The coming era of too few physicians
FEATURES

The coming era of too few physicians
Richard A. Cooper, MD

The impact of transparency on patient safety and liability
F. Dean Griffen, MD, FACS

Risk management programs: A means to lower premiums
Melinda Baker

DEPARTMENTS

From my perspective
Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

From my perspective: Guest column
The practice of general surgery today requires growth and adaptability
Paul H. Lin, MD, FACS

Dateline: Washington
Division of Advocacy and Health Policy

What surgeons should know about...
Chartered value exchanges
Caitlin Burley

On the cover: The 2007 American Urological Association lecturer addresses the potential problem of a physician shortage considering the projected demand (see article, page 11). (Photo courtesy of Punchstock.)
NEWS

College publishes consumer book on the surgical experience 27

ATLS® extends reach to Pakistan 29

Connecticut COT to host conference in April 31

COT honored with CDC injury prevention award 31

Disciplinary actions taken 33

CoC conference scheduled for July 34

Specialty board reports available on Web portal 34

Letters 36

A look at The Joint Commission: Study examines preoperative nursing assessments for ASCs 39

ACOSOG news: Measuring national surgical and medical opinions of a clinical trial idea 41

David M. Ota, MD, FACS; and Heidi Nelson, MD, FACS

NTDB® data points: 60-something 43

Richard J. Fantus, MD, FACS

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.
From my perspective

Having been out of practice for more than eight years now, I understand that some members of our profession may believe that I am no longer in touch with the day-to-day hassles and worries of running a practice in this century. While it is true I no longer play a hands-on role in patient care or practice management, I make sure to stay abreast of many concerns within the surgical community through my participation in ACS chapter meetings, national and regional conferences, and one-on-one conversations with College members.

Many surgeons use these opportunities to voice their frustrations with reimbursement, workforce, liability, and other socioeconomic issues. Other surgeons, however, share their experiences in trying to adapt and make the most of the evolving health care climate.

In the September 2007 issue of the Bulletin (pages 4-5), a rural surgeon, Kent Kessler, MD, FACS, wrote a guest “From my perspective” column at my request about the strategies he and his colleagues in Kentucky are implementing to cope with the challenges they are facing. Based on the positive response to this guest columnist experiment, I have decided to periodically use my space in this publication as a venue for practicing surgeons to present their ideas about how to maintain a financially and professionally rewarding career in this time of transition.

This month, I have asked Paul H. Lin, MD, FACS, a general surgeon in Spokane, WA, to discuss the changes he has witnessed in the course of his 15 years of private practice in a metropolitan location. In his commentary, which appears on pages 4-5, Dr. Lin shows how the composition of the surgeon population in Spokane has become more specialized. He discusses how his small group practice merged with two others to create one stronger and more diverse general surgery group. In addition, Dr. Lin explains how he and his colleagues have helped the city avert an emergency workforce crisis while simultaneously improving their lifestyles by creating a surgeon-hospitalist program.

These are some of the fresh, forward-thinking concepts that surgeons are most likely going to need to develop and implement in the coming years. Although many of us are understandably reluctant to change the way we do things, many signs are pointing to the fact that change may well be inevitable, making it difficult to maintain the status quo. As Dr. Lin’s experience shows, by coming together, surgeons can help each other succeed and find ways to maintain a viable and healthy practice.

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.
The practice of general surgery today requires growth and adaptability

by Paul H. Lin, MD, FACS

I have rarely reflected on the changes that have occurred in my general surgery practice in Spokane, WA, over the past 15 years. Frankly, we didn’t seem to be doing anything extraordinary. Then I met Thomas R. Russell, MD, FACS, ACS Executive Director, last fall at the annual banquet for the Henry Harkins Surgical Society, and I mentioned that my small general surgery group practice had recently merged with two other surgical practices, resulting in the formation of a 13-member group. Dr. Russell seemed intrigued by what we had done and asked me to elaborate on some of the changes in surgical practice that I have witnessed in the course of my surgical career. Some of these observations may be useful to other general surgeons who are trying to sustain their practices during this time of transition in our specialty.

The early years

I finished my surgical training in 1992 at the University of Washington and decided to go into private practice, joining a group of four other general surgeons in Spokane. The few surgeons in town who had completed specialty fellowships after completing general surgery residencies were vascular surgeons.

Given these circumstances, within the first week of practice, I had the opportunity to perform a redo thyroidectomy, an abdominal-perineal resection, and an axillary-bifemoral bypass for a mycotic aortic aneurysm. Surgeons in our small group were expected to competently provide the whole spectrum of general surgery services. Some of the surgeons in my group also performed vascular surgery, J-pouches, Whipples, and advanced laparoscopic procedures. In terms of physical resources, we had our own stereotactic breast biopsy machine. I thought I had hit the clinical goldmine.

Changing environment

In the past 15 years, numerous general surgeons with fellowship training have migrated to Spokane. We now have two colorectal surgeons, three surgical oncologists, two laparoscopic surgeons, and two full-time breast surgeons (one of whom is fellowship trained) in the area. As a result, I handle fewer breast and colon cases and no longer offer vascular services. Instead, I have learned to do advanced laparoscopic procedures.

Another transformation occurred three years ago, when the merger mentioned previously took place. Five of the 13 surgeons in our expanded practice are fellowship trained. We share call, so everyone does some “general surgery.” We allow surgeons to carve out niches in their practice, but we have a generous revenue-sharing plan to prevent turf battles. We share patients liberally and frequently use surgeon availability as a basis for assigning post-call cases.

The formation of our large group and our on-call policies came at an opportune time, given the trauma and emergency call crisis plaguing so many cities. Although the number of surgeons in this area is adequate for our patient base, the four area hospitals all want 24/7 coverage of their emergency department (ED). In addition, Spokane has a level II trauma service that the two large downtown hospitals share. This situation really stretched the call pool quite thin.

Hospitalist program

To address this situation, last fall we started a surgical hospitalist program with the four hospitals in town. Because these institutions are components of two hospital systems, when participants in the hospitalist program take call, we cover two EDs, provide trauma services, and do inpatient consults. We do not schedule office visits or elective procedures during these times. This arrangement ensures that two surgeons...
always are available to take call. In return, they receive a stipend from the institutions for each day of on-call duty.

The surgical hospitalist program has proven to be a win-win situation for the surgeons, the hospitals, and our patients. Providing ED coverage has always interfered with surgeons’ ability to maintain an active elective caseload. Under this arrangement, we no longer have to cancel patients if a trauma case rolls in, nor do we have to wait until the end of the day to do an appendectomy. This arrangement has taken a perceived liability and turned it into a lifestyle-improving revenue source. Furthermore, patients are able to undergo urgent operations in a timely manner, and the operating room schedule is more efficient. Patients also have greater access to subspecialists, such as surgical oncologists, who no longer are required to take emergency call.

Making this system work takes a critical mass of surgeons as well as ED volume. Hospitals are more likely to consider having practicing surgeons in the community serve their patients palatable than trying to hire their own surgeon-hospitalist staff. And, despite all the grumbling from general surgeons about the hassles associated with taking ED call, the fact of the matter is that 20 percent to 25 percent of our patients come to us through the ED.

**Conclusion**

In retrospect, it seems that the changes that have occurred in my practice specifically over the past 15 years really are reflective of the changes that have been taking place in general surgery as a whole. Like other general surgeons, I no longer provide what once was considered the full scope of general surgery services. I now play the role of surgical hospitalist four to five days each month. Nonetheless, my lifestyle is better than ever, although I do miss being a general surgeon in the broadest sense of the term.

These trade-offs are the compromises that practicing general surgeons now face. Likewise, forward-thinking residents must now decide whether to specialize and practice in an urban environment, to be an acute care surgeon with a limited scope of practice, or to be a general surgeon in the broadest sense and practice in a rural location. Perhaps the greatest irony is that soon general surgeons who want to practice the way their predecessors did 60 years ago will be the ones who need to complete a fellowship.

Although change is often a disconcerting and sometimes difficult process, the members of our group practice believe that the modifications we’ve made have allowed us to continue to serve our patients well and establish a viable and positive practice for ourselves.

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**Dr. Lin** is a general surgeon in Spokane, WA.

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MedPAC supports 1.1 percent pay increase

On January 10, the Medicare Payment Advisory Commission (MedPAC) recommended a 1.1 percent increase in Medicare physician payments for 2009. MedPAC arrived at this figure by subtracting the expected growth in productivity (1.5%) from the expected acceleration in price inputs (2.6%). The recommendation also calls for Congress to pass legislation allowing Medicare to confidentially report back to physicians about their resource use. For more information, go to http://www.medpac.gov.

At this point, because of the stopgap measure that Congress passed late last year, Medicare physician payments are 0.5 percent higher in 2008 than in 2007. However, without further congressional action, Medicare payments to physicians will be reduced by approximately 10.6 percent beginning July 1. For details about the stopgap legislation, which President Bush signed on December 29, 2007, see “Dateline: Washington” in the February 2008 issue of the Bulletin (page 6).

CMS delays anti-markup rule

On December 28, 2007, the Centers for Medicare & Medicaid Services (CMS) announced that it will delay implementation of the expansive “anti-markup rule” until January 1, 2009. The anti-markup rule, promulgated in the 2008 Medicare physician fee schedule, prohibits physicians from billing for any diagnostic test performed outside of the office where the patient received most of his or her related care. More specifically, the rule limits the payment a physician can receive for technical and professional services purchased from outside suppliers.

In response to harsh criticism from physician groups, CMS indicated it had decided to study the issues further and delay the effective date of the anti-markup provisions. During this delay period, CMS intends to issue clarifying guidance as to what constitutes the office of the billing physician or other supplier, propose additional rulemaking, or both. Surgeons should be aware that the delayed effectiveness of the anti-markup rule does not apply to anatomic pathology diagnostic testing services furnished in a location that meets the following conditions: it is used by a group practice as a “centralized building” for purposes of complying with the Stark rules and does not qualify as a “same building” under the Stark rules. For more information, visit http://a257.g.akamaitech.net/7/257/2422/01jan20081800/edocket.access.gpo.gov/2008/pdf/07-6280.pdf.

Part B claims must include NPI

CMS has announced that effective March 1, Medicare Part B fee-for-service claims must include a National Provider Identifier (NPI) in the primary provider fields. These fields pertain to the billing, pay-to-provider, and rendering physician’s information. Surgeons may continue to submit NPI/legacy pairs or only their NPI. Secondary providers (that is, referring, ordering, and supervising physicians) may continue to include only their legacy numbers, if they choose. Failure to submit a NPI in the primary provider fields will result in claims rejection beginning March 1. For more information, go to http://www.trailblazerhealth.com/.
To better protect Medicare beneficiaries’ personal information and prevent fraud, CMS is instructing contractors to omit the Health Insurance Claim Number (HICN) from Medicare Summary Notices (MSNs). Since January 7, contractors have been told to replace the first five numbers of the HICN with Xs on all MSNs. If Medicare eligibility cannot be established, administrative contractors and carriers are to return the claim to the provider as “unprocessable,” using reason code 140, and not mail a MSN.

According to CMS, MSNs enable identity theft and fraudulent claims. More specifically, the agency says that when a beneficiary’s name and HICN do not match on a claim, the contractor denies payment and sends a MSN to the beneficiary. These MSNs may also include personally identifiable information and, if they arrive in the wrong hands, open the door to identity theft and fraud. To read the transmittal (1399), go to http://www.cms.hhs.gov/transmittals/downloads/R1399CP.pdf.

On December 31, the Georgia Alliance of Community Hospitals and the Georgia Hospital Association filed a lawsuit against the Georgia Board of Community Health and Albany Surgical PC. The hospital groups filed the complaint soon after the state’s Board of Community Health officially adopted rules amending Georgia’s Certificate of Need (CON) requirements for ambulatory surgical centers. Under the adjusted language, general surgery is recognized as a single specialty for purposes of applying for an exemption from the CON process. The board’s decision culminated months of comment, including a public hearing featuring extensive testimony from the Georgia Chapter of the ACS, the College, and other surgical and medical organizations. The amendment had also gained the support of the state’s governor.

The fact that Albany Surgical PC is named in the lawsuit is essentially viewed as an attack on Georgia surgeons for the regulatory actions of a government body. With considerable political antagonism and hostility surrounding the entire CON process, it is likely that the state legislature will need to get involved during the 2008 session. For more information, contact Jon Sutton at jsutton@facs.org.

In February, College members with access to e-mail should have received the first two editions of Advocacy in Action, a new electronic newsletter. This monthly publication is designed to provide brief overviews of the activities in Washington, DC, carried out by the College’s Division of Advocacy and Health Policy, the organization’s leadership, and the American College of Surgeons Professional Association. The inaugural issue encapsulated advocacy efforts in 2007, and the first regular edition summarized activities that occurred at the beginning of this year. Typically, Advocacy in Action will be published on the third Monday of each month. Because this e-newsletter will provide ACS members with the most up-to-date information about College-related activities in Washington, beginning in April, the “Dateline: Washington” column in the Bulletin will be reduced to one page. For more information on Advocacy in Action, contact the Division of Advocacy and Health Policy at ahp@facs.org.
Chartered value exchanges

by Caitlin Burley, Quality and Regulatory Assistant, Division of Advocacy and Health Policy

Massachusetts Health Quality Partners (MHQP) has developed an online tool for consumers to review comparative data on providers. Using patient experience surveys for physicians’ offices and clinical data for medical groups, MHQP allows consumers to compare results across the state of Massachusetts. As a whole, MHQP—a collaboration of physicians, hospitals, health plans, purchasers, consumers, and government agencies—has been recognized by the U.S. Department of Health and Human Services (HHS) as a community leader, a major step toward becoming classified as a chartered value exchange under the department’s Value-Driven Health Care Initiative.

Soon, if not already, community leadership groups similar to MHQP likely will be organizing in your region. This article explains why this phenomenon is occurring and why you should consider participating in these collaborative organizations.

What spurred the development of the HHS’ Value-Driven Health Care Initiative?

In August 2006, President Bush signed an Executive Order for Health Care Transparency, which became effective in January 2007. This order mandates that federal health care agencies carry out the following activities: disclosing information regarding prices and quality of health care services, promoting the use of health information technology (IT) to increase data sharing, and developing programs to increase the quality and efficiency of care. The objective of the transparency order is to allow consumers to compare the cost and quality of services and evaluate overall value of care that individual institutions and physicians provide so they can make informed decisions.

What are the key elements of the initiative?

The Value-Driven Health Care Initiative was launched by HHS Secretary Michael Leavitt in response to the President’s mandate. This program centers on the following four cornerstones of value-driven care: interoperable health IT, measurement and dissemination of quality information, measurement and publication of price information, and promotion of quality and efficient care.

The first of these four pillars, the development of interoperable health IT, is critical to the success of the transparency initiative. Key stakeholders and health policymakers believe that interoperable health IT will affect health care in positive ways similar to advances that have occurred in the banking industry since the switch from paper to online billing occurred. They believe that enhanced health IT will reduce the time for reviewing test results and patient history and decrease the chance of human error by reducing opportunities for information to get lost. However, an electronic health care industry needs a strong financial foundation and principals and standards to ensure security, privacy, and accuracy. The American Health Information Community was created to help develop and implement these standards, including a certification process for health IT products. HHS’ objective is to link providers and payors throughout the U.S., supplying a pool of data that will ultimately measure cost and quality for the Value-Driven Health Care Initiative.

The second cornerstone—measurement and dissemination of quality information—will allow consumers to have access to information about quality of care before making important health care decisions. Increasingly, consumers are being encouraged by their employers and their health plans to explore provider options and quality rankings and to take on a greater role in their own health care decision-making. Until recently, however, information that would be useful in making these decisions had been unavailable to the public. HHS’ quality measurement initia-
tives are premised on measures developed by consensus-based organizations, including the AQA and the National Quality Forum. To date, most of the work on development of quality measures has focused on chronic care and preventive services. As a result, efforts to develop surgical quality measures and reports that provide meaningful information to consumers are still in their infancy.

Measurement and publication of price information—the third component of the initiative—is intended to ensure that patients are aware of costs before receiving treatment. However, this activity is more easily said than done. In order to effectively measure, control, and publish such information, it is necessary first to define the services that are paid for and the cost of those services. But in health care, costs are split across payors, providers, and patients, making this task extremely complicated. As the first step in this process, the Centers for Medicare & Medicaid Services (CMS) has published payment and cost information for specific and widespread procedures. The pricing information is classified by hospital, state, country, and procedure. These two pieces—measuring and reporting both quality and cost—are the building blocks for defining value and efficiency.

The fourth and final element is the promotion of quality and efficient care. This component provides incentives for medical centers and professionals that provide high-quality, economically priced health care for the patients who purchase it. These incentives include financial rewards for providers who offer this care and for consumers who select those providers. Consumer-directed health plan products, popular with large employers today, are an example of how this approach may be applied. HHS’ stated goal is to stimulate competition throughout the health care industry based on quality and efficiency.

How is the Value-Driven Health Care Initiative being implemented at the community level?

To put the initiative into action in the marketplace, HHS has launched the development of chartered value exchanges. Through three new programs, HHS expects to increase the quality and lower the cost of health care. These programs include the Better Quality Information (BQI) for Medicare Beneficiaries Projects, Community Leaders for Value Driven Health Care, and value exchanges. These three programs can be seen as stepping-stones, each building on the previous one until the U.S. has a network of value exchanges in every major community and region.

The BQI for Medicare Beneficiaries Project was funded by CMS in 2007 and involves six regional collaboratives chosen as pilot sites. These sites are operating as learning laboratories, helping to establish methods of combining private sector and Medicare claims data into a single community-wide quality report. The results of these efforts will be beneficial to physicians, allowing them to view performance information for Medicare beneficiaries and, thus, improve their quality of care. BQI pilot sites include the following: the MHQP, the California Cooperative Healthcare Reporting Initiative, the Indiana Health Information Exchange, Minnesota Community Measurement, Arizona State University–Center for Health Information & Research, and the Wisconsin Collaborative for Healthcare Quality.

Value exchanges are viewed as the ultimate vehicle for the implementation of value-based health care. A value exchange is defined on the HHS Web site (www.hhs.gov) as “a multi-stakeholder collaborative that has taken clear action in its community to convene community purchasers, health plans, providers, and consum-

Resources

- For more information on value-driven health care, visit http://www.hhs.gov/valuedriven/index.html
- For more information on the BQI pilots, visit http://www.hhs.gov/valuedriven/pilot/index.html
- To see who the designated community leaders in your area are, or to apply to become a community leader, visit http://www.hhs.gov/valuedriven/communities/communityleaders/communities.html
- To apply to become a chartered value exchange, download the application and instructions at http://www.ahrq.gov/qual/value/chartered.htm
ers to advance the four cornerstones of Value-Driven Health Care.” The first step to becoming a chartered value exchange is to be recognized as a community leader by the Secretary of HHS. A community leader must demonstrate the following:

- Active engagement with all stakeholders in the community
- Collaboration with stakeholders for information exchange
- Ability to serve as an independent nonprofit organization with experience
- Financial stability
- Collection of provider-level measurement across the Institute of Medicine domains
- Effective public reporting efforts using performance measures
- Rewards for performance improvements
- Use of interoperable health IT
- Continuing evaluation and improvement efforts

To date, the HHS Secretary has recognized 110 community leaders. Community leaders reflect the extensive diversity of health care markets throughout the U.S. Each area has unique marketplace and cultural health care characteristics, exemplifying the need for strong collaborative leaders in each community.

Once HHS recognizes an organization as a community leader with shared collaboration among purchasers, health plans, providers, and consumers, it may apply to become a chartered value exchange. HHS certifies new value exchanges every six months. At press time, the first round of applications (more than 30) was under review.

What exactly is a chartered value exchange, and why would I want to be part of one?

The value exchange continues its functions and roles as a community leader with continual modification and improvement, but participation has added benefits. A value exchange adapts the national efforts to a local effort. It allows a community to develop its own board to direct quality, reduce waste, and create safe and affordable care. A true value exchange has a balance of community leaders in purchasers, payors, providers, and patient advocates. Acting as the oversight board, the value exchange can provide population-based studies to determine the best health and health care needs for the community.

Members of a value exchange can access the Learning Network. Sponsored by the Agency for Healthcare Research and Quality, this network plays a valuable role in promoting health care reform by evaluating methods within the value exchanges and encouraging change through sharing of evidence-based best practices from other value exchanges across the country. Quality initiatives developed in one part of the country will be available for other chartered programs to use in their own environment. Another benefit of chartered value exchange membership is that it includes access to summaries of Medicare provider performance data, which may be helpful in determining provider performance across all payors in a market.

Many organizations throughout the U.S. are in the process of becoming community leaders and chartered value exchanges. The American College of Surgeons encourages its members to look for such groups and to become involved in these efforts at the earliest possible opportunity. There are tremendous political forces at work to propel the development of value exchanges. Surgeons must be part of the development to ensure that their role in the medical community and in the overall care of the surgical patient is appropriately recognized and rewarded.
The coming era of too few physicians

by Richard A. Cooper, MD
Editor’s note: This article is an edited version of Dr. Cooper’s American Urological Association (AUA) Lecture presented at the 2007 Clinical Congress in New Orleans, LA.

It was an enormous honor for me to be the 2007 AUA lecturer and to have the opportunity to address the College and its many distinguished guests.

I felt not only personally honored but profoundly pleased that the College had chosen that moment in time—the beginning of its 93rd Clinical Congress—to address the important problem of physician shortages. It continues the College’s long-standing commitment to this issue.

The coming era of too few physicians is a disturbing topic—one that requires action. My hope is that each of you will take action to reduce the severity of these shortages.

Demand for physicians

It is important to frame the need for physicians in the context of the major forces that drive demand. Figure 1 on page 13 depicts the close relationship that has existed for more than 70 years between the number of physicians per capita and the level of economic growth, as indicated by the nation’s gross domestic product (GDP), expressed in per capita terms.

With ever-expanding possibilities for beneficial services—and with an insatiable appetite for health care among the public—it is the level of economic growth that ultimately determines how much health care the nation can afford, and it is the amount of health care that the nation is able to purchase that determines the demand for physicians. This relationship between economic growth and the demand for physicians is key in understanding how many doctors we will need to train for the future.

Figure 1 notes that this relationship held throughout the period of more than 70 years depicted here—except for the years after World War II, when there were fewer physicians than would have been predicted by the level of GDP, and that, of course, was the last physician shortage. In response, medical schools were built and residency programs were expanded, and the supply of physicians subsequently increased. Physician supply overshot a bit in the 1990s, which allowed managed care to exert leverage, but that was short-lived, and balance was achieved by century’s end.

The straight-line projection of future demand in relation to GDP assumes that the economy will continue to grow and that the underlying principles that have governed the relationship between economic growth and growth in the demand for health care will persist. Furthermore, this projection assumes that this same dynamic will create an increasing demand for physicians. Nothing on the horizon seriously challenges these assumptions.

The problem is that there will be too few physicians to meet this projected demand. Considering factors such as the aging of the physician workforce, the fact that many more women are becoming physicians, the added emphasis physicians now place on lifestyle, the effect of duty-hour restrictions, and the fact that more physicians are following nonclinical paths, it becomes apparent that the “effective supply” of physicians will be even less (see Figure 2, page 13).

Putting all of this together spells a shortage...
of approximately 200,000 physicians in 2020 or 2025, roughly 20 years from now. That amounts to approximately 20 percent too few physicians. But you don’t have to wait until then: Evidence abounds that we are already in the early stages of a deepening shortage. The evidence includes longer waiting times for patients, longer referral times for physicians, difficulties in recruiting physicians, and increased salaries and bonuses for new physicians.

**Effects of physician shortage**

Physician shortages are promoting a restructuring of clinical practice. Hospitalists, and now proceduralists, cover defined segments of care. Primary care physicians are setting up concierge practices. The shortage of intensivists has spawned remotely monitored intensive care units. Teleradiology has become common. And locum tenens has become more popular, as hospitals seek to fill the gap and as doctors seek more structured time.

The problem of adequate coverage for emergency rooms has led to the widespread practice of compensating physicians in certain specialties in order to ensure their availability. In a recent legal opinion that essentially condoned this arrangement, the Office of the Inspector General cited scarcities in specialties such as general surgery, neurosurgery, orthopaedics, urology, otolaryngology, cardiology, gastroenterology, neurology, hematology/oncology, and obstetrics/gynecology.

Other professions are responding to the physician shortages too, and necessarily so. For example, nurse practitioners are moving up the professional ladder by training at the doctoral level, and physician assistants are evolving to higher levels by undertaking specialty training.

**Economics and quality care**

Flowing from the old adage that necessity is the mother of invention, physician shortages have spawned new businesses, such as medical tourism and retail clinics. Entrepreneurs abroad and at home see new opportunities, and more of the same is sure to come, all in the name of making more care available to more people.

But is that approach wise? Is additional health care worthwhile? Is what we do of value?

The usual answer is, “Yes.” Having more physicians and having the advances in health care that physicians provide are generally viewed as worthwhile. We have seen major increases in cancer survival—more than 10 million cancer survivors are alive today—and major decreases in mortality from heart disease. Life expectancy has increased, and at the same time adult disability has decreased. The result is longer and more
the total number of jobs in 2007 had increased by more than 1 million—an 8 percent increase—and more than one-third of these jobs were in health care. It’s not simply that the growth of health care services depends on economic growth, as I explained previously. To an increasing degree, health care is the economy. It’s not only what people want—it’s what people do.

Yet, not everyone agrees that more health care is better. For example, a large and prominent body of work from Dartmouth Atlas project concludes that “states with higher Medicare spending and more specialists have poorer quality health care.” That idea is a terrible indictment of what we do and how we do it. Is it true?

It is true that states with higher Medicare expenditures per enrollee have poorer health care quality—but that’s more of a reflection of the sociopolitical environment of the states in which this occurs than of health care outcomes. It turns out that states with high Medicare expenditures also have larger percentages of African-Americans, more uninsured individuals, and more residents below the poverty line. These states spend less on K–12 education and more on incarcerating prisoners. It is noteworthy, however, that although Medicare spending is greater in these states, the total amount spent on health care is actually less. In short, higher Medicare spending is a proxy that identifies states that have larger social burdens overall.

Clearly, the quality of health care in a hospital or in private practice offices is not related to any one reimbursement source—Medicare or any other. Quality relates to the total funds available—it relates to per-capita health care expenditures from all sources, Medicare among them. (See Figure 3, this page.) When the relationship between total funds per capita and quality is examined, the answer that emerges is exactly what logic predicts. States where per-capita health care expenditures are higher have better-quality health care. Yes, spending matters.

What about physicians? The Dartmouth group says that states that have more specialists have poorer-quality health care. But these researchers are not referring to real physicians like you and me—rather, they are referring to a theoretical statistical construct that they refer to as “spe-

productive lives for many members of society.

Moreover, the economy has benefited. Health care has created jobs and has contributed to the economic growth that has, in turn, facilitated health care spending. The jobs report issued by the U.S. Department of Labor in October 2007, just days before the start of the Clinical Congress, tells the story. In September, employment rose by 110,000 jobs, of which 30 percent were in health care, principally in ambulatory services and in hospitals. At the time this report was released,
cialist residuals,” not real doctors. And it is true. States with more of these “specialist residuals” do have poorer-quality health care.

But what about real doctors—physicians like you and me, specialists per 100,000 of population? What’s the relationship between actual doctors and quality? When physician supply is measured in per-capita terms—which is the way that everyone else in the world measures it—logic rules once again. States with more specialists per capita have better quality health care. (See Figure 4, page 14.) Yes, physicians matter.

Simply, but unequivocally stated, more actual specialists and more total health care spending per capita are associated with better-quality care. And quality could be even better, and disability could decrease further, and functional life could be further prolonged as the products of basic research and clinical trials reach the bedside, but it will require skilled and caring physicians to make all of this happen.

By the numbers

So why is there a problem? Why are there too few physicians? The reason is that allopathic medical schools entered a period of voluntary population control in 1980—and that blocked an important source of future doctors. But that’s not the principal reason, since after a brief period of no growth, osteopathic schools continued to expand their output, and in the early 1990s the gates opened to let in more international medical graduates (IMGs).

The principal reason for the physician shortage is that residency positions were capped at 1996 levels by the Balanced Budget Act of 1997, and the number of incoming residents in their first year of postgraduate study (PGY-1s) flattened, and it hasn’t changed very much since then. (See Figure 5, this page.)

Why did that happen? A national consensus developed around the notion that there was going to be a surplus of physicians, and health economists convinced policymakers that too many physicians would be bad for the economy. These inaccurate assumptions were embodied in the 1980 report of the Graduate Medical Education National Advisory Committee; continued with reports and papers from the Council on Graduate Medical Education and the Bureau of Health Professions throughout the 1990s; and culminated with the “consensus statement” in 1996, which was sponsored by the American Medical Association and signed onto by the Association of American Medical Colleges (AAMC), the American Osteopathic Association (AOA), and a number of other organizations. It called on Medicare not only to freeze the number of graduate medical education (GME) positions but to reduce them by approximately 20 percent. The good news is that the Balanced Budget Act didn’t reduce residency slots. The bad news is
that it froze them, and here we are today.

It’s clear now—as it was clear to many thoughtful physicians even then—that the opposite is needed. GME must be increased. We must increase the number of doctors who are being trained annually by approximately 10,000, or 40 percent (see Figure 6, page 15). That’s the size of the increase that was accomplished during the 1960s and 1970s, so it seems reasonable to do it again. Of course, to feed those residencies, we’ll have to increase the output of both allopathic and osteopathic medical schools as well as increase our reliance on IMGs.

Addressing this issue creates some real challenges. They involve medical schools, applicants, and, of course, GME.

Medical schools

Achieving the necessary number of medical graduates will require a substantial increase in medical schools, even more than was the case in the 1960s and 1970s. Before 1960, most medical schools were small, admitting fewer than 100 students per class. They had room to grow, and they did—in fact, 65 percent of the growth of medical school capacity in the 1960s and 1970s was the result of the expansion of existing schools. But having grown, these schools have little additional expansion capacity, and many of the new schools that were established in the 1960s and 1970s are community-based and lack expansion capacity. Various surveys indicate that, on average, existing medical schools can expand by approximately 15 percent, so the majority of growth will have to come from new medical schools. We’ll need as many as 75 more.

At present, there are 25 medical schools in various stages of development. They’re mainly in the sunbelt but some are in the north. All are small. Of these schools, three allopathic schools and six osteopathic schools are already operational. Others may come on line in the next few years. Each has been a massive effort, all the more so because there hasn’t been any national program to foster the development of medical schools—not at the federal level nor through foundations, which played such an important role in medical education in the past. Yet, these efforts will yield, at best, one-third of the needed growth. More must be done to expand the infrastructure for undergraduate medical education.

Applicants

The next question is, “If we build them, will they come?” Are there enough qualified applicants to fill 75 new schools plus some expansion in existing schools? Figure 7 on this page shows the number of first-time applicants to allopathic medical schools over the years. This number rose sharply when medical schools were
expanded in the 1960s and 1970s, but that was because enrollment at colleges and universities also increased—the percentage of baccalaureates applying to medical school didn’t change. Applications peaked during the Viet Nam War draft, but from the end of the draft forward, growth in the number of applicants has averaged only 0.5 percent per year. Based on these trends and data from the National Center for Education Statistics, we’ve projected the future size of the applicant pool, and it follows the same trend line. But this projection only deals with applicants to allopathic medical schools. What about osteopathic schools and U.S. citizens going abroad for medical school?

Working with colleagues at the AAMC, the Educational Commission for Foreign Medical Graduates, and the American Association of Colleges of Osteopathic Medicine, we’ve recently completed an analysis of the entire applicant pool, including applicants to allopathic schools, osteopathic schools, and off-shore schools. It turns out that the total pool is only approximately 10 percent larger than the allopathic medicine applicant pool. So where does that leave us?

Currently, there are approximately 30,000 unduplicated, first-time applicants to one or more of the pathways to becoming a doctor—allopathic or osteopathic schools in the U.S. and abroad. And at present, almost 80 percent of these applicants gain entry to some school somewhere. Furthermore, virtually all of these individuals will subsequently enter residency programs sponsored by the American Council of Graduate Medical Education or the AOA.

What will happen if medical schools expand to the degree that we believe is necessary, and if the applicant pool increases as we have projected? The answer is that almost 90 percent of applicants will become physicians. It’s unlikely that 90 percent of applicants are qualified to be physicians. Yet, it’s also likely that young people who are not now applying might pursue medicine if the early hurdles created by the Medical College Admissions Test and the U.S. Medical Licensing Examination Step-One exam were different; furthermore, the financial hurdles of a medical education can’t be ignored. These issues must all be addressed.

**GME**

The final challenge is, of course, GME. GME is critical because it is the portal to practice. Unlike in Canada, Britain, and Europe, where physicians who have trained elsewhere may become licensed to practice, licensure in the U.S. demands residency training in the U.S. Perhaps that could change. If the physician shortage becomes severe enough, the public may demand that qualified physicians from other countries be allowed to practice here. But for now, residency in the U.S. is the portal to practice in the U.S.
As mentioned previously, GME positions progressively increased from 1960 to the mid-1990s and were frozen in 1997. These increases were not planned and were uneven over time, but over the course of 35 years, first-year residency positions increased on average by approximately 400 per year (see Figure 8, page 16).

That represents an increase of approximately 2.5 percent per year—1.5 percent more than population growth—barely enough to keep up with technology and economic growth. Nonetheless, had that rate of growth continued beyond the mid-1990s, and had residency positions continued to expand at a rate of approximately 500 per year, we would not now be facing a physician shortage. (See Figure 9, page 17.)

But that was more than a decade ago. Time and tides wait for no man, and so a decade has passed. Sadly, increasing residencies by the same amount—500 annually—starting in 2010 will have little impact over the subsequent decade. It’s too little, too late. Even reaching the target I proposed of adding 1,000 new PGY-1 positions annually for 10 years—a total of 10,000 more first-year residents and more than 40,000 over all years of training—will fail to correct the shortages by 2020.

Nor will it correct them over the ensuing decades. We will never fully catch up (see Figure 10, page 17). But we can narrow the gap, and while doing so, we can work to find other ways to ensure that patients will have access to the care that they will need. Further delays will only assure an even bleaker medical future. A great deal must be done and it must be done now.

The reality

It’s easier for policymakers to believe that all is well, that there are enough doctors—really too many—and more will only make things worse. And it’s easier to believe that there’s no need for more medical students or medical schools—or for more residents or residency programs—or for more funds for either. And it is comforting to believe that there are enough medical school applicants and that they are the most uniformly qualified in history.

Sadly, none of this is true. We have a looming doctor shortage, a woefully inadequate number of residency positions, a need for major expansion of medical schools, and a crisis in the way medical students are selected, educated, and tested.

Never before in history—not in the time of Flexner nor during the great expansion of the 1960s and 1970s—has there been a greater need for leadership from organized medicine, foundations, and government. And rarely before has there been so much complacency—indeed, “active inertia.”

If we do not rise to meet the challenge, future generations will wonder what ours was all about—what purpose was served by allowing a great profession to stagnate—and why they and their loved ones must experience illness without access to competent and caring physicians.

But that need not happen. Both the American Surgical Association and the American College of Surgeons are firmly on record that GME must be expanded and that Medicare’s caps on GME must be lifted. It is time for colleagues in other specialties to sign onto these goals so that a broad national consensus can be created.

The medical profession has long accepted the responsibility for ensuring an adequate supply of physicians. Fulfilling that responsibility is an obligation that we must now embrace.

References

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Dr. Cooper is a professor of medicine and senior fellow with the Leonard Davis Institute of Health Economics at the University of Pennsylvania, Philadelphia.
The impact of Transparency on patient safety and liability

by F. Dean Griffen, MD, FACS
Professional liability and unsafe care resulting in adverse outcomes are uppermost among the problems we surgeons face today. We have attempted to mitigate liability through tort reform and bad outcomes by way of continuing medical education (CME) and peer review protected by confidentiality. Even so, both problems continue to plague us.

In terms of outcomes, it can be empirically stated that CME for improving patient safety has been productive. But benefits from CME are arguably maximized, and errors are still all too prevalent: Researchers identified adverse events in 2.9 percent to 3.7 percent of hospital charts, 27.4 percent to 32.6 percent of which were caused by medical errors.1,2

In terms of liability, insurance premiums have continued upward as the severity of awards has relentlessly increased: Gradually increasing over the decades, more than 7.7 percent of plaintiff awards exceeded $1,000,000 in 2004 with no ceiling in sight.3 State tort reforms have proven that liability insurance premiums can be mitigated: Premiums in states with tort reforms are 17.1 percent lower on average compared with states without reforms.4 In addition, states with reforms increased their physician supply 2.4 percent between 1985 and 2001, but this came at the expense of states without reforms, creating access-to-care problems as physicians migrated to the more liability-friendly states.5 This maldistribution of the physician workforce could be resolved by federal reforms that make all states equal, but federal reforms are not forthcoming. Unfortunately, there are no demonstrable signs in states with tort reforms that peer review is enhanced, error reporting is facilitated, defensive medical practices are deterred, injured patients are more globally compensated, claims run their course quicker, sued physicians are less aggrieved, jackpot justice is curbed, or claims without merit are decreased.

New approaches

Faced with these failures to additionally reduce bad outcomes and liability, new approaches are being pursued. Prompted by the Institute of Medicine (IOM) reports To Err Is Human and Crossing the Quality Chasm, health policymakers and legislators from both sides of the stagnant tort reform issue have found a way to put their gridlocked differences aside by focusing on the common ground of patient safety.6,8 Among these policymakers, the American College of Surgeons is a major player. On behalf of surgeons and their patients, the College sponsors the Surgical Quality Alliance chaired by Frank Opelka, MD, FACS.9 This alliance has gained credibility among other policymaking groups and government agencies, enabling surgeons to have significant input. Moving forward with a new approach, patient safety and liability are now firmly linked.

Pursuing patient safety and liability as a single agenda is gaining momentum. The common thread for change is transparency: clear honest communication for the purpose of disclosure. Examples of national changes involving disclosure include the Surgical Care Improvement Project (SCIP), the Patient Safety and Quality Improvement Act of 2005, the Centers for Medicare & Medicaid Services Physician Quality Reporting Initiative, and pay for performance. At the state level, examples include laws in Pennsylvania, Utah, and Florida that require mandatory notification of patients when an error in care occurs.10 Many other plans at national and state levels are already in place or in the pipeline.

Changing surgeons’ programming

Disclosure and transparency are contrary to that which surgeons have traditionally considered the best approach. We have always touted confidentiality as a critical protection for reporting errors and conducting peer review for safer care.11,12 Intuitively, surgeons are programmed by the punitive nature of our tort system, which creates a culture of blame, to resist even confidential disclosure much less transparent disclosure. Now, there is strong evidence that indicates transparent disclosure is better. Transparency for disclosure, including the disclosure of errors, may actually benefit safe care and quell liability. For those who equate confidentiality with secrecy, deception, and neglect, the opportunity for transparency provides relief.

In 1987, after losing two malpractice judgments totaling more than $1.5 million, officials
at the Veterans Affairs (VA) Medical Center in Lexington, KY, initiated an innovative new risk management policy that included careful review of all adverse events, transparent disclosure of errors with an apology or expression of regret when preventable adverse events were identified, and an offer of reasonable awards according to the circumstances. The results from a report presenting data for 1990 through 1996 were astounding. Even though the frequency of losses increased as additional deserving, injured patients received awards, the severity of awards was profoundly curtailed. The average loss per award in the VA system as a whole was $98,000, but the average loss per event at the Lexington VA was $15,622. Even though the costs for defending claims in the VA system could not be exactly measured, expenses were clearly reduced with this new transparency-based style of risk management. Comparisons with other VA hospitals with varying workloads were difficult, but among 36 similar facilities in the VA system, the Lexington VA losses were among the lowest. Plaintiff attorneys were accepting of honest disclosure and were not generally inclined to seek awards for noneconomic damages, such as pain and suffering.

The University of Michigan Health System implemented a somewhat similar approach to risk management in 2002. Before implementation of the transparent disclosure/apology/early offer/patient safety improvement program for risk management in 2001, the system’s annual litigation costs were $3 million. By 2005, costs were reduced to $1 million. The average time from introduction to closure of claims and lawsuits was reduced from 20.7 to 9.5 months, and the number of claims was reduced from 262 to 114 annually.

These risk management programs based on transparent disclosure have clearly reduced the costs of litigation and improved justice for injured patients. If we accept that transparent disclosure is better than secretive confidentiality, then more material for peer review may improve patient safety and outcomes as well, but this potential benefit is difficult to measure. Health care providers at the University of Michigan report that transparency has enhanced peer review, promoted the emergence of a team approach for triage and investigation of adverse events, and created a shift from the traditional “find blame” focus to a new “get it right” focus. Time will tell if these changes will lead to safer care and better outcomes.

Transparency for disclosure is after the fact—that is, after an error occurs. Beyond disclosure, the ACS Closed Claims Study (a review of 460 closed claims against general surgeons from nationwide data sources) has shown transparency for illumination, mutual understanding, and trust between surgeons, their patients, and other health care providers to be critically important for preventing bad outcomes and litigation before the fact—that is, before an error occurs.

The importance of communication

The extreme importance of communication in general, and transparent communication in particular, was not appreciated by the Fellows of the ACS who formulated the standardized data-collection form for the ACS Closed Claims Study. This awareness came after the data were collected: Complications and litigation were largely caused by the failure to communicate in 101 (22%) of the 460 claims. This profound impact of communication failures on patient safety and liability prompted a review of the dictated narratives for each of those 101 claims for additional insight. The results from the narratives for communication in general have been previously reported. Focus was then turned again to the narratives seeking information specific to the particular aspect of communication involving transparency. From among the 101 claims involving communication failures, 10 claims were excluded because of insufficient information and 10 claims were excluded because no specific transparency failures were identified. The remaining 81 (18%) of the 460 claims were filed largely if not entirely because of failure on the part of the defendant-surgeon to communicate transparently. The adverse consequences of these failures included medical errors, escalation of the consequences of otherwise nonpreventable adverse events, and anger or mistrust even when the standard of care was met.

Among these 81 claims, 40 involved the failure
to communicate with the patient and/or family and 49 involved communication failures between the defendant-surgeon and other health care providers. Eight claims involved failures with health care providers and patients and/or families.

Two claims involved the deliberate failure to transparently disclose information about an error with the patient and/or patient’s family. For example, a patient experienced significant albeit self-limiting musculoskeletal injury while being transferred from the operating table to the stretcher. A claim was filed because a health care provider other than the dishonest surgeon revealed the event to the patient belatedly and only incidentally. Paradoxically, the failure to disclose caused the lawsuit that transparency might well have prevented. The remaining 79 claims involved the failure to illuminate, establish mutual understanding, or prevent mistrust.

Meeting the standard of care

When transparency was lacking between the defendant-surgeon and the patient and/or family, the standard of care was met in 25 cases, not met in 14, and impossible to judge in one. When the standard of care was met, claims were filed largely because of anger and mistrust stemming from the surgeons’ failure to spend enough time preoperatively to transparently explain the surgical risks associated with the procedure, the disease, or the comorbidities. For example, a patient required an amputation after a failed bypass graft and subsequently filed a claim. It was apparent from statements in the patient’s deposition that the surgeon’s lack of transparency during the consent process resulted in the failure to provide the patient with a clear understanding regarding the frequency of graft failures related to disease factors beyond the surgeon’s control and in spite of skillfully performed surgery.

Postoperatively, when the standard of care was met, litigation was often the result of a failure to make clear to the patient or family that their complaints were of concern and that an organized approach was being implemented to seek the cause of a symptom, sign, complication, or other adverse event. Failure to explain the details of why an unpreventable adverse event or complication occurred left patients lacking trust and suspecting errors, which led to claims without merit.

When transparency was lacking with other health care providers, the standard of care was met in only seven cases and not met in 42. Unlike the failure to establish clarity through transparency with patients, failures with other health care providers usually lead to errors. For example, during the removal of a portacath using conscious sedation, the surgeon failed to communicate a clear, transparent, mutual understanding with the anesthetist regarding the use of electrocautery. This communication failure led to totally preventable facial burns when oxygen ignited beneath tented drapes. In another example, a surgeon failed to confirm the site of a cutaneous malignancy for wide excision from among several sites shaved by the referring dermatologist and proceeded to excise the wrong site. In addition, transparency during hand-offs was frequently found lacking. These findings are consistent with other recent work on communication failures during surgical care.18,19

These are only a few examples from among many claims in this closed claims study that involved litigation against skillful surgeons whose surgical knowledge and technical skill were undermined by the lack of transparency. Certainly, there are skills to be learned to assist us in communicating transparently. Even so, transparency through communication is largely a matter of diligence, vigilance, tenacity, and time spent. Surgeons are not held to a standard of perfection in technical matters, but preventable adverse events resulting from the failure to establish clarity and mutual understanding are almost always inexcusable.

In the absence of transparent care, litigation proceeded in the milieu of a tort system that has run amok of its purposes of fairly compensating injured patients and protecting health care providers from claims without merit. When defendant-surgeons met the standard of care but failed to communicate transparently, uninjured patients receive an unwarranted award nonetheless, in 42 percent of cases. When defendant-surgeons fail to meet the standard of care, 23 percent of injured, deserving patients who sued received no award. The tort system is truly a system of jackpot justice.
Conclusion

In conclusion, data show that transparency for disclosure after an error has occurred can minimize the consequences of litigation. Disclosure may also improve patient safety through enhanced peer review, but this effect has not yet been studied. Data also show that errors can be prevented, escalation of nonpreventable adverse events can be minimized, and lawsuits without merit resulting from anger and mistrust can be avoided by transparent communication with patients and all members of the health care team. Finally, the tort system has run amok of its purposes and is a system of random awards and jackpot justice. Although tort reform has been shown to modestly prevent escalation of liability premiums in selected states, it has failed in every other way. Health care policymakers and legislators are increasingly addressing the problem of liability by linking risk management to patient safety.

References


Dr. Griffen is the Immediate Past-Chair of the ACS Patient Safety and Professional Liability Committee.
Almost all medical liability carriers have risk management programs. Some offer premium discounts for participation in their programs or for participation in projects that are specialty based (and not open to all their policyholders). Many carriers that don’t offer premium discounts often offer continuing medical education (CME) credits.

The programs mentioned in this article are not exhaustive of all the programs that each of these companies offer. Rather, this article is intended to highlight the various types of programs that are often available. Contact your specific carrier to see what discounts (if any) are available and any other resources that may be offered.

Most programs contain the same major components (and are available to both the physicians and their medical office personnel). Although some companies still offer the traditional risk management seminars, many medical liability carriers are moving away from this approach and instead are teaching by using a variety of personalized and independent learning techniques. Some of the newer types of programs include the following:

- Self-study (newsletters and journals)
- E-learning
- Hotlines
- Compact discs/digital video discs
- Office visits
- Learning collaboratives

**Risk management seminars**

The Texas Medical Liability Trust (TMLT) offers courses for CME credit and premium discounts. TMLT offers six separate one-hour courses for CME credit (see boxed item, next page). Individuals who participate in a one-hour course...
are not eligible for a premium discount; participants in a three-hour course are eligible for the credit. TMLT offers 10 general risk-management courses, five specialty-specific topics, and three sessions on government regulation.

According to TMLT’s Web site:

The risk management education discount (3% discount, not to exceed $1,000) is awarded for risk management CME courses that are at least three hours in length. The discount is awarded per course, not per hour. A physician can take two CME courses per year and qualify for up to a 6 percent discount, not to exceed $2,000. Discounts are applied to the upcoming policy period. If more than two risk management courses are taken per year, the courses can be applied to the following policy period, but not to any policy periods thereafter.1

The West Virginia Mutual Insurance Company offers a program called Communicate and Respond Effectively (CARE), which requires attendance at a specific skills-development workshop. This workshop may provide a 2 percent premium credit. After attendance at this workshop, physicians are eligible to participate in the CARE program. Participation in the program may provide an additional 3 percent premium credit. These credits are applied at the next policy renewal (after attendance and/or participation) and apply for two years.2

Health technology and online programs

The West Virginia Mutual Insurance Company offers several programs that may result in a premium discount including a health information technology program. This program offers a 2 percent credit for use of approved health information technology, including personal digital assistants, electronic patient records, electronic dictation software, and so on. This credit is applied for two years.3

American Physicians Assurance Corporation policyholders may call a risk management hotline or take online CME courses. The CME courses are available for physicians and their staff.4

ProAssurance also offers a toll-free phone number to answer any risk management questions their customers may have.5

Office visits

The West Virginia Mutual Insurance Company offers a 2 percent credit for a three- to four-hour risk management office visit. According to its Web site, the credit may be applied and will be effective for two years.6

First Professionals Insurance Company offers many on-site management surveys, including the following:

• Office layout and appearance
• Storage and handling of pharmaceuticals and supplies
• Office surgery scope
• Patient interactions via telephone, fax, e-mail, and appointments regarding medical advice, answering service, prescription refills, waiting time, billing and collection, and emergency procedures
• Written report citing strengths and weaknesses with recommended action plan
• Follow-up determination of action plan implementation
• Risk management consultations
• Individualized guidance and consultations of risk management and legal issues7

The Mutual Insurance Company of Arizona offers a discount for small groups of five to nine physicians who agree to use selected risk management strategies and a periodic audit. Physicians can receive up to a 10 percent premium discount (personal communication, Judy Avery, risk management education coordinator, Mutual Insurance Company of Arizona, November 2, 2007).

Publications and newsletters

First Professionals Insurance Company offers a quarterly newsletter, Preventive Action, and several reference guides, including the following:

TMLT’s one-hour CME courses

• Don’t Make Me Sue You
• Don’t Be a Sitting Doc
• RM Update & Current Trends in Malpractice Allegations
• Avoiding the Courthouse: 10 Practice Pitfalls
• Informed Consent: Not Just a Piece of Paper
• You’ve Received a Letter from the Texas Medical Board: What’s Next?
NPIC also has four major risk management/patient safety programs, including the Surgical Collaborative Workgroup/Patient Safety Alliance, an obstetrical collaborative group, an ambulatory collaborative, and a simulation learning initiative. The Oregon Chapter of the ACS is already involved in two these programs (personal communication, Dieter Zimmer, vice-president of patient safety/practice support, Northwest Physicians Insurance Company, October 31, 2007).

Conclusion
In addition to checking with your carrier to discover what programs it offers, you may also join the Surgical Patient Safety community on the College’s Web portal for up-to-date articles and news about patient safety. Simply click on “Communities and Specialties” and go to the link that says “Click Here to Modify Your ACS Communities” and add the “Surgical Patient Safety” community.

Participation in risk management programs is just one way ACS Fellows can continue to realize the College’s mission, “…improving the care of the surgical patient and...safeguarding standards of care in an optimal and ethical practice environment.”

References
College publishes consumer book on the surgical experience

A new book for surgical patients and their families—*I Need an Operation...Now What? A Patient’s Guide to a Safe and Successful Outcome*—has been published by the American College of Surgeons in conjunction with Thomson Healthcare. Written by Thomas R. Russell, MD, FACS, Executive Director of the College, the book lays out the key things patients should consider before consenting to an operation, the questions they should ask their surgeon, and helpful preoperative and postoperative tips to ensure they achieve the best results.

Questions addressed in this helpful guide include how to find a qualified surgeon who’s right for the patient; what questions to ask the surgeon before an operation; how to prepare for an operation, from what to pack and what to wear to when to stop eating; and how to ensure a comfortable recovery period. In addition, checklists at the end of several chapters pose questions patients and their families should ask when they meet with the surgeon.

Publication of the book comes on the heels of the release of the results from the College’s latest “On the Table” consumer survey, which indicates that typical patients prepare more thoroughly for vacation or to buy a new car than they do before they have an operation.

The front cover of the new book.
According to the survey, one in three Americans (32%) has had a surgical procedure within the past five years, one in two (51%) has bought or leased a new car, and three in five (62%) have spent more than $1,000 on something for their home (furniture, home entertainment, and so on). And whereas surgical patients spend an average of just one hour researching their surgical procedure or their surgeon, they spend significantly more time researching other decisions:

- Changing jobs (10 hours)
- Buying/leasing a new car (eight hours)
- Buying a big ticket item of at least $1,000 for their home (five hours)
- Planning a vacation that costs at least $1,000 (four hours)

Even more shocking, more than one-third of Americans who had an operation in the last five years (36%) did not check their surgeons’ credentials before having the procedure. According to this survey, when it comes to needing an operation, patients are significantly less proactive in learning about the surgical procedure they will undergo. The findings suggest that for patients, obtaining additional knowledge about their operation before the procedure could improve their overall experience and outcome.

“Being an informed consumer is important, but being an informed patient is even more so. A surgical procedure should not be something that is done to you while you passively sit by. Patients should know that they can improve their odds for a good outcome if they do their homework upfront, just as they do when they’re buying a car, researching a vacation, or purchasing a house,” Dr. Russell said. “This book provides patients with the basic strategies and information necessary to help them gain peace of mind about how to prepare and what to expect when they have an operation.”

*I Need an Operation...Now What?* is not only practical, but also highly respectful and educational. Patients can use this book to navigate through their surgical experience while we all push for a better organized health care delivery system,” Richard J. Umbdenstock, president and chief executive officer of the American Hospital Association, said.

“This book gives excellent advice on how to ask good questions and become an informed, empowered consumer,” Helen Darling, president of the National Business Group on Health, said. “Most importantly, this book urges you, the patient, to take control and become fully informed about your options.”

Margaret E. O’Kane, president of the National Committee for Quality Assurance, said, “In clear English, this book allows people to undergo surgery with all of the information they need to help make it a safe and successful operation.” And Arnold Milstein, MD, medical director of the Pacific Business Group on Health, commented, “Practical suggestions embed great sensitivity to the public’s right to know about a surgeon’s prior results, to be told when unexpected events occur, and how difficult it is for many patients to advocate for themselves. Buy this book for your parents…and be prepared to borrow it back from them.”

More information on *I Need an Operation...Now What? A Patient’s Guide to a Safe and Successful Outcome* can be found on the College’s Web site at http://www.facs.org/public_info/patientguidebook.html. The cover price for the book is $19.95, but members of the College can obtain it at a discount of $14.95 per copy; nonmembers may purchase it from the College for $15.95 each. Quantity discounts are also available. The book can also be purchased through national Web retailers at the cover price.
ATLS® extends reach to Pakistan

With more than 50 countries worldwide offering the Committee on Trauma’s Advanced Trauma Life Support® program to train more than 1 million physicians and counting, ATLS has international recognition as the ideal training program for trauma systems. After years of working toward its launch, the program has increased its global reach by now offering its training course in Pakistan.

Prof. Zafar Ullah Chaudhry, president of the College of Physicians and Surgeons Pakistan (CPSP), presided over the inaugural ceremony to launch ATLS in October 2007. In welcoming the program, the first of its kind in the South Asian Association for Regional Cooperation, Professor Chaudhry said that, given the increasing number of vehicles, consequently leading to more traffic accidents, and a series of manmade and natural disasters in Pakistan in recent decades, the country is due for an organized trauma system that could minimize morbidity and mortality.

“Our is a country that sits on fault lines and has suffered one of the worst earthquakes in 2005,” Professor Chaudhry said. “This course thus acquires special importance for our country, where doctors equipped and organized could save many precious lives, which are otherwise lost” (Karachi Times). He also noted that the ATLS program is universally accepted as the best for trauma care.

The first-ever, three-day course was conducted in Karachi in November 2007 at CPSP’s facility, which includes classrooms, libraries, e-learning facilities, and living quarters for faculty and students. The ATLS faculty instructing the 16 medical graduate registrants included Christoph Kaufmann, MD, FACS, ATLS International Coordinator; John Kortbeek, MD, FACS, ATLS Subcommittee Chairman; Subash Gautam, MBBS, FACS, Director of the

The campus of the College of Physicians and Surgeons Pakistan.

Dr. Kaufmann (left) and Professor Ayyaz (center) during the initial assessment demonstration in Pakistan’s first ATLS course.
ATLS of the United Arab Emirates; Jameel Ali, MD, FACS; Professor Chaudhry; Irshad Waheed, MD; Mahmood Ayyaz, MBBS; and Mohammad Farooq Afzal, MBBS. Among these participants, nine were selected for the Instructors’ Course—based on attitude, affect, and experience—to teach future students the ATLS curriculum for trauma care.

During ceremonies celebrating the inaugural course, Dr. Kaufmann described the history of ATLS’ international promulgation and the potential benefit to trauma patients in Pakistan. Dr. Kortbeek talked about the history of recent natural disasters in Pakistan and how ATLS will assist Pakistani physicians in caring for victims of future disasters.

According to Will Chapleau, EMT-P, RN, TNS, ATLS Program Manager, Pakistan’s diverse population that is spread across densely populated urban areas and largely desolate rural areas provides a big challenge in organizing emergency medical systems. An emergency calling system similar to 911 (in Pakistan, 1122) was implemented in Lahore only recently; however, results thus far have been positive and growth in such programs is expected.

The CPSP is expected to organize future courses at major teaching centers throughout Pakistan.

Bibliography


Over 50 countries have adopted ATLS while many others interested are having discussions. *Pulse*. Available at: http://www.pulsepakistan.com/

Nine CPSP Fellows complete Instructor’s course for Advanced Trauma Life Support. *Pulse*. Available at: http://www.pulsepakistan.com/
The American College of Surgeons’ Connecticut Committee on Trauma (COT) will hold its 10th annual Connecticut Trauma Conference at the Foxwoods Resort and Conference Center April 3–4.

This trauma conference has gained national recognition for the caliber of the faculty and the quality of its content.

Because it is the 10th anniversary of the conference, the Connecticut COT has invited back all of the nationally known speakers who have formed the faculty in the past, such as Donald Trunkey, MD, FACS; Kimball Maull, MD, FACS; Robert Mackersie, MD, FACS; Lawrence Gentillelo, MD, FACS; Samir Fakhry, MD, FACS; Michael Rotondo, MD, FACS; L. D. Britt, MD, MPH, FACS; Norman McSwain, Jr., MD, FACS; Eric Frykberg, MD, FACS; and Basil Pruitt, Jr., MD, FACS. Speakers from the Connecticut trauma centers will be part of the faculty as well.

Presentations will include the following: Thoracic Trauma: Have We Made Any Progress?, Challenges in Trauma Care, Vascular Trauma, Changing Practice Models: A New Paradigm, Evolving Concepts in Critical Care, Resuscitation: Are New Standards Reviving the Past?, and Survivor: Trauma. Kenneth L. Mattox, MD, FACS, the conference’s keynote speaker, will deliver a lunchtime presentation, Those Who Cannot Remember the Past Are Condemned to Repeat It.

The goal of the conference is to present and examine complex and controversial issues in trauma care and is appropriate for physicians, nurses, and prehospital personnel alike.

Registration is limited to 500 attendees; a limited block of hotel rooms has been held at conference rates, so early registration and reservations are suggested.

Requests for information should be directed to Ronald I. Gross, MD, FACS, at 860/545-4187 or rgross@harthosp.org.

COT honored with CDC injury prevention award

For its work in alcohol screening and brief intervention activities, the Committee on Trauma (COT) of the American College of Surgeons is a 2007 recipient of the Prevention and Control Health Impact Award, bestowed by the Injury Center at the Centers for Disease Control and Prevention (CDC).

The Injury Center recognized the work the COT has done to further the field of injury prevention through communication, collaboration, and programmatic efforts.

John Fildes, MD, FACS, Chair of the COT, accepted the award on behalf of the COT at the annual meeting of the American Public Health Association’s Injury Control and Emergency Health Services Section in Washington, DC, in November 2007.
Join us in San Francisco for the 94th annual Clinical Congress. As always, it will be an educational opportunity you won’t want to miss!

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

The following disciplinary actions were taken by the Board of Regents at its October 6, 2007, meeting:

• A general surgeon from Silver Spring, MD, was admonished following charges that this surgeon had violated Article VII, Sections 1(f) and (i), of the Bylaws when he provided expert witness testimony in a particular malpractice lawsuit.

• John D. Brownlee, MD, a general surgeon from Highland Heights, OH, had his Fellowship suspended following charges that he violated Article VII, Section 1(b), of the Bylaws. Dr. Brownlee’s license to practice medicine in the State of Ohio was rendered not active, pursuant to an October 2006 consent agreement.

• Bruce L. Fariss, MD, a urologist from Knoxville, TN, had his Fellowship with the College suspended. He had been charged with violation of Article VII, Sections 1(a) and (b), of the Bylaws earlier this year following discipline by the Tennessee Department of Health Board of Medical Examiners. His license to practice medicine in the State of Tennessee was placed on probation for five years with terms and conditions beginning in January 2007.

• A general surgeon from Dallas, TX, was admonished after being charged with violation of Article VII, Sections 1(f) and (i), of the Bylaws. The action was taken following examination of this surgeon’s expert witness testimony in a series of malpractice lawsuits.

• A general surgeon from Tampa, FL, was admonished after being charged with violation of Article VII, Sections 1(f) and (i), of the Bylaws. This action was taken following review of the surgeon’s expert witness testimony in a malpractice lawsuit.

• Mark D. Schreiber, MD, was expelled from the College. Dr. Schreiber had been immediately temporarily suspended from the College pending completion of the disciplinary process and charged with violation of Article VII, Section 1(b), of the Bylaws in June 2007. He voluntarily relinquished his license to practice medicine in the State of Florida on October 6, 2006, after being found to have continued to practice medicine in Florida while under an Order of Emergency Suspension of License.

• A general surgeon from Columbia, SC, was admonished. This surgeon had been charged with violation of Article VII, Section 1(b), of the Bylaws after his license to practice medicine in the State of South Carolina had been limited because of dishonorable, unethical, or unprofessional conduct regarding controlled substances.

Definition of terms

Following are the disciplinary actions that may be imposed for violations of the principles of the College.

Admonition: A written notification, warning, or serious rebuke.

Censure: A written judgment, condemning the Fellow or member’s actions as wrong. This is a firm reprimand.

Probation: A punitive action for a stated period of time, during which the member (a) loses the rights to hold office and to participate as a leader in College programs; (b) retains other privileges and obligations of membership; (c) will be reconsidered by the Central Judiciary Committee periodically and at the end of the stated term.

Suspension: A severe punitive action for a period of time, during which the Fellow or member, according to the membership status, (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the member’s name from the Yearbook and from the mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; (e) is not subject to the payment of annual dues.

When the suspension is lifted, the Fellow or member is returned to full privileges and obligations of Fellowship.
**Expulsion:** The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.

**CoC conference scheduled for July**

The Commission on Cancer (CoC) will hold its conference —Coming Together 2008: A National Forum on Cancer Care in the United States— July 14–15 at the Baltimore Marriott Waterfront in Baltimore, MD, to highlight the legislative, regulatory, and advocacy issues affecting the future of cancer care in the U.S. The meeting is open to anyone involved in the care of cancer patients, especially those who support the regulatory and legislative efforts of the member organizations of the CoC.

The purpose of this conference is to raise awareness of the proposed health care legislation and regulatory initiatives that will affect cancer patient care and to educate and strengthen the participation of the cancer care community in these activities.

All hospitals accredited by the CoC are at the forefront of these issues, and the CoC invites physicians, nurses, allied health personnel, and administrative leadership from these facilities to participate in this conference.

Members of the legislature in Washington, DC, as well as major advocacy leaders, have been invited to present plenary talks and participate in several breakout sessions dedicated to examining workforce concerns in cancer care, state cancer plan development and implementation, genetic testing, and important issues relative to the implementation of clinical trials. A breakout session targeting methodology in advocacy is also planned.

This meeting will also highlight the agendas of candidates running for president in 2008. Presidential candidates or their designees will be invited to discuss their own particular cancer agenda as it pertains to the overall health care policy of their future administration.

All who are interested in the future of cancer care, especially in the important areas of legislation and regulation, are welcome to come together in Baltimore. Program information is available at [www.facs.org/cancer](http://www.facs.org/cancer). Online registration will open March 17.

**Specialty board reports available on Web portal**

Each year, the boards of the 10 surgical specialties recognized by the American Board of Medical Specialties compose reports that are presented to the ACS Board of Regents.

The specialty board reports keep Fellows and other interested readers informed of the changes and developments occurring within these groups, specifically the boards of colon and rectal surgery, neurological surgery, obstetrics and gynecology, ophthalmology, orthopaedic surgery, otolaryngology, plastic surgery, surgery, thoracic surgery, and urology.

The reports, which in previous years appeared in the *Bulletin*, are now accessible via the Web portal at [http://efacs.org/portal/page/portal/ACS_Content/ACSHOME/HomePagePortlets/NEWSOURCES/WHATSNEW](http://efacs.org/portal/page/portal/ACS_Content/ACSHOME/HomePagePortlets/NEWSOURCES/WHATSNEW).
SAVE THE DATE!

THE AMERICAN COLLEGE OF SURGEONS AT THE
SOUTHWESTERN SURGICAL CONGRESS

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

Opening Remarks
Alan G. Thorson, MD, FACS; Gerald B. Healy, MD, FACS

Panel: What’s New at the ACS
Moderator: Gerald B. Healy, MD, FACS
Panelists:
L. D. Britt, MD, MPH, FACS
Josef E. Fischer, MD, FACS
Thomas R. Russell, MD, FACS

Panel: What Practicing Surgeons Need to Know About Maintenance of Certification and How the American College of Surgeons Can Help
Moderator: Barbara L. Bass, MD, FACS
Panelists:
Ajit K. Sachdeva, MD, FACS, FRCSC
Russell G. Postier, MD, FACS

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

To register, visit www.swscongress.org or call 913/402-7102

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

FOR INFORMATION ON ACS, visit www.facs.org or call 800/621-4111.
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” column written by Executive Director Thomas R. Russell, MD, FACS.

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

The value of teaching anatomy to medical students

We read with interest the report by Drs. Seyfer, Welling, and Fox in the October 2007 issue of the Bulletin (Seyfer AE, Welling D, Fox JP. The value of surgeons teaching anatomy to first-year medical students. Bull Am Coll Surg. 2007;92[10]:9-14), where Dr. Seyfer and colleagues suggest three potential effects of programs such as theirs: alleviating the shortage of anatomy instructors, providing early favorable exposure to surgery, and disabusing students of the unfavorable surgeon image frequently proposed by medical specialists. The impact of the latter—clearing our good name—may, in fact, have the greatest impact on medical students’ early interest in surgical specialties.

At the University of California, San Francisco (UCSF), we have experienced similar success with the involvement of surgeons in the medical school anatomy courses, and we have likewise had no difficulty in recruiting faculty to participate. Surgeons with particular expertise have generally been most interested in dissection sessions concentrated on the anatomy they deal with most frequently. In addition, we have invited surgery residents (those on “research years” with more flexible schedules) to participate as instructors in the dissection sessions, and this has been mutually popular among students and residents. The incorporation of residents has the added contribution of promoting their development as educators.

The Uniformed Services University of the Health Sciences program discussed in the article includes clinical correlates taught by surgeons, and we agree that this is a tremendously valuable component of anatomy education. Such lectures provide tangible application of the seemingly abstract information students are studying. They also expose the depth of surgical cognition, demonstrating for students that our discipline involves more than simply “cutting and tying.” Although the UCSF School of Medicine has been unwilling to grant official time for such sessions, student interest has been so high that we hold the lectures during extracurricular afternoon hours, with attendance of up to 40 percent of the student body. A resident on dedicated research time develops and delivers these clinical correlate lectures, and students seem impressed by the knowledge and capabilities of a mid-level surgical resident; this fact in itself further elevates their estimation of our profession. In our experience, involvement of house staff has had triple impact by benefiting the students, the residents themselves, and our overall image. We encourage other programs to consider this approach.

We are excited to see our colleagues on the opposite coast pursuing similar educational goals and congratulate them for attempting to quantify the impact of their interactions with first-year medical students. Benchmarks such as standardized test scores, student teaching awards, specialty selection, and interest group membership are measures that medical schools can use to objectively validate these programs. Our students want to enrich their education and we should answer their call by actively pursuing prominent roles in the preclinical years of medical school.

Ramin Jamshidi, MD, Hobart Harris, MD, MPH, FACS, Andre R Campbell, MD, FACS
San Francisco, CA

The joys of patient care

I have reread Dr. Russell’s “From my perspective” in the June 2007 Bulletin (page 4) and I fully agree with his statement, “We need to concentrate on the joys of patient care and worry a bit less about whether and how we will be paid.” I would also refer readers to my May 2002 Bulletin article, “What makes a general surgeon” (87, 5:28).

I am now retired and looking back on my surgical life. My most precious memories concern the confidence and trust of families who were unable to pay anything for surgical management, including middle-of-the-night surgical procedures on many who were unable to pay. These people have a way of showing up years later to say “Thanks.” That’s why I chose general surgery.

Then, too, 20 years of short-term surgical missions to Honduras and Haiti, which included more than 500 general surgical cases, have given me a new perspective on just what is important in life.

I believe surgery is a special calling that requires commitment, perseverance, and, most of all, compassion. It is a special thrill for me to see these qualities in a young resident today.

Thank you for expressing so perfectly what is felt by many of us old-timers from the past “Golden
Age of Surgery” (though most of us still believe that any age is the “golden age of surgery.”)

Bill Scurlock, MD, FACS
El Dorado, AR

A model for national health care

In his update on the activities of the Governors’ Committee on Surgical Practice in Hospitals and Ambulatory Settings (2007;92[10]:31), R. Phillip Burns, MD, FACS, indicated concern about the future if surgeons became institutional employees. He needs to look no further for a model than the National Health Service here in the United Kingdom.

All doctors, including surgeons, became active employees of the HM government in 1948 aside from a few senior medical staff who remained in an honorary appointment with the hospital. Since that time, in general, the government has controlled all aspects of surgical practice, including the number of consultants (attendings) as well as residents and interns in training grades. The hours of work initially were never really monitored and many undertook more than what was required in the interest of providing an excellent service.

Gradually, the government approach changed and eventually pressure was put on the profession in a variety of ways. Targets as to how much work should be done and when patients should be seen as well as treated in specified time periods increased pressure, as did the increasing number of patients requiring treatment. Pressure to reduce the long hours of work undertaken by residents was changed to conform to the European Working Directive with a slight amount of increase in hours. This, combined with the reduction in the period of training required, put even further pressure on the consultants.

A certain amount of pressure from residents and interns led the government to introduce a change in the selection and training of residents, which has been a disaster, as a number of excellent residents have been lost from further training. At present, the government is reviewing a report that recommends a further change in training overseen by a government committee (with medical input), which, from my limited reading on the subject, would indicate that it would become nearer to the U.S. model it was initially meant to resemble.

Another aspect of being a government employee was the need to negotiate pay and conditions each year, which was done by a committee of doctors who met with government officials. The money available was determined by the treasury and usually required hard negotiating to receive gradual compensation for the amount of work actually done, though now pay is based on 10 programmed sessions per week (approximately 35 hours). The government never recognized that there was a difference in workload between, say, frontline surgical specialists and a dermatologist, as all received a same payment in general. I would add that private practice is allowed within the framework to a certain extent controlled by the insurance companies.

The future development of medical practice in the UK is dependent entirely on the government in power and each individual minister for the health service. However, the decisions are influenced significantly by the treasury, which indicates how much money is available to be divided among all employees of the health service, including doctors and others, and other necessary expenses such as buildings and equipment.

My brief personal view gives some idea of what could happen if there is a significant amount of surgical practice purchase by individual organizations. It is my opinion that a certain amount of individual freedom has been lost.

Robert T.J. Holl-Allen, MD, FACS, FRCS
Solihull, West Midlands, UK

What is happening to the profession?

Medicine has advanced beyond all expectations since my internship. I recall many long and arduous nights spent sustaining children who had measles encephalitis—leading some to death and others to brain deficits—or were paralyzed by polio, some whose breathing had to be sustained by the so-called iron lung. Lobar pneumonia was deadly for many, as were a number of bacterial infections, streptococcal endocarditis being the worst. Advanced tuberculosis was often treated by collapsing a lung, at times permanently, and other procedures of questionable value. Such diagnoses and treatments are uncommon today. Superspecialization for dealing with all aspects of physical disorders has extended life expectancy. But a half-century has also brought changes that are not consistent with the scientific progress and, in my view, are inappropriate in the practice of medicine.

Perhaps the most significant change is in advertising. Why have we suddenly found it necessary to advertise in the competitive manner of business and industry? Why have we abandoned one of our most cherished doctrines—that of modesty? Advertisements appear in national magazines and newspapers, though more commonly on television or radio, extolling the virtues of one particular institution or a specialty within it, suggesting that its care surpasses that of others in the region. The commercials, however, do not come from within just one city. It
is indeed surprising to see institutions in Pittsburgh and Cleveland advertising in Boston, a city that has always regarded itself as an outstanding medical center. But, in turn, it has taken up a similar drumbeat across its medical groups. I was quite proud of my own institution, which for a long time resisted this behavior, until recently when I saw a television ad proclaiming its distinction.

When I questioned the ad’s existence, I was told, of course, “How can we not when everyone else is doing it?”

Although there are a number of well-recognized teaching hospitals in the Boston area, the determination to trumpet performance is evident. One television commercial displays several physicians in three scenes, proclaiming, “We are leading the way in treating cardiovascular disease.” Yet, they have little more to offer than their neighboring institutions or some of the suburban hospitals that have strained to achieve the progress of modern medicine.

Perhaps one of the most glaring displays of professional commercialism I’ve seen was in a drug company’s repeated television advertisement where a well-known cardiologist and inventor proclaims the virtue of his product as superior for lowering blood cholesterol levels, though he does, in the end, mention briefly that his is one of many treatment options. In these times of concern about the cost of medical care, such expenditures, which must be significant, are hardly justifiable. This same criticism can be applied to full-page ads that have appeared in Time, Newsweek, and The New York Times.

My comments must represent a minority opinion, which was often the case during my career, but in these times when we have accomplished so much, when the hue and cry again has risen for universal health care, when hardships occur because medical care has become too costly, we should not be competing for “customers” but should support the traditions and dogma of our splendid profession.

**Charles A. Fager, MD, FACS**  
**Burlington, MA**

**How to enhance interest in surgical specialties**

Medical education has covered the extremes of what medical students get to do in the operating and delivery suites. In the past, students were permitted to do almost anything whereas today it is rather restricted. How can a student decide if he or she wants to be a general surgeon if he or she does not get an opportunity to sew and operate? How can a student decide to be a plastic surgeon if he or she has never closed skin with a subcuticular suture? How can a student sew if he or she cannot tie knots? How can a student consider being an obstetrician if he or she has never delivered a baby or sewn the uterus at cesarean section? We have become so restricted by our own made rules that we limit the educational opportunities of those trying to learn.

Recently, an older, retired obstetrician/gynecologist told me that during his medical school training, there was a lecture on instrumental obstetrics every day because the forceps deliveries were done by medical students. I know of one student who was allowed to “put on blades” during my appointment at this institution. Many residents today have not had that opportunity. Recently a graduate of my residency told me that she was never given the opportunity to do a midforceps delivery during her training. How sad!

Teaching surgical skills and techniques allows students the opportunities to explore their own interests and abilities. It also gives the attending physician teaching those skills the opportunity to see who is good with their hands and likewise who is not. One of the jobs of attending physicians and clerkship directors is to identify medical students who may have yet been unaware of their own unique skills. The student who is fabulous with his or her hands needs to be aware of those skills and that there are doors to the future that he or she may have not looked at. Sometimes students close doors that should not have been shut, thinking that they do not possess the necessary skills.

Exploring unappreciated skills and talents may open doors of opportunity to new challenges that students may wish to pursue. Encouragement on the part of attendings and clerkship directors help guide students to areas of medicine perhaps previously not considered. Sewing on models, foam, and cloth and tying knots on doorknobs and chairs is good only for a period of time. Eventually students must sew the real thing with gloves on while dealing with scar tissue, bleeding, and appropriate approximation of tissue.

Typically, women who have excellent agility do not appreciate their natural talents and do not consider surgical specialties when they should. Many come to medical school with limited expectations of themselves when anything in medicine is possible.

For those who want to learn and do so, give them the opportunity!

**Daniel M. Avery, MD**  
**Tuscaloosa, AL**
A look at The Joint Commission

Study examines preoperative nursing assessments for ASCs

The Joint Commission is collaborating on a study of the potential risks and weaknesses of inaccurate or incomplete preoperative nursing assessments in ambulatory surgery centers (ASCs). The one-year study is being funded by a $198,000 grant from the Agency for Healthcare Research and Quality (AHRQ).

Collaborators on the project with The Joint Commission are United Surgical Partners International (USPI) and Battelle, Pacific Northwest Division. Together they are conducting failure mode and effects analyses (FMEA) on preoperative nursing assessments in 10 USPI freestanding ASCs accredited by The Joint Commission under its Ambulatory Health Care Accreditation Program. The primary investigator for the study is Nancy Kupka, DNSc, MPH, RN, project director for the department of health services research, division of quality research and measurement, at The Joint Commission.

The FMEA process, a prospective risk-assessment technique to improve patient safety, is being used to examine the nursing assessment process as it was designed to work and as it was actually implemented. By using FMEA, the study will identify where the preoperative nursing assessment process, which was designed to promote patient safety, is most vulnerable.

“Accurate preoperative nursing assessment of a patient’s candidacy for a procedure at an ASC—which can often have limited access to emergency assistance because it is not part of a hospital—is critical to providing safe care and preventing patient harm,” says Jerod M. Loeb, PhD, executive vice-president of the division of quality research and measurement at The Joint Commission. “Very little is known to date about the risk points of preoperative nursing assessments in this setting. This work will inform strategies for reducing risk that are likely to be relevant across the population of freestanding ASCs.”

“We’re very excited about the new patient safety research projects we’re funding,” says Carolyn M. Clancy, MD, director of AHRQ. “These projects build on our previous work by focusing on issues across settings and transitions of care and will further existing efforts to achieve safe, high-quality health care.”

The Joint Commission requires accredited ASCs to conduct preoperative assessments. The study is being conducted independently of accreditation.

The study is under way and concludes August 31. For more information about the study of the potential risks and weaknesses of preoperative nursing assessments in ASCs, contact Ms. Kupka at nkupka@jointcommission.org.
2008 Coding Workshops
American College of Surgeons
2008 Coding Workshop Series for Surgeons and Their Staff

DENVER, CO
FEBRUARY 28
2008 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding
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2008 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding
AUGUST 8
2008 Surgical and Office-Based Coding and Reimbursement (Advanced)

CHICAGO, IL
SEPTEMBER 18
2008 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding
SEPTEMBER 19
2008 Surgical and Office-Based Coding and Reimbursement (Advanced)

For more information and to register, go to http://www.facs.org/ahp/workshops/index.html or contact Debra Mariani, Practice Affairs Associate, tel. 202/672-1506, e-mail dmariani@facs.org
An important topic at many hospital tumor boards is the management of the primary tumor for patients with stage IV breast cancer. Because metastatic disease precludes the possibility of cure, it is not clear if there is a role for surgical extirpation of an asymptomatic primary tumor. Surgery has generally been reserved for symptom control.

Recently, retrospective studies have indicated a potential benefit of removing the primary tumor to prolong overall survival.\(^1,2\) Such results are confounded by potential patient selection bias, and only a prospective phase III clinical trial can detect a benefit from the procedure. There is a precedent for considering such a trial: Nephrectomy in stage IV renal cell carcinoma significantly improved overall survival compared with symptom management of the primary disease.\(^3\)

Although enthusiasm is increasing for a phase III trial design to answer the question of primary tumor management in stage IV breast cancers, there are important questions about the feasibility and equipoise in the medical community. In other words, will surgeons and medical oncologists enroll their patients into a phase III randomized trial designed to answer this question? There is a strong perception that randomized trials comparing surgery versus no surgery are difficult to complete because of inherent physician and patient preferences.

The American College of Surgeons Oncology Group (ACOSOG) approached the ACS to conduct a Web-based survey to measure equipoise in the medical community. Seema Khan, MD, FACS, drafted the trial design and a two-question survey that appears on the next page.

The College sent an e-request to ACS general surgeons in the U.S. and Canada and to members of the Cancer and Leukemia Group B (CALGB) to respond to the survey. It was decided prospectively to establish threshold rules that determine feasibility. If there were fewer than 50 positive responders, the trial idea would not move forward. If there were more than 150 positive responders, the trial idea would continue on a development path toward a national trial. It should be noted that there was no published experience for setting the threshold at 150 positive responders.

There were 822 responders to the survey. By specialty, 86 percent of responders were surgeons and 13 percent were medical oncologists. In response to the enrollment question, 92 percent said that they would enroll patients into the trial and 8 percent said no. By the threshold set before the survey, there is evidence of equipoise in the medical community. The survey did not address equipoise in the patient community.

ACOSOG would like to thank the members of ACS and CALGB who responded to the survey. The cost of developing and launching a phase III trial is approximately $500,000. There is also immeasurable value to patient expectations and sponsors. Your participation in this survey provides evidence that the trial is feasible and there is a likely return on investing resources into such a trial.

ACOSOG will work with the National Cancer Institute and medical oncologists to move this trial idea forward. Although this survey is like measuring the pulse rate of national opinion, there are other parameters to assess the overall feasibility of a clinical trial idea. For example, patient equipoise was not
ACOSOG trial design and survey

The conventional therapeutic approach to women presenting with stage IV breast cancer and an intact primary tumor has been systemic therapy, with primary tumor resection reserved for palliation of symptoms. However, 30% to 50% of these women undergo resection of the primary tumor, presumably with the intent of avoiding uncontrolled chest wall disease. Several large retrospective studies have suggested that resection of the primary tumor may offer a survival advantage for women with de novo Stage IV breast cancer, but selection bias remains a very plausible explanation for these findings.

The American College of Surgeons Oncology Group (ACOSOG) is considering the feasibility of a randomized trial to address the question of whether or not local therapy for the primary tumor is beneficial in this patient group, from the perspective of local control and overall survival. The proposed schema is shown here. The primary endpoint would be overall survival.

800 women with stage IV disease and intact primary tumors (exclude sites with very poor prognosis, like meningeal or lymphangitic lung)

Optimal systemic therapy at discretion of treating physician (provide guidelines)

Randomize women who respond to systemic therapy (n=600)
Stratified by soft tissue/skeletal mets vs. visceral mets

Early local therapy following response to systemic therapy (excision with free margins and XRT, or mastectomy +/- XRT)

Delayed local therapy only if local tumor progresses (extent of local therapy at physician discretion).

Please respond to the following questions:
1. Would you enroll stage IV breast cancer patients with intact primary tumors into a clinical trial with the above design?
   Yes____  No____
2. Indicate your oncologic specialty:
   Medical _____  Surgical /breast_____  Radiation _____

References

Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG co-chairs.
This article marks the 60th consecutive “NTDB data points” column in the Bulletin. It is only fitting then to look at what happens when one reaches his or her 60th year. The oldest baby boomers began turning 60 last year. By January 1, 2047, the hardiest of the 78 million boomers will celebrate their 100th birthday. A generation known for challenging authority and redefining everything from marriage to race relations will start experiencing the physiologic effects of aging. Age-related losses of taste and smell occur in many older than 60. In addition, as some individuals age and become less active, there is an associated loss in balance and coordination. This loss of balance can lead to an increased number of falls and subsequent injuries.

In order to examine the occurrence of age-related injuries in the National Trauma Data Bank® Dataset 7.0, all records for patients aged 60 to 69 years were identified, and 102,387 records with discharge status were found. Of these patients, 65,428 were discharged to home, 20,052 to acute care/rehabilitation, and 10,991 to nursing homes; 5,916 died. Victims were 57 percent male and on average 64.2 years of age; there was an average length of hospital stay of 6.9 days, an intensive care unit stay of 2.8 days, and an average injury severity score of 10.9. Of those tested for alcohol, 16 percent were positive. Of note, although motor vehicle-related injuries accounted for a similar overall percentage, falls were 1.6 times more frequent in this age group when compared with the overall 2007 report. These data, along with the mechanism of injury, are pictured on this page.
If you are one of the 78 million who has or will soon turn 60, do not fret. With proper lifestyle modifications, one can enjoy a long, healthy, and fulfilling life. Exercise is a key component to aging with grace. Make sure to put aside the necessary time for cardiovascular, stretching, and core exercises. Also, do not forget to exercise your brain. The brain needs to be challenged; try puzzles or learning new skills. With improved cognition and regained balance, you are less likely to be injured and therefore more likely to become 60-something.

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

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

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