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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.
Perhaps the most noteworthy movement occurring within the profession is the migration from independent solo or small-group practices to hospital-based or health system-based practices.

Wither independent practice?

Perhaps the most noteworthy movement occurring within the profession is the migration from independent solo or small-group practices to hospital-based or health system-based practices. According to a report in the February 12 New England Journal of Medicine, the percentage of U.S. physicians who own their practice has been declining at a rate of approximately 2 percent for each of the last 25 years, and the percentage of independent surgeons dropped from 75.5 percent in 1996-1997 to 68.4 percent in 2004-2005.*

The reasons for the decline in independent practice are complex but can be traced largely to payment, regulatory, and lifestyle concerns. Like other physicians, surgeons increasingly are growing tired of fighting with the government and insurers over declining reimbursement rates at a time when practice expenses, including liability insurance premiums, are on the rise. This financial stranglehold has led a growing number of physicians to give up independent practice and either to accept salaried positions in larger health care organizations or to retire early. It also may discourage young physicians and surgeons from entering private practice, especially when they are concerned about paying off the massive debt that they incurred during medical school and residency training.

Surgeons and other physicians also have grown weary of demands that their practices comply with government-imposed regulations, some emanating from agencies that typically have little influence over health care. A recent example is the Federal Trade Commission’s (FTC’s) “Red Flags Rule,” which was scheduled to take effect May 1, but was delayed at press time. Issued in November 2007, this regulation requires entities that regularly extend, renew, or continue credit to establish a written program for preventing identity theft. The FTC has taken the unofficial position that hospitals, physicians, and other health care providers fall under the definition of “creditors” if they issue invoices, receive payments in installments, or otherwise defer payment for services. Each “knowing violation” of the regulation will result in a penalty of up to $2,500.

Another driving force for the movement to contracting with hospitals and health care systems is the demographic change in medical school graduating classes and the lifestyle concerns of the new generation of surgeons. According to the American Association of Medical Colleges,
women accounted for 49.1 percent of medical school graduates in 2007. Many women, and an increasing number of men, want to spend more time with their families and less time worrying about administrative details.

In addition, evolving public and professional demands for more comprehensive and validated care and electronic recordkeeping may be contributing to the decline of independent practices.

**Attractive benefits**

Most surgeons who enter large group and institution-based practices are seeking to break free from the hassles of independent practice. As part of these large health systems, they need not worry about reimbursement issues because generally they are salaried employees. Furthermore, the hospitals or health plans often take responsibility for liability coverage and for regulatory compliance. Hospital physicians also work a prescribed number of hours, so they have a good idea of when they will be off-duty and able to fulfill personal obligations. And, institutional practices afford surgeons more opportunities to provide coordinated care to patients with chronic conditions, to compare outcomes and adopt best practices, and to install and implement health information technology.

I have spoken with several surgeons who have left private practice to work for health plans and hospitals, and most of them seem very satisfied with their decision. For example, a surgeon in Fresno, CA, recently joined the Kaiser-Permanente health system. On a scale of one to 10, this surgeon rates his satisfaction with being a salaried physician as a 10. Before the move, this individual was experiencing all of the frustrations described previously. He says he is relieved that he can now focus on patient care rather than on the business of running a practice.

More and more residents also have expressed interest in contracting with large groups. For example, I recently met two residents at Scott and White Hospital and Clinic in Temple, TX, who are in the process of negotiating a salaried position at other institutions in Temple, TX.

Nonetheless, the movement has its critics. They worry that the intelligent, ambitious, independent people once drawn to private practice will enter other professions that will allow them to have more autonomy. Others say that salaried employees have fewer incentives to be productive and to work hard. Furthermore, most large-group and institution-centered practices are found in metropolitan areas, so this trend may make access to care even more difficult for rural populations.

**Effect on the profession**

As a professional association, the American College of Surgeons must address these concerns and play a role in ensuring that surgical patients receive the best possible care—regardless of whether it is from an independent or a hospital-based practitioner. Obviously, we intend to maintain our rigorous requirements for attaining Fellowship in this organization. But we also need to think about the very different needs our members may have as they enter into institutionalized practices and what we can do to help those surgeons who want to remain in independent practice fulfill that aspiration.

Suggestions that I have received on this subject include establishing group purchasing alliances for medical liability insurance and for health information technology. The College intends to explore these and other possibilities. I am certain that many of you in the trenches have other ideas about steps the College needs to take in order to better serve your evolving needs. If you have recommendations about how the College can better serve the membership during this time of transition, I would like to hear from you.

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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On February 17, President Barack Obama signed into law The American Recovery and Reinvestment Act (ARRA) of 2009. Among many other provisions, the “stimulus” legislation directs funding and incentives to the development, adoption, upgrade, and use of health information technology (HIT). The inclusion of HIT funding in this legislation follows years of failed congressional attempts to pass HIT legislation. By adding funding to this spending legislation, many of the policy debates that had previously stalled HIT in the past were circumvented.

The ARRA contains several provisions to promote HIT and fund its adoption, including making direct payments to Medicare physicians, hospitals, and other providers that can demonstrate meaningful use of certified electronic health records (EHRs). These payments are designed to reduce health care costs by accelerating the use of HIT to improve quality, safety, and efficiency. It is important to note that most of the funding programs can be implemented only pursuant to rulemaking by the U.S. Secretary of the Department of Health and Human Services (HHS).

Who is eligible for the HIT incentives in the ARRA?

The stimulus contains incentives to certain health care providers in the form of cash payments for those who demonstrate “meaningful use” of certified EHR technology in 2011 through 2016. It also establishes disincentives in the form of reductions in Medicare payments for those who do not use certified technology by 2015.

The incentives primarily benefit office-based physicians and hospitals. Physicians who participate in the Medicare and Medicaid programs and who demonstrate that they are “meaningful users” of certified EHR technology during the measurement years are deemed as “eligible professionals” for bonus payments. This provision excludes physicians who are hospital-based, such as radiologists, anesthesiologists, and emergency department physicians.

Who qualifies as “eligible professionals?”

Eligible professionals for the Medicare HIT incentive program are limited to physicians as defined in the Social Security Act (§1861(r)), which includes:

• A doctor of medicine or osteopathy
• A doctor of surgery or of dental medicine
• A doctor of podiatric medicine
• A doctor of optometry
• A chiropractor

To receive Medicare incentive payments, the physician must:

• Not be hospital-based
• Demonstrate meaningful use of a certified EHR
• Submit Medicare Part B claims of at least 133 percent of the maximum incentive for a program year to qualify for the maximum incentive payment

The Medicaid HIT incentive program expands the definition of “eligible professionals” to include:

• Certified nurse midwife
• Nurse practitioner
• Physician assistant (under certain circumstances)

To receive Medicaid incentive payments, eligible professionals must:

• Not be hospital-based
• Demonstrate meaningful use of a certified EHR
• Treat a patient population of whom at least 30 percent receive medical assistance (or 20 percent if the physician is a pediatrician).

Whereas the incentives are not dependent on the eligible provider being a participating...
Medicare provider, the incentive amount available to any provider is the lesser amount of 133 percent of their annual billed Medicare Part B charges or the maximum payment specified for the year in the regulations. (For example, a surgeon would have to bill $16,000 in Part B charges to qualify for a year in which the maximum allowable incentive payment is $12,000.) There are no distinctions between physicians (such as specialty versus primary care) in terms of the incentives.

What proof do I need to offer to show whether I qualify for the HIT incentives?

Funding and incentives are tied to “meaningful use.” The Secretary of HHS will develop a form of attestation or the means for eligible physicians to demonstrate whether they are meaningful users of certified EHR technology. While no one yet knows the full definition of meaningful use, preliminary descriptions include the following:

- **Certified EHR technology** will be technology that is certified by an independent body recognized by the Secretary of HHS as meeting standards for such technology established by the Secretary by rulemaking before Dec. 31, 2009.

- **Meaningful use** will be demonstrated if an eligible professional can show that the EHR technology is connected in a way that improves the quality of health care through reported results on clinical quality, e-prescribing, and other measures selected by the Secretary of HHS.

  - **Clinical quality measures** shall be reported using certified EHR in a form and manner specified by the Secretary. These quality measures shall be selected by the Secretary of HHS. The Secretary shall seek to improve the use of EHRs and health care quality over time by requiring more stringent measures of meaningful use.

  - **Information exchange and connectivity** will be demonstrated if the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.

What sort of Medicare incentive payment amounts will be made to eligible professionals?

Each physician meeting the requirements will be eligible for a bonus payment of up to $44,000 over five years. This amount is subject to a per-physician cap of 75 percent of Medicare allowed charges by an eligible physician in any year, and the incentive payments vary depending on the first year a physician is deemed a meaningful user, with no payments made to physicians who do not qualify until after 2014. (See Table, this page.)

The maximum allowable Medicare incentive for office-based physicians during the first year of meaningful use increases from $15,000 to $18,000 in 2011 or 2012. This early adopter incentive raises the total amount physicians can qualify for from $41,000 to $44,000. A benefit for office-based physician early adoption is unavailable under the Medicaid incentive program.

The Secretary of HHS will be expected to develop regulations aimed at avoiding duplicative or conflicting requirements imposed by other federal and state programs.

The Secretary of HHS will publish the names, addresses, and telephone numbers of eligible professionals receiving incentive payments.

What penalties will nonparticipating physicians face?

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For Medicare-covered services rendered in 2015 or thereafter by a professional who cannot demonstrate meaningful EHR use, the Medicare physician fee schedule shall be reduced by 1 percent in 2015, by 2 percent in 2016, and by 3 percent in 2017. The Secretary of HHS may continue to reduce payments by an additional percent each year beginning with 2018, if less than 75 percent of potential meaningful users have actually adopted EHRs. These reductions cannot exceed 5 percent of Medicare billings. There is a clause for professionals who can demonstrate significant hardship, but that clause will apply to a professional for a maximum of five years.

**When will the payments be made?**

Funds become available for physicians on January 1, 2011. Eligible professionals may apply through January 1, 2012, and still receive full benefits. Providers should begin planning as soon as possible to allow time to achieve meaningful use of certified solutions during this time period in order to qualify.

**I understand that ARRA provides an additional incentive for rural physicians. Who qualifies for that benefit?**

An eligible professional who predominantly furnishes services in a geographic area that the Secretary of HHS designates to be a health professional shortage area may receive a 10 percent increase in their annual payment.

**What are the next steps toward implementing the incentive program?**

The stimulus legislation set in motion the mechanisms for adoption of HIT by providing guidance in the area of standard setting and financing mechanisms to encourage the use of EHRs. Clarifying the criteria used to determine meaningful use of this technology and setting standards for the technology itself are critical next steps that the Secretary of HHS must pursue in a timely fashion. These and other determinations will allow for continued dialogue with the provider community, and the College will remain engaged on all levels.
Building a surgical career

by Carlos M. Mery, MD, MPH; and Heena P. Santry, MD
Every summer, the Resident and Associate Society of the American College of Surgeons (RAS-ACS) has the privilege of contributing to an issue of the Bulletin that will uniquely reflect the vantage point of a new generation of surgeons. In the past, we have written at length about the most defining features of our lives as surgeons so far, namely surgical training and the future of surgery. These previous efforts have been mainly focused on how we learn to be surgeons rather than on how we become surgeons. The former is reflected in our technical challenges in the operating room, our frustrations with learning the scientific basis of surgery, and our fears that we may never develop sound clinical judgment. We have mused that finding the right role models in surgery would help us alleviate these concerns. However, amid these concerns floats an even larger sense of insecurity that we will never become surgeons who are able to function outside of the relatively sheltered world guarded by our attendings and governed by a preordained hierarchical structure of attaining surgical skills and knowledge.

Surgical residency, with its clinical, technical, and didactic curricula, is just the first step in a lifelong process of building a surgical career. And as all veteran surgeons can attest, building a surgical career is far more complex than mastery of these curricula. Surprisingly, surgeons haphazardly learn to market their attributes, manage complex finances, master career goals, and make time for themselves. These most critical skills required to become a surgeon are not taught or openly discussed in surgical training. Furthermore, recent changes inside and outside of the surgical field such as work hour reform, trends toward increased subspecialization, decreased reimbursement, greater diversity in the field, a desire for an adequate work-life balance, and cuts in research funding, among others, have significantly affected the foundation and structural paradigms of a surgical career.

The RAS-ACS contributions to this issue of the Bulletin will begin with an essay by our current Chair, Jacob Moalem, MD, who has recently entered practice at the University of Rochester. He will reflect on his years of training and his transition to his current faculty position and highlight important problems with the current structure of surgical residency. His reflections will suggest alternatives to and improvements in the current format of surgical training that may better prepare us for becoming surgeons.

Undoubtedly, the acquisition of surgical knowledge, clinical judgment, and technical skills during residency will remain the bedrock of our careers as surgeons. However, in this issue of the Bulletin, members of the RAS-ACS Communications Committee have written four articles that will explore the less tangible aspects of becoming a good surgeon—qualities that can and should be fostered throughout a surgical career. The articles reach beyond the clinical boundaries of surgery and explore in a very practical way some of the subtleties encountered by surgeons as they construct and live their surgical careers. The objective of this series of topics, geared toward surgeons of all ages and at all stages in their careers, is to explore the process of becoming a surgeon outside of the operating room, the wards, and the clinics. We will explore how to build and maintain a surgical practice, how to negotiate a contract, how to succeed as a surgeon-scientist, and how to achieve an adequate work-life balance.

Surgeons and policymakers have been increasingly worried in recent years about the challenges in meeting surgical workforce needs.
The article on negotiation will be of interest to young surgeons in need of work, established surgeons in need of partners, and chairs seeking to fill their academic ranks. To find meaningful positions in our areas of interest and interesting people to share in our work, we must understand how we become contractually bound to perform our duties as surgeons. Solutions to a surgical workforce crisis will rise out of knowledge of how job opportunities are marketed, sought, and formalized.

The number of bureaucratic hurdles that must be overcome to successfully run a surgical practice are another chief concern across all generations of surgeons. Surgeons who are just entering practice likely have learned little in their training programs about billing, credentialing, and maintaining overhead. Surgeons who have learned along the way as they have built their own practices are likely confounded by recent changes in the health care landscape that profoundly affect our ability to offer the best care and services to our patients while remaining profitable. The article about bureaucracy will attempt to delineate how best to build or maintain a surgical practice by sifting through the rules and regulations imposed by our modern health care system.

An academic career is fraught with a series of obstacles that can be overwhelming for someone trying to enter the academic surgical field. The article on becoming a surgeon-scientist will discuss various fields of research that are salient to surgical practice today. The authors analyze some of the options that surgeons have to incorporate an academic focus into their career and give some suggestions as to how to start building a fruitful research portfolio, obtain research funding, and establish oneself as a candidate for tenure.

All of these work-related challenges on top of the rigors of a busy clinical and operative schedule bring with them a tension with one’s personal life. Another article explores the elusiveness of work-life balance in surgery. The authors examine the history of surgeons’ attitudes and beliefs about work and life, current trends in work-life balance, and the possibility that more work-life balance will actually make the work of surgeons better.

The final article in this section is sponsored by the RAS-ACS Issues Committee. Each year, this committee picks a bellwether topic that will also be the theme of the RAS-ACS Symposium at the upcoming Clinical Congress. This year, the Issues Committee’s article discusses how the scope of the different clinical specialties has been changing, as specialization has become more common among surgical residents. It will explore some of the factors that are leading surgical residents to seek further specialization and the effects that this change will have in the future of health care.

The RAS-ACS hopes that this special section of the Bulletin will provide some insight on all these issues and help surgical residents, young surgeons, and older surgeons alike in building and maintaining a surgical career.
With the exceptions of the 80-hour workweek’s introduction in 2003 and the elimination of the “training pyramid” in the 1980s, the structure of general surgery training programs has changed little since the days of William S. Halsted. Under the auspices of the Accreditation Council for Graduate Medical Education and the Surgical Residency Review Committee, the specific requirements regarding numbers and types of operations have changed over the years, but the overall training paradigm, introduced more than a century ago, has remained unaltered.

The current model, based on a five-year core training period, has been remarkably successful in training surgeon-scientists and clinicians for generations. With an emphasis on equality, this model ensures that all graduating chief residents fulfill standardized minimum requirements, have similar case logs, and are exposed to the full breadth of general surgery. Particularly over the past 20 years, however, although residency structure has remained fixed, the stakeholders in surgical education have all changed dramatically. As I will discuss, the patients, residents, faculty, health care system, and even the field of surgery itself are no longer reminiscent of their century-old counterparts. As a result, and despite the outstanding history that residency training has had, I believe that the time has come to consider change. Our system, so effective in the past, is an outdated model and is lacking in its ability to promote professionalism, mentorship, and preparedness for the realities of practice in the 21st century. Increasingly, and in various ways, residents

From the Chair of the RAS-ACS:

Surgery residency training: The time for change has come

by Jacob Moalem, MD
are stating that the current residency structure inadequately satisfies their needs. Despite enormous financial, familial, and social pressures, an increasingly high number of graduating chiefs defer becoming an attending and prolong their training by pursuing fellowships. Moreover, despite the grueling nature of residency, many senior residents consider the current hours limitations to be a serious barrier to their education and would appreciate the opportunity to work beyond 80 hours per week when educational opportunities arise.

A different world

Burdened by an average educational debt of more than $200,000 and represented by an equal number of women and men, medical students and residents themselves have changed over the years. They have a strong sense of the importance of work-family balance and autonomy, yet desire mentorship, leadership skills, and opportunities for volunteerism. They are also eager to emerge into the workforce after having spent their youth in school and in residency. In a survey of surgical residents, only 15 percent of 319 respondents agreed with the statement, “I would be willing to add a year to my residency if it meant I could work shorter hours.” Despite this telling result, many residents do at least one year of research during residency, and 80 percent do a fellowship at its conclusion. Thus, for many graduating medical students, the initial five-year commitment is extended to eight years or more, their emergence to practice delayed until their mid- or late 30s, and their educational loans are inflated as a result of the power of compounding of interest.

Older and sicker than ever before, the average inpatient is also different from who was the average inpatient when our current residency structure was conceived. As length of stay for surgical procedures has progressively decreased, and as outpatient services have improved, there are almost no inpatients of low acuity. Octogenarians, once exceedingly rare on a surgical service, now represent a large subset of our patients; with their multiple comorbid conditions and propensity for imperfect outcomes, they are among the most challenging patients to care for. Far more savvy and educated, today’s patients are also increas-ingly demanding of specialty care and less likely to identify individual residents on the team as their doctor. They are also less trusting and willing to accept physicians’ orders and recommendations at face value.

Perhaps more than the patients and residents, the health care environment itself has completely changed over the past several years. Gone are the days of resident autonomy, when entire operations were done unsupervised by faculty. As regulation has tightened, so have the burden of documentation and the required knowledge of billing and coding—critical facets of medicine that are generally not taught in residency—increased. As oversight and scrutiny into individual surgeons’ outcomes continue to increase and become public, faculty’s incentive to allow residents meaningful participation in operations and care decreases. This trend is exacerbated by the decreased availability of residents, whose prime directive is to comply with hours regulations.

The past several years have also witnessed an explosion of surgical technology and innovation. Entire specialties have been born; laparoscopic, endovascular, and endoscopic procedures have become standard; and other minimally invasive approaches continue to be developed and refined. Each of these changes requires the understanding of a different physiology, the acquisition of a different set of technical skills, and the mastery of a different vocabulary, far beyond that which was traditionally associated with general surgery training.

Because of the changes previously discussed, the demands on today’s surgical residents are greater than ever. As more and more knowledge and skill areas are incorporated into the curriculum and contact time with faculty is reduced, the pressure builds. Patients are sicker and more demanding, and regulatory demands have burgeoned. Moreover, with an increasing reliance on cross-coverage systems, residents’ familiarity with patients and the educational benefit of each case have decreased, as has their personal investment in patient care. Educators have observed the development of a shift-work mentality among junior residents and a decrease in their professionalism and ownership of patients. In my opinion, this trend is a direct result of our current rules, which prohibit residents from providing the longitudinal...
care they wish to and forces them to sign out to colleagues whenever their shift is over.

**New structure for residency training?**

I believe that we must modify the existing residency structure in order for surgery training to remain relevant and attractive to graduating medical students. Although some authors have advocated a competency-based model of progression, I do not believe that that model addresses many of the challenges I have outlined. An early differentiation program, however, as proposed by the American Surgical Association’s Blue Ribbon Panel, might be more effective. By providing all residents with basic surgical core training during the first two years and then allowing them to differentiate into tracks, this new model would allow for more focused and improved educational opportunities for residents, and for enhanced instruction and mentorship by faculty.

Under this new paradigm, residents would be able to better master the technical and perioperative details of the procedures that they are most likely to actually do when they emerge into practice, and many might feel less compelled to pursue fellowship training. Residents would benefit from increased contact time with their mentors who, in turn, would be more motivated to teach and mentor the residents who have committed to their field of specialty. With the decreased breadth of exposure, continuity of care for patients would improve, and residents’ increased involvement in the care would foster a heightened sense of responsibility and professionalism. The slightly decreased scope of exposure would also allow for the introduction of a specialty-specific curriculum in ethics, regulatory requirements, and financial implications of treatment decisions—all integral elements of practice that currently are not commonly taught.

In summary, although the current residency paradigm has produced and continues to produce surgeons who receive excellent training, the price that current residents pay to achieve competence for independent practice is too high. Presently, graduating residents in surgery routinely invest 15 years or more in training and education and make enormous financial, familial, and social sacrifices. As a system, we must make better use of the limited work hours that we are allotted to train our residents by focusing their exposure to the specialties in which they will practice and by limiting their experience in operations that are less related to their specialty of choice.

**Acknowledgments**

The author would like to thank Gregory Cherr, MD, FACS, and Ted James, MD, FACS, for their assistance in crafting this article.

**References**

Despite having completed a lengthy and thorough training, most surgeons find the prospect and process of finding a job very daunting. After years of being guided in our paths from undergraduate school through postgraduate education by college directories and even U.S. News & World Report, we are left to fend for ourselves in the unfamiliar world outside the confines of the hospital. It is a world composed of small and large, public and private enterprises involved in the exchange of money for goods and services. The sooner the realization is made that medical practice is one of these entities, the more successful one will be in the pursuit of a good job opportunity. The lack of attention focused toward business skills and medical practice management in most residency curricula puts the graduating surgeon at a clear disadvantage. It is only empathy from the colleagues we join that brings on a fair treatment throughout this process. Nevertheless, it behooves us to be diligent and knowledgeable in the basic tenets required to negotiate a good job opportunity. In this article, we will review the processes of interview, negotiation, and compensation and components of contracts and covenants against competition as key elements to develop savvy negotiation skills.

Interviewing

Finding an opportunity that is in line with your goals and needs is frequently the hardest part of the job search. The first interaction with a potential employer is often over the telephone. This initial step may provide an opportunity, mostly for the potential employee, to decide whether the position is worth pursuing. It is important to remember that you are selling your services as well as yourself. The ability to create and expand on opportunities is central to any organization and, therefore, it is critical to emphasize the unique attributes you will bring to the practice, including special skills you have developed as part of your training.

General interviewing tenets, including the following, are fairly simple:
- Speak the truth, but do not speak ill of anyone
- Do not gossip
- Be prepared with questions to ask
- Dress well and be punctual
- Use a firm handshake
- Smile, smile, and smile
- Do not offer to pick up the check
- Do not accept any offer on the spot
- Discuss a timeline for the next step (one month is standard allowance for making a decision once an offer is tendered)
- In general, do not negotiate terms of the contract during the interview (this should be done once the contract is received)

Compensation

The employment environment for surgeons is highly competitive; it is a buyer’s market. Salary, benefits, and bonuses are key components of successful recruitment strategies. Specifics regarding these issues will give you a global idea of your compensation package. Often, an excellent benefits package may make a job more lucrative than if one looked at the salary alone. Also, knowing what you are not getting will help in negotiations for other needs. Keep a checklist. It is essential to know what is the competitive salary in the field as well as in the geographic area. This information can be candidly obtained from colleagues, former residents, and even online salary surveys. A guar-
anteed annual salary should be a component of your compensation. A schedule of payments needs to be defined (that is, whether it will be weekly, biweekly, or monthly), and if a multiyear contract is agreed upon, then annual pay increases should be clear.

Since many organizations use incentive-based (bonus) compensation for their surgeons, productivity should be defined (that is, based on billing or collections). Most surgeons will not be included on all insurance plans for months after they start, so a surgeon must consider how production in these months will be measured. There is also an increasing trend to use quality measures as part of incentive-based payments. Nevertheless, such payments are typically not more than 2 percent to 3 percent of cash compensation if used. Whatever the method for calculating the bonus, you should understand well the various components of the actual formula.

Signing bonuses have traditionally been used to provide capital for weathering the transition from one job to the next. Often during this period, no salary is drawn, but money is needed for everything from down payment on a home to purchasing new clothes. The bonus helps a person financially survive this period. It is sometimes given as a reward for signing with the employer early and thereby allowing for the company to avoid further inquiries and expenses in filling the available position.

**Benefits**

Health benefits will not be as comprehensive or as economical as you had in training. If there is a lag when you are in between jobs, some employers will cover the gap in medical coverage. Inquiries should be made regarding vision, dental, and disability benefits and the contract should clearly state whether your family is also covered. Vacation time should be specified as “paid time off.” Sick days, maternity leave, paternity leave, and continuing medical education benefits should also be delineated. Moving expenses, life insurance, and disability insurance are not always a given. If there is requirement for travel between hospitals, ask about the compensation for automobile wear and tear as well as gas expenses. Retirement plan contributions, such as a 401(k), are often begun one year after employment. Though professional liability insurance coverage is typically not an issue, “tail” insurance coverage is less commonly offered and should be negotiated. Liability tail coverage protects against claims that are brought against a physician after termination of a claims-made malpractice policy. A claims-made policy protects the policyholder from claims for acts that occur and are reported to the insurer only while the policy is in force. Practice agreements should state that the employer will pay for or contribute to the cost of tail coverage. This agreement is important because your next employer may not deem you eligible for “prior acts” (“nose”) coverage.

**Contracts**

There are not many opportunities in surgical training to garner the skills of negotiations. Regardless, there should be no stigma tied to negotiating for employment. The fear of negotiating is a very difficult, but important, issue to overcome. Contracts are not written in stone; there is no such thing as a “standard” contract. There is no reason to feel guilty if your needs are different from last year’s hire.

The first step after receiving the contract should be to review it yourself. Often, you will be surprised at how many notations and corrections must be made. The agreement should be reviewed by a lawyer experienced in contract law in the state where the new job is located. The length of the contract should be stated, but be aware of automatic renewals, which, in general, are a bad idea; renewals should be discussed and perhaps contract terms renegotiated. Paths to partnership, as well as academic advancement (such as assistant professor to associate professor) need to be defined; otherwise, there will be no written agreement regarding the specific goals you are working toward and how to get there.

Employment status as an independent contractor, employee, or shareholder can affect your tax and legal liability, so you should know your status. The organization will not withhold payroll taxes (including Social Security, Medicare, or benefits) for independent contractors. Though the employer saves a lot of paperwork and capital, this means you will have to pay estimated income taxes to the Internal Revenue Service every three months, as well as purchase your own health and disability insurance. Independent contractors only earn
income when they are working and do not receive compensation for vacation, sick, and personal days. The advantage is that independent contractors have more control of work hours, time off, and insurance choices. As an independent contractor, you also can profit from many more tax deductions for business-related expenses. Organizations are not your employers per se, but your clients, and as such, they are not entitled to direct you in your work. Under U.S. law, as staff you are either an independent contractor or an employee. Less often, one can be employed as a shareholder. As a physician shareholder, you have both a financial ownership position and a voice (via vote) in the organization in addition to your salary. This status may provide another revenue stream.

Work hours and call expectations must be stipulated in the contract. These specifications are a very popular inclusion in many current physician agreements, especially when employers are large institutions.

Finally, both parties should be able to get out of the contract. Provisions for termination are of two basic types: with cause and without cause. The provisions for termination with cause are usually clearly defined in the contract. Termination without cause should allow ample time for each party to secure employment (generally three months). The termination clause should not conflict with the noncompete clause.

**Covenants to not compete**

“Restrictive covenant” is a general term that refers to the agreements that prevent competition against the employer. The hiring practice’s main goal is to shield and protect their patient base and referral sources. Therefore, such limitations prevent any significant diversion of patients from the employer’s practice as well as interfering in the employer’s relationships with other employees. In general, the American Medical Association (AMA) and patients dislike restrictive covenants because they hamper trade and prevent patients from following up with their physician of choice. Ideally, the noncompete restrictions should make it inconvenient but not impossible for patients to continue to see their departing doctor.

Too often, the negotiating surgeon does not present enough concern about the noncompete restrictions because of good faith and expectation of a long-term practice. Nevertheless, it is very important to define what these restrictions are. Typically, noncompete restrictions are composed of three main factors: scope of activity (practicing your specialty or just some specific procedures), range of activity (prohibiting practice within a certain radius from a location), and period of restrictions (length of time). Typical radius of restrictions in urban areas spans up to one mile, whereas in rural areas it can reach 25 miles. Often, the more specialized the field, the greater the area restricted; an internist in a given area will have less of a geographical restriction compared with a hand surgeon in the same area. As a rule of thumb, most practices use a mileage radius that covers 80 percent of their patient base.

Employers will often have new hires acknowledge the “fairness” of the restrictions in addition to recognizing that they had the opportunity to seek specific counsel to such covenants. Though unfair noncompete covenants are typically not enforceable, they require litigation, time, and substantial expense. It is, therefore, much better to negotiate upfront and agree on acceptable restrictions. Attorneys play a major role in researching what has been found to be “reasonable” and “unreasonable” in the specific jurisdiction in question. It is important to keep in mind that the law varies significantly from region to region, to the point where restriction covenants are illegal in some states altogether (Delaware and Colorado). In Massachusetts, on the other hand, noncompete agreements are usually not enforceable to certain professions, namely physicians, nurses, lawyers, broadcasters, and social workers. You should check with your lawyer regarding the specifics of the state you are planning to work in. The AMA’s Annotated Model Physician Employment Agreement* is another good reference.

The following recommendations should be taken to heart when negotiating a noncompete clause:

- Scope of activity should not include teaching, working for certain insurance companies, or working in a noncompeting company.
- Range of activity should not prevent you from actively relocating your family if you wanted to stay in the area. Get a map, draw out the covered

area, and highlight other institutions that would be germane.

- Period of restrictions is generally one to two years but can be up to five years.

Though most noncompete restrictions take effect simply by terminating the contract, sometimes the employer’s interest in preserving its investment in the physician employee (for example, recruiting costs, moving expenses, opportunity costs) could be accomplished by limiting the trigger to when the physician initiates termination of the contract. If the employer decides to terminate the physician’s employment, it is assumed that there is dissatisfaction with the doctor and thus the departing physician should not be constrained in future employment opportunities. Restrictive covenants can benefit physicians as well: If a physician is employed by a group where all of the physicians’ contracts contain covenants, none of the physicians can compete directly with the group upon leaving.

Lastly, it is vital to include a buyout provision in the agreement. Some states require such provisions by law, which enable the departing physician to compensate the organization in exchange for a release from the noncompete agreement. This buyout should be set at a reasonable price (often one year’s salary). Lastly, arbitration provisions, to avoid the costs, time, and stress of recourse in the courts, are an increasingly popular option. Both parties should agree on the method of selecting the arbitrator as well as other procedural issues. Often an arbitrator is agreed upon ahead of time.

Conclusion

Surgical education is demanding in many ways and spans a broad scope. Unfortunately, understanding of the job market, negotiating a contract, and starting your own practice are not part of the standard curricula. Most finishing residents find the job search process very challenging and frustrating. Even worse, some end up trapped in a malignant practice, which a properly negotiated contract could have prevented. It is essential to remember that you are well trained and would bring outstanding professional and personal skills to a prospective practice. The group (or individual) with whom you are negotiating will be your close partners. They will be your colleagues and you need to maintain that perspective when resolving all of the issues mentioned. Always remember, if it is not written, it is not agreed to, and if you don’t ask, you don’t get. Good luck!

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Some might say the simplest aspect of being a surgeon is operating. North American surgery residency programs are excellent in preparing the surgeon to walk into the operating room comfortable with his or her ability to help the patient. But the question remains if our training programs prepare us to confront the most nonintuitive aspects of our specialty—specifically, managing the institutional red tape we encounter every day. The bureaucracy we face includes, but is not limited to, the specifics of coding for medical services rendered, hospital credentialing, purchasing new technology, and constructing an efficient outpatient clinic. Presenting all of these components and additional topics regarding red tape would engender a very large textbook that may prove to be outdated before it hits the shelves. For the scope of this article, we present two subjects: (1) how to navigate the alphabet soup of coding, touching on the definitions of and differences in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes, Current Procedural Terminology (CPT),* and evaluation and management (E/M) codes, why they are important, and how knowledge of these systems might make our practice financially efficient; and (2) how to navigate the process of credentialing, both for clinical privileges (whether it’s starting

*S specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2008 American Medical Association. All rights reserved.
your surgical career or changing or adding clinical venues) and for specific technical privileges.

**ICD-9-CM, CPT, and E/M: Understanding the alphabet**

*by David T. Cooke, MD*

For a surgeon at any point of his or her career—whether it is during residency, as new faculty, or in an established practice—it may be difficult to understand and grasp the complexities of coding for medical services provided. Inaccurate coding can lead to inefficiencies in reimbursement and loss of data related to morbidity, mortality, and practice patterns. The following is a primer for the alphabet soup of ICD-9-CM, CPT, and E/M and a list of educational resources.

**ICD-9-CM**

The ICD-9-CM is modeled after the World Health Organization’s (WHO) Ninth Revision of the International Classification of Diseases (ICD-9). The ICD is used to provide descriptive and unique codes for disease diagnoses and conditions and allows for statistical tracking of morbidity and mortality. The assigned codes assist in data acquisition and maintenance, reimbursement of services in the hospital and outpatient settings, and outcomes research.

The ICD coding system has been developed over the past 100 years. In 1948, the WHO took the charge of periodically revising and updating the system. Many countries make their own modifications based on the WHO’s published system. The U.S. National Center for Health Statistics (NCHS) modified the ICD-9 to make it more germane to U.S. health care. The ICD-9-CM contains a list of numeric disease codes; an alphabetical index of diseases; and a classification system of diagnostic, surgical, and other procedures. The NCHS and the Centers for Medicare & Medicaid Services (CMS) are responsible for managing all changes to the ICD-9-CM.

In 1992, the WHO completed the 10th revision of the ICD. The NCHS has modified the ICD-10, and the ICD-10-CM is now available to the public. Additional elements found in the ICD-10-CM include information important in outpatient encounters, additional injury codes, combination diagnosis/symptom codes that make it easier to code a condition, laterality, and easier code specificity. In August 2008, the U.S. Department of Health and Human Services proposed a rule to adopt the ICD-10-CM to replace the current ICD-9-CM. Under that proposal, implementation of the ICD-10-CM will begin October 1, 2013.


**CPT**

The CPT is a system of assigning five-digit codes for accurately identifying surgical procedures and medical and diagnostic services. The extensive codes are used to provide information on services rendered to physicians, patients, clinical administration, and third-party payors. The CPT is currently in its fourth edition; the American Medical Association (AMA) is responsible for modifying and updating the system. The AMA first published the CPT in 1966. In 1983, the CPT was adopted by CMS, and in 1987, CMS required the use of CPT for coding outpatient surgical procedures. CPT is currently used in the Medicare and Medicaid programs and is the most common system adopted by nongovernmental insurers to describe health care services rendered. The resource-based relative value scale (RBRVS) is a formula used by CMS to determine reimbursement for health care services rendered by a health care provider. The RBRVS determines a relative value unit (RVU) based on the procedure, geographic region where the surgery is performed, and a fixed conversion factor that is updated annually. A RVU is assigned to a specific CPT code, and serves as a benchmark for the reimbursement of that procedure. The AMA has a limited online resource ([https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp?_requestid=927229](https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp?_requestid=927229)) for finding a relative value associated with a CPT code.

Since CPT is instrumental in physician reimbursement, accuracy in coding is critical, especially for surgeons who perform myriad complicated procedures that must be documented precisely; thus, residents would benefit from some instruction regarding such procedures in their curricula. Novitsky et al examined 50 consecutive dictated operative notes by postgraduate...
years 3, 4, and 5 residents. The residents were unaware that the attending was also dictating the notes simultaneously. The researchers found a 28 percent error rate by the residents, including four cases of missed procedure and 10 cases where there was insufficient documentation for an appropriate CPT code and/or modifier. Their analysis concluded that the dictation errors would have reduced reimbursement by 9.7 percent during the study period. The results of this study underscore the importance of resident education and the formulation of a curriculum in the procedural and financial aspects of a surgical practice.

The AMA Board of Trustees authorizes a CPT editorial panel to manage and update CPT. The 17-member panel is composed of 11 physicians who are nominated by the national medical specialty societies and approved by the AMA Board of Trustees. In addition, four seats are filled by members of the American Health Insurance Plans, the American Hospital Association, the Blue Cross Blue Shield Association, and CMS. A larger group, the CPT advisory committee, offers advice on procedure codes, provides peer reviewed background, and suggests modifications to CPT. The editorial panel meets three times a year.

There are three categories of CPT codes. Category I codes are the only codes that have relative value associated with them and are the five-digit codes that describe the majority of procedures. Category II codes are optional codes with no relative value assignment; they are used for performance measurement and data acquisition for quality of care. Category III codes, which are used to evaluate emerging technology, are temporary codes used for collecting information on new procedures and technology, to justify increased usage of the product, or to facilitate the U.S. Food and Drug Administration’s approval process. The category III codes may also be part of a clinical trial. They do not have relative value associated with them and therefore reimbursement for category III codes is up to the insurer.

The CPT codes are updated annually and come into effect January 1 of each year. Individuals can complete a “coding change request form” to suggest changes or new CPT codes. The proposed changes or additions are vetted by the CPT advisory committee and, if deemed relevant, forwarded to the editorial panel for consideration. More information on CPT and available resources can be found at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml.

**E/M**

E/M services encompass the visits and consultations that a surgeon performs in the ambulatory and inpatient setting. Diagnoses for these visits are assigned an ICD-9-CM code and services rendered are assigned a CPT code. E/M services have multiple categories, including office or other outpatient services, inpatient services, and emergency department services. Within those categories, there are multiple levels of services, including new patient and established patient. The visits and consultations are assigned an E/M code.

The level of reimbursement of visits is contingent upon clear documentation to assist in assigning an E/M code. Determining the level of E/M services requires three key components: patient history, physical exam, and medical decision making. Additional components that contribute to determining the level include counseling; coordination of care; nature of presenting problem; and time, which refers to face-to-face time in the ambulatory setting and patient’s time spent on the unit/floor in the inpatient setting. For purposes of CPT coding, 14 systems are recognized in the review of systems aspect of patient history. In regard to comprehensive exam, a general multisystem exam or a complete exam of a single organ system is required.

Clear and committed documentation of services rendered is key for accurate E/M coding and appropriate reimbursement. In the study by Kuo et al, the researchers studied their institution’s financial records for the division of general surgery over a two-year period and found that actual inpatient E/M charges were 40 percent to 47 percent of predicted charges and concluded that E/M coding may be an underused source of revenue among academic departments of surgery.

Although the intricacies of ICD-9-CM, CPT, and E/M can be difficult to master, understanding these systems is important to the financial success of a surgical practice. The American
College of Surgeons sponsors online courses and other educational resources as part of its Advanced Practice Management Webcasts to assist surgeons in maximizing the potential of their practice. For more information, visit http://www.YourMedPractice.com/ACS.

References


Navigating the credentialing process
by Judi Smedra, CPMSM, CPCS; and Joshua A. Broghammer, MD

The process of licensing and credentialing go hand in hand. Whether a new graduate or an established surgeon, the credentialing process can be both tedious and daunting. Applying for clinical and surgical privileges often leaves a surgeon feeling frustrated and helpless, with little control over the situation. The actual application does not always seem intuitive and can be redundant. Much of the reason for the complex nature of credentialing is, in many instances, the requirement for primary, source-verified documents, which adds time to processing and causes delays.

State licensing

Licensing requirements vary from state to state but are based on uniform principles. The main components of licensing include identity establishment, verification of medical and postgraduate training, examination history, disciplinary history, and board certification. In 1996, the Federation of State Medical Boards created the Federation Credentials Verification Service (FCVS). For a fee, the service will collect data, acting as a bank of primary, source-verified, personal information to be used by state medical boards. This profile can be accessed in the future when the initial application has been completed. The FCVS profile is accepted in 48 states and two U.S. territories; 11 states require use of the FCVS for some of their applicants. A similar data bank of primary, source-verified information is collected by the American Medical Association in its Masterfile Program. These verified documents can be used for credentialing with a charge for each profile to the requesting hospital. Recent licensing changes in some states require fingerprinting and a background check at cost to the applicant.

Hospital credentialing

The fundamental aspect behind credentialing is one of patient safety. Although the specific credentialing protocols vary by institution, they are based on guidelines created by the Joint Commission, Centers for Medicare & Medicaid Services, the National Committee on Quality Assurance, and other regulatory agencies. The process attempts to verify the surgeon’s identity, appropriateness of his or her training, and overall competency. There is no direct testable nomogram to measure for competency, but the best effort is made to verify quality via board eligibility or certification, peer references, and a review of disciplinary actions or licensure suspension. All hospitals are mandated by federal law to query the National Practitioner Data Bank and Healthcare Integrity and Protection Databank to look for any licensure suspension, suit settlements, disciplinary actions, or suspension of clinical privileges. A physical examination and background check is often required as well. The Office of the Inspector General is routinely queried for any Medicare/Medicaid sanctions.

As of January 1, 2008, The Joint Commission is now requiring that physicians applying for hospital privileges go through a “proctoring” plan as determined by the department chair at each institution. Once a physician has passed institutional credentialing, he or she is granted privileges to see patients. However, other obstacles may prevent the surgeon from practicing. Despite
the rigorous process required by the hospital, a nearly duplicate application is mandated by insurers and third-party payors, adding another three to six months for clearance. Some hospitals negotiate contracts with insurers, automatically clearing the surgeon if the institutional vetting process is passed. This practice varies greatly and needs clarification prior to scheduling patients by a newly hired surgeon.

Credentialing for technical privileges

Technology plays an important role in the credentialing process. As new instruments and devices begin to flood the market, a hospital must ensure that its surgeons are using this technology in a safe, efficacious manner. Unfortunately, the hospital’s perception of “state of the art” often lags behind that of the surgeon. One must determine if proctoring is required for certain modalities such as laparoscopy or use of lasers. If a partner is not available to supervise, then it is essential to clarify who is going to bear the cost of obtaining an outside proctor. This task is the surgeon’s responsibility but can be negotiated with the hospital. Recent graduates who have modern, state-of-the-art training will find the proctoring process trying and unwarranted as they been supervised throughout their residency in the use of these more advanced technologies. Other documents—including course certifications from national meetings or training programs such as the College’s Fundamentals of Laparoscopic Surgery course—can be used to demonstrate competency.

Retaining detailed case logs from both residency and practice can bolster the application. The College has an excellent Case Log System (American College of Surgeons Practice-Based Learning System). Individual surgeons can track outcomes to help improve the quality of care. In addition, this system can be used to accumulate cases for board certification and Maintenance of Certification.

Easing the burden of credentialing

The credentialing process cannot be circumvented but can be navigated by a proactive surgeon. Maintaining a repository of key documents eases the burden of the process and should include the following:

For more information...


- Medicare Provider-Supplier Enrollment: Available at [http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_overview.asp](http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_overview.asp).


- Register for the ACS Practice-Based Learning System: Available at [http://www.facs.org/members/pbls.html](http://www.facs.org/members/pbls.html).


- Credentialing and recredentialing:
• Identification: Driver’s license, passport, and/or birth certificate
• Education: Copies of collegiate and medical school diplomas and transcripts
• Training: Internship, residency, research, and fellowship certificates
• Board certification certificates
• Recent medical examination
• Current and expired medical licenses, Drug Enforcement Agency certificates, and state pharmaceutical board certificates
• Copies of malpractice certificates verifying coverage for the past 10 years
• Certification cards such as Advanced Trauma Life Support®, Advanced Cardiac Life Support, and so forth
• Documented training for laser use, advanced laparoscopy, fluoroscopy, and so forth
• Telephone and fax numbers for all training directors, faculty appointments, department chairs, and references (best to use references who have a reputation of being prompt in responding to requests)

The final assurances to help credentialing are simple steps. Complete the application legibly, enter all blank fields, submit all requested documents, and answer questions accurately. Contact references to inform them a request is submitted from your credentialing organization and confirm a receipt of the inquiry several weeks later. Each surgeon should establish a respectful, cooperative relationship with the medical staff coordinator at his or her institution. Willingness to work together will speed up the process, result in two-way communication, and allow the planning of an effective start date. Meticulous attention to detail and completion of these steps can lead to a successful outcome in an otherwise laborious process.

Physicians graduate from surgical residencies with the knowledge and training to diagnose, treat, and manage a wide array of medical illnesses. Despite the investment it takes to train a surgeon, there is often an educational gap when it comes to the administrative aspects of practice. New hires can be left to complete the credentialing process in a largely independent fashion and, when beginning a practice, the young surgeon has to learn expeditiously how to navigate the often unfamiliar billing and credentialing requirements. With increased knowledge and use of a few simple steps, both coding and credentialing can be streamlined to help build a successful practice.

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General surgery stands out as one of the few specialties in which many residents pursue protected research time during residency. This research typically extends the residency training from five years to six to eight years, and many trainees legitimately question the value of extra time spent in research investigation. Robertson and colleagues recently suggested that the number of years spent in research before and during residency is significantly correlated with better research funding and subsequent academic growth as an attending surgeon. In a survey of recent graduates of surgical training, Thakur and colleagues found that trainees who perform research in a certain field are more likely to do fellowships in the same clinical area. More importantly, research can be a wonderfully rewarding and fulfilling experience, both for the surgical trainee and for the attending surgeon-scientist.

Being in research requires: a baseline inquisitive mind, strong intellect, and ambitious spirit; favorable circumstances, especially the existence of an inspiring and available mentor; and a source of funding. In view of the fact that President Barack Obama’s stimulus package carries approximately $16 billion in new funds for research and research infrastructure, funding is expected to become more accessible in the years to come. In fact, a total of $10 billion of this money has been allocated for the National Institutes of Health (NIH), $3 billion for the National Science Foundation, and $700 million for the Agency for Healthcare Research and Quality (AHRQ), with definite opportunities and serious commitment to research on the horizon.

Traditionally, the concept of research in surgery has been associated with the “bench” model, namely, basic science research. In the next few paragraphs, we will explore the research options and opportunities available for the surgeon-scientist. The model has expanded in the last two decades beyond bench research to include clinical and outcomes research, health policy research, and even surgical innovation.

Basic science research

Basic science research has long been an integral component of many academic surgical departments, and past contributions of surgeon-scientists to modern medicine clearly tell the success of their endeavors. The current incorporation of dedicated research time in many surgical residency programs testifies to the importance of research and its place at the core of modern surgical training. In addition to the traditional focus on disease processes and treatments, the surgical basic scientist is in a unique position to assume a pioneering role in translational research.

There are numerous options available to individuals who wish to pursue basic science research. Three key decisions should be made upon entering the research world. The first choice to be made is a specific area of research, which is usually influenced by previous clinical experiences and general intellectual curiosity. The next step is identifying an appropriate research mentor, which may, in reality, be the first step, as interactions through the clinical realm may have already led to the de-
velopment of a mentor-mentee relationship. The third step—one that is often overlooked by the first-time researcher—is to ensure the availability of adequate resources to conduct the research until completion.

For many residents, one or two years of research time may already be incorporated into their residency. When residents stay within their own department, funding for their salary is often provided. If they seek research outside of their residency program or have already completed residency, then funding sources should be sought and secured. Several institutions, such as the NIH and the National Cancer Institute, have both extramural and intramural research fellowships. Surgical associations—such as the American College of Surgeons, the Society of University Surgeons, and the Association for Academic Surgery—all have competitive research fellowship awards, which help provide funds. In attempting to find an appropriate research position, the track record of the laboratory is important to assess; reviewing the productivity of previous research fellows may aid in such an assessment. The choice of a project that is simultaneously challenging and feasible is a difficult task but is necessary for successful research. In addition, collaboration with the laboratory personnel—including nonclinical scientists, doctoral students, and technicians—is essential for success in basic science research. As a surgeon, likely with limited experience in basic science research, such collaborations will be essential to the productivity in the laboratory. Working with a recently formed research team may not be optimal, given the short time frame a surgical resident usually has. Furthermore, the guidance of a mentor is a key step toward success. A mentor not only helps keep mentees on track but also assists them in clearing roadblocks as research projects unfold.

The advantages of choosing basic science research are abundant. Discoveries made on the bench-top may lead to advances in surgical science and subsequently improve the treatment of patients. The intellectual challenge itself is particularly rewarding, and scientific success is especially satisfying. In addition, the practical and scientific knowledge acquired are very valuable for progression in an academic surgical career. On the other hand, basic research might be frustrating at times. Even perfectly executed experiments may not be fruitful despite invested time and careful scrutiny. Finally, because of publishing bias toward positive results, many lines of investigation may need to be attempted before a successful one with positive results is discovered.

Clinical research

If you see trends in the clinical behavior of patients and develop clinical hypotheses while performing your daily clinical duties, then you probably should explore clinical research, keeping in mind that scientific curiosity and intellectual sharpness are only the starting point. It takes enormous effort and discipline to be a clinical investigator; as Albright once noted, it resembles riding two horses simultaneously, representing the clinical world and the research world. In this analogy, any significant imbalance toward one or the other can lead to failure, as it is the bridging role of the clinician scientists that allows them to perceive which hypothesis is clinically relevant and which investigation methodology is actually feasible.

Clinical research, as the NIH defines it, has three major subcategories that the surgeon scientist can explore: patient-oriented research (such as clinical trials and therapeutic interventions), epidemiologic studies, and outcomes/health services research.

In surgery, randomized clinical trials are time consuming, difficult to design, and expensive to perform. In addition, when contrasted with medical clinical trials, such trials raise important ethical concerns with regard to patient randomization and practical concerns with regard to “blinding” of patients and surgeons. Nonetheless, randomized trials are essential, and surgeons are gradually overcoming methodological and logistical difficulties with multiple surgical trials performed in the last few years. More importantly, most high-quality trials require many years to complete and are thus more suitable for the attending surgeon rather than the surgical resident with limited research time available.

Surgical outcomes research is a favorite area for the surgeon-scientist and the surgical resident during their research years. Outcomes data have proven powerful and their implications on driv-
ing substantial quality improvement and crucial policy decisions have been at the core of surgical care improvement efforts. The young investigator or resident has access to large nationwide clinical databases that provide a rich substrate for high-quality surgical outcomes research. The National Surgical Quality Improvement Program (NSQIP) and the ACS-NSQIP methodology (www.acsnsqip.org) have been consistently validated as reliable sources of risk-adjusted surgical outcomes, and their databases are the source of multiple outcomes and quality improvement initiatives all around the nation. The Surveillance, Epidemiology, and End Results registry (seer.cancer.gov) currently collects cancer incidence and survival data covering approximately 26 percent of the U.S. population. Alternatively, administrative databases are also readily available through venues such as the Healthcare Cost and Utilization Project (www.hcup-us.ahrq.gov). This database, started in 1988, includes the largest collection of longitudinal hospital care data in the U.S., with all-payer, encounter-level information.

These databases enable research on a wide range of clinical hypotheses and health policy issues, including cost and quality of surgical care, medical practice patterns, health care disparities, and outcomes of surgical care at the national, regional, state, and local levels. In addition, there is a new frontier of clinical research in surgery, focused on areas of patient safety, quality improvement, and the derivation and validation of surgical quality measures. The Surgical Outcomes Club (www.surgicaloutcomesclub.org) has recently emerged as the premier venue for networking and sharing of outcomes research conducted all across the nation.

As with basic science research, effective mentorship for outcomes and health services research may be difficult to find within some surgery departments. Choosing an open model of mentorship and embracing faculty members from other clinical departments or schools can lead to very effective mentoring relationships. Initial funding sources for residents are usually from the hospital or department of surgery. Private foundations such as Robert Wood Johnson (www.rwjf.org) and the Commonwealth Fund (www.commonwealthfund.org) are also available for health services research. AHRQ (www.ahrq.gov) also provides K awards in health services research for new investigators. With more than $700 million dollars allocated to AHRQ alone, and with President Obama’s repeated references to the need for health reform and increased efficiency and quality of health care, it is clear that research opportunities in these areas are bound to increase.

Health policy research

Clinical research and health policy research are intimately intertwined. “Good data make good advocacy,” says George F. Sheldon, MD, FACS, Director of the ACS Health Policy Research Institute (personal communication, February 23, 2009), and academic surgeons often use clinical and health services research to drive health policy. Addressing the perennial issues of cost, access, and quality, as well as newer concepts such as evidence-based case reimbursement, will require well-modeled research. Surgical outcomes data influence treatment protocols for heart disease, cancer, and trauma, the three diseases that account for the highest U.S. health expenditures. Whether working on reducing surgical site infections, establishing more streamlined patient care flow, or eliminating health care disparities, the opportunity for surgeons to enhance policy through an academic approach is present. Academic surgeons establish and lead multidisciplinary quality-improvement efforts that collect and review clinical data to establish quality benchmarks for hospital, state, and national regulatory committees. Academic surgeons serve as consultants and advisors and are sometimes appointed to government service.

Health care is a $2.4 trillion industry, the largest in the country. As the U.S. health care expenditures continue to grow, sound health care policy becomes vital. The surgeon’s role as a leader in such policy is well established. Former Surgeons General Richard H. Carmona, MD, FACS, and C. Everett Koop, MD, FACS, and former Senate Majority Leader William H. Frist, MD, FACS, are examples of surgeons at the frontier of policymaking. They have clearly shown us that a surgeon’s impact through policy can extend far beyond the operating room. The American College of Surgeons has seen the potential for this type of tremendous impact and has acted on it by establishing the ACS Health Policy Research
Institute because, as stated by Dr. Sheldon, “Surgeons provide a unique contribution in the health care system.” Surgeons are responsible for some of the most valued and essential care in the health care system. Surgery is given credit for 60 percent of patient cure from cancer, and trauma systems led by surgeons save thousands of lives each year. For these reasons, among others, it is perfectly appropriate that surgeons continue to be leaders in the health care policy arena.

Young surgeons have become increasingly interested in molding the future of the nation’s health care system. Surgeons now gain expertise in public health, law, and economics. The challenge becomes a dual one of accessing the most effective skills and experiences and melding them with a career in surgery. One venue for gaining the requisite knowledge is the ACS Division of Advocacy and Health Policy’s annual Joint Surgical Advocacy Conference. This conference allows participants to fully explore major health care policy issues with advocates and legislative staff. (For coverage of this year’s conference, see page 43.) Furthermore, the community surgeon can also look to the local and state medical and surgical societies and join committees dedicated to access, reimbursement, and quality issues. Most state legislatures have pending legislation posted on their Web sites, and following the progress of relevant bills is an excellent way of maintaining expertise in local issues. In addition, many medical and surgical organizations have state lobbyists, and dedicating some time shadowing them can improve legislative acumen. Ultimately, becoming involved in the legislative cycle through formal testimony and advisement can be very rewarding. Serving on state commissions that evaluate specific health care issues can also be accomplished.

The College offers a health care policy scholarship that provides an opportunity each year for awardees to attend a health care policy symposium at Brandeis University. In addition, the American Association of Colleges of Osteopathic Medicine offers a health care policy fellowship specifically for osteopathic surgeons (http://www.aacom.org/events/Pages/HPFellowship.aspx). A list of formal

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**Table 1. Examples of funded clinical and health policy fellowships available to surgical residents**

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**Table 2: Examples of surgical innovation fellowships available to surgeons and surgical residents**

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<tr>
<td>University of Missouri–Columbia Biodesign and Innovation Program</td>
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<td>University of Minnesota Medical Devices Center Fellows Program</td>
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health policy training experiences can also be found on the Kaiser Family Foundation Web page (http://www.kaiseredu.org/fellowships/default.aspx). Table 1 on page 28 delineates some of the funded clinical, health services, and health policy fellowships available for research residents. This list is not intended to be comprehensive.

With the increasing national dialogue regarding our health care system, and with public sentiment becoming more resolved toward significant change, it is clear that we are in one of the most exciting times for surgeons to be involved in health care policy.

**Surgical innovation**

The field of surgery has advanced, thanks to a few visionary surgeons who had the ability to identify unmet clinical needs and the will to do something about it. Surgical innovation is an alternative pathway that can complement or form the basis of a surgical career. Because of several factors—such as the current complexity in technology, surgical subspecialization, and busier clinical practices—innovation is being increasingly left to industry alone. Lack of surgeons’ involvement in this process may lead to the development of suboptimal solutions to clinical problems or to a focus on problems that may not be the most critical to address. Surgeon involvement is therefore vital in the process of innovation.

Innovation is the process by which creative ideas are successfully implemented. As such, surgical innovation is not only about creating a new device or coming up with a new procedure. It requires the identification of an important problem, the generation of an adequate idea, and the development of a concept to the point where it can be brought back to the bedside and have an impact on patient care. Transforming an idea into a useful innovation requires time; perseverance; commitment; and, particularly for medical devices, money.

The first step in the process of surgical innovation is to identify unmet clinical needs. Surgeons, being at the forefront of clinical practice, are in the ideal position to identify those needs, characterize them, and conceptualize possible solutions. Therefore, surgical innovation lends itself as an ideal discipline to complement a surgeon’s clinical practice. Once clinical problems are identified and well characterized, the next step is to brainstorm possible solutions and create a multidisciplinary team that can materialize those solutions. The team’s composition will vary depending on the scope of the problem but typically includes engineers, technicians, business people, and other clinicians.

The extent and duration of involvement of surgeon-inventors will vary depending on the time and resources they are willing to invest and the other commitments of their practice. Some surgeon-inventors will take the idea as far as human testing or even commercialization whereas others decide to participate in the early development of an idea before passing it on to a team willing to pursue it further. Regardless of the decision, surgeon involvement is vital in every step of the development of the product or technique.

Pursuing a career in surgical innovation can
be exciting and personally and professionally rewarding. In clinical practice, a surgeon helps one patient at a time. A surgeon-innovator has the potential to have an impact on myriad patients and help advance the field of surgery. Furthermore, it is easy for surgeons to visualize and relate to patient care the problems and solutions that are within the scope of surgical innovation.

There are several barriers that a surgeon-innovator has to overcome, however. Creating a multidisciplinary team can be challenging, but one has to recognize that an effective and proactive team is perhaps the most important ingredient of the innovation equation. Funding plays an important role in the development of the project. Funding for the development of early ideas usually includes a combination of departmental funds, small government-sponsored grants (in the form of research, development, or small business grants), personal funds, angel or venture capital investments, or corporate sponsorship from major corporations. The type of funding will obviously depend on the scope and stage of the project and the intention of the innovators. Surgeons can get involved in surgical innovation by learning the process on the fly or by obtaining formal teaching in the process of innovation. Several educational programs in the form of fellowships have been developed around the U.S. and abroad to help train people in the process (see Table 2 on page 28).

Conclusion

Whether one chooses the basic science research track, the clinical research arena, the health policy and advocacy path, or surgical innovation research, the opportunities are ample for success, productivity, and effectiveness. On a more personal level, research in surgery can be as rewarding to the surgeon-scientist as operating itself. It is the exact combination of clinical work and research in surgery that undoubtedly puts the surgeon in the unique position of advancing the clinically relevant (rather than any) basic science, testing the appropriate (rather than any) clinical hypothesis, advocating the urgent (rather than the exclusively political) health policy themes, and innovating the clinically needed (rather than only industry-sponsored) surgical tool.

References

The modern surgical lifestyle

by
Anathea C. Powell, MD;
Jennifer S. Nelson, MD;
Nader N. Massarweh, MD;
Luke P. Brewster, MD, PhD, MA;
and Heena P. Santry, MD
The core value that binds us together as surgeons is continuity of care: the principle that we, and not surrogates, are responsible for the patient, regardless of time, geography, or personal commitments. William S. Halsted formalized the principle of continuity of care when he created the first residency training program at Johns Hopkins University in 1897. The underpinning of Dr. Halsted’s educational goals was a restrictive lifestyle that committed trainees solely to their patients.

Since the time of Dr. Halsted, surgical training and practice have been questioned as a result of many factors, including growing numbers of women in surgery and work-hour reform. There is increasing recognition of doctors as susceptible to fatigue and illness; as having the same hopes and desires for personal development as others not in medicine; and, like their patients, as being human. The profession of surgery stands at a fundamental crossroads: how do we balance the core values of professionalism and continuity of care with the need to be human? In this article, the authors will examine some of the history that has brought us to this point and explore current trends in the personal lives of surgeons.

History of surgical education

Dr. Halsted was influenced greatly by his contemporary, Sir William Osler, who championed the ideas of strict dedication to the bedside study of diseases and graded responsibility with an involved teacher. Dr. Halsted’s model established that surgery was best learned by hands-on education within a hierarchical program. An internship, followed by six years as an assistant resident, culminated in two years as “house surgeon.” House surgeons lived in the hospital, where room, board, and training were provided in exchange for 24/7 service to the hospital. This pattern of personal sacrifice was established as the sine qua non of the life of a surgeon. Dr. Osler advised trainees, “What about the wife and babies, if you have them? Leave them! Heavy as are your responsibilities to [them], they are outweighed by the responsibilities to yourself, to the profession, and to the public.”

The enactment of the Servicemen’s Readjustment Act of 1944, or GI Bill, was a defining moment for surgical education. The GI Bill, created to train medical officers returning from World War II, marked the first time surgical trainees received stipends. Despite financial compensation, the life of a surgical resident remained austere throughout the 1950s, 1960s, and 1970s. Trainees essentially never left the hospital where they were provided meals, whites, laundry, and a sleep room. Enactment of the Medicare and Medicaid Act of 1965 was a turning point for trainee lifestyles. Residents who had previously been providing care to the indigent for free now had a mechanism for compensation. At San Francisco General Hospital, when George F. Sheldon, MD, FACS, was a resident (1965–1969), he saw his salary increase from $120/month to $1,200/month as a result of that landmark health care mandate.

Over time, attitudes began to shift and the restrictive lifestyle of Halsted’s model began to lessen. Trainees began to marry and move out of the hospital; they were no longer available 24 hours a day. Despite these changes, surgical training remained arduous, with long hours and overnight call as often as every other night. Trainees went home only when the work was done. But then the death in 1984 of a patient in a New York teaching hospital brought these long hours into sharp focus.

The impact of work-hour reform

Libby Zion was an 18-year-old woman admitted to a New York hospital with fevers, agitation, and delirium on March 4, 1984; she died within 24 hours. Her father, Sidney Zion, a New York Times columnist and lawyer, believed that she died as a result of inadequate care from overworked and inadequately supervised residents. A grand jury investigation did not return a criminal indictment but made recommendations concerning resident supervision and work hours that were considered “an indictment of the American graduate medical education system.” The case led to a formal evaluation of the training and supervision of physicians in New York State by the Bell Commission, whose recommendations—including work-hour limits of 24 hours per shift and 80 hours per week—were adopted by the state in 1989. In July 2003, the Accreditation Council for Graduate Medical Education (ACGME) enacted similar regula-
Protest from surgical educators followed swiftly. Barone and Ivy portrayed their response as resembling Elisabeth Kubler-Ross’ five stages of grief, describing the tone of the 2004 annual meeting of the Association of Program Directors in Surgery as “funereal.” One New York surgeon commented in a 2003 *New York Magazine* article, “We have to act as cops and chase people out of the hospital. It’s antithetical to everything being a doctor is about.” Josef Fischer, MD, FACS, summed up the reasons behind the protest, writing that “The 80-hour work week is seen as damaging to the essence of surgery’s being. It is the denial of the foundation of...continuity of care.”

Still, there was evidence that overwork among trainees was harmful to their emotional and physical health and that work-hour reform improved quality of life. A survey of interns (from all specialties), conducted the year before the ACGME duty-hour restrictions were enacted, found that post-call interns were more likely to suffer needlestick injuries or be involved in motor vehicle collisions. A survey of surgery residents (n=86) after work-hour reform found that 88 percent felt more rested and 71 percent experienced improvement in the quality of their personal relationships. A meta-analysis (54 studies) published in the *Journal of the American Medical Association* in 2005 found similar results.

The effects of work-hour
reform on patient care and surgical education have been more controversial. In a survey of New York State surgical residents, the majority of residents believed that continuity of care had been affected negatively by work-hour reform; fewer thought that the quality of care had been affected negatively. However, objective metrics for patient care and education have not been shown to decrease after work-hour reform. A study at Massachusetts General Hospital before and after implementing work-hour restrictions found no differences in quality of care based on the ACS National Surgical Quality Improvement Program, or in education based on ACGME case logs and in-service exam scores. The Residency Review Committee for Surgery evaluated operative experience before and after work-hour reform and found no change in operative volume, both overall and for chief residents.

**Women in the surgical workforce**

Increasing representation of women in surgery is another factor driving the discussion of work-life balance. Since the 1960s, the percentage of women entering medical training has increased steadily to parity (see Figure 1, page 33). Although the proportion of women subsequently entering surgical training and practice has lagged behind that of nonsurgical specialties, there has been a consistent trend toward more women across all surgical specialties (see Figure 2, page 33). Though they are not yet at equal representation and were once a rarity, women are now an expected constituent of the surgical workforce.

At the biologic level, the presence of women in surgery has challenged Osler’s and Halsted’s paradigm of the surgeon’s wife bearing children and carrying out all family and domestic responsibilities. In the modern world, the surgeon may now be both doctor and mother. A recent survey of women urologists revealed the difficulties of reconciling these identities. Women urologists were, on average, eight years older than national norms at the time of the birth of their first child. Pregnancy complications were 5 percent to 20 percent higher than national rates. Assisted reproductive technology was required for this group approximately 10 percent of the time, compared with 1 percent nationally. As these data show, delaying childbearing until after residency is not without risk to both mother and child.

Beyond the biologic imperatives of childbearing lies the responsibility of maintaining the family. Over the past 20 years, more and more surgeons have married other professionals within and outside of medicine. Two different surveys of academic surgeons (n=386 women and 338 men, and n=572 women and 1,050 men, respectively) found that 80 percent to 90 percent of women surgeons and 26 percent to 50 percent of men surgeons were married to a full-time professional. The reality of two-professional households has shifted responsibility for domestic and family obligations from solely the province of women to a realm where both partners share in the burdens—and joys—of home life.

Balancing the identities of professional surgeon with partner, parent, and friend, however, requires a change in residency training and surgical practice. Julie A. Freischlag, MD, FACS, chair of the department of surgery at Johns Hopkins University in Baltimore, MD, has observed: “Raising children cannot be delegated to others. As parents, we need to be there.” She encouraged program directors to accommodate pregnant residents during training and encouraged chairs to support young female faculty in maintaining their academic productivity. Difficulty combining work as a surgeon with family life is often cited as a detractor to a career in surgery; promoting and sustaining women in the surgical workforce may ultimately dispel this notion.

Today, outstanding female surgeons serve as role models for men and women alike. In describing the female students—whose role models in surgery include Dr. Freischlag; Carol Scott-O’Connor, MD; the late Olga Jonasson, MD, FACS; Rosalyn Sterling-Scott, MD; and Barbara Bass, MD, FACS—Eddie L. Hoover, MD, FACS, has said they not only want to “become surgeons, faculty members, medical executives, deans, and departmental chairs” but also want to “succeed as wives and mothers who attend soccer games, ballet performances, and parent-teacher meetings.” Young men aspiring to become leading surgeons can also look to these women and aspire to succeed as husbands and
fathers. The increasing presence of women in the surgical workforce has demonstrated to both male and female students “that there are a variety of ways to achieve balance between professional and personal life.”

In pursuit of balance

Achieving work-life balance is difficult because it is easy to put aside outside interests or neglect the people we care about when we are passionate about our profession. Pearsall describes this effect as “toxic success.” For example, two-thirds of academic surgeons surveyed (n=54) reported their demands at work “adversely affected their relationships with spouses.” Half the surgeons in another survey (n=317) felt that their work schedules did not allow enough time for their personal lives. Campbell measured burnout among practicing surgeons (n=582) and found that 32 percent manifested “high” levels of emotional exhaustion and 13 percent showed high levels of depersonalization. Burnout was associated with a perceived imbalance between career, family, and personal growth. How, then, can we reap the rewards of both our professional and our personal lives and avoid career burnout?

Spiritual and worldly interests must be fostered; although it is no sign of social ineptitude to enjoy one’s work, the importance of caring for mind and body must not be underestimated. A study of University of Wisconsin surgery program graduates between 1978 and 2002 found that surgeons were at risk of neglecting their physical and mental health. John Tarpley, MD, FACS, serves as an excellent example of avoiding such neglect. Dr. Tarpley likens his work as a surgeon and an educator to a ministry. His faith in God grounded him through years of work in Nigeria and leads him today as he counsels residents who are demoralized by the rigors of residency. He still finds time, however, to read a nonmedical book every night and go to weekly choir practice because this, too, grounds him.

Ambition must be put into perspective; the pursuit of career success need not come at the expense of personal satisfaction. In a qualitative study, a leading female academic surgeon stated that “It’s okay to say...my focus is going to be a little bit more on my family...I’m still going to be productive...but I am not going to marry myself to my job.” When Orrom describes his fellow surgeons as professional high-achievers, he advises them that “The pursuit of mastery is a good thing, whereas the excessive pursuit of mastery to the exclusion of intimacy and other life experiences is not.” Achieving work-life balance in surgery is incumbent on acceptance that pursuing interests outside of surgery is not a sign of professional underachievement.

Expectations must be manageable; work and life will not always be precisely balanced. Personal interests and professional ambitions may occasionally need to be sacrificed in favor of the other. Speaking at the Radcliffe Institute for Advanced Study in 2006, Myriam Curet, MD, FACS, a surgeon and associate dean for medical education at Stanford University, noted that “Work-life balance is different for different people. It’s also different for the same person at different times in her life. Doing it successfully, however, requires building a network and finding backup systems.... Some people have a spouse who works a job whose hours can accommodate the demands of child care. Others live near family and rely on them to help out. Still others hire nannies and use professional care.” Dr. Curet urged the audience to be flexible and to realize that life doesn’t have to be perfect to work.

In his keynote address to the Pacific Coast Surgical Association in 2004, Pearsall gave some advice on how to avoid the “toxic success of surgeons.” He said “Much of the focus...has been on time management..., stress management..., trying to ‘live in balance...,’ ‘cutting back...,’ or ‘quality time’.... [But,] it is the nature of our consciousness that has the most significant influence on whether our work and view of success causes our families and us to flourish or languish and what that success ultimately does to our health and well-being. When it comes to the effect of our work on our life, a key factor seems to be whether we are mindless or mindful in our approach to daily life.”

Mindfulness at a crossroads in surgery

Thus, we have arrived at the current challenge facing surgeons and patients alike: how do we resolve the apparent conflict between continuity
of care and the need for surgeons to fully realize their personal interests? The authors submit that this dilemma is not a conflict but instead an opportunity to continue perfecting the art and science of surgery. Dr. Halsted demanded “a system...which will produce not only surgeons, but surgeons of the highest type, who will stimulate [others] to study surgery and to devote their energy and their lives to raising the standard of surgical science.”35

Today, surgeons of the “highest type” are mindful not only of the core value of continuity of care but also of the need to be fully present in both personal and professional life.

Arriving at the crossroads of those two paths defines work-life balance and allows surgeons to give the best of ourselves to our patients, our colleagues, and our families. With creativity, flexibility, planning, and cooperation, surgeons can remain true to the qualities that make them human while maintaining fruitful careers and an unassailable commitment to patient care. Patients benefit when surgeons couple clinical acumen and technical skill with “narrative medicine” which, as Dr. Tarpley has taught us, better enables us to understand that people with illness are shaped more by their human experience than by the pathophysiology of their disease.36 Our vivid lives outside of work give us the insight to appreciate our patients’ capacity to suffer and heal in the face of surgical illness.

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It should come as no surprise to the majority of surgeons that the number of surgical residents pursuing advanced training beyond their general residency requirements is continuing to escalate. Attrition across the country among practicing surgical generalists is increasing not only as a result of fewer medical students applying for surgical residencies, but also as more graduating surgical residents seek fellowship training. An article published in the 2005 *Journal of the American College of Surgeons* reported that more than 70 percent of recent surgical residency graduates have pursued fellowship specialty training (n=1,044), representing an increase from 55 percent in 1992.* This trend has been observed across all surgical fields, not just general surgery. The reality of this issue is that what was once thought to be limited to general surgery is now affecting other surgical specialties, including orthopaedics, otolaryngology, ophthalmology, neurosurgery, and urology.

**General training as a stepping-stone**

Surgical generalists are trained to be proficient in the majority of procedures within their specialty’s scope of care without any further specific designation or specialization. Is surgical training as a generalist, irrespective of the field, becoming a mere stepping-stone to advanced surgical specialization? Each year, additional fellowships are being...

offered across the country and are increasing not only in number but also in defined categories and subsets of categories. In 2007, the Fellowship Council—the accrediting body for minimally invasive, endoscopy, hepatobiliary, and bariatric fellowships—increased the total number of fellowship programs by nearly 15 percent.\(^1\) The Fellowship Council currently offers more than 120 fellowships. This array of fellowship options exemplifies the growing trend toward further superspecialization.

**Who is driving?**

**Surgical generalist careers**

The driving force behind the observed trends in decreasing interest in a surgical generalist career is multifactorial. As the public becomes more Internet-savvy with an increasing number of medical education resources, the desire of the contemporary patient population to participate in medical decision making is driving the trend. Requests for care by “the specialist” are common in health care institutions across the country. These appeals are made in an earnest belief that the specialist will provide the best care. What if the surgical problem is outside of the specialist’s scope? If multiple specialists are required for a procedure, how many are too many to be involved? Which physician determines how or if to proceed? One way to circumvent such quandaries is the development of Centers of Excellence, which are composed of multidisciplinary teams of physicians. For example, at Cedars-Sinai Medical Center in Los Angeles, CA, the Spine Center provides multidisciplinary surgical and nonsurgical treatment for a variety of spinal disorders. Both open and minimally invasive techniques are offered to patients. The surgery is delivered by a spine specialist, who may have an orthopaedic, neurosurgery, thoracic surgery, or general surgery background. This provides seamless care to the patient who simply requests a specialist to resolve his or her spine disorder.

Yet, a significant number of patients patronize their local community hospital where they receive care from their local generalists. There, they are likely to encounter a generalist surgeon who has reached master surgeon status in addition to a few specialists. Most specialists are clustered in large urban centers, remote from these communities. Such communities are not limited to rural areas but also include suburbs and small cities. Yet, there is no evidence that these patients are suffering from substandard care.

**Specialties**

These demands are not unique to surgical patients and influence other medical fields as well. A driver affecting surgical and medical specialties is the overall acceptance of minimally invasive procedures. In addition to surgery, this trend has affected cardiology, radiology, and gastroenterology, such that each specialty has a pathway for a physician to become an interventionalist. There are procedures that multiple specialists within various fields are trained to perform, however, which has led to turf battles and imperialism over some surgical procedures by interventionalists. Surgeons have countered by developing training programs in endoscopy, natural orifice transluminal endoscopic surgery, and endovascular surgery. Fortunately, there are several examples of specialists from various fields collaborating in the multidisciplinary training of fellows to become interventionalists who share these procedures and patient care responsibilities in a collegial and mutually beneficial manner.

**Residents**

If the public continues to desire care received from specialists, then more trainees may choose to pursue paths leading into specialist fields based on future prospects for operative cases. Predicting the needs of the population in the future is a key component driving residents toward their career aspirations. For example, as the number of open-heart procedures being performed in the mid- to late-1990s began to decline, more cardiothoracic surgeons were left without work, and the number of applicants for cardiothoracic fellowships declined in parallel to this trend.

Another driver is a desire to enhance basic training received in residency. The argument

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for fellowship training after generalist surgical training is that the changing paradigm of surgical education, such as work-hour restrictions, has led to deficits in technical skills, which result in insecurity regarding technical skills upon completion of baseline training. Thus, fellowship training affords more individualized apprenticeship that continues the development of technical skills. Many generalist programs produce graduates who are confident in their technical skills and prepared practitioners. If these individuals have advanced degrees, marked research productivity, or distinguished administrative talents, they may be as competitive as their fellowship-trained counterparts. Is the goal of fellowship training to allow surgeons an opportunity to hone particular techniques used to provide a superior level of surgical care, or does fellowship training provide a surgical finishing school that builds confidence and exposes the participant to advanced techniques? The accompanying lifestyle options that specialization often offers are an equally attractive option for trainees. This issue has been widely debated and there appears to be no change of these trends in sight.

**Who cares for the patient?**

There are issues, however, that remain to be worked out. While there is public demand for increased specialization and more generalist trainees envision greener pastures after fellowship, is this shift safe for the patient? Historically, the primary care physician consulted the generalist and the generalist has been the central care provider for the surgical patient. Who is to direct the care of the patient when surgical specialists and superspecialists become all too common? Are the primary care physicians to direct the surgical specialists in the management of a complex patient? Few surgeon generalists would likely agree to relinquish the primary oversight of their patient, whereas specialists may be more motivated to do so. However, as their clinical scope becomes further narrowed, will specialists be prepared to oversee all care of their patients?

As every patient issue has the potential to become micromanaged, the specialist may lose sight of the overall picture in caring for the patient. As more fellows are being trained, then a pseudo-derivation of the Monroe doctrine would argue that the number of generalists being trained must be decreasing. Hospitals in rural communities and outlying communities surrounding large cities, small cities, and indigent areas rely heavily on surgical generalist providers. Even if specialists practice in these settings, the generalist may be forced to provide at least temporizing care until the specialist arrives. From a geographical perspective, this country is reliant on these providers and would be confronted with an unyielding dilemma if every broken arm could only be treated by a fellowship-trained, long-bone specialist orthopaedic surgeon.

**Changing curriculums**

If the consensus agrees to support continued specialization and increased attrition away from generalist surgical training, then what is the role of the current five-year training model? The idea of a skills-based curriculum in surgical training versus the “everyone does five years” approach has become more than suggestion in recent years. Current investigations into this novel concept are under way within residency regulatory bodies. The argument has been made to truncate residency to allow for individuals to seek their surgical niche. Northwestern University in Chicago, IL, has developed a pilot program within its general urology residency to allow residents to pursue mini-fellowships during their fifth year. This new approach equates to allowing the chief residents to focus their surgical case exposure to a specific field. If, for example, one chooses a focus on infertility urologic procedures, he or she may be excused from the oncologic requirements set forth in the traditional general urology training program. Although this system causes an obvious lack of uniformity among graduates and deficiencies in certain procedural areas, it is rationalized that the graduates will not include the less focused scope of care into their practice.

**Influence of health care**

The state of health care reform plays an enormous role in the state of favor toward surgical generalists. Remuneration has continually decreased over the last decade, and the end does
not appear to be in sight. Reflective changes in the surgical world have forced some surgeons to adapt to these reimbursement changes in the care they provide. By partially focusing on particular procedures and operations for which they can bill and be reimbursed, some generalist surgeons have begun limiting their scope of practice in an effort to remain in an economically viable business. In essence, some surgical generalists have become pseudospecialists as they try to stay afloat financially.

Rather than being “good” at a wide variety of things, surgeons must be “great” if they intend to be paid for their services. Thus, most would agree it is easier to master a few skills rather than a lot, or, in other words, narrow scope of care and specialize within a field. As mentioned previously, the surgical specialist opportunity has historically offered surgeons a more lucrative lifestyle, which is yet another motivating factor for fellowship training. Competence across a wide variety of surgical tasks is not as challenging for the master surgeon. The value of these individuals becomes increasingly salient with their increasing scarcity.

It is within reason to imagine third-party payors reimbursing surgeons partly based on their level of training. Likely this would be established as a benchmark tool of quality of care delivered. Hence reimbursement rates might differ if a colon resection is performed by a colorectal trained surgeon versus a general surgeon.

The role of the College

It remains crucial that this debate exists at the forefront of topics being considered by the American College of Surgeons. The role of the ACS is to ultimately ensure that patient safety is never compromised. It is also the charge of our surgical societies to provide oversight and assistance in addressing each of the components of this issue. It may be argued that indeed the surgical generalist is falling out of favor, and this change in health care may prove to be rather significant for the population. Our responsibility as surgeons in this climate is to be cognizant of the morphing paradigm around us and evaluate our role and potential future as changes occur.

To this end, the Resident and Associate Society of the ACS will be providing a venue to further explore the role and relevance of the surgical generalist at the ACS Clinical Congress in October in Chicago, IL. The RAS Symposium—scheduled for Sunday, October 11—will address the question of obsolescence as it relates to the surgical generalist using a debate format. The audience will have an opportunity to participate in the debate during a frank and open question-and-answer period. This session is a rare opportunity for surgeons and other attendees to weigh in on this important issue. Make plans now to join RAS at this year’s Clinical Congress.
One of the most important tools in a surgeon’s “advocacy toolbox” is the relationships he or she creates—with elected officials or agency staff, peers and other physician advocates, or other not-for-profit organizations. It is important to have these relationships in place before you need to lobby an issue, as it is much easier to work with someone who is familiar with your organization rather than having to explain who you are, what you do, and why they should listen to you.

American College of Surgeons

One of the most important relationships for any surgeon advocate should be with the College’s Division of Advocacy and Health Policy. The State Affairs team is available to help with various aspects of state grassroots advocacy, and the Legislative Affairs team provides the same assistance for issues in Congress.

Other associations

Working with other state and national specialty societies and local state health organizations is a good way to combine strengths and reach more people. Attending their events and inviting their members to your events helps to create solid working relationships. These organizations are more likely to be allies on surgical issues and it will pay off in the long run if these relationships are established early.

Doctor for a Day

An effective way of starting relationships with a state legislature is through the Doctor for a Day program: each day the legislature is in session, a member agrees to be the doctor for the legislature and staff of the Capitol. Many times, they are introduced on the chamber floor by a legislator and have an opportunity to observe the legislative process from the inside out.

Many chapters or state medical associations already have this program in place and are looking for volunteers. Certainly, if your state doesn’t have this type of program, it would be an opportunity for the chapter to sponsor one. Some states divide up the months, with each specialty society providing volunteers for their designated months.

Lobby days or a day at the state capital

State lobby days may add some excitement to an annual meeting and provide an opportunity to advocate on behalf of surgical issues. Even if there are no specific issues to lobby for, it is recommended to have some kind of set event to continue building those important relationships. As a state senator from Illinois once said, “It’s nice to see someone who’s not asking for anything.”

Health fairs

Many elected officials host various informational “fairs” in their communities. “Senior Health” and “Back to School” fairs are especially popular. Legislators are always looking for participants, and chapters or local surgical groups offering to host a table create considerable good will with a short commitment of only a couple of volunteers. Local chambers of commerce or towns/cities have similar fairs or events, and it’s likely your state senator or representative will also have a table there.

In addition, state legislatures may host their own health fairs for elected officials and their staff. These gatherings are usually held in the Capitol building itself and participants offer free screening and informational tables. While you may not be talking about legislative issues at these fairs, you will be putting a face to your organization, and that is an important first step in being a successful advocate.
Surgeons rally together in a politically charged year

by Diane S. Schneidman, Manager of Special Projects, Division of Integrated Communications

A total of 429 surgeons representing a range of specialties and dozens of advocates for the profession participated in the Second Annual Joint Surgical Advocacy Conference (JSAC) March 22-24 in Washington, DC. The American College of Surgeons (ACS) and the 18 other surgical specialty societies listed on page 44 sponsored this event.

Conference highlights included sessions focused on advocacy training, the legislative process, the quality improvement agenda, and health care reform, as well as a lively keynote address. In addition, several Members of Congress, as well as congressional staff and representatives from the private sector, shared their perspectives on health care issues, and JSAC attendees had the opportunity to participate in Capitol Hill visits with their legislators.

Grassroots advocacy
Kicking off the JSAC was Michael E. Dunn, who runs his own political consulting firm in Washington, DC. “Each one of you has to accept personal responsibility for how your lawmaker votes on issues that affect surgery,” Mr. Dunn said, noting that the paradigm for achieving political power has shifted over the years. He explained that the influence that paid lobbyists can wield has been limited in recent years due to the ban on “soft dollar” campaign contributions. Consequently, grassroots advocacy has become more important than ever.

According to Mr. Dunn, surgeons can be “either players or victims,” in the new political reality. Being a player at the grassroots level involves voting and building a relationship with one’s elected official. “The question isn’t how well you know your lawmaker; it’s how well does the lawmaker know you?” he said.

In addition, Mr. Dunn said that surgeons who want to influence the political process should get involved in and contribute to their organization’s political action committee (PAC). “Grassroots plus political action is a winning formula in this political environment,” he noted. PACs are useful to surgical organizations in a number of ways. They allow groups to cultivate close ties with legislators, provide access to lawmakers, help policymakers to better understand the profession, and add credibility, Mr. Dunn added.

How Congress works
Perennial favorite Judy Schneider, a specialist on Congress at the Congressional Research Service, provided insights on how the legislative branch of the federal government really works.

“You were all taught that Congress was created to pass the laws of the land,” Ms. Schneider said. “[But actually] Congress was not created to pass laws but to stop bad laws from getting enacted,” she explained. The theory is that if a bill can survive the legislative process, it deserves to be implemented.

Over the course of a two-year Congress, approximately 10,000 bills are introduced, but only 400 or so become law, Ms. Schneider observed. The reason that Congress passes such a small percentage of introduced legislation is because the institution is driven by three factors: policy, politics, and procedures. “If any one of those is out of whack, your legislation is dead,” Ms. Schneider said.

Nonetheless, the relevance of each of those three factors depends upon the chamber in which the legislation is being debated. The Senate is driven largely by internal politics, while the House is driven by procedures, according to Ms. Schneider.

Policy, ultimately, is driven by constituents. “The role of the Congress is to slow everything down for a very simple reason—they’re waiting to hear from all of you,” Ms. Schneider said.
Therefore, surgeon advocates are extremely important in ensuring that appropriate and necessary policies are enacted. “If you don’t tell them what to do, somebody else will tell them what to do,” Ms. Schneider warned.

**Message development**

Surgeons who want to see effective policies enacted need to broadcast their message not only on Capitol Hill, but through the media as well. Leading a session on communicating with the public sector through the media was Patricia A. Clark, a consultant to the American Medical Association, the American Hospital Association, the Texas Medical Association, and other organizations.

Ms. Clark noted that some surgeons feel they are too busy to talk to the media. She warned these individuals that, “There’s going to be a story done whether you talk the reporter or not.” Therefore, it is in the profession’s best interests to be available and to voice the surgeon’s perspective. When reporters call to arrange an interview, surgeon advocates should get back to them right away and know what to say ahead of time. “A question is not something to be answered. A question is an opportunity to share your message,” Ms. Clark said.

Surgeons need to be available not only to the national media, but to their local newspapers and electronic media outlets as well. Members of Congress and their staffs read not only *The Washington Post, The New York Times*, and *The Wall Street Journal*, but also their hometown papers, Ms Clark explained.

When preparing to talk to reporters, surgeons need to think about what the media wants to use, what the media actually will use, and what they will want to use, Ms. Clark said. The standard TV news story runs for 90 to 110 seconds, and sources get about 10 to 20 seconds of airtime. In newspapers, an interviewee might get only about an inch or so of column space. So it is important that a source bring at least one of three attention-grabbing qualities to the table: interesting sound bites, appealing visuals, and/or controversy, Ms. Clark said.

**Keynote address**

Paul Begala, political analyst and commentator for CNN and advisor to former President Bill Clinton, provided insights into the current presidency. He noted that President Barack Obama has been popular with the general public, with an approval rating of 64 percent. Like two other well-liked presidents—Mr. Clinton and Ronald Reagan—President Obama has been able to use his personal appeal and speaking skills to ensure that the policies he supports are implemented. Mr. Begala noted that within the first 23 days of his presidency he signed legislation expanding the State Children’s Health Insurance Program, issued an executive order calling for the closure of the Guantanamo Bay detention camp, released a budget plan, and approved the American Recovery and Reinvestment Act (ARRA).

Mr. Begala called passage of the ARRA “an extraordinary accomplishment,” noting that “it

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**JSAC participating societies**

- American Academy of Facial Plastic and Reconstructive Surgery
- American Academy of Ophthalmology
- American Academy of Otolaryngology-Head and Neck Surgery
- American Association of Neurological Surgeons
- American Association of Orthopaedic Surgeons
- American College of Obstetricians and Gynecologists
- American College of Osteopathic Surgeons
- American College of Surgeons
- American Osteopathic Academy of Orthopedics
- American Society of Breast Surgeons
- American Society of Cataract and Refractive Surgery
- American Society of Colon and Rectal Surgeons
- American Society of Plastic Surgeons
- American Urological Association
- Congress of Neurological Surgeons
- Society of Gastrointestinal and Endoscopic Surgeons
- Society of Gynecological Oncologists
- Society of Thoracic Surgeons
- Society for Vascular Surgery
is the single biggest one-shot expenditure of public money since the Louisiana Purchase. Usually big spending bills are heavily debated and revised before they receive congressional approval.

Mr. Begala said he believes that President Obama is sincere in his desire to achieve health system reform for both personal and political reasons. On the personal side, Mr. Obama has written about his mother’s battle with terminal cancer and how “even on her deathbed, she was fighting with the insurance companies,” he noted. In terms of political reasons, White House budget director Peter Orszag has claimed that if the nation doesn’t fix health care, the economy will continue its tailspin.

The Administration’s goal is to reduce health care spending by eliminating Medicare Advantage, withholding reimbursement for readmission of patients with hospital-acquired conditions, and expanding health information technology, Mr. Begala said.

In terms of physicians’ concerns about Medicare payment cuts, Mr. Begala said the President is committed to eliminating the constant threat of reductions by setting a baseline for reimbursement. “I’m impressed that this President has said, ‘No. I’m not going to cut 21 percent of your income next year and 5 percent in subsequent years,’” Mr. Begala said. “The problem is you have to get Congress to go along with that, but you do have the President on your side.”

Mr. Begala is familiar with how important it is for a president who wants to achieve health care reform to work with Congress. He explained that one of the reasons health care reform did not occur during the Clinton presidency is because the President told Congress that if it did not send him a bill that contained 100 percent of the items in the package that his Administration developed, “I will take this pen, veto that bill, and we will start all over again.” Mr. Begala said. “Maybe if we had said it was okay to just get 90 percent of those provisions passed, we would have health care reform today.”

President Obama is unlikely to repeat this episode because he has “a gift” for learning not only from his experiences but also from his predecessors’ missteps and for synthesizing that information into action, Mr. Begala said. “Now, he’ll make mistakes, but they will be new and original mistakes,” he quipped.

Quality improvement

Carolyn M. Clancy, MD, director of the Agency for Healthcare Research and Quality, spoke about the Obama Administration’s views on and approaches to quality improvement. She noted that the health care provisions in the ARRA spell out the steps this administration believes will be useful in improving quality of care.

One significant provision in the stimulus package calls for establishing a Federal Coordinating Council for Comparative Effectiveness Research (CER). The legislation allocates a total of $1.1 billion for CER, of which $400 million is to be used at the discretion of the U.S. Secretary of the Department of Health and Human Services (HHS) to speed the development and dissemination of CER, Dr. Clancy said. As defined in the ARRA, CER includes: (1) comparative analysis of items, services, and procedures used to prevent, diagnose, and treat patients; and (2) the work conducted through clinical registries, clinical data networks, and other electronic means for purposes of generating outcomes data.

The Institute of Medicine has been charged with studying the issues surrounding CER and to disseminate a report on the topic by June 30, a very rapid turnaround time for an institute known for extensive analysis and deliberation, she added.

People who oppose CER argue that it is a tool to deny patients access to certain treatments, Dr. Clancy said. They also claim that this research might fail to account for the concerns of racial or ethnic minorities or that the information will be used to deny care to segments of the population, she explained. To alleviate their fears, AHRQ is encouraging all groups to play a collaborative role, to submit their data, to review draft reports, and so on. “If this information is going to be useful to people, it’s got to be trusted and it’s got to be credible,” she said.

In addition, Dr. Clancy noted that some members of the medical and surgical communities have misconceptions about evidence-based medicine and JUNE 2009 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
Representative Berkley.

CER. “Evidence-based medicine is never, ever intended to exclude clinical judgment,” Dr. Clancy said. “This is not about limiting health services. It is about getting clinicians the best possible information so that they can make good decisions,” she explained.

**Members of Congress**

Five Members of Congress offered their views on health care reform, Medicare reimbursement, and other issues.

Rep. Roy Blunt (R-MO) said that Congress may pass health care reform legislation this year, if there is a big enough “buy-in” from everyone involved. “There is broad agreement on the general principles [that health care reform should address]—access, affordability, quality,” he observed. However, lawmakers disagree about the means for achieving these objectives.

For instance, President Obama has suggested that a health care reform bill should include an option for Americans to purchase government-run health insurance. The Congressman said he opposes this idea “because the government does not compete fairly and the government’s not very good at running stuff.”

Representative Blunt said he would support a system that would allow patients and employers to stay with their current insurance providers, if they are happy with the coverage they have. Other key health care reforms that he would be likely to back include assurances that patients will be able to continue their relationship with their physician and guarantees that the employer-based insurance coverage option remains in place.

According to Representative Blunt, most Americans would object to health care reforms that would tamper with the way they currently receive care. “Most everybody says the current health care system is not working, but about 82 percent say it’s working for them,” he said, adding that it’s very hard to change a system that most people are satisfied with.

Rep. Shelley Berkley (D-NV), a member of the House Ways and Means Subcommittee on Health, said one of the major strains on the health care system is the cost of providing care to 47 million uninsured Americans. “It is not as if they do not get health care, but they get the most expensive kind of health care. They get health care after they are terribly sick, and they end up in our emergency rooms where the cost of medicine is over the roof,” Representative Berkley said. “If we don’t figure out how to get a handle on the uninsured in this country and give them at least a baseline of care, our entire health care system is going to fall apart,” she added.

With regard to Medicare physician reimbursement, Representative Berkley, who has been married to a nephrologist for 12 years, assured surgeons that Congress will prevent the potential 21.5 percent cut in Medicare reimbursement for 2010 from taking effect. “I can tell you without fear of contradiction that that cannot happen and that will not happen,” Representative Berkley stated.

In addition, the congresswoman noted that at the time of the JSAC, she and Rep. Mark Kirk (R-IL) were circulating a letter on Capitol Hill that calls upon Congress to ensure that any Medicare reform legislation that passes does not increase payments to primary care by
decreasing reimbursement to specialists. “It makes no sense that we’re going to rob Peter to pay Paul, and I’ll put up the best fight I can to make sure that doesn’t happen,” Representative Berkley said.

Representative Berkley also called for shifting some of the money spent on end-of-life care to prevention and early detection. “If we do that, not only will we be saving billions of taxpayer dollars, but we will be improving the lives and quality of life of many, many people in this country as well,” she said.

Sen. Ben Cardin (D-MD) noted, “Congress has a strange way of thanking the physicians in our country for providing the best health care in the world.” He added that he agrees with Representative Berkley that the government needs to change the way physicians are reimbursed for providing Medicare services. “It’s time that we fixed this system, and we need your help getting it done right. If we don’t, more and more Americans are going to be denied access to health care because the reimbursement rates will not be adequate.”

The senator also is an advocate for health care reform because the current system is draining the economy. “Let me give you a dose of reality. We have a huge problem in this nation. Our economy is in the tank. We are swimming in red ink,” Senator Cardin said.

Health care reforms that the senator believes should be enacted include ensuring that all Americans have health insurance and that they have access to comprehensive, preventive care. Senator Cardin also said that the nation needs to make better use of health information technology. “[The current methods of medical recordkeeping] are robbing our nation of billions and billions of dollars and depriving you of the information you need,” he said.

Sen. Tom Carper (D-DE), who serves on the Senate Finance Committee, said the rising costs associated with the Medicare, Medicaid, and Social Security programs are unsustainable. Like the other lawmakers who spoke at the meeting, Senator Carper believes that Congress should pass health care legislation that will allow the nation to reduce spending, improve outcomes and quality, ensure access to care, and provide incentives for health care research.

To ensure that Congress passes health care legislation this year, Senator Carper said, “What we need to do is focus on the stuff we agree on.” He also noted that members of Congress “are not brain surgeons, and we need your help.”

Rep. John Shadegg (R-AZ) said the current health care system is adrift because it has placed third-party payors between the physician and the patient. “I would suggest to you that the answer [to this prob-
"I would suggest to you that we fight for health care reform in this country that puts patients and doctors back in charge of making educated decisions," Representative Shadegg said. He added that rather than continuing a system in which employers shoulder the burden of providing health insurance benefits, patients should be able to choose their own plans, and if they can’t afford to buy one, they should receive stipends to cover the costs.

The congressman also said that the Medicare physician reimbursement system is flawed and must be repaired.

Public and private sector perspectives

Two congressional health policy advisors and two representatives from the private sector also shared their perspectives on health care reform.

Cheryl L. Jaeger, MPP, is senior policy advisor to Rep. Eric Cantor (R-VA), House Republican Whip and a member of the House Republican task force that is crafting a health care reform plan. Ms. Jaeger noted that the GOP members of Congress are fighting to play a leadership role in the health care debate at a time when both Congress and the White House are under Democratic control.

In contrast, Meghan Taira, MPH, advisor to Sen. Charles Schumer (D-NY), said, “[Democrats] have not yet figured out what our real obstacles are going to be, who our real partners and friends are going to be, and we don’t know how far we’re going to get.” Ms. Taira said it is helpful for surgeons to meet with their elected officials as Congress tries to develop health care reform legislation because lawmakers need to know how specific policies will affect clinical practice, patient care, and the “big picture.”

Maria Ghazal, JD, MPP, director of public policy for the Business Roundtable, which is composed of 150 chief executive officers from a variety of companies, said that from the health plan purchaser’s perspective, “A lot of this is really about costs—the cost pressures [associated with providing employer-based health care coverage],” Ms. Ghazal said. According to Ms. Ghazal, issues of primary importance to the business community are compliance with Employee Retirement and Investment Security Act rules, the potential of more employer mandates, and tax credits for businesses that offer health insurance coverage to employees.

Members of the Business Roundtable are committed to being engaged in the health care reform process and to working with the medical community. “They know that in Washington it’s a matter of ‘together we stand, divided we fall,’” Ms. Ghazal said.

Scott Keefer, JD, MPP, vice-president of policy development for the Center for Policy and Research at America’s Health Insurance Plans (AHIP), offered the payor’s perspective. “The public wants portability. They want us to build on the employer-based system, and they want guaranteed issue,” Mr. Keefer said. Balancing these expectations with demands for cost controls is most achievable if an individual mandate, requiring all Americans to have health care coverage, is instituted, according to Mr. Keefer.

In addition, Mr. Keefer said that all stakeholders need to join together in the spirit of collaboration. “That ultimately will determine the success or failure of health reform,” he added.

Capitol Hill visits

The program ended with Christian Shalgian, Director of the ACS Division of Advocacy and Health Policy, and legislative staff from the specialty societies providing briefings on issues for discussion with lawmakers and their health policy aides. The main issue that all surgeons were urged to raise during their Capitol Hill visits was that of Medicare payment reform. More specifically, the ACS and the surgical specialty societies have three top priorities for this effort: (1) repealing the sustainable growth rate (SGR) and establishing a new baseline for the physician payment system; (2) replacing the current SGR with a system of multiple conversion factors; and (3) ensuring that any additional payments that are made to primary care physicians are not made at the expense of specialty physicians, including surgeons.

Other topics that surgeons had the option of discussing during their Capitol Hill visits and on which they were given briefing materials are as follows: enhancing quality
improvement initiatives, stabilizing the surgical workforce and preserving quality resident training, alleviating the medical liability crisis, improving trauma and emergency care, and investing in health care research. Through the JSAC, surgeons visited a total of 272 legislators’ Capitol Hill offices.

**Operation Patient Access**

Lastly, JSAC participants had the opportunity to witness the launch of Operation Patient Access: Quality Surgical Care for All. This public affairs campaign is designed to draw attention to surgical workforce shortages. For more information about Operation Patient Access, go to [http://www.operationpatientaccess.facs.org/](http://www.operationpatientaccess.facs.org/).

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**A look at The Joint Commission**

## WHO Surgical Safety Checklist in comparison with Universal Protocol

The Joint Commission would like to clarify its expectations of compliance with the Universal Protocol both in comparison with the World Health Organization (WHO) Surgical Safety Checklist and with recent modifications to the Universal Protocol.

Recently, the WHO released its Surgical Safety Checklist. There have been questions regarding whether this checklist can fulfill the requirements of The Joint Commission’s Universal Protocol. The requirements of the Universal Protocol and the WHO checklist do not conflict. However, they were created for different purposes, so there is not a one-to-one comparison between the two documents. Some of the differences include the following:

- The Universal Protocol aims to prevent wrong site, wrong procedure, and wrong person surgeries, and it focuses on those issues in great detail.
- The WHO Surgical Safety Checklist aims to promote safe surgery, and it addresses other aspects of surgery.
- Both the Universal Protocol and the WHO checklist cover preprocedure verification, site marking, and a time-out before the procedure. However, the WHO checklist includes unique issues such as postprocedure sign-out while the Universal Protocol contains more details about the performance of the time-out.

While not in conflict, compliance with the WHO Surgical Safety Checklist does not ensure compliance with the Universal Protocol. Accredited health care organizations are still required to meet all elements of performance of the Universal Protocol.

The Joint Commission has also received comments from accredited organizations about the practical implications of complying with recent modifications to the Universal Protocol. In response to these concerns, The Joint Commission has been reviewing the Universal Protocol to determine if refinements are needed. During the first quarter of 2009, The Joint Commission sought input from professional organizations, health care providers, and accredited organizations. Based on this input, The Joint Commission is modifying the Universal Protocol. The revised Universal Protocol was sent to the field for review in May.

Until modifications are approved and implemented, Joint Commission–accredited hospitals and ambulatory care facilities, as well as organizations in the disease-specific care certification program, are still expected to comply with the requirements of the Universal Protocol. Please direct any questions to the Standards Interpretation Group at 630/792-5900 or via the online form at [http://www.jointcommission.org/Standards/OnlineQuestionForm](http://www.jointcommission.org/Standards/OnlineQuestionForm).
Leadership conference focuses on quality, ethics, and future of surgery

by Diane S. Schneidman, Manager of Special Projects, Division of Integrated Communications

The American College of Surgeons presented the 2009 Leadership Conference for Young Surgeons and Chapter Leaders in conjunction with the Joint Surgical Advocacy Conference on March 22 in Washington, DC. The meeting comprised three shared sessions for young surgeons and chapter leaders as well as a block of breakout sessions.

Leadership for quality improvement

Opening the conference was a joint plenary session featuring Michael Glenn, MD, FACS, who was instrumental in developing and leading a quality improvement initiative at Virginia Mason Medical Center in Seattle, WA. He said the medical center got its “wake-up” call that it was time to take action when a postoperative patient was injected with a drug rather than saline solution and died. At least three similar adverse events had occurred previously in the state, “but no one ever really talked about it,” Dr. Glenn said. After that incident, Virginia Mason set one goal for 2004, which was to promote patient safety.

To effect and manage organizational change, Dr. Glenn said that leaders need to create a sense of urgency, build a guiding team, establish a clear vision, communicate effectively so that the other people in the organization will “buy into” the change, and empower action. He also said that leaders should relentlessly promote the institution’s mission and the means of achieving it. They also must implement strategies to ensure that positive changes “stick.”

At Virginia Mason, the leadership created a mandate for change and implemented a joint accountability model with the goal of becoming the “quality leader” in the region, Dr. Glenn said. To achieve this objective, the institution’s culture had to change. Previously, the physicians and staff at Virginia Mason put the provider first, viewed waiting as inevitable, and expected errors to occur. The hospital also had a diffuse accountability structure and added resources regularly. The cultural mores now in place at the institution stress that the patient comes first, waiting is waste, and the goal is defect-free care, Dr. Glenn said. Virginia Mason also has adopted policies calling for rigorous accountability and a cap on new resources.

In addition, the medical center adopted the Lean systems-based model for quality improvement, which Toyota used in post-World War II Japan to become a bestselling, highly trusted automaker. Under this system, an organization must identify value. Lean emphasizes the need to be responsive to the needs of the provider and other stakeholders—the patient, the payor, employers, and so on. “It’s really about having a better outcome for everyone,” Dr. Glenn said.

Ethics of leadership

LaSalle D. Leffall, Jr., MD, FACS, Charles R. Drew Professor of Surgery at Howard University College of Medicine, Washington, DC, emphasized the importance of ethical principles in leadership during a breakout session for young surgeon attendees.

Dr. Leffall said leaders define an organization’s mission, objectives, and priorities. He said an ethical leader must “always be willing to compromise on goals, but never compromise on principles.” An ethical leader also should be fair and be willing to cut his or her losses, but “demand the best of everyone.”

Effective leaders anticipate disappointments and are willing to listen, even to perspectives with which they may disagree, Dr. Leffall noted. He also emphasized a concept he learned from Charles R. Drew, MD, who said, “Excellence of performance will transcend artificial obstacles made by man.”

Leaders should be able to
maintain a level of “equanimity under duress” and “respect the dignity of the other person,” Dr. Leffall said. A key part of showing consideration for patients is telling them the truth about their medical condition and their treatment options. “Sometimes the truth hurts, but overall, when you really look at it [being honest] is the proper thing to do,” he added.

“The physician invites trust,” Dr. Leffall explained. Patients are vulnerable and sometimes frightened when they must consult with a surgeon. It is the surgeon’s job to demonstrate responsibility, capability, and a focus on the primacy of patient care.

Ethical surgeons also show restraint in using treatments that may not be of real benefit to the patient. “Provide access to therapies that will realistically improve the patient’s health and condition,” and be forthcoming with information about why certain treatments will provide little or no advantage, Dr. Leffall said.

The bottom line is “everything we do has to be based on what we can do for the patient,” Dr. Leffall added. “Isn’t that what life really is all about—seeing someone in need and giving aid? And when you do that, you have the satisfaction of knowing that you have done one of the best things that can be done.”

Outlook

Jon Chilingerian, PhD, associate professor of human services management at Brandeis University’s Heller School for Social Policy and Management, Waltham, MA, discussed the hot issues in and outlook for surgical practice.

Trends he discussed included workforce shortages, payment issues, and the movement away from solo practice and toward large-group or hospital-based practice. Because these are uncertain times, the surgical profession “has a need for leadership and a need for a strategic vision,” Dr. Chilingerian said.

In the past, physicians have tended to worry about the wrong issues. For example, during the Medicare and Medicaid debates of the 1950s and 1960s, physicians argued that Medicare would result in the loss of physician autonomy and reduced income, “when in reality, by the 1970s, it made millionaires out of a lot of them,” he said. As it turns out, the real problem with Medicare was that it put unsustainable strains on the federal budget. “Now the ostensible problem is pay for performance,” but that may not prove to have been the real issue 10 years from now, Dr. Chilingerian said.

According to Dr. Chilingerian, young surgeons who are trying to decide where and how they will set up their practices need to analyze the plusses and minuses of each situation before defining their objectives and pinpointing their alternatives. More specifically, he suggested that young surgeons who are considering institution-based practice bear in mind that “hospitals are the most complex organizations on earth.” He also recommended reviewing the financial statements of hospitals before making any commitments.

Before choosing a practice location, “identify your competitors—whether there are specialists or superspecialists in the area,” Dr. Chilingerian added. To remain competitive, any business must offer services either at a lower cost or provide extraordinary performance. “When you succeed, someone is going to come after you. So you’ve got to continually rethink your strategy and what you’re doing to differentiate yourself,” he noted.

As quality improvement demands increase, surgeons will want to make sure that their hospitals are involved in programs, such as the ACS National Surgical Quality Improvement Program, that measure outcomes throughout the institution and compare them to other facilities, Dr. Chilingerian said. When considering joining a practice, think about whether it’s a good cultural fit and “put financial considerations aside. Ask questions about the group and quality measures,” he advised.

Organized surgery

L.D. Britt, MD, FACS, Chair of the ACS Board of Regents, spoke about leadership and the role of organized surgery in an era in which “clinical practice is being overwhelmed.” Challenges surgeons are facing relate to workforce shortages, growing demands for the use of health information technology, cost controls, Medicare reimbursement, health care reform, and disparities in care.
"I think the College can take a stand, as one of the members of the ‘House of Surgery,’ to try and address many of the challenges that threaten the profession,” Dr. Britt said.

He noted that the College has been aggressive in its efforts to address surgical workforce issues, ensuring that the media informs the public about the shortages in general surgery. Furthermore, the analysts at the ACS Health Policy and Research Institute are conducting substantive research into this issue. Dr. Britt said that rural populations are feeling the most severe effects of the general surgeon shortage, noting that 80 percent of general surgeons live in or near metropolitan areas with populations of more than 50,000.

Dr. Britt also emphasized the need for surgeons to adopt electronic medical recordkeeping systems and for the College to assist in this endeavor. Electronic medical records (EMRs) are going to be an important component of quality measurement, yet only 17 percent of all physicians have installed and implemented EMR systems. Part of the problem is that adoption of the technology is cost-prohibitive for small practices, he explained. The ACS needs to think about what the organization can do to help physicians transition to EMR. “If this is not done correctly, I think it’s going to spell the death of [clinical] practice,” Dr. Britt said.

In addition, Dr. Britt spoke about the need to control costs, noting that the U.S. spent $2.4 trillion on health care last year. He attributed the high costs to waste, administrative burdens, the provision of inappropriate services, and other factors.

With respect to Medicare reimbursement, Dr. Britt said, “We cannot continue to take cuts.” To deflect the scheduled 21.5 percent payment reduction in 2010 and to prevent further cuts in the future, Dr. Britt noted that the College is asking Congress to repeal the use of the sustainable growth rate (SGR) in calculating reimbursement. The ACS also is recommending that Congress replace the existing formula with a system that would establish separate physician category targets or multiple conversion factors.

As for health care reform, “I believe it will happen,” Dr. Britt said, pointing to President Barack Obama’s commitment to overhauling the health care delivery system. He noted that the College has disseminated the ACS Statement on Health Care Reform to members of Congress and other stakeholders. The ACS also has been working with other physician groups to develop a unified message on health care reform.

Furthermore, Dr. Britt said, the geographic and ethnic disparities in health care represent “the civil rights issue of this century. [Americans] should never tolerate disparities in education, security, or health care.” All patients should have equal access to innovations in medicine. “What good is a scientific discovery if we can’t translate it to everyone?” he asked.

Sessions for chapter leaders
Concurrent to the sessions described previously, which were intended for the young surgeon representative participants, were programs designed for chapter leaders. This portion of the program included the following sessions and speakers:

- CME As a Bridge to Quality, presented by Murray Kopelow, MD, MS, FRCPC, chief executive of the Accreditation Council for Continuing Medical Education (ACCME)
- State Legislative Update, presented by Mindy Baker, State Affairs Associate, ACS Division of Advocacy and Health Policy
- Strategic Planning the Tennessee Way, presented by Gayle Minard, MD, FACS, President of the Tennessee Chapter of the ACS

The disruptive surgeon
During a joint plenary session for young surgeons and chapter leaders, T. Forcht Dagi, MD, FACS, Vice-Chair of the ACS Committee on Perioperative Care, spoke about disruptive behavior. Dr. Dagi explained how surgeons can take a leadership role in preventing and addressing this hindrance to providing quality care.

“This is a real problem,” Dr. Dagi said. “It’s our problem, and we have to deal with it.”

In the profession’s effort to address disruptive behavior, The Joint Commission issued a sentinel event alert on July 9, 2008, which is intended to stop hostile behaviors that undermine patient safety. The new Joint Commission stan-
standard of behavior took effect January 1, when all health care organizations were called upon to create a code of ethics, Dr. Dagi said. The commission’s document also outlines methods of managing unacceptable conduct, including condescending language, verbal outbursts, threats, and physical intimidation.

The Joint Commission’s directive is just the most recent example of the profession’s efforts to control surgeons and other physicians who exhibit unprofessional behavior, Dr. Dagi noted. Another example is the ACS Statements on Principles, which indicate that Fellows should demonstrate effective communication skills, professionalism, and an awareness of the surgeon’s role in the larger context of patient care. The College’s statement also addresses discrimination and harassment in the workplace.

Although the ACS and other physician groups have set standards of conduct, the surgical profession traditionally has tolerated the “l’enfant terrible MD”—the surgeon who is disruptive but somehow is excused from typical standards of behavior because of his or her technical and cognitive talent, Dr. Dagi said.

Many surgeons aren’t aware of how their behavior affects the other members of the operative team and patient care. “People will tell you that very rarely do they intend to be objectionable. They will tell you that they just want to get things done,” Dr. Dagi said. Surgeons need to be reminded that “language and behavior are very powerful tools.”

Dr. Dagi asserted that surgeons must be involved in addressing disruptive conduct and must discuss problems as they arise. “These concerns are not going to dissipate. They’re only going to get worse [left unchecked],” he said.

Open forum

The conference concluded with an open forum in which the meeting participants were able to voice their concerns and to ask questions of Dr. Britt and Thomas R. Russell, MD, FACS, ACS Executive Director. Issues discussed included health care reform, reimbursement, and EMRs.

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**Call issued for Early Career Women Faculty Mentorship Program**

The American College of Surgeons and the Association of Women Surgeons are seeking applications from women surgeons who wish to be considered for the Early Career Women Faculty Mentorship Program. This opportunity to develop a mentoring relationship is open to early career assistant professors who are in academic practice in general surgery or a general surgery subspecialty.

Applicants will be required to attend the 2009 ACS annual Clinical Congress; therefore, only women surgeons who are planning to attend the annual Clinical Congress in Chicago, IL, this October should apply this year. Applicants must be Fellows or Associate Fellows of the College, or currently in the process of applying for Fellowship in the ACS.

The application should describe how the mentoring relationship will be of benefit to the applicant in her career. Mentors will then be selected and assigned based on the preferences, career priorities, and goals of the applicant. All mentors will be surgical leaders with a record of excellence in mentorship.

Early career women faculty who are interested in this opportunity should send a one-paragraph description of their current position, career goals, and mentorship program objectives together with a CV to mentor@facs.org.

Applications must be received before July 1.
NEW! ACS MULTIMEDIA ATLAS OF SURGERY Colorectal Volume. This DVD and accompanying book provide an interactive demonstration of 26 colorectal surgery procedures, both laparoscopic and open. Especially designed to address the cognitive element of surgical procedures, each procedure is presented in a step-wise fashion, offering expert commentaries that highlight specific nuances and actions to be taken to prevent errors. Upcoming volumes include Pancreas Surgery and Hernia Surgery.

NEW! PROFESSIONALISM IN SURGERY, 2nd Edition: This DVD presents an additional 12 new vignettes that depict professionalism challenges faced by surgeons in everyday practice, as well as possible courses of action in the context of the core competency of professionalism. The vignettes are ideal for teaching purposes and CME credit is available.

NEW! ACS SURGERY RESIDENT OSCE: This program provides a tool to assess the entry-level knowledge and skills of PGY-1 surgery residents to deliver safe care to surgery patients with critical and life-threatening conditions. It includes a CD-ROM manual with all the materials needed to administer the OSCE, and a DVD that provides a gold standard performance of each clinical scenario. This project was supported by grant number U18 HS12021 from the Agency for Healthcare Research and Quality.

NEW! PATIENT SAFETY 2008 CD. This CD features patient safety sessions from the 2008 Clinical Congress.

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

PRACTICE MANAGEMENT for Residents and Young Surgeons: This series of three CDs covers important topics such as mechanics of setting up or running a private practice, essentials of an academic practice and career pathways, and basics of surgical coding. CME credit is available.

ADDITIONAL CDs, including the Bariatric Surgery Primer and Personal Financial Planning and Management for Residents and Young Surgeons.

DVDs AVAILABLE AT NO CHARGE, including Disclosing Surgical Errors: Vignettes for Discussion, and Communicating with Patients About Surgical Errors and Adverse Outcomes, each supported by a grant of the Agency for Healthcare Research and Quality.

VIDEO-BASED EDUCATION SESSIONS: Select video sessions from the Clinical Congress are available on CD/DVD. The ACS Video Library contains narrated videos, donated by the authors.

For more information, contact Olivier Petinaux, MS, at elearning@facs.org, or 866/475-4696.
College nominates Dr. Reiling to AMA Council on Medical Education

Continuing its commitment to active and strategic interaction with the American Medical Association (AMA) through councils, committees, and the House of Delegates (HOD), the College has nominated Richard B. Reiling, MD, FACS, for reelection to the AMA Council on Medical Education.

Dr. Reiling, the College’s Second Vice-President and past recipient of the College’s Distinguished Service Award (2004), has a record of impeccable service to organized medicine and has worked steadfastly within the AMA HOD to bridge gaps and form coalitions to tackle the tough issues. He believes that “Together, We Are Stronger” is more than a slogan; these words define physician relationships within the “House of Medicine” to improve the care of the patient.

“Medical education is caught in the vortex of national and global challenges,” Dr. Reiling said. “Costs continue to rise, while the payment systems for medical education continue to erode. More physicians are needed to care for our growing and aging population, yet the financing of health care delivery at current levels is unsustainable. Our profession has moved into demonstrations of physician quality and safety through the Maintenance of Certification and licensure process, yet the cost-effectiveness of these efforts is unknown.”

Dr. Reiling has served in the AMA HOD since 1994 and has been a passionate advocate for solutions to critical medical education issues in national workforce planning and defined financing of medical education at all levels. He has succeeded, as Chair of the College’s delegation, in reflecting the diversity of surgeons and their practices. He served on the AMA’s Special Advisory Group Extraordinaire (SAGE) and the Committee on Organization of Organizations and is a member of the National Board of Medical Examiners.

Dr. Reiling noted, regarding his service on the Council, “During the past four years, I have joined my colleagues in asking the hard questions about the future of medical education and have worked diligently with them to find realistic answers through the Initiative to Transform Medical Education. It remains my distinct privilege to serve the surgical profession and the AMA HOD, and I approach the future with the optimism of greater possibilities for innovation and relevance across the continuum of student, resident, and continuing medical education.”

Trauma meetings calendar

The following continuing medical education course in trauma is cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

- **Advances in Trauma**, December 11–12, 2009. Kansas City, MO.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at [http://www.facs.org/trauma/eme/traumtgs.html](http://www.facs.org/trauma/eme/traumtgs.html), or contact the Trauma Office at 312/202-5342.
Richard E. Anderson, MD, FACP
Chairman and CEO, The Doctors Company

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ACS Foundation to sponsor breakfast panel at Clinical Congress

by Amilu Stewart, MD, FACS

For the past several years the American College of Surgeons Foundation has sponsored a breakfast meeting at the annual Clinical Congress to bring together for open discussion members of the medical and device industry and various segments of the College involving program directors, ACS Officers and Regents, members of the Committee on Emerging Surgical Technology and Education, the Foundation Board, and members of the Board of Regents’ Committee on Ethics.

The 2009 Medical Industry Breakfast will take place Tuesday, October 13, from 7:00 to 9:00 am, in the McCormick Convention Center, Chicago, IL.

A panel of experts will consider Medical Industry Support for Continuing Medical Education. Scheduled panelists are Maureen Doyle-Scharff, director, Medical Education Group, Pfizer Inc; Andy Cron, vice-president, Cook Medical; Julie A. Freischlag, MD, FACS, ACS Regent and William Stewart Halsted Professor and surgeon-in-chief, The Johns Hopkins Hospital; and Richard B. Reiling, MD, FACS, medical director, Presbyterian Cancer Center, and Vice-Chair of the ACS Foundation.

Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College’s Division of Education, will serve as moderator for the panel discussion. Dr. Sachdeva will also provide follow-up to last year’s panel, which addressed the role of industry representatives in the operating room. The 2008 panelists provided unique perspectives involving the interaction with the health care industry representative (HCIR) and the other medical personnel in the operating room. Issues addressed included obstacles associated with credentialing of the HCIR and the variability presenting from one OR setting to another with the credentialing process. Currently there is action regarding credentialing and verification being undertaken—including discussion by the ACS Committee on Perioperative Care at its spring meeting held last month in Chicago, IL.

Further information about the 2009 Medical Industry Breakfast may be obtained by contacting David Korajczyk, Director of Corporate and Foundation Relations, ACS Foundation, at tel. 312/202-5506 or via e-mail at dkorajczyk@facs.org.

Dr. Stewart is Secretary and member of the ACS Foundation Board, and Chair of the Foundation’s Corporate and Foundation Relations Committee.
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“If you read these issues, passing board examinations would be no problem.”
—Academic surgeon

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The University of Alcohol

by Richard J. Fantus, MD, FACS

Last month was National Trauma Month, with a focus on alcohol awareness and the dangers of underage drinking. In last month’s Bulletin, this public health issue was examined by looking at the NTDB records for the age group of 12-thru 20-year-olds. This month’s analysis focuses in on a subset of underage drinking that includes college-age individuals. Several times each year one is reminded of this unfortunate problem by another news story of a college youth who has died from acute alcohol intoxication.

There has been an outcry by chancellors and presidents of colleges and universities across the country that the current legal drinking age is not working. In spite of education and efforts aimed toward addressing underage college drinking, there persists a “culture of dangerous, clandestine binge-drinking” that has resulted in deaths on college campuses. This reform movement has been termed the Amethyst (derived from the Greek term for “not intoxicated”) Initiative, and supports informed and unimpeded debate on the 21-year-old drinking age (http://www.amethystinitiative.org/). Proponents believe that lowering the drinking age would result in a more responsible use of alcohol.

College bingeing began increasing in the late 1990s, long after the legal drinking age was raised to 21 by the 1984 National Minimum Drinking Age Act (up for reauthorization this year). College bingeing varies by state and even by colleges located within the same cities. Currently, all major public health authorities—including the American Medical Association, Centers for Disease Control and Prevention, and the National Highway Traffic Safety Board—support the current drinking age (http://www.slate.com/id/2198522#Q).

In order to examine the occurrence of college underage alcohol-related trauma in the National Trauma Data Bank Research dataset, 2007 admissions (formerly called research dataset 8.0) records were searched for admission dates between August 15 through May 15 (representing the academic calendar year), age 18 through 20, and by the field “alcohol present in blood.” Among the results, 24,229 records contained an age between 18 and 20 during this date range; 12,556 had a usable response of alcohol present or not detected/not suspected and 3,305 records indicated the patients were positive for alcohol. Of the alcohol-present group, 2,986 records had discharge sta-
tus recorded, including 2,558 discharged to home, and 305 to acute care/rehabilitation; 23 were sent to nursing homes, and 100 died. These patients were 77.9 percent male and on average 19.1 years of age; they had an average length of stay of 5.3 days, an average injury severity score of 10.5, and 21.8 percent penetrating trauma. Among 2,241 of the alcohol present patients who were also tested for drugs, 949, or over 40 percent, tested positive. When compared with the alcohol not detected/not suspected group, an increase in male gender and penetrating injury type were found to be statistically significant (these data are displayed in the graph on page 59).

Alcohol on many college campuses is as ubiquitous as water. In preparing this article, the author consulted with two family members—one of drinking age, one not—who are students at colleges that vary in geographic location, urbanism, campus size, percentage of Greek participation, surrounding community demographics, and are located in two different Midwestern states. These colleges required completion of a Web-based alcohol education module prior to starting college and offer ongoing programs on alcohol use that educate through demonstrations, role-playing, as well as mentor groups. Programs such as these are available on most campuses throughout the country; however, they have not stemmed the tide of underage drinking and bingeing. There remains a variable pattern of consumption across the country. Raising the tax on beer (the most commonly consumed alcoholic beverage on campus) in a manner similar to the cigarette excise tax has reduced consumption (http://www.iconocast.com/00033/L6/News3.htm).

Underage drinking on college campuses is a complex problem with no simple answer. As with many prevention strategies aimed at youths and adolescents, parental involvement is a key component. What education is done in the home can be powerful, long lasting, and can translate to the college environment. Parental guidance will better prepare students for a college education instead of a University of Alcohol experience.

The full NTDB Annual Report Version 8.0 is available on the ACS Web site as a PDF and a PowerPoint presentation at http://www.ntdb.org.

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

Acknowledgment

The author acknowledges the assistance of Richard Jacob Fantus, a premed junior majoring in biochemistry at Washington University in St. Louis, MO, and Robert Joshua Fantus, a premed freshman majoring in biology at DePauw University in Greencastle, IN, for their contributions and insights into the current college environment.

The author also acknowledges the assistance of Sandra Goble, MS, in the preparation of this column.

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

**ACOSOG symposium to focus on changing role of surgical oncologists**

The American College of Surgeons Oncology Group (ACOSOG) will sponsor the continuing medical education program, The Changing Role of Surgical Oncologists, during the 2009 ACOSOG annual symposium, June 18-20, at the Hyatt Bonaventure in Weston, FL.

New imaging technologies, as well as genomic and proteomic methodologies for the treatment of cancer, are significantly changing the role of surgical oncologists who work closely with laboratory scientists, medical oncologists, and radiation oncologists to further develop:

- New laboratory and imaging diagnostics
- Novel therapeutics that target specific cell growth pathways expressed in a primary tumor
• Methods for tissue acquisition
• Neoadjuvant treatments for resectable primary tumors
• Diagnostics that lead to personalized cancer treatment

The program will provide a greater understanding of the surgical oncologist’s changing role in cancer diagnostics and how these new procedures will affect practice. For more information, visit http://dcri.org/research/meetings/acosog.

Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its February 6, 2009, meeting:

• A retired general surgeon from Geneva, IL, was admonished following a finding that he violated the ACS Bylaws and Statement 8, the Statement on the Physician Acting as an Expert Witness, when providing expert witness testimony in a medical malpractice lawsuit.

• William Wilson Hampton, a general surgeon from California, was expelled from the College. Dr. Hampton was convicted of one count of health care fraud, a felony offense, and sentenced to 120 months in federal prison followed by three years of supervised release with terms and conditions. He had been indicted for performing unnecessary surgical procedures and fraudulent billing to insurance companies for those procedures. As a result, his medical license in the State of California was suspended for the duration of his federal trial and has now been revoked, effective April 20, 2009. This action was reported to the NPDB by College staff.

• Bradford C. Roberg, a plastic surgeon from Crystal Lake, IL, had his Fellowship suspended with terms and conditions for reinstatement. This action was taken following the temporary suspension of his license to practice medicine in the State of Illinois. Dr. Roberg self-reported the state action and the reasons for it to the College. He was found to have written prescriptions in the names of multiple family members for controlled substances for his personal use. This action was reported to the NPDB by College staff.

Definition of terms

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

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

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

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

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

When the suspension is lifted, the Fellow or member is returned to full privileges and obligations of Fellowship.

Expulsion: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
To report your chapter’s news, contact Rhonda Peebles at 888/857-7545 or e-mail rpeebles@facs.org.

**Chapter anniversaries**

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**Connecticut committee holds hearing on UEVHPA bill**

In February, the Connecticut Joint Committee on Public Safety and Security held a hearing on pending legislation that would put in place Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) legislation (H.B. 5893). A large, diverse coalition of organizations—including the American College of Surgeons, the Connecticut Chapter, and the Connecticut State Medical Society—support H.B. 5893 (see photo, this page). Testifying on behalf of the ACS was Kimberly Davis, MD, FACS, Chair of the state Committee on Trauma and trauma medical director for Yale–New Haven Hospital (see photo, this page).

For more information, contact Mindy Baker, State Affairs Associate, Division of Advocacy and Health Policy, at mbaker@facs.org.

**Former New Jersey Chapter Executive Director celebrated**

In honor of the retirement of Arthur R. Ellenberger, after more than 50 years of serving as
## Chapter meetings

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

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

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<td><strong>June 2009</strong></td>
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<td>June 13–16</td>
<td>Washington &amp; Oregon (CS)</td>
<td>Location: Campbell’s Resort, Chelan, WA Contact: Lynette Hazard, 503/494-3074, <a href="mailto:hazardl@ohsu.edu">hazardl@ohsu.edu</a></td>
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<tr>
<td>June 26</td>
<td>Italy</td>
<td>Location: Palace Grand Hotel, Varese, Italy Contact: Via B. Verro, 02 89540427, <a href="mailto:artcom@artcomarl.it">artcom@artcomarl.it</a></td>
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<tr>
<td><strong>July 2009</strong></td>
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<td>July 17–19</td>
<td>North Carolina &amp; South Carolina (CS)</td>
<td>Location: Grove Park Inn, Asheville, NC Contact: Carol Russell, 919/467-3818, <a href="mailto:ctrussell@mindspring.com">ctrussell@mindspring.com</a> ACS representatives: LaMar S. McGinnis, Jr., MD, FACS; Jon Sutton; Rhonda Peebles</td>
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<tr>
<td>July 20–23</td>
<td>Ecuador</td>
<td>Location: XXI Latinoamerican Congress in Coloproctology, Guayaquil, Ecuador Contact: Nestor A. Gomez, MD, FACS, 5934/2 293459, <a href="mailto:ngomez@gye.satnet.net">ngomez@gye.satnet.net</a> ACS representative: H. Randolph Bailey, MD, FACS</td>
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<td><strong>August 2009</strong></td>
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<td>August 18–21</td>
<td>Colombia</td>
<td>Location: Convention Center, Medellin, Colombia Contact: Francisco Henao, MD, FACS, 571 2362831, <a href="mailto:fhenao@javeriana.edu.co">fhenao@javeriana.edu.co</a></td>
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<tr>
<td>August 28</td>
<td>Oklahoma</td>
<td>Location: Tulsa, OK Contact: Linda O’Rourke, 405/271-5506, <a href="mailto:surgery@ouhsc.edu">surgery@ouhsc.edu</a></td>
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<td><strong>September 2009</strong></td>
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<td>September 12–13</td>
<td>Kansas (CS)</td>
<td>Location: Doubletree Hotel, Overland Park, KS Contact: Gary Caruthers (785) 234-3319, <a href="mailto:gcaruthers@kmsonline.org">gcaruthers@kmsonline.org</a></td>
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<tr>
<td>September 13–16</td>
<td>Kentucky (CS)</td>
<td>Location: Hyatt Regency, Louisville, KY Contact: Linda Silvestri, 859/323-6346, <a href="mailto:lsilv2@uky.edu">lsilv2@uky.edu</a></td>
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<tr>
<td>September 17–18</td>
<td>Italy</td>
<td>Location: Catania, Sicily Contact: Nicola Di Lorenzo, MD, FACS, 39 06 20902927, <a href="mailto:nicola.di.lorenzo@uniroma2.it">nicola.di.lorenzo@uniroma2.it</a> ACS representative: John L. Cameron, MD, FACS</td>
</tr>
<tr>
<td>September 23</td>
<td>Jacksonville</td>
<td>Location: Marriott Southpoint, Jacksonville, FL Contact: Patti Chapman, 904/994-7355, <a href="mailto:rotaryexecsec@aol.com">rotaryexecsec@aol.com</a></td>
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<tr>
<td>September 26</td>
<td>Arkansas (CS)</td>
<td>Location: Jackson T. Stephens Spine and Neurosciences Institute, Little Rock, AR Contact: Linda Clayton, 501/753-3500, <a href="mailto:lindac92@comcast.net">lindac92@comcast.net</a></td>
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Executive Director for the New Jersey Chapter, a dinner was held on March 4 at Mayfair Farms in West Orange, NJ.

The dinner was organized by the leaders of the New Jersey Chapter, as well as the leaders of the Essex County Medical Society (ECMS), which Mr. Ellenberger also managed.

In addition to remarks by Thomas R. Russell, MD, FACS, the College’s Executive Director, the evening festivities featured comments and observations from former New Jersey Chapter leaders (see photo, this page) and ECMS leaders.

New Jersey Assemblyman Eric Munoz, MD, FACS, presented Mr. Ellenberger with a joint legislative congratulatory resolution for his longtime contributions to New Jersey patients and medical professionals.

New Jersey Chapter, left to right: Lewis Wetstein, MD, FACS, President; Mark Moritz, MD, FACS, Immediate Past-President; Frank Padberg, Jr., MD, FACS, Vice-President; Mr. Ellenberger; Dr. Russell; Andrea Donelan, current Executive Director; and Paul Carniol, MD, FACS, President-Elect.

The Residency Assist Page of the American College of Surgeons offers a medium for program directors to acquire updates and advice on topics relevant to their needs as administrators and teachers.

Our goals are to offer practical information and approaches from summaries of published articles, invited editorials, and specific descriptions of lessons learned from program directors’ successful and not-so-successful strategies. Through the development of the Residency Assist Page, the ACS intends to support program directors and faculty by providing succinctly presented information helpful in addressing the challenges associated with administering state-of-art residency education.

www.facs.org/education/rap

For additional information, please contact Olivier Petinaux, MS, at elearning@facs.org, or tel. 866/475-4696