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

Dateline: Washington
Division of Advocacy and Health Policy

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Clinical Congress
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2009 Chicago, IL, October 11-15
2010 Washington, DC, October 3-7

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, 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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ACS Web portal hits milestone

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.
I maintain that broad-based specialty care provided by the generalist surgeon will be alive and well throughout the coming decades.

For the past few decades, many surgeons and other physicians have found the financial and lifestyle rewards associated with subspecialization quite enticing. However, this movement away from providing a broad range of specialty services may have the tragic consequence of placing the nation on the verge of an access-to-care crisis.

For example, many surgical residents have trained under the tutelage of surgeons who confine their expertise to the performance of specific procedures, and, thus, young surgeons are often leaning toward centering their own practices on those operations. As a result, many surgeons who recently have entered practice no longer feel comfortable providing the broad range of services that they are expected to deliver in emergency care settings. Even more unsettling is the probability that these physicians will be unable to treat the multiple chronic conditions likely to beset America’s aging population.

Furthermore, our nation is in the process of developing a reformed health care delivery system with an emphasis on patient-centered care. Under this system, the physicians and surgeons who understand how to treat a broad range of disease processes and who can help patients to navigate systems of care are the ones who will thrive.

To ensure that all patients have adequate access to the level of care they will need in the coming years, the medical and surgical professions must start encouraging young people to pursue more generalized careers. That is to say, we need to redirect medical students and residents to the broad specialties of general surgery, orthopedics, neurosurgery, and other surgical disciplines—and, yes, primary care.

Subspecialization stimuli

A number of factors have contributed to the despondency seen in some generalists’ offices today. First, the ongoing threat of reimbursement cuts combined with increasing overhead expenses, especially liability costs, is straining the economic fabric of many practices. As mentioned multiple times in this column and elsewhere in the Bulletin, the College and numerous specialty societies have been working together to promote long-term legislative solutions to this situation before it drives a disproportionate number of surgeons and physicians into subspecialization or early retirement.

In addition, some nonsurgeons have sought to encroach upon territory that has traditionally been within surgery’s domain. These health care professionals claim that their treatments are less invasive, have shorter recovery times, and are more effective than conventional operations. The reality is that the scope of practice for nonsurgical professionals has been expanding largely because of advances in devices and drug therapies, and, in turn, subtracting not only from the total number of procedures surgeons perform but also from their job satisfaction.

Advances in technology not only present growth opportunities for nonsurgeons, they have also made subspecialization more clinically challenging and fiscally rewarding. Subspecialists who become highly skilled at using specific diagnostic and operative devices can focus largely on providing a narrow range of high-end, low-risk procedures. Hence, the idea of being a “generalist surgeon” is less appealing than it perhaps once was.
What's ahead?

Although it may be cathartic to bemoan the debasement of generalist surgical and medical practice, doing so helps little in addressing where the profession is now and, more importantly, where it is headed. A more effective strategy would be to build on the disciplines’ strengths and to think about how they fit into the future of patient care.

The fact of the matter is that generalists have the broad knowledge of chronic illnesses that will likely afflict the nation’s aging patient population. Indeed, what the next-generation health care system will need most are professionals who have a working knowledge of all types of medical and surgical problems and their effective treatment. Training programs will need to adapt to these new demands by promoting the multidimensional competencies that generalist surgeons possess and the satisfactions of treating a range of conditions.

Surgeons also need to think about how surgical procedures and practice patterns are evolving. For example, surgeons in all specialties are supplanting open operations with minimally invasive and noninvasive procedures. Furthermore, as the nation seeks to make coordinated care delivered in multidisciplinary clinical settings a key feature of a reformed health care delivery system, surgeons will be expected to have a broad knowledge of disease processes and how they can be best managed or cured. They also will need to be adept at communicating with patients about the benefits and risks of specialized care. In short, they will need to take a more holistic approach to patient care—helping patients to understand the indications for certain procedures, as well as the effectiveness and appropriateness of certain courses of nonsurgical treatment modalities.

In the future, generalist surgeons who possess more expansive portfolios will have the most successful practices. Generalist surgeons in both urban and rural settings will have a deeper understanding of surgical patients and will be more skilled in helping patients to choose and pursue high-quality, cost-effective surgical interventions. They will be in the best position to refer patients to other specialists within the highly organized, multidisciplinary systems of care, or what some physicians describe as “medical homes.”

Of course, 21st century generalist surgeons will still spend considerable time in the operating room and maintain a surgical practice and clinic; however, they will also play a key role in ensuring that patients receive value-based care. That is to say, they will be responsible for ensuring that patients receive the right services at the right time from the right specialists.

It’s in your hands

I maintain that broad-based specialty care provided by the generalist surgeon will be alive and well throughout the coming decades. In fact, it may well be a key component of a reformed and revitalized health care system, with generalists directing and consulting with a wide range of patients and a multifaceted team of health care professionals. Now is the time for surgeons in all specialties to immerse themselves in attaining the skills and knowledge they will need to be the trusted source of information for patients who require operative care as a part of their treatment plan.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
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**American College of Surgeons 95th annual Clinical Congress, October 11-15, 2009 Chicago, IL - McCormick Place West Building**

Visit [www.facs.org](http://www.facs.org) in the coming months for more details regarding the educational programs, registration, housing, and transportation.
The final 2009 Inpatient Prospective Payment System (IPPS) rule was released on July 31 and expands the list of hospital-acquired conditions (HACs) that Medicare will no longer cover. Beginning October 1, the Centers for Medicare & Medicaid Services (CMS) will no longer allow hospitals to assign an inpatient hospital discharge to a higher payment level if certain conditions developed as a consequence of inpatient care. The new HACs include manifestations of poor glycemic control and deep vein thrombosis. In addition, CMS is expanding the surgical site infection HAC to include surgical site infection following certain elective orthopaedic procedures and bariatric operations. CMS has also refined the current HACs pertaining to foreign object retained after surgery and pressure ulcers by updating the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes in these categories. Many states, insurance carriers, and institutions are following Medicare’s lead by implementing nonpayment policies for specific mistakes. A copy of the final rule is available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf. (See related story, page 18.)

On August 15, the U.S. Department of Health and Human Services (HHS) announced a long-awaited proposed regulation that would replace the ICD-9-CM code sets now used to report health care diagnoses and procedures with greatly expanded ICD-10 code sets. The ICD-10 codes would become effective October 1, 2011. In a separate proposed rule, HHS calls for adopting updated standards for electronic transactions, which would be compatible with the ICD-10 codes.

Developed almost 30 years ago, ICD-9 is now widely viewed as outdated because of its limited capacity to accommodate new procedures and diagnoses. ICD-9 contains only 17,000 codes and is expected to start running out of available codes next year. By contrast, the ICD-10 code sets contain more than 155,000 codes and accommodate a host of new diagnoses and procedures. The additional codes will help to enable the implementation of electronic health records because they will provide more detailed descriptions of the work performed. At press time, ACS regulatory staff was reviewing the proposed rule, which may be viewed at http://www.cms.hhs.gov/TransactionCodeSetsStandards/02_TransactionsandCodeSetsRegulations.asp#TopOfPage.

On August 14, CMS announced that it has awarded contracts for the ninth statement of work for the 53 contractors participating in Medicare’s Quality Improvement Organization (QIO) program. The QIO contracts extend from August 1, 2008, through July 31, 2011, and mark a new direction for the QIO Program. The ninth statement of work aims to improve the quality of care for Medicare beneficiaries through three means, to be implemented by each of the 53 QIO contractors nationwide throughout the contract period: beneficiary protection, patient safety, and preventive medicine. In addition, QIOs in select states will focus on health disparities reduction, care transitions, and chronic kidney disease treatment. For more information, visit http://www.cms.hhs.gov/QualityImprovementOrgs.
in the current resident training paradigm

by Edward M. Copeland III, MD, FACS

“Professionalism” is almost a new word in the surgical lexicon. It has evolved because of the new training paradigm in surgery. The Accreditation Council for Graduate Medical Education (ACGME) has mandated that all residencies be no more than 80 hours per week in length and has dictated that the six competencies—professionalism, patient care, medical knowledge, practice-based learning and improvement, systems-based practice, and interpersonal skills—must be documented as being taught during the residency. Imparting medical knowledge through patient care, systems-based practice, and practice-based learning can be accomplished in a classroom when combined with supervised direct patient care. Educators are struggling, however, to teach, or even to define, professionalism and interpersonal skills. Edmund Pellegrino, MD, director emeritus of the Kennedy Institute, defines professionalism best: “A declaration of a way of life in which expert knowledge is used not primarily for personal gain, but for the benefit of those who need the knowledge.”

In the past, we have relied on close contact with faculty members for residents to introject from them the excellent qualities of a physician and to reject those qualities that were deemed to be onerous. This behavior pattern is rather typical for individuals who delay short-term goals to attain long-term ones. Surgical faculties then were famous for having great mentors and also for having individuals to be avoided. We hoped the residents learned from the former and not the latter.

As I have gone through life, however, I have noted that, with more regularity than I would wish, the negative characteristics were introjected by some of the residents, especially those who were the most recalcitrant. Systems were in place, however, to identify these more recalcitrant
individuals because faculty mentors were able to closely observe the residents. The same patients were shared essentially 24 hours a day, seven days a week, and each depended on the other to get a block of work done in order to generate free time for all concerned. The person who was not “professional,” had poor interpersonal skills, and could not communicate was easily identified, and the problem was corrected or the individual was eructated from the residency program. This mentoring system will be more difficult now because of limited time spent with residents. Likewise, continuity of care requires much more communication today to ensure patient safety because of night float, handoffs, cross-coverage, sign outs, and the emphasis on lifestyle-friendly residencies.

**Surgical way of life**

A mentor is one who establishes for the protégé the professional ethics that will dictate practice patterns years after the protégé leaves the direct supervision of the mentor. Mentors strive to in-grain in the protégé core values of patient safety that, if violated, would result in uncomfortable anxiety in the protégé. The object is to create what I have chosen to label as a “surgical way of life,” defined as the art and practice of surgery staying continually in conscious thought. Surgeons take pride of ownership in the patients who have put their trust in their surgeon’s expert hands. The surgeon looks forward to applying the talents that took so long to attain to the betterment of mankind. In a sense, surgery could be viewed as a hobby. It has been said that 80 percent of people work to support their hobbies. Surgeons are the lucky ones, for their work should be one of their hobbies.

In 2005, a national survey of fourth- and fifth-year residents was done to identify the characteristics of a satisfying surgical residency. Almost all positive factors involved the attending surgeon, such as the citing of evidenced-based literature, spontaneous and unplanned discussions, clinical teaching aimed at the chief resident level, continuity of care, and clinical decisions made jointly and contemporaneously with the resident. However, this survey was conducted with residents who had their predominant training before implementation of the 80-hour workweek rule. In many residency programs today, the association between the attending surgeon (potential mentor) and resident has been diluted.

In an Ohio medical school, students were surveyed in two groups: one group rotated on the surgical service before implementation of the 80-hour workweek and the other after its implementation. The purpose of the survey was to see if a surgical career was more appealing once the workweek was limited to 80 hours. Those students rotating when the workweek was 100 hours thought that surgeons had big egos and were more demanding of hospital personnel, yet the students thought surgery was a rewarding career. These traits were not as readily identified in the residents during the 80-hour workweek. The authors were critical of these traits, but I have a different interpretation. The decrease in work hours, with its handoffs and other resultant effects, lessened the intensity of longitudinal patient care and the residents’ feelings of responsibility for the patients. A more laid-back resident is a less demanding one, will appear less egotistical, and may be preoccupied with something other than patient care. The students were impressed that residents’ lifestyle had improved when work hours were limited but were no more stimulated toward a career in surgery. In another medical student survey on factors influencing career choices, rotations through community hospitals had as much positive influence on surgery as a career as did the academic hospital rotations. The limitation of work hours has often eliminated these rotations, at least for the residents if not also for the students.

Most studies on duty hour restrictions have come from single institution experiences and the results have been mixed. A common theme has been a decrease in quality of patient care because of disruption of continuity of patient care and communication errors. These negative effects were secondary to cross-coverage and handoffs to comply with the 80-hour workweek. More recently, a multi-institutional study of the effect of the 80-hour workweek has revealed by percentage of 259 respondents that resident satisfaction is increased (55 percent), fatigue has decreased (70 percent), and more time is allowed for leisure activity (90 percent). However, 72 percent of the respondents believed that surgical education was
more important than quality of life, 82 percent thought that continuity of care was diminished, and only 19 percent believed that quality of care was improved.\textsuperscript{6} One clear outcome from the survey was that women’s satisfaction with a surgical residency was improved.

Responsibility for the patient at the resident level has been diffused among several different caregivers. Physician extenders and hospitalists have proliferated and assumed some of the work previously done by residents. Hospitalists also sign out to each other every eight to 12 hours and may have the same issues with continuity of care and communication as do residents. Residents during the day may abrogate patient care responsibility to physician extenders. Residents might no longer have the anxiety, sense of urgency, and compulsion that accompany primary patient responsibility and then translate into behavior appropriate for patient safety. When all three groups—residents, hospitalists, and physician extenders—are in the hospital, quality and safety of patient care may be improved; but the reverse is also true if each thinks the other has completed an undone task. Attending physicians usually want to make rounds with the person who has the most knowledge about the patients and that person might not be the resident—separating, once again, the potential mentor from the protégé.

\textbf{Surgical competencies}

To be critical of the method of teaching the ACGME competencies now requires an examination of the success in teaching them in the past. As an active and senior member of the American Board of Surgery for 25 years, I am comfortable that we examined for excellence in patient care, practice-based learning, and medical knowledge by placing the examinees into a wide range of clinical scenarios that required these competencies to pass the examination; however, systems-based learning is a new term and difficult to dissect from those three competencies. Professionalism and interpersonal skills, especially communication with patients and colleagues, was almost impossible to examine. Other measures need to be used to examine these competencies. One measure is to look at closed claims analyses of medical malpractice lawsuits against surgeons trained in the earlier residency system. A recent review that eliminated “failure to diagnose” as a cause for the claim showed that communication errors and technical inexperience of the surgeons predominated as the major causes of lawsuits.\textsuperscript{7} Underscoring the communication problems among surgical team members was that 17 percent of errors were wrong site/wrong patient or retained foreign bodies. These systems errors should be minimized, especially today when many, if not most, patients undergo operations as outpatients or are admitted after surgical procedures. The surgeon may not have seen the patient for a period of time before the operation; therefore, accurate records and cross-checks need to be at the forefront of patient safety. Another recent analysis of closed claims dispelled the notion that most settled claims are frivolous. Non-error claims seldom resulted in large payments, and most plaintiff compensation came from error-laden claims.\textsuperscript{8} Malpractice claims emanate from an infinitesimally small percentage of patient-doctor contacts when one considers the number of such contacts that occur per day in this country. Measuring malpractice claims as an indicator of patient safety may be like measuring airline safety by the number of crash fatalities per year. Nevertheless, studies such as these do indicate where the problems are, allow the potential to create solutions for them, and serve as a baseline for comparisons with the track records of future surgeons.

There is enthusiasm for taking a lesson from the airline industry that the captain of the ship is not all-powerful and must function within the framework of multiple individuals with responsibility for different but important components of the flight that ensure safety.\textsuperscript{9} Patient safety is now more diffused within this team concept. This diffusion will predictably increase as those surgeons trained in the 80-hour workweek graduate into practice and carry the philosophy of teamwork through handoffs and seamless communication with them. This philosophy does, however, dictate that everyone dealing with the patient has equal skills for his or her responsibilities and the same motivations to ensure patient safety. It has the added benefit of multiple individuals thinking about the same patient problem. It also puts an extra burden on the medical profession to ensure that all graduating physicians are responsible
and have the capacity for self-improvement. Unprofessional behavior can lead to disaster in the team concept of patient care. The inability for self-improvement can be detected in medical school and these individuals often exhibit unprofessional behavior. Medical educators need to do a better job identifying these individuals and eliminating them from the medical profession as early as possible.

Teamwork can also be in the eyes of the beholder. For example, there is no argument that disruptive behavior of the surgeon is detrimental to the atmosphere in the operating room, and stress among operative team members can increase the incidence of errors. Surgeons often think that cooperation among members of different disciplines in the operating room is fine even when other members of the team don’t share this view. Surgeons do need to be alert to their behavior when among their colleagues. I don’t know how the surgeon can be removed as the one with primary responsibility and have the system improve. I will leave this question to be answered by the next generation of administrators.

The best solution to excellent teamwork in the operating room, in my opinion, is to have the same surgeons and nurses work together on a daily basis. This system helps eliminate the lack of necessary equipment for the operation, an improperly positioned patient, and slow reaction time by the nurses in a tense situation. The most commonly recorded disruptive behavior by the surgeon is a raised voice. Once again, the reason for the raised voice is in the eyes of the beholder, and the person responsible for the mistake that leads to the raised voice may be the one assigned the task of reporting disruptive behavior. Therefore, the surgeon may be reticent to take remedial action in the operating room for fear of reprimand. When my voice has been raised in the operating room, it has been carefully calculated to improve patient care and the results have been positive. This outcome, however, is both difficult and unpopular to measure.

Paradigm shift

We “old-timers” do fear, hopefully unjustifiably, that the new training paradigm may lead to a shift mentality that will be detrimental to patient care. Fortunately, new checks and balances are being put in place to measure patient outcomes and install reimbursement in the form of pay for performance. The Leapfrog Group, sponsored by private and public health care purchasers, is gaining the clout to put into effect decisions on reimbursement based on their data that contain both volume and outcome measures. Even better, in my opinion, is the National Surgical Quality Improvement Program implemented and verified as accurate by the Veterans Affairs system. Data on outcomes are determined locally by individuals trained to recognize the appropriate outcome measures from direct review of patient records rather than to rely on any national data bank. This program is now available to the private hospital community through the American College of Surgeons. All hospitals should be stimulated, if not required, to participate, if for no other reason than that inappropriate outcomes can be identified locally and corrective actions instituted before being dictated by a national organization. Any disincentives for excellent patient care that might creep into the health care system on the physician side because of lifestyle needs will be offset by the need for adequate performance to get paid.

The American College of Surgeons has a Committee on Ethics that is charged with a portion of the program of the Clinical Congress. This program, year to year, has one of the highest attendance records. A questionnaire was recently sent to the members of the Southeastern Surgical Congress, primarily private practitioners, asking for a prioritization of topics for the guest speakers. Medical ethics and patient safety topped the list. No question that these topics are at the forefront of the conscious thought of all of us today. Possibly we have not given professionalism, communication skills, and interpersonal relationships enough emphasis in residency programs in the past. Viewed in this light, the dictates of the ACGME are actually late in coming. All of us involved in resident education should be referred to the article in the May 2008 issue of the Bulletin that recognized Karen Horvath, MD, FACS, for being honored with the ACGME Parker J. Palmer Courage to Teach Award. As program director for the department of surgery at the University of Washington, Dr. Horvath and her colleagues have devised a safe, effective, and well-received...
method of resident education that benefits both patient and resident.15

Medical students today come from more diverse backgrounds than in the past.16 Nevertheless, they enter medical school willing to study for seven to 14 years for the privilege of providing care for patients. Fully trained surgeons from other countries are willing to repeat their residencies in this country for the same privilege. We, as educators, work with better intellectual and moral raw material than most other professions. The shortened training programs have reduced the contact time between mentor and protégé. Students and residents will not have the luxury of close communication with potential mentors. They may not have introjected the personality traits expected of a physician immediately upon entering practice. Their medical folkways and mores may not yet be fully developed. They may not have adapted to or accepted the surgical way of life. Those of us in practice may find ourselves in the unusual role of mentors for physicians who have finished their residency and are still receptive to additional education, especially role modeling. Professionalism and ethics cross all boundaries both to supplement in the current residents what might have been learned in the past and to fortify what should have been learned in the past by all of us.

References


Dr. Copeland is Emeritus Distinguished Professor of Surgery, department of surgery, University of Florida College of Medicine, Gainesville. He is Immediate Past-President of the College.

VOLUME 93, NUMBER 10, BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
The concept of streamlining the evaluation and management of patients with diseases of the breast through an organized breast center is not new. Silverstein, more than 30 years ago, was struck by the observation that patients presenting with breast symptoms or abnormal imaging findings entered a fragmented medical care system.* This system often resulted in long delays and lack of coordination between each segment of care. It became clear to Silverstein that the disciplines of surgery, medical oncology, radiation oncology, radiology, and pathology needed to be brought together as an interdisciplinary group to meet the needs of these patients. The result was the establishment of a breast clinic at University of California–Los Angeles in 1973. Thereafter, the Van Nuys Breast Center became the first freestanding multidisciplinary breast center in the U.S.

A large (but unknown) number of breast centers in the U.S. have been established over the last three decades to meet the enormous demand placed on the health care system to deal with patients with benign and malignant breast diseases. Some of these centers are hospital based, whereas others have been established in the private practice setting. Whereas some of the centers are purely diagnostic, others provide a full range of services for patients. The American Cancer Society estimated that there will be nearly 250,000 patients diagnosed with either invasive or noninvasive breast cancer in the U.S. in 2008.\(^1\) This number, however, does not take into account the multitude of patients presenting with benign conditions of the breast requiring diagnostic evaluation to rule out breast cancer.

The U.S. lags behind the European countries in systematizing breast centers. For the past several years, European countries have succeeded in developing multidisciplinary standards of care for patients with diseases of the breast and a survey process to monitor compliance with these standards.\(^2\)

Although breast centers have become a widely available and acceptable system of care, few organizations or groups of organizations have examined the quality of care rendered in these centers. The medical professionals engaged

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\*Liaison board membership
in the care of breast patients should lead this effort, not the government nor the insurance industry.

It seemed logical that the American College of Surgeons, with its longtime experience in accrediting cancer and trauma centers and more recently bariatric centers, should initiate a dialogue among the many disciplines involved with the care of these patients.

The NAPBC

More than three years ago, a consortium of organizations with interest and experience began examining this issue. This group evolved into the National Accreditation Program for Breast Centers (NAPBC) that then began the complicated process of defining the modern breast center, optimally organized to provide the best possible evaluation and management of patients with breast problems. Through the concerted volunteer efforts of professionals from a variety of disciplines with expertise in breast disorders, the developmental phase has been completed. The time for implementation has arrived.

The box on page 14 lists the national professional organizations whose representatives compose the NAPBC Board of Directors.

The mission statement of the NAPBC is as follows: “The National Accreditation Program for Breast Centers is a consortium of national, professional organizations dedicated to the improvement of the quality of care and monitoring of outcomes for patients with diseases of the breast.” The objectives to fulfill the mission statement include the following:

- Develop a consensus of standards for breast centers and a survey process to monitor compliance.
- Strengthen the scientific basis for improving quality care.
- Establish a national breast disease database to effect quality improvement.
- Reduce the morbidity and mortality of breast cancer by improving access to screening and comprehensive care, promoting risk reduction and prevention, and advocating for increased access and participation in clinical trials.
- Expand programs of quality improvement measurement and benchmark comparison.

The Center Criteria and Approvals Committee, under the leadership of Dr. Kurtzman, defined 27 standards for breast center accreditation. The next step was to validate these standards. This was accomplished by conducting on-site surveys at 18 breast centers across the U.S. The NAPBC...
is grateful for the voluntary participation of these centers that enabled us to revise and refine our standards. The 18 centers ranged from a small group of multidisciplinary private practitioners to large academic medical centers. This process enabled the NAPBC board to identify 17 key components for evaluation and management of patients with diseases of the breast. In these breast centers, these components were either provided on-site or referred to affiliated or associated providers at a nearby locale. For the centers that were surveyed in the pilot phase, as long as the patient was afforded the full range of components and the center met the 27 standards, full three-year accreditation could be awarded. The breast accreditation network enables the patient to receive quality care, close to home, much in the same way the 1,460 cancer centers accredited by the Commission on Cancer (CoC) do.

NAPBC committees

• Quality Improvement and Measurement Committee. Chaired by Dr. Anderson, this group is charged with the responsibility of identifying evidence-based and/or consensus-developed quality improvement measures. The NAPBC has worked with several national organizations with expertise in this arena. These include the Quality Outcomes Performance Improvement program of the American Society of Clinical Oncology, the Performance Assessment for the Advancement of Radiation Oncology Treatment program of the American Society for Therapeutic Radiology and Oncology, the National Quality Measures for Breast Centers program of the National Consortium of Breast Centers, the Mastery of Breast Surgery Program of the American Society of Breast Surgeons, the outcomes measures of the Rand Corporation, and the performance measures development contributions of The Joint Commission. The program currently measures compliance with three standards of care measures for breast cancer developed by the CoC, in collaboration with the American Society of Clinical Oncology and the National Comprehensive Cancer Network, that have been endorsed by the National Quality Forum. The committee recognizes that the measure sets used by the NAPBC will vary through the years, depending on the current state of knowledge.

• Information Technology and Outcomes Committee. Co-chaired by Dr. El-Tamer and Robert Smith, PhD, the committee’s database will contain items pertinent to quality improvement. Although the Quality Improvement and Measurement Committee provides the data items, this committee will deal with the technologic aspects of simplified and cost-effective data entry into systems that may already be in existence or need to be developed. The database will help breast centers prospectively collect quality measures and compare their respective performance with other similar programs. The database will also interact with existing databases to facilitate extraction of the required quality measures. The availability of such a database will facilitate the completion and electronic submission of the accreditation application: The NAPBC Survey Application Record.

• Access and Utilization Committee. Led by Ms. Kim, this committee includes many of the breast advocacy groups. Organizations with rep-
representatives serving on this committee include the National Breast Cancer Coalition, Breast Cancer Network of Strength (formerly known as Y-Me), Susan G. Komen for the Cure, Research Advocacy Network, and the National Lymphedema Network, to name a few. This committee is working to identify and develop strategies to address issues with access to and utilization of quality breast health care resources.

• **Education and Dissemination Committee.** Chaired by Dr. Masood, the committee is developing the educational programs that address the standards and survey process, along with best practices that can assist interested and participating centers with reaching and maintaining accreditation. This committee is also responsible for developing educational materials targeted at the public that outline the benefits of obtaining care in a NAPBC-accredited center.

• **Executive Committee.** Dr. Kaufman, vice-chair of the NAPBC board, is the chair of the executive committee that conducts the business of the NAPBC between full board meetings.

**Conclusion**

One of the major concerns the NAPBC board has dealt with during development is ensuring that this program will not disadvantage private practice general surgeons by shifting their patients into larger academic centers. This potential negative effect was not observed in our pilot surveys, as previously described. Accreditation will be awarded to several different practice models. These include breast centers based in a surgeon’s office, collaborating with the other necessary multidisciplinary specialists, freestanding surgical breast centers with or without imaging capabilities, centers “without walls” in hospitals, and centers in designated geographic locations in hospitals. A non-tiered, single level of accreditation applies to all of these models and avoids changes in referral patterns.

We believe the time has come, particularly in light of the evolving transparency and accountability in the practice of medicine in the U.S., for breast centers to address and provide the highest possible quality of care for their patients. The NAPBC can facilitate this effort. We must constantly strive to improve the care of our patients. We believe accreditation does, indeed, make a difference.

Individuals and centers interested in the NAPBC and applying for accreditation are encouraged to visit the NAPBC Web site at www.accreditedbreastcenters.org.

**Dr. Kurtzman** is a member of the board of directors of the NAPBC and chairs the center criteria and approvals committee. He is chairman, department of surgery, and program director of the general surgical residency program, Waterbury Hospital, Waterbury, CT.

**Dr. Masood** is a member of the NAPBC board and chairs the education and dissemination committee. She is chair, department of pathology, University of Florida College of Medicine–Jacksonville, and director of the pathology residency training and cytopathology and breast pathology fellowship programs.

**Ms. Kim** is a member of the NAPBC board and chairs the access and utilization committee. She is the president and CEO of Translating Research Across Communities, a professional services firm that works to advance research progress and interaction among the patient, research, public, and private communities.
CMS announces quality and regulatory changes in the final 2009 Inpatient Prospective Payment System rule

On July 31, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the fiscal year (FY) 2009 Inpatient Prospective Payment System. The highlights of the regulation include the addition of three hospital-acquired conditions (HACs) to the previous list of eight illnesses for which Medicare will not pay if they were not present upon admission, the deletion of one and the addition of 13 quality measures that hospitals are required to report in order to receive a full payment update, and significant changes to the “stand in the shoes” aspect and period of disallowance of the physician self-referral law.

HAC updates
Since October 1, 2007, CMS has required hospitals to submit information on Medicare claims specifying whether secondary diagnoses are present upon admission. Beginning the first of this month, Medicare will no longer allow hospitals to assign an inpatient hospital discharge to a higher-paying diagnostic group if a defined HAC was not present upon admission. The HAC provision is part of a larger Medicare policy often referred to as value-based purchasing, which attempts to align payment incentives with performance to encourage the delivery of high-quality care.

The final rule made two additional conditions—manifestations of poor glycemic control and deep vein thrombosis—subject to the HAC provision. CMS suggested these new conditions in the proposed rule issued earlier this year. In the final rule, CMS expanded the surgical site infection condition to include infection following certain orthopaedic procedures and after bariatric surgery.

CMS had originally proposed adding nine conditions to the HAC list. In a comment letter on the proposed rule, the College took the position that adding nine more conditions would be premature, would create confusion about priorities, and would excessively burden hospitals and physicians. The College also strongly opposed expanding the HAC payment policy before the first phase of implementation has been evaluated. Furthermore, the College opposed several proposed, specific HACs and, along with other medical organizations, successfully persuaded CMS to remove seven of the nine proposed conditions from the final list of conditions.

Last year, CMS selected the following eight conditions for inclusion on the HAC list: foreign object retained after surgery, air embolism, blood incompatibility, stage III and IV pressure ulcers, in-hospital falls and trauma, catheter-associated urinary tract infection, vascular catheter-associated infection, and surgical site infection (limited to mediastinitis after coronary artery bypass graft). The FY 2009 final rule refined two of these conditions—foreign object retained after surgery and pressure ulcers—by updating the International Classification of Diseases, Ninth

by Vinita M. Ollapally, JD, Senior Regulatory Associate, Division of Advocacy and Health Policy
Revision, Clinical Modification (ICD-9-CM) codes that are subject to the HAC provisions.

See the Table that begins on this page and continues on page 20 for a complete listing of HACs selected for implementation on October 1.

Revised quality reporting measures

The FY 2009 final rule also updates the Reporting Hospital Quality Data for Annual Payment Update Program. By law, CMS must reduce payments to hospitals that do not report specified quality measures. Hospitals that successfully report the quality measures in a given fiscal year will receive the full market-basket update in the subsequent fiscal year, whereas hospitals that fail to successfully report these measures will receive an update that is 2 percent less than the market-basket update that would otherwise apply for that fiscal year. The annual payment update program is another value-based purchasing tool that CMS is using to attempt to promote increased quality and efficiency of care.

The final rule adds 13 quality measures to the current list of 30 measures and deletes one measure, for a total of 42 measures for FY 2009 reporting. CMS originally proposed to add 43 new quality measures, but after the comment period decided to finalize only 13 measures. In the comment letter to CMS mentioned previously, the College expressed strong concern about the proposed expansion of the reporting obligations imposed on hospitals and their physicians. The College also expressed support for using existing registries and data banks to enhance and expand quality reporting without adding to the demands on hospitals and physicians. In addition, the College opposed several proposed quality measures, which CMS eventually removed from the final rule.

Other changes

The final rule contains major changes to the “stand in the shoes” aspect and period of disallowance in the physician self-referral statute. The finalized rule requires only physician owners or investors to stand in the shoes of their physician-owned organization. In such a case, any arrangement between a physician group and an entity to which the physician group refers Medicare patients for designated health services (DHS)

<table>
<thead>
<tr>
<th>HAC</th>
<th>Complication and comorbidity (CC)/major complication and comorbidity (MCC) (ICD-9-CM codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign object retained after surgery</td>
<td>998.4 (CC) 998.7 (CC)</td>
</tr>
<tr>
<td>Air embolism</td>
<td>999.1 (MCC)</td>
</tr>
<tr>
<td>Blood incompatibility</td>
<td>999.6 (CC)</td>
</tr>
<tr>
<td>Pressure ulcer, stages III and IV</td>
<td>707.23 (MCC) 707.24 (MCC)</td>
</tr>
<tr>
<td>Fulls and trauma:</td>
<td>Codes within these ranges on the CC/MCC list:</td>
</tr>
<tr>
<td>• Fracture</td>
<td>800-829</td>
</tr>
<tr>
<td>• Dislocation</td>
<td>830-839</td>
</tr>
<tr>
<td>• Intracranial injury</td>
<td>850-854</td>
</tr>
<tr>
<td>• Crushing injury</td>
<td>925-929</td>
</tr>
<tr>
<td>• Burn</td>
<td>940-949 991-994</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infection</td>
<td>996.64 (CC)</td>
</tr>
<tr>
<td>Vascular catheter-associated infection</td>
<td>999.31 (CC)</td>
</tr>
<tr>
<td>Manifestations of poor glycemic control*</td>
<td>250.10-250.13 (MCC) 250.20-250.23 (MCC) 251.0 (CC) 251.10-251.11 (MCC) 250.20-250.21 (MCC)</td>
</tr>
</tbody>
</table>

*HAC added in FY 2009 Inpatient Prospective Payment System rule.
benefits of ownership or investment in the physician organization (labeled by CMS “titular owners”). This part of the rule also does not apply to arrangements that satisfy the requirements for the exception of academic medical centers. In addition, the final rule allows physicians who are not owners to choose to stand in the shoes of their physician organization, thereby allowing these physicians greater flexibility to make referrals to DHS entities. CMS proposed but did not finalize the entity “stand in the shoes” provision, which would have required a DHS entity to stand in the shoes of any entity that owns or controls it. In that case, the DHS entity would be deemed to have the same compensation arrangements, with the same parties, and on the same terms as the entity that owns or controls it.

CMS also finalized provisions that identify the period of disallowance during which a physician cannot refer to a DHS entity nor can the entity bill Medicare because the financial relationship between the two violates the self-referral statute. The final regulation, which differs minimally from the proposed rule, states that the period of disallowance begins when the financial arrangement fails to satisfy an exception to the physician self-referral statute, and ends no later than any of the following dates:

- When the agreement comes into compliance, if the noncompliance does not relate to compensation
- When the excess remuneration is returned, if the noncompliance relates to excess remuneration
- When additional money is paid, if the noncompliance relates to insufficient payment

The final rule also provides a special exception when noncompliance with the physician self-referral statute is solely the result of a missing signature.

Overall, the final rule reflects a greater focus on value-based purchasing and the evolution of the physician self-referral statute and takes into account the concerns that the College expressed in its comments. As a result, the rule reflects a more balanced approach to CMS’ quality and regulatory changes.

An online version of the final rule is available at http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf. The rule was published in the August 19 issue of the Federal Register.
The majority of physicians would likely agree that at some point in their lives, they have been labeled a “leader.” In addition to excelling in the classroom, physicians have found the time to be the captains of sports teams, presidents of clubs, and organizers of local volunteer activities. This ability to identify important issues and rally others to participate has made them stand out as they have traveled the path from college, to medical school, and finally to residency.

So now, as residents, do we still need those leadership skills? The July issue of the Bulletin focused on the future and challenges of surgical education. Ted A. James, MD, Chair of the Resident and Associate Society of the American College of Surgeons (RAS-ACS), highlighted the fact that it is necessary to develop essential nonclinical skills such as leadership, advocacy, and policy-making. These skills, in combination with our technical training, will help us tackle the issues that threaten surgery today and prepare us for possible challenges in the future.

What does leadership look like now from a resident’s perspective? As a junior resident—especially with the hierarchical design of surgery programs—I look to my senior residents and faculty for leadership. I don’t think that just because someone carries the title “chief,” it automatically makes him or her a leader. Just as with technical skills, there is a constant process of identifying those areas where individuals are deficient and setting defined goals and timelines to develop the leadership skills they need to obtain. Since not everyone can be a chief at the
same time, there are areas where everyone, regardless of training level, can become involved, make an impact, and acquire those skills necessary to be a leader.

What defines a leader? Common descriptions of a leader include the abilities to communicate, motivate, adapt, act as a catalyst, have a vision, and align others toward a goal. John Kotter, Konosuke Matsushita Professor of Leadership, Emeritus, at Harvard Business School, defined leadership by what leaders do: they cope with change, they set direction, they align people to participate in that new direction, and they motivate people.* How do we, as surgery residents, develop these leadership skills?

**Become active in your residency program**

While we spend a considerable amount of time at the hospital developing our clinical skills, it is just as important to focus on nonclinical skills such as leadership. Getting involved at the local level will probably have the most tangible impact. There are many opportunities at the level of the individual residency program and hospital for residents to be involved in decisions that specifically affect them and their patients, hospital, and training program. Such opportunities may involve serving as a liaison to a hospital-wide committee, serving on a resident council, or providing input into the graduate medical education requirements.

Residents are an important commodity in the hospital structure; never minimize the impact your input may have on how things are done or what path is taken. Another way in which residents can build upon leadership skills is by taking an active interest and role in the new resident interview process. Residents should make time to meet potential candidates and share their perspectives on the residency culture. These are the future residents who will carry on the traditions and reputation of residency programs.

**Become active on the national level**

Leadership training also takes place within a wider arena. An integral part of this nonclinical skill is learning how to disseminate information. Every day we discuss patient care, fascinating surgeries, and ongoing research with our fellow residents. We should be willing to share our interesting cases and research projects with those outside of our institutions by presenting at surgical conferences. Most conferences convene sessions specifically for resident presentations. These opportunities expand our ability to communicate with our peers and discuss cutting-edge topics.

At the national level, the easiest place for residents to cultivate leadership skills is through the RAS-ACS. This group, run by residents and young fellows in general surgery and other surgical specialties, works to provide a forum for discussion, represents the resident voice for the College, and promotes further education and training. These goals are met through several committees, symposia, and training courses.

Last year at the Clinical Congress in New Orleans, LA, I attended the Sunday residents’ meeting and was impressed by the number of residents present and their depth of knowledge.

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on current surgical issues. I wanted to be involved and take some of that knowledge back to my own institution. I served on the RAS-ACS Membership Committee this year. What a remarkable experience to get to interact with other residents around the country and work toward a common goal. Although the changes made at this level might not directly affect an individual resident, they do have an impact on the practice environment that we will eventually enter.

**Become active in training and education**

Medical students are an untapped audience. They rotate through during their third-year clerkships without a clear idea of their long-term career goals. It is our responsibility as residents to provide mentorship to students interested in surgery and students planning on pursuing other fields.

In the July *Bulletin*, in “Teaching surgery to medical students: Perspectives from our mentees” (pages 48–53), several medical students provided comment on their surgical clerkship experiences. Each contributor mentioned role models, many of them residents, who shaped their view of surgery and the type of physician they wished become. Interacting with medical students is, in many ways, a pinnacle of leadership skills. Residents are required to translate many of the complexities of surgery to a more basic level and provide constructive critique of performance and skill. They also need to be able to demonstrate both correct surgical technique and proper patient interaction. Both the skills and the modeling of behavior will help medical students throughout their medical careers.

By becoming active in a residency program, at the national level and in the training and education of medical students, a resident can develop the leadership skills that can then influence education and training in addition to the care provided to patients. My residency, like many, is not a “democracy,” but residents can still have a visible impact as leaders, role models, and clinicians. Improving leadership skills allows individuals to convey opinions, teach concepts, and promote change effectively. These skills are not just for the future program chairs, but for any surgeon who wants to start their own practice, head a research study, or make changes in institutional protocols. The most effective and influential surgeons are lifelong leaders who develop their skills early in their careers.

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**Dr. Rader** is a third-year postgraduate student at University of Tennessee–Chattanooga and incoming Vice-Chair of the RAS-ACS Membership Committee.
Coding for consultations has become an issue of recent concern for physicians and Fellows of the American College of Surgeons. The July 2006 issue of the Bulletin included an article entitled “In compliance... with consultation coding requirements.” Since then, Current Procedural Terminology (CPT) guidelines for reporting consultations have remained the same. However, the degree to which the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services’ Office of the Inspector General (OIG) have begun looking at and auditing consultations has placed increased scrutiny on documentation. This article reviews this issue and focuses on the definition of consultations, accurate reporting, requesting documentation, and the definition of “transfer of care.”

**Issue raised by the OIG**

In a March 2006 report to CMS, the OIG reported that Medicare paid approximately $1.1 billion more in billings for consultation in 2001 than it should have allowed. More specifically, the OIG reported that approximately 75 percent of services billed as consultations and allowed by Medicare in 2001 did not meet all applicable program requirements, resulting in $1.1 billion in improper payments. The following were often true of services billed as consultations:

- Did not meet Medicare’s definition of a consultation (19 percent, $191 million)
- Were billed as the wrong type or level of consultation (47 percent, $613 million)
- Were not substantiated by documentation (9 percent, $260 million)

At that time, the OIG found that consultations billed at the highest billing level (the most complex services, which generate the highest reimbursements under the physician fee schedule) and follow-up inpatient consultations were particularly problematic, asserting that approximately 95 percent of each was miscoded. Subsequently, follow-up inpatient consultations were deleted from CPT and are no longer applicable or available.

The OIG report went on to state, “There are significant concerns that physicians are improperly using the codes for consultative services in order to increase reimbursement, and are not complying with consultative service provider requirements.” Although the ACS General Surgery Coding and Reimbursement Committee (GSCRC) does not agree with this statement, its members would agree that detailed documentation is critical to substantiating a consultative service.

**Consultation defined**

According to CPT 2008,

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient’s medical record. The consultant’s opinion and any services that were ordered or performed must also be documented in the patient’s medical record and communicated by written report to the requesting physician or other appropriate source.

In the online manual, 100-04, Claims Processing, Chapter 12, Section 30.6.10, states, in part, “A request for a consultation from an appropriate source and the need for consultation (i.e., the reason for a consultation service) shall be documented by the consultant in the patient’s medical record and included in the requesting...
physician or qualified NPP’s [nonphysician practitioner] plan of care in the patient’s medical record,” and “The intent of a consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc., in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional’s knowledge.”

Pursuant to 42 CFR § 11.351 and section 15506 of the Medicare Carriers Manual, Medicare allows reimbursement for consultations if the following conditions are met:

• The referring physician requests the consultant’s opinion or advice regarding evaluation and/or management of a specific medical problem (REQUEST)

• The written or verbal request and need for the consultation are documented in the patient’s medical record (RENDER)

• After the consultation is provided, the consultant prepares a written report of his or her findings, which is provided to the referring physician (REPORT)

Unresolved issues

Two issues have been discussed at length by the CPT editorial panel, local Medicare carriers, or both: that is, the documentation of the request for the consultation and the definition of transfer of care.

Documenting the request. Requests for a consultation may be verbal but still must be noted in the patient’s medical record and/or plan of care. A written request and opinion and recommendation in a common medical record meet the documentation requirements of a consultation in the hospital setting.

In the outpatient setting, the request must be included in both the plan of care of the requesting physician and in the patient’s medical record maintained by the consultant. There’s the rub.

In an academic institution or clinic with a common medical record or electronic medical record, the consultant can easily verify that a request has been made and documented. In the private sector, or between offices managed by different physicians, entities, or academic institutions, the situation becomes more difficult. The following solutions have been offered and tested:

• A commonly available consultation request form originates in the requesting physician’s office, copies of which are maintained in the requestor’s office and in the consultant’s record

• A letter from the originating physician states the request with copies maintained in both charts

• The consultant sends his or her letter back to the requesting physician clearly stating that “Your patient was seen on [date] at your request for a consultation regarding the management of his/her [condition]”; thereby, copies of the statement of the request will be in both charts

• Some consultants require the receipt of an appropriate request form before seeing the patient or performing the consultation

Your practice may have other means of verifying that a request has been made and documented. Whatever method you use to indicate that this effort has been made, your compliance plan should spell it out. It is also helpful to have agreement among your consultant requesting sources as to how this should be done.

Transfer of care. Providers continue to struggle with determining and documenting the intent of the request. First and foremost, we need to consider the intent of a consultation service: “the originating physician or qualified [NPP] asks another physician or qualified NPP for advice, opinion, recommendation, suggestion, direction, or counsel in the evaluation or treatment of a patient, because that consultant has expertise in a specific medical area beyond the originating physician’s or NPP’s knowledge.” In this case, the requesting physician anticipates continuing to treat the patient condition.

The documentation of the intent of the request is Medicare’s determining factor in whether a service is a consultation or a new or subsequent patient visit code.

The ACS GSCRC maintains that the decision to accept the transfer of care cannot usually be made until the consultation has occurred. There are certainly instances when a patient is transferred from another facility and a true transfer of care occurs. However, in the day-to-
day practice, a surgeon will need to completely evaluate a patient (and, of course, document that request and communicate it back to the requesting physician or NPP) before making that determination. That could only occur after the requested consultation has been performed and reported. In support of this approach is the following excerpt from the *Statements on Principles* of the American College of Surgeons:

“However, the surgeon bears the ultimate responsibility for determining the need for and the type of operation. In making this decision, the surgeon must give precedence to sound indications for the procedure over pressure by patients or referring physicians, or the financial incentive to perform the operation.”

**Summary**

The three parts of documenting a consultation remain the same: request, render, report. It is also important to document the intent of the request. If there is mutual agreement that this involves the transfer of care, a consultation is not appropriate and a new patient evaluation should be reported. However, until the surgeon has evaluated the patient—that is to say, performed the consultation—it is difficult to justify accepting the transfer of care. It is helpful if a compliance plan specifies how this intent is documented, such as a consult/transfer of care request form or letter originating with the requesting physician, and retained in both charts or in a common document.

**Acknowledgments**

This article was produced in collaboration with the ACS GSCRC and Debra Mariani, CPC, Practice Affairs Associate, Division of Advocacy and Health Policy.

**References**

Editor’s note: Michael E. DeBakey, MD, FACS, was arguably the world’s best-known surgeon. His death occasioned a well-deserved, international outpouring of memorial essays, listing his prodigious accomplishments. For a less conventional, educationally oriented commentary on Dr. DeBakey, the Bulletin asked Dr. Hanlon, a former President and longtime Director of the College, to record a few aspects of his friend Michael’s 59 years of Fellowship in the College.

Michael E. DeBakey, MD, FACS, was a preeminent educator who cooperated significantly with the American College of Surgeons in its earlier years. Data on these relationships are to be found in the newly refined Archives of the College under the direction of Ms. Susan Rishworth.

On April 23, 2008, Dr. DeBakey received the Congressional Gold Medal of the U.S. at an impressive ceremony in the Capitol Rotunda in Washington, DC. Individuals in attendance, including the President of the U.S. and leaders of both political parties, commented on the extraordinarily diversified accomplishments of the honoree in national and international venues. Understandably, the speakers placed a major emphasis on the operative surgical aspects of his eminent career.

Educational activities

But there is an important, less well-known aspect of his achievements, focused on his intense dedication to education for patients and for individual practitioners at every level of the health care enterprise. One such example concerns the preparation of young people for careers in various health-related disciplines.

Dr. DeBakey’s distinguished work in such preparatory education was brought home to me by a recent meeting with the principal of a special school, founded in Houston, TX, in 1972 and now known as the DeBakey High School for Health Professions. This remarkable institution has compiled a distinguished record of sending its graduates, many from minority backgrounds, on to successful lives as nurses, pharmacists, physicians, and other health care practitioners.

Even more striking is the activity of the present principal...
of the school in her outreach to the founding of a comparable institution in Qatar, half a world away. Charlesetta Deason, EdD, has been principal of the DeBakey High School for 18 years, succeeding the previous principal who had served from the school’s inception.

Encouraged by Dr. DeBakey to submit an educational proposal to Qatar early in 2008, Dr. Deason has traveled there on several occasions to implement her approved plans for opening the new school. There will be 100 students in the eighth grade “academy” and 100 each in the ninth and tenth grades for a total of 300 original students. In five years, the original “academy” group will have graduated from the twelfth grade.

The inspiring story of this venture in preliminary undergraduate medical education serves as a sidelight on the better known public record of Dr. DeBakey as a gifted and phenomenally productive clinical surgeon, a physician to the great and famous, an organizer and chronicler of military surgery, a successful developer of a great academic medical center, an advisor to presidents and heads of state, and a teacher for thousands in surgery, directly or by way of his pupils worldwide.

This listing omits many important areas of his activity, such as his critical role in the renaissance of the National Library of Medicine (NLM) and his public defense of laboratory research as chairman of the Foundation for Biomedical Research (FBR). In this organization, dedicated to promoting public understanding and support for humane and responsible use of animals in medical research, he has for a quarter century led the fight against those who aim to eliminate essential laboratory investigation. For seven years, the DeBakey Journalism Awards of the FBR have facilitated the vital relations between research and the press. The College has contributed steadily and significantly to such support of scientific research as set out in its Articles of Incorporation.

**Work with ACS**

Dr. DeBakey had a close but unheralded relationship to important educational interests of the American College of Surgeons. As far back as 1951, then-Director of the ACS, Paul R. Hawley, MD, FACS(Hon), complimented him on his participation in an important study of undergraduate medical education under the auspices of the American Surgical Association. In a “Dear Mike” letter, Dr. Hawley said of the committee study, “It is no overstatement to say that it is a masterpiece.” In a gracious response, Dr. DeBakey cited Oliver Cope as deserving of the major credit and suggested that a letter of commendation to him would be in order.

In the 1951 correspondence between these two surgical leaders, Dr. Hawley asked for advice not only on educational matters, but on another major College concern: “Why are we making such slow progress in driving unethical conduct from the practice of surgery?” He continued, “Is it that we talk, but do not act?” Dr. DeBakey’s answer remarked on the “increasing emphasis on material gain in the practice of medicine rather than upon humanity’s benefit.” And he associated this tendency toward venality with a lack of courage in vigorous ethical advocacy.

**Academic surgery/ACS**

Early in 1952, Dr. Hawley commented favorably on Dr. DeBakey’s annual report of his surgical department at Baylor, adding, “I hope you professors of surgery will push the College, not only in your faculty but also among your residents in training.” It is easy to forget that the American College of Surgeons, then in its fourth decade of existence, was not highly regarded by all parts of academic surgery in America. Thus, it was a special compliment that Dr. Hawley directed to Dr. DeBakey for his faculty roster, heavy with College Fellows. And he exhorted him: “Get behind [the College] and push! Not that you haven’t always done that.” This was an implicit recognition of Dr. DeBakey’s position and influence as a leader in ACS participation by academic surgical departments.

In 1960, Dr. DeBakey was appointed to an ACS subcommittee on Training of the Surgeon, part of the overall Graduate Training Committee of the College under Frank Glenn, MD, FACS. This body later adopted the more appropriate term of “graduate surgical education” rather than “training.” And in 1962, preceding the stellar work of Hilger Perry Jenkins, MD, FACS, Dr. DeBakey made valuable suggestions for organizing
various surgical film libraries throughout the country under College auspices. This advice and organizational work led to his appointment as “archivist and bibliographer” for the Committee on Medical Motion Pictures of the ACS. As a practical participant in the committee’s work, he was complimented by the staff for the submission of four teaching films to the collection.

President Commission

In 1965, Pres. Lyndon B. Johnson appointed Dr. DeBakey Chairman of the President’s Commission on Heart Disease, Cancer, and Stroke. The controversial aspects of this legislatively enacted commission led the Board of Regents to invite the chairman to Chicago for a special, extended meeting of the Regents. Subsequently a committee of five Regents, under the chairmanship of Jonathan E. Rhoads, MD, FACS, was appointed to address the many implications of the President’s Commission as it influenced academic and community surgical practice.

In 1966, the College noted the increasing importance of cardiovascular components in the overall practice of surgery and established a standing Committee on Cardiovascular Surgery. In the planning stages for this entity, Dr. DeBakey was part of the ad hoc group to define the nature of the committee and its relation with other professional groups in medicine. The committee was designed to be comparable to the well-established College bodies dealing with trauma and cancer. Dr. DeBakey was an initial appointee to the 21-member committee.

The educational activities of the American College of Surgeons can be traced back to Franklin Martin’s founding of a scientific journal, Surgery, Gynecology, and Obstetrics in 1905. Subscribers to that journal constituted the invitees to Chicago for operative clinics and seminars in 1910; these meetings evolved into the Clinical Congress of Surgeons of North America. The fusion of this body into the American College of Surgeons, incorporated in 1912, produced a complex educational institution with a formidable library service. That library, in its full flowering, employed more than two-dozen people who dispatched packaged scientific materials to a wide range of Fellows and others. It was a remarkable testament to the educational vision of Dr. Martin and his associates.

NLM

An even more remarkable saga is the story of Dr. DeBakey’s influence on the NLM. If his educational achievements were limited to this one effort, they would be sufficient to place him in the illustrious company of John Shaw Billings, MD, and Donald A. B. Lindberg, MD, whose library stewardships span a century and a half of phenomenal progress. In a classic Journal of the American Medical Association article on the evolution of the NLM, Dr. DeBakey gave readers a lively account of the straitened circumstances of the Library of the Surgeon General’s Office in 1836 and its tortuous, politically charged journey to a 1968 establishment as a world-class enterprise on the campus of the National Institutes of Health in Bethesda, MD.*

Not content with the foundation of the nation’s foremost library research center, Dr. DeBakey worked successfully to establish a regional library network of some 5,000 medical institutions as well as a NLM research facility named the Lister Hill National Center for Biomedical Communications. Other acronymic entities in the area of medical informatics, artificial intelligence, and an international medical library network now constitute a truly global resource for the benefit of lay and professional users. At various points in the story of full NLM development, we see reference to assistance by Fellows of the College, such as I. S. Ravdin, Chairman of the Board of Regents from 1954 to 1960.

Writings

Dr. DeBakey’s Fellowship in the ACS extended over six decades, involving numerous presentations from his total output of close to 1,600 papers. At a recent meeting of the Michael E. DeBakey International Surgical Society, attendees were given a book containing 13 carefully selected publications from the vast store of his literary output. Not only do these represent some of his seminal contributions between 1934 and 2006, but they are testimonials to his

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Technique and style of composition. The book’s foreword by a close associate, Kenneth L. Mattox, MD, FACS, speaks to Dr. DeBakey’s penchant for composing with a manual writing instrument on a lined pad of paper, transferring data from books and journal articles into a literal manuscript for later revision and polishing.

The picture accompanying this memorial article captures the essence of that technique, alone, late at night, and clad in the uniform of the operating room where he achieved such monumental feats of care for thousands of patients. It symbolizes the composite nature of a surgeon, a research scientist, and a literary craftsman.

**Family and associates**

As literary companions in his written educational output, Dr. DeBakey was blessed with his redoubtable sisters, Selma DeBakey, PhD, and Lois DeBakey, PhD, both professors of scientific communication at Baylor. The ACS was fortunate during the 1970s to enlist these two paragons of education in scientific writing as leaders of highly regarded seminars in the composition of scientific papers. Participant surgeons in these programs had the benefit of hands-on criticism and advice on their efforts, giving rise to enthusiastic testimonials about gratifying improvements in their writing. But the courses were not merely about grammar and style; they stressed the role of writing as a part of self-directed learning from analysis of the physician’s practice.

To capture this gradual move away from classroom education for practitioners, Lois DeBakey and Phil Manning, MD, published the first edition of their book, *MEDICINE: Preserving the Passion*, with a second edition amplifying developments for the 21st century. The books call attention to the methods that selected physicians have used to continue their practice-linked continuing education, now styled as “continuing professional development.”

Aphorisms and advice in the book are derived from hundreds of interviews with practitioners. It is a happy circumstance that this book has provided so sympathetic a vehicle for the concise biography and essential philosophy of this surgical titan. In a 15-page essay, “Preparing and Enjoying an Intellectually, Emotionally and Morally Fulfilling Career,” Dr. DeBakey speaks to family influences, significant teachers, the importance of self-discipline, and a devotion to the humanities.

**International interests**

Among the humanities, Dr. DeBakey was particularly devoted to the discipline of history. In 2002, he sent me a copy of the eminent historian Bernard Lewis’s short but profound book, *What Went Wrong?*, a trenchant analysis of Middle Eastern history that was in page proofs at the time of the attack on September 11, 2001. Dr. DeBakey’s international practice and travel opportunities enhanced his penetrating insight into global developments.

As a young surgeon, encouraged by his mentor Alton Ochsner, MD, FACS (President of the ACS from 1951 to 1952), he had traveled abroad to work with Rene Leriche in Strasbourg and with Martin Kirschner in Heidelberg. These European experiences developed valuable professional associations and amplified the philosophical breadth contributed by a familial background sympathetic to an older culture. Precision in language was a hallmark of his style, with nearby professorial experts in communication as part of his family circle.

**Teacher**

Through Michael DeBakey’s long and distinguished career, there has been a host of journalistic feature articles and analyses of every facet of his complex life and incredible technical achievements. The present communication is merely a glancing reference to certain relationships with the American College of Surgeons viewed from a narrow, personal focus. In an essay in the *Archives of Surgery*, I positioned him in the great pantheon of surgical teachers, noting “…his precision of thought, his self-disciplined life, his joy in work and his compassionate clinical care."

His memory will live on in the admiring emulation of his pupils and the profound gratitude of his myriad patients.

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In memoriam

Moses Judah Folkman, MD, FACS: 1933–2008

by Patricia K. Donahoe, MD, FACS

Editor’s note: Dr. Folkman received the 2006 ACS Jacobson Innovation Award in recognition of his founding of the field of angiogenesis research.

A legendary giant has been lost from the academic leadership of U.S. pediatric surgery with the death of Moses Judah Folkman, MD, FACS. It will be long before this immeasurable void can be filled. His legacy of training and mentoring hundreds, however, has ensured a long line of surgical investigators for the future who have been touched by his energy, ingenuity, and creativity and will strive to follow the example he has set.

While surgeon-in-chief at Children’s Hospital in Boston, MA, and the director of the growing vascular biology program, he trained 159 surgical research fellows, three of whom went on to become members of the National Academy of Sciences and at least four of whom were elected to the Institute of Medicine of the National Academy of Sciences. During his tenure as surgeon-in-chief, his pediatric surgical fellowship produced 21 graduates and a host of others who did part of their training under his auspices. Many went on to become recognized leaders in American pediatric surgery.

The story of Dr. Folkman’s discovery of angiogenesis is memorable, first at the Naval Medical Center, Boston City Hospital, then Children’s Hospital. His first experiment in the early 1970s demonstrated the existence of the tumor-specific vascular growth factors (VGF) and led to his subsequent discovery of angiogenesis inhibitors. Never one to avoid speculation regarding his observations, he opened himself to skepticism that he weathered while his theories regarding the potential clinical role of tumor VGF and endogenous or engineered inhibitors became accepted; they have since been confirmed by a multitude of laboratories joining the field that he founded.

Anti-angiogenesis agents, potentially free of toxicity, now number more than 30, with angiostatin and endostatin leading the way and finally being successfully developed and used to treat patients in China. The concept of angiogenesis pervades virtually all of cancer theory. The discovery that abnormal angiogenesis could be blocked led to the prediction by Dr. Folkman and his colleagues that the hypervascularity of macular degeneration could be attenuated, leading to the commercialization of vascular endothelial growth factor antibodies, which now are used in wide clinical application, helping millions previously consigned to progressive blindness.

Those individuals who worked with Dr. Folkman as young investigators experienced first-hand his irressistible energy and learned the importance of perseverance and the discipline of remaining focused. It mattered not when one left the laboratory, as there was always a note regarding the previous day’s work or the
next day’s work that somehow miraculously was there when we arrived the next morning. Perseverance boiled down to long days and nights of dogged hard work and the building of a dedicated infrastructure in which ideas could be transformed into experiments that, in turn, yielded data that could continually be interpreted in the light of evolving hypotheses. In addition, Dr. Folkman almost never considered anything traditionally but cast it in a new light, giving old facts and old observations new interpretations. I was privileged to have been present at a “eureka!” moment when he and his beloved colleague, Ramsey Cotran, MD, first saw endothelial cell mitosis under the microscope.

Dr. Folkman was born in 1933 in Cleveland, OH, where his childhood was marked by astonishing curiosity, perseverance, and energy. After his undergraduate years at Ohio State University, where he worked in the laboratory of William Clatworthy, MD, FACS, he had a stellar career at Harvard Medical School while also working in the laboratory of Robert E. Gross, MD, FACS. Surgical training at Massachusetts General Hospital further enthralled him with the beauties of surgical techniques and enabled him to adhere to the principle that “nothing is impossible,” which prevailed throughout his life thereafter. As research fellows, we were often treated to a Folkman-led pilgrimage across Boston from Children’s Hospital to Massachusetts General Hospital, which he dearly
loved, to seek enlightenment from the Ether Dome.

His compassionate response to the needs of thousands of patients will forever be recognized as his defining mantra. One of his lesser-known qualities was his impact on his fellows and trainees, to whom he was always available and whom he continued to help well into the seniority of their careers.

Dr. Donahoe is Marshall K. Bartlett Professor of Surgery, Harvard Medical School, and chief of pediatric surgical services, emerita, Massachusetts General Hospital, Boston, MA.

Historical films needed for Archives

by Susan Rishworth, Archivist

As many ACS Fellows know, the College, once a leading national force in the use of motion pictures for educational purposes, produced a number of films starting in the late 1920s. This movement encompassed all facets of the motion picture industry and thus places the ACS at the center of a critical era in the history of cinema. And yet, the role of the ACS is unknown among film scholars. But help is needed to fill in the gaps in the historical record and tell the story of medical motion picture production in the U.S.

Although most of the ACS films were highly technical and designed for an audience of specialists, several were also produced for the general public, including R.N.—Serving All Mankind (1942). This film was made to recruit girls in high school and college to careers in nursing, especially through the U.S. Cadet Nurse Corps, to address the profession’s shortage during World War II. The film was seen by at least half a million viewers and was credited in an issue of the 1943 Bulletin as being “one of the greatest aids in the effort to attract more young women to nursing.”

Another important film was Hands We Trust (1959), which described the process of training to become a surgeon and was narrated by Ronald Reagan. This film was broadcast on television many times and by 1962 was seen by more than 8 million viewers.

The ACS Archives does not have copies of these films. If you have an old 16 mm or 35 mm print of either of these important films, contact Susan Rishworth, Archivist, ACS, 633 N. Saint Clair St., Chicago, IL 60611.

In addition, if you are interested in sharing your recollections about the medical motion pictures program at the College, contact Dr. Kirsten Ostherr, Department of English.
MS-30, Rice University, 6100 Main St., Houston, TX 77005; kostherr@rice.edu; 832/338-3642. Dr. Ostherr is writing a book called *Medical Visions: Producing the Patient through Film, Television and Imaging Technologies*, which is based on research at the College’s Archives, the National Library of Medicine, and other historical archives. The Medical Motion Picture Program at the College will be the focus of several chapters in Dr. Ostherr’s book, and she is eager to supplement her archival research with stories from the surgeons who made or saw the films.

A scene from *R.N.—Serving All Mankind*

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CoC announces Paper Competition winners

The Commission on Cancer (CoC) has announced the three winners of the 2008 Commission on Cancer Paper Competition. Announced in November 2007, this competition was open to general surgery residents, surgical specialty residents, subspecialty residents, and oncology fellows in the U.S.; it is funded by the CoC and a memorial gift from Mrs. A. Lee Campione, in honor of her late husband, Matthew P. Campione, MD, FACS.

There were 80 abstracts submitted describing cancer care in basic laboratory research, clinical investigation, or quality of care/health services research. Reviewed by members of the CoC’s Committee on Cancer Liaison, abstracts were scored on originality, scientific merit, research quality, and relevance and importance. Selecting winners was not an easy process, as all papers showed promise and progress in the fight against cancer.

The first-place winner received a $1,000 award and has been invited to speak at the CoC meeting on Sunday, October 12, in San Francisco, CA, held in conjunction with the Clinical Congress. The second- and third-place winners received a $500 award and have been asked to present their work at the Cancer Liaison physician breakfast on Monday, October 13.

The winners were as follows:

1st place: Jocelyn Logan-Collins, MD, University of Cincinnati (OH) College of Medicine: Silencing of the RON Tyrosine Kinase Receptor Results in Decreased Cell Survival and Increased Sensitivity to Gemcitabine in vivo

2nd place: Karl Y. Bilimoria, MD, MS, Evanston Northwestern Healthcare, Evanston, IL: Sentinel Lymph Node Biopsy Alone vs. Completion Axillary Lymph Node Dissection for Node-Positive Breast Cancer

3rd place: J. Robert Newman, MD, University of Alabama at Birmingham, Birmingham, AL: Blocking Anti-CD147 Antibody Suppresses Growth of Head and Neck Cancer Xenografts and Sensitizes Tumors
In a study published in the August 1 issue of the Journal of Clinical Oncology (JCO), researchers from the National Cancer Data Base (NCDB) of the American College of Surgeons found that more cancer deaths could be avoided by focusing national quality initiatives on factors that affect long-term survival. The investigators compared patient mortality in the days and weeks following cancer operations with survival outcomes five years beyond surgical treatment.

“We were surprised by the number of deaths that could be avoided long term if care at lower-volume hospitals could be improved,” reported lead author Karl Y. Bilimoria, MD, a general surgery resident at Northwestern University’s department of surgery in Chicago, IL, and a former research fellow at the American College of Surgeons. Dr. Bilimoria and colleagues compared these outcomes in the highest-volume hospitals with those in the lowest-volume hospitals across the country.

This study is “not just another article on cancer surgery and patient outcomes,” Nicholas J. Petrilli, MD, wrote in the commentary that accompanies the article published in JCO. “Dr. Bilimoria and associates look at this issue from a different perspective,” he noted. “The authors’ objective was to determine whether differences in hospital surgical volume have a larger effect on perioperative mortality or on long-term survival.”

“In some ways, focusing on long-term outcomes is a common-sense observation,” Dr. Bilimoria said. “A small percentage of cancer patients die in the hospital just after a surgical procedure. More people die of cancer in the long term. Current national quality improvement efforts primarily address the perioperative period, but few measures address long-term surgical cancer care,” he explained. “We wanted to know whether the focus on the perioperative outcomes is merited or whether quality initiatives should be expanded to address factors affecting long-term outcomes. No one had previously directly compared short-term and long-term outcomes to see where the most lives could be saved.”

The study team monitored 243,103 NCDB records for patients who underwent surgical procedures for nonmetastatic colon, esophageal, gastric, liver, lung, pancreatic, or rectal cancer from 1994 through 1999. The team used two approaches to compare survival during the perioperative period within 60 days of death and five-year survival, excluding perioperative deaths. “First, we compared the magnitude of the relative differences between hospitals in both time frames, perioperative and long term. Second, we calculated the number of potentially avoidable deaths if outcomes could be improved at lower-volume hospitals to those seen at highest-volume hospitals,” Dr. Bilimoria explained.

The researchers discovered that hospital surgical volume was a factor for both time periods studied for all cancer sites except for liver resection surgery, where no survival rate differences were noted. Upon evaluating outcomes during the 60-day perioperative period, the researchers found that overall, patients treated at highest-volume hospitals had significantly lower mortality rates compared to patients treated at the lowest-volume centers. Likewise, over a five-year period, patients who...
were treated at the highest-volume centers had significantly higher survival rates compared with patients treated at lowest-volume centers. However, this cancer care study was not done for purposes of evaluating surgical volume outcomes. "The purpose of this study was to try to determine the best strategy for directing future quality-improvement efforts," Dr. Bilimoria emphasized.

Therefore, the researchers performed an analysis of the hospital volume data to see if deaths could be avoided if the low-volume hospitals improved their outcomes to the same levels as the highest-volume hospitals. They discovered that for the seven cancer sites combined, the total number of potentially avoidable deaths in the U.S. each year was 2,207 during the 60-day perioperative period and 7,245 for long-term survival under these adjusted circumstances. "We found that the magnitude of the risk of dying is greater early on, but the number of lives affected long term is considerably greater," reported Dr. Bilimoria.

“Our results indicate that quality initiatives should move beyond measuring factors affecting perioperative outcomes,” Dr. Bilimoria reported. In order to accomplish this goal, he explained, “The cancer care community needs to identify the things that high-volume hospitals do that affect long-term outcomes so that those steps can also be utilized in low-volume hospitals to improve their patient outcomes.” He cited as an example that top performing hospitals generally examine 12 or more lymph nodes for approximately 80 percent of their colon cancer patients. “In contrast, many low-performing hospitals examine a dozen or more nodes in far fewer patients,” he explained.

Quality-improvement initiatives are already being developed to identify the practices employed at high-volume hospitals to achieve good outcomes and transfer these practices to low-volume hospitals. It has been unclear, however, whether quality initiatives in surgical oncology should focus on factors affecting short-term or long-term survival.

Based on his group’s research findings, Dr. Bilimoria believes the key is to improve the quality of surgical treatment at all hospitals to potentially affect long-term outcomes: “We can achieve this goal by making sure we remove all of the cancer, take out the right number of lymph nodes, give all appropriate individuals chemotherapy and other treatments as necessary, and aggressively follow patients for recurrences. We may also encourage some patients to participate in clinical trials.”

Quality measures for cancer treatment have already been developed specifically for pancreatic cancer and melanomas, Dr. Bilimoria said. “We assembled experts from across the country and from various specialties and asked them what we absolutely need to ensure quality care for pancreatic cancer patients as well as melanoma patients. We ranked the number of potential quality indicators and distilled that down to a valid quality measure that most of the experts believed important. For both cancers, we already have a number of quality measures that potentially affect long-term outcomes,” he said. Thus, findings from this study soon will be attached to practical guidelines for low-volume hospitals to follow.

“Most patients in the U.S. undergo cancer resection at low-volume hospitals,” Dr. Bilimoria said. “Moving all patients to high-volume centers is an impractical policy initiative at the national level. Rather, we would like to find what those highest-volume hospitals do to get their better outcomes and transfer those treatment strategies to the lowest-volume hospitals. Small changes could have a big impact,” he concluded, “and quality measures, such as those endorsed by the National Quality Forum, will be a big help. Our goal is to raise the tide to improve the quality of care across the board.”

Dr. Bilimoria’s co-investigators include David J. Bentrem, MD, FACS; Mark S. Talamonti, MD, FACS; James S. Tomlinson, MD; Andrew K. Stewart, MA; David P. Winchester, MD, FACS, Medical Director, Cancer Programs, ACS Division of Research and Optimal Patient Care; and Clifford Y. Ko, MD, MS, MSHS, FACS, Director, ACS Division of Research and Optimal Patient Care. The study was supported by the American College of Surgeons Clinical Scholars in Residence program and the department of surgery at Feinberg School of Medicine at Northwestern University.
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Surgical stapler’s 100th anniversary celebrated by Covidien at SAGES

by Karen Stein, Associate Editor

A staple of surgical instrumentation itself, the surgical stapler has reached its 100th anniversary in 2008. This milestone was celebrated at the Society of Gastrointestinal and Endoscopic Surgeons (SAGES) annual conference in April in Philadelphia, PA.

Hosted by Covidien Surgical Devices and presented to more than 300 attendees, the celebration included historical videos, slide presentations, and speeches to highlight the creation of the surgical stapler and how it revolutionized the medical industry. Adrian Park, MD, FACS, the program chairman of SAGES 2008, delivered the keynote address, which focused on the stapler’s role in medical history and how research and technology have contributed to improved patient outcomes over the last century. Scott Flora, president, surgical devices, at Covidien, kicked off the festivities and Ross Segen, MD, FACS, global medical director, presented a brief history of surgical stapling, including Covidien’s role as the leading innovator of stapling technology over the last 40 years.

This event also paid tribute to the stapler as a major medical achievement of the last millennium and the surgeons who pioneered its use—including Humer Hultl, the Hungarian scientist who first used staples...
in surgery. Felicien Steichen, MD, FACS, who—along with Mark M. Ravitch, MD, FACS—is credited with developing and advancing worldwide use of the stapler, was honored by Covidi-en with a Lifetime Achievement Award at this event.

**Surgical stapler: 100 years**

The first surgical stapler debuted in 1908, used by Professor Hultl, and although it was effective in reducing blood and fluid loss during surgery, its broad adoption was limited by its 3.5 kg weight and the need to hand-load individual steel staples, which required approximately two hours to complete.

Dr. Ravitch obtained a bronchial stapling instrument during a trip to Russia and brought it back to Johns Hopkins University. He and Dr. Steichen used this stapler—and subsequent models—in extensive laboratory, then clinical, applications.*

Leon Hirsch sought to improve the device in 1963, first using a design that incorporated balsa wood and a disposable staple cartridge. The eventual prototype was crafted of metal and built for $75,000. Mr. Hirsch then founded U.S. Surgical in 1964, and by 1967, the first commercially available surgical stapler, the Autosuture TA, was released. Several additional types of staplers followed in rapid progression, enabling surgeons to perform more complex anastomoses and procedures. Between 1967 and 1975, U.S. Surgical Corporation’s Autosuture line of devices were used in approximately 1.3 million cases worldwide. By 1978, that total reached more than 4 million in aggregate (personal communication, Dr. Segan, July 31, 2008).

**Lifetime Achievement Award**

At the same time that Mr. Hirsch was working at perfecting the stapler, Dr. Steichen continued to pursue his interest in staplers. Then a member of the faculty at Albert Einstein College of Medicine and the associate director of the department of surgery at Lincoln Hospital, Bronx, NY, he explored new models as they were developed and designed new surgical techniques for their use, including the end-to-end anastomosis procedure used today. In addition, the first clinical gastrectomy, pulmonary lobectomy, and Hunt-Lawrence and Paulino pouch procedures with American staplers were performed at Albert Einstein and Lincoln Hospital.

Dr. Steichen moved to the University of Pittsburgh in 1970, where he and Dr. Ravitch designed and conducted the first postgraduate courses in surgical stapling. He was also one of the first surgeons to use the double-stapling technique and he developed the triple-stapling technique.

It is because of Dr. Steichen’s pioneering efforts in surgical stapling and his innovation, design, and execution of many of the surgical stapling procedures performed routinely today—in addition to the many books and book chapters and hundreds of articles he authored or co-authored—that Covidien presented him with the Lifetime Achievement Award at the surgical stapler anniversary event (see photo, page 39).

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*All information regarding Dr. Steichen’s contribution to surgical stapling was provided via personal communication with Ruth Wolsch, RN, a retired OR nurse, former director of professional education for USSC and co-author of Ciné-Med’s text on the history of mechanical sutures in surgery. A close friend of Dr. Steichen, she was selected to introduce him at the SAGES event.
ACOSOG news

In situ ablation of breast cancers

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

In a previous Bulletin article,* this column described an American College of Surgeons Oncology Group (ACOSOG) trial that will assess in situ radiofrequency ablation of early stage non-small cell lung carcinoma (ACOSOG Z4033). ACOSOG is moving this technology forward in another organ site with the activation of a cryoablation trial of T1 breast cancers (Study Chair: Rache Simmons, MD, FACS). As with Z4033, ACOSOG Z1072 surgeons and radiologists will be using advances in imaging technologies to determine if early cancers can be completely ablated. Z1072—Exploring the Success of Cryoablation Therapy in the Treatment of Invasive Breast Carcinoma—is a phase II trial.

The primary objective of the study is to determine the rate of complete tumor ablation in patients treated with cryoablation, with complete tumor ablation defined as “no remaining invasive or in situ carcinoma present upon pathological examination of the targeted lesion.”

Secondary objectives are as follows:

- To evaluate the negative predictive value of MRI in the post-ablation setting to determine residual in situ or invasive breast carcinoma
- To describe the adverse events associated with cryoablation
- To prospectively gather pain assessment data on cryoablation and surgical resection
- To explore technical variables that may affect success of cryoablation

The target accrual is 99 patients. The study schema is shown in the Figure on page 42.

Patient selection criteria are important when designing such a prospective clinical efficacy trial. Although magnetic resonance imaging (MRI) for the breast may not be perfect in selecting isolated primary breast cancers, it has increased surgeons’ ability to better identify those patients who have localized early disease, which is suitable for in situ ablation. The trial will also use post-ablation MRI to determine if residual disease remains. In this trial design, all patients will undergo resection of the ablation site so that microscopic evaluation for residual disease can be done. There is also an optional correlational science component of this trial to investigate the immune response to cryoablation, which includes three blood samples.

Patient eligibility criteria include the following:

- Unifocal primary invasive ductal breast carcinoma diagnosed by core needle biopsy. Patients with multifocal and/or multicentric ipsilateral breast cancer, multifocal calcifications, or ductal carcinoma in situ with microinvasion are not eligible. Patients with contralateral disease will remain eligible.
- No history of rotational vacuum-assisted core biopsies, en bloc open surgical biopsy, and/or lumpectomy for diagnosis/treatment of the index breast cancer.
- Tumor size is <2.0 cm in greatest diameter. Specifically, the tumor must measure <2.0 cm in the axis parallel to the treatment probe and <1.5 cm in the axis antiparallel to the treatment probe. Largest size measured by mammogram, ultrasound, or MRI will be used to determine eligibility.
- Tumor enhancement is present in prestudy MRI.
- Tumor biopsy has <25 percent intraductal components in the aggregate.
- There is no prior or planned neoadjuvant chemotherapy for breast cancer.
- Patient is not pregnant and not lactating.
- Adequate breast size for safe cryoablation. Male and female breast cancer patients with breasts too small to allow safe cryoablation are not eligible, as the minimal thickness of the breast tissue does not lend itself to cryoablation.

Cryoablation of breast cancers is a new procedure and, therefore, credentialing criteria for surgeons or radiologists to participate in the trial are described in the protocol. The following criteria are written in the protocol. The protocol will only be available to those who initially meet at least one of the following criteria:

1. Surgeon is certified in ultrasound by the American Society of Breast Surgeons and has completed at least five ultrasound-guided cryoablations for breast fibroadenoma/cancer

2. Surgeon is partnering with a radiologist certified by the American College of Radiology in breast ultrasound and has completed at least five ultrasound-guided cryoablations for breast fibroadenoma/cancer

3. Surgeon can provide case list documentation of the last 20 breast interventional ultrasounds within the past six months and has completed at least five ultrasound-guided cryoablations for breast fibroadenoma/cancer

The trial will be conducted in up to 20 clinical sites where the interventional radiologists and/or surgeons meet these qualifications.

The imaging and instrumentation technologies are constantly improving and there is a real need to conduct prospective multisite procedural trials in order to assess efficacy and patient selection criteria. Given that in situ cryoablation of T1 breast cancers is a new procedure and patient data will be collected, the protocol requires approval by the participating clinical site’s Institutional Review Board and study-specific patient informed consent. We are pleased that Cancer Treatment Evaluation Program and The Cancer Imaging Program of the National Cancer Institute and Sanarus Inc. are supporting this trial. ACOSOG surgeons, research staff, and patients’ advocates played a major role in designing the trial.

For more information regarding this trial, contact Dr. Simmons at rms2002@med.cornell.edu.

Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG co-chairs.
Surgeons Diversified Investment Fund’s second quarter 2008 performance report
If you have any questions, contact Savi Pai at 312/202-5056 or spa@facs.org, or Tom Kiley at 312/202-5019 or tkiley@facs.org. Both individuals are registered representatives available to discuss specific details regarding SDIF. You may also visit www.surgeonsfund.com or contact SDIF directly at 800/208-6070 for more information.
**Financial checkup**

**Tips for evaluating net worth**

by Laura M. Linger

Being physically healthy requires more than just a well-balanced diet and regular exercise. Similarly, true financial health entails more than simply earning solid investment returns and staying in control of debt. A financial checkup for individuals of high net worth should include a careful evaluation of each piece of the wealth mosaic, which includes the following:

- Financial self-discovery
- Strategic asset allocation
- Charting a path to retirement
- Achieving tax efficiency
- Managing risk exposure
- Philanthropy: making every dollar count
- Preparing for education expenses

**Financial self-discovery**

Just as “first, do no harm” is a central tenet of practicing medicine, “know yourself” should be viewed as a fundamental principle of wealth management. Before thinking about asset allocation, estate planning, or any other financial issue, a person needs to first identify what is important to him or her and how wealth relates to those aspects of his or her life.

**Strategic asset allocation**

Asset allocation—the process of diversifying investments across different asset classes—may be the single greatest determinant of a portfolio’s risk and return. The goal is to develop an asset allocation strategy that achieves an appropriate mix of equities, fixed-income securities, alternative investments, and cash to meet growth and cash-flow needs, all within an acceptable level of risk.

**Charting a path to retirement**

Retirement planning involves numerous factors that are impossible to accurately predict, such as economic cycles, life expectancy and health issues, tax rates during retirement, and inflation.

But one thing is certain—the sooner a person starts planning and saving, the better the chances of reaching his or her goals.

**Achieving tax efficiency**

Earning large returns is nice for any portfolio, but maximizing what a person gets to keep is what really counts. Income tax implications should be considered with every investment decision.

**Managing risk exposure**

Prudent investors realize that portfolio volatility is not the only type of risk that merits attention. Nearly every aspect of an individual’s personal and professional lives contains some element of risk, and effective financial planning requires identifying these risks and determining how to best manage them.

**Creating an estate plan**

The foundation of any effective estate or multigenerational plan is a clear vision of what the individual or family hopes to pass along to subsequent generations. This vision encompasses not just the transfer of wealth, but also the endowment of wealth, but also the endowment of values and principles.

**Philanthropy**

Philanthropy provides meaningful opportunities for individuals to enrich their communities and promote the values they hold dear. Effective philanthropy, however, is not determined by the size of the checks written—and it does not happen without planning.

**Education expenses**

Individuals planning to contribute to a child’s education expenses face numerous options. In addition to deciding how much to save, they must also determine the best vehicle for those funds.

Individuals and families should revisit these issues regularly because milestones, such as a career change, a li-
quidity event, or the birth of a child or grandchild, create new challenges and opportunities. A holistic, integrated approach to dealing with these interrelated issues is the best way to achieve a clean bill of financial health.

Ms. Linger is head of business development of the private wealth management group at William Blair & Company, Chicago, IL.

Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its June 13, 2008, meeting:

- Jake J. Allen, MD, a general surgeon from Lansing, MI, was expelled from the College. This action was taken following disciplinary action by the Montana Medical Board against his license to practice medicine for failure to conform to generally accepted standards of practice and having engaged in conduct likely to deceive, defraud, or harm the public.

- The Fellowship of John W. Shaw, MD, FACS, a general surgeon from Defiance, OH, was placed on probation with conditions for reinstatement. Dr. Shaw’s license to practice medicine in the State of Ohio was the subject of disciplinary action, including a monitoring program and conditions set forth in a series of consent agreements because of a history of chemical dependency. The disciplinary action taken by the College was reported to the National Practitioner Data Bank (NPDB).

- An otolaryngologist from Lumberton, NC, had his full Fellowship privileges restored following a period of probation. This surgeon’s Fellowship was placed on probation with conditions for restoration in February 2005, after being charged with violation of ACS Bylaws, Article VII, Sections 1(b) and (f). His license to practice medicine in the states of North Carolina, Nebraska, and Kentucky had been subjected to discipline because of his history of chemical dependency. This surgeon fulfilled all of the conditions imposed by the College to have his full Fellowship privileges restored, including the restoration of his medical license to full and unrestricted status.

- An orthopaedic surgeon from Redwood City, CA, had his full Fellowship privileges restored following a period of probation. This surgeon’s Fellowship was placed on probation with conditions for restoration in February 2006, after being charged with violation of the ACS Bylaws, Article VII, Sections 1(b) and (f). His license to practice medicine in the state of California had been placed on probation following a finding of gross and repeated negligence, excessive prescribing, and failure to maintain adequate and accurate medical records. This surgeon fulfilled all of the conditions imposed by the College to have his full Fellowship privileges restored, including the restoration of his medical license to full and unrestricted status.

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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**So, You Want to Be a Surgeon...**

**Medical student guide to residency training**

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

[http://www.facs.org/residencysearch](http://www.facs.org/residencysearch)

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

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

2009 Clinical Congress of the American College of Surgeons

Oral presentations
- Surgical Forum*
  Program Coordinator: Kathryn L. Matousek, 312/202-5336, kmatousek@facs.org
  (11 $1,000 Excellence in Research Awards were given in 2008)
  Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)
- Papers Session*
  Program Coordinator: Beth Brown, 312/202-5325, ebrown@facs.org

Poster presentation
- Scientific Exhibits
  Program Coordinator: Kay Anthony, 312/202-5385, kanthony@facs.org

Video presentation
- Video-Based Education
  Program Coordinator: GayLynn Dykman, 312/202-5262, gdykman@facs.org

Submission information
- Abstracts are to be submitted online only
- Submission period begins November 3, 2008
- Deadline: 5:00 pm (CST), March 1, 2009
- Late submissions are not permitted
- Abstract specifications and requirements for each individual program will be posted on the ACS Web site at www.facs.org/education/. Review the information carefully prior to submission.
- Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.
A look at The Joint Commission

Alert aims to stop bad behavior among health care professionals

Health care is a high-stakes, pressure-packed environment that can test the limits of civility in the workplace. A new Sentinel Event Alert issued by The Joint Commission warns that rude language and hostile behavior among health care professionals goes beyond being unpleasant and poses a serious threat to patient safety and the overall quality of care.

Intimidating and disruptive behaviors are such a serious issue that, in addition to addressing it in the new Sentinel Event Alert, The Joint Commission is introducing new standards requiring more than 15,000 accredited health care organizations to create a code of conduct that defines acceptable and unacceptable behaviors and to establish a formal process for managing unacceptable behavior. The new standards take effect January 1, 2009, for hospitals, nursing homes, home health agencies, laboratories, ambulatory care facilities, and behavioral health care facilities across the U.S.

Health care leaders and caregivers have known for years that intimidating and disruptive behaviors are a serious problem. Verbal outbursts, condescending attitudes, refusal to take part in assigned duties, and physical threats all create breakdowns in the teamwork, communication, and collaboration necessary to deliver patient care. The Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during disruptive events occurring during patient care rather than question a known intimidator. To help put an end to once-accepted behaviors that put patients at risk, the Sentinel Event Alert urges health care organizations to take action.

“Most health care workers do their jobs with care, compassion, and professionalism,” says Mark R. Chassin, MD, MPP, MPH, president, The Joint Commission. “But sometimes professionalism breaks down and caregivers engage in behaviors that threaten patient safety. It is important for organizations to take a stand by clearly identifying such behaviors and refusing to tolerate them.”

To help put an end to intimidating and disruptive behaviors among physicians, nurses, pharmacists, therapists, support staff, and administrators, the Sentinel Event Alert recommends that health care organizations take 11 specific steps, including the following:

- Educate all health care team members about professional behavior, including training in basics such as courtesy during telephone interactions, business etiquette, and general people skills
- Hold all team members accountable for modeling desirable behaviors and enforce the code of conduct consistently and equitably
- Establish a comprehensive approach to addressing intimidating and disruptive behaviors that includes a zero-tolerance policy, obtaining strong involvement and support from physician leadership; reducing fears of retribution against those who report intimidating and disruptive behaviors; and empathizing with and apologizing to patients and families who are involved in or witness intimidating or disruptive behaviors
- Determine how and when disciplinary actions should begin
- Develop a system to detect and receive reports of unprofessional behavior, and use nonconfrontational interaction strategies to address intimidating and disruptive behaviors within the context of an organizational commitment to the health and well-being of all staff and patients.

Addressing unprofessional behavior among health care professionals is part of a series of alerts issued by the Joint Commission. Previous
alerts have addressed pediatric medication errors, wrong-site surgery, medication mix-ups, health care-associated infections, and patient suicides, among others. The complete list and text of past issues of Sentinel Event Alert can be found on The Joint Commission’s Web site at www.jointcommission.org/SentinelEvents/SentinelEventAlert/.

Volunteerism resources on the OGB Web site

In addition to timely information regarding volunteer opportunities available for surgeons, Operation Giving Back (OGB) provides myriad other resources that individuals interested in volunteerism may find of use and of interest. Because of the rapid growth of this section of the OGB Web site, it has been restructured to make it easier to find what you’re looking for.

On the OGB homepage, www.operationgivingback.org, you will find a menu tab entitled Resource Centers. By clicking on this tab, you will see links to a wide variety of information that is organized according to its subject matter and relevance to different groups. For instance, under a new Resource for Surgeons in Practice tab, you’ll find general information useful to all actively practicing surgeons exploring volunteerism, as well as information specific to the needs of military and international surgeons.

The Resources for Surgeons in Training include sections for surgical residents and medical students with links to programs that allow participation from surgeons-in-training, information on possible funding sources, educational resources, and so on. Resources for retired surgeons contain information related to retiree licensure, liability issues, and other issues unique to these volunteers.

A new category of information is found at the Resources for the Surgical Team page, where you’ll be directed to surgical safety and quality initiatives applicable to all volunteers and volunteerism programs instituted by surgical colleagues in the anesthesia, nursing, physician assistant, and surgical technologist communities. Because you may be looking for information related to your particular training and skills, a new category called Resources by Specialty has been created. The new section Resources for Volunteering in the U.S. provides relevant information on that topic. A separate section addresses the unique considerations of Disaster Response, which includes educational resources, legislative updates, and links to various disaster response organizations.

The newly organized Reading Room section includes links to scientific articles of interest on volunteerism, relevant books, news stories, and features from previous articles in the Bulletin that have featured the humanitarian outreach of ACS members.

If you are interested in either providing or receiving donations of medical equipment, supplies, or texts, there are many organizations that specialize in the appropriate exchange of such materials. For your convenience, we have links to several dozen such organizations under the heading Donations of Medical Goods. Although each volunteer opportunity listed in OGB includes a country-specific toolkit with information on the culture, customs, political climate, and other factors relevant to that opportunity, the Resource Center also contains links to these same travel resources in generic form that allows you to search by whatever countries you are interested in.

Contact OGB if you have suggestions for other resources that might enhance this section of the Web site. As a reminder, links and references provided are done so as a service to surgical volunteers and other interested parties; as such, the content and policy of any outside link are not necessarily reflective of the policies of the ACS.
The suggested minimum investment to participate in SDIF has been reduced to $10,000. For those who find it appropriate to participate in an automatic investment plan, the minimum initial investment is $5,000 assuming an automatic investment plan of at least $100 per month is implemented; waivers of the minimum are possible. The minimum investment has been modified for Medical Student Members ($500), Resident Members ($1,000), and Associate Fellows ($2,500) of the College.

For more information about SDIF or regarding the waived minimum, please contact Savi Pai, 312/202-5056 or spai@facs.org, or Tom Kiley, 312/202-5019 or tkiley@facs.org. Both are available to discuss specific details regarding SDIF. You may also visit the Web site at www.surgeonsfund.com or call 800/208-6070.

An investor should consider the investment objectives, risks, and charges and expenses of SDIF carefully before investing. SDIF’s prospectus contains this and other information about SDIF and should be read before investing. SDIF’s prospectus may be obtained by downloading it from SDIF’s Web site at www.surgeonsfund.com or by calling 800/208-6070.

¹A program of regular investing does not ensure a profit or protect against depreciation in a declining market. Because a consistent investing program involves continuous investment in securities regardless of fluctuating prices, you should consider your financial ability to continue to purchase through periods of various price levels.

SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246. The phone number is 513/587-3400.
The moon, Earth’s only satellite, circles in an elliptical orbit at 2,300 miles per hour and takes approximately 27 days to complete. Spacecraft have been studying the moon for almost 50 years. Direct lunar exploration began in 1959 when probes from a Soviet Luna spacecraft impacted the surface. On July 20, 1969, Neil Armstrong, with Apollo 11, fulfilled humanity’s dream of putting a man on the surface of the moon. Over time, 850 pounds of moon rock have been brought back for analysis. However, much of the composition and structure of the moon is still a mystery. Apart from the science, however, there is a large body of conjecture and some facts relating to the various effects of full moons.

The autumn full moons in the northern hemisphere are special. Because of the elliptical orbit, the moon rises earlier from one night to the next. This results in no long period of darkness between sunset and moonrise. The September full moon is the harvest moon, allowing for more light and a longer time to harvest crops while the 14th of this month marks the hunter’s moon, also known as the “blood moon” or “sanguine moon.” There is a longer period of light, the leaves are falling, the deer are fattened, and it is time to hunt. The fields have been harvested and the hunters can easily see their prey, which has come out to gather food.

The moon has fascinated inhabitants of earth for centuries. Shrines and monuments have been built honoring her while calendars follow her orbits. Full moons have long been implicated in our behavior. The word “lunatic” is derived from the Latin “luna,” or moon. Early psychologists encouraged extra staffing of the asylums in the occasions of full moons. It is only fitting that in this month, the month of the “blood moon,” this column looks at the effect of full moons on trauma activity.

In order to examine the occurrence of injuries sustained during a full moon, the National Trauma Data Bank® Dataset 7.1, records were searched by date of injury. Using a list of full moon dates for 2002 through 2006 (one full moon date per month, 12 months per year, and a five-year window for this dataset), there were 60 dates included in the full moon injury group. Out of 1,926,255 incidents, there were 5,825 records with discharge status that occurred on a full moon date and 1,698,273 records with discharge status that occurred on a date when there was no full moon. This figure represents approximately 3.1 percent, which is very close to the percentage of full moon days to non-full moon days (60 full moons divided by 1,824 days equals 3.2 percent).

Of the 54,482 discharges on a day with a full moon, 40,724 were discharged to home, 7,320 to acute care/rehabilitation, and 3,938 to nursing homes; 2,500 died. (These data are displayed in the graph on this page.) The
patients were 65.6 percent male, and on average 38.5 years of age; they had an average length of stay of 5.36 days and an average injury severity score of 10.2. Of those patients also tested for alcohol, 25 percent tested positive and of those tested for drugs, more than half tested positive. These data were similar to the group of patients on days with no full moon.

Special allowances have been made for full moon events. Charles Hyde was acquitted of murder charges in the 1880s on the grounds of being under the spell of a full moon. The records in the NTDB do not appear to validate an increase in trauma occurrence or lethality based on this cursory review. The next time you are out and taking a moonlit walk on a full moon night, you will not have to be concerned about the potential dark side of the moon.

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

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

Acknowledgment

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

Dr. Fantus is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago, IL. He is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.
To report your chapter’s news, contact Rhonda Peebles at 888/857-7545, or via e-mail at rpeebles@facs.org.

Maine Chapter honors Loring Pratt, MD, FACS
The Maine Chapter held its 58th annual meeting June 6–8 at the Harborside Hotel in Bar Harbor, ME. Distinguished guests and speakers included ACS Executive Director Thomas R. Russell, MD, FACS; John Preskitt, MD, FACS; Frank Opelka, MD, FACS; Loring Pratt, MD, FACS; and Bob McAfee, MD, former president of the American Medical Association. The chapter presented a special Lifetime Service Award to Dr. Pratt, who served as Maine Chapter Secretary–Treasurer from 1955 to 1974, on the ACS Board of Governors from 1970 to 1973, and on the ACS Board of Regents from 1973 to 1982. Additional photos and the presentations may be downloaded from the Maine Chapter Web site at www.maine-acs.org. (See photo, this page.)

Carolina chapters and vascular society meet
In July, for the first time, the South Carolina and North Carolina Chapters and the South Carolina Vascular Society convened a meeting at the Wild Dunes Resort in Charleston, SC. A wide variety of topics were presented during the educational program, including nutrition, operating room safety, resident work hours, and training. In addition, a joint residents’ paper competition was held; winners included the following:

From the South Carolina Chapter: First place, Trauma: Jeremy Reeves, MD*; first place, Basic Science: Jean Ruddy, MD*; first place, Clinical General Surgery: Wesley Jones, MD*; second place, Clinical General Surgery: Chris Schneider, MD*; third place, Clinical General Surgery: Jason Moore, MD.*

From the North Carolina Chapter: First place, Clinical Science: Jeffrey Carter, MD*; second place, Clinical Science: Rita Brintzenhoff, MD*; third place, Clinical Science: Jennifer Keller, MD*;

*Denotes Resident Membership in the College.

first place, Basic Science: Andy Courtwright, MD; second place, Basic Science: Jacqueline Carter, MD; third place, Basic Science: Brian Bednarski, MD.

In addition, two special presentations were given: Robert Cordell, MD, FACS, was honored posthumously for his career and his contributions...
### Chapter meetings

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

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

<table>
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<tr>
<th>Date</th>
<th>Chapter</th>
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<tbody>
<tr>
<td><strong>October 2008</strong></td>
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<tr>
<td>October 24</td>
<td>Connecticut (CS)</td>
<td>Location: Holiday Inn Select, Waterbury, CT Contact: Christopher Tasik, 203/674-0747, <a href="mailto:info@CTACS.org">info@CTACS.org</a> ACS representative: Mindy Baker</td>
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<tr>
<td>October 24–25</td>
<td>Iowa</td>
<td>Location: Iowa City, IA Contact: Sue Hyler, 515/270-3613, <a href="mailto:sue.hyler@pioneer.com">sue.hyler@pioneer.com</a></td>
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<tr>
<td>October 25–26</td>
<td>Minnesota Surgical Society—A Chapter of the ACS (CS)</td>
<td>Location: Arrowwood Resort, Alexandria, MN Contact: Jami Burbidge, 651/999-8999, <a href="mailto:jburbridge@nonprofitsolutions.com">jburbridge@nonprofitsolutions.com</a> ACS representative: Thomas R. Russell, MD, FACS</td>
</tr>
<tr>
<td>October 25</td>
<td>Metropolitan Washington (CS)</td>
<td>Location: Uniformed Services University of the Health Sciences, Bethesda, MD Contact: Tavia Dixon, 202/337-2701, <a href="mailto:tdixon@facs.org">tdixon@facs.org</a></td>
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<td><strong>November 2008</strong></td>
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<tr>
<td>November 1–2</td>
<td>Arizona</td>
<td>Location: Omni Tucson National Resort Contact: Joni Bowers, 602/347-6904, <a href="mailto:jonib@azmedassn.org">jonib@azmedassn.org</a></td>
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<tr>
<td>November 7–8</td>
<td>Wisconsin Surgical Society—A Chapter of the ACS</td>
<td>Location: The American Club, Kohler, WI Contact: Terry Estness, 414/453-9975, <a href="mailto:wisurgical@execpc.com">wisurgical@execpc.com</a></td>
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<td><strong>December 2008</strong></td>
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<td>December 5–6</td>
<td>Massachusetts (CS)</td>
<td>Location: Westin Copley Place, Boston, MA Contact: Stan Alger, 978/927-8330, <a href="mailto:salger@prri.com">salger@prri.com</a></td>
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<td>December 11</td>
<td>Delaware (CS)</td>
<td>Location: Christiana Care, John H. Ammon Medical Education Center, Newark, DE Contact: Glen Tinkoff, MD, FACS, 302/733-4280, <a href="mailto:gtinkoff@christianacare.org">gtinkoff@christianacare.org</a></td>
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<td><strong>January 2009</strong></td>
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<td>January 16–18</td>
<td>Southern California (CS)</td>
<td>Location: Four Seasons Biltmore Resort, Santa Barbara, CA Contact: C. James Dowden, 310/364-0193, <a href="mailto:jdowden@prodigy.net">jdowden@prodigy.net</a></td>
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<tr>
<td>January 16–18</td>
<td>Louisiana (CS)</td>
<td>Location: Ritz-Carlton Hotel, New Orleans, LA Contact: Janna Pecquet, 504/733-3275, <a href="mailto:pecquet@LAACS.org">pecquet@LAACS.org</a> ACS representatives: L. D. Britt, MD, FACS</td>
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to surgery throughout the Carolinas, and Sanjay Gupta, MD, FACS, the chief medical correspondent for CNN, was given a Fellowship plaque, as he was unable to attend his Convocation ceremony in 2007 (see photo, page 54).

Chapter anniversaries

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<td>Belgium</td>
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<td>Kansas</td>
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ACS Web portal hits milestone

The innovative features on e-facs.org—the members-only Web portal of the American College of Surgeons—are becoming increasingly popular, as evidenced by the fact that the portal recently surpassed 1 million page views. Usage statistics indicate that approximately 7,500 unique visitors visit the portal each quarter, and that the number is increasing.

Following are just a few of the things you can do in the portal:

• Track continuing medical education credits at http://efacs.org/portal/page/portal/ACS_Content/MYPAGE/myCME
• Update your College profile at http://efacs.org/portal/page/portal/ACS_Content/MYPAGE/ MYPROFILE
• Log your cases at http://efacs.org/portal/page/portal/ACS_Content/MYPAGE/MYCASES
• List all of your favorite Web sites in one place at http://efacs.org/portal/page/portal/ACS_Content/MYPAGE/myBookmarks
• Check out the newly redesigned women surgeons community at http://efacs.org/portal/page/portal/ACS_Content/ACSCOMMUNITIES/SPECIALTIES/WomenSurgeons
• View the minimally invasive surgery “image of the month” at http://efacs.org/portal/page/portal/ACS_Content/ACSCOMMUNITIES/SPECIALTIES/GenSurg_Spa/MinInvCmty

A work-in-progress, the ACS Web portal continues to grow and develop daily, so if you have not done so already, come and see for yourself why more and more members are taking advantage of this free, useful tool for members of the College. Visit http://www.efacs.org and log in with your ACS membership ID. You can change your username and password at any time.

The College’s Web portal is directed by George F. Sheldon, MD, FACS, Editor-in-Chief, and Lazar J. Greenfield, MD, FACS, Associate Editor.