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

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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
If the government seriously intends to reduce costs, improve quality, and expand access, then insurers, physicians, and all other stakeholders should be held to the same standards.

From my perspective

In a recent column, I noted that the medical and surgical professions have gone out of their way to respond to government demands for increased accountability and transparency, whereas some health insurance companies have failed to compile and analyze reliable data to support their payment decisions. The main point of that commentary was that if the government seriously intends to reduce costs, improve quality, and expand access, then insurers, physicians, and all other stakeholders should be held to the same standards.

However, the evidence is mounting that physicians are bearing the brunt of efforts to reduce federal health care spending. Furthermore, it would appear that some policymakers expect health care professionals to accept greater financial sacrifices for the common good than they demand of health insurance companies.

Pay cuts

A recent example of legislators opting to protect the financial interests of insurance companies rather than those of physicians was notable in this past summer’s Senate votes on the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331). This legislation, which was enacted despite the objections of some prominent senators and the President, stops the 10.6 percent Medicare physician reimbursement cut that went into effect July 1 and replaces the 5.4 percent reduction scheduled for 2009 with a 1.1 percent hike.

During the initial round of voting on H.R. 6331, a total of 39 Republican senators opposed passage of the legislation. Like President Bush, they objected to the law because it trims $13.6 billion from the Medicare Advantage program to offset the nominal physician reimbursement increase. In other words, when forced to choose between protecting physicians participating in Medicare from a steep pay cut and maintaining government funding for Medicare Advantage, these individuals sided with the large insurance companies that administer Medicare Advantage plans.

The senators and the President rationalized their decision by claiming that reductions in Medicare Advantage—a government-subsidized initiative that allows beneficiaries to purchase supplemental coverage from private insurers—would obstruct patient access to care. Either these legislators thought physicians would sit idly by and continue to treat Medicare beneficiaries for what would amount to a 16 percent pay cut over the course of 18 months, or they didn’t contemplate the long-term access problem that would arise if tens of thousands of physicians dropped out of the Medicare program.

Fortunately, a significant number of physicians and patients made their voices heard throughout much of the two weeks following the initial vote, contacting their senators to express their deep concerns about the lawmakers’ decision. Consequently, several senators reversed their positions on the bill, passing H.R. 6331 on July 9 in a 69 to 30 vote. The President proceeded to veto the law, maintaining his opposition to any legislation that would cut funding for Medicare Advantage, but Congress overrode his interdiction on July 15.
**Moneymaking vehicle**

Who stood to lose the most as the result of reduced Medicare Advantage funding? Mostly, it seems to be the insurance companies that administer the plans, especially in light of the fact that Medicare Advantage was paying them 12 percent more per patient than traditional Medicare reimbursement. Oddly enough, though, many physicians report that Medicare Advantage plans reimburse them at a lower rate than traditional Medicare. If the money isn’t being directed to the providers of the services the insurance companies cover, it stands to reason that the government funds are contributing to the insurance companies’ bottom line.

Indeed, the federal government has become a significant revenue source for a number of major health care insurers. In fact, many insurance companies now view the administration of government-subsidized programs—including Medicare Advantage, as well as Medicare Part D (for prescription drugs), Tricare, and Medicaid—as a small but rapid-growth component of their business portfolios. As an example, in the third quarter of 2007, Humana brought in $4.6 billion from its government-sponsored plans and just $1.7 billion from its group and individual health insurance plans. Meanwhile, UnitedHealth Group’s business has spiked since its purchase of Unison Health Plans, which in 2007 administered benefits for 370,000 Medicaid recipients to the tune of $1 billion. Furthermore, insurance industry executives and analysts anticipate continued financial growth in earnings from government plans as the number of Medicare-eligible baby boomers balloons.

Meanwhile, the system that many insurers use to process claims for non-Medicare patients continues to block physicians’ ability to receive timely payment for the services they provide. According to the American Medical Association (AMA), physicians allocate up to 14 percent of their total collections to claims administration. The AMA maintains that eliminating, or at least reducing, inefficiencies in claims processing would save the health care system millions of dollars, which would yield lower insurance premiums and, thereby, expand access to affordable coverage. More manageable claims processing systems also would free up time for physicians to devote to patient care and quality-improvement activities.

**Equitable treatment**

Unquestionably, insurance companies provide an important product for American consumers, so they should expect to reap some financial rewards. However, physicians also provide necessary services to patients, which ensure that they can continue to be productive members of our society. Therefore, it is unreasonable for the government to expect physicians to always be the ones who take a pay cut, who implement quality controls, and who strive for greater efficiency. The health care system is eroding not only because of issues that exist within the medical community, but also because many insurance companies are too focused on what is best for their bottom line and not for patients.

The key to overcoming the challenges in the U.S. health care system is to ensure that all stakeholders work together to cut costs, boost quality, and expand access to care. That means we must all make equal sacrifices and adjust our demands accordingly. Physicians cannot and should not be the only ones “walking the walk.”

**References**


*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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Congress overrides Medicare veto

On July 15, Congress voted to override President Bush’s veto of the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331). The President’s veto of H.R. 6331 was issued earlier that same day. This legislation ends the 10.6 percent cut in Medicare reimbursement that went into effect on July 1 and replaces the 5.4 percent cut scheduled for January 1, 2009, with a 1.1 percent increase. The House of Representatives voted 383 to 41 and the Senate voted 70 to 26 to override the President’s veto. On July 16, ACS Executive Director Thomas R. Russell, MD, FACS, participated in a press conference with leaders from the American Medical Association, the American Osteopathic Association, and the Chicago (IL) Chapter of the AARP to commend members of the House and Senate for their actions. With more than two-thirds of Congress supporting the override, the bill was enacted in spite of the President’s veto.

Thousands of Fellows contacted their legislators multiple times to urge members of Congress to support H.R. 6331. Fellows’ advocacy efforts played a critical role in building the congressional support needed to override the President’s veto and in helping to bring much-needed stability in Medicare payments to surgical practices over the next 18 months.

CMS issues fee schedule

On June 30, CMS released the proposed rule for the 2009 Medicare physician fee schedule. As required under the formula used to set Medicare payment, the proposal called for reducing physician reimbursement by 5.4 percent. However, enactment of H.R. 6331 nullified that provision. On July 16, the Centers for Medicare & Medicaid Services, as required under H.R. 6331, replaced the mid-year 2008 Medicare physician fee schedule rate of −10.6 percent with a 0.5 percent update, retroactive to July 1.

In addition, the proposed rule calls for expanding the Physician Quality Reporting Initiative (PQRI), which provides financial bonuses to health care professionals who report quality data. Suggested changes for the 2009 PQRI include the following:

• Establishing quality measures based on 175 metrics drawn from the 113 current 2008 PQRI measures, 17 new measures that have been endorsed by the National Quality Forum (NQF), 20 new measures adopted by the AQA, and 25 new measures awaiting NQF endorsement or AQA adoption at press time
• Adding measurements for coronary artery disease, human immuno-deficiency virus/acquired immune deficiency syndrome, coronary artery bypass surgery, rheumatoid arthritis, perioperative care, and back pain
• Instituting two reporting periods—January 1 to December 31 or July 1 to December 31—to provide eligible professionals with more opportunities to participate
• Accepting PQRI data from clinical registries and electronic health records systems

CMS also proposes to require health care professionals who conduct diagnostic testing in their offices to meet certain quality and performance standards currently applied to independent testing facilities. At press time, the College was drafting comments on the proposed rule, and the final regulations were scheduled for issuance by November 1.
Surgeon leads pediatric disaster planning initiative

by Lola Butcher
By the time Jeffrey S. Upperman, MD, FACS, finished a stint as a trauma surgeon at the Abu Ghraib prison in Iraq in 2004, his perspective on emergency preparedness had been forever changed.

“You just come to realize what security really means,” Dr. Upperman said in an interview with the Bulletin at that time. “You find yourself questioning whether you work and where you live would really be prepared for a catastrophic incident.”

Four years later, he is making sure he can answer “Yes, it would be” to that question. Dr. Upperman, director of the trauma program at Children’s Hospital Los Angeles and associate professor of surgery at Keck School of Medicine, is also directing the Pediatric Disaster Preparedness Project, designed to bolster the county’s readiness to deal with a major disaster. With a $5 million grant from the U.S. Department of Health and Human Services (HHS), the hospital, in collaboration with the Los Angeles Emergency Medical Services Agency, has established the Pediatric Disaster Resource and Training Center (PDRTC).

Through the grant, Dr. Upperman and his colleagues are working to improve hospital surge capacity, increase the capabilities of the emergency care system, and bolster community and hospital preparedness for public health emergencies ranging from a pandemic or natural disaster to a manmade or bioterrorist attack.

“We need all hands on board to effectively prepare,” Dr. Upperman said in a recent interview.

“As the only children’s hospital with a level I pediatric trauma center in southern California, it’s a natural extension for us to lead the regional effort in pediatric disaster preparedness,” said Henri R. Ford, MD, FACS, vice-president and surgeon-in-chief, Children’s Hospital, and vice-chairman of the surgery department at the University of Southern California Keck School of Medicine. “And as international leaders in pediatrics, it is a natural extension of our mission to ensure that the children of southern California receive the best possible care in the event of a major disaster.”

In addition to improving the hospital’s ability to serve pediatric patients regionally, in part through the use of telemedicine, the PDRTC will demonstrate best practices to health care providers around the country.

“This type of preparation hopefully will be a model for the rest of the nation regarding the optimal way to coordinate pediatric patient care in the event of a disaster,” Dr. Ford said.

The need for preparation

With the federal government leading the way, America’s health care system has invested considerable time and money in preparing for a disaster since the 9/11 attacks called the nation’s emergency readiness into question. But as time has passed, many planning efforts have lost their urgency as attention has been diverted elsewhere.

In Dr. Upperman’s view, disaster planning does not focus on a bad event that might happen but on the inevitability of a sure thing. In the past 15 years, the Los Angeles area has been hit by earthquakes, coastal flooding, wildfires, and civil unrest, even as its residents await a long-dreaded earthquake of epic proportions.

“It’s not a matter of ‘if’—it’s just a matter of ‘when,’” Dr. Upperman said. “Will health care providers throughout the 4,000 square miles of L.A. County be prepared to handle the emergency medical needs of the region’s 2.8 million children?”

In his role as program director for the disaster training center, Dr. Upperman spends a lot more time planning and evaluating disaster drills, organizing conferences, and networking with county officials than most trauma surgeons. He thinks about things like how to reunite pediatric patients with their parents in the aftermath of a mass disaster and how to create disaster training technologies that can deployed anywhere in the country.

He acknowledges that many types of disasters might not be generally considered a surgical problem at first glance, but he sees it differently. Disaster planning needs every type of health care provider to be at the table, and the personal attributes of surgeons make them particularly appropriate for this task.

“The complexity of our universe has changed, and I think we all have to be engaged in problem...
solving,” Dr. Upperman said. “Trauma surgeons in particular, who have a sense of urgency in the care that they provide, are naturals to be leaders in terms of disaster planning and responding.”

Furthermore, he thinks pediatric surgeons have a particular responsibility because children have frequently been overlooked in disaster planning efforts. One indication of this problem surfaced in a 2007 survey of members of the American Pediatric Surgical Association, conducted by Dr. Upperman and several co-investigators. Whereas 77 percent of the 265 survey respondents felt “definitely” responsible for helping out during a disaster, only 24 percent felt “definitely” prepared to do so. In addition, nearly three-quarters of the respondents indicated they “definitely” or “probably” need to obtain more training to be ready for a disaster.²

“The surgeons who felt most prepared were the [ones who had been] most engaged in the disaster-related activities of their facilities,” Dr. Upperman said. “The ones who were really engaged and felt most prepared were those who had been given a job—a coordinator, a medical director, or some other position.”

Surgeons who participate in disaster planning efforts not only improve their own ability to respond, but they also improve the overall plan. Although surgeons are accustomed to working in emergency situations, the equipment and supplies they need may not be available if they have not participated in planning. Moreover, their natural leadership ability will not be used to full effect.

“If surgeons aren’t at the table, then the response of the health care system may be incomplete,” he said.

Road to disaster planning

The survey of pediatric surgeons found that surgeons with combat experience were much more likely to indicate a willingness to respond to a disaster than their peers who had no such experience. That finding may ring especially true for Dr. Upperman, who served on a surgical team at Abu Ghraib for three months.

A longtime member of the U.S. Army Reserves, Dr. Upperman was a pediatric surgeon at Children’s Hospital of Pittsburgh, PA, at the time. He arrived at Baghdad Airport on his 40th birthday for his first-ever deployment.

“I was an academic pediatric surgeon in the middle of the Sunni Triangle—that was truly a baptism by fire,” he said.

He performed 50 operations in the Army prison before returning home. Two years later, he moved to Childrens Hospital Los Angeles with a particular goal on his mind: “We’re all hearing about how California is going to have the ‘Big One’ [earthquake] happen—well, is there anything I can do to make that chaos a little less painful?”

He considered how the hospital might build a robust capacity to serve children during disasters—and help not just the local community but first-responders everywhere.

“I think we could make a very important contribution to the field of trauma medicine, and to the narrower field of disaster preparedness in general,” he said.

Grant activities

Childrens Hospital was one of five programs selected to receive a grant from the HHS, each funded at $5 million, to serve as “best practice” examples.

“The over-arching purpose of this grant is really to expand the capabilities of our center, to
strengthen that infrastructure in terms of training and access to some of the technology we have,” Dr. Upperman said.

The programming goals for Childrens Hospital’s one-year grant include the following:

• Identifying drugs and supplies needed for a pediatric population surge capacity resulting from a local disaster
• Helping first responders make best use of existing resources and helping them acquire the drugs, supplies, and shelters that their pediatric patients would need
• Training first-response providers throughout the area
• Creating a virtual critical care network that, in the event of a major crisis, would allow satellite hospitals and trauma centers to consult one-on-one in real time with Childrens Hospital’s intensive care specialists
• Developing software to help first responders create their own pediatric disaster plans
• Advising health care providers throughout the county on how to stage disaster drills that include pediatric care issues

The vision for the Childrens Hospital effort extends far beyond the grant’s timetable. Dr. Upperman is working closely with Robert Neches, PhD, a division director at the University of Southern California’s Information Sciences Institute, on ways to revolutionize disaster-preparation training.

“We’ve been working together to develop not just a way of dealing with children but something that could actually be promoted for all ages,” Dr. Upperman said. “And it has to do with not only having appropriate care standards but being able to share these care standards in a way that all practitioners, even in remote corners of our country, could take advantage.”

Dr. Neches describes the work plan as a set of initiatives needed to support the entire “life cycle” of a disaster scenario. That cycle includes a preparatory phase, in which health care providers identify the supplies, equipment, and personnel needed in a disaster and work to assemble them and train personnel in their use. The second, or response phase, is when disaster response is actually occurring, and the final phase is the evaluation phase, when systemic changes are identified to improve preparedness for future disasters.

Although the activities are focused on disaster planning, they actually support capacity building that will be incorporated into everyday life.

“People who respond to a disaster don’t learn new skills,” he says. “They do what they are already good at.”
That system requires training for disasters and conducting drills—but it also means building the use of disaster-related skills and equipment into nondisaster routines.

“The tools we’re trying to put in place for use during a disaster are tools that will help people every day. That way, operating in a disaster may mean going into a special, more stressful mode, but it’s doing so using tools you’re already familiar with,” Dr. Neches said.

Robot to the rescue?

One of the most innovative elements of the grant program is the pilot testing of a mobile robot that can help physicians “teletriage” patients at locations throughout the county.

This program builds on Childrens Hospital’s pioneering capabilities in the emerging field of virtual pediatrics. Using specially designed software programs and sophisticated robotic equipment installed off-site, the hospital’s pediatric intensivists are consulting in real time with health care providers who are treating critically ill or injured youth in outlying areas of the county.

Through the grant, the hospital’s disaster preparedness team is designing a two-directional, Internet-based, audiovisual communications network specifically for pediatric disaster care. Dr. Upperman has already given the novel technology a go during a three-hospital disaster drill earlier this year.

“It really blew my mind what I could see and what I could hear,” he said. “You can hook up a stethoscope to it. You put on noise-reduction headsets and you can listen to heart tones, lung sounds, just like you’re at the bedside. The cam-
era is great—I can zoom in on eyes and I can look at pupil reactions and do a neurologic exam.”

In keeping with Dr. Neches’ perspective, Dr. Upperman has been using the robot technology in the course of his normal work.

“I’ve been using it in our emergency department when trauma victims come in,” he said. “While the technology does not replace the benefits of actually examining a trauma patient in person, it is much better than exchanging information about a patient via a telephone call.”

Who’s your mommy?

Fewer than 25 percent of the hospitals and public health emergency agencies in Los Angeles County have written disaster plans that specifically address the needs of pediatric patients.

“It’s presumed that if an adult is awake and alert, they can make their way back home if they go to a hospital because of a disaster,” Dr. Upperman said. “A three-year-old is a different story. You have to question, ‘Who’s your mommy? Who’s your daddy?’ and you have to have a system in place to be able to care for them, even if they have no observable wounds.”

A survey conducted by the California Emergency Medical Services Authority found that only approximately 30 percent of respondents had participated in disaster training that considered children’s issues in the past year, and only 10 percent have a disaster plan that includes strategies for reuniting pediatric patients with their families during a large-scale emergency. And it’s likely that California hospitals are actually more prepared than hospitals in less-populated states.

Against that backdrop, the Pediatric Disaster
Preparedness Project is working to influence planning strategies nationally. Its efforts include the following:

- **Pediatric reunification.** The PDRTC hosted a conference that brought nearly 60 experts from around the country together to discuss issues regarding pediatric disaster evacuation and family reunification. The group—which included representatives from state and local emergency medical services, area hospitals, the National Center for Missing and Exploited Children, and the American Red Cross—tackled the clinical issues as well as psychological support, patient movement, and technology that can be used for tracking.

  At a follow-up consensus session, the group members finalized a family reunification strategy to be recommended to HHS.

- **Special needs populations.** The PDRTC cosponsored a conference to discuss how to serve individuals with special needs during a disaster. “There were about 250 people in the room from all over the region, as well as representatives from national organizations,” Dr. Upperman said.

- **Research for disaster planning.** This month, the center will convene a national Pediatric Disaster and Emergency Services National Summit to bring together medical experts, government officials, and leaders in pediatric emergency services preparedness to present research findings and best management practices for various pediatric disaster planning issues. One of the objectives of the summit is to develop a research agenda for pediatric trauma and disaster.

### Call to action

One point that surfaced in the survey of pediatric surgeons is troubling: 66 percent of the surgeons who said they definitely needed more disaster training were not willing to participate in it.

Suspecting that survey outcome reflects unsatisfactory training experiences in the past, Dr. Upperman says the center is working to develop training that is effective and engaging—and avoids the “death by Powerpoint” pitfall. Meanwhile, he wants surgeons to be open to the possibility of learning something important.

“Surgeons need to make themselves available to be engaged,” he said. “They need to be the leaders that they are and really step up to the table.”

### References


Ms. Butcher is a freelance writer in Springfield, MO.
Transformational change in health care: Identifying the current state and future state

by
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To say that the U.S. health care system is unsustainable is no longer just rhetoric or theory. Surgeons feel the impact through decreased reimbursements, increased paperwork, and less time available to thoughtfully interact with patients. Furthermore, surgeons see their work environment deteriorating, and it is tempting to believe that they are feeling the brunt of efforts to control spending. In reality, however, all health care stakeholders—patients, businesses, insurers, and other providers—are feeling the impact of this unsustainable system.

Working within the current framework, all stakeholders are recognizing that only partial, short-term, and often frustrating changes are possible. Instead of trying to patch a broken system, transformational change must occur and deliver a new health care framework. This future system must include marked improvement in quality, a payment system that rewards providers for the best care for each patient, and reduction in per-capita spending.

Will the future be defined by slight alterations of the current system or will there be transformational change that leads to a very different health care system? In this article, we will examine the current state and the future state of U.S. health care. We will look at the impact of the current state on all stakeholders and break down the opportunities for change into specific domains. Through this exercise, we hope to gain some clarity about what the optimal future state for surgery (as a component of the larger system) would look like.

Current state overview

Frustrations with the current state of U.S. health care are everywhere. Patients see their health care benefits eroding, becoming increasingly costly, or disappearing altogether. The relationship between patients and providers is deteriorating as patients feel the impact of providers’ increasingly busy schedules. Businesses are finding it more difficult to provide health care benefits and many are forced to pass on more of the premium costs to their workers or to consumers by way of the cost of their products. General Motors adds $1,500 to the cost of every vehicle to cover health care costs for retirees, employees, and their families. U.S. businesses cannot continue to grow and expand with health care benefits undermining their business models when compared with other global enterprises. Corporate America is losing ground on global competition, and health care is one of the reasons.

Health insurance companies are feeling the impact, too. Businesses look to their health insurance companies to keep health care costs down, which, in turn, leads insurers to impose restrictions and measurement systems on providers. As employers become increasingly unhappy with the results, large businesses are choosing to self-insure or limit agreements with private health insurance companies. This is forcing insurers to implement complex systems to limit expenditures or to become third-party administrators of employer-based insurance. Under the current system, none of the stakeholders are “winning,” and all are becoming increasingly frustrated in fighting a losing battle.

Current and past efforts to rein in spending are not achieving the goal. Government attempts to control growth in Medicare spending, such as the sustainable growth rate (SGR) system, are not improving our health care system but are instead making the system increasingly unsustainable. As the SGR drives down payments per visit and per procedure, providers increase volume and intensity to maintain their income levels or limit their clinical practice to viable business models rather than to necessary clinical care.

Under the current system, payments are distributed with little regard for the appropriateness of the treatment or the quality of care delivered. The inconsistency of payments among procedures leads physicians and hospitals to focus on high-margin areas without understanding the real needs of their patient population. Many have heard the old adage of “no margin, no mission.” Health care capacity, including providers and infrastructure, is increased in these high-profit areas, and research shows that once capacity is in place, it will be used, leading to exponential growth in health care spending. Our system is often driven by the supply of services available rather than by the community’s need for services. Problems regarding medical malpractice result in excessive testing and overuse...
of services to protect providers well beyond the evidence-based needs of the patients.

Providers who try to increase efficiency and communication are actually penalized with lower income. Preventative care with long-term quality of life and cost benefits are not rewarded by our current system, which cares for the sick and not the healthy. In addition, the consistency of evidence-based care delivery is lacking, and there are serious disparities by region, race, and socioeconomic level.\textsuperscript{6,7}

The situation sounds dire, but it is only through our understanding of the current state that we can begin to envision the elements of our future state. Each of us likely feels a sense of urgency, but the problems seem beyond our individual reach. Small tweaks to the current system are not going to solve the problem. How do we begin to frame our problems and seek solutions?

\textbf{Domains of change}

\textbf{Patient-centeredness}

Most surgeons believe that we operate in a patient-centric system. But is this accurate? Have we asked our patients about their surgical experience? Do we know our wait times for appointments?

Patients struggle to navigate the health care system. For some, the experience is filled with stress and anxiety. For most, it is filled with inefficiency and frustration. Seeking care takes time away from work. Once patients arrive at the appointment, they often wait for long periods of time before they are seen by the physician. Once they are seen, surgeons discover that critical information such as laboratory results or imaging information is unavailable. Decisions are delayed, second appointments are scheduled, and patients are left in limbo. The inefficiencies cost patients lost wages and employers lost productivity.

Most office hours are based on the provider’s preferred schedule instead of times that are most convenient for patients to have an appointment. When patients need primary care after regular hours, they must visit an emergency room. This outcome is wasteful for the system and inconvenient for the patient.

Patients often do not have ownership of their health and health care. Instead, ownership is deferred to the provider. Suppose the surgeon decides that the patient is a surgical candidate. Our current practice model offers the patient informed consent, but is this truly shared patient decision making? Data suggest patients are not always informed of all their nonsurgical options, and that, if they had been informed, they would have made different choices.\textsuperscript{8} Currently, there is little effort toward educating patients beyond the legal requirements in an effort to help them understand the risks and benefits of treatment or, perhaps more importantly, the comparative effectiveness of several options.

The consequence of this lack of patients’ empowerment and information about their care is that they then make faulty assumptions, including that more care equates to better care or that more expensive care is higher-quality care. We often excuse our current model with a sense that patients do not wish to understand all the detailed...
decisions. But perhaps we have not presented the choices in a manner that engages them.

Most patients do not have access to their health records. And, as this article will discuss later, if the patients have multiple providers, their treatments and conditions are not being effectively communicated among settings of care. Following discharge from the hospital, patients are often confused about their instructions and unclear about whom to call if problems arise. Better communication with patients following discharge should lead to lower readmissions, which are costly for the system and dangerous for the patient.

At the heart of transformational change in health care is a shift in focus from the providers to the patients. The future state should put the patient at the center of the framework. Appointments could be scheduled directly by patients through online services. Appointment options would be available during evenings and weekends to increase convenience for patients and their employers. To keep costs down and increase access, new models that encourage nonphysician providers to administer basic care should be encouraged.

This shift affects surgeons in a variety of ways, including the rise of new communication models and additional time with patients. Surgeons will be asked to improve their communication and collaboration skills. Care transitions and handoffs will be a strong focus with surgeons expected to relay information quickly and effectively to other providers. Surgeons will also have a new focus on what the individual patient needs and wants. As we will describe in the following paragraphs, the future state will encourage and reward surgeons for performing surgery when optimal and choosing another course of action when surgery is not appropriate. Those decisions will be based on evidence-based guidelines and conversations with patients. The episode of care would be less about 90 days of global care and more about valuing the patient experience, the quality and outcomes of a surgical decision.

**Quality and public reporting**

Although no provider likely believes that he or she is providing substandard care, studies show that there is room for improvement. A study by RAND found that roughly 50 percent of evidence-based care is delivered for 30 common conditions. Can surgeons today reflect on all their cases for the last five years and report on their overall morbidity, readmits, or mortality? Without a repository and standardized collection of data, would it be accurate? When data are collected, patterns of care and problems are easily visible. The data allow us to find gaps and variances in care.

Current efforts to measure the quality of care being delivered are limited. Most programs are being administered by one stakeholder using data from billing systems (such as a health insurance company) and are focused on individual providers, making it difficult to reliably evaluate the quality of care being delivered. Efforts are also limited by the lack of electronic records and meaningful performance measures. Current measures, such as those being used in Medicare’s Physician Quality Reporting Initiative, are basic process measures that provide little insight for the physician or patient into how to improve quality.

At the center of the quality improvement transformation is the question of whether surgeons are going to lead efforts to measurably improve surgical care or are they going to have it done to them? Obviously, efforts led by surgeons have the potential to be more meaningful and successful. However, to achieve that success, surgeons must understand that the future state looks very different. Quality improvement must be transparent and available to the public in a format that is easily understandable. Designing these programs will require input from all stakeholders to ensure that multiple perspectives are being addressed. It is only through a concerted effort among stakeholders that providers will benefit from a single measurement system instead of multiple systems for multiple stakeholders.

Many surgeons view the current quality measures as primitive and believe that insurer-based measures are forced upon them with little buy-in that they are meaningful. As the performance measurement field matures, breakthroughs in meaningful measurement will occur. Electronic capture of data will reduce the burden of data collection for performance measurement and give providers the ability to examine their entire patient population.

Quality improvement is done at the local level, and to be successful, surgeons must take ownership of their quality programs. They must work with the hospital and the community to assess the
current state of surgical care and define measures that will drive improvement.

**Efficiency and value**

For many, it is hard to think of efficiency as a necessary component of our health care system, because it is often equated with rationing. However, a focus on quality is not about rationing care. It is about providing appropriate, high-quality care for each patient in the most cost-effective way—and this means working with patients to make informed choices about their medical care. Perhaps it is inappropriate and inefficient to put a $12,000 hip prosthesis into a nonambulating, 90-year-old woman. Such scenarios should make us question whether we have a true appreciation for the quality and the cost of the services we provide and, more importantly, their effect on the system.

The other side of efficiency is eliminating waste, which can include duplicate testing as well as unnecessary appointments and hospital admissions. Studies show that systems that provide more care actually have slightly worse outcomes than their counterparts. Contrary to the concept of rationing, providing the right amount of care actually leads to better outcomes than does overtreating patients.

To improve the efficiency of any system, both providers and patients need to be educated and accountable for their expenditures. Under the current system, the only accountability for putting in that $12,000 implant is from the insurance company. In the future system, incentives for all stakeholders will be aligned to provide the most appropriate and efficient care for the patient.

In recent years, health care organizations have begun to look at other industries for lessons in waste reduction, process improvement, and quality management. Six Sigma, a management strategy originally created by Motorola, is designed to eliminate errors in a system. Hospital and clinical practices have also learned from the Toyota Production System, including how to foster an environment of constant improvement by examining processes and removing barriers and waste.

**Standards and guidelines**

With further expansion of medical science, the use of evidence-based medicine has become widespread over the past two decades. Using the best evidence available, practice parameters and guidelines have been established. In the future state of care, guidelines are an especially important tool in defining appropriate, quality care. They help providers make good decisions for patients and protect providers against malpractice.

Transforming evidence-based medicine into guidelines, and subsequently performance measures, is a difficult task. To be meaningful, guidelines and their derived measures need to evolve to encompass the “real” patient. Because guidelines are often written with a straightforward patient in mind, not for a patient with multiple comorbidities, the true benefits of translating evidence into guidelines and best practices remains limited.

Guidelines that fit a complex sea of patients are limited, which leads to gray areas in medicine. These blurs cause variations in the system as providers make their own non-evidence-based judgments regarding treatment. Lack of evidence opens the door for disagreements between providers and payors, often resulting in long hours on the phone to seek approval for a procedure. The future state of health care will need to involve large data repositories that hold the essential information to analyze patient care. This system will allow tracking of multiple variables and better alignment of practice outcomes with clinical trials and evidence-based medicine.

**Health information technology**

Health care providers are one of the last businesses to enter the electronic age. It is hard to find paper records at the bank, the grocery store, or at the video store. It is safe to say that the information retained by providers is significantly more important to patients than their video rental history. Most health records cannot be viewed while a surgeon is on vacation or when a patient arrives at the hospital with an emergency.

Electronic health records (EHRs) are still a major investment for small practices and are often seen as a hurdle, because they represent a change in workflow with initial decreased efficiency and increased costs. The full value of EHRs has not been recognized because the value comes less from the ability to store information than from the ability to share information across platforms. Many EHRs are not interoperable with other platforms, which greatly decreases
their value to providers and patients.

EHRs will evolve to allow patients to access their records and create personal health records (PHRs), which they can use to track their own health. Patient engagement is a rapidly emerging field with Google and Microsoft developing the next generation of health information technology (HIT). E-prescribing will become the most common form of prescriptions with payer mandates pushing providers into systems with patient safety mechanisms. Providers will also receive e-alerts from the FDA about device warnings and drug alerts. All of these advances will create enhanced efficiencies once their interoperability is complete.

The future has arrived early, with patients gaining access to their laboratory test information, pharmacy reports, drug interactions, and, soon, radiology data through PHRs available online. As more physicians adopt e-prescribing, prescriptions are available more quickly and patients are able to check for medication interactions themselves. The next round of HIT will move providers’ clinical decision support closer to the point of care helping providers stay updated on the latest evidence and guidelines. Patients will also have applications available to measure real-time events such as blood pressure, weight, and blood glucose measurements, which will transmit back to the providers and their records in real time.

Payment system

The business model for our nation’s health care does not promote a system of integrated care delivery. It is a series of silos within which we purchase episodes of care, a drug, or a diagnostic procedure. As described previously in this article, payments in the current system are completely dependent on volume and intensity with no regard to quality or appropriateness of the care provided. Our payment system provides incentives to hospitals, providers, and ancillary services to offer more care instead of the best care. To improve the care of a population and increase efficiency, all providers must work together as a system of care for their patients.

It is time to think about alternatives to simply paying for an episode of care within a global period of time. Models are evolving to promote systems of care and reward systems that improve quality and reduce per capita costs. In the Bridges to Excellence model, payments are related to a base rate for the hospital and the surgeon and adjustments are made based on the expected outcomes. The Medical Payment Advisory Commission has considered payment systems involving accountable care organizations. In this model, payments based on the care for a population and the health of the population could align incentives for all providers. In other words, a surgeon would be paid for performing an operation or for not performing an operation, as long as it was the best decision for the patient.

For many of us, it is hard to imagine this type of payment and care model because we are so entrenched in our current payment structure. Providers would be paid as part of a system rather than acting as an individual silo, and a portion of their payment would be based on the provider’s ability to meet benchmarks for technical quality, efficiency, and patient experience. If a health system can reduce costs by removing waste and creating efficiencies, the system can reward both the physicians and the hospital. In these models,
providers’ incomes are sustained (revenue minus costs), but costs to the system are reduced.

Shared savings programs can help increase the system’s focus on efficient care, but to protect patients in these initiatives from overcutting services, shared savings programs should always be contingent on meeting specified quality measures that include patient experience with care. Paying providers as a team based on the health of the population will also reorient the system toward prevention and maintenance. It is much cheaper to keep patients out of the hospital. If all providers received a portion of those savings, everyone would have incentive to maintain a healthier population.

Conclusion

Stakeholders within the entire system feel the urgency to transform health care. Few are interested in the additional administrative hassles or more top-down utilization reviews and clinical management systems. Everyone is ready for a system that rewards providers for working smarter, not harder.

We hope that by clearly defining the current and future state, we will open your creative instincts to embrace the changes as true transformations. Individual surgeons who become part of systems of care to work smarter will be valued by insurers, purchaser groups, and patients. The environment that encourages efficient, transparent, and high-quality care will be rewarded.

The future domains described in this article culminate in a practice environment in which surgical practices are simpler and more focused on the patients. By removing the link between volume and payment, pressure to keep increasing work hours should be diminished. More robust guidelines and the removal of fee-for-service payment should eliminate the confrontations with insurance companies. Finally, the ability to truly focus on the health, and not just the sickness, of a population should be a rewarding experience for all providers and an important benefit to the patients they serve.

References

Surgeons Diversified Investment Fund: Two years later

by Savitri P. Pai, President, Surgeons Diversified Investment Fund
As of June 30, 2008, the Surgeons Diversified Investment Fund (SDIF) net assets were approximately $24 million. SDIF’s total return since the inception date of September 22, 2006, to June 30, 2008, was 3.74 percent. SDIF’s return can be compared against the return of 2.03 percent for the combined index of the S&P 500 Index/Lehman Brothers U.S. Aggregate Index during the same period (see Table 1, this page). According to Morningstar Inc., for the period ending June 30, 2008, SDIF placed in the top 25 percent of moderate allocation mutual funds for its three-month performance, and for the one-year period, SDIF placed in the top 35 percent. For more details, go to: http://quicktake.morningstar.com/fund/totalreturns.asp?symbol=ACSFX.

In February 2008, several changes were made to SDIF. First, the expense ratio of SDIF was lowered to 1.08 percent, including underlying exchange-traded fund (ETF) costs. Recognizing the goal of offering members of the American College of Surgeons and affiliated organizations a reasonably priced investment product, the decision was made to lower the expense ratio. The lower expense ratio will have a positive impact on the performance returns for shareholders.

Second, a 3 percent commodities allocation was added to SDIF in an effort to further align its asset allocation with that of the ACS endowment. The commodities component allows SDIF shareholders to obtain exposure to various types of commodities, including industrial and precious metals, agriculture, livestock, and

| Table 1: Average annual total returns* for periods ended 6/30/08 |
|-------------|-----|-----|-----|
|             | Qtr  | YTD† | One year | Since inception‡ |
| SDIF        | −0.29% | −5.72% | −5.26% | 3.74% |
| S&P 500 Index/Lehman Brothers U.S. Aggregate Index | −2.11% | −8.02% | −7.25% | 2.03% |

*Average annual total return figures include changes in principal value, reinvested dividends, and capital gain distributions.
†YTD (year-to-date) return is not annualized and represents an aggregate total return.
‡SDIF commenced operation September 22, 2006.

Disclosure

- Gross expense ratio: 1.96%*
- Net expense ratio: 1.08%†

Current performance may be lower or higher than the quoted past performance, which cannot guarantee future results. Share price, principal value, and return will vary and you may have a gain or loss when you sell your shares.

*The gross expense ratio reflects the actual costs of SDIF, not including acquired fund fees and expenses.
†The net expense ratio is the cost to the shareholder, including acquired fund fees and expenses. Surgeons Asset Management LLC (the “manager”) has contractually agreed for the life of SDIF to limit SDIF’s annual fund operating expenses (exclusive of acquired fund fees and expenses) to 0.82 percent per annum of SDIF’s average daily net assets.
energy. Commodities exposure adds an asset class to SDIF that provides further diversification and one that historically has a negative correlation to stocks and bonds.

SDIF was created in September 2006 to help ACS members and affiliated organizations develop a healthy financial future. SDIF provides busy surgeons and organizations with access to a professionally managed, diversified investment program. SDIF is a diversified, no-load, open-end, asset allocation mutual fund, which seeks to provide long-term capital appreciation and income through the fundamental investing principles employed by the endowment.

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**Disclosure**

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.

Performance numbers have been positively affected by fee waivers and/or expense reimbursements. Without such fee waivers and/or expense reimbursements, performance numbers would have been lower.

All index returns listed herein also include the reinvestment of dividends, distributions, and interest (total return). The returns shown do not reflect the deduction of taxes a shareholder may pay on the redemption of SDIF shares or SDIF distributions.

The S&P 500 Index/Lehman Brothers U.S. Aggregate Index is composed of 70 percent S&P 500 Index and 30 percent of Lehman Brothers U.S. Aggregate Index.

Target allocations are subject to change. As a result of SDIF investing in other funds, an investor will pay proportionate share of the expenses charged by the underlying funds invested in. In addition, SDIF is subject to the same risks as the underlying exchange-traded funds that it invests in, including, among others, interest rate risk, credit/default risk, market risk, international investment risk, derivative risks, commodity risks, management risks, and liquidity risks.

Commodity-Linked Derivative Investment Risk—SDIF’s investments in the Index may subject SDIF to greater volatility than investments in traditional securities. The value of commodity-linked derivative instruments may be affected by changes in overall market movements, commodity index volatility, changes in interest rates, or factors affecting a particular industry or commodity, such as drought, floods, weather, livestock disease, embargoes, tariffs and international economic, political and regulatory developments. The current or “spot” prices of the underlying physical commodities may also affect, in a volatile and inconsistent manner, the prices of futures contracts in respect of the relevant commodity.

SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246. The phone number is 513/587-3400.
fund of the College—asset allocation, diversification, and rebalancing.

Asset allocation is the discipline of combining asset classes—stocks, bonds, and cash—to achieve an optimally balanced portfolio. Asset classes, considered alone, may vary greatly in performance and risk potential. By combining them in a diversified portfolio, one can seek an ideal ratio of risk versus reward. For instance, adding bonds to a 100 percent stock portfolio may lower return potential and possibly reduce volatility by an even greater margin.

Diversification and rebalancing are two additional investment principles used by SDIF. Diversification can help to manage risk and may increase return potential by ensuring that a portfolio remains invested in a variety of sub-asset classes, each of which will exhibit performance variations over time. Rebalancing is the process of returning to the original allocation. Over time, a portfolio’s diversified asset allocation will shift as certain investments outperform others. Rebalancing keeps a portfolio focused on specific objectives and prevents the risk level from moving too far in one direction or another. Rebalancing can be one of the hardest things to do, as it is counterintuitive: You must sell your winners and buy more of your losers in order to get back to your target allocation. Busy professionals may lack the time to rebalance regularly and consistently. SDIF rebalances to the determined allocation at least quarterly.

Targeted allocation
SDIF invests, on average, 70 percent of its securities in equities and 30 percent in fixed income. The asset allocation for SDIF is actively managed. As previously mentioned, in February 2008, the investment advisor recommended to adjust the allocation by shifting 3 percent from fixed income to commodities. (See Table 2, page 24.)

SDIF currently invests in ETFs, which hold a portfolio of common stocks or other securities designed to track the performance of a particular index. ETFs differ from traditional index funds in that their shares are listed on a securities exchange and can be traded intraday.

How to invest
SDIF is available to be used as an investment vehicle in individual accounts, such as traditional individual retirement accounts (IRA), Roth IRAs, simplified employee pension IRAs, simple IRAs, rollover IRAs, beneficiary/inherited IRAs, profit-sharing plans, and regular personal investment accounts. SDIF can also be used as an investment vehicle in institutional accounts, such as associations, foundations, societies, chapters of the ACS, hospital and university retirement plan platforms, surgical group practice plans, and others. Following is a list of participating organizations:

- ACS Alabama Chapter
- ACS Arizona Chapter
- ACS Connecticut Chapter
The suggested minimum investment to participate in SDIF has been reduced to $5,000, assuming an automatic investment plan of at least $100 per month is implemented, and $10,000 if no automatic investment plan 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 those who find it appropriate, an automatic investment plan is available.

It is never too late to begin investing. The Figure on page 25 presents the benefits of starting early versus starting late. The Figure illustrates the difference between two investors who invest identical amounts, starting with $100 per month, and increase their contributions by 10 percent each year. The Figure assumes an average annual return of 6 percent, compounded monthly. The only difference is that one investor starts today and the other starts 10 years from now. Forty years later, the investor who started early has a portfolio of more than $1 million. The investor who started later has only $400,000.

This is a powerful message for younger investors who are starting their careers and believe they have no spare cash to invest. Setting aside even a little bit for investing may reap big dividends over time.

A 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.

More information

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

The American College of Surgeons hopes that many of you will explore this investment opportunity it is providing for its members. It is anticipated that this service will be of assistance in alleviating some of the financial pressures that members all face.
Mommy, Daddy, are we rich?

by Susan Beacham

My girls have asked many times, “Are we rich?” Each time, I would answer that we were very rich because we had each other and our health.

That worked in the early years. By middle school, however, they knew as well as I did that this was not the question they were asking. They wanted numbers.

This question of when is the right time to bare the family finances—to open the “financial curtain”—is one most parents struggle with. They are afraid to do too much too soon or too little too late.

Last summer, I knew my oldest daughter, Allison, not yet 16, was ready. My husband and I took her along for our quarterly meeting with our financial advisor.

I would like to tell you this was a purposeful moment in the financial education of my daughter. It was not. We did it at the last minute, mostly because it was summer and she was bored. But Allison is a money-savvy kid. She has been managing her monthly allowance, using the Money Savvy Generation allowance contract, since she was eight years old. She grew up using the Money Savvy Pig™, so she knows she has four choices for money—save, spend, donate, and invest—and how to set goals for those choices. By the time she was 13, she had saved $780 and transferred it from her savings account to a mutual fund. She understood the power of paying herself first and knew that compound savings would grow her money in her savings account and her mutual fund.

She was clearly ready to leverage what she knew about money and learn more.
Sooner or later, every child is going to ask what’s behind the financial curtain—so here is how you can get ready for that inevitable day now.

Consider doling out tidbits of information just to see how it’s received. For example, the next time your child asks for $20, open your wallet to show him or her how much is inside. Then walk the child through the expenses you’ll have to pay out of the remaining cash. It may not keep him or her from grabbing the $20, but it will help put the cash in perspective.

Or, the next time you sit down to pay the big monthly bills—the mortgage, utilities, phone, cable, and cell phone bills—ask your child to join you. Let him or her watch as the balance in the checkbook goes down, down, down. Make a point of showing how you take responsibility for making deposits to get that balance back up for next month.

If those lessons seem to be sinking in, consider opening the curtain a little wider.

But first, set some ground rules. The most important rule is to make sure the child understands that anything he or she learns about the family finances is confidential. It is to be discussed only with you. Unless and until your child understands this number-one rule, keep that curtain closed.

Next, be sure your child has the foundation necessary to understand what he or she is seeing once you open the curtain. If there isn’t an understanding of the basics of money, what the child sees can be confusing, overwhelming, and scary.

Then, and only then—regardless of the age of the child—is it time to reveal all.

When we took Allison with us to meet our advisor, we gave her a pen and paper and told her not to talk during the meeting. She could listen and write down her questions for her father and me to answer later.

I have never seen my daughter listen so closely to our instructions. But this meeting was about money, and money will always capture a child’s attention.

Since it was a last-minute decision, we didn’t have time to warn our advisor that Allison would be joining us. But he didn’t skip a beat. At the most appropriate times, he spoke directly to Allison, explaining the power of compound savings, taxes, and how little people save today. Mostly, our meeting was the same as it always is: a lively discussion of our business, our investments, and the essential planning we need to do to maximize what we earn and save. After a three-hour meeting, we left to have lunch with Allison so we could answer her questions. She had many good ones.

During the car ride home, we asked Allison what the most important things were that she had learned that day. She had a ready answer: She learned that money is complicated. “If you want to live it up later, you can’t live it up now,” she said.

Knowing she understands that is worth more than everything we have behind our financial curtain.

Ms. Beacham is the founder and chief executive officer of Money Savvy Generation and the co-author of the new children’s series, “The Millionaire Kids Club.”
Sunday luncheon event

Empowering Children on Financial Issues
Sunday, October 12, 12:00 noon–2:00 pm;
lunch to be provided

Presenter: Susan Beacham, CEO, Money Savvy Generation
Cost: $10 per attendee

Money Savvy Generation develops innovative products that help parents and educators teach basic personal finance skills to school-aged children. The mission of the company is to empower children and young adults to take control over their financial lives and financial futures in a world of increasing financial complexity. Susan Beacham is the founder of Money Savvy Generation and creator of the Money Savvy Pig® piggy bank—the centerpiece of the Money Savvy Kids™ Basic Personal Finance Curriculum. This pioneering system uses age-appropriate instructional materials to teach kids about the value of money.

Sponsored by ACS Surgeons Diversified Investment Fund.

Monday breakfast event

Investing in Health Care: Risks and Opportunities
Monday, October 13, 7:00–8:15 am;
breakfast to be provided

Presenter: Ben Andrew, Principal,
William Blair & Company LLC
Cost: $10 per attendee

Mr. Andrew is a principal with William Blair & Company LLC and a medical technology analyst with coverage including cardiovascular, orthopaedics, sleep disorders, blood products, and other sectors. Previously, Mr. Andrew was an equity research analyst at Vector Securities International, worked in product development at Baxter International, and was a synthetic organic chemist at Abbott Laboratories. William Blair & Company LLC is a Chicago-based investment firm offering investment banking, asset management, equity research, institutional and private brokerage, and private capital to individual, institutional, and issuing clients. Since 1935, William Blair has been committed to helping clients achieve their financial objectives. As an independent, employee-owned firm, William Blair’s philosophy is to serve its clients’ interests first and foremost.

The range and depth of issues within the domestic health care system are well understood and the potential solutions hotly debated. Despite a noise level that will increase as the political landscape changes with its likely influence on the health care industry through this fall’s elections, we believe there are numerous opportunities for investors in this long-term growth market. Our recommendations include a blend of certain traditional device and drug markets, but also nontraditional sectors that have performed well in recessionary environments and are not as exposed to reimbursement pressure. Please join us for what should be a thought-provoking, interactive session.

Sponsored by ACS Surgeons Diversified Investment Fund.

Tuesday breakfast event

ACS Surgeons Diversified Investment Fund: 2008 Update
Tuesday, October 14, 7:00–8:15 am;
breakfast to be provided

Presenters:
Charles D. Mabry, MD, FACS, Member, Board of Directors, Surgeons Asset Management LLC
Savi Pai, President, SDIF
Tom Kiley, Vice-President, SDIF

An update on the ACS Surgeons Diversified Investment Fund (SDIF) will be presented. Highlights include the most recent quarterly performance, lower expense ratio, lower investment minimum, and asset allocation changes made to SDIF, as well as a discussion on the current market outlook and its impact on SDIF.

To register for any of these sessions, go to www.facs.org/clincon2008.

An investor should consider the charges, risks, expenses and investment objective carefully before investing. For more information about the SDIF, please visit www.surgeonsfund.com or call 800/208-6070. Read the prospectus carefully before you invest or send money.

SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246. The phone number is 513/587-3400.
The incorporation of laparoscopic surgery into the armamentarium of general surgeons occurred rapidly in the early 1990s. There was a distinct learning curve during the uptake of laparoscopic cholecystectomy, and an increase in bile duct injuries was noted.\textsuperscript{1} Much of the education offered in laparoscopic techniques for established surgeons was provided by industry and many surgeons learned “one-handed” operating techniques while the underpinning cognitive aspects unique to laparoscopy were given short shrift. Courses were usually brief, extremely variable in quality and content, and directed at teaching a specific operation (that is, laparoscopic cholecystectomy). Upon completion, course attendees were presented with a certificate of attendance that then formed the basic currency for acquiring clinical privileges in laparoscopy in their institution.

In the late 1990s, the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) began development of the Fundamentals of Laparoscopic Surgery (FLS), a comprehensive program designed to teach the cognitive and psychomotor aspects unique to laparoscopic surgery, associated with a mechanism for assessment. It was not SAGES’ intent to develop a certifying examination but rather to provide tools for the teaching and assessment of the cognitive knowledge, technical skills, and clinical judgment related specifically to basic laparoscopic surgery. The final product was the result of the combined effort by many surgical experts, educators, and administrators and represents one of the first fully developed competency evaluation tools available for surgeons.\textsuperscript{2}

The FLS program thus consists of two components: a didactic module for education and an examination to assess competency. The didactic component covers the knowledge, judgment, and technical skills that form the basis for performing basic laparoscopic surgery. The cognitive portion addresses four broad content areas: preoperative, intraoperative, and postoperative considerations and basic laparoscopic procedures. It is presented electronically, on CD-ROM (and more recently a Web-based format), making extensive use of illustrations and multimedia with videos and animation. The content was thoroughly vetted by a panel of content experts in laparoscopy to ensure that the material is essential for basic laparoscopic surgery and independent of specific procedures or surgical specialties.

The second portion of the educational program incorporates an inexpensive, portable, and flex-
ibly designed physical model to teach the specific skills fundamental to performance of laparoscopic surgery. A portable pelvic trainer box with built-in video camera was developed to facilitate the manual skills component of FLS. These technical skills were derived from a review of operative videos by experienced, practicing laparoscopic surgeons. They were asked to identify the skills that are unique to laparoscopy. The list they compiled then formed the objectives for the manual skills component. A series of exercises that could be performed in the simulator, using actual laparoscopic instruments, under the monocular magnified optical system characteristic of laparoscopic surgery, was developed. Performance of each task was evaluated using metrics designed to reward efficiency and precision, with penalties applied for errors.

The manual skills training practicum was based on the McGill Inanimate System for Training and Evaluation of Laparoscopic Skills program, originally developed by Dr. Fried and colleagues at McGill University in Montreal, QC. Each of these tasks is demonstrated on the digital educational platform and related to the specific clinical skills it was designed to teach. The manual skills include bimanual transferring, precise cutting, use of ligating loops, and suturing with intracorporeal and extracorporeal knotting. A cannulation exercise is currently being validated and will be added to the current skill set.

Competence is assessed through a two-part examination. The cognitive examination is computer-based and consists of a timed, secure test with multiple-choice questions and clinical scenarios. These questions and scenarios were subjected to rigorous oversight by medical educators. The proctored test is taken at designated testing locations and raw data are then transmitted to a central administrative center for grading and analysis. The technical skills examination is proctored, taken on the standardized endoscopic training boxes with uniform equipment and testing materials, also at designated test locations. This manual skills test has been shown to have excellent reliability and has been subjected to extensive validation. The FLS simulator scores correlate with laparoscopic experience and are predictive of performance in the operating room.

After developing the teaching and evaluation modules of FLS, this program was subjected to beta testing among seven designated testing centers located across North America. Surgical trainees and practicing surgeons with differing levels of laparoscopic experience and skill took part in this evaluation that has been reported elsewhere. The beta test results for the FLS examination demonstrated that it was feasible to administer, had appropriate psychometric properties, and that it met standards of reliability and validity required for high-stakes assessment.

In 2005, the American College of Surgeons partnered with SAGES to lend support to this first fully developed competency evaluation tool available for surgeons. FLS is now a joint program of SAGES and ACS and is managed by a steering committee that includes representatives from both organizations. Since that time, great momentum has developed around the FLS program, and many general surgery residency programs have incorporated the FLS program as a key component of laparoscopic training for residents. The recently released joint ACS-Association of Program Directors in Surgery technical skills curriculum for surgical residents includes the components of the FLS program in both its basic and advanced laparoscopic modules. Several hospitals have mandated that surgeons practicing laparoscopic surgery must have passed the FLS examination to be privileged to perform these operations. At least one captive malpractice insurance company has provided financial incentives for participating laparoscopic surgeons to complete the FLS program and attain certification.

**Dr. Soper** is the Loyal and Edith Davis Professor and chairman, department of surgery, Northwestern University Feinberg School of Medicine, Chicago, IL.
There also has been increased interest in the FLS program among international groups of surgeons. For instance, the Royal Australasian College of Surgeons has now incorporated FLS into its training programs for all surgical residents and will be using it as a component of board certification among practicing surgeons.

Despite these advances, there has been a great deal of concern that the cost of the FLS program made it prohibitive for most general surgery training programs. In response to this concern, Covidien recently funded a large educational grant to the FLS program to support rapid dissemination among surgical training programs.* This generous grant will allow each general surgery resident training program in the U.S. and Canada to obtain one of the FLS video training boxes as part of simulation efforts mandated by the Residency Review Committee on Surgery. Furthermore, complimentary vouchers for completing the testing component of FLS will be supplied for each graduating chief resident in general surgery as well as fellows in the Fellowship Council and gastrointestinal surgery and colorectal fellowships within the U.S. and Canada.

In April, notices were sent out to all general surgery and fellowship program directors informing them of this program and how to register to receive the FLS program and test vouchers. By mid-June, 166 residency programs and 45 fellowships had enrolled in the Covidien Educational Fund, representing more than 1,000 postgraduates in their fourth or fifth year and approximately 230 fellows. It thus seems likely that FLS will be incorporated in virtually all North American residency training programs. Most recently, the American Board of Surgery (ABS) determined that passing the FLS certifying examination will be a requirement for taking the ABS qualifying (written) examination.

In summary, the FLS program was developed because of an identified need to educate surgeons in the underlying principles and basic skills of laparoscopic surgery and because of the growing demand to document competency in surgical practice. This program has been shown to be reliable and valid by a rigorous metrics process and multi-institutional beta testing. Given the partnership between SAGES and the American College of Surgeons, the recent mandate for FLS certification before sitting for the ABS examination, the growing recognition of FLS internationally, and the recent Covidien Education grant facilitating widespread adoption by general surgery trainees, the FLS program has the potential to have a large impact on the quality of education in laparoscopic surgery and to promote patient safety.

More information about the FLS program is available at http://www.flsprogram.org/.

References


*See related story on page 33 of the August issue of the Bulletin.

Dr. Fried is professor of surgery and Adair Family Chair of Surgical Education at McGill University, Montreal, QC.
Statement on use of cell phones in the operating room

Cellular telephone technology has become ubiquitous. Whether for voice or for data, many surgeons have come to rely on cellular devices for communication outside the office. Nevertheless, the casual use of cellular devices in the operating room (OR) may be distracting. For these reasons, the use of cellular devices in the OR should be guided by the following considerations:

1. The undisciplined use of cellular devices in the OR—whether for telephone, e-mail, or data communication, and whether by the surgeon or by other members of the surgical team—may pose a distraction and may compromise patient care.

2. Surgeons should be considerate of the duties of personnel in the OR suite and refrain from engaging them unnecessarily in activities, including assistance in cellular communication, that might divert attention from the patient or the conduct of the procedure.

3. Cellular phones must not interfere with patient monitoring devices or with other technologies required for patient care.

4. Whenever possible, members of the OR team, including the operating surgeon, should only engage in urgent or emergent outside communication during surgery. Personal and routine calls should be minimized. Calls should be kept as brief as possible.

5. Whenever possible, incoming calls should be forwarded to the OR desk or to the hardwired telephone in the OR to minimize the potential distraction of cellular phones.

6. Whenever possible, cellular telephone calls and data transmissions should be forwarded to voice mail or to memory. The ring tone should be silenced. An inaudible signal may be employed.

7. Whenever possible, a distinct signal for urgent or emergent calls should be enabled. This signal may be implemented via a “page” option in most cellular telephones. Callers should be advised to use this function.

This statement was developed by the College’s Committee on Perioperative Care and approved by the Board of Regents at its June 2008 meeting.
only for urgent and emergent calls if the phone is unanswered.

8. The use of cellular devices or their accessories (such as earphones or keyboards) must not compromise the integrity of the sterile field. Special care should be taken to avoid sensitive communication within the hearing of awake or sedated patients.

9. Communication using hardwired phones in the operating room is subject to the same discipline as communication using cellular technology.

10. The use of cellular devices to take and transmit photographs should be governed by hospital policy on photography of patients and by government regulations pertaining to patient privacy and confidentiality.
More than 5 million central venous catheters (CVCs) are placed each year in the U.S. with an associated complications rate of more than 15 percent. Mechanical complications such as arterial puncture and pneumothorax are seen in up to 21 percent of patients with CVC complications, and up to 35 percent of insertion attempts are not successful.

Several prospective, randomized trials as well as two meta-analyses document that the use of ultrasound has been associated with a reduction in complication rate and an improved first-pass success when placing catheters in the internal jugular vein.

Real-time (rather than static) ultrasound guidance is the safest, most cost-effective and successful method for CVC placement compared with the traditional, percutaneous, landmark-based approach for cannulation of the internal jugular vein. The use of ultrasound for central venous catheterization increases success rate while simultaneously decreasing procedural time and complication rate. Standardization of education, training, and practice is also an important component of this technique.

In 2001, the Agency for Healthcare Research and Quality recommended the use of ultrasound guidance for the placement of CVCs as one of the top 11 evidence-based practices that health care providers can use to improve patient care and patient safety.

The Guidance on the Use of Ultrasound Locating Devices for Placing Central Venous Catheters from the National Institute for Clinical Excellence had the following major recommendations:

- Two-dimensional (2-D) imaging ultrasound guidance is recommended as the preferred method for insertion of CVCs into the internal jugular vein in adults and children in elective situations
- The use of 2-D imaging ultrasound guidance should be considered in most clinical circumstances where CVC insertion is necessary either electively or in an emergency situation
• It is recommended that all those involved in placing CVCs using 2-D imaging ultrasound guidance should undertake appropriate training to achieve competence
• Audio-guided Doppler ultrasound guidance is not recommended for CVC insertion

The American College of Surgeons supports the uniform use of real-time ultrasound guidance for the placement of CVCs in all patients.

References


Additional resources

Like it or not, Medicare recovery audit contractors (RACs) probably are here to stay. Because these firms have the potential to affect payment to surgical practices, it would be a good strategy to invest time in learning about and preparing for RAC evaluations.

In Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress directed the U.S. Department of Health and Human Services (HHS) to study the effectiveness of RACs in identifying overpayments and underpayments to physicians and other Medicare providers. The Centers for Medicare & Medicaid Services (CMS) processes more than 1 billion Medicare claims each year, which works out to approximately 4.5 million claims per work day, 574,000 claims per hour, and 9,579 claims per minute. Needless to say, errors can account for billions of dollars in improper payments each year, and Congress issued the mandate in an effort to protect the solvency of the Medicare Trust Fund.

**Demonstration and expansion**

In 2005, HHS launched a three-year demonstration program using RACs to detect and correct improper payments in the Medicare Fee-For-Service (FFS) program. Subsequent legislation, the Tax Relief and Health Care Act of 2006, directed HHS to implement the RAC program on a permanent and nationwide basis by January 1, 2010.

Under the three-year demonstration project, the RACs were instructed to detect and correct Medicare (Parts A and B) overpayments and underpayments. RACs are private companies that are able to use proprietary Medicare edit systems. These contractors are paid a percentage of the payment errors that they identify. To resolve improper payments, the RACs were authorized to collect money from overpaid providers and to repay money to underpaid providers.

Because of their large Medicare populations, Florida, New York, and California were selected as the first states to...
participate in the RAC demonstration project. In 2007, the pilot test was expanded to include Massachusetts, South Carolina, and Arizona. The RACs that were awarded the contracts are Connolly Consulting for New York and Massachusetts, Health Data Insights for Florida and South Carolina, and PRG-Schultz for California and Arizona. The pilot study ended in March 2008, and permanent expansion is scheduled to begin.

During the demonstration project, CMS did not specify which claims the RACs were required to audit or even how the firms should identify claims for review. RACs have been known to rely on annual reports from the Office of the Inspector General and the Government Accountability Office, which highlight Medicare services that are vulnerable to improper payments.

The RACs must follow Medicare policies, regulations, national and local coverage determinations, and manual instructions when reviewing claims. In instances where no Medicare policy is in place to guide auditors’ decision making, the RACs are expected to apply the accepted clinical standards available at the time of the claim submission. Like CMS, the RACs hire medical personnel such as nurses, therapists, and certified coders to review claims. In addition, each RAC has a physician medical director who oversees the medical record review process and assists staff upon request. During the three-year demonstration project, RACs could review any Medicare claims except those involving incorrect level of physician evaluation and management codes, hospice and home health services, and payment made to providers under the auspices of another CMS pilot study. The RACs also were prohibited from reviewing claims previously evaluated by another Medicare contractor or involved in a potential fraud investigation.

**RAC-identified improper payments**

The RACs identified and corrected $371 million in improper Medicare payments in 2007. More than 96 percent of these errors were overpayments and the remaining 4 percent were underpayments. Excess reimbursement amounts were repaid to Medicare. Most of the overpayments and underpayments involved inpatient hospitals.

Because the RACs are paid on a contingency fee basis, they generally focus on high-dollar improper payments to ensure the highest rate of return for the expense of reviewing the claim and/or medical record. Overpayments that the RACs identified, starting with the most common errors, are as follows:

- Incorrect coding
- Medically unnecessary service
- No or insufficient documentation
- Other (duplicate claims, unbundling procedures, and so on)

Nearly half of the improper payments were the result of incorrect coding, noncovered services (local coverage determination), and duplicate services. The top improperly paid services, according to the auditors, are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient:</td>
<td>Excisional debridement</td>
</tr>
<tr>
<td>Outpatient:</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td>Skilled nursing facilities (SNF):</td>
<td>Physical and occupational therapy</td>
</tr>
<tr>
<td>Physician</td>
<td>Pharmaceutical injectables</td>
</tr>
<tr>
<td>Laboratory/ambulance:</td>
<td>Ambulance services during a hospital inpatient stay</td>
</tr>
<tr>
<td>Durable medical equipment:</td>
<td>Items during a hospital inpatient stay or SNF stay</td>
</tr>
</tbody>
</table>

**How do RACs detect improper payments?**

One method that the RACs use to detect improper payments is automated review. By using their proprietary automated review software algorithms, the RACs can evaluate claims errors that are detectable without a medical record review. For example, a RAC may use automated information systems to search for claims for two or more identical surgical procedures performed on one beneficiary on the same day at the same hospital. Duplicative procedures are clearly not medically necessary and should not have been billed multiple times and, therefore, should not have been paid more than once by the Medicare claims processing contractor.
The RACs also perform complex reviews to uncover improper payments. In these scenarios, the RACs make their determination after evaluating the medical record associated with the claim in question. For example, they may review the medical record to check if the diagnosis code listed on the claim matches the diagnosis documented in the medical record.

CMS can use this detailed information from the RAC program and the improper Medicare FFS payments report to prevent these types of improper payments in the future by conducting more provider education and outreach or establishing new system edits. Finally, providers can use these findings to help ensure that they are submitting correctly coded claims for services that meet Medicare’s medical necessity criteria. By establishing strong internal controls, hospitals can use these RAC findings to train coders, physicians, medical record staff, and others to help minimize future improper payments.

**Internal check system**

When considering whether to appeal a RAC decision, surgical practices should carefully consider what was done and how it was documented. Some questions to consider include the following:
- Does the operative note support the codes billed?
- Does the diagnosis code match the procedure performed?
- Has the code been unbundled?
- Have the Correct Coding Initiative edits been applied?
- Is the procedure coded thoroughly?
- Do the codes used by the facility correspond to those used by the local surgical practice? (For example, did the surgeon code a basic gastric banding and the hospital code gastric bypass?)

Coding errors account for a large number of claim errors, so it is important to double-check whether the claims form includes the correct place of service and the right number of units and complies with the global periods for procedures and to monitor for inappropriately unbundled procedures. Following these simple guidelines should help surgical practices to avoid audits and receive full and proper payment.


**Bibliography**

Dr. Collicott selected to receive 2008 Distinguished Service Award

The Board of Regents of the American College of Surgeons has named Paul E. Collicott, MD, FACS, of Chicago, IL, the recipient of its highest honor, the College’s Distinguished Service Award for 2008. Dr. Collicott will receive the award on October 15, during the 2008 Clinical Congress in San Francisco, CA.

The Board will recognize Dr. Collicott with this award in appreciation of his staunch and devoted service as a Fellow of the American College of Surgeons, including his role in developing the Advanced Trauma Life Support® (ATLS®) course, acting as a national and international ATLS course director, serving as a member of the General Surgery and Coding Reimbursement Committee and the Committee on Trauma and for his service as a Regent of the American College of Surgeons.

Dr. Collicott was further commended for his superb clinical activity as a peripheral vascular and trauma surgeon in Lincoln, NE, for nearly three decades, and as trauma director and chief of surgery at Lincoln General Hospital. This award also acknowledges his activity inorganized medicine, currently as Director of the Division of Member Services of the College, and previously as president of the Nebraska Medical Association and the Lancaster County Medical Society, as an eight-year member of the Nebraska Medical Association’s delegation to the American Medical Association (AMA) House of Delegates, and as a special advisor to the AMA/Specialty Society Relative Value Update Committee. Lastly, this honor also reflects admiration of his leadership and service to the College as well as to the surgical profession.

Dr. Collicott has been Director of the Division of Member Services since 2001. In that role, he is responsible for numerous activities and areas: the Board of Governors activities and committees, chapter activities and committees, membership recruitment and retention, the Resident and Associate Society, the Committee on Young Surgeons, 12 specialty Advisory Councils, the Central Judiciary

OFFICIAL NOTICE

Annual Business Meeting of Members, American College of Surgeons

In accordance with Article I, Section 6, of the Bylaws, the Annual Business Meeting of Members of the American College of Surgeons is called for five o’clock in the afternoon of Wednesday, October 15, 2008, at the Moscone Convention Center, San Francisco, CA.

This session constitutes the Annual Business Meeting of the Members, at which time Officers and Governors will be elected and reports from officials will be presented. Items of general interest to the Members will also be presented. Members are respectfully urged to be present.

Courtney M. Townsend, Jr., MD, FACS Secretary American College of Surgeons August 1, 2008
Committee, Research Integrity Officer, Operation Giving Back, scholarships administration, seven additional committees, the online Job Bank, and affinity programs offering direct benefits to members.

Dr. Collicott received his medical degree from the University of Nebraska College of Medicine (1966) and served as a general rotating intern (1966–1967) at Lincoln General Hospital before his training was interrupted by military service in the U.S. Air Force during the Viet Nam conflict. He completed his residency in general surgery (1969–1973) and a peripheral vascular surgery fellowship (1972) at University of Washington Hospitals, Seattle.

After completing postgraduate training, Dr. Collicott was a community surgeon in Nebraska for 28 years, specializing in peripheral vascular and trauma surgery. In addition, he was the trauma director (1982–1983, 1989–1995, and 1998–1999) and chief of surgery (1984–1985) at Lincoln General Hospital and held clinical faculty appointments at the University of Nebraska and Creighton University.


Furthermore, Dr. Collicott has been Chair of the Central Judiciary Committee (1998–2001), a member of the Advisory Council for Vascular Surgery (1993–1996 and 1999–2002), and a member of the General Surgery and Coding Reimbursement Committee (2001–2003). He also has been an active participant in the College’s trauma-related endeavors, serving as a member of the Committee on Trauma and its Executive Committee (1983–1993), Chair of the ATLS Subcommittee (1983–1987), and National and International ATLS Course Director, and he was instrumental in introducing ATLS in 1980. He has received numerous awards for his trauma endeavors and is known as the “father of ATLS.”

In addition to Dr. Collicott’s involvement with the College, he has been a leader in numerous surgical and medical organizations, including the American Board of Surgery, American Surgical Association, Central Surgical Association, Western Surgical Association, Southwestern Surgical Congress, Society for Vascular Surgery, AMA, American Association for Vascular Surgery, International Society of Surgery, Society for Clinical Vascular Surgery, and American Association for the Surgery of Trauma.

It is in recognition of his continued and dedicated service to and on behalf of the American College of Surgeons and the surgical community that the Board of Regents is pleased to present Dr. Collicott with its highest honor, the 2008 Distinguished Service Award.
Fellows honored for volunteerism

The Governors’ Committee on Socioeconomic Issues is pleased to announce the 2008 recipients of the American College of Surgeons/Pfizer Inc Surgical Volunteerism Awards and the newly established Surgical Humanitarian Award. The committee received nominations for many exceptional individuals, once again demonstrating the substantial commitment of the Fellows of the College to the care of the underserved. The awards will be presented at Clinical Congress in October in San Francisco, CA.

Joseph A. Gurri, MD, FACS, of Melbourne Beach, FL, will be awarded the Surgical Volunteerism Award for domestic outreach in recognition of extensive work in his local community. Upon arriving in Brevard County, FL, in 1981 as a young surgeon, Dr. Gurri reached out to migrant workers in the area, calling upon his fluency in Spanish to help them with their health care needs. In 1992, when the local hospital launched a system of free clinics, Dr. Gurri immediately offered his services as a surgical volunteer.

Assessing gaps in available care, Dr. Gurri created a successful program for the identification, education, treatment, and follow-up of women with breast cancer at the Brevard Health Alliance Breast Cancer Clinic, resulting in complete access to breast health services for the women of Brevard County. Through this and similar programs over nearly three decades, Dr. Gurri has proved to be a champion in providing surgical care to the uninsured and the less fortunate.

Bradley D. Wong, MD, FACS, of Honolulu, HI, will
be awarded the Surgical Volunteerism Award for international outreach in recognition of his participation in numerous medical missions to the Philippines, Viet Nam, China, American Samoa, and Nepal. Dr. Wong first engaged in volunteerism in medical school in Philadelphia, PA, at an outreach clinic in Philadelphia’s Chinatown. In 1988, he began participating with the Honolulu-based Aloha Medical Mission and has regularly held a leadership role in organizing and executing these annual missions. He has served on the board of directors of Aloha Medical Mission and helped the organization expand its services and acquire a clinic in Honolulu.

In addition to these extensive duties, he also engages local residents and physicians as volunteers. By immersing himself in all aspects of these missions, from patient care to educating local professionals and collecting needed supplies, Dr. Wong demonstrates his strong and ongoing commitment to international surgical care.

Guy Theodore, MD, FACS, of Pignon, Haiti, is the inaugural recipient of the 2008 American College of Surgeons/Pfizer Inc. Surgical Humanitarian Award. The Surgical Humanitarian Award recognizes surgeons who have dedicated a substantial portion of their career to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. A native of Haiti, Dr. Theodore received his graduate medical training in the U.S. and later joined the U.S. Air Force. While away from his homeland, he remained focused on the profound needs of his fellow Haitians and developed a strategy to build the Hôpital de Bienfaisance de Pignon when he returned in 1983. Over the past 25 years, Dr. Theodore has built not only a hospital, but a rich and diverse set of public health services encompassing human immunodeficiency virus care, dental and eye clinics, midwifery, clean water and sanitation initiatives, and microfinance programs in Pignon and the surrounding communities.

With the assistance of expatriate surgeons who volunteer with the Christian Mission of Pignon, Community Coalition of Haiti, and Project Haiti, Dr. Theodore regularly holds courses for physicians from all areas of Haiti. His efforts have resulted in a modern hospital facility with a broad complement of medical and surgical services.

The exceptional contributions made by Dr. Gurri, Dr. Wong, and Dr. Theodore will be formally recognized at the annual Board of Governors dinner on Tuesday, October 14. Congress attendees are invited to hear these physicians speak about their inspiration and work at the plenary session on volunteerism (GS08)—which will convene Monday, October 13, 9:45 am–1:00 pm—and to meet them and others dedicated to surgical volunteerism in its many forms at a volunteer networking reception later that evening.

Full details on these events will be available in the Clinical Congress News and on the Operation Giving Back Web site at www.operationgivingback.facs.org.
Shortened AMA HOD meeting gets the job done

by Jon H. Sutton, Manager of State Affairs

For the first time in recent memory, the American Medical Association (AMA) House of Delegates (HOD) completed its annual meeting a half-day early. Primarily because of the hard work of delegates and reference committees, as well as emerging consensus on most issues, the HOD wrapped up business just in time to begin preparing for events celebrating the presidency of Nancy Nielsen, MD, PhD, an internist from Buffalo, NY.

From a surgical perspective, a number of issues came to the fore, including two supported by the College. Resolution 206 called on the AMA to support the Uniform Emergency Volunteer Health Practitioner Act (UEVHPA) and its passage in all 50 states. As the author of this resolution, the College sought and received co-sponsorship from a number of specialty societies, including the American Academy of Ophthalmology, American College of Emergency Physicians, American Society of Anesthesiologists, American Society of Plastic Surgeons, and the Society for Vascular Surgery. Debate was mostly supportive, with the AMA Board of Trustees indicating its intent to present a report on the UEVHPA at the November HOD meeting. As such, the resolution was referred to the Board of Trustees, and the College looks forward to interacting with the Board on the development of this report.

The College was a co-sponsor of Resolution 319 with the South Carolina Medical Association, a significant collaboration between specialty and state societies. It asked the AMA to study the current status of disaster preparedness education and training in medical schools, graduate medical education programs, and continuing medical education, and it was passed with strong support from the HOD.

Additional highlights of the HOD meeting included the following:

• Resolution 208—Fairness in Medical Imaging Interpretation. The use of imaging modalities by specialists has been a regular issue in the HOD for many years, with the College promoting adoption of the policy a number of years ago. Resolution 208, adopted by the HOD, enhanced current AMA imaging policy by directing the AMA to actively oppose efforts to preauthorize, precertify, or otherwise restrict the application of advanced imaging services provided by qualified physicians who follow appropriate practice guidelines and technical standards for the imaging modalities used. The protocols should be developed by specialty societies involved with the diagnosis and treatment of patients with the conditions being tested. It also directed the AMA to work to ensure that all physician specialties involved in the care of patients with specific illnesses who need imaging services have equal participation and authority in the development of quality and efficiency measures for imaging services.

June 2008 ACS delegation to the AMA HOD

Richard Reiling, MD, FACS, delegation chair
John Armstrong, MD, FACS, delegate
Charles Logan, MD, FACS, delegate
Chad Rubin, MD, FACS, delegate
Amilu Stewart, MD, FACS, delegate
Sanjay Parikh, MD, FACS, Young Physician Section delegate
Patricia Turner, MD, FACS, Young Physician Section liaison
Kathryn Berndt, MD, Resident and Fellow Section delegate
Report 14—The RUC: Recent Activities to Improve the Valuation of Primary Care Services.

During the last few HOD meetings, there has been considerable discussion with regard to the role of the Relative Value Scale Update Committee (RUC), the specialty distribution among RUC seats, and the valuation of primary care services. This report thoroughly discussed these issues, noting that since the inception of the Resource-Based Relative Value Scale, the RUC has successfully achieved a 45 percent increase in evaluation and management work relative values whereas other major categories of physician services have either decreased or increased slightly in work valuation. Although primary and specialty care organizations testified in support of the report, a few physicians were still focused on increasing the number of primary care seats on the RUC to at least equal to the proportion of primary care physicians in the physician workforce—even though it was noted the RUC currently has the expertise that is required to review the valuation of all physician services and that RUC representatives exercise their independent judgment in a manner that is beneficial to all physicians.

- CEJA Report 1—Industry Support of Professional Education in Medicine. Controversy surrounded this Council on Ethical and Judicial Affairs (CEJA) report as soon as it was released, with a very large number of physicians voicing concern about “throwing the baby out with the bathwater” by prohibiting all industry support for professional education. Many physicians also felt frustration because they had not been asked for their input for development of the report so that it could more accurately reflect and acknowledge existing guidelines from the American Council for Continuing Medical Education and from individual specialty societies. Not surprisingly, the report was referred back to CEJA for further consideration.

Surgical Caucus of the AMA

The Surgical Caucus continues to operate smoothly with College support and has become a well-recognized brand for unifying the surgery, anesthesiology, and emergency medicine specialty societies. The number of dues-paying members has increased by one-third, to 190 members, over the past two years, and caucus attendance continues to grow, now numbering 100 to 125 participants and guests at the Saturday afternoon education/business meeting. This meeting’s educational session—Sun, Sand and Surgery?!?: A Discussion of Medical Tourism—was presented by James Unti, MD, FACS, a member of the ACS Patient Safety and Quality Improvement Committee. In addition, the Caucus sponsored a handbook review session on Saturday morning to facilitate identification of relevant reports and resolutions across surgery, emergency medicine, and anesthesiology. This session was well received by those specialty societies invited to participate and is incrementally expanding from meeting to meeting.

Elections

Dr. Nielsen was sworn in as AMA president, and J. James Rohack, MD, a cardiologist from Texas, was named president-elect. William Hazel, MD, FACS, an orthopaedic surgeon from Virginia, was reelected to the Board of Trustees, and Mary Ann McCaffree, MD, a pediatrician from Oklahoma, was elected to an open Trustee position.

Richard Reiling, MD, FACS, Chair of the College’s delegation and a member of the AMA Council on Medical Education, announced his intention to run for reelection to the Council at the June 2009 meeting. This is expected to be a competitive race, with the possibility of two other Council members running for reelection as well, and at least two individuals running for two open seats.

Delegate retirement

After eight years of dedicated service, Amilu Stewart, MD, FACS, retired from the College’s delegation to the AMA HOD. She was recognized for a distinguished career of leadership and commitment in representing the College as a delegate.

For further information on the annual 2008 AMA HOD and surgical involvement in this meeting, contact Jon Sutton at jsutton@facs.org.
2009–2011 ACS/NREF/AANS Faculty Career Development Award available

The American College of Surgeons and the Neurosurgery Research and Education Foundation of the American Association of Neurological Surgeons (NREF-AANS) are offering a two-year faculty career development award to neurological surgeons. The award is to support the establishment of a new and independent research program in an area of neurological surgery. The award to support the research is $40,000 per year for two years and is not renewable thereafter.

The award is open to surgeons who meet the following criteria:
- Are members or candidate members in good standing of both the ACS and the AANS
- Have completed specialty training within the preceding five years
- Have received a full-time faculty appointment at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada.

Applicants should provide evidence (by publication or otherwise) of productive initial efforts in laboratory research.

The full requirements and application form are available on the AANS Web site at www.aans.org.

The closing date for receipt of applications is November 15, 2008. Submit the completed application to Neurosurgery Research and Education Foundation, AANS, 5550 Meadowbrook Dr., Rolling Meadows, IL 60008-3852. To submit an application or make inquiries electronically, send an e-mail to NREF@aans.org.
COT accepting submissions for 2009 Resident Trauma Papers Competition

Papers are now being accepted by the ACS Committee on Trauma (COT) for the 2009 Resident Trauma Papers Competition, which will be held during the COT’s annual meeting March 19–21, 2009, in Chicago, IL.

The Resident Trauma Papers Competition is open to general surgery residents, surgical specialty residents, and trauma fellows. The papers should describe original research in the area of trauma care and/or prevention, categorized as either Basic Laboratory Research or Clinical Investigation. Papers should be sent to the appropriate COT state/provincial chair. A list of chairs is available at http://www.facs.org/trauma/regional.html.

The papers competition is funded by the Eastern and Western States COT, Region 7 COTs, Wyeth Pharmaceuticals, the National Trauma Institute, and the American College of Surgeons.

Deadline for state/provincial chairs to submit papers to the COT region chiefs is November 14, 2008. Further information can be obtained on the ACS Web site at http://www.facs.org/trauma/trauma-papers.html or by contacting Bridget Blackwood in the ACS Trauma Office at 312/202-5380 or bblackwood@facs.org.

Outcomes Research Course scheduled for November

The American College of Surgeons’ Surgical Research Committee is sponsoring the third Outcomes Research Course November 14–16 at ACS headquarters in Chicago, IL.

Although the course is intended primarily for surgeon researchers, its flexible curriculum and interactive format are designed to meet the interests of investigators with varying skills and experiences. Novices will learn the key concepts of outcomes research, including how to work with and interpret data. Surgeons with previous experience in outcomes research will get direct feedback on their work and practical advice from leaders in the field.

This course emphasizes the core concepts of outcomes research and its practical applications to important questions confronting surgeons and surgical practice. The first day of the course provides a broad overview of the field, primarily in lecture format. On the second day, participants may choose among several skills laboratories, according to their backgrounds and primary research interests. Breakout sessions provide the opportunity for participants to get feedback from experts on their ongoing work or study proposals. And finally, on the third day, selected course faculty will present their own research-in-progress in interactive sessions, allowing participants to see the nuts and bolts of the work of established investigators.

Because this course is popular, space is limited, and this course is offered only every other year, reserve your spot as early as possible. Preference is given to members of the College. Visit http://www.facs.org/cqi/src/outcomesres.html for additional information about the course—including a course schedule and course fees—and a registration form. If you have questions, contact Mary Fitzgerald at 312/202-5319 or mfitzgerald@facs.org.
The Executive Committee on Video-Based Education and Ciné-Med have developed the interactive Multimedia Atlas of Surgery. Each volume presents a comprehensive list of surgical procedures, featuring:

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The Resident and Associate Society (RAS) of the American College of Surgeons will sponsor a symposium—Economics of Medicine: Is It Threatening Surgical Education?—during the 2008 Clinical Congress. The symposium will convene Sunday, October 12, from 1:00 to 4:00 pm, at the Moscone Convention Center in San Francisco, CA.

The impact of the following issues on the future of surgical training and practice will be addressed:
• Deferred student loan repayment for surgical residents: How long and how far?
• Maintenance of Certification: Who should foot the bill?
• Industry support for medical education: Savior or devil in disguise?
• Can we provide relative value units or salary support to faculty for medical student and resident teaching?
• Paying for additional fellowship training: Will the fellow always have a salary?
• Financial incentives for specialties in need: Should the government pay?

For further information regarding the RAS symposium, contact Peg Haar at phaar@facs.org or 312/202-5312.
“I think I have decided to do academic surgery,” said the bright-eyed and determined medical student at the Auckland City Hospital in New Zealand. I was spending time with medical students and surgical trainees in the department of surgery at the University of Auckland. As the Australia New Zealand Travelling Fellow of the American College of Surgeons, I was invited by John Windsor, MD, FACS, to meet with students and trainees who were involved in research in the department of surgery at the University of Auckland.

A group of approximately 15 young trainees and their mentors and collaborators sat around a table and shared ideas about their research projects and the reasons they chose to engage in biomedical research. Strikingly, many of the reasons were almost identical to what I have heard from students, residents, and physician-scientists in the U.S. The driving force for some of these people ranged from raw scientific curiosity and the joy of discovery, to a desire to contribute more to medical science beyond direct patient care. Despite a relatively smaller research budget in New Zealand as a whole and within their medical schools, there still remains a strong desire by many to passionately pursue careers involving both laboratory and biomedical research—something I found particularly encouraging, given the difficulty that many physician-scientists in the U.S. have obtaining research funding.

Although I had spent more than two weeks in Hong Kong at the annual meeting of the Royal Australasian College of Surgeons (RACS) and visited the endocrine surgical unit at the Royal North Shore Hospital in Sydney, Australia, I was invigorated by this group of young people in Auckland, so eager to contribute to medicine. The faculty of medical and health sciences at the Uni-
versity of Auckland is at the forefront of surgical education and patient care in New Zealand. Established in 1883, it is one of the eminent institutions in Auckland.

The department of surgery is headed by Professor Windsor, a pleasant, energetic, motivated and unassuming individual. Professor Windsor was instrumental in developing a surgical skills center that we visited (see photo, page 51). This center is important in training and skills acquisition for medical students, fellows, and faculty.

Professor Windsor is also a Fellow of the American College of Surgeons and active in the International Hepatobiliary and Pancreatic Association. He arranged for me to spend some time in the operating room with Wayne Jones, MD, a breast and endocrine surgeon at the Auckland City Hospital. I watched Dr. Jones perform a mastectomy with immediate reconstruction. Our discussion revealed the fact that the similarities far exceeded any differences in surgical practice. He related his experience with operating room turnover, administration, and surgical education.

Landscape of New Zealand

With an estimated population of approximately 4 million people, New Zealand is a relatively sparsely populated country. Auckland is home to almost one-quarter of the country’s population—no surprise, given its numerous harbors and oceanfront views. Not surprisingly, the cost of living in Auckland is higher than the less-populated parts of New Zealand. Culturally, New Zealand is perhaps one of the most integrated cities that I have visited. A visit to the Auckland Museum was most educational, revealing New Zealand’s rich history of integration and mutual respect among its diverse people.

It was particularly warming to learn that the early European settlers of New Zealand partnered with the indigenous Maori population. The city is replete with evidence of a robust, well-preserved Maori culture and language. Many city landmarks and streets have two signs—one in English and one in Maori. This custom is particularly visible and well preserved at the wonderful Auckland Museum, where I had the opportunity to spend a few hours (see photo, this page).

Hong Kong/RACS and YFF meetings

My family and I started the Travelling Fellowship after a 14-hour flight from Los Angeles, CA, to Hong Kong. Although we were delighted to revisit the bustling city of Hong Kong, I spent the weekend attending the Younger Fellows’ Forum (YFF) as a guest of Richard Page, MD (see photo, page 53). The YFF is similar to the Committee on Young Surgeons and the Resident and Associate Society of the American College of Surgeons. They meet before the RACS meeting to discuss issues of interest to RACS fellows who are within
10 years of obtaining their fellowship.

During the two-day meeting, I was impressed by the extent of the discussion, which spanned the gamut from surgical training to protecting young surgeons in new practices in remote locations. Again, the similarities to the U.S. system were striking. Though much less regulated than U.S. surgeons, Australasian surgeons share similar difficulties with patient referrals, maintaining quality of care, and dealing with patient safety.

During a brief discussion with the RACS president, Prof. Andrew Sutherland, MBBS, FRCSC, FRACS, it was clear that rural surgery and acute care surgery were frontline issues for the RACS and we shared thoughts on how to best provide surgical care to patients in remote locations while preserving the role of specialist surgeons. Given the size of the Australian land mass and the relatively low population density (6.4 people/square mile, compared with 32 people per square mile in North America), the Australian surgeons have significant challenges providing comprehensive specialty surgical care to rural residents. In fact, Australia is the second least populated country in the world (second to Mongolia). This population distribution makes it difficult to provide all aspects of specialist care to many people in remote locations. One option in use is having some specialists, such as ophthalmologists, travel to remote locations once or twice a week to provide service.

Another Fellow of the American College of Surgeons, Scott LeMaire, MD, FACS, from Baylor College of Medicine in Houston, TX, was also attending the meeting as a representative of the Association for Academic Surgery (AAS). Dr. LeMaire gave a nice overview of the AAS and many younger fellows at the YFF expressed their surprise at the similarities between the two organizations. There was certainly a strong desire to collaborate with the AAS on matters of surgical education and career development of young surgeons. There are ongoing discussions about potential joint educational events between both organizations.

My wonderful host at the combined meeting of the Hong Kong Surgical Society and the RACS in Hong Kong was Chung-Yau Lo, MBBS, FRACS, FACS, who graciously invited my family to lunch with his family on the Sunday before the RACS meeting (see photo, page 54). Although my wife and I had visited Hong Kong before, we continue to be pleasantly surprised by the delightful activity they refer to there as lunch. Several hours spent in a well-appointed dim sum restaurant rendered us moribund for the rest of the day. Compared to our usual rushed meals, Hong Kong residents, like many Europeans, take ample time to enjoy their meals.
Later that evening, we attended a very elaborate opening ceremony that featured dignitaries from government and academia in Hong Kong and Australia. It was clear from the speeches that the government was very supportive of surgical care in Hong Kong, and perceived the relationship between physicians and government as a collaborative one designed to result in the best health for the population. This system struck me as different from the U.S., and we could certainly learn a lot from that relationship.

I had been asked to participate in the scientific sessions at the meeting. Starting with a panel session on thyroid nodules, which I co-presented with Barney Harrison, MBBS, MS, FRCS, from Sheffield, England, I learned that our management of small thyroid nodules did not differ significantly. Dr. Harrison and I shared differences in practice between the England, the U.S., and Asia. The rest of the scientific sessions were very educational for me.

I later spent time as a guest of the Australia/New Zealand (ANZ) Chapter of the American College of Surgeons. I cannot overemphasize my gratitude to the members of the ANZ Chapter for their hospitality. Ross Blair, MB, ChB, FACS, FRACS; Ian Civil, MB, ChB, FACS, FRACS; Stephen Deane, MBBS, FACS, FRACS, FRCSC; and John Buckingham, MBBS, FACS, FRACS, went out of their way to ensure that I was comfortable and did not want for anything. I really felt at home with this group of outstanding individuals and now understand why the ANZ Travelling Fellowship is so popularly pursued. Such genuine international professional collaboration is a rare but valuable aspect of our professional interactions.

**Sydney**

As a guest of Stan Sidhu, MD, at the Royal North Shore Hospital, I visited the Biomedical Research Complex and found many laboratories busily occupied by Australians, New Zealanders, Europeans, and Asians engaged in the familiar “dance” of biological research: western blots, microarrays, tissue databases, and so forth. Their commitment to translational research was laudable. With a desire to better identify malignant pheochromocytomas early after surgery, one group was performing microarray studies on human pheochromocytoma tumors.

These observations were good to see and further strengthened my commitment to advancing medical knowledge through science. In fact, we developed a collaboration that I hope will some day lead to exciting discoveries.

During our stay in Sydney, my family and I were guests in the lovely home of the Sidhu family and were schooled in the rules of rugby by their very active children. This was a wonderful social experience for us as we learned the marked similarity between life in Australia and in the U.S.

While in Sydney, the Australian Prime Minister announced an increase in the funding to public hospitals with the goal of reducing wait times for patients who needed specialist care. This echoed my experience in Hong Kong and further indicated to me the philosophical differences that we have...
toward the provision of health care in Australasia and Asia compared with the U.S.

Sydney was every bit the city I had imagined: a sprawling metropolis inhabited by people from all over the world. A visit to the Rocks, an old part of the city, showed artists and artisans showcasing local crafts, including glass blowing and weaving.

I had the opportunity to spend the day with the endocrine surgery unit at the Royal North Shore Hospital. The University of Sydney endocrine surgical unit is perhaps the largest endocrine surgical unit in Australia and has been in existence for more than 50 years. This unit has achieved worldwide recognition for its contributions to endocrine diseases first under the leadership of Thomas Reeve, AC, CBE, FACS(Hon), FRACS, and currently Leigh Delbridge, MBBS, FACS, FRACS.

Professor Reeve joined the unit in 1957 and started a database that now has documentation of every aspect of more than 18,000 thyroid, parathyroid, and adrenal procedures performed in the unit. This database has been integral to the writing of more than 130 articles on the topics of thyroid, parathyroid, or adrenal surgery. Such publications have been integral to significant changes in endocrine surgical practice worldwide, including the use of total thyroidectomy for multinodular goiter. I was a guest of the head of the unit, Professor Delbridge, and his associates, Dr. Sidhu and Mark Sywak, MD.

I had the opportunity to participate in a thyroidectomy for Grave’s disease with Dr. Sidhu. The time in the operating room was unbelievably relaxing and familiar. The evening was marked by grand rounds at the Royal North Shore Hospital, during which I presented my experience with minimally invasive adrenal surgery in Dallas, TX.

At Dr. Sywak’s request, I spent a few minutes comparing health care systems in the U.S. and Australia and was heartened by the exciting discussion by other physicians who shared their own ideas about health care across the world. Interestingly, access to health care is universal in Australia. The cost is borne by the government and private insurance. Patients are seen by general practitioners who then refer them to surgical specialists. While such a system has its drawbacks, many advantages exist within it. For example, everyone has access to health care and no one can become bankrupt from unanticipated illness.

Finally, we spent the rest of the evening attending a delightful dinner at the home of Professor Delbridge and his family. Drs. Sywak and Sidhu and their spouses were present and we had a nice evening discussing health care, culture, travel, and food.

**Conclusion**

Overall, the ANZ Travelling Fellowship of the American College of Surgeons is truly an outstanding opportunity to share professional and social experiences with surgeons and physicians from other parts of the world. I may never have had the opportunity to exchange ideas with a group such as this in a similar setting. It is really a jewel of an opportunity for which I am very grateful.

Dr. Nwariaku is an associate professor of surgery and vice-chairman at University of Texas Southwestern Medical Center, Dallas.
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A look at The Joint Commission

Code of conduct requirement outlined in new Leadership chapter

Conflict management and disruptive behavior are issues that all surgeons will encounter at some point in their career, and they are also among the issues addressed in The Joint Commission’s revised Leadership chapter, which becomes effective January 1, 2009, for all accreditation programs.

The chapter focuses on the important role that leadership groups such as the organized medical staff occupy in operating an organization. Although the majority of the changes to the chapter are applicable only to hospitals and hospital-based ambulatory surgery organizations, some changes will affect surgeons working in organizations accredited under the ambulatory and office-based surgery programs.

Many leadership responsibilities directly affect the provision of care, treatment, and services and operations of the organization. These revised standards describe the overall responsibility of the governing body for the safety and quality of care, treatment, and services provided by all these individuals. In hospitals, the medical staff is responsible for overseeing the quality of care provided by those with privileges, and the structure of the medical staff and its responsibilities are covered in the Medical Staff chapter. However, the Leadership chapter addresses how well the leaders, including the organized medical staff, work together.

The standards stress that a cooperative relationship among the leadership is key to effective organization performance. Leaders from different groups—governance, senior management, and the organized medical staff—bring different skills, experiences, and perspectives to the organization. Working together means that leaders from all groups have the opportunity to participate in discussions and have their opinions heard.

Key changes in the revised chapter include the following:

• A new standard for all accreditation programs requires leaders to maintain a culture of safety and quality throughout their organization. The standard describes certain features of a culture of safety. The standard also requires organizations to create a code of conduct that defines acceptable, disruptive, and inappropriate behaviors, and to create and implement a process for managing disruptive and inappropriate behaviors.
• Relocating standard MS.1.10 from the current Medical Staff chapter to the Leadership chapter at LD.1.50 (LD.01.05.01 in 2009), to place a stronger emphasis on the role of the organized medical staff leaders in organization management. This standard applies to hospitals only.
• A new standard for all accreditation programs that addresses leadership skills and the need for leaders to have access to information and training.
• A new standard on conflict of interest that applies to hospitals only and deals with conflicts of interest that occur when decisions need to be made at the highest leadership levels—for example, when a physician on the governing board has ownership interests in a competing specialty hospital.
• A new standard for all accredited organizations that requires the governing body, senior managers, and leaders of the organized medical staff to communicate with each other regularly on issues of safety and quality.
• A new standard for hospitals that requires the governing body to establish a process for making decisions when a leadership group fails to fulfill its accountabilities—for example, the medical staff is accountable for the care provided by its members.
• A new standard on co-
Conflict management for hospitals only that requires organizations to manage conflict among leaders so that it does not affect patient care; a separate standard in the chapter addresses conflict of interest for others who work in the organization.

The process to revise and update the chapter took several years and involved a special leadership accountability task force that addressed the way in which leaders work together. The intent of the chapter’s revision was to increase emphasis on important organization-wide systems and to emphasize the importance of safety and quality. Look for information on recommended steps that organizations can take to address disruptive and intimidating behavior in the October Joint Commission column.
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 plan¹, 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.

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SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246. The phone number is 513/587-3400.
Hasta la vista, bad data

by Richard J. Fantus, MD, FACS

The National Trauma Data Bank® is the largest aggregation of trauma data in the world, containing close to 3 million records. The old saying goes that there is safety in numbers. However, having a large amount of data is not as powerful as having a smaller quantity of quality data. In 2004, with funding from the U.S. Health Resources and Services Administration, several interest groups, along with the Committee on Trauma, collaborated on the National Trauma Data Standardization Project.

In the June 2006 Bulletin, the concept of a new national set of standardized trauma variables and definitions was reported.* In spring 2008, the first NTDB call for data using the new National Trauma Data Standard version 1.2.2 (www.ntdsdictionary.org/dataElements/datasetDictionary.html) was issued. What makes this a monumental year for trauma data collection is the fact that, for the first time, all data submitted to the NTDB will have consistent data elements, data definitions, and software-compliant format, and will have passed through the “Validator.”

The Validator is a software program that was created by Digital Innovations, the technology consultant to the NTDB. This software plug-in is akin to a spellchecker in a word-processing program. It can and should be run at the trauma center data-collection level and it is run again at the national level when trauma centers submit their data to the NTDB online data center.

The Validator conjures up images of a relentless machine, like Arnold Schwarzenegger’s Terminator, that does not stop until all invalid data are annihilated. All records are subjected to 300 edit checks, must have a facility identification, patient identifier, and last modified date; all fields must have a value (no blanks allowed) and no out-of-range or invalid values.

The graph on this page is a sample benchmark report from the 2007 call for data that shows number of records loaded per facility. Not listed are an additional 11 facilities whose submitted records were unable to be loaded. This exclusion process took place at

the national level. With the local trauma center use of the Validator, these facilities will have the opportunity to fix the identified errors before submitting their data at the national level. This year, all institutions will have all of their records loaded because it will have to pass through the Validator. It is as if the Validator is saying, “Hasta la vista, bad data.”

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.

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