Redesigning U.S. health care:

Statement on Health Care Reform
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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.
Most Americans—regardless of whether they are physicians, patients, policymakers, or leaders in the private sector—agree that the current health care delivery system is unsustainable and dysfunctional. Throughout this decade, both government-run and private insurers have implemented policies and programs intended to address the system’s inability to ensure patient access to quality medical and surgical care and to limit spending.

The demand for reform is intensifying. Indeed, in light of the nation’s economic worries—the government-funded bailout of lending institutions, a roller coaster stock market, and increased unemployment—the government is likely to intensify its efforts to uncover sources of wasteful spending and to seek entirely new methods of providing health insurance coverage for all U.S. citizens. In fact, some experts believe that the questions of universal health insurance and the reform of our health care system will become the focus of intense national debate shortly after the inauguration of President-Elect Barack Obama early next year.

Never has the time been so ripe for physicians and other stakeholders to become actively involved in determining how to transform our health care system. As one of the nation’s largest medical associations, the American College of Surgeons recognizes its acute obligation to help policymakers understand what changes should occur to improve care for surgical patients in this country.

I am pleased to report that the ACS Health Policy Steering Committee answered this charge by drafting a Statement on Health Care Reform, which outlines actions the College urges Congress and the incoming Presidential Administration to take concerning three critically important and interrelated goals for health care: quality and safety, access/workforce, and reduction of health care costs. The document sets forth for each of these priorities specific actions that the U.S. government should support, as well as related activities that the ACS is committed to undertaking.

The Board of Regents reviewed the draft document during its meeting just before the 2008 Clinical Congress, and it was shared with and reviewed by members of the ACS Board of Governors who were in attendance at a first-ever joint meeting of the Regents and Governors. Soon after it received final approval, we released the College’s Statement on Health Care Reform to our members and to all other interested parties. It is printed on pages 5–9 of this issue of the Bulletin.

The College anticipates that this statement will be a useful starting point for further negotiation and for the elucidation of ideas from the broad range of stakeholders. In other words, the College’s leadership views the Statement on Health Care Reform as simply one step in our efforts to effectively collaborate with patients, payors, other providers, and the business sector to create a better health care system—one grounded in the principles of quality, patient safety, efficiency, and equitable access to care.

Thomas R. Russell, MD, FACS

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

The American College of Surgeons (ACS) is an organization of 74,000 surgeons from all surgical specialties who perform more than 30 million operations in the U.S. on an annual basis. The ACS was founded in 1913 and is dedicated to high-quality, safe surgical care delivered in a compassionate, ethical manner. The American College of Surgeons appreciates the challenges facing the U.S health care system. It believes that the time has come to move beyond rhetoric and to start taking action to improve on the three critical and interrelated areas of concern:

1. Quality and safety
2. Access/workforce
3. Reduction of health care costs

The College also believes that achieving these goals will require all stakeholders to work together in order to build a better U.S. health care delivery system.
QUALITY AND SAFETY

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.

—Mission statement of the American College of Surgeons

With this mission driving all of its activities, the ACS believes that providing safe and effective quality surgical care will also help reduce the cost of health care delivery; the College also believes that efforts to reduce costs should be similarly linked to quality improvement efforts.

* Improve the quality of care for patients with surgical diseases

The American College of Surgeons urges Congress and the Administration to support:

1. Research and financial aid to encourage the adoption of risk-adjusted outcomes of surgical care such as those developed by the National Surgical Quality Improvement Program (NSQIP) and to promote transparency of quality measurement.

2. Efforts to ensure available and appropriate care to prevent, detect, and treat cancer, vascular disease, and other surgical diseases at the earliest stage possible and to deliver well-coordinated care for patients across the health care continuum. Increased funding for research to prevent these diseases should also be supported.

3. Increased funding for wellness programs with an emphasis on personal responsibility.

4. Funding for injury prevention and trauma systems that provide well-coordinated care for trauma patients across the health care continuum.

5. Increased preparedness for mass casualties and disasters.

6. Adoption of fully deployed, interoperative, integrated and coordinated Health Information Technology (HIT) systems featuring care and safety prompts. Help for surgeons in shouldering the financial burden of adopting such systems should be supported.

The American College of Surgeons commits to:

1. Taking steps to help the *individual* surgeon easily measure his or her quality and to enable surgeons to report their quality data to other institutions, the boards, and the public.

2. Improving cancer and trauma care by coordinating data collection with enhanced feedback and reporting to hospitals, individual providers, patients, and the public.

3. Taking strategic steps to ensure that the National Surgical Quality Improvement Program (NSQIP) becomes a quality measurement leader for surgical patient care.

4. Providing educational programs to assist surgeons in developing the professional competencies and clinical skills they must demonstrate to attain and maintain board certification and licensure.

5. Refining and reorganizing ACS educational resources to better equip the surgeon across the surgical care continuum with regard to the delivery of quality care and the measurement of quality, health care efficiency, clinical skills, and other factors related to quality.

6. Pursuing continued development of educational and programmatic efforts for trauma and cancer care by the ACS Committee on Trauma and the Commission on Cancer.

7. Promoting further expansion of the Advanced Trauma Life Support (ATLS) course, Pre-Hospital Trauma Life Support (PHTLS) course, and Rural Trauma Team Development Course (RTTDC) to reduce the cost, morbidity, and mortality due to trauma.

8. Partnering with Congress to direct resources to aid adoption of electronic medical records and other health information technology (such as e-prescribing) into surgical practice.
The American College of Surgeons urges Congress and the Administration to support:

1. The development and testing of surgical and other patient-safety initiatives in partnership with the ACS and the surgical community that will reduce medical errors, improve safety, provide patients with higher-quality care, and potentially reduce the incidence of medical liability cases.

2. Testing of established safety initiatives for validity and effectiveness, with the goal of increasing safety while reducing the cost of unnecessary, repetitive, or redundant processes and regulations.

3. The development or adoption of evidence-based guidelines and pathways, as well as promotion of those guidelines and pathways into clinical practice.

4. Legal protection of improvements in surgical quality efforts, including continued protection of peer-review and quality improvement processes from discoverability.

The American College of Surgeons commits to:

1. Pursuing the development and adoption of surgical patient-safety initiatives and the testing of safety initiatives for validity and effectiveness.

2. Continuing the development and adoption of quality and safety measures to eliminate medical errors.

3. Developing and supporting the adoption of guidelines and compliance measures for surgeons and other health care professionals that will reduce medical errors, provide patients with higher-quality and safer care, and potentially reduce the incidence of medical liability cases.

4. Developing and promoting patient education programs surgeons can use to improve communications with patients and their families and involve them in joint decision making regarding their care. Such programs should foster a better understanding of surgical diseases and their management and should help to improve the health literacy of patients and their families.

5. Assisting surgeons in learning techniques such as improved, open communication and open acknowledgment of mistakes in geographic areas where federal and state liability laws encourage and support such disclosure.

6. Developing policy statements on patient safety standards outlining support for safety mechanisms and efforts by the surgical team to protect patients.

• Improve safety and reduce medical errors and adverse events
The American College of Surgeons urges Congress and the Administration to support:

1. The elimination of disparities in the availability and delivery of surgical and other health care in America—for example, expanding the National Health Service Corps to include surgeons as a means of increasing public service and providing medical school debt relief.

2. Increased funding for and national awareness of graduate surgical medical education and other programs in order to maintain an optimal surgical workforce and to promote retention of surgeons.

3. The establishment of demonstration projects that explore alternative methods of paying for health care and that ensure the presence of an adequate and robust surgical workforce over time. Surgical care is an essential component across the full spectrum of the health care continuum. Surgeons, with their unique expertise and training, are not interchangeable with other physicians.

4. Options to improve access to surgical care by reducing liability costs through such means as alternative compensation mechanisms for adverse events.

5. Funding for the creation of a national health workforce database to identify areas of need as the nation faces an impending crisis of a surgical workforce shortage.

The American College of Surgeons commits to:

1. Providing educational programs to address new paradigms of surgical specialists and the delivery of surgical care in order to ensure that there is an adequate workforce to supply high-quality care through the changing delivery system in this country.

2. Focusing research and advocacy efforts in order to gain an understanding of the challenges that exist in attempting to ensure the availability of a sufficient, yet flexible, surgical workforce that will provide equitable access to quality and timely health care.

3. Developing systems to eliminate disparities in the availability and delivery of surgical and other health care in America.

4. Conducting research on the adverse impact of the declining surgical workforce, focusing on rural and underserved hospitals and providing analysis for the national health workforce database.

5. Providing educational outreach and respite support for surgeons practicing in rural and underserved areas in order to maintain a surgical workforce in these areas.
The American College of Surgeons urges Congress and the Administration to support:

1. A focus on reducing the payor waste and inefficiency that currently characterizes the health insurance industry in this country. The College also supports enhancing administrative simplicity, reduction of administrative overhead, and provision of incentives to do so.

2. The concept of shared savings within surgery in situations where it benefits patients and reduces cost.

3. Research on the development or adoption of evidence-based, value-driven care algorithms to promote appropriate care for surgical diseases.

4. Research focused on the comparative effectiveness of the treatment of surgical patients as well as an assessment of technology in providing that treatment. This research should include comparable cost/benefit ratios across the range of potential treatment options, including cost utility analyses and incremental cost-effectiveness considerations.

5. Funding for research on patient shared decision making regarding surgical care and enhanced patient education. A major focus on health literacy is necessary.

6. Patient- and family-centered care that focuses on information exchange, understanding, and a joint decision process at all levels of care to ensure that patients and their families are engaged, educated, and consulted in health care decisions.

7. The development of educational and support programs for health care providers on the importance of palliative care and when to utilize those programs for the patient's benefit in order to lessen harmful, painful, costly, and unnecessary procedures and testing of patients with life-limiting illnesses.

The American College of Surgeons commits to:

1. Assessing, developing, and promulgating guidelines for surgical disorders leading to cost-effective care of the patient with surgical disease, so that care is optimized and coordinated across the full spectrum of health care.

2. Developing, maintaining, and educating a surgical workforce that is responsive to public demands for outcome and cost data and committed to providing cost-effective, safe, quality care with maximum value.

3. Actively participating in projects that define quality and cost of health care delivery for major categories of surgical diseases or procedures, assist in prioritizing components that improve the quality and safety of care, and reduce administrative overhead.

4. Seeking endorsement from the Agency for Healthcare Research and Quality (AHRQ) of the surgical Consumer Assessment of Health Providers and Services (CAHPS).

5. Developing and promulgating patient education materials, Web-based resources, and other educational material to assist the surgeon in communicating with patients and their families and to fully involve patients and their families in the decision-making process regarding the surgical disease and its treatment.

6. Developing and adopting guidelines, educational resources, and tools for the care of patients with surgically related, life-limiting illnesses to address the dangers and costs of futile care, while addressing the physical, psychosocial, economic, and spiritual needs of patients and their families, with a focus on quality of life.

Reduction of Health Care Costs

Provision of high-quality, cost-effective, safe, and appropriate patient care will involve enhanced participation of patients in their own health care decision making, as well as the development of a payment mechanism that promotes quality and value. This effort should be inclusive of the need for available, appropriate, and compassionate palliative care for patients with life-limiting illnesses, including an understanding of all potential options.

The American College of Surgeons recognizes that payment reform that maintains a sustainable workforce needs to be accomplished in conjunction with overall health care reform. The ACS positions on Medicare payment reform are addressed in a separate document. Surgeons should be driven to eliminate waste and inefficiency wherever possible, including consideration of overuse, underuse, and misuse of services where identified.

The American College of Surgeons recognizes that payment reform that maintains a sustainable workforce needs to be accomplished in conjunction with overall health care reform. The ACS positions on Medicare payment reform are addressed in a separate document. Surgeons should be driven to eliminate waste and inefficiency wherever possible, including consideration of overuse, underuse, and misuse of services where identified.

DECEMBER 2008 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
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ETHICAL ISSUES IN CLINICAL SURGERY
Edited by Mary H. McGrath, MD, MPH, FACS

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Editor’s note: Because Fellows are able to receive timely updates on the College’s activities in Washington, DC, through the organization’s electronic news sources, the Bulletin will no longer feature “Dateline: Washington” as of January 2009. To stay informed about the College’s legislative and regulatory efforts, check your email weekly for ACS NewsScope and monthly for Advocacy in Action.

College hosts policy summit

On October 22, the American College of Surgeons and 13 surgical specialty societies met in Washington, DC, to discuss how the organizations can work together on health care reform and Medicare issues in the year ahead. Elizabeth Fowler, PhD, JD, Senior Counsel to Senate Finance Committee Chairman Max Baucus (D-MT), participated in the meeting, providing the legislative outlook for 2009. In addition, the specialty societies and the College discussed their legislative priorities and concerns. Specific issues raised during the summit included reforming Medicare’s payment system, promoting surgeon-led quality improvement efforts, and ensuring that payment reforms do not threaten patient access to surgical care. The societies expressed a consensus of support for the College’s proposal to replace the current sustainable growth rate method of calculating Medicare payments with a reimbursement structure based on type of service, including a category for major surgical procedures. For more information, contact sfriesen@facs.org.

New billing edits aimed at reducing errors

On October 1, the Centers for Medicare & Medicaid Services (CMS) began publishing recent changes to the medically unlikely edit (MUE) program, which is designed to reduce payment errors for Medicare Part B claims. Previous studies have identified significant Medicare overpayments resulting from repetitive reporting of a single service provided to one patient. These redundancies may be caused by numerous factors, including clerical errors and coding errors.

CMS first implemented the MUE program in January 2007, with edits for approximately 2,600 codes from the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT). The MUE program has been updated quarterly since then. The October 1 version contains edits for approximately 9,700 HCPCS/CPT codes; additional edits will be published on January 1, 2009. To access the new edits, go to http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage.

Check PQRI report availability

CMS recently announced that a new tool is available on the Physician Quality Reporting Initiative (PQRI) portal (http://www.qualitynet.org/pqri), which allows program participants to check on the availability of their 2007 feedback reports. Once on the site, participants should enter their tax identification number (TIN) in the “Verify TIN Report Portlet.” This service only allows physicians to check on the availability of their 2007 PQRI feedback report; it does not provide access to the actual report. To obtain that documentation, health care professionals must register for a special account. For more information about this process, go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf.
Lessons from victory and possibilities for reform:

A recent history of Medicare advocacy efforts

by Shawn Friesen,
Legislative Affairs Associate,
Division of Advocacy and Health Policy
It was a hot July day in Washington, DC, when more than 350 members of the U.S. House of Representatives and more than two-thirds of the U.S. Senate united to pass significant changes to Medicare’s physician payment system.

For surgeons who have closely followed developments in Medicare physician payment policy, the preceding account sounds much like this past July when Congress enacted the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (H.R. 6331)—the law that not only reversed a 10.6 percent cut in Medicare payments that took effect on July 1 of this year but also replaced a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase. However, the same opening sentence could just as easily describe July 1997, when bipartisan majorities in the House and Senate passed the Balanced Budget Act (BBA) of 1997—the law that replaced Medicare’s multiple volume performance standard (MVPS) with a new method of calculating reimbursement known as the sustainable growth rate (SGR). Unlike the MVPS, which based reimbursement on type of service, the SGR established a new method of calculating Medicare physician payments that sought to limit the annual growth in Medicare spending for physician services by linking reimbursement to growth in the gross domestic product and by requiring that any growth beyond that amount be recouped in future years.

It has been more than 11 years since the BBA was enacted, and the SGR has become the familiar shorthand that policymakers and physicians use to describe a Medicare payment system sorely in need of a drastic overhaul. Whatever logic may have guided the introduction of the SGR, policymakers of all stripes acknowledge the methodology has proven to be unsound.

From frustration to crisis

The SGR’s problems were first felt in 2002 when the Medicare conversion factor was cut 5.4 percent. In 2003, the conversion factor was scheduled to be cut another 4.4 percent, but earlier that year, Congress passed legislation replacing that decrease with a 1.6 percent increase. Further cuts in 2004 and 2005—of 4.5 percent and 3.3 percent, respectively—were replaced with increases of 1.5 percent through the Medicare Modernization Act (MMA) of 2003. Last-minute congressional actions prevented further cuts of 4.4 percent in 2006 and 5 percent in 2007 by freezing the conversion factor at 2005 levels. Although each of these actions was necessary to preserve Medicare patients’ access to physician services, they only made the long-term scenario for Medicare physician reimbursement more precarious as the amount of dollars the SGR needed to recoup in future years grew precipitously—leading to projections of future Medicare cuts in excess of 40 percent over the next 10 years.

Needless to say, the annual threat of pending cuts has become a frustration not only for surgeons but for patients and policymakers as well. For surgeons, the possibility of payment cuts has compromised their ability to plan from one year to the next and has left surgeons wondering how they will continue to cover basic costs such as salaries and health insurance for employees. This uncertainty leaves employees worrying whether they will continue to have health insurance or even jobs. For patients, it has fueled uncertainty about whether a surgeon will be there when they need one. For policymakers, the SGR has become an impediment to focusing on Medicare reform and other health policy issues, consuming valuable time and forcing elected officials—on an almost annual basis—to address the issue in crisis mode before the end of the year. On multiple occasions, this has led to a year-end panic within the physician community, which has been compelled to dedicate considerable resources to lobbying lawmakers to step in and avert a payment cut.

Last year was no different, and, arguably, December 2007 marked a low point for efforts to stave off a reduction in Medicare payment. Indeed, physicians were facing the largest projected Medicare cut yet—a 10.1 percent decrease in 2008—and lawmakers were at an impasse about how to offset the costs of stopping the cut. Much of the disagreement centered on provisions that could affect payments to Medicare Advantage plans, which are offered by private insurers to beneficiaries as an alternative to traditional fee-for-service coverage.

Ultimately, Congress averted the cut and approved a 0.5 percent increase—the first Medicare payment increase in three years. However, these
provisions were scheduled to expire on June 30 of this year. So, for the first time since the SGR was created, physicians were facing a potential mid-year cut, and if Congress could not act within the following six months, this modest increase would be replaced with a 10.6 percent cut on July 1.

Hence, the usual year-end anxiety that accompanied the push to stop the looming cut was abruptly followed by an acute sense of uncertainty. The physician community not only was concerned about how Congress would come to an agreement to stop a 10.6 percent reduction, but it was unsure what might happen if Congress could not come to an internal agreement or could not reach a compromise with the White House, which had indicated that any plan to decrease government funding for Medicare Advantage plans would be vetoed. What would happen if the 10.6 percent cut went into effect? How would physicians respond? Would physicians, for the first time ever, revisit their Medicare participation agreements? What would such an unprecedented scenario mean for patient access to care?

**Bills discussed in this article**

For the text of the bills mentioned in this article, visit the following sites:


Uncertainty in uncharted territory

As lawmakers returned to Washington in early 2008, attention focused on the Senate, whose cloture rule requires 60 votes in order to end debate and proceed to a final vote on a piece of legislation. In addition, attention shifted to the Senate because it had been only a few months since the House had passed the Children’s Health and Medicare Protection (CHAMP) Act of 2007, which included provisions to replace scheduled Medicare payment cuts in 2008 and 2009 with 0.5 percent increases in both years. The payment provisions were part of larger legislation to reauthorize and expand the State Children’s Health Insurance Program (SCHIP). Whereas the House bill had included Medicare provisions, the Senate’s version of the bill had focused solely on SCHIP. During negotiations between the House and Senate, the Medicare provisions were removed from the legislation, meaning the Senate did not consider the Medicare payment provisions in the CHAMP Act. This back-and-forth set the stage for the temporary measure passed in December 2007.

With House leaders pointing to the CHAMP Act as their marker, attention was squarely on the Senate and the Senate Finance Committee. Finance Committee Chairman Max Baucus (D-MT) forged ahead with an effort to craft a Medicare package that would stop the payment cut in July and in 2009, and from early on, discussions included Senator Baucus; Sen. Charles Grassley (R-IA), the Committee’s Ranking Member; the two senators’ respective staffs; and the White House.

From the beginning of 2008, the advocacy staff for the American College of Surgeons was an active participant in meetings with Senator Baucus and Senate Finance Committee staff to discuss the legislative effort to stop the Medicare payment decrease. As spring approached, ACS staff and representatives from other physician and allied health associations participated in a meeting with Senator Baucus, during which he outlined his initial thoughts on the legislation.

Senate negotiations on Medicare legislation commenced early in the legislative session, but as time passed, it became apparent that the Senate Finance Committee would not have an opportunity to consider Medicare legislation before receiving consideration by the full Senate. Even so, discussions continued through the spring, but in late May, Senate negotiations reached an impasse, which culminated in a statement from Senator Baucus indicating his intentions of working with fellow Democratic senators over the Memorial Day recess to craft a package that would stop the scheduled Medicare payment cuts through the end of 2009. The plan would be slated for Senate consideration in early June, with Republican support very much in doubt.

The political lines had been drawn and a sense of apprehension gripped the physician community as the likelihood of the 10.6 percent cut taking effect seemed to grow with each passing day. In response, ACS staff and colleagues at other physician organizations participated in separate meetings with staff to Senators Baucus and Grassley to discuss their respective efforts. In addition, ACS staff was included in meetings with these senators and the Senate Democratic and Republican Leadership, including Senate Majority Leader Harry Reid (D-NV) and Senate Minority Leader Mitch McConnell (R-KY).

Overcoming defeats, achieving victory

By early June, it had become clear that Senator Baucus’ legislation, the MIPPA of 2008 (S. 3101), would become the legislative vehicle for averting the payment cut on July 1. The College and most of the physician community fully supported the effort to enact the legislation. However, the fate of S. 3101 was far from certain because of Medicare Advantage provisions opposed by both the White House and many Republican senators. In addition to limiting certain payments to these plans, S. 3101 also would require certain Medicare Advantage plans, known as private fee-for-service plans, to develop networks and negotiate contracts with physicians and other providers. ACS advocacy staff—along with colleagues at the American Medical Association (AMA), surgical societies, and other physician organizations—engaged in an intense campaign to pass MIPPA, meeting with advisors to numerous Republican senators and asking for their support of S. 3101.

On June 6, Senator Baucus and Sen. Olympia
Snowe (R-ME) introduced S. 3101, which included measures to stop the pending 10.6 percent payment cut in July and replace a scheduled 5.4 percent cut in 2009 with a 1.1 percent increase. In a June 9 letter to Senator Baucus, ACS Executive Director Thomas R. Russell, MD, FACS, expressed the College’s commitment to achieving passage of S. 3101. That same day, Dr. Russell issued what would be the first of 10 e-mail alerts over the next seven weeks, calling upon ACS Fellows to contact their senators and ask them to allow a vote on S. 3101. In spite of a considerable response from Fellows, on June 12, the effort to invoke cloture and proceed to a vote on S. 3101 fell five votes short of the mandated 60 needed, with 55 senators—45 Democrats, nine Republicans, and two Independents—supporting the motion, and 38 senators, all Republicans, voting against cloture. The final vote was 54 to 39 nays1 because Senator Reid, who originally supported the motion, changed his vote to allow himself the right as Majority Leader, under Senate rules, to revisit the vote in the future.

Although the failure to invoke cloture was disappointing, it also provided a glimpse of hope. If all senators had been present, the motion would have passed. Yet, with one of the absent senators, Edward Kennedy (D-MA), severely limited by his illness, it appeared that the best possibility for passing MIPPA would be to secure additional Republican support.

At this point, it also was uncertain what action the House might take, if any at all. The House had previously indicated that its position was contained in the CHAMP Act and for months gave few indications of modifying its stance. Yet, as the week following the Senate cloture vote drew to an end, the House changed course, and on June 20, Ways and Means Chairman Charlie Rangel (D-NY) and Energy and Commerce Chairman John Dingell (D-MI) introduced a slightly modified version of MIPPA, H.R. 6331. On the following Monday, in a June 23 letter to Representatives Rangel and Dingell, Dr. Russell expressed ACS support for H.R. 6331, which retained the bill’s original provisions to stop the Medicare cuts through the end of 2009. On the same day, Dr. Russell called on Fellows to call their representatives and urge them to support H.R. 6331.

Uncertainty now centered on whether the House would be able to garner the support needed to pass H.R. 6331. House Democratic leaders made plans to bring MIPPA to the floor for consideration under a procedure known as suspension of the rules, which allows for expedited consideration of legislation but also requires a two-thirds majority for passage. Drama surrounded the events of the day, as the House Republican leaders pressed members to oppose the bill, citing the Medicare Advantage provisions as their primary disagreement with H.R. 6331. Rumors were circulating that some Republican members were privately speaking against their leaders and intending to support the bill, in particular because of its provisions to stop the Medicare payment cuts. On June 24, the House passed H.R. 6331 in an overwhelming 355 to 59 vote.2

With the House’s resounding vote as the backdrop, on June 26, Senate Democratic and Republican leaders reached an agreement to combine the votes for cloture and final passage on H.R. 6331, meaning that if MIPPA could garner the 60 votes needed for cloture, it would pass. Again, Dr. Russell summoned Fellows to call on their senators and ask them to stop the imminent Medicare cut that was but days away. Meanwhile, advocacy staff for the ACS and other physician groups renewed the push for Republican votes. On the evening of June 26, the final Senate vote was 58 to 40,2 with Senator Reid again changing his vote at the last minute to reserve his right to bring the bill up again following the July 4 recess.

In an e-mail following the vote, Dr. Russell told Fellows, “When forced to make a choice between a position that was supported by almost every physician group...and another position that was supported by the health plans and the President.... As a result, for now, the 10.6 percent cut in Medicare reimbursement to physicians will go into effect on July 1. The full arsenal of ACS advocacy resources will continue to be employed in the coming days in order to ensure that Congress passes legislation to retroactively stop the 10.6 percent cut. We must not give up or give in.”

Over the course of the week of July 4, as senators returned to their home states, Fellows did not give up or give in, and neither did their colleagues.
Instead, they vocally expressed disappointment with the senators who had voted against H.R. 6331 and asked that they change their vote when the bill would be revisited.

When Congress returned from the July 4 recess, all eyes remained on the Senate to see whether the support for MIPPA would hold and whether the bill’s supporters could gain the vote needed to secure cloture and passage. If that one vote could be secured, it was widely believed that additional votes would follow, and the two-thirds majority needed to override a widely anticipated presidential veto would likely be secured as well.

On July 9, Senator Reid called for the Senate to revisit the vote on H.R. 6331. In anticipation of the vote, the ACS, along with others in the physician community, continued to reach out to senators and ask for their support. In addition, Dr. Russell issued yet another call to Fellows to contact their senators.

What began as a normal Senate vote, with legislators milling around the floor in conversation, soon transformed into an almost euphoric atmosphere as Senator Kennedy, who had missed the previous votes, triumphantly entered the chamber to cast the critical deciding vote to secure Senate passage of H.R. 6331. In spite of its often partisan tone, the Senate is still a fairly collegial body, and even Senator Kennedy’s political foes could be seen welcoming him and applauding his return. With Senator Kennedy’s return and passage no longer in doubt, the anticipated additional votes followed, and the bill ultimately passed with a veto-proof majority of 69 to 30.4

Even with the bill’s passage in the Senate, it now faced a veto threat from President Bush, which ultimately became reality on July 15. Wasting no time, the House took up the bill the same day and, this time in a 383 to 41 vote,5 overrode the President’s veto; a few hours later, the Senate would follow in a 70 to 26 vote6 and enact MIPPA over the President’s objection.

Reasons to celebrate, lessons learned

This victory was achieved largely as a result of the time and energy that Dr. Russell, ACS staff, and, most importantly, the Fellows of the College dedicated to this effort. Although it is impossible to measure the number of calls placed by Fellows to Capitol Hill, anecdotal evidence suggests that this legislative effort generated a response unlike any other in recent memory. Thousands of phone calls were made to Senate and House offices asking for support of MIPPA. These efforts, combined with those of colleagues in other specialties, led to a tide of support that ultimately overwhelmed the opposition.

Passage of MIPPA was gratifying for several reasons. First, it marked the longest Medicare payment provisions secured since 2003 when the MMA secured payment increases of 1.5 percent for 2004 and 2005. Second, it meant that physicians would receive their largest payment increase since 2005. Lastly, it demonstrated the influence that the College, the surgical specialties, and the physician community as a whole can wield when working together.

In addition, the legislation included other provisions of interest to surgery. For example, the law addresses how Medicare values the work involved in certain surgical services. Under the Medicare physician fee schedule, there is a requirement that any changes be administered across the spectrum of services in a budget-neutral fashion. Following the AMA/Specialty Society Relative Value Update Committee’s completion of the five-year review of the work values of the resource-based relative value scale in 2006, the College and the rest of the physician community requested that CMS apply the budget neutrality requirement to the Medicare conversion factor. Contrary to this request, CMS applied this budget neutrality requirement to work values in 2007 and 2008. MIPPA changes this policy, and, in 2009, Medicare’s budget-neutrality requirement will be applied to the conversion factor as opposed to the work values assigned to physician services, meaning additional payment increases for some surgical services.

Nonetheless, much work remains to be done. If Congress does not act in 2009, the SGR will again require a cut in Medicare payments—this time in excess of 20 percent for 2010. But the efforts of the past year have been helpful and instructive, providing insights into possible payment reforms the Congress will consider in 2009.

When examining the events of the past year, it becomes apparent that lawmakers view the College as a leader on health policy issues. Not only was ACS staff in regular contact with legislators
on Capitol Hill, the College was among a select group of physician organizations to be included in all physician group meetings with Democratic and Republican leaders in the Senate and House to discuss efforts to craft and enact legislation to avert Medicare cuts. Instrumental support for these efforts was provided by Fellows who reached out to their legislators.

Fellows contributed in other ways as well: For example, in January, Josef E. Fischer, MD, FACS, then-Chair of the ACS Board of Regents, traveled to Washington to meet with Senator Baucus as well as staff to Sens. Grassley and Kennedy to discuss the effects of declining reimbursement on the surgical workforce; and in April, Charles F. Rinker II, MD, FACS, a general surgeon from Bozeman, MT, met with Senator Baucus to highlight the effects of Medicare reimbursement on access to surgical care in rural areas. Dr. Rinker also authored an opinion piece highlighting these issues in the April 5 edition of the Billings Gazette.* Thomas Foley, MD, FACS, of Marshalltown, IA, authored an article describing the effect of declining Medicare reimbursement and the challenges posed to Iowa’s surgical workforce in the March 21 edition of the Des Moines Register.† With the payment cut approaching, Charles D. Mabry, MD, FACS, Chair of the ACS Health Policy Steering Committee, testified regarding the effects of declining Medicare reimbursement and the threat that the pending Medicare cut could pose to small surgical practices and the patients and communities they serve.§

**Possibilities for reform**

The lessons from this experience are especially important because Congress will need to revisit the Medicare payment issue again in 2009. In its effort to stop the 20-plus percent cut in 2010, Congress is likely to consider much broader reforms. MIPPA provides helpful insight into the likely direction of Medicare policy and larger-scale health reforms Congress will consider in 2009:

- **Quality incentives**: MIPPA included an extension of the Physician Quality Reporting Initiative (PQRI) through 2010 and an increase in PQRI bonus payments from 1.5 percent to 2 percent in 2009 and 2010. By May 2010, the Secretary of the U.S. Department of Health and Human Services (HHS) must submit a report to Congress that includes a plan to transition to value-based purchasing. MIPPA also will establish a Physician Feedback Program in 2009 to provide physicians confidential information about their resource use in caring for Medicare patients.

- **Health information technology**: Although the bill did not include requirements for health information technology systems, MIPPA establishes a mandate for e-prescribing in 2011. Non-compliant physicians will face a penalty assessed on Medicare charges in the following year. The penalty starts at 1 percent in 2012 and phases up to 2 percent in 2014 and future years. To promote e-prescribing, MIPPA provides bonuses of 2 percent for e-prescribing in 2009 and 2010, with bonuses gradually phasing out by 2014. Exempt from the e-prescribing mandates are physicians for whom e-prescribing is associated with less than 10 percent of Medicare charges and physicians who issue less than a certain number of prescriptions under Medicare’s drug benefit.

- **Imaging and accreditation**: As imaging is one of the fastest growing service areas in Medicare, policymakers have often discussed options for limiting the growth of unnecessary and low-quality imaging. Under MIPPA, starting in 2012, Medicare payment for the technical component of advanced imaging services—excluding X ray, ultrasound, and fluoroscopy—will be limited to physicians and others who have been accredited by an organization designated by the HHS Secretary.

With private insurers often looking to Medicare’s lead, each of the preceding factors is viewed as an important component of efforts to control rising health care costs. Furthermore, comparative effectiveness research, which stud-
ies the relative effectiveness of various treatment options, is increasingly viewed as a critical component of these efforts to promote quality care, to achieve the best value for patients, and to ultimately restrain rising costs. To this end, on July 31, Senator Baucus and Senate Budget Committee Chairman Sen. Kent Conrad (D-ND) introduced the Comparative Effectiveness Research Act of 2008, which would provide federal funding to promote comparative effectiveness research.

Policymakers also have shown an interest in promoting primary and preventive care. In response, MIPPA provides an additional $100 million to expand Medicare’s current medical home demonstration project if the HHS Secretary determines that these health systems are useful in improving quality of care for patients and in achieving cost savings. In addition, the Medicare Payment Advisory Commission (MedPAC) has recommended that Congress increase payments to primary care physicians using a budget-neutral mechanism, which would result in Medicare payment cuts for all other physician services, including major surgical procedures. Of the 17 Commissioners, only two opposed the recommendation: Karen Borman, MD, FACS, and William Scanlon, PhD. In a May 16 letter to MedPAC Chairman Glenn Hackbarth, the College and 13 surgical specialty societies expressed strong opposition to MedPAC’s recommendation, noting that primary care is not the only specialty facing significant reimbursement and workforce challenges. The letter was copied to leaders on the Senate Finance, House Ways and Means, and House Energy and Commerce Committees.

In light of this strong interest in promoting primary care, the surgical community must work with the Congress and the primary care community to ensure that these efforts do not compromise patient access to surgical care. It is in this spirit that the College has joined forces with the American Osteopathic Association (AOA) to offer a proposal to reform Medicare’s physician payment system. The proposal, which was highlighted in the December 2006 Bulletin (Friesen S. Surgery’s future under Medicare? The College proposes effort to reform Medicare payment structure. 2006;91[12]:14-17.) would replace the SGR with a system called the service category growth rate (SCGR). Under the SGR, when Medicare spending exceeds the SGR target, Medicare payments for all physician services are cut, regardless of whether a particular type of service has been growing beyond the limits of the SGR. As the SCGR name implies, the ACS/AOA proposal would eliminate the blunt across-the-board SGR target and would replace it with separate targets based on type of service, including a category for major surgical procedures. With the creation of new targets based on type of service and with the elimination of the SGR’s blunt payment cut, the SCGR would enable policymakers to dedicate additional dollars to promote certain services, such as primary and preventive care, without penalizing other specialties. The proposal would also provide policymakers with an opportunity to examine services that have experienced higher growth, such as imaging and office-based procedures, and to determine whether the growth is appropriate; if policymakers conclude that the growth is appropriate, they can dedicate additional dollars to those services as well.

The positive, collaborative efforts of the College and the AOA embodied in the SCGR proposal have been well received by lawmakers, and the proposal has generated significant interest in Congress. The ACS/AOA proposal was first introduced by Rep. Pete Sessions (R-TX) as the Medicare Physician Payment Reform Act of 2007 (H.R. 3038), and a modified version of the proposal was included in the CHAMP Act. Following the passage of the CHAMP Act, Rep. Lincoln Davis (D-TN) and Representative Sessions led a bipartisan coalition of 140 House members in sending a letter, dated December 8, 2007, to Speaker of the House Nancy Pelosi (D-CA) and Republican Leader John Boehner (R-OH) expressing support for measures that would both increase Medicare payments in 2008 and 2009 and replace the Medicare payment formula with a system that establishes separate service category targets starting in 2010. By either voting for the CHAMP Act or signing the Davis-Sessions letter, 279 members of the House have expressed support for separate service category targets. Furthermore, the service category approach is often mentioned by policymakers as a starting point for the Medicare
physician payment reforms that Congress will consider next year.

Looking ahead

Whatever reforms are introduced, lawmakers have clearly indicated their desire that Medicare legislation should have bipartisan support. Of course, as the SGR has shown, bipartisanship in Congress on any particular issue does not necessarily guarantee positive results. Furthermore, legislation’s potential future consequences—both intended and unintended—must be closely studied, not only by lawmakers but by those whom the legislation stands to affect most directly. For this reason, the College will closely monitor the final details of any proposal, even if it is modeled after the SCGR, and continue to actively partner with lawmakers, the surgical community, and the larger physician community to ensure that Medicare does not simply exchange one broken payment system for another.

The success of this past July can be a helpful guide for the year ahead and for future advocacy efforts well beyond Medicare. The past year’s experience demonstrates that the legislative process must be viewed as just that—a process. Sometimes, as was the case with MIPPA, it is a process that lasts only a few months, but more often, as in the case of the Medicare payment reform effort, it is one that can take much longer before the desired end is ultimately achieved. If meaningful reform for patients and surgeons is attained, it will be through the same spirit that together the Fellows and the College marshaled in this year just past—by holding firm and remaining resolute until victory is secured.

References

Navigating the perfect storm

by John Zelem, MD, FACS
Many in the industry recognize the financial hardships that hospitals and physicians are facing today—reimbursement reductions, rising operational costs, the onset of pay-for-performance initiatives, and the list goes on. As most would agree that physicians have often experienced financial hardships on the individual level, this group is on the cusp of facing many of the financial challenges that, up until now, only hospitals have had to deal with.

The rapidly changing regulatory landscape currently serves as the eye of a “perfect storm.” The government continues on its quest to recoup what it believes to be billions of dollars in overpayments made to hospitals, and, while the attempt by the government to reduce physician reimbursements was overturned in the eleventh hour previously, many anticipate CMS will continue to try and eventually will succeed.

There have been many regulatory changes that are fueling today’s perfect storm, including the following:

• Recovery audit contractor (RAC) program: The government mandated that the Centers for Medicare & Medicaid Services (CMS) work to uncover fraudulent activity and recover overpayments to hospitals, which resulted in the RAC pilot program. CMS claims that there was $10.8 billion in overpayments in 2007 alone, which is actually 3.9 percent of the annual Medicare operating budget. It is important to note here that lack of medical necessity is the leading cause for these overpayments.

• The Tax Relief and Healthcare Act: This Act was signed into law in December 2006, expanding the RAC program nationally by 2010, and these auditors can look at medical records going back three years.

• Quality improvement organizations (QIO), formerly called peer review, had initiated focused one-, two-, and three-day stay review programs, reviewing high-risk diagnosis-related groups (DRG) as part of the eighth scope of work. Surgical procedures will also be looked at with a critical eye under these review programs. This initiative has pushed hospitals toward more liberal use of observation to help avoid scrutiny.

• Medicare Administrative Contractor (MAC) program: This legislation coordinates Medicare Part A and Medicare Part B payments under a single processor and is directed to look for Part A/B billing mismatches.

• Present on admission (POA): POA was initiated in October 2007 along with severity-adjusted DRGs, which creates joint liability for both physicians and hospitals.

• Medlearn Matters on Condition Code 44: This code clearly demonstrates that CMS is committed to a “prior to discharge” requirement, which means hospitals and physicians must determine accurate patient status before the patient is discharged.

Today’s physicians need to be prepared to brave the storm if they want to maintain their own individual compliance and revenue integrity.

The RACs are coming

First, physicians need to understand the RAC program and the potential ramifications from inaccurate and/or vague documentation. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the RAC program on a three-year demonstration basis in three states: New York, Florida, and California; toward the end of the demonstration project, Massachusetts, South Carolina, and Arizona were added. According to federal regulations, RACs are tasked with detecting and correcting Medicare improper payments, which could include either collecting overpayments from providers or repaying underpayments to providers. During the RAC demonstration, only 4 percent of improper payments were underpayments that were repaid to providers.

RACs are paid through contingency fees whereby the auditors get a percentage of the overpayments they uncover, plus expenses. The contingency fee amounts were proprietary in the demonstration project but have been disclosed in the permanent program. When overpayments were identified, providers had to pay the total amount back but could submit an appeal if they disagreed with the RACs’ findings. The RACs focused on high-risk DRGs, short stays, and medical necessity, among other areas. For the moment, the RAC program is mainly focused on hospitals and skilled nursing facilities. However, it does not seem unreasonable to as-
sume the government will look to mandate and implement a similar focus, aimed at physicians and private practices, in the future.

The demonstration RACs that ended in March 2008 were allowed to go back four years to review charts. The permanent RACs can only go back three years and may not request charts from before October 2007.

As mentioned previously, the demonstration project in the first three states concluded earlier this year and the program is now set to roll out nationally by 2010 (see Figure 1, this page).

CMS has clearly demonstrated through the RAC program that lack of medical necessity is one of the largest causes for identified and recovered overpayments; it was the focus 62 percent of the time for in-patient hospitals. Nearly one-third of the identified and recovered overpayments in fiscal year 2007 resulted from this categorization (see Figure 2, this page).

Lack of medical necessity really equates to lack of documentation, and CMS has clearly demonstrated that there must be documentation to support the patient’s status. Individual clinical opinions, as the sole standard beyond severity of illness and intensity of service criteria, is no longer acceptable to support this patient status as stated in CMS Ruling 95-1. It is imperative that physicians today document and prove medical necessity using evidence-based, literature-backed protocols. Detailed and consistent documentation is the key.

**Getting patient status right**

Physicians must pay greater attention to patient status in order to survive today’s perfect storm. With the tendency for QIOs and other organizations to encourage a more liberal use of
observation status, physicians must have a better understanding of the definitions of inpatient versus observation status, as defined by Medicare in the first chapter of the *Medicare Benefit Policy Manual*.

Without properly understanding these definitions, an appropriate certification of inpatient status can be difficult, resulting in a need to use observation more frequently to avoid continued scrutiny, especially in high-risk DRGs. Overuse of observation brings with it negative effects on hospitals, physicians, and patients. These negative effects include a greater impact on hospital revenue when patients qualifying for an inpatient status are inadvertently placed in observation, artificially elevated lengths of stay at the hospital, higher co-pays and billings for tests and procedures for patients, and high compliance-related risks for both hospitals and physicians.

Although fully understanding that the definitions of inpatient versus observation status are important, medical necessity and adequate documentation surface again as being imperative. Physician decisions in treating patients are, and should be, based securely on many years of training, education, experience, and evidence-based clinical standards of care. Realize that the determination of the correct patient status has no implication on this clinical care rendered. Yet, the medical necessity for this care must be clearly provided in adequate documentation.

Medicare states that “the decision to admit is a complex medical decision which can only be made after the physician has considered a number of factors.” Some of these factors include medical history, current medical needs, severity of signs and symptoms, and the predictability of an adverse event. Case reviewers need to be able to see the physician’s thought and decision-making process in each patient’s chart, which may help to mitigate the risk of a RAC denial.

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**Figure 3**

<table>
<thead>
<tr>
<th>Hospital utilization review determination</th>
<th>Physician order</th>
<th>Hospital claim (Part A)</th>
<th>Physician claim (Part B)</th>
<th>Physician impact</th>
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<td>OBS</td>
<td>IP</td>
<td>OP or none</td>
<td>IP</td>
<td>NC</td>
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</tbody>
</table>

IP = Inpatient  
OK = Concordant  
OBS = Observation  
C = Concordant but incorrect  
OP = Outpatient  
NC = Nonconcordant

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**The MACs are coming**

Physicians, as a rule, have a tendency to think that patient status is only a hospital billing problem, right? No longer, as physicians will have more accountability in this matter going forward. Presently, physicians are paid by carriers and hospitals are paid by fiscal intermediaries. As the MACs are rolled out to all 50 states in the next few years, Medicare Part A and Part B payments to hospitals and physicians will be combined into a single process. With this payment system being combined, it will result in the data from physicians and hospitals being housed together and it must match. The MACs are authorized to search out mismatches for episodes of care.

There are four aspects to this concordance: the utilization review patient status decision, the treating physician order for admission patient status, the hospital claim (Medicare Part A), and the physician claim (Medicare Part B). If all four areas do not match, there is nonconcordance, which may lead to delays/denials of payments or other significant actions.

As can be seen in Figure 3 on this page, if a patient is listed as inpatient or observation across the board, there is no negative impact on the physician. Three of the four remaining situations are incorrect, but the last one has the most potential for negative impact on the physician. If the hospi-
tal utilization review decision is observation, yet the physician writes an order for inpatient and will not change it to the appropriate observation, the hospital will bill as outpatient or may not bill at all. If the physician then bills as inpatient, it can have a significant negative impact on the physician, as he or she is billing for a patient who seems to have never existed in the hospital system.

Medicare is presently working with 3M to develop software to find these nonconcordant hospital-physician claim mismatches and when they do identify them, it can lead to an audit of the physician billing practices. The consequences to those physicians when nonconcordance is determined and found to be a pattern of frequent use can include the following:

- Ask the physician for the money back
- Request that the claim be resubmitted if the two-year time frame for claim submission has not expired
- Pursue the physician for a potential penalty/investigation (usually only if this sort of billing is deemed to be a common practice)

As a result, it is crucial for hospitals and physicians to work together more closely today than ever before to make sure they are setting patient status and billing in unison. With the rise of MACs and concordance-related initiatives, physicians are now just as much affected by the perfect storm as hospitals are.

POA

Another area physicians need to pay attention to is the POA. Before October 2007, Medicare would pay for complications and comorbid conditions, sometimes totaling up to thousands of dollars more than just the standard DRG payment. With the advent of POA, Medicare will cease paying for certain situations that were not POA, including, but not limited to, the following:

- Serious preventable events
- Object left in patient during surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Pressure ulcers
- Vascular catheter-associated infection
- Surgical site infection: mediastinitis after coronary artery bypass graft surgery
- Falls and trauma: fractures, dislocations, intracranial injuries, crushing injuries, and burns

CMS has come up with a way to pay less for what it deems as low quality, also known as value-based purchasing. This is CMS’ attempt to transform Medicare from a passive payor to a purchaser of high-quality, efficient health care. Simply put, CMS does not want to pay for complications that occur during a hospitalization that it believes are preventable through evidence-based guidelines.

This stance is obviously a concern to both physicians and hospitals. Hospitals have to be worried about the impact this will have on revenue and physicians must be concerned with the data that will be generated regarding the quality of care they deliver to their patients and the outcomes of their patients’ hospital stays. Again, medical necessity and strong documentation will play a big part in the ability of hospitals to appeal POA denials and the ability for physicians to accurately demonstrate the quality of care they provide to their patients.

In conclusion, this perfect storm no longer applies just to hospitals and other providers. Physicians will begin seeing the effects sooner rather than later and need to prepare now in order to successfully navigate this storm.

Author’s note: The information and statistics relevant to the permanent RAC program contained within this article were up-to-date as of June 2008 when this article was submitted for consideration. The RAC Expansion Schedule, displayed in Figure 1, has been updated and data are current as of October 2008. For more details on the RAC program, visit Executive Health Resources’ Compliance Library at www.ehrdocs.com.

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How a bill becomes a law

by Melinda Baker, State Affairs Associate, and Sara Morse, Manager of Political Affairs, Division of Advocacy and Health Policy

Editor’s note: This article begins a new column for the Bulletin that will address a wide range of issues related to state and federal advocacy. Staff of the Division of Advocacy and Health Policy will share their expertise and experience in order to help Fellows and ACS Chapters become more successful legislative advocates.

There are roughly 6,000 bills introduced in Congress each year, and as of July 2008, approximately 80,000 bills were introduced in state legislatures. Only approximately 500 bills (8 percent) get passed by Congress and approximately 23,000 bills (27 percent) get adopted in the states.

The first step to becoming an effective advocate is to understand how a bill becomes a law at the federal and state levels. Though basic in scope, there is a process and special vocabulary used throughout that process. If you were to pick up a copy of a bill with the word “engrossed” stamped on it, would you know what that meant? Or if someone told you a bill was “stuck on second reading,” would you know where in the legislative process that bill may be?

In the states

Step 1: Precommittees: Most states allow bills to be filed before the start of a legislative session and are considered “prefiled”—but bills are not officially introduced until the start of the legislative session. Bills may be introduced in either chamber and are usually required to be read three times before passage. First reading occurs after the bill introduction and is often the time when the bill is assigned to committee—either by the leadership of the Senate or the House or by a rules committee charged with this function.

Step 2: Committee: After committee assignment of a bill, the committee may hear, amend, pass, or table it—or conduct any combination of these actions or simply ignore it. Committee deadlines also come into play and are preset dates that all bills must be voted out of their committee. Any bill that is not out of committee by that date is essentially “dead” for that session. There are committee deadlines for bills in their chamber of origin (such as House bills in a House committee) and separate deadlines for engrossed bills, a term used for bills that have passed the chamber of origin and been sent to the secondary chamber.

Step 3: Postcommittee: Any bill that passes out of committee is placed on second reading and amendments to it may be offered from the floor. After this, the bill is placed on third reading, which is when the floor vote is taken. Many times there is a third reading deadline or a crossover deadline, which is another preset date that all bills must have passed out of their chamber of origin or will be considered dead for the session regardless of the action of the committee.

One caveat to these deadlines is they may be suspended by action of the leadership or the legislative body. Appropriation (budget) bills are often exempt from these deadlines.

Step 4: Secondary chamber: Once an engrossed bill crosses over to the secondary chamber, it goes through the first three steps again. If amended, the bill will be returned to its chamber of origin for concurrence and is usually referred to as being on the concurrence calendar. If the original chamber accepts the amendments, the bill is sent to the governor. If the original chamber refuses to accept the amendments, a conference committee is appointed. This committee is made up of members from each chamber. If the conference committee develops a compromise, both chambers must accept it before the bill can go to the governor. Any bill, once accepted by both chambers, is enrolled.

Several state legislatures have two-year sessions and many of these allow their bills to carry over from one year to the next. However, it is extremely rare for a bill that failed in one year to be automatically active in the next. Often the bill is simply reintroduced.
Step 5: The governor’s desk: A governor has three options after receiving a bill: sign, ignore, or veto. If signed, the bill turns into a “public act” and that version of the bill is called the adopted version.

There are only 12 states (Alabama, Delaware, Iowa, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, Oklahoma, Vermont, and Virginia) where governors can kill legislation by refusing to sign it within a certain timeframe; this is called a pocket veto. In any other state, the bill will simply become law.

Following are the four other types of vetoes*:

• Package veto: This is the most common type of veto and occurs when a governor vetoes a bill in its entirety. This can be overridden by the legislature and usually requires a supermajority, that is, 60 percent. The governors of all 50 states have the authority to use a package veto.

• Line-item veto: The line-item veto is available in 43 states and allows governors to remove specific sections of a bill. This type of veto can also be overridden by a supermajority of the legislature. (The states that do not grant this authority to governors are Indiana, Maryland, Nevada, New Hampshire, North Carolina, Rhode Island, and Vermont.)

• Reduction veto: A reduction veto can only be used on budget bills and gives the governor the authority to reduce the amount budgeted for individual items. Only 12 governors have this authority—Alaska, California, Illinois, Maine, Massachusetts, Michigan, Nebraska, New Jersey, Pennsylvania, Tennessee, West Virginia, and Wisconsin.

• Amendatory veto: This veto allows a governor to revise any bill that has been approved. All approvals must go back to the legislature for confirmation or rejection. If the legislature does not override or concur with the governor’s changes, the bill dies. The eight states where governors have this authority are Alabama, Illinois, Massachusetts, Montana, New Jersey, South Dakota, Virginia, and Wisconsin.

In Congress

Bill introduction. A bill is drafted by a member of Congress and his or her staff and may be introduced at any time the House is in session. A member of Congress, the sponsor, delivers the bill to the “hopper,” a box located at the rostrum, or Speaker’s desk. A private bill affects a particular individual whereas a “public bill” impacts the public as a whole. On introduction, a bill number is assigned. House bills begin with “H.R.” and Senate bills begin with “S.”

The parliamentarian refers the bill to the committee or committees with jurisdiction (that is, responsibility for certain areas of public policy) over the subject matter of the legislation. The House has 19 standing committees and the Senate has 16, and the Speaker may impose a time limit in which the committee must report back.

In committee. The path of a bill varies, but once most bills reach committees, they are tabled, meaning they are never dealt with and die in committee. In order to avoid that fate, sponsors work to gain as much support as possible for their bill. The more bipartisan support the bill has, the better, and congressional offices will circulate “Dear Colleague” letters asking for additional cosponsors. Members can also force a bill out of committee and onto the House floor by filing a discharge petition, which requires a majority vote of 218.

Bills that do not get tabled will generally be referred to a more specialized subcommittee to more deeply explore the bill. Subcommittees often hold hearings on the bill where groups or individuals interested in testifying may request an opportunity to present oral and/or written testimony in support of or in opposition to the legislation.

The subcommittee marks up, or makes changes to, the bill and votes on it. If approved, the bill goes to the full committee for consideration, where the bill can be amended more before final markup and vote. If approved by the full committee, the bill is reported to the full Senate or House for vote.

Floor vote process. The House Rules Committee determines when the House will consider the legislation, how long the debate of the “committee as a whole” (that is, the entire House) will last, and the number of amendments that will be considered. In the House, amendments and debate must be germane—in other words, limited to the topic at hand. In the Senate, the Majority Leader schedules the legislation process. Senate debate is open-ended—therefore allowing for the possibility
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Dean A. Rein named Executive Director of ACS Foundation

Dean A. Rein, a fund-raising and philanthropic gift support executive, has been named Executive Director of the American College of Surgeons Foundation. The former senior vice-president of Carroll University in Waukesha, WI, Mr. Rein officially became the Executive Director of the ACS Foundation September 15.

Mr. Rein received his bachelor’s degree in journalism and public relations from Northern Illinois University, Dekalb. He also earned a professional certificate in managing institutional advancement from the University of Chicago and a professional certificate in nonprofit management from Northwestern University’s Kellogg School of Management, Chicago, IL.

During his 13-year tenure at Carroll University, which began in 1993, Mr. Rein served as a member of the institution’s senior staff, led advancement efforts, and provided administrative oversight to the intercollegiate athletic program. Under his leadership, Carroll successfully completed three capital campaigns, all surpassing their original goals ahead of schedule, and in the process secured more than $100 million in philanthropic gift support.

Before joining the Carroll University staff, Mr. Rein served as vice-president for the Children’s Hospital Foundation in Milwaukeee. While in that position, his work contributed to an increase of more than 300 percent in the hospital’s philanthropic gifts and the creation of a successful $30 million fund-raising campaign. Mr. Rein’s advancement experience also includes positions at Northwestern University, Northern Illinois University, and the Chicago-Kent Law School.

In addition to his professional experience, Mr. Rein has served in a variety of volunteer capacities and has presented at regional and national conferences of the Council for the Advancement and Support of Education, the Association of Healthcare Philanthropy, and the Association of Fundraising Executives (AFP). In 2001, he was awarded the AFP Milwaukee Chapter’s Scott Cutlip Award, the organization’s highest honor for professionals in the not-for-profit sector.

The American College of Surgeons Foundation was established by the College’s Board of Regents in February 2005 and officially began its activities in July 2005. The Foundation’s sole focus is to raise funds to support the mission of the American College of Surgeons, which is to improve the care of the surgical patient and safeguard standards of care in an optimal and ethical practice environment. The Foundation serves as the College’s philanthropic arm for reaching out to both its members and its public constituencies.

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Go to the College’s “members only” Web portal at www.efacs.org
Heller School Executive Leadership Program scholarships available

The American College of Surgeons is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management (http://heller.brandeis.edu/academic/elp.html) at Brandeis University in Waltham, MA. The 2009 course takes place June 14–19, and the $8,000 award is to be used toward the cost of tuition, travel, housing, and subsistence during the course and post-course follow-up periods.

Two 2009 scholarships are reserved for general surgeons and are fully funded by the College. In addition, several of the surgical specialty societies have partnered with the ACS to cosponsor a scholarship for a member in good standing of both the College and his or her surgical society. The participating societies supporting scholarships are the American Academy of Otolaryngology–Head & Neck Surgery Foundation, the American Association of Neurological Surgeons, the American Association for the Surgery of Trauma, the American Pediatric Surgical Society, the American Society of Breast Surgeons, the American Society of Colon and Rectal Surgeons, the American Society of Plastic Surgeons, the American Surgical Association, the American Urogynecologic Society, the Society of Thoracic Surgeons, and the Society for Vascular Surgery. The American Urological Association (AUA) will also cosponsor a health policy scholarship with the College, via the mechanism of the AUA’s Gallagher Scholars program (visit www.AUAnet.org/Gallagher).

General policies covering the granting of the scholarships are as follows:

- The award is open to surgeons who are general surgeons or members in good standing of one of the listed societies and of the American College of Surgeons. Applicants must be at least 30 years of age, but younger than 55 on the date that the completed application is filed.
- The award is to be used to support the recipient during the period of the course and the period of service following. Indirect costs are not paid to the recipient or to the recipient’s institution.
- Applications for this scholarship consist of one copy of each of the following items:
  —The applicant’s current curriculum vitae
  —A one-page essay, discussing why the applicant wishes to receive the scholarship
- Application for this award may be submitted even if comparable application to other organizations has been made. If the recipient accepts a similar scholarship from another agency or organization, the scholarship will be withdrawn.

It is the responsibility of the recipient to notify the Scholarships Section of the ACS, which administers this program, of competing awards.

- The scholarship must be used in the year for which it is designated. It cannot be postponed.
- The selected scholar is required to provide one year’s health policy-related assistance to the ACS and the cosponsoring society, attending meetings, reviewing applications, and so forth, as requested by either organization.
- A brief report of the scholar’s experiences and activities is due at the conclusion of the course and again at the end of scholarship period. A simple accounting is also required.

The closing date for receipt of applications is February 1, 2009. All applicants will be notified of the outcome of the selection process by March 31, 2009.

Questions may be directed to the ACS Scholarships Administrator at 312/202-5281. Requirements for the scholarships are available at http://www.facs.org/memberservices/research.html.

Send applications for this scholarship to Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
CALL FOR SUBMISSIONS

2009 Clinical Congress of the American College of Surgeons

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

✧ the 95th annual Clinical Congress, October 11–15, 2009, Chicago, IL

Oral presentations

✧ Surgical Forum*
  Program Coordinator: Kathryn L. Matousek, 312/202-5336, kmatousek@facs.org
  (11 $1,000 Excellence in Research Awards were given in 2008)
  Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)

✧ Papers Session*
  Program Coordinator: Beth Brown, 312/202-5325, ebrown@facs.org

Poster presentation

✧ Scientific Exhibits
  Program Coordinator: Kay Anthony, 312/202-5385, kanthony@facs.org

Video presentation

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

Submission information

✧ Abstracts are to be submitted online only
✧ Submission period begins November 3, 2008
✧ Deadline: 5:00 pm (CST), March 1, 2009
✧ Late submissions are not permitted
✧ Abstract specifications and requirements for each individual program will be posted on the ACS Web site at www.facs.org/education/. Review the information carefully prior to submission.
✧ Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.
On Sunday, July 23, 1967, it was hot and dry, a typical mid-summer day in Detroit, MI. The early morning hours had seen nothing unusual. A few drunks were arrested for disorderly behavior. A number of stabbing victims were successfully treated at the city hospital; a “blind pig” was raided for after-hours liquor violations; there were a number of minor fires without serious injury.

The afternoon was calm. The rotating intern at the city hospital thought it was an ideal time to see her new city. After working the Saturday night shift, she napped in her dingy six-by-six living quarters on the fifth floor above the operating suite. The room was sweltering, the only source of relief being the meager fan the cleaning lady had been kind enough to provide. Decay and rot had left holes in the wood under the sink. The place resembled a prison cell. It had been 23 days since she left the hospital. The young intern stored most of her worldly possessions in her car, as this room that she would call “home” for the next 11 months was too small to accommodate them.

The intern started on her exploratory tour of the city close to 4:00 pm. As she sat waiting at a red light, an elderly African-American woman in the adjacent car hollered to her, “Ma’am, you ought to not go up there. They’re rioting.” The young intern smiled, thanked the old woman, ignored her advice, and continued to proceed “up there.” It soon became apparent, however, that the woman was correct. The young intern turned back toward the city hospital and was able to reach the parking lot shortly before barricades were erected around the grounds.

In a nearby suburb, the city hospital’s chief of surgery was driving with his spouse. The car radio announced that there was a disturbance outside a blind pig that had been raided that morning; the newscaster asserted that everything appeared to be under control. The chief of surgery, however, was alarmed. Having grown up in Cape Town, South Africa, where racial strife was often downplayed, he was sure that this “minor disturbance” was the beginning of a race riot. He immediately drove home, confiding in his wife his suspicions about what was really happening in the city. She thought he was crazy, but at his urging...
agreed to keep all three kids in the house that evening. He then took his shaving kit and extra undergarments and made the trip to the city hospital, arriving as the barricades were being erected.

The chief surgical resident left home shortly after 5:00 pm to serve his nightly stint on the emergency surgical service of the city hospital. Because the hospital routinely saw such a large volume of trauma and nontrauma emergencies, there were two emergency surgery teams: for one month, one team worked nights and the second team worked days and then they switched. Each team was headed by a fourth-year surgical resident. The chief surgical resident was in his fifth year of residency and worked two months of nights. As the chief surgical resident approached the downtown area, he was concerned to see dark smoke billowing over the skies of Detroit. Had there been a warehouse fire or did a gasoline station explode? he wondered. The radio gave no hint of what was happening. Shortly thereafter, he arrived at the city hospital just as the barricades were being erected.

The commotion that began when the blind pig was raided in the early morning hours spread throughout the day as the police skeleton crew staffing a supposedly peaceful Sunday afternoon had difficulty containing this “civil disturbance.” The city officials, in briefings with the news media, downplayed the disturbance, refusing to see it for what it was. Despite the fact that other cities had experienced race riots recently, the officials thought this could never happen here. After all, race relations in Detroit were excellent, weren’t they? Surely, the gains made since the 1943 Detroit race riot precluded any recurrence, or so they thought. Sadly, they were mistaken. It was only when Bill Bonds arrived to anchor the evening news for one of Detroit’s television network stations, and recognized what others refused to admit, that the news media finally reported the reality of the situation. The disturbance, he announced, that had begun as a protestation to the blind pig raid on the near west side was now out of control and had expanded to the near east side. One of the worst riots of the turbulent 1960s had begun.

The hospital

In the early 1900s, Detroit was a working-class city closely aligned with the expanding automobile industry. St. Mary’s Hospital, supported by the large Archdioceses of Detroit, was the primary provider of indigent health care. The combination of a good work ethic, strong tax base, and strong religious affiliations in the city led to a higher prioritization of health care for the needy. The Detroit Receiving Hospital (DRH) opened in 1916 in order to serve the poor and downtrodden of Detroit. The Wayne University, later Wayne State University (WSU) College of Medicine, a city-owned institution of higher education, partnered in the provision of care for the have-nots of Detroit. The new hospital was erected next door to the St. Mary’s Hospital, which continued to be a resource to the new city hospital in times of need for many years.

For half a century, this partnership served the needy of Detroit and fostered the training of medical students and residents in all specialties. During these years, this large, 750-bed, full-service hospital experienced many ups and downs generally related to the economic welfare of Detroit. Skeletal crews provided care through the two World Wars, and finances were scarce during hard times, including the Great Depression. Resources were always found to keep the hospital open but there were few amenities. Many times nurses and nurses’ aides were compelled to “borrow” linens from the adjacent St. Mary’s Hospital. These borrowings were really long-term loans without collateral—the only payment being heartfelt thanks to the St. Mary’s Hospital administrative personnel who looked the other way. DRH survived these many difficult times and, by 1967, was providing emergency care to 140,000 citizens per year.

Although the Emancipation Proclamation was enacted into law 50 years before the city hospital was constructed, separation of the races continued throughout the northern cities including Detroit and was evident during these early years at the new city hospital. The chief surgical resident, many years later as a faculty member, provided medical care to the first African-American
registered nurse to work at the city hospital when she was a patient there. She taught him about how, in her day, people of color were not expected to be registered nurses but rather were expected to work as practical nurses or nurses’ aides. She credited one of her teachers at WSU with challenging her to overcome this stifling attitude. Upon receiving her degree and beginning her career at DRH, she was forced to bring a bag lunch to work every day because people of color were not allowed to eat in the whites-only dining room. She described how the restrooms also were for white people only, so when she had to use the bathroom, she would go outside to the corner store, affectionately known by the hospital staff as “the Greeks.” The proprietor would nod when she and others would come in to use the facilities. The remnants of this discrimination were still present in 1967.

The treatment
On that fateful day in July, the chief of surgery was serving his second year as chairman of the WSU department of surgery. When he arrived at the hospital that evening, the atmosphere was relatively calm. Intuitively, he knew that things were about to get very busy, though this view was not shared by many others. He implemented the hospital disaster plan and enticed the community surgeons, many of whom had done their training at the DRH/WSU program, to be available. These surgeons canceled their elective schedules and came into the hospital to be available for what might happen. Working through the administrative and nursing offices, he arranged for the nurses to stay and work a second shift while police vehicles conveyed the night shift nurses to the hospital under armed protection.

His foresight and actions were critical to the successful treatment of almost 1,500 patients in the emergency department, including almost 500 patients who presented during a span of 36 hours. Many of these latter patients had sustained life-threatening gunshot wounds. At the peak of the crisis, all nine operating rooms were in use; two additional operating “rooms” were set up in the hallway, but fortunately, the turnover of rooms was such that these makeshift facilities never had to be used. By all standards, the treatment of the sick and injured during this period of time was an outstanding success, mostly because of the foresight of the new, young chairman.

The challenge
The new chief of surgery received plaudits from near and afar for his planning and handling of the civil disturbance. He instinctively knew, however, that successful surgical response to an urban riot was only window dressing; the underlying causes of widespread inequities had to be addressed. Although many residents, nurses, and faculty had become inured to these inequities, the chief’s previous experience with apartheid taught him that corrective
action was badly needed. Now secure in his new position as the WSU chairman of surgery, it was time to deal with these inequities within his sphere of influence. He called upon his lovely and capable spouse to help him in this endeavor. She was given a tour of the hospital and was asked to make the hospital more inviting to patients, students, residents, and attending physicians. The challenge was enormous.

The first hurdle was a fiscal one. City leaders clearly were less than enthusiastic about a hospital modernization and beautification program; the city was still financially sound but the post-World War II automotive industry boom had clearly passed. But it seems that each hospital has a person who knows where the hidden resources are located: the DRH had Al Plotkin, the chief executive officer who was a hard-nosed, crusty man-for-all-seasons with a soft underbelly, and the chief’s spouse instinctively found the soft underbelly. They worked out a pact: if she were able to procure external donations, he would match them. These matching funds would come from the Research Corporation into which all physician third-party payments were made.

A DRH Beautification Committee was formed with the chairman’s spouse providing the artistic leadership and Mr. Plotkin overseeing the financial considerations. In her quest for donations, the chairman’s spouse met with Men’s Clubs and Women’s Clubs of Detroit’s major corporations, including industrial giants such as General Motors Corporation, Chrysler Corporation, and Parke-Davis Pharmaceuticals. In the early days of the Beautification Committee, donations trickled in and, as a result, only the most pressing aesthetic needs of the hospital could be addressed.

The first priorities were the large, 13-bed, open wards. In these antiquated treatment areas, no curtains separated the old wrought-iron beds and tattered shades without curtains were the only window dressings. There were three or four rickety chairs for each 13-bed ward. Each ward had a physician sitting room where records were reviewed, X rays examined, and orders written. The rooms resembled old broom closets with a couple of chipped and eroded desks and rickety old chairs.

The first priority for the Beautification Committee was to vastly improve the appearance of these open wards by placing curtains around each bed, replacing the old shades, adding window curtains, upgrading the bedside tables, and procuring at least one chair for each bed. In addition, at least one picture was hung on the wall of each of these large wards. This simple, inexpensive beautification was enormously appreciated by the patients and relatives but perhaps even more so by the nursing and physician staff, who suddenly realized how callously accustomed to the dreary décor they had been for so many years. In the physician workrooms, the addition of carpeting, fresh paint, window curtains, clean and sturdy furniture and, of course, a picture on the walls created a whole new atmosphere. The house officers and medical students could actually be cheerful while working long hours well beyond the current 80-hour workweek.

As a modest increase in donations began to flow into the Beautification Committee, the next priority was to upgrade the waiting room at the hospital entrance. This area contained long benches, which had not been replaced since the hospital opened more than 50 years earlier. The floors, walls, and ceiling lighting were primitive. The registration and information windows resembled the ticket counters of an old train station and did not foster congeniality. Again, simple, inexpensive upgrading with chairs, brighter lighting, repainted walls, restructured reception and information desks and the all-important addition of art pieces to grace the walls created a tremendous difference and were appreciated by all.

The next challenge was the fifth-floor living quarters that the rotating intern and many other house officers called “home.” These tiny rooms were hot and stuffy, pocked with holes from dry rot, and reeked of food smells from the cooking that was being done in the small common kitchen, which suffered from poor circulation and lack of air conditioning. Again, simple but inexpensive solutions were found. The atrium was recarpeted and furnished with proper seating accommodations, the lighting
was upgraded, air conditioning was installed, plumbing and carpentry needs were addressed, and each of the dormitory rooms was freshly painted in colors designed to create a sense of well-being. The whole effect was nicely enhanced by the addition of pleasant, but inexpensive, art pieces to the atrium walls.

During the 1940s, DRH added a large extension known as the Farwell Building; the eighth floor housed the on-call rooms. These rooms were almost as Spartan as the fifth-floor living quarters. The mattresses were saggy and should have been thrown away many years earlier. When curtains were present, they were tattered and often nonfunctional. The paint was chipped from age and the underlying plaster was cracked. The chairman claimed that it would be highly unlikely for quality medical students to choose the WSU/DRH surgery program when the night call facilities provided no comfort, poor accommodations, no desks, and no communication with the outside world.

Simple, inexpensive improvements by the Beautification Committee included an upgrade of the communal shower facility, new beds, new shades and curtains, and replastered and repainted walls, and proper reading lights markedly improved the environment; of course, let us not forget the addition of artwork to the walls.

The morgue in a hospital serves two purposes: prosecution by the pathology team and viewing of the deceased by the immediate family. Somehow, DRH physicians had grown accustomed to the dark, dank, cramped environment when doing work related to prosecution. Unfortunately, the substandard, dreary environment extended to the viewing room. The chairman’s spouse championed the effort to create a proper viewing room, helping to ease the terrible burden upon the family and loved ones of the deceased. Artwork was included.

Each successful improvement in these simple but basic amenities of everyday patient care and hospital life strengthened the reputation of the Beautification Committee. Those individuals who once had been mere bystanders became supporters and advocates. Getting more financial support became easier; the future looked rosy. Another bump in the road, however, was just around the corner.

**The shooting**

During the late morning of July 13, 1971, a muscular, middle-aged man entered the hospital through the Farwell Annex, which joined the original building and the Farwell extension, and strode through the halls toward the administration offices. He attracted everyone’s attention because of his deliberate pace but, mostly, because of the rifle he gripped with both hands. As is so often the case, witnesses assumed that he was performing some administrative function and went about their work. As he turned down the long hallway leading to the main administration offices, few took notice. Shortly before
entering the administrative office suite, he was recognized by a senior employee who rapidly shoved him aside and then slammed and locked the main administrative suite door. The mayhem had begun.

The shooter was a former employee who had been dismissed for cause. He suffered from schizophrenia but was thought to have been cured after a 14-month inpatient stay. He had vowed to kill Marty Battle, a middle-level administrator who had had to be the bearer of bad news regarding his dismissal. The shooter was well armed with rapid-fire capabilities.

While each of the individuals within the main administrative suite closed their doors in order to protect themselves, he blasted through the outer door with multiple rifle rounds and entered into the main suite. Simultaneously, an emergency alert went out to the Detroit Police Department First Precinct across the street. They deployed the SWAT team. The chairman’s spouse, preparing for the next Beautification Committee meeting, was shoved into one of the administrative offices where she and two others, including Mr. Battle, pushed a desk against the door. As they were barricading the door, Marty was shot through the closed door and sustained life-threatening chest and abdominal injuries. One of the secretaries received a large destructive wound to her forearm and the chairman’s spouse received a superficial wound to her upper extremity.

While multiple shots were fired in many different directions, the chairman’s spouse held Marty’s hand as he progressively exsanguinated. Shortly thereafter, the SWAT team arrived and fatally shot the assailant.

The chief surgical resident, now an attending physician and chairman of the Disaster Committee, instituted the Disaster Plan. All operations were canceled. Six operating teams were assembled to provide care for the six individuals known to be in the administrative suite. The shooter was the first to be rushed by the triage point, but he was obviously beyond treatment. Mr. Battle followed immediately and he was taken directly to the resuscitation room where he underwent an emergency thoracotomy; he had temporary restoration of heartbeat but died soon thereafter in the emergency department. The injured secretary was rapidly evaluated and then taken directly to the operating room for the debridement of soft tissue, primary neurorraphy, and primary tenorraphy performed by a general surgical faculty member who had been trained in the care of these injuries as part of the WSU/DRH surgical residency. The chairman’s spouse presented with the superficial wound, which was treated with a small dressing. She experienced excruciating epigastric pain, which was successfully treated with two cartons of whole milk.

Once the dust had settled and calm had been restored, the chairperson’s spouse informed him that she was not about to spend another moment at the DRH. With the wisdom born of his experience as a soldier in World War II, he advised that she needed to return to the hospital, preferably as soon as possible, so she could expel this horrific nightmare and reinvigorate herself with the many challenges to come. It is a testament to her strength, perseverance of spirit, and commitment to the Beautification Committee that she consented to let him escort her back to the hospital the next Monday.

The growth

The many early successes in creating a positive environment at minimal expense were rewarded by a continued increase in donations. The Men’s Clubs and Women’s Clubs of Detroit industries supported expansion of the beautification program. Through the largesse of the Kresge Corporation, a modest park was constructed across the street from the front door of the hospital. On pleasant days, patients’ relatives, medical students, and house officers could rest there for a few moments and enjoy the calming scenery before going back to the hectic hospital environment. On occasion, it provided a respite for homeless people to spend the night. One of the surgical residents later stated “seeing these homeless people spending the night there reminded me that after my call is over, my wife and kids will be waiting for me at a real home.”

Each success identified new goals. July 1975 was one of the hottest months on record in Detroit. The former chief surgical resident, now faculty, was called to the chairman’s
office to deal with a crisis in the critical care step-down unit. The unit contained nine beds and had many patients on ventilators. There was no air conditioning and there were no screens. A frustrated surgical critical care resident wrote an order to “shoo flies from trach stoma prn,” and the hospital administrator wanted him fired. The chairman had a better idea. The former chief surgical resident met with the administrator and they agreed that the surgical critical care resident would be chastised as soon as screens were placed on the windows. The screens were in place by noon the next day; the surgical critical care resident was treated to a beer and burger that evening. This entire critical unit was upgraded by the Beautification Committee shortly thereafter.

On the campus of the WSU Medical School, a new Radiation Oncology Center had been created. Capitalizing on her newfound supporters, the chairman’s spouse managed to adorn the Radiation Oncology Center with multiple murals. Much of this success exemplified her persuasive powers in coaxing business people to donate artwork that was no longer going to be used in their office buildings. The Children’s Hospital of Michigan utilized the Children’s Cancer Center within the Harper Hospital for children requiring bone marrow transplantation. The art team was able to make this area warm and inviting to children. These continuing successes engendered even more support for the Beautification Committee.

The new hospital
The new DRH was slated for completion in July 1980. The art program at the old hospital was so successful that the art committee was given a new challenge. Detroit Mayor Coleman A. Young and WSU President George Gullen each appointed four people to this committee. They, in turn, enlisted the aid of spouses of WSU professors, including many from the law school and the medical school. Representatives of the Detroit Institute of Arts were included
on this committee. The task was to plan not only for a beautifully constructed hospital, but also for beautiful artwork within the hospital. Both aims were highly successful (see photos, page 37–39).

The hospital opened on schedule in July 1980 with 40 beds. Within one year, all 340 beds were opened. Approximately 200 works of art were taken from the old hospital to the new hospital and, as each new ward was opened, the walls were adorned with art. The new hospital had a maximum of two patients per room, was spacious, effectively used natural light, and had an excellent attached University Health Center to facilitate outpatient care. It also had courtyards that later were to be filled with giant works of art that had to be moved in by huge cranes.

The challenge to financially support these new works of art was successfully carried out through fundraising dinners, donations from friends and faculty, and multiple letters sent out by the chairman at the direction of his spouse. These endeavors permitted large works to be commissioned at no expense to the hospital.

The chairman was now world-renowned and accepted invitations to speak in many different cities in many different countries. His spouse, when accompanying him, made it her job to identify local art to be acquired for the hospital so that the artwork represented all parts of the globe. Again, her frugal instincts allowed for these tremendous works to be brought to the hospital at minimum expense. By the 1990s, the hallways had an international artistic flavor and the quality of the art pieces continued to increase.

The last hurrah
While the art program flourished, so did the chairman. He became a leader in many of the nation’s surgical associations and his name was recognized and respected everywhere. As he gave his Presidential Address at the American College of Surgeons annual meeting in October 1995, Alexander J. Walt, MD, FACS, suffered severe pain from metastatic kidney cancer. As he was dying in early 1996, Irene Walt was involved in another large project for the hospital atrium. When this was dedicated, she identified this as her “last hurrah” (see photo, this page). How wrong she was.

After Dr. Walt died, the demands made upon Mrs. Walt intensified. Her work at the DRH became known throughout Southeast Michigan. She led the beautification of the Federal Building in Detroit, the People Mover within the central city, the Alexander J. Walt Breast Center within the Harper Hospital, and helped with the artworks at the nearby Henry Ford Hospital. The ceramic replica of the current emblem of the American College of Surgeons is another example of her continued involvement in the art world. All Fellows of the American College of Surgeons should view this beautiful piece, which was crafted of Detroit Pewabic tile and hangs in the lobby of the College’s

The DRH art program has continued to thrive because of the administrative support by the hospital and because of the many support groups in Southeast Michigan. Mrs. Walt conducts many art tours for medical students, DRH and WSU visitors, and for speakers at the DRH/WSU Annual Trauma Symposium, the oldest trauma symposium in America and an event strongly supported by Dr. Walt.

During these art tours, Mrs. Walt often opined that a historical record of the art program should be preserved in a book dedicated to the beautification of DRH and the 1,000 works of art currently on display. Indeed, this wish was repeated yearly until the former rotating intern and the former chief surgical resident organized a fundraising project to finance this new book and the CD-ROM that would accompany it. When the surgeons who had trained under the leadership of Dr. Walt were invited to financially support this program, the outpouring of support was tremendous. Within two months, the financial goal was exceeded.

On April 30, 2007, the benefactors who could make the trip to downtown Detroit shared in an art tour provided by Mrs. Walt, followed by a celebration dinner that was attended by more than 75 former trainees (see photo, this page). The art book was completed in September 2007 and is available at the WSU Press (University Press, 4809 Woodward Ave., Detroit, MI 48202).

Dr. Lucas is professor of surgery, Wayne State University, and senior attending, Detroit Receiving Hospital, Detroit, MI.

Dr. Ledgerwood is professor of surgery, Wayne State University, and senior attending, Detroit Receiving Hospital, Detroit, MI.
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Are you frustrated with the amount of time it takes your hospital’s laboratory, radiology, or pathology department to report critical test results? For instance, during an intraoperative procedure, surgeons don’t want to wait unnecessarily long for frozen section results on a biopsy—they need results quickly. Likewise, in the emergency department, a surgeon needs to know quickly if a patient’s chest pain is a medical problem or a surgical problem; promptly reported test results contribute to the accuracy of the diagnosis.

When every moment counts, delayed diagnostic results can affect the workflow of the surgical team and potentially harm the patient, but what can surgeons do about this? Surgeons should request to learn their hospital’s compliance success with The Joint Commission’s National Patient Safety Goal Requirement 2C that addresses the timeliness of reporting critical test results. Requirement 2C states: “Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test and critical results and values.”

Requirement 2C was introduced in 2005; however, organizations still face significant compliance challenges. The requirement was among the top 10 areas cited for noncompliance during routine surveys conducted in 2007, and hospital and laboratory programs aren’t alone in their struggles. This requirement also appeared on the lists of top compliance areas for 2007 for the critical access hospital, ambulatory, and home care accreditation programs.

Organizations are expected to do the following:
- Define the terms “critical tests” and “critical results and values”
- Define the acceptable length of time between the ordering of critical tests and reporting the critical tests and critical results and values
- Define the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed caregiver
- Collect data on the timeliness of reporting critical tests and critical results and values
- Take appropriate action to improve and measure the effectiveness of those actions

The term “critical test result” refers to both the results of a critical test and test results with critical values and applies to all diagnostic tests including imaging studies, electrocardiograms, and laboratory tests and other diagnostic tests defined by an organization as “critical.” Organizations need to make a distinction between “critical tests” and “critical results.” Critical tests will always require rapid communication of the results, even if normal. Critical results, also known as critical values, refer to test results that fall significantly outside the normal range and may represent life-threatening values even if from routine tests.

Surgeons should address what their organization’s expected turnaround time is for reporting. The turnaround time must be established by policy, and it should include measurement of the timeliness of reporting the results of critical tests. The measurement in this situation is from the time the test is ordered to the time the result is reported to the responsible licensed caregiver.

The ultimate objective, however, is for critical test results to be reported to the responsible licensed caregiver and for any unnecessary delays in the treatment or care of patients to be avoided.
The suggested minimum investment to participate in SDIF has been reduced to $10,000. For those who find it appropriate to participate in an automatic investment plan\(^1\), the minimum initial investment is $5,000 assuming an automatic investment plan of at least $100 per month is implemented; waivers of the minimum are possible. The minimum investment has been modified for Medical Student Members ($500), Resident Members ($1,000), and Associate Fellows ($2,500) of the College.

For more information about SDIF or regarding the waived minimum, please contact Savi Pai, 312/202-5056 or spai@facs.org, or Tom Kiley, 312/202-5019 or tkiley@facs.org. Both are available to discuss specific details regarding SDIF. You may also visit the Web site at www.surgeonsfund.com or call 800/208-6070.

\(^1\)A program of regular investing does not ensure a profit or protect against depreciation in a declining market. Because a consistent investing program involves continuous investment in securities regardless of fluctuating prices, you should consider your financial ability to continue to purchase through periods of various price levels.

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

Letters should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to sregnier@facs.org, or via mail to Stephen R. Nier, Editor, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

A startling transformation

In August 2003, an article endorsed by 7,784 physicians and medical students, “Proposal of the Physicians Working Group for Single-Payer National Health Insurance,” was published in the Journal of the American Medical Association. In his commentary on the article, Thomas Russell, MD, FACS, Executive Director of the American College of Surgeons, reminded us that “tremendous administrative costs and competition between plans that have a for-profit mentality have resulted in an arcane and costly system, which diverts money from patient care and breeds the corporate mindset that has become pervasive in the medical profession.” A position espoused by me and thousands of my colleagues in Physicians for a National Health Program. However, Dr. Russell did not believe that the “crisis in health care has reached a threshold that would command such a startling transformation.” To this, I responded, “The crisis in our health care system may be below the threshold only because we keep elevating the threshold.”

Five years later, it appears that we may have finally reached the threshold, as evidenced by the surfacing of health care as a major issue on the national agenda and in the presidential election.

Our present system of health care delivery is not sustainable. It may putter along for a decade or two, but it will finally collapse. And as it self-destructs, tens of thousands more will be hurt. Presently, the Institute of Medicine estimates that 1,500 Americans die every month due to lack of health care coverage. I would argue that it is not universal health care that is un-American—it is our present system.

Few in the surgical and medical profession would disagree that change is needed. Respected surgical leaders are speaking out. Donald Trunkey, MD, FACS, called the U.S. health care system the “best mediocre health care in the world.” In a lecture at Rice University, the late Michael DeBakey, MD, FACS, stated, “Our health care system is in disarray and cannot be rectified by the incrementalism approach.”

The disagreement has to do with the type of change. You cannot build a second floor on a house with a rotten foundation. Although we have all the components to indeed have the best health care in the world, our health care delivery system is terminal. The problem of the uninsured is the most visible and perhaps the most profound. I travel frequently on surgical missions to east Africa. I am ashamed to say that I am starting to see here in California the type of late presentations and catastrophes I typically see in Kenya, Tanzania, and Zambia. But multiple other problems abound. Private insurers thrive by denying care and inject-
Ironically, most joint replacements in the U.S. are also paid for by a single-payor system: Medicare! Under Medicare, waiting lists are not an issue because spending and system capacity are significantly higher than those in Canada. We should also remember that Canadians spend approximately half of what we spend per capita on health care, cover everyone, and have public health and some tertiary care outcomes superior to ours. Shrinking the waiting list is a national priority in Canada, as evidenced by last year’s attendance of Prime Minister Stephen Harper at the annual “Taming of the Queue” conference. The Canadians have problems with their system, but they have a system.

The conventional wisdom is that a single-payor system is not popular with the public or physicians and cannot be realized in the U.S. But in a recent survey by the American Academy of Pediatrics, one-third of pediatricians favored a single-payor system, a substantial finding given that it is very difficult to get this many physicians to agree on another specific alternative. In a survey of 904 Massachusetts physicians randomly chosen from the American Medical Association master file, almost two-thirds of respondents identified single payor as “the structure that would provide the best care for the most people for a fixed amount of money.” In poll after poll, a majority of Americans favor a universal health care system, even if financed through increased taxation.

Americans, the public, and their physicians have a major decision ahead. Will health care continue to be treated as a commodity bought and sold according to means or as a service sought and delivered according to need? American surgeons should continue to lead the world in innovation and creativity, but they should also apply the results of their resourcefulness to any patient in need, in an atmosphere of evidence-based care, patient freedom to choose their doctor, and resource optimization, free from micromanagement and bureaucratic hassles. I don’t believe this can be achieved through expanding or amending our current nonsystem.

As called for by an idealistic, young surgeon in the August Bulletin, “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.” A radical shift in our approach and our priorities—a shift that would produce a startling transformation—is necessary!

References

Sherif Emil, MD, CM, FACS
Irvine, CA

The art of medicine?
I find it interesting that Dr. Pauline Chen (“The art of medi-
cine at the end of life: The challenges ahead.” Bull Am Coll Surg. 2008;93[2]:19-21) can relate the story of a resident being forced (forced!) to remain in the hospital to tend to an unstable patient without noting the irony that nowadays it is the surgical attendings who are being forced (forced!) to let that same resident leave the hospital so that somebody else can care for the patient.

The art of medicine? It will not exist in the future. The resident Dr. Chen describes learned a valuable lesson about patient care that (hopefully) remained with him throughout his career. I am certain it shaped his sense of responsibility. I believe the current crop of surgeons-in-training will not hold those same values when released into the real world.

If they have not commiserated with the patient and the family over a difficult outcome from beginning to end, but only from time to time as their schedule allows them, then I do not see how the future surgeons will become truly caring or compassionate.

Charles Eisengart, MD, FACS
Lawrenceville, NJ

Getting to know ACS staff
As a Fellow and avid reader of the Bulletin, I wanted to first compliment Jon Sutton for his recent article, “What surgeons should know about...Fairness and transparency in contracts” (Bull Am Coll Surg. 2008;93[8]:9-48). The article covers a difficult topic for surgeons. It provided key concept clarification and will serve as an excellent reference for my practice in our next negotiation.

Secondly, I would also give kudos to all the College staff members who provide reviews of topics to surgeons who would have few other places to turn for such salient information. I would, however, offer one criticism. Whenever a surgeon writes
an article for the *Bulletin*, there is always a photo at the end of the article. It helps to put a face on the thoughts of the writer. Why, then, do you not put photos of ACS staff when they write an article for the *Bulletin*? I would very much like to know their faces. I would then recognize who they are at the Clinical Congress, just as I recognize Dr. Cameron and Dr. Healy. Putting a face to the staff would also help Fellows know the people out there working day to day for our profession.

Christopher K. Senkowski, MD, FACS
Savannah, GA

**Transparency**

The article by F. Dean Griffen, MD, FACS, in the March 2008 *Bulletin*, “The impact of transparency on patient safety and liability” (pages 19–23) has interesting facts, but I disagree with the conclusion that implementing this system nationally will reduce litigation cost.

Dr. Griffen’s finding that transparency caused more injured patients to receive less compensation and the fairness of attorneys not to sue for noneconomic loss when surgeons disclose errors is admirable, but naive.

If this practice becomes widely publicized, the increased number of claims will cause a feeding frenzy for free, no-cost lottery dollars that will overcome any initial savings and the true greed of the plaintiffs’ attorneys will make an already bad situation more costly, increase premiums, and make an already stressful surgeon’s environment more stressful and less safe psychologically. And focusing on the patient’s care will become more difficult.

The real solution is, first, to train surgeons how to communicate well to their patients and to show true compassion and care—as good rapport breeds fewer lawsuits—and second, to pass caps on noneconomic loss and have the loser pay the legal costs. These two pieces of legislation would literally stop frivolous lawsuits better than a transparency system.

Donald Dennis, MD, FACS
Atlanta, GA

**Surgical workforce shortage**

I want to extend my compliments to Richard A. Cooper, MD, regarding his lecture on “The coming era of too few physicians,” which was originally presented at the 2007 Clinical Congress and published in the March *Bulletin* (pages 11–18). This article should serve as a clarion call to all those concerned about the health care of our next generation. I know that I have been stimulated to submit a resolution to the Tennessee Medical Association, which emphasizes the responsibility of today’s physicians to tomorrow’s patients on this subject. If we do not act, then the dire consequences for our “complacency—indeed, active inertia” should rightly be left at our doorstep. Thank you for a well-researched and enlightening piece.

Mark A. Brzezienki, MD, MS, FACS
Chattanooga, TN

**Locum tenens**

As a general surgeon now doing locum tenens work, I read with interest and agreement the articles by Ronald M. Tolls (“The practice of locum tenens: Views of a senior surgeon,” pages 8–10) and Stuart A. Reynolds (“The practice of locum tenens: Commentary,” pages 11–12) in the May *Bulletin*. I would like to comment on two issues. Degradation of technical skill so aptly discussed by Dr. Reynolds can be minimized or avoided by doing long-term assignments of several months or recurring one to two weeks at the same hospital, where not only on-call coverage is provided, but the locum tenens surgeon also has regular clinic duties and schedules elective cases referred to him. This sort of longer-term...
commitment is more likely to result in the sort of familiarity with staff and referring physicians that leads to a more normal practice of surgery and larger caseload. A second issue deals with credentialing by the locum tenens agencies and is an area where the surgeon needs to be careful and persistent. Ultimately the client hospital credentials the locum tenens surgeon for work at its facility. However, in being the first to introduce laparoscopic surgery to Afghanistan (“The best and worst week of my life: A surgeon at war.” Bull Am Coll Surg. 2008;93(4):15–21). We all know the advantages of this procedure, but it does need much skill and training and involves expensive equipment. In the 1980s, before laparoscopic cholecystectomy became routine, I used the small-incision open approach to cholecystectomy. A 2” transverse subcostal incision was used (though one registrar used only a 1” incision!). The advantages are similar to the laparoscopic approach—when an intercostal block is performed at the end of the operation, powerful analgesics are rarely required and the patient is usually able to go home the next day. The time taken is much shorter and, in the event of anatomical, pathological, or surgical difficulties, it is simple to enlarge the wound without so much “loss of face.” It might be simpler and safer to train local surgeons in third-world countries to use the small-incision open approach to abdominal surgery than risk the complications that bedeviled the laparoscopic operation in its early days. K. Bridson Orr, FACS, FRACS, FRCS Blakehurst, NSW, Australia

Teaching medical students

The article “Teaching surgery to medical students: Perspectives from our mentees” (July 2008, pages 48–53) provides surgeons with important insights that should be considered a challenge. I suspect many of us had similar thoughts years ago when we were in the same position—when we were expected to do as we were told. I have several observations that may be useful for students and others.

When I was trying to decide on a specialty, it seemed to me that people who enjoy working with their hands should enter a surgical field (or a procedurally oriented medical field). Medical students put off by the demands of a surgical career may not realize that performing surgery is usually fun and rewarding. Simply “confessing” that pleasure, while mentioning that people who dislike working with their hands should enter a medical specialty, may inspire undecided students to look again at surgery.

As an ethicist, I understand Jun Matsui’s moral distress at inflicting unnecessary pain and participating in a system that makes students part of the problem when surgery does not live up to its ideals. Unfortunately, medical ethics rarely deals with organizational issues, especially involving power structures, instead focusing on broader problems such as organ transplantation and end-of-life issues. I would hope that the ACS can address Ms. Matsui’s very appropriate concerns.

Muriel R. Friedman, MD, FACS Missoula, MT

Laparoscopy in third-world countries

It is all very well for Dr. Ross Segan to make a name for himself in being the first to introduce laparoscopic surgery to Afghanistan (“The best and worst week of my life: A surgeon at war.” Bull Am Coll Surg. 2008;93(4):15–21). We all know the advantages of this procedure, but it does need much skill and training and involves expensive equipment. In the 1980s, before laparoscopic cholecystectomy became routine, I used the small-incision open approach to cholecystectomy. A 2” transverse subcostal incision was used (though one registrar used only a 1” incision!). The advantages are similar to the laparoscopic approach—when an intercostal block is performed at the end of the operation, powerful analgesics are rarely required and the patient is usually able to go home the next day. The time taken is much shorter and, in the event of anatomical, pathological, or surgical difficulties, it is simple to enlarge the wound without so much “loss of face.” It might be simpler and safer to train local surgeons in third-world countries to use the small-incision open approach to abdominal surgery than risk the complications that bedeviled the laparoscopic operation in its early days. K. Bridson Orr, FACS, FRACS, FRCS Blakehurst, NSW, Australia

Trauma meetings calendar

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

- Advances in Trauma, December 12–13, Kansas City, MO.
- Trauma, Critical Care, & Acute Care Surgery–2009, April 6–8, 2009, Las Vegas, NV.
- Trauma, Critical Care, & Acute Care Surgery 2009–Point/Counterpoint XVIII, June 8–10, 2009, Atlantic City, NJ.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
of filibuster—and the number and topic of amendments is unrestricted. In order for the Senate to prevent or end a filibuster, a vote for cloture (60 votes) must pass.

If the bill is first introduced in the House, companion legislation that is identical or similar to the House bill may be introduced in the Senate (or vice versa). If identical bills are approved in both legislative bodies, the measure is enrolled and sent to the President to sign. If the bills are different, a conference committee, composed of members of both the House and Senate, is appointed to iron out the differences. After compromise is achieved, a conference report is generated and sent to both branches of the legislature for approval and then forwarded to the President.

The President acts. The President can either sign the legislation into law or veto the measure and return it to Congress. The President has 10 days (Sundays not included) to act on a piece of legislation. A pocket veto occurs when the President does not sign the bill within the 10-day span and Congress has adjourned—the bill automatically dies. A vetoed measure requires a two-thirds majority vote by the House and Senate to override a veto. If overridden, the measure automatically becomes law.
Traumatic brain injury (TBI) is a result of either a blunt force or penetrating injury to the head that disrupts the brain’s normal function. TBI can range from a mild form with only a brief mental status change or brief change in consciousness to severe TBI seen with injuries that result in extended periods of unconsciousness or amnesia.

According to the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (CDC), more than 1.4 million people sustain a TBI each year in the U.S. Among those victims, 50,000 die and 235,000 are hospitalized, whereas 1.1 million are treated and released from an emergency department. In the 0 to 14 years age group, TBI results in 2,685 deaths, 37,000 hospitalizations, and 435,000 emergency department visits annually. CDC estimates that 5.3 million (2 percent) of the U.S. population has long-term or lifetime need for assistance with performing activities of daily living as a result of a TBI. The direct medical costs and indirect costs in lost productivity as a result of TBI were estimated at $60 billion in 2000 (http://www.cdc.gov/ncipc/tbi/TBI.htm).

In order to examine the occurrence of head injuries in the National Trauma Data Bank® (NTDB) Dataset 7.1, records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification codes for brain injuries (850–854.19, 803.1–803.49, 800.1–800.49, 800.6–800.99, 801.1–801.49, 801.6–801.99, 803.6–803.99, 804.1–804.49, and 804.6–804.99) along with the codes for skull injuries (800.0–800.09, 800.5–800.59, 801.0–801.09, 801.5–801.59, 802–803.09, 803.5–803.59, 804–804.09, and 804.5–804.59). Out of the 1,926,245 incidents in the NTDB, 396,722 records contained one of these diagnosis codes. The primary mechanisms for injury were blunt force trauma, accounting for 97 percent of all records. Blunt force mechanisms in order of frequency were motor vehicle crashes (52 percent) followed by falls (28 percent) and struck by/against events (7 percent). There were 358,845 records that noted discharge disposition, including 252,134 discharged to home, 60,799 to acute care/rehabilitation, and 20,328 sent to nursing homes; 25,584 died. (These data are displayed in the graph on this page.) The patients were 68.8 percent male, on average 37.6 years of age, and had an average length of stay of 6.12 days and an average injury severity score of 14.7. Of those also tested for alcohol, 41 percent tested positive and of those tested for drugs, half tested positive.

Not all head injuries are major and obvious. There are subgroups of TBI in which the only symptoms or sequelae may
be loss of concentration, mood swings, or difficulty with short-term memory. These patients need to be identified and offered the appropriate resources so they are better able to deal with their subtle deficits.

TBI is a major cause of morbidity and mortality, so given the spectrum and magnitude of TBI, please be careful in your daily activities and watch your head.

The full NTDB Annual Report Version 7.1 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 Chrystal Price, Data Analyst.

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.

Dr. Stone is in the department of neurological surgery and neurology, University of Illinois at Chicago, and the department of surgery, division of neurosurgery, Cook County Stroger and Advocate Illinois Masonic Hospitals.

So, You Want to Be a Surgeon...

Medical student guide to residency training

The online resource, So You Want to Be a Surgeon… A Medical Student Guide to Finding and Matching with the Best Possible Surgery Residency, is now available on the American College of Surgeons Web site at:

http://www.facs.org/residencysearch

This online, contemporary version of the popular “Little Red Book” has proven to be an invaluable resource for medical students seeking opportunities in graduate medical education. The revised online version of this helpful reference includes a searchable database containing a complete list of accredited surgical specialty residency programs, as well as a section devoted to assisting students in choosing a residency program that is their best match.

For further information, contact Elisabeth Davis, MA, Education Research Associate, Division of Education, at 312/202-5192, or via e-mail at edavis@facs.org.
Chapter news

by Rhonda Peebles, Division of Member Services

To report your chapter’s news, contact Rhonda Peebles at 888/857-7554 or via e-mail at rpeebles@facs.org.

New York Chapter conducts 2008 symposium

The New York Chapter conducted its 2008 annual symposium April 26 at the Otesaga Resort in Cooperstown, NY; for the first time, this symposium was cosponsored by the Florida Chapter. During the daylong meeting, sessions on residents’ reports, bariatric surgery, the surgical workforce, and mentoring were presented. In addition, Gerald B. Healy, MD, FACS, the ACS Immediate Past-President, served as the John H. Madden Lecturer. Finally, changes in the New York Chapter’s leadership were implemented (see photo, this page).

Two chapters convene in the West

This year, the Idaho Chapter and the Montana–Wyoming Chapter convened August 7–9 in Cody, WY. The educational program featured presentations on various types of cancer operations, advocacy, surgical education and credentialing, issues related to call, and the National Surgical Quality Improvement Program. Various leaders from the two chapters are included in the photo, this page.

Georgia Chapter conducts annual meeting

The Georgia Chapter conducted its 2008 annual meeting August 23–24 at the Emory Conference Center in Atlanta. This year’s session continued on page 52.

Georgia Chapter, left to right: Jeremiah L. Deneve, MD,* Emory University School of Medicine (first place); Chad G. Ball, MD, *Emory University School of Medicine (second-place tie); D. Scott Lind, MD, FACS, Chair, Educational Program Committee; James G. Bittner IV, MD,* Medical College of Georgia (second-place tie); Amy B. Moore, MD,* Medical Center of Central Georgia (third place); and Angela L. Gucwa, MD, Medical College of Georgia. (*Denotes Resident membership in the College.)

New York Chapter, left to right (all MD, FACS): Soumitra Eachempati, Vice-President; David Wormuth, Secretary; Dr. Healy; John Sherman, Treasurer; Saqib Chaudhry, Immediate Past-President; and Peter D’Silva, President.

Idaho and Montana-Wyoming Chapters, left to right (all MD, FACS): Sara Hartsaw, Montana–Wyoming Governor; Adam Deutchman, President, Idaho Chapter; Charles Swannack, President, Montana–Wyoming Chapter; and Anne Williams, Governor, Montana–Wyoming Chapter.
## 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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<tr>
<td>January 16–18</td>
<td>Southern California (CS)</td>
<td>Location: Four Seasons Biltmore Resort, Santa Barbara, CA</td>
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<td></td>
<td></td>
<td>Contact: C. James Dowden, 310/364-0193, <a href="mailto:cjdowden@pacbell.net">cjdowden@pacbell.net</a></td>
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<td>Contact: Janna Pecquet, 504/733-3275, <a href="mailto:pecquet@LAACS.org">pecquet@LAACS.org</a></td>
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<td>March 14</td>
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<td>April 2–4</td>
<td>Japan</td>
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<td>Contact: Kyoichi Takaori, MD, FACS, 81-75-751-4323, <a href="mailto:takaori@live.jp">takaori@live.jp</a></td>
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<td>Contact: Amy Clinton, 518/283-1601, <a href="mailto:NYCoFACS@yahoo.com">NYCoFACS@yahoo.com</a></td>
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<td>Contact: Leann Tschider, 701/223-9475, <a href="mailto:leann@ndmed.com">leann@ndmed.com</a></td>
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focused on safety and U.S. health care policy; in addition, a residents’ competition was held, and there were five winners (see photo, page 50). As part of its 2008 activities, the Georgia Chapter developed an outreach plan for advocacy, expanded its Education Program Committee, and adopted the following mission statement: “The mission of the Georgia Chapter of the American College of Surgeons is to provide educational opportunities for its members as well as surgery residents and medical students, be an advocate for its members and the patients they serve, and to encourage the highest standards of ethical surgical practice in the state of Georgia.”

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**Chapter anniversaries**

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**SAVE THE DATES!**

The American College of Surgeons is pleased to announce its continued collaboration with the Southeastern and Southwestern Surgical Congresses, to develop and implement educational programs in the spring. The College looks forward to sponsoring half-day symposia at these prestigious events.

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**THE AMERICAN COLLEGE OF SURGEONS AT THE SOUTHEASTERN SURGICAL CONGRESS**

Southeastern Surgical Congress  
FEBRUARY 7–10, 2009  
Atlanta Marriott Marquis  
Atlanta, GA  
To register, visit www.sesc.org or call 800/558-8958

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**THE AMERICAN COLLEGE OF SURGEONS AT THE SOUTHWESTERN SURGICAL CONGRESS**

Southwestern Surgical Congress  
MARCH 22–25, 2009  
Hotel del Coronado  
San Diego, CA  
To register, visit www.swscongress.org or call 913/402-7102

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**FOR MORE INFORMATION**, contact Julie Tribe, MSeD, Senior Manager, Educational Programs, Division of Education, at jtribe@facs.org or 312/202-5433.  
**FOR INFORMATION ON the ACS**, visit www.facs.org or call 800/621-4111.
2009 Coding Workshops

American College of Surgeons
2009 Coding Workshop Series for Surgeons and Their Staff

FT. LAUDERDALE, FL
FEBRUARY 26
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

FEBRUARY 27
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

ST. LOUIS, MO
MAY 14
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

MAY 15
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

CHICAGO, IL
JULY 9
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

JULY 10
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

LOS ANGELES, CA
AUGUST 27
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

AUGUST 28
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

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