih.gov/training/careerdevelopmentawards.htm](http://grants.nih.gov/training/careerdevelopmentawards.htm) for details.

upon request from: Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211 or by visiting [http://www.facs.org/member_services/acsresident.html](http://www.facs.org/member_services/acsresident.html)
Applications are to be submitted on form PHS 398 and will be accepted on or before the receipt deadline of October 12, 2008. Forms are available at most institutional offices of sponsored research and from the Division of Extramural Outreach and Information Resources, National Institutes of Health, 6701 Rockledge Dr., MSC 7910, Bethesda, MD 20892-7910; phone 301/435-0714; fax 301/480-0525. The forms are also available at http://grants.nih.gov/grants/funding/phs398/phs398.html.

In addition to the copies required by the NIH, a copy of all application materials must be sent to the ACS Scholarships Administrator by the October 12 deadline in order to be eligible for the award. Send the materials to Scholarships Administrator, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; for more information, call 312/202-5281 or e-mail Kate Early at kearly@facs.org.

Review considerations: Applications that have been approved for funding by NIH will receive a secondary review by a committee of ACS and TRIO representatives. Applicants approved for funding by NIH will be asked to furnish a copy of their NIH summary statement for review by the ACS and TRIO review committee.

Award process: The ACS Scholarships Administrator will notify applicants of the decision of the selection subcommittee regarding the supplemental funding.

The Clowes ACS/AAST/NIGMS Mentored Clinical Scientist Development Award available

The American College of Surgeons and the American Association for the Surgery of Trauma (AAST) announced a program that will provide supplemental salary funding of up to $75,000 per year to an individual who has received a Mentored Clinical Scientist Development Award (K08/K23) from the National Institute for General Medical Science (NIGMS). This award is directed at surgeon-scientists working in the early stages of their research careers and supports a three-, four-, or five-year period of supervised research experience that may integrate didactic studies with laboratory or clinical research.

This award program offers a means to facilitate the career development of individuals pursuing careers in trauma surgery research by enhancing salary support over and above that offered by the K08/K23 mechanism.

The application deadline is October 12. To apply, submit the complete K08 or K23 application simultaneously to NIGMS and to Kate Early, the ACS Scholarships Administrator. Previously submitted applications and previously granted awards are not eligible for consideration. If applicants receive a K08 or K23 from NIGMS, their applications will undergo further review by special committee for prospective supplemental funding. Funding begins July 1, 2009.

Awardees must be members in good standing of the College and eligible for membership in AAST. For further details, visit http://www.nigms.nih.gov/ or e-mail Ms. Early at kearly@facs.org.

Corrections

- On page 24 of the June 2008 Bulletin, in the “Socioeconomic tips” column, the answer to the question “What is the correct way to code for sentinel lymph node biopsy if done concurrently with initial modified radical mastectomy?” was erroneously provided as “code 19305”—it should have been “19307.” 19305 is the radical mastectomy code; 19307 is the modified mastectomy code.
- On page 40 of the June 2008 Bulletin, Sam C. Wang, MD, is incorrectly identified as a resident in neurosurgery at the University of California, San Francisco. Dr. Wang is a resident in general surgery at the university.
Surgeons who perform cancer surgery work closely with their pathologists. Our preoperative planning requires accurate assessment of tissue diagnosis. Our resected specimens are sent for final histopathological diagnosis, tumor grading, margin assessment, and clinicopathological staging. Expression of specific biomarkers in the resected primary tumor is also assessed. Breast surgeons are familiar with receptor expression in breast cancer; urologists follow prostate-specific antigen tests and gastrointestinal surgeons order carcinoembryonic antigen tests for their colorectal cancer patients.

Because of advances in laboratory pathology technologies and newly targeted agents, the number of diagnostic tests for a surgeon to request is accelerating. For primary breast cancer, there are gene-expression profiling (Oncotype Dx, Mammoprint) for prognosis, immunohistochemical detection of micrometastases in sentinel lymph nodes, and now GeneSearch intraoperative reverse transcriptase-polymerase chain reaction (PCR) detection of micrometastases in sentinel lymph nodes. Laboratory investigations in clinical trials are studying novel expression profiles that will predict the response of estrogen receptor-positive breast cancer to antihormonal therapy.

Mutations of a specific gene in the primary tumor is also an important diagnostic test in a resected tumor. Gastrointestinal stromal tumors (GIST) are known to overexpress c-kit and a specific agent, imatinib (Gleevec®), inhibits the tyrosine kinase of c-kit, resulting in tumor regression. Ron Matteo, MD, FACS, presented the results of the American College of Surgeons Oncology Group (ACOSOG) Z9001 trial in 2007. This is a phase III, double-blinded, randomized adjuvant trial of one year placebo versus imatinib in patients with R0/R1 >3 cm resected GIST. This trial showed that imatinib taken for one year after complete resection of GIST significantly increased recurrence-free survival (RFS).

In addition to discovering improved RFS, there is an important laboratory investigation. ACOSOG conducted a parallel trial, Z9000, which was a phase II trial of adjuvant imatinib for one year in 106 patients who had a complete resection of >10 cm resected GIST. It turns out that the c-kit gene in GIST can have different mutations. These mutations are detected by PCR analysis and are found in exon 11, exon 9, platelet-derived growth factor receptor, or wild type. Dr. DeMatteo correlated these mutations with recurrence-free survival in the 106 patients of Z9000 and recently reported the results in 2008. He found that while imatinib suppressed tumor recurrence during the one year of adjuvant therapy, those patients whose GIST had the exon 9 mutation had a much higher recurrence rate compared with the other mutational types.

ACOSOG Z9000 showed that mutations of the target (c-kit) may affect response to an agent such as imatinib. This finding is also being observed in other tumor types such as colorectal cancer. Inhibitors of epidermal growth factor receptor (EGFR) are available. Mutational analysis of k-RAS gene has shown that tumors with a k-RAS mutation have a lower response to EGFR inhibitors compared with wild type. These mutation findings are already being incorporated into postoperative adjuvant chemotherapy trials for colorectal cancer.

Thus, surgeons now have a multitude of biomarkers to request when resected specimens are sent to pathology. Tumor
diagnostics will continue to expand as more targeted anticancer therapies make their way through the clinical trials pipeline. These diagnostics will be specific for tumor type and systemic therapy and surgeons will likely become more involved in ordering such tests in diagnostic biopsy tissue or resected specimens.

Because ACOSOG is a surgeon-oriented cooperative group with an emphasis on tissue collection, future trials will incorporate diagnostic tests into a trial design. The c-kit and k-RAS mutation studies will be used to design the future therapeutic trial.

Your participation in ACOSOG trials will bring you and your patients closer to these novel molecular diagnostics and therapeutics.

References


Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG co-chairs.
The American College of Surgeons’ online job bank

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

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

Candidates:
- View national, regional, and local job listings 24 hours a day, 7 days a week—free of charge.
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A look at The Joint Commission

Updated Universal Protocol clarifies requirements

The Joint Commission’s updated Universal Protocol and 2009 National Patient Safety Goals and related requirements for all accreditation programs have been released. The goals were first introduced in 2003 to promote specific improvements in patient safety. They highlight problematic areas in health care and describe evidence and expert-based solutions to these problems. Compliance with these goals and requirements is a condition of continuing accreditation and certification. Organizations are assessed for compliance at the time of survey, and the results are posted on their public quality report at www.qualitycheck.org.

The full text of the Universal Protocol and the 2009 goals and requirements for all programs, along with the implementation expectations, is now available on The Joint Commission’s Web site at www.jointcommission.org.

Each year, the Sentinel Event Advisory Group—an expert panel that includes widely recognized patient safety experts, nurses, physicians, pharmacists, risk managers, and other professionals who have hands-on experience in addressing patient safety issues in hospitals and other health care settings—works with The Joint Commission to undertake a systematic review of the literature and available databases to identify new goals and requirements. The revised goals are announced mid-year, and implementation for most goals begins January 1 of the following year.

Major changes for 2009 include three new hospital and critical access hospital requirements related to preventing deadly health care-associated infections caused by multiple drug-resistant organisms, central line-associated bloodstream infections, and surgical site infections. These additions build on an existing goal to reduce the risk of health care-associated infections and recognize that patients continue to acquire preventable infections at an alarming rate within hospitals. The new requirements related to central line-associated bloodstream infections also apply to ambulatory care facilities and office-based surgery practices. In addition, prevention of surgical site infections will be a new goal for ambulatory care facilities and office-based surgery practices. The new requirements have a one-year phase-in period that includes defined milestones, with full implementation expected by January 1, 2010.

Other changes to the goals include a requirement to eliminate transfusion errors related to patient misidentification in hospitals, critical access hospitals, ambulatory care facilities, and office-based surgery practices; there is also new language related to existing requirements for improving the safety of medications and medication reconciliation across most accreditation programs.

Several requirements for the Universal Protocol to prevent errors in surgical and non-invasive surgical procedures also were clarified for 2009, and the introductory material was incorporated into rationales for each of the Universal Protocol requirements. These changes—which address topics such as marking the site, alternatives for patients who refuse site marking, and conducting a time-out immediately before starting the procedure—were based on feedback received at the Wrong Site Surgery Summit in 2007 in Rosemont, IL. The Universal Protocol is used by hospitals, critical access hospitals, disease-specific care organizations, ambulatory care facilities, and office-based surgery practices.

Questions about complying with the goals and the Universal Protocol may be directed to The Joint Commission’s Standards Interpretation Group at 630/792-5900. For a response by e-mail, go to www.jointcommission.org, select “standards,” and then select “Online Question Form.”
Recognizing the goal of offering members of the American College of Surgeons and affiliated organizations a reasonably priced investment product, the expense ratio of the College’s Surgeons Diversified Investment Fund (SDIF) has been lowered to just over 1%. The lower expense ratio will have an immediate positive impact on our shareholders, and, over time, will positively impact the performance returns for prospective and current shareholders. The new expense ratio, including ETF costs, is 1.08%.

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An investor should consider the charges, risks, expenses and investment objective carefully before investing. For more information or for a free copy of the prospectus, please download a copy at www.surgeonsfund.com or call 1-800-208-6070 and a copy will be mailed to you.

Read the prospectus carefully before you invest or send money.

SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246. The phone number is 513-587-3400.
NTDB® data points

Uncovered and underpaid

by Richard J. Fantus, MD, FACS

We are in the midst of a Presidential election and the final answer for the next four years is right around the corner. Unfortunately, most of the rhetoric during the primaries has been bickering among the candidates as opposed to addressing the real issues, including the looming public health crisis: the continually growing number of Americans without health insurance.

Annual census bureau estimates for 2006 revealed that there were 47 million people (almost 16 percent of the U.S. population) without health insurance. The number of uninsured Americans has increased 22 percent since 2000. It is getting harder for working people to get insurance.

A large number of the young workforce is in entry-level jobs that do not provide health care benefits. In fact, the number of uninsured full-time workers rose to a staggering 22 million in 2006 (http://www.census.gov/hhes/www/hlthins/hlthin06.html).

In order to examine the occurrence of patients without health care coverage in the National Trauma Data Bank® Dataset 7.1, records were searched by the “self-pay” payment type. Out of 1,926,245 incidents, there were 278,473 incidents where the payment type was self-pay—approximately 15 percent of the total incidents. Among the self-pay records, there were 253,336 records that had discharge status recorded, including 214,023 discharged to home, 18,082 to acute care/rehabilitation, 3,119 to nursing homes, and 3,046 to jail; 15,066 died. (These data are displayed in the graph on this page.)

The patients were 78.1 percent male and on average 32.4 years of age, with an average length of hospital stay of 4.2 days and an average injury severity score of 9.6. Of those also tested for alcohol, 40 percent tested positive and of those tested for drugs, more than half tested positive.

Health care is often considered a right, not a privilege. Individuals in all walks of life, of all ages, of all races, and of all colors should have health care and proper coverage. As one goes to the polls this fall, it is incumbent upon him or her to cast a vote in a way that will improve the state of health care for all. The current system is not sustainable, the American people cannot continue to be uncovered, and the health care system cannot continue...
to be underpaid.

The full NTDB Annual Report Version 7.0 is available on the ACS Web site as a PDF 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.

**Acknowledgment**

Statistical support for this article has been provided by Sandra M. Goble, MS.

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**Dr. Fantus** is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago, IL. He is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.

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**AMERICAN COLLEGE OF SURGEONS • DIVISION OF EDUCATION**

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**Intended audience:** Surgical residents and surgeons recently in practice.

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

(Additional $16 for shipping and handling of international orders.)

Orders may be placed through ACS Customer Service at 312/202-5474 or via the College’s Web site at: [www.acs-resource.org](http://www.acs-resource.org)

For more information contact Olivier Petinaux, MS, at elearning@facs.org or tel. 866/475-4696
Chapter news

by Rhonda Peebles, Division of Member Services

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

Tennessee Chapter joins NSQIP efforts

Last April, the Tennessee Chapter’s organizational and negotiation efforts, which began in 2006, culminated in the formation of the Tennessee National Surgical Quality Improvement Project (NSQIP) Surgical Quality Consortium. Other members of the NSQIP Consortium are the BlueCross and BlueShield (BCBS) of Tennessee Health Foundation and the Tennessee Center for Patient Safety of the Tennessee Hospital Association. The NSQIP Consortium is funded with a three-year grant from the BCBS Tennessee Health Foundation. The hospitals that will participate in the NSQIP program will be selected this summer, and surgeon-champions at three Tennessee hospitals will serve as mentors for the new participating hospitals and physicians.

Indiana Chapter convenes at state capital

The Indiana Chapter convened at the Indiana University–Purdue University Indianapolis medical campus for its annual meeting April 25–26. This year’s education program was arranged by Don J. Selzer, MD, FACS. The keynote address was presented by Alfons Pomp, MD, FACS, and the ACS Update on Value-Based Purchasing presentation was delivered by Frank Opelka, MD, FACS. In addition, the following five residents won this year’s residents competition (see photo, this page):

• Ahmed Halal, MD: Isoperistaltic Right Colon Interposition with Ileocolic Artery and Vein “Supercharging” for Long-Segment Esophagogastric Reconstruction
• Jesus Matos, MD,* Novel Model of Alcohol-Induced Hepatomatocellular Carcinoma
• Micah Smith, MD: Non-reformatted CT Scanning of the Abdomen and Pelvis As a Screening Tool for Significant Thoracolumbar Injury Resulting from Blunt Trauma
• Terence Wade, MD: Adiponection Obesity and Steatopancreatidis: Fat Matters
• Benjamin Williams, MD: Ten-Year Retrospective Study of Delayed Diagnosis of Injury in Pediatric Trauma Patients

Scanning of the Abdomen and Pelvis As a Screening Tool for Significant Thoracolumbar Injury Resulting from Blunt Trauma

The Indiana Chapter leaders also recognized Executive Director Carolyn Downing for more than 20 years of service to the chapter and presented her with a diamond necklace (see photo, this page).

Merger completed in Minnesota

In April, the Minnesota Chapter and the Minnesota Surgical Society completed their merger. The name of the new organization is

*Denotes Associate or Resident Membership in the College.
the Minnesota Surgical Society—A Chapter of the American College of Surgeons. The officers of the new organization include (all MD, FACS) David Farley, President; Kevin John Bjork, Treasurer; and David Dries, President-Elect. Ms. Jamie Burbidge continues to serve as Executive Director.

**Ohio Chapter holds annual meeting**

On May 9–10, the Ohio Chapter conducted its annual meeting in Columbus. During the two-day education program, various residents presented results of research projects; a session on communication skills to reduce risk exposure also was presented. The chapter decided at this meeting to proceed with creating a new patient education newsletter and forming a development committee that would focus on securing financial support from chapter members and industry.

With regard to the chapter’s advocacy efforts, it was agreed that up to $12,000 would be spent during the upcoming statewide elec-

### Chapter meetings

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

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

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<th>Date</th>
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<tr>
<td>August 2008</td>
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| August 19–22| Colombia | Location: Convention Center, Bogota, Colombia  
Contact: Francisco Henao, MD, FACS, 571/236-2831, fhenao@javeriana.edu.co |
| August 22   | Oklahoma | Location: University of Oklahoma Health Sciences Center, Oklahoma City, OK  
Contact: Jeffrey S. Bender, MD, FACS, 405/271-5781, Jeffrey-bender@ouhsc.edu  
ACS representative: Thomas V. Whalen, MD, FACS |
| August 23–24| Georgia (CS) | Location: Emory Conference Center Hotel, Atlanta, GA  
Contact: Lois Shinall, 912/667-6000, loisshinall@aol.com |
| September 2008 |          |                                                                                              |
| September 6–7| Kansas (CS) | Location: Airport Hilton, Wichita, KS  
Contact: Gary Caruthers, MBA, 785/235-2383, gcaruthers@kmsonline.org |
| September 20 | Arkansas (CS) | Location: Crowne Plaza, Little Rock, AR  
Contact: Linda Clayton, 501/753-3500, claytonlindaa@uams.edu |
| October 2008 |          |                                                                                              |
| October 3–4 | Kentucky (CS) | Location: Marriott Griffin Gate, Lexington, KY  
Contact: Andrew Bernard, MD, FACS, 859/323-6346, acbern00@uky.edu  
ACS representative: J. David Richardson, MD, FACS |
| October 24–25 | Iowa | Location: To be determined, Iowa City, IA  
Contact: Sue Hyler, 515/270-3613, sue.hyler@pioneer.com |
| October 26  | Connecticut (CS) | Location: Holiday Inn Select, Waterbury, CT  
Contact: Christopher Tasik, 203/674-0747, info@ctacs.org |
tions. Finally, the Residents Liaison Committee reported on plans to increase communications with resident members and to invite them to participate in the chapter’s advocacy activities. (See photo, this page.)

**Illinois Chapter meets at state park**

The Illinois Chapter held its 2008 annual meeting at the Pere Marquette State Park in Grafton, IL. This year’s program was planned by Keith R. Thomae, MD, FACS, the new Chapter President. During the education event, several residents participated in the annual competition (see photo, this page).

In addition, the Illinois Chapter leaders recognized Carolyn Koch, Chapter Administrator, for her 25 years of service (see photo, this page). Finally, the chapter leaders bestowed honorary chapter membership on Ms. Koch and Rhonda Peebles of the ACS Division of Member Services.

### Chapter anniversaries

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<td>Rhode Island</td>
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Ohio Chapter officers, left to right (all MD, FACS): Michael D. Sarap, President-Elect; Linda Barney, Immediate Past-President and Governor; Christopher McHenry, President; and Amy Reed, Secretary.

Illinois Chapter winning residents, left to right: Franziska Huettner, MD,* and E. Dawn Wietfeldt, MD; James W. Thiele, MD, FACS, presented the awards.

Illinois Chapter, left to right: Daniel Johnson, MD, FACS, Immediate Past-President; Max Hammer, MD, FACS, Governor; Ms. Koch; Jim Koch; Lynne Jalovec, MD, FACS, Governor; and Lorin Whittaker, MD, FACS, Governor.
2. Ask to see a copy of the fee schedule before signing the contract. If not required by law to provide a copy, the insurer may still be willing to share it, or at least a list of the most common codes for the specialty, if asked.

3. Deal with the contract in a timely manner. Waiting until the signing deadline before reviewing it is not a successful business strategy and may result in being stuck in an unhappy situation.

4. Find out what the contract process involves and if state law provides any protections. Legal counsel should be able to assist with obtaining that information as part of the contract review, and the state medical society may have a handy contracting guidebook reflecting current state law.

5. Complaints about insurer contracting practices may be filed with a state department of insurance or the attorney general’s office and may be helpful in demonstrating a potential pattern of abuse. State medical society reimbursement or third-party payor committees also want to hear from physicians and may be able to facilitate a solution to a payment or contract issue.

6. Educate personal legislators and engage in advocacy on reform measures to address fairness and transparency. This advocacy might include encouraging the state chapter of the ACS and the state medical society to address the issue.