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On the cover: Project Access in Chattanooga, TN, demonstrates that for surgeons planning to do volunteer work, many meaningful opportunities exist here at home (see article, page 13). (Photo courtesy of Punchstock.)
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
In several recent “From my perspective” columns, I have commented on why the College needs to reach out to regional and specialty societies as well as the broad range of consumer and business groups that have a stake in the nation’s health care system. I believe we need to work collectively because we live and practice in an era in which technology is pulling us closer together. Moreover, surgeons are undergoing seemingly abrupt changes in the professional culture, such as demands that they meet new Maintenance of Certification (MOC) requirements. Meanwhile, policymakers are trying to reconstruct the nation’s health care system. In an age of rapid transformation, it is simply unrealistic to believe that one organization—the American College of Surgeons, or any other—can independently meet the needs of all the members of the profession it represents.

**Partnerships in education**

One example of how this phenomenon is affecting the College’s activities can be noted in our recent decision to eliminate the yearly Spring Meeting. Instead of presenting the Spring Meeting, the College will be participating in the annual meetings of the Southeastern Surgical Congress (SESC) and the Southwestern Surgical Congress (SWSC).

The inaugural Spring Meeting was presented in 1972 as part of the College’s efforts to emphasize its support for general surgery. The Spring Meeting was intended to provide participants with an enhanced understanding of the many facets of surgical care that can be used to elevate the standards of general surgical practice and improve patient care.

For more than three decades, the Spring Meeting served its intended purposes very well. However, it is becoming increasingly difficult for surgeons in all specialties to take extended periods of time away from their practices to attend meetings. In response, for the past few years, the College has presented the Spring Meeting in conjunction with the annual meeting of the Society of American Gastrointestinal Endoscopic Surgery, creating the “Surgical Spring Week.” The idea behind this format was that general surgeons could participate in multiple continuing education programs without traveling from one site to another.

We are now taking the concept of one-stop, specialty-specific educational programming a step further through our partnership with SESC and SWSC. By collaborating with these regional societies, we are able to make learning opportunities more accessible for surgeons who want to stay closer to their homes and offices.

The College’s contributions will involve one half-day of programming at each meeting, as well as grant support for the conferences. The 2008 SESC will meet February 9–12 at the Sheraton Birmingham (Alabama), and the 2008 SWSC will convene March 30–April 2 at the Fairmont Princess in Acapulco, Mexico. The College’s programs will take place Sunday, February 10, from 2:00 to 5:45 pm and Monday, March 31, from 8:00 am to 12:00 noon, respectively. Our portions of these meetings will include opening remarks from ACS officials, a panel discussion on ACS activities, and a session on what practicing surgeons need to know about MOC and how the College can help. In addition, the College will present an exhibit at each meeting.

“**In these complex times, no single organization can fully meet the needs of all its constituents.**"
to demonstrate the College’s new educational products aimed at helping surgeons to meet MOC requirements. I strongly encourage surgeons to mark their calendars and monitor their mail for more information about these meetings.

Our plan is to expand educational partnerships like these and, over time, develop relationships with groups representing all of the surgical specialties.

**Partnerships in advocacy**

As regular *Bulletin* readers know, the College and the American College of Surgeons Professional Association have formed alliances with multiple coalitions that are studying how we can make the health care system more quality-centered and cost-effective. Most recently, we joined the National Coalition on Health Care, the largest group working on behalf of physicians, consumers, and business to improve health care in the U.S. Under the leadership of Henry E. Simmons, MD, MPH, this coalition’s diverse membership is united in support of the following principles as a framework for improving our nation’s health care: coverage for all, cost management, improvement in quality and safety, equitable financing, and simplified administration.

In addition, we are working with many organizations to achieve passage of Medicare payment reform. For instance, the ACS and the American Osteopathic Association joined forces to develop a proposal for separate expenditure targets and conversion factors for various categories of physician services in the Medicare fee schedule. This methodology would replace the sustainable growth rate system that is now used to arrive at the conversion factor, thereby ending the current problem of across-the-board payment reductions for all physicians’ service regardless of volume and spending growth.

Furthermore, the College formed the Surgical Quality Alliance in 2006 to deliver surgery’s message about quality improvement. More than 20 surgical specialty societies are active in this group. The College also meets regularly with representatives of these and other organizations to discuss our shared political concerns, and our involvement with other coalitions that are working to develop outcome measures has been well documented in previous editions of the *Bulletin*.

**Moving ahead together**

In these complex times, no single organization can fully meet the needs of all its constituents. By branching out and presenting educational programs in cooperation with other specialty societies, we will be able to better meet the evolving needs of surgeons hoping to attain and maintain board certification. Our new relationship with the SESC and SWSC is just a first step in this multidimensional process.

Furthermore, anyone who believes that any one organization has all the answers to the very complicated policy issues facing the nation today is not only arrogant but delusional. If we want to survive this potentially transformative era, we must acknowledge and value the opinions and ideas that other groups bring to the table.

The College’s leadership realizes that the days of organizational autonomy are over. We look forward to continuing to gather our collective strength to promote a better future for the surgical profession and our patients.

*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.
On November 1, 2007, the Centers for Medicare & Medicaid Services (CMS) released its final rule on the 2008 Medicare physician fee schedule. The regulation includes important payment policy changes for Medicare physician services, which, at press time, were scheduled to take effect January 1.

Of particular interest, the regulation provided that a 10.1 percent across-the-board reduction in Medicare physician payments would be implemented unless Congress intervened by the end of 2007. Without congressional action, the fee schedule conversion factor was set to drop from $37.8975 to $34.0682. Other important provisions in the final rule call for the following actions:

- Increasing the physician work relative values for anesthesia services by 32 percent
- Revising the geographic practice cost indices for the physician work, practice, expense, and malpractice components of the fee schedule to reflect more current cost data
- Extending the Physician Quality Reporting Initiative through calendar year 2008

For a detailed discussion of the provisions of the final rule, see “What surgeons should know about... The 2008 Medicare fee schedule” on page 8. The full text of the regulation may be viewed on the CMS Web site, at http://www.cms.hhs.gov/physicianfeesched/downloads/CMS-1385-FC.pdf.

On November 5, ACS Executive Director Thomas R. Russell, MD, FACS, and Shawna Willey, MD, FACS, testified before a U.S. Food and Drug Administration (FDA) advisory committee on a proposal to regulate stereotactic breast biopsy under the Mammography Quality Standards Act (MQSA). The National Mammography Quality Assurance Advisory Committee to the FDA convened the hearing to discuss possible modification of the definition of mammography under the MQSA to include stereotactic breast biopsy.

Dr. Willey, director of the Betty Lou Ourisman Breast Health Center at Georgetown University Hospital, Washington, DC, noted that the proposed changes could have detrimental effects on patients who need breast biopsy and, ultimately, on their access to care.

Dr. Russell said that federal regulation of interventional medical procedures, such as stereotactic breast biopsy, is inappropriate under the MQSA in the absence of a clinically significant mammography-related problem and that MQSA standards need to address that specific discrepancy. In addition, Dr. Russell said that no federal regulation should restrict the type of physician who can provide services or procedures. Technology is driving a diverse spectrum of health care professionals together, he noted, and it is obscuring the lines with regard to which specialists are qualified to use certain imaging technologies.

For more information about the College’s testimony, contact Christal Edwards, Esq., Regulatory Associate, Division of Advocacy and Health Policy, at cedwards@facs.org.
On November 6, the U.S. House of Representatives passed the conference report on H.R. 3043, the fiscal year (FY) 2008 Labor–Health and Human Services–Education (L-HHS-E) spending bill. The conference report provides $3 million in funding for the Health Resources and Service Administration (HRSA) Trauma-EMS (Emergency Medical Services) Program. Unfortunately, the 269-142 vote (with 22 members not voting) is short of the 290 votes needed to override an expected presidential veto, assuming all 435 members of the House vote. The following day, the Senate passed its spending bill by a vote of 56-37. However, because the L-HHS-E conference report exceeded the administration’s spending target by approximately $10 billion, President Bush vetoed the bill. At press time, the legislation was in the process of being renegotiated. For more information, contact Adrienne Roberts, Government Affairs Associate, Division of Advocacy and Health Policy, at aroberts@facs.org.

A recent Congressional Budget Office (CBO) report examines the implications of current public and private sector U.S. health care spending trends over the next 75 years. CBO projections suggest that in the absence of changes in federal law, total health care expenditures will rise from 16 percent of gross domestic product (GDP) in 2007 to 25 percent in 2025, 37 percent in 2050, and 49 percent in 2082. Federal spending on Medicare and Medicaid will rise from 4 percent of GDP in 2007 to 7 percent in 2025, 12 percent in 2050, and 19 percent in 2082. Factors cited as important contributors to the growth in health care spending include technological innovation, higher personal income, and aging of the population. One policy option suggested to help reduce Medicare and Medicaid costs is greater reliance on “comparative effectiveness” strategies to change the behavior of physicians and patients. The full text of the report, The Long-Term Outlook for Health Care Spending, can be accessed at http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf.

During its 2007 Interim Meeting of the House of Delegates, 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 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 reforms. 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 presented during the ACS Leadership Conference.
The Centers for Medicare & Medicaid Services (CMS) released the final rule on the 2008 Medicare physician fee schedule on November 1, 2007, and published it in the November 27 Federal Register. The regulation includes important payment policy changes for Medicare physician services in 2008, which became effective January 1.

At press time, Congress still was considering legislation that could affect many provisions in the final rule. In particular, legislative changes may involve the fee schedule conversion factor and expiring provisions of Medicare law that aim to support physicians practicing in rural and other underserved areas.

This article is intended to answer questions that surgeons may have about the new Medicare payment policies for 2008 as described in the final rule. Any other policy changes that Congress may implement between publication of this article and its adjournment for 2007 will be published in ACS NewsScope, the College’s weekly electronic newsletter, and in a future edition of “Dateline: Washington,” which is published in the Bulletin each month.

What will the fee schedule conversion factor be for 2008?

Unless Congress intervenes, the fee schedule conversion factor will be reduced 10.1 percent in 2008, dropping from $37.8975 to $34.0682.

Why does Congress have to intervene every year to prevent a cut in the Medicare conversion factor?

The formula for setting the annual update to the Medicare fee schedule conversion factor is based, in part, on the sustainable growth rate (SGR), which is a prospectively determined allowable rate of spending growth that is established each year. If aggregate Medicare physician spending in a given year exceeds the SGR, it must be recouped in subsequent years through reductions in the fee schedule conversion factor. Every year since 2002, aggregate spending on physician services has exceeded the target, fueled by increases in the volume and intensity of services provided to Medicare beneficiaries. Volume growth has been particularly high for minor procedures, imaging, and laboratory tests.

The conversion factor update formula restricts efforts to recoup “excess” spending by imposing a limit of 7 percentage points on the amount that can be deducted from the normal inflation update, known as the Medicare Economic Index (MEI). So, when excessive spending occurs over a period of years, the 7 percent limit effectively spreads the accumulated “debt” over a very long period. Currently, negative conversion factor updates are anticipated annually for approximately 10 more years.

Typically, the MEI for a given year falls in the range of 1.5 percent to 2.5 percent; when combined with the –7 percent update, the result is a conversion factor update somewhere in the range of –5 percent. The cut is significantly steeper in 2008 because of the mechanism Congress used to finance the short-term conversion factor “fix” for 2007: To freeze the 2007 conversion factor at the 2006 rate, Congress eliminated a scheduled 5 percent cut by allocating additional funds for one year only. Consequently, the calculation for determining the 2008 conversion factor began at the rate that would have been effective in 2007 if the freeze had not been implemented. In effect, the two 5 percent pay reductions that were scheduled for 2007 and 2008 were implemented at the same time.

In 2007, significant payment redistributions occurred among the various specialties following the five-year review of the relative value units (RVUs) for physician work in the Medicare fee schedule. Does the 2008 regulation make any changes in the work RVUs?
Yes, there will be changes. The most significant changes in this year’s fee schedule involve the work RVUs for anesthesia services.

During the five-year review process, a so-called “building block” approach was used to determine if anesthesia services were properly valued. The American Medical Association/ Specialty Society Relative Value Scale Update Committee (RUC) determined that the work associated with anesthesia services was significantly undervalued, and it subsequently recommended a 32 percent increase in the anesthesia work RVUs. This recommendation was adopted for 2008 and, in order to maintain budget neutrality, an additional 1 percent negative adjustment in all physician fee schedule work RVUs was applied. In other words, all work RVUs in the fee schedule are reduced by approximately 12 percent (using an adjuster of 0.8806) as a first step in calculating payment amounts.

The first year of a four-year transition to new RVUs for practice expenses was implemented in 2007. Is that transition continuing in 2008?

Yes, this transition will continue. In 2008, practice expense payments will reflect a 50-50 blend of new and old (2006) values. In 2007, the blend was composed of 25-75 new and old values. For most surgical specialties, the net result will be a small decrease in payments (between 0% and 1%) beyond the reduction that will be imposed by the lower conversion factor and the increased anesthesia work values. Table 1 (this page) shows CMS’ estimate of the combined impact of all the RVU changes on each surgical specialty.

Were any changes made in the malpractice RVUs for 2008?

No changes will be made in malpractice payments, other than what may be produced by the revised geographic practice cost indexes described as follows.

What is the bottom-line impact of the work and practice expense RVU changes and fee schedule conversion factor reduction?

Table 1 (page 10) shows the average combined impact of all the changes on payments for key surgical services across various specialties. The first column that provides percentages shows the impact of the RVU changes alone; the other column that provides percentages shows the percentage change in payments that will occur if Congress has failed to act and the 10.1 percent conversion factor cut has, in fact, taken effect on January 1.

Were any changes made in the geographic practice cost indices (GPCIs)?

Yes, there were GPCI changes. By law, the GPCIs applied to the physician work, practice expense, and malpractice components of the fee schedule must be revised at least once every three years to reflect more current cost data. In addition, authority to use a 1.0 “floor” (the
national average) on geographic adjustments for the physician work component of the fee schedule that tends to benefit rural areas expires January 1, unless Congress intervenes.

The most significant positive change resulting from the GPCI revisions occurred in the “Rest of Maine” locality, where changes in the GPCCIs for the three components combine to produce a 5.91 percent payment increase. The most significant decreases produced by the GPCI changes will take place in Detroit, MI, where payments will drop by 4.32 percent. In absolute terms, the nation’s highest payment amounts are in San Mateo, CA, where the combined geographic adjustment is 1.232 percent of the national average, and the lowest payments are in the territory of Puerto Rico at 0.789 percent of the national average.

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How can CMS justify any GPCI reductions?

Increases or decreases in GPCI values do not necessarily reflect changes in the actual costs in a particular locality; rather, they reflect relative costs when compared to a national average. As a hypothetical example, if the rate of growth in office rents is 5 percent in Locality A and 20 percent in Locality B, and the national average growth in office rents is 10 percent, the practice expense GPCI will be reduced in Locality A and increased in Locality B, even though both areas experienced a net increase in office rent costs.

The fee schedule purports to be a relative value scale that is intended to produce relatively appropriate payment amounts. Few policy experts would claim it produces “correct” payments.

For some time, there has been controversy regarding the GPCCIs in California, where

<table>
<thead>
<tr>
<th>Procedure</th>
<th>2007 average payment ($)</th>
<th>2008 average payment if conversion factor is frozen at 2007 level</th>
<th>2008–2007 % change</th>
<th>2008 average payment with 10.1% conversion factor reduction ($)</th>
<th>% change 2008–2007</th>
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<tr>
<td>19307, Removal of breast</td>
<td>1,008</td>
<td>1,001</td>
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<td>27130, Total hip replacement</td>
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<td>31290, Nasal/sinus endoscopy</td>
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<td>1,070</td>
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<td>33512, Coronary artery bypass graft 3—vein</td>
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<td>–12.1</td>
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<td>–3.0</td>
<td>934</td>
<td>–12.8</td>
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<td>44140, Partial removal of colon</td>
<td>1,191</td>
<td>1,169</td>
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<td>49505, Repair inguinal hernia</td>
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<td>52601, Prostatectomy</td>
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<td>794</td>
<td>2.3</td>
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<td>63047, Removal of spinal lamina</td>
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<td>66984, Remove cataract, insert lens</td>
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<td>623</td>
<td>–3.0</td>
<td>560</td>
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</tr>
</tbody>
</table>
communities with high costs have been included with lower cost rural areas in a single payment locality. Has CMS addressed this inequity?

No, this issue has not yet been addressed. A number of options have been suggested, including three that were discussed in the proposed rule issued last summer. Unfortunately, GPCI changes in states that have more than one payment locality must be made in a budget-neutral manner. In other words, payments in one locality cannot be increased unless offsetting payment reductions are made in another locality in the same state. As a result, CMS has been unable to identify a supportable option for addressing a widely acknowledged need to address inappropriately low payments in certain communities in California and elsewhere. However, CMS is looking at other suggested methodologies and has indicated that it intends to address the issue again.

Medicare payments in underserved areas have been eligible for bonus payments in an effort to further encourage physicians to practice in these communities. Will this policy continue in 2008?

On January 1, the 5 percent “bonuses” paid for services provided in CMS-designated primary care or specialty care scarcity areas will expire unless Congress passes legislation extending them. These incentives were effective between January 1, 2005, and January 1, 2008.

In the proposed rule, CMS indicated that it was considering the possibility of expanding the list of procedures subject to payment reductions when multiple procedures are performed at the same session. Was that policy implemented?

Yes, the policy was implemented. Until now, Mohs’ micrographic surgery procedures have not been subject to the multiple payment reduction policy that applies to all other procedure codes in the surgery/integumentary section of the Current Procedural Terminology manual. Starting January 1, a 50 percent payment reduction for subsequent Mohs’ procedures performed during a single session will be applied.

What plans does CMS have for the Physicians Quality Reporting Initiative (PQRI) for 2008?

CMS intends to continue the PQRI program in 2008, with an expanded list of measures and a full-year reporting period. (See “Socioeconomic tips” on page 48 for a detailed description of the 2008 PQRI program.) Physicians and other providers who bill under the Medicare fee schedule will be asked to choose from among 117 PQRI measures, as opposed to the 74 measures that were used in 2007. Like last year, PQRI relies primarily on process measures for reporting quality information, although two new structural measures were added to the list pertaining to the use of electronic medical records and electronic prescribing.

What sort of payment bonus will be applied for those who report the PQRI measures?

The bonus payment rate has not yet been set. Through legislation passed in late 2006, Congress allotted $1.35 billion for quality measurement purposes. Whatever bonuses are paid at the conclusion of the 2008 PQRI project are subject to that aggregate payment cap. Preliminarily, CMS estimates that the bonus rate for those reporting PQRI measures on their Medicare claims forms in 2008 will fall between 1.5 percent and 2.0 percent. Once again, the bonus payments will be made in a lump sum after the reporting period ends.

The College and many other medical and surgical specialty organizations argued in comments on the proposed rule that this $1.35 billion should be allocated to reducing the scheduled cut in the fee schedule conversion factor. Given the overwhelming support for this recommendation, why did the CMS choose to continue the PQRI instead?

In their comments, the College and others noted the poor logic behind providing “bonuses”
of 1.5 percent to 2 percent as an incentive to physicians whose payments have been slashed more than 10 percent. In the final rule, CMS acknowledged the overwhelming support for using the $1.35 billion to partially offset the negative fee schedule update, which would make a “fix” less expensive for Congress to legislate. However, because this amount is a fixed sum and Medicare is an entitlement program with no fixed spending, CMS said it was unable to guarantee that reducing the negative update by one or two percentage points would not result in additional program spending beyond the $1.35 billion available. Because of concerns about the legal ramifications of exceeding or falling short of the capped amount, the agency opted instead to apply the additional funding to an extension of the PQRI.

Has CMS given any indication of the 2007 PQRI program’s success?

No, that information is still being collected. CMS said in the final rule that, after the 2007 PQRI reporting has concluded, the agency intends to assess and make available to the public information such as participation rates by specialty, associated trends in clinical performance and beneficiary outcomes, and other observable effects. These assessments may include aggregated data by specialty, state, and so forth, but no plans are in place to release data that would enable the public to identify individual physician participants or practices.

Where can surgeons and their staff obtain information about the 2008 PQRI measures and the rules involved in reporting them?

At press time, only some of the measure specifications had been finalized. However, federal legislation requires CMS to publish the final list of measures no later than November 15. After that date, no new measures can be added, although technical corrections and minor refinements may be made until January 1. CMS makes all PQRI-related information available on its Web site, at www.cms.hhs.gov/PQRI. In addition, the College has been developing its own PQRI material, which has more of a surgeon focus; this information is available at www.facs.org/ahp/pqri. Members of practices that plan to participate in PQRI in 2008 should check both Web sites often for the latest information.
Project Access: Giving back at home

by Joseph B. Cofer, MD, FACS
As I read the plea for a surgeon to accompany a medical mission to Honduras in the August 10, 2007, edition of the ACS NewsScope, I was reminded of a surgical mission trip I made to Haiti where I performed many inguinal hernia operations on several young men, most of whom probably had had hernias since infancy. The trip was significant to me in many important ways and I honor the work of selfless physicians who perform medical mission work overseas. At the same time, I was struck by the large amount of resources expended to provide a relatively small amount of medical care. This trip was a significant financial expense to me, including the direct costs of airplane tickets, lodging, and meals, and the indirect costs of being away from my practice. In fact, there are many opportunities for surgeons to perform meaningful charity work right here at home in programs that are vastly more cost-effective (cost/relative value unit) than overseas medical efforts. For example, we have a program in Chattanooga, TN, that might serve as a model for other surgeons around the country who are interested in providing domestic charity care.

**Creation of Project Access**

The Project Access model was initially developed in 1995 by the Buncombe County (North Carolina) Medical Society under the leadership of Suzanne E. Landis, MD, MPH, professor of family medicine at University of North Carolina School of Medicine in Chapel Hill, a founder of the Physicians Innovation Network, and a chief architect of Project Access. In 2002, the leadership of the Chattanooga-Hamilton County Medical Society (CHCMS) decided to create a similar program to serve Hamilton County residents. By October 2002, the CHCMS had brokered a meeting that included CHCMS leadership and the chief executive officers of the three major hospitals in Chattanooga.

At that meeting, we decided to create our own version of the Project Access model in Chattanooga. The hospitals were convinced to come on board because we could clearly make the case that it is easier and less costly to provide free care to perform an elective same-day cholecystectomy or outpatient treatment of hypertension or outpatient treatment of diabetes than to treat their respective complications such as gangrenous cholecystitis/biliary pancreatitis, hypertensive stroke, or diabetic ketoacidosis. If treatable medical conditions are allowed to progress, the patients will end up in the emergency room and hospitals will eventually be forced to provide the care anyway. The plan was to construct a county-wide network of primary care physicians and specialists together with the hospitals to provide free care to a segment of the uninsured residents of Hamilton County. Once the agreement was reached to move forward, seed money was raised; $50,000 donated by the CHCMS and another $150,000 donated by the three hospitals and the local dialysis clinic. With this seed money, we were able to hire an experienced director, Rae Bond, to head up this initiative (see photo, page 15). She began work in February 2003.

At that point, the Project Access team began to seek longer-term funding and to recruit other partners to participate in the program, including health centers operated by several entities (that is, the county health department, a nonprofit hospital system, and federally qualified health centers), and to launch a major physician recruitment effort.

Physician leaders and representatives from partner agencies formed the Project Access Operations Council, which developed eligibility criteria, operational strategies, and policies and procedures for the initiative. This effort received significant assistance from Project Access initiatives in other communities, most notably Sedgwick County (Wichita, KS) Project Access, which allowed us to use their policies and procedures as a starting point. Eventually, the Hamilton County program also purchased Wichita’s Charisma Salus software to coordinate care. Ms. Bond also wrote a successful proposal that brought us a three-year, $1.9 million federal Healthy Communities Access Program grant in September 2003. With the grant money, we were able to purchase computer hardware and software, add phone lines, and hire a few employees. The Project Access staff screens potential patients, coordinates care, manages patient allocation, recruits physicians, enters and manages data, and helps our patients navigate the numerous and confusing pharmacy industry-sponsored drug programs.
Project Access staff at work. Counter-clockwise from upper left: J. Patrick Dilworth, MD, with a patient; program manager Tonya Williams; Ms. Bond; Ms. Williams and Holly Lyons review files.
**Table**

<table>
<thead>
<tr>
<th>Category</th>
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<td>New patients enrolled</td>
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<td>651</td>
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</tr>
<tr>
<td>Total patients currently enrolled</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Patient care completed (disenrolled)</td>
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<td>549</td>
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<tr>
<td>Patients disenrolled due to noncompliance</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>11</td>
<td>39</td>
</tr>
<tr>
<td>Not eligible; directed to other resources</td>
<td>183</td>
<td>466</td>
<td>667</td>
<td>317</td>
<td>1,633</td>
</tr>
<tr>
<td>Physician care claims received</td>
<td>717</td>
<td>3,848</td>
<td>5,103</td>
<td>2,413</td>
<td>12,081</td>
</tr>
<tr>
<td>Hospital claims received</td>
<td>162</td>
<td>1,328</td>
<td>2,415</td>
<td>1,086</td>
<td>4,991</td>
</tr>
<tr>
<td>Physician care delivered</td>
<td>$152,886</td>
<td>$939,474</td>
<td>$1,569,496</td>
<td>$745,309</td>
<td>$3,407,165</td>
</tr>
<tr>
<td>Hospital care delivered</td>
<td>$588,752</td>
<td>$3,977,382</td>
<td>$8,085,759</td>
<td>$4,769,577</td>
<td>$17,421,470</td>
</tr>
<tr>
<td>Total care for all claims</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$20,828,635</td>
</tr>
</tbody>
</table>

**Project Access opens its doors**

By April 2004, we were ready to admit our first patient. To qualify for the program, a person must be a resident of Hamilton County for at least 90 days, have income lower than 150 percent of the federal poverty level ($25,755 for a family of three), and have no other access to health insurance (such as employer provided, Medicare, Medicaid, and so on). Potential patients are referred to the program by partner health centers, hospitals, and physicians; they can also apply directly. Project Access is housed at the Medical Society. Patients are evaluated and those who qualify are enrolled and issued a Project Access enrollment card that allows them to receive care at partner facilities. Each new patient is connected to a primary care home, typically at one of the various health centers in the community. Patients’ primary care physician can, in turn, contact Project Access to coordinate specialty care needed by the patients. Patients are strongly encouraged to use the emergency room (ER) only for true emergencies and inappropriate use of the ER can result in disenrollment from Project Access.

When Project Access began in 2004, we quickly had more than 350 physicians volunteer their services. By June 2007, more than 580 physicians in Hamilton County have agreed to see Project Access patients free of charge.

Typically we ask the specialists (general surgeons, cardiologists, urologists, and so on) to agree to see 10 to 20 patients a year, and we ask the primary care physicians to see five to 10 patients a year. The physicians provide this care completely voluntarily. Essentially all specialties are represented. All hospitals provide free surgical and other imaging and laboratory services as necessary, and the allocation of patients to physicians is coordinated with the help of the Project Access software program that tracks physician commitments and availability. Each partner facility and physician creates a Project Access identifier in their billing system, as though it was an insurance company, to generate a HCFA-1500 form for all care that is provided. The system is then programmed to write off the care as charity. This process enables Project Access to document the date, treatment, care provided, and the value of the care. As there are currently more than 580 physicians involved, the individual workload of each physician is really quite small. For example,
I myself might see one surgical consult every other month as almost all the general surgeons in town have agreed to see these patients.

Since the program’s inception in April 2004 through June 2007, we have screened more than 4,037 patients. Of these patients, 2,235 were enrolled. The value of total physician care delivered to date is $3.4 million. The value of total hospital care delivered is $17.4 million (see Table, page 16).

**Project Access’ benefits**

One of the beauties of this program is that if a person has a medical condition that makes him or her unemployable, that person can join Project Access, have the condition (such as an inguinal hernia) treated, and then six weeks later return to the workforce where health insurance often can be obtained. At this point, the person drops out of Project Access. Of the 2,235 patients we have enrolled over the last three years, 2,067 participants have now had their care completed and they have been disenrolled. Approximately 20 percent of these individuals now have health insurance. We currently have 387 patients enrolled in the program.

Another significant benefit of this program is that many of the patients initially screened do not truly need help from Project Access but need referral to some other agency that can solve their problem. Over the last three years, of the 4,037 patients we screened, 1,633 were not eligible for our program but were directed to other resources to receive help. In essence, Project Access serves as an umbrella organization to provide resources to the uninsured people in our community who need medical care or some other type of resource to sustain them.

Finally, we provide assistance to other communities who wish to do the same thing. We have helped communities from as far away as Michigan, and recently helped our “sister city,” Knoxville, TN, get its program up and running.

Our program has truly made an impact in our community. It has been widely accepted by the physicians because it is our program, run by us, and not the result of some government mandate. Although this program is not as dramatic as going to a foreign country and providing medical care under adverse circumstances, I believe it performs a vital function in providing medical care for a segment of the uninsured in our community. Although traveling to other countries to care for those in need is important, as surgeons we should not lose sight of the fact that we can care for those individuals in need in our backyards as well.
This article summarizes changes in the 2008 Current Procedural Terminology (CPT)* that are relevant to general surgery and closely related specialties. This information should be useful not only to surgeons but also to office staff who perform coding functions.

**Multiple procedure changes**

Three codes have been added to the multiple procedure rules. More specifically, two codes became subject to the multiple procedure rules, and one code became an add-on code. The multiple procedure rules require that modifier –51 be appended to the code and reimbursement is generally reduced. (Medicare does not require the –51 modifier be appended but does reduce payment by 50 percent.) Code 35600, *Harvest of upper extremity artery, one segment, for coronary artery bypass procedure*, became an add-on code because it is always performed in conjunction with the coronary artery bypass codes (codes 33533–33536). Code 36660, *Catheterization, umbilical artery, newborn, for diagnosis or therapy*, is no longer a modifier –51-exempt code because it involves significant work before and after the procedure. Modifier –51-exempt codes do not have significant service time for before and after the procedure associated with them and, therefore, it is unreasonable to reduce payment for them. Code 38792, *Injection procedure; for identification of sentinel node*, has been removed from the modifier –51-exempt list in part because Medicare already treats the code as subject to the modifier –51 rules.

**Excision and repair of skin lesions**

Notes have been added to the sections on excision of benign and malignant skin lesions (codes 11400–11646) and adjacent tissue transfer (codes 14000–14061) to clarify that excision of the lesion is not separately reported when an adjacent tissue transfer is performed.

**Vascular procedures**

The code for transcatheter placement of a wireless physiologic sensor in an aneurysmal sac during an endovascular repair was moved from category III (code 0153T) to category I (code 34806). A new code 35523 was established to report a brachial-ulnar or brachial-radial bypass procedure.
Central venous access procedures

Three new codes related to central venous access procedures were established and two codes were assigned new names. The new codes are code 36592, Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified; code 36595, Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access; and code 36596, Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen. Code 36540, Collection of blood specimen from a completely implantable venous access device, was reassigned to be code 36591, and code 36550, Declotting by thrombolytic agent of implanted vascular device or catheter, was changed to code 36593. Notes were added directing users not to report codes 36591 or 36592 with any other service and not to report code 36595 or 36596 with code 36593.

Choledochal cysts

Three new codes have been established for reporting the excision of choledochal tumors, differentiated by the size of the tumor. If more than one tumor is removed or destroyed, the code for the largest tumor is reported. All three codes contain the language Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors. Code 49203 is used when the largest tumor is 5 cm diameter or less; code 49204 is used when the largest tumor is 5.1 to 10.0 cm in diameter; and code 49405 is used when the largest tumor is greater than 10.0 cm in diameter. Codes 49200 and 49201, which were for the simple and extensive excision or destruction of intraabdominal or retroperitoneal tumors or cysts or endometriomas, were deleted.

G-, D-, J-, G-J-, and C-tubes

The Figure on page 20 shows all of the new and existing codes in CPT to report an array of services regarding percutaneous gastrointestinal tubes, including many that are frequently performed by specialties other than general surgeons. Code 43750, Percutaneous placement of gastrostomy tube, has been deleted; a note directs users to existing code 43246, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube, for percutaneous insertion of a gastrostomy tube that does not require imaging guidance. Existing code 43761, for repositioning the gastric feeding tube through the duodenum, was modified by removing “any method” to avoid confusion with other codes.

Expanded use of abdominal mesh

The codes for the implantation and removal of abdominal mesh—codes 49568 and 11008, respectively—have been revised to permit reporting the mesh for closure of debridement for infection. The codes, which are add-on codes, had previously been limited to use in incisional and ventral hernia repair.

Aspiration of thyroid cyst

Code 60001, Aspiration and/or injection, thyroid cyst, has been moved to 60300.

Evaluation and management codes

The evaluation and management (E/M) section of the CPT contains a number of new codes of potential interest to surgeons. It is essential that coders meet all of the administrative requirements of the codes and provide complete documentation of the services furnished in the medical record. If insurers pay for these codes, they doubtless will be interested in performing post-payment reviews of the use of these codes.
<table>
<thead>
<tr>
<th>Code number</th>
<th>Descriptor</th>
<th>Status of code</th>
</tr>
</thead>
<tbody>
<tr>
<td>43246</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube</td>
<td>Existing</td>
</tr>
<tr>
<td>43752</td>
<td>Nasogastric or orogastric tube placement, requiring physician’s skill and fluoroscopic guidance (includes fluoroscopy, image documentation, and report)</td>
<td>Existing</td>
</tr>
<tr>
<td>43760</td>
<td>Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance</td>
<td>Modified</td>
</tr>
<tr>
<td>43761</td>
<td>Repositioning of the gastric feeding tube, through the duodenum for enteric nutrition</td>
<td>Modified</td>
</tr>
<tr>
<td>49440</td>
<td>Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>49441</td>
<td>Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>49442</td>
<td>Insertion of cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>49446</td>
<td>Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>49450</td>
<td>Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>49451</td>
<td>Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>49452</td>
<td>Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report</td>
<td>New</td>
</tr>
<tr>
<td>49460</td>
<td>Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>49465</td>
<td>Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation, and report</td>
<td>New</td>
</tr>
<tr>
<td>75984</td>
<td>Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision, and interpretation</td>
<td>Modified</td>
</tr>
</tbody>
</table>

**Figure.** Codes for reporting various procedures involving tubes in the gastrointestinal tract.
New codes are replacing the old codes for medical team conferences. Code 99367 is used to report a physician’s participation in a medical team conference when the patient or family is not present. (Code 99368 is for use by nonphysicians.) The conference may include a minimum of three health care professionals from different specialties, with no more than one individual from the same specialty. Each participant must have treated or evaluated the patient within the previous 60 days and each must document what he or she contributed to the discussion and the treatment recommendations made as a result of the conference. If also reported, the care plan oversight codes (codes 99374–99380) must account for separate time. Conferences lasting less than 30 minutes are not separately reported.

For team conferences with the patient and/or family present, physicians should use the regular E/M codes for the site where the team conference takes place. Existing reporting instructions say that when counseling and/or coordination of care accounts for at least 50 percent of the time of the visit, then time is the controlling factor and is used to decide which code to report. The extent of counseling or coordination of care must be documented in the medical record. Code 99366 has been established for a nonphysician health care professional to report his or her participation in the conference. The rules for the nonphysician’s participation are the same as when the patient or family is not present, as discussed previously.

Two codes have been added for a structured screening and brief intervention service related to alcohol and other substance abuse. Code 99408 is for Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes; code 99409 has the same descriptor but is for more than 30 minutes. Services of less than 15 minutes are not separately reported. These codes are used to report the SBI that must be available at level I trauma centers. Either a physician or a qualified nonphysician health care professional may report these codes.

Codes have been established for reporting telephone calls initiated by an established patient. Code 99441 is for reporting five to 10 minutes of discussion, code 99442 is for 11 to 20 minutes of discussion, and code 99443 is for 21 to 30 minutes of discussion. These codes are not to be used to report a telephone call made if the patient is within the postoperative period of a recent procedure or received a related E/M service within the previous seven days or if the telephone call results in seeing the patient within the next 24 hours or next available urgent appointment.

Code 99444 has been established for an online E/M service provided by a physician using the Internet. However, the code is not to be used if the patient has had a related E/M service in the previous seven days or is within the postoperative period of a recent procedure.

Dr. Bothe is chief quality officer, Geisinger Health System, Danville, PA.
HIGHLIGHTS
OF THE 93RD ANNUAL
CLINICAL CONGRESS
A mong the highlights of the American College of Surgeons’ 2007 Clinical Congress in New Orleans, LA, was a diverse assortment of general sessions related to practice, educational, and clinical topics of interest to surgeons and 39 postgraduate courses.

The meeting hosted 11,167 attendees, 6,671 of whom were physicians; the rest were exhibitors, spouses, guests, and convention personnel.

Convocation

At the Convocation ceremonies that heralded the official opening of the Clinical Congress, Gerald B. Healy, MD, FACS, was installed as the 88th President of the American College of Surgeons. The first otolaryngologist to serve as ACS President, Dr. Healy is the Healy Chair in Pediatric Otolaryngology and Professor of Otolaryngology and Laryngology at Harvard Medical School and otolaryngologist-in-chief at Children’s Hospital in Boston, MA.

Dr. Healy’s Presidential Address to the 1,290 Initiates focused on the idea of FACS—not just Fellow of the American College of Surgeons but also Forever A Caring Surgeon—and what the 21st century will require of surgeons to be both (see photo, page 22).

Also installed at the Convocation were Mary H. McGrath, MD, MPH, FACS, as First Vice-President and Paul Friedmann, MD, FACS, as Second Vice-President. Dr. McGrath is a professor of surgery in the division of plastic surgery at the University of California–San Francisco. Dr. Friedmann is executive director of Pioneer Valley Life Sciences Institute in Springfield, MA.

The following individuals were conferred Honorary Fellowship in the College during Convocation: Juan M. Acosta, MD, FACS, PhD, of Rosario, Argentina; Hans G. Beger, MD, FACS, of Ulm, Germany; Adam Dziki, MD, PhD, of Lodz, Poland; Nicola Scopinaro, MD, of Genoa, Italy; and Heinz R. Stammberger, MD, FRCSEd(Hon), of Graz, Austria.

Also at the Convocation, for the first time a young surgeon was invited to speak on behalf of the Initiates. Gregory S. Cherr, MD, FACS, then-Chair of the Resident and Associate Society who was initiated at Convocation, presented this speech (see photo, page 22).

Named Lectures

The American Urological Association Lecture, The Coming Era of Too Few Physicians, was presented by Richard A. Cooper, MD, immediately after the Opening Ceremony. That same day, Mark B. Orringer, MD, FACS, presented the John H. Gibbon, Jr., Lecture, Esophageal Mythology, and David L. Nahrwold, MD, FACS, delivered his presentation, Joseph Lovell: First-Generation American, First Surgeon General, for the Charles
G. Drake History of Surgery Lecture. Other lectureships at the meeting included Trauma: A Social and Medical Challenge, delivered by Dario Birolini, MD, FACS, as the Scudder Oration on Trauma; Mind Wars: Brain Research and National Defense, presented by Jonathan D. Moreno, PhD, for the Ethics and Philosophy Lecture; The Excitement of Cancer Research in the Next Decade, the Commission on Cancer Oncology presentation by John E. Niederhuber, MD, FACS; the I.S. Ravdin Lecture in the Basic Sciences, Tissue Engineering and Regenerative Medicine: Building Living Replacements for Surgical Reconstruction and Transplantation, by Charles A. Vacanti, MD, and Joseph P. Vacanti, MD, FACS; and the Distinguished Lecture of the International Society of Surgery, What Can the Academic Community Offer the Third-World Surgeon?, which was presented by Michael G. Sarr, MD, FACS. The closing lecture, the Martin Memorial Lecture, Fighting the Great Pandemics: Challenges and Opportunities, was presented by Richard Feachem, KBE, FREng, DSc(Med) (see photo, page 22).

At this year’s Congress, two new Named Lectures also made their debut. The inaugural Olga Jonasson Lecture—which had been established in Dr. Jonasson’s memory as a testimony to leadership and education in surgery and a reflection of the capacity of women to reach academic pinnacles—was delivered by Nancy L. Ascher, MD, PhD, FACS, who presented The Ultimate in Surgical Translation: Transplantation (see photo, page 22). The first Herand Abcarian Lecture, created to address issues of relevance to the surgical community at-large and focus on emerging issues in surgery, focused on Surgical Mentoring; Thomas R. Russell, MD, FACS, Executive Director of the College, presented this lecture.

Awards, honors, and celebrations
The 2007 ACS/Pfizer Medical Humanities Initiative Surgical Volunteerism Awards were presented to Sylvia D. Campbell, MD, FACS, for domestic outreach; Van C. Knowles, MD, FACS, for international outreach; and Col.
Thomas G. Crabtree, MD, FACS, for volunteerism performed while on active duty as a military surgeon. This year marked the first time that an award was presented in all three categories. The three recipients were honored at the Board of Governors dinner (see photo, page 24).

The Distinguished Service Award, the College’s highest honor, was presented to David B. Hoyt, MD, FACS, chairman of the department of surgery at the University of California–Irvine Medical Center. Dr. Hoyt received his award during the Annual Business Meeting of the Members (see photo, page 23).

The Commission on Cancer presented the State Chair Outstanding Performance Award to three state chairs to recognize their extensive leadership and support to physician volunteers and cancer programs in their respective states. Recipients of this award were Arnold Baskies, MD, FACS, of New Jersey; Phillip Roland, MD, FACS, of Florida; and Michael Vezeridis, MD, FACS, of Rhode Island. (See photo, this page.)

Mark Puder, MD, FACS, an assistant professor at Harvard Medical School and an assistant in surgery at Children’s Hospital in Boston, MA, was conferred the Jacobson Promising Investigator Award. (A full article regarding Dr. Puder’s award will appear in the February issue of the Bulletin.)

This year the Forum on Fundamental Surgical Problems was dedicated to Lazar J. Greenfield, MD, FACS (see photo, page 26). The Surgical Forum Excellence in Research Awards, established to recognize surgical residents who submit outstanding Surgical Forum papers, were presented to: Ankit Bharat, MD, of Washington University in St. Louis, MO; Deepak Gupta, MD, of Stanford University in Stanford, CA; Krit Kitisin, MD, of Georgetown University Hospital in Washington, DC; Marcia L. McGory, MD, of the David Geffen School of Medicine at the University of California–Los Angeles; Jitesh Patel, MD, of University of Pittsburgh (PA) Medical School; Danielle B. Peterson, MD, of Medical College of Wisconsin, Children’s Research Institute, in Milwaukee; Dan M. Ridgway, MBChB, MRCS, of North Lincolnshire and Goole Hospitals, NHS Trust, Scunthorpe, North Lincolnshire, United Kingdom; Joachim Schmidt, MD, of the University of Pittsburgh (PA); J. Joshua Smith, MD, of Vanderbilt University Medical Center in Nashville, TN; Ryan M. Spivak, MS, of Children’s Hospital of Philadelphia, PA; Christopher L. Stout, MD, of Mercer University School of Medicine at the Medical Center of Central Georgia in Macon; and Zhen Wang, MD, of Stanford University in Stanford, CA (see photo, page 26).

Commission on Cancer State Chair Outstanding Performance awardees, left to right: Dr. Baskies, Dr. Vezeridis, and Dr. Roland.
Carcinoma—that appeared among the Top Posters of Exceptional Merit (see photo, page 27).

The Highlights from International Meetings video session, sponsored by the Committee on Video-based Education and chaired by Horacio J. Asbun, MD, FACS, highlighted outstanding surgical videos previously presented at various international meetings, and nominated by prominent international surgeons. At the conclusion of the session, members of the audience voted on the two best videos. The winners were Praveen Raj Palanivelu, MD, Coimbatore, India, for the video entitled Thoracoscopic Esophagectomy for Carcinoma Middle-Third Esophagus in Prone Position, and Augusto Tinoco, MD, Itaperuna, Brazil, for Laparoscopic Gastroduodenopancreatectomy (Whipple Operation). Dr. Asbun presented each with an award and a one-year subscription to the ACS Online Video Library (see photo, page 27).

The fifth annual ACS Resident Award for Exemplary Teaching was presented to David A. McClusky III, MD, a sixth-year postgraduate student and minimally invasive surgery fellow at the Mayo Clinic in Jacksonville, FL; he completed his general surgery residency at the Emory University School of Medicine in Atlanta, GA. Dr. McClusky was selected by an independent review panel of the Committee on Resident Education to recognize his excellence.
Coauthors of the winning Poster of Exceptional Merit: Dr. Talens (left), and Dr. Dela Cruz.

Dr. Asbun (far left) presented the award for best video at the Highlights from International Meetings video session. Pictured are winners Dr. Tinoco (second from left) and Dr. Raj (second from right), along with Dr. Raj’s father and video coauthor, Chinnusamy Palanivelu, MCh, FACS.

in teaching as a resident and to highlight the importance of teaching in residents’ daily lives (see photo, page 28).

The Florida Chapter of the ACS presented an award to Edward M. Copeland III, MD, FACS, Immediate Past-President of the College, for being the first ACS President to hail from Florida.

The following International Guest Scholars and Traveling Fellows were honored by the International Relations Committee: Adeyinka C. Adisa, MBBS, FWACS, of Aba, Abia State, Nigeria; Kwok-Leung Chung, MBBS, FACS, FRCS, of Nottingham, England; Luis Mariano Ferreira, MD, of Buenos Aires, Argentina; Robert Gruetzmann, MD, PhD, the 2007 Germany Exchange Fellow; Marc Leroy Guifo, MD, of Yaounde, Cameroon; Alexander Julianov, MD, of Stara Zagota, Bulgaria; Yuko Kijima, MD, PhD, the 2007 Japan Exchange Fellow; Reginald V. N. Lord, MD, FRACS, of Darlington, NSW, Australia; Rina Mariano Pereira Porta, MD, of Sao Paolo, Brazil; Hector H. Pulido, MD, of Bogota, Colombia; Yongfeng Shao, MD, of Nanjing, People’s Republic of China; Taejin Song, MD, FACS, of Ansan City, Gyunggi-do, South Korea; and Maarit Anita Venermo, MD, of Helsinki, Finland (see photo, page 28).

The 2007 Nizar N. Oweida, MD, FACS, Scholarship was presented to Michael C. Gynn, MD, of Dublin, CA. Stephen E. Olson, MD, FACS, of Burns, OR, presented the scholarship to Dr. Gynn during the annual Rural Surgeons Meeting (see photo, page 29).

Project New Orleans

This year, for the first time, the ACS/Operation Giving Back (OGB) organized a humanitarian effort in conjunction with Clinical Congress. Led by Kathleen Casey, MD, FACS, Director of OGB, approximately 180 Congress attendees donated part or all of their Tuesday
Dr. McClusky, recipient of the Resident Award for Exemplary Teaching (third from left), pictured with (left to right): Gayle E. Woodson, MD, FACS, Vice-Chair, Committee on Resident Education; Dr. Healy; Dr. Russell; Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education; and Josef E. Fischer, MD, FACS, Chair, Board of Regents.
New Officers-Elect

New Officers-Elect were named at the Annual Business Meeting of Members. John L. Cameron, MD, FACS, was named President-Elect and will serve as the 89th President of the American College of Surgeons beginning at the 2008 Clinical Congress in San Francisco, CA. Dr. Cameron is a professor of surgery and the Alfred Blalock Distinguished Service Professor at The Johns Hopkins University School of Medicine in Baltimore, MD (see photo, this page).

Jack W. McAninch, MD, FACS, a professor of urology at the University of California–San Francisco and chief of urology at San Francisco General Hospital and a Regent of the College, was named First Vice-President. Richard B. Reiling, MD, FACS—medical director of the Presbyterian Cancer Center, Chair of the ACS representatives in the American Medical Association House of Delegates, and a former recipient of the Distinguished Service Award—was named Second Vice-President.

Where to find more information

Some of the information presented in these highlights has been discussed in greater detail in previous issues. Following is a list of where to find more on these topics in the Bulletin:

September 2007:
• Full description of the humanitarian achievements of Surgical Volunteerism Award recipients, page 27.

November 2007:
• Biography of Dr. Healy, page 36.
• Distinguished Service Award presented to Dr. Hoyt, page 37.
• Citations for Honorary Fellows presented at the Convocation, page 39.

December 2007:
• Dr. Healy’s Presidential Address in its entirety, page 8.
Members of the Board of Regents (B/R) and ACS Officers met for their annual luncheon. Pictured (with their titles just prior to the Clinical Congress) front row, left to right (all MD, FACS): Richard J. Finley; Dr. Cameron, Treasurer; Dr. Healy, President-Elect; Dr. Russell, Executive Director; Josef E. Fischer, B/R Chair; Edward M. Copeland III, President; L. D. Britt, B/R Vice-Chair; Courtney M. Townsend, Jr., Secretary; Robert E. Berry, Second Vice-President; Alden H. Harken; and David L. Nahrwold, First Vice-President.

Second row: Thomas V. Whalen; Jack W. McAninch; H. Randolph Bailey; Charles D. Mabry; Robin S. McLeod; Barrett G. Haik; Julie A. Freischlag; Barbara L. Bass; and Mark C. Weissler.

Back row: Karl C. Podratz; John T. Preskitt; J. David Richardson; A. Brent Eastman; Martin B. Camins; Carlos A. Pellegrini; and Raymond F. Morgan.

Not pictured: Mary H. McGrath, First Vice-President-Elect; Paul Friedmann, Second Vice-President-Elect; and Regent Bruce D. Browner.

Members of the Advanced Trauma Life Support® international family met to discuss issues related to the program.
Past recipients of the College’s most prestigious honor, the Distinguished Service Award, gathered for their annual luncheon. Pictured in the front row, left to right (all MD, FACS): John O. Gage; Patricia J. Numann; Murray F. Brennan; and LaMar S. McGinnis, Jr. Back row: C. Thomas Thompson; Richard B. Reiling; Donald R. Trunkey; and Frank Padberg.

The Past-Presidents of the College met for their annual luncheon. Pictured left to right, front row (all MD, FACS): C. Rollins Hanlon; W. Gerald Austen; George F. Sheldon; and Frank C. Spencer. Back row: Edward R. Laws; Edward M. Copeland III; Richard R. Sabo; and R. Scott Jones.

**Board of Regents**

Howard M. Snyder III, MD, FACS, associate director of pediatric urology at The Children’s Hospital of Philadelphia (PA) and professor of urology at the University of Pennsylvania School of Medicine, was elected to the Board of Regents. In addition, Barbara L. Bass, MD, FACS; A. Brent Eastman, MD, FACS; and Barrett G. Haik, MD, FACS, were reelected to three-year terms. Joseph E. Fischer, MD, FACS, and L. D. Britt, MD, FACS, will remain the Chair and Vice-Chair, respectively.

**Board of Governors**

Mark B. Orringer, MD, FACS, was elected to the Board of Governors Executive Committee. Valerie Rusch, MD, FACS, was reelected to another term as Chair; Michael J. Zinner, MD, FACS, was elected to a one-year term as Vice-Chair; and Karen E. Deveney, MD, FACS, was reelected to another one-year term as Secretary.
PROJECT NEW ORLEANS

by KATHLEEN CASEY, MD, FACS,
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Though the national discussion of Hurricane Katrina abates with the passage of time, the hurricane’s devastating effects on New Orleans, LA, continue to this day, with schools, hospitals, medical clinics, and other critical infrastructure still struggling to recover. The 2007 Clinical Congress provided an opportunity for many in attendance to participate in efforts to help restore these much-needed services.

**Volunteers at work**

The American College of Surgeons’ Project New Orleans encompassed several ways for individuals to contribute to the city’s recovery. On Tuesday, October 8, and Wednesday, October 9, 180 volunteers—surgeons, family members, residents, industry executives, exhibitors, and others—donned head-to-toe protective gear, from hard hats and hairnets to hazmat jumpsuits and shoe booties, to begin demolition on a former school building that was approved as the site of a new medical clinic for economically disadvantaged and uninsured residents of the Ninth Ward. The Daughters of Charity Health Clinic at St. Cecilia’s has been designated as a national Center of Excellence, meaning that it will be built as a model for ideal provision of integrated health care in conjunction with local community and academic centers.

After a blessing by representatives of St. Cecilia’s and an introduction and safety briefing by representatives of Habitat for Humanity, everyone went right to work. Participants were assembled into groups by the color of bandanas distributed as they entered the worksite. Despite the extreme humidity in New Orleans’ semitropical climate, contributors approached the work with enthusiasm, swinging sledgehammers, climbing ladders, wielding spades, and maneuvering crowbars to remove walls, ceilings, floors, an entire kitchen facility, blackboards, and furniture before pushing wheelbarrows full of debris to the dumpsters lined up outside. Organizers repeatedly told the volunteers that they were way too efficient and way ahead of schedule; New Orleans dumpster suppliers had a difficult time keeping up with the pace, as seven dumpsters were filled over the course of the two-day project.

In the end, volunteers completed demolition of 24,000 square feet of the building’s interior, far exceeding the expectations of the site’s overseers. The contractors who will later build the new clinic estimated the value of this donated work at more than $60,000.

In addition to hands-on opportunities to help, donations were accepted in support of ongoing efforts by the two agencies that were central to this project: New Orleans Area Habitat for Humanity and Daughters of Charity of New Orleans–St. Cecilia Health Clinic. More than $22,000 had been raised as of November 2007, including substantial donations by the University of Cincinnati Medical Center, KCI, the American Association of Surgical Physicians Assistants in conjunction with Montefiore Medical Center Surgical Residency Program, and multiple individual donors.
Another aspect of Project New Orleans was a school supply drive that was suggested and organized by Mike Trotter, MD, FACS, of Houma, LA. This effort was kicked off by the staff at the ACS who collected boxes of supplies over a week-long drive. Once at Congress, exhibitors were invited to donate materials from their displays. By the end of the meeting, dozens of exhibitors had contributed enough notepads, pens, pencils, markers, water bottles, office supplies, notebooks, binders, and tote bags to fill 13 pallets. This donation was so large that it required an 18-wheel truck to transport the supplies to a warehouse for sorting and preparing for delivery to the schools in need in November. Dr. Trotter has undertaken similar efforts at several other medical conventions that have been held in New Orleans this year. The ACS school supply drive was the most successful to date.
Surgeons were all over the local news the week of Clinical Congress, as it was the first conference convened in New Orleans in several months. But Project New Orleans itself garnered much media coverage, including an Associated Press story published in three newspapers. Following is a list of media outlets that reported on Project New Orleans.

**Print media**

**Broadcast media** (all aired October 9)
- WGNO (ABC affiliate), New Orleans: ACS to build medical clinic—interview with Ann Mancino, MD, FACS.
- WVUE-TV (Fox affiliate), New Orleans, and WWL4 (CBS affiliate), New Orleans: ACS to build medical clinic—interview with Kathleen Casey, MD, FACS, Director of Operation Giving Back.
- Coverage based on the AP news story by Ms. McCounnaughey:
  — WDSU (NBC affiliate), Louisiana: Surgeons help turn Bywater school into clinic.
  — KATC, Louisiana: Surgeons in hard hats and hazmat suits help turn school into clinic.

**Voice of the volunteers**

For many of the volunteers, the impetus to participate in Project New Orleans came from that feeling of needing to do something and they were all proud to be a part of this mission. Tricia A. Kelly, MD, FACS, a breast surgeon at George Washington University in Washington, DC, said that after hearing so much about Katrina on the news, she felt obligated to do her part to help. This sentiment was echoed by Thomas Shin, MD, a member of the University of Cincinnati contingent of residents, program director, and the chief resident’s wife, who decided as a group to participate (see photo, page 34). “This is my first time working with Habitat for Humanity,” Dr. Shin said, “and I just want to contribute whatever I can to help.” Jose Serrano, a third-year medical student at Ponce School of Medicine in Puerto Rico and a first-time Congress attendee, felt the same way: “In Puerto Rico and Pennsylvania [where he is from], I would hear about Katrina all the time, and I got tired of hearing about it on television without being able to touch it. I wanted to see it firsthand and see what I could do to help.”

Dennis Witmer, MD, FACS, chief of surgery at the Veterans Administration in Wilmington, DE, appreciated the opportunity to give back and improve the environment for the people of New Orleans. “Everyone in their hearts wants to help but doesn’t know how,” Dr. Witmer said. “Project New Orleans provides us the mechanism to do something concrete.”

At the conclusion of the first leg of the project on Tuesday morning, Tara Bruslun, MD, FACS, of Ann Arbor, MI, commended Project New Orleans: “I wish there was something similar at all College meetings,” she said, adding, “Certainly there is a need no matter where we go.”

**Thank you**

We are grateful to all who have generously contributed to making these events so meaningful for all involved. The College’s partnerships with the New Orleans Area Habitat for Humanity and the New Orleans Daughters of Charity were essential to the success of this effort. We would also like to express deep gratitude to the local and national leadership of Ascension Health and the staff of Freeman (the general contractor for Clinical Congress). In-kind donations of building supplies, transportation, food, and beverages were graciously provided by Ethicon Inc. and Womack Construction. Lastly, Telusys Inc. created the Project New Orleans Web site pro bono.

If you would like to support the ongoing work of the St. Cecilia Medical Clinic (slated to open in March 2008) or Habitat for Humanity, information on the project and ways to donate needed equipment or cash are available online at this dedicated and secure site: [http://www.acsprojectnola.org/](http://www.acsprojectnola.org/).
For more than a decade now, the annual Governors’ report, which is the voice of the Fellows to the Board of Regents, has emphasized three areas in which Governors believe the College must improve its lot. These areas are as follows:

- Reimbursement
- Professional liability
- Hostile work environment

Interestingly, these three topics have rarely been on the Governors’ agenda as discussion items. The setup of the Governors meetings, which is about to be changed by the Chair, Valerie W. Rusch, MD, FACS, and the remainder of the Executive Committee, will emphasize discussions of matters that are important to the Governors. In addition, the Governors’ Report will be discussed by the Board of Regents and—thanks to the efforts of Dr. Rusch in conversations with Thomas R. Russell, MD, FACS, Executive Director of the College, and members of the Board of Regents—it is anticipated that there will be a joint meeting of the Board of Governors and the entire Board of Regents at the Clinical Congress to replace the rather short report given by the President, the Chair of the Board of Regents, and the Executive Director.

As many of you know, there are two components to the American College of Surgeons. The first is the traditional American College of Surgeons, a 501(c)(3) corporation, which is a professional organization emphasizing education, accreditation, and setting standards, which the College does very well. There is also a trade organization, which is a 501(c)(6) corporation that enables greater expenditure on lobbying and socioeconomic matters of interest to the Fellows. In any organization, there is always a tension between this duality. Various organizations have addressed it in different ways. With respect to these dual roles, the College has tried to maintain both. The Fellows have not always been aware of the efforts on the part of the College, specifically the trade organization side, on their behalf. This perception has resulted in anger that I personally have not seen previously in the Governors’ report, nor in the recent column by David Cossman, MD, FACS, in General Surgery News, nor in my encounters when I attended the town meeting at the 2007 Spring Meeting in Las Vegas, NV. But the anger in the halls at the Clinical Congress was almost palpable. It clearly seems to many of the Fellows that the College is not representing them, nor is it expending a great deal of energy, treasure, or time in representing them in the three areas that are most important to them.

However, this is not the case. The College and the officers have been tirelessly working and expending a great deal of energy and funds in this area. Our problem seems to be communicating to the Fellows what we are doing on their behalf—our communications with them seem to have been largely unsuccessful.

Reimbursement

Reimbursement took a big hit this year. The primary care physicians and the American College of Physicians have sold the concept of an “American medical home” in the recent Five-Year Review of the Centers for Medicare & Medicaid Services (CMS), which states that because most of the Medicare expenditures in this country are for the 76 percent of patients who have a single chronic disease and an additional 20 percent who have multiple chronic diseases, the physicians who care for the chronically ill were underpaid. Therefore, the primary care physicians and the American College of Physicians argued that increased reimbursement to the individuals caring for these patients was a necessity. This concept, strategically put together by primary care physicians and internists, has been accepted without any knowledge of how expensive this approach
will be nor how effective it will be. The initial indications are that this system will be very expensive and that many of the tasks outlined in the American medical home for the primary care physician can be carried out by nurse practitioners. In general, this concept seems to be a return to the gatekeeper concept.

There are a number of pilot programs and although thus far they appear to have yielded some benefit, the expense is substantial. Nonetheless, code 99213, the most commonly used evaluation and management (E/M) code, was increased by 37 percent and with budget neutrality, we estimate there will be a transfer of $4 billion in order to pay for this increase from those who carry out procedures to those who solely use E/M codes. Incidentally, surgeons use E/M codes too, but they receive a pitance compared to proceduralists. In reviewing my own billings and collections in 2007, despite the fact that I performed 300 more relative value units per month, I only collected $100 a month as a result of the fall in the conversion factor paying for surgical procedures.

What has the College done in response to this issue?

• The College finally got a surgeon on the Medicare Payment Advisory Commission, the organization that makes recommendations to Congress and CMS for reimbursement of physicians. This individual, Karen Borman, MD, FACS, probably is known to many of you. Dr. Borman has lots of experience with the Relative Value Update Committee. She knows many of the key players in Washington and now meets with the policymakers regularly to get an idea of what they are thinking so that we may plan our strategy accordingly.

• A bill with six different conversion factors, including a single one for major procedures and others for pharmacy, imaging, and minor procedures, was passed by the House. There is some history with comparing the growth of surgical procedures with the E/M codes and with pharmacy and imaging as far as what is responsible for the fantastic increase in health care costs. Between 1992 and 1997, there were two separate conversion factors. The surgery conversion factors over these five years increased by 41 percent before CMS, under pressure from the primary care profession, abolished the two separate conversion factors. CMS did that when it became clear that those responsible for the increase in health care were not the surgeons (after all, patients only have one gallbladder and the indications have remained basically the same; and, the surgeons are captive to the 90-day global period for any charges associated with that surgical procedure).

• The Coding and Reimbursement Committee, chaired by John Preskitt, MD, FACS, has tried to create a surgical home—that is, guidelines for referral under the medical home as to when a patient should be referred for surgery directly instead of carrying out a variety of tests, some that may be unnecessary.

• Because of efforts of the Health Policy Steering Committee, a Health Policy Institute has been organized and a director named. It should shortly be producing areas of studies of interest as far as workforce, access, and other information that can be shared with the policymakers in Washington.

• Two well-known individuals at the Harvard School of Public Health, Marc Roberts and Bob Blendon, have been asked to conduct a four-year initiative emphasizing access and workforce.

• My article, “The impending disappearance of the general surgeon,” was published in the November 14, 2007, Journal of the American Medical Association. I am trying to distribute a synopsis electronically to all the Fellows. The commentary points out that the number of general surgeons has now been halved over the past decade to only 5 percent of physicians from close to 10 percent. This has affected access to critical care, especially in the critical access small urban or rural hospitals, which 55 million patients depend on for their care. The general surgeon in these hospitals deals with emergencies and trauma, sometimes definitively and sometimes stabilizing the patient before transferring them to a trauma center. In addition, the general surgeon usually is the one who will see a trauma patient and in the case of fracture will prepare the patient for the orthopaedic surgeon to carry out the appropriate procedure. In addition, general surgeons produce upwards of 40 percent of the hospital margin. Randy Zuckerman, MD, FACS, a surgeon who has studied this effect
in New York State and has led a workshop for the American Association of Medical Colleges (AAMC), has documented that when a general surgeon leaves it often takes up to 16 months for the hospital to recruit such a general surgeon. If such a general surgeon is not found, the hospital closes its doors, thereby limiting access.

The importance of these data can be seen when the College has argued about the issue of access with CMS. We have always been told that the numbers indicate that an increased number of Medicare patients are being seen, which of course one would expect since the population is aging. For the first time, however, 75 percent of hospitals report difficulties in getting the emergency room staffed and difficulties in getting patients seen. Older surgeons are now delaying retirement until the institution can secure the services of a new general surgeon. In many instances, incentives—and the chief executive officers of small hospitals at the AAMC meeting have spelled “incentives” with dollar signs—have provided rather munificent salaries of $300,000 or sometimes $400,000 to general surgeons in order to staff the rural hospital. However, the pipeline is broken and it appears that increased difficulties in access and difficulties in staffing emergency rooms will soon be the order of the day.

Professional liability

Actions taken by the current Congress suggest that tort reform at the federal level is dead. However, there is some progress on a state-by-state basis with the help of the College’s Washington Office. Two additional initiatives are in progress. The first, which has been spearheaded by ACS President Gerald B. Healy, MD, FACS, is to work with a major insurance company to provide decreased premiums for individuals who have excellent records and to educate others so that ability to get decreased premiums is enhanced. Obviously Fellowship in the College would be required to have access to these reduced premiums. A second initiative is to offer an educational course that several insurance companies already provide, and upon completion, a modest decrease in premium would result. The decreased premium is offered because it has been demonstrated that individuals who take this course are less likely to be sued.

The hostile work environment

To a large extent, the hostile environment and the circumstances under which we work are a result of the huge overhead that medical insurance companies take of the premium. It is usually between 21 percent and 29 percent of the premium and in some cases may be as high at 35 percent. This overhead is used for huge salaries for executives (in Boston, for example, the recently retired head of Blue Cross Blue Shield got a $16.4 million bonus for retiring) and armies of nurses and other technicians whose only goal it seems is to deprive the physician and surgeon of payment post-hoc. Imagine if you did not pay your plumber after he had done work for you: Would he ever appear at your doorstep again? Our goal is to increase the medical loss ratio—that is, the amount spent on patients—to between 93 percent and 95 percent. This will deprive the insurance companies of huge staffs, decrease the obscene salaries of the executives, and make more of the premium available for patient care. There has been progress in this area as Gov. Arnold Schwarzenegger (R), who prevented a plan for universal health insurance in California, stipulated that the medical loss ratio must be at least 85 percent of the premium. For the first time, the AARP has stated that the medical loss ratio is up for discussion.

The new contract between General Motors and the United Auto Workers may offer a clue to a new arrangement in health insurance. General Motors has funded a $39 billion trust fund for the health care of retired workers, which allegedly will pay for 70 percent of the foreseen health care and the remaining 30 percent by investment of the corpus. One of the current ideas is to pass along the duties of the health insurance companies, which heretofore have been responsible for getting the money, keeping the “float,” and paying physicians and surgeons, to a company that does not keep the float but crunches the numbers and decides for either the trust fund or perhaps larger corporations exactly how much is to be paid. A large corporation—for example, Boeing—might choose to keep the float itself. That particular percentage for number crunching might be as low as 5 percent to 7 percent of the premium since Medicare advertises that its costs are between 2 percent
and 3 percent, although individuals have stated that some costs have been shifted elsewhere. This system, we believe, will result in a more equitable environment for physicians and surgeons and will probably lower premiums, but will also result in perhaps better and fairer reimbursement for physicians and surgeons without the armies of technicians and nurses who specialize in post-hoc denial.

**Branding and visibility campaign**

The College has engaged Weber Shandwick, one of the largest public relations firms, to improve the visibility of the American College of Surgeons and tell the world about what good work surgeons do. They have attempted to use their contacts with the press and the media to increase the visibility of the College and the Fellows and the good work that we do. An article on trauma that was initially published in the *Wall Street Journal* received wide reporting on various television media and Dr. Healy was interviewed on NBC national news. The purposes of the contract with Weber Shandwick are twofold; first, increase our visibility to the external world, and second, to better communicate to our members what the College is doing.

**The Quality Alliance Steering Committee**

The Quality Alliance Steering Committee is a broad-based group of health care organizations and quality experts, which seeks to make the nation’s health care system more value driven. Frank Opelka, MD, FACS, is one of 30 members of this committee and represents the American College of Surgeons. He leads a workgroup that is studying surgical quality measures and has put together a quality and safety initiative on behalf of the College to improve patient outcomes. It is too early to tell how this program will pan out, but with an important initiative such as this, it is extremely vital that we have a place at the table where decisions are made.

As someone who has worked on behalf of the Fellows since 1988, it is gratifying to see that we finally may have arrived at a point where we do have a serious place at the table and can make our opinions known for the benefit of our Fellows in the areas they would like to see improvement. I will be in contact with you through the year and hopefully thereafter to try and make you aware of our efforts on your behalf.
The Board of Governors met on October 7, 2007, and again at the adjourned meeting on October 10. In addition to reviewing reports from all of the Board of Governors subcommittees, the Governors received and discussed reports from Cynthia Brown, Director of the Division of Advocacy and Health Policy, on the surgical workforce study currently being undertaken by the College (see the report by Josef E. Fischer, MD, FACS, Chair of the Board of Regents, on page 36).

The panel presentation on Sunday afternoon addressed the current severe problems in the delivery of emergency surgical care and presented potential solutions to these problems in both the urban and the rural settings. Considerable time was devoted to discussing other issues that the Governors view as substantive problems—some of which Dr. Fischer mentioned—including liability, reimbursement, advocacy, the surgical workforce, and the need to increase ACS membership and foster participation in College activities. Measures to enhance effective communication across the Board of Regents, the Board of Governors, ACS Chapters, and all ACS Fellows were discussed at length.

Based on all of these discussions, in the coming year, the Board of Governors will be undertaking strategic planning. With respect to the mission and activities of the subcommittees, the Board will revise the format and conduct of our activities at the annual meeting and will be initiating more frequent and extensive communication within the Board of Governors and with the Board of Regents and the ACS Chapters.

Finally, the Board of Governors considered motions regarding membership criteria for international Fellows and regarding ways to enhance participation in the Clinical Congress. The results of these discussions were presented to the Board of Regents.
I am pleased to have this opportunity to update the members of the American College of Surgeons on the College’s activities for 2007. This account is presented as I conclude my eighth year as Executive Director of the organization.

**Overview**

As the College moves forward, we are mindful of how the profession of surgery is being redefined through heightened emphasis on the provision of value-based care. Indeed, the major objectives of current health care reform efforts are reducing costs, expanding access, and improving quality of care. The College is striving to develop the resources that will enable us to ensure that the policymakers who are determining how these goals can be satisfied understand the unique nature of surgery and how their decisions affect our ability to provide optimal care to surgical patients.

In addition, the College is responding to surgeons’ concerns about reimbursement, practice management, and other financial issues. We also are working to provide surgeons with the tools and resources they need in order to maintain board certification.

As always, the College’s four major divisions—Advocacy and Health Policy, Education, Research and Optimal Patient Care, and Member Services—and our support service areas are largely responsible for carrying out programs and activities aimed at addressing these issues. However, given the complexity of many of the challenges with which we are confronted, the College continues to expand its efforts to collaborate with other stakeholders.

Furthermore, the College is reinforcing its vitality through ongoing strategic planning. Our current and future activities to best serve all surgeons who are working rigorously to provide high-quality care to surgical patients are summarized throughout the remainder of this report.

**Advocacy and Health Policy**

Fellows of the College frequently express their distress with regard to ongoing threats of significant Medicare reimbursement cuts. We and other specialty societies continue to work with members of Congress, congressional staff, and policymakers to demonstrate the flaws in the current methodology used to calculate physician fees. In particular, we have highlighted the problems associated with using the sustainable growth rate (SGR) to arrive at the conversion factor applied in the Medicare physician fee schedule.

We were pleased that the Children’s Health and Medicare Protection (CHAMP) Act of 2007, which the House passed in August, contained many constructive provisions that would have had a positive effect on physician reimbursement. In addition to renewing and expanding the State Children’s Health Insurance Program, the bill called for replacing the 9.9 percent and 5 percent Medicare reimbursement cuts slated for 2008 and 2009, respectively, with 0.5 percent increases. Even more significantly, it also would have supplanted the SGR with a new system of six expenditure targets and fee schedule conversion factors for various categories of physician services. The proposed spending targets and conversion factors are consistent with a proposal that the American College of Surgeons and the American Osteopathic Association have advocated. This new methodology holds promise of ending the current problem of across-the-board payment reductions imposed on service categories, such as major procedures, that have experienced relatively low volume and spending growth. Unfortunately, our political system is in a state of paralysis, and the CHAMP bill was gutted in the Senate.

In addition, policymakers continue to explore the concept of pay for performance. Hence, the College also had been involved in the Centers for Medicare & Medicaid Services’ (CMS) efforts
to implement the Physician Quality Reporting Initiative (PQRI), which launched July 1, 2007, and was scheduled to expire on December 31, 2007. However, the program has been renewed for 2008 (see “Socioeconomic tips” on page 48 for details), and the College is monitoring its effects on surgeons’ practices.

As efforts to link payment with outcomes continue, the ACS remains committed to collaborating with the various groups seeking to vet quality measures, including the American Medical Association’s Physician Consortium for Performance Improvement, the National Quality Forum, the AQA, and the Hospital Quality Alliance. In addition, the more than 20-member Surgical Quality Alliance (SQA), which originated through the College, is successfully delivering surgery’s message about quality improvement. Frank Opelka, MD, FACS, chairs the SQA and is providing excellent leadership thanks to his expertise in health policy and quality issues.

Our plans for the location of the College’s new office in Washington, DC, near Capitol Hill are progressing steadily, and we anticipate that the move will be completed in 2010. Several specialty societies have already agreed to lease space for their Washington staffs in our building, so our efforts to build a more unified house of surgery are coming closer to fruition. In addition, we are developing the plans for the ACS Health Policy Research Institute to gather and analyze data on surgeons’ practices and the effects of legislation and regulations on how we deliver surgical services to our patients. This institute, which will operate under the direction of a surgeon and be headquartered in the new Washington Office, will serve as a “think tank” and arm us with the hard facts we need to bring to the table during our negotiations with health policymakers.

However, it is disappointing to note that the federal Agency for Healthcare Research and Quality continues to delay publishing regulations to implement the Patient Safety and Quality Improvement Act of 2005. The College supported this legislation, has repeatedly indicated its interest in serving as a patient safety organization, and has met with regulators on multiple occasions to discuss a safety reporting system for ambulatory surgery.

Research and Optimal Patient Care

Because the primary focus of health system reform continues to be on quality improvement, the College is fostering its research programs and implementing new ones. Our Division of Research and Optimal Patient Care is now under the direction of Clifford Ko, MD, MSc, FACS. Dr. Ko is an attending surgeon at the West Los Angeles Veterans Affairs (VA) Hospital. This experience serves him well, given that the ACS National Surgical Quality Improvement Program (ACS NSQIP) originated within the VA system.

ACS NSQIP is now being applied in more than 150 hospitals. The College continues to work with the CMS to determine how ACS NSQIP data might be applied in a broader context to evaluate the quality and value of surgical care. For instance, the ACS NSQIP Surgical Care Improvement Project module has been developed and is being tested with CMS.

In addition, we have successfully launched our Scholars in Residence program, under which surgical investigators are providing us with invaluable assistance in making the best possible use of our National Cancer Data Base and National Trauma Data Bank®. These clinical scientists are enabling the College to adopt a more academic posture and to develop evidence-based guidelines for surgical care.

The College’s Advanced Trauma and Life Support® (ATLS®) program also has new leadership. Will Chapleau, ATLS Manager, brings to the program extensive experience in emergency medical services. Under his direction, we have now published the seventh edition of the ATLS manual.

Finally, the National Cancer Institute has renewed the grant for the American College of Surgeons Oncology Group (ACOSOG). ACOSOG is conducting important clinical trials in the management of patients with malignant solid tumors at Duke University Medical Center in North Carolina. This location has allowed the group to function within a strong academic and biostatistics environment.

Education

Last year, the College successfully launched the ACS Program for the Accreditation of Education Institutes. Through this program, the College now certifies nearly 20 Level I Compre-
hensive Education Institutes, and institutions continue to submit applications for the College’s review. To receive the College’s endorsement, regional educational centers must meet rigorous standards and offer programs that will help surgeons sharpen their cognitive and technical skills through the use of state-of-the-art training instruments.

Because of the ongoing decline in registration, the College has decided to end its annual Spring Meeting program. However, we continue to work with a broad range of specialty societies to co-sponsor programs at their annual meetings. For example, we most recently have contracted with the Southwestern and Southeastern Surgical Congresses. (For more information, see “From my perspective” on page 4.)

In addition, we are developing a growing array of programs to assist surgeons in the development of skills they will need to nonsurgically diagnose and treat patients. More specifically, we are offering more courses in imaging, ultrasound, irradiation, natural orifice procedures, and so on, at the annual Clinical Congress. We are attempting to train surgeons who will be competent in providing the full spectrum of services that an aging patient population will need in an era of continued technological and scientific advancements.

Plans also are under way to develop the 14th edition of the Surgical Education and Self-Assessment Program (SESAP). SESAP 13 implemented several important changes in the program. Additional enhancements in SESAP 14 will make it even more useful as a self-assessment and review instrument.

In addition, the College has accepted full responsibility for presenting Selected Readings in General Surgery to help surgical residents stay abreast of the current literature and to assist practicing surgeons in their efforts to meet Maintenance of Certification (MOC) Part II requirements. Lewis Flint, MD, FACS, will serve as editor-in-chief. Under his direction, we intend to enhance the relevance of the publication by halving the review cycle to every two-and-one-half years and by expanding content to include critical new topics, such as evidence-based surgery, patient safety, and outcomes. We anticipate that integration of Selected Readings into various other ACS programs, such as SESAP and the Surgical Index, will ensure that the College will continue to be a critical resource for surgeons striving to meet MOC requirements.

Furthermore, our efforts to improve patient education continue. We have launched a “Patients As Partners in Surgical Care” Web site, which contains educational material to help members of the public become informed about surgical care so that they have the knowledge and skills to make sound decisions with regard to their own surgical care. We also are expanding our public visibility program.

**Member Services**

In further recognition of our members’ ongoing concerns about MOC requirements, we continue to refine our Case Log System and Web portal to enhance their utility in practice-based education and outcomes evaluation.

To encourage the spirit of volunteerism, the College’s Board of Governors Committee on Socioeconomic Issues and the Operation Giving Back program will present the ACS/Pfizer Medical Humanities Initiative Surgical Volunteerism Award to three Fellows. The 2007 recipients were as follows: Sylvia D. Campbell, MD, FACS, Tampa, FL; Van C. Knowles, MD, FACS, Albany, GA; and Col. Thomas G. Crabtree, MD, FACS, Kailua, HI. (For the full story on the 2007 awardees, read “ACS Fellows honored with 2007 Surgical Volunteerism Awards” on pages 27-29 of the September 2007 Bulletin.)

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University of British  
Columbia Faculty of Medicine  
*Vancouver, BC*
Board of Regents

Julie A. Freischlag
Vascular surgery
William Steward Halsted Professor and surgeon-in-chief,
The Johns Hopkins Hospital
Baltimore, MD

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University of California–San Francisco, East Bay
Oakland, CA

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University of Tennessee Health Science Center,
College of Medicine
Memphis, TN

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University of Toronto, and head, division of general surgery,
Mt. Sinai Hospital
Toronto, ON

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Private practice
Pine Bluff, AR, and assistant professor of surgery, practice management advisor to the chairman,
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Mayo Clinic
Rochester, MN
John T. Preskitt  
*General surgery*  
Attending surgeon,  
Baylor University  
Medical Center  
*Dallas, TX*

J. David Richardson  
*Vascular surgery*  
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and vice-chairman,  
department of surgery,  
University of Louisville  
School of Medicine  
*Louisville, KY*

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of pediatric urology,  
The Children’s Hospital  
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and professor of urology,  
University of Pennsylvania  
School of Medicine  
*Philadelphia, PA*

Marc C. Weisssler  
*Otolaryngology*  
Joseph P. Riddle  
Distinguished Professor of  
Otolaryngology, professor  
of otolaryngology–head and  
neck surgery, professor  
and chief of head  
and neck oncology,  
University of North Carolina  
Neurosciences Hospital  
*Chapel Hill, NC*

Thomas V. Whalen  
*Pediatric surgery*  
Chair, department of surgery,  
Lehigh Valley Hospital  
*Allentown, PA*
A

s noted in “What surgeons should know about...the 2008 Medicare fee schedule” on page 8, the Centers for Medicare & Medicaid Services (CMS) will continue the voluntary pay-for-reporting program, known as the Physician Quality Reporting Initiative (PQRI) in 2008. The PQRI is the first nationally available program for the reporting of individual provider-level performance data. Authorized by the Tax Relief and Health Care Act of 2006 (TRHCA), the first PQRI reporting period launched in July 2007 and concluded on December 31. The 2008 reporting period, which will serve as an opportunity for new participants to begin reporting, will run from January 1 through December 31.

Performance measures available for reporting
For 2007, 74 performance measures were available for reporting by physicians and other health care professionals. Specialty societies, often in collaboration with the American Medical Association’s (AMA) Physician Consortium for Performance Improvement (PCPI), developed many of the performance measures included in the program.

To increase consistency among the performance measures, TRHCA mandated that all measures included in the 2008 program be endorsed by the National Quality Forum (NQF) or approved by the AQA (formerly the Ambulatory Care Quality Alliance). The NQF and AQA are multistakeholder organizations that promote consensus-based endorsement or approval of performance measures.

The performance measures for the 2008 PQRI include the following:
- 59 measures from the 2007 PQRI measure set
- 38 new measures from the AMA PCPI
- Seven nonphysician measures developed by Quality Insights of Pennsylvania, a CMS Quality Improvement Organization (QIO)
- Two structural measures developed by Quality Insights of Pennsylvania
- Five additional measures from the AQA Starter Set, a measure set approved by the AQA for measurement of primary care physicians
- Six measures developed by the American Podiatric Medical Association

In 2007, CMS received numerous comments regarding the inability of some physicians and other health care professionals to participate in the PQRI because of the limited measure set. The contract with the Pennsylvania QIO to develop specific performance measures was one method CMS used to broaden the program. The structural measures developed by the QIO are in accordance with TRHCA and include the adoption of e-prescribing and the use of electronic medical records.

The American College of Surgeons developed a set of surgical performance measures in 2006, known as the Perioperative Care Measure Set, in collaboration with the AMA PCPI and the Surgical Quality Alliance. The measure set comprises six measures related to antibiotic and venous thromboembolism prophylaxis that were endorsed by the NQF, approved by the AQA, and included in the 2007 and 2008 PQRIs. Other measure topics in the 2008 PQRI that could be of interest to surgeons include stroke, osteoporosis, eye care, coronary artery bypass graft, urinary incontinence, acute otitis externa, and otitis media with effusion.

Choosing measures to report
At press time, CMS had posted the first version of measure specifications on its Web site at www.cms.hhs.gov/PQRI. Although no additional measures can be added, minor changes and corrections may continue until the end of 2007. Surgeons interested in participating should choose three performance measures to report and may want to consider the following factors when doing so:

continued on page 50
Steps for successfully participating in the 2008 PQRI

Timing: Immediately

Step 1: Review the available quantitative and qualitative value of participating in the program.

<table>
<thead>
<tr>
<th>Quantitative: General surgery practice example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total physician charges in 2007</td>
</tr>
<tr>
<td>Percentage of Medicare patients in practice</td>
</tr>
<tr>
<td>Total Medicare dollars</td>
</tr>
<tr>
<td>Potential bonus percentage</td>
</tr>
<tr>
<td>Potential bonus dollars</td>
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</tbody>
</table>

Qualitative rationale: During the 2007 PQRI reporting period, the College conducted a survey of the twenty physicians participating in the ACS PQRI monitoring program. The survey found that in addition to the financial rewards, physicians were also participating because they believed that the PQRI would be relevant to future pay-for-reporting and pay-for-performance programs. In addition, physicians cited general quality improvement as a motivator.

Step 2: Choose performance measures to report from the final list of 2008 PQRI measures.

Consult the measure specifications on the CMS or ACS Web site and choose the performance measures that are most applicable to your Medicare patients. Additional tools to help with this decision can be found on the ACS Web site at www.facs.org/ahp/pqri.

For the general surgery practice example, measures might include the following:
1. Timing of antibiotic prophylaxis
2. Selection of antibiotic prophylaxis
3. Discontinuation of antibiotic prophylaxis
4. Venous thromboembolism prophylaxis

Note: Although CMS only requires three measures to be reported, four measures have been chosen in this example to protect the practice against the volume-based payment cap.

Step 3: Download workflow sheets for your selected performance measures at www.facs.org/ahp/pqri/flowsheets.html.

Step 4: Review program requirements, workflow, and submission of quality data with office staff to ensure an 80 percent reporting rate to CMS. In addition, physicians and staff members can register for an ACS-sponsored Web-based seminar to learn more about the program and participate in a question-and-answer session.

Timing: January 1, 2008

Step 5: Begin reporting quality data on your selected measures on eligible Medicare claims.

Timing: February 1, 2008

Step 6: Conduct a sample audit of your practice to ensure that you are achieving an 80 percent reporting rate by randomly selecting eligible patients and checking for the appropriate submission of quality data to CMS. As a basic example, practices can pull 10 charts and confirm that quality data were accurately reported for at least eight of the procedures and/or visits.

Note: Because CMS will not be giving interim feedback until mid-2008, it will be important for physicians to self-assess their reporting rate early in 2008. This approach will allow providers to immediately resolve any reporting problems that could affect their reporting rate and, subsequently, their bonus payments.

Timing: Mid-2008 to 2009

It is possible that CMS will provide an interim report to physicians in mid-2008. After the reporting period closes on December 31, 2008, CMS will calculate reporting rates and distribute bonus payments and physician feedback in 2009.
• A minimum of three measures should be chosen, assuming that at least three apply to the surgeon’s practice
• If fewer than three measures from the measure list apply to the practice, then only the relevant one or two measures should be reported.
• If three measures only cover a small portion of Medicare patients in the practice, then additional measures should be chosen.

Payment cap
As a general rule, PQRI participants should choose performance measures that will allow them to report quality data for most Medicare patients in their practices. Using this approach will prevent the provider from getting caught in the PQRI payment cap, which is invoked based on the volume of quality reporting. The cap, which is present in both the 2007 and 2008 programs, was designed to penalize participants who report a relatively small amount of quality information.

Bonus payments
Participants who report quality data for at least 80 percent of appropriate Medicare claims are eligible for a bonus payment. For 2007, participants could receive a bonus payment of up to 1.5 percent of all Medicare claims allowed during the reporting period. At press time, a specific percentage had not yet been set for 2008 because of legislative language in TRHCA that includes a $1.35 billion aggregate limit on bonus payments. CMS has stated that the 2008 bonus payment per provider will likely be 1.5 percent of all Medicare claims.

Unfortunately, data regarding 2007 bonus payments were unavailable at press time and by the launch of the 2008 PQRI. CMS has stated that provider reports and bonus payments for the 2007 program will not be distributed until mid-2008. In the 2008 program, participant feedback reports will continue to include all PQRI data used to calculate the eligibility and amount of the bonus payment. CMS will be unable to provide interim reports for 2008 until after the 2007 feedback reports have been distributed. Because an 80 percent reporting rate is needed to qualify for the full bonus payment, participants should begin reporting immediately in January.

Reporting of quality data
As in the 2007 program, CMS has stated that provider-level data collected in the PQRI will not be publicly reported. Whereas aggregate data might be available, information that could allow for physician or group identification will not be posted.

Data collection and submission
For 2008, performance measures will continue to be collected using Current Procedural Terminology® category II codes or G-codes using the Medicare claims processing system. These codes should be submitted on the same claim as the related procedure or visit. Additional information regarding quality data submission is available on the ACS and CMS Web sites.

In compliance with TRHCA, CMS will test data submission from alternative sources such as registries and electronic health records (EHR). Two methods of data collection by registries will be tested by voluntary, self-selected registries. Under the first method, the registry will collect the relevant quality data, as well as diagnostic and procedure codes. CMS will use beneficiary information to match the quality data to the information in the related claim and calculate provider performance rates. Under the second method, the registry will collect all data necessary to calculate reporting and performance rates. A validation process is required for the second option. CMS will also partner with self-nominated EHR vendors to test clinical quality data submission. It is important to note that providers participating in registry and EHR testing also need to submit quality data via the claims processing system to be eligible for the bonus payment in 2008.

College activities
For the 2007 program, the College developed guides and tools to assist surgeons who were interested in participating; these materials are available at www.facs.org/ahp/pqri. The Web site, which will be updated for 2008, includes an introductory presentation, workflow sheets to assist surgeons’ offices in measure collection, a sample...
In memoriam

Remembering John H. Isaacs, MD, FACS

by Andy Isaacs

John H. Isaacs, MD, FACS—a former Regent of the American College of Surgeons, the College’s Second Vice-President from 1990 to 1991, and former chairman of the department of obstetrics and gynecology at Loyola University, Chicago—died July 29, 2007. Dr. Isaacs was a pioneer in gynecologic oncology—a skilled clinician, an active scholar, and a gifted teacher. He will be deeply missed by his family, friends, colleagues, patients, and the many surgeons he trained.

Beginnings

“Jack” Isaacs was born September 2, 1922, in Alton, IL, the son of Abram and Ann Lucille McGuan Isaacs. He grew up in Gillespie, a small coal-mining town in southern Illinois, and aspired to be a physician from his earliest childhood. After graduating from Gillespie High School in 1940, he entered St. Louis University on a war-accelerated path to his medical degree, which he received in 1946.

After completing a rotating internship in Chicago at Mercy Hospital and Loyola University Clinics, Dr. Isaacs took his first year of residency in obstetrics and gynecology at Mercy under Dr. Herbert Schmitz. In 1948, Dr. Isaacs entered active service in the U.S. Army and served at Tokyo General Hospital in Japan from 1949 to 1950.

Upon returning to civilian life, Dr. Isaacs completed his residency in obstetrics and gynecology at Mercy, and then served one extra year (1952–1953) as executive resident, directing the residency program in obstetrics and gynecology, and a second extra year (1953–1954) as an American Cancer Society clinical fellow. During this time as Dr. Schmitz’s executive resident and fellow, Dr. Isaacs developed a lifelong interest in medical education and coauthored his first scientific paper, on placenta previa.

Private practice and academic medicine

After completing his training at Mercy, Dr. Isaacs set up a private practice in obstetrics and gynecology on Chicago’s North Shore. He began as an attending physician at both St. Francis Hospital in Evanston and Resurrection Medical Center in Chicago. Eventually, the demands of maintaining a solo practice in obstetrics and gynecology compelled him to consolidate at St. Francis, which remained his primary professional institution throughout his career and where he was chairman of the department of obstetrics and gynecology from 1962 to 1986. Besides St. Francis and Resurrection, Dr. Isaacs also served as an attending physician at Holy Family Hospital, the Veterans Administration’s West Side Hospital, Cook County Hospital, Illinois Masonic Hospital, Lutheran General Hospital, and Evanston Hospital.

For many years beginning in the 1950s, Dr. Isaacs was a familiar figure on Cook County Hospital’s Ward 40, collaborating with Dr. Schmitz and others to establish local and national standards of care in gynecologic oncology. During these years, Dr. Isaacs maintained his interest in medical education, first assisting in programming for the residency program in obstetrics and gynecology at St. Francis and then directing the program himself from the mid-1960s on. From 1952 until his retirement in 1996, Dr. Isaacs was also active in the department of obstetrics and gynecology at the Stritch School of Medicine at

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Loyola University, Chicago, rising from clinical assistant from 1952 to 1956, to director of the division of gynecologic oncology from 1979 to 1991, to chairman of the department from 1986 to 1990. Dr. Isaacs was a busy man: In addition to office hours and surgery for his private practice, he spent Mondays at Cook County, Tuesdays at Loyola, and Saturday mornings with his residents at St. Francis.

Dr. Isaacs also nurtured a passion for golf and joined Evanston Golf Club in 1959. Thursdays would find Dr. Isaacs golfing and playing gin at the Club. On weekends, he would try to escape to Little Prairie, WI, where he owned 70 forested acres and developed skills for which the American Tree Farm System named him Tree Farmer of the Year in 2000. On many occasions, he traveled abroad, visiting six continents and even practicing medicine in London for several months.

**Leadership and scholarship**

Dr. Isaacs was a leading member of the professional medical community in Chicago and the U.S. at large. He was a member of more than two dozen medical and scientific societies, including the American College of Obstetricians and Gynecologists, the Chicago Medical Society, the Central Association of Obstetricians and Gynecologists, the American Association of Obstetricians and Gynecologists, the Society of Pelvic Surgeons, and the Society of Gynecologic Oncologists (charter member). In 1989, his students even formed a professional society in his name, the John H. Isaacs Society, which continues to meet annually to discuss advances in gynecologic oncology.

Dr. Isaacs served on numerous national committees and boards, including the Board of Directors of the American Board of Obstetrics and Gynecology (1980–1990). He was an examiner for the American Board of Obstetrics and Gynecology and served on the Residency Review Committee of the American College of Obstetricians and Gynecologists. He was also an officer of many organizations, serving as president of the Barren Foundation of Chicago (1970), president of the Chicago Gynecological Society (1970-1971), and treasurer of the American Board of Obstetrics and Gynecology (1984-1988).

Dr. Isaacs published more than 70 scientific articles or book chapters and edited or coedited four books, most that focused on the diagnosis and treatment of gynecologic cancers. These publications ranged from case reports to findings from clinical research projects to compilations of authoritative guidelines for practitioners.

**Legacy**

Dr. Isaacs left a rich personal legacy. His memory will live on through his family, his wife of 60 years, his five children, and his eight grandchildren. They remember his intelligence, his wit, his devotion to his family, his endless willingness to play golf and cards, his high standards in all things, and his love.

Dr. Isaacs will also live on through those he trained. He taught them that patients are not cases—they are people who need to be cared for; sick people who need help getting better. He taught his students never to stop learning, to be active members of their professional communities, and to balance clinical skill, research knowledge, and human compassion. He taught them that medicine is not just a career—it’s a calling.

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*Mr. Isaacs is Dr. Isaacs’ son. He lives in Chicago, IL.*
College seeks nominations for volunteerism and humanitarian awards

The American College of Surgeons, in association with the Pfizer Medical Humanities Initiative (PMHI), is accepting nominations for the 2008 Surgical Volunteerism Award(s). In addition, nominations are being accepted for 2008 for a newly established award, the Surgical Humanitarian Award.

The ACS/PMHI Surgical Volunteerism Award is given “In recognition of those surgeons committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities.” This award is intended for surgeons who are Fellows in active practice, whose volunteerism activities are undertaken above and beyond the usual professional commitments, or Fellows in retirement who have been involved in volunteerism during their active practice and into retirement. For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism does not include pro bono or uncompensated care provided as a matter of necessity in most practices. Instead, volunteerism should be characterized by the prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gains.

The ACS/PMHI Humanitarian Award is given “in recognition of those surgeons who have dedicated a substantial portion of their career to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement.” This award is intended for a surgeon who has dedicated a significant portion of his or her surgical career to nearly or completely full-time humanitarian efforts rather than routine surgical practice. This may reflect a career dedicated to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received a salary for this work does not preclude a nominee from consideration; in fact, it may be expected, based on the extent of the professional obligation. Please note that there is a separate form to nominate those in this category.

These awards honor ACS Fellows who are making a significant contribution to surgical care through volunteer actions. Candidates for the volunteerism award may practice their surgical volunteerism either in a domestic, international, or military setting. All surgical subspecialties are eligible for consideration.

Nominations will be evaluated by the Board of Governors’ Socioeconomic Issues Committee, with final approval of award winners by the Executive Committee. Note that the nomination forms have been revised in an effort to make them more user friendly.

Additional considerations are as follows:

- Supplemental materials should be kept to a minimum and will not be returned.
- Self-nominations are permissible but require an outside letter of support.
- Previous nominees can be resubmitted with an updated application.

The deadline for receiving nominations is February 29, 2008.

The nomination forms will be available in the Announcement section of the Operation Giving Back Web site in early January at [http://www.operationgivingback.facs.org](http://www.operationgivingback.facs.org).

Forms may also be received by mail if needed. Contact Meghan Benson, Operation Giving Back Program Coordinator, with such requests.

Forms should be sent to Michael Dalsing, MD, FACS, Chair, Board of Governors’ Committee on Socioeconomic Issues, c/o Meghan Benson, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; 312/202-5458; fax 312/202-5021; mbenson@facs.org.
Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings

October 6–11, 2007

by Paul E. Collicott, MD, FACS, Director, Division of Member Services

American College of Surgeons Professional Association (ACSPA)

One current Governor and three former Governors were reappointed to a second term on the ACSPA-SurgeonsPAC Board. Sara L. Hartsaw, MD, FACS, of Gillette, WY, was reappointed to her second and final term on the ACSPA-SurgeonsPAC Board of Directors. Dr. Hartsaw is also currently serving her second term on the College’s Board of Governors. The reappointed former Governors are Charles W. Logan, MD, FACS, Little Rock, AR; C. Alden Sweatman, MD, FACS, Columbia, SC; and Steven D. Wexner, MD, FACS, Weston, FL.

American College of Surgeons

Strategic planning consumed the bulk of the content of the Board of Regents meetings during the 93rd annual Clinical Congress in New Orleans, LA. Strategic planning is an ongoing process that will continue into the February 2008 meeting of the Board.

Advocacy

It is the responsibility of each Governor to communicate to the College’s leadership the concerns of the Fellows they represent regarding major issues related to surgery. Communicating these issues is accomplished through the annual Board of Governors survey. The results of these annual surveys are used by the College’s leadership to determine the future direction and programs of the College.

The analysis of the 2007 Board of Governors survey was considered part of the strategic planning. The College’s actions as a result of the Board of Governors surveys were also reviewed and discussed.

Education

The Board of Regents approved a business plan for transferring the Advanced Trauma Operative Management (ATOM) Course to the College. The hands-on surgical skills course, developed by Lenworth M. Jacobs, Jr., MD, FACS, has been well received and currently...
needs a national sponsor. It was determined through needs analysis that the course would fill a gap in surgical skills education in the U.S.

The Board of Regents approved the request to combine the data in the ACS Case Log System with the data from the outcomes database of the Society of American Gastrointestinal and Endoscopic Surgeons. This combination will be done in order to create a single and larger dataset.
SAVE THE DATES!

THE AMERICAN COLLEGE OF SURGEONS AT THE
SOUTHEASTERN SURGICAL CONGRESS

SUNDAY, FEBRUARY 10, 2008
2:00–5:45 PM

Panel: What’s New at the ACS
Panel: What Practicing Surgeons Need to Know
About Maintenance of Certification and How
the American College of Surgeons Can Help

Presenters:
L. D. Britt, MD, MPH, FACS; Edward M. Copeland III, MD, FACS;
Josef E. Fischer, MD, FACS; Thomas R. Russell, MD, FACS;
Ajit K. Sachdeva, MD, FACS, FRCSC; and
Steven C. Stain, MD, FACS

Southeastern Surgical Congress
FEBRUARY 9–12, 2008
Sheraton Birmingham
Birmingham, AL

To register, visit www.sesc.org
or call 800/558-8958

An exhibit will be presented at the time of each Surgical Congress demonstrating
the new educational programs and products of ACS that are specially
designed to help practicing surgeons meet MOC requirements.

FOR MORE INFORMATION, contact Julie Tribe, MSEd, Senior Manager,
Educational Programs, Division of Education, at jtribe@facs.org or 312/202-5433.

FOR INFORMATION ON ACS, visit www.facs.org or call 800/621-4111.

THE AMERICAN COLLEGE OF SURGEONS AT THE
SOUTHWESTERN SURGICAL CONGRESS

MONDAY, MARCH 31, 2008
8:00 AM–12:00 NOON

Panel: What’s New at the ACS
Panel: What Practicing Surgeons Need to Know
About Maintenance of Certification and How
the American College of Surgeons Can Help

Presenters:
Barbara L. Bass, MD, FACS; L. D. Britt, MD, MPH, FACS;
Josef E. Fischer, MD, FACS; Gerald B. Healy, MD, FACS;
Russell G. Postier, MD, FACS; Thomas R. Russell, MD, FACS;
Ajit K. Sachdeva, MD, FACS, FRCSC; and
Alan G. Thorson, MD, FACS

Southwestern Surgical Congress
MARCH 30–APRIL 2, 2008
Fairmont Princess
Acapulco, Mexico

To register, visit www.swscongress.org
or call 913/402-7102
A look at The Joint Commission

Joint Commission appoints new president

On January 1, Mark R. Chassin, MD, MPP, MPH, became president of The Joint Commission, succeeding Dennis S. O’Leary, MD.

Dr. Chassin was the Edmond A. Guggenheim Professor of Health Policy and chairman of the department of health policy at Mount Sinai School of Medicine in New York, and executive vice-president for excellence in patient care at The Mount Sinai Medical Center. Before joining Mount Sinai, the board-certified internist served as Commissioner of the New York State Department of Health. Dr. Chassin is a member of the Institute of Medicine of the National Academy of Sciences and co-chaired its National Roundtable on Health Care Quality.

Dr. Chassin’s 12 years of experience practicing emergency medicine, work as a researcher and as a state and federal regulator, and his most recent role of overseeing the quality, safety, and risk-management activities at a large teaching hospital have shaped his thoughts on quality and patient safety. While at The Mount Sinai Medical Center, Dr. Chassin built a nationally recognized quality-improvement program that focuses on achieving substantial gains in all aspects of quality of care, encompassing safety, clinical outcomes, the experiences of patients and families, and the working environment of caregivers. In addition, he led successful efforts to introduce six sigma quality-improvement methods in the organization’s hospital and medical school, using them to enhance both patient safety and the efficiency of operations. Dr. Chassin also has a tie to the American College of Surgeons: His father, Jameson Chassin, a Fellow, is a general surgeon and a renowned teacher who authored the highly acclaimed surgical textbook, Operative Strategy in General Surgery.

As president of The Joint Commission, Dr. Chassin believes that the biggest challenge and opportunity is to build on the momentum of demands for major improvements that will bring about durable change that improves patient outcomes. Accreditation is vital to improvement, but Dr. Chassin acknowledges that it is not sufficient by itself. He has pledged to seek ways to go beyond measurement and other current accreditation processes to help organizations achieve real improvements in quality and safety. Dr. Chassin intends to explore ways of providing organizations with practical lessons learned that they can adapt to their unique patient populations in order move more rapidly toward improvement.

During the coming months, Dr. Chassin will continue to meet with accredited organizations, regulators, patient and safety advocates, and other important constituencies to build upon The Joint Commission’s tradition of health care leadership and explore new ideas for adding greater value to the accreditation process for all stakeholders.

Trauma meetings calendar

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

- Trauma, Critical Care, & Acute Care Surgery—2008, March 24–26, 2008, Las Vegas, NV.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
Join us in San Francisco for the 94th annual Clinical Congress. As always, it will be an educational opportunity you won’t want to miss!

Please be sure to visit WWW.FACS.ORG in the coming months for more details regarding the educational program, registration, housing, and transportation.
ACOSOG news

Passion is fleeting, but money sustains

by David Ota, MD, FACS, and Heidi Nelson, MD, FACS

Previous columns from the American College of Surgeons Oncology Group (ACOSOG) in the Bulletin have encouraged greater surgeon participation in clinical trials. The articles have stressed scientific aims that improve patient care through prospective clinical trials. Surgeons have responded to these ACOSOG communications and patient enrollment into these trials has increased. Surgeons have also shown the capability to acquire the skills and methodology to conduct clinical trials. This ability is shown in recent publications that document surgeon compliance with federal guidelines and regulations.* There remain, however, questions about the financial management of clinical trials and a short discourse on this subject is important as ACOSOG opens more trials for surgeons.

The primary goal of a clinical trial financial plan is to generate sufficient revenue to cover costs so as to achieve budget neutrality. Although the National Institutes of Health/National Cancer Institute (NCI) is an attractive place to find trials, reimbursement for each patient enrolled may be $2,000 or less. ACOSOG sites have learned that the initial enthusiasm to enroll patients into trials was later tempered by the financial reality of covering the cost of monitoring patients and submitting long-term follow-up data.

Cost analysis to conduct clinical oncology trials have been published elsewhere.† The C-Change data show that the median cost for a phase III trial antihormonal therapy breast cancer trial is $3,700/patient. ACOSOG has used these data to seek supplemental funding from industry sponsors. For example, ACOSOG has secured supplemental grants for Z1031 in order to increase capitation to $3,494/patient. As a NCI cooperative group, we collect the data and publish the results in partnership with NCI and industry sponsors. This public–private partnership is based on the philosophy that trials are supported by taxpayers and industry, who benefit considerably from the results of a trial.

Not all NCI trials have such attractive capitation in order to maintain budget neutrality and another approach is needed. Industry-sponsored trials are an alternative revenue source. Reimbursement is generally higher than for NCI trials and can be used to diversify a portfolio of clinical trials to keep a balanced budget. This approach is much like managing a practice–payor mix for health services. Many surgeons who have successful clinical trials programs have a mix of government- and industry-sponsored trials. Finding such industry-sponsored trials can be problematic, but ACOSOG is introducing industry sponsors to our surgeon network. ACOSOG surgeons are highly encouraged to enroll patients into NCI trials but each site is allowed to determine how best to manage the revenue source.

Another potential source of funding is a local underwriter, which can be either a local hospital or foundation. Obtaining such funding requires negotiation skills and navigating the competing interests in a locality. There is one other option for generating revenue to cover the cost of clinical trials: Occasionally, there are opportunities to enroll the same patient into two different trials. A good example is ACOSOG Z1041. This is a phase III neoadjuvant chemotherapy for locally advanced breast cancer. The cap-

†C-Change: A guidance document for implementing effective cancer clinical trials.
tation is $2,000. ACOSOG is currently developing a sentinel node trial after neoadjuvant chemotherapy with a $2,000 capitation. When activated, it may be possible to enroll the same patient into both trials, assuming the patient will consent to participating in both trials. Nonetheless, when this strategy is used, the cost of collecting data for two trials is reduced.

Although ACOSOG offers practicing surgeons the chance to contribute to scientific discovery in its clinical trials, the group also understands that such enthusiasm requires a financial basis. Furthermore, though this brief discourse identifies revenue sources to support clinical trials, you may be aware of other revenue streams, and we would greatly appreciate your ideas (send an e-mail to david.ota@duke.edu). This article does not address multiyear budgeting, especially for oncology trials that measure recurrence-free or overall survival. In addition, managing costs were not addressed. We will continue these themes in future articles and offer a mix of scientific potential and realism in our ACOSOG news columns.

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

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claim form, measure specifications, and answers to frequently asked questions.

In addition, the College has developed a program to examine the implementation and burden of reporting to the PQRI program. Twenty surgical practices have volunteered to participate in the ACS PQRI monitoring program. Using information from these practices, the College has identified implementation challenges in the program and communicated them to CMS. The College will continue to follow these practices through the end of the reporting period as well as track CMS provider feedback and bonus payment.
So, You Want to Be a Surgeon...

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

http://www.facs.org/residencysearch

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

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


by Richard J. Fantus, MD, FACS, and David E. Clark, MD, FACS

The 2007 Annual Report of the National Trauma Data Bank® (NTDB) Version 7.0 is an updated analysis of the largest aggregation of trauma registry data that has ever been assembled. The NTDB now contains more than 2.7 million records. This 2007 report is based on 1,485,098 records from the years 2002–2006. The NTDB uses a rolling five-year time frame for the annual analysis in order to focus on the most recent, highest-quality data. Before analysis, NTDB data are subjected to a quality screening for consistency and validity.

The report contains several enhancements over previous annual reports. There are new tables and figures describing specific organ systems in greater detail than was possible in previous versions. In addition, this year’s report includes three new graphs for different level designation by hospital using all the 2006 admission year data. These graphs present the number of records submitted, data completeness, and case fatality rate by hospital for level designation I, II, III, or IV (see figure on this page). Level designation is defined as ACS verification level or state designation level.

The mission of the American College of Surgeons Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center registry data. We estimate that 78 percent of level I and 71 percent of level II trauma centers in the U.S. have contributed to the NTDB.

The purpose of this report is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. It has implications in many areas including epidemiology, injury control, research, education, acute care, and resource allocation.

Many dedicated individuals...
on the ACS COT, as well as at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, our goals in the coming years include improving data quality, updating analytic methods, and enabling more useful interhospital comparison. These efforts will be reflected in future NTDB reports to participating hospitals as well as in future annual reports.

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 Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma, Chicago, IL.

Dr. Clark is Chair of the NTDB Subcommittee of the COT. He lives in Portland, ME.

**Fellows in the news**

**Richard A. D’Amico, MD, FACS,** medical director of the Plastic Surgery Skin Care Center in Englewood, NJ, was elected president of the American Society of Plastic Surgeons in October 2007.

The Society of Ear, Nose, and Throat Advances in Children’s Ruben Award for Lifetime Achievement in Research was presented to **Craig S. Derkay, MD, FACS,** professor and vice-chairman of the department of otolaryngology and pediatrics and the director of pediatric otolaryngology at Eastern Virginia Medical School in Norfolk.

**Myron Gordon, MD, FACS, FACOG,** of the Albany Medical Center in Albany, NY, was conferred the American College of Obstetricians and Gynecologists’ District II/NY Lifetime Achievement Award. Dr. Gordon was honored for his tireless and active participation and commitment to quality care in the field of obstetrics and gynecology.

Among the 10 recipients of the Accreditation Council for Graduate Medical Education 2008 Parker Palmer Courage to Teach Award was **Karen D. Horvath, MD, FACS,** surgery program director at the University of Washington. This honor recognizes distinguished program directors for their commitment to teaching and development of innovative and effective residency programs.

The 2007 Presidential Early Career Award for Science and Engineering, the nation’s highest honor for scientists in the early stages of their research careers, was awarded to **J. Peter Rubin, MD, FACS,** an assistant professor of plastic and reconstructive surgery at the University of Pittsburgh and codirector of the Adipose Stem Cell Center. Dr. Rubin was recognized for his groundbreaking research on using fat-derived stem cells to engineer soft tissue, which is hoped to eventually be used to generate replacement tissue for breast cancer survivors.

ACS Web portal Editor-in-Chief, chair of surgery and professor of surgery and social medicine at the University of North Carolina–Chapel Hill, and University of Kansas alumnus **George F. Sheldon, MD, FACS,** received the Alumni Distinguished Achievement Award from his alma mater. The purpose of this award is to recognize professional achievements, dedication to the community, and involvement with the university.
The Resident and Associate Society (RAS) is fostering young surgeon involvement in the ACS through its presentation of an annual Leadership Award, which enables recipients to attend a College course of their choosing. In addition, the RAS surveyed younger members to determine their gravest concerns about the future; topping their list were medical liability, patient safety, and reimbursement, the same as with their older colleagues.

To help surgeons ease their financial worries, the College launched the Surgeons Diversified Investment Fund (SDIF) last year. As of June 30, the SDIF net assets were approximately $43.5 million. SDIF’s total return since the program’s inception in September 2006 was 12.63 percent. We are pleased that SDIF is off to a healthy start.

Other business

The College, too, remains financially secure, based on a recent audit of our endowment fund and other accounts. In addition, we have recently named Gay L. Vincent, CPA, to serve as first Chief Financial Officer of the College. For many years, Ms. Vincent held the title of ACS Comptroller.

Finally, the College continues to keep an eye on the future, and earlier this year the Regents met to update the strategic plan and to think about how we can keep the College moving forward. We identified the College’s major strengths and weaknesses, reviewed the external factors that we anticipate will have the greatest effect on the organization over the coming years, and set short-term and long-term goals for the ACS. I believe an ongoing strategic planning process is necessary to maintain the organization’s viability in a rapidly changing health care environment.

As always, I truly appreciate the support and interest of the Board of Regents, Board of Governors, and ACS staff. Our combined accomplishments represent how much we can achieve when we all work together to advance patient safety and patient care.

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 Sunday, 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/canews.html or contact the CoC office at 312/202-5183 or cjones@facs.org.