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From my perspective

As stated many times in this column, the leadership of the American College of Surgeons is committed to playing an influential role in helping to create an improved health care system. To achieve this goal, the College must cultivate the brainpower, fresh ideas, and new perspectives that young surgeons have to offer.

Engaging young surgeons and residents

With this goal in mind, one of my priorities as ACS Executive Director has been to ensure that young people have a voice in the College’s decision-making process by allowing them to participate in our committee meetings and by welcoming the leaders of the Committee on Young Surgeons and the Resident and Associate Society (RAS) to the meetings of the Board of Regents.

Another initiative has centered on expanding the scope of scholarships and fellowships that are available to young surgeons. Many of these awards enable residents and young surgeons to explore interests outside the realm of clinical practice. For example, the College and 12 surgical societies cosponsor Health Policy Scholarships for individuals who are interested in being directly involved in the socioeconomic and political aspects of modern-day practice. In addition, the RAS offers a Leadership Scholarship for our Resident and Associate Members.

Furthermore, the College recently endorsed a surgical ethics fellowship at the MacLean Center for Clinical Medical Ethics at the University of Chicago (IL). This program is designed for surgeons who are interested in gaining training and experience in medical ethics and is intended to prepare surgeons for academic work related to medical ethics. Fellows will also receive training in ethics consultation and will complete at least one research project. A similar program is in place at Washington University, St. Louis, MO, which provides training for the Emerson Ethics Scholar.

It is extremely important that the College continues to fund these educational opportunities, and we have every intention of keeping this tradition alive. But in these politically charged times, we need to have our own cadre of scholars—surgeons and physicians who can study and disseminate information about the issues on which we can, and must, provide leadership. To these ends, we have recruited a number of promising residents and young surgeons to help the College examine issues such as outcome measurement, patient safety, and the surgical workforce crisis.

Support for ACS division

One prominent example of our growth in this direction is the involvement of Clinical Scholars in the activities conducted under the auspices of the College’s Division of Research and Optimal Patient Care.

For instance, Mehul V. Raval, MD, a current Clinical Scholar, is actively involved in several projects at the College, including an assessment of multispecialty representation in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) and alpha testing of the pediatric NSQIP module. Dr. Raval also has been using information from the College’s National Cancer Data Base (NCDB) to assess overall pediatric representation and to study nodal evaluation in pediatric Wilms’ tumors. Studies accepted for publication have included a national assessment of melanoma care using formally developed quality indicators and a review of NCDB quality-assessment tools. Funding for Dr. Raval’s
work comes from the department of surgery at Northwestern University, Chicago, IL, where he is a general surgery resident and is pursuing a master’s degree in clinical investigation.

Clinical Scholar Angela Ingraham, MD, a graduate of Loyola Medical School, Maywood, IL, has been using ACS NSQIP and National Trauma Data Bank® (NTDB®) data to study outcomes in emergency surgical care, the cost of complications incurred by hospitals, and mechanisms for hospital benchmarking. Dr. Ingraham is conducting much of this research in conjunction with leaders of the Division of Research and Optimal Patient Care as well as with former ACS Clinical Scholar Karl Bilimoria, MD. Dr. Ingraham also supports and is developing projects that enable hospitals to use ACS NSQIP information to provide optimal care. Finally, she is collaborating with the ACS Committee on Trauma to examine the effect of complications on outcomes and resource use in severely injured trauma patients by evaluating data gathered via the NTDB, in support of the development of a Trauma Quality Improvement Program.

For the first time, the College also is benefiting from the knowledge and expertise of a Robert Wood Johnson fellow. Stanley Frencher, MD, MPH, a general surgery resident at Yale New Haven (CT) Hospital, is collaborating with the College and the Center for Surgical Outcomes and Quality at the University of California–Los Angeles on several projects, including the following: (1) improving the ACS NSQIP audit system; (2) studying the effects on surgical care of the Centers for Medicare & Medicaid Services’ policy of nonpayment for hospital-acquired illnesses, particularly catheter-associated urinary tract infections in surgical patients; and (3) using California hospital data to evaluate readmission rates as a quality indicator.

**Support for ACS institutes**

The College’s Nora Institute for Patient Safety also has enlisted the services of two surgeons to assist us in developing plans for the long-term growth of this recently established component of the organization.

One of these Medical Associates, Amy Lynne Halverson, MD, FACS, has provided assistance with the selection of areas of concentration related to surgical patient safety. Dr. Halverson is a colon and rectal surgical oncologist and an assistant professor of surgery at Northwestern Memorial Hospital. Her research interests lie in the area of quality improvement and patient safety with an emphasis on the concept of team training and communications failures in the operating room.

Another Medical Associate at the Nora Institute, James Alan Unti, MD, FACS, is evaluating the area of human factors as they relate to the safe surgical care of patients. Dr. Unti has also studied the subject of medical tourism. He is a colon and rectal surgeon and clinical assistant professor of surgery at the University of Illinois, Chicago, and is currently completing his master’s degree in health care quality and patient safety at Northwestern.

In addition, the ACS Health Policy Research Institute currently operates out of the Cecil G. Sheps Center for Health Policy Research at the University of North Carolina (UNC), Chapel Hill. The Sheps Center has 140 full-time researchers and numerous graduate students on staff and benefits from substantial grant support from
government agencies. Under the leadership of George F. Sheldon, MD, FACS, Zack D. Owens Professor of Surgery at UNC’s School of Medicine and Past-President of the College, the team at the Sheps Center has already conducted considerable research into the impending surgical workforce crisis and has generated ideas about how the federal government can help to ensure that surgeons remain accessible to patients. Currently seven researchers have been assigned to investigate issues under the purview of the ACS Health Policy Research Institute. They are as follows:

- Jim Byrd, MD, a Research Fellow, is studying scope of practice for surgeons who have completed fellowships, as well as other dimensions of progressive specialization.
- Anthony Charles, MD, MPH, a Research Associate, is actively involved in mentoring research fellows and has completed studies on practice location of African-American surgeons. He has determined that economics, not ethnicity, seems to be the dominant factor in selecting a practice location.
- Jennifer Doorey, a Visiting Researcher, an economist, and a certified emergency medical technician, is studying surgical team communication modalities and is applying her background in economics to surgical issues.
- Erin Fraher, PhD, the Institute’s Candidate Research Associate/Database Manager, is studying the health care workforce. She recently presented general surgery workforce data to the American Medical Association Council on Graduate Medical Education.
- Jennifer King, a Research Associate and doctoral candidate, has used hospital discharge data to study procedures performed by general surgeons.
- Lindsee McPhail, MD, a Research Fellow, is studying the effects of the 80-hour workweek and the distribution of pediatric surgical specialists.
- Stephanie Poley is a doctoral candidate at UNC and a Research Coordinator and Project Manager. Her emphasis is on orthopedic procedures—where they are performed and the types of operations used to treat related conditions.

The breadth of educational backgrounds that these individuals bring to their work encourages collaboration across the spectrum of professionals involved in health policy decision making and enables the College to look at issues from many different angles.

Preparing for the future

The next-generation health care system in the U.S. is likely to be considerably different than the one we have now. The American College of Surgeons wants to ensure that young surgeons are adequately prepared to face the challenges that lie ahead and that they will have a role in determining the environment in which they will practice. We owe them opportunities to study and comment on issues such as outcome measures, patient safety, and the causes of dwindling workforce numbers, because they and their patients are the ones who stand to benefit or lose under a new health care system.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
What surgeons should know about...

Successful participation in the PQRI

by Caitlin Burley, Quality Associate, Division of Advocacy and Health Policy

In July 2008, the Centers for Medicare & Medicaid Services (CMS) began releasing feedback reports and bonus payments to eligible professionals who successfully reported quality measures under the 2007 Physician Quality Reporting Initiative (PQRI). Since the release of this information, the College’s Washington Office has received an overwhelming flow of phone calls, primarily from disappointed Fellows whose reporting efforts were deemed unsuccessful. This column answers questions and concerns that surgeons have raised about how to make their PQRI experience a successful one. It also outlines some of the common reasons for failure uncovered in the past few months and addresses changes to the PQRI program for 2009.

Please provide a reminder of why CMS developed the PQRI and how the program works.

CMS initiated PQRI in 2007 with a six-month trial of the voluntary pay-for-reporting program from July 1 to December 31. Mandated by the 2006 Tax Relief and Health Care Act, and continued in the 2007 Medicare, Medicaid, and SCHIP Extension Act, PQRI remains a voluntary pay-for-reporting program created in an effort to steer the health care community toward a value-based purchasing system. Under PQRI, eligible professionals who satisfactorily report quality measures on claims receive incentive payments. For 2007 and 2008, the bonus amount was 1.5 percent of total allowed charges for covered Medicare Part B services. For 2009, the incentive increased to 2.0 percent of allowed charges, and the 2007 payment cap was removed for 2008 and 2009.

Why should I participate in PQRI?

PQRI is the current model for quality reporting, and CMS anticipates that establishment of a pay-for-reporting program will be an initial step toward value-based health care. The American College of Surgeons urges Fellows to take advantage of the current voluntary PQRI program as a way to familiarize themselves and their office staff with such value-based initiatives.

What do I need to do to participate in PQRI 2009?

There is no registration process to begin reporting. Choose the measures most applicable to your practice and review the measure specifications. For surgeons, the most applicable measures are typically the perioperative care measures (20, 21, 22, 23, 30, 45, 157, 158, and 172); however, others may apply to your surgical practice. There is a new perioperative care measures group for 2009, which includes 20, 21, 22, and 23. After choosing the measures most applicable to your practice, begin reporting your selected measures by submitting the specified quality-data codes on claims for services paid under the Medicare physician fee schedule.

How many measures are included in PQRI 2009?

The PQRI 2009 encompasses 153 quality measures and seven measures groups. To view the list of measures, go to http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

What is a measures group?

A measures group is a set of PQRI quality mea-
sures that pertain to a common clinical condition. Reporting with the measures groups is available for both claims-based and registry-based reporting. The seven measures groups for 2009 each contain at least four PQRI measures. Health care professionals who choose to use one of the groups must report on all measures within that set, and patients must have conditions that are applicable to the measure group used. Applicable patients are defined by the denominators. When submitting measures groups through claims-based reporting, the G-code is necessary to signify the first of the consecutive patients and must be submitted in order to qualify. G-codes are only needed when using claims-based reporting.

What do the numerator and denominator in each quality measure indicate?

The numerator describes the clinical action required for reporting and performance. The denominator describes the population of eligible cases for which a measure applies.

What are CPT* category II modifiers?

Inclusion of a modifier when reported CPT II codes exclude patients from a particular measure’s denominator when the measure’s specifications allow their use. There are two types of CPT II modifiers: performance measure exclusion modifiers (1P, 2P, and 3P) and a performance measure reporting modifier (8P).

How do I use the modifiers in reporting?

The exclusion modifiers indicated that the measure’s action was not performed because of a reason documented in the medical record. Modifier 1P indicates that the measure was excluded because of medical reasons, such as not indicated, contraindicated, and so on. Modifier 2P indicates that the measure was excluded for patient reasons, such as economic, social, religious, and so on. Modifier 3P indicates the measure was excluded for system reasons, such as unavailable resources, limited insurance coverage, and so on. Modifier 8P indicates the measure was excluded and the reason was not documented.

Can I resubmit a claim if I realize that I have forgotten to report on some claims?

No, you cannot resubmit claims to CMS to include quality data codes. So, it is important that you know what measures are most applicable to your practice and thoroughly read the measure specifications to make sure you report in all instances.

How does CMS determine if I successfully reported a measure?

The number of quality data codes submitted by the participant is divided by the number of opportunities to report, giving a percentage.

What are the different reporting methods for me to choose from in reporting to PQRI 2009?

There are nine different methods that can be used for reporting to PQRI in 2009, including full-year and half-year periods, as well as claims-based and registry-based options (see Figure, page 9.)

When can I expect my feedback report and/or incentive payment if I satisfactorily report in PQRI 2009?

Feedback reports and incentive payments for 2009 are expected in fall 2010.

What are some of the common causes of failure to satisfactorily report?

The analysis of PQRI 2007 indicates that some of the most common causes for failure to satisfactorily report are as follows:

- Invalid submission/reporting. There are various reasons for an eligible professional incorrectly reporting quality measures, including incorrect Health Common Procedure Coding System (HCPCS) denominator codes, incorrect diagnosis codes, incorrect age, and incorrect sex.
CMS deemed failures resulting from these errors to be user related.

—An incorrect HCPCS denominator code submission may include the common error associated with measure 30, Perioperative Care: Timing of Prophylactic Antibiotic—Administering Physician, where a CPT II code is required for the denominator rather than a HCPCS code.

—For an incorrect diagnosis code submission, the quality data code and diagnosis code were reported, but the diagnosis code is not appropriate for the reported measure. This error can be especially common when reporting a measure that requires multiple diagnoses.

—Incorrect reporting of age and/or sex occurs when Quality Data Codes are submitted for patients outside the population determined by the measure. Therefore, it is important to fully read and understand the specifications and populations of each measure.

• Split-claims. PQRI requires that the Quality Data Code be submitted on the same claim as the billing and diagnosis codes associated with the measure specifications. Failure to have these codes on the same claim form would indicate invalid reporting. CMS found that in some cases, this problem was not user related. In 6.3 percent of cases where Quality Data Codes were submitted with no billing/diagnosis codes on the claim, CMS found that the claims were split by the billing software or clearinghouse or during the processing by carrier/Medicare administrative contractor (MAC). Thus, CMS was unable to attach all Quality Data Codes to the related claims, thereby deeming some eligible professionals as unsuccessful. For PQRI 2008 and beyond, CMS has applied an analytic adjustment to bring together split claims caused

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<th>Figure. PQRI 2009 reporting options</th>
<th>Claims-based methods</th>
<th>Registry-based methods</th>
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<tr>
<td><strong>Full-year period</strong></td>
<td></td>
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<tr>
<td>Individual measures</td>
<td>At least three PQRI measures (one or two if less than three apply) for 80% of applicable Medicare Part B fee-for-service (FFS) patients of each eligible professional</td>
<td>At least three PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional</td>
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<tr>
<td>Measures groups</td>
<td>One measures group for 30 consecutive Medicare Part B FFS patients</td>
<td>One measures group for 30 consecutive patients (patients may include, but may not be exclusively, non-Medicare patients)</td>
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<td></td>
<td>One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (minimum of 30 patients during reporting period)</td>
<td>One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (minimum of 30 patients during the reporting period)</td>
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<td><strong>Half-year period</strong></td>
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<tr>
<td>Individual measures</td>
<td>At least three PQRI measures for 80% of applicable Medicare Part B FFS patients of each eligible professional</td>
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<tr>
<td>Measures groups</td>
<td>One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (minimum of 15 patients during reporting period)</td>
<td>One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (minimum of 15 patients during the reporting period)</td>
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by technical error. This adjustment is also being retroactively applied to 2007 submissions, and CMS expects that additional eligible professionals will receive incentive payments for PQRI 2007 reporting.

- Failure to include National Provider Identifier (NPI) on the claim. PQRI requires that the NPI be on the claim form in order to run analysis at the individual professional level. Failure to include the NPI on the claim is a user-related error. Since March 2008, inclusion of the NPI has been required for all Medicare payment. Therefore, CMS hopes this will not be a significant cause of error for PQRI 2008 and beyond.

How do I correctly report on a single CMS 1500 claim?


How will I know if I successfully reported in PQRI?

CMS does not send feedback reports to each eligible professional who reported. To view your feedback report, you must register to view it through the agency’s Individuals Authorized to Access CMS Computer Systems (IACS). This registration process is very time-consuming because of the government-wide security requirements; however, you must register in order to view your feedback report. CMS representatives will explain the steps of IACS registration during the national provider calls.

What will my feedback report tell me?

Feedback reports are available to all participating professionals. They provide reporting rates, clinical performance, and earned incentives.

How do I receive my payment if I was successful in reporting?

CMS will send the incentive payments for those eligible professionals who satisfactorily reported electronically or via check to the TIN by the carrier/MAC.

Is there an appeals process for eligible professionals to contact CMS if they did not receive an incentive payment for successful reporting?

Unfortunately, there is no appeals process in the PQRI program because of the statutory authorization.

Will my PQRI data be available to the public?

For PQRI 2008, the names of all eligible professionals who attempted submission of a quality data code will be made available to the public. This list includes individuals who reported in the PQRI 2008 successfully and individuals who reported unsuccessfully. For PQRI 2009, CMS has yet to determine which data will be publicly available.

If I successfully reported in PQRI 2007, do I need to change any reporting methods for PQRI 2009?

For those individuals who have previously reported in PQRI, please note that some performance measures retained from 2007 and 2008 may have slightly changed. It is very important to look closely at the measure specifications for 2009 even if you are reporting a measure from a previous year. Code Changes to 2008 Perioperative Measures Specifications is accessible at [http://www.facs.org/ahp/pqri/2009/changes to2008measuresgroups.pdf](http://www.facs.org/ahp/pqri/2009/changes to2008measuresgroups.pdf).

Where can I learn more about PQRI 2009?

Visit the CMS PQRI Web page at [http://www.cms.hhs.gov/PQRI/](http://www.cms.hhs.gov/PQRI/) or the ACS PQRI Web page at [http://www.facs.org/ahp/pqri/index.html](http://www.facs.org/ahp/pqri/index.html). In addition, CMS hosts national provider calls monthly that cover PQRI changes and allow for a question-and-answer session at the end. You can find information to register for these calls on the CMS PQRI Web site under “CMS Sponsored Calls.”
ACS-developed curriculum is becoming a centerpiece of training in ethics

by Diane S. Schneidman,
Manager, Special Projects,
Division of Integrated Communications
Recent transformations in surgical practice and training—the increased emphasis on the business aspects of running an office, the reduced work hours for residents, and so on—have had a range of negative consequences. Not the least of these deleterious effects is the limited time surgical residents and their mentors can carve out to address ethical issues.

To help surgeons and residents deal with this particular conundrum, the American College of Surgeons’ Committee on Ethics developed *Ethical Issues in Clinical Surgery*. This case-based educational resource, first published in 2007, offers surgeons and trainees an opportunity to examine the ethical underpinnings of modern clinical practice. In her acknowledgments published in the two manuals that are at the core of this program—one for residents and one for instructors and practicing surgeons—Mary H. McGrath, MD, MPH, FACS, Editor-in-Chief, noted that these materials were intended to serve as “the basis for the development of bioethics programs at the local level.” That aspiration is coming to fruition at several major training institutions throughout the nation, largely because of financial support from a self-described “grateful patient.”

**ACS ethics curriculum**

The *Ethical Issues in Clinical Surgery* manuals are just one component of a three-pronged effort to encourage surgeons at all stages of their careers to place renewed value on professionalism and compassionate care, Dr. McGrath explained in an interview.* In addition to the written materials, the College offers a DVD called *Professionalism in Surgery: Challenges and Choices*, now in its second edition. This program includes 24 vignettes depicting realistic dilemmas that surgeons face in clinical practice, presents possible courses of action, and highlights the implications of each response. As a next step, the ACS Committee on Ethics plans to offer a new CD-ROM that will focus specifically on issues of concern to practicing surgeons.

What sets the *Ethical Issues in Clinical Surgery* manuals apart from the other materials is that they are designed to function as interactive educational instruments for use in today’s time-pressed training environment. The Committee on Ethics decided to develop a curriculum targeted to residencies for the following three reasons: (1) surgical residents learn best when a respected surgeon is doing the teaching, (2) surgeons had become so entrenched in responding to socioeconomic concerns that they were failing to nurture the altruistic qualities inherent in most individuals who choose a surgical career, and (3) the profession has developed requirements for attaining and maintaining board certification.

Previous generations of surgical trainees spent most of their waking hours in the company of their professional role models. As Ira J. Kodner, MD, FACS, who has been instrumental in launching the program, noted, “I chose my mentors when I was in training and spent my residency trying to emulate my mentors. I was with them all day and all night, and I saw how they talked to patients. I saw their level of compassion, and the ones who didn’t show it, I dumped as mentors.” Unfortunately, the recently imposed 80-hour workweek has restricted the amount of time trainees spend with respected leaders. Consequently, trainees today are often deprived of the benefits associated with these tightly knit relationships. To compensate, some training program directors arrange for the bioethicists at their institutions to present lectures and symposia on related topics. “But it really doesn’t have the same impact as having a surgeon talking to a resident about patients whom they are both treating and how to handle ethical dilemmas when they arise,” Dr. McGrath, professor of surgery at the University of California–San Francisco and Past–First Vice-President of the ACS, said.

Furthermore, she added, the bioethics textbooks published over the years have been “much more academic and less clinically oriented—less practical.” The College’s Committee on Ethics wanted “to get surgeons involved and to develop more practical didactic material, which we’d like to think surgeons and residents will relate

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*Unless otherwise noted the information in this article was gathered in the following settings: interviews with Drs. Klingensmith, Kodner, and McGrath and Mr. Kamangar that were conducted during the 2008 Clinical Congress in San Francisco, CA; formal lectures that the surgeons presented at the Clinical Congress; and a day-long forum for recipients of the Kamangar Awards.*
to more than a textbook with whole chapters on the philosophical underpinnings [of bioethics].”

The College’s ethics curriculum also is designed to respond to the fact that as clinical practice has become more business-oriented, a different set of values has taken hold. “We stood by and watched surgery become what I call, ‘generic,’” Dr. Kodner said. “The cherished relationship between physician and patient has been corrupted by the business aspect. We’ve excluded the compassionate part of surgery. When all is said and done, most of us go into surgery because we want to take care of sick folks and we want to do it in a compassionate way, but we get corrupted along the way by the financial—the political—aspects of it,” he added.

Dr. Kodner says that young people are hungry for the opportunity to think about the ethical values of the surgical profession. “I teach a course for medical students at Washington University called ‘Dealing with sick folks and their families,’ and I ask students to write a one-page paper on their biggest apprehensions about going into medicine. Their biggest fear is that they’re going to hurt somebody. Their second biggest fear is that they’re [entering training] with altruistic values, and we’re going to take those values away as we teach them to become physicians. And we do,” he said.

So, the surgeons who collaborated on the ethics curriculum agreed to work from the following premise: “Let’s see if we can teach compassion. Let’s see if we can teach the ethical practice of surgery,” Dr. Kodner said.

Another rationale for the College to offer a modernized ethics curriculum is a pragmatic one. The fact of the matter is that surgeons now are required to have a firm grasp of what constitutes professional behavior, Dr. McGrath said. Indeed, the American Board of Medical Specialties and the boards’ residency review committees have identified professionalism as one of the six core competencies necessary to achieve and sustain board certification. Needless to say, ethics is an underlying component of professionalism.

A model program

Several training institutions are now incorporating Ethical Issues in Clinical Surgery into their residencies. The first program to apply the curriculum was the Washington University School of Medicine, St. Louis, MO. Leading that effort were Dr. Kodner and Mary E. Klingensmith, MD, FACS. Dr. Kodner is the Solon and Bettie Gershman Professor of Colon and Rectal Surgery, School of Medicine, and the director of the Center for the Study of Ethics and Human Values at Washington University. Dr. Klingensmith is the program director in surgery, director of the surgical skills laboratory, and an associate professor of surgery at the School of Medicine. Washington University had several years’ ex-
perience of providing surgical residents with a curriculum in ethics before adding *Ethical Issues in Clinical Surgery* to the mix. The institution is now in its seventh year of presenting a multi-disciplinary curriculum in ethics, according to Dr. Klingensmith.

“We surveyed residents before starting the formal curriculum and discovered that they felt they frequently encountered ethical dilemmas and that they often discussed these problems with fellow residents but not with the faculty,” Dr. Klingensmith said. “They were interested in bioethics in general and wanted more programming aimed at helping them to deal with these issues,” she added.

Washington University’s first session of its surgical ethics curriculum for residents involved a debate about three separate cases. It then moved on to monthly case-based discussions. “We finished off that first year with a very formal curriculum,” Dr. Klingensmith said. “We concluded that the case-based format worked really well.”

In light of the program’s success with the case-based structure, Washington University was excited about the proposition of adopting the *Ethical Issues in Clinical Surgery* curriculum. Specifically, Washington University established regularly scheduled one-hour per month “pizza rounds.” During these conferences, Washington University surgical residents explore cases in the ACS-published manuals as well as any real-life difficulties the residents have encountered in recent weeks. “Initially, we used pizza to get residents to come. Now they show up because they really enjoy the discussion,” Dr. Klingensmith said.

Participation in the pizza rounds at Washington University extends beyond surgery. In addition to other members of the operative team—anesthesiologists, operating room nurses, technicians, and so on—some of the sessions have involved obstetrician-gynecologists and colleagues from other medical specialties, Dr. Klingensmith explained. Participants have included faculty from other nearby universities, chaplains, nurses, social workers, and other professionals who deal with ethical issues on a day-to-day basis. In addition, she said, “We have energized the curriculum with an annual ethics debate between individuals in different specialties.”

“We’re fortunate to have ethicists in our community, but the one great thing about [the *Ethical Issues in Clinical Surgery* manual for residents] is how the principles are illustrated. If you don’t have someone who can articulate those principles, that book is a really great resource,” she said.

And it appears that Washington University residents are absorbing the material and are anxious to share their knowledge with newer
trainees. “As residents become more senior, they are actually able to lead the discussion. For a medical educator, that’s particularly gratifying. There aren’t many conferences where students feel empowered and safe to speak up, but this is one place where they can,” Dr. Klingensmith said.

Kamangar Ethics Awards

Washington University was able to incorporate the ACS manuals into its ethics curriculum for surgical residents because of the generous financial support of Parviz Kamangar, a California businessman. Mr. Kamangar describes himself as a grateful patient who wants to give back to the profession that saved not only his life but his spirit as well some 14 years ago.

After a gastroenterologist misdiagnosed his colon cancer, Mr. Kamangar called another physician for guidance in selecting a surgeon. That physician arranged for Mr. Kamangar to see Yanek S. Y. Chiu, MD, FACS, a colon and rectal surgeon in San Francisco, CA. Dr. Chiu assured Mr. Kamangar that if he was willing to endure the challenges of treating advanced colon cancer, the operative and oncology teams would do everything possible to send the cancer into remission.

Obviously, Dr. Chiu and the other physicians who cared for Mr. Kamangar preoperatively, intraoperatively, and postoperatively eradicated the cancer. Ridding him of the anger he felt toward the gastroenterologist who misdiagnosed and mistreated his illness would take a little more time. As he regained his physical health and strength, Mr. Kamangar started thinking about what he could do to ensure that no other patient would be subjected to that physician’s incompetence. He wanted to sue.

“I was going to bring legal charges against the physician, but the doctors that I ended up with subsequent to my illness—and they were terrific doctors, great human beings—not only saved me...not only did they cure my [physical] disease, but they cured [my anger], which is more important,” Mr. Kamangar said. Those doctors told him that he was not strong enough to go through lawsuits. Instead, they suggested that he channel his energy into something more positive.

After many discussions with cancer patients and physicians, Mr. Kamangar decided to start providing financial support for ethics training programs. For the past 13 years, he has funded an ethics program during the annual meeting of the Northwest Society of Colon and Rectal Surgeons, and for the last six years, he has sponsored the Humanities in Surgery lectureship at the annual meeting of the American Society of Colon and Rectal Surgeons. This activity put Mr. Kamangar into contact with Dr. Kodner, and the two agreed to collaborate to bring ethics training to a broader range of physicians. He then became a founding supporter of the Washington University Center for Ethics and Human Values and established the Parviz Kamangar Foundation. The foundation is dedicated to helping future generations of physicians learn the principles of ethical medical practice and the value of compassionate care and, in 2008, began presenting the Kamangar Ethics Award. The award provides the support and materials that training programs need to launch or expand an ethics curriculum. The awards are administered through Washington University’s Centers for the Study of Ethics and Human Values.

On November 6, 2008, 16 training programs were accorded the Kamangar Ethics Awards. (See page 16 for a list of the winning institutions and the individuals who spearheaded their ethics curricula.) Each program receives the following materials: copies of both the instructors’ and the residents’ manuals for Ethical Issues in Clinical Surgery; support for an ACS-approved instructor to help plan and implement the first training session; ongoing consultation through the Center for the Study of Ethics and Human Values at Washington University; and, in some cases, additional supporting funds to cover the overhead costs of conducting regular surgical ethics conferences involving residents.

The awardees were selected on the basis of whether their institutions had the resources in place to start or expand an ethics training program and whether they had innovative ideas, Dr. Kodner said. Each institution is using Ethical Issues in Clinical Surgery as a basis for building or expanding an ethics training program designed to assist residents in making appropriate ethical choices, he added. Some examples of how the winning programs intend to use the funds to fit their unique needs and purposes include...
Kamangar Ethics Award winners

Following is a list of the surgical training programs that received the Kamangar Ethics Awards for 2008. Also identified are the individuals who sought the grants and are responsible for their administration.

**University of Chicago (IL) Medical Center**
Peter Angelos, MD, PhD, FACS, professor of surgery and chief of endocrine surgery, University of Chicago, and associate director of the MacLean Center for Clinical Medical Ethics

**Lankenau Hospital in Pennsylvania, Wynnewood**
Barry D. Mann, MD, FACS, associate professor of surgery, Medical College of Pennsylvania

**Loyola University Medical Center, Maywood, IL**
Raymond Joseph Joehi, MD, FACS, chief of surgical service and manager of surgery service line, Edward Hines, Jr., Veterans Affairs Hospital, and professor of surgery, Loyola University Medical Center

**Massachusetts General Hospital, Boston, MA**
Janey S. A. Pratt, MD, FACS, attending, department of surgery

**Maricopa Integrated Health Systems, Phoenix, AZ**
Kevin N. Foster, MD, MBA, FACS, attending, department of surgery, and clinical assistant professor of surgery, Mayo Clinic

**New York Hospital, Queens**
Simon D. Fink, MD, FACS, active staff, department of surgery, and assistant clinical professor of surgery

**New York Medical College, Valhalla**
John A. Savino, MD, FACS, professor of surgery; Donald A. Risucci, PhD, associate professor of surgery; and Jay Yelon, DO, FACS, associate professor of surgery

**Oregon Health Science University, Portland**
Karen E. Deveney, MD, FACS, professor of surgery

**University of Pennsylvania, Philadelphia**
Jon B. Morris, MD, FACS, professor of surgery

**University of Pittsburgh (PA) Medical Center**
Pragattheeshwar Thirumunavukarasu, MBBS, resident, general surgery; Kenneth Kwock Wah Lee, MD, FACS, associate professor of surgery; and Daniel E. Hall, MD, MDiv, MHSc, assistant professor, general surgery

**St. Agnes Hospital in Baltimore (MD)**
Gavin L. Henry, MD, FACS, attending staff, clinical assistant professor of surgery

**Temple University, Philadelphia, PA**
Chris D. Tzarnas, MD, FACS, clinical associate professor of surgery, plastic surgery residency program

**Vanderbilt University Medical School, Nashville, TN**
John L. Tarpley, MD, FACS, professor of surgery

**Washington University Medical School, St. Louis, MO**
Mary E. Klingensmith, MD, FACS, associate professor of surgery, residency program director in surgery

**Wisconsin Medical Center, Milwaukee**
Alonzo P. Walker, MD, FACS, professor and chief, division of general surgery; Ruth Teske, MD, professor in surgical oncology, program director, general surgery residency; and Karen Brasel, MD, FACS, associate professor of surgery

**Wright State University Boonshoft School of Medicine, Dayton, OH**
Paula M. Termuhlen, MD, FACS, associate professor of surgery, general surgery residency program director, and chief, division of surgical oncology
the following:
- Prepare and encourage surgeons to serve on their hospitals’ ethics consult services
- Create monthly surgical ethics conferences
- Conduct regular surgical grand rounds with a focus on ethics
- Collaborate with other organizations experienced in bioethics education
- Coordinate ethics training at health systems in which residents rotate through multiple institutions
- Use the College’s standardized case-based program in which the ethical issues become more complicated as residents progress through their training
- Incorporate issues related to genetics, cultural heritage, and gender
- Evaluate how ethics concerns in education affect patient satisfaction and outcomes
- Participate in the development of specialty-specific ethics curricula

Looking ahead

These projects reflect the type of creative thinking that Dr. McGrath and other leaders in surgical ethics view as key elements in achieving their ultimate goals: To make training in ethics a standard component of the surgical curriculum and to ensure that surgeons are once again a recognized force within the bioethics community.

According to Dr. McGrath, the Accreditation Council on Graduate Medical Education (ACGME) now accredits a palliative care fellowship for young physicians in all specialties. It was established by the American Board of Internal Medicine and went into effect July 1, 2008. The College is urging surgeons to participate in that program and believes that it could serve as a model for a similar fellowship in bioethics. Having a fellowship that is accredited and results in certification will reinforce the perception and acceptance of palliative care as a legitimate clinical specialty. “And ethics is right in with it. I would love to see ethics with accreditation and a fellowship. I’m willing to bet there are enough professors at enough high-level institutions who feel the same way that we may well be headed in that direction,” Dr. McGrath added.

The next step will center on getting surgeons involved in their hospitals’ ethics committees. “There’s a certain decisiveness that surgeons can bring to those panels that is currently lacking,” Dr. McGrath said. The College needs to provide surgeons with a methodology for thinking about ethical dilemmas and laying out the options for action. In this way, surgeons could be very helpful in moving the often sluggish decision-making process along.

“The challenge is to get surgeons to step up to the plate,” Dr. Klingensmith noted.

Another challenge is to uncover evidence that teaching ethics is a valuable use of an institution’s financial and clinical resources. Palliative care succeeded in establishing an accredited fellowship because a number of studies have shown well-trained palliative care specialists decrease costs to hospitals, Dr. Klingensmith said. “So I’ve been thinking about whether there’s a way we can show that institutions with robust ethics programs have reduced liability claims.”

Neither the boards nor the ACGME has yet determined how to measure the effects of ethics on cost and outcomes, Dr. McGrath added. Until that methodology is developed, some institutions are likely to continue to undervalue the education in professional principles.

“Every time I approach someone to get support for the Center of Ethics and Values, people ask, ‘Well, what’s the value in it?’” Dr. Kodner observed. “How do you put a financial value on ethical medicine? A chief of general surgery can measure how much revenue I bring into the department of surgery but can’t measure how much I do by practicing ethical medicine. We as a society have devalued compassion.”

If Dr. Kodner, Dr. McGrath, Dr. Klingensmith, and Mr. Kamangar have a say in the matter, that mind-set is about to change. Indeed, at press time, Mr. Kamangar announced that he will fund 16 more training in surgical ethics programs next year. To apply for the award, go to http://humanvalues.wustl.edu/.
The 111th Congress is ready to tackle health care issues

by Cate Blankenburg, Government Affairs Associate, Division of Advocacy and Health Policy

The 111th Congress was sworn in and began work on January 6. This article identifies newly elected legislators and their respective positions on health care issues. In addition, it provides an overview of the specific concerns that these individuals and their more senior colleagues are likely to address this year.

The Senate

As a result of the November 2008 election, nine outgoing senators were replaced with seven Democrats and two Republicans, while five seats were left open or unfilled. At press time, the Senate was composed of 56 Democrats, 41 Republicans, and two Independents. Many of the new members ascended from the House of Representatives, and all have taken a position on issues that affect health care delivery, education, and access. In Alaska, Mark Begich (D) defeated incumbent Ted Stevens (R). Senator Begich focused on providing affordable student loans for Alaska’s college and vocational-technical students when he was chair of the Alaska Student Loan Corporation. Senator Begich has been appointed to the Senate Commerce and Armed Services Committees.

Mark Udall (D) of Colorado succeeded retiring Sen. Wayne Allard (R). Environmental and energy issues will drive much of Senator Udall’s agenda, as they did during his five terms in the House. Senator Udall will serve on the Senate Armed Services Committee and on the Committee on Energy and Natural Resources.

Jim Risch (R) succeeded retiring Sen. Larry Craig (R) of Idaho. Before his bid for national office, Senator Risch served the state of Idaho for more than 30 years. Senator Risch believes innovation and technology make for high-quality health care and, as governor, he created a task force to deliver more well-educated nurses with strong technology skills to the medical profession.
In Nebraska, Mike Johanns (R) succeeded retiring Sen. Chuck Hagel (R). Senator Johanns has had a long career in executive service as a mayor, as the governor of Nebraska, and as U.S. Secretary of Agriculture under former President George W. Bush. He supports a permanent tax credit for research and development.

Jeanne Shaheen (D) of New Hampshire defeated incumbent John Sununu (R). Senator Shaheen served as governor of New Hampshire from 1997 to 2003 and has identified health care as a top priority. She hopes to offer Americans more access to preventive care and investment in health care technology. As a small business owner, Senator Shaheen also is concerned about the ability of small businesses to provide health care coverage to their employees.

Tom Udall (D) of New Mexico succeeded retiring Sen. Pete Domenici (R). A five-term U.S. House member, Senator Udall has been a champion for universal health care and supports the concept of allowing uninsured Americans older than age 55 to buy into Medicare at a fixed cost. He also maintains that small businesses should be allowed to buy into the federal employee benefit package. Senator Udall serves on the Senate Commerce Committee.

In North Carolina, Kay Hagan (D) defeated incumbent Elizabeth Dole (R). Senator Hagan previously served in the North Carolina Senate, where she attained extensive experience in working on budget issues. With respect to health care reform issues, Senator Hagan favors allowing reimportation of prescription drugs to cut prices. She also believes Congress should reauthorize and strengthen the State Children’s Health Insurance Program (SCHIP) and expand it to cover mental health care. She supports programs aimed at encouraging small businesses to provide health care coverage to their employees, including enabling small firms to pool coverage and providing tax credits for premiums.

In Oregon, Jeff Merkley (D) defeated incumbent Gordon Smith (R). Senator Merkley is Oregon’s former House Speaker and is a former Congressional Budget Office analyst. Citing a deep interest in health care that he shares with his wife, a registered nurse, he has been awarded a seat on the powerful Health, Education, Labor, and Pensions (HELP) Committee.

The seat vacated by retiring Virginia Sen. John Warner (R) of Virginia will be filled by Mark Warner (D). A popular governor from 2002 to 2006, Senator Warner has said he wants to build coalitions of both parties in the Senate and intends to exhibit the same bipartisan impulses as he did in Richmond. He has been appointed to the Senate Commerce Committee.

When the Congress began its work on January 6, several Senate seats were still vacant. After considerable debate over his appointment by Illinois Gov. Rod Blagojevich (D), who has been accused of trying to appoint President Barack Obama’s vacated Senate seat based on what he could get in exchange, Roland Burris (D) was officially sworn in on January 15. Two senators, Hillary Clinton of New York and Ken Salazar of Colorado, have resigned their seats in order to serve in Obama’s cabinet: Senator Clinton as Secretary of State and Senator Salazar as Secretary of the Interior. New York Gov. David Paterson (D) appointed Rep. Kirsten Gillibrand (D-NY-20), a member of the moderate Blue Dog Coalition from upstate, to replace former Senator Clinton, and Colorado Gov. Bill Ritter, Jr., announced that he had chosen Michael Bennet (D), Denver Public Schools Superintendent, to replace former Senator Salazar. In addition, based on recount results, Al Franken (D) claimed victory against incumbent Sen. Norm Coleman (R) of Minnesota, but, at press time, Mr. Coleman was challenging the results in a lawsuit. And in Delaware, Vice-President Joseph Biden’s Senate seat has been filled by Ted Kaufman (D), who previously served as Senator Biden’s chief of staff. Kaufman will serve a special two-year term and has announced he will not run again for the seat in 2010.

In addition, Sen. John Barrasso, MD (R-WY), won reelection; Tom Coburn, MD (R-OK), was not up for reelection.

The House

In the House of Representatives, Democrats now occupy 256 seats, having gained 21 seats in the 2008 election. Republicans, who suffered losses in the election, occupy 178 seats. At press time, one House seat remained vacant as a result of Democrat Rahm Emanuel (IL-5) becoming Chief of Staff to President Obama.
Of note, with the incoming freshman class of 54 members and two delegates, four physicians were added to the chamber.

A board-certified radiation oncologist and businessman, **Parker Griffith, MD (D-AL-5)**, was elected to fill the seat held by retiring Rep. Bud Cramer (D-AL). Representative Griffith received his medical degree from the Louisiana State University (LSU) Medical School and completed his residency at the University of Texas. After spending much of his career treating cancer patients, Dr. Griffith plans to focus his efforts in government service on access to and affordability of health care. A former Alabama senator, he won the early endorsement of the Blue Dog Coalition, a group of fiscally responsible, moderate Democrats in the House that are a forceful voting block.

A hepatologist from Baton Rouge, **Bill Cassidy, MD (R-LA-6)**, defeated incumbent Don Cazayoux (D) in one of five seats that Republicans picked up from Democrats. Dr. Cassidy, whose wife is a surgeon, is an associate professor of medicine at LSU Health Science Center, Baton Rouge, and teaches at Earl K. Long Hospital. Dr. Cassidy has said that any solution to the health care crisis must address access, cost, and quality. He advocates portable insurance, increased competition among insurers, and the establishment of insurance pools to expand choices for consumers. In the days following Hurricane Katrina, he led a group of volunteers to convert an abandoned building into a makeshift field hospital where several hundred evacuees were treated.

An obstetrician-gynecologist who has delivered more than 5,000 babies in his 31 years of practice, **David “Phil” Roe, MD (R-TN-4)**, received his medical degree from the University of Tennessee, Knoxville. He defeated incumbent David Davis in the Republican primary. Dr. Roe wants to draw attention to health risks, such as obesity and smoking, and to improve access to care without adding to physicians’ regulatory burdens. His district houses several drug manufacturers and a major medical hub at East Tennessee State University, Johnson City.

Family physician, author, and businessman **John Fleming, MD (R-LA-4)**, has been elected to replace retiring Rep. Jim McCrery (R). Representative Fleming received his bachelor of science and medical degrees at the University of Mississippi at Oxford. He served in the U.S. Navy to help fund his medical education and in 2006 his book, *Preventing Addiction: What Parents Must Know to Immunize Their Kids Against Drug and Alcohol Addiction*, was published. He served on Republican Gov. Bobby Jindal’s transition team and on the governor’s advisory council on social services, providing advice on health care issues.

These four physician-legislators join reelected House incumbents Vic Snyder, MD (D-AR); Tom Price, MD (R-GA); Paul Broun, MD (R-GA); Phil Gingrey, MD (R-GA); Charles Boustany, MD (R-LA); Ron Paul, MD (R-TX); Michael Burgess, MD (R-TX); Jim McDermott, MD (D-WA); and Steve Kagen, MD (D-WI).
Issues to be addressed

The top health care issues likely to emerge in the 111th Congress pertain to reauthorizing and expanding SCHIP, improving access to health coverage for all Americans, and overhauling Medicare. Late in the last congressional session, the Bush Administration and congressional Democrats came to agreement on the continuing resolution funding measure, avoiding a shutdown of the federal government at the start of the 2009 fiscal year (FY) on October 1, 2008. This legislation provides funding for many federal programs, including the National Institutes of Health and Title VII health professions education, through March 6, 2009. The 111th Congress is likely to increase funding for all of these programs when the appropriations process begins early in the 2009 legislative session.

Indeed, by press time, the House had already passed SCHIP legislation, providing a temporary extension of the program, which was set to expire in April. The new legislation raises the income threshold for eligibility. In the 110th Congress, Democrats could not garner enough votes to overcome the Bush veto of legislation that would have increased the eligibility cap for SCHIP from 200 percent of the federal poverty level to 300 percent. With the new Administration in place, this expansion is much more likely to occur. Extension of coverage through the SCHIP program will help to ensure that many of the 46 million Americans without health insurance are covered.

In addition, several prominent members of Congress and the Obama Administration have been drafting proposals that would provide patients with options for obtaining access to affordable health care. Senate Finance Committee Chairman Max Baucus (D-MT) released his plan as a white paper at the end of 2008. It is anticipated that Senate HELP Committee Chairman Edward Kennedy (D-MA) will release a plan as well.

Another issue that Congress is likely to consider is Medicare physician reimbursement rates. Last summer, the Congress voted to override President Bush’s veto of the Medicare Improvement for Patients and Providers Act (MIPPA), which included a physician payment “fix.” Without congressional intervention, physicians faced a 10.6 percent reduction in Medicare payments retroactive to July 1, 2008, and additional projected cuts of 5.4 percent cut in 2009. MIPPA replaced these cuts, extending through December 31, 2008, the 0.5 percent conversion factor bonus that expired June 30, and established a 1.1 percent update for 2009.

Whereas congressional action averted these cuts for 18 months, physicians face a 22 percent cut in reimbursement starting in January 1, 2010. Though all-encompassing reforms are being discussed, the costs are high. Another “temporary” solution would cost an estimated $20 billion. The 111th Congress is hoping to enact numerous changes to the Medicare program, including modifications to the Part D benefit, such as prescription drug price-negotiating authority, extension of the therapy cap exceptions process, and cuts to Medicare Advantage plans to reimbursement with fee-for-service rates. It may be necessary to attach these initiatives to the must-pass legislation that halts the physician payment cuts.

It is estimated that the FY 2009 deficit may well exceed $1 trillion, compared with $407 billion in 2008 and $162 billion in 2007. The new Administration and Congress also will have to deal with the cost of continuing the wars in Iraq and Afghanistan and the expiration of the 2001 and 2003 tax cuts, possibly limiting the ability to move forward rapidly on health system reform. Late in 2008, the White House and congressional Democrats came to agreement on the continuing resolution funding measure for FY 2009, avoiding a shutdown of the federal government at the start of the federal fiscal year on October 1. This legislation provided funding for many federal programs, including the National Institutes of Health and Title VII health professions education, through March 6, 2009.

In anticipation of actions that might be carried out in the 111th Congress and through the incoming Obama Administration, the American College of Surgeons released a comprehensive policy statement to help frame the debate. In this comprehensive Statement on Health Care Reform,* the College calls on policymakers to support an approach that improves access to safe,
high-quality, and affordable surgical care. The College takes a shared responsibility approach in its policy statement and recommends that all stakeholders work together to build a better health care delivery system, embracing policy initiatives that will accomplish the following goals:

- Help eliminate disparities in surgical care by expanding the National Health Service Corps to include surgeons. The College believes that doing so will help increase public service and also assist surgeons with medical school debt.
- Support and help fund a national health workforce database to identify areas with little or no access to surgical care.
- Explore alternative methods for paying for health care to ensure the presence of an adequate and robust surgical workforce over time by working with the ACS to develop a demonstration program.
- Reduce medical errors, improve safety, provide patients with higher-quality care, and potentially reduce the incidence of medical liability cases by partnering with the College and the surgical community to test surgical and patient safety initiatives.

In addition, the statement outlines related activities that the College is committed to undertaking to meet its policy objectives. These commitments include providing better educational and quality measurement resources and opportunities, promoting health information technology among the surgical community, and developing better patient safety standards to help reduce medical errors.

Furthermore, the ACS and many surgical specialty organizations have compiled a united agenda regarding long-term Medicare payment reform. This agenda includes the following:

- Repealing the current sustainable growth rate (SGR) and establishing a new baseline for the physician payment system
- Replacing the current SGR with a system of multiple conversion factors based on category of service, similar to the approach that was included in the Children’s Health and Medicare Protection Act
- Ensuring that any additional payments that are made to primary care physicians are not taken from payments made to surgeons

Much of the legislative agenda will be influenced by the personalities and priorities of committee chairmen. At the beginning of the 111th Congress, there are still some unanswered questions. On the powerful House Energy and Commerce Committee, for instance, Henry Waxman (D-CA) successfully ousted former Chairman John Dingell (D-MI), who had headed that committee for 16 years. Also unknown is how the House Energy and Commerce Committee and the House Ways and Means Committee, which have a history of friction and that both handle Medicare issues, will share jurisdiction.

Of concern is that Senator Kennedy continues to face serious personal health issues that may hinder him from taking an aggressive role in shaping policy. In addition, changes in the leadership and makeup of the Appropriations Committees could affect funding for health care research and other priorities.

Despite these challenges, President Obama’s Administration will enjoy a honeymoon period, during which there will be the opportunity to set the agenda and tone in Washington. The close collaboration and smooth transition between the Bush and Obama Administrations and the depth of experience in the new White House team—which includes veterans of the Clinton Administration—indicate that the new President will have the ability to take advantage of the early months of his Administration.

The 111th Congress will most certainly bring congressional hearings on aspects of health system reform, the release of reform proposals by committees of jurisdiction, bill introductions, policy papers, and outside coalition activities. However, the difficult budget situation could delay enacting comprehensive health reform efforts until 2010 or later. Nonetheless, the 111th Congress will undoubtedly have a heavy health care agenda. In fact, it could well be quite robust. Congress will no longer face a Presidential veto threat that previously halted efforts to significantly modify both the public and private sector of health care. With this new revelation will most certainly come many new activities, and many opportunities for the ACS to participate in the reform debate.
hat began as a response to the restoration of the medical system to a city under water for weeks, and to provide trauma education to the involved region of the storm, has developed into a program offering Advanced Trauma Life Support (ATLS®) and Prehospital Trauma Life Support (PHTLS®) in rural communities throughout the state of Louisiana. This educational format provides up-to-date trauma patient care at the local community hospital to physicians and their prehospital providers.

Because of the need for trauma education and the lack of teaching facilities, Tulane Life Support Training Center (TLSTC) developed an “on the road” educational program designed to provide the same quality education on the road that is available in trauma centers. We include in this teaching format ATLS and PHTLS simultaneously on the road to local rural and urban community hospitals. The mission of “ATLS/PHTLS on the Road” is as follows: (1) to offer education to physicians and prehospital providers that do not have easy access to either class from their rural location; (2) to pro-

by
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mote the team concept of trauma care, combining the two major (independent but interdependent) trauma educational programs for the emergency providers; (3) to demonstrate to both provider groups the roles, duties, and responsibilities of the other; and (4) to determine how both entities can work together in order to provide the best patient care.

The impact of ATLS/PHTLS

Several studies have already shown the effectiveness of the ATLS course, such as decreased mortality in the first hour of admission and improved survival in high-risk patients in rural trauma hospitals when these specific ATLS interventions were performed.1 Other studies have shown improved outcomes in trauma patients, along with improved knowledge and demonstrable skills among ATLS participants.2-4 ATLS has even been shown to be a factor contributing to lower per capita trauma death rates in a population review of the U.S.5

The PHTLS course has been shown to be valuable as well, with decreased mortality and morbidity in established emergency medical services (EMS) systems.6 Arreola-Risa and colleagues suggested the effectiveness of PHTLS courses was in an increase in the use of life-saving interventions en route to the hospital, producing a decrease in patient mortality from 8.2 percent to 4.7 percent after introduction of the course. This improvement was produced without an associated increase in on-scene time.7

The need for ATLS on the road

Before Hurricane Katrina, TLSTC, which is housed in the department of surgery of Tulane University School of Medicine, trained more than 250 students in ATLS each year, along with 2,880 Advanced Cardiac Life Support students. Most of the fall 2005 courses had been filled when Hurricane Katrina forced evacuation of the city. Katrina hit one week after the eighth course out of 14 ATLS courses scheduled for 2005; furthermore, a full year of courses had been planned for 2006. The hurricane’s devastation left many physicians without a place for ATLS training for the upcoming months. In addition, many physicians in rural Louisiana had not been trained in trauma care, when the need to participate in the management of injured patients suddenly became necessary. As a result, the demand in Louisiana for ATLS training increased, while the largest ATLS training provider in the region was temporarily out of commission.

As the population of southern Louisiana scattered throughout the surrounding parishes, communities absorbed quite an unexpected population shift and medically needy patients significantly increased. The aftermath left local physicians and other health care providers overburdened with work. It also highlighted the need for specialized casualty/trauma care training for people and facilities that might not use it regularly. At the same time, Hurricanes Katrina and Rita destroyed or decommissioned the majority of the other medical educational resources in southern Louisiana.

To respond to the need, TLSTC created a mobile training unit for ATLS with the goal to take it on the road where it was necessary. It became apparent that training for the prehospital providers was as needed as physician training. The offshoot was a program to train providers and physicians together in order to add their skills as a team for trauma care and not as isolated personnel working without the knowledge of the jobs of others. There is a need for continuity of care from the time of the incident to the discharge from the hospital. The principles of care are the same—only the preferences of care are different because of the situation, condition, skills, and fund of knowledge and equipment available.8

The impetus for the creation of ATLS was the need to establish a uniform system of trauma care delivery that could be implemented in rural communities. James Styner, MD, FACS, identified the need for the course in 1978 after his plane crash in the cornfields of Nebraska. The EMS staff provided better care for his patient than did the personnel in the hospital. The idea was to take urban trauma center-level treatment algorithms to low-volume trauma clinics and hospitals in order to achieve a positive impact in outcomes. This approach, not surprisingly, has shown that rural physicians benefit from ATLS training significantly more than those practicing in urban trauma centers where those care plans are frequently used. The ATLS, however,
did set the standard for emergency trauma care in both large and small hospitals, just as PHTLS has set the standard for prehospital care. In the larger facilities that have a large volume of trauma patients, care sometimes is carried out automatically by a multidisciplinary team with responsibility for decision making based on ATLS details, and when the operating room is immediately available and the patient can be in that operating room within five to 20 minutes after arrival. The majority of courses are taught in or near these large urban trauma centers.

The aftermath of the hurricane forced the recognition of the need for this training in more rural areas where educational resources are not readily available. Consideration of alternatives was necessary. The use of uniform educational process and accepted ATLS/PHTLS patient care principles were used in the training.

Site visits were first conducted by the ATLS coordinator with subsequent approval by the American College of Surgeons ATLS division. Previously, TLSTC had used live, anesthetized animals for all of the skills laboratories under Institutional Animal Care and Use Committee approval. Simulaid Corporation donated two Trauma-Man systems for the surgical skills portion of the course. The Louisiana Department of Health and Hospitals advertised the availability of the course. The visiting facilities offered their space to hold the courses without charge. A total of six courses in Louisiana and two in Austin, TX, were held.

The courses allowed physicians to establish new bonds and referral resources for critical patients. The course evaluation questionnaires demonstrated a significant improvement in knowledge, skills, and professional interactions as a result of the participant having taken an ATLS course “on the road.” The experiences reinforced studies showing that attitudes and confidence toward trauma scenarios is improved after proper training.

The addition of PHTLS

Since its induction in 1980, the ATLS course has grown in popularity worldwide, now being adopted in more than 55 countries. The course addresses the management of an injured patient immediately upon arrival at the hospital. ATLS represents one link on the chain of care. The PHTLS course addresses the same needs of the patient before arrival in the hospital.

Trauma is a surgical disease from beginning to end. The beginning is when the injury occurs, not when the patient arrives in the hospital emergency department door. The PHTLS course teaches the knowledge and skills necessary to treat trauma patients in the prehospital environment—components that are now included in the curriculum of “Trauma on the Road.”

The Louisiana Emergency Response Network (LERN) was developed to coordinate statewide trauma care from a recognized need. In consultation with TLSTC, the LERN and FLEX (Medicare rural hospital flexibility grant) programs helped increase awareness for the integration of rural EMS operations into local, regional, and statewide networks and other activities designed to strengthen education of rural EMS providers. PHTLS courses were not available after the hurricane, so the decision was made to bring both courses on the road at the same time.

Combining the ATLS and the PHTLS has the potential to offer a better team approach than when they are taught separately. Three ATLS and PHTLS courses were held simultaneously at the different locations. These courses were offered to critical access hospitals physicians and EMS medics who transport to those facilities, allowing the physicians and medics to interact during lunch presentations on both days. On the first day, the two groups were given a presentation of the LERN goal and vision. On the second day, both groups received a lecture on the critical care transport teams by EMS. Allowing and fostering interaction between different medical personnel has its own benefits. Interdisciplinary training has shown to lead to high levels of participation, group skills, information sharing, networking, and sense of community.

ATLS and PHTLS have been offered at the same site with combined breaks and luncheons for interaction between the physicians and the EMS providers. The next step will be to develop a prototype educational format that will combine lectures with the approval of the ATLS subcommittee and the PHTLS Committee, which should assist in the understanding of the same care at different locations but using the same principles.
As noted previously, trauma is a surgical disease from beginning to end. The beginning is not when the patient arrives in the emergency department, but when the incident occurs. The beginning of patient care is not when the emergency physician or surgeon sees the patient, but when the emergency medical technician arrives on the scene and begins to provide care. Unless the prehospital provider and the surgeon think alike, speak the same language, and manage patients in the same way, the patient will not necessarily receive a continuum of care from the scene to the emergency department to the operating room to the intensive care unit.

For this continuity to happen, the prehospital provider and the surgeon must follow the same protocol principles and standards of care. The PHTLS course was developed in cooperation with the Committee on Trauma of the American College of Surgeons so that the PHTLS would be based on ATLS principles and correct surgical preferences. Therefore, teaching the PHTLS and the ATLS courses together highlights the same principles to both groups. More importantly, however, having two groups together at the same time and interacting builds a framework for team patient care. It allows the surgeon and the prehospital provider to know each other and be able to exchange ideas and teach each other about the uniqueness of each environment so that the patient receives the best possible care.

Teaching PHTLS and ATLS courses together achieves these goals. The combined ATLS/PHTLS program has received good reviews from physicians and prehospital providers. The number of participants in the courses to this date has not been sufficient for a scientific assessment, but the approval rating is certainly high enough to continue the program.

Conclusion

There has been acceptance of the program by the physicians and the prehospital providers. Developing a mobile course that uses manual simulators has made the program portable so that it can be easily transported to rural physicians. In the past, the rural physicians had to visit the major trauma center, either in the northern part of the state (Shreveport) or the southern part of the state (New Orleans) to have access to live animals. Currently this program is available on an as-needed basis throughout the state. Therefore, participants from smaller
communities with only a few physicians do not have to travel a distance and leave their patients without care while taking the course. The portability makes the course available to rural physicians in adjacent states. This trial model has been very successful as a prototype and is being expanded throughout Louisiana, and such a prototype could be used for other rural communities throughout the U.S.

What began as a temporary response to a disaster that was expected to continue only until the buildings were repaired developed into a vital advancement in the offering of ATLS and PHTLS together. This approach is a new tradition of trauma education for the ATLS and PHTLS training team in Louisiana. This advancement in trauma education can be replicated in other educational centers.

References
According to the annual report of the Board of Governors, professional liability continues to be among the top concerns of Fellows of the American College of Surgeons. It’s no wonder. Severity of losses continues upward. Liability insurance costs are commonly more than 20 percent of a surgeon’s taxable income. These costs may lead to forced retirement, unwanted change in practice venue, or risking one’s estate by going “bare.” A recent trend toward stability in the frequency of claims has led many liability insurers to hold the line on escalating insurance premiums. However, the current unchecked escalation in severity of losses and economic conditions that lessen the income earned from investing premiums and reserves signal that future premium increases may be forthcoming.

Since 2002, the College has sponsored a liability insurance program underwritten by The Doctors Company (TDC) for Fellows to consider in comparison with other insurance options. Largely unmarketed, the ACS program has been available primarily for Fellows who find themselves in egregious liability insurance circumstances, although the product has always been one worthy of consideration by all.
The new ACS liability insurance program

During his recent College presidency, Gerald Healy, MD, FACS, urged the ACS leadership to begin pursuing a cost-saving liability insurance program sponsored by the College from a different perspective: aggressively linking liability with risk management and patient safety programs. Seeking ways to alleviate Fellows’ liability woes, Dr. Healy reasoned that Fellows of the ACS should be favorable outliers that are less expensive to insure than the norm by virtue of membership selection criteria, especially if their insurance is linked to an upscale patient safety/risk-management education program. After meeting with ACS leaders and giving due consideration, TDC embraced this logic and agreed to underwrite a redesigned ACS liability insurance program that should be sustainable with lower premiums and more deductions, reflecting the lower risk of surgeon-policyholders with enhanced risk-management skills obtained from ACS and TDC patient safety risk-management education tools.

The proposed program, as envisioned by Dr. Healy, would also link the Fellows’ educational requirements for premium reductions to states’ Maintenance of Licensure and Maintenance of Certification requirements of surgical certifying boards. These requirements are becoming much more stringent. Thus, joining all these efforts into one package would hopefully mitigate the hassle factor of more and more paperwork.

ACS sponsorship of the program reflects an enthusiasm for TDC, not a criticism of any other insurance carrier. The College is committed to this program because it has the potential to provide tangible economic benefit for its Fellows through risk management and safe care. Even so, College members are encouraged to explore all insurance options and decide for themselves which carriers can best provide for their needs.

In tandem with this important recognition, the ACS leadership realizes that many Fellows are active on the boards of other insurance companies, working to ensure favorable insurance products and services throughout the industry. In that regard, it is noteworthy that physicians fill half the positions on TDC’s board, and Donald Palmisano, MD, FACS, former member of the ACS Professional Liability Committee and past-president of the American Medical Association, is uniquely positioned as a member of the TDC board to speak for the interests of surgeons and their patients.

The ACS program is self-funded; for TDC, it is a separate block of business. The actuarial success of the program depends on the combined loss ratios* of Fellow-subscribers and is evaluated separately from the other TDC business. A viable program requires that premiums exceed expenses plus losses. Thus, the cost of insurance and success of the program depend on the quality of care provided and the risk-management behavior practiced by the participating Fellows. In this case, premiums are expected to be lower, because policyholders are all Fellows of the College and because TDC’s risk-management and patient safety education programs, in concert with the ACS Division of Education, should be superior to any currently available.

The ACS program is unique, but similar programs have been developed by TDC with other specialty and subspecialty groups: the American Society of Plastic Surgeons (since 1990), the American Academy of Otolaryngology–Head and Neck Surgery (2003), the American Association of Neurological Surgeons (2001), and the American College of Physicians (2002). Developing these programs has provided TDC with valuable experience, and our newly crafted contract, which expands the boundaries of such ventures, reflects the confidence we share in the prospects for sustaining lower premiums through safer care.

Even so, success is not guaranteed. The original contract between TDC and the College was negotiated in 2002. Although without significant marketing and without a sophisticated patient safety/risk-management plan, TDC’s small ACS book of business† is performing slightly worse than its book of surgeons outside of the program. The program’s combined loss ratio has averaged 109 percent since inception, 106 percent over the last five years, and 105 percent over the last two.

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*The combined ratio is the ratio of total insurance costs (claim costs plus operating expenses) to revenue; 100 percent represents break-even; anything below 100 percent represents a profit.
†As of the 2nd quarter report for 2008, 281 Fellows are insured.
Our new contract includes a wide range of favorable premium discounts driven by new training and patient safety initiatives. We hope the program will quickly develop a risk pool of sufficient size that achieves superior performance, leading to meaningful long-term reductions in the cost of insurance for Fellow-subscribers. Time will tell.

**Patient safety/risk-management agenda**

The patient safety/risk-management agenda is a major emphasis of the program. Arguably, recent improvement in the program’s combined loss ratio may well be a reflection of the Division of Education’s dedication to patient safety initiatives. In 1999, the Institute of Medicine’s report *To Err Is Human* challenged policymakers to pursue changes in the delivery and governance of health care to reduce errors and enhance patient safety. Following the lead of the Accreditation Council for Graduate Medical Education and data from the ACS Closed Claims Study, the Division of Education began to augment and diversify its education programs. Among the six core competencies, practice-based learning, professionalism, and communication have received newfound emphasis. TDC and the Division of Education are working together to develop an educational package that will protect the assets of the program and lower premiums by enhancing patient safety and reducing surgical risk. Designed in accordance with the vision of ACS leaders, this package has the potential to reduce the hassle factor of the ongoing escalation of paperwork; it is hoped that documentation of continuing medical education requirements for the program will be accepted as sufficient for Maintenance of Licensure, Maintenance of Certification, and possibly even provide evidence for the Fellows to negotiate a true pay-for-performance plan. Efforts toward this end are ongoing.

**TDC**

TDC has achieved substantial market share in nine states (California, Florida, Georgia, Maryland, Ohio, Oregon, Texas, Virginia, and Washington) and is positioned to assess risk and price coverage with a high degree of confidence. In five states, the liability environment is so unpredictable as to preclude any attempt to correctly judge losses; TDC premiums in New York, New Jersey, Massachusetts, Mississippi, and Illinois will not likely be competitive. The remaining states are all reasonably in play.

Soon TDC will begin to aggressively market the ACS liability insurance program. Initially, efforts will be in states where losses can be most accurately predicted. Even though the program will be available to all of us, competitive rates will be more random in the other states. However, TDC will attempt to contact Fellows everywhere that its pricing seems to be sufficiently attractive. Over time, data will accrue to facilitate more accurate pricing nationwide. In the meantime, the stability of the program is likely to be enhanced by selective marketing, maximizing participation by Fellows in those states where losses can be accurately predicted. Even so, Fellows in other states should take advantage of the program depending on careful comparisons with other options. Given the program’s unprecedented deductions, TDC is apt to be a preferred choice.

TDC provides deductions for all of its subscribers: a claims-free discount of 17.5 percent and a Tribute Plan contribution that is currently 11.4 percent. In addition, as a result of TDC negotiations with the ACS leadership (represented largely by Dr. Healy and Paul Collicott, MD, FACS, Director of the Division of Member Services), ACS program members receive an additional 5 percent discount and the College will receive a 2.5 percent to 5 percent unrestricted grant. In sum, the current potential for savings is 38.9 percent of premiums. Rates will vary depending on actuarial results, but the deduc-

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4 Discounts are common in the liability insurance industry, but the Tribute Plan is unique to TDC. Introduced in 2007, this plan is funded by the TDC board to pay a tribute for loyalty commensurate with the level of premiums paid over time. To receive Tribute, a subscriber must have at least five years of continuous coverage with TDC; reach at least age 55; and retire or become permanently disabled (upon death, Tribute becomes part of the subscriber’s estate and thus can be inherited). Tribute is now in its third year of a planned $250 million, five-year initial allocation. Designed to fulfill TDC’s mission to “advance, protect and reward the practice of good medicine,” this benefit plan has met with overwhelming approval according to annual member surveys.
tions will continue for Fellows with favorable loss experience.

Because premiums can be higher or lower depending on an insurance company’s return on investment of reserves and other business activities, the ACS has carefully assessed the financial practices and stability of TDC. The physician-owned company was founded in 1976 to address the first-ever liability crisis. Now with 43,000 members, more than $3 billion in assets, and $840 million in policyholder capital, A.M. Best gives TDC an A– rating (excellent) and Fitch Ratings gives it an A rating (strong). Reflecting its conservative investment strategy, the company has sustained itself during the recent financial crisis with minimal impact to its portfolio. To ensure ongoing transparency, TDC leadership will report actuarial and membership data quarterly to the ACS and will meet with the ACS Professional Liability Committee at least once a year.

**ACS pledge to its Fellows: Mitigate liability**

The ACS has been extremely sensitive to the liability issues of its Fellows. With College support, tort reforms that include caps on noneconomic damages have been enacted in more than half of the 50 states and are effective: Even including states with poor cap legislation, physicians pay premiums that are on average 17 percent lower than the premiums of physicians in states without caps. However, efforts to promote federal tort reform have been expensive and largely unsuccessful; given the current political climate in Washington, current efforts at the federal level are directed toward supporting pilot programs for medical courts and other tort alternatives.

The College has also promulgated standardized informed consent forms to assure that patients clearly understand the potential risks of surgical procedures. For use by defense and plaintiff attorneys, guidelines for identifying quality expert witnesses have been promulgated in an attempt to reduce the pervasiveness of “hired guns.” To enhance accountability, an expert witness affirmation form—which, when signed, expresses the witness’ willingness to submit his or her testimony for peer review—has been crafted. Risk management courses and CDs designed to assist Fellows in navigating the perils of liability are available as well.

This new and improved ACS-sponsored liability insurance program is the latest addition to the College’s efforts to mitigate Fellows’ liability woes. This product is currently offered and information is available on the ACS Web portal, which also provides a link to TDC. To obtain this information, (1) go to www.efacs.org and log in; (2) under “Member Services” at top of home page, click “Member Benefits”; (3) click on the “New programs and exclusive member benefits” link halfway down the page under “ACS Medical Liability Insurance Program.”

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**Dr. Griffen** is professor of clinical surgery at Louisiana State University Health Sciences Center, Shreveport, and chairs the ACS Committee on Professional Liability. He serves as Vice-Chair on the Public Profile and Communications Steering Committee and is a member of the Health Policy Steering Committee.
The following articles are the first of a series of brief essays the Bulletin will publish in the coming months under the theme “My mentor.” These essays are the result of efforts made by the Resident and Associate Society (RAS) of the American College of Surgeons in launching its first essay contest asking residents, fellows, and new faculty to describe in 500 words or less the role that a mentor has played in their development.

In this series, you will read what several outstanding surgical trainees who responded to the contest have to say about the individuals who have mentored them. Through this series, members of the College and other Bulletin readers will learn about 10 extraordinary mentors who have provided both personal and professional guidance for their mentees at various stages of their training.

The leadership of the RAS believes that these mentors are more than just role models—they are pillars of strength and good examples for future generations of surgeons who are attaining technical and clinical skills, while also advancing their interest in research, education, and outreach in an increasingly challenging health care environment. The winner of this year’s essay contest will be announced at the 2009 Clinical Congress in Chicago, IL.
I have recently started as a third-year postgraduate student in general surgery at University of California–Los Angeles (UCLA). My rotations will be a rigorous but standard mixture of trauma and gastrointestinal, thoracic, and vascular surgery, which is an expected training pathway for a U.S. graduate in surgery. However, I am not a U.S. graduate, and my career pathway has been anything but standard.

I attribute a large part of my surgical career in the U.S. to an extraordinary mentor in Julie Freischlag, MD, FACS. Applying to surgical residency three years ago, I had sent my application to many top-ranked programs. By January, I had been invited to interview at only two programs. Departing the interview in Professor Freischlag’s office in drizzling January rain, all I felt was hope; her positive and encouraging tones were like a bright torch of light in a damp and emotionally turbulent few months.

I matched as a preliminary surgical resident at Johns Hopkins in the intern class of 2006–2007. Professor Freischlag recognized the sacrifices and emotional and financial hardship I had endured in coming here and had the open-mindedness and strength of character that it takes to bring one’s professional reputation into question for the sake of someone else’s aspirations.

Without a social security number, automobile, cellular phone, or apartment, I would steam my shirt in the hotel shower, hail a cab in the morning and evening, and use a pay phone to call internationally to my parents. Through those trying first few months, I called upon my mentor for advice and direction. Professor Freischlag encouraged, sympathized, and ultimately had enough faith in me to smooth the edges of a raw transition into residency in the U.S.

Two years into residency, I was about to enter probably the most important interview of my career: a categorical surgery position at UCLA. I was reminded when I met the program director how historically UCLA has not taken an international medical graduate into its categorical program. Two weeks passed with no word. I called my mentor and uttered superlatives regarding the position. The job signified my transition from passive onlooker to part of the process, and Professor Freischlag understood the significance of this in my life.

It was after a call from the program director at UCLA that I realized the full extent of my mentor’s dedication to my cause. Sitting near the chairman of surgery at a surgical meeting in California, conversation turned to the opening at UCLA. Professor Freischlag handed a folded napkin across the table. “This is the person you need to take in your program. He is perfect for the job.”

As I tried to remain composed when replying to the one position that validated the past five years of hard work, the lasting words of the program director at UCLA could not have more greatly underlined the compassion and understanding extended to me by Professor Freischlag. “I look forward to working with you at UCLA. I am expecting great things from a man with such stellar support from his chair.”

Dr. Bath is a third-year postgraduate student in general surgery at University of California–Los Angeles.
Omaha, NE, is a railroad town, which ensures that it’s on the right track. This city played a historic role in the triumphant westward expansion of the U.S. and, consequently, in its unprecedented national growth and prosperity. To me, John Mellinger, MD, FACS, is like Omaha, in that he represents an extraordinary station along my Iron Road to professional and personal expansion and success.

Professional growth during surgical training is imperative and best engineered by a dedicated, tireless mentor. Dr. Mellinger not only functions as the chief of the section of gastrointestinal surgery and program director of the general surgery residency at the Medical College of Georgia, but he serves an even more vital role—mentor. To his credit, he avoids merely driving everyone down the same track. Instead, individual students, residents, and faculty choose their own track as Dr. Mellinger stokes the furnace, flips the switches, and throws the brakes to ensure each ends up on the right rail for their desired destination. He conducts his mentorship with impressive enthusiasm and undeniable class while offering an unparalleled model of persistent professionalism. All the individuals who work with or around him grow into genuinely respectful and exceptionally competent surgeon physicians.

Although professional development is critical, it occurs in conjunction with significant personal maturation, a progression that should not be overlooked. Well aware of this concept, Dr. Mellinger energetically fosters the personal growth of all learners. He accomplishes this worthwhile goal through various means, including invitations to his home, participation in extracurricular activities with students and residents, team-building exercises, faith-based opportunities, and an open-door policy for professional and personal issues. In addition, resident personal development is an important point of discussion during required biannual review sessions. In essence, Dr. Mellinger serves as an exceptional model of professionalism but, perhaps more importantly, provides a genuine representation of all the best humanity has to offer.

Although benefits of mentorship are great, few are tangible; yet, Dr. Mellinger strongly believes that the finest mentors become increasingly less valuable as the learners mature and prosper. He reminds me that true mentorship is not measured by the length of the curriculum vitae but rather in humility and the reflected glory of others. Again, these are examples of wise council and deep appreciation for his primary role—that of mentor.

As I embark on my surgical journey, I recall Promontory Summit, where driving of the golden spike signified completion of the transcontinental railroad. The joining of westbound tracks from Omaha and eastbound tracks of the Union Pacific Railroad established a means for growth and prosperity. As a general surgery resident, I drive to reach my own Promontory Summit, the end of one line and the beginning of the next. Such a journey is only possible with the tireless inspiration and support of a celebrated mentor. Therefore, I feel it is imperative to pay homage to the railroad town, furnace feeder, switch operator, and brake man who provides me with a point of embarkation, a well-fed fire, and an iron-clad direction—thank you, Dr. Mellinger. I hope to be half the mentor to others that you are to me.

Dr. Bittner is a general surgery resident, department of surgery, Medical College of Georgia School of Medicine, Augusta, GA.
Only a few weeks after graduating from the Boston EMS Academy as an emergency medical technician (EMT), my truck responded to a working fire in the southern part of the city. Flames poured from the upper level of the house and the noise was overwhelming, with screaming and rushing sounds of fire and water. We took two of the most badly burned patients and made our way to Boston City Hospital (BCH) as quickly as possible. Erwin Hirsch, MD, the director of the BCH trauma service, met us at the trauma doors. Unfazed and commanding, he directed the patients into the trauma rooms and oversaw the resuscitation efforts. As a naïve and inexperienced EMT shaken by the anguish of the fire, to me, he seemed larger than life during those moments, a reassuring presence that medicine could help the suffering.

Almost five years later to the day, I arrived on the surgical floor at the old BCH, now the Harrison Avenue campus of Boston Medical Center, in the short white coat of a Boston University medical student. Dr. Hirsch was no different than I remembered from the ambulance; he still suffered no fools and his priorities remained patient care and education. Dr. Hirsch reminded us at every opportunity that BCH offered the highest standard of care and that all patients who came there, no matter their socioeconomic status, should be given that care. His intensive care unit (ICU) rounds were legendary for the fear they inspired; no resident dared be unprepared for “guerilla rounds.” Past an age when most attendings would be thinking of retiring, Dr. Hirsch was not only still actively working, he was still taking frequent trauma call. He was notorious for roaming the halls at odd hours while on call, and we always knew he was nearby if we needed him.

As gruff and “guerilla” as he could be, the other side of his devotion to medicine was his devotion to the people in his life and those of the hospital. At the wedding of one of his former residents, he beamed with pride when he saw her so happy. When a Boston EMS member was admitted to the hospital, he personally watched over the care and fiercely protected the member’s privacy. And on most of the nights he took call, he could be found in the ICU break room, counseling chief residents on their career plans.

As a student, I simply thought of these things as “Dr. Hirsch-isms”; now, during surgical residency, these lessons of professionalism, lifelong learning, and compassion keep me both grounded and vigilant. Eleven years after I met him in the parking lot of BCH, he remains larger than life in memory. Dr. Hirsch—husband, father, Viet Nam veteran, Naval officer, surgeon, and mentor to countless doctors, nurses, EMTs, and paramedics—died in a boating accident on May 23, 2008.

BCH, and those of us he trained, will never be the same.

Dr. Powell is a general surgery resident at New York University School of Medicine, New York, NY.
Coding issues related to the global surgery period

by Debra Mariani, CPC, Practice Affairs Associate, Division of Advocacy and Health Policy

This column lists some frequently asked questions regarding Current Procedural Terminology (CPT)* recently posed to the ACS Coding Hotline and the respective responses. ACS members and their staff may consult the hotline without charge as a benefit of membership in the organization. (For details, go to http://www.facs.org/ahp/coding/secoding.html.) Members and their coding staff may contact the ACS Coding Hotline at 800/227-7911 between 8:00 am and 6:00 pm Mountain Time, holidays excluded.

Several days after hernia repair (49560), a patient developed an infection at the site of the incision. When the patient came into the office, the surgeon inspected and cleaned the wound, changed the patient’s dressings, and administered antibiotics. Can we bill for this visit?

Because the surgeon was able to treat the postoperative complication without returning to the operating room (OR), the visit and treatment are included in the global surgical package of the hernia repair and are not separately reportable.

A patient developed an infection several days after a hernia repair (49560). The infection was severe, reaching deep into the surgical wound. The surgeon sent the patient back to the OR for debridement. How should the debridement be coded during the global period for the hernia repair?

Use the debridement codes, such as 11000, Debridement of extensive eczematous or infected skin; up to 10% of body surface, with the modifier –78, Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period.

It is important to note that, according to the National Correct Coding Initiative (NCCI) manual,

*Treatment of complications of primary surgical procedures is separately reportable with some limitations. The global surgical package for an operative procedure includes all intraoperative services that are normally a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require return to the operating room. Thus, treatment of a complication of a primary surgical procedure is not separately reportable (1) if it represents usual and necessary care in the operat-

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2008 American Medical Association. All rights reserved.
ing room during the procedure or (2) if it occurs postoperatively and does not require return to the operating room.

The surgeon performed a hip replacement on a patient, who later, during the postoperative period, came to the office for a sprained wrist caused by a fall. Treatment for the wrist was performed in the office. Can we bill separately for this?

Yes, this office visit can be billed separately. Use modifier –24, Unrelated evaluation and management service by the same physician during a postoperative period, when, during the period of follow-up care for one surgical service, the surgeon provides an evaluation and management (E/M) service unrelated to the original condition.

A new patient visited the office for a consultation for abdominal pain. The surgeon determined that the patient needed immediate surgical care and scheduled the operation for later that same day. Is the initial visit separately reportable, or is it considered part of the global period for the surgery?

An E/M service that resulted in the initial decision to perform an operation may be identified by adding modifier –57, Decision for surgery, to the appropriate level of E/M service.

The NCCI manual offers the following guidance: “If an E/M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E/M service is separately reportable with modifier –57. Other E/M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable.” The global period for a major procedure is 90 days.

The manual also states that, “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service.”

A new patient who had recently had surgery with a physician in another state visited the office for postoperative care only. Do we bill each visit for postoperative care because our physician did not perform the operation?

The physician who performs the postoperative management reports the operative procedure code with the modifier –55, Postoperative management only.

Where can I go for additional information?

For help with coding and bundling issues, go to http://acs.codingtoday.com/ for a free 30-day trial of Coding Today, sponsored by the ACS.

Resources

- National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, Centers for Medicare & Medicaid Services
- Principles of CPT Coding, 5th ed, American Medical Association
Then and now: A three-year progress report on e-FACS.org
by George F. Sheldon, MD, FACS, and Jerry Schwartz, Managing Editor, ACS Web portal

This report encompasses the three-year anniversary of the launch of the College’s members-only Web portal, which should be viewed as a continuous work-in-progress with rapid growth and proficiency of utility.

Since the 2008 Clinical Congress in San Francisco, CA, e-FACS.org has experienced unprecedented growth—during the fourth quarter of 2008, the Web portal enjoyed its largest single increase in visitors and usage since its launch three years ago. In the words of Don E. Detmer, MD, FACS, president and chief executive officer of the American Medical Informatics Association, “It is obvious why the site is being used more by surgeons and used by more surgeons. It is really an asset to the College at this point and has come a long way in a fairly short time” (personal communication, May 27, 2008).

The visitor statistics are revealing: Almost 197,000 page views were generated from October 2008 through December 2008—a 58 percent increase in page views from the previous quarter, and an approximate 38 percent increase over the same quarter in 2007. It should be noted that the fourth quarter has been the portal’s busiest quarter in each of its first three years of existence, as members update their continuing medical education (CME) records during and after the Clinical Congress each year by using the portal’s “My CME” feature. To date, the portal has received a total of more than 1,365,000 page views.

With regard to one of the portal’s most telling statistics—the number of unique visitors—the portal achieved its record highest number of unique visitors during the fourth quarter of 2008. More than 9,200 individuals logged onto the portal during that time, compared with 3,025 who did so during
the first quarter of the portal’s existence. There were 32,285 total visits to the portal in the last quarter of 2008 alone.

One of the reasons for this latest success is the portal’s redesign, which was undertaken and completed last year. Dr. Sheldon credits Mr. Schwartz for the redesign, which took most of the year and was beta tested. Howard Tanzman, Director of Information Technology, and staff addressed technical and design details. Linn Meyer, Director of the Division of Integrated Communications, continues to provide a range of useful analysis and input.

Last fall, reviews of the redesign (received via the portal’s feedback mechanism) indicated that it was having a positive impact on the portal’s usefulness. The innovative features on e-FACS.org are also becoming increasingly popular, as evidenced by the increased number of visits to the Minimally Invasive Surgery

### ACS Web portal editorial board

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Amy C. Degnim, MD, FACS  
- Co-Community Editor: Breast Cancer Surgery

*Names of Associate Community Editors are listed in their respective communities in the portal.

continued on next page
community’s “Image of the Month.” The constant addition of new content, resources, and tools like “My CME” as well as the link to the ACS Case Log system and changes made to the portal as the direct result of user feedback are ongoing. It is expected that these additions and improvements will continue to draw more people into using the portal during the coming year.

The editorial board for e-FACS.org continues to expand. There are now 18 at-large board members in addition to George F. Sheldon, MD, FACS, Editor-in-Chief; Lazar J. Greenfield, MD, FACS, Associate Editor; 51 community editors, and 234 associate community editors. The portal now contains 43 communities, of which 12 are specialty communities; nine are subspecialty communities under the larger General Surgery category. The remainder of the communities focus on areas of special interest—for example, minimally invasive surgery, rural surgeons, international surgery, and surgical patient safety, to name a few. Many of the communities include robust information that is of great educational value to Fellows, Associate Fellows, Resident Members, and Medical Student Members in all specialties.

In addition to new features and content, the portal continues to help the College maximize usage of its print

ACS Web portal editorial board (continued)

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<td>Ira J. Kodner, MD, FACS</td>
<td>Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education</td>
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<td>Community Editor, Ethical Issues in Surgery</td>
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<td>Rosemary A. Kozar, MD, FACS</td>
<td>Heena P. Santry, MD</td>
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<td>Community Editor, Women Surgeons</td>
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<td>Douglas A. Levine, MD, FACS</td>
<td>Marshall Z. Schwartz, MD, FACS</td>
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<td>Co-Community Editor, Gynecology and Obstetrics</td>
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<td>M. Michael Shabot, MD, FACS</td>
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<td>Community Editor, Plastic Surgery</td>
<td>Community Editor, Surgical Informatics</td>
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<td>Robert L. Sheridan, MD, FACS</td>
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<td>Community Editor, Burn Medicine and Surgery</td>
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<td>Wiley W. Souba, MD, ScD, FACS</td>
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<td>Community Editor, Career Mentoring</td>
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<td>Howard Tanzman, Director, Information Technology</td>
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<td>Courtney M. Townsend, Jr., MD, FACS</td>
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<td>Community Editor, Surgical Critical Care</td>
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<td>Community Editor, History and Philosophy</td>
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<td>Juan C. Paramo, MD, FACS</td>
<td>Randall S. Zuckerman, MD, FACS</td>
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<td>Community Editor, Young Surgeons</td>
<td>Co-Community Editor, Rural Surgeons</td>
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<td>John H. Pemberton, MD, FACS</td>
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At-Large Member
vehicles. As an example, at the recommendation of the College’s Advisory Council chairs, the annual reports that are submitted by the boards of the 10 surgical specialties recognized by the American Board of Medical Specialties are posted within the portal’s specialty communities rather than published in the Bulletin.

The authors made a special effort during the past year to encourage increased usage by the Resident and Associate Society (RAS) and the Committee on Young Surgeons. Under the leadership of Heena P. Santry, MD, Residents and Associate Fellows Community Editor, and Juan C. Paramo, MD, FACS, Young Surgeons Community Editor, great progress has been and will continue to be made via conference calls with those groups. Dr. Santry was invited to be a guest speaker at the annual meeting of the portal’s editorial board and to present her community’s goals in an effort to assist other community editors with planning and implementing goals within the portal’s framework. That format was so successful that it will be used for future meetings.

During the coming year, portal content and features will be further expanded even as portal staff explores the full capabilities of the latest version of the College’s portal software. The portal is now entering its second phase of development, and it still has many advancements to offer members of the College. In addition, recruitment of new editors will help to strengthen some of the communities.

The confidence of the ACS Board of Regents in the mission of the Web portal is most appreciated, as is the useful input regularly received from the members of the College’s Committee on Informatics.

Dr. Sheldon is Editor-in-Chief of e-FACS.org, the College’s Web portal. He is professor of surgery and social medicine and former chair of surgery, University of North Carolina–Chapel Hill. He is a former Regent and Past-President of the College.

Top 20 most visited communities on the Web portal

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<tr>
<th>Minimally Invasive Surgery</th>
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<td>General Surgery</td>
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<td>Surgical Oncology</td>
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<td>Surgical Patient Safety</td>
<td>Career Mentoring</td>
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Trauma meetings calendar

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

- Medical Disaster Response 2009, April 5, Caesars Palace, Las Vegas, NV.
- Practical Methods & Techniques: Bedside ICU Skills Workshop, April 5, Caesars Palace, Las Vegas, NV.
- Trauma, Critical Care, & Acute Care Surgery–2009, April 5–8, 2009, Las Vegas, NV.
- Trauma, Critical Care, & Acute Care Surgery 2009–Point/Counterpoint XXVIII, June 8–10, 2009, Baltimore, MD.

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/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
Programs accredited by the Commission on Cancer (CoC) of the American College of Surgeons make a commitment to their patients to invest their resources in the best available methods for the early detection and treatment of cancer. And the Commission is there—every step of the way—to help each accredited program meet the challenge.

The Commission on Cancer provides a model for managing your facility’s cancer program by:

- Setting standards to promote high-quality, multidisciplinary patient care
- Facilitating ongoing assessment of your program’s activities
- Providing real-time access to National Cancer Data Base data to evaluate and improve your delivery of care

Even more, CoC-accreditation earns recognition from national health care organizations for meeting performance measures for high-quality cancer care. The American Cancer Society also acknowledges and supports the importance of CoC accreditation through its National Cancer Information Center and other patient-focused resources.

Patients rely on your facility to provide a comprehensive approach to their cancer care, and the Commission on Cancer can help your program provide access to the highest level of cancer care for your patients.

Get ready. Learn about the Commission on Cancer Approvals Program today.

Visit the Commission’s Web site at: www.facs.org/cancerprograms/mh08
Or send an E-mail query to: CoC@facs.org
Issues and policies addressed at the AMA Interim HOD meeting

by Jon Sutton, Manager, State Affairs, Division of Advocacy and Health Policy

The American Medical Association (AMA) Interim House of Delegates (HOD) meeting began during a momentous week for the nation that concluded with the election of President Barack Obama and a new Congress. While these events played on the minds of the delegates, a more somber air hung over the meeting because of the passing of the AMA’s immediate past-president Ronald M. Davis, MD. Dr. Davis, a public health physician from Michigan, lost his nine-month battle with pancreatic cancer immediately before the HOD met. A moving tribute to him was made at the opening session of the HOD, setting a tone of reflection for the rest of the meeting.

The College’s delegation strongly advocated on behalf of the American College of Surgeons and the surgical community and was composed of the following surgeons:
- Richard B. Reiling, MD, FACS, Delegation Chair
- John H. Armstrong, MD, FACS, Delegate
- Carlo A. Dall’Olmo, MD, FACS, Delegate
- Charles W. Logan, MD, FACS, Delegate
- Chad A. Rubin, MD, FACS, Delegate
- Sanjay R. Parikh, MD, FACS, Young Physician Section Delegate
- Patricia L. Turner, MD, FACS, Young Physician Section Liaison
- Hannah Zimmerman, MD, Resident and Fellow Section Delegate

The Surgical Caucus of the AMA (SCAMA), which continues to operate smoothly under the management of the College, met during the HOD meeting. This meeting’s education session—Eighty-Hour Work Week: Where Did It Come From and Where Is It Going?—was presented by Timothy Flynn, MD, FACS, vice-chair of the board of directors of the American Council for Graduate Medical Education; Member, Executive Committee of the ACS Board of Governors; past-chair of the American Board of Surgery; and interim senior vice-president for clinical affairs at the University of Florida College of Medicine. Following this session, William Huffaker, MD, FACS, a plastic surgeon from St. Louis, MO, assumed Caucus chairmanship from Dr. Armstrong, who completed his three-year tenure. Dr. Rubin was elected to serve as a Member-at-Large of the SCAMA Executive Committee, as was Cynthia Goto, MD, a delegate from the American College of Obstetricians and Gynecologists.

**Issue highlights**

With a reduced number of resolutions and reports, the HOD had many important advocacy issues for consideration, including several of greater interest to surgery.

- **College-sponsored resolutions:** The College joined a number of national specialty societies to cosponsor two specific resolutions, both of which were adopted by the HOD.

  The first resolution, substitution of biosimilar medicines and related medical products, directed the AMA to monitor legislative and regulatory proposals to establish a pathway to approve follow-on biological products and to analyze these proposals to ensure that physicians retain the authority to select the specific products their patients will receive. The resolution also asked the AMA to work with the U.S. Food and Drug Administration and other scientific and clinical organizations to ensure that any legislation that establishes an approval pathway for follow-on biological products prohibits the automatic substitution of biosimilar medicines without the consent of the patient’s treating physician.

  The second resolution dealt with use of retired questions from the U.S. Medical Licensure Examination Step 3. Many specialty organizations and the AMA have expressed serious reservations about the National Board of Medical Examiner’s (NBME) decision to use these
questions out of concern that the doctors of nursing practice certification exam process could be used to draw inaccurate and misleading comparisons of equivalency among different health care providers or among different NBME exams. The HOD concurred and adopted the policy that the integrity of the physician (medical doctor and osteopath) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills, and training of physicians. In addition, HOD directed the AMA to develop model state legislation for use by state medical societies and national specialty societies to prohibit NBME from using the present or past content of the USMLE Step 3 exam in the certification processes for nonphysician providers.

- **Patient-centered medical home:** A resolution was adopted to accept the principles of the patient-centered medical home while encouraging further study of the concept with particular emphasis on funding sources and payment structures. These broad principles were originally developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. During extensive testimony, the ACS delegation and specialty care community expressed serious concerns regarding the details associated with promoting the medical home as a model for patient care and physician payment and reminded delegates that the AMA Council on Medical Service is working on a major report on the patient-centered medical home for this year’s annual HOD in June.

  As part of this discussion, the HOD also referred language developed by the surgical community for consideration by the Council on Medical Service, calling on the AMA to work with all interested specialty societies to continue to study the patient-centered medical home concept. Particular emphasis would be on ensuring that the value-added services of the medical home are fully funded by financing mechanisms outside the Medicare Part B physician payment pool, including from private insurance, Medicare Parts A and D, and Medicaid; that patient access to necessary quality specialty care without a gatekeeper is preserved; that patients can select any qualified physician practice as his or her medical home; and that unity within the House of Medicine be preserved.

- **Self-referral:** An ethics policy that offers specific guidance pertaining to legally permissible contractual arrangements that provide opportunities for self-referral was adopted.

- **Disruptive behavior:** The AMA will work with The Joint Commission and other interested parties to develop a definition of disruptive behavior by a physician to include the actions that would rise to the level of true abusive behavior and to include rules for an appeals process that complies with due process for physicians accused of disruptive behavior. It will work to ensure that allegations of disruptive behavior by a physician are handled by the organized medical staff through its established bylaws and will approach The Joint Commission to delay by one year implementation of the new standard regarding disruptive behavior to give medical staffs time to bring their bylaws into compliance.

**Other news**

Dr. Reiling is running for reelection to the AMA Council on Medical Education at the AMA’s annual meeting in June in Chicago, IL.

Dr. Armstrong chaired the AMA Disaster Medicine Caucus, which featured a presentation regarding lessons learned from Hurricane Ike by Kenneth Mattox, MD, FACS, an Alternate HOD Delegate from Texas. Dr. Mattox emphasized that effective medical response is always local and that acute clinical health needs in the storm’s aftermath are over within 36 hours.

For further information on the Interim 2008 AMA HOD and surgical involvement in this meeting, contact Jon Sutton at jsutton@facs.org.
Symposium on end-of-life care to be held in May

A national symposium dedicated to enhancing physicians’ understanding, comfort levels, and skills in dealing on a more personal level with terminally ill patients will be held May 8 at The New York Academy of Medicine (NYAM). The Art of Medicine at the End of Life, a continuing medical education symposium, will expose physicians to the cultural, spiritual, and practical aspects of the physician-patient relationship at the end of life.

Geoffrey Dunn, MD, FACS—medical director, Palliative Care Consultation Service, Hamot Medical Center, Erie, PA, and Chair of the College’s Surgical Palliative Care Task Force—will join a faculty of experts on end-of-life issues, including Arthur Caplan, PhD, a well-known authority on bioethics.

This highly interactive course is an annual symposium sponsored by the Cunniff-Dixon Foundation and the NYAM. Using short, didactic lectures, discussions, and case presentations, speakers will address how to achieve the following:

• Prepare patients and their families for the transition to the end of life
• Implement a strategy to provide a more personal and informed level of patient care and thus enhance the quality of life for terminally ill patients
• Recognize the appropriate time to suggest palliative care or hospice for terminally ill patients and facilitate the process
• Anticipate common ethical and legal issues that arise in the context of end-of-life medical care
• Apply an understanding of the psychiatric aspects of mortality to improve the quality of interactions with terminally ill patients and their families
• Recognize and accommodate the needs of patients and families from various cultures and religions who are coping with the end of life
• Understand research and policy trends in palliative care

The fee for the course is $225 for physicians and $125 for resident physicians who register before April 1, 2009. Fees will increase after the registration deadline and at the meeting. For detailed course information and to register, visit http://www.nyam.org/events/?id=494.

ACS Career Opportunities

The American College of Surgeons’ online job bank

A unique interactive online recruitment tool provided by the American College of Surgeons.

An integrated network of dozens of the most prestigious health care associations.

Residents:

• View national, regional, and local job listings 24 hours a day, 7 days a week—free of charge.
• Post your resume, free of charge, where it will be visible to thousands of health care employers nationwide. You can post confidentially or openly—depending on your preference.
• Receive e-mail notification of new job postings.
• Track your current and past activity, with toll-free access to personal assistance.

Contact phaar@facs.org for more information.
As I report on my experiences at the 2008 Clinical Congress in San Francisco, CA, which convened in October 2008, I reflect on how the Nizar N. Oweida, MD, FACS, Scholarship provided educational opportunities and financial support, enhanced collegial relationships, and made the meeting a positive influence on my surgical practice. I have attended the Clinical Congress several times in the past, but the Nizar N. Oweida scholarship made this particular meeting most memorable.

My educational expectations were well met. Scientific programs were arranged so that I was able to maximize my experience while not feeling as if I was missing out on other coinciding sessions. The sessions I chose provided relevant information that will enhance my practice of general surgery for years to come. Once again, I am encouraged to practice with increased confidence, knowing the decisions I make in practice with my patients in rural Iowa are in line with the standards of the Fellowship of the American College of Surgeons.

Financial support provided through the scholarship allowed me to attend skills-oriented postgraduate courses. At past Clinical Congresses, I rarely attended postgraduate courses because of their cost and conflicts with other sessions. Being able to attend the entire Clinical Congress this year provided the additional time needed to select courses and scientific programs that complemented one another, making this an exceptional experience.

The Clinical Congress always provides an avenue to renew relationships with colleagues from my training program at Wright State University in Dayton, OH. In addition, the meetings provide ample opportunities to establish and nurture relationships with colleagues that will be valued for years to come. Specifically, these were enhanced through the Scholarship Program luncheon and the rural surgeons meeting.

My surgical practice always receives a boost when I am able to attend the Clinical Congress. The scholarship provided the financial freedom and flexibility of time that helped make this meeting exceptional. Hopefully, my patients, partners, and employees are also reaping benefits from my receipt of the scholarship and attendance at the meeting.

The Nizar N. Oweida Scholarship has been very beneficial to me. I am grateful to the Oweida family for their continued scholarship support and to the ACS for administering it. I also wish to encourage other qualified surgeons to submit their applications for this scholarship in the future.

Dr. Breon is cofounder and director of Iowa Rural Surgical Associates, Oskaloosa, IA.
One-year surgical ethics fellowship available

The MacLean Center for Clinical Medical Ethics at the University of Chicago has announced the opportunity to apply for a surgical ethics fellowship endorsed by the American College of Surgeons. This program is designed for surgeons who are interested in gaining training and experience in medical ethics and is intended to prepare surgeons for academic work related to medical ethics.

The program will begin with a six-week, full-time, intensive introduction in July and August. From September 2009 to June 2010, fellows will meet one day a week for a structured ethics curriculum that will include Topics in Clinical Ethics, Conceptual Foundations of Health Law, and Analytic Philosophy and research-in-progress seminars. Fellows will also receive training in ethics consultation and will be expected to commit to two to three months of consult service. Working with faculty mentors, each fellow will design and execute at least one research project. Additional activities for each surgical ethics fellow will be individualized.

Funding of up to $50,000 for participation in the yearlong fellowship training program is available to a limited number of applicants. An additional option of a part-time surgical ethics fellowship is also available. Applicants should prepare a personal statement plan that explains the following: (1) how the surgical ethics fellowship will be useful in their career, (2) how much projected time the applicant will have to pursue his or her goals during the fellowship year, and (3) how and whether the funding will ensure the necessary projected time to achieve these goals.

Applications must be submitted by March 15, 2009, and are available at http://medicine.uchicago.edu/centers/ccme/SurgicalSite/Fellowships.html. For further information, contact Peter Angelos, MD, FACS, at pangelos@surgery.bsd.uchicago.edu or Mark Siegler, MD, at msiegler@medicine.bsd.uchicago.edu.

CSPS to co-convene symposium in May

The Council on Surgical & Perioperative Safety (CSPS) and Joint Commission Resources Inc. are cosponsoring a symposium—Improving, Enhancing, and Sustaining Positive Patient Outcomes—to convene May 8–9 in Chicago, IL, at the Sheraton Chicago Hotel and Towers.

The target audience for this symposium is surgeons, anesthesiologists, nurse anesthetists, perianesthesia and perioperative nurses, surgical physicians’ assistants, surgical technologists, pharmacists, and all others who provide care and services within the surgical area. The conference goals of increased teamwork and improved communication translate to better patient outcomes, which are topics of interest to business leaders (such as chief executive officers and chief financial officers) and risk management professionals.

At the end of the conference, participants will be able to describe the current state of perioperative safety and prioritize strategies for improvement within their respective organizations; analyze the methods presented to determine which would most effectively enhance the interdisciplinary care model at their organization, evaluate and apply interdisciplinary approaches designed for specialty patients/situations, examine tenets of and advocate for medication safety in the perioperative area, and investigate causes of surgical/anesthesia errors as a means to develop preventive processes.

To register for the symposium and for more information, visit http://www.jcrinc.com/Conferences-and-Seminars/Perioperative-Safety-Symposium/1512/. For more information on the CSPS, visit http://www.cspsteam.org/, or contact Denise Goode at dgoode@facs.org.
The outstanding 34-year reputation of Selected Readings in General Surgery (SRGS) for surgeons and residents continues. Published by the American College of Surgeons, Division of Education, SRGS offers the same high-quality content, put into practical applications and various viewpoints.

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- Commentary on advances in basic sciences—providing a more complete understanding of surgical problems.
- An online CME program where you can earn credits that meet the requirements of Part II of the American Board of Surgery’s Maintenance of Certification program.

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Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its October 11, 2008, meeting:

• Prasad Chalasani, a general surgeon from Mill Neck, NY, was suspended from the College following disciplinary action by the New York Office of Professional Medical Conduct. His license to practice medicine in New York was revoked on March 10, 2008, following a finding that he had violated his previously imposed terms of probation. The disciplinary action taken by the College was reported to the National Practitioner Data Bank (NPDB).

• Jose Alberto Gonzalez Garcia, a colon and rectal surgeon from Mexico City, Mexico, was expelled from the College after it was determined that he had falsified his credentials.

• Leon G. Josephs, a general surgeon from North Easton, MA, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following disciplinary action by the Massachusetts Board of Registration in Medicine which placed his license to practice medicine on probation effective July 9, 2007. The disciplinary action taken by the College was reported to the NPDB.

• Milton Moore Slocum, a general surgeon from Shreveport, LA, was expelled from the College. This action was taken following disciplinary action by the Louisiana State Board of Medical Examiners on August 20, 2007. Specifically, his license to practice medicine was placed on probation for three years following charges of computer-aided solicitation of a minor for sexual purposes, indecent behavior with juveniles, and attempted possession of child pornography. The disciplinary action taken by the College was reported to the NPDB.

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

• The Fellowship of Michael S. Clarke, an orthopaedic surgeon from Springfield, MO, was placed on probation with conditions for reinstatement. This action was taken following disciplinary action by the Missouri Board of Healing Arts, which placed his license to practice medicine on probation effective July 9, 2007. The disciplinary action taken by the College was reported to the NPDB.

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.
Membership in the American College of Surgeons?

HERE’S WHY IT’S IMPORTANT:

AS A BODY REPRESENTING ALL OF SURGERY, THE COLLEGE:

• Provides a cohesive voice addressing societal issues related to surgery.
• Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
• Is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients.
• Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

THERE IS STRENGTH IN NUMBERS.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to shape the College’s agenda for the future.

If you aren’t a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain that status and consider getting involved in the work of the College.

Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

HERE ARE SOME OF THE MANY BENEFITS BEING A MEMBER OF THE COLLEGE AFFORDS YOU:

• Free preregistration at the Clinical Congress
• Access to the College’s free coding consultation hotline
• Subscription to ACS NewsScope, the College’s weekly electronic newsletter
• Subscription to the Bulletin of the American College of Surgeons
• Subscription to the Journal of the American College of Surgeons
• Access to all College-sponsored insurance, credit card, and other helpful programs
• Free posting of resume on ACS Career Opportunities

Information on becoming a member of the College and an application form are available online at www.facs.org/dept/fellowship/index.html

or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800/293-9623, or via e-mail at chicks@facs.org.
An essential feature of a sustainable clinical trials organization, such as the American College of Surgeons Oncology Group (ACOSOG), is a network of site investigators who are actively enrolling patients. In 1999, ACOSOG was a startup clinical trials organization that had to develop clinical protocols and simultaneously build a network of participating surgeons and sites. An open membership model was used to attract interested investigators and, thus, develop a multisite network to work cooperatively to conduct cancer trials.

The ACOSOG membership has grown to 3,200 physician/surgeon investigators and since 1999 there have been approximately 350 investigators who have consistently participated in ACOSOG trials and are identified in its membership database. The network for conducting trials in breast, thoracic, and gastrointestinal cancers was born.

A clinical trials network can be defined as a group of site investigators who consistently enroll patients into series of prospective clinical trials, follow treatment regimen, and provide clinical data for the primary and secondary endpoints. Such investigators are not only dedicated to providing clinical care but also to improving treatment outcomes through evidence-based approaches.

A unique feature of a breast, thoracic, and gastrointestinal network is that it recognizes the specialization that has occurred in cancer treatment. The breast cancer investigators are different than the thoracic and gastrointestinal investigators. Surgeons and medical and radiation oncologists tend to specialize in specific organ site cancers. This difference is apparent with ACOSOG breast, thoracic, and gastrointestinal networks of investigators.

A network is crucial to the long-term success and sustainability of ACOSOG. ACOSOG, like many of the other cancer cooperative groups, offers multiple trials within a disease site and is continuously pursuing successor trials. This approach is somewhat unique to oncology, where incremental improvements in patient survival or other outcomes come from a series of trials that are conducted over decades. In addition to trials, networks are important for communications and cost-effectiveness. Each ACOSOG network has e-mail lists that are useful for targeting news updates, announcing investigator meetings, and conducting Web-based electronic surveys (see pages 41-42 of the March 2008 Bulletin for a related story).

A network is also cost-effective. The infrastructure of ACOSOG includes accounting, contracting, site monitoring, and data management. When these functions are considered, the cost of overseeing 100 sites versus 20 sites is very different. Although a network of 20 sites is ideal, it may not be feasible in all oncology trials because specific cancers may be rare and distributed at hundreds of sites—an important justification of National Cancer Institute (NCI) support of the cooperative group mechanisms. Without such support, advances in cancer treatments could not occur.

The ACOSOG Breast Cancer Committee and its network serve as an example. In 1999, the ACOSOG sentinel lymph node trials were initiated. A group of active investigators were established. In 2005, the ACOSOG neoadjuvant aromatase inhibitor and neoadjuvant chemotherapy Herceptin trials were opened and communications were sent to the established network of investigators and to all ACOSOG members.

ACOSOG is dedicated to supporting disease-specific networks with more trials. This network provides fresh scientific involvement, a steady revenue stream to support the site clinical trials research staff, and steady accrual and
justification for a NCI-funded cooperative group. ACOSOG is focused on government-funded trials, but industry-funded trials are being developed in order for the disease-specific network to diversify the portfolio of trials.

ACOSOG’s organ site networks have developed since 1999. Ten years later, there is consistency in its participating members who have become seasoned trial investigators with a viable business model to sustain their clinical trials activities. In the future, ACOSOG will search for other means to support these disease-specific networks. Additional NCI funds were recently distributed to high-enrolling ACOSOG sites based on the recommendations of the Clinical Trials Working Group. ACOSOG membership will likely evolve and you are encouraged to become part of the ACOSOG network of investigators. To learn more about becoming a member, go to www.acosog.org or contact Dr. Ota at david.ota@duke.edu or Dr. Nelson at nelsonh@mayo.edu.

Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG co-chairs.
Surgeons who seek accreditation for their ambulatory surgery center (ASC) from The Joint Commission can be ensured of the accreditation program’s continuing “deemed” status option. The Centers for Medicare & Medicaid Services (CMS) has again granted The Joint Commission deeming authority for ASCs for its maximum six-year period.

The CMS designation means that ASCs accredited by The Joint Commission will be deemed as meeting Medicare certification requirements. CMS found that The Joint Commission’s standards for ASCs meet or exceed those established for the Medicare and Medicaid programs. CMS estimated in 2007 that approximately 4,600 ASCs participate in Medicare.

“This public-private collaboration between CMS and The Joint Commission provides quality oversight for ASCs, which are increasingly important as patients undergo surgical procedures in freestanding centers, that are often owned and operated by surgeons, outside of the traditional hospital setting,” says Michael Kulczycki, executive director of The Joint Commission’s Ambulatory Care Accreditation Program.

“Accreditation is voluntary and seeking deemed status through accreditation is an option, not a requirement. Beginning in 2007, organizations seeking entry into the Medicare program must be certified initially by one of four accrediting bodies, including The Joint Commission, that have been awarded deeming authority by CMS. For subsequent surveys, organizations may choose to be surveyed either by an accrediting body, such as The Joint Commission, or by state surveyors on behalf of CMS. All deemed status surveys are unannounced.

Established in 1975, The Joint Commission Ambulatory Accreditation Program accredits more than 1,600 freestanding organizations that offer surgical, diagnostic/therapeutic, and medical/dental services. More information about the program is available on The Joint Commission Web site at www.jointcommission.org or contact Michael Kulczycki at 630/792-5286 or mkulczycki@jointcommission.org.
EXAMINE THE ETHICAL UNDERPINNINGS OF THE ISSUES YOU FACE EVERY DAY

A case-based educational resource for surgeons at all stages of their careers, Ethical Issues in Clinical Surgery has all the components needed to help surgeons and residents examine the ethical underpinnings of clinical practice and address the ethical issues they face every day caring for their patients.

Ethical Issues in Clinical Surgery was developed by the Committee on Ethics of the American College of Surgeons.

TOPICS
- Framework for considering ethical issues in clinical surgery
- Competition of interests
- Truth telling and the surgeon-patient relationship
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FEATURES OF EACH CHAPTER
- Realistic surgery-based cases
- Learning objectives
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- Analyses of cases and questions
- Bioethics bottom line
- Suggested readings
- Glossary and additional resources

There are two versions of the book: one for course instructors and practicing surgeons that has CME credit available, and one for use with residents.

Pricing and ordering information can be found at http://www.facs.org/education/ethicalissuesinclinicalsurgery.html or by calling 312/202-5335.
The National Trauma Data Bank® (NTDB) consists of data that have been voluntarily submitted by trauma centers around the country. Therefore, by nature, the database provides a convenience sample and not a population-based data sample. In order to obtain a nationally representative sample of trauma patients treated in U.S. level I and II trauma centers, the American College of Surgeons was awarded a contract in 2005 from the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention to create the National Sample Project (NSP). We introduced the NSP as a new application of the NTDB in the February 2006 Bulletin (see page 44). Through the hard work and dedication of countless individuals, data aggregation and analysis have continued and for the first time the results appear in the NTDB Annual Report.

The NSP is a stratified statistical sample based on NTDB data of 100 level I and II trauma centers. Stratification was based on U.S. Census region (Northwest, Midwest, South, or West), level of trauma center designation (I or II), and whether the trauma center participated in voluntary NTDB data submission for the submission year 2003 (NTDB submitter versus non-NTDB submitter), resulting in 16 strata. Statistically derived weights were then assigned for each hospital. Weighted estimates from admission year 2003-2006 were computed based on the NSP data. The yearly comparison of number of incidents, age (see graphic on this page), sex of patient, Injury Severity Score, mechanism of injury, and percentage of deaths are displayed in Appendix C of the Annual Report, version 8.0.

The goal of the NTDB NSP is to enhance current injury information by providing nationally representative baseline estimates of trauma care to meet the needs of trauma care assessment, clinical outcomes research, and injury surveillance. For more information on the NSP, including a detailed description of how the sample was created and how the sample is maintained, as well as a user manual, visit http://www.facs.org/trauma/nsp/
When reviewing the NTDB 2008 Annual Report, remember: “Don’t overlook the appendix.”

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.

**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.

**Dr. Fildes** is chair, department of trauma, University Medical Center, Las Vegas, NV. He is also program director for general surgery, surgical critical care, and acute care surgery; professor and vice-chair, department of surgery; program director, general surgery residency program; and chief, division of trauma/critical care, University of Nevada School of Medicine, Las Vegas. He is Chair of the ACS Committee on Trauma.

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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](http://www.facs.org/education/rap)

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