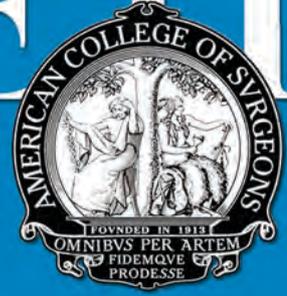
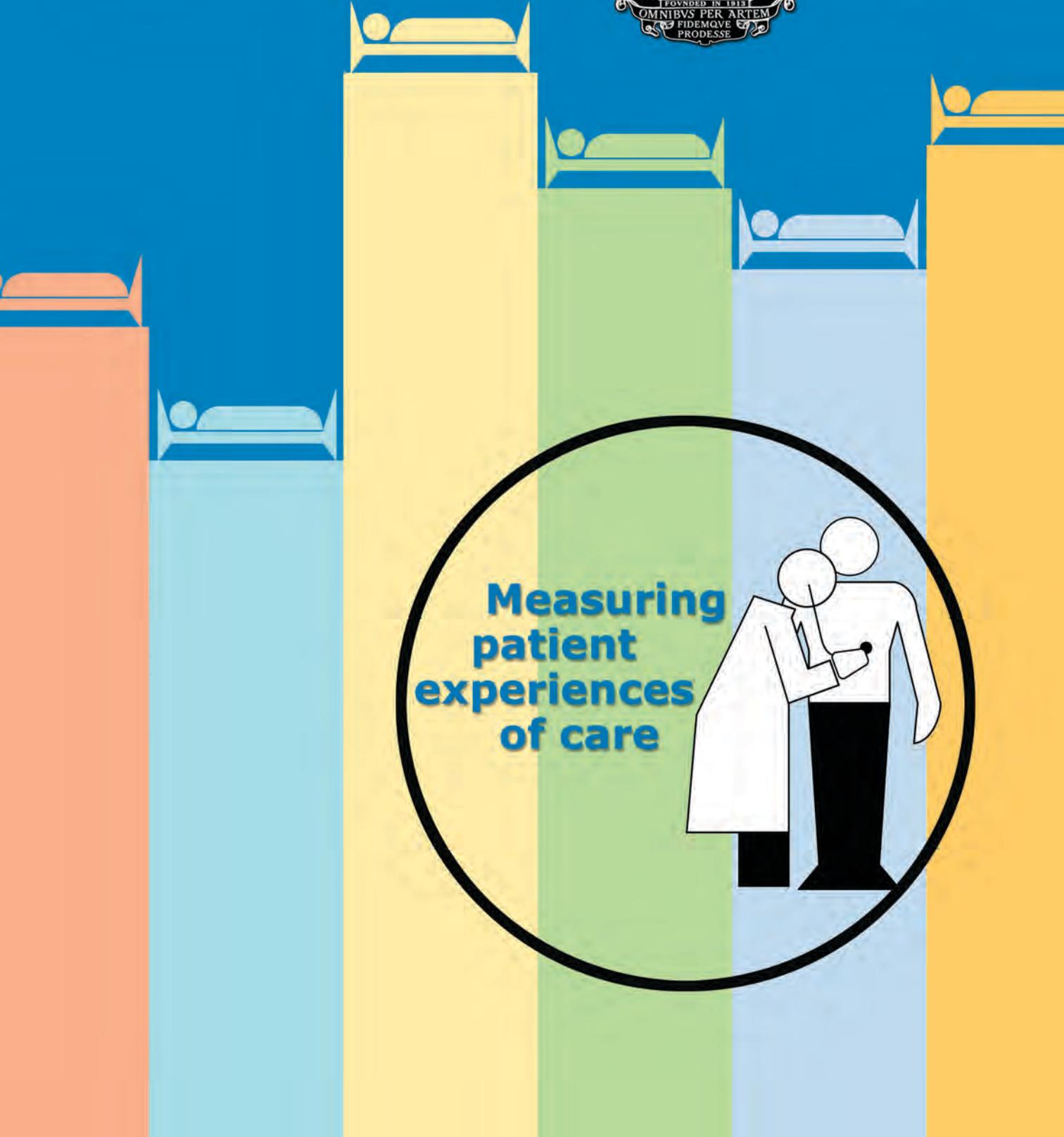


# BULLETIN

AMERICAN COLLEGE OF SURGEONS



May 2008  
Volume 93, Number 5



**Measuring  
patient  
experiences  
of care**



# BULLETIN

AMERICAN COLLEGE OF SURGEONS



MAY 2008  
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## FEATURES

- 
- The practice of locum tenens:  
Views of a senior surgeon** **8**  
*Ronald M. Tolls, MD, FACS*
- 
- The practice of locum tenens:  
Commentary** **11**  
*Stuart A. Reynolds, MD, FACS*
- 
- Measuring patient experiences of care** **13**  
*Elizabeth Hoy, MHA*
- 
- Building a successful residency program:  
Insights from an award-winning program director** **17**  
*Lola Butcher*
- 

## DEPARTMENTS

- 
- From my perspective** **4**  
*Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director*
- 
- Dateline: Washington** **7**  
*Division of Advocacy and Health Policy*
- 

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## Future meetings

### Clinical Congress

**2008** San Francisco, CA,  
October 12-16

**2009** Chicago, IL,  
October 11-15

**2010** Washington, DC,  
October 3-7

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*Letters to the Editor should be sent with the writer's name, address, e-mail address, and daytime telephone number via e-mail to [sregnier@facs.org](mailto:sregnier@facs.org), or via mail to Stephen J. 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.*

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**On the cover:** *Patients expect a certain level of service from their health care providers; recent methods of measuring patient experiences of care aim to create better clinical outcomes and reduced risk of litigation (see article, page 13).*

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## NEWS

<b>ACS establishes Health Policy and Research Institute</b>	<b>21</b>
<b>ACS selects 2008 Oweida Scholar</b>	<b>22</b>
<b>Joint symposium to focus on neurotrauma/critical care</b>	<b>23</b>
<b>From the Archives: Photos shed light on history of surgery in Mexico Susan Rishworth</b>	<b>25</b>
<b>Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings, February 8-9, 2008 Paul E. Collicott, MD, FACS</b>	<b>27</b>
<b>Disciplinary actions taken</b>	<b>39</b>
<b>A look at The Joint Commission: Joint Commission designated to improve safety of office-based surgery</b>	<b>41</b>
<b>NTDB® data points: Pedal to the metal Richard J. Fantus, MD, FACS</b>	<b>43</b>

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

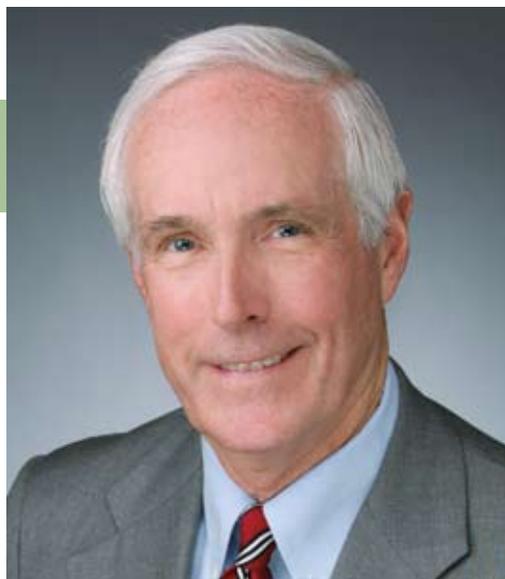
Over the past few years, the government has sought to make health care more transparent. Most of the efforts that have been undertaken have scrutinized how surgeons, other physicians, medical institutions, and other providers use resources, make decisions, and control quality. The purposes of these activities are to reduce waste and errors, improve quality, and limit spending through pay-for-performance and pay-for-compliance strategies.

As a result, medical organizations and institutions—including the American College of Surgeons, Dartmouth University, Harvard University, and so forth—have devoted considerable time, thought, and money to developing and testing instruments that measure resource use, outcomes, volume, variances in care, and other quality indicators. For example, the ACS has revitalized its national trauma and cancer data banks and has taken responsibility for bringing into nonfederal hospitals what is now known as the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). ACS NSQIP uses risk-adjusted data to examine surgical outcomes and has been vetted through numerous government agencies and quality-improvement programs.

We also have dedicated ourselves to educating the professionals who comprise our membership, faculty, and staff about the value of participating in clinical and scientific research and staying abreast of and adhering to emergent standards of care. In other words, our profession has acknowledged the need for openness about systems of care and accepted responsibility for analyzing and disseminating data that medical professionals and hospitals can use to deliver cost-efficient and effective care.

### *Insurers*

While the medical and surgical professions have been responsive to the demand for increased transparency, some health insurance companies have not. A notable example came to the public's attention on February 13, when New York Attorney General Andrew Cuomo announced plans to sue UnitedHealth Group after a six-month investigation into the insurer's Ingenix subsidiary revealed that the company's



**“While the medical and surgical professions have been responsive to the demand for increased transparency, some health insurance companies have not.”**

database was deficient.\* Most large insurers rely on Ingenix data to calculate the “usual, customary, and reasonable” (UCR) payment for physician services.

The probe verified physician claims that Ingenix had manipulated UCR rates for out-of-network providers to keep them artificially low. As a result, UnitedHealth and 16 other subpoenaed insurance companies profited, whereas consumers, who pay higher premiums for plans that offer access to out-of-network physicians, have been getting less coverage than they anticipated.

Typically, insurers that provide out-of-network coverage agree to pay most of the bill—generally 80 percent of the physician's full fee or 80 percent of the UCR amount, whichever is less. According to Mr. Cuomo, the problem with UnitedHealth's policies is that the faulty Inge-

\*Information regarding the New York/UnitedHealth case came from the following source: Berry E. N.Y. takes on United over tactics as industry arbiter of doctor pay. *Am Med News*. 2008;51(9):1-2.

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nix data yielded UCR prices below physicians' actual costs. Hence, the 80 percent of the UCR amount insurers pay out-of-network physicians is far less than the amount physicians charge, and patients are left to pick up the remaining tab. Needless to say, this situation often creates a rift between physicians who want to be appropriately reimbursed and patients who believe their insurance will compensate providers for the bulk of their care.

Specific problems with the database cited by the attorney general's office are as follows:

- Lacks information about the provider's training and qualifications, the type of facility where the comparative service was delivered, and the patient's medical condition
- Deletes valid high charges and omits proportionally more high charges than low ones
- Pools data from dissimilar providers, such as nurses, physician assistants, and physicians
- Contains outdated information
- Contains data that have not been audited to ensure that the contributors have submitted all appropriate information and have omitted negotiated or discounted rates

Mr. Cuomo also asserts that some data contributors delete higher charges from the information they submit, thereby skewing reimbursement rates downward. He further alleges that Ingenix uses the defective data in the repository and a flawed methodology to "derive" additional charges, resulting in a rate that is deflated.

### *Consistent rules needed*

For many years, physicians have asked UnitedHealth to explain how it sets UCR prices. The insurer has responded to these requests only by claiming that its methods for determining the UCR figures are proprietary and completely reliable. Likewise, when UnitedHealth members complained about low reimbursement for out-of-network care, the company dismissed their concerns by saying that the prices are based on "independent research from across the health care industry," according to the attorney general's notice of proposed litigation.

As American Medical Association president-elect Nancy H. Nielsen, MD, PhD, said, "It is shocking and unacceptable for any health insurer to hide behind a shroud of secrecy." It also

is ethically aberrant to mislead patients about how a company operates. The reality is that UnitedHealth owns Ingenix and its data come from UnitedHealth and other insurers, all with an interest in reducing UCR rates to boost their profit margins.

These findings are particularly disturbing at this point in the evolution of our nation's health care system. A commonly held belief among policymakers is that the future of health care delivery will be determined largely on the basis of scientific research and the information gathered through electronic databases. Hence, the College and other medical institutions have attempted to be absolutely meticulous in the development of such repositories and scrupulous in the analysis and dissemination of information derived from them.

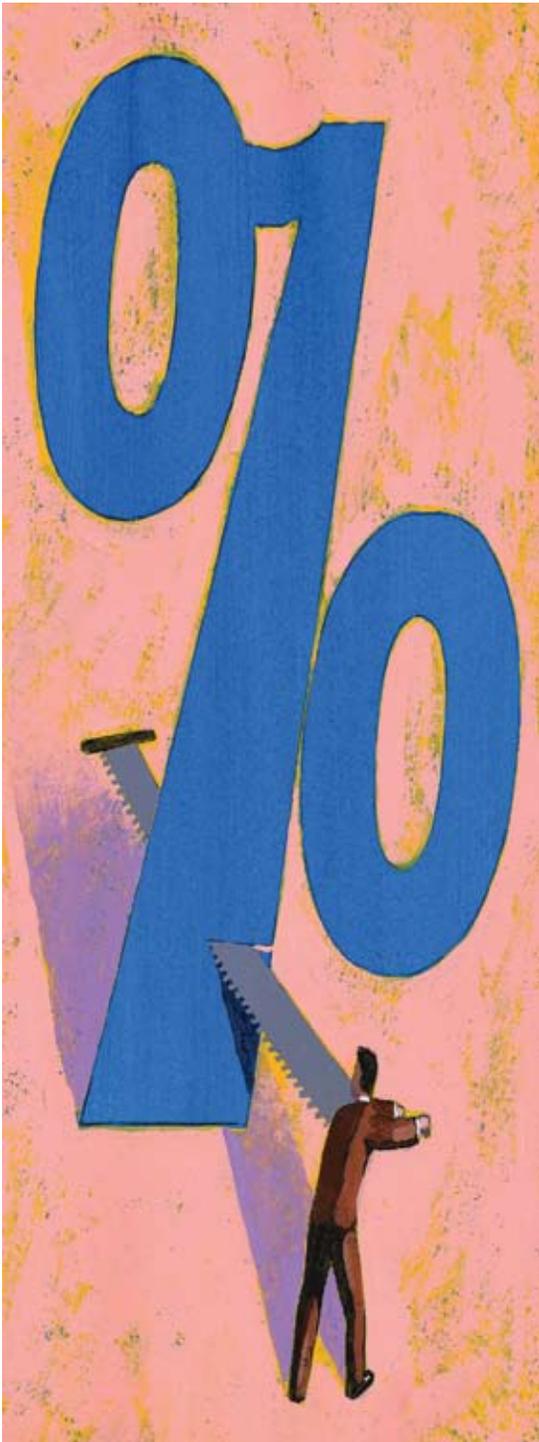
If this nation truly intends to build a safer, more equitable, and cost-effective health care system, all stakeholders—physicians, consumers, business, the government, and insurers alike—should be held to the same standards of accountability and should operate with the overarching goal of putting patients before profits. The lawsuit that the New York Attorney General has filed should prove useful in ensuring that we all will play by the same rules.



*Thomas R. Russell, MD, FACS*

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If you have comments or suggestions about this or other issues, please send them to Dr. Russell at [fmp@facs.org](mailto:fmp@facs.org).



## WE CUT OUR EXPENSE RATIO

Recognizing the goal of offering members of the American College of Surgeons and affiliated organizations a reasonably priced investment product, the expense ratio of the College's Surgeons Diversified Investment Fund (SDIF) has been lowered to just over 1%. The lower expense ratio will have an immediate positive impact on our shareholders, and, over time, will positively impact the performance returns for prospective and current shareholders. The new expense ratio, including ETF costs, is 1.08%.

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



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# Dateline|Washington

prepared by the Division of Advocacy and Health Policy

## **ACS cosponsors advocacy conference**

Approximately 330 surgeons participated in the Joint Surgical Advocacy Conference March 9–11 in Washington, DC. The conference featured presentations on how Congress works, advocacy skills, and the upcoming national elections, as well as opportunities for participants to hear from six members of Congress and to meet with legislators and their health policy advisors on Capitol Hill. The American College of Surgeons cosponsored the event with organizations representing the following surgical specialties: gastrointestinal and endoscopic surgery, neurosurgery, ophthalmology, osteopathic surgery, otolaryngology, and plastic and reconstructive surgery. A key discussion topic for surgeons in all of these specialties during the Capitol Hill visits was the impending 10.6 percent reduction in Medicare physician payment scheduled to take effect July 1. Details about the conference will be published in the June issue of the *Bulletin*.

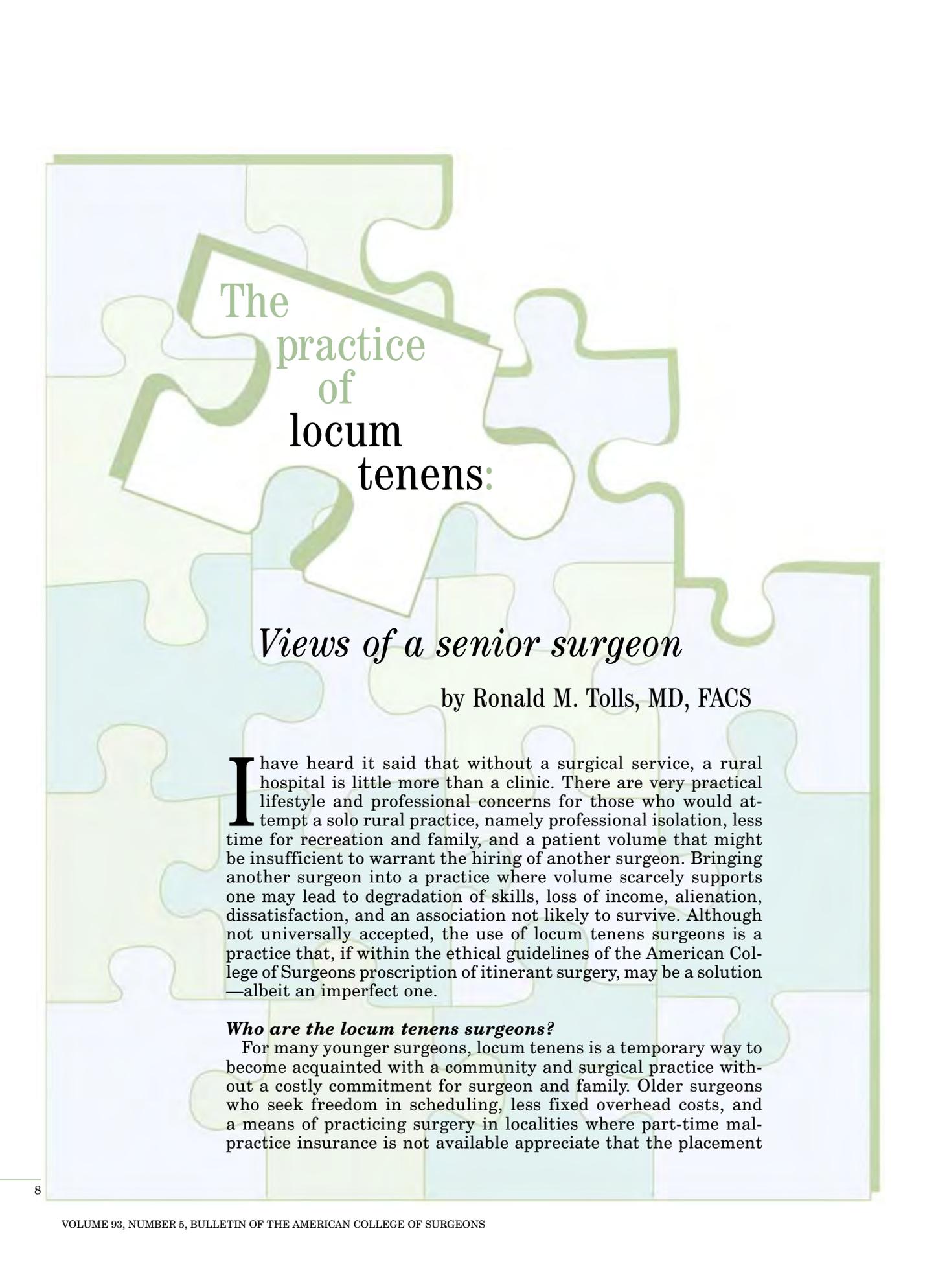
## **College testifies on value-based purchasing**

On March 6, the Senate Finance Committee hosted a roundtable discussion, called the “Plan to Implement a Medicare Hospital Value-Based Purchasing Program.” Testifying on behalf of the College was Frank Opelka, MD, FACS, Chair of the ACS Committee on Patient Safety and Quality Improvement. In his statement, Dr. Opelka said, “Questions surrounding hospital value-based purchasing must be framed within the overall goals for our nation’s health and health care.” He also said that combined efforts to measure the care provided both by physicians and hospitals could greatly improve patient care and reduce the burden of data collection for providers. As Congress continues to consider how to measure and improve the quality of patient outcomes, the College is working to ensure that governmental efforts will not inhibit, but rather build on, the organization’s quality improvement programs. For more information, go to <http://www.senate.gov/~finance/sitepages/VBProundtable030408.htm>.

## **Bill would limit Medicare spending**

Legislation to limit Medicare spending was introduced in Congress February 25. In the House, Majority Leader Steny Hoyer (D-MD) and Republican Leader John Boehner (R-OH) introduced H.R. 5480; in the Senate, Finance Committee Chairman Max Baucus (D-MT) and Sen. Judd Gregg (R-NH) introduced S. 2662. Although Congress is not required to act on either proposal, the introduction of the bills was necessary because, for two consecutive years, Medicare trustees have forecasted that within seven years, general revenues will exceed 45 percent of the funds needed to pay Medicare benefits. The Medicare Modernization Act of 2003 requires the President to submit a plan to limit Medicare spending growth when the trustees reach this determination in back-to-back annual reports. As required, President Bush submitted a Medicare proposal to Congress, which then had to be introduced in the House and Senate.

Unfortunately, the bills address neither the 10.6 percent reduction in Medicare physician payments scheduled for July 1 nor scheduled cuts in future years. The bills also contain value-based purchasing provisions, including public reporting of price and quality information, and liability reforms.



# The practice of locum tenens:

## *Views of a senior surgeon*

by Ronald M. Tolls, MD, FACS

**I** have heard it said that without a surgical service, a rural hospital is little more than a clinic. There are very practical lifestyle and professional concerns for those who would attempt a solo rural practice, namely professional isolation, less time for recreation and family, and a patient volume that might be insufficient to warrant the hiring of another surgeon. Bringing another surgeon into a practice where volume scarcely supports one may lead to degradation of skills, loss of income, alienation, dissatisfaction, and an association not likely to survive. Although not universally accepted, the use of locum tenens surgeons is a practice that, if within the ethical guidelines of the American College of Surgeons proscriptio of itinerant surgery, may be a solution—albeit an imperfect one.

### ***Who are the locum tenens surgeons?***

For many younger surgeons, locum tenens is a temporary way to become acquainted with a community and surgical practice without a costly commitment for surgeon and family. Older surgeons who seek freedom in scheduling, less fixed overhead costs, and a means of practicing surgery in localities where part-time malpractice insurance is not available appreciate that the placement

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agencies purchase and provide coverage on an hourly basis. For others, the opportunities for travel and varied experiences is attractive even in mid-career.

Assignments vary from an occasional weekend to six months or more. They occur most frequently during holiday periods, summer vacations, and important surgical meetings but may occur for prolonged periods while clients are seeking permanent surgeons or in the event of surgeon illness. Most placements are done through various agencies that assist with license preparation, travel, lodging, and credentialing. Such agencies exact substantial fees for their service, with their share often exceeding that of the surgeon with whom all responsibility for patient care ultimately falls. Personal service contracts with client hospitals would avoid much of this, but like a multiple listing service program in real estate, often opportunities are only generally known through the various agencies.

Once a curriculum vitae has been presented, the agency claims ownership for a two-year period such that it is not possible for a surgeon to work with that client directly or with another agency. Although they compete intensely for control of a surgeon, employees in the agency are generally devoid of any surgical background, understandably are motivated by physician placement fees rather than quality of care, in the event of conflict are focused on client satisfaction rather than due process for professionals, and bear no liability in the event of malpractice. Likewise, a high finder's fee is granted to the agency whereupon a locum tenens surgeon takes on a permanent position.

### ***The downside for locum tenens surgeons***

The seemingly carefree practice style of locum tenens surgery has its downsides, including the following:

*Performance degradation.* It is the unusual locum tenens opportunity that provides the surgeon with a caseload that is varied and of high volume. Most assignments are to cover call only rather than follow a clinic and an elective surgery schedule. Because of continuity issues, primary care physicians may rightly be hesitant to refer elective surgery to surgeons who cannot ensure continuity of care. Not simply in jest,

some of my regular surgical colleagues have said that the principal function of a locum tenens surgeon is to maintain practice viability so that referral patterns are not lost. Ironically, clients in search of prospective locum tenens surgeons will insist on documentation of substantial caseloads, a near impossibility if one were to do locum tenens surgery for an extended time.

*Boredom and loneliness.* Although a locum tenens surgeon must constantly be ready to respond to an emergency, workloads are generally light. Time management—with studying, exercise, computers, and activities that can be immediately set aside—requires discipline.

*Isolation.* Surgical practices in metropolitan areas can generally be cross-covered by colleagues. It is in rural America and small-town practices where locum tenens coverage is most needed. The locum tenens surgeon quickly learns that quite often he or she is asked to cover because of conflicts, particularly between surgeons and administrators on matters of call coverage. The locum tenens surgeon arrives as a total stranger and must adroitly identify the political process without becoming a casualty.

*Due process.* Unlike his or her permanent colleagues, a locum tenens surgeon is not entitled to a “bad day.” Past performance is unknown, and he or she is likely to be judged by superficial attributes, his smile, demeanor, self-effacement, and trivial likes and dislikes, particularly as he or she interacts with the nursing staff. Hospital bylaws protect medical staff. Errant physicians are disciplined only after meetings with peers and a series of steps, including formal written allegations, case reviews, confidential meetings with peers in attendance, and a forum for rebuttal. The locum tenens surgeon has no such protection. Any apparent infraction—such as an allegation that he could not be reached even though he or she may have been in assigned quarters, an error in posting his or her phone number, or the pager provided was not the one on the call roster—is sufficient that he may not be invited to return.

*Adaptability.* Rural hospitals may be surprisingly insular. Caseloads are light. Because of limited resources, a surgeon may be required to work with unfamiliar equipment. There is often but one way of doing things with which the

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nursing staff is familiar. Any departure from a predecessor's practice even months before may be quite unacceptable with resultant inaction, nursing debriefings, and formal complaints. It is the locum tenens surgeon's challenge to practice in a manner he has learned to be safe and comfortable while blending with local practice standards.

**Risk management.** Upon arrival on a new assignment, the surgeon must quickly identify the availability of specialty consultations; evacuation capabilities; competence of assistants, nurses, and anesthesia providers; blood products; and a host of similar concerns. Often he or she is asked to provide cover over holidays when hospital services and staffing are minimal. He or she must always remember that when his or her assignment is over, he or she remains the outsider in a tightly knit team and may not be there to defend his or her actions or maintain the essential rapport with patient and family to avoid litigation in the event of an adverse outcome. Much like the commando who drops out of the sky on a clandestine mission, the locum tenens surgeon must quickly identify those staff members he or she can trust; learn telephone numbers, names, and personalities; and be prepared even upon arrival for a life-threatening emergency wherein he or she may mobilize and direct a dozen players.

**Acceptance.** One of the most appealing aspects of a rural practice for an established surgeon is the high esteem he enjoys with hospital team and community. To many there is no one, certainly not a locum tenens surgeon, who can match up. Satisfying as that may be for the established surgeon, if he requests the support of a locum tenens surgeon in his absence, it is only fair that he encourage his entourage to provide the fullest support for the locum tenens surgeon, though his ways may be different. To bask in adulation upon his return to the detriment of the locum tenens surgeon is egoistic and unprofessional behavior that does not merit his further temporary reprieve by a locum tenens surgeon.

**Continuity of care.** The American College of Surgeons regards as itinerant surgery the practice of leaving the care of postoperative patients with someone other than a trained colleague until they have recovered sufficiently. Although of no concern to the agencies compensated for

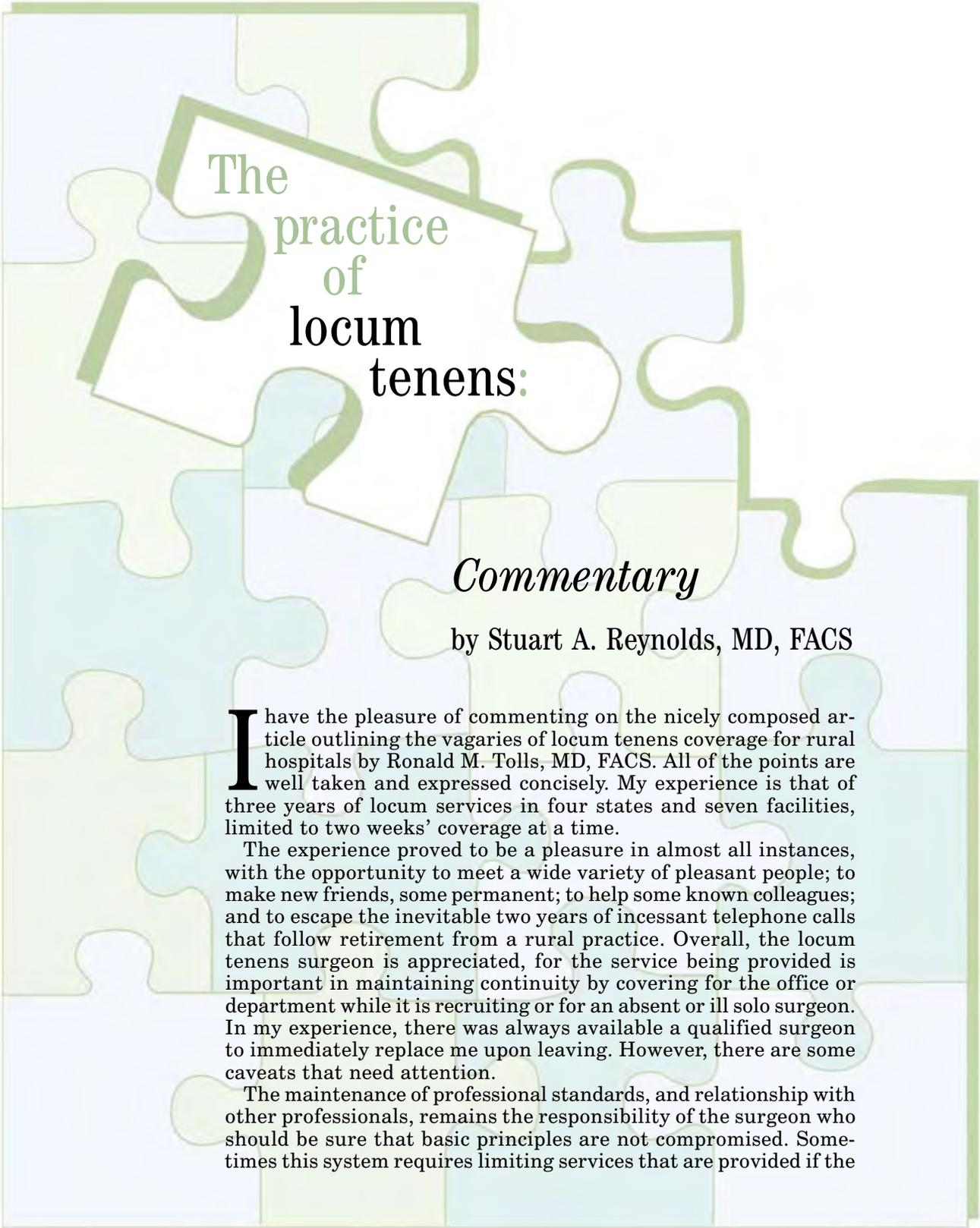
placing surgeons, on various occasions I have learned, when taking an assignment, that upon my departure, there was no surgical coverage other than vague plans of distant referrals or the possible coverage by a busy colleague miles away. The pressures by colleagues and administrators to operate without adequate follow-up can be overwhelming. In such circumstances, it is the locum tenens surgeon's responsibility to declare outright what he can safely do and no more.

### **Conclusion**

I am an avid reader of the *Bulletin of the American College of Surgeons*, but over the years I have seen little or nothing about the practice of locum tenens surgery, specifically no position statement as has been written for many other areas of interest. I know that the practice is not proscribed because of the job postings for many locum tenens positions I have seen in times past on the College's Web site. Locum tenens surgeons fill a much-needed role in the support of surgical practices in rural America. I believe it is time we define as an organization what is expected of a locum tenens surgeon, provide opportunities for client hospitals and surgeons to work without exorbitant fees to placement agencies, and welcome our locum tenens surgical colleagues as fellow professionals in the fullest sense. Ω

**Dr. Tolls** is a retired colonel of the Medical Corps, U.S. Army, and a locum tenens general surgeon in Livingston, TX.





# The practice of locum tenens:

## *Commentary*

by Stuart A. Reynolds, MD, FACS

**I** have the pleasure of commenting on the nicely composed article outlining the vagaries of locum tenens coverage for rural hospitals by Ronald M. Tolls, MD, FACS. All of the points are well taken and expressed concisely. My experience is that of three years of locum services in four states and seven facilities, limited to two weeks' coverage at a time.

The experience proved to be a pleasure in almost all instances, with the opportunity to meet a wide variety of pleasant people; to make new friends, some permanent; to help some known colleagues; and to escape the inevitable two years of incessant telephone calls that follow retirement from a rural practice. Overall, the locum tenens surgeon is appreciated, for the service being provided is important in maintaining continuity by covering for the office or department while it is recruiting or for an absent or ill solo surgeon. In my experience, there was always available a qualified surgeon to immediately replace me upon leaving. However, there are some caveats that need attention.

The maintenance of professional standards, and relationship with other professionals, remains the responsibility of the surgeon who should be sure that basic principles are not compromised. Sometimes this system requires limiting services that are provided if the

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infrastructure for optimal performance is not provided. Rarely was this a problem for administration or colleagues. All rural facilities have a long-term staff that will provide guidance in dealing with local issues, and the tertiary referral and transport processes are well defined for patients whose needs exceed the ability of the facility to provide care. Standards are not, and should not be, the concern of the contracting agency that simply provides a business conduit for the hospital in need and the appropriate physician. The two agencies that I worked for simultaneously were quite flexible and cooperative with me and each other and the “handlers” were well trained and skillful.

The rural locum tenens surgeon for the most part is relegated to providing low-volume urgent and emergent care for the reasons expressed in Dr. Tolls’ article. However, in the rural setting, the services tend to cross a broad spectrum of surgical practice, including many urban subspecialties. Therefore, the practice load is not conducive to maintaining knowledge or skills over the long haul, a fact that the locum tenens surgeon must seriously consider.

I have two concerns for the potential locum tenens surgeon that I believe are imperative for ensuring optimal performance and patient care.

My first concern is experiential match. The young, just-trained surgeon might fit either a rural or urban setting, but the older surgeon will not do so. The urban surgeon may very well have had a practice that is narrowly restricted by subspecialists and not have the broad skills that are commonly required in the rural setting. Conversely, the rural surgeon has, of necessity, maintained a broad array of surgical subspecialty skills suitable for the rural setting but may have (appropriately) abandoned procedures for which the rural facility cannot provide infrastructure, though those skills may be required in the urban setting. Therefore, the rural surgeon should stay rural as a locum tenens surgeon and the older urban surgeon should be careful in covering the rural facility.

My second concern is locum tenens time limit. As noted, knowledge and performance degradation must be recognized as an inherent outcome of a low-volume, basically nonelective, surgical

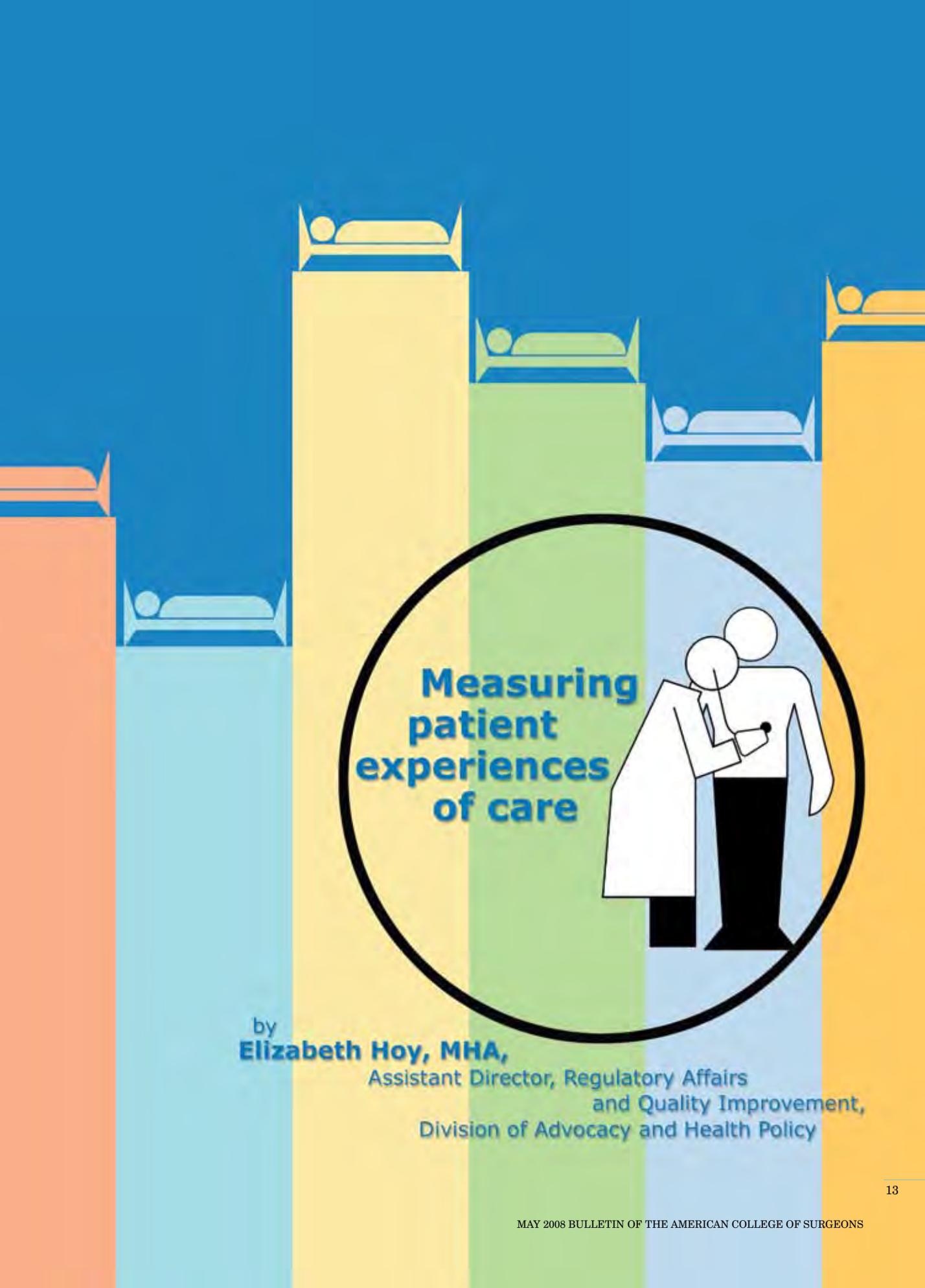
practice. The locum tenens surgeon should impose a time limit for performing in that venue and must honestly assess skills and knowledge levels on a regular and planned basis. The inevitable degradation must be compared with acceptable levels during a normal surgical practice, and the locum tenens activity discontinued when personally acceptable performance is not possible. This approach requires a high degree of honesty and is quite difficult because it imposes a negative evaluation of oneself. In my case, an upfront limit of three years was imposed and proved to be the correct assessment.

I agree that locum tenens surgeons fill a much-needed and appreciated role in the support of surgical practices in rural America. The continuity of surgical care during my experience left no implication that the activity implied itinerant character. The development of guidelines by the American College of Surgeons might be beneficial to surgeons contemplating a locum tenens practice. □

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**Dr. Reynolds** is a retired rural general surgeon and an emergency medical services and Advanced Trauma Life Support® consultant in Havre, MT.





## Measuring patient experiences of care



by  
**Elizabeth Hoy, MHA,**  
Assistant Director, Regulatory Affairs  
and Quality Improvement,  
Division of Advocacy and Health Policy

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**P**atient-centeredness is one of the six dimensions of the quality of health care defined by the Institute of Medicine's (IOM) landmark report, *Crossing the Quality Chasm*. But what does patient-centeredness really mean for surgeons and other health care professionals in terms of how they provide care? The IOM defines patient-centered care as follows:

Patient-centered care is care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.... [There are] several dimensions of patient-centered care, including (1) respect for patients' values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support—relieving fear and anxiety; and (6) involvement of family and friends.\*

As part of the healing relationship, all physicians want to cure and relieve suffering. To accomplish these objectives, surgeons shape technical facility, interpersonal skills, and processes of care to meet the needs of patients. Patient-centered care involves a shared decision-making process and an ability to see the health care system from the patients' point of view. Research has shown that increased patient satisfaction is correlated with better clinical outcomes, appropriate use of the health care system and benefiting from the services provided, and reduced risk of litigation.

### Seeing your practice as a patient

Jennifer Daley, MD, senior vice-president of clinical quality and chief medical officer for Tenet Healthcare, notes that recent research indicates that patients assume they will receive high-quality clinical care when they enter the hospital. What differentiates one provider from another and creates loyal patients and customers is caring service. Specifically, patients and

families want their health care professionals and providers to communicate with them, provide them with needed information and include them in decision making, treat them with respect and dignity, receive timely care, respect their privacy, listen to their complaints or concerns, and employ empathetic staff.

These precepts hold true for care delivered in the physician's office as well. So how can you know how your patients experience the care they receive from your practice? One way to obtain this knowledge is through the use of a "patient's-eye view" walk-through of the care system. This process enables providers to better understand the care experience from the patient's and family's points of view by going through the experience themselves. Physicians' offices, clinics, and hospitals all have made use of this type of study.

The Institute for Healthcare Improvement ([www.ihl.org](http://www.ihl.org)) has a free walk-through tool that is available to medical and surgical practices. (You have to register as a user of the Institute for Healthcare Improvement Web site to access this instrument, but registration and the tool itself are free.) This questionnaire is short and easy to use and will give you a sense of what it is like to be a patient in your organization. It builds awareness of simple things that your organization can do to improve the process of providing care and to enhance the patient experience.

As you walk through your practice, looking at things as if you were one of your patients, take note of which steps in the process—from attempting to make an appointment to checking out after the visit—frustrate you or make you angry and what contributes to a smooth and positive interaction. Pay attention to events like repeated requests for the same information or steps in the care process that cause delays. Are the signs clear, visibly located, and easy to read? In the waiting area, can patients overhear the staff, including conversations about information that should be private? Call your own phone system: Are the instructions and information for patients clear and accurate?

However, there are some things only patients can communicate about the quality of the care they receive. So, one of the most objective and

\*Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001: 40,49.

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quantifiable ways to assess patient-centeredness is through patient surveys.

### The CAHPS® family of surveys

The concept of patient surveys is simple—ask the people who use the health care system whether it meets their needs. Ensuring that surveys result in reliable, scientifically valid, and actionable information is somewhat less simple. Patients need to be selected to answer the survey in an unbiased manner, the questions used in the survey must accurately assess the key dimensions of care, and the results of the survey must be analyzed in a way that minimizes bias (including risk adjustment for patient factors, such as age, that systematically influence the responses given).

The most widely used surveys of patient experiences of care are the Consumer Assessment of Health Providers and Services (CAHPS) survey instruments. Developed through a public-private partnership of the Agency for Healthcare Research and Quality and researchers at Harvard University, The RAND Corporation, Research Triangle Institute, Westat, and American Institutes for Research, these surveys have been widely adopted by the Centers for Medicare & Medicaid Services, state Medicaid programs, and private health plans. More than 55 million

enrollees currently are covered through health plans that rely on CAHPS.

CAHPS surveys have a number of distinguishing characteristics that have contributed to their rapid adoption.

- The CAHPS surveys focus on the characteristics of quality that are of importance to patients and for which they are the most reliable source of information. Therefore, CAHPS surveys ask about dimensions of care like provider communication skills, access to care, helpfulness of office staff, and being treated with courtesy and respect. Although clinical quality is important to consumers, the surveys don't ask about that, because consumers are not always the best judges of clinical quality.

- The CAHPS surveys are extensively tested for validity and reliability. Every CAHPS survey goes through extensive field testing in multiple geographic areas and with broadly representative samples of the intended respondent population.

- CAHPS surveys are cognitively tested with respondents to ensure that survey questions are understandable, that the response options available on the survey are appropriate to the experience being measured, and that respondents are able to accurately answer the questions as written. For example, the CAHPS Hospital Survey initially contained a question about whether hospital personnel asked the patient about medication allergies before prescribing any new medications. Although this is an important dimension of preventing medication errors, it was dropped from the final questionnaire because consumers were unable to answer the question in a way that accurately assessed allergy awareness by hospital staff because of variations in protocols for allergy alerts.

The CAHPS Consortium has developed a version of the survey designed to measure patient experiences of care at the individual clinician and group practice level. The Clinician and Group CAHPS (CG-CAHPS) questionnaire includes questions about the following dimensions of care in its core item set:

- Getting care quickly
- Getting answers to medical questions by telephone
- Coordination of care

### Financial contributors to the Surgical CAHPS Project

- American Academy of Ophthalmology
- American Academy of Orthopaedic Surgeons
- American Academy of Otolaryngology–Head and Neck Surgery
- American Board of Orthopaedic Surgery
- American College of Osteopathic Surgeons
- American College of Surgeons
- American Society of Anesthesiologists
- American Society of Colon and Rectal Surgeons
- American Society of Plastic Surgeons
- American Urological Association
- Society of Thoracic Surgeons
- United Health Foundation

- 
- Physician communication skills
  - Health promotion and education
  - Office staff communication skills

The CG-CAHPS instrument was field tested in several geographic locations and with multiple specialties. Field test partners included the Massachusetts Health Quality Partnership and the American Board of Medical Specialties (ABMS). ABMS initiated the working relationship with the CAHPS consortium as a means of establishing national benchmarks for performance using a standardized instrument. ABMS intends for CAHPS to be incorporated into the Maintenance of Certification (MOC) requirements of its member boards. Specialties that participated in the ABMS field testing were family practice, orthopaedics, obstetrics and gynecology, and radiology.

### Developing a surgical CAHPS questionnaire

As the CG-CAHPS questionnaire became publicly available, a number of surgical specialty societies reviewed the instrument and noted that although it did a good job of assessing ongoing or chronic care, the questionnaire had serious shortcomings if used to assess surgical care, given its episodic and procedure-based nature. In addition, the CG-CAHPS instrument omitted questions about some key elements of the quality of surgical care, such as informed consent and follow-up care.

As a result, the American College of Surgeons, representing the Surgical Quality Alliance, has contracted with American Institutes for Research (AIR) and Westat to develop a survey to assess patient experiences in surgical care. AIR and Westat have extensive experience working on other CAHPS instruments and are following all AHRQ guidelines and protocols for developing a CAHPS survey. When the survey is complete in October, it will be submitted to AHRQ for endorsement as an official CAHPS instrument.

Eleven surgical specialty societies and one surgical board (see box, page 15) are supporting the project financially, are providing technical input to the questionnaire design, and have recruited surgical practices to participate in field testing the questionnaire. The draft field test questionnaire contains sections covering preoperative

care, interactions with surgeons and anesthesiologists on the day of the operation, postoperative follow-up care, and interactions with surgeons' office staff. The survey will provide a common core set of questions that can be used for quality improvement within practices, part IV of MOC, and public reporting of quality information for consumer choice. Specialty societies that wish to assess aspects of care unique to their specialty practice will be able to develop supplemental questions to incorporate in the core survey.

The core mission of the American College of Surgeons is to improve the care of the surgical patient. Providing the highest-quality surgical care requires clinical knowledge and technical skill and the tools to assess surgical practice and systems of care. The Surgical CAHPS questionnaire, when it is completed, will provide a valuable tool for assessing the degree to which the care individual surgeons provide patient-centered care. <sup>Q</sup>

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For more information on the CAHPS surveys and their development, check out the CAHPS Web site at <https://www.cahps.ahrq.gov/default.asp>.



In February, Karen Horvath, MD, FACS, was honored by the Accreditation Council for Graduate Medical Education (ACGME) with the Parker J. Palmer Courage to Teach Award. This honor recognizes Dr. Horvath as one of 10 outstanding residency program directors in the nation.

Dr. Horvath did not intend to head the residency program when she joined the University of Washington department of surgery in 1998. A graduate of New York Medical College, she completed a residency in general surgery at Columbia University, with a surgical research fellowship in colorectal surgery and a clinical fellowship in surgical critical care at Mount Sinai Medical Center.

After residency, she moved to Oregon Health Science University and Legacy Emanuel Hospital for a fellowship in laparoscopic surgery and on to Tokyo

## **Building a successful residency program:**

**Insights from an award-winning program director**

**by Lola Butcher**

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for a visiting fellowship in transabdominal and endoscopic ultrasound.

Then she arrived at the University of Washington School of Medicine, the only academic medical center in Washington, Alaska, Idaho, Montana and Wyoming.

But the medical school is also a research powerhouse, ranking first among public medical schools—and second among all medical schools—in federal research funding. In fiscal year 2007, UW Medicine faculty received \$579.7 million in National Institutes of Health research awards.

The department is affiliated with four Seattle-area medical centers: Children's Hospital and Regional Medical Center, Harborview Medical Center, Veteran's Affairs Puget Sound Health Care System, and the University of Washington Medical Center.

Shortly after arriving at the university, Dr. Horvath was asked to serve as assistant program director. In 2002, Carlos A. Pellegrini, MD, FACS, chairman of the department of surgery at the University of Washington and a Regent of the College, asked her to become residency program director and chair of the department's resident education committee.

### ***Why she was nominated***

What had convinced the ACGME committee to select Dr. Horvath for the Parker J. Palmer Courage to Teach Award was the endorsement she received from Dr. Pellegrini. When Dr. Pellegrini learned of this award program for residency program directors, the deadline for making nominations was only one week away. But he believed his colleague deserved to be recognized, so he moved into high gear.

He sent notes to several residents and faculty members, hoping that at least one of each might carve out a few minutes to write a letter in support of Dr. Horvath's nomination.

"Since the deadline was only a few days away, I expected that many would not find the time," he said. "To my surprise, 100 percent of those asked sent me a letter within 24 hours. This is perhaps the best expression of Karen's perceived value to our residents and our faculty."

His nomination letter rattled off Dr. Horvath's long list of accomplishments, but its summation is what stands out: "One meets a lot of people

when working in the academic environment," Dr. Pellegrini wrote. "Once in a while you find a superstar in every respect—professionalism, clinical acumen, the courage to teach and to stand always for what is right, a person who you cherish the opportunity to share your work with. Karen Horvath is just that person."

One of her primary attributes, Dr. Pellegrini said, is fearlessness in a time of rapid change in surgical education. "If you're afraid of change and you want to keep the old models, then you are not going to be able to move forward," he said.

Indeed, Dr. Horvath identifies constant adaptation to the changing educational requirements and the evolving needs of the surgical residents to be one of her top priorities.

Following are Dr. Horvath's insights regarding various components of surgical education today.

### ***The 80-hour workweek***

Dr. Horvath and her colleagues developed UWCores, a computerized rounding and sign-out system to improve the quality and efficiency of patient hand-offs, to help meet the challenge of the 80-hour workweek.

"The 80-hour workweek has been very good for residents because they are much more well rested, which makes it easier for them to focus not only on patient care but on other competencies," Dr. Horvath said. "We, along with many others around the country, have written about our concern about the increasing number of patient handovers, which is one negative effect of the 80-hour workweek. Communication errors are a problem in health care, and when the number of times that you hand over a patient to another physician increases, the potential for more errors increases as well."

With the UWCores system, the residents do not have to spend much time in the morning on tasks such as looking at the computer and writing down by hand all of the patients' laboratory values. Instead, the data are available electronically and residents just need to press the print button. According to Dr. Horvath, this system saves residents a substantial amount of time, allowing them to improve the continuity of patient care by decreasing the number of patients missed on resident rounds. This program has

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generated much interest from institutions across the country.

Dr. Horvath believes systemic problems related to communication and team-based care surfaced long before the 80-hour workweek. But when the 80-hour workweek was adopted, she said, ongoing problems were basically multiplied by a factor.

According to Dr. Horvath, a paper that she wrote along with Erik Van Eaton, MD, a former resident, and Dr. Pellegrini reflects the authors' thoughts about some of the important ways that surgical training is facing fundamental changes.\* Whereas the traditional sense of professionalism required a clinician to practice unlimited devotion to the care of every patient, she noted, surgical residents today have a limited amount of time with patients, an increasing amount of responsibilities at the hospital, and a larger team sharing in the care of their patients.

"With the rising complexity of health care in the last quarter of the 1900s," Dr. Horvath said, "surgical education has added more and more onto residents' backs until they were pretty much maxed out before the 80-hour workweek was implemented. Computerized axial tomography, positron-emission tomography, and magnetic resonance imaging scans did not exist until the latter part of the last century. The complexity has skyrocketed, and now the residents have to transfer all that information every time they hand off a patient. So, both the hours restrictions and the complexity of care are limitations to the idea of unlimited devotion to their patients or 'professionalism.'"

The authors believe the challenge of doing more in less time requires a new, explicitly taught approach to professionalism. This methodology should include a clear understanding—on the part of faculty and residents—of trainees' responsibilities and a new way for residents to have "patient ownership."

"We believe that it's possible for residents to still

\*Van Eaton EG, Horvath KD, Pellegrini CA. Professionalism and the shift mentality: How to reconcile patient ownership with the 80-hour work week. *Arch Surg.* 2005;140:230-236.

†Horvath KD, Mann GN, Pellegrini CA. EVATS: A proactive solution to improve surgical education and maintain flexibility in the new training era. *Curr Surg.* 2006;63(2):151-154; and Horvath KD, Pellegrini CA. Designing an EVATS rotation for your program. Available at: <http://www.facs.org/education/rap/horvath0406.html>.

'own' their patients, but it may just look different than it has in the past," Dr. Horvath said. "It's not necessarily worse, just a different context. Our educational programs and patient care systems must improve communication and make team-based care easier, and surgical educators must be the authors and role models of these concepts."

Dr. Horvath acknowledges that a project of such scope is an enormous undertaking, noting that she doesn't know if she will ever feel as though the task is "done." After the paper was published, however, the dean of the University of Washington Medical School appointed Dr. Pellegrini to lead the School of Medicine's standing committee on professionalism—the Continued Professionalism Improvement Committee—which is charged with stimulating activities at all levels of the school that lead to improvement in professional behavior, by finding ways to effect these kinds of changes in meaningful and practical, not merely theoretical, ways.

### **EVATS**

An EVATS (emergency coverage, vacation, academic project, and technical skills) rotation is an innovation from Dr. Horvath's department to provide residents with a specific time for simulation training, vacation, covering for emergency absences, and formal learning in the ACGME competency areas that are not covered during other rotations.

According to Dr. Horvath, the EVATS experience in her program has been extremely positive, but recognizing that every program is different, she does not know how easily it could be adopted into other programs. She and her colleagues have written about EVATS, partly to share this particular system with other programs that want to implement it, but mostly in hopes that sharing knowledge about such an innovation might stimulate others to create something even better for their own program and others.†

### **International medical graduates**

Dr. Horvath's department has also implemented a program for improving the success rate of international medical graduates (IMGs). When any resident leaves the program in the middle of the year, Dr. Horvath said, it creates problems for the other residents because it affects everybody's

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schedule. “And,” she added, “it is heartbreaking to watch any students fail when they are just not in the right place.”

Though many IMGs are very qualified for residency, identifying the correct match for resident and residency program is difficult. “Just like U.S. medical school graduates, not every international medical student will do as well in program X as he or she will in program Y,” Dr. Horvath said. “But we often find that IMGs will take whatever they can get and sometimes they are definitely mismatched to a particular program.”

Dr. Horvath’s department is also seeking to confront the major challenges IMGs face. “English is usually their second language. The U.S. medical students have already had two years of training in the U.S. hospital system. They know how we think, how the computer systems work, how the teams function, the hierarchy, the culture of the surgical team, and how we communicate with each other. So the IMGs often find it is difficult to catch up because they started 10 steps behind at the gate,” Dr. Horvath said.

Her department has developed a certificate program that admits approximately six international students each year. For eight weeks, these students are essentially functioning—and being evaluated against the same high expectations—as fourth-year medical students by Dr. Horvath and her colleagues.

This system gives the IMGs and the faculty the opportunity to see if the IMGs are suitable for and comfortable in working in a U.S. hospital. At the end of the eight weeks, some decide they do not want to train in the U.S., but some of them go on to become residents in Dr. Horvath’s program or another—and do extremely well. In fact, Dr. Horvath said, “Some of the University of Washington’s super-exceptional graduates have been people who started out in this program.”

### ***Challenges of today’s surgical educators***

Dr. Horvath believes there are two big challenges for today’s surgical educators: (1) teaching patient ownership (or professionalism) and team communication skills to residents in this new era, simultaneously defining the new system and teaching the teachers while also teaching the residents and students, and (2) keeping pace with the exponential growth rate of change occurring

in surgical education and in other areas of health care while maintaining the same or better level of clinical training in surgery.

“Certainly the ACGME competencies project and the 80-hour workweek and all of the new outstanding opportunities for training with simulation and other initiatives are really wonderful,” Dr. Horvath said. “They are providing us the opportunity to train surgeons even better than we did in the past.” However, she noted, with significantly fewer hours in which to do it, there are major challenges. Though there are positives, such as the new hospital requirements like the Health Insurance Portability and Accountability Act of 1996 and The Joint Commission’s efforts to improve health care, she said, the tradeoff in the many positive outcomes is that they mean more steps in the process, more forms to fill out, and more complexity to effect task completion.

“Leaders in graduate medical education around the country have acknowledged that there is a limit to how much residency programs and residents can handle beyond patient care activities. I don’t think anyone knows where this ceiling is, but it definitely has a finite capacity,” she said, adding that it is essential to be very careful about not compromising the clinical experience for residents too much. “The experience of taking care of patients is really one of the best educational tools that we have, and at least for surgery, we’ve already started to compromise it,” she said.

Dr. Horvath commented that as she spends more time working in this field, she realizes that with many new, positive things happening in surgical education, finding ways to streamline the system is imperative, suggesting that adjusting computer programs to perform old and new tasks could help residents gain more time instead of extra work.

“But we also need to sit down and assess all of these many things we are doing—and maybe decide that some of them don’t need to be done any more,” she said. “It is crucial that we think about this, because the system does not have infinite capacity. In the end, I believe that if we can meet both of these challenges, we will be able to train better surgeons in less time, and our patients will benefit.” □

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***Ms. Butcher*** is a freelance writer in Springfield, MO.

# ACS establishes Health Policy and Research Institute

The American College of Surgeons has established a new Health Policy and Research Institute and has appointed its Director: George F. Sheldon, MD, FACS, Zack D. Owens Distinguished Professor of Surgery, University of North Carolina (UNC) School of Medicine, Chapel Hill, and Past-President of the ACS. Thomas J. Ricketts, PhD, deputy director of UNC's Cecil G. Sheps Center for Health Policy Research, is the Administrative Director. Initially, the Sheps Center will serve as headquarters for the institute.

"The Sheps Center has a long and distinguished record in conducting health policy research, so basing the ACS Health Policy Institute at UNC enables the College to begin our research quickly," said Thomas

R. Russell, MD, FACS, ACS Executive Director. Dr. Russell said the new institute will conduct research in many areas of health policy that promise to be increasingly important in the evolving health care environment.

"[T]he need exists for scholarly, well thought-out policies, based on the best evidence that can be generated. This collaboration should develop information and policy recommendations of use as we continue to participate constructively in health care reform," Dr. Sheldon said.

For its first assignment, the institute is studying the surgical workforce issue. "Most experts who have studied the issue believe that we are going to have a shortage of surgeons in the not-too-distant future,"

Dr. Russell said. "We need to be able to address that, and the ACS Health Policy and Research Institute will play a very important role in providing the data needed to guide policy decisions on this and many other issues." Some research dealing with issues related to the surgical workforce has already been conducted as a result of the collaboration between the ACS and UNC, Dr. Sheldon noted. These projects will be credited jointly and co-branded with the ACS, he said.

"There is growing pressure on physicians to document the work they do and to be as cost-effective as possible," Dr. Ricketts added. "The institute will help develop the data that can show what surgeons are doing well and where there may be ways to reduce costs."



Dr. Sheldon



Dr. Ricketts



Dr. Russell

In addition, the ACS Health Policy and Research Institute has received requests for collaborative projects from other highly respected research institutes, including the Institute for Health Policy Change and the American Association of Medi-

cal Colleges Workforce Center. "We expect that the research program of the ACS Health Policy and Research Institute will be productive fairly rapidly because of these relationships and our access to this unique expertise," Dr. Sheldon said.

The College intends to relocate the Health Policy and Research Institute to the College's Washington Office when the new building is completed in 2010. Some efforts thereafter will be continued at the Sheps Center.

## ACS selects 2008 Oweida Scholar

Timothy A. Breon, MD, FACS, of Oskaloosa, IA—who helped to establish the Iowa Rural Surgical Associates, which provides required surgical services to rural communities in the southeast of the state—was selected to receive the 2008 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons.

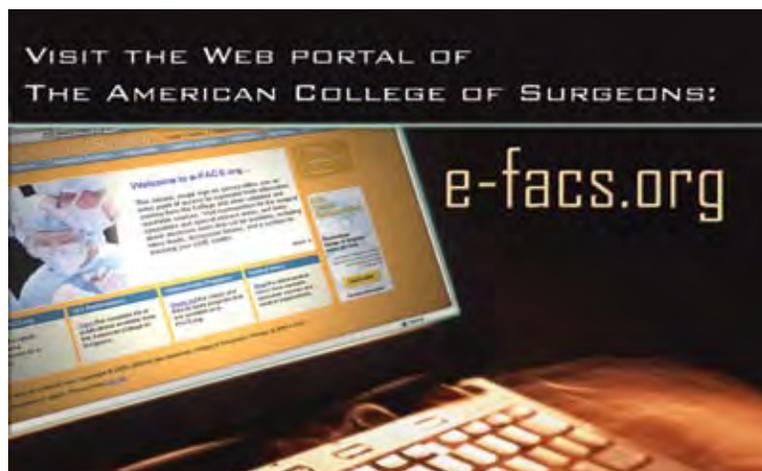
The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The purpose of the \$5,000 award

is to subsidize attendance at the annual Clinical Congress, including postgraduate course fees, in order to help young surgeons practicing in rural communities benefit from the educational experiences the Congress provides. It is awarded each year by the Executive Committee of the Board of Governors.

The Oweida Scholarship requirements are available on the College Web site at *www.facs.org*. The application deadline for the 2009 Oweida Scholarship is December 1, 2008.



Dr. Breon



- View surgical news
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# Joint symposium to focus on neurotrauma/critical care

Members of the American College of Surgeons are invited to attend the first joint symposium of the National Neurotrauma Society and the American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS) Section on Neurotrauma and Critical Care, which will take place July 27–30 at the Hilton Walt Disney World in Orlando, FL.

This meeting, which will occur under the banner of the 26th Annual National Neurotrauma Symposium, will provide attendees an opportunity to learn about the most up-to-date clinical and basic science in neurotrauma and critical care in a collaborative environment.

Through this joint effort, specific clinical sessions have been created for practicing physicians, neurotrauma nurses, and basic scientists. These sessions are intended to help attendees better understand the state-of-the-art management of neurotrauma and critical care through didactic sessions (such as management of traumatic brain injury, spinal cord injury, and intensive care) and hands-on sessions (such as spinal column trauma reconstruction, multimodality monitoring, and surgical management for brain trauma).

It will provide attendees an excellent opportunity to learn what is new and easily incor-

porated into clinical practice and to hear about what is on the horizon clinically and scientifically in neurotrauma and critical care, with plenty of trauma-specific continuing medical education credits (up to 25 hours of *AMA PRA Category 1 CME Credits*<sup>™</sup>).

The goal of this joint symposium is to create a better dialogue and collaboration among clinicians and scientists that might “translate” into improved

patient care in the future.

For program information and to register online, visit <http://www.neurotrauma.org/2008/index.htm#>. Contact David Adelson, MD, FACS, FAAP, Chair, AANS/CNS Section on Neurotrauma and Critical Care and Chair, Neurosurgery Subspecialty Group, Committee on Trauma, American College of Surgeons, via [karen@tlceventsgroup.com](mailto:karen@tlceventsgroup.com) for further information.

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□ **PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons:** Topics covered on this interactive CD include debt management and financial planning for surgical practice. This program provides a printable CME certificate upon successful completion.

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For more information, contact Olivier Petinaux, MS, at [elearning@facs.org](mailto:elearning@facs.org), or 866/475-4696.



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From the Archives

## Photos shed light on history of surgery in Mexico

by Susan Rishworth, ACS Archivist

When Ricardo F. Gonzalez Fisher, MD, FACS, of Aguascalientes, Mexico, stopped by the American College of Surgeons' Member Services booth at the 2007 Clinical Congress in New Orleans, LA, he told us he had some rare photographs of a surgical procedure performed in Saltillo, Coahuila, Mexico, in 1909.

Mr. Rodrigo Cabello-Iniesta, a medical student working with Dr. Gonzalez, was the source for these photos (one of which is featured at right) and assisted with researching the photos since the surgeon depicted was his great-uncle.

They discovered that the photos showed what is claimed to be the first thyroidectomy in the Americas. The surgeon, standing at the right side of the patient, is Dr. Anselmo Cabello-Aguirre (1868–1931), the son of Mr. Anselmo Cabello-Leon and Mrs. Jesucita Aguirre.

Dr. Cabello studied medicine in Paris, France, and graduated with honors in 1901. According to the rules of the university, the best students were sent to an internship at the Pean Clinic. Some of the staff of the university did not agree that a Mexican student should be sent to that clinic, but the president of the jury supported Dr. Cabello.

Dr. Cabello stayed at the Pean Clinic for seven years. His per-



formance was excellent and he was invited to become a resident of the country, but he had a debt with his native country and his family and decided to come back to Mexico in 1908.

In 1909, Mrs. Margarita Aparicio, a wealthy woman from San Antonio, TX, came to Mexico looking for Dr. Cabello because there was no one in her hometown who could cure her. The thyroidectomy was a complete success. Mr. and Mrs. Aparicio gratefully gave Dr. Cabello a wagon with four white horses and a servant who was freed when he started to work for Dr. Cabello.

Dr. Cabello was invited to work in Mexico City but he preferred to stay in his home-

town where he served the poor people.

The other doctors in the picture are Dr. Juan Cabello y Siller, who later became mayor of Saltillo, and at the head of the patient, Dr. Pomposo García, who gave the anesthesia. For reasons unknown, the image of a nurse was erased from the center of the photograph.

The Archives would like to thank Dr. Gonzalez Fisher and Mr. Cabello-Iniesta for sharing these illuminating photos that predate even the Clinical Congresses that preceded the formation of the ACS.

If you have photos you would like to share, contact Susan Rishworth at 312/202-5270 or [srishworth@facs.org](mailto:srishworth@facs.org).

# PERSONAL FINANCIAL PLANNING AND MANAGEMENT

## FOR RESIDENTS AND YOUNG SURGEONS

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

### OBJECTIVES

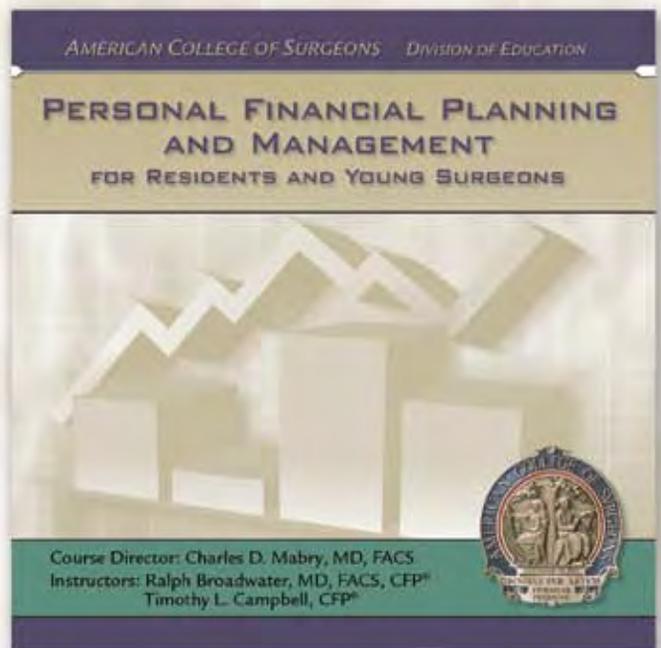
At the end of the course, the participants will be able to describe:

- The essentials of personal financial management as they relate to young surgeons in practice and residents and their families.
- The impact of interest rates and time upon loans, compound interest, and the implications for debt management.
- The building blocks necessary for the surgeons to invest successfully.
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### INTENDED AUDIENCE:

- Surgical residents and surgeons recently in practice.

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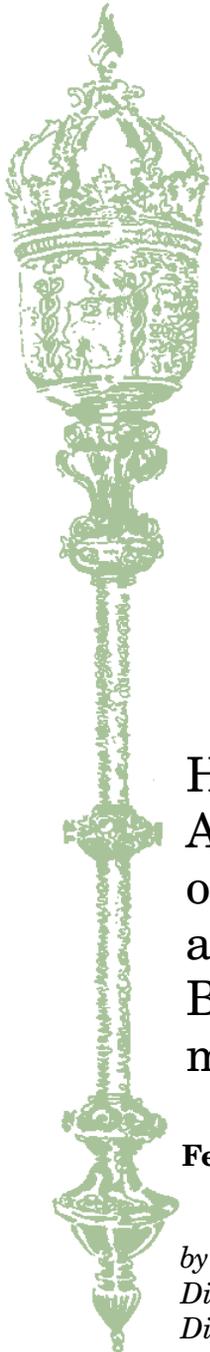


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## Highlights of the ACSPA Board of Directors and the ACS Board of Regents meetings

**February 8–9, 2008**

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

### ***American College of Surgeons Professional Association (ACSPA)***

The ACSPA-SurgeonsPAC (political action committee) is doing well. It is now the fifth largest physicians' PAC (up from the seventh). The PAC raised \$639,000 in the 2006–2007 election cycle. Telephone solicitation continued to be a major component of the PAC's fundraising efforts. Political disbursements were made to 129 candidates, leadership PACs, and party committees.

Among the U.S. Governors, 50 percent made contributions averaging \$495. Among the U.S. Regents, 85 percent made contributions averaging \$912.

The ACSPA-SurgeonsPAC will continue to support congressional leaders and other members of Congress who support surgery's legislative agenda. The PAC will be used as a tool for gaining access to legislators and for ensuring that a sustainable growth rate (SGR) fix is at the forefront of the legislative agenda.

### ***American College of Surgeons***

#### **Board of Governors**

The Board of Regents approved the following recommendations and requests from the Board of Governors.

In order to improve relationships with international surgeons and increase international membership, the College should do the following:

- Reduce the number of years in practice required to apply for Fellowship
- Accept successful completion of a local surgical training program with documentation, three years of practice in that location, and review by Governor or local council
- Increase the number of International Guest Scholarships
- Develop second-tier scholarships to cover Clinical Congress registration fees

In light of heightened concern regarding surgical workforce and manpower issues, the College should make a priority of improving or extending its efforts to document what truly is

the workforce for surgery in America.

Other recommendations/requests included that the College should do the following:

- Reinstate publication of the *Surgical Forum*, the proceedings and abstracts from the Forum sessions, and the abstracts and summaries that are presented at the poster sessions
- Become more proactive in helping the chapters
  - Increase staff in the state legislative office
  - Develop state- or chapter-level ACS PACs
  - Make Operation Giving Back (OGB) a stable and progressive force
    - Bring OGB to the chapters
    - Invite Regents (and other College representatives) who present at chapter meetings to be participants in the entire meeting
      - Create better oversight and coordination of educational sessions by the Program Committee
      - Board of Governors committees should focus on the issues brought out by the Governors' annual survey

### **Strategic planning**

The strategic planning process that had begun earlier continued during this February meeting of the Board of Regents. The Strategic Planning Committee held its first telephone conference call meeting on January 15. The purpose of this meeting was to discuss the College's action in the socioeconomic arena and to formulate plans for future socioeconomic action. At the conclusion of the meeting, preliminary recommendations to the College included the following:

- Must have meetings involving socioeconomic and other issues between Board of Governors and Board of Regents; must increase communications between Regents, Governors, and Fellows, especially on socioeconomic issues
  - Initiate discussions with medical malpractice carriers; offer discount up to 35 percent for Fellows who have perfect records, and for the remainder, provide risk management and edu-

cational courses through ACS education centers that would eventually allow individuals to become eligible for discounts; tie to Maintenance of Certification process and state licensure

- Review Washington Office to determine if budget, staffing levels, and other resources are adequate
  - Resuscitate floundering chapters with shared permanent secretariat and staff; group chapters regionally to help them increase their membership and organize meetings involving young surgeons

### **Advocacy**

The ACS Health Policy and Research Institute became operational in January. It will be headquartered at the Cecil G. Sheps Center for Health Policy Research at the University of North Carolina until the College's Washington, DC, headquarters building is completed. At that time, it is anticipated that the institute will relocate to Washington, DC.

The Sheps Center is realigning personnel to obtain a quick start for research pertinent to surgical interests. One large review article and two submitted abstracts dealing with issues related to the surgical workforce have already been completed. They will be credited jointly and, by agreement, co-branded with the American College of Surgeons.

The College's Division of Advocacy and Health Policy has been striving to improve communications with ACS leaders and the Fellowship. A new series of Web-based teleconferences has been initiated for ACS Governors and other leaders, a new electronic newsletter featuring ACS and ACSPA advocacy activities has been launched, Web-based educational teleconferences were organized to educate surgeons about quality reporting under Medicare, and discussion forums focusing on Medicare and other advocacy topics were created on the Web portal.

The College continues to fulfill its role as a coalition builder. Advocacy efforts spearheaded by the College include extensive campaigns to generate support for a system of separate fee schedule spending targets and conversion fac-

tors under Medicare, reauthorization of trauma systems development legislation, and refinement of legislation to promote the implementation of health information technology (IT).

### **Physician Quality Reporting Initiative (PQRI)**

The Medicare PQRI program (initiated in 2007) will be continued through 2008. The program links a 1.5 percent Medicare physician payment bonus to reporting quality data on Medicare claims.

This year, the program has 199 measures from which physicians can choose to report. Physicians who report on three or more performance measures for at least 80 percent of relevant procedures are eligible for the full 1.5 percent bonus payment. For physicians who report more than four performance measures, the Centers for Medicare & Medicaid Services (CMS) will choose the three measures with the highest reporting rate to calculate the bonus payment.

Through its Division of Advocacy and Health Policy, the College hosted four Web-based teleconferences, or webinars, in December to educate surgeons' practices about participating in the PQRI program. Two of the webinars were oriented to practices that had not previously participated, and two were focused on changes to the program in 2008 for those practices that were already participating in 2007. All of the PQRI-related materials developed by the College were updated on the Web site to reflect new measure specifications for 2008.

### **Consumers' Checkbook lawsuit**

On August 22, the U.S. District Court for the District of Columbia issued a decision that will make physician-identified Medicare claims data available for use by Consumers' Checkbook/Center for the Study of Services in order to assess health care quality. Specifically, the court decision requires the U.S. Department of Health and Human Services (HHS) to provide physician-specific Medicare claims data to Consumers' Checkbook for use in reporting to the public on the number and types of procedures

each physician provides under Medicare and to somehow translate those data into an assessment of health care quality.

In meetings with HHS officials, the College and other specialty organizations expressed appreciation for the intent behind the Consumers' Checkbook lawsuit, but expressed skepticism about whether these Medicare data will improve the current lack of meaningful provider-specific data for consumers to use and make wise health care decisions. HHS has notified the court of its intention to appeal the decision, and the College is one of 17 medical and surgical specialty societies planning to file an amicus brief in support of the appeal.

### **Medicare physician payment**

On December 18, 2007, the Senate passed the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (S. 2499) by unanimous consent. The bill included provisions to increase the Medicare fee schedule conversion factor by 0.5 percent for all physician services provided between January 1 and June 30 of this year. The House of Representatives passed S. 2499 on December 19, 2007, on a 411-3 vote, and the bill was signed into law December 29.

The Medicare fee schedule conversion factor was scheduled to be cut by 10.1 percent on January 1 because of the SGR system used to determine Medicare payment updates. Without further congressional action, Medicare payments will be reduced 10.1 percent on July 1 or by 10.6 percent from the current payment level. The bill also included six-month extensions of other payment policies, particularly those that support payments in rural areas. CMS has announced that, because of the change in 2008 payment rates, it will reopen the period for physicians to make decisions about whether to sign Medicare participation agreements for 45 days. It is not known whether CMS will allow physicians to revisit their participation agreement status if and when payments are reduced mid-year.

The House had passed a more comprehensive Medicare measure that included payment in-

creases of 0.5 percent in 2008 and 2009, but the House and Senate could not reach agreement on all details of the package, particularly with respect to proposed payment cuts elsewhere in Medicare that would have been used to offset the increase in physician payments. The disagreements largely centered on payment rates to Medicare Advantage plans, which are Medicare plans administered by private health insurance companies.

In early December, the College contacted Fellows via e-mail on multiple occasions and asked them to telephone their senators and representatives regarding this issue. From responses received, it appears that approximately 3,000 Fellows made these contacts—the College's most successful effort to generate such grassroots support. Advocacy efforts also included bringing surgeons in to meet with key senators and representatives.

### **ACS multiple conversion factor proposal**

On August 1, 2007, the House passed the Children's Health and Medicare Protection Act (H.R. 3162, or CHAMP Act) on a 225–204 vote. The bill, which included measures to reauthorize SCHIP, also included provisions that would have provided two years of Medicare fee schedule updates of 0.5 percent in 2008 and 2009. Importantly, the bill would have implemented more comprehensive Medicare payment reforms by establishing a system of six separate fee schedule updates and conversion factors based on service categories, including a separate category for major surgical procedures. These provisions were similar to those included in the College's service category growth rate reform proposal, which was included in legislation HR 3038. In a letter dated December 8, 2007, a bipartisan coalition of 140 representatives led by Reps. Lincoln Davis (D-TN) and Pete Sessions (R-TX) expressed support for the Medicare reform measures included in the House-passed CHAMP Act to House Speaker Nancy Pelosi (D-CA) and House Republican Leader John Boehner (R-OH). This letter was proposed and drafted by the College. By either voting for the CHAMP Act or signing the Davis-Sessions let-

ter, 279 representatives expressed support for separate service category targets.

### **ACS efforts to promote separate targets**

In September 2007, the College and 11 surgical specialty organizations sent letters to all 100 senators expressing support for two years of fully funded, positive fee schedule updates, as well as the CHAMP Act provisions pertaining to the multiple spending targets and conversion factors. This letter was organized and produced by the College. In addition, College staff met with more than 80 Senate offices in the fall, in an effort to build awareness of and support for these provisions of the House CHAMP Act.

In late October 2007, the College led medical and surgical specialty organizations in advocating against a letter being circulated by Sen. Herb Kohl (D-WI) regarding imaging issues in the CHAMP Act. As originally drafted, the letter opposed the multiple targets included in the CHAMP Act. Through these advocacy efforts, the offending language was removed from the final letter.

### **CMS**

On July 12, 2007, CMS published a proposed regulation outlining Medicare physician payment policy changes for 2008. At that time, the Medicare fee schedule conversion factor was still slated for an estimated 9.9 percent reduction effective January 1.

On November 1, 2007, CMS released the final rule on the fee schedule. Most of the provisions included in the proposed rule were retained. In addition, the final rule announced that a 10.1 percent across-the-board reduction in Medicare physician payments would be implemented unless Congress intervened by the end of the calendar year. Without congressional action, the fee schedule conversion factor was set to drop from \$37.8975 to \$34.0682.

The College submitted an extensive comment letter on the proposed rule on August 31, 2007, and separately submitted comments on provisions in the final rule that were open to public comment, particularly interim relative

value unit provisions that were detrimental to surgery.

### **Ambulatory surgery centers (ASC) legislation**

Introduced by Sen. Mike Crapo (R-ID) in October 2007, S. 2250, the Ambulatory Surgical Center Payment Modernization Act of 2007, would provide a more equitable payment system for ASCs and follow a MedPAC recommendation to modify the ASC procedures list. S. 2250 would provide a more equitable payment rate of 75 percent of the Hospital Outpatient Prospective Payment System. In addition, the bill would allow payments to ASCs for any surgical service, except for those procedures where the HHS Secretary identifies a specific risk concerning a certain procedure being performed in an ambulatory surgery setting, or when an overnight stay is required. The College sent a letter to Senator Crapo to support the bill and College staff has been meeting with numerous Senate offices in order to gain more support for the bill.

### **Stereotactic breast biopsy regulatory proposal**

On November 5, the National Mammography Quality Assurance Advisory Committee (NMQAAC) of the U.S. Food and Drug Administration (FDA) held a hearing to discuss the possible modification of the definition of mammography under the Mammography Quality Standards Act (MQSA). This action would have the effect of regulating stereotactic breast biopsy procedures under MQSA.

Thomas R. Russell, MD, FACS, Executive Director of the College, and Shawna C. Willey, MD, FACS, director of the Betty Lou Ourisman Breast Health Center at Georgetown University Hospital, presented testimony on behalf of the College on how stereotactic breast biopsy is an important diagnostic tool for surgeons and their patients. Dr. Russell testified that federal regulation of interventional medical procedures is inappropriate under MQSA, in the absence of a clinically significant mammography-related problem and MQSA standards that could address that specific problem. Dr. Willey stated

that the proposed regulatory changes could be detrimental to the interests of patients in need of breast biopsy and ultimately hurt patient access and care. In particular, the College's witnesses emphasized that there should be no federal regulations to restrict certain physician specialties from providing specific services or procedures. The NMQAAC has not taken any further action on the proposal.

### **Trauma systems**

Congress finished work on 11 fiscal year (FY) 2008 appropriations bills, including the Bush-vetoed Labor-Health & Human Services-Education bill (L-HHS-E), by wrapping them together in an omnibus bill at the end of the year. However, to ensure the President would sign the enormous bill, funding was cut to adhere to the spending levels proposed in his original budget request. During that process, \$3 million for trauma systems development—which was won on the Senate floor when the L-HHS-E bill was considered separately in October and included in the final L-HHS-E bill that was passed by the House and Senate—was dropped from the bill. The trauma program is authorized for \$10 million for FY 2009, and the College and its supporters are again working to secure its funding.

The College and other key member groups are working together to launch an initiative to formally establish in statute and provide significant federal funding for trauma-focused grants for the National Trauma Institute. Legislation has been introduced in the House (H.R. 3673) by Reps. Ciro Rodriguez (D-TX) and Charlie Gonzalez (D-TX), and the coalition is working to achieve the introduction of companion legislation in the Senate.

Introduced in November 2007 by Sens. Patty Murray (D-WA), Johnny Isakson (R-GA), Jeff Bingaman (D-NM), and Kay Bailey Hutchison (R-TX), S. 2319, the National Trauma Center Stabilization Act of 2007, would provide critical funding to trauma centers that are at risk of closing because of the increased uncompensated and pro bono care costs they must absorb. Spearheaded by the National Foundation for Trauma Care, the bill language was taken from

the original Trauma Systems legislation, Title XII of the Public Health Service Act, passed in 1990. It was modified to include all trauma centers and to include new language specifying that trauma centers must use ACS trauma registry guidelines and must participate in a trauma system to receive federal funding. There is \$100 million authorized for the program in FY 2009 and such sums as necessary for FYs 2010–2014. Grants would be for three years and may be extended for an additional year as long as qualifying conditions are met. Individual grants may not exceed \$2 million nor exceed the level of uncompensated care provided in a facility's emergency department.

On October 30, 2007, the College and other surgical societies met with officials at the U.S. Department of Homeland Security (DHS) to lay the foundation for cooperation in the development of contingency plans for meeting national and local health care needs in the event of a national disaster. The surgical groups explained how trauma systems provide a model for coordinating the necessary resources beyond those typically involved in meeting public health requirements. DHS plans to organize a national conference to lay the groundwork for developing such plans.

### **Emergency workforce**

The College, along with the American Association of Neurological Surgeons and the American Academy of Orthopaedic Surgeons, developed a legislative agenda to address the ongoing surgical workforce crisis in emergency departments across the country. The priority issues identified were liability protections, reimbursement for treatment of the uninsured, loan deferment extension, and the regionalization of emergency care. Next steps included approaching other surgical specialty groups for support and enlisting a member of Congress to sponsor this agenda in the second legislative session of the 110th Congress.

### **Health system reform**

In June 2007, Rep. Tom Price, MD, FACS (R-GA), introduced H.R. 2626, Comprehensive

HealthCARE (Coverage and Reform Enhancement) Act of 2007. Soon after the bill was introduced, the College sent a letter to Representative Price in support of this bill, which includes several provisions that are consistent with longstanding College policy, such as the following:

- Anti-trust reform
- Common sense medical liability reform
- Replacement of the SGR with a Medicare Economic Index update system
- Reimbursement for uncompensated care
- Commitment to the development of performance-based quality measures with input from specialty physician groups

### **Joint surgical advocacy**

The College worked with six surgical specialty societies—American Academy of Otolaryngology–Head and Neck Surgery, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Osteopathic Surgeons, Society of Gastrointestinal Endoscopic Surgeons, and Society of Thoracic Surgeons—to sponsor a Joint Surgical Advocacy Conference in Washington March 9–11. Other specialty societies were planning to send delegations to the event as well. The conference, which was open to all Fellows and members of the other participating organizations, featured issues and political briefings and visits with legislators on Capitol Hill. If the conference has proven to be successful, there are plans to make it an annual event.

### **Loan initiatives for residents**

Medical school graduates are now finding they owe an average of \$130,000 when their educational bills come due. The College supports H.R. 1407, the Higher Education Affordability and Equity Act of 2007, sponsored by Rep. Phil English (R-PA), which would remove the limits on tax deductions for student loan interest. The College also supports S. 1066, the Medical Education Affordability Act, introduced by Sen. Chris Dodd (D-CT), which would provide relief by allowing young surgeons who qualify for the economic hardship deferment

to use this option beyond the current limit of three years into residency, ensuring they will not have to begin repaying their loans or put their loans into forbearance during residency. On September 4, 2007, the College joined other national organizations in urging the U.S. Secretary of Education to increase the aggregate combined Stafford loan limit for students of the health professions from \$189,125 to \$223,793, arguing that the current limit has remained stagnant for over a decade and does not account for recent increases in annual unsubsidized Stafford loan limits or reflect programs of different duration.

### **College opposes optometric equity**

Introduced by Rep. Jan Schakowsky (D-IL), H.R. 1983, the Optometric Equity in Medicaid Act of 2007, would inappropriately expand the scope of practice for optometrists treating Medicaid beneficiaries. The College sent a letter to Representative Schakowsky to oppose this bill. H.R. 1983 would require Medicaid coverage of “medical and surgical services furnished by an optometrist to the extent such services may be performed under state law.” Although optometrists have failed to gain surgical privileges in 17 states since its success in Oklahoma in 1998, they continue to press for licensure expansions.

### **Health IT**

Congress has produced near misses in the area of health IT legislation in each of the previous two years and the issue has been placed high on the health care agenda for 2008. At the request of congressional leaders, the College took the lead in negotiations on health IT legislation known as the Wired for Health Care Quality Act (S. 1418). An identical bill, the Promoting Health IT Act (H.R. 3800) was introduced in the House. This legislation—which would provide \$278 million in grant funding for physicians to adopt health IT and create a permanent federal office for standards development—promises to be the primary legislative vehicle for health IT again this year.

Attempts to “hotline” (that is, passing by

unanimous consent in the Senate without formal floor debate) this health IT legislation in November 2007 were stymied after concerns were raised by the College and other physician groups over a provision that would have undermined years of progress on the development of risk-adjusted quality measures by calling for the public release of raw Medicare claims data. Negotiations were successful and resulted in significant concessions by the sponsors including major qualifications on the release of these data. Although lesser concerns with this bill regarding the lack of privacy provisions and the inadequacy of grant funding remained, ultimately the decision by Congress to pass a trimmed-down Medicare vehicle did not leave room for the inclusion of this health IT bill.

### **ACS supports increased cancer research funding**

The College continues to be an active member of One Voice Against Cancer and will continue to lobby Congress for adequate levels of funding for cancer programs and research in 2008. In 2007, Congress enacted small increases in funding from the previous year for the National Institutes of Health (NIH), which translated into slight increases at NIH cancer programs, including a 0.25 percent increase for the National Cancer Institute and a 0.2 percent increase for the National Center on Minority Health and Health Disparities. The Centers for Disease Control and Prevention (CDC) cancer programs saw a 2.7 percent funding increase from the previous year with relatively large shift funding toward programs targeting cervical cancer. The CDC’s Ovarian Cancer Awareness program saw an 18.7 percent increase and the National Breast and Cervical Cancer Early Detection Program saw a 1.2 percent increase, whereas the remaining seven cancer programs at CDC saw decreases of 1.7 percent.

### **ACS Health Policy Steering Committee (HPSC)**

The HPSC has been considering a proposal to develop a risk management course that could be offered at chapter meetings in part-

nership with liability insurance carriers. The plan is to develop an ACS program or to co-sponsor programs developed by liability insurers that would confer premium discounts on Fellows who participate. Background research was conducted by staff and shared with the committee, and F. Dean Griffen, MD, FACS, was asked to spearhead the effort. Letters about the proposal were sent to 15 carriers. Dr. Griffen will be making personal contacts with both the carrier representatives and the chapters to facilitate this collaboration. The HPSC suggested that an article be published in the *Bulletin* informing Fellows of the many types of risk management education and premium discount programs already sponsored by liability insurance carriers (see the March 2008 issue), and plans are under way to develop resource material on this issue for the College's Web site.

The HPSC reviewed a request from Ethicon to participate in an effort to remove overly broad legislative language in the Farm Bill that banned the use of live animals in marketing medical devices. The concern was that the proposal would interfere with manufacturers' activities in training surgeons on the use of medical devices. At the committee's request, the Washington Office collaborated with Ethicon and other organizations in an advocacy effort and the problematic language was eliminated.

### **GSCRC**

The ACS General Surgery Coding and Reimbursement Committee (GSCRC) reviewed seven separate sets of Correct Coding Initiative edits. For three sets of edits, the GSCRC did not agree with the proposed edits. Clinical rationales describing concerns with these edits were sent to the Medicare contractor charged with developing and maintaining the Medicare edit files. CMS accepted the rationales and will not implement the proposed edits for those codes.

Medically unlikely edits are Medicare edits that limit the number of times a procedure may be performed and billed in a single day. A set of 1,377 proposed edits was reviewed by the GSCRC, and comments for 153 general surgery

codes were submitted. CMS accepted all the requested changes.

### **ACS Patient Safety and Quality Improvement Committee**

The committee reviewed its patient safety course presented at the Clinical Congress. The course was well received, and there is interest in expanding it. The syllabus contained basic principles such as high reliability, systems approach, teamwork, communication, leadership, and distribution of the workload. Evaluations revealed that attendees of the course would take the information back to their institutions where it could be used as a resource. Because the course was relatively small, there was a great deal of engagement. The committee would like to allow the course to mature into a safety certification course that the ACS would convene, similar to what it does for the Advanced Trauma Life Support® (ATLS®) course. This would include not only didactic sessions but also simulation-based training.

### **Coding workshops scheduled for 2008**

The College has again contracted with Karen Zupko and Associates to provide a series of Current Procedural Terminology (CPT) and International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding workshops during 2008. These one-day workshops—Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding—are intended for all general surgeons, closely related specialties, and their staffs.

### **2008 practice management webcasts**

The College has once again joined with Economedix to present a series of practice management webcasts in 2008. The program consists of 24 live distance-learning courses dealing with critical aspects of practice management and is designed to help surgeons maintain productive, efficient, and profitable practices in today's challenging environment. The Wednesday webcasts are followed by on-demand audiocasts for surgeons and their staffs in the event they miss the live session.

For more extensive information on the efforts of the College's Division of Advocacy and Health Policy, visit the division's Web page at <http://www.facs.org/ahp/index.html>.

### **Education**

The Board of Regents approved the recommendations presented by the ACS Program Committee for the reorganization of the Clinical Congress educational format. A concise summary of the changes will be published in upcoming issues of the *Bulletin* and *Surgery News*.

### **Journal of the American College of Surgeons (JACS)**

Online and fax submissions to *JACS* continuing medical education (CME)-1 Online Program currently exceed 179,000 cumulative credits, provided as a member benefit. In 2007, 540 new users earned 7,969 credits. Total credits provided in 2007 equaled 43,576 (a 25% increase over 2006). This program would be beneficial for all ACS chapters.

### **ACS Committee on Trauma**

Work continues on international promulgation of ATLS in Pakistan, Poland, and India. ATLS is now given in 49 countries.

The Rural Trauma Committee is developing an instructor course for the Rural Trauma Team Development Course. The committee is also studying communication between level III/IV hospitals and level I/II hospitals regarding transfers.

### **Commission on Cancer (CoC)**

The CoC will host a national conference, *Coming Together 2008: A National Forum on Cancer Care in the United States*, July 14–15 in Baltimore, MD. National leaders and advocacy experts will discuss legislative and regulatory issues that will affect the future of cancer patient care. Participants will learn the new directions that national organizations, such as the National Cancer Institute, FDA, and CDC, are taking to improve cancer patient care. Presentations will address how the health care environment can be changed to improve quality

and eliminate disparities in care and how the leading advocacy organizations are making an impact on national policy.

The CoC is offering a new webinar series with one-hour programs to support the educational needs of cancer program team members in CoC-accredited cancer programs. At the time of publication, eight programs had been developed and scheduled. Each webinar is presented live on the date scheduled and includes a Q&A session with the presenter. Following the original presentation, the program will be available via streaming video (with audio) for 90 days to the registrant. Registration is required to participate in the 2008 Web conference series. CME/CE hours are provided.

### **ACS-BSCN Accreditation Program**

The Bariatric Database of the ACS Bariatric Surgery Center Network (BSCN) Accreditation Program was fully operational in February. The submission of outcomes data on all bariatric operations performed at provisionally and fully approved centers is required for centers to obtain and uphold accreditation. The data will be reviewed on an annual basis.

Bariatric data collectors at level A-accredited centers were invited for the first ACS Bariatric Database training February 26–27, and a second training session was held March 25–26 for bariatric data collectors at level B-accredited centers. After training of the current ACS-BSCN sites is complete, future trainings for newly enrolled sites will be Web based.

Partnership efforts with The Joint Commission have resulted in Joint Commission recognition of the ACS-BSCN Accreditation Program. Accredited ACS-BSCN centers will be acknowledged with a merit badge on the Joint Commission's Quality Check Web site. This site allows visitors to search through roughly 15,000 accredited health care organizations and learn about a facility's accreditations, services provided, and special quality achievements.

## ACS-NSQIP

The ACS National Surgical Quality Improvement Program (ACS-NSQIP) is being modified to make improvements related to a number of issues encountered by private sector hospitals. A sample of the changes includes decreasing the amount of data collected per case, changing the sampling frame to collect more of the important and clinically meaningful cases, providing surgeon-specific outcomes, and providing more instruction to hospitals on how to improve their outcomes.

A number of working groups are developing ways to enhance ACS-NSQIP, such as the development of pediatric and gynecology modules. Meetings have been set with the Society for Thoracic Surgery and the Society for Vascular Surgery to discuss possible areas for collaboration regarding data collection and feedback. The Geriatric Surgery Task Force is identifying potential geriatrics-specific variables for potential collection in ACS-NSQIP in order to help measure and improve care to geriatric surgery patients.

A number of hospitals internationally have requested to participate in ACS-NSQIP. Work is under way to develop an international ACS-NSQIP. The issues currently being addressed include criteria, feasibility, data definitions, auditing, and so forth. A working plan is being developed to begin piloting ACS-NSQIP in three to six international hospitals.

Since initiating the program three years ago, ACS-NSQIP has been recognized by The Joint Commission, CMS, Leapfrog, and specific payors such as Blue Cross.

The ACS-NSQIP Surgical Care Improvement Project (SCIP) has been developed and successfully tested with CMS, and several sites are currently evaluating the use of this module for the submission of their SCIP data. The Joint Commission module will also be available to organizations that want to use the tool to submit their data.

The American Board of Surgery now recognizes ACS-NSQIP as an acceptable program in meeting the evaluation of performance in practice requirement for Maintenance of Cer-

tification. With increasing formal recognition and endorsement, ACS-NSQIP is becoming the acknowledged standard for surgical quality of care measurement and improvement.

## Public profile and Communications update

In early December 2007, work was completed on the College's book for patients. *I Need an Operation...Now What?* is available on the Amazon, Borders, and Barnes & Noble Web sites. A promotional page for the book has been created on the College's Web portal, *e-FACS.org*.

Work has begun on redesigning the Communities & Specialties area of the College's Web portal. Beginning with the General Surgery Community, the design changes will eventually be made across all areas of the portal. The next communities to be updated with the redesigned format will be the General Surgery Subspecialty Communities and the Resident Member/Associate Fellow Community.

The Communications staff has been working on Web site development for the College's new Nora Institute for Surgical Safety with Paul F. Nora, MD, FACS, and staff of the Division of Advocacy and Health Policy. The Nora Institute Web site is scheduled to launch by mid-June. Although this new Web site will be housed on the College's public Web site, it will also have a major presence on *e-FACS.org*.

*Surgery News* is now in its fourth year of publication and progressed in 2007 with a number-three ranking in terms of overall readership among competing surgical publications, as there are more articles on socioeconomic issues affecting surgical practice, broader coverage of regional society meetings, and increased participation by board members. "The 20/20 Vision," a section launched last September, has enhanced the newspaper's socioeconomic coverage with invited commentaries from experts addressing topics such as SCHIP funding, health policy changes, medical tourism, and the future of this country's health care system. Articles on surgical innovation, the on-call crisis, and the emerging acute care specialty have been featured along with an overview of

the health care proposals being put forth by several presidential candidates.

### **Resident Associate Society (RAS-ACS)**

Ted A. James, MD, RAS Chair, gave an update on the projects and goals of the RAS-ACS. Dr. James stressed the importance of involving RAS members in the activities of the College. It was recommended by a Regent that each Governor bring a resident to mentor during the annual Clinical Congress as a way to encourage College membership.

### **Committee on Young Surgeons (CYS)**

The CYS will present two education programs during the 2008 Clinical Congress, one in conjunction with the RAS. The 2008 Initiates Program will focus on personal financial planning, and the other session will examine strategies to combat stress and improve health and wellness. A major priority for CYS in 2008 will be to identify programs and activities that can be undertaken by the chapters to enhance young surgeons' participation and representation at the local level.

### **OGB**

Substantial personnel resources continue to be devoted to the upkeep and further development of the OGB Web site. Since the last Board of Regents report, partnerships with the following not-for-profit organizations have been established: Friends of Good Samaritan, International Surgical Missions, Remote Area Medical, SMART Teams, CRUDEM, Surgical Volunteers International, Solidarity Bridge, and Mission Cataract. Domestic partner agencies total 39, and international agencies total 48.

Traffic to the OGB Web site has exceeded 3.2 million hits since its inception. Profiles have been completed by more than 900 surgeon volunteers.

A productive inaugural meeting of the OGB Advisory Council was held in September 2007, in Chicago. The Advisory Council's Chair Bruce D. Browner, MD, FACS, and Vice-Chair Andrew L. Warshaw, MD, FACS, presided. Other

members of the Advisory Council are Benjamin Aune; William A. Bernie, MD, FACS; Sylvia D. Campbell, MD, FACS; Julie A. Freischlag, MD, FACS; former senator (1994–2007) William H. Frist, MD, FACS; Edward R. Laws, MD, FACS; West Livaudais, Jr., MD, FACS; Anthea Carlson Powell, MD; Randolph Sherman, MD, FACS; John L. Tarpley, MD, FACS; and Michael C. Magee, MD, FACS. The group undertook a thorough review of existing programs and future goals. Short-term (one-year) goals established include the following:

- Increased involvement of ACS chapters in domestic volunteer issues, including identification of available opportunities and support for advocacy at the state level
- Creation of a disaster response resource center for the OGB site
- Collaboration with the Committee on Trauma (COT) Disaster Subcommittee and Division of Advocacy and Health Policy on disaster response paradigms
- Support for establishment of volunteer electives for surgical residents
- Identification of ACS educational materials that can be made available to volunteers
- Summits of national leaders in domestic, educational, and disaster-related volunteerism efforts

At the time of publication, progress on meeting goals included the following:

- Discussion with Board of Governors Chair related to disaster efforts, chapter involvement
- Disaster resources added to OGB Web site
- Continued collaboration with COT on disaster response with Washington agencies
- Collaboration with president of the Association of Program Directors in Surgery (APDS) related to garnering support for residency electives
- Agreement to develop survey for program directors to complement existing surveys of residents

The annual APDS meeting in April in Toronto featured a panel discussion on international surgical experiences for surgery residents.

As a gesture of contributing to the recovery of the New Orleans health care infrastructure in the continuing aftermath of Hurricane Katrina, Project New Orleans, in partnership with New Orleans Habitat for Humanity and the Daughters of Charity Health Care Clinics, took place during Clinical Congress 2007. Along with more than \$22,000 in additional contributions from individuals, this work was estimated to save the Daughters of Charity approximately \$60,000 in construction costs. Surplus materials from Congress exhibitors were also donated to benefit 10 Louisiana elementary schools. These efforts generated considerable positive local and national press (television and print) for the College. Participants reported extremely high satisfaction with the projects and expressed interest in future opportunities of a similar nature.

The Surgical Volunteerism plenary session featuring presentations by the three 2007 Surgical Volunteerism Award winners was very well attended and was capped off by a lively Q&A session from an engaged audience. Final comments were made by Immediate Past-President Edward M. Copeland III, MD, FACS, who expressed his strong support of the programs and resources that the College has invested in to facilitate and encourage volunteer outreach.

The Surgical Volunteer Networking Reception was very well attended and was a wonderful informal forum for interaction with the award winners and other members of the College who were interested and involved in volunteerism. Attendees included the senior leadership of the Pfizer Medical Humanities Initiative and a number of medical students interested in a career in surgery.

### **ACS Advisory Councils for the Surgical Specialties**

Each of the College's 12 Advisory Councils meets twice a year—in the spring and during the Clinical Congress. Items of common interest and concern are discussed throughout the year. All Advisory Councils routinely discuss the Jacobson Innovation Award, Sheen Award,

and Honorary Fellowship and forward nominations to the ACS Honors Committee for its consideration.

In an effort to increase ACS membership, several Advisory Councils will send mailings to program directors, highlighting the membership benefits available to Resident Members and encouraging 100 percent participation in the College from all programs and their residents. Advisory Council members are encouraged to communicate ACS membership benefits to their specialty organizations.

The Advisory Councils continue to develop specialty-sponsored programming presented at the Clinical Congress. Beginning in 2008, the resident-gear-ed sessions and Churchill Lecture previously presented at the Spring Meeting will now be presented at the Clinical Congress.

### ***HealtheCareers***

As of mid-January, there were 1,057 open jobs listed on the Web site and 302 posted résumés. This site is a valuable service for our members, young and old. The service is complimentary to our Resident Members.

### **SDIF drops expense ratio**

Recognizing the goal of offering members of the College and affiliated organizations a reasonably priced investment product, the expense ratio of the College's Surgeons Diversified Investment Fund (SDIF) has been lowered to just more than 1 percent. The lower expense ratio will have an immediate positive impact on current shareholders, and, over time, will have a positive impact on the performance returns for prospective and current shareholders. The new expense ratio, including exchange-traded fund costs, is 1.08 percent.

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

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# Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its February 8, 2008, meeting:

- Gerald Saul Kane, MD, an orthopaedic surgeon from Highland Park, IL, was expelled from the College. This action was taken following the indefinite suspension of his license to practice medicine in the State of Illinois after his actions regarding three patients were found to constitute an immediate danger to the public. Dr. Kane prescribed controlled substances to three patients for other than legitimate medical purposes, resulting in the deaths of those three patients.

- A general surgeon from Los Angeles, CA, was admonished. This surgeon had been charged with a violation of the ACS *Bylaws* for unprofessional conduct and misleading the public when providing expert witness testimony in a medical malpractice lawsuit.

- A general surgeon from Vidalia, GA, had his full Fellowship privileges restored. This surgeon had been placed on probation with conditions for reinstatement in February 2002, after being charged with a violation of the ACS *Bylaws*, Article VII, Sections 1(a) and (b). His medical license in the States of Georgia and Louisiana had been limited due to a history of chemical dependency. His medical license status in both of those states has now been returned to full and unrestricted.

## **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.



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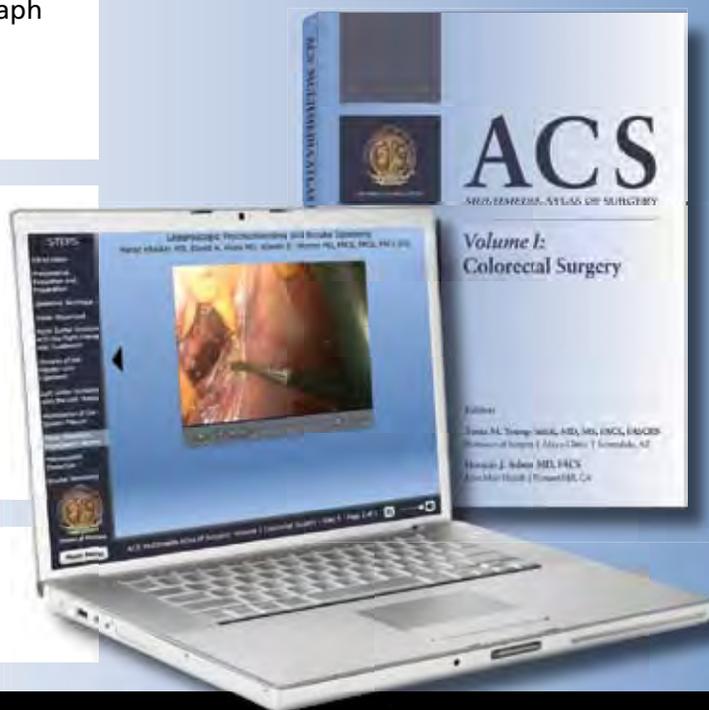
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## A look at The Joint Commission

# Joint Commission designated to improve safety of office-based surgery

New York has long been at the forefront of state patient safety initiatives. Since 1998, the state has mandated the reporting of adverse events, and in 2001, it introduced a protocol aimed at the prevention of wrong site, wrong patient, wrong side, and wrong invasive procedure events.

Now, a new patient safety law in New York requires physician practices that perform office-based surgical procedures to attain accreditation.

The accreditation requirement is part of 2007 legislation designed to protect the thousands of patients who undergo surgery in physician offices each year in New York. One of the primary components of the law is that office-based operations must be performed by physicians in a setting that achieves and maintains accreditation from a nationally recognized accrediting organization, such as The Joint Commission, as determined by the New York State Health Commissioner.

The need for strengthened quality oversight for office-based surgery has grown as the number of increasingly complex surgical and invasive procedures performed in doctors' offices has more than doubled in the last decade, with nearly 10 million surgi-

cal procedures performed annually in office-based settings nationwide since 2000.

New York State office-based surgery practices that are not already accredited by The Joint Commission or the two other approved accrediting agencies must become accredited on or before July 14, 2009. This new law reflects a national trend of state health departments and boards of medicine strengthening their oversight of quality efforts.

The Joint Commission began accrediting office-based surgery practices in 2001. The Joint Commission's office-based surgery standards emphasize attention to those issues that most directly affect patients and cover essential areas such as patient care, patient safety, staffing, customer service, improvement in care, and responsible leadership.

As a national evaluator of the safety and quality of care provided by health care organizations, The Joint Commission has more than 30 years of experience in promoting safe, high-quality care for patients at more than 50 types of ambulatory care settings. The office-based surgery standards were established specifically for physicians offering surgical or invasive procedures in an appropri-

ate physician-based setting. Many different types of office practices that are eligible for accreditation and are affected by this new law, including endoscopy suites and plastic surgery and urology practices.

Ambulatory care organizations and office-based surgery practices can often reap the benefits of Joint Commission accreditation, such as strengthening community confidence in the safety and quality of care, strengthening patient safety efforts, and enhancing business operations.

Currently, 25 states recognize Joint Commission accreditation for ambulatory care settings—in whole or in part—in fulfillment of regulatory requirements, and 14 states recognize Joint Commission accreditation for office-based surgery.

# THE BASIC ULTRASOUND COURSE on CD-ROM

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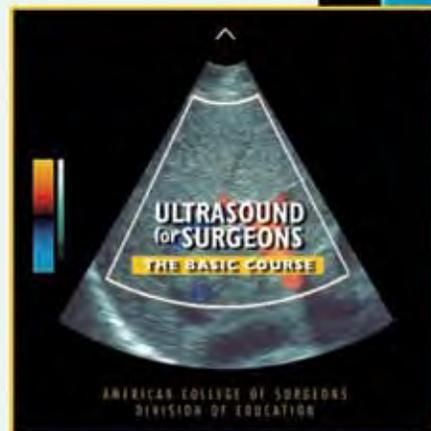
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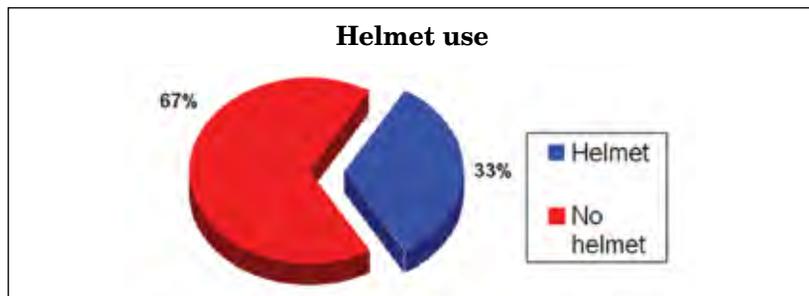
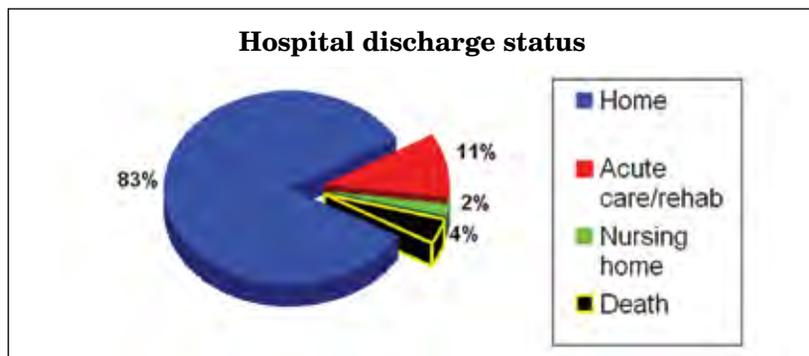
# Pedal to the metal

by Richard J. Fantus, MD, FACS

In the October 2007 *Bulletin* (page 69), this column reported on the unusual mechanism of pedestrians being struck by bicyclists. Now that spring is in full swing and the dreary winter weather is merely a bad memory, throngs of bicyclists take to the trails, sidewalks, and, unfortunately, the streets, resulting in the much more frequent occurrence of a bicyclist being injured by a motor vehicle.

The origin of the bicycle was once attributed to Leonardo da Vinci, with a 1490 sketch of a nonsteerable, two-wheeled device. However, like da Vinci's "code," there has been much debate and many accusations that the sketch was a forgery. What we do know is that in 1817, Baron von Drais invented a walking machine with two wheels but no pedals. The velocipede followed this in 1865, when pedals were applied to the front wheel. The metal and wood device was also known as a bone shaker, getting its name from the ride one experienced when going along the cobblestone roads.

With advances in metallurgy, the all-metal high wheel "bicycle" was designed in 1870. However, if one of the wealthy young men who favored this cycle (which cost the average worker the equivalent of six months' pay) hit a stone in the road, with the high center of gravity, he would go over the



top, and thus the phrase "taking a header" was coined.

Bicycle advancements that followed included the high-wheel tricycle for ladies, the high-wheel safety, the hard-tired safety, and in 1898, the pneumatic-tired safety bicycle designed by an inventive Irish veterinarian, Dunlop, who wanted to make the ride more comfortable for his son. Then, after World War I, several manufacturers made bicycles for children, and these 65-pound devices continued into the 1950s. Now there are bicycles of all shapes, sizes, and design.

Despite advances in design, dating back to the early days

of cycling there were head injuries. These injuries likely increased as more and more roads were paved. Fortunately, bicycle clubs recognized this trend, and helmets were first used as far back as 1880. This protective gear was of a crude design, but because there were no cars on the road, it only needed to protect riders from road impact. Over the years, the helmet was refined, and national standards were put into place in 1984. Unfortunately, current helmet use ranges from one extreme to the other, depending on the geographic area and population

demographic, with overall use close to 25 percent.

In order to examine the occurrence of bicyclists injured by motor vehicles in the National Trauma Data Bank® Dataset 7.0, we used the International Classification of Diseases, Ninth Revision, Clinical Modification cause of injury code E813.6, *Motor vehicle traffic accident involving collision with other vehicle injuring pedal cyclist*. In the dataset with this E code, there were 10,680 records with discharge status recorded. Of the victims in these records, 8,867 were discharged to home, 1,158 to acute care/rehabilitation, and 221 to nursing homes; 434 died. These data are depicted in the figure on page 43. Among victims, 84.5 percent were male and on average 28.2 years of age; they had an average length of hospital

stay of 5.1 days and an average injury severity score of 11.0. Of those bicycle riders tested for alcohol, one-fourth tested positive, whereas one-half of those screened for drugs tested positive. Information on helmet use was available in 4,129 of the cases, and approximately one-third (1,381) of the injured riders were wearing a protective helmet.

No one can argue the fact that helmets are protective devices and save lives. Otherwise, why would football players, hockey players, and baseball players wear them? A word to the wise: when getting ready to mount your metallic steed, do not drink, do not take drugs, and wear reflective clothing and reflectors after dark. But most of all, wear a bicycle helmet—especially if you are heading to the streets—so you will be pro-

tected in case you put your pedal to the metal of a motor vehicle.

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](mailto:mneal@facs.org).

### Acknowledgment

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

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

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