Dealing with DIFFICULT PATIENTS
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
Since 1984, the Association of Program Directors in Surgery (APDS) has fulfilled an important function—to provide a forum for those surgeons who are responsible for ensuring that surgical residents acquire the skills and knowledge they will need to provide optimal patient care. A key figure in the APDS and the American College of Surgeons, Robert E. Berry, MD, FACS, has written a highly detailed account of the organization. In light of this development, I thought now would be a good time to look back on the history of the APDS and the College’s ongoing relationship with it.

**History of the APDS**

The APDS is truly the brainchild of Dominic A. DeLaurentis, MD, FACS, who in 1966 was appointed chief of surgery at Baystate Medical Center, Springfield, MA. At that time, Dr. DeLaurentis was an active member of both the ACS and the Whipple Society. The purpose of the Whipple Society was to provide a forum for discussing problems in surgical education. In time, the organization extended into a national group and formed an alliance with the like-minded Society of Surgical Chairmen.

As some of you may recall, surgical training was entering a transformative period in the late 1960s and early 1970s. Until then, residency programs varied, with chiefs of surgery having a degree of freedom to design their own curricula. However, once the American Board of Surgery (ABS) and the American Medical Association (AMA) combined forces to create the Conference Committee on Graduate Training in Surgery—now known as the Residency Review Committee for Surgery (RRC-S)—training programs had to start adhering to certain prescribed requirements and offering a well-defined curriculum.

Because of our significant interest in surgical education, the College presented a seminar at the 1974 Clinical Congress designed to familiarize surgery residency program directors with the RRC-S’ purposes and activities. It was appropriate for the College to present this program, given its long-standing relationship with the ABS and the AMA.

Then, in 1978, the Whipple Society presented its last forum. Disappointed with the demise of the organization, Dr. DeLaurentis; Robert Hermann, MD, FACS; and several associates lobbied the ACS to present a seminar specifically for program directors and surgical educators. The Director of the College at that time, C. Rollins Hanlon, MD, FACS, and Assistant Director, Frank Padberg, MD, FACS, agreed to provide a venue for the first meeting of the program directors at the 1979 Clinical Congress in Chicago, IL.

The session that sprang from this collaborative effort, “Forum for General Surgery Program Directors,” addressed some of the problems unique to university hospitals, non-university hospitals, and veterans’ hospitals. It also included discussion of the following concerns: The creation of a central registry for openings in residency programs, what to do about displaced residents who might want to change programs, replacement of residents, whether residency programs should be reduced in number, whether to restrict the number of residency slots available to international medical graduates, the ideal amount of training in trauma care, and so on. The program drew a standing-room-only audience.

Subsequent to that meeting, Dr. Hermann
received approximately 20 letters expressing enthusiastic support for the program and requesting the formation of an organization specifically for program directors. The interested parties came together in 1980 as a steering committee charged with drawing the blueprint for the APDS (see sidebar, page 6). As Dr. Berry said in a recent e-mail exchange, “They are the people who identified the major issues that needed to be passed on to the neophytes, the residents who became surgeons.”

**Relevance today**

Dr. Berry’s book, *The Association of Program Directors in Surgery: A History of Origin and Maturation, 1966–2001*, is based largely on the prodigious minutes and notes archived by Robert S. Sparkman, MD, FACS, as well as Dr. Berry’s own material and information provided by Dr. DeLaurentis; Dr. Hermann; Arthur H. Aufses, Jr., MD, FACS; and Paul Friedmann, MD, FACS. It chronicles the APDS’ subsequent growth and maturation into an independent group, which continues to have strong ties with the ACS and to sponsor a program at the Clinical Congress. It also remains closely linked with other groups that are dedicated to surgical education, including the American Association of Medical Colleges, the Association of Residency Coordinators in Surgery (ARCS), and the Association for Surgical Education (ASE). In fact, the APDS, ARCS, and ASE present an annual Surgical Education Week. This year’s Surgical Education Week took place in April in San Antonio, TX, and featured the unveiling of Dr. Berry’s book.

Throughout the history of the APDS, its leaders have demonstrated a rare ability to foresee and address head-on the issues that affect postgraduate surgical education, such as work-hour...
restrictions and workforce shortages. Furthermore, the APDS remains a potent force in training our residents’ trainers, matching medical school graduates with residency programs, and cosponsoring multiple activities tailored to the changing needs of program directors. In short, the APDS has been, and continues to be, vital to the ongoing improvement of our nation’s health care system and the strengthening of the surgical workforce.

The College and the APDS maintain a close working relationship, one that clearly demonstrates how the ACS can work with smaller groups of surgical professionals to deliver the educational programming and services that all surgeons need now and will depend on in the future.

David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
As part of the federal stimulus package, Congress enacted the Health Information Technology for Economic and Clinical Health (HITECH) Act, which includes a number of provisions designed to encourage the adoption and use of health information technology (HIT) tools. Specifically, the HITECH Act provides incentive payments to eligible professionals (EPs) and eligible hospitals that participate in Medicare and/or Medicaid programs, and that adopt, and meaningfully use, certified electronic health records (EHRs).

In this article, information is provided regarding what an EP must do to show “meaningful use” of an EHR, how an EHR becomes “certified,” who is eligible for the incentive payments, the incentive payment amounts, the timeline for showing meaningful use, and what surgeons can do now to prepare to meet these requirements.

What is a certified EHR?

The EHR incentive payments will be available only to those EPs and eligible hospitals that meaningfully use certified EHRs. The Office of the National Coordinator for Health Information Technology (ONC) also plans to release two final rules early this summer, along with the CMS meaningful-use criteria final rule. The first ONC rule will establish the initial standards, implementation specifications, and certification criteria that EHR technology will need to include in order to, at a minimum, support meaningful use. The second ONC rule will set forth the actual process and procedure by which those systems will be certified, including the identification of certifying organizations. These two ONC rules will provide the framework and the process for determining whether an EHR is certified for meaningful use in an ambulatory setting.

What is meaningful use of electronic health records?

The Centers for Medicare & Medicaid Services (CMS) is expected to release the definition of meaningful use—including the specific criteria that EPs must meet—in a final rule by early summer. This rule will enumerate specific parameters in the form of measures for showing meaningful use of certified EHR technology. Although the specific measures have not been finalized by the CMS, at this time, the HITECH Act requires that meaningful use must encompass, at a minimum, the following requirements:

- Use of certified EHR technology in a meaningful manner
- Use of certified EHR technology in a manner that provides for electronic exchange of health information to improve quality of care
- Use of certified EHR technology to submit information on clinical quality measures to the Secretary for the Department of Health and Human Services

The HITECH Act states that the program must start in 2011, but does not indicate specific requirements that will begin in 2011, or how those mandates may change over time. The CMS rule will finalize the meaningful use criteria for 2011, and future CMS rules will describe how the requirements will change in subsequent years.

Who is eligible for the HIT incentive payments?

Most surgeons will fall under CMS’ definition of an EP, and thus will qualify for the Medicare incentive payments. Hospital-based physicians—defined as those who provide at least 90 percent of their professional services in an institutional setting as determined from Medicare claim point-of-service codes—are ineligible for the Medicare
incentive payments. Based on CMS’ definition, the vast majority of surgeons would not be considered hospital-based and, therefore, would be eligible for the HIT incentive payments.

To qualify for the Medicaid incentive payments, an EP must attest that at least 30 percent of all patient encounters in a continuous 90-day period in the most recent calendar year were with Medicaid patients.

**What is the incentive payment amount, and when would penalties for noncompliance kick in?**

The American Recovery and Reinvestment Act of 2009 makes an estimated $19 billion in incentive payments available to EPs under Medicare/Medicaid programs over a specified five-year period. These payments are intended to encourage physicians to adopt and use certified EHRs in a meaningful way.

**Medicare incentive payments**

Physicians (non-hospital based) are eligible for Medicare incentive payments based on an amount equal to 75 percent of the allowed Medicare Part B charges, up to a maximum of $18,000 for early adopters whose first payment year is 2011 or 2012. Incentive payments would be reduced in subsequent payment years, eventually phasing out in 2016. Physicians who do not adopt an EHR system before 2015 will face a reduction in their Medicare fee schedule starting at 1 percent in 2015, but there are exceptions for significant hardship cases. EPs could receive a maximum of $44,000 in Medicare incentive payments. Physicians in rural health professional shortage areas who use EHRs could be eligible to receive a 10 percent increase on Medicare incentive payments.

The table on this page shows the expected incentives and potential reductions from 2011 to 2016.

**Medicaid incentive payments**

EPs (non-hospital based) who annually meet a patient volume threshold of 30 percent Medicaid patients are eligible for the Medicaid incentive, which is a maximum of $63,750 in a six-year period.

**When should I start demonstrating meaningful use of my EHR to qualify for the incentive payments?**

For EPs, each “payment year” is the same as a “calendar year.” For years 2012 and onward, meaningful use must be demonstrated for the entire payment year. For example, to demonstrate meaningful use for the 2012 payment year and receive the 2012 incentive payment, EPs must demonstrate meaningful use from January 1, 2012, to December 31, 2012.

For 2011 only, the first year of the program, the rules are slightly different. For 2011, EPs must demonstrate 90 days of continuous meaningful use by the end of the 2011 fiscal year, which is October 1. That means, in order to receive the first $18,000 piece of the EHR

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**Maximum total amount of EHR incentive payments**

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>First calendar year in which the EP receives an incentive payment</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 and on</th>
</tr>
</thead>
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<td>$18,000</td>
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<td>2013</td>
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<td>12,000</td>
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<tr>
<td>2014</td>
<td>4,000</td>
<td>8,000</td>
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</tr>
<tr>
<td>2015</td>
<td>2,000</td>
<td>4,000</td>
<td>8,000</td>
<td></td>
<td></td>
<td>$0; -1 percent of Medicare fee schedule (penalty)</td>
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<td>2016</td>
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<td>$39,000</td>
<td>$24,000</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

*Note: A calendar year equals a payment year.*
incentive payment, EPs must demonstrate that they met meaningful use requirements daily for 90 days, starting no later than July 1, 2011, and ending on October 1, 2011.

What can surgeons who do not already have an EHR do to prepare to achieve meaningful use?

EPs shopping for an EHR should look for a vendor who will guarantee that its product will achieve meaningful use as defined by CMS in the final rule. Although the final rule has not yet been released, it is important that a potential EHR vendor include such a guarantee as a written contractual obligation. In addition, the contract should include a clearly defined punishment clause or penalty in the event the EHR fails to support meaningful use as defined by CMS. The penalty could include some, or all, of the incentive payment that the EP would have received for that year if the EHR had the capacity to support meaningful use.

It is also important to ask whether the EP will be required to pay extra to update the EHR to meet the meaningful use definition once it is finalized. In addition, EPs should research vendors and consider how financially healthy the companies are. There is a greater chance that new, small vendors with limited resources may go bankrupt in a year or two, leaving the EHR unsupported as rules are updated and finalized. If using a small vendor, it is recommended that the EP obtain a contingency plan in writing in the event that the vendor goes out of business or is bought out by another company.

What can surgeons who already have an EHR do to prepare to achieve meaningful use?

EPs who already use an EHR should review the vendor contract. The College recommends asking a lawyer for a line-by-line analysis of the EHR vendor’s contract to determine how obligated the vendor is to support the EHR as certification standards change and as CMS rules are deleted, revised, or finalized. In addition, EPs should discuss whether the vendor is required to provide meaningful use upgrades for free, or if additional modules will cost more. It is also important to ask the vendor how it plans to keep current with the changing meaningful use rules, including how the EHR will be updated, how much of a work flow disruption the upgrades will create, and how long the upgrades will take to implement.

For more information on the meaningful use incentive and for the most recent updates, go to http://www.cms.hhs.gov/Recovery/11_HighlitIT.asp#TopOfPage.
The difficult or disruptive surgical patient: Practical strategies for diagnosis and management

by Mary H. McGrath, MD, MPH, FACS

In today’s society, many people value courtesy and civility less than they do assertiveness and entitlement. Coupled with negative attitudes about authority, these attitudes can produce patients who behave in a demanding, hostile, or rude way. Dealing with people who are acting unpleasantly is stressful. As surgeons consider their own professionalism, they need to recognize inappropriate patient behavior and have a strategy for managing difficult interpersonal situations.
There are patients whose personality styles and mindsets stimulate conflictual relationships. These individuals may have characteristics that range from demanding or manipulative to serious and pervasive neuroses or distorted thinking. The following series of articles will describe the personality characteristics of difficult patients, show how to recognize them, and explore the types of negative feelings these individuals can evoke in surgeons dealing with these patients. The key step in managing difficult patients is for physicians to understand their own feelings about them. When the surgeon can define the provocation and recognize his or her own reaction to it, that surgeon is able to step back and take constructive action. By avoiding emotions that cloud judgment or over-personalize interaction with the patient, a physician is in a position to be calm, professional, and able to set limits.

Research shows that physicians who report having many difficult patient encounters are 12 times more likely to report “burnout” than those reporting fewer difficult encounters. Thus, it appears that the professional and personal well-being of a physician depends, in part, on managing conflict and reducing unpleasantness in the practice environment. That same research shows that older, more experienced physicians do recognize unhappy patient encounters, but consider fewer patient visits “difficult.” These findings suggest that dealing with problem patients can be mastered.

The following three articles offer practical suggestions for dealing effectively with the difficult patient and the difficult family, and the risk management perspective on these issues in a surgical practice. The core lesson to be learned is that any plan must include the surgeon’s strategy for coping with his or her subjective feelings in these doctor-patient interactions.

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All physicians encounter patients they find difficult to manage and treat. Such patients engender myriad feelings in us, including aversion, anger, fear, guilt, frustration, and anxiety. They may be noncompliant with recommended treatment, challenging to their physicians’ approaches to their care, or resistant to forming an effective alliance with their doctors. Physicians’ negative responses to such patients can offer important clinical data that can help health care professionals take better care of difficult-to-treat patients. Failing to consider and acknowledge negative responses to patients may lead physicians to deliver suboptimal health care and may have a negative impact upon their enjoyment of this profession.

What can surgeons do when they experience these powerfully negative feelings? Ideally, they should use their feelings to help them take better care of the patient. However, sometimes physicians act out such feelings in maladaptive ways. Some potentially maladaptive initial responses to the difficult patient are shown in the table on page 13.

There are several reasons why physicians may act in a maladaptive fashion. The patient–physician relationship can be influenced by factors about which both the patient and physician are unaware. Empathy, when accompanied by

Responding to the difficult patient

by Laurie A. Stevens, MD
patience and tolerance, can lead to insight into the patient’s negative behavior and enable the physician to develop a better partnership with the patient. Failing to exhibit empathy can occur in the presence of “counter-transference.”

**Counter-transference and counter-reaction**

Counter-transference refers to the development, in the physician, of positive or negative feelings toward the patient based on issues in the physician’s own life. For example, if a physician is somewhat emotionally needy, he or she may become overly involved with a dependent patient, leading the physician to provide the patient with undue access to the physician (for example, giving out e-mail or cell phone numbers). If the physician has an overly demanding parent, he or she may overreact with aggression and hostility toward a patient who shares the negative characteristics of that parent.

“Counter-reaction” needs to be differentiated from counter-transference, as this is usually a common or normal response to the patient’s emotions or behaviors. For example, when the patient becomes hostile toward the doctor, the doctor may wish to withdraw, or may feel anger in response. The physician has to try to figure out how to better respond to the patient’s feelings and responses, without personalizing them. This is easier said than done, as physicians, like their patients, are only human, and are subject to their own feelings and those of others toward them.

**Characteristics of difficult patients**

In his insightful article in the *New England Journal of Medicine*, titled “Taking Care of the Hateful Patient,” James E. Groves, MD, describes difficult patients as those who “kindle aversion, fear, despair or even downright malice in their doctors.” In trying to understand the nature of this situation, Dr. Groves classifies “hateful patients” into the following categories: “dependent clingers,” “entitled demanders,” “help-rejecting complainers,” and “self-destructive deniers.” In placing the difficult patient into one of these categories, it is easier for a health care professional to see their patient’s psychopathology more objectively. Once the surgeon conceptualizes the patient’s pathology, coming up with a clinical approach to deal with the patient’s difficult behavior fits more into the medical model of treating illness and symptoms.

**The dependent clinger**

Dependent clingers alternate between requesting reassurance and demanding many different forms of attention (such as analgesics, long explanations, or the physician’s time). These patients feel like bottomless pits of need, and a physician often finds that they are avoiding the patient’s calls and visits. The behavior of these “velcro patients” comes from a profound need to be taken care of.

One warning sign of the dependent clinger is the patient who idealizes the physician and professes their undying admiration for their doctor. This patient initially makes health care professionals feel special. However, it does not take long for the physician to become “the inexhaustible mother; the patient becomes the unplanned, unwanted, unlovable child.” These are the patients who take up too much time, call outside office hours, request objectively unnecessary office visits, and may “cry wolf” to your answering service, simply to get your attention.

**Maladaptive responses to the difficult patient**

- Ignoring phone calls
- Telling the patient to go to another doctor
- Being accusatory
- Getting angry
- Blaming the patient
- Telling the patient there is nothing wrong with him or her
- Telling the patient there is nothing more to be done for him or her
- Overmedicating the patient to silence him or her
- Dismissing the patient as a “malingering”
- Handing the patient a “sign out against medical advice” form
The best management of such a patient is to set very firm limits regarding appointments and telephone calls. The physician needs to kindly, but clearly, remind the patient that he or she cannot be an inexhaustible resource to the patient, available at any time of day or night. Regular office visits should be scheduled when the patient can see the doctor and ask questions. These actions should give the patient the contact he or she needs without disrupting the office and the physician’s life.

**The entitled demander**

The entitled demander is fundamentally similar to the dependent clinger in terms of his or her neediness; however, this patient’s demeanor is quite different. This patient can be demanding, devaluing, insistent, hostile, on the attack, and intimidating. The entitled demander may threaten to bring lawsuits against the physician, or contact the patient relations department when the surgeon does not respond to his or her demands.

The primary state of this patient is one of entitlement. This state is actually a defense against feelings of loss of control and helplessness. However, when a physician is at the other end of the angry demands and entitled behavior, it is easy to understand how one could become enraged with this patient. An entitled demander makes the physician feel fearful of their threats, such as threat of a lawsuit or a threat to contact the patient relations department and file a complaint. A typical physician’s reaction to this patient is to let him or her know, in no uncertain terms, how undeserving they are of what they are demanding. When the physician reacts in this fashion, the patient becomes even more enraged, demanding, and threatening.

Dr. Groves speaks eloquently about how to handle such a patient, by addressing the patient as follows:

> You say you’re entitled to repeated tests, damages for suffering and all that. And you are entitled—entitled to the very best medical care we can give you. But we can’t give you the good treatment you deserve unless you help. You deserve a chance to control this disease; you deserve all the allies you can get. You’ll get the help you deserve if you’ll stop misdirecting your anger to the very people who are trying to help you get what you deserve—good medical care.

Dr. Groves’ approach enables the physician to tactfully address the entitled and demanding behavior in a constructive manner, rather than to respond with rage and retaliation, which are natural responses to this kind of mistreatment. This approach allows the patient to gratify his or her underlying belief in their entitlement, and reinforces their wish to receive the best medical care.

**The help-rejecting complainer**

The help-rejecting complainer will try to thwart any help offered to them. After their refusal to follow the physician’s instructions, these patients tend to express their feelings of hopelessness by stating that no doctor can help them. Week after week, he or she returns to the doctor’s office to assert that the recommended treatment has failed once again. When the physician is exhausted, the patient declares that the treatment has been unsuccessful. The physician ends up feeling tortured by the patient.

Like the dependent clinger and the entitled demander, the help-rejecting complainer can be viewed as a bottomless pit of need. They seem to wish an undivorceable marriage with their physician, yet they do not seem to wish to get well. When one symptom resolves, another magically appears to replace it. These patients often suffer from undiagnosed and untreated depression.

This patient group makes physicians feel helpless, anxious, and uncertain about their clinical skills. It is usually not constructive to confront this patient about his or her self-defeating behavior. It is important to realize that the patient’s goal is to always be connected to the doctor. They are terrified that if they get better, that they will lose that relationship with the physician.

A good strategy for the physician is to share the help-rejecting complainer’s pessimism that they cannot be “cured.” The physician could suggest treatments that may provide partial relief (but not enough that the patient will be cured, thereby provoking fear in the patient of losing the physician). The physician has to guard against trying to “turf” the patient to another
The self-destructive denier

All physicians encounter patients who exhibit denial of their illnesses. The defense mechanism of denial can be quite positive and adaptive in coping with illness. However, denial is pathological when it interferes with the patient’s ability to seek and accept proper medical care, as is the case of the self-destructive denier.

Unlike the adaptive deniers, patients in this group are fundamentally dependent on others, and seem to be oblivious to their own self-orchestrated destruction. From the physician’s perspective, these patients seem to take great pleasure in placing roadblocks on the way to receiving optimal care. An example of such a patient is the intravenous drug abuser who keeps coming back with yet another complication related to their drug use (such as cellulitis or endocarditis), but avoids seeking treatment for their underlying substance-abuse problem.

The self-destructive denier prompts a physician to feel used, abused, angry, and helpless. The physician resents the fact that this patient uses medical services that could be given to patients who are seemingly more deserving. While younger physicians may try to rescue this type of patient, more experienced doctors may have fantasies of them signing out against medical advice, or even dying. As a result, many physicians often will feel guilty about their hateful feelings towards the patient.

The best management of the chronically self-destructive denier is to be aware of the patient’s unrelenting self-destructive behavior, and to acknowledge his or her helplessness to change that behavior. The physician also needs to set realistic expectations for the medical staff relative to the patient’s ability or inability to follow a course of medical care that will lead to health. One way of thinking about these patients is that they are no different than those patients who have a degenerative or terminal illness for which there is no medical treatment. Our goal as physicians, then, is to provide supportive care and alleviate suffering to the best of our ability.

In summary, taking care of difficult patients can undermine a physician’s enjoyment and satisfaction in the practice of medicine. A negative physician-patient relationship can lead to a very unhappy physician and a dissatisfied patient. Developing clinical strategies to manage difficult patients can foster a better relationship, and lead to a lower risk of litigation and to improved medical care.

References


Dr. Stevens is associate clinical professor of psychiatry, Columbia University College of Physicians and Surgeons, New York, NY.
The words “difficult family” can refer to the conduct of a healthy family in an abnormal situation, or a family with maladaptive dynamics under any circumstances. The common denominator is the families’ need for effective and empathic communication by the surgeons caring for them. The issue of communication has recently received long overdue attention from surgeons and nonsurgeons because of the public’s increasing expectations for disclosure, and the mounting evidence of adverse psychological, economic, and legal consequences of communication failure. Life-threatening illness, in particular, has the potential for long-term repercussions, putting family members at risk for emotional turmoil and major psychological disorders. There is evidence that the way bad news is communicated to families has a profound impact on grieving, bereavement, and subsequent psychosocial function. Despite the rationale for improved clinical communication with families, several barriers remain for surgeons, including attitudinal barriers, practical barriers, and lack of a well-developed framework for communication with families from multiple cultural backgrounds, in various clinical settings.

Attitudinal barriers

Many surgeons see the doctor-patient relationship as just that: the patient—not the patient’s family—is the focus of attention. Family members may be seen as an unwelcome intrusion into an intimate relationship in which the surgeon has assumed grave responsibilities. The “son from out of town” is the familiar shorthand used to describe the scenario in which the surgeon believes he has been challenged unnecessarily by an entitled family member rearing his or her head at the worst possible time, and for the most selfish...
of motives. Challenging the traditional model of the physician-patient relationship is the growing social complexity of medical decision making that parallels the growing complexity of illness itself. The capacity to live with multiple comorbidities assumes a socioeconomic context that extends far beyond the needs and perspectives of the individual patient. The trajectory of illness now frequently passes through periods of prolonged dependence, debility, and incompetence of patients that impose financial, social, and legal obligations upon their family members, in addition to an adverse impact on the health of family caregivers. The focus of health care appears to be evolving from a disease-based model to a more broadly accommodating model that focuses on health and illness as multidimensional experiences for patients and their families. Should this be true, it is inevitable that surgeons will need to acknowledge the importance of family systems theory to better prepare themselves to provide guidance and care.

**Practical barriers**

Practical barriers also complicate communication with families, as anyone who has attempted to locate a private place for a family discussion on a busy hospital floor will attest. Pauline Chen, MD, FACS, pointed out recently, when commenting on a study that documented a lack of empathic behavior by oncologists and surgeons, that the first thing that she worries about when having to disclose bad news to patients is time. The one-hour family meeting occasionally required for complex decision making is not reimbursable, for even the most trivial procedures, despite the fact that communication of bad news is a highly “invasive procedure” when viewed in the context, for its impact upon trust, compliance, and hope.

**The communication sequence**

Since the seminal work of Robert Buckman, MD, in clinical communication in the early 1990s, guidelines for communication with families have been outlined and modified by others with applications in oncology, critical care, and palliative care settings. The approaches to communication with families are an extension of the approaches to communication with an individual. The disclosure of bad news is a fundamental component of clinical communication. This component may be modified to accommodate more complicated communication tasks, such as discussing the transition of goals of care in the face of a rapidly changing clinical situation.

The general sequence of maneuvers in all communication situations is the establishment of the appropriate setting (privacy, comfort), eliciting the patient and family’s understanding of the situation (“Tell me what you know about your husband’s illness”), obtaining permission to proceed with the discussion (“Would you like me to tell you what his test results showed?”), imparting knowledge (“I’m afraid I have some bad news...”), the empathic response (“I can see that this news has come as a terrible shock to you”), and summation (“Why don’t I come by later after he has been seen by the other doctors, then we can discuss where to go from here”).

Joseph Weiner, MD, PhD, and Jesse Roth, MD, working with families of patients near end-of-life, have identified common counterproductive behaviors by clinician communicators that have the potential to increase psychosocial distress (see Figure 1, page 18).

The communication sequence—which progresses from respect to empathy, and, ultimately, to trust—is designed to protect the patient and family from further harm, by giving them a chance to “take a breath” as they adjust to new realities. Whether imparting bad news or setting new goals, the communication sequence will not be perceived as a supportive one if the empathic response is absent.

When stepping into a room with a large, hostile family, the immediate first step is to acknowledge the emotion in the room. Not doing so would be the same as starting a major elective operative procedure without being aware that the patient is profoundly hypotensive. The safe conduct of an operation is a useful metaphor. For both a successful operation and effective communication, the setting and good support staff are key; consent is required; there is a “point of no return”; awareness of the immediate impact of an operative maneuver is critical; and closure is desirable, though not always possible. Like surgery, effective communication with the difficult
family is a learnable skill that is best taught through mentoring.

The palliative care setting

Further refinement in working with difficult families—beyond the basic communication strategies outlined in this article—will require customized approaches that are adaptable to each family’s unique characteristics. This will require increased training and instruction for surgeons regarding family systems concepts. Several models of family systems theory, which have not previously been taught in formal medical curricula, can be applied to end-of-life scenarios—and may provide a useful framework for communication with families of all degrees of psychological health and cohesion.

Recognizing the value of family systems theory, Deborah King, PhD, and Timothy Quill, MD, at the University of Rochester School of Medicine and Dentistry, Rochester, NY,11 applied a theoretical model proposed by Wynne12 in their work with families in the palliative care setting. This model conceptualizes family relational processes as a progressively developing capacity that builds upon previously acquired competencies and experiences. In this model, the most basic level of relating consists of attachments formed between individual members. The more stable these bonds become over time, the better the foundation is for subsequent higher order processes—such as open communication and a willingness to see from another’s perspective—that are prerequisites for collaborative complex decision making. This model predicts that the stronger the underlying attachment bonds within the family system, the more resilient the family will be under duress. Within this framework, the Rochester group was able to identify warning signs of families with seriously disrupted relational abilities, and make recommendations for how to proceed, specifically during the conduct of a family meeting (see Figure 2, this page).

Clinical experience with patients and families receiving palliative care and hospice experience has provided us a rich source of insight into family dynamics and adaptive patterns occurring in the frequently

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**Figure 1**

Avoiding iatrogenic harm while discussing goals of care in the context of serious illness

- Prior to discussion of goals of care with family/patient, assess readiness to acknowledge possibility of serious or life-limiting illness or complications
- Do not make the relief of suffering conditional upon acceptance of a limited or potentially limited life-span
- Do not confuse “denial” with avoidance and normal grieving when characterizing a family that seems reluctant to address goals of care or overly reliant on treatments that yield little benefit
- Do not debate with patient and family about the reality of a serious medical situation
- Avoid presenting medical decisions in a hypothetical, impersonal, and binary manner


**Figure 2**

Recommendations for working with families with seriously impaired relational abilities

- Recognize the warning signs of deep relational dysfunction in the family
- Be prepared to address high levels of family disorganization, conflict, or instability
- Increase the level of structure in family meetings to minimize conflict

harsh light of life-threatening and terminal illness. The application of these models should not be arbitrarily confined to palliative care venues, because the need for effective communication is a clinical constant—its value is not correlated with the patient’s prognosis, but rather, with its capacity to sustain or restore the patient and his or her family’s homeostasis.

Illness is no longer simply a personal experience—recognition of the importance of working effectively with the difficult family is a sign of how far medicine has evolved during the past quarter-century. Much of the clinical experience and evidence regarding how to go about this has come from a specialty—hospice and palliative medicine—that did not even exist a few years ago. Future psychosocial research should identify family system models adapted to surgical settings not limited to end-of-life, and the best way to introduce these models to surgeons in training. Through effective communication, the encounter with the difficult family, previously dreaded, can result in a rewarding experience, with positive long-term repercussions for all parties involved.

References


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The practice of medicine has become more difficult in many regards. Overhead has increased, while reimbursements have decreased. Patients experience similar stress from a financial position, and from the challenges related to access, as well. Patients may experience personal problems that certainly affect their doctor and office relationships. The patient may have a past negative experience—either with care or financial and insurance-related issues—that may influence their current relationships with the medical community. Society, sadly, has frequently encouraged unrealistic expectations that create patient demands and blame, if an inherent risk—even one that is fully explained in advance—occurs. It is also important to consider the fact that people are people, and...
there are those patients and health care providers with personality disorders that can challenge these relationships.

This article focuses on what the physician and the practice can and should do to avoid conflict and to provide a continuous level of good medical care.

If permitted, patient selection—screening difficult patients before acceptance—is the best method to avoid unpleasant patients. The practice administrators should verify whether or not they have a contractual responsibility to treat the new patient. Emergency room call responsibilities usually create a contractual responsibility to see the patient, as does an exclusive managed care relationship, unless otherwise stated. Develop a plan with your office staff for recognizing difficult patients. Do not schedule appointments with challenging patients during busy hours; rather, schedule these patients at the end of the day, when the office staff has additional time available. Always have the staff person ready and available to see the patient, and be sure to avoid utilizing the patient’s family as chaperones. Document activity and discussions honestly, and utilize written care instructions for this documentation. These challenging patient scenarios often create added liability, as well as interfere with a successful patient outcome. When care is challenged, utilize second opinions, and consider firing the patient when you can no longer be responsible for their outcome. (This topic is addressed in greater detail later in this article.)

Patients with personality disorders further challenge care. These disorders can include the following behaviors: manipulative, seductive, confrontational, indecisive—all with unique complexities.

**Generational differences**

In addition to these behaviors, generational differences between the physician and the patient can add another layer of frustration to the situation. Generational differences include “Silents”—the generation before the “Boomers”—who usually are quieter, with a very strong work ethic and the mindset of simply doing what they believe is right. Sometimes patients describe a lack of understanding for their condition. Practitioners should have a team member who can sit with the patient and openly discuss his or her care. Boomers usually have demonstrated a good discussion record, but may have less comfort in interacting with the noncompliant patient. The next younger generations, “X” and “Y,” have unique discussion patterns that impact care.

Basically, recognize that generational differences between the surgeon, the office staff, and the patient may interfere with care. Develop a team to interact with the difficult patient, combining methods to address the patient’s issues. Patients learn in many ways, but the leading three methods of learning and retention are visual, auditory, and kinesthetic. The team should develop visual aids to help instruct the patient, a written or discussion aid to address auditory learners, and lastly, develop a specific patient interaction that addresses kinesthetic learners. This last is the most difficult learning style, as these learners wish to know how care specifically affects them.

To avoid difficulty in dealing with challenging patients, it is also important to establish rules for care, for filling prescriptions, for behavior in the office, and to verify that all the team members are on the same page. The entire team should understand and accept these recommendations. These patients or their family will often “bait” one team member against another, by asking the same questions to multiple caregivers. It is also important to arrange second opinions to confirm care, and to remember to see the patient as often as necessary, allowing adequate time for discussions and documentations, and always with a staff member present. It would be best to refuse to see the patient with their attorney, if the attorney accompanies the patient.

**Financial challenges**

Review billing statements with the patients, as there are patients who can become disruptive solely to avoid billing issues. Others who receive bills during a complication or after care have irate reactions, further escalating the situation. It is recommended to keep the charges reflective of care, but it may be wise to delay sending invoices to the patient until aftercare issues have
been resolved. It is important to have a financial information sheet available that outlines the patient and practice responsibilities. This sheet should cover the deductible and copay amounts, and the patient’s insurance and fees, as well as any additional fees for facility, pathology, radiology, and laboratory, if applicable.

**First visit (without contractual obligation)**

Imagine that the staff tells you a first-visit patient was very difficult in scheduling the visit, and mildly abusive in the reception room while waiting to be seen, uttering negative comments overheard by others. It is recommended to see the patient if you feel you must, but be very cautious and careful about not giving advice or accepting the patient into your care. Avoid getting into an argument with the patient, but be sure to state that you could not provide the required care, possibly saying you believe you could not meet their expectations. The first visit is often the best, and when it starts that poorly, things can only go downhill. If permitted by your managed care contracts, stick to your guns and do not accept this patient for care. The big caveat here is to make sure there isn’t a medical reason for the behavior. Our practices probably would be easier with all simple and pleasant patient problems, but, as we know, that is not often the case. We must take the bad with the good to help appropriate patients. The key is to determine whether there is a medical issue affecting the patient’s behavior that can be reversed. Another approach would be to seek consultation with a psychiatrist who can help manage such a difficult patient. One final note: be cautious about referral patterns. It is wise to have your staff inquire about referring physicians, and difficult patients sent by very good referrals pose an additional burden to provide care or risk losing the referral line.

What if there is a managed care or emergency room contractual obligation to see the patient? It is strongly recommended for practices to negotiate an “out” specifically for patients with a history with the practice. For example, say you were recently sued for malpractice and won a defense verdict by patient Mary Plaintiff. Mary now appears in the emergency room when you are on call, and, to make matters worse, you have the exclusive contract for that group of patients in which she is a member. What should you do? It is important to remember when renewing these contracts to add language that allows you to refuse to see the patient under these and similar circumstances (for example, you recently fired the patient), or to work with the hospital call schedule, rules, and regulations to achieve the same goal. Make sure it has nothing to do with their financial circumstances. Be sure not to violate “dumping laws,” and make specific objections, in writing, for caring for such patients with a pre-existing, altered, or negative doctor-patient relationship.

**After the first visit**

In this scenario, the patient may have had a complication, or any number of issues that interfere with care. You and the entire practice team have outlined what is expected, and the patient continues to violate rules, not follow directions and advice, and keeps coming back with complaints about your care and the outcome. Document your instructions and carefully explain to the patient that you can no longer be responsible for his or her outcome if they do not follow instructions. If he or she continues on this path, make the patient aware that you will release them as your patient. This situation is always difficult for everyone involved, yet continuing down this destructive path does not help the patient, and significantly exposes the physician to possible litigation.

At some point, when the patient repeatedly refuses to follow directions, the physician must give them a time frame—for example, 14 days—in which they must locate another physician. You have an obligation to direct them to a source of doctors—for example, the county medical society, the Yellow Pages, or managed care panel. It should be noted that the physician is required to care for this patient during that 14-day period. The physician should send this notification via both certified letter and through regular mail. It is a generally held belief that nothing good comes via a certified letter, and many patients will not accept such a letter. Therefore, there is a “mail presumption” that if a letter is mailed,
it is received—although the patient may argue this point as well. It is advisable, therefore, to send the patient a copy of the document in a plain envelope without your name or address listed on the outside.

It is important for the physician to strictly adhere to that 14-day deadline, and after the 14 days, to notify the managed care company, emergency room, and hospital, so all can be made aware of this situation. It is also important to continue to respect the Health Insurance Portability and Accountability Act, and to send the patient’s name and release from care notice to those who are protected, or who have a business associate contract with you. It might also be a good idea for the physician to notify his or her liability carrier. Carriers like to hear about such issues, and such disclosures usually do not affect your record.

The most challenging patient of all

The difficult patient who does not reach the level of firing, or whose difficulty was missed during the patient’s first appointment screening, poses a high risk to the practice.

The manipulative, flattering patient can be the most challenging of all. It is important to avoid the ego trap of falling for a patient’s compliments, even as they are not following your medical advice and directions. Physicians should be nice to, but firm with, these patients, and avoid even the slightest perception of inappropriate behavior. I am aware of instances where a comforting hug, even in the presence of a chaperone, has led to state board formal complaints.

There are a plethora of personality disorders that will influence care. Be liberal about including the patient’s family practice physician, clergy, and family support to achieve a positive treatment plan. No matter how nice these patients may be, always consider second opinions when difficult situations arise—this action shows you truly care about the patient, and it ensures that you do not miss anything. It may be suggested that you offer to pay for the visit, if insurance is a problem, although many colleagues will not charge a fee to you.

In summary, the difficult patient presents many varied characteristics. Rarely do they wear a badge that announces, “I am a difficult patient.” The physician should be sure to listen to their staff and to carefully document—but not excessively—assessment and care recommendations. (Excessive documentation can appear to be more “defensive,” and may not reflect an unbiased account of the circumstances. It is possible to be concise and at the same time accurately document the situation.) Develop a communication team that is able to assist all types of learners and individuals from various generations. The difficult office experience affects everyone in the practice, so listen to the staff about their experiences with the patient and family. Devise an agreed-upon plan for the entire practice. When care is, or could be, compromised, seek second opinions, and consider ending the destructive relationship before harm is done to either the patient or you.

Additional resources


Dr. Reisman is chief, plastic surgery, St. Luke’s Episcopal Hospital, and clinical professor of plastic surgery, Baylor College of Medicine, Houston, TX.
Checklists for success inside the OR and beyond:

An interview with Atul Gawande, MD, FACS

by Tony Peregrin, Associate Editor
Physicians wield an astounding arsenal of knowledge, due in large part to recent advances in science and technology; and yet, even in the hands of highly skilled surgeons, avoidable errors occur. “We can do better,” asserts general and endocrine surgeon and author Atul Gawande, MD, FACS. Specifically, Dr. Gawande points to the humble checklist, used in tandem with good, old-fashioned teamwork, as a way to improve not only quality of care, but as a viable approach to other issues that are important to surgeons in today’s world, such as disaster medical response and health care reform.

To the general public, Dr. Gawande is perhaps best known for his articles in The New Yorker and as the author of two books, Better and Complications, both of which explore ideas for improving the practice of medicine; however, these titles represent only a small portion of Dr. Gawande’s professional contributions. He is an associate professor of surgery at Harvard Medical School, an associate professor in the department of health policy and management at the Harvard School of Public Health, and the associate director of the Brigham and Women’s Hospital Center for Surgery and Public Health. He is also a practicing surgeon, performing 250-plus operations a year.

In his latest book, The Checklist Manifesto: How to Get Things Right, Dr. Gawande examines how a wide variety of disciplines, including medicine, have used a checklist to master extraordinary levels of complexity. The book begins by addressing two fundamental reasons for failure: ignorance (errors that are made due to lack of knowledge) and ineptitude (failing to apply what is already known). “Failure in the modern world,” he writes, “is really about the second of these errors,” and, according to Dr. Gawande, that is why checklists are so essential, particularly for the medical profession.

**Disaster medical response**

Of all the federal and local organizations available to provide disaster relief, it was actually Wal-Mart, the large discount retailer, that had one of the most organized responses to Hurricane Katrina in 2005, observes Dr. Gawande in The Checklist Manifesto. The 43-year-old author is quick to point out that Wal-Mart’s effectiveness wasn’t because the private sector is better than the public sector in handling complex situations. “No, the real lesson,” writes Dr. Gawande, “is that under conditions of true complexity—where the knowledge required exceeds that of any individual and unpredictability reigns—efforts to dictate from the center will fail.” In providing water, diapers, ice, and other goods to the victims of Hurricane Katrina, Wal-Mart store managers in New Orleans relied on a set of checks to ensure critical items were not overlooked, and another set of checks to ensure communication among store employees and senior Wal-Mart managers.

“I came away from Katrina with a kind of theory: under conditions of complexity, not only are checklists a help, they are required for success. There must always be room for judgment, but judgment aided, and even enhanced by procedure,” writes Dr. Gawande.

Checklists have been key for the disaster medical response in Haiti, as well. “With each disaster, surgeons are learning to be more responsive and better organized,” Dr. Gawande says. “The College’s communication alerts

Opposite: Dr. Gawande (photo by Fred Field).
have provided valuable information for the surgeons who are considering joining the relief effort in Haiti.

“I have had the opportunity to speak with members of the International Red Cross about how these situations are managed. Extensive training is provided for medical personnel. At a certain point, these people are sent back to their everyday lives, until another disaster happens and they are called back into action. The Red Cross organizers do not assume that medical personnel and others will be able to recall everything from their training, and so they actually have checklists designed to help them carry out various tasks. That’s how they avoid having things fall through the cracks,” he says.

**Thoughts on health care reform**

“I have never been a crystal ball gazer. I don’t think it’s my strength,” says Dr. Gawande, when asked if he thinks health care reform will pass this year. “I’ve come to the same conclusion that a lot of people have—before the election in Massachusetts, it seemed like a done deal. The reality of the situation is that the number of uninsured people is rising. At the current rate of increase, the cost of family insurance will reach $27,000 or more within a decade, taking more than a fifth of every dollar that people earn.”

The medical profession has developed significant scientific knowledge, but improvements need to be made regarding how that knowledge and care is delivered to the community. According to Dr. Gawande, policymakers need to focus on care that is much better organized, and he underscores the importance of solutions such as checklists to get rid of wasted or unnecessary care.

“We are capable, as a democracy, of taking the steps we need to deal with these problems,” says Dr. Gawande. “In a general sense, we have taken on huge problems like this before as a country. We’ve always had the ability to self-correct. It feels messy, but we have always managed to do it, and we’re not giving up now.”

Specifically, Dr. Gawande is referring to agriculture at the start of the 20th century as an historic example of a costly problem the country has managed to solve. This topic was addressed in a recent article authored by Dr. Gawande for *The New Yorker* titled “Testing, testing: The health care bill has no master plan for cutting costs. Is that a bad thing?” In the article, he points out that in 1900, 40 percent of a family’s income went to paying for food, and that only by improving the productivity of farming was the nation able to raise its standard of living and emerge as
an industrial power. Dr. Gawande believes the country can do the same thing with health care.

**Clinical Congress**

“What struck me about my first Clinical Congress meeting was how huge it was,” says Dr. Gawande, who wrote about the experience in his first book, *Complications: A Surgeon’s Notes on An Imperfect Science.* “I think there were as many surgeons there as there were people living in my hometown. It’s a nation of surgeons—that’s what I call it. You sort of feel like you are in your own country with fellow colleagues who share the same base of experiences, and a certain set of values. We all live with the risks of this hard job, and with the frailty of human beings. It’s a fascinating culture.

“Surgeons can find themselves removed from this world,” observes Dr. Gawande, “while engaging in the day-to-day tasks of their own practice. [By] attending medical conferences, such as the College’s Clinical Congress, surgeons can sustain and reinforce their shared sense of values and standards.”

Dr. Gawande’s colleagues have been very supportive of his writing, even as his books and articles have offered the general public an often candid, unedited view of medicine.

“What I hope people realize is that I am not trying to make us look bad. I am simply asking the question, ‘What does it mean for me to be good at what I do?’ Many of these problems are not addressed in the medical textbooks, questions like, ‘How do you deal with power struggles in the OR?’ What has really been amazing for me, is that I feel like my colleagues have really gotten what I am trying to do. Oh, sometimes people disagree with me, but they always engage with me in a constructive way and we have great arguments! But no one has ever said, ‘You are way out of line.’”

There is actually one member of the medical community who has given Dr. Gawande a hard time: his father.

“He has said to me, ‘What you write is good for the patients, but I’m not so sure it is good for medicine,’” says Dr. Gawande with a good-natured laugh. (Dr. Gawande’s father was a urologist).

Dr. Gawande has attended many Clinical Congress meetings, often as a session panelist, since his first book was published. In fact, he shared the preliminary results of the World Health Organization’s checklist study at the Clinical Congress meeting in November 2008, in San Francisco, CA.

**Writing and surgery**

“Writing and surgery are very complimentary in the sense that they are extremely different, and therefore, satisfying for me,” admits Dr. Gawande. “I’m not sure that my writing has made me a better surgeon, but being a surgeon has made me a much better writer. I don’t burn out on surgery, because of the writing. However, if I was in a room by myself all the time, writing, I would go crazy. I love the messiness of trying to bring science to the individual. But I also love the blood and the guts and the sense of there being some risk involved in surgery.

“In surgery, you don’t get to revise,” adds Dr. Gawande. “In writing, you are revising all the time and you are constantly striving to do something new. If I started following a formula with my writing, everyone will know it and it will fail. In surgery, you are trying to do, as much as possible, the same thing over and over again, and to perfect what you do. I like having both.”
In August of 2005, the U.S. Gulf Coast was slammed by a series of hurricanes that left cities and towns under water and thousands homeless, and had physicians rushing to the aid of patients and health care facilities that were in desperate need of relief. Many physician volunteers were soon deadlocked in their efforts and unable to offer their services, due to a lack of uniformity in state laws that prohibited the hospitals and health care facilities from verifying physician licenses and credentials. James Korndorffer, MD, FACS, and Melanie Korndorffer, MD, FACS, from Tulane University, New Orleans, LA, were just two of the physicians hoping to help during Hurricane Katrina, when they encountered barriers that left them unable to assist those most in need.

In a letter received by the College, Drs. James and Melanie Korndorffer describe the challenges experienced during Hurricane Katrina. The only functioning hospital on the coast had one surgeon present, according to the letter, and that surgeon had been at the hospital for four consecutive days and was in desperate need of additional surgical support. When help finally arrived, the lone surgeon was very surprised to receive assistance, as he had not considered the fact that many physicians, such as the Korndorfers, would want to volunteer their help during such a chaotic time. But despite significant efforts by the [hospital] administration, the Korndorfers could not get sufficient information and approval for them to receive temporary privileges to allow the lone surgeon to leave the hospital for some rest after a long, 96-hour shift.

In response to the serious problems resulting from the horrific hurricane season of 2005, the National Conference of Commissioners on Uniform State Laws adopted model emergency response legislation known as the Uniform Emergency Volunteer Health Practitioner Act (UEVHPA). Passage of UEVHPA would open the door for volunteers—with appropriate skills and expertise—to volunteer services in a state with an emergency as if they are licensed in that particular state. As referenced in the Korndorfers’ letter, this could result in better, faster services for the victims of disasters. It would mean more lives saved, more victims treated, and more relief to disaster-affected areas.

How does it work?

According to the UEVHPA summary, the objective of this legislation is to create a system that can quickly deploy health practitioners to health care facilities and disaster relief organizations pursuant to clear and well-understood rules that would meet both the needs of volunteers and relief agencies, and provide an effective framework to ensure the delivery of high-quality care to disaster victims. As established, the UEVHPA would allow health professionals to register either in advance of, or during, an emergency to provide volunteer services in a state that has enacted UEVHPA legislation. States and physicians may use governmentally established registration systems or a registration system established by disaster relief organizations, such as the American Red Cross. UEVHPA would allow health care facilities and disaster relief organizations in a disaster state to use professionals registered with the aforementioned systems, and to rely on the registration systems to confirm that registrants are appropriately licensed and in good standing.

UEVHPA would open the door for volunteers to quickly respond to a disaster and provide the appropriate care for patients during a time of need. In addition to UEVHPA potentially offering health practitioner volunteers more flexibility, the bill also offers important protections for the volunteers. First, a health professional licensed in another state is subject to the scope of practice for practitioners licensed in the state with the emergency. In addition, out-of-state professionals may not exceed the scope of practices as established by their licensing state. UEVHPA model legislation also protects physician volun-
teers by addressing the civil liability raised in disaster volunteer situations.

**UEVHPA and the states**

It is the goal of the College and other supporting organizations to see UEVHPA passed in all 50 states. Since the Uniform Law Commission drafted model legislation in 2006, 11 states have adopted UEVHPA. Those states include: Arkansas, Colorado, Indiana, Kentucky, Louisiana, New Mexico, North Dakota, Oklahoma, Oregon, Tennessee, and Utah (see figure on this page). The District of Columbia held a hearing on UEVHPA in November 2009, and the City Council is expected to pass the legislation in April.

During the 2010 state legislative sessions, the College is continuing to push passage of UEVHPA. The bill has been introduced in five states, including Connecticut, Georgia, Illinois, Mississippi, and Washington.

For more information on the Uniform Emergency Volunteer Health Practitioner Act and other StateSTATs topics, contact the ACS State Affairs Department, Division of Advocacy and Health Policy, at state_affairs@facs.org.
his article offers Fellows and their staff members resources to assist in their efforts to comply with federal regulations and address practice management issues. These tools have been developed through the American College of Surgeons, government agencies, and other stakeholders, such as the American Academy of Professional Coders and the American Medical Association (AMA).

Complying with PECOS
The Provider Enrollment, Chain and Ownership System (PECOS) is a Centers for Medicare & Medicaid Services (CMS) policy that became effective on April 5 and applies to all health care professionals who see Medicare Part B patients. Any health care professional who is not currently enrolled in the Medicare program or who has been enrolled for more than six years, but has not submitted any updates or changes to enrollment information, must enroll in PECOS. For example, a surgeon who has participated in Medicare Part B for 20 years and has not submitted any updates or changes to enrollment must sign up—regardless of whether there were any changes. This requirement affects all physicians, nonphysician practitioners, and other Part B providers and suppliers submitting a claim for items or services that were ordered or referred. For more information, go to https://www.cms.gov/mlnmattersarticles/downloads/MM6417.pdf.

CMS has established a new payment stipulation that physicians must observe when ordering health care products and services for Medicare patients, or when referring beneficiaries to another source of such products or services. This policy was developed by CMS in an effort to curb Medicare waste and abuse, particularly in the providing of durable medical equipment.

Under this mandate, which has been in effect since November 2003, Medicare payment contractors may only honor claims for health care products or services when patients are referred, or the products are ordered, by a health care professional listed in the PECOS database.

Surgeons who are not registered should start the enrollment process as soon as possible. The enrollment process will take some time, and failure to comply would interrupt the flow of income.

To see if you are already enrolled in PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do. For policy information and examples, go to http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp.

General coding resources
To assist surgeons in their efforts to deal with coding questions, the College offers the following resources:
• The Coding Hotline. Tel. 1-800-ACS-7911; hours: 7:00 am–4:00 pm Mountain Time. The coding hotline will answer five free coding questions a year for each member of the College. The program is sponsored by Physician Reimbursement Systems (PRS). Web site: http://www.facs.org/ahp/coding/secoding.html.
• ACS Coding Today. This program is designed to respond to surgeons’ billing and coding questions. The program includes NCCI (National Correct Coding Initiatives), Local Coverage Determinations information, and more. Sign up today for a 30-day trial period. The program is offered at a discount for members of the College and is sponsored by PRS. Web site: http://acs.codingtoday.com/.
• ACS-sponsored coding workshops. These workshops are co-sponsored with Karen Zupko and Associates, Inc. Dates and locations: New York, NY, New York Athletic Club, May 13–14; Nashville, TN, Hilton Nashville Downtown, August 26–27; Chicago, IL, ACS headquarters (meeting), November 4–5. The College will also provide these two coding workshops during Clinical Congress 2010, October 2–3, 2010, in Washington, DC.
For more information, visit the Web site http://www.facs.org/ahp/workshops/workshops.html.

**NCCI**

CMS developed the NCCI to promote national correct coding methodologies, and to control improper coding that leads to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the AMA Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The NCCI also comes with a manual that is helpful for correct coding.

The NCCI Web site is http://www.cms.hhs.gov/NationalCorrectCodInitEd/

**ICD-10-CM**

This coding system is an updated version of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). ICD has changed to reflect the current clinical understanding and technological advancements of medicine, and the code descriptions are designed to provide a more consistent level of detail. It contains a more extensive vocabulary of clinical concepts, body part specificity, patient encounter information, and other components from which codes are built. For more information, refer to the article regarding ICD-10-CM and general equivalency mapping in the March 2010 issue of the *Bulletin (Bull Am Coll Surg.* 2010;95[3]:31-33). The implementation date for using ICD-10-CM is October 1, 2013; CMS and World Health Organization resources to reference in order to get your office ready for the change appear in the box on this page.

**2010 Medicare fee schedule**

The 2010 Medicare physician fee schedule lists all CPT codes and includes payment information for each code, including relative value units, global days, if the surgery can be billed as a bilateral surgery, when an assistant surgeon may be used, payment for co-surgeons, and so on. The fee schedule comes with a manual that surgeons and their billing staff should reference in order to correctly read the letters and numbers in each column of the fee schedule.

For more information, visit http://www.cms.hhs.gov/PhysicianFeeSched/.

**E-prescribing program**


**Physician Quality Reporting Initiative (PQRI)**

To participate in the 2010 PQRI, eligible professionals may choose to report information on individual PQRI quality measures or measures groups using one of the following mechanisms: (1) to CMS on their Medicare Part B claims, (2) to a qualified PQRI registry, or (3) to CMS via a qualified electronic health record product. Individual eligible professionals who meet the criteria for satisfactory submission of PQRI quality measures data continued on page 35
Dr. Fildes named Trauma Medical Director

John Fildes, MD, FACS, was recently named Trauma Medical Director, ACS Division of Research and Optimal Patient Care, succeeding J. Wayne Meredith, MD, FACS, in March of this year.

Dr. Fildes is professor and vice-chair, department of surgery; program director, general surgery residency program; and chief, division of trauma and surgical critical care and acute care surgery, University of Nevada School of Medicine, Las Vegas, NV.

In addition, Dr. Fildes is medical director and chair of trauma at the University Medical Center of Southern Nevada, Las Vegas.

Dr. Fildes has been active in the American College of Surgeons since becoming a Fellow in 1992. He has been a member of the ACS Committee on Trauma (COT), Trauma Registry, and National Trauma Data Bank® since 2001, and a State Advocacy Representative. Dr. Fildes served as Chair of the COT from 2006 to 2010. He is also President of the Nevada Chapter.

Among the awards and honors Dr. Fildes has received are the White House Medical Unit Certificate of Appreciation (1988) and Centers for Disease Control Certificate of Appreciation (2009). He has received numerous awards for excellence in teaching, including the Olga Jonasson Award from the University of Illinois and Cook County Hospital, Chicago, IL. Dr. Fildes was named the Physician of the Year by the Nevada State Medical Association (2006) and the Las Vegas Chamber of Commerce (1998).

Dr. Rotondo named Chair, ACS Committee on Trauma

Michael F. Rotondo, MD, FACS, professor and chairman at the department of surgery, The Brody School of Medicine, Eastern Carolina University, Greenville, NC, has been named the 18th Chair of the College’s Committee on Trauma (COT).

Dr. Rotondo succeeds John Fildes, MD, FACS, who completed his term. The transition occurred March 11 at the COT annual meeting in Las Vegas, NV.

Dr. Rotondo is an innovator, educator, and national leader in American surgery. His international reputation as an innovator stems from his accomplishments in clinical outcomes research, his considerable administrative skill in program development, and advocacy for the field on behalf of the injured.

A Fellow since 1993, Dr. Rotondo has been a member of the COT since 2006, and served as COT State Chair, North Carolina, from 2003 to 2006, and Chair of the Trauma Systems Committee (2007–2010).
More than a decade after its initial inquiry, Malaysia became the 50th country welcomed into the international Advanced Trauma Life Support® (ATLS) family in January.

While the initial request came in the early 1990s, efforts began in earnest approximately two years ago, when Siew Kheong Lum, MD, FACS, became the president of the Malaysian College of Surgeons within the Malaysian Academy of Medicine. Dr. Lum garnered the support of the director general of the Ministry of Health and worked tirelessly to bring the ATLS program to Malaysia.

Introduction of ATLS in a new country follows a “train the trainer” model to ensure success and sustainability of the program. The process begins by submitting a promulgation application and request letter, which must be sponsored by a surgical organization in the host country; in Malaysia’s case, this was the Malaysian College of Surgeons. Once the application is approved by the ATLS subcommittee, a site visit is carried out in the requesting country to make certain that the course-designated facilities are well-equipped for the program. Michael Hollands, MD, FACS, Region XVI Chief and coauthor of this article, and Christoph Kaufmann, MD, FACS, former ATLS International Course Director, visited Malaysia in April 2009, and approved the course facility. At this point in the process, potential instructors were identified to take both provider and instructor courses. The selected group of Malaysian instructor candidates traveled to Singapore in

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September 2009 and successfully completed both courses, acquiring instructor candidate status. The final step in the process is to have the instructor candidates conduct their own student course, led by a course director candidate, coordinator candidate(s), and educator candidate, with the help and supervision of regional faculty and the ATLS subcommittee. The strength of the ATLS program in other countries in Region XVI, along with the collaborative nature of ATLS faculty within the region, allowed for the most international faculty ever assembled for an inaugural course.

“It is fantastic to have a multinational faculty representing the different nations of Region XVI,” Dr. Hollands said during the first ATLS provider course in Malaysia last month. Dr. Hollands, Region Chairperson for Australasia and Asia, referred to ATLS representatives from Australia, Singapore, Thailand, Malaysia, and the U.S., who participated in the inaugural courses January 18–23. The international faculty was led by Karen Brasel, MD, FACS, Chair for the ATLS subcommittee and coauthor of this article, along with Dr. Hollands, who directed the course. The Chair of ATLS-Malaysia, Dr. Lum, was evaluated as a director candidate, and five other Malaysian doctors were critiqued as successful instructor candidates. (Dr. Lum is now a director, and the five instructor candidates are now instructors.)

The inaugural courses took place in a facility at Sungai Buloh Hospital, just north of Kuala Lumpur, built specifically for the ATLS courses. The venue featured a lecture theater, rooms for the moulage scenarios, and a site for surgical skills, accommodating two teams at a time. Two other rooms were set aside for faculty use. Lesley Dunstall, National Coordinator for ATLS-Australia, coordinated the course with Jasmine Alkhatib, ATLS International Coordinator and co-author of this article. Wan Marina Wan Ismail and Yusof bin Said participated as coordinator candidates. Additionally, Mary Lawson from Australia was the educator and monitored Prof. Moses Samuel as Malaysia’s educator candidate. “I am very impressed that the course participants can convert to new ways of thinking and approaches in a short span of five days. We can apply the same principles in training our teachers,” observed Professor Samuel.

Sixteen students—mostly senior clinicians and leaders of the profession within Malaysia—participated in the provider course. These students represented a number of hospitals in the western peninsula of Malaysia. Nine of the 16 participants were invited to the inaugural Malaysian instructor
course. These doctors consisted of five surgeons (four general surgeons and one orthopaedic surgeon) and four emergency physicians, all of whom attended and completed the course successfully.

The courses ran 7:30 am–6:30 pm for five days. However, the long work hours did not discourage social gatherings in the evenings. At one point, Dr. Brasel, Ms. Lawson, Ms. Dunstall, and Ms. Alkhatib were treated to a traditional Malaysian dinner and dance show, and on an evening after the first day of the course, the Malaysian College of Surgeons hosted a dinner for the ATLS international faculty. To celebrate Malaysia’s inauguration, Dr. Brasel hosted a dinner for students, staff, faculty, and representatives from the Ministry of Health at the Chynna Restaurant in the Hilton Kuala Lumpur. Yvonne Lum arranged a menu of Chinese food typically served during Chinese New Year; the Director General of Health in Malaysia was the guest of honor.

The following day, those identified as potential instructors studied their new course materials, while the international faculty went to Malacca for sightseeing. Malacca is approximately 140 miles south of Kuala Lumpur, readily accessible via modern highways. A United Nations Educational, Scientific and Cultural Organization World Heritage Site, it is famous for its colonial architecture. Portuguese and Dutch buildings have survived into the 20th century, and are remarkably well preserved. Lunch was regional Nonya food, followed by a walking tour of Chinatown.

The inaugural instructor course was held over the next two days. On the last day, we received a surprise visit from the Director General of Health, who was keen to see for himself what ATLS was all about. Before sitting down for afternoon tea, he addressed the course participants and was given a presentation on the history and ethos of ATLS by Dr. Hollands.

Plans to run back-to-back student and instructor courses in Malaysia in the upcoming months are currently in progress. An important note regarding future courses is the fact that the Director General has ensured ongoing financial support for this program.

The 50th country to inaugurate ATLS training, Malaysia is also the first country to join the ATLS family in what will be the busiest year to date for ATLS promulgation. By the end of 2010, Lebanon, France, Nigeria, Paraguay, Uruguay, Bosnia, and Slovenia will have conducted their inaugural courses, bringing the number of countries that have adopted the ATLS program up to 57. The inaugural courses in Lebanon, France, and Nigeria will take place in May and July, while the other countries’ course days are yet to be determined. Will Chapleau, ATLS Manager and coauthor of this article, is excited about the collaboration between ATLS and its international partners. “The expansion of ATLS at this rapid pace would not be possible, were it not for the efforts of our partners in regions XIV, XV, and XVI,” said Mr. Chapleau.

Dr. Brasel is ATLS subcommittee Chair, Milwaukee, WI.
Dr. Hollands is ATLS Region XVI Chief, Wahroonga, NSW, Australia.
Mr. Chapleau is ATLS Program Manager, Chicago, IL.
Ms. Alkhatib is ATLS International Coordinator, Chicago, IL.

SOCIOECONOMIC TIPS, from page 31

via one of the reporting mechanisms, for services furnished during a 2010 PQRl reporting period, will qualify to earn a PQRl incentive payment equal to 2 percent of their total estimated Medicare Part B PFS-allowed charges for professional services furnished during that same reporting period.

Beginning with the 2010 PQRl, a group practice may also qualify to earn PQRl incentive payment equal to 2 percent of the group practice’s total estimated Medicare Part B PFS-allowed charges for covered professional services furnished during a 2010 PQRl reporting period, based on the group practice meeting the criteria for satisfactory reporting specified by CMS. Additional information on PQRl is available at the links in the box on page 31.
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A cut above the rest: Surgical Caucus turns 20

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

Many meetings and events will contribute to a very busy annual American Medical Association (AMA) House of Delegates (HOD), which, this year, will be held June 12–16 in Chicago, IL. One special event at this meeting will be a celebration of the 20th anniversary of the Surgical Caucus of the AMA (SCAMA), scheduled during the June 12 meeting. In addition to the standard business and education component of the session, former leaders and founders of SCAMA have been invited to speak about the history of the Caucus and the impact it has had over the years within the HOD.

What is the Surgical Caucus?
According to the SCAMA by-laws, its purpose is “to provide a forum at each session of the House of Delegates for discussion and recommendations concerning professional and socioeconomic issues of particular interest to surgeons.” As such, it has given a surgical voice to discussion of the policy implications of resolutions and reports, and enabled surgeon delegates to enhance the development of AMA health policy to reflect a cross-specialty consensus.

Who may participate?
Membership in the Caucus is open to all physicians who are designated by the AMA as practicing surgery, or any of its subspecialties, and who may be serving as delegates or alternates in the HOD, the Organized Medical Staff Section, the Medical Student Section, or the Young Physicians Section. Officers of the AMA, state medical society presidents, and residents in surgery or the surgical subspecialties who are delegates or alternate delegates of the Resident and Fellow Section may also be members.

Recognizing the important clinical interactions between surgeons and other physician specialties, the SCAMA, in 2008, expanded membership criteria to include anesthesiology, critical care, emergency medicine, interventional cardiology, and interventional radiology. While this action had the practical effect of increasing membership, more importantly, it broadened the Caucus and its ability to achieve consensus on health policy discussions within the HOD. It also energized the SCAMA by bringing in natural allies under the “surgical tent.”

How is the SCAMA governed?
Every year at the November meeting, elections are held to select members of the SCAMA Executive Committee. This committee is composed of a chair, chair-elect, secretary, treasurer, and three members-at-large. In addition, the Young Physicians Section, the Resident and Fellows Section, and the American College of Surgeons all have one slotted seat filled by those respective entities.

Administrative support for the Caucus is provided by the ACS. This involves maintaining an “office” and records for the Caucus, updating the Web site (http://www.facs.org/ahp/activity/caucus.html), as well as collecting annual dues, which are $35 per year and are used to pay for meeting expenses for two meetings a year. Jon Sutton, Manager of ACS State Affairs, Division of Advocacy and Health policy (and author of this article) serves as the administrator for the Caucus.

How did the SCAMA begin?
In June of 1989, two Fellows of the College, Grant Rodkey, MD, FACS, and James Hoehn, MD, FACS, created a Steering Committee to begin the work of developing the SCAMA—and in December of that year, the first executive committee was elected. Dr. Rodkey became the first chair of the Caucus, and guided the Caucus for three years as it established itself as an independent voice for surgery within the structure of the AMA HOD.

Surgical leaders in the HOD, and from organizations such as the American College of Surgeons, American Society of General Surgeons, American Society
of Plastic Surgeons, and others, provided support and leadership for the SCAMA. Over the years, many members of the Caucus have served as AMA trustees, officers, and council members. Most recently, LaMar S. McGinnis, Jr., MD, FACS, former ACS delegate and officer of the Caucus executive committee, became President of the ACS, and numerous executive committee members have served as ACS Governors as well.

Current leadership in the SCAMA includes the following:
- William H. Huffaker, MD, FACS, Chair (second term)
- Charles Drueck, MD, FACS, Chair-Elect (second term)
- Michael Simon, MD, Secretary (second term)
- Michael Deren, MD, FACS, Treasurer (second term)
- Members-at-Large: David G. Gerkin, MD (expires November 2012); Cynthia J. Goto, MD (expires November 2011); Chad Rubin, MD, FACS (expires November 2011)
- ACS Delegate: John H. Armstrong, MD, FACS
- RFS Representative: Luke Brewster, MD, PhD (June 2009–2010)
- YPS Representative: Susan Pike, MD, FACS

Fellows in the AMA HOD are encouraged to participate in the 20th anniversary celebration. The Saturday, June 12, session of the Caucus will begin at 12:45 pm, at the Hyatt Regency Chicago.
ACOSOG news

Translational science in ACOSOG trials

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

Laboratory research must be translated into practical applications in order to improve cancer treatment. A unique feature of a surgeon-based clinical trials group is the ability to collect annotated tissue specimens from prospective therapeutic trials for laboratory research. Surgeons are referred patients who have potentially resectable disease, and thus are well-positioned in the health care delivery stream to explain treatment option, explain the purpose of research tissue acquisition, and, above all, obtain patient informed consent. New laboratory research technologies often require fresh tissue specimens that are either frozen or placed in a preservative and shipped to a central specimen bank. This process follows all regulatory laws that protect patient identity and, at the same time, provides specimen access to the scientific community.

Laboratory scientists’ need for cancer specimens has changed in the past decade. Genome sequencing, RNA expression, and proteomics require well-preserved specimens in order to extract DNA, RNA, and proteins with minimal degradation. While much can be accomplished with formalin-fixed paraffin embedded tissues, emerging laboratory technologies are often hindered by the degradation of important molecules in tissue fixatives.

Surgeons are referred patients with resectable disease, at which point they perform routine clinical staging, and discuss treatment options with their patients. Because surgeons stand at this pivotal position of cancer care, their discussion with patients regarding clinical trial participation is becoming crucial to neoadjuvant and adjuvant therapeutic trials and specimen collection.

Neoadjuvant trial designs for locally advanced primary disease offer surgeons an opportunity to obtain a research biopsy of the primary tumor, which is in a relatively accessible site. An important focus of cancer research is to identify a subset of patients whose tumors express a specific biomarker for drug sensitivity. A great example is the breast surgeon who frequently orders hormonal and HER2/neu sensitivity tests in resected primary breast cancer. In the future, surgeons may be ordering tests for specific epidermal growth factor receptor EGFR mutations in non-small cell lung cancer NSCLC to assess sensitivity to EGFR tyrosine kinase inhibitors.*

The collection of blood samples before surgical resection of primary tumors offers scientists a great opportunity to study biomarkers for early detection of disease; ACOSOG is currently involved with such endeavors. ACOSOG Z4031 is an outstanding example of thoracic surgeons looking to solve the problem of developing a blood test for early detection of NSCLC in a high-risk population. Proteomics are currently being studied by a group led by Steven Dubinett, MD, at the University of California, Los Angeles, CA, using samples from Z4031.

Another remarkable technology application is whole-genome sequencing. A decade ago, the cost of sequencing the first human genome was $3 billion, and it took 10 years to complete. Today’s “next-generation sequencing” instruments can sequence a human genome for $50,000 in seven days, with further dramatic decreases in cost and throughput. Dr. Mardis (one of the coauthors of this article) is Chair of the ACOSOG Basic and Translational Science Committee and is codirector of The Genome Center at Washington University, St. Louis, MO, where the

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*Govindan R. INTERESTing biomarker to select IDEAL patients for epidermal growth factor receptor tyrosine kinase inhibitors: Yes, for EGFR mutation analysis, others, I PASS. J Clin Oncol. 2009;25:1637.
application of whole genome sequencing to cancer cases is being pursued aggressively.

This genomic technology—along with the analytical software needed to identify key mutations and structural changes in the genome—may provide clues to understanding genetic mechanisms of tumor response or no response in neoadjuvant trial designs, and to identify new targets for systemic treatment. The approach already has identified highly recurrent mutations with prognostic value in acute myeloid leukemia specimens. This approach is also now being applied to ACOSOG Z1031 pretreatment specimens, in order to identify the gene signature profiles of the tumor response/no response to aromatase inhibitor phenotypes. The hypothesis is that tumor response to therapy is genetically determined. If this hypothesis is proven with Z1031, then it may be applied to other ACOSOG neoadjuvant trials, as well.

This research is the culmination of computing technology, DNA sequencing technology, and massive digital data storage and processing capabilities. The key to unlocking this research capability is appropriately preserved DNA from patients who have given informed consent. Surgeon participation is crucial to obtain such DNA with clinical data.

ACOSOG, with its surgeon network, is well positioned to support cancer DNA, RNA, and protein research. Future clinical trials are needed and may allow surgeons, medical oncologists, and radiation oncologists to tailor therapies to subsets of patients who will likely benefit from specific resection/ablation and systemic therapies.

ACOSOG leaders are excited about the future of a surgeon-oriented national cooperative group and the pivotal role of practicing surgeons in cancer research. Your participation will likely improve cancer treatment outcomes. To learn more about ACOSOG go to http://www.acosog.org.

Dr. Ota, of Durham NC, and Dr. Nelson, of Rochester, MN, are ACOSOG Group Co-Chairs.

Dr. Mardis, of St. Louis, MO, is Chair, ACOSOG Basic and Translational Science Committee.

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Style and format

Manuscripts should be no more than 3,200 words in length, excluding tabular material or illustrations. Manuscripts should be composed of seven to nine pages in Microsoft Word—doublespaced and with one-inch margins. Please turn off tracked changes before sending the document. Manuscripts submitted as PDF will be returned to the author with the request that a Word document be submitted instead.

Give full names of authors and their degrees, academic or professional titles, professional affiliations, and complete addresses. Specify to whom galley proofs are to be sent.

References should be listed numerically in the text, with full citations to appear on a separate page at the end of the text of the article. Please be sure to keep the references separate; do not use the feature in Word that automatically generates footnotes. References should follow American Medical Association style guidelines. Following are some examples:


All manuscripts should include a brief biography (including employer name, position title, and city and state) and a photo of each author. Each photograph must be a head shot/portrait in JPG or TIF format, at least two inches wide, and at least 300 pixels per inch. Do not submit the photos in a Word document,
as this affects the publishing quality. If preferred, submission of a hard copy of photos (minimum passport size) is acceptable.

**Tables/illustrations**

Figures, tables, and/or other illustrations are welcomed as long as they add significantly to the author’s discussion in the text. Data display should be called a “Table” when presenting precise numerical values that show item-to-item comparisons; the term “Figure” should be used when presenting patterns or trends or illustrating comparisons in text.*

Displays that present lists of any kind (such as names of board members or checklist items) should be called “box.” Photos should be referred to in text as photos, not figures.

Drawings (including graphs and charts) should be created either in MSWord, PowerPoint, or as a JPG, TIF, or PDF file, with lettering large enough to be legible after necessary reduction. If camera-ready art is supplied in lieu of an electronic file, be sure that the original is clear, clean, and will be legible when reduced. A separate page with legends for the illustrations should be supplied. Tables submitted with the manuscript should be on separate pages at the end of the manuscript. Be sure to label the tables and illustrations clearly and be sure to refer to their placement in the text of the article.

Photographs or other illustrative art, if supplied in an electronic (JPG, TIF, or PDF) format, should have a resolution of no less than 300 pixels per inch, or at least 1200 pixels in width. Anything less than that may not reproduce at publishing quality. Photographs and illustrations pasted into a Word document are discouraged, as they do not always print at ideal resolution. Please provide captions for photographs on a separate page.

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Authors will receive galley proofs (as a Word document) of their edited manuscript for their review in advance of the scheduled month of publication. Galleys may include queries from editorial staff.

Before publication, revised proofs must be returned either as a Word document with any edits indicated using the tracked changes function or as a list of requested changes to the editors. Authors of feature articles will have the opportunity to see a PDF of the article in magazine format that reflects any changes made to the document during the galley stage. After viewing the PDF, authors may only request changes to text that is currently outdated or presents egregious errors; all other edits will be rejected at that time.

**Inquiries**

Inquiries regarding potential articles for consideration, deadlines, the submission of manuscripts, author proofs, or style should be directed to Stephen J. Regnier, Editor, *Bulletin of the American College of Surgeons*; or Linn Meyer, Director, Division of Integrated Communications, via e-mail at sregnier@facs.org or lmeyer@facs.org, or by mail at American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; 312/202-5331; fax 312/202-5021.

NTDB® data points

Another national chapter

by Richard J. Fantus, MD, FACS; Avery B. Nathens, MD, PhD, FACS; and John Fildes, MD, FACS

May is National Trauma Awareness Month. First established in 1988 by President Ronald Reagan, the goal of National Trauma Awareness Month is to heighten national attention on trauma and efforts to reduce the consequences of severe injury. The health care landscape has changed considerably since 1988, but trauma continues to be a major public health problem. Yearly, trauma accounts for 37 million emergency department visits, resulting in 2.6 million hospital admissions. Trauma injury is responsible for 31 percent of all life years lost in the U.S., which is more than the next two causes—cancer and heart disease—combined. The economic burden is more than $400 billion a year, including both health care costs and lost productivity (http://www.nationaltraumainstitute.org/home/trauma_statistics.html).

Since the launch of the first trauma awareness month, there have been significant advances in the care of the injured patient and in the development of trauma centers, with an increasing number of trauma systems, as well as improvements in the aggregation and utilization of trauma data. With respect to trauma data, there have been several landmark advances. One of the first advances—dating back to the early 1990s—was the development of the National Trauma Data Bank® (NTDB), currently the largest aggregation of U.S. trauma registry data ever assembled. The most recent advances have been the development of the National Trauma Data Standard (NTDS) and the Trauma Quality Improvement Program (TQIP).

The NTDS is a data standard that has been previously reported in the September 2008 Bulletin, and refers to a new standardized data set that includes the definitions of each data element, along with the computer programming specifications for each field. The NTDS is designed to serve as the data infrastructure for all trauma data collection. As such, it describes all required data elements for the NTDB, along with other optional data elements that are not currently required by the NTDB. With cooperation from the trauma registry vendor community, the NTDS has allowed for a standardization of trauma data submission to the NTDB that in turn has significantly improved the overall data quality.

The improvement of data quality associated with imple-
mentation of NTDS has allowed the development of TQIP, a program that has, as its fundamental goal, the provision of risk-adjusted benchmarking of designated/verified trauma centers that will allow the tracking of outcomes and improvement in patient care. Using the NTDS, we have developed a new set of process-specific measures that allow us to understand how patients are cared for in trauma centers. While these process measures will be mandatory for TQIP centers, they will remain as optional elements for centers not participating in TQIP. This new chapter in the NTDS will allow centers to use these new fields for their own purposes, while assuring that they are collecting and interpreting data consistent with a national standard.

The NTDS is a fluid reference book that will be reviewed annually and modified to meet the needs of stakeholders. This book currently contains only a few chapters, as described above, but has the capacity to grow and add new chapters as data sets come along. These new data sets will be housed as another national chapter of the NTDS, “the national trauma data reference book” (see figure on page 43).

Please refer to the following Web sites for more information on the NTDB (http://www.facs.org/trauma/ntdb/index.html), the NTDS (http://www.ntdsdictionary.org/theNTDS/index.html), and for TQIP (http://www.ntdsdictionary.org/theNTDS/index.html).

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2009 is available on the ACS Web site as a PDF file and a PowerPoint presentation at http://www.ntdb.org. In addition, information is available on our Web site regarding how to obtain NTDB data for more detailed study. 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 Past-Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.

Dr. Nathens is Canada research chair in systems of trauma care, division head of general surgery, and director of trauma, St. Michael’s Hospital, Toronto, ON; and chair, National Trauma Data Bank Subcommittee of the Committee on Trauma.

Dr. Fildes is chair, department of trauma, University Medical Center, Las Vegas, NV, and director for general surgery, surgical critical care, and acute care surgery; professor of surgery and vice-chair, department of surgery; and chief, division of trauma/critical care, University of Nevada School of Medicine, Las Vegas. He is Trauma Medical Director for the American College of Surgeons.