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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.
At this point, many surgeons seem disinterested in participating in the Physician Quality Reporting Initiative (PQRI) and other performance measurement programs. They say that the reporting process is too time-consuming and that the existing measures examine the most rudimentary aspects of patient care. These concerns are certainly valid. However, it is important for surgeons to look at the bigger picture when deciding whether to take part in these efforts because they are likely to play a key role in creating the road map the federal government is crafting for the future of health care delivery.

**PQRI’s origins**

The PQRI was established in the 2006 Tax Relief and Health Care Act (TRHCA), which provided a 1.5 percent incentive payment for physicians who satisfactorily provided reports on up to three measures for at least 80 percent of their Medicare patients between July 1 and December 31, 2007. A total of 74 performance measures were available in 2007 for use by physicians and other health care professionals. The American College of Surgeons developed six measures that are applicable to many surgical specialties, whereas the American Academy of Ophthalmology produced three and the Society of Thoracic Surgeons generated four that are specific to their respective specialties. According to a report that the Centers for Medicare & Medicaid Services (CMS) released in February, 99,319 (15.74%) of Medicare participating physicians, practitioners, and therapists enrolled in the 2007 project. Slightly more than half of those participants qualify for the 1.5 percent bonus.

Unquestionably, most of the quality measures in the 2007 PQRI pilot project rewarded participating surgeons for adhering to very fundamental standards of care, such as the use and discontinuation of perioperative prophylactic antibiotics. However, these metrics were just a starting point for what is likely to evolve into a far more sophisticated set of standards of care and for deciding whether a physician provides high-quality services that merit payment.

Where it’s going

Legislators and regulators are continually strengthening and broadening the PQRI. As Sens. Max Baucus (D-MT), and Charles E. Grassley (R-IA)—Chairman and Ranking Member, respectively, of the Senate Finance Committee—said in a January 23 letter to CMS, PQRI-related activities are intended to move the federal government “toward our long-term vision for a valid, consumer-friendly mechanism for measuring and rewarding the quality of care that clinicians provide.”

Congress passed legislation late last year—the Medicare, Medicaid, and SCHIP Extension Act (MMSEA)—which extended the PQRI through December 31, 2008. To increase consistency among the performance measures, TRHCA mandated that all measures in the 2008 program be endorsed by the National Quality Forum (NQF) or approved by the AQA (formerly the Ambulatory Care Quality Alliance). The 2008 PQRI comprises 119 measures, including the following:

- 59 measures from the 2007 PQRI metric set
- 38 measures from the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI)
• Seven nonphysician measures developed by a CMS Quality Improvement Organization
• Two structural measures for practices that adopt e-prescriptions and electronic medical records
• Five additional measures from the AQA for primary care physicians
• Six measures from the American Podiatric Medical Association

Senators Baucus and Grassley say they intend to push for passage of legislation that would extend the bonuses throughout 2009 and beyond in order to “continue progress toward aligning Medicare payments more closely with the quality of care provided.” To that end, Congress has called upon CMS to specify an expanded and refined set of measures for use in 2009. To generate the new measures, Congress has directed CMS to continue adopting NQF-endorsed measures. For conditions that do not have available NQF-approved metrics, Congress has indicated that CMS may use other consensus-based measures from the AMA PCPI, AQA, specialty societies, and other stakeholders.

Congress also is asking that CMS explore alternative approaches for reporting quality measures. One option would be to develop composite measures for the treatment of chronic conditions or preventive care. It is anticipated that such measure sets would provide a more comprehensive view of patient care while targeting the aspects of the health care system in most need of reform. CMS is in the process of considering clinically related measure groups for diabetes, preventive care, chronic kidney disease, and end-stage renal disease.

Furthermore, CMS has started to address the use of clinical data registries to report on quality measures. As required under the MMSEA, CMS is attempting to establish alternative criteria and reporting periods for satisfactorily reporting measures under PQRI through registries.

Congress is also recommending that CMS take steps to allow physician group practices to employ a valid statistical sampling model to report performance information on an aggregate basis. Congress suggests that participating physician groups could report on specified measure sets that target costly chronic conditions using the model CMS has applied in Physician Group Practice demonstration. This project launched in 2005 and provides incentives to large group practices that coordinate care to improve quality and lower spending. The government maintains that group practices, especially multidisciplinary group practices similar to those found within the Kaiser-Permanente network and the Mayo Clinic, promote enhanced care coordination and often deliver better patient outcomes. Therefore, Congress is suggesting that CMS develop means of recognizing multiple physician network structures.

Finally, Congress is requesting that CMS post on its Web site the names of clinicians and group practices that satisfactorily participate in PQRI. Indeed, Senators Baucus and Grassley have indicated that they intend to “pursue additional statutory authority for this important step in upcoming legislation.” This activity obviously is aimed at stimulating transparency among physicians and other providers.

What’s the College doing?

Clearly, the PQRI and its related programs are here to stay. As a result, transparency, outcomes data analysis, coordinated care, and, ultimately, compliance with evidence-based standards of care will be the touchstones of our evolving health care system. So, what do these changing expectations mean for surgeons, and what is the American College of Surgeons doing to help surgical practices during this transformative period in health care?

Essentially, surgeons can anticipate that the nation will steadily move in a direction where failure to report outcomes or to comply with evidence-based clinical guidelines will result in low or no payment for services from Medicare and Medicaid as well as other health plans. Right now these payors may be checking to ensure that surgeons and other clinicians are performing simple tasks that anyone worthy of a medical degree should know must be done, but soon the standards and requirements are likely to become much more specific and stringent. For example, a surgeon who operates on a patient with colon cancer may be required to remove a certain number of lymph nodes in order to appropriately stage the patient. These are the types of standards surgeons will need to set using information from
the College’s data banks and other sources so they can help drive these kinds of performance measures.

The College has been directing many of its efforts toward ensuring that surgeons understand the import of outcomes reporting and of staying abreast of new standards of care. First of all, the ACS has been working with and educating surgeons who participate in the PQRI. We have presented teleconferences and webinars on the program, and individuals in the Division of Advocacy and Health Policy have authored Bulletin articles on the subject (for example, see page 48 of the January 2008 issue for an overview of this year’s efforts). We also have created a Web page devoted entirely to the pay-for-reporting initiative at http://www.facs.org/ahp/pqri/index.html. Here surgeons can find up-to-date resources, including background materials, workflow sheets to assist in the measure collection process, a sample claim form, measure specifications, and answers to frequently asked questions.

Moreover, the College has developed a program to examine the implementation and burden of reporting to the PQRI. A total of 20 PQRI-participating surgical practices have volunteered for this tracking program. Using information from these practices, the ACS has identified implementation challenges in the PQRI and communicated them to CMS.

In addition, the College actively participates in the organizations that are vetting the PQRI measures. We have a seat on the AMA PCPI and on the NQF and have established the Surgical Quality Alliance to develop evidence-based performance measures that account for the unique nature of surgical care.

The College also continues to make progress in bringing the ACS National Surgical Quality Improvement Program into the private sector for outcomes evaluation and is working with other surgical specialty societies to generate performance measures that are common to all surgical specialties. Furthermore, the College has been enhancing its National Cancer Data Base (NCDB) and National Trauma Data Bank® to make these registries more useful in quality improvement efforts. In fact, the Commission on Cancer used some of the NCDB data to develop measures for cancer care, which NQF has endorsed.

To many surgeons, programs like the PQRI may seem to be annoying complications that currently will result in few positive tradeoffs for busy surgical practices. In fact, many of us would like to see these kinds of initiatives disappear so we can go back to the ways of the past. As is true with many things in life, however, there is no going back, so we have no choice but to move forward.

The bottom line is that surgeons need to be engaged in the PQRI and other programs aimed at developing a patient-based, high-quality healthcare system. None of the existing evidence suggests that the momentum for linking payment to performance is slowing. Rather, all indicators point toward these initiatives becoming increasingly relevant and prevalent.

At press time, we had just received word that CMS is changing the rules for PQRI participation in 2008 to encourage more physicians to report, so the College encourages you to get involved now when the process is easier. It will become more complex later on, but if your practice is already participating, accommodating changes in the future will be much easier for you and your staff.

An article about the new requirements and other updates on the PQRI will be published in the July issue of the Bulletin.

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.
College backs bill to stop pay cuts

On March 25, ACS Executive Director Thomas R. Russell, MD, FACS, wrote to Sen. Debbie Stabenow (D-MI) to offer the College’s support for her introduction of S. 2785, the Save Medicare Act of 2008. This bill would stop the 10.6 percent cut in Medicare physician payments scheduled to take effect July 1 and would maintain current reimbursement levels through the end of 2008. Importantly, the legislation also would replace the scheduled 5.4 percent payment cut in 2009 with a 1.8 percent increase. To view Dr. Russell’s letter, go to http://www.facs.org/ahp/index.html.

Medicare trustees issue bleak report

Medicare’s Hospital Trust Fund will go bankrupt by 2019, as expenditures for Parts A and B continue to outstrip the overall economy, according to an annual report that the Medicare trustees released on March 25. The report presents a particularly bleak outlook for physician payment updates. At press time, Medicare reimbursement was scheduled to drop by 10.6 percent on July 1 and then by another 5.4 percent on January 1, 2009. Under current law, these reductions will be followed by annual cuts of approximately 5 percent through 2016. However, in 2013, the actuaries predict a positive update of 3.3 percent because of a one-year infusion from the physician assistance and quality initiative (PAQI) fund established last year. On the other hand, because the PAQI allows for only $4.96 billion in additional spending, the estimated increase in program costs in 2013 will require a −13.1 percent offset in 2014. To view the report, go to http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf.

ACS supports performance charter

In early April, the College expressed support for the Consumer Purchaser Disclosure Project’s efforts to develop a patient charter for physician performance measurement. The charter promotes fairness and transparency in health care quality measurement and reporting programs. It also calls for physicians to be involved in developing measures and reporting systems and states that individual physicians should have adequate notice and opportunity to correct inaccuracies in the data about their practices. To view the charter, go to http://healthcaredisclosure.org/docs/files/PatientCharter040108.pdf.

New York requires accreditation for OBS

The New York State Department of Health requires that physicians who perform office-based surgical (OBS) procedures receive accreditation from a nationally recognized organization by July 7, 2009. OBS procedures are defined as any surgical or other invasive procedures performed outside of a hospital, diagnostic and treatment center, or other facility in which moderate or deep sedation or general anesthesia is used. In addition, as of January 14, adverse events must be reported to the Department of Health Patient Safety Center. An adverse event is defined as follows: patient death within 30 days; unplanned transfer to a hospital; unscheduled hospital admission within 72 hours of the office-based surgery and for longer than 24 hours; or any other serious or life-threatening event. For further information, including a list of approved accrediting agencies, go to http://www.health.state.ny.us/professionals/office-based_surgery/.
A surgeon’s role in state advocacy:

Interview with Hugh A. Gamble II, MD, FACS

by Melinda Baker, State Affairs Associate, Division of Advocacy and Health Policy

Hugh Gamble II, MD, FACS, has been a Fellow of the American College of Surgeons since 1985. A graduate of the University of Mississippi Medical Center (where he did both his surgical internship and residencies), Dr. Gamble has held many leadership positions both in the College—such as Governor, Chapter President, Chair of the Committee on Trauma, and his current post as a member of the Health Policy Steering Committee—and with the Mississippi State Medical Association (MSMA), where he is a past-president and is currently serving as its delegate to the American Medical Association’s House of Delegates.

He is currently a thoracic and cardiovascular surgeon at Gamble Brothers & Archer Clinic, a subsidiary of Delta Regional Medical Center in Greenville, MS.

Dr. Gamble was asked to share his experiences in advocacy in hopes of encouraging other Fellows to think about how they can assist in advocating for their profession.

How did you get involved in advocacy?

I grew up in advocacy. My grandfather, great-uncle, and father were all presidents of the MSMA. Mississippi is a relatively small state, especially for specialty societies, so most legislative activity in health care involves MSMA.

My great-grandfather was also in the first candidate group of the College in 1913. I have his certificate, which is dated November 13, 1913. His brother, Paul Gaston Gamble, was initiated a few years later.

You were president of the Mississippi Medical Association during the “medical liability wars.” What was that like?

Within two months of my becoming president of the MSMA, liability companies across the state started to increase premiums by up to 70 percent. Almost immediately, the amount of time required to deal with legislators, the press, and other tort reform partners increased dramatically. For almost a year, this became a second job in addition to my private practice.

What do you think holds surgeons back from becoming involved in advocacy?

I think people, surgeons in particular, don’t think they can have an impact and that’s just not true. You can’t always be asking for something; sometimes you just need to show up and listen. The pressures of practice, family, and personal interests all provide excuses to avoid becoming involved. “Showing up” really is 90 percent of the battle.
What do you see as the biggest issue affecting surgery today? How is that different than when you began practicing?

The biggest issues today are the ones that the ACS is trying to address. Patient safety, manpower, liability, and reimbursement are always at the top of the list. These issues never change. I remember hearing discussions about all of these issues as a child at my family dinner table. The battles end only if we allow others to make all the decisions for us.

Why should surgeons become involved in advocacy?

No one else can or will speak for us. We are the only ones with the insight to be advocates for surgical patients.

Are there any specific skills that surgeons tend to possess that make them more suited for advocacy?

Surgeons tend to be good advocates because they are able to direct their focus on specific issues. Persistence is a surgical virtue that is essential to adequately address problems that require long-term involvement.

How can chapters get more surgeons involved? Do you have any suggestions for recruiting younger surgeons?

The major thing that chapters can do is communicate with their respective members. There are many national forums to address national issues, but individual states need to focus on their own local issues. Whether at the state or national level, the projected changes in our health care delivery system are far too important to be left to bureaucrats and politicians. Their objectives may be good, but the input of real-world practitioners is essential.

Every resident in any surgical training program should be exposed to the benefits and programs that the College offers. Program directors, local chapters, and Governors should carry the message of the ACS. We should consider making every resident a member of the candidate group upon acceptance into a training program. Physicians in training need to understand that while they are primarily focused on learning their craft, the impact of outside influences can be overwhelming. If we do not speak up, others who have a stake in the health care system will move on without us. Such an occurrence will be to the detriment of our profession and our patients.
A lot has been written recently about the medical “perfect storm.” In the next six years, spending on health care will double. Cost per treated patient, population at risk, and deficiencies in care provided are predicted to increase by 50 percent, 30 percent, and 50 percent, respectively. Reimbursement for health care is declining and federal and state governments already fund 45 percent of health care costs. Americans with no health care coverage total 47 million—25 percent of whom are children—despite that the majority of the adults have jobs. More than 60 percent of full-time employees have no health benefits.

There had been no increase in U.S. medical school graduates for 30 years until recently, a situation that is confounded by an aging and expanding U.S. population. Richard A. Cooper, MD, projects a deficit as high as 200,000 practicing physicians by 2020.* This figure will be somewhat tempered by the pace of economic growth.1 Already the numbers of general surgeons as a percent of the total physician workforce have fallen by 4 percent since 1975, whereas the numbers in other surgical specialties have remained almost constant.2

Members of the so-called generation Y in this country are just beginning to complete medical school. They have been variously described as multitask experts and computer literate as well as not joiners and protective of leisure time and lifestyle. They have become accustomed to having their time organized for them in school and in the summer in various activities such as sports teams, musical groups, and so on. They are often isolated in academic communities of equal intelligence. Rather than having classes for the intellectually challenged students, schools have gone to the other extreme of having the intellectually gifted students cordoned off into separate classes.

These students are termed “the best and the brightest.” Will they become physicians? Probably not, because the expected income compared with that of other competitive professions is inadequate relative to the length of training. Can they be stimulated to become physicians? Possibly they might become interested if the income is increased or the debt is decreased—an unlikely solution—or by shortening the length of training to become a surgical specialist, a solution under consideration. Does it really take five years of general surgical training and then a breast fellowship to become a dedicated breast surgeon? Of course not. Orthopaedic surgeons and neurosurgeons become quite competent in their specialty with only an internship in general surgery.

Instead, there is a decrease in reimbursement for most medical specialties, training programs are lengthening, and debt is increasing. There is a good possibility that surgical practice in the near future will have all physicians as employees, with surgical care siloed into preoperative, intraoperative, and postoperative periods with the intraoperative surgeons trained in a narrow field. The workday will be eight hours and the workweek 40 hours, and continuity of care by a single surgeon will be extinct. The only broadly trained general surgeons will be in trauma and emergency care.

Already “burnout” has been identified as a problem. In a survey of surgical oncologists, Kuerer and associates found that 28 percent of 549 respondents met the criteria: 24 percent suffered from emotional exhaustion, and 30 percent screened positively for depression.3 Burnout was most prevalent in women and young surgeons of both sexes. Common causes were stated to be lack of gratification compared with the length of training, an imbalance between career and family, long working hours, and income versus debt.

As Josef Fischer, MD, FACS, so aptly points out in his must-read article in the November 14, 2007, Journal of the American Medical Association, 54 million Americans depend on small urban and rural hospitals for critical care.4 Reib and his associates from Bassett Health Care in Cooperstown, NY, sent a questionnaire to the administrators of 111 rural hospitals: 83 percent responded that the general surgeon was key to the hospitals’ financial viability; 83 percent responded that, were they to lose the general surgeon, overall medical services would be reduced; and 12 percent said their hospital would close.5

There is an ever-increasing pool of physicians.

*Dr. Cooper spoke on this topic in his American Urological Association Lecture at the 2007 American College of Surgeons Clinical Congress in New Orleans, LA. An edited version of Dr. Cooper’s lecture appears in the March 2008 Bulletin (page 11).
trained outside the U.S. to fill the quantity void. Many of these individuals are U.S. citizens and not subject to any visa restrictions. For example, currently there are 3,157 students matriculating through St. George Medical School in Grenada. Approximately 800 students are accepted per year. Of these students, 70 percent are U.S. citizens and 90 percent are projected to pass the U.S. Medical Licensing Examination (USMLE) on the first try. Clinical rotations are contracted out primarily to U.S. and U.K. sites. Total cost for the experience is approximately $200,000 (Colin E. Dowe, assistant dean of enrollment planning, Caribbean admissions, St. George’s University, St. George’s, West Indies, personal communication, March 31, 2008). The obvious conclusion is that this country has a wealth of extremely motivated citizens who wish to become physicians, predictably, regardless of the lifestyle.

There is also an importation of physicians from other countries such as India, a country that now has at least 250 medical schools. The reported quality of the graduates, particularly from the private schools, is highly variable. In addition, the U.S. participates in the “brain drain” from developing countries whose leaders have established their own medical schools. For example, of a sample of 871 physicians trained in Ghana between 1993 and 2002, 604 left the country. The same is true for physicians trained in Kenya, Zambia, and Zimbabwe. Currently, these physicians face restrictive regulations for entering and practicing in this country. But these restrictions could be modified if or when the physician quantity crisis demands it.

So, there well may not be a physician quantity crisis, since there are physicians from around the world, many of whom are U.S. citizens, who would most likely be eager to practice medicine in the U.S. wherever they were needed. Results from the American Board of Surgery for 2006–2007 show that 12.9 percent of U.S. graduates fail the qualifying exam and 14.5 percent fail the certifying exam. Similar figures for international medical graduates are 17.5 percent and 18.6 percent, and for U.S. medical graduates abroad are 25.0 percent and 20.7 percent.

Interestingly, by 1996, the failure rates for international and U.S. medical graduates were
similar, but the rates are again diverging (see Figure, page 12). The failure rate for all individuals retaking the examination has risen from 38 percent in 1996 to 58 percent in 2006 (Tom Biester, director of psychometrics and data analysis, American Board of Surgery, Philadelphia, PA, personal communication).

Instead of a crisis in the quantity of physicians in this country, the crisis may be in the quality of the physicians. Small urban and rural hospitals may lower standards to keep the hospitals viable, especially in the quality standards of the general surgeon. For example, board certification may not be a requirement to gain access to the operating room. To be accredited, all hospitals must have a credentials committee, a medical executive committee, or both, but there are no set national standards for the credentials of the physicians. Likewise, most credentials committee members have a vested interest in the viability of their hospital, as they should. As a child, Dr. Copeland’s life was saved in a rural town in Georgia by a general practitioner who admitted him to the one bed in the back of his office. Communities should preserve their hospital because the majority of illnesses can easily be treated locally and many of the physicians practicing in the smaller communities are now and will be adequately trained in the future.

Another way to look at the American Board of Surgery data is to point out that 75 percent or more of U.S. and international medical graduates pass their board examinations. Likewise will U.S. medical graduates be as well trained in the future? Cost per student trained continues to rise and cross-subsidization of their training often comes from faculty group practice plans. These plans are suffering financially from decreases in reimbursement and an increasing uninsured population. Time constraints now limit the contact time among clinical faculty members, students, and residents.

The question is how to identify the physicians who are not adequately trained. Measurement of outcomes and pay for performance may be two methods to identify them. Once identified, what should be done? Should their licenses be revoked? No. Rather, they should be educated to eradicate their deficiencies. The American College of Surgeons has a long and distinguished history in education and could be an important component of a solution to a quality crisis. Likewise, the National Surgical Quality Improvement Program of the American College of Surgeons could be valuable in both identifying and correcting quality issues among its members rather than the discovery being made by a government agency.

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Dr. Trunkey is professor emeritus in the department of surgery at Oregon Health and Science University School of Medicine, Portland, OR.
Georgia

on our minds:

General surgery wins fight for recognition

by Jon H. Sutton,
Manager, State Affairs,
Division of Advocacy and Health Policy
Author’s note: Deadlines for publication of articles and the calendars of state legislatures very often do not coincide, and that is true of the following article, which is reflective of a certain period of time during the spring session of the Georgia General Assembly.

At press time, the issue of recognition of general surgery as a single specialty had been successfully resolved for the state’s general surgery community with the enactment of S.B. 433. Georgia general surgeons are now able to open ambulatory surgery facilities in the state like any other “single specialty,” and they may apply for an exemption from certificate-of-need regulations.

State legislatures kicked into high gear earlier in the year, with many set to adjourn by the end of this month. Georgia was no exception to this rule, although the General Assembly’s session lasts only 40 days with adjournment by April 4. Not surprisingly, the issue of general surgery being defined as a single specialty and certificate-of-need (CON) reform were high on the legislative agenda, competing for legislators’ attention among tax cuts; funding for the state’s trauma system; and bailing out Grady Memorial, the financially ailing public hospital in Atlanta.

The crux of the matter
A detailed description of the general surgery issue in Georgia can be found in a November 2006 Bulletin article.* In short, general surgery is defined as a multispecialty for purposes of the ambulatory surgery center (ASC) CON exemption for single surgical specialties. Other surgical specialties, such as orthopaedics and plastic surgery, are eligible for the single-specialty exemption.

This discriminatory regulation was particularly offensive to a group of Albany general surgeons who wanted to open an ASC under the exemption. After years of legal wrangling, grassroots advocacy, stomping out a rumor that defining general surgery as a single specialty would result in general surgeons opening abortion clinics, and repeated requests for regulatory relief to the Department of Community Health (DCH), the Board of Community Health sponsored a public hearing on November 28, 2007, to consider a series of proposed amendments to the state’s CON program. Of particular interest to surgeons and the physician community was an amendment that would recognize general surgery as a single specialty.

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

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

As it did years ago in the first lawsuit filed to overturn the ASC CON definition of general surgery, the College was planning to file an amicus brief. The Medical Association of Georgia was intervening in the case, as was the Georgia Society of General Surgeons. In addition, the ACS planned to continue its ban on sponsoring meetings in the state until general surgery was properly defined.

The process plays on
Though the author was optimistic that this issue would be quickly resolved without a snag, such hope faded when the compromise language of a bill was initially held up by legislative leadership in the Georgia House. Developed by the House Special Committee on CON, S.B. 433 would amend many sections of the CON program and finally recognize general surgery as a single specialty. Relating to ambulatory surgery centers,

the proposal would exempt the following entities from the CON process:

- **Physician-owned single specialty ASCs.** These ASCs are exempt provided they address the following requirements: meet a $2.5 million capital expenditure threshold (indexed for inflation) or be the only ASC in the specialty in the county with no more than two operating rooms and have a hospital affiliation agreement; provide 4 percent indigent care if not a Medicaid provider or 2 percent indigent care if a Medicaid provider; and provide annual reports to the DCH.

- **Joint venture ASCs (physician/hospital ownership).** These entities are exempt provided that capital expenditures are less than $5 million, indigent care is provided at the same levels of the hospital, and annual reports are submitted to DCH.

- **Existing physician-owned ASCs.** These facilities are grandfathered in, but, like all facilities, must submit annual reports to DCH and provide 4 percent indigent care if not a Medicaid provider or 2 percent indigent care if a Medicaid provider, but only if capital expenditures are more than $800,000, a new operating room is built, or the ASC relocates.

A representative coalition of medical and health care organizations, including the following, supported S.B. 433: Medical Association of Georgia, Georgia Chapter of the American College of Surgeons, Georgia Society of General Surgeons, Georgia Society of Ambulatory Centers, Georgia Orthopaedic Society, Georgia Society of Ophthalmologists, and Hometown Health (a group of rural hospitals). College advocacy efforts included regular e-mails to Fellows, directing them to call and write to legislative leaders as well as their respective state legislators through the Surgery State Legislative Action Center.

S.B. 433 unanimously passed out of the Georgia House Special Committee on CON on March 31, with the House Rules Committee releasing the bill to the entire House on April 4. Significantly, that day was the last day of the 2008 session of the Georgia General Assembly, and pressure remained high on legislators to deal with the CON reform issue. Late in the day, the House took up the measure and approved it on a 138–17 vote, with the Senate shortly following with a 44–7 vote. Capping this legislative victory, the bill was finally signed by the governor on April 9, statutorily recognizing general surgery as a single specialty and making moot the lawsuit filed by the hospital lobby.

**Lesson learned: Grassroots advocacy**

Georgia’s general surgery issue is a prime example of how grassroots advocacy works in the states. The focus is not just on the legislature, but it can also involve regulatory and judicial initiatives. Sometimes all three components are needed to successfully achieve a desired outcome, although this may take many years of hard work and the expenditure of considerable sums of money. Coalitions become critical at many points in the process, and when physicians stick together and present a united front, good things can happen.

The real key, however, is that of individual surgeons contacting their own legislators about an issue—whether through phone calls, letters, faxes, or e-mails—and building relationships with them. Grassroots advocacy is all about individual, one-to-one interaction, and the more surgeons do contact their lawmakers directly, the more successful they will be on the state and federal level. State Affairs staff is available to help with this entire process, and we encourage you to make use of our expertise.
Contemporary surgeons bring technical and cognitive skills to patient care:

A PATTERNS OF CARE SURVEY

by Charles M. Balch, MD, FACS, and Thomas R. Russell, MD, FACS

Surgical practice in the 21st century continues to evolve and is no longer defined solely on the basis of procedures performed in the operating room. Surgeons realize that they increasingly need to be adept in a broad range of surgical skills and medical management. With the continued advances and widespread availability of safer, more effective drugs and other systemic agents, combined with advances in diagnostic and operating room technologies, the surgeon of today is engaged in a much more holistic approach to treat the whole patient, using both cognitive and technical skills to provide comprehensive, rather than episodic, care, especially for chronic conditions.

In contrast, Fellows of the American College of Surgeons are still viewed by some outside the surgical community as providers of technical rather than cognitive skills. Often, these individuals assume that we surgeons spend almost all of our time in the operating room and play a relatively minor role in prescribing an array of drugs as a component of comprehensive surgical patient care. While we may know from our own experience and practice patterns that this perception is false, until now we lacked data strong enough to document this aspect of our profession and the inherent value we attach to holistic patient care.

The authors decided to test a hypothesis, by providing evidence through an ACS-conducted study, that surgeons actually prescribe systemic agents and use diagnostic technologies more than is generally recognized.

This article is the first of a three-part series on the findings from this patterns of care survey, the largest ever conducted. This initial publication offers a broad overview of the study and the results. The next article will focus specifically on surgeons’ prescribing habits, and the third will explore surgeons’ use of advanced imaging and surgical technologies.
Survey respondents
The electronic survey of ACS members took place in fall 2007. The response rate was impressive: 4,207 individuals participated, representing the broad range of practice settings and surgical specialties. Almost 13 percent of respondents were younger than 35 years of age, 53 percent were between 35 and 54 years, and 34 percent were 55 years or older. Nearly 45 percent of the respondents work in a university/teaching hospital, 39 percent are in private practice, and the remainder provides care in other environments. The largest percentage of respondents (40%) classified themselves as general surgeons, and the other 60 percent represented the majority of surgical specialties. The breakdown of surgical subspecialties was very similar to that of the ACS membership overall.

The survey documented that ACS Fellows were busy clinicians, as 75 percent of the respondents said they see more than 25 patients each week, and 13 percent reported seeing more than 75 patients per week. They were committed to the importance of clinical trials, as 50 percent reported that they had entered a patient into a clinical trial or referred a patient to go into a clinical trial within the past year. This commitment was especially prevalent among the cardiovascular, trauma/critical care, and general surgery specialties.

Prescribing patterns
This study, the largest ever published on this subject, clearly indicates that surgeons in a range of settings and specialties commonly prescribe a wide range of medications. The majority of respondents (80%) said that on average, they or trainees working under their supervision prescribe more than 10 drugs each week; 56 percent prescribe more than 20 drugs per week; and 45 percent prescribe more than 25 in the course of a week.

Not surprisingly, most of the prescriptions are for drugs used in perioperative care, such as analgesics, antibiotics, and antiemetics. However, it is interesting to note that surgeons report prescribing a range of medicines for respiratory, cardiovascular, gastrointestinal, critical care, and thrombosis conditions on a weekly basis. Furthermore, half of the study participants said that within the past year, they have ordered or prescribed a recently approved therapy or one under investigation.

Use of technology
Surgeons also use a broad range of devices. As anticipated, most of the respondents reported using the sort of equipment commonly associated with operative procedures, such as suction/drainage devices (87%), surgical stapling products (85%), and minimally invasive instruments (81%). A major finding of this study documented that surgeons are becoming increasingly comfortable with using diagnostic equipment. Thus, an astounding 56 percent reported using a portable ultrasound, and 38 percent used a stationary ultrasound within the past year.

Conclusion
The results of this survey clearly demonstrate that ACS members embrace a continuum of care with the dual role of bringing both technical expertise and overall medical care to the optimal management of the surgical patient. Surgical care today involves the blending of technical skills in the operating room and cognitive skills in administering medications and other systemic agents to see patients safely through the perioperative period. Clearly, surgeons in almost all specialties are engaged in a more comprehensive disease-management approach, often in a multidisciplinary setting with other specialties to provide “Centers of Excellence” such as those organized for gastrointestinal, cardiac, vascu-
lar, breast, brain, and prostate diseases.

This study has some implications for the College and the surgical profession. First, the College should continue to promote high-quality, comprehensive patient care and research through its educational programs and publications. Second, training programs should emphasize the indications, risks, and benefits of using various drugs and systemic agents that enhance the near-term and long-term outcome of our patients to provide optimal patient care. Third, we should continue to incorporate the testing and validation of disease management and perioperative medications in our patients through clinical trials, such as those conducted by the American College of Surgeons’ Oncology Group.

We are grateful that so many ACS Fellows took the time to respond to this survey, for it helps the College to better understand our profession and respond to the needs of our members.

Dr. Russell is Executive Director of the College in Chicago, IL.
Editor’s note: The following is the first of an ongoing series of articles written by members of the Resident and Associate Society of the American College of Surgeons (RAS-ACS). The series will provide a forum for the concerns and needs of residents and young surgeons in all surgical specialties.

Upon embarking on my thoracic surgery career, I never thought that I would have innumerable sleepless nights until my friend and former attending said to me, “The problem with you guys is that you have no ownership of the patients.” By “you guys,” he meant the cardiothoracic surgery residents. At the time, I resented the comment. What did he mean by saying I had no ownership of my patients? After all, I had participated substantially in their operative care. Worse yet, who was the guy getting called at all hours of the night with patient updates ranging from the annoying to the troubling? Me! That’s who. I took care of my patients.

It was not until I started as an attending thoracic surgeon in January 2007 that I began to fully understand the meaning behind the earlier admonition. I have learned that true ownership occurs at a much earlier phase than following an operation or procedure: It occurs from the moment I meet the patients and their families. (In actuality, the patients’ trust in me begins with the trust placed in me by the referring physicians.) The relationship that ultimately evolves brings with it a tremendous responsibility, and that responsibility starts to become truly evident when individually tailoring the best operative strategy within the context of the patient’s clinical situation. The feeling of ownership is cemented before making any incision, simply by noticing my name on the patient’s hospital identification card.

The surgical procedure itself is frequently the most familiar and relaxing part of the patient’s care. I just do what I was trained to do. A healthy obsession for the postoperative well-being of my patient ensues almost immediately after the skin is closed. That obsession begins with wondering if I “did enough,” and then it progresses to doing everything in my power to make sure my patient will do well. Fortunately, thus far, my patients have experienced an unremarkable postoperative course and, following discharge, despite their release from the inpatient setting, “out of sight, out of mind” is hardly the case. It is through the cumulative effect of these experiences that I truly understand what “ownership” means. The funny thing about this situation is that I would not want it any other way. I enjoy guiding my patients safely through their surgical journey.

My job satisfaction has evolved from the fact that I believe I was trained in a fundamentally sound manner. Of course, when I was in training, I had neither the insight nor the mind-set to ap-
preciate this fact. I remember one case in which I was the “first assist” on a redo sternotomy for an aortic valve and coronary artery bypass procedure. Standing on the left side of the table, I remember thinking, “This stinks. When am I going to get to do the operation?” The attending surgeon was a seasoned professional, but in the back of my mind, I was also thinking, “Isn’t he experienced enough to get me out of trouble if I were to get into it?” Little did I know that by doing the case himself, he was keeping me out of trouble.

I was too inexperienced at the time to realize that a redo sternotomy is a procedure that even a veteran cardiothoracic surgeon approaches with caution. As expected, the case was a difficult one. We got into torrential bleeding on the approach as a result of a vein graft that had crossed the midline. I remember thinking that we—especially the patient—were in a precarious situation. I was surprised (and happy) to see how the veteran surgeon calmly told our perfusionists that we were going on “pump sucker bypass.” After the turbulent takeoff, we settled into a pleasant cruising altitude, performed the operation, and ultimately landed the plane safely. The patient suffered no ill effects, and he was discharged following the usual postoperative course.

I walked out of the operating room that day, impressed by two things. The first thing that impressed me was that quick thinking and action by the surgeon orchestrating the operating room team (including surgical assistants, anesthesiologist, perfusionists, and nursing staff) literally saved a life. What I saw that day was truly a command performance. I was also impressed by the fact that I could learn so much by watching those who have gone before me. This concept was reinforced for me while preparing for my oral thoracic board examination—I easily answered a question about a hypothetical situation in which I encountered “horrible bleeding during a redo sternotomy.” That hypothetical question—like this one in which I was more intimately involved—brought me closer to understanding what ownership is really about.

My relatively new career as a general thoracic surgeon is exciting. I wish I could better pinpoint why I love what I do, but I can’t decide what it is, except to say that cardiothoracic surgery is a great field. You take patients at death’s door and give them a second chance at life. The people who say that this current era is the worst time to begin a career in cardiothoracic surgery are absolutely incorrect. History has repeatedly demonstrated that the creative, resourceful, and successful individual can find new avenues when other roads are closed. Cardiothoracic surgery has tremendous opportunities in areas within the cardiac and thoracic disciplines.

I can tell you that if you choose a career in cardiothoracic surgery, you will be rewarded by having an opportunity to form wonderful relationships with your patients and to learn from some of the most talented and thoughtful physicians you will ever meet. I suppose you can also look forward to some sleepless nights, too, but to me, that is a price of ownership worth paying!

For additional information regarding the activities and benefits of the RAS-ACS, please contact Peg Haar, Administrator, Division of Member Services, 633 N. Saint Clair St., Chicago, IL 60611-3211; phone 312/202-5312; fax 312/202-5007; e-mail phaar@facs.org.

Dr. Kim is a general thoracic surgeon and assistant professor at Rush University Medical Center in Chicago, IL, and the recipient of the 2004 ACS Resident Award for Exemplary Teaching.
This column lists some questions regarding Current Procedural Terminology (CPT)* recently posed to the ACS Coding Hotline and the responses. ACS members and their staff may consult the hotline 10 times annually without charge as a benefit of membership in the College.

If your office has coding questions, please contact the Coding Hotline at 800/227-7911 between 7:00 am and 4:00 pm Mountain Time, holidays excluded. (For more information, visit http://www.facs.org/ahp/coding/secoding.html.)

Despite the relative clarity of procedural intent among surgeons performing breast operations, the complexity of accurate coding remains a significant challenge. The intent of this column is to try to clarify the confusion surrounding sentinel lymph node procedures based on best evidence available in publication.

Local carrier policy and physician practice patterns may result in different interpretation of CPT coding practice. Sentinel lymph node sampling for surgeons generally includes two component procedures: injection of dye or radiotracer and identification and excision of the lymph node or nodes.

As always, accurate coding is the responsibility of the provider and this summary is meant as a guide, not the irrefutable solution to all coding concerns.

**Acknowledgments**

The authors wish to acknowledge Eric B. Whitacre, MD, FACS, and Mark T. Savarise, MD, FACS, for their review and comment on this article.

**Resources**


**Dr. Barney** is associate professor and associate program director for general surgery, department of surgery, Wright State University Boonshoft School of Medicine, and member, Wright State Surgeons, Miami Valley Hospital, Dayton, OH.

**Dr. Bothe** is chief quality officer, Geisinger Health System, Danville, PA.
### What is the correct way to code for sentinel lymph node (SLN) biopsy...

#### Coding Modifiers Clarification

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<th>Description</th>
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<tr>
<td><strong>If done concurrently with initial partial mastectomy</strong></td>
<td>Use 19301 with either 38500, *Biopsy or excision of lymph node(s) open, superficial, or 38525, *Biopsy or excision of lymph node(s) open, deep axillary nodes(s), plus 38792 for the injection procedure if performed.</td>
<td>Injection code 38792 is inclusive of blue dye and/or radionuclide tracer (intraoperative lymphoscintigraphy); use of a gamma counting device is included in the SLN biopsy code.</td>
<td>What distinguishes 38500 from 38525? 38500 (superficial) suggests one or two superficial nodes and has a 10-day global period. 38525 implies a more complicated procedure and has a 90-day global period. Level II and III nodes are considered deep. Level I nodes can be deep or superficial depending on depth, patient habitus, and extent of required dissection.</td>
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<td><strong>If performing partial mastectomy with axillary lymphadenectomy, when a sentinel node biopsy was done at the same surgery</strong></td>
<td>Use 19302, plus add 38792 for the injection procedure if performed.</td>
<td>National Correct Coding Initiative (NCCI) edits prohibit the use of 38500 or 38525 whenever an ipsilateral axillary dissection is included as a component of the more complex operation. Since the injection of dye is a separate service not routinely included in 19302, add 38792 for the injection. Modifier –59 (Distinct Procedural Service) is not intended for procedures with the same diagnosis, same incisions, or same side. If a separate site such as ipsilateral (cervical 38510, or internal mammary 38530) or contralateral axillary SLN biopsy was performed at the same setting, then 38500 or 38525 with modifier –59 could be used.</td>
<td>Regardless if the SLN procedure was done before intraoperative decision to complete the axillary dissection, the work of performing any axillary dissection is considered bundled into the overall service code. (This is similar to laparoscopic cholecystectomy converted to open, when the laparoscopic portion of the operation cannot be coded as a separate procedure.)</td>
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<td><strong>If done concurrently with initial simple mastectomy</strong></td>
<td>Use 19303 with either 38500, *Biopsy or excision of lymph node(s) open, superficial, or 38525, *Biopsy or excision of lymph node(s) open, deep axillary node(s), plus 38792 for the injection procedure if performed.</td>
<td>If the procedure to establish the diagnosis has a global period of 10 to 90 days and the definitive operation falls within this period, the staged procedure modifier –58 is appropriate.</td>
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**What is the correct way to code for sentinel lymph node (SLN) biopsy... (continued)**

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<td><strong>If done concurrently with initial modified radical mastectomy</strong></td>
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<td>Use 19305 plus 38792 for the injection procedure if performed.</td>
<td>If the procedure to establish the diagnosis has a global period of 10 to 90 days and the definitive operation falls within this period, the staged procedure modifier –58 is appropriate.</td>
<td>Regardless if the SLN procedure was done before intraoperative decision to complete the axillary dissection, the work of performing any axillary dissection is considered bundled into the overall service code. (This is similar to laparoscopic cholecystectomy converted to open, when the laparoscopic portion of the operation cannot be coded as a separate procedure.)</td>
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<td><strong>If done as a stand-alone procedure without a primary breast service (for example, before preoperative neoadjuvant chemotherapy)</strong></td>
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<td>Use either 38500, <strong>Biopsy or excision of lymph node(s) open, superficial, or 38525, Biopsy or excision of lymph node(s) open, deep axillary nodes(s),</strong> plus 38792 for the injection procedure if performed.</td>
<td>NCCI edits state that superficial axillary lymphadenectomy 38740 should not be reported for a sentinel lymph node biopsy. Code 38740 requires removal of all superficial axillary adipose tissue and all lymph nodes contained in this adipose tissue.</td>
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<td><strong>When the patient returns to the operating room for definitive partial mastectomy or simple mastectomy after preoperative excisional biopsy has established the diagnosis</strong></td>
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| Use 19301 or 19303 with either 38500, **Biopsy or excision of lymph node(s) open, superficial, or 38525, Biopsy or excision of lymph node(s) open, deep axillary nodes(s),** plus 38792 for the injection procedure if performed. Add modifier –58 to indicate that this is a related procedure by the same physician during the postoperative period of the excisional biopsy. | If the procedure to establish the diagnosis has a global period of 10 to 90 days and the definitive operation falls within this period, the staged procedure modifier –58 is appropriate. Needle core biopsies and fine needle aspiration biopsies do not require a modifier as there is no postoperative period. | 19102, **Biopsy of breast; percutaneous, needle core, using imaging guidance 0-day global**  
19103, **Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance; 0-day global**  
19120, **Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; 90-day global**  
19125, **Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion; 90-day global** |
| **When the patient returns to the operating room (planned, based on biopsy results) for completion axillary dissection only, after final SLN pathology is positive** | | |
| Options are 38740, **Axillary lymphadenectomy, superficial, or 38745, Axillary lymphadenectomy, complete,** depending on the extent of resection. | Again, it is appropriate to append modifier –58 to indicate that this is a related procedure by the same physician during the postoperative period for the original operation. | The procedure is an isolated lymphadenectomy and is not being performed as a component of another bundled breast procedure. 38740 requires removal of all superficial axillary adipose tissue and all lymph nodes contained in this adipose tissue. 38745 requires a complete axillary dissection. |

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What is the correct way to code for sentinel lymph node (SLN) biopsy...

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<td><strong>If return to the operating room is for significant re-resection of a partial mastectomy margin and completion axillary dissection</strong></td>
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<td>Use 19302–58. It is appropriate to recode partial mastectomy if that work was accomplished and axillary dissection was a component.</td>
<td>Append modifier –58 to indicate that this is a related procedure by the same physician during the postoperative period.</td>
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<td><strong>If, based on original resection margins, the patient opts for complete breast removal at the second operation</strong></td>
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<td>If a partial mastectomy plus sentinel node procedure was previously performed, 19303–58, <em>Mastectomy, simple, complete</em>, with modifier –58 would suffice. If completion axillary dissection is required, 19307–58, <em>Mastectomy, modified radical, including axillary dissection</em>, could be utilized.</td>
<td>Again, it is appropriate to append modifier –58 to indicate that this is a related procedure by the same physician during the postoperative period for the original operation.</td>
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<td><strong>If the patient returns to the operating room after simple mastectomy with SLN biopsy for completion axillary dissection only</strong></td>
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<tr>
<td>Options are 38740, <em>Axillary lymphadenectomy, superficial</em>, or 38745, <em>Axillary lymphadenectomy, complete</em>, depending on the extent of resection.</td>
<td>Again, it is appropriate to append modifier –58 to indicate that this is a related procedure by the same physician during the postoperative period.</td>
<td>38740 requires removal of all superficial axillary adipose tissue and all lymph nodes contained in this adipose tissue.</td>
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<td><strong>The patient presents to the OR following bilateral needle core biopsy proven breast carcinoma, and she opts for bilateral partial mastectomy with sentinel lymph node biopsy</strong></td>
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<td>This procedure would be coded as follows: 19301–50 plus either 38500–50, <em>Biopsy or excision of lymph node(s) open, superficial</em>, or 38525–50, <em>Biopsy or excision of lymph node(s) open, deep axillary node(s)</em>, plus 38792 for the injection procedure if performed and add modifier</td>
<td>Modifier –50 is added because this was a bilateral procedure. Modifier –58 would be added as well if the procedure was done by the same physician during the postoperative period of an excisional biopsy.</td>
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Surgeons unite at joint advocacy conference in Washington

by Diane S. Schneidman, Manager, Special Projects, Communications

Approximately 330 surgeons representing a range of specialties participated in the first Joint Surgical Advocacy Conference (JSAC) March 9–11 at the Mayflower Hotel in Washington, DC. The program featured presentations on congressional policies and procedures, advocacy skills, and the upcoming national elections. In addition, surgeon attendees had opportunities to hear from six members of Congress and to meet with legislators and their health policy advisors on Capitol Hill.

The American College of Surgeons, as part of its ongoing coalition-building efforts, cosponsored the event with the following surgical specialty societies: American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS), American Association of Neurological Surgeons, American College of Osteopathic Surgeons, American Society of Cataract and Refractive Surgery, American Society of Plastic Surgeons, Congress of Neurological Surgeons, and Society of American Gastrointestinal and Endoscopic Surgeons.

During his opening remarks, ACS Executive Director Thomas R. Russell, MD, FACS, said that the high attendance rate at the meeting was emblematic of the need for surgeons to speak with one voice on the amazingly complex issues facing the surgical community. Similarly, David R. Nielsen, MD, FACS, executive vice-president and chief executive office of the AAO-HNS, said that the widespread surgeon participation in the meeting would enable all of the organizations to increase their influence on Capitol Hill. “Policy is made by the people who show up,” Dr. Nielsen noted.

Congress

The first full day of the conference served largely as a primer on Capitol Hill and grassroots advocacy. As she has done at past ACS advocacy meetings, Judy Schneider, a specialist on Congress at the Congressional Research Service and adjunct scholar at the Brookings Institution Center for Public Policy Education, gave a highly interactive and entertaining presentation on how Congress functions. “My job is not to teach you about the way you think it works, but the way it really works,” Ms. Schneider said.

According to Ms. Schneider, the U.S. Senate and House of Representatives take different approaches to reviewing and passing legislation. “Most Senate work is done on the floor,” she said, with all 100 senators debating key elements of each bill to achieve passage. In the House, committees on specific issues hold sway over how legislation is written. Furthermore, the House operates under a complicated set of rules. Indeed, the House has more than 30 volumes of rules and precedents, Ms. Schneider noted.

Approximately 10,000 legislative proposals are introduced in Congress each year, but only 400 or so receive real consideration, she said. Needless to say, broad bills that cover multiple issues require more extensive review. For example, a bill that originates in the House sometimes undergoes review by two or more committees. These committees then add or delete provisions before the full House votes on whether to pass the legislation. If a bill passes in the House, it then goes to the Senate, where senators often rewrite the legislation with different language and provisions than were in the House’s version. A joint House-Senate conference committee then develops a compromise bill.

To increase the odds of this process running smoothly and of having desired policies enacted, Ms. Schneider suggested that organizations and individuals who ask a member of Congress to introduce a bill be very specific when stating what they want and why. Often when legislation fails, “The problem is not [legislators]; it’s us. We send them mixed messages,” she said. “The narrower
Stephanie Vance, a former legislative and staff director for various members of Congress and author of Government by the People: How to Communicate with Congress, also recommended specificity in discussing issues with legislators and their policy advisors. “Advocates don’t always deliver their message in a way that’s relevant to their members,” Ms. Vance said. “You need to ask for something specific.”

Ms. Vance noted that constituents call upon and meet with members of Congress for a variety of reasons, including asking legislators to introduce, cosponsor, or vote for or against a bill. Ms. Vance called these types of requests “policy asks.” An example of a policy ask that is particularly relevant to surgeons at this juncture, she noted, is the request that a senator or representative take action to prevent the 10.6 percent Medicare physician payment reduction, which at press time was scheduled to take effect July 1.

Effective advocates also contact their legislators to engage in relationship-building activities, Ms. Vance said. Examples include arranging for the legislator or health policy aide to visit your institution, inviting the member of Congress to attend a local meeting, and publishing a commentary from the senator or representative in your organization’s newsletter or on its Web site.

Ms. Vance—who is currently a partner at Advocacy Associates, the organization that arranged the Capitol Hill visits for JSAC participants—noted that many of these meetings would be with congressional staff. She offered the following tips for dealing with legislative staff: (1) talk to the right person; (2) recognize that your issue is one of many that staffpeople are discussing; (3) remember that health policy staff are the key to getting a message through to a legislator and are more likely to be familiar with surgery-related issues because health care is their specialty; (4) remind them of what Congress has done about the specific issue in the past, because institutional memory can be short; and (5) expect and appreciate youth, as most congressional aides are in their early to mid-20s. In addition, Ms. Vance encouraged surgeons who would be participating in meetings on Capitol Hill to tailor their messages so that they are specific, personal, positive, informative, trustworthy, and brief.

“Strategy is all-important” when acting as an advocate, added Julius W. Hobson, Jr., senior policy advisor for advocacy and government relations with the Washington-based consulting firm Powell Goldstein. “Strategy is a process that requires rational and reciprocal adjustment of tactics,” Mr. Hobson explained.

In recent years, the tactics necessary to succeed in health care lobbying have changed. “[Physicians] are a minority in the provider community,” Mr. Hobson said. Therefore, they need to be persistent and vocal when advocating for legislative change. “You know the difference between a lobbyist and a dog?” he joked. “The dog stops barking when you let him in the door.”

“People are going to be distracted,” Mr. Hobson added. Therefore, effective lobbyists make their arguments in a way that a young congressional staffer can understand. They also listen carefully to what members of Congress and their proxies say and how they say it, he said.

**Upcoming elections**

Providing an insider’s look at the Democratic and Republican primaries and the November presidential elections was guest luncheon speaker Ronald Brownstein, political director for Atlantic Media Company publications, which include The Atlantic, National Journal, and Congress Daily. Mr. Brownstein observed that the American people are living through a presidential primary season that is unprecedented in terms of spending and voter turnout.

At the time of the JSAC, the Democratic primaries were still taking place, with Sens. Barack Obama (D-IL) and Hillary Clinton (D-NY) in a near dead-heat for the nomination. Mr. Brownstein noted that this virtual tie is a result of the fact that the two candidates appeal to different voters. “Obama believes his election will change the way the world looks at America,” Mr. Brownstein said. He is sending a message of optimism and consequently has “melded the constituencies of [former presidential hopefuls] Gary Hart and Jesse Jackson,” he said. Senator Clinton, meanwhile, is trying to appeal to voters’ sense of pragmatism.

Overall, Senator Obama has
more support than Senator Clinton among college-educated men, whereas Senator Clinton has an edge with women who do not have a college education. Men without a college education generally find neither candidate appealing, and college-educated women tend to be “swing voters,” seeing pros and cons to both contestants, Mr. Brownstein said.

Meanwhile, Mr. Brownstein observed that, “Anybody who understands the Republican primary race probably understands the plot of [the television show] Lost.” In the final months preceding the primaries, most pundits were predicting that the major contenders would be former New York City Mayor Rudy Giuliani and former Massachusetts Gov. Mitt Romney. These same individuals were claiming that Sen. John McCain (R-AZ) was too old and too moderate on certain social issues to win the nomination. “Through the Florida primary, McCain did not receive a plurality of [votes from] people who call themselves ‘conservatives,’” so it still seemed unlikely that he would garner enough support to achieve the nomination, Mr. Brownstein said. Florida was the turning point with Mr. Giuliani’s poor showing that allowed Senator McCain to clinch the Republican nomination.

When it comes to the November elections, most Americans say they want a President who can reverse the current divisiveness in Washington, which they believe results in “either polarization or paralysis,” Mr. Brownstein said. “The political system is more divided than the nation,” he added.

Legislators
All of the several members of Congress who spoke at the JSAC agreed that, in the words of Rep. Tom Price, MD, FACS (T-TX), “Over the next four to six years, there is going to be significant change, especially for health care.”

“I would suggest to you that the health care system is woeefully broken,” Representative Price added. He maintains that one way to repair the system is to institute Medicare physician payment reforms that encourage individuals to pursue and continue a career in medicine. To this end, Representative Price has introduced legislation, H.R. 5445, that revises the update to the single conversion factor in the formula used to determine physician reimbursement by 1 percent for the period between July 1 and December 31 and 1.8 percent for all of 2009. This legislation would give Congress adequate time to develop long-term fixes to the payment problem.
Representative Gordon, MD (R-TX), a member of the House Energy and Commerce Subcommittee on Health, agreed that payment reform is a pressing issue and that Congress needs to develop long-term solutions. Representative Burgess noted that he has introduced a bill, H.R. 5545, that would eliminate use of the sustainable growth rate (SGR) in the formula used to calculate Medicare conversion factor updates. (Flawed use of the SGR in the reimbursement methodology is cited as the primary source of the ongoing reduction to the conversion factor.) Representative Burgess urged meeting participants who would be visiting Capitol Hill to ask their members of Congress to review H.R. 5545 and to consider co-sponsoring it.

In the House, the Ways and Means Committee has primary responsibility for Medicare financing. Rep. Fortney “Pete” Stark (D-CA), Chairman of that committee’s Health Subcommittee, said, “You’re looking at a payment structure that explodes by the end of June.” However, he also said that Congress would likely stall the major cut for one to two years to give legislators time to devise a solution.

Representative Stark noted that in 2007, the House passed the Children’s Health and Medicare Protection Act, which would have reauthorized the State Children’s Health Insurance Program (SCHIP) and eliminated the SGR and replaced it with six separate categories of health services. However, the Senate passed a dramatically different version of a bill to reauthorize SCHIP, which excluded the Medicare payment provisions. The College and other organizations have been advocating for the Medicare reform provisions.

Another issue of concern to members of Congress as well as surgeons is the workforce shortage. Rep. Bart Gordon (D-TN), senior member of the House Commerce Committee, said, “There really is a crisis brewing in access to care for Medicare patients and in the emergency room.” Representative Gordon noted that reduced reimbursement is affecting physician willingness to provide care to Medicare beneficiaries and to trauma patients. To help resolve this situation, Representative Gordon said that he advocates passage of legislation that would increase payment for emergency room services by 10 percent.

In addition, Congress is looking at ways to encourage expanded use of health information technology (IT) to cut spending and better coordinate the delivery of services among multiple providers. Representative Burgess said that the Senate had developed a “bad bill” pertaining to e-prescribing, which would give physicians who use electronic prescriptions a positive 1 percent payment update. Noting that this increase is very minor when weighed against the potential 10.6 percent Medicare payment reduction, Representative Burgess said, “Incentives will work, but they have to be meaningful.” Representative Stark echoed that sentiment, saying, “We have got to pay you back for the investment you make [in IT].” Moreover, he added, health IT must be interoperable across practices and institutions.
One other issue that the members of Congress addressed is universal access to health care. “We’re going to hear a great deal about universal coverage in this presidential race…. Everyone ought to have coverage, but in a free society, it’s hard to see how you get there,” Representative Burgess said, adding that he opposes individual mandates.

Representative Stark also shared his views on universal health care. He said that a first step will be providing coverage for all children, and then “inch[ing] into a plan that the public and providers can agree on.” He went on to say, “I don’t think this country’s ready for [a] single-payer [system].” Instead, he noted, policymakers will likely develop an all-payer system, under which all insurers will be required to abide by certain standards.

Meanwhile, Representative Price has introduced legislation, H.R. 2626, that takes a more market-based approach and would move the nation’s health care delivery system toward a defined contribution plan. The congressman has also spearheaded efforts to expand coverage for the uninsured by coauthoring legislation that would accelerate state initiatives.

Finally, Representative Gordon said that he believes Congress should pass medical liability reforms. Rep. Shelley Moore Capito (R-WV) said the

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**Surgeon takes JSAC lessons home to Connecticut**

*by Philip R. Corvo, MD, FACS*

**Editor’s note:** The following is an abridged version of a commentary that Dr. Corvo wrote for the Connecticut Chapter newsletter. This item appears with the permission of the Connecticut Chapter.

I had the pleasure of participating in the first Joint Surgical Advocacy Conference (JSAC) sponsored by the American College of Surgeons and several other surgical specialty societies. As President of the Connecticut Chapter, attending the meeting just seemed like the right thing to do.

The goal of the meeting, which took place March 9–11 in Washington, DC, was to educate participants about the issues related to surgery that Congress is addressing. The conference also was designed to teach surgeons how to communicate our concerns to legislators and their staffs. For a day and one-half, we learned how Congress works, how to get our points across, and what to avoid. Then we were turned loose on Capitol Hill! It was a very humbling and exciting experience to walk the halls of Congress, to be in the offices of our senators and representatives, and to talk to the decision makers. It was also very enlightening.

The public expects members of Congress to be “experts” on all the issues that come before them, but of course that would be an impossible achievement. Instead, legislators largely depend on their policy assistants to meet with constituents, to gather information and opinions, and to present them with the analysis they need to make decisions that will benefit the people in their home states and districts. Hence, JSAC attendees who participated in the Capitol Hill visits mostly met with the health policy assistants or specialists and presented our data and personal stories to them. Of course, the next day the insurance companies and lawyers met with the same people. Everyone seems to have the right answer, and that is where things get complicated, and that is why it seems nothing ever gets done.

**Lessons learned**

The two biggest lessons I learned about physician-lawmaker relationship are: (1) legislators think doctors don’t care about legislation; and (2) we are cut from a very different cloth. Surgeons are perceived as apathetic because we don’t get involved to the extent that other groups do. We complain to each other during grand rounds and in the hospital hallways, but when it comes to communicating our issues to the right people, the people who can do something more than just commiserate, we fall short. Not enough of us leave our offices and talk to our legislators as often as we should. One congressman told me that six letters or e-mails are considered an avalanche of input!

Those of us that do take the time to contact our members of Congress soon learn lesson number two—we are very different types of individuals. Physicians, especially surgeons, are used to doing things, and quickly: now, today, yesterday.
liability issue was a source of anxiety for many West Virginians, who were upset because their physicians were leaving the state. This exodus led to a grassroots uprising, Representative Capito said, and ultimately the state legislature was forced to pass cutting-edge malpractice reforms. “The best way to bring your message to your member of Congress is to explain what the issue means to the people on the street,” she added.

Other meeting highlights

On the final day of the meeting, advocacy staff from the College and the surgical specialty societies briefed their members on the policy issues for discussion with elected officials. Although surgeons in different specialties have certain subjects that are of greater relevance to them than to their colleagues in other surgical disciplines, the one topic on which they all agree is that the Medicare physician payment system needs to be reformed. Hence, this issue was the central focus of all of their meetings on Capitol Hill.

In addition to the didactic presentations and the Capitol Hill visits, meeting participants had several networking opportunities. A welcoming reception took place the evening of March 9 and a congressional reception was held March 10. The political action committees (PACs) for the American College of Surgeons Professional Association (ACSPA) and other

We are comfortable making life or death decisions based on limited information. Legislators, on the other hand, need time to work out compromises and to digest lots of details from conflicting sources. Because the legislative process moves so much more slowly and deliberately than medical decision making, we think lawmakers don’t do anything and feel frustrated after talking to them. We need to learn the rules of their game and play appropriately.

Taking action

Upon returning from the JSAC, I received an invitation to Doctors’ Day in Hartford, CT, on Friday, March 14. After looking at my calendar, I wanted to turn down the offer because it would require too much time away from the office. I am a general surgeon in private practice in Stamford, and Doctors’ Day wasn’t going to pay the rent for my office, the utility companies, and my staff’s salaries. After a few days and e-mails, however, I realized that I had to go. That was the main take-home message from the JSAC—that physicians need to prove we care and be involved in the legislative process.

My Fridays are half-filled with office visits and half with operations. I thought both would disappear into the ether on Doctors’ Day. However, my staff was able to rearrange my morning appointments for other times during the week and to reschedule the operations.

Hartford was my second foray into politics in one week and was worth every minute away from the office. They say “all politics is local,” and it is easy to see why. Your representatives are elected to work for you, your neighborhood, and your patients. How much more local can you get? Of course, once elected, they still need to know what you want. Your job is to keep telling them what needs to be done. Talking with your legislators face-to-face is clearly the best approach. You can meet in their district office, in a diner over coffee, or during a community function. Can’t manage that? E-mail them. All their e-mail addresses are available through the Surgery State Legislative Action Center at http://capwiz.com/sslac/home/. If nothing else, do your part when the College calls on you for assistance. Follow the links in the e-mail you receive and then send the prewritten letter out.

No matter how busy you are, you can spare two minutes a month to fight for patient access, professional liability insurance reform, and reimbursement. As we learned during the JSAC, policy is made by the people who show up and who speak out.

Dr. Corvo is a private practice general and laparoscopic surgeon in Stamford, CT. He is President of the Connecticut Chapter of the ACS and of the Connecticut Chapter of the American College of Surgeons Professional Association.
surgical specialties presented a wine-tasting fundraiser and raffle. The ACSPA SurgeonsPAC raised $36,000 at this event and Rep. Pete Sessions (R-TX), a champion of Medicare payment reform, was in attendance.

**Surgeon reactions**

Surgeons who attended this year’s conference as well as previous advocacy meetings presented solely by the College in the past said they favored the new structure. “I thought this one was terrific,” said Andrew L. Warshaw, MD, FACS, ACS Treasurer. “First, it was highly attended. The meeting room was filled beyond capacity. Second, certainly having multiple surgical disciplines present was very important because it allowed us to hear how different people view things,” he added. Dr. Warshaw also noted the value in having large numbers of surgeons on Capitol Hill discussing similar issues in unison. “The more we can get people side-by-side to think about these issues and to advocate on behalf of the profession and the patient, the more likely we are to succeed,” he said.

Thomas R. Gadacz, MD, FACS, Vice-Chair of the Florida Chapter’s Legislative Committee, said, “This meeting showed surgery coming together as a group. It provided an opportunity for meeting other surgeons from other specialties and discussing issues with them.” Dr. Gadacz, who has attended four advocacy conferences, also said, “The College should engage in more political activities with other surgeons. This helps bring the house of surgery together and shows our political unity.”

Dr. Gadacz participated in the Capitol Hill visit portion of the program and said he had particularly good experiences in dealing with the staffs for Sen. Bill Nelson (D-FL) and Rep. C.W. “Bill” Young (R-FL). “I had over 45 minutes with [Representative Young’s health assistant] Brad Stein. I got an e-mail from him when I got home and also met with Representative Young’s staffer in Florida to follow up on a few other issues,” Dr. Gadacz said.

For another surgeon’s perspective on how this conference affected his views on grassroots advocacy, see the commentary by Philip R. Corvo, MD, FACS, President of the College’s Connecticut Chapter, on page 30.
Leadership conference prepares surgeons for the future

by Diane S. Schneidman, Manager, Special Projects, Communications

The American College of Surgeons presented the 2008 Leadership Conference for Young Surgeons and Chapter Leaders immediately before the Joint Surgical Advocacy Conference described in the article that begins on page 26. Approximately 100 ACS chapter officers, council members, executives, and young surgeon representatives participated in this event, which took place March 9 at the Doubletree Hotel in Washington, DC.

What is leadership?

ACS Executive Director Thomas R. Russell, MD, FACS, delivered the keynote address. His presentation on leadership was largely improvised and, in his words, “from the heart,” having been called upon at the 11th hour to substitute for Wiley “Chip” Souba, MD, ScD, FACS, who was snowbound in Columbus, OH.

According to Dr. Russell, “Leadership boils down to one thing—the ability to resolve conflict.” Some conflicts involve individuals; others emanate from environmental and cultural changes. More specifically, Dr. Russell noted, some surgeons oppose the transformations that are occurring in health care and are devoted to protecting the past, whereas others believe it’s time to “figure out where we’re going and how surgeons are going to fit into this very complex system.”

Today’s surgical leaders need to lead a cultural change that will help to overturn the public’s negative view of the profession. “Surgeons are thought of as ‘hardly ever right but never in doubt.’ We need to shed that reputation,” Dr. Russell added.

In addition, Dr. Russell said, surgeons need to lead by example and “walk the talk.” They should be supportive, truthful, forward-thinking, competent, worthy of respect, and inspired. Referencing Jim Collins, author of several books on leadership in American business, Dr. Russell said that leaders should behave as follows:

- Do the right thing at the right time and for the right reasons
- Demonstrate will and humility
- Out-listen the other people in the room
- Perform more like plow horses than show horses
- Be kind
- Don’t talk about people behind their backs
- Give credit graciously and generously
- Celebrate other people’s successes
- Never do anything today that they would not want to see on the front page of the paper tomorrow

On the other side of the spectrum are “toxic leaders [who] inebriate their followers” and use their power to destroy, Dr. Russell said. “Today, the temptation is to use the power of medicine for personal reasons,” he added. “Be careful of doctors in white who are following the green.”

In addition to providing his insights, Dr. Russell presented some of the concepts that Dr. Souba had intended to discuss. According to Dr. Souba, “A leader motivates and empowers.” Behaviors that have the opposite effect—that inhibit individuals’ creativity and ability to perform—are disrespect, keeping hidden agendas, unwillingness to compromise, and hostility.

Dr. Souba also believes that today’s leaders need to promote collective thinking, confront reality, “embrace the heat,” and define and create a healthy culture.

The topic of leadership was explored further during a panel discussion for young surgeons moderated by Mark Savarise, MD, FACS, Vice-Chair, ACS Committee on Young Surgeons. John H. Armstrong, MD, FACS, and Chad A. Rubin, MD, FACS, explained how their volunteer experiences have enabled them to become significant players and leaders in health policy. Drs. Armstrong and Rubin both represent the College in the American Medical Association’s
House of Delegates. In addition, Dr. Rubin serves on the ACS General Surgery Coding and Reimbursement Committee and is President-Elect of the South Carolina Chapter.

**Strategic planning**

John T. Preskitt, Sr., MD, FACS, an ACS Regent, led a session on strategic planning for chapter leaders and executives. Dr. Preskitt said that vibrant chapters have sustainable leadership, a supportive administrative structure, enthusiastic member involvement, and worthwhile member services. Chapters can cultivate these attributes through strategic planning, which Dr. Preskitt defined as “a systematic process through which an organization agrees on and builds commitment among key stakeholders to priorities that are essential to its mission and responsive to the environment.”

“It is not a prediction of the future. It is not a substitute for judgment. And it is definitely not smooth and linear,” Dr. Preskitt added.

Strategic planning, Dr. Preskitt said, occurs in the following seven stages:

- Working with leadership to decide whether this is an activity that the chapter needs and is ready to do
- Defining and articulating the organization’s mission, vision, and values
- Assessing the internal and external environment in which the chapter operates
- Setting goals and priorities
- Writing and reviewing the plan
- Implementing the plan
- Continuously evaluating and monitoring the strategic plan and its effectiveness

“Strategic planning is a process for visionary leaders. You are the visionaries of the future and of today,” Dr. Preskitt concluded.

Bruce J. Waring, MD, FACS, Governor of the College’s Colorado Chapter, explained how that organization developed a needs assessment survey in 2007 to guide its strategic planning efforts. Spurring the decision to conduct the study was the fact that only 5 percent of the group’s members were attending its annual meeting. “We needed to determine a course of action for the future of our chapter,” Dr. Waring said.

The survey was sent statewide to all members, and chapter leaders participated in regional face-to-face interviews, Dr. Waring said. The study results indicated that Colorado Chapter members wanted the organization to be more involved in payment/insurance issues, surgical advocacy, medical liability reform, political action, the provision of services aimed at practice viability and sustainability, and patient advocacy.

Furthermore, the survey revealed that only 40 percent of the Colorado Chapter members believe that presenting an annual meeting is the best use of the organization’s time and resources, given that they can get continuing medical education credits elsewhere. In light of these findings, the chapter decided to become more responsive to socioeconomic issues and to serve as the political advocate for surgeons and patients in the state, Dr. Waring said.

Kevin Lally, MD, FACS, Governor and Past-President of the South Texas Chapter, said that, by 2005, “We had become the worst chapter of the ACS.” The same individual had served as Secretary of the South Texas Chapter for many years and did not have a system for managing the organization’s accounts. Indeed, the chapter was operating without a budget or membership database. Hence, when the organization undertook strategic planning later that year, “Our goal was to not be the worst chapter in the country,” Dr. Lally said.

To initiate this effort, the South Texas Chapter called upon Dr. Preskitt to serve as a facilitator and to lead a preparatory session. The chapter also examined its strengths and weaknesses and developed a mission statement. Since then, the pieces are starting to fall into place and the chapter is making better use of its assets, including the large number of ACS members, training programs, and academic faculty in the area, Dr. Lally said.

**Advocacy**

Linda M. Barney, MD, FACS, President of the Ohio Chapter, said that the organization’s 2000 mission statement indicated that one of its key purposes was to “be an advocate for its members and the patients they serve.” Hence, she said, the Ohio Chapter set out
to increase its ability to shape policy, influence the legislative process, and gain access to decision makers.

The chapter developed a one-to two-year timeline for enhancing its political presence. The first step was retaining a lobbyist. Next, the chapter updated its Web site to include public policy information, a member chat room, and patient information on how policy affects access to care.

Key components of the Ohio Chapter’s advocacy improvement process included developing a cadre of dedicated physician volunteers, a support staff, funding, and a communications platform, Dr. Barney said. The chapter also created a grassroots action plan, which involved building relationships with legislators, identifying key decision makers, developing connections with the Ohio insurance director’s office, and contributing to campaigns.

In addition, John Kilkenny, MD, FACS, Chair of the Legislation Committee for the ACS Florida Chapter, presented what he called “Some Thoughts from the Land of the Hanging Chad.” According to Dr. Kilkenny the elements of successful advocacy include the following:
- Identifying movers and shakers
- Building coalitions
- Knowing the facts about the issue
- Understanding the opposition
- Obtaining evidence to refute negative responses
- Finding a champion for the cause
- Being aware of the obstacles
- Getting a foot in the door and continuing to come back
- Knowing when to compromise
- Setting reasonable time-frames

In addition, Dr. Kilkenny emphasized the importance of mobilizing and motivating individuals to take action and reinforced the message that “advocating is good medicine.”

Melinda Baker, State Affairs Associate, ACS Division of Advocacy and Health Policy, noted that the College offers a number of services to help chapters become more involved in the legislative process. For example, through the Surgery State Legislative Action Center, individuals send letters to their state lawmakers. The College’s state affairs staff also coordinates a State Advocacy Representative (StAR) program. StARs participate in occasional conference calls to exchange information with the College and other members of the program, Ms. Baker noted.

Young surgeon sessions

Meanwhile, the young surgeon attendees had the option of attending two other presentations. Bruce Harms, MD, FACS, professor of surgery at the University of Wisconsin–Madison, spoke on personal wellness as a foundation for leadership and successful surgical practice. Peter Muscarella, MD, FACS, a member of the ACS Committee on Young Surgeons, moderated.

Dr. Harms’ presentation was followed by a panel presentation on the Health Policy Scholarship program, which Patricia Turner, MD, FACS, a member of the Committee on Young Surgeons, moderated. Two recent recipients of ACS Health Policy Scholarships—Frederick A. Boop, MD, FACS, and Richard Freeman, MD, FACS—reported on their experiences and advised young surgeons about the best routes for engaging in health policy.

Leading policy issues

The leadership conference also included a review of current health policy issues. Perry Shen, MD, FACS, Chair of the Committee on Young Surgeons, moderated the panel discussion.

According to Dr. Russell, some of the most significant issues affecting surgery are expanding access to care, reforming the Medicare payment system, developing quality measures, and the expanding scope of practice for nonsurgically trained health professionals.

The College supports the idea of ensuring that all patients have access to care and has issued a statement on the matter (ST-45, Statement on Universal Health Care). Noting that the government already pays for approximately 50 percent of the health services delivered in this nation Dr. Russell said, “We don’t need to spend more money, but we do need to figure out how to redistribute the money.”

With regard to Medicare physician payment reform,
the College has advocated for eliminating the sustainable growth rate (SGR) from the formula used to calculate reimbursement updates, Dr. Russell said. The College is calling for replacing the SGR with six separate spending targets for categories of services. Provisions that would establish this new methodology were included in the Children’s Health and Medicare Protection Act, which the House of Representatives passed last year. The Senate version, however, omitted the Medicare payment provisions. The College and its allies intend to continue calling upon Congress to pass these reforms, Dr. Russell said, adding, “It’s not going to be done by the ACS alone.”

In addition, the surgical community must devise measures for assessing quality of care, he said. The College has been attempting to examine surgical outcomes through the ACS National Surgical Quality Improvement Program and is in the process of making this instrument more usable and meaningful for smaller hospitals, Dr. Russell noted.

Furthermore, the College has established a Health Policy and Research Institute, which will enable the organization to analyze and disseminate information about a range of quality-related subjects. The ACS’ efforts to generate a fair and reasonable payment system and to assess quality are designed to ensure that “surgeons are doing surgery” now and in the years to come, Dr. Russell said.

“The good news is that Congress knows the [Medicare payment] system is broken,” said Cindy Brown, then-Director of the ACS Division of Advocacy and Health Policy. But to achieve meaningful reform, “We’re going to have to gore a lot of oxen,” she said.

The purpose of establishing the separate categories is to isolate areas that experienced flat spending growth, such as major operative services, Ms. Brown explained. Under the existing fee schedule, Medicare has “borrowed from docs to pay docs,” she said.

Sustaining the financial viability of the Medicare program is of utmost importance to Congress at this time. However, the Administration is making it difficult to find reasonable solutions. “The current President will veto anything that cuts Medicare Advantage,” Ms. Brown noted.

In addition, she said, surgeons are becoming increasingly politically energized. For example, last year 3,000 surgeons called the Senate to urge their legislators to pass Medicare payment reforms. This was the largest grassroots effort the College has initiated.

The College also intends to address the surgical workforce issue before it develops into a crisis. Indeed, growing concerns about this problem have inspired the ACS Health Policy and Research Institute to make this subject its first priority. “The canary in the coal mine” is emergency care, Ms. Brown said. “People are not taking emergency call.”

The program concluded with Ms. Baker giving an overview of state legislative activities—noting that the College is tracking 120 new bills this year—and an open forum with Dr. Russell.
In March, the First Lady of the Eurasian country of Georgia, Sandra Elisabeth Roelofs, along with Georgian Embassy staff, visited the College to meet with representatives of Advanced Trauma Life Support®—Christoph Kaufmann, MD, FACS, International ATLS Director; and Will Chapleau, ATLS Program Manager—to discuss health care in her nation and the reforms she believes are necessary.

This visit was partially inspired because plans are in place for ATLS to launch in Georgia (Georgia’s application was approved at the ATLS annual meeting, and the first site visit will take place this summer). Also during First Lady Roelofs’ visit, she and her delegation—which included Mikheil Dolidze, MD, who is involved in establishing the first Georgian trauma center; and Levan Jugeli, MD, who works on health initiatives with her—were given a tour of the trauma center at Northwestern University Hospital by Michael West, MD, FACS.
SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available online at www.acs-resource.org or on CD-ROM.

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

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

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

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

ONLINE CME: Courses from ACS Clinical Congresses are available online. Each course features a video introduction, slideshow presentations with synchronized audio, printable written transcripts, and printable CME certificate upon successful completion. The courses are accessible at www.acs-resource.org.
Resident Research Scholarships for 2008 awarded

The Board of Regents awarded six American College of Surgeons Resident Research Scholarships for 2008 in February. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2008. Unless otherwise noted, scholarships are sponsored by the Scholarship Endowment Fund of the College.

The recipients are as follows:

Matthew Santore, MD, resident in surgery, University of Pennsylvania, Philadelphia, PA.

Research project: Developing effective in utero hematopoietic cell transplantation using intrathymic injection to facilitate engraftment in order to treat genetic disorders.

Sae Hee Ko, MD, resident in surgery, University of Pittsburgh, Pittsburgh, PA.

Research project: The Role

Dr. Santore  Dr. Ko  Dr. Kratz
Dr. Short  Dr. Wang  Dr. Nasr
of HIF overexpression in bone marrow mesenchymal stem cells on wound healing. (Dr. Ko’s scholarship is sponsored by Ethicon and will be conducted at Stanford University.)

**Johannes E. Kratz, MD**, resident in surgery, Massachusetts General Hospital, Boston, MA.

*Research project:* Linking inflammation and lung adenocarcinoma: Aberrant Wnt/Shh signaling in lung cancer stem cells. (Dr. Kratz’s scholarship is sponsored by Wyeth Pharmaceuticals and will be conducted at the University of California–San Francisco.)

**Joshua J. Short, MD**, resident in surgery, University of Alabama at Birmingham.

*Research project:* Development of fluorophore labeled advanced generation pancreatic adenocarcinoma targeted conditionally replicative adenovirus (CRAd).

**Sam C. Wang, MD**, resident in neurosurgery, University of California–San Francisco.

*Research project:* Defining the contributions of pancreatic ductal and acinar cells to tumorigenesis.

**Isam W. Nasr, MD**, resident in surgery, University of Pittsburgh, Pittsburgh, PA.

*Research project:* Role of tertiary lymphoid organs in chronic allograft rejection.

The requirements for these research-oriented scholarships offered by the College for 2009 will be published in a later issue of the *Bulletin*. This information will also appear on the scholarships page of the College’s Web site at [http://www.facs.org/memberservices/research.html](http://www.facs.org/memberservices/research.html).

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**Faculty Research Fellowships awarded by College**

The American College of Surgeons Faculty Research Fellowships for 2008 were awarded by the Board of Regents in February. These two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and carry awards of $40,000 per year from July 1, 2008, through June 30, 2010.

Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College. The Franklin H. Martin, MD, FACS, Faculty Research Fellowship honors the founder of the College. The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico.

The recipients of these fellowships are as follows:

- **Franklin H. Martin, MD**, FACS, Faculty Research Fellow: **Jen Jen Yeh, MD**, assistant professor, University of North Carolina, Chapel Hill, NC.
  
  *Research project:* Identification and validation of targets associated with prognosis in pancreatic cancer.

- **C. James Carrico, MD**, Faculty Research Fellow: **Dr. Tsung**, assistant professor, University of North Carolina, Chapel Hill, NC.
FACS, Faculty Research Fellow: Allan Tsung, MD, FACS, assistant professor, University of Pittsburgh, Pittsburgh, PA.

Research project: High mobility group box-1: An endogenous alarm molecule in liver inflammation.

The Scholarship Endowment Fund of the American College of Surgeons was established in 1965 to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Members wishing to make tax-deductible gifts to fund these vital programs are encouraged to contact the Development Office at 312/202-5376.

Dr. Camins named AANS vice-president

Martin B. Camins, MD, FACS, clinical professor of neurosurgery at The Mount Sinai Hospital, an attending neurosurgeon at Lenox Hill Hospital, and a Regent of the American College of Surgeons, was named vice-president of the American Association of Neurological Surgeons (AANS) at its annual meeting in Chicago in April.

Dr. Camins has been a member of the AANS since 1980 and is a member of the bylaws, executive, finance, long-range planning, and professional conduct committees and the Neurosurgery PAC Board of Directors.

He received his medical degree from Chicago Medical School/University of the Health Sciences in 1969, followed by an internship in general surgery at New York University–Bellevue Medical Center in 1970. He completed his residency in neurosurgery at The Neurological Institute of New York, Columbia–Presbyterian Medical Center in 1975. During his residency, Dr. Camins was an International College of Surgeons Fellow at the National Hospital for Nervous Diseases, Queens Square, London, England. After his residency, he undertook a fellowship in electron microscopy at the department of neurosurgery, New York University–Bellevue Medical Center. Dr. Camins received the Distinguished Alumnus Award from Chicago Medical School in 1994.

Dr. Camins served on the executive committee of the Congress of Neurological Surgeons from 1985 to 1991 and was its vice-president in 1988. He is past-president of the American Academy of Neurological Surgeons and of the New York City Society of Neurosurgeons. Dr. Camins also is a member of the administrative committee of the World Federation of Neurological Surgeons and a member of the Neurosurgical Society of America and the Society of Neurological Surgeons.

In addition to being a Regent of the College, he served on the Executive Committee of the Board of Governors from 1992 to 1997 and as the Chair of the Advisory Council for Neurological Surgery from 1998 to 2001.

The AANS, which is dedicated to advancing the highest-quality neurosurgical care to the public, has more than 7,200 members worldwide.
The Executive Committee on Video-Based Education and Ciné-Med have developed the interactive Multimedia Atlas of Surgery. Each volume presents a comprehensive list of surgical procedures, featuring:

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EVMS and ACS launch medical simulation site

Eastern Virginia Medical School (EVMS), in conjunction with the American College of Surgeons, has developed a comprehensive database aimed at increasing general awareness of and collaboration in the emerging field of medical modeling and simulation (MMS) among product developers, medical professionals, and researchers.

The database, publicly available at www.medicalmodsims.com, includes more than 200,000 resources covering all aspects of the field of MMS that previously existed only in a diffuse network of information sources.

“The goal is to increase the use and quality of medical modeling and simulation,” said C. Donald Combs, PhD, associate dean for planning and health professions at EVMS. “We all have an interest in growing the field.”

MMS encompasses three main elements: the creation of models that with reasonable accuracy mirror reality, the analysis of such models, and the creation of simulators based on those models. It brings virtual reality from the realm of science fiction to the medical classroom and the operating room, and as the field has gained attention, the volume of research and development activity has gone up exponentially.

Seeing the potential to help the nascent sector, Dr. Combs and his colleagues compiled existing data that cover everything from research publications and convention proceedings to product details that address MMS. Bringing all this information to one user-friendly platform means that individuals beginning new projects don’t have to worry about duplicating work that’s already been done.

“People can really get a firm idea of what’s out there before they embark on their own project,” Dr. Combs said.

L. D. Britt, MD, FACS, chair of the EVMS department of surgery and Vice-Chair of the College’s Board of Regents, helped facilitate the partnership that allows the College to cosponsor the database, a move that fits with the ACS’ national leadership in promoting the use of MMS as a training tool to improve surgical practice.

“This database will be a vital resource for physicians, educators, and others interested in advancing the use of simulation in surgical and medical education,” said Ajit K. Sachdeva, MD, FACS, FRCS, Director of the ACS Division of Education. The driving principle behind the database’s development is to provide a central jumping-off point for new partnerships in MMS. Advances stemming from such partnerships are crucial in a world where the medical field is evolving constantly, thanks to advances that increasingly make technology such as machine-aided surgery a physical extension of the practicing surgeon. This reality demands new training possibilities for upcoming and practicing physicians, and the use of simulators for training, instead of actual patients, benefits patient safety.

The database can be searched using any of nine browse folders, including two that list articles preselected by health care profession or surgical specialty. Additional browse folders will be added as new areas of demand are identified.

As the database evolves over time, its creators hope to incorporate it into a broader Web site—including collective discussion features like forums and weblogs—to further foster collaboration between researchers and developers. Other goals include developing ways to describe research based on its quality and importance and creating research articles and presentations on high-priority simulators and procedures.
A look at The Joint Commission

Standards get an overhaul

Improved standards for several accreditation programs will be revealed next month and become effective in January 2009. The standards improvements include format and language changes as well as a refined decision and scoring process.

These changes affect the accreditation programs that are of relevance to surgeons, including the hospital, critical access hospital, office-based surgery, ambulatory accreditation, and home care accreditation programs.

The changes are a result of the Standards Improvement Initiative (SII), a comprehensive project launched in 2006 to assess The Joint Commission’s standards and ensure their relevance.

The improvement process resulted in the deletion of redundant and nonessential standards, language modifications to almost every standard and element of performance, the reorganization of the standards and elements of performance within the manuals, and the renumbering of the standards and elements of performance. No new requirements were added as a result of this initiative.

These changes will benefit health care organizations by making the standards, rationales, and elements of performance easier to interpret and employ and the manuals easier to navigate. Scoring will be simpler, and the decision process will more accurately reflect organizational performance related to safety and quality of care.

The improved standards will be posted in early July on The Joint Commission’s Web site and on the secure extranet site of each accredited organization. The standards will be posted with a comparison table showing what happened to the current standard, its new number, and, if applicable, how it changed. The standards and the comparison table will remain online until the print versions of the manuals are available in fall 2008.

Improvements to the standards for the behavioral health care, laboratory, and long-term-care accreditation programs are now under way. The changes to the scoring and decision process for these programs will go into effect in January 2009; however, the improved standards will not go into effect until January 2010.

The SII is part of The Joint Commission’s work to continuously assess its standards to ensure their relevance in a changing health care environment. The standards guide safety and quality of care efforts in more than 15,000 health care organizations nationwide.

ACS cosponsors K08/K23 NIH Supplement Awards

The American College of Surgeons has announced a program that will provide supplemental funding to up to five individuals who receive a National Institutes of Health (NIH) Mentored Clinical Scientist Development Award (K08/K23).

This award is directed at surgeon-scientists working in the early stages of their research careers. The award requires cosponsorship with an approved surgical society of a three-, four-, or five-year period of supervised research experience that may integrate didactic studies with laboratory or clinically based research.
This award program will offer a means to facilitate the career development of individuals pursuing careers in surgical research by enhancing salary support over and above that offered by the K08/K23 mechanism.

The application deadline is June 12, 2008, with funding to begin July 1, 2009. Applications are made by submitting a copy of the NIH application to the College.

Awardees must be members in good standing of both the College and the cosponsoring surgical society.

Participating surgical societies include the American Association of Plastic Surgeons, American Head and Neck Society, American Society of Transplant Surgeons, American Vascular Association, Society of Gynecologic Oncologists, Society of University Surgeons, and Thoracic Surgery Foundation for Research and Education.

For more details, contact Kate Early, ACS Scholarships Administrator, at kearly@facs.org.

The American College of Surgeons Division of Education presents the Personal Financial Planning and Management Course for Residents and Young Surgeons, which uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children) and proper planning for financial stresses related to their surgical practice.

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

- Fellows of the American College of Surgeons: $120
- Non-Fellow: $215
- RAS member: $75
- Surgical resident, not a RAS member*: $95

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

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

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

For more information contact Olivier Petinaux, MS, at elearning@facs.org, or tel. 866/475-4696
The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

The objective of the course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications.

- Replaces the basic course offered by the American College of Surgeons.
- A printable CME certificate is available upon successful completion.
- CD will install the necessary software (PC or Mac).
- The learner is offered two attempts to pass a multiple-choice exam with a minimum score of 80% at the completion of the program.
- Residents must submit a letter from their director/chair to document residency status.
- Only one user per CD is allowed. Online access is needed to register the CD and to take the exam.

$300 for nonmembers
$225 for Fellows of the American College of Surgeons
$125 for residents with letter proving status*
$90 for Resident and Associate Society (RAS) members
(Additional $16 for shipping and handling of international orders)

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

The CD can be purchased online at http://www.acs-resource.org or by calling Customer Service at 312/202-5474.

The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this educational activity for a maximum of four AMA PRA Category 1 CME Credits™ toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity. The American Medical Association has determined that physicians not licensed in the U.S. who participate in this CME activity are also eligible for AMA PRA Category 1 CME Credits. ™
NTDB® data points

Repeal Prohibition

by Richard J. Fantus, MD, FACS

Alcohol—a chemical that is made by fermentation, distillation, chemical modification, or chemical combinations—has been a perpetual part of life. Alcohol dates back to 4200 BC, where fermentation scenes appear on Mesopotamian pottery. For a brief period in U.S. history—that is, Prohibition (1920–1933)—its sale was illegal. As most know, this experiment in social behavioral modification was a failure.

In past “NTDB data points” articles published in the Bulletin the presence or absence of alcohol was mentioned when discussing various types of injuries. Anyone who works in a trauma center is all too aware of the association between alcohol and injury. If one were to type the words “alcohol-related trauma” into an Internet search engine, more than 1.8 million results would appear. Why is alcohol so prevalent in our trauma centers?

Furthermore, what can we do to reduce this public health problem? What is our obligation as health care providers to interrupt this cycle of alcohol and injury?

In order to examine the occurrence of alcohol-related trauma in the National Trauma Data Bank® Dataset 7.0, records were searched by the field “alcohol present in blood.” There were 912,356 records that contained a usable response of alcohol present or not present. The remaining 949,423 records did not mention alcohol testing or provide a definitive response. There were 230,333 records with alcohol present and 682,023 records with no alcohol present.

Of the alcohol present group, 639,301 records had discharge status recorded, including 470,132 discharged to home, 83,496 to acute care/rehabilitation, and 47,037 to nursing homes; 33,026 died and 5,160 went to jail. In the alcohol present group, patients were 80.5 percent male and on average 35.9 years of age with an average length of hospital stay of 5.8 days, an average injury severity score of 11.5, 15.8 percent penetrating trauma, and 26.9 percent self-pay.

Of those also tested for drugs, more than half tested positive. These data are compared with the group with no alcohol present and are displayed in the graph on this page.

Before reviewing these data, this author would have expected a higher positive alcohol rate. However, there has been a decrease in willingness to test for alcohol as a result of insurance companies enforcing the Uniform Accident and Sickness Policy Provision (UPPL) law, which allows these companies to deny payment of medical bills for injuries sustained while intoxicated or under the influence of a controlled substance.

There have been significant efforts made on a state-by-state basis to repeal the UPPL, but as of press time only 13 states and the District of Columbia explicitly prohibit the denial of claims based on the insurer’s intoxication level. Not only does the UPPL law reduce testing but...
it may also hinder health care providers from performing the necessary screening and intervention efforts needed to break the cycle of alcohol and injury. The American College of Surgeons Committee on Trauma feels so strongly about this important initiative that it now requires screening in level I and II trauma centers as well as brief intervention capabilities in level I trauma centers.

For more information on available sponsored programs, go to http://www.facs.org/trauma/injmenu.html and click on Alcohol Screening and Brief Intervention (SBI). SBI is important and should take place in all centers for alcohol-related trauma cases. We should not succumb to the pressure of UPPL. In fact, we should repeal the prohibition of payment by insurance companies in cases of alcohol-related injury.

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

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

Acknowledgment

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

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

So, You Want to Be a Surgeon...

Medical student guide to residency training

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

http://www.facs.org/residencysearch

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

For further information, contact Elisabeth Davis, MA, Education Research Associate, Division of Education, at 312/202-5192, or via e-mail at edavis@facs.org.
Recognizing the goal of offering members of the American College of Surgeons and affiliated organizations a reasonably priced investment product, the expense ratio of the College’s Surgeons Diversified Investment Fund (SDIF) has been lowered to just over 1%. The lower expense ratio will have an immediate positive impact on our shareholders, and, over time, will positively impact the performance returns for prospective and current shareholders. The new expense ratio, including ETF costs, is 1.08%.

Moving forward, all current and prospective investors will have the ability to invest at a lower cost in a no-load, open-end, diversified, actively managed mutual fund. SDIF is broadly modeled after the ACS’s endowment utilizing the same investing principles of asset allocation, diversification and rebalancing.

For more information about SDIF, please contact Tom Kiley at 312/202-5019, tkiley@facs.org, or Savi Pai at 312/202-5056, spai@facs.org.
Chapter news

by Rhonda Peebles, Division of Member Services

Peru cosponsors IV Congress

The Peru Chapter served as a cohost of this year’s IV Congress, which was held March 7–8 in Lima. According to Eduardo Barboza, MD, FACS, the Chapter’s Governor, more than 600 surgeons from Peru and adjacent countries attended the educational event, and there were 11 international faculty members. Randolph H. Bailey, MD, FACS, a Regent of the College, presented three lectures on colon-rectal surgery, and he provided an update on the College’s activities with the Peru Chapter members (see photo at right).

Chapter anniversaries

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<td>May</td>
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<td>Maryland</td>
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South Texas Chapter meets in Houston

The South Texas Chapter held its 2008 annual meeting in Houston, February 28–March 1. The

*Denotes Associate or Resident Membership in the College.
opening session was the Young Surgeons Forum, which featured the College’s Executive Director, Thomas R. Russell, MD, FACS, and Adam Cohen, MD, FACS, a member of the College’s Committee on Young Surgeons.

Also, the preliminary round for the chapter’s Surgical Jeopardy Bowl was conducted; the winning team this year was from Methodist Hospital (see photo, page 50). On February 29, the chapter hosted a poster competition; the winning poster among the 14 entries, presented by Ricardo Alvarado, MD,* was entitled Burn Resuscitation of Severely Burned Military Casualties: Fluid Begets More Fluid (see photo, page 50).

In all, this year’s program featured sessions on trauma and surgical critical care, gastrointestinal surgery, surgical oncology, vascular surgery, and “surgical potpourri.”

**SDIF welcomes chapters’ participation**

In 2006, the College established the Surgeons Diversified Investment Fund (SDIF)

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**Chapter meetings**

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

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

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<th>Date</th>
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<td><strong>July 2008</strong></td>
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<td>July 11–13</td>
<td>South Carolina and North Carolina (CS)</td>
<td>Location: Wild Dunes Resort, Isle of Palms, SC&lt;br&gt;Contact: Debbie Shealy, 803/798-6207, <a href="mailto:debbie@scmanet.org">debbie@scmanet.org</a>&lt;br&gt;ACS representative: Thomas R. Russell, MD, FACS</td>
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<td><strong>August 2008</strong></td>
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<td>August 7–9</td>
<td>Idaho and Montana/Wyoming (CS)</td>
<td>Location: TBA, Cody, WY&lt;br&gt;Contact: Sara Hartsaw, MD, FACS, 307/682-7555, <a href="mailto:shartsaw@vcn.com">shartsaw@vcn.com</a></td>
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<td>August 19–22</td>
<td>Colombia</td>
<td>Location: Convention Center, Bogota, Colombia&lt;br&gt;Contact: Francisco Henao, MD, FACS, 571/236-2831, <a href="mailto:fhenao@javeriana.edu.co">fhenao@javeriana.edu.co</a></td>
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<td>August 22</td>
<td>Oklahoma</td>
<td>Location: TBA&lt;br&gt;Contact: Jeffrey S. Bender, MD, FACS, 405/271-5781, <a href="mailto:jeffrey-bender@ouhsc.edu">jeffrey-bender@ouhsc.edu</a>&lt;br&gt;ACS representative: Thomas V. Whalen, MD, FACS</td>
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<td>September 6–7</td>
<td>Kansas (CS)</td>
<td>Location: Airport Hilton, Wichita, KS&lt;br&gt;Contact: Gary Caruthers, MBA, 785/235-2383, <a href="mailto:gcaruthers@kmsonline.org">gcaruthers@kmsonline.org</a></td>
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<td>Location: Crowne Plaza, Little Rock, AR&lt;br&gt;Contact: Linda Clayton, 501/526-7053, <a href="mailto:claytonlindaa@uams.edu">claytonlindaa@uams.edu</a></td>
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<td><strong>October 2008</strong></td>
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<td>October 26</td>
<td>Connecticut (CS)</td>
<td>Location: Holiday Inn Select, Waterbury, CT&lt;br&gt;Contact: Christopher Tasik, 203/674-0747, <a href="mailto:info@CTACS.org">info@CTACS.org</a></td>
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to serve as an investment vehicle for the College’s U.S. members. Since then, participation has been extended to various tax-exempt organizations—including the College’s chapters. So far, four chapters—Alabama, Ohio, Virginia, and West Virginia—have begun participation, and it is anticipated that the Arizona Chapter will be participating soon. For more information about the benefits of chapters’ participation in SDIF, contact the staff at 800/208-6070 or send an e-mail to info@surgeonsfund.com.

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

SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246; 513/587-3400.

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**Operation Giving Back**

**Volunteer opportunities available**

A Disaster Response Toolkit has been added to the Operation Giving Back (OGB) Resource Center. This toolkit provides access to several Web sites featuring general disaster response information, resources created by the American College of Surgeons Committee on Trauma, and information on existing disaster response mechanisms. The following are examples of some of the resources currently available:

- **Relief Web**: Time-critical humanitarian information on emergencies and natural disasters
- **Center for Excellence in Disaster Management and Humanitarian Assistance**: Promotes effective civilian-military management in international humanitarian assistance, disaster response, and peacekeeping via education, training, research, and information programs
- **ACS Statement on Disaster and Mass Casualty Management**
- **AMA Center for Public Health Preparedness and Disaster Response**: An educational resource for enhancing disaster preparedness and response capabilities
- **Disaster Management Assistance Teams**: Nationally deployable, rapid-response units
- **Medical Reserve Corps**: Community-based units that supplement local emergency and public health resources
- **The Uniform Emergency Volunteer Health Practitioners Act**: Legislation currently being considered in many states; it would establish uniformity in credentialing of disaster responders to facilitate response across state lines and address licensing and liability concerns
- **ESAR-VHP**: A system of state-based electronic databases of health care personnel eligible to volunteer to provide aid in declared emergencies
- **The Sphere Project**: Focused on improving the quality of assistance provided to people affected by disasters and enhancing the accountability of humanitarian disaster response systems

Additional resources and programs will be added to this toolkit as appropriate; contact OGB with any suggestions.

You can view all of the current resources on disaster response and a variety of other topics on the OGB Web site at www.operationgivingback.facs.org.