End-of-life care: Facing the challenges of hospice and palliative medicine
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On the cover: End-of-life care issues have gained greater visibility thanks to the creation of a new medical subspecialty and a recent symposium on the subject (see articles on page 8, 13, 17, and 19). (Photo courtesy of Punchstock.)
NEWS

In memoriam:
G. Tom Shires, MD, FACS, 1926–2007
Philip Barie, MD, FACS; Ronald V. Maier, MD, FACS; Malcolm O. Perry, MD, FACS; Donald D. Trunkey, MD, FACS; and Roger W. Yurt, MD, FACS; edited by Lewis Flint, MD, FACS

Arthur Ellenberger honored with meritorious achievement award

ACGS seeks nominations for Members-at-Large

Dr. Puder honored with 2007 Jacobson Promising Investigator Award

Young Surgical Investigators Conference scheduled

College seeks nominations for 2008 Jacobson Promising Investigator Award

AMA HOD adopts health policy
Jon Sutton

Call for abstracts: CoC Paper Competition

ACS German Traveling Fellowship available for 2009

ACS Traveling Fellowship to Japan available

ACOSOG news:
A phase II trial for minimally invasive esophagectomy
David Ota, MD, FACS; and Heidi Nelson, MD, FACS

NTDB® data points:
Pediatric Report 2007: Too many kids
Richard J. Fantus, MD, FACS, and Arthur Cooper, MD, FACS

A look at The Joint Commission:
Annual report details health care quality in U.S. hospitals

Chapter news
Rhonda Peebles

American Philosophical Society seeks clinical investigation award nominations

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.
This initiative will go a long way toward helping the American College of Surgeons have a greater voice in medical, health care, and policy decision making and a role in influencing policy outcomes.

From my perspective

Last year at this time, the American College of Surgeons Board of Regents approved a proposal to launch a major initiative aimed at improving this organization’s visibility and, thus, its influence in the public arena. The primary goal of this program is to build a deeper understanding and recognition of the value and relevance of the College among high-level health policymakers, the news media, and leading health care consumers and advocates so that it can be a major player in attempting to create a more positive climate for practicing surgeons and their patients. We believe that by enhancing and broadening the College’s credibility, it will have a greater voice in medical, health care, and policy decisions and can more effectively work to bring about positive change for its members and the surgical profession as a whole.

The College’s Public Profile and Communications Steering Committee—chaired by ACS First Vice-President-Elect and former Regent Jack W. McAninch, MD, FACS—has been leading this effort with the assistance of Weber Shandwick Worldwide, a well-respected international communications management firm. The ACS Director of Communications, Linn Meyer, is the staff coordinator for this project and interacts closely with our account executive at Weber Shandwick Health Care.

Media relations

The College has long had a very active and effective media relations program, and staff members are in regular contact with reporters representing the consumer press, both print and electronic, and the trade press. Our working relationship with Weber Shandwick is allowing us to significantly augment our media relations efforts with top-tier media outlets throughout the country, including major broadcast media. For example, in recent months, several members of the College’s leadership were interviewed and quoted in major news stories on trauma care and various public health issues that were featured in the Wall Street Journal and the New York Times, and ACS President Gerald B. Healy, MD, FACS, was featured in an NBC Nightly News segment on the need for effective trauma systems.

The College’s Project New Orleans, which was organized by the Operation Giving Back staff and took place during the 2007 Clinical Congress, received excellent media attention. The purpose of the project was to enlist the aid of surgeons in attendance at the meeting to do demolition work in preparation for a new medical clinic that will be built in the economically depressed Bywater neighborhood of New Orleans’ 9th Ward. During this project, 180 surgeons volunteered their time and effort for this purpose, and the activity was captured by five local television stations and by USA Today in a major feature story. (For more information, see the detailed feature about the project and the media coverage in the January Bulletin, page 32.)

Future top-tier media relations efforts will concentrate on using important current topics as a platform for news stories that will highlight the surgeon’s role in medical innovation and showcase our skills, expertise, and life-saving abilities. We anticipate that these high-level efforts
will help to soften some of the public’s negative perceptions of surgeons.

Patient advocacy

If the College is to continue to maintain its credibility as a patient advocate, we simply cannot state that “the College has no position” on the complex and difficult issues facing surgeons, their patients, and society as a whole today. Hence, the Public Profile and Communications Steering Committee is appointing a Subcommittee on Issues that will function as a clearinghouse on subjects the College needs to address through informal or official comments or policy statements.

The subcommittee will work with various ACS committees and the advisory councils to pinpoint matters of concern to surgeons and their patients now or in the immediate future. The subcommittee will then provide that information to the steering committee, along with recommended positions for the College to take and suggestions as to whether those stances should be expressed in the form of comments or official policy statements.

The work of this subcommittee will be an essential underpinning in helping to raise its credibility and visibility in these complex and challenging times.

Partnering for public visibility

Another area in which we are actively engaged is building relationships with leading health care consumer and patient advocate groups. We believe such partnerships are of paramount importance to the future viability of the American College of Surgeons and the surgical profession. A predominant focus of the visibility campaign will be to have a dialogue with other organizations about possible collaboration on projects addressing trauma readiness, patient education, and public health issues.

In addition, we are seeking to increase our presence at medical forums. For example, we recently met with a representative of the World Health Care Congress about the College’s possible participation in its upcoming annual meeting.

Attracting and retaining members

Finally, we are working to spread the message within the surgical community that the American College of Surgeons is vigorously advocating on Capitol Hill and at the state level for our members and their patients. We particularly want surgeons in all specialties to realize the value of ACS membership with respect to representing the surgical profession with one voice in the policymaking process. In addition, we are actively getting the word out about the robust tools and resources the College is providing its members to assist them in fulfilling Maintenance of Certification requirements and to help them to continue to provide optimal patient care in today’s politically charged, complex, and challenging environment.

In short, I am very pleased with the progress the College has made with respect to increasing the organization’s public profile and visibility. I believe that this initiative will go a long way toward helping to build a deeper understanding and recognition of the value and relevance of the American College of Surgeons so that ultimately it will have a greater voice in medical, health care, and policy decision making and a role in influencing policy outcomes.

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.
Just before its holiday recess, Congress passed legislation providing a modest increase in Medicare physician payments for the first six months of 2008. President Bush signed the law on December 29, 2007. Instead of reducing the Medicare fee schedule conversion factor by 10.1 percent as required by the sustainable growth rate (SGR) system, the Medicare, Medicaid and State Children’s Health Insurance Program Extension Act of 2007 calls upon the Centers for Medicare & Medicaid Services (CMS) to increase payments by 0.5 percent for all services provided between January 1 and June 30. Beginning July 1, the 10.1 percent reductions from 2007 payment levels will take effect, unless Congress intervenes again.

Congress was compelled to enact this very limited measure because of disagreements over the scope and cost of more comprehensive Medicare reforms. In particular, legislators could not agree on how to achieve the spending cuts necessary to offset the estimated $262 billion, 10-year cost of eliminating the SGR altogether and implementing a new physician payment update system based on annual rates of Medicare inflation. The House passed legislation this past summer containing these provisions, which also would have established six separate fee schedule updates based on type of service—including a separate category for major surgical procedures, as proposed by the College. However, once again, legislators disagreed about the offsetting budget cuts.

Although this latest measure offers some relief in that the major payment reduction will not occur on January 1 as anticipated, the College and other medical and surgical specialty societies are discouraged by the prospects of revisiting the issue immediately in the new year. Thousands of Fellows wrote to and called their respective state senators and representatives in the closing days of the legislative session to urge passage of a more comprehensive proposal.

CMS has announced that, in light of the change in 2008 payment rates, it will provide an additional 45-day period for physicians to decide whether to sign Medicare participation agreements. Physicians now have until February 15 to select whether to participate. In making this decision, it is important that surgeons appreciate the uncertainty of Medicare payment rates after July 1, especially since CMS has not indicated whether physicians will be allowed to revisit participation if the mid-year reductions occur. For more information on surgeons’ payment options under Medicare, go to http://www.facs.org/fellows_info/bulletin/cebuhar0802.pdf, and http://www.facs.org/ahp/pubs/whatsurg0207.pdf.

The American College of Surgeons realizes that we have a big job ahead in the coming months with respect to Medicare payment and other advocacy issues, so this organization began strategizing for action in 2008 during the last quarter of 2007. For example, on March 9–11, we will host the first Joint Surgical Advocacy Conference with a number of the surgical specialty societies. We expect this event to attract hundreds of participants and give surgery the presence it needs on Capitol Hill. We also have new communications strategies planned to keep the
College’s membership and leadership better informed about legislative and regulatory issues and activities. Furthermore, we will continue our efforts to coordinate and collaborate with surgical and medical specialty societies to ensure that our voice is strong and united.

**CMS announces new NPI policy**

CMS has announced that, effective March 1, Medicare fee-for-service claims must include a National Provider Identifier (NPI) in the primary fields on the claim, such as in the billing, “pay to,” and rendering fields. Surgeons may continue to submit claims with NPI/legacy number pairs in these fields or submit only their NPI. Providers may not submit claims containing only a legacy identifier in the primary fields. CMS will reject or return as “unprocessable” any claims omitting a NPI in the primary fields. Until further notice, CMS is continuing to allow legacy identifiers only for the secondary fields.

It is important to note that participants in Medicare’s Physician Quality Reporting Initiative (PQRI) must use NPIs correctly in submissions of quality reporting data. Surgeons who intend to submit PQRI measures as of January 1 must use the NPI, even though Medicare permits legacy numbers on claims until March 1. For more information, contact dmariani@facs.org.

**Public hearing on general surgery in Georgia**

The Georgia Board of Community Health sponsored a public hearing on November 28, 2007, regarding a series of proposed amendments to the state’s certificate of need (CON) program. Of particular interest was an amendment that would recognize general surgery as a single specialty for purposes of exemption from the CON program for ambulatory surgery centers. Currently, other surgical specialties, such as orthopaedics and plastic surgery, are eligible for the single-specialty exemption. However, Georgia defines general surgery as a multispecialty, thereby preventing general surgeons from applying for the exemption.

Testimony offered at the hearing was impassioned and overwhelmingly in favor of recognizing general surgery as a single specialty. More than 25 general surgeons, other surgical specialists, patients, and representatives of Georgia medical organizations and the American College of Surgeons filled the Atlanta hearing room. In addition, more than 150 Georgia Fellows sent letters of support through the Surgery State Legislative Action Center.

The Board of Community Health took into account the strong support of the general surgery community and voted to formally adopt the rules on December 13, 2007. On December 31, the Georgia Alliance of Community Hospitals and the Georgia Hospital Association filed their lawsuit as promised against the Board and against Albany Surgical PC.

In addition, legislative activity on this issue is expected during the current session of the Georgia General Assembly, and all Georgia surgeons will be contacted to become engaged in advocacy initiatives with their state legislators. For more information, contact jsutton@facs.org.
HOSPICE AND PALLIATIVE MEDICINE:

Surgeons effectively push for new specialty

by Lola Butcher
G eoffrey P. Dunn, MD, FACS, saved many lives through his work in the operating room. But he has experienced a different kind of professional satisfaction from situations in which death was the inevitable outcome.

“If you can guide a person and a family through all the uncertainty of a progressive illness that you know is going to result in death, if your guidance can allow them to get as much as they can out of their life under those circumstances, it’s a tremendously fulfilling feeling,” he said. “Believe me, I have a lot more cards and letters from families I did that for than from people whose lives I did save.”

Dr. Dunn is one of nearly 3,000 physicians certified by the American Board of Hospice and Palliative Medicine. Its decade-long campaign to advance the field will hit a milestone this year certified by the American Board of Hospice and Palliative Medicine, one of the largest academic hospice programs in the nation—trains internists, family physicians, and surgeons who are preparing for careers in hospice and palliative medicine.

 “[Compared with] any other specialty, physicians differentiate early on and don’t jump fences like that,” he said. “Surgeons should be proud that they’re in there at the beginning of this subspecialty and that the field is open to them.”

What it means to surgeons

In the two years since the ABMS created the new hospice and palliative medicine subspecialty, nearly a dozen surgeons have contacted Frank R. Lewis, Jr., MD, FACS, ABS executive director, to inquire about details. Of those, maybe half have indicated plans to register for the examination. Most of them are in their 50s, looking for a mid-career change, Dr. Lewis said.

“All the physicians I have talked to have been surgical oncologists who have gravitated to the treatment of terminally ill patients,” he said.

Meanwhile, Dr. von Gunten’s fellowship program includes three surgeons, all of whom are certified in obstetrics and gynecology, preparing for a career change.

Approximately 5 percent of the physicians currently certified in hospice and palliative medicine have a primary certification in surgery—and no one expects that the formal recognition of the new subspecialty will increase that proportion.

That said, the individuals who pushed for the ABMS recognition say it has important ramifications for all surgeons. At the broadest level, Dr. von Gunten said, the creation of the subspecialty makes it official: “All of organized medicine agrees that there is specialist knowledge and specialist expertise that exceeds that of the physicians trained in any other way.”

That statement liberates surgeons in two ways: They are not expected to be medicine’s top experts in pain management and end-of-life care—and can stop feeling guilty about their lack of expertise—and they know specialists are available to help them provide this care for their patients.

“The relief is ‘Now I know where to turn,’” Dr. von Gunten said.

The new subspecialty embraces two situations that surgeons frequently encounter:

Hospice care—which Dr. Dunn refers to as “palliative care at the very end of life”—is relevant to surgeons treating patients whose life expectancy is six months or less.

“But palliative care is a much bigger tent than just hospice,” he said. “Palliative care is a conceptual framework for medical care. No matter how
much we value preservation and prolongation of life, it should always be with a concurrent goal of the release of suffering and the promotion of a person’s quality of life.”

Dr. Dunn believes the subspecialty will attract some young surgeons interested in the research opportunities within the field and middle-aged surgeons who want to redirect the focus of their work.

Beyond that, he sees four levels of engagement for active surgeons:

• Basic: Understanding of when and how to refer patients for hospice or palliative care specialists
• Supportive: Using leadership opportunities, such as service on ethics, critical care, or other committees, to extend surgeons’ awareness and consideration of hospice and palliative care services and concepts
• Advocacy: Service of a palliative care or hospice team
• Research: Subspecialty certification as a preface to conducting research in palliative and hospice care, a field that is expected to attract many participants and have enormous impact

One surgeon’s experience

Dr. Dunn was at the prime of his career—chief of surgery at Hamot Medical Center in Erie, PA—in 1995, when he decided to take a leave of absence from his work.

In hindsight, he sees a series of life experiences and recurring concerns that led him out of the operating room and onto a new path. But that pattern was not evident to him at the time. “A lot of people thought I was nuts,” he said.

A fourth-generation surgeon, Dr. Dunn was trained with the Harvard Surgical Service at the New England Deaconess Hospital (now Beth Israel Deaconess Medical Center). While learning to treat severely ill patients, he perceived a disconnect between the excellent clinical care that patients received and the missed opportunities to provide spiritual and social solace to those who needed it.

“Even as early as my residency, I saw what I thought were great shortcomings and outright failure in the care of people with very advanced disease,” he said.

Returning to his hometown, Dr. Dunn developed a busy general surgery practice, treating burn and trauma patients along with cancer and pediatric patients and the variety of cases that come with service in a community hospital.

In 1988, he joined a group of local volunteers who traveled to a very poor city in India, where they delivered operating room equipment and trained hospital employees on its use. There he encountered the cultural phenomenon of intentional burns inflicted on women who were suspected of adultery or who failed to provide sufficient dowry for a marriage.

“I very quickly learned that because of the extent of these kinds of burns—usually 80 percent to 90 percent of the total body surface area—there really was no chance for survival,” he said. “Without calling it such, I was in a burn hospice.”

Almost all the patients died, but Dr. Dunn found something was salvaged by their time in the burn unit.

“Their symptoms were obviously horrifying, but these people at least had a chance to have their dignity restored,” he said. “I learned the importance of spiritual support and saw the value of family support where they were actively participating in care. And in many ways, I felt sort of transformed myself although I didn’t recognize it at the time.”

That transformation took another step in 1994, when Dr. Dunn’s mother died of breast cancer, providing him an insight into what a good death can look like.

“If you were to look for an example of what you want end of life to be, hers would be a pretty good example in terms of the resources, the quality of life, what she was able to accomplish,” he said. “That provided a personal and emotional counterpoint to the intellectual things that were beginning to gestate in my mind.”

The next year, shortly after he stepped away from his surgery practice, a hospice asked him to serve as a part-time medical director. There, Dr. Dunn found his calling.

“When I saw the problems of getting access to good hospice care, the problems brought on by advanced oncologic illness, advanced congestive heart, neurological problems—and how little preparation there was in the medical field for
even communicating about these things, let alone remedying the clinical problems—it really opened my eyes,” he said. “And at that point, I thought, ‘This is where I need to be.’”

A couple of years later, one of his former partners asked Dr. Dunn to fill in when a scheduled speaker for a local ACS chapter meeting cancelled at the last minute. As he began telling his former colleagues about his new work, he was struck by how much patients could benefit if surgeons were more knowledgeable about palliative care and hospice options—and how much the hospice field could benefit from surgeons’ knowledge of complex medical problems.

“That marked the beginning of my trying to pull the world of hospice and palliative medicine right into the world of surgery,” he said.

A time of transition

Dr. von Gunten, editor-in-chief of the Journal of Palliative Medicine, and other advocates of the new subspecialty spent a decade—1996 to 2006—trying to win ABMS recognition.

“To some people, that seems very long, but from the ABMS point of view, which has a much longer view of life than we do, that actually is about as short as it possibly could have been,” Dr. von Gunten said.

ABMS recognition required demonstration of the following three broad domains:

• Hospice and palliative medicine uses a new and distinct body of knowledge that does not overlap with other existing specialties
• A course of training that imparts that specialty knowledge is available
• There is a job—a practice of medicine—that uses this specialized knowledge

With ABMS recognition in place, the American Board of Hospice and Palliative Medicine has discontinued its certification process. Physicians who hold this certification must take the new ABMS examination before 2012. Beginning in 2013, only fellowship-trained candidates will be eligible for the exam—which creates an urgent need for more fellowship programs.

With 4,000 hospice programs and 6,000 hospitals in the U.S., each of which should have at least one physician certified in hospice and palliative medicine, the subspecialty’s ranks—approximately 3,000 physicians—need to grow significantly.

Currently, 61 fellowship programs across the country train approximately 150 physicians each year, Dr. von Gunten said, adding, “That capacity clearly needs to double or triple. Having a stable source of funding is going to be key to that.”

He encourages members of the American College of Surgeons to advocate for establishing more fellowship programs—and more positions in existing programs. Other ways for surgeons to participate in the advancement of the hospice and palliative care field include the following:

• Attend skill-building educational sessions at the Clinical Congress
• Participate in a growing number of conferences and continuing-education offerings that will emerge to spread the skills of hospice and palliative medicine to physicians in many disciplines
• Consider “mini-residencies”—generally one or two weeks in duration—that allow surgeons to gain experience in hospice and palliative medicine at the bedside

Much to learn about pain and death

Before coming to the ABS, Dr. Lewis spent more than 20 years as a trauma surgeon in charge of a critical care unit. He treated hundreds of patients on life support with mechanical ventilators. Invariably, high-dose opiates were used—sometimes for months at a time—to minimize pain and suppress the cough reflex. Conventional wisdom would suggest a high incidence of addiction.

“And yet, in every instance, those people, if they got better, were weaned off the opiates without any trouble, were extubated, returned to a state of health, and were totally free of opiates,” he said. “In all that time, I never saw a single person who was addicted.”

Understanding why those patients did not become addicted to opiates could reduce some of the fear associated with prescribing pain medication for severely ill patients. That aspect requires research, which is a significant need in medicine’s newest subspecialty.

Dr. Dunn listed broad research areas—ethics, quality of life, symptom control—that cry out
for attention, along with specific research questions that every hospice worker wonders about. For example, what is the proper role of forced nutrition in most advanced illness?

He believes some physicians will be attracted to the subspecialty because America’s aging population will bring the questions to bear with ever-increasing frequency. At the moment, the research methods appropriate for palliative care and hospice medicine are still being worked out, along with the evaluation and interpretation of evidence.

For hospice patients, successful therapy does not affect the disease state; its impact is on the experience of the patient and his or her family members.

“These are harder things to measure than, say, did the size of the lesion shrink from five centimeters to two centimeters,” Dr. Dunn said.

**What every surgeon should know**

Many surgeons have little experience with managing chronic pain or referring patients to hospice—and are not eager to acquire such experience. But Dr. Dunn is encouraged by the universal acknowledgement that those skills are needed for surgery patients.

“What amazes me is that, when I talk to surgeons about this, I don’t think I’ve ever been given the brush-off,” he said. “Whether they’re comfortable with it or not, they always say, ‘This is really important.’”

Believing that patients deserve more than lip service, he wants all surgeons to achieve a minimum threshold of competence.

“You should not call yourself a surgeon if you do not know how to appropriately communicate bad news and appropriately manage acute or uncomplicated chronic pain,” he said. “And if you’re calling yourself a surgeon, you should know how to appropriately refer to hospice services.”

In his view, physicians who have never sent a patient to hospice are denying them an appropriate form of care. The recognition of hospice and palliative medicine as a subspecialty is a big step toward making it professionally unacceptable to allow a patient to suffer unrelieved pain or to die without access to the support system that is available. The beneficiary is not only the patient and family, but also the surgeon who recognizes and makes use of the resource.

“For time immemorial, surgeons have been proud of the fact that they could relieve suffering,” he said. “There’s nothing different about that now—but what we can do for people is a lot more complex and effective.”

**Ms. Butcher is a freelance writer in Springfield, MO.**
A one-day symposium—The Art of Medicine at the End of Life—convened in November 2007 at the University Club in New York, NY, and was attended by 100 registrants from 14 states (including 78 physicians representing 16 specialties) who treat and care for patients at the end of life. This symposium was jointly sponsored by the Cunniff-Dixon Foundation (see sidebar, page 15), the University of South Florida Health, and the H. Lee Moffitt Cancer Center and Research Institute in Tampa, FL.

**Human psyche and mortality**

The symposium’s first speaker, Susan Block, MD, chief of psychosocial oncology and palliative care at the Dana-Farber Cancer Institute and Brigham and Women’s Hospital, and co-director of Harvard Medical School Center for Palliative Care, Boston, MA, discussed the human psyche as it confronts mortality and engenders peace at the end of life.

Dr. Block discussed the very real “disconnection” with physicians that patients encounter at the end of their life, citing studies that indicate there is dissatisfaction with symptom management, physician communication, emotional support, and respectful care among family members of patients who died in the hospital; that fewer than half of physicians know whether patients prefer to avoid cardiopulmonary resuscitation (CPR); and that 70 percent of patients in the last six months of life report there has been no discussion with their physicians about what to expect at the end of life.

Dr. Block stated that physicians on the whole tend to be overly optimistic when they communicate with patients, thus depriving them of an opportunity to prepare for the final days of their life.

Dr. Block explored with the audience members how they would define “peace” at the end of life. Among the components of peace discussed were the following:

- Acceptance of diagnosis
- Feeling well loved
- A sense of inner calm, harmony, and tranquility
- Tolerance of changes in physical appearance
- Ability to enjoy life despite worries about illness
- A sense that life is not yet over
- A lack of anger about or a feeling of not feeling beaten by the illness
- Lack of shame/embarrassment about illness

Dr. Block noted factors influencing peace and acceptance, including a therapeutic alliance with one’s physician, encompassing feelings of connectedness and trust, discussions of the
Many, perhaps most, people do not know what life support entails operationally and do not end-of-life options—such as whether to stop or during treatment. Hospice and palliative care rules to begin artificial ventilation with a breath-understand the limits of CPR or mechanical ventilation, according to Dr. Kaufman. “Most individuals do not understand the institutional rules to begin artificial ventilation with a breathing machine that drive much of medical practice in hospitals. [These individuals] are not prepared for the emotional turmoil and guilt that arise when they are confronted with complex, end-of-life options—such as whether to stop or start life-sustaining drugs—or [when they find themselves] in an emergency with no time to reflect,” she said.

Dr. Kaufman stated that hospitals are the root of public angst regarding dying—they are perceived as institutions that have too much technology and not enough compassionate care. “In the gray areas between life and death and end-of-life issues, the hospitals’ use of technology provides more questions than answers,” she said.

There are different pathways within a hospital—one of heroic intervention and one of a “revolving door” syndrome—that affect how patients are managed and how families are addressed during treatment. Hospice and palliative care is an alternative pathway to medical care at the end of life, according to Dr. Kaufman, and is perhaps best suited to address at what stage of terminal illness one halts care and prepares for death.

Religious traditions

Abdulaziz A. Sachedina, PhD, Frances Myers Ball Professor of Religious Studies at the University of Virginia, Charlottesville, spoke about religious traditions at the end of life, noting that biomedical ethics at this time remain very secular. He said he believes the time has come to introduce religion as a partner to end-of-life medicine.

Dr. Sachedina said that there is a very human need to connect with one another during suffering and illness, and that religious and cultural beliefs can play a crucial role in preparing a patient to complete the whole life experience. This fact, he believes, is often lost to organized medicine. Human relationships are at the heart of religion in different cultures, and the need to be connected to other human beings and the value of human contact should not be discounted in end-of-life treatment regimens, Dr. Sachedina said.

Hospitals become too insensitive to the human needs of their patients, Dr. Sachedina said, adding that a person’s religious traditions can begin to ameliorate real and imagined insensitivities during illness and can facilitate a human connection between patient and family in the last days of life.

Legal/medical issues

Winthrop Rutherford, Jr., LLB, a partner with White and Case LLP in New York, NY, presented an overview of legal, liability, and medical issues at the end of life. He urged greater cooperation among physicians and lawyers in helping patients with end-of-life issues. “At present, there is little or no confluence between the two most important advisors that patients have at the end of their life,” he said.

Mr. Rutherford offered a short history of informed consent law in the U.S., along with a discussion regarding the development of current
guidelines governing health care proxies. Health care proxies need not be family members, and they can play a vitally important role in advising patients and families regarding end-of-life issues and ensuring that state legal statutes are known and followed, he said.

**Ethics**

Arthur Caplan, PhD, the Emmanuel and Robert Hart Professor of Bioethics, Center for Bioethics, University of Pennsylvania, Philadelphia, addressed the ethics of the transition to the end of life.

Dr. Caplan presented many questions for consideration. Should patients be able to hasten their own death by refusing a respirator, feeding tube, or other life support? If patients are unable to communicate their wishes, should others be able to decide for them? If so, who should make the decision—family members, medical professionals, or both? Does it matter if the patient is young or old? What if the individual is not terminally ill but severely and chronically ill? Is there a difference between refusing life supports and asking for medical intervention that would hasten death?

These and other questions have spawned a national dialogue on the quality of death and the rights of dying patients. Dr. Caplan reviewed as examples the cases of Karen Ann Quinlan and Terri Schiavo and the legal implications for palliative care.

Dr. Caplan posited that, regarding end-of-life ethical issues, the following needs to be done:

- Patients must reaffirm their right to monitor/control all medical care at the final stages of life
- Living wills alone are insufficient—patients need to add durable power of attorney to their legal documentation
- Organized medicine should establish the management of end-of-life treatment as a routine part of comprehensive medical care
- Hospice and palliative care should be reimbursable expenses
- End-of-life treatment should never be started without discussion as to when to stop such treatment
- Physicians should always offer their opin-

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**Cunniff-Dixon Foundation**

The Cunniff-Dixon Foundation was created in 2005 in memory of Carley Cunniff and in recognition of Peter S. Dixon, MD. Ms. Cunniff died in January 2005 after a three-and-a-half-year battle with breast cancer. Dr. Dixon was her attending physician during her last year of life. “He was the guiding light who enabled Carley to die a peaceful death at home, with her family and loved ones,” said Andy Baxter, her husband and a founding member of the Cunniff-Dixon Foundation.

The mission of the foundation is to enrich the physician-patient relationship at the end of life. “Our goal is to educate individual physicians and inspire them to provide the kind of care at the end of life that we all wish for ourselves and our loved ones,” Mr. Baxter said. The foundation will present a series of continuing medical education conferences designed to educate physicians about end-of-life issues. Three such conferences in various locations are planned for this year.

In addition, the foundation is developing a Web site meant to be a leading source of information and interaction on palliative care. Initially, the Web site will target the medical community, with the hope of expanding it for the benefit of patients and their families. The Web site will be available at www.cunniffdixon.org and is expected to launch in the near future.

In the fall of this year, the foundation will award the first annual Cunniff-Dixon Prizes in recognition of clinical contributions and commitment to the practice of end-of-life medical care. Current plans are to award four prizes totaling $95,000. Three of the awards will be in the amount of $15,000 and will go to residents and/or fellows who have demonstrated a serious commitment to the field of palliative medicine and have already made a contribution, through practical research or clinical work. The fourth award—in the amount of $50,000—will go to a physician who has demonstrated, through leadership and practice, a major, valuable commitment to end-of-life care.

Additional information regarding the foundation and the prizes may be obtained by contacting the Cunniff-Dixon Foundation, PO. Box 800, Essex, CT 06426; tel. 860/434-6476; fax 860/434-8815.
ion regarding informed consent—their views need to be heard and considered

- All members of a medical/palliative care team should be on board regarding a course of treatment for terminally ill patients

**Keynote address**

Pauline W. Chen, MD, FACS—a general surgeon and writer from Boston, MA, who authored *Final Exam: A Surgeon’s Reflections on Mortality* (New York: Vintage; 2008. ISBN 978-0307263537)—provided the keynote address during the symposium’s lunch. She offered a poignant, introspective look at the care of several terminally ill patients she has encountered. She spoke of what drew her to the field of palliative care, the challenges it now faces, and to where she believes this field of medicine is progressing. (See Dr. Chen’s related remarks on page 19).

**Hospice/palliative care: When and how**

Dr. Block and Peter S. Dixon, MD, led an interactive session with audience members regarding the current challenges faced in implementing palliative care. Among the insights provided during this session were the following:

- Patients often view hospice as abandonment by physicians or health care providers
- Physicians in the palliative care field often believe they are fighting the medical industry complex
- There are palpable respect issues associated with this field of medicine, as many physicians, nurses, and health care workers do not appreciate or respect palliative care professionals; there is a critical need for better public relations
- Many physicians (notably oncologists) equate palliative care with “symbolic” care

**Physician-patient relationship**

Edward M. Copeland III, MD, FACS—the Edward R. Woodward Distinguished Professor in the department of surgery at University of Florida College of Medicine, Gainesville, and the Immediate Past-President of the American College of Surgeons—spoke on the evolution of the physician-patient relationship.

Dr. Copeland offered his personal insights as to how a surgeon may create and foster a trusting relationship with the patient and family and how a surgeon should never underestimate the power of the “personal touch.” (An adaptation of Dr. Copeland’s presentation appears on the next page.)

**Q & A session**

A question and answer session with a panel of faculty/presenters ended the symposium. Andy Baxter (see sidebar, page 15) offered closing remarks and acknowledged the efforts of course directors Dr. Dixon and Thomas S. Herman, MD, FACS, of Tampa, FL.
The doctor-patient relationship is a time-honored tradition and a reward for the compassionate physician and appreciative patient. The first code of ethics between physician and patient appeared in 1750 BC, when Hammurabi was commissioned in Babylon to establish laws that governed the practice of medicine. At that time, an internist recited incantations and surgeons opened abscesses with a bronze lancet. If a patient died or lost an eye, the physician’s hands were cut off—not an especially rewarding experience from an appreciative patient.

Over the years, fortunately, the relationships and rewards have changed. The turn of the 19th century was the era of the “country doctor” in his horse and buggy tending to patients at home with little else to offer than compassion. In today’s world, with the many evolving tests both invasive and noninvasive, restrictive insurance programs, and the recent eagerness of young physicians to have a better lifestyle than the country doctor, the relationship between the physician and patient is in the process of change. In the 1970s, the terms “consumer” and “provider” crept into the lexicon of medical practice, stimulating me to address this issue before the Association of Academic Surgery in a presidential address in 1979. During that speech, I said the following:

I have remained in academic medicine for one prevailing reason: to be exposed to bright young minds eager to learn the morals and ethics of medicine, and eager to be instilled by example with the powers and rewards of sound professional judgment. To serve as an example to the young physician, the teacher must first embody the principals and skills he wishes to impart and then have patients who relate to him as their private physician. Through this unique experience, the student learns the meaning of the patient-doctor relationship as opposed to the relationship between consumer and provider.

...If the people are never exposed to the warmth of a relationship between a concerned physician and his trusting patient, they will learn to wait in line for care, see a different physician on each visit, and pay out in higher taxes what they think they are receiving in free care at an assigned clinic. If this occurs, the reason many of us entered and remained in academic surgery will have died.

These statements were written almost 30 years ago and, in my mind, are somewhat prophetic. If the prophecy proves accurate as I described it, the patient at the end of life may suffer the most. The views of physicians regarding death of one of their patients have been studied. Death is often considered a professional failure; physicians are uncomfortable dealing with end-of-life issues with both the patient and the family; impending death of a patient may awaken unresolved or unexpected anxieties within the physician; and one-third of family doctors have trouble coping with their own emotional responses aroused by the end of life and, interestingly, their negative responses increase with the length of practice.

It, thus, becomes quite easy to understand why and how hospice care and palliative medicine as a specialty evolved. Both fill a void in the life of everyone. Having just buried my father-in-law and mother-in-law, both of whom were elderly but healthy, within two months of each other, I have a personal respect for hospice care. Nevertheless,
the event that was most comforting for my wife was the attention paid to her parents and to her by their family physician of long standing. To lose this kind of personal involvement would indeed be unfortunate.

Long-standing relationships between physician and patient are rapidly becoming the exception rather than the rule because of a mobile society and changes forced by insurance issues. The surgeon’s role at the end of life is often to make the decision to do a palliative procedure in the face of impending death. An example would be to attempt to relieve a small bowel obstruction in a patient with carcinomatosis or do a total gastrectomy in a patient with linitus plastica with liver metastases. A simple rule to follow is that it is often harder to make the decision not to operate rather than to do an operation. Once the decision has been made to do a palliative procedure, it becomes the responsibility of the surgeon to ensure recovery so that the patient can enjoy the benefits of the procedure. The personal bond between the patient and the surgeon is often the strongest, especially at the end of life.

Having been a surgical oncologist for my entire career, any one of my patients has the potential to be a statistic, even though the chance may be small. Since I have worked in referral institutions my entire career, the majority of patients come to me with the malignant diagnosis having already been made and they think the diagnosis is a death sentence. So, the news I give them about survival is often good news. Nevertheless, in this setting I have several personal axioms: create a trusting relationship with the patient and family—which often requires listening rather than telling; detail the informed consent in a compassionate manner; the truth of the illness should be shared with the patient and the patient’s designee before and after the operation face-to-face and be reinforced on subsequent visits; emphasize hope in the context of reality; and don’t forget the power of the personal touch. The bottom line is that physicians should empower their patients to make personal decisions and should be aware of the psychological, social, and spiritual dimensions surrounding their illnesses.

Surgery must remain a profession, not a trade. Edmund Pellegrino, director emeritus of the Kennedy Institute of Ethics, defines professionalism best: “a declaration of a way of life in which expert knowledge is used not primarily for personal gain, but for the benefit of those who need that knowledge.” And in the words of Gerald Healy, MD, FACS, in his Presidential Address before the American College of Surgeons in 2007: “Your patients do not care how much you know until they know how much you care.”

References

Dr. Copeland is the Edward R. Woodward Distinguished Professor of Surgery in the department of surgery at University of Florida College of Medicine, Gainesville. He is Immediate-Past President of the College.
I accepted an invitation to be the keynote speaker at the Art of Medicine at the End of Life symposium, organized by the Cunniff-Dixon Foundation, because I found the foundation’s mission—“to educate individual physicians and inspire them to provide the kind of care at the end of life that we all wish for ourselves and our loved ones”—particularly compelling. I think most other physicians would feel similarly, as the mission resonates with the very reason we chose this profession in the first place: We want to help others.

For surgeons, I think there is something even deeper. The Cunniff-Dixon Foundation’s mission (see page 15) evokes a deep sense of responsibility to patients, a sense that I believe lies at the very heart of how surgeons define themselves.

Surgeons routinely push the limits of endurance in order to do the best they can for their patients. I think some of the most moving examples of empathy in medicine exist among surgeons. When a surgeon opens up a patient and finds tumor so diffusely studded in the abdomen that a curative operation is impossible, the silence in the operating room (OR) is profound. When a patient becomes critically unstable, a surgeon will hover close by, spending the night at the patient’s bedside or in the hospital office. Putting patients’ needs above your own is part of the ethos of surgery.

When I was a junior resident, I remember watching a fellow resident learn the meaning of surgical responsibility from the late C. Elton Cahow, MD, FACS, the gifted and highly respected elder statesman at Yale University at the time. The resident was eager to leave the hospital one afternoon, even as one of the patients under his watch became unstable. Dr. Cahow stepped in front of the resident, literally blocking his path out of the hospital, and pointed back at the patient’s room. “Son,” he said in the sternest voice I had ever heard him use, “once you lay your hands on a patient, that patient is yours.” The resident ended up staying at the hospital late into the night, and I don’t think he, or I, ever forgot that lesson.

To me, that sense of responsibility fits seamlessly with the goals of palliative care. But it also poses a particular challenge for surgeons.

Death is difficult for all of us, but it is made all that much harder for surgeons because of our highly refined sense of responsibility. Moreover, we use our hands to effect therapy; it’s hard not to leave the OR feeling a kind of shared identity with that patient on the table.

Although the strong connection with patients inspires some pretty heroic caregiving on a surgeon’s part, it can also be problematic when we interpret therapeutic “failure” as a personal failure. It is devastating for surgeons when patients are dying, because it’s hard not to wonder if the outcome is, in some way, our fault. Moreover, like so many other challenges in our clinical work, these deaths end up becoming something we face alone in a health care environment that barely gives us enough time to get the job done, let alone reflect on it. Helping our dying patients die well thus puts our professional ethos to one of its toughest tests.

Here is where the work by the Cunniff-Dixon Foundation is invaluable. Through its educational work, the Foundation gives individual clinicians the opportunity to discuss the challenges of caring for the dying, to share their experiences, and to place those experiences within the larger palliative care framework.

At the recent symposium, for example, there were roughly 100 attendees. (Of note, there was a
sizeable surgical presence among the attendees, and two exemplary surgeons—Edward M. Copeland III, MD, FACS, Immediate Past-President of the College, and Thomas Herman, MD, FACS, one of the conference’s chief organizers—were involved in the symposium’s planning.) There were lectures by leading experts in end-of-life care that covered a wide range of topics relevant to any clinician.

But what was most remarkable were the questions, comments, and even challenges from the audience after each lecture. The lively and spontaneous discourse reflected a void in health care. There are few opportunities for clinicians to reflect openly with one another on the challenges of practicing quality end-of-life care, to discuss ways we can provide dying patients with the kind of care “we all wish for ourselves and our loved ones.”

The Cunniff-Dixon Foundation symposium was one of those rare opportunities. And, fortunately for all of us, the Foundation is planning on sponsoring more symposia in the future.

The draw to palliative medicine

I think I have always been at least curious about palliative medicine. A resident sees, on average, 28 deaths a year, so it’s hard not to go through residency without reflecting at some point on how our patients die.

Unfortunately, what many of us end up taking away from these reflections is that death should be depersonalized. Medical sociologists have written about the “informal curriculum” of medical training—the language and the subtle gestures and responses that form the professional culture of medicine. Through the informal curriculum, young doctors learn the values of our professional culture and come to believe that these values, such as distancing ourselves from the terminally ill, will somehow make them better doctors. I, for one, certainly embraced the informal curriculum during my training.

What made me begin to question these values were two things. First, I had the good fortune of training with some exceptional individuals—surgeons and other health care professionals, patients, and their families. Second, I began writing.

I did not write much in residency, but after my training was done, I found myself writing stories in notebooks, on my computer, and on loose papers in my white coat pocket. It was as if some pot inside had finally boiled over and I had to scramble to catch the contents that kept spilling out. Most of the pieces I wrote back then were fictional, and nearly all of them had some medical theme.

After a few months, I signed up for two writing courses at the University of California–Los Angeles, where I was an attending surgeon in the division of liver transplantation. Midway through the second course, the instructor asked to meet with me privately. I was convinced that she was going to ask me to tone down the graphic clinical details of my stories or to repeat the course since I had missed several classes because of transplants. Instead, she said simply, “Pauline, you have to write these stories.” She and my other writing instructor recognized my short stories as thinly veiled personal narratives, and her comment gave me the kind of permission I needed to write what I really wanted to write about—that is, my experiences with patients.

I began then to write in a more organized fashion, and as I collected the stories, I saw that a fair number of them had to do with grief—grief over patient complications, grief over deaths, and grief over the kind of care I had provided over the years. But some stories were also hopeful; they involved surgical colleagues and teachers or other health care professionals who had pushed me to think or to act a little differently. Unbeknownst to me at the time, they were teaching me about palliative care. They were showing me that there was much more we doctors could do for our patients than simply cure.

In retrospect, I think that writing the stories gave me an opportunity not only to reflect on the past but also to consider ways in which I might improve my work in the future. As I wrote these stories, I was, in fact, experiencing narrative medicine, a field that uses writing, reading, narratives, and the approaches used in literary critique as a way for physicians to improve themselves. And what was emerging for me from this experience was a greater understanding of and appreciation for the power of palliative care.
Skills for end-of-life care

In terms of end-of-life care and the skills necessary, there is a terrific canon of research out there, including the excellent series of articles by Geoffrey Dunn, MD, FACS, and others that were published a few years ago in the Journal of the American College of Surgeons.

I think that, given our strong sense of responsibility toward patients, we surgeons are uniquely qualified to provide effective care to patients at the end of life. In fact, some of the most moving caregiving testimony I have heard since my book came out has been from surgeons, particularly from some of the more senior members of our specialty. A retired general surgeon told me with pride that some of the most rewarding moments of his career were those times he had helped his breast cancer patients die with dignity. An older thoracic surgeon told me about the lessons of his mentor: that part of being a good surgeon was knowing when one could do no more and being honest with patients and their families.

Probably the most moving story I heard was from the adult daughter of a surgeon who had practiced in the Midwest from the 1950s until his death from pancreatic cancer in the mid-1980s. Her father had been head of surgery at a couple of local hospitals and had had a terrifically busy practice. One day, as a teenager, she went to look for her father at one of his hospitals. She found him in a patient’s room. He was sitting at the bedside reading the Bible aloud.

The daughter became annoyed. Her father was so busy clinically that he was always running late for the OR, for the clinic, and especially for family occasions like dinner at home. Why, she asked herself, was he now just sitting there reading by his patient’s bedside?

When her father finally came out of the room, the daughter confronted him. Her father looked surprised for a moment, then quietly told her that the patient had asked him to read a Bible passage aloud. “She is dying,” he explained. “When I realized that there was nothing more I could do for her medically, I did what I could.”

I’m not sure we can change that unpleasant aspect of death for our patients and their families, but I do think we make the experience much worse for all, including ourselves, by denying death’s very existence. We doctors are in a unique position; we are often the guardians of the last days of life. We can talk with our patients and their families, we can provide guidance and support, and we can be present.

And in the end, I think that being present may be the most important thing all of us can do, surgeon or not.
The third and final phase of physician self-referral regulations—called the Stark Laws in reference to Rep. Pete Stark (D-CA), who introduced the legislation that originally called for banning self-referrals—became effective on December 4, 2007. This article is intended to bring surgeons up to date on the rules and their effects on surgical practices.

**Background**

The first Stark Law (Physician Self-Referral Law, Sec. 1877 of the Social Security Act, 42 U.S.C. § 1395nn) was enacted in 1989 with the intent of prohibiting physicians from referring Medicare patients to laboratory service facilities in which they had a financial interest, a practice termed “self-referral.” This restriction, known as Stark I, became effective January 1, 1992. In 1993, legislation passed to extend the Stark I Laws to services provided to Medicaid patients and amended the original law to include additional health care services considered to be particularly susceptible to overuse because of physicians’ financial interests. These amendments went into effect January 1, 1995, and are referred to as Stark II Laws.

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Regulatory issues addressed in Stark II, Phase I, II, and III

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<th>Regulatory issue</th>
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<th>Stark II, Phase III</th>
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<td>Safe harbor provision</td>
<td>CMS created a voluntary “safe harbor” provision for calculating fair market value of hourly payments to physicians for their services. The safe harbor provision reduces or eliminates a party’s liability under the law when actions are performed in good faith.</td>
<td>Phase III eliminates the safe harbor provision; however, CMS will continue to scrutinize all fair market value arrangements.</td>
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<td>Physician recruitment</td>
<td>The recruit’s medical practice must relocate. Under the rule, the recruited physician will be deemed to have been relocated if the physician’s medical practice moves at least 25 miles or if at least 75% of the recruited physician’s revenues are provided to new patients not seen at the previous practice site.</td>
<td>Phase III expands the “geographic area served by the hospital” test to include the area comprising all the contiguous zip codes from which the hospital’s inpatients are drawn. It allows group practices to impose practice restrictions and permits practices to offer more generous income guarantees to a physician recruited to take the place of a deceased, retiring, or relocating physician. It also adds provisions exempting certain physicians from the relocation requirement.</td>
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<td>Intra-family rural referrals</td>
<td>Phase II created a new exception for cases in which no other entity furnishes the designated health service (DHS) within 25 miles of the patient’s home. If the patient is receiving at-home care, the exception applies if no DHS entity is available “in a timely manner in light of the patient’s condition.”</td>
<td>Phase III modifies the exception to include an alternative distance test based on transportation time (45 minutes) from the patient’s residence. This new alternative test requires case-by-case analysis of the conditions existing at the time of the referral (for example, snow blocking access to roads).</td>
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<td>Personal service arrangements</td>
<td>The exception covers services provided by the referring physician or his or her immediate family member and/or employees, but not contractors. A personal service contract can mean any kind of services personally performed and can be between a DHS entity and an individual and may include equipment that the physician needs to provide services.</td>
<td>Phase III changes the personal service arrangements exception to include a provision that permits a holdover personal service arrangement for services provided after the terms of the contract expires, extending for up to six months such arrangements that otherwise meet the requirements of the personal services exception.</td>
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## Regulatory issues addressed in Stark II, Phase I, II, and III (continued)

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<td><strong>Nonmonetary compensation</strong></td>
<td>Items or services not exceeding an aggregate of $300, provided they are not solicited by a physician, do not take into account the value of referrals and do not violate the anti-kickback statute. In phase II, the $300 limit of nonmonetary compensation will be updated annually for inflation and displayed on the CMS self-referral Web site after September 30 of each year.</td>
<td>Phase III makes two substantive changes to the nonmonetary compensation exception by (1) allowing physicians to repay certain excess nonmonetary compensation within the same calendar year to preserve compliance with the exception, and (2) allowing entities without regard to the $300 dollar limit to provide one medical staff appreciation function (such as a party) for the entire medical staff per year.</td>
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<td><strong>Professional courtesy</strong></td>
<td>The professional courtesy provision provides for a new and narrow exception to allow the provision of certain free or discounted health care items or services. Phase II defines professional courtesy as “the provision of free or discounted health care items or services to a physician or his or her family members or staff.” Certain requirements must be met before the exception applies, and CMS cautions that these arrangements should be examined to determine whether they violate the anti-kickback statute or the civil monetary penalties laws.</td>
<td>Phase III modifies the professional courtesy exception by deleting the requirement that an entity notify an insurer when the professional courtesy involves the whole or partial reduction of any coinsurance obligation.</td>
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<td><strong>Definition of referral</strong></td>
<td>In Phase I, HCFA excluded from the definition those services personally performed by the physician, explaining that it is not possible for a physician to make a referral to himself or herself for services that he or she provides.</td>
<td>Phase III further clarifies that there are few, if any, situations in which a referring physician could personally furnish durable medical equipment (DME), because this would require the physician be enrolled in Medicare as a DME supplier and personally perform all of the duties of a supplier.</td>
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<td><strong>“Stand in the shoes”</strong></td>
<td>Phase II’s definition of a referring physician states that the physician may be treated as “standing in the shoes” of his or her wholly owned professional corporation and does not apply to group practices.</td>
<td>Phase III added the definition for physician organizations, which means a physician, including a professional corporation in which the physician is the sole owner, a physician practice, or a group practice.</td>
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"Stand in the shoes" CMS has delayed enactment of this provision for academic medical centers and 501(c)(3) health care systems.
The Stark II Laws prohibit physicians from making referrals for a designated health service (DHS) payable by Medicare or Medicaid to entities with which they or members of their immediate family have a financial relationship. A financial relationship means either an ownership interest or a compensation arrangement. For the purposes of the Stark Law, a DHS falls within one of 11 categories, including inpatient and outpatient services; clinical laboratory services; home health; prosthetics, orthotics, and prosthetic devices; and supplies. The law is wide-ranging; for example, a physician’s practice or group may be an entity to which referrals are prohibited. Penalties for violating the Stark Law include denial of payment for the services, civil penalties, or even exclusion from the Medicare or Medicaid programs.

On January 4, 2001, the Health Care Financing Administration (HCFA), now known as the Centers for Medicare & Medicaid Services (CMS), issued the first phase of the Stark II final regulations, also known as Stark II, Phase I. These rules addressed the general prohibition, general exceptions applicable to both ownership or investment interests and compensation arrangements, new exceptions that are applicable only to compensation arrangements, and definitions. Stark II, Phase I only applied to referrals of Medicare beneficiaries and went into effect January 4, 2002, one year after publication.

CMS issued Phase II of the final regulations on March 26, 2004. Phase II addressed provisions of the Stark Law not addressed in Phase I and provided additional regulatory exceptions and responses to public comments on Phase I regulations.

The current system

Finally, on August 27, 2007, CMS released the long-awaited Phase III rules. Under the statute, physicians cannot refer Medicare patients to facilities in which they have a financial interest unless the business arrangement meets one of a number of exceptions. Phase III final regulations were published September 5, 2007, and became effective December 4, 2007. Generally, Phase III responds to comments on Phase II and addresses the entire regulatory scheme. Phase III does not contain any sweeping changes to the Stark Laws. No new exceptions are extended to physicians, hospitals, and other providers implementing business and referral arrangements. However, Phase III does revise and clarify some regulatory language in a few areas in hopes of simplifying compliance. Phases I, II, and III of the rulemaking are intended to be integrated and read together as a whole. The accompanying chart (pages 23-24) provides highlights of all three phases of Stark II.
This column lists some questions regarding Current Procedural Terminology (CPT)* recently posed to the ACS Coding Hotline and the responses. ACS members and their staff may consult the hotline 10 times annually without charge as a benefit of membership in the College. If your office has coding questions, contact the Coding Hotline at 800/227-7911 between 8:00 am and 6:00 pm central time, holidays excluded.

A surgeon performed the following: 44160, colectomy, partial, with removal of terminal ileum with ileocolostomy; 49560, repair initial incisional or ventral hernia; reducible; 49568 (add-on code), implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection; and 44005, enterolysis. Why was only the claim for 44160 approved?

The National Correct Coding Initiative (NCCI) edits allow reporting of the three codes (with a modifier); however, if the hernia repair is performed at the site of an incision for an open abdominal procedure, the hernia repair is not separately reportable. The mesh code 49568 is an add-on code for hernia repair. According to the NCCI edits, the enterolysis (44005) is considered an integral component of the colectomy code.

If I make one incision to repair two or more hernias, may I code for multiple hernia repairs?

Medicare will pay for only one hernia repair per incision. If the surgeon believes the hernia repair was unusually complex and added significantly to the overall procedure, then modifier –22, “unusual procedural service,” can be appended to the hernia repair code. Documentation explaining the unusual circumstance should be added to the claim.

Has there been a code developed for laparoscopic hernia repair that is newer than code 49659?

The unlisted procedure code 49659 is the correct code for Medicare. If this is a non-Medicare patient, you might check with your insurer to see if it has an alternative preferred code.

What is the correct way to code for a repair of parastomal hernia and ventral hernia repair with mesh?

If the surgeon did a revision of the colostomy with repair of a paracolostomy hernia, then use...
code 44346. If two separate and distinct hernias were repaired (such as parastomal and ventral), then it is appropriate to also report code 49560 with a multiple procedure modifier –51. If mesh was used for the ventral hernia repair, use 49568 as an add-on code.

How does one code for the mesh when billing an umbilical hernia repair with mesh? Can the add-on code of 49568 still be used?

No, this add-on code is only for incisional or ventral hernia. With the exception of incisional and ventral hernias (49560 and 49566), use of mesh is not separately reportable.

The surgeon performed an inguinal hernia repair (49505, repair initial inguinal hernia, age 5 years or older; reducible) and billed and is getting paid for the add-on code of 49568, implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection along with 49505. Can he continue to bill for the mesh placement?

This setup is incorrect billing of 49568. The add-on code of 49568 is for incisional and/or ventral hernia repairs only. Medicare rules indicate that mesh placement is inclusive to all other types of abdominal hernia repairs.

When reporting on the flow sheet required for participating in the Physician Quality Reporting Initiative (PQRI), should we use the modifiers next to the CPT code 49560?

What PQRI code do I use? Do I use the “F” code, and which modifier should I use, “p1” or “p8”?

The only measure that applies to CPT code 49560 is number 23, ordering and administering venous thromboembolism (VTE) prophylaxis. To report this measure, you must use the appropriate CPT II or “F” code on the same claim form that you bill the original procedure.

- If VTE prophylaxis was ordered or administered according to the measure, then you report the code 4044F.
- If it was not ordered or administered for a medical reason, then you report 4044F-1P.
- If it was not ordered or administered and there is no documented reason, then report 4044F-8P.

Refer to the sample claim form at http://www.facs.org/ahp/pqri/claimexample.pdf for an example to follow. This Web site has other valuable information on measures and codes, frequently asked questions, and flow sheet explanations. More information can also be obtained at the Centers for Medicare & Medicaid Services Web site, www.cms.hhs.gov/PQRI.

Resources

National Correct Coding Initiative
http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage

Medicare Correct Coding Guide

Dr. Bothe is chief quality officer, Geisinger Health System, Danville, PA.
G. Tom Shires, MD, FACS, 1926–2007

by Philip Barie, MD, FACS; Ronald V. Maier, MD, FACS; Malcolm O. Perry, MD, FACS; Donald D. Trunkey, MD, FACS; and Roger W. Yurt, MD, FACS; edited by Lewis Flint, MD, FACS

In memoriam

G. Tom Shires, MD, FACS, died at his home in Henderson, NV, on October 18, 2007. Dr. Shires became a Fellow in 1959 and served the College with distinction in numerous capacities, including President (1981–1982), a member of the Board of Regents (1971–1980, 1981–1982), and Chair of the Board of Regents (1978–1980) and the Communications Committee of the Board of Regents (1974–1982). He was Editor of Surgery, Gynecology & Obstetrics (now the Journal of the American College of Surgeons) from 1982 to 1993.

A native Texan, Dr. Shires completed his undergraduate studies at the University of Texas in Austin and received the medical (MD) degree from the University of Texas Southwestern Medical School. He completed his residency in surgery at the Parkland Memorial Hospital in Dallas, TX, where his mentor was Carl Moyer. After completing his training, he entered the Navy, returning after the completion of military service to Southwestern, where he joined the faculty.

Following are reminiscences from Dr. Shires’ colleagues.

Thoughts on the Dallas years by Dr. Perry

In 1960, Dr. Shires was appointed acting chairman of the department of surgery at the University of Texas Southwestern Medical School in Dallas. During the following months, one of his many responsibilities was to act as host for several prominent surgeons who were candidates for the chair of surgery. Parkland Memorial Hospital was the major teaching site for the medical school and there were some rotations at the Dallas Veterans Administration Hospital. Those of us in the surgery program watched these visits with great interest and learned much from the conferences set up to “see the candidates in action.” At the same time, the visiting surgeons were critically evaluating us, the hospitals, the other training programs, and the resources of the medical school.

Southwestern was quite young, as medical schools go, and not well known. This situation was to change with dramatic speed. The department of medicine, led by Dr. Donald Seldin, was moving ahead rapidly and developing solid and credible teaching and research programs. Dr. A. J. Gill, a professor of pathology and a charismatic speaker, had been appointed dean of the medical school. His leadership philosophy was founded on the precept that his job was to remove obstacles that impeded growth and development by the faculty and departmental leaders. This attitude served to accelerate the advances being made in several clinical and basic science areas. When the search committee for chair of surgery completed its evaluations and nominated Dr. Shires to be the permanent chair, he took full advantage of Dr. Gill’s leadership philosophy and employed it fully with energy and insight.

Dr. Shires was 35 years old in 1961 when he assumed the chair of surgery. Many of us had been on his clinical service and had worked with him on the wards and in the operating
room. We knew him as a brilliant diagnostician and skilled surgeon. He was a polite, dedicated teacher. We were all happy with the choice that the medical school had made.

We were more than satisfied. Dr. Shires began by abolishing the pyramidal residency. He then relaxed the night call schedule to a one-in-three rotation. He frequently said, “Tired residents can’t learn.” He successfully convinced the hospital administration to raise resident salaries. As he applied his considerable administrative skills in areas not immediately apparent to us, major improvements followed rapidly. He began the search and recruitment process for new faculty, seeking people with strong research skills to complement their abilities in teaching and the practice of surgery. He recognized that the spectrum of patient experiences at the Parkland Hospital and the Veterans Administration Hospital would need to be expanded to successfully prepare surgeons for a practice career. He concluded teaching agreements with the Presbyterian Hospital and the Gaston Hospital. These were places with practitioners and patients similar to those a surgeon would encounter in practice.

Parkland Hospital had a heavy load of trauma and burn patients and Dr. Shires began to strengthen these areas of care. A burn center and a dedicated trauma unit were established and major research proposals were written to obtain peer-reviewed research support from the National Institutes of Health. A four-bed trauma unit located adjacent to the recovery room was built with full instrumentation and a computer database. These efforts led to the implementation of strong research fellowships in trauma and burns.

During these building phases, Dr. Shires was hiring faculty to augment the research programs, including scientists in chemistry and biomedical science. His inclination, in many instances, was to encourage residents from his program to go elsewhere for fellowship training and then return to bring their skills back to Dallas. It was a successful undertaking and several of us, upon completion of our training, went away for one or two years, returning with new skills in oncology, vascular surgery, endocrinology, and applied clinical research. These were exciting times for faculty, and the department made huge strides in patient care, surgical education, and research. Many young faculty members went on to become heads of major divisions and departments of surgery. The end result of Dr. Shires’ vision and leadership was a department of surgery widely recognized as a center of excellence for clinical training and research.

The Seattle transformation by Dr. Maier

Dr. Shires visited the University of Washington in Seattle on several occasions during 1973; the culmination of this recruitment occurred when he was appointed chair of the department of surgery at the University of Washington. He arrived in 1974 to assume the post and to build what he envisioned as the leading trauma center in the country. He came with a record of having built an outstanding trauma research and clinical care center in Dallas at Parkland Memorial Hospital. The University of Washington, for its part, made an exceptional commitment to provide the resources, facilities, and faculty support to create a truly world-class trauma and burn institute. As part of that commitment, the university completed the addition of a nine-story clinical facility dedicated to the trauma and burn activities at the University of Washington and located at Harborview Medical Center, a future level I regional trauma center serving four northwestern states covering one-quarter of the land area of the U.S. and a long-standing county-owned safety net facility dedicated to the care of all patients requiring exceptional medical care, including the severely injured and burned patients.

As part of the university commitment, Dr. Shires was encouraged to bring with him additional faculty to build this mission. The group included (all MD, FACS) Peter Canizaro, C. James Carrico, William Currier, Claude DeShazo, David M. Heimbach, Joel Horowitz, Robert Jones, and Malcolm Perry, along with Janet Marvin, RN, a nurse clinical specialist of the Burn Center at Parkland Memorial Hospital. In addition, Dr. Shires brought eight residents, two at each of the first four levels of training, to
supplement the current surgical training program in Seattle. Thus, through this dramatic maneuver, Dr. Shires, virtually overnight, was able to transform the university training program and lay the groundwork for a remarkable clinical and research center focused on burn and trauma care.

This move of such a large number of established investigators was heretofore rarely encountered, and it spoke significantly to the loyalty that Dr. Shires engendered among his faculty and residents. He was indeed an exceptional leader who provided the ultimate in academic environment, support, and infrastructure to nourish an inquisitive clinical scientist and the facilities and structure for world-class clinical care. His ideals and proven capabilities unified this group and catalyzed the change in Seattle.

As in all human endeavors, rapid change is difficult and there were stresses that accompanied this dramatic change in direction and commitment. It was in the setting of this tension that, when yet a subsequent golden opportunity was presented by Cornell University Medical School, Dr. Shires was convinced to take on yet an additional challenge and accepted the position of chairman of surgery at that institution in New York. Upon leaving Seattle, he was accompanied to Cornell by several faculty members, including Drs. Canizaro, Curreri, Horowitz, and Perry.

Although he was in Seattle but a short 18 months, he was able to create an outstanding academic surgical department as well as a world-class trauma and burn center. He left behind a cadre of outstanding surgical scientists and clinicians who carried on the efforts that he had begun and left instilled in the residents who had joined him a commitment in their academic careers that many have pursued to outstanding roles in the academic surgical community. Wherever Dr. Shires touched the surgical environment, he left an indelible print and a loyal, dedicated following. He was indeed a unique and loved leader and his legacy is a powerful testimony to the outstanding qualities of this surgical giant.

**The Cornell years by Dr. Barie and Dr. Yurt**

Dr. Shires became the fourth Lewis Atterbury Stimson Professor of Surgery and chairman of the department of surgery at Cornell University Medical College in 1975, his predecessors having been Frank Glenn, MD, FACS; C. Walton Lillehei, MD, FACS; and Paul Ebert, MD, FACS. He arrived in September with a vision to transform The New York Hospital into a true tertiary-care academic health center and to modernize the care of critically ill and injured patients in the metro New York area and beyond. He began by recruiting a critical mass of surgical talent and these surgeons began numerous new and expanded clinical programs, including the opening of a level I trauma center that is now the busiest in New York City.

One of Dr. Shire’s top priorities was the development of a modern burn care center, which was accepting patients within months of his arrival. Crucial to its enduring success has been the generosity of the New York Firefighters Burn Center Foundation, which was created in parallel to Dr. Shires’ personal pleas in firehouses throughout New York City—the result was one of Dr. Shires’ lasting legacies, what has come to be called the William Randolph Hearst Burn Center of New York-Presbyterian Hospital/Weill Cornell Medical Center. The center is one of the nation’s busiest, with more than 1,000 admissions annually and providing acute and rehabilitative care to more than 4,000 outpatients each year.

Despite a long tradition on the part of the hospital and medical college of producing surgical leaders and a history of innovation in emergency and injury care fostered in the 1950s by Preston (Pep) Wade, MD, FACS, a Past-President of the American College of Surgeons, the surgical services of The New York Hospital by 1975 had been without stable leadership for nearly a decade. The hospital was focused primarily on its mission of providing elective surgical care to its local community, and the tradition of providing care to critically ill and injured patients had largely lapsed. There was no peer-reviewed federal research funding at the time. Full-time faculty members were performing relatively few operations, especially in general surgery.
The residency program was out of compliance with regulatory requirements. Dr. Shires’ goal was to recruit academically oriented faculty to build on the core that was recruited from Seattle, and similarly oriented residents so as to restore the department’s historic mission of teaching, research, and clinical excellence.

The residency program was strengthened immediately in 1977 as part of Dr. Shires’ first recruitment class when Anthony Antonacci, MD, FACS; Dr. Barie; and Carolyn Reed, MD, FACS, joined at the first postgraduate year level, and David Herndon, MD, FACS; Bruce Wolff, MD, FACS; and Roger Yurt, MD, FACS, joined the program at more senior levels. Notable faculty recruitments orchestrated or influenced by Dr. Shires included O. Wayne Isom, MD, FACS, in cardiothoracic surgery; E. Dar-racott Vaughan, MD, FACS, in urology; William Ledger, MD, FACS, in obstetrics and gynecology; and Stephen Lowry, MD, FACS, in nutrition and metabolism.

It was while at Cornell that Dr. Shires’ own career reached its zenith. Already having served as the chairman of the American Board of Surgery (1972–1974) and having been elected to the Institute of Medicine of the National Academy of Sciences (1975), there was more to come. He served as chairman of the Surgery A Study section of the National Institute of General Medical Sciences, National Institutes of Health, from 1976 to 1978. From 1979 to 1980, Dr. Shires served as president of the American Surgical Association. In his presidential address to the centennial meeting of the American Surgical Association, The Fourth Surgical Renaissance? (referring to the rise of the surgical biologist since 1945), Dr. Shires made several prescient observations regarding American surgery, including the justification of cost-effectiveness, surgical manpower and lifestyle issues, reimbursement, professional liability, and the hazards of an overregulated medical marketplace. These concerns certainly ring true today.

Dr. Shires’ lifelong commitment to the American College of Surgeons culminated during the Cornell years. In 1982, he became the Editor of Surgery, Gynecology & Obstetrics for 11 years.

In 1987, while continuing to serve as the Stimson Professor and Chairman, Dr. Shires became The Stephen and Suzanne Weiss Dean and provost of Cornell University Medical College, positions he held until 1991.

Research contributions by Dr. Trunkey

Soon after finishing his residency, Dr. Shires made surgical science an area of major interest in his academic surgical career. His primary interest was in fluid and electrolyte shifts occurring during a severe shock insult. Initially, his studies focused on volumes of distribution using radioisotope techniques that had been popularized during World War II. His initial data were presented in the Forum on Fundamental Surgical Problems in 1960 and described for the first time the shifts not only out of the interstitial fluid into the plasma space, but the loss of additional interstitial fluid into cells once they began anaerobic metabolism. This effect was further defined in an Archives of Surgery paper in 1964, “Fluid therapy in hemorrhagic shock.” From a purely personal standpoint, this had a profound effect on how we treated patients in shock from trauma. Before this time, it was routine to start catecholamine drips on shock patients, which simply compounded their vasoconstriction and poor organ perfusion.

This initial work was criticized from the standpoints of fluid overload and faulty methodology. Dr. Shires never supported overload of fluid, but he recognized the risk of fluid overload that could result from overgeneralization of his results and the effect this had on resuscitation practice during the Viet Nam conflict and thereafter. He spoke out against this erroneous extension of his research findings. Dr. Shires later adopted a new method of measuring fluid shifts by measuring transcellular membrane potentials in skeletal muscle in primates. Knowing this membrane potential, total tissue water content, electrolyte content, and the Nernst equation would allow distributions between the extracellular space and intracellular space to be calculated. This methodology confirmed
his original observations using radioisotopes.

In addition to his studies on skeletal muscle and fluid shifts, the same membrane potential technique was used in the liver following hemorrhagic shock, which showed that the liver is much more sensitive to ischemia, as evidenced by the fact that membrane potentials fell, usually within an hour. Burn patients were also studied in regard to lung injury and the effects of crystalloid and colloid resuscitation. Colloid resuscitation exacerbated the fluid shift and increased the pulmonary dysfunction. Burn patients were studied on the use of cultured epidermal cells and their utility as a graft following the injury. Increasingly, Dr. Shires took his laboratory investigations into the intensive care unit, and particularly the burn unit, where he studied extravascular lung water during burn resuscitation and also after high-frequency ventilation.

In the late 1980s, Dr. Shires became interested in the role cytokines played in hemorrhagic and septic shock. Initial studies were done with tissue necrosis factor but increasingly expanded into other cytokines and their complicated, interrelated feedback mechanisms. Studies were also carried out to assess the role of catecholamines and adrenal cortical hormones in the activation and modulation of the inflammatory cascade, particularly the cytokines. Another arm of these studies looked at leukotrienes and prostaglandins and their roles in tissue injury and repair. Although he was initially enthusiastic about the role that tumor necrosis factor played in sepsis, he subsequently showed that attenuating this cytokine did not alter the tissue-damaging effects of sepsis. Throughout all of these various investigative efforts, he continued to focus on resuscitation fluids following shock. Studies with hypertonic saline and the addition of antioxidants to various resuscitative fluids were studied in-depth. His last paper on basic research involved the role that activated protein C may have on downregulating some of the inflammatory mediators.

Conclusion

Dr. Shires was a renowned figure in the world of surgery. He went on to chair yet another department at the Texas Tech University School of Medicine in Lubbock. Memorable among his many contributions are the following: he authored Care of the Trauma Patient, which summarized the clinical approaches to care of the injured practiced at the Parkland Hospital and served as the main resource text for trauma care for more than two decades; he served as a principal editor of the Schwartz Textbook of Surgery; and, until shortly before his death, he was actively leading the Nevada Trauma Research Institute in Las Vegas.

He is survived by his wife, Robbie Jo Shires, of Henderson; two daughters, Jo Ellen Shires and Jackie Blain, both of Portland, OR; a son, G. Tom Shires III, MD, FACS, who has followed in his footsteps as a surgeon in Dallas; and three grandchildren.

Dr. Barie is professor of surgery and public health and director, division of trauma and critical care, Weill Medical College of Cornell University, New York, NY.

Dr. Maier is Jane and Donald D. Trunkey Professor and vice-chair, department of surgery, and surgeon-in-chief, Harborview Medical Center, University of Washington School of Medicine, Seattle, WA.

Dr. Perry is professor of surgery emeritus, University of Texas Medical Center at Dallas, Dallas, TX.

Dr. Trunkey is professor of surgery and chair emeritus, department of surgery, Oregon Health Sciences University, Portland, OR.

Dr. Yurt is Johnson and Johnson Professor of Surgery and vice-chair, department of surgery, Weill Medical College of Cornell University, New York, NY.

Dr. Flint is editor-in-chief, Selected Readings in General Surgery, Division of Education, American College of Surgeons, and adjunct professor of surgery, Feinberg School of Medicine, Northwestern University, Chicago, IL.
The American Medical Association (AMA) honored Arthur R. Ellenberger, Executive Director of the New Jersey Chapter of the American College of Surgeons and the Essex County Medical Society, with the 2007 Medical Executive Meritorious Achievement Award. The award recognizes a medical association executive who has demonstrated exceptional service and contributions to the goals and ideals of the medical profession. Mr. Ellenberger received the award November 10, 2007, at the AMA’s semi-annual policy-making meeting.

Mr. Ellenberger became the first executive director of the Essex County Medical Society in 1952 and the first Executive Director of the New Jersey Chapter of the ACS in 1962. Throughout his service to both organizations, he has been a firebrand for medical liability and Medicare payment reform. In acknowledgment of his dedication to the New Jersey Chapter and to the surgical profession as a whole, the American College of Surgeons established the Arthur Ellenberger Award for Excellence in Advocacy in 2003, which is awarded periodically and presented during the annual ACS Leadership Conference.

ACGS seeks nominations for Members-at-Large

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

- Individuals should be Fellows of the ACS and members of their state or local ACS chapter.
- Individuals being nominated should be in active surgical practice.
- Individuals should recognize the importance of representing all who practice general surgery.
- Nominees should be loyal members of the College who have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

Geographic representation and type of practice will be considered. The College encourages consideration of women and other underrepresented minorities.

The functions performed by the ACGS are as follows: to advise the Board of Regents on policy matters and policy formulations; to discuss matters that the Council believes are appropriate to be brought to the attention of the Board of Regents and/or other organizations; to serve as a liaison in the communication of information to and from general surgery organizations to the Board of Regents; to nominate individuals from general surgery to serve on College committees and other bodies; and to aid in the development of programs for the annual Clinical Congress.

Questions about the estimated time commitment or Advisory Council workload may be directed to David V. Feliciano, MD, FACS, ACGS Chair, at defilici@emory.edu.

Submit nominations to ms@facs.org through April 1.
Dr. Puder honored with 2007 Jacobson Promising Investigator Award

Mark Puder, MD, FACS, was selected as the third annual Joan L. and Julius H. Jacobson II Promising Investigator Award winner and received a sculpture award during the Annual Business Meeting of the Members at the Clinical Congress in New Orleans, LA, in October 2007. Dr. Puder was also honored at a luncheon with Dr. and Mrs. Jacobson.

Currently, Dr. Puder is associate professor of surgery at Harvard Medical School and assistant program director of pediatric surgery at Children’s Hospital, Boston, MA. After receiving his medical degree from Vanderbilt University School of Medicine in Nashville, TN, Dr. Puder received his initial postgraduate training in pediatrics at Yale-New Haven Hospital and completed his residency at Beth Israel Deaconess Hospital in Boston.

Following his general surgery residency, he completed a research fellowship program at the Dana Farber Cancer Institute and a pediatric surgery fellowship at Children’s Hospital in Boston.

He also earned a doctorate degree in virology/biochemistry at Harvard and was conferred a K08 award from the National Institute of Digestive and Diabetes and Diseases of the Kidney; his research receives funding from the U.S. Department of Defense and the March of Dimes.

The Jacobson Promising Investigator Award

In 2004, Dr. and Mrs. Julius H. Jacobson II generously established The Joan L. and Julius H. Jacobson II Promising Investigator Award, as a way of recognizing the vital importance of new knowledge and new technology in promoting the quality of surgical care. This award is intended to recognize outstanding surgeons engaged in research advancing the art and science of surgery who have shown through their research early promise of significant contribution to the practice of surgery and the safety of surgical patients. The award of $30,000 is to be given at least once every two years. The College’s Surgical Research Committee administers the award.

See page 36 for information about applying for the 2008 award, including application criteria.
Since 2002, Dr. Puder has devoted his research to investigating the pathophysiology of parenteral nutrition-associated liver disease and potential treatment strategies. Research on the role of the intravenous fat emulsion used in parenteral nutrition led him to conclude that currently available fat emulsions may contribute to the development of this condition. He conducted studies in a murine model to determine if a different source of fat may reverse or prevent this fatal complication. He and his colleagues determined that fat emulsions derived from fish oils were effective in reversing parenteral nutrition-associated liver disease (PNALD) and could also prevent its development. His findings were applied to a five-month-old patient with severe PNALD (and listed for a liver transplant) within months of animal experiments. Within two months of starting therapy, the patient’s liver function improved, his jaundice resolved, and he was removed from the transplant list. He is now almost four years old and still on parenteral nutrition with normal bilirubin levels. A compassionate use protocol has since been developed at Children’s Hospital in Boston and more than 69 children have been treated. To date, no child has died from PNALD at the institution since implementation of the protocol.

Dr. Puder has also done extensive work in the area of angiogenesis and in studies investigating matrix metalloproteinase activity on wound healing. By using the resources available to him, he has been able to collaborate with a variety of individuals on projects that complement one another. His training in both the basic sciences and medicine has afforded him a unique opportunity to rapidly translate laboratory discoveries to clinical practice.

### Young Surgical Investigators Conference scheduled

The American College of Surgeons is offering the ninth biennial Young Surgical Investigators Conference March 7–9, 2008, at the Bethesda North Marriott Hotel and Conference Center in North Bethesda, MD. The conference is designed to assist surgeon-scientists in obtaining extramural, peer-reviewed grant support for their work and to introduce them to the process, content, style, and people involved in successful grant-writing and interact with representatives of the National Institutes of Health (NIH).

As participants, surgeon-scientists meet their peers, selected mostly from surgery departments in U.S. and Canadian academic medical centers. The conference provides opportunities to meet and talk with key NIH staff and many of the leading surgeon-scientists who have been successful in obtaining NIH grant support for their work and who participate in the conference as leaders of various small-group meetings and as plenary session speakers.

The program includes intensive exposure to the following:
- NIH programs and policies
- What programs are most appropriate and available for your research project and how to apply
- Grant-writing strategies
- Workshops in hypothesis testing, methodology, background, and preliminary results
- Mock study sections reviewing model grants
- Presentations by representatives from 10-12 institutes about research priorities, pilot programs, and training grants targeted to new investigators

The conference fee is $1,795. This fee includes all related conference materials, meals, breaks, receptions, and lodging for two nights.

Information and a registration form are available on the College’s Web site at [www.facs.org/cqi/src/youngsurg.html](http://www.facs.org/cqi/src/youngsurg.html). Direct questions to Mary Fitzgerald at mfitzgerald@facs.org or call 312/202-5319.
College seeks nominations for 2008 Jacobson Promising Investigator Award

The American College of Surgeons is accepting nominations for the fourth Joan L. and Julius H. Jacobson II Promising Investigator Award to be conferred in 2008. This award has been established to recognize outstanding surgeons engaged in research advancing the art and science of surgery who have shown through their research early promise of significant contribution to the practice of surgery and the safety of surgical patients. The award amount is $30,000, to be given at least once every two years. The College’s Surgical Research Committee administers the award.

Award criteria:

- Candidate must be board-certified in a surgical specialty and must have completed surgical training within the past three to six years.
- Candidate must be a Fellow or an Associate Fellow of the American College of Surgeons.
- Candidate must hold a faculty appointment at a research-based academic medical center (military service appointments included).
- Candidate must have received peer-reviewed funding such as a K-series award from the National Institutes of Health (NIH), Veterans Administration, National Science Foundation, or U.S. Department of Defense merit review to support their research effort.
- Nomination documentation must include a letter of recommendation from the nominee’s department chair. Up to three additional letters of recommendation will be accepted.
- Only one application per surgical department will be accepted.
- Nomination documentation must include a NIH-formatted biosketch and copies of the candidate’s three most significant publications.
- Nominee must submit a one-page essay to the committee explaining why he or she should be considered for the award and discussing the importance of the research he or she has conducted/is conducting.

Special consideration will be given to surgeons who are at the “tipping point” of their research careers with a track record indicative of early promise and potential (such as degree program in research or K-award). Surgeon-scientists who are well established (for example, funded by NIH RO-1 grants) are not eligible candidates.

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

Nomination procedures

Nominations are accepted at any time, but to be considered for the award in 2008, submissions must be e-mailed or postmarked no later than March 19, 2008. After compiling the necessary award criteria documentation in electronic format, you may submit it via e-mail to Mary T. Fitzgerald at mfitzgerald@facs.org. Nomination materials can also be submitted on a CD-ROM and mailed to Ms. Fitzgerald at the following address: American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Applicants are encouraged to verify that all necessary documentation has been received before the March 19 deadline. For additional information, contact Ms. Fitzgerald by e-mail or call 312/202-5319.
There are many forums beyond state legislatures or the federal government where health policy can be developed, and the American Medical Association’s (AMA) House of Delegates (HOD) is one such venue. Many specialty societies send delegations to the HOD to assist with this advocacy activity, and the American College of Surgeons is well represented by a diverse group of surgeons.

**HOD business**

A number of issues came to the fore at the November 2007 meeting of the AMA HOD. One concern dealt with improving abdominal aortic aneurysm screening, calling on Congress to extend a one-time screening to all Medicare beneficiaries between the ages of 65 and 75 years. The HOD adopted this policy with support from the College, the Society for Vascular Surgery, and other surgical specialty societies.

There was strong support for other issues, such as improving reimbursement for physicians, encouraging use of restraints on children’s school buses, and efforts to extend the State Children’s Health Insurance Program. Another issue brought forward by the ophthalmology delegation and supported by the College and many specialty societies dealt with the voting composition of the Physician Consortium for Performance Improvement (PCPI). Specifically, there were concerns that changes to the PCPI bylaws to allow nonphysician representatives to vote on physician-developed performance measures would result in nonphysicians determining what physicians should be doing as well as providing additional support for expansion of the scope of practice of nonphysician health care providers. The complexity and emotion surrounding this issue resulted in it being referred to the AMA Board of Trustees for decision.

**Surgical Caucus**

The Surgical Caucus continues to be a smooth and mature operation with administrative support from the ACS. The Executive Committee of the Caucus is composed of delegates or alternates from numerous surgical specialty societies with elections held every year. For the first time, and in reflection of bylaws revisions allowing Caucus membership and election of nonsurgeons with significant clinical interaction with surgeons (such as anesthesiology, critical care, emergency medicine, interventional cardiology, and interventional radiology), an anesthesiologist, Michael Simon, MD, was elected to the Executive Committee.

The Caucus implemented a significant programmatic change by holding its first open handbook review, which generated a refined list of priority positions on resolutions and reports being considered by the HOD. Surgical specialty societies were invited to send representatives to this meeting, which enabled full Caucus discussion of important items in an efficient manner following the educational session on Saturday afternoon.

The educational session of the Caucus was entitled Making Sense of The Joint Commission. James Rohack, MD, an AMA commissioner, and Robert Wise, MD, the vice-

**2007 ACS Delegates/Alternates**

Richard Reiling, MD, FACS, Charlotte, NC, Delegation Chair
John Armstrong, MD, FACS, Gainesville, FL
Charles Logan, MD, FACS, Little Rock, AR
Jacob Moalem, MD (Resident/Fellow Section), San Francisco, CA
Sanjay Parikh, MD, FACS (Young Physicians Section), Bronx, NY
Amilu Rothhammer, MD, FACS, Colorado Springs, CO
Chad Rubin, MD, FACS, Columbia, SC
Patricia Turner, MD, FACS, Baltimore, MD
Thomas Whalen, MD, FACS, Allentown, PA
president for the division of standards and survey methods, were the presenters and focused on how hospital-based physicians can engage The Joint Commission constructively. The discussion was well received by an audience of 100, with an interesting question-and-answer session.

**Special award presentation**
During the opening session of the HOD, the AMA honored Arthur R. Ellenberger, Executive Director of the New Jersey Chapter of the American College of Surgeons and the Essex County Medical Society, with the 2007 Medical Executive Meritorious Achievement Award. (See story, page 33.)

**Delegate retirement**
Following seven years of service as a delegate, Thomas Whalen, MD, FACS, decided to retire from the delegation following this November 2007 meeting. Dr. Whalen, an ACS Regent and pediatric surgeon, was recognized for a distinguished career of leadership and commitment in representing the College as a delegate.

**Surgical Caucus Executive Committee 2007–2008**
John Armstrong, MD, FACS, Chair, ACS Alternate Delegate
William Huffaker, MD, FACS, Chair-Elect, Missouri Delegate
Charles Drueck, MD, FACS, Secretary, Illinois Delegate
Michael Simon, MD, Treasurer, Alternate Delegate, American Society of Anesthesiologists
Michael Deren, MD, FACS, Member At-Large, Connecticut Delegate
Randolph Gould, MD, FACS, Member At-Large, Virginia Delegate
Willard Stawski, MD, FACS, Member At-Large, Michigan Delegate
Richard Reiling, MD, FACS, ACS Representative
Brigitta Robinin, MD, FACS, AMA Young Physicians Section Representative
Hannah Zimmerman, MD, AMA Resident and Fellow Section Representative

**Call for abstracts: CoC Paper Competition**
The Commission on Cancer (CoC) has announced the 2008 call for abstracts for its Paper Competition. The competition is open to general surgery residents, surgical specialty residents, subspecialty residents, and oncology fellows in the U.S. The papers should describe original research in cancer care in either basic laboratory research, clinical investigation, or quality of care/health services research.

Residents or cancer fellows should submit a three-page abstract to the CoC office by March 15. CoC State Chairs will review the submitted abstracts by region and select a first-, second-, and third-place winner by July 15. The first-place winner from each of the 14 regions will move on to a national competition. First-, second-, and third-place winners of the national competition will be selected and notified by August 15.

First-place winners of the national competition will receive a $1,000 award and present at the CoC annual meeting on October 12 during Clinical Congress in San Francisco, CA. Second-place winners will be recognized at the annual meeting and receive a $500 award.

This competition has been funded by the CoC and by a memorial gift from Mrs. A. Lee Campione in honor of her late husband, Matthew P. Campione, MD, FACS.

For information, log onto the CoC Web site at http://www.facs.org/cancer/cannews.html or contact the CoC office at 312/202-5183 or cjones@facs.org.

For more information
For further information on the Interim 2007 AMA HOD and surgical involvement in this meeting, contact Jon Sutton at jsutton@facs.org.
The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Germany.

**Purpose**

The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Germany, and a German Traveling Fellow will visit North America.

**Basic requirements**

The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

- Has a major interest and accomplishment in clinical and basic science related to surgery
- Holds a current full-time academic appointment in Canada or the U.S.
- Is younger than 45 years on the date the application is filed
- Is enthusiastic, personable, and possesses good communication skills

**Activities**

The Fellow is required to spend a minimum of two weeks in Germany and to achieve the following:

- Attend and participate in the annual meeting of the German Surgical Society, which will be held in Munich, Germany, April 28–May 1, 2009
- Attend the German ACS Chapter meeting during that meeting
- Visit at least two medical centers (other than the site of the annual meeting) in Germany before or after the annual meeting of the German Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the German Surgical Society and the German ACS Chapter. The surgical centers to be visited would depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Germany.

A spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction in addition to professional activities.

**Financial support**

The College will provide the sum of U.S. $6,000 to the successful applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society. The Traveling Fellow must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his or her own travel arrangements in North America, as this makes available reduced fares and travel packages for travel in Germany.

The American College of Surgeons’ International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained from the College’s Web site (http: www.facs.org/memberservices/research.html), or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is April 1, 2008.

The successful applicant and an alternate will be selected and notified by June 30, 2008.
ACS Traveling Fellowship to Japan available

The International Relations Committee of the American College of Surgeons announces the availability of the ACS Traveling Fellowship to Japan.

**Purpose**
The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America.

**Basic requirements**
The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

- Has major interest and accomplishment in clinical and basic science related to surgery
- Holds a current full-time academic appointment in Canada or the U.S.
- Is younger than 45 years on the date the application is filed
- Is enthusiastic and personable and possesses good communication skills

**Activities**
The Fellow is required to spend a minimum of two weeks in Japan, pursuing the following goals:

- To attend and participate in the annual meeting of the Japan Surgical Society, which will be held in Fukuoka, Japan, April 2–4, 2009
- To attend the Japan ACS Chapter meeting during that congress
- To visit at least two medical centers (other than the annual meeting city) in Japan before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the Japan Surgical Society and the Japan ACS Chapter. To some extent, the surgical centers to be visited would depend on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Japan.

A spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction in addition to professional activities.

**Financial support**
The College will provide the sum of $7,500 U.S. to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society.

The selected Traveling Fellow must meet all travel and living expenses. Senior Japan Surgical Society and Japan ACS Chapter representatives will consult with the Fellow about the centers to be visited in Japan, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his or her own travel arrangements in North America, as this makes available reduced fares and travel packages for travel in Japan.

The American College of Surgeons International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested before the final selection.

Applications for this traveling fellowship may be obtained from the College’s Web site at [http://www.facs.org/memberservices/research.html](http://www.facs.org/memberservices/research.html), or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is June 2, 2008.

The successful applicant and an alternate will be selected and notified by November 1, 2008.
Minimally invasive surgical procedures for malignant diseases are increasing in many surgical specialties. A recent example is minimally invasive esophagectomy (MIE). Luketich et al described a single institution experience of 222 patients who underwent MIE. This study represented the largest single institution experience with this procedure. Surgeons at other institutions have also published their results and, as with any new procedure, a group of proponents and critics of MIE has developed. And as is the typical pattern of new procedures, discovery is soon followed by feasibility studies from a few key leaders.

However, before the procedure is widely accepted, there are equally wise leaders who ask for evidence from prospective clinical trials, preferably a phase III randomized trial design before the procedure is accepted as standard of care. There are many examples of phase III procedure trials in oncology. The laparoscopic colectomy trial and the breast sentinel lymph node trial are respective examples of many such trials published in the literature. MIE is moving in a similar direction toward level 1 evidence. However, in comparison with breast and colon cancer, the incidence of esophageal cancer and the numbers of esophageal resection performed nationally are significantly lower. Even open esophagectomy is technically demanding of the surgeon and of the hospital resources, particularly when complications arise.

E2202 is a phase II clinical trial entitled Minimally Invasive Esophagectomy: A Multicenter Feasibility Study. If E2202 can demonstrate accrual, safety, and efficacy, a phase III trial design may be a natural progression. The study chair is James Luketich, MD, FACS, and the ACOSOG co-study chair is Hiran Fernando, MD, FACS.

The primary objective of E2202 is to evaluate the feasibility of performing MIE in centers that have experience both in esophageal surgery and minimally invasive techniques. Feasibility is defined as the ability to carry out esophagectomy using a minimally invasive approach without significant perioperative mortality. A 30-day mortality will be measured as a primary endpoint. Secondary objectives include the following: (1) determine the complications associated with MIE; (2) determine the rate of conversion to open operation; (3) determine the length of the operation, the duration of intensive care unit stay, and length of hospital stay; (4) determine feasibility and conversion rate of MIE after neoadjuvant therapy; (5) assess the effectiveness of lymph node dissection by MIE; and (6) assess outcomes at follow-up to three years.

The patient eligibility criteria include patients with high-grade dysplasia of the esophagus who will undergo esophagectomy or patients with esophageal cancer at stage T1-T3, N0-N1, who require esophagectomy. Patients with M1 disease and/or bulky lymph node involvement are excluded. Patients must have pathological confirmation of a diagnosis of cancer or high-grade dysplasia of the esophagus by biopsy. Computed tomography scan of chest and abdomen are required before registration. Stomach must be available for use as a conduit and patients with cancers extending into the stomach for more than 20 percent are excluded. Patients with esophageal cancer who are treated with neoadjuvant chemotherapy and/or radiation are eligible. Prior right thoracotomy or prior major neck operation other than removal of superficial skin lesion will exclude the patient from the trial.
trial. Preoperative staging includes endoscopic ultrasound and positron-emission tomography scan and/or laparoscopic staging.

One of the unique and beneficial aspects of prospective clinical protocols for new procedures is the credentialing process. E2202 is no different and the protocol has clear credentialing criteria. The surgeon or surgeon group should have performed a minimum of five MIE using the approach described in the protocol (right video-assisted thoracoscopic surgery mobilization laparoscopy and neck incision). The operative reports of the five MIE cases will need to be submitted to the principal investigator to confirm the operative approach used. The surgeon or surgeon group should perform a minimum of eight esophageal resections/year. These resections can include open or MIE procedures.

The surgeon or surgeon group should perform 10 minimally invasive esophageal cases/year. Acceptable minimally invasive esophageal cases include laparoscopic fundoplication, laparoscopic repair of hiatal hernia, laparoscopic/thoracoscopic myotomy, laparoscopic/thoracoscopic removal of an esophageal diverticulum, laparoscopic/thoracoscopic removal of leiomyoma, and laparoscopic/thoracoscopic staging of esophageal cancers.

Before being credentialed for this study, each surgeon/surgeon group/center with fewer than 30 cases will need to submit a videotape of an MIE case to be reviewed by a steering committee composed of Dr. Luketich or Dr. Fernando. All surgeons will need to watch a skills videotape reviewing the MIE steps and attend a one-day course on MIE at the University of Pittsburgh. In some situations, two surgeons (for example, a general and a thoracic surgeon) can work together to perform these procedures. When two surgeons typically work together, this is defined as a surgical group. Dr. Luketich or Dr. Fernando can be contacted with any questions regarding credentialing.

E2202 has been endorsed by the American College of Surgeons Oncology Group and the protocol and credentialing requirements are accessible through the ACOSOG Web site. This study is a high-priority trial for ACOSOG and we are actively recruiting sites and surgeons. If you are an ACOSOG surgeon who meets the credentialing criteria, go to www.acosog.org to review the protocol.

If you have questions regarding the E2202 trial, contact Isa Lamerton at 919/668-8827 or isa.lamerton@duke.edu. Dr. Fernando can be contacted at hiran.fernando@bmc.org. If you have questions regarding ACOSOG membership, contact Helen Harbett at 919/668-8836 or harbe011@notes.duke.edu.

ACOSOG very much needs your active participation and enrollment of patients into this trial in order to prospectively show feasibility and safety of the new procedure. New procedures will continue to emerge from creative surgeons and ACOSOG will bring procedure-oriented trials to the surgical community.

References


Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG co-chairs.
NTDB® data points

Pediatric Report 2007: Too many kids

by Richard J. Fantus, MD, FACS, and Arthur Cooper, MD, FACS

This year marks the first time that both the Annual Report and the Pediatric Report of the National Trauma Data Bank® were released simultaneously. The Annual Pediatric Report of the National Trauma Data Bank Version 7.0 represents and reflects the collaborative efforts between the National Trauma Data Bank Committee and the Pediatric Surgical Specialty Group of the American College of Surgeons Committee on Trauma. As with the NTDB Annual Report, the pediatric report is an updated analysis of the largest aggregation of pediatric trauma registry data ever assembled. The pediatric component of the NTDB contains more than 550,000 records from admission years 1988 to 2006.

The 2007 Pediatric Annual Report is based on 334,095 records from the years 2002 through 2006. The report also contains several enhancements over previous annual reports. There are new tables and figures describing head, thoracic, and abdominal injuries in greater detail than was possible in previous versions. For all three body regions, case frequency and case fatality rates are shown by body organ injured (see figure on this page). However, no inferences should be drawn from these data with respect to causality, since the NTDB contains no specific information on proximate cause of death but only those injuries associated with death.

The purpose of this report is to inform the medical pediatric community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured infants, children, and adolescents in our country.

It has implications in many areas including epidemiology, injury control, research, education, acute care, and resource allocation.

The NTDB Committee and Pediatric Surgery Specialty Group would like to thank all of the adult and pediatric trauma centers that contributed pediatric data and hope that this report will attract new participants. The support of the Emergency Medical Services for Children program of the Maternal Child Health Bureau, Health Resources and Services Administration, and the U.S. Department of Health and Human Services is also gratefully acknowledged.

Although this report repre-
sents an enormous aggregation of pediatric trauma data and a wealth of information, we should redouble our prevention efforts because these injuries represent just too many kids.

The full NTDB Annual Report Version 7.0 is available on the ACS Web site as a PDF and a PowerPoint presentation at http://www.ntdb.org.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

**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. Cooper** is director of trauma and pediatric surgery at Columbia University/Harlem Hospital, New York, NY. He is Chair of the Pediatric Surgery Specialty Group of the American College of Surgeons Committee on Trauma.

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A look at The Joint Commission

**Annual report details health care quality in U.S. hospitals**

American hospitals are making measurable strides in the quality of care provided for patients with heart attacks, heart failure, pneumonia, and surgical conditions, according to The Joint Commission’s second annual report on health care quality and patient safety in the nation’s hospitals. The detailed report portrays the aggregate performance of accredited hospitals against The Joint Commission’s standardized national performance measures and its National Patient Safety Goals.

**Improving America’s Hospitals: The Joint Commission’s Annual Report on Quality and Safety 2007** also shows, however, that whether patients receive proven treatments for these common reasons for hospitalization often depends on where they live. For example, statewide performance of hospitals on the measure of providing discharge instructions to patients with heart failure ranges from 49 percent to 91 percent.

The Joint Commission issues this annual report as part of its ongoing efforts to emphasize the importance of accountability and continuous improvement for hospitals and to empower consumers with information that will make them more active participants in their health care. This report examines how America’s accredited hospitals performed against quality-related performance measures and safety goals in 2006 and in previous years.

This year, The Joint Commission plans to add measures to the pneumonia and surgical care measure sets and to introduce new measure sets for hospital outpatient care and hospital-based inpatient psychiatric care.

In addition, The Joint Commission will begin to publicly report hospital performance data that are gathered by the Centers for Medicare & Medicaid Services, such as the Hospital Consumer Assessment of Healthcare Providers and Systems Survey results.

The Joint Commission offers a comprehensive guide to hospital performance measurements at the Quality Check Web site. To view hospital-specific performance on specific measures, go to Quality Check at www.qualitycheck.org.

To view the annual report, visit www.jointcommission.org.
Chapter news

by Rhonda Peebles, Division of Member Services

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

Arkansas Chapter convenes annual meeting

Last September, the Arkansas Chapter met in Little Rock for a day-long educational program that included basic and clinical science reviews as well as financial and retirement planning. Edward M. Copeland III, MD, FACS, the College’s Immediate Past-President, presented an update of the College’s federal legislative and regulatory activities affecting surgeons and their patients (see photo, right).

Chapters continue support for the College’s funds

During 2007, 17 chapters contributed a total of $23,000 to the College’s Endowment Funds. The chapters’ commitments to the various funds support the College’s pledge to surgical research and education. Chapters can contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. The chapters that contributed during 2006 include the following:

Recipient of the R. Gordon Holcombe, MD, FACS, Chapter Award*: Louisiana
Life Members of the Fellows Leadership Society†: Arizona, Brooklyn–Long Island (NY), Florida, Illinois, Maryland, Nebraska, North Carolina, North Texas, Ohio, South Carolina, Southern California

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

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

Arkansas Chapter, left to right (all MD, FACS): John Burge, Governor; Dr. Copeland; and John Hayes, President.

Honorary Affiliate Membership for New Jersey Executive Director

In December 2007, during the annual meeting of the New Jersey Chapter, the College honored Arthur Ellenberger by awarding him Honorary Affiliate membership (see photo, this page). The honorary membership was presented to Dr. Healy (right) presents Mr. Ellenberger with his Honorary Affiliate membership.
Mr. Ellenberger by the College’s President, Gerald M. Healy, MD, FACS. Mr. Ellenberger has served as the Executive Director of the New Jersey Chapter since 1962, and through the years, he has engaged the chapter’s members in continuous, effective advocacy activities at the state and national levels. Through his leadership, the College’s members in New Jersey—and their patients—have been well represented in the legislative and regulatory arenas. (See story on page 33 regarding another honor bestowed on Mr. Ellenberger.)

The Residents’ Competition was held during the annual meeting as well; see photo (this page) for this year’s winners.

Kansas Chapter appoints new Executive Director

In fall 2007, the Kansas Chapter appointed Gary Caruthers, MBA, as its new Executive Director. Mr. Caruthers serves as the director of administrative services for the Kansas Medical Society, where he has been employed for more than 25 years. Mr. Caruthers succeeds Charles (Chip) Wheelen, who left the chapter to head up a statewide professional liability enterprise.

Chapter Executives convene in Chicago

In December 2007, Chapter Executives convened at College headquarters for a day-long
education program (see photo, page 46). The executives learned about new Internal Revenue Service filing requirements, the benefits of beginning a development program to support education activities, and shared “best practices” concerning membership recruitment, dues collections, and membership communications.

2008 Leadership Conference—Register today
The 2008 Leadership Conference will be held March 9–11 at the Mayflower Hotel in Washington, DC. Chapters are encouraged to send their Chapter Officers, two or three Young Surgeons (aged 45 years or younger), and their Chapter Administrator

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.

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

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<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
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<tbody>
<tr>
<td>February 2008</td>
<td></td>
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<tr>
<td>February 2</td>
<td>Utah (CS)</td>
<td>Location: The Hotel Monaco, Salt Lake City, UT&lt;br&gt;Contact: Teresa Holdaway, 801/747-3500, <a href="mailto:teresa@utahmed.org">teresa@utahmed.org</a>&lt;br&gt;ACS representative: James K. Elsey, MD, FACS</td>
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<tr>
<td>February 16</td>
<td>Alberta</td>
<td>Location: Rimrock Resort Inn, Banff, AB&lt;br&gt;Contact: Philip Mitchell, MD, 403/264-6720, <a href="mailto:philipmitchell@mac.com">philipmitchell@mac.com</a></td>
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<tr>
<td>February 21–23</td>
<td>Puerto Rico</td>
<td>Location: La Concha Hotel, San Juan, PR&lt;br&gt;Contact: Aixa Velez-Silva, 787/277-0674, <a href="mailto:genteinc@prtc.net">genteinc@prtc.net</a>&lt;br&gt;ACS representatives: Bruce L. Gewertz, MD, FACS, and Paul E. Collicott, MD, FACS</td>
</tr>
<tr>
<td>February 22</td>
<td>North Texas (CS)</td>
<td>Location: TBA, Dallas, TX&lt;br&gt;Contact: Marcia McIntyre, 314/579-9707, <a href="mailto:Marcia@lettuceplanet.com">Marcia@lettuceplanet.com</a>&lt;br&gt;ACS representative: Andrew L. Warshaw, MD, FACS</td>
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<tr>
<td>February 28–March 1</td>
<td>South Texas (CS)</td>
<td>Location: Omni Houston Hotel, Houston, TX&lt;br&gt;Contact: Janna Pecquet, 504/733-3275, <a href="mailto:janna@southtexasacs.org">janna@southtexasacs.org</a>&lt;br&gt;ACS representatives: Thomas R. Russell, MD, FACS, and Adam J. Cohen, MD, FACS</td>
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<td>March 2008</td>
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<td>March 5–7</td>
<td>Peru</td>
<td>Location: Los Delfines Hotel, Lima, Peru&lt;br&gt;Contact: Eduardo Barboza, MD, FACS, 511/219-0051, <a href="mailto:edbarboza@qnet.com.pe">edbarboza@qnet.com.pe</a>&lt;br&gt;ACS representative: H. Randolph Bailey, MD, FACS</td>
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<td>April 2008</td>
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<td>April 25–26</td>
<td>Indiana (CS)</td>
<td>Location: University Place Conference Center, Indianapolis, IN&lt;br&gt;Contact: Carolyn Downing, 317/261-2060, <a href="mailto:cdowning@ismanet.org">cdowning@ismanet.org</a></td>
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<td>April 26</td>
<td>New York (CS)</td>
<td>Location: Otesaga Resort, Cooperstown, NY&lt;br&gt;Contact: Amy Clinton, 518/283-1601, <a href="mailto:NYCoFACS@yahoo.com">NYCoFACS@yahoo.com</a>&lt;br&gt;ACS representative: Gerald B. Healy, MD, FACS</td>
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or Executive Director. The College’s Washington Office will schedule Capitol Hill visits, to be conducted on Tuesday afternoon, for representatives of all participating chapters. To register, call the chapter hotline at 888/857-7545.

Chapter anniversaries

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<th>Month</th>
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<tr>
<td>January</td>
<td>Northern California</td>
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<td>Louisiana</td>
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American Philosophical Society seeks clinical investigation award nominations

The American Philosophical Society is seeking nominations for the 2008 Judson Daland Prize for Outstanding Achievement in Clinical Investigation to recognize excellence in patient-oriented research. This $20,000 prize will be awarded at the meeting of the American Philosophical Society in November 2008. The Society reserves the right to award a shared prize.

Candidates must be nominated by the chair of a clinical department of a medical school or hospital located in the U.S. The nominator must submit an abstract of the work to be honored, together with the curriculum vitae and bibliography of the nominee. A letter from the nominator must make clear the patient-oriented nature of the investigation. Three additional letters of support for the nominee should be sent separately to the American Philosophical Society. No more than one of these three supporting letters should be from a person at the same institution as the nominee.

Nominees must have done their work in an institution in the U.S. but they need not be U.S. citizens. Nominees should be no more than 15 years beyond receipt of the medical (MD) degree.

Nominations and all three letters of support must be received by March 15, 2008. Contact Linda Musumeci, research administrator, at 215/440-3429 or e-mail LMusumeci@amphilsoc.org with any questions and/or to verify receipt of materials.

Send nominations to Judson Daland Prize Committee, American Philosophical Society, 104 South 5th St., Philadelphia, PA 19106.

Recent recipients of the Judson Daland Prize

2006

George Q. Daley, MD, PhD, Harvard Medical School, Children’s Hospital of Boston, MA, and the Dana Farber Cancer Institute, for his work in the area of chronic myeloid leukemia and in the application of stem cell biology to the treatment of leukemia and genetic diseases

2005

• Brendan Lee, MD, PhD, Baylor College of Medicine, for his work on skeletal genetics and inborn errors of metabolism
• James A. Levine, MD, Mayo Clinic, for his work on energy expenditure and obesity

VOLUME 93, NUMBER 2, BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS