Special issue: New approaches to liability reform
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21 V98 No 3 BULLETIN American College of Surgeons
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Looking forward

by David B. Hoyt, MD, FACS

In an era when the stability of the nation’s health care system hinges largely on improving patient safety and quality of care, many institutions and surgeons are seeking out innovative approaches to ensuring that the right patient gets the right care in the right place at the right time. One health care provider that has made great strides in this direction is Memorial Hermann Health System (MHHS) in Houston, TX.

During a recent meeting of The Joint Commission, M. Michael Shabot, MD, FACS, system chief medical officer at Memorial Hermann, gave a presentation on the steps in MHHS’ six-year journey to becoming a high-reliability organization. The outcome of this transformational process is remarkable and the entire story well worth sharing.

Culture change

Memorial Hermann is the largest not-for-profit health care system in Texas. It comprises a total of 12 hospitals—nine acute care, two rehab, and one children’s. Other health care institutions that make up Memorial Hermann include 18 ambulatory surgery centers, three heart and vascular institutes, 21 imaging centers, nine breast care centers, 32 sports medicine and rehab centers, 21 diagnostic laboratories, one retirement/nursing center, three home health branches, and seven cancer centers.

Several years ago, Memorial Hermann reached out to safety experts in the aviation and nuclear power industries to develop and implement initiatives that would enable MHHS to evolve into a high-reliability organization. MHHS’ transformation began August 14, 2006, with the launch of a program called Breakthrough in Patient Safety (BIPS).

As a first step in the BIPS project, Memorial Hermann declared that patient safety was no longer just a priority, but the institution’s core value. By making safety MHHS’ core value, the stage was set for changing the health care system’s culture and behavioral expectations, according to Dr. Shabot. The focus was now on attention to detail, clear communication, a questioning attitude, best practices, and team support.

Health care professionals were trained to self-check with STAR: Stop, Think, Act, and Review. They also were encouraged to support each other through the use of CUSS words; that is, to let other team members know when they are Concerned or Uncomfortable about the patient’s Safety and to Stand up and Stand together.

MHHS also developed a set of Red Rules, which all medical professionals and employees of the health care system are

As a first step in the BIPS project, Memorial Hermann declared that patient safety was no longer just a priority, but the institution’s core value.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
More than 20,000 MHHS employees and more than 2,000 physicians underwent safety culture training. As a result, MHHS was able to eliminate or substantially minimize the occurrence of many hospital-acquired conditions as defined by the Centers for Medicare & Medicaid Services.

required to follow. Using the Red Rules, health care professionals must take the following precautions: verify that the right patient is present by checking two patient identifiers before acting; take a time out before invasive and high-risk procedures; and have two providers check before administration of blood, blood products, and high-risk medications.

MHHS also examined whether its employees and health care professionals were complying with hand hygiene guidelines and found that compliance was considerably lower than anticipated. In response, Memorial Hermann set the following goals to be achieved at all of the health care system’s hospitals between July 2010 and June 2011: implement The Joint Commission’s Targeted Solutions Tool to achieve baseline compliance rates, uncover factors that contribute to noncompliance and provide feedback to staff; use contributing factors data to implement targeted solutions for improvement; and increase compliance by at least 30 additional percent. More than 92 percent of all caregivers are now in compliance with hand hygiene procedures as measured by more than 10,000 “secret shopper” observations per month.

Eliminating HACs
More than 20,000 MHHS employees and more than 2,000 physicians underwent safety culture training. As a result, MHHS was able to eliminate or substantially minimize the occurrence of many hospital-acquired conditions (HACs) as defined by the Centers for Medicare & Medicaid Services (CMS). In fact, not one case of blood incompatibility occurred in the period of January 2007 to December 2012 among the approximately 750,000 transfusions performed at MHHS medical centers. Several hospitals went for years without a ventilator-associated pneumonia or a central line-associated blood stream infection. Serious medication errors decreased to zero most months, and many hospitals went a full year without a HAC.

To encourage the continued use of BIPS, MHHS created the Memorial Hermann High Reliability Certified Zero Award to honor hospitals that go a year without any adverse events. Since April 2011, 78 recipients of the award have been announced. Prior to the BIPS initiative, HACs were a near monthly occurrence at MHHS hospitals. According to Dr. Shabot, “The Certified Zero Award has crystallized Memorial Hermann’s determination to become a high-reliability organization in all respects, providing safe and efficient care to every patient and family.”

The National Quality Forum and The Joint Commission have named MHHS the 2012 recipient of the John M. Eisenberg Patient Safety and Quality Award at the National Level.

Learning from each other
All surgeons and other health care professionals want their institutions to achieve these goals and to see their patients leave the hospital on a clear path to leading healthy, productive lives. I’ve chosen to spotlight the MHHS experience because it provides a valuable template for other institutions to follow in their quest to improve patient safety and quality of care. Patient safety should be a core value not only at Memorial Hermann, but at every health care institution.

I would encourage all Fellows of the ACS to champion these sorts of initiatives in their hospitals and offices. Likewise, those Fellows who are at institutions that are making similar strides are invited to share their stories with me at the e-mail address in the sidebar on page 7. We have much to learn from each other.
New approaches to liability reform
The current medical liability system in the U.S. is broken. It is costly, draining the health care system of approximately $55.6 billion per year and accounting for 2.4 percent of annual health care spending. An estimated $45.6 billion is spent on defensive medicine. Of the money spent within the medical liability system itself (excluding defensive medicine), administrative costs comprise 54 to 60 percent of total costs, including attorneys’ fees and other overhead.

Furthermore, fewer than 3 percent of patients who are injured as a result of medical errors ever seek compensation for their injuries. Additionally, nearly 25 percent of awards are not factually supported by the merits of the case. Fear of litigation leads practitioners to modify their practices to focus on specialties with lower risk and to avoid procedures and patients perceived as higher risk.

Drivers of inefficiencies
Many stakeholders have stated that the liability system is simply too costly and inefficient, and the process of compensating injuries related to medical errors too inaccurate. How did we get here, and why is change so difficult? Surely, no one would purposefully devise a system like this.

Several forces have converged to create this expensive, inefficient, and damaging system. First, the medical liability system is based on tort law—an adversarial process in which the plaintiff must prove that the breach of a duty caused injury resulting in damages. In theory, this process is meant to illuminate the truth through discovery, expert testimony, and cross-examination in order “to deter unsafe practices, to compensate persons injured through negligence, and to exact corrective justice.” By its very nature the process is contentious and can be emotionally and financially damaging to both sides involved. It is not linked to quality and safety improvements; the process is purely an ex post facto financial resolution.

Second, tort law differs from state to state, making national reforms very challenging. In the U.S., reforms to personal injury law in the 1960s and 1970s reduced the barriers for injured patients to file claims. Liability claims rose, sparking the liability insurance crises of the early 1970s and mid-1980s. In the past 40 or 50 years, a number of states have experienced liability crises, influenced in part by market forces and successive reforms to the liability system. Each crisis renews discussion of reform. Calls for reform, however, have been met by deeply entrenched opposition. Some health policy experts claim the Obama Administration did not pursue medical liability reform as part of the Affordable Care Act for precisely this reason. The Administration did not want opposition to liability reform to derail health care reform at large.

New direction
Traditionally, the American College of Surgeons (ACS) and other physicians’ groups have advocated for tort reform to address the problems in the liability system. These reforms may include caps on noneconomic damages, statutes of limitation and repose, pretrial screening panels, certificate of merit requirements, limits on attorney’s fees, joint and several liability “fair share” rules, periodic payments, and collateral-source rules that reduce portions of the award already paid to the patient by another source. Overall, these reforms have reduced costs and defensive medicine practices to some extent in those states that have passed tort reform legislation, but the impact has been small and inconsistent.

Given the current state of affairs, the College’s Legislative Committee has determined that a new direction in liability reform is needed. Cost containment cannot be the only goal of this effort. Reforms also must focus on improving safety and developing a system of just response and compensation. As a thought leader in the field of surgery, the ACS strives to develop new options and alternatives beyond traditional tort reform. These
Several forces have converged to create this expensive, inefficient, and damaging system.

Solutions should not only achieve financial goals, but also create a culture of transparency and accountability that ultimately improves safety and quality in surgical care in the U.S.

It is time for a culture change. We must work toward a system that encourages and supports a culture of safety. The punitive and inconsistent nature of the current liability system inhibits open reporting and discussion of errors at a system level. A culture of safety would encourage error reporting and investigation that recognizes that in many instances errors arise not simply from the actions of an individual, but from a failure of the system. A culture of safety should integrate existing hospital programs to ensure that all errors become an opportunity for system-wide improvements in quality and patient safety.

To achieve hospital-wide safety improvements, institutions’ risk management frameworks must be closely linked to their quality and safety improvement efforts. Risk management must be integrated into the quality improvement process to provide a feedback loop of improvement. Linking risk management and quality improvement is one step in improving communication across all levels of administration and patient care. Open communication and transparency about errors, near misses, and concerns are fundamental to identifying and correcting problems.

This communication also should include injured patients and their family members, who often want to ensure that these errors do not occur again. Involving these individuals in a transparent investigation process and sharing the resulting changes to prevent that error in the future can help assure patients that the hospital and clinicians are committed to patient safety.

Formulating a vision
For physicians and hospitals alike, delivering safe, high-quality patient care is the ultimate goal. We need a liability system that is integrated with the

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Welcome and Introductions
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Alternative Dispute Resolution
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Disclosure and Offer Programs
Rick Boothman, JD, executive director, office of clinical safety, University of Michigan Health System, Ann Arbor, MI
Janet Cohn, JD, Deputy Director, NYS Stem Cell Science/NYSSTEM New York State Department of Health, Albany, NY
Health Courts—A Debate on the Venue’s Viability
Philip K. Howard, founder and chair, Common Good, Brooklyn, NY
Max Mehlman, JD, Arthur E. Petersilge Professor of Law and director, Law-Medicine Center, Case Western Reserve University School of Law, Cleveland, OH
Keynote Luncheon
Michelle Mello, JD, PhD, professor of law and public health, Harvard School of Public Health, Boston, MA
Safe Harbors—Can They Protect Patients and Providers?
Allen Kachalia, MD, JD, associate professor, Harvard Medical School, Boston, MA
Stakeholder Panel: View from the Insurers, the Trial Bar, and Patients
Mark Horgan, JD, vice-president of claims, CRICO, Cambridge, MA
Jean Rexford, executive director, Connecticut Center for Patient Safety, Hartford, CT
Patrick Malone, JD, Patrick Malone & Associates, PC, Washington, DC
Attendee Forum and Wrap-up
John G. Meara, MD, FACS, Chair, ACS Legislative Committee, Washington, DC
health care infrastructure to promote those ends. We need a system that focuses less on risk management and more on managing risk through the creation of a just culture of safety and quality improvement. We need a system that provides just compensation when patients are injured as a result of medical errors, and movement away from the “lawsuit lottery.”

We need a system that is efficient—a system in which the majority of the money is spent compensating the injured patient, and frivolous claims are dismissed early to avoid wasting resources. We need a system that compensates patients in a timely manner. Injured patients should not have to wait an average of five years to receive compensation. Achieving an affordable, efficient, and effective liability system focused on patient safety, appropriate accountability, and health care quality will require more than tort reform.

It is for these reasons that the College’s Legislative Committee recognizes that the ACS needs to take the lead in creating a more equitable and patient-centered approach. To this end, the College convened the 2012 Medical Liability Reform Summit October 19, 2012, at the ACS Washington Office (see agenda in the sidebar on page 11). Participants in this program sought to develop and promote comprehensive solutions that will best serve our patients and the system in which we work. The following articles in this special edition of the Bulletin of the American College of Surgeons are drawn from the discussions that occurred at the meeting. The College’s leadership anticipates that the symposium and publication of these articles will stimulate further exploration and discussion of this important issue.

REFERENCES

Medical liability reform efforts traditionally have focused on lowering the cost and increasing the availability of liability insurance for physicians. Caps on awards have been viewed as the key means of addressing these problems. Over the past several years, however, new strategies have emerged for pursuing medical liability reform. These efforts center on improving patient safety and reducing the number of lawsuits against physicians. Patient safety is of the utmost importance, and research shows that increased patient safety is associated with lower rates of liability litigation.1

In June 2009, President Barack Obama addressed the American Medical Association on the subject of liability reform. The President acknowledged the medical community’s concerns, saying that many physicians “feel like they are constantly looking over their shoulders for fear of lawsuits.”2 President Obama also emphasized the importance of patient safety and of creating an environment in which health care professionals could focus on delivering high-quality care, rather than on practicing “defensive” medicine. The President reiterated this message in a September 2009 address to Congress during which he announced that the U.S. Department of Health and Human Services (HHS) would allot $25 million through the Agency for Healthcare Research and Quality (AHRQ) to an initiative promoting patient safety and medical liability reform.

HIGHLIGHTS

• This article summarizes the purposes and ongoing results of the Agency for Healthcare Research and Quality’s (AHRQ) Medical Liability Reform and Patient Safety Initiative.
• The $25 million initiative provides grants to health care organizations that have agreed to develop systems that promote patient safety and medical liability reform.
• Examples of how institutions are using the grants are provided.

TABLE 1.

GOALS OF MEDICAL LIABILITY REFORM AND PATIENT SAFETY INITIATIVE GRANTS3

| Make patient safety first; reduce preventable injuries |
| Foster better doctor-patient communications |
| Ensure fair and timely compensation for injured patients |
| Reduce number of frivolous lawsuits |
| Reduce liability premiums |

AHRQ action

In preparation for the new endeavor to promote patient safety and medical liability reform, HHS and AHRQ consulted a broad range of experts and stakeholders, reviewed existing evidence, and invited interested parties to submit innovative
proposals. The result of these efforts was the launch of the Medical Liability Reform and Patient Safety Initiative. The goals of the initiative were to enhance patient safety, improve physician-patient communications, ensure fair and timely compensation to injured patients, reduce the number of frivolous lawsuits, and cut liability premiums (see Table 1, page 13).1

Demonstration grants valued at up to $3 million over three years were announced for the “implementation and evaluation of evidence-based patient safety and medical liability demonstrations.”4 One-year planning grants of up to $300,000 were established to fund plans and provide technical assistance for an evidence-based safety and liability demonstration.5

The AHRQ reviewed prior safety and liability efforts. Published in December 2009, this effectiveness review was intended to guide the initiative, inform applicants, and help the AHRQ evaluate grant proposals. Based on this analysis, the AHRQ concluded that there was a lack of evidence regarding the impact of liability reforms on patient safety and that the existing evidence suggested that medical errors tended to be infrequently and inaccurately reported.6

**Grants and results**

In evaluating applicants for the grants, AHRQ focused on three “areas of promise”: preventing harm through best practices, improving professional liability, and alternative dispute resolution. The goals of the initiative included expanding and enhancing judge-directed negotiation programs, coupled with a new hospital early disclosure and settlement model. (See article on page 26, describing the New York State AHRQ project)

**Table 2.**

DEMONSTRATION GRANTS AWARDED (2010) BY THE MEDICAL LIABILITY REFORM AND PATIENT SAFETY INITIATIVE

<table>
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<tr>
<th>Area of promise</th>
<th>Recipient</th>
<th>Proposal</th>
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<tr>
<td>Best practices and patient safety</td>
<td>Fairview Health Services, Minneapolis, MN</td>
<td>Establish perinatal best practices in 16 hospitals to assess the impact on patient safety and the level of malpractice activity</td>
</tr>
<tr>
<td></td>
<td>Ascension Health System, St. Louis, MO</td>
<td>Create uniform, evidence-based obstetrics practice model; expect that eliminating variation in obstetrical practice improves patient safety</td>
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<tr>
<td>Improved provider-patient</td>
<td>University of Illinois at Chicago</td>
<td>Build on Seven Pillars Program; expand existing disclosure program and evaluate impact on malpractice activity</td>
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<td>communication</td>
<td>University of Washington, Seattle</td>
<td>Develop statewide initiative involving communication training for health care workers; collaboration between hospitals and a malpractice insurer to improve adverse event analysis, disclosure, and compensation</td>
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<tr>
<td></td>
<td>University of Texas Health Science Center,</td>
<td>Establish disclosure and compensation model; identify and disseminate best practices for disclosure to improve patient safety; focus on incorporating patient and family input into root cause analysis</td>
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<td></td>
<td>Houston</td>
<td>Engage clinicians, patients, malpractice insurers, and the state public health agency to ensure more timely resolution of medical errors</td>
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<td></td>
<td>Massachusetts State Department of Public</td>
<td>Identify key areas contributing to ambulatory medical errors and malpractice in a group of Massachusetts primary care practices</td>
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<td>Health, Boston</td>
<td>Promote patient-centered communication</td>
</tr>
<tr>
<td>Alternative dispute resolution</td>
<td>New York State Unified Court System, New York</td>
<td>Protect obstetrical and/or surgery patients from injuries caused by providers’ mistakes Reduce the cost of medical malpractice through an expanded and enhanced judge-directed negotiation program, coupled with a new hospital early disclosure and settlement model</td>
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Patient safety is of the utmost importance, and research shows that increased patient safety is associated with lower rates of liability litigation.
communication with patients, and promoting alternative methods of dispute resolution. Across these areas, the AHRQ awarded seven demonstration grants and 13 planning grants (see Table 2, page 14). The results of these initiatives have been very promising thus far, as the following examples illustrate:7

- Fairview Health Services in Minneapolis, MN, was awarded a demonstration grant to establish perinatal best practices across its 16 hospitals and to assess the impact on patient safety and liability activity. The program has resulted in a 74 percent reduction in preventable birth trauma to full-term newborns (preventing 30 cases over four years), 38 percent fewer preventable neonatal intensive care unit admissions of full-term babies, and a 12 percent reduction in preventable maternal complications (172 cases prevented over four years).

- Ascension Health system in St. Louis, MO, was awarded a grant to implement a "uniform, evidence-based obstetrics practice model," with the expectation that eliminating variation in practice would enhance patient safety.

### Table 3.

**Planning Grants Awarded (2010) by the Medical Liability Reform and Patient Safety Initiative**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Recipient</th>
<th>Initiative</th>
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</table>
| Safe harbors and evidence-based practice guidelines | Office for Oregon Health Policy and Research, Portland                     | Set priorities for evidence-based practice guidelines. Create safe harbor legislative proposal  
Conduct effectiveness analysis (if applicable)                                                                 |
| Shared decision making                      | University of Washington, Seattle                                         | Develop shared decision-making tools and processes for orthopaedic surgery patients  
Empower patients through knowledge                                                                 |
| Quality of care monitoring                  | Washington State University, Pullman                                      | Develop best practice medication risk-management systems that can be integrated into transitional care  
Maximize safety, quality, and cost-effectiveness while reducing medical liability  
Increase providers' confidence and experience disclosing errors to patients                                                                 |
| North Carolina State/Department HHS, Raleigh |                                                                           | Establish near-miss reporting and improvement tracking system in primary care                                                                                                                                |
| Johns Hopkins University, Baltimore, MD     |                                                                           | Monitor the quality of care at hospital discharge  
Identify safety concerns and notify leaders in real time                                                                                           |
| Multicare Health System, Tacoma, WA        |                                                                           | Plan for an integrated medical liability and patient safety program  
Provide acknowledgement, apology, and standardized compensation                                                                                                                     |
| Sanford Research, Sioux Falls, SD           |                                                                           | Create infrastructure for a patient advocacy reporting system  
Collect information on patients' and families' concerns  
Identify individual physicians and system components at disproportionate risk for unsafe care and possible lawsuits  
Reduce patient suicides  
Conduct surveys and focus groups to determine how medical liability can be restructured                                                                 |
| Jackson Memorial Hospital, Miami, FL        |                                                                           | Establish statewide pregnancy-associated mortality review system  
Recommend interventions to reduce maternal mortality and disparities                                                                                                                                  |
| Ohio State University, Columbus             |                                                                           | Set priorities for evidence-based practice guidelines  
Conduct effectiveness analysis (if applicable)                                                                                                   |
| Early disclosure and offers                 | University of Utah, Salt Lake City                                        | Set policy and protocol for disclosure to patients and families                                                                                                                                           |
| Beth Israel Deaconess Medical Center, Boston, MA |                                                                       | Develop disclosure-and-offer patient safety initiative in Massachusetts  
Create new medical liability system to improve trust, reduce fear, and improve patient safety                                                                                           |
| Improved communication following preventable injuries | Carilion Medical Center, Roanoke, VA                                    | Foster improved teamwork and communication among providers and with patients  
Collect, analyze, and evaluate data regarding claims management model  
Promote open communication and identify risk-prone areas                                                                                                          |
| Wishard Health Services, Indianapolis, IN   |                                                                           | Set priorities for evidence-based practice guidelines  
Conduct effectiveness analysis (if applicable)                                                                                                   |
Liability lawsuits cause pain and suffering for all parties involved, and physicians often describe themselves as “forever changed” by the experience.

As of February 2012, no liability cases or notices of intent for shoulder dystocia had been filed. Ascension historically would have experienced at least three incidents over the 20-month period since the program was established in July 2010. In addition, rates of reporting breaches in patient safety increased three-fold in that interim, but the severity of reported cases decreased. Finally, fewer birth traumas occurred in the five hospitals included in the initiative.

• The University of Illinois, Chicago (UIC), was awarded a demonstration grant to expand its Seven Pillars Program and to evaluate its impact on liability activity. The initiative has yielded an 80 percent reduction in time to settle full disclosure cases, a 70 percent reduction in litigation-related costs, and UIC reports that no meritless suits were filed for at least 18 months. The initiative saved payors, including Medicare and Medicaid, an estimated $3 million annually since 2006. In all, 20 more hospitals have joined the initiative, even though they received no funding to do so. Furthermore, the initiative seems to have significantly slowed the practice of defensive medicine, reducing the rate of growth in clinical lab orders by 24 percent and radiology orders by 18 percent.

Current status and future directions
Currently, planning grants are near completion and demonstration grants are beginning their third and final year. Grants are on target to accomplish their aims. James Bell Associates, Inc. and the RAND Corporation intend to release a comprehensive evaluation of the initiative later this year. This report will assess the effects of interventions on patient safety, patient-provider communication, liability premiums, the timeliness and fairness of compensation, and the number of lawsuits filed.

Conclusion
These types of patient safety and liability reforms are so important. Poor clinical outcomes harm patients and physicians. Lawsuits cause pain and suffering for all parties involved, and physicians often describe themselves as “forever changed” by the experience. It is truly fair to say that when patient safety improves, everyone benefits: patients, clinicians, and the public.

REFERENCES
Patients and providers both want a health care system that ensures the delivery of safe, effective care. However, when errors, systems failures, or unanticipated outcomes occur, the existing process of resolving liability claims—that is, through litigation—may actively discourage discovery or even discussion of the root causes of these problems. The concept of alternative dispute resolution (ADR) has been introduced as an adjunct or alternative to traditional litigation. ADR includes a panoply of mechanisms designed to improve communication and reach resolution of disputes outside of the courtroom. ADR techniques may be implemented before, during, or after litigation.

The four categories of ADR—mediation, arbitration, negotiation, and collaborative law—differ in terms of the degree of privacy and level of autonomy they afford to the disputants. Furthermore, decisions derived through various methods of ADR differ in their binding nature. This article focuses on the form of ADR that has been applied most widely in medical liability cases—mediation.

**Shortcomings of current model**

Traditional resolution mechanisms are inefficient. They are resource intensive, impede the flow of information between interested parties, and create an adversarial environment between physicians and patients. According to

**HIGHLIGHTS**

- This article focuses on mediation as a viable form of alternative dispute resolution (ADR) in medical liability cases.
- The problems with the existing system of litigating liability claims are addressed.
- Benefits of mediation, including greater patient and provider satisfaction, are discussed.
- Two models of mediation are presented.
- Roadblocks to implementation of ADR are described.

by Cecilia Ong
According to one study, the length of time required to resolve legal claims was twice as great for litigated versus non-litigated claims. Although most court decisions ultimately favored the physician, that resolution came only after months or even years of litigation.¹

Traditional litigation tends to lock parties into positions that they then feel forced to defend. Intractable positions destroy communication regarding the relevant issues. Arguments over “who” is right rather than “what” is right further damage the physician-patient relationship and provide little benefit to either party. Being sued can have a significant impact on physicians and their families. Lost productivity, anxiety, diminished professional reputation, financial costs, and increases in liability and malpractice insurance are some of the hardships defendants typically experience in these situations.¹

These stressors could be reduced if the process of resolving claims were swifter and encouraged greater transparency. In the aftermath of an adverse event, patients and their families often are confused and angry. Few are immediately inimical. Most want basic information about the event, an understanding of how it occurred and how it might be prevented in the future, and an apology that reflects recognition of their loss.²,³ Physicians are given little training and few tools to engage in such conversations. Instead, health care practitioners have been counseled that open disclosure can lead to litigation. Those who try to communicate may say too much too early. They may ultimately be punished for their collaboration with and concessions or apologies to the opposing party, as these actions are all perceived to be an acceptance of personal responsibility for negative outcomes. When these barriers to open communication arise, litigation may seem like the only recourse.

However, the stifling of communication that occurs due to fear of litigation ultimately has a detrimental effect on patient safety. Up to one-quarter of physicians reported having seen an error in the previous year. Among them, 60 percent believed that a similar error was very or somewhat likely to occur at the same institution during the next year.⁴ This lack of communication often leads to stagnation in patient safety improvements.

Projected benefits of ADR

It is in this context of disjointed communication that mediation and other forms of ADR may provide the most benefit. Mediation augments direct communication between parties by introducing a neutral third party, a mediator, who facilitates negotiations. The mediation process addresses barriers to communication by encouraging information sharing, mitigating high emotions, promoting collaboration, and fostering trust between parties.¹ Patients often favor mediation because it provides an opportunity to share their feelings and concerns and obtain relevant information.⁵ Physicians also appreciate the opportunity to draw the distinction between bad medicine and bad outcomes and to express their frustrations with being sued.⁶ By improving communication, the enhanced relationship between patient and provider may help both parties potentially avoid or minimize the impact of lawsuits.⁷

Mediators do not dictate an outcome; rather, they help both parties understand their motivations and elucidate the events and influences leading up to the incident. They help parties develop and evaluate new options for resolving the issues at hand, tailoring the solution to the specific needs of both parties, and broadening the possible outcomes beyond the linear constraints of the litigation process. The findings uncovered through mediation are non-binding unless parties reach an agreement. Satisfaction among plaintiffs and defendants in mediated cases is approximately 90 percent.⁸

Once an event is disclosed and mediated, a more open discussion may follow that allows health care providers to learn from and reduce future medical errors. The changes that occur as a result of these experiences can ultimately improve patient safety.
Models for mediation

In 1995, Rush Medical Center in Chicago, IL, developed a prototype for ADR in response to the rapid growth in legal costs and unpredictable rising jury awards in malpractice cases. The Rush model features a mediation agreement, mediation conferences, and, most notably, co-mediators, including a lawyer who traditionally would represent a plaintiff in a medical liability case and a lawyer who would traditionally defend these cases.9,10

In the first five years of the program, 55 cases spanning errors in medication, diagnosis, and treatment were mediated. More than 80 percent of the cases that underwent mediation were resolved within one year of the lawsuit being filed and within three to four hours of starting mediation.10,11 The mediated cases were resolved in half of the time in which non-mediated cases in Cook County were settled or came before a jury.11 Though payouts were lower, patients were willing to accept the awards because they were received quickly.10

Another model, the Pew Demonstration Mediation and ADR Project prototype, was implemented in four Pennsylvania hospitals in 2002, including a large, decentralized network of urban teaching and suburban hospitals with more than 2,500 staffed beds and a suburban community teaching hospital with approximately 500 beds. This model focused on equipping physicians with mediation skills by encouraging physicians to learn communication skills for disclosure conversations; providing experts to help plan, conduct, and debrief disclosure conversations; and using mediation to settle potential claims.2 Mediation settlements included provisions that met patient and family needs, such as ensuring that policies or procedures were changed to prevent similar errors or adverse events from occurring again. The parties were encouraged to explore both monetary and non-monetary solutions, whereas court proceedings typically result only in judgments.12 Although only two cases were mediated in this demonstration project, it successfully showed that the apology and change in practices to avert future errors were the most important elements of the settlements.

Current role of ADR and future implications

ADR has been demonstrated to have a positive impact on physician-patient relationships, improve the efficiency of settlement proceedings, reduce the costs of resolving claims, enhance the confidentiality of proceedings, and encourage improvements in patient safety.

Despite these benefits, multiple unresolved issues and challenges to implementation remain. ADR payments made on behalf of physicians must be reported to the U.S. Department of Health & Human Services’ National Practitioner Data Bank (NPDB). This mandate increases physicians’ willingness to go through the traditional legal process, which tends to favor the physician defendant.5 Hence, the impact of reporting must be weighed against the benefits of ADR and revisions of the NPDB requirements should be considered.

Some discomfort exists surrounding the introduction of mediators to the conversation. Mediators do not have the same authority as judges and cannot compel the release of information or impose the results of the decision, thus necessitating the full compliance of both parties.5 Mediators may find it difficult to navigate conversations on complex medical and health systems issues; however, with the advent of specialized mediators, this problem may become less of an issue. In fact, this mechanism may be superior to the current system that relies on lay jury members to come to a consensus on these complex issues.
The mediation process addresses barriers to communication by encouraging information sharing, mitigating high emotions, promoting collaboration, and fostering trust between parties.

Some courts, for example those in North Carolina, now require “compulsory mediation” before any case can be tried. This policy maintains that mediation is an adjunct to, not a replacement for, litigation. However, this model of mandatory mediation has been demonstrated to be less effective than voluntary mediation, with rates of success measuring 23.7 percent and 90 percent, respectively.6,13 This discrepancy likely reflects the fact that the greatest strength of mediation and ADR in general is its flexibility in meeting the unique needs of each case. Different systems have pioneered various forms of mediation, for example, by court mandate or by employee or department head training in conflict management. The success in implementation of these programs remains to be seen.

An understanding of ADR in comparison with traditional litigation methods will enable physicians to choose the most appropriate mechanism of resolving for each situation. This understanding of the processes of ADR will empower physicians to better communicate in difficult situations and improve their strategies for resolving malpractice allegations.

Acknowledgment

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Medical liability litigation is a powerful force in the U.S. health care community. The mere possibility of being sued may affect clinical decision making, strain physician-patient relationships, and shape the professional experiences and attitudes of physicians. When they occur, liability lawsuits can be a financially and emotionally devastating experience. As a result, hospitals across the country rely on professional risk managers to reduce their legal liability. Given the short-term financial exposures associated with liability claims, risk management—historically expected to “circle the wagons”—has often been perceived as a financial necessity first and foremost.

However, the concept of risk management is evolving. The core challenge to medical risk management is not litigation but harm to patients. Patient safety is, and must be, the central goal of any risk management program. To illustrate this point, this article looks at the early disclosure and offer (D&O) program at the University of Michigan Health System (UMHS), Ann Arbor, which has shown promising results since its implementation 10 years ago.

Reduced medical liability is indeed a desired outcome of the D&O program, but the best risk management is reduced...
patient injuries. This program demonstrates that the D&O approach cuts the costs associated with liability claims by creating the safest possible environment for patients.

Restoring accountability
In late 2001 and early 2002, UMHS changed the way the health system responded to patient injuries, applying what has become known as the Michigan Model and has since been described as an early disclosure and offer program. The UMHS’ approach was designed to promote patient safety through the principles of honesty, transparency, and accountability. In 2004, UMHS announced its goal of becoming the safest hospital system in the nation.

The program was informed by two central observations: (1) honesty is indispensable for safety improvement, and (2) a short-term focus on financial risk impedes long-term improvement. The tenets of the D&O system include compensating patients quickly and fairly when inappropriate medical care causes injury, communicating openly with patients about error(s), supporting staff vigorously when appropriate care has been provided, and reducing future injuries and claims through application of knowledge garnered through the discovery process. The system emphasizes UMHS’ commitment to patient safety, as well as its accountability to patients and to clinicians who provide high-quality care.

Recognizing that problems can only be addressed if they are known, the UMHS’ D&O system uses multiple strategies to capture unintended clinical outcomes. UMHS promptly investigates patient complaints. At all stages of the investigation, UMHS prioritizes open communication with patients, and representatives offer to meet with patients, families, and legal counsel to obtain their views, discuss the complaint, and explain the progress of the investigation. These meetings provide an important opportunity to help manage patients’ expectations regarding continuing clinical needs and dispute resolution. When the investigation is complete, UMHS communicates its full findings to patients and promptly offers compensation when it determines that inappropriate care led to an injury.

A UMHS internal committee assesses errors in patient care after thorough investigation and review. This approach, as opposed to reliance on outside “experts,” promotes a sense of ownership among UMHS care providers. It also reduces physicians’ anxiety over whether their clinical reasoning and decision making will be undervalued and lessens their feelings of victimization at the hands of a broken and unfair litigation system. Most importantly, a careful internal assessment of clinical events dramatically increases the chance that safety problems will be fixed going forward.

Departure from deny and defend
UMHS’ D&O program represents a radical departure from the traditional “deny and defend” paradigm. Under that model, the health care community categorically rejects fault for adverse events and outcomes, and complex medical and emotional issues are systemically “turfed” to lawyers. Consequently, the physician-patient relationship inevitably becomes adversarial. Attorneys on both sides, focused on winning the case that might ensue, advise stonewalling the patient instead of discussing the case openly and honestly. Patients are kept in the dark about clinical decisions and events related to their care and often describe feeling abandoned. As misunderstandings and resentments solidify, patients increasingly turn to lawyers who, in turn, recommend litigation, regardless of the merits of the case.

Although physicians are well-aware of the financial and emotional impact of litigation, deny and defend only increases these burdens. Deny and defend exacerbates several factors that drive patients to seek legal counsel. For instance, patients often contact lawyers in search of answers, but the threat of legal involvement has a chilling effect on communication between patients and clinicians because they are now perceived as being in opposition to one another. Similarly, patients who have suffered an adverse event have a natural desire for justice and accountability. When the medical community denies and defends, lawsuits become the only constructive recourse.

Furthermore, the fact that patients feel compelled to protect others from the same adverse clinical outcome has been grossly underappreciated. Several studies on why patients sue their caregivers cite this sense of obligation to fellow patients as a strong motivat-
ing factor for pursuing litigation. Deny and defend undermines this driving force because it rejects the notion that the outcome was preventable. Instead, it commits physicians and their attorneys to justifying the care provided, even if it was substandard. For all members of the health care community, deny and defend provides a disincentive for investigating clinical events and decisions for fear that such scrutiny would reveal compensable error. Finally, and most powerfully, deny and defend serves neither the individual nor the common good. By systematically justifying substandard care, this approach is both an obstacle and a threat to patient safety. It undermines accountability, actively ignores dangerous individuals and patterns in the health care system, and disregards the ongoing risks that they present to patients.

Two sides of the coin
The impression that medical liability suits are an inevitable cost of doing business can render settlement an appealing option for defendants, even when no medical error has been committed. However, for individual physicians, this pattern can be painful and demoralizing, and for health care systems, it is an extremely costly strategy. It leaves caregivers dispirited and less likely to make evidence-based clinical decisions and may encourage patients and attorneys to pursue meritless lawsuits risk-free.

If UMHS concludes that a patient was injured due to inappropriate care, its policy is to offer patients a prompt apology and fair compensation. Conversely, if UMHS finds that the adverse outcome was not a result of inadequate care, it generally refuses to settle, regardless of expediency. In this situation, open communication with patients takes on additional value as a means of informing potential plaintiffs and their attorneys that they do not have a meritorious legal case and the reasons for that conclusion. Furthermore, it is important that UMHS providers see the clear and robust connection between quality of care and risk management; settling non-meritorious claims would undermine this correlation. Ironically, UMHS officials agree that refusing to settle such claims has been one of the most difficult components of the model to implement. It is costly to refute frivolous accusations in court, and it is often less expensive to appease plaintiffs with a settlement payment. However, the UMHS views court cases in which they defend reasonable care as an investment in the integrity of their institution and the D&O program, and as an important demonstration of UMHS’ commitment to safe, high-quality care.

Results of the program
UMHS’ D&O model has successfully resulted in fewer claims, fewer lawsuits, and lower liability costs. Kachalia and colleagues found that the rate of new claims at UMHS has decreased from approximately seven per 100,000 patients to fewer than five. The rate of lawsuits has declined from 2.13 suits per 100,000 patients per month, to roughly 0.75. The median time from claim to resolution has dropped from 1.36 to 0.95 years. Cost rates due to total liability, patient compensation, and legal fees have decreased as well. Because UMHS generally refuses to settle what appear to be non-meritorious claims, patient compensation is now a direct indicator of substandard care in UMHS and a powerful motivator for increased safety and adherence to standards of care.

Anecdotal evidence suggests that the D&O program has helped UMHS retain patients, even after they were harmed because of a medical error or mistake. In that respect, the institution’s response to the adverse event seems not to undermine patient trust in the medical system but to actually help restore it. Anecdotal evidence also suggests that the program has had a positive effect on clinician morale. Health care professionals find reassurance and validation in UMHS’ staunch defense of high-quality care and have reason to believe and expect that their work will be recognized and honored by their professional liability.
Well-received program
The UMHS model has been generally well-received in Michigan and elsewhere. In Michigan, the plaintiffs’ bar has embraced the model, in part because they do not benefit from pursuing groundless litigation. In contrast, the defense bar consistently views it in a negative light, possibly because early resolution negatively affects their practice. Nationally, the model has been covered by major newspapers and newsmagazines and was cited by then-Sens. Barack Obama (D-IL) and Hillary Clinton (D-NY) in a 2006 editorial on health care reform.10,11 Although the UMHS D&O program is novel in its focus on patient safety improvement, the model was not without precedent. The Department of Veterans Affairs (VA) initiated a D&O program in Lexington, KY, in 1987.12,13 The model spread to several private institutions and VA hospitals, but was not adopted by the VA system overall. Primarily an early resolution model, the VA’s program was not linked to patient safety improvement.

Traditionally, many health systems and insurance carriers have engaged in “service recovery,” a practice in which risk managers spot potential claims early and intervene with modest payments as a means of intercepting litigation. In Colorado, for instance, the liability insurance provider COPIC established a compensation model in which patients could be reimbursed up to $5,000 for lost time and $25,000 for out-of-pocket expenses related to their adverse outcome or event.12

The program was very limited, however. Patients who had legal counsel were excluded. Payments were made largely for out-of-pocket costs, not as compensation for injuries. By design, no admissions or apologies were attempted. Generally under the compensation-only model patients who accept the payout retain the right to sue. Severe or fatal injuries, and adverse outcomes clearly due to medical error, are exempt from this process. Notably, compensation models do not involve investigations into possible provider error, and no connection is drawn between injury and patient safety efforts.

Patient safety through D&O
In terms of patient safety, early and open communication with patients is not simply the right thing to do—it is also the smart thing to do. Most health systems view liability costs as simply a cost of doing business, and not a legitimate indication of the quality of their care. By significantly reducing spurious lawsuits, the UMHS D&O program provided the institution with an additional metric with which to measure the quality of care it delivers regularly. Data pertaining to settlements and court cases are now seen as robust indicators of what UMHS is doing well, and where and how it continues to put patients at risk.

In other words, D&O helps the institution isolate problematic or dangerous processes and health care professionals. The model forces the host institution to confront unpleasant and often tragic realities and determine its own accountability for them. In offering early disclosure to patients, UMHS must first admit mistakes to itself. It follows, too, that patient safety will always be at risk if UMHS and the health care system overall are unwilling to remove the individuals who provide substandard care. UMHS’ awareness of the weaknesses of systems and staff can and must be leveraged to shape improvements, reduce risk, and protect patients. Having taken stock in an accountable way, the D&O approach stimulates honest, evidence-based peer review and forward-thinking approaches to improvements in patient communication and engagement.

In addition, the systematic and thorough investigation of patient complaints—not simply patient claims—is a powerful means of uncovering opportunities to improve patient safety. At UMHS, patient complaints and the peer review process are used to inform educational initiatives for clinicians and to direct other quality improvement efforts.

The physician’s role
Several points pertaining to clinician responsibilities in the D&O program warrant mention. Of note, UMHS discourages physicians from disclosing errors to pa-
By significantly reducing spurious lawsuits, the UMHS D&O program provided the institution with an additional metric with which to measure the quality of care it delivers regularly.

tients. There are several reasons for this. First, physician disclosure is likely to be biased in some way and based on partial or otherwise imperfect information or emotional bias. Furthermore, clinicians risk losing credibility if their disclosure is in some way wrong—a “false positive” or “false negative”—and the goal of the D&O program is to maintain and foster trust between patients and providers. At the UMHS, the risk management staff sees itself as advocating for the institution and its clinicians, but with the understanding that defending care that should not be defended benefits no one.

Some clinicians are hesitant to apologize to patients for fear that the apology will be used against them in court. Although physician apology is an important component of the D&O model, such expressions of regret tend not to make physicians more legally vulnerable. Under this model, clinicians are encouraged to offer formal apologies only if an internal UMHS medical committee has judged the care to be substandard. In that case, however, an offer of prompt and fair compensation reduces the likelihood of litigation.

UMHS offers alternate guidance to clinicians available 24 hours, seven days a week. In particular, physicians are encouraged to help patients understand the risks of procedures or treatments and are discouraged from stating things that patients might interpret as promises or guarantees. Patients who have unrealistic expectations may experience a heightened sense of disappointment, suspicion, distrust, and betrayal should an adverse event or outcome occur.

Conclusion
The UMHS disclosure and offer program is a compelling demonstration of the power of honesty, transparency, and accountability as pillars of medical liability management, serving the dual goals of improving patient safety and ameliorating the costs of avoidable medical mistakes. The program makes every effort to put patients and their safety first and, in that way, fulfills its commitment to serving and protecting physicians, providers, and health systems.

REFERENCES
New York State shows benefits of CRP demonstration project

by Susan Senecal; Margo M. Hoyler; and Janet Cohn, JD

As other authors in this special edition of the Bulletin of the American College of Surgeons have noted, medical liability lawsuits are financially and emotionally costly. In these respects and more, they harm patients, providers, and the medical and legal systems. The pervasive tropes of “bad apple” physicians, greedy lawyers, and exploited patients do little to promote patient well-being and patient-provider trust. Nonetheless, achieving medical liability reform has proved difficult in New York and elsewhere. New York State has responded to these challenges in part through an Agency for Healthcare Research and Quality (AHRQ)-funded Patient Safety and Medical Liability Reform Demonstration Project. This article describes the processes and systems created to meet its objectives.

The AHRQ request for applications

Already looking for creative alternatives to New York’s medical liability system, a small interdisciplinary state team responded with interest to AHRQ’s request for applications to participate in the 2009 Medical Liability Reform/Patient Safety demonstration project. The AHRQ initiative offered funding to states and/or hospital systems for programs that would promote patient safety, improve patient-provider communication, ensure fair and prompt settlements for injured patients, and reduce the incidence of frivolous lawsuits and liability premiums. Although many reform efforts were under way, AHRQ’s emphasis on improving patient safety added a critical challenge.

New York State project

To meet the wide-ranging requirements of the AHRQ initiative, the New York team expanded to include additional representatives from the Department of Health and the Unified Court System, as well as five major academic medical centers in New York City. It also recruited Michelle Mello, JD, PhD, a public health researcher who would evaluate components of the project, and Richard Boothman, JD, a pioneer in disclosure and offer programs.

A central component of the project was a communication and resolution program (CRP), to be piloted in the departments of general surgery of the five participating hospitals. Its goals were to reduce preventable harm to patients and, when harm nevertheless occurred, to resolve disputes while preserving the physician-patient relationship. The New York State proposal also included an expansion of a pre-existing judicial program for disputes that resulted in lawsuits. The proposal was successful. In 2010, AHRQ awarded...
In 2010, AHRQ awarded New York State a $3 million demonstration grant to fund the pilot program for three years. The program is currently in its third and final year.

**Focus on patient safety**
In keeping with the AHRQ guidelines, the New York State project focused on patient safety. The work plan identified three areas of emphasis: development of a culture of safety, enhanced adverse event reporting, and implementation of patient safety activities.

Participating institutions were responsible for assessing their safety culture by administering AHRQ’s Hospital Survey of Patient Safety Culture to general surgery department staff. Hospitals were required to identify opportunities for improvement and design initiatives to address them. The survey will be re-administered in the final months of the project.

Building upon improvements in the culture of safety, participating institutions were encouraged to enhance their systems of tracking and responding to adverse events. Hospitals expanded adverse event data sources beyond traditional clinical reporting. Known complications were included for further evaluation, with a focus on the patient’s perspective on the event.

Hospitals were expected to adopt appropriate safety measures and incorporate current initiatives into the project scope. These included the use of surgical safety checklists and “zones of silence” to reduce distraction and error. In addition, the development of an obese surgical patient practice guideline and better preoperative assessments, among other initiatives, were identified to help reduce preventable harm.

**CRP elements and processes**
The CRP established personnel and protocol for the identification, reporting, and resolution of study events. A CRP study event was defined as an adverse event that did or could result in serious harm to a patient while in the care of the perioperative unit. Level of harm is
assessed using the AHRQ scale. Study events are reported to the “hospital designee,” who notifies other hospital staff and oversees the process. Responding to the patients’ immediate needs is the first priority.

An investigation is conducted promptly and the findings are presented to a review committee, which recommends systems improvements and determines the appropriate resolution. If monetary compensation is to be offered, an early settlement subcommittee is convened. Representatives of the review committee and the early settlement subcommittee meet with patients and families to explain the findings of the investigation and, if appropriate, to offer an apology and to discuss resolution, as well as measures to prevent recurrences. At all stages of the CRP process, the emphasis is on consistent communication with the patient and family. To facilitate CRP implementation, general surgery department staff participated in a customized training program to improve post-event communication with patients.

Judge-directed negotiation

The New York State Patient Safety and Medical Liability Reform program included an expansion of a program that had been piloted by the New York State Unified Court System for cases filed against New York City public hospitals. The judge-directed negotiation program was intended to handle those cases that the CRP did not resolve, as well as pre-existing cases. The project team developed a new “medicine for judges” curriculum, including lectures on medical records, anatomy, specific medical injuries, settlement techniques, and legal issues related to medical liability litigation. A total of 60 judges attended a three-day training course. The materials and presentations were subsequently made available online to all New York State judges.

Under the program, all lawsuits against one of the five participating hospitals are assigned to trained judges who retain the cases for their duration or until a plaintiff opts out. The plaintiff may request a jury trial at any point. An RN/JD provides clinical assistance to the judges. The parties meet in the judge’s chambers instead of a courtroom, and they are required to appear fully prepared and with authority to settle. Case conferences are frequent and focused on the prompt achievement of a fair settlement.

The judge-directed negotiation program, which has since expanded to Erie County, has been met with enthusiasm from both the plaintiff and defense bars. Significantly, the program has provided confidence to hospitals in a high-risk liability climate like New York’s to participate in the CRP.

Next steps

A formal evaluation of the CRP and judge-directed negotiation programs is forthcoming and will be performed by Ms. Mello and colleagues at the Harvard School of Public Health, Boston, MA. Meanwhile, data from the hospital sites and the court system are being gathered.

The experience of developing and implementing the program has underscored the interconnectedness of diverse approaches to medical liability reform. Above all, patient safety is at the heart of the matter: it must be the chief driver for all stakeholders, including providers, public health officials, hospital administrators, attorneys, and the judiciary. As AHRQ foresaw in creating this initiative, putting patient safety first can promote liability reform. ♦

Author’s note

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America’s medical liability system is broken. It incurs high administrative costs, does little to improve the care that patients receive, and compels health care providers to waste billions of dollars on unnecessary tests and procedures. Special health courts would address these shortcomings by compensating injured patients more efficiently and equitably and by distinguishing good care from bad so that physicians can act on their best judgment—rather than fear of a lawsuit. These courts would go a long way toward reducing defensive medicine and fostering the openness that’s necessary to improve the quality and safety of medical care.

Improving accountability
A goal of any tort system should be to create reliable accountability. In a well-functioning medical liability system, lawsuits would discourage substandard care and ensure that patients who are injured due to medical errors receive fair compensation. Rulings need to be tied to actual error and similar cases must be decided in a similar manner. The current jury system is ad hoc, producing rulings that are inconsistent, including unjust rulings against physicians in cases where errors did not occur as well as failures to compensate patients who were injured by errors.1

Because physicians cannot predict when they will be exposed to an erroneous claim, they engage in the costly practice of defensive medicine.2,3 In this climate, physicians and hospitals also fear admitting errors or suspected errors—whether their own or those of others.4–7 As a result, many problems go uninvestigated, and opportunities to improve the quality and safety of medical care are lost. By bringing reliability to medical justice—and lessening the current demoralizing nature of the modern tort trial—health courts would address this culture of secrecy by promoting and justifying candor among health care providers.

Addressing existing problems
Under a health court system, trained, specialized judges would hear and rule on liability claims and would issue written rulings that would serve as precedent in future cases. And, as is the case in other administrative systems, such as tax courts and workers’ compensation tribunals, there would be no juries. Furthermore, instead of relying on expert witnesses hired by plaintiffs or defendants, health courts would employ neutral medical experts to evaluate claims and testify on proper standards of care.

The expedited proceedings and improved efficiency under a health court system would reduce the amount of time an injured patient waits to receive compensation, which currently averages three to five years.1 Health courts would also establish a schedule for payment of noneconomic damages to introduce consistency and fairness to the compensation system.7

Some health court advocates argue for changing the standard in liability claims from one of negligence to “avoidability,” thereby shifting the focus of error analysis from the individual to the system in which in the individual works.7 Others argue that the benefits of a health court system would still exist under a negligence standard. Either standard would markedly improve both the fairness and the reliability of the medical liability system.
The current liability system creates a situation in which compensation does not align well with the absence or presence of medical error. A 2006 study by Studdert and colleagues asked medical experts to review 1,452 closed claims. They found that in 28 percent of the cases in which no medical error occurred, the plaintiff received payment. Conversely, in 27 percent of cases where the experts judged that an error had occurred, injured patients received no payment. Data suggest that fewer than 5 percent of patients with serious injury from medical error ever file a claim. Furthermore, the current system is very inefficient. For every dollar paid into the liability system, 54 cents goes to legal fees and administrative costs.

Under the current system, jury decisions are non-binding, so two juries presented with the same set of facts might rule differently. “The civil jury,” as Yale University law professor George Priest asserts, “is an engine of inconsistency.” Juries also never issue a written ruling that explains their decision. The written rulings that health court judges would issue would set a legal precedent for determining whether acceptable care has been provided.

Improving quality
Reforming the liability system to include special health courts will improve the quality of health care while decreasing the costs associated with defensive medicine. In fact, error reporting could be supported explicitly with special health courts, with penalties enforced on hospitals and physicians that fail to disclose errors.

Defensive medicine is estimated to cost the U.S. health care system from $45 billion to more than $200 billion a year, and the practice is widespread. A 2005 study in the Journal of the American Medical Association revealed that 93 percent of Pennsylvania specialists admitted to practicing defensive medicine. By bringing reliability to medical justice, physicians will feel comfortable making decisions based on medical need and not legal fear, thus reducing the cost of defensive medicine and America’s health care tab as a whole.

Success stories
Other countries and some U.S. states have adopted administrative solutions to medical injuries with great success. In New Zealand, the Accident Compensation Corporation (ACC), which was established in the 1970s, covers all injuries caused by medical treatment. Compensation covers lost earnings and rehabilitation costs, as well as a one-time payment to claimants for miscellaneous expenses. This system has helped to maintain total administrative costs to about 10 percent. The ACC processes approximately 3,000 claims annually, which suggests that even in a system with easy reporting, not all injured patients are filing claims.

Sweden also has adopted an administrative system for compensating patients who experience medical injuries. Injured patients in Sweden submit their claims for review by an impartial expert. Between 40 and 45 percent of the claims in the system are reimbursed—and in up to 80 percent of claims, physicians actually help patients file for reimbursement.

In the U.S., Florida and Virginia have developed administrative systems to address claims for birth trauma. Although both programs have limitations, they have demonstrated that non-tort based compensation plans for medical injuries are feasible and can decrease the cost for physicians in high-risk specialties like obstetrics.

Success with administrative solutions to malpractice in these locales and growing recognition of the problems with our current medical liability system have led to increased support for health courts. Political supporters include President Barack Obama, former Massachusetts Gov. Mitt Romney, and New York City Mayor Michael Bloomberg. In addition, four 2011 deficit reduction commissions and several federal and state bills have called for establishing health courts. Professional societies, including the American Medical Association and the America College of Obstetricians and Gynecologists, support piloting this reform. The American public also supports health courts, with 66 percent of respondents in a recent poll favoring their creation to adjudicate medical liability claims. The only group in opposition is the trial bar, which benefits from the ad hoc nature and inequity of the current system.

In a well-functioning medical liability system, lawsuits would discourage substandard care and ensure that patients who are injured due to medical errors receive fair compensation.
Other countries and some U.S. states have adopted administrative solutions to medical injuries with great success.

**Strongest solution**

Health courts are preferable to other proposed medical liability reforms because they would successfully and reliably separate good care from bad and address the totality of flaws in the current system. Caps on damages would limit the costs of claims but would do nothing to protect a physician who acted appropriately. Early disclosure and offer programs improve transparency and address the issue of delayed compensation but do not enhance reliability. Safe harbor proposals fail to address who decides whether standards were followed. Would it fall to the same inconsistent juries under the current system? Additionally, it is impossible to establish evidence-based guidelines for every case or even most cases in health care. Physicians would continue to care for patients for whom no guidelines exist and the current culture of legal fear—the cause of defensive medicine—would persist.

Health courts, on the other hand, are the best solution to the failures of the current system because they address the issues of reliability and consistency in rulings, costs associated with defensive medicine, fair and efficient compensation for injured patients, patient safety, and physician accountability.37

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Proponents of health courts say that they will address several problems with the current medical liability system, including uncertainty in judgments, an unpredictable compensation structure, and minimal emphasis on quality and safety improvements. Health courts, however, are ill-conceived and will inadequately address the issues of concern to their proponents. Furthermore, health courts will likely reduce the rights of injured patients; will create a new, costly, unnecessary administrative system; and will not improve the safety or quality of health care delivery.

**Unjust system**

Health courts most likely would deny justice to injured patients by diminishing the rights that they are afforded under the current civil justice system, including the right to a jury trial, the right to legal representation, and the right to seek remuneration for injuries.

Health courts would employ specialist judges to adjudicate the injury claims, which would limit patients’ access to a jury trial. Health courts would require all patients seeking compensation for injury due to medical error to participate in the new system. This would further deny access to a jury trial by limiting patients’ ability to seek redress through the traditional tort system. Health courts would limit patients’ access to legal representation as well. Because the health court proposals encourage hospitals to make early disclosures of errors and early settlements with patients, health courts may encourage hospitals to dissuade patients from seeking legal counsel before accepting an offer.

Proponents support limiting access to legal representation as a way to further reduce the administrative costs of the liability system. This constraint would create greater inequity for patients in that physicians, hospitals, and insurance companies will have legal representation, while those injured through medical error or negligence would not. To further limit administrative costs, health courts would set a minimum claim or deductible for compensation. This policy would prevent patients who require less compensation from seeking any recourse. Together these changes would limit the rights of injured patients to seek a remedy after they have been injured.

Proponents of health courts argue that these significant and costly changes are necessary to address the errors that judges and juries have made in deciding liability lawsuits under the current system. They also argue that the unpredictability of the rulings in the current system leads to frivolous lawsuits and inappropriately large judgments against physicians. However, the data do not support this claim.

A study by Studdert and colleagues found that most cases were resolved correctly. In a random sample of 1,452 closed claims, they found that in cases where medical errors occurred, 73 percent of the patients were awarded compensation. Conversely, in only 10 percent of the total claims did a plaintiff receive compensation when their medical experts determined that no error occurred. Furthermore, cases in which no injury occurred were compensated less than 1 percent of the time. In 16 percent of the claims, juries erroneously sided with physicians, offering no reward to patients who were injured by medical errors. In addition, the American Medical Association reported 2005 data from the Physician Insurers Association of America indicating that defendants won 83 percent of the liability cases that went to trial. They also noted that more
more than 75 percent of cases were resolved without payment to the plaintiff. These findings indicate that the current jury system does not unfairly favor patients or frequently award large, inappropriate judgments. In fact, the numbers suggest that the current system favors physician-defendants.

The reality of the current system is that most claims are not actually decided by juries. In a study of 26,297 claims in Florida between 1990 and 2008, Holman and colleagues found that 94 percent of paid claims either settled before trial or during a trial but before a verdict. Studdert found that only 15 percent of the 1,452 claims that they reviewed were decided by jury verdict. So, eliminating patients’ right to trial by jury probably will have little impact on the majority of cases.

**Costs**

Proponents of health courts argue that they are necessary to address high costs in the tort system that arise both from excessive jury verdicts and high administrative costs. Proponents advocate controlling costs by adopting a schedule of awards for different types of injuries. A physician panel would develop the schedule or list of accelerated compensation events. A schedule of awards, however, would deny individual patients the right to compensation based on the facts of their individual case. Award limits also deny individual patients just compensation. As noted previously, claims and rewards of injuries not caused by error comprise only a small part of the liability system. Even eliminating all of these claims would not have a significant effect on the costs of liability. In their review, Studdert and colleagues found that only 12 to 16 percent of the costs of all the claims could be attributed to cases without merit. Based on these findings, the majority of the costs incurred are to adjudicate claims of injured patients.

**Negligible quality improvement**

Advocates argue that health courts will improve the safety and quality of medical care. They argue that changing the standard of injury in liability claims from “negligence” to “avoidable” would create a climate that encourages disclosure of errors, increases the number of patients who are reimbursed, and supports quality improvement programs. However, the “avoidability” standard is ill-defined. The standard that health courts are to apply varies among proponents, including the Progressive Policy Institute, the Republican Policy Committee, and Common Good, a nonpartisan reform coalition. These different groups advocate standards ranging from a failure to deliver good care to negligence. Most descriptions, however, differ little from the current standards of negligence. Health courts are unlikely to alter the factors that discourage physicians and hospitals from disclosing errors under the current system.

Health courts rely on disclosure of injury to patients without providing safeguards to increase disclosure. Nothing in the health court proposals guarantees that physicians will report errors more frequently. Physicians who report errors will still be subject to the same public shame they experience in the current system, as well as possible repercussions from their hospitals. Hospitals would also have a disincentive to report errors because their insurance costs, which are based on claims data, would rise. While supporters of health courts argue that fines that are imposed for late reporting of errors will prevent this problem, it is unlikely that

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**Health courts most likely would deny justice to injured patients by diminishing the rights that they are afforded under the current civil justice system, including the right to a jury trial, the right to legal representation, and the right to seek remuneration for injuries.**
fines will be imposed because patients will be unaware of errors that are not disclosed by providers, and there is no oversight or enforcement of the self-reporting. Thus, health courts are unlikely to result in increased voluntary disclosure of injuries to support an investigatory process and quality improvement.

One difference between jury trials and the procedures recommended under the health court proposal is the creation of a written decision. No legal precedent is set in a jury trial, and health court proponents argue that by creating written legal precedents and maintaining them in a searchable database, standards of medical care delivery will be codified. They argue that this will, in turn, lead to improved outcomes. However, a written decision for one case may have limited application to other cases in which the facts and unique medical history of the patient differ. As health care becomes more patient-centered, appropriate standards from one case may not apply to another. Creating a body of written decisions is unlikely to add clarity to medical standards or expectations.

**Improvements without incurring large costs**

Health courts would create a large, expensive administrative system financed by the health care industry and taxpayers. Proponents argue that this expense is necessary to achieve overall cost savings and improve safety and quality. However, the current system could be leveraged to achieve similar improvements, without incurring large costs. Many of the issues addressed previously in this article, including the ability of the current system to render appropriate decisions and to improve quality and safety, could be enhanced without drastic or costly changes. Health courts would be ineffective in reducing erroneous jury decisions because in 89 percent of the cases the current system either rules correctly or favors physicians. Changing the system also is unlikely to reduce costs because 80 percent of the costs of litigation go toward resolving legitimate claims. Reworking the system would not reduce the need to address these cases. Furthermore, changing the standard of proof in liability claims and encouraging self-reporting would potentially increase the number of claims and, thus, the overall costs.

An expensive new system is unnecessary in order to improve quality and safety. A large body of data on different errors and safety problems already exists in the form of claims filed. However, physicians, hospitals, and policymakers do not appear to be using these data to seek out methods for improving patient care. New systems for collecting data provide no guarantee that they will be applied to improving patient care. Health courts will be a challenge to implement and finance. Proponents of health courts argue that clinical practice guidelines can be developed to support judges deciding health court claims. Developing guidelines to support physicians’ practices in clinical medicine is difficult. Evidence-based medicine is a dynamic process that must be applied to each individual. Each patient has a unique set of medical conditions and personal circumstances that limit the applicability of specific standards and algorithms. As medical science continues to progress and the field of personalized medicine grows, it will become more difficult to establish generic guidelines. As a result, basing decisions in a health court system on standard guidelines, or the precedent of prior decisions as the standards of care, will be nearly impossible.

Creating a new administrative system will be costly in many ways. Establishing the new structure, training judges, and paying expert witnesses—as proponents support—will be expensive. Physicians, hospitals, and the public will have to contribute to financing a new health court system. Physicians and hospitals are likely to see increased, rather than decreased, liability premiums. Insofar as increased liability rates currently are driven largely by the insurance cycle and not claims in
Physicians and hospitals are likely to see increased, rather than decreased, liability premiums.

the system, health courts are unlikely to address the root cause of high premiums, and may make rates higher.1 Furthermore, liability costs could increase if, as proponents argue, changing the system will lead to increased disclosure of error. These disclosures will result in more claims filed and more payments to injured patients. Health courts overall would create logistic and financial challenges, while falling short of the goals that proponents desire.

**Conclusion**

Health court proponents are correct in arguing that the current system is slow to reward patients, is costly, and could be used more effectively to improve the safety and quality of health care delivered. However, a new, expensive bureaucracy that infringes on the rights of injured, vulnerable patients is not the answer. Efforts to encourage early disclosure and compensation offers to patients can decrease the time an injured patient must wait in order to be compensated. Further payment reforms, such as structured damage awards, could also be applied in the current tort system. Clinical guidelines could, in select areas, help to establish standards of care. Advocates of this approach could work to develop these guidelines to provide additional evidence in liability cases, which could be used to guide plaintiffs and defendants alike without an expensive overhaul of the tort system. Use of expert witnesses selected by the courts to avoid simply “buying” an opinion could also be increased under the current tort system. Thus, many of the innovations that advocates of health courts support in their proposals could be applied in the current tort system without incurring large costs, denying patients’ rights, or foregoing a jury system that historically has been quite capable of appropriately adjudicating claims. ♦

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HIGHLIGHTS

- The current medical liability system has multiple shortcomings, which are summarized in this article.
- The authors describe the pros and cons of several alternatives for reforming the liability system, including safe harbors, early disclosure and offer (D&O) programs, judge-directed negotiation programs, and health courts.
- The authors call for a paradigm shift away from liability and toward the establishment of a “just culture.”

America needs transformative medical liability reform. The current liability system costs $55 billion annually, accounting for 2.5 percent of annual health care spending.1 Traditional reforms, such as caps on noneconomic damages, have had only limited success in reducing costs of liability premiums, improving quality of care, or decreasing the cost of defensive medicine.2,3 Reducing medical liability costs is one goal of reform; another is to make the system work better as a mechanism of quality improvement.

The existing medical liability system fails nearly all of its major stakeholders: patients, physicians, and insurers. The system compensates patients inequitably and slowly.4 The average time from injury until compensation is five years.4 The system is difficult to access, so only a small percentage of patients who are injured due to medical error or negligence seek or receive compensation.5 For physicians, the system is unpredictable. Nearly one in four claims is not resolved concordantly with its merit.4 The punitive nature of the system discourages clinicians from reporting errors and may have a tremendous professional and personal impact on physicians who are sued.1,6-9 The insurance market also is unpredictable and volatile and has experienced many crises in the last 50 years.10 Transformative liability reforms that address all of these shortcomings are urgently needed.

Traditional reforms
Medical liability reforms in this country typically have focused on tort reform.1 Historically, three major approaches have been used: limiting access to the courts, modifying liability rules, and limiting damage awards. The effects of tort reform on health care and liability are not easily evaluated. Reforms can be assessed based on their impact on liability metrics, including frequency of claims, costs of claims, overhead costs, and
insurance premiums. They can also be assessed using care-related metrics such as the costs of defensive medicine, physician supply (especially in high-risk fields), and quality improvement measures.

Studies that have evaluated the effect of care-related metrics have found that most tort reforms have little or no impact. The exceptions are collateral-source offsets and caps on noneconomic damages. Collateral-source offsets allow defendants to deduct from their payment to a plaintiff any compensation for injury that a plaintiff receives from external sources. Under traditional tort law, such deductions are prohibited. Caps on noneconomic damages limit the compensation that plaintiffs may seek for physical or emotional distress. Caps on noneconomic damages and collateral-source offsets have been found to have a small but statistically significant impact on both the practice of defensive medicine and on physician supply.

Tort reforms have been adopted in up to one-half of all U.S. states. Some states have adopted multiple reforms; however, these reforms have limited scope. They aim to control the costs of the liability system without addressing other fundamental issues, such as safety, quality, and equity in compensation.

Because of these limitations, tort reform alone will not solve all of the problems in the liability system. For instance, in spite of previous reforms, the current liability system does not serve patients fairly. Injuries occur in 3 to 4 percent of all medical cases, and in 1 percent of all medical cases those injuries result from negligent medical care. Among patients injured by negligence, only 2 to 3 percent file claims. In contrast, the system encourages and rewards many claims of uncertain or no merit. Compensation is correlated with merit, but about one-quarter of cases are resolved discordant with their merit. Claims reviews have found that approximately one-third of all claims were not associated with injuries, yet 24 percent of those claims were compensated. In reviews of closed claims, 26 percent are of uncertain merit, and 54 percent of these claims are compensated. Of the 44 percent of claims that are meritorious, 79 percent of patients are compensated. For all claimants, payment is slow. Reforms are needed that address the fundamental issue of inequitable compensation, in addition to patient safety and quality of care.

**Possible liability reforms**

Several proposals for transformative liability reform have been put forward, including establishment of safe harbors, early disclosure and offer (D&O) programs, judge-directed negotiation programs, and health courts. Each approach has advantages and disadvantages and may address fundamental system failures to some degree.

Safe harbors provide a legal defense for physicians who adhere to a credible and applicable clinical guidelines. Safe harbors have attracted wide, popular interest because people easily agree with the notion that a physician should not be penalized for following accepted standards of care. However, selecting those guidelines is challenging, as experts in a field may themselves disagree on best practices. Furthermore, not all medical conditions can be treated using standardized guidelines, and thus safe harbors could not be applied to all liability claims. Finally, guidelines would need to be under constant review to be able to respond to the rapid pace of biomedical research that influences medical practice.

D&O programs focus on telling injured patients early on what went wrong and promptly offering compensation when appropriate. One advantage of these programs is that hospitals and insurance companies can implement them without a legislative mandate. In fact, some institutions and insurance companies have already begun to use this approach. Successes at individual institutions such as the University of Michigan are promising and have roused interest from a broad range of stakeholders, including the plaintiff’s bar. (For more information on the University of Michigan’s D&O program, see article on page 21.)
However, implementation of D&O may be more difficult than it first appears. Significant culture changes are required to achieve the routine reporting and disclosure needed for the reform to succeed. Furthermore, these programs require considerable institutional investment. Physicians and hospitals also may approach patients before they obtain legal counsel, which could deter patients from seeking representation when seeking compensation. Thus, D&O programs have wide theoretical appeal, but practical considerations may limit their successful implementation.

Another approach to transformative liability reform is judge-directed negotiations. In this system, claims would be routed to a subset of judges who have received special training and are assisted by neutral court attorneys who also have health care degrees, such as nursing degrees. These judges would encourage earlier settlements. As with D&O programs, no new legislation is required to implement judge-directed negotiations. This proposal also attracts a broad range of stakeholder interest for its potential to address failures in the current system, including long compensation delays and inconsistencies in decisions. Judge-directed negotiations would also prevent huge jury verdicts, which account for the worst excesses in the current system.

However, establishing a judge-directed negotiation system requires some level of investment, especially in judicial talent and education. Furthermore, claims under this system could be resolved faster than in the current system, but judge-based intervention would still occur rather late in the dispute. Overall, judge-directed negotiations have the potential to address the challenges in the current system, but have not yet been widely adopted and fail to occur early in the dispute process.

Another type of transformative liability reform, specialized health courts, has been suggested as a viable option. This model would involve creating a new administrative court system to process liability claims. Specialized judges would hear claims and issue written decisions. Courts would employ neutral medical experts to review the evidence. Health courts would also apply a broader standard than negligence, such as “avoidability,” as the basis for determining patient compensation. Health courts align well with liability reform goals in several ways. They would likely encourage providers to use information from claims to learn why errors occur and how to improve patient safety. A written record of the cases could promote consistency in adjudication and inform physicians of expected legal standards. Health courts would also provide a quid pro quo for most stakeholders. Although more cases would be eligible for compensation, and claims would be easier to bring under health courts, judges’ rulings would create a written legal precedent that would make decisions more predictable and limit the number of large jury awards. Although individual compensation levels may be lower, health courts would make awards more attainable. However, this increase in the number of compensated patients will likely offset the savings from lower awards and overhead costs, resulting in modest, if any, cost reductions.

Furthermore, health courts face potential legal challenges. In some states, eliminating a jury trial in liability claims may be prohibited under the state constitution. Federal constitutionality has been questioned, as well. So, although health courts have the potential to address many of the shortcomings of the current system, they also would require restructuring the system and may not produce any cost savings.

A paradigm shift
All of the options for transformative reform may control costs and reduce inequitable compensation to greater or lesser extents. However, reforms must also address the current system’s lack of accountability to patients. Medical litigation focuses primarily on individual clinicians, but in the health care community it has become fashionable to discuss medical errors solely as “system failures.” The reality is that both individual and systems errors occur, often in intertwined ways. Professional self-regulation is seen as weak, and data support this perception. Although nearly one in five physicians say they have personal knowledge...
of an impaired or incompetent colleague, only 67 percent of those physicians have reported that information. Members of the health care community worry that reporting incompetent physicians will attract a punitive response or no response, and attitudes about reporting vary across high- and low-liability states.23

Inequity and inaccuracy in patient compensation and fears of reprisal and punitive action are problems that must be addressed. However, attention is only turned to reforming the liability system when crises arise. Yet in the midst of a crisis it is difficult to make decisions and institute the transformative reforms needed to improve the litigation system.

True reforms must include a paradigm shift away from liability and toward accountability. Rather than simply focusing on individual versus system faults, reforms should promote a “just culture” in which “people are not punished for making errors, but deliberate violations and misconduct are not tolerated.”24 The primary objective of liability reforms must shift from cost-containment to supporting safe patient care and responding justly to injured patients.

This paradigm shift would satisfy what most patients want from the liability system: a system that is patient-centered, that focuses on addressing the root cause, and involves the patient and family in a meaningful way including involvement early in the error investigation.25 A patient-focused system also would promote robust self-regulation among physicians and hospitals. If the system shifts away from liability as the main mechanism of regulating quality, the profession needs to be able to assure the public that it is on the job. Just culture principles would align well with this patient-focused regulatory environment.24,26

There should be an open, fair, and just culture in which individuals are held accountable when they have erred but in a less punitive way than is done now. When errors occur, we must delineate system failures from individual

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continued on next page
failures, and respond appropriately to both problems with solutions that support patient safety and improved quality. Finally, a patient-focused system would be transparent with respect to the failures and successes in achieving accountability. To achieve that aim, physicians and hospitals must commit to using the information collected in error investigations to strengthen quality improvement and accountability.

Conclusion
Reforms that can transform the current medical liability system into a system that is patient-focused—in which safety, quality, accountability, and equity are paramount—will require a sustained commitment and iterative efforts from the health care community. The first step is setting up experiments with innovative reforms that are focused on the appropriate goals. The regulatory system must begin to support notions of just culture as well as mechanisms for early dispute resolution.

Furthermore, providers and insurers must publicly demonstrate a commitment to vigorous self-regulation; if liability is no longer the main mechanism of enforcing quality standards, the medical community must assure the public that it can assume greater responsibility for that task. Encouraging this paradigm shift and looking toward reforms that solve shortcomings in the liability system beyond cost containment are paramount to developing a system that truly drives quality and safety improvements. The American College of Surgeons should seize the opportunity to lead surgeons nationwide in a movement toward transforming and revamping our medical liability system.

Acknowledgment
This article is based on the keynote address that Michelle Mello, JD, PhD, presented at the Medical Liability Reform Summit. See the summit agenda in the sidebar on page 11 for details.

REFERENCES (CONTINUED)
Professional liability practicing physicians may be unsettled by the fact that over the course of their careers, more than 75 percent of all physicians are likely to be named in a liability claim. Moreover, not all claims are resolved as expected, with one study estimating that one in four claims may not be resolved in accord with the claim’s merit. The high lifetime claims rate and the incomplete overlap between the merit of a claim and its disposition have left many physicians feeling that the medical liability environment is unpredictable.

The unpredictability is readily illustrated during the claims resolution process. Because of the ambiguity that can exist as to what constitutes reasonable (for example, non-negligent) care, many liability claims often lead to a “battle of the experts” that occurs when both the plaintiff and defendant bring in qualified experts to support their side of the case. If the experts on both sides are well-qualified and equally convincing,
Some physicians worry that the introduction of prescribed practice standards will lead to “over-standardization” and cookbook medicine. However, clinical judgment will still be required to determine whether such standards are applicable to a certain case or clinical scenario.

adjudicators (for example, judges and juries) trying to decide the merits of the claim may be left without clear guidance on how to resolve the dispute.

In fact, some experts argue that the ambiguity of the claims resolution process and the desire to avoid being named in a liability suit altogether could have potentiated the practice of defensive medicine. The very existence of defensive medicine—which includes the ordering of tests or procedures primarily to reduce legal risk—clearly demonstrates how the legal system may at times be causing physicians to divert their focus away from cost-effective and high-quality care. To introduce better predictability and reliability into the existing litigation system while promoting more evidence-based standardized care (and less unnecessary utilization), many health policy experts have advocated for the creation of “safe harbors.”

**Definitions and aims**

Safe harbors are designed to protect physicians from liability risk if they provide care that follows approved clinical practice standards. If an adverse event occurs and a liability claim is asserted, safe harbors operate by establishing a presumption of non-negligence if the named physician adhered to the applicable, approved standards. This presumption can be either rebuttable or non-rebuttable via introduction of evidence. However, safe harbors can potentially offer additional benefits.

By providing direct guidance for negligence determinations, safe harbors may help ameliorate some of the current ambiguities in today’s litigation system for both patients and providers. At any stage in litigation, safe harbors can be a mechanism to facilitate rapid and accurate evaluation of claims for their merit. Due to the fact that they are described and documented in advance of a case, safe harbors may actually help patients (and their attorneys) better evaluate whether a claim is worth bringing forward. The availability of liability protection for following approved standards may lead to greater standardization in care and better patient outcomes as well.

Of note, safe harbors can also be deployed not only to provide liability protection, but also to help define the appropriate standard of care. This would mean that in addition to being available to physicians merely as a defense, safe harbors could also be used by injured patients to presumptively establish negligence if an approved and applicable standard was not followed. This use of safe harbors would further bolster the incentives for physicians to adhere to approved evidence-based standards.

**Previous experimentation**

Though safe harbors are receiving greater attention today, they are not new concepts in medical liability reform. In the 1990s, a handful of states conducted demonstration projects to test the implementation of safe harbors. However, due to their limited design or use, very little was learned from these trial implementations.

The Maine Medical Liability Demonstration Project, created by the state legislature in 1990, was a five-year safe harbor program in which implementation was limited to four clinical areas: obstetrics and gynecology, anesthesia, emergency medicine, and radiology. The safe harbor standards were selected from national medical association guidelines and were modified by a physician committee to reflect local practice. The program noted high rates of physician opt-in. However, in the five years that the program was in place, only once were the guidelines used as a defense.

Florida conducted a Cesarean Demonstration Project in safe harbors from 1994 to 1998. The project enabled obstetricians to use evidence of compliance with practice standards as a defense in liability claims. And while there was a 20 percent participation rate among obstetricians in this project, it was not renewed. However the final report recommended further experimentation and evaluation.
The various stakeholders in medical liability reform—specifically physicians, patients, and policymakers—each have their own interests in and concerns about the implementation of safe harbors.

In Minnesota, legislation enacted in 1992 allowed the state health commissioner to designate clinical guidelines. No outcomes data emerged from the project, and the programs were not renewed. Current Minnesota law now forbids admission of guidelines issued by external review organizations into evidence.8

A recent study funded by the Agency for Healthcare Research and Quality (AHRQ) sought to determine whether safe harbors could improve both patient safety and liability system performance.9 State of Oregon investigators reviewed 266 closed claims for commonly occurring diagnostic or medical management issues for which guidelines were likely to apply.9 In claims in which guidelines were applicable, reviewers found that injury might possibly have been avoided in 30 percent of the claims had the provider adhered to a guideline, demonstrating a considerable potential for safety improvement. Some possible benefits in the claims resolution process were also suggested. Reviewers found that up to 32 percent of the cases might have been resolved more quickly had safe harbor protection been applied. However, safe harbors did not appear to provide much protection from incorrectly adjudicated claims, as only a small percentage of paid claims would not have been paid under safe harbor protection.

Oregon’s retrospective application of safe harbor guidelines underscored the potential benefits and uncertainties regarding their use. Safe harbors appear to have the potential to prevent harms, and therefore, resultant claims. Furthermore, the faster resolution of claims could decrease the emotional burden that prolonged cases can have on providers and patients and, in the process, reduce administrative and legal costs as well. However, the exact extent of the benefits and how much they will affect overall compensation payouts remains unknown.

Perspectives on implementation
The various stakeholders in medical liability reform—specifically physicians, patients, and policymakers—each have their own interests in and concerns about the implementation of safe harbors. Some physicians worry that the introduction of prescribed practice standards will lead to “over-standardization” and cookbook medicine. However, clinical judgment will still be required to determine whether such standards are applicable to a certain case or clinical scenario. Moreover, the potential for standardization to increase patient safety should not be overlooked.

When adverse events occur, systematic standards for adjudication can also provide greater clarity of what constitutes reasonable care, possibly also decreasing defensive practices. This improved consistency in claims resolution may also restore faith in the self-regulatory ability of the medical profession and in the fairness of the legal system. These cultural benefits should not be overlooked in evaluating the impact of safe harbor guidelines.

The Oregon results demonstrate a potential for safe harbors to improve patient safety. This may be the greatest benefit from safe harbors, for patients and providers alike. In addition, if safe harbor rules are used to define the standard of care, many claims for injury that have gone unpaid may ultimately result in patient compensation. Nevertheless, it remains an open question as to whether safe harbor protection will provide enough encouragement to result in standardized care that translates to safety improvements.

Incorporation of evidence-based medicine to clinical practice standards has already become essential to medical practice today. The Choosing Wisely campaign provides a precedent for the fair and unbiased compilation of guidelines. In this initiative, specialty physician groups partnered with the American Board of Internal Medicine and Consumer Reports, an independent not-for-profit consumer organization, to release guidelines on 45 common tests and procedures that might be overused or unnecessary.10 It provides an example of the dissemination of guidelines to providers and patients via professional organizations and consumer organizations, respectively, for the facilitation of conversations about the guidelines and their implication on care.
Safe harbors have many potential benefits, which include discouraging nonmeritorious liability claims, mitigating the unpredictability of settlements and verdicts, reducing defensive practices, and bolstering the integration of evidence-based care into clinical practice to improve patient safety.

However, the selection of the applicable standards for safe harbors—especially given the effect they may have—may be a highly debated issue. It will be critical to determine who will be responsible for selecting the standards, how standards will be chosen, and how they will be kept current and appropriate. This includes the frequency and mechanism by which these guidelines will undergo continuing review and revision to reflect current medical science and local variations in medical practice. Reliance on an expert committee composed largely of physicians, such as that which helped to launch the Choosing Wisely campaign, may be best suited to ensuring medical soundness, but may also be perceived as being biased toward physicians. Nevertheless, designation of eligible standards can have many downstream benefits, such as the resolution of disputes between conflicting best practices, heading off potential sources of contention in litigation, and improved administrative efficiency.

Conclusion

The creation of safe harbors may improve both patient safety and medical liability system performance. Safe harbors have many potential benefits, which include discouraging nonmeritorious liability claims, mitigating the unpredictability of settlements and verdicts, reducing defensive practices, and bolstering the integration of evidence-based care into clinical practice to improve patient safety. Previous experimentation has been limited in scope. The current political will and professional interest in generating standards of care, coupled with the need for liability reform, makes this an appropriate time to further investigate the effects of safe harbors.

REFERENCES

Alternatives to litigation are available: The liability insurer’s perspective

by Mark Horgan, JD, and Margo M. Hoyler

Medical liability insurance plays a large and essential role in the U.S. health care system. This article demonstrates how one insurance carrier, CRICO, has embraced and achieved the twin goals of protecting health care providers and promoting patient safety.

CRICO is the largest medical liability insurer in Massachusetts and an internationally known leader in evidence-based risk management. CRICO’s mission is to provide superior medical liability insurance to its members and to assist them in delivering the safest health care in the world. To achieve this mission, CRICO is committed to defending good medical practice, offering compensation for substandard medical care, and contesting at trial nonmeritorious cases in which no medical fault is apparent. CRICO applies this strategy to serve 12,000 physicians and 15,000 mid-level providers at 22 hospitals, including Harvard flagship hospitals, such as Massachusetts General Hospital and Brigham and Women’s Hospital, and more than 200 health care organizations.

Charitable immunity

Formed in 1976 by the Harvard Medical Institutions, CRICO operates primarily within the Massachusetts legal context, which is significant in that the efficacy of the tort system varies by jurisdiction. Massachusetts and New Jersey are the only states to provide “charitable immunity” to health care institutions, limiting their liability to $100,000 per claim. The practical effect is that patients who allege harm sue individual providers and only infrequently not-for-profit health care entities or systems. Massachusetts juries historically have viewed providers favorably. Nonetheless, CRICO is committed to fair outcomes for patients and providers alike.
Because litigation is often financially and emotionally costly to all parties, CRICO seeks to avoid going to trial whenever possible. Clinicians are encouraged to empathize with and support patients in order to restore and maintain trust, and in cases involving obvious error, prompt settlement is pursued. In these instances, CRICO provides physicians with guidelines for disclosure, emphasizing attention to patients’ clinical needs, as well as family questions and concerns. CRICO also advocates a team approach to disclosure, and an “institutional coach” to facilitate the process.* To date, CRICO has resolved most claims with clear liability through disclosure and apology without protracted litigation and often without any court involvement.†

CRICO’s approach to risk management has meant that, over time, the organization has seen more formally asserted claims, fewer lawsuits, and even fewer jury trials. The frequency of CRICO claims is approximately 2.3 per 100 physicians per year, well below state and national averages; 0.46 claims are paid per 100 physicians per year.‡ Awards tend to be of mid- to high financial severity because only significant cases are pursued. Very few frivolous cases are brought to court. Of the 252 CRICO claims and suits resolved in 2011, 52 percent were denied, dismissed, or abandoned by plaintiffs; 33 percent were settled; 13 percent resulted in a jury verdict or arbitration award for the defense; and 2 percent in a verdict or award for the plaintiff. Year after year, more than 90 percent of CRICO jury verdicts are for the defense. These data indicate that CRICO is meeting its goal of addressing most cases with open dialogue and payment when warranted, while reserving litigation for the 15 percent of cases that are truly contested.

**Binding arbitration**

CRICO also embraces binding arbitration as an alternative to trial. In binding arbitration, opposing parties present their cases to an arbiter, often a retired judge, who determines their relative merits. Key features of binding arbitration include a private and informal setting outside of the courtroom, no appeals process, and a written decision and explanation from the arbiter. Binding arbitration tends to occur as scheduled and without delay, unlike many court cases. Damage awards tend to be more predictable and usually are more in line with settlement values than those afforded by jury trials.

CRICO is successful in approximately three-quarters of binding arbitration cases. CRICO’s experience with binding arbitration may indicate the potential of health courts to reduce liability litigation, as described elsewhere in this issue of the Bulletin.

The key to CRICO’s success in arbitration and trial lies in its analytic process, which systematically recognizes and resolves those cases in which clinicians are clearly or likely at fault. CRICO pays meritorious claims, instead of allowing them to proceed to trial. Most fundamentally, CRICO has been successful because the group realizes that the best way to protect its members is by promoting best medical practices and patient safety. Avoiding litigation through open communication and prompt settlement where warranted is a strategy that benefits the insurer, provider, and patient alike.◆

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The U.S. health care system boasts some of the world’s most sophisticated medical treatment, superior medical education and training, and hundreds of thousands of conscientious and committed health care professionals. Nonetheless, patient safety in the U.S. has been the source of concern for many years now. Patient injury is widespread, and there is little evidence of consistent improvement. The Centers for Disease Control and Prevention (CDC) estimates that up to 10 percent of hospitalized patients develop a hospital-acquired infection (HAI), and that 1.6 to 3.8 million infections occur annually in long-term care facilities. The annual direct costs of these infections may be as great as $45 billion. Shockingly, in 2011, 13 wrong site operations and three wrong person procedures were performed in Connecticut alone.

Behind each of these statistics is a name, a family, and a story of sorrow. Some patients and families suffer medical bankruptcy or unemployment, others loss of life or limb. For patients harmed while receiv-
No patient expects to visit a licensed medical facility and receive a deadly infection along with their treatment.

ing health care services there is also physical and emotional pain, broken trust, and disbelief.

The Connecticut Center for Patient Safety (CTCPS), a not-for-profit patient advocacy group, was established in response to the medical mistakes and preventable harms that patients and health care consumers all too regularly endure. CTCPS’ mission is to promote patient safety, improve the quality of health care, and protect the rights of patients through public media, patient education, and legislative action.

Initially, CTCPS’ advocacy efforts focused on HAIs given the magnitude and severity of the HAI problem and the common belief that many providers had taken the issue for granted. Indeed, stakeholders ranging from hospital executives to the CDC have argued that nosocomial infections may be “expected”—a statement that illustrates a dramatic rift in the expectations of patients and the health care community. No patient expects to visit a licensed medical facility and receive a deadly infection along with their treatment.

The CTCPS is part of a growing patient safety and advocacy movement, including the Consumer's Union. There is evidence that the health care system is starting to respond to this movement and the voices it represents. The newly established Patient-Centered Outcomes Research Institute represents a focus on patient well-being, and the Agency for Healthcare Research and Quality has plans to pilot test a patient harm complaint system. The CDC and the American College of Surgeons are collaborating to monitor surgical site infections.

These developments are encouraging, but much work remains to be done to protect health care consumers. In tackling these challenges, the CTCPS looks forward to working with and not against the health care sector. By collaborating to improve patient safety, patient advocates and providers can honor the needs and rights of patients, acknowledge the harm that has previously been done, and help ensure that such harm does not occur in the future.

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REFERENCES
Attorneys and physicians share common goals:

What do surgeons and liability attorneys want for patients and the health care system? Their answers are likely more similar than is frequently acknowledged.

Commitment to safety

Both surgeons and patient attorneys are committed to patient well-being and the relief of patient suffering, and both have a vested interest in patient safety. They demand high-quality surgical care for patients, meaning that the right patient gets the right operation at the right time done in the right way by the right surgeon.

Yet that ideal cannot always be met. When things go wrong, when patients get hurt through no fault of their own, when looking back we can see the patient’s injury was entirely preventable, physicians and patient attorneys share two additional goals: to ensure that medical errors are not repeated and to correct the harm that was done.

Surgeons and liability lawyers believe that the causes of medical errors must be identified and discussed so that health care professionals know how to prevent injuries in the future. American surgery can pride itself on its spirit of accountability and perpetual improvement, evident for instance in the tradition of regular morbidity and mortality conferences. From a trial lawyer’s point of view, liability cases are equally powerful tools for promoting reflection, re-education, and reform in medical practice. Injured patients are aware of this already when they seek legal counsel for their medical case. Indeed, anecdotal evidence suggests that many patients pursue lawsuits largely as a means of preventing harm to others. They see a lawsuit as their only means of making the medical system safer for other patients. Many liability lawyers are motivated by a similar conviction.
Surgeons and patient attorneys also share the belief that injured patients should receive care that improves their conditions or some other type of reparations. For surgeons, this often means providing patients with the most appropriate medical or surgical services immediately after an error has been made. Attorneys and our civil justice system address patient harm through compensation, using money as an inadequate but necessary substitute for loss of health or life.

**Restoring balance**

Surgeons belong to an ancient and esteemed profession; every day, surgeons cure disease, relieve pain, and make lives better. Attorneys see themselves as members of another healing profession, helping to restore to broken lives some measure of independence and dignity. Indeed, the word “compensation” is derived from the Latin “pensare,” meaning to weigh one thing against another. To compensate injured patients thus means, quite literally, to restore a balance in their lives.

Part of the legal healing process that health care providers should want to encourage is restoring the patient’s trust in their caregivers. When injured patients are treated fairly in the legal system, it helps restore their trust by facilitating communication between the clinician and the patient and providing clarity about a potential error and how it occurred. Finally, liability cases and fair compensation are means of honoring patients. Because they draw attention to patient suffering and physician error, they help ensure that the opportunity to prevent harm to another patient will not be lost or wasted.

**Essence of civil justice**

Democracy, Winston Churchill once said, is definitely the worst form of government, “except for all those other forms that have been tried from time to time.” Likewise, the civil justice system is easy to criticize. It’s too expensive. It takes too long to reach resolution. It can be emotionally difficult on all the participants. But it’s not broken. And like other democratic institutions, nothing better has been invented for the fair resolution of disputes. Our system is fair to the participants in the following fundamental ways:

- The system is even-handed; the same rules apply to both sides.
- The system respects the uniqueness of each litigant. Patients have the opportunity to demonstrate the full dimensions of their injury and suffering without barriers like caps on damages (at least in some jurisdictions) or payment schedules, and health care providers can justify their treatment decisions by demonstrating the uniqueness of a patient’s case.

- The American civil justice system respects and maximizes the freedom of the litigants, enabling each side to run its own lawsuit as it sees fit. Litigants hire whatever lawyers they want, pay whatever fee they negotiate, and hire whatever expert witnesses they want. Then they present their cases in courtrooms over which professional judges trained in neutrality preside and to juries drawn from a cross-section of their communities. Even in other Western democracies, these freedoms do not always exist.

**Honoring patients**

In the spirit of honoring patients who have suffered injury, several patient cases are described here. It is tempting to view liability litigation and reform from 40,000 feet; these patients represent the view from sea level.

- A backhoe operator lost median nerve function after undergoing a brachial plexus “cut down” for asymptomatic subclavian atherosclerosis. On repeat operation by a different surgeon, the area of nerve damage matched the width of a retractor, indicating how the nerve had likely been killed. At the trial, two vascular surgeons testified in defense of the patient’s original surgeon, defending the surgeon’s clinical prerogative even as they acknowledged unfamiliarity with the technique he used and the absence of literature advocating the “cut down” technique. In this case, as in many others, the defense defended indefensible care.
• Another patient, a diesel engine mechanic, underwent what was supposed to be a routine cholecystectomy. His surgeon, however, severed the common bile duct and, when he realized the mistake two days later, performed a Roux-en-Y repair. The surgeon had no hepatobiliary expertise but chose not to refer the patient to an internationally renowned surgical center a short distance away. The patient later died of liver failure due to recurrent, ascending infections from the new, too short “bile duct.” Again, surgeons testified in defense of the responsible clinician.

• A home builder underwent a revision mastoidectomy by a general otolaryngologist. After the operation, he had difficulty reading and recalling friends’ names. A computed tomography scan clearly indicated that a surgical instrument had been inserted into his temporal lobe from the operative site in the mastoid cavity. The surgeon’s strategy throughout the case was deny and defend—claim that nothing had gone wrong and argue that the procedure was performed appropriately.

Incentivizing high-quality care

Although the incidents previously mentioned are not representative of the vast majority of operations performed in the U.S., the “deny and defend” response from physicians is quite common. This reaction may be due in part to the perverse and dangerous incentives that characterize the American medical system. For instance, the fee-for-service model provides a disincentive for less-qualified surgeons to refer patients to trained specialists. Also, until the recent establishment of Medicare “never events,” hospitals were actually paid more for worse care in that they received payment for treatment of complications.

Finally, the common model of independent medical and surgical practices means that there is often no employer with the authority and incentive to ensure appropriate credentialing of employee physicians and to oversee the delivery of high-quality care.

One legal reform could go a long way toward fixing this problem. If surgeons were employees of their hospitals and not independent contractors, the employer would have both the muscle and the financial motivation to better supervise individual practitioners. It’s called “enterprise liability.” Military and Veterans Affairs hospitals already have this policy in place, and it has been beneficial to both patients and providers. Enterprise liability also lowers litigation expenses, because there is one defendant, the institution, and one defending legal team. Enterprise liability facilitates equity in insurance premiums, as the institution can determine which percentage of global insurance fees can reasonably be borne by a small number of high-risk subspecialists. Outside the government, medical practice is becoming more corporatized, and so enterprise liability fits into a trend that is already happening. Surgeons in particular would stand to benefit from this practice model.

A related concept is “enterprise notice.” Under this policy, the plaintiff’s attorney brings a notice against an institution where the patient suffered apparent harm, stops the statute of limitations “clock,” and can then carefully determine which clinicians ought to be included. This practice prevents lawyers from using the “sue everyone who touched the patient” tactic, especially when they are faced with a limitations deadline for filing suit.

Liability reform

Given the aforementioned strengths of the U.S. civil justice system, patient attorneys are confident that the tort system is the best method for the resolution of medical disputes and the compensation of patient injury. Nonetheless, some currently proposed liability reforms could be effective adjuncts to the tort system. A malpractice attorneys’ perspective on several of these approaches follows:

Disclosure and offer (D&O) programs

D&O programs might be summarized as acting openly and honestly with the patient, and no new laws or legal reforms are needed to enable physicians to be upfront and honest after harm has occurred. Fur-
Surgeons belong to an ancient and esteemed profession; every day, surgeons cure disease, relieve pain, and make lives better. Attorneys see themselves as members of another healing profession, helping to restore to broken lives some measure of independence and dignity.

Moreover, insofar as the civil justice system promotes fairness and truth, it already fulfills some of the central goals of D&O programs.

Nonetheless, lawyers tend to be receptive to early offer and apology programs, with several key conditions. First, participation of all hospital staff, including non-employee physicians, must be mandatory. If not, patients may misread a clinician’s failure to apologize as an indication that whatever happened was not a preventable, compensable error. Second, patients must have the right to hire their own attorneys, and lawyer presence should be encouraged. Just as physicians, hospitals, and health care systems have their own counsel, so too should patients. Equal representation will ultimately protect hospitals from accusations of undue influence or fraud. Third, any clock for legal deadlines should be stopped for the duration of the patient-hospital talks. Patients should be offered fair compensation, and patients who decline early offers must not be penalized. Finally, whereas apologies should be protected from use in court, the facts behind them should not.

Safe harbors
Although the safe harbor principle may be touted as a novel proposal, features of it are already written into law. Federal Rule of Evidence 803(18) states that clinical practice guidelines and other authoritative professional literature may be discussed at trial by either side with a sponsoring expert witness to explain them. Plaintiff and defense attorneys already use guidelines to support or defend the claim. However, the safe harbor concept becomes unacceptable if it allows guidelines to be used as a “get out of jail free” card. Guidelines must be useful in exonerating and implicating clinician wrongdoing.

Acceptance of one-way guidelines would foster a “race to the bottom” in terms of the quality and clinical utility of those guidelines. Safe harbor legislation would incentivize only minimalistic standards of care. In addition, guidelines vary in quality. Different professional groups endorse different guidelines, often in keeping with their own professional interests, and not all guidelines are based on the gold standard of randomized controlled trials.

Clinicians will appreciate that guidelines do not always apply to an individual patient’s care. Physicians would not be necessary if medicine were solely a matter of guidelines and algorithms. Why should clinical guidelines be legally conclusive if they are not always conclusive in real-life medical practice?

Compensation schedules
In the eyes of many attorneys for injured patients, compensation schedules are “a solution in search of a problem.” Clinicians may favor compensation schedules in part because they often tend to overestimate average lawsuit payments to plaintiffs and similarly underestimate juries’ favor of physicians. Indeed, research studies have shown that even among cases that insurance companies have classified as “indefensible,” plaintiffs win only half the time. It is also important to note that the occasional outlandish verdict/award is invariably revised and reduced by the trial judge or the appellate court. The better approach is what the system already has: individual decisions on appropriate damages, with the jury acting as the “conscience of the community” and judges providing oversight.

Health courts
Many clinicians favor the implementation of health courts, in which a judge with special training in medical liability determines the verdict instead of a jury. However, this scenario may be less favorable to clinicians than they think. Are juries biased? Absolutely, but not against physicians, as the medical community tends to assume. Juries have a very heavy thumb on the scales of justice favoring the physician defendant. Indeed, it is unlikely that a health court—and a judge trained in medical law and impartiality—will be as biased in physicians’ favor as juries tend to be. In veterans’ and military hospitals, for instance, where life-appointed federal judges from both political parties decide cases, the plaintiff’s win rate is considerably higher than it is for equivalent cases before juries.

Additionally, a shift from negligence to preventability as the legal standard solves no problems. The system must maintain and enhance accountability for errors, and avoid conflating harm due to error with
In discussing health courts, safe harbors, and other reform proposals, surgeons should consider the following litmus test of fairness: Is this reform one you would advocate if the tables were turned, and instead of speaking for physicians you were advocating for a family member injured by care at a medical institution other than your own?

unavoidable clinical risk; if we compensate all harms in hospitals, even non-preventable ones, the system loses all connection to accountability for doing a poor job. Furthermore, the goals of the medical liability system should not be to compensate all patients who suffer harm, but to compensate those individuals who have injuries that were preventable and are severe. It’s the disabled, maimed, paralyzed, brain-damaged patients, and family members of those killed who need a system that tries to bring some measure of justice to what’s happened to them. The health court system must not divert resources from the compensation of relatively few severely injured patients to that of many mildly injured patients. The system must serve those who have suffered the greatest harm and greatest loss.

In discussing health courts, safe harbors, and other reform proposals, surgeons should consider the following litmus test of fairness: Is this reform one you would advocate if the tables were turned, and instead of speaking for physicians you were advocating for a family member injured by care at a medical institution other than your own?

Patient safety initiatives
Patient safety is a priority for medical liability lawyers and clinicians alike. It has been demonstrated that patient safety initiatives result in healthier patients and dramatic savings for insurers and hospitals. For those clinicians who have little sympathy for patient injury attorneys and their work, this should be a particularly appealing solution. Furthermore, patient safety is a strategy that does not require the participation of the plaintiff’s bar or state or national legislatures.

The statistics regarding medical error are dramatic and dire, but the numbers themselves are not the point: behind each number is a patient, a person, and a family whose lives were broken by preventable medical errors. These people deserve to be treated honestly and fairly by our compensation system. Just as importantly, these patients want assurance that their suffering has not been in vain; they want to help make sure that the same thing doesn’t happen to other people. Indeed, this is the charge for both the legal and medical professions.

REFERENCES
Centennial reprint:
Graduate training for general surgery and the surgical specialties

To help commemorate the American College of Surgeons’ (ACS) Centennial, the Bulletin is reprinting articles on topics that represent how the ACS has responded to ongoing challenges in the profession. This month’s reprint is excerpted from “Graduate training for general surgery and the surgical specialties,” first published in the January 1939 Bulletin.

This excerpt includes the following:

- Introductory comments
- Criteria for hospitals that offer graduate surgical training, for the selection of residents, and for inspection of graduate training centers
- A manual of graduate training for surgery, which elaborates on the proposed criteria
- The Fundamental Principle—Graduate Training for General Surgery and the Surgical Specialties
- An overview of U.S. and Canadian hospitals approved for graduate surgical training as of January 1, 1939
- A map indicating the location of approved U.S. training centers*

The College issued these standards after completing a thorough study of graduate training and on the heels of updating the requirements for Fellowship in 1936 to mandate that applicants for membership in the organization present evidence of having completed three years of hospital service. As the introductory remarks indicate, “The raising of the standard for fellowship has obligated the College to make certain that no qualified [individual] who aspires to future fellowship shall lack the opportunity to obtain the graduate training required.”

This reprint is emblematic of the College’s enduring commitment to ensuring that surgical patients receive care from properly trained and appropriately credentialed surgeons working in an optimal environment.

*Due to space constraints, the Bulletin is not reprinting the entire list of approved training centers but will provide that information upon request.
GRADUATE TRAINING FOR GENERAL SURGERY AND THE SURGICAL SPECIALTIES

NINE years ago the American College of Surgeons began a study of graduate training which approaches culmination with the publication in this issue of the Bulletin of the first list of hospitals approved for graduate training in general surgery and the surgical specialties. This list furnishes a definite starting point for a new effort to make the list of hospitals approved for graduate training as significant and stimulating in this particular field as the Approved List of hospitals has been throughout the hospital field as a whole.

Study of a vast amount of collected data and wide observation of actual practices, upon which were built conceptions of the proper organization, conduct, and content of graduate training programs, have preceded the compilation of this first Approved List. The list itself demonstrates the need for developing more comprehensive and better correlated plans than now exist in most hospitals and other medical educational institutions.

In his report on page 41, Dr. Dallas B. Phenister, chairman of the present Committee on Graduate Training, mentions the earlier committee under the chairmanship of Dr. Samuel C. Harvey whose recommendations, published in the December, 1935, Bulletin, stimulated the extensive personal surveys and analyses of findings which have since been conducted, and the formulation of Criteria and a Manual for Graduate Training for Surgery and the Surgical Specialties which were first published in the January, 1938, Bulletin, and which are reprinted on pages 6 to 11 of the present one. The Criteria and Manual were prepared by Dr. Malcolm T. MacEachern, associate director of the College in charge of hospital activities, following analysis of information obtained in surveys made under his direction.

On May 16, 1936, the Board of Regents of the College passed the following resolution on requirements for fellowship:

BE IT RESOLVED that applicants for fellowship whose qualifying medical degree shall have been obtained after the date of January 1, 1938, shall be required to present evidence of having completed three years of hospital service in one or more acceptable hospitals, of which two years shall have been spent in training in surgery in hospitals approved by the American College of Surgeons. In the case of graduates of medical schools which withhold the medical degree until after the fifth year of hospital internship, the date set will be January 1, 1939.

The raising of the standard for fellowship has obligated the College to make certain that no qualified man who aspires to future fellowship shall lack the opportunity to obtain the graduate training required. The support of hospitals and other medical educational institutions in providing wider graduate training opportunities is essential to qualify candidates for fellowship, which is equivalent to qualifying them as competent surgeons from a surgical training point of view. In furthering graduate training for surgery the College is pursuing its general objective—to advance the science of surgery and to insure the competent practice of its art.

A comprehensive investigation of the possibilities for graduate training for surgery was conducted by special field representatives of the College during the years 1937 and 1938. The results of the first survey were published in the Bulletin for January, 1938, and the current report is published in the present issue on pages 41 and 42. The first report disclosed that there existed “no basic standard of uniformity in the methods of graduate training” and that it was most desirable that some definite organization or planned program for each year of the training period should be formulated. The current report includes recommendations, briefly stated (see page 41), covering general principles, outline of program for 2-year and 3-year or more periods of graduate training, and statement of “adequate organization and functioning of the attending staff for the program in graduate instruction.” These recommendations are elaborated upon in the plan for graduate training for surgery in a hospital by Dr. Harold Earnheart, assistant director of the College, which is published on pages 42 to 44. These principles, and the plan, supplemented by the Criteria and the Manual, furnish a basic guide for the hospital which desires to furnish graduate training of an acceptable standard. As an additional aid, to give suggestions on practical application under different circumstances, outlines of 13 plans now in operation in representative

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hospitals were published in the September, 1938, issue of the Bulletin; outlines of 7 more plans appear in this Bulletin on pages 29 to 39; and other plans will be described in future issues.

The surveys have shown that although in general the large hospitals connected with medical schools are providing excellent training, and that the major effort for extension and improvement of graduate training in residency must be concentrated upon hospitals not connected with medical schools, nevertheless the training programs in hospitals with large surgical services are not necessarily ideal. Pyramiding of the house staff in such hospitals may result in incomplete or short-time training for all except the successful one or two who are chosen to complete the comprehensive program. The man with only a year or two of training who is not selected for a longer term in residence often goes into practice with his limited preparation. For such a man the opportunity for further training would be greatly enlarged if more hospitals not connected with medical schools would properly assume their educational obligations, through correlating their clinical facilities with the science study advantages of some medical school with which they could affiliate for that purpose. The surveys have revealed that the potential facilities for training are ample, but that there is a great need for central, authoritative guidance in their planned utilization and co-ordination.

The graduate training program of the College has been stimulated by the exchange of opinions and experiences through meetings of committees, conferences, and symposia, in which surgeons—professors of surgery, heads of surgical departments in hospitals—and others, have participated. The discussions presented in the Symposium on Graduate Training for Surgery during the 1937 Clinical Congress were published in the January, 1938, Bulletin; those presented in the Symposium during last year's Hospital Standardization Conference and at other sessions of the Clinical Congress are published in this issue.

The Approved List which appears on subsequent pages is expected to stimulate other hospitals which are suitably equipped and organized, to inaugurate programs of graduate training for general surgery and/or the surgical specialties, or, if they already have such programs, to bring them into accord with the fundamental principles which are outlined on page 12. Surveys and resurveys of graduate training plans and possibilities will be continued, and the College will exert its utmost influence to establish graduate training for surgery and the surgical specialties on a recognized high standard.

CRITERIA FOR GRADUATE TRAINING FOR SURGERY AND A MANUAL OF GRADUATE TRAINING FOR SURGERY1

GENERAL SURGERY AND THE SURGICAL SPECIALTIES

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CRITERIA FOR GRADUATE TRAINING FOR SURGERY

THE following criteria are submitted for consideration in establishing residencies for graduate training for surgery (general surgery and the surgical specialties). These criteria are not intended to be arbitrary, but rather flexible and adjustable to the individual institution. Neither can they be considered as final, as they will of necessity be subjected to additions and adjustments from time to time.

I. THE HOSPITAL

1. A well organized medical staff with department chiefs or heads responsible for the organization and operation of the graduate training program.
2. An adequate average patient census comprised of the types of patients required and used for teaching purposes.
3. Complete laboratory and X-ray facilities under the full time supervision of an approved or accredited pathologist and radiologist respectively, with qualified technical assistants.
4. Other adjacent diagnostic and therapeutic facilities now considered essential for diagnosis and treatment in a completely equipped hospital.
5. Departmental conferences in surgery and the surgical specialties at least weekly in which the resident should be permitted and encouraged to take an active part.
6. Weekly clinicopathological conferences for the demonstration and study of interesting cases of surgical and postmortem pathology.
7. An outpatient department with systematic follow-up clinic in which the resident, under proper supervision, may spend definite time.
8. A medical library containing a wide range of standard textbooks, current medical journals and periodicals in sufficient number to provide for supplementary reading.
9. Affiliation, if possible, with other educational institutions for the purpose of providing the resident with opportunity for collateral basic science study and study on the cadaver or animals.
10. Assigned personnel responsible for active and personal supervision and direction of the residents.
11. Reports of actual work performed by the residents, and such reports by members of the medical staff as may be necessary to ensure an equitable distribution of work.

GRADUATE TRAINING FOR SURGERY

these reports to include additional educational activities offered by the hospital and participated in by the resident.

II. THE RESIDENT

1. Qualifications.
   a. Character. Character, in its broadest interpretations, involves many distinct qualities, but so far as the surgeon is concerned, it may be summarized in one word—HONESTY. It embraces ethics, conscientiousness, judgment, industry, and all other elements which make up the background of a surgeon. Honesty must be evident in action, in example, in utterances, in writings, and in all contacts with patients, conferees, and all others who are allied to the practice of surgery. Honesty demands that the welfare of the patient shall be ever foremost. Honesty, coupled with surgical judgment, learning, and technical skill, assures a proper balance in diagnostic and operative procedures. Therefore, the primary qualification for a resident should be evidence of high character.
   b. Preliminary Education. A college training, preferably culminating in a degree (A.B., A.M., B.Sc., D.Sc., Ph.D.), is desirable as a cultural background since it enables the resident better to appreciate the theory of medicine and to apply it more efficiently in practice.
   c. Medical Education. Graduation from a medical school which is approved by the American Medical Association and the Association of American Medical Colleges.
   d. Internship. An internship of one year or more in a hospital providing acceptable interne training.
   e. Duration of Training. A period of at least two years, but preferably three or more years, in graduate training for general surgery or a surgical specialty.

2. Activities and Educational Program for the Resident Staff.
   Members of the resident staff should:
   a. Devote adequate time to the study of gross and microscopic surgical pathology, clinical roentgenology and radiology, and the auxiliary basic sciences.
   b. Have included in their active surgical service a sufficient number of patients to provide opportunity for study and experience in the diagnosis and treatment of a variety of surgical conditions, during which time they should obtain sufficient operative experience under supervision to give them a reasonable degree of technical efficiency.
   c. Have opportunity to observe and participate in autopsies on patients who have died postoperatively or on their surgical service, and carefully study the findings in correlation with the clinical history and course.
   d. Devote as much time as possible to reading of scientific literature, past and current, under specific suggestion and supervision of their preceptors.
   e. Supplement their knowledge by anatomical dissections and study on the cadaver and animals.
   f. Be encouraged to participate in clinical or experimental research.
   g. Devote an assigned period of time to diagnostic and follow-up work in hospitals with an out-patient department.
   h. Actively participate in medical staff and clinicopathological conferences and in the departmental meetings.
   i. Be encouraged to engage in some teaching activities, such as educational programs for student and graduate nurses, and other groups.

3. Reports of Progress; Examinations.
   a. The members of the resident staff should keep a record of their progress and at periodic intervals they should submit for the consideration of their preceptors a prescribed summary of their work.
   b. At the termination of the residency the residents should present themselves to an Advisory Committee on Graduate Training for Surgery for examination, which may consist of:
      i. A thesis jointly selected by the resident and the sub-committee, or
      ii. A written or oral scientific and clinical examination, or
      iii. Both (i) and (ii), as may be deemed advisable.

III. INSPECTION OF HOSPITALS

Hospitals selected for graduate training for surgery should be surveyed at regular intervals by competent, authorized officials. The reports of these surveys and all other essential data should be considered by the proper authorities of the organization sponsoring the work, and all hospitals which meet the requirements should be included on the Approved List of Hospitals for Surgical Residencies (General Surgery and the Surgical Specialties). Hospitals should be continued on this approved list as long as they meet the minimum requirements on which the survey is based.

A MANUAL OF GRADUATE TRAINING FOR SURGERY (GENERAL SURGERY AND THE SURGICAL SPECIALTIES); AN ELABORATION OF THE PROPOSED MINIMUM STANDARD OR CRITERIA

GENERAL STATEMENT

The primary object of the American College of Surgeons since it was founded has been the elevation of the practice of surgery. All activities of the College are directed toward this aim. Among them is the furtherance of graduate training for surgery which has received continued consideration during the past seven years from committees appointed by the Board of Regents to study

"Graduate Training for Surgery" wherever used in this report is intended to include general surgery and the surgical specialties.

the problem. The field representatives of the College have investigated the facilities which are available in selected hospitals of the United States and Canada. Graduate training for surgery requires a carefully directed and supervised apprenticeship in which the graduate actually participates in practical surgical work. This training is not merely a classroom or laboratory function, and it should not be confused with postgraduate study—the further pursuit of an already acquired training in a specialty. Graduate training for
surgery should embrace as an essential background continuous study of the basic medical sciences—anatomy, physiology, and pathology. Three avenues of approach to graduate training for surgery and the surgical specialties are now available and through these the American College of Surgeons may be helpful:

1. Graduate training for surgery in universities or teaching hospitals supervised by departments of general surgery and the surgical specialties of medical schools. Through this plan an excellent training of five years or more is provided for recent graduates in medicine who have a proper background of medical education. Most fellowships of this character relate to general surgery alone, and are available only to a selected few. The College should encourage medical schools to inaugurate and develop graduate training for general surgery and the surgical specialties, and should accept for approval such courses as meet an acceptable standard.

2. Fellowships in outstanding clinics. These fellowships are of great merit, but they are limited in number. Existing fellowships should be surveyed to determine where fellowships in general surgery or in the surgical specialties are now offered and where they might be established. The College should encourage, endorse, and support two to five-year fellowships in clinics of recognized standing, and approval should be given to such courses as meet the proper standard.

3. Two to five-year surgical residencies in selected hospitals. Residencies in selected hospitals afford the most extensive opportunities for training a larger number of surgeons. There are certain outstanding hospitals where existing two to five-year residencies in surgery and the surgical specialties could be considered as acceptable courses of training. In many other hospitals such courses could be readily organized. This type of training should be approved if it meets the proper standard, and the number of hospitals meeting the standard could be gradually increased. This plan appeals to the hospitals because it offers added recognition and prestige, and assures increased scientific efficiency of the medical staff through the opportunity to teach. The young graduate would be interested in the intensive training and experience offered.

THE HOSPITAL

The hospital desirous of participating in an organized program for graduate training for surgery must meet certain requirements pertaining to physical facilities, organization, medical staff, personnel, and many other features that are desirable for a high grade, instructive program. A brief study of the various elements follows:

1. A well organized medical staff with department chiefs or heads responsible for the organization and operation of the graduate training program. A well organized medical staff is one of the most important requisites and may be the determining factor in the success or failure of a graduate training program in any given hospital. Staff organization must be very definite, and specific responsibilities must be assumed by designated individuals. This presupposes the ability of the medical staff and the administration to overcome local prejudices and jealousies in making appointments. Those responsible for graduate training for surgery must be chosen solely on the basis of ability, aptitude, and interest. Too often expediency is the major consideration in filling important and responsible positions on the hospital staff. Adequate organization of the medical staff presupposes the careful selection of the chief of staff and the various heads of departments. These should be exclusive specialists in their respective fields. They must be of high scholastic and professional standing and must possess the attributes of a teacher.

2. An adequate average patient census comprised of the types of patients required and used for teaching purposes. The amount of available clinical material for the resident staff is vaguely stated but the actual number of patients is not as important as the use which is made of those who are available. They should be of such number and variety as will assure the young surgeon of a varied training and experience. The completeness of the preliminary study necessary in arriving at a correct diagnosis should be emphasized. The variety and nature of the pathological conditions encountered are also important. The status of the patient as judged from the classification (free, private, or public) is of no value in determining suitability for teaching purposes. In some state owned university hospitals none of the patients is listed as “free,” the charges being fully paid through county or state taxation, but all such patients are available for teaching purposes.

The commendable attitude has been developed in some hospitals whereby no distinction is made between private patients or others as far as the resident staff is concerned, and the private patients are used as freely as ward patients for teaching purposes. If previous explanation is properly made to the private patient, only occasionally will he object to having an intern or resident in attendance, or to being used for teaching purposes. The majority of private patients co-operate wholeheartedly and are appreciative of the added attention. The private patient-physician relationship is a matter of attitude and state of patient. More imaginary than real is the fear of losing patients as a result of using them for teaching purposes and allowing the resident staff to assume supervised responsibility for their care.

3. Complete laboratory and x-ray facilities under the full time supervision of an approved or accredited pathologist and radiologist respectively, with qualified technical assistants. The importance of complete clinical laboratory and x-ray services is fully recognized in any plan for graduate training for surgery. The hospital must have a complete range of facilities and personnel to do all phases of the necessary work in both of these departments. These aids in diagnosis and therapy should be well supervised and directed. This presupposes three important requirements: first, that the departments or services be supervised by an approved or accredited pathologist and an approved or accredited radiologist respectively; second, that the services of the pathologist and the radiologist be on a full time basis; third, that there be an adequate number of approved, trained, technical assistants in each department.

There are many situations where two or more hospitals share the services of a pathologist and a radiologist with satisfaction to all concerned. Planned supervision of this nature must sometimes be recognized, but individual consideration should be given to each case.

4. Other adjunct diagnostic and therapeutic facilities now considered essential for diagnosis and treatment in a completely equipped hospital. The extent to which adjunct
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diagnostic and therapeutic facilities are available is variable, but their importance is obvious. It is reasonable to expect that a hospital purporting to give training of any type should have adequate, properly supervised facilities for electrocardiography, basal metabolism, physical therapy, oxygen therapy, and such other adjacent services as are necessary to elucidate or confirm the diagnosis and carry out the scientific treatment.

5. Departmental conferences in surgery and the surgical specialties at least weekly in which the resident should be permitted and encouraged to take an active part. The essentials of a good medical staff conference are described in detail on pages 21-23 of the Manual of Hospital Standardization, 1937. The educational value of well conducted staff conferences is very closely related to an effective program of graduate training for surgery. The purpose of the conferences is to critically review and evaluate the clinical work of the service, including particularly selected deaths, unimproved cases, wound infections, errors in diagnosis and technique, problem cases, and other aspects of the clinical activities of the department or service. Careful minutes should be kept of the staff conference for both current and future reference. Complete details of the conduct of staff conferences will be found in the Manual above mentioned.

6. Weekly clinicopathological conferences for the demonstration and study of interesting cases of surgical and post-mortem pathology. In the larger hospitals clinicopathological conferences for the demonstration of pathological material from the operating room and autopsy room are held weekly, bi-weekly, or monthly, depending upon the amount of material to be reviewed and upon whether or not the conferences are arranged for the entire medical staff or by and for the surgical staff alone. Weekly meetings are to be preferred for they permit of more extensive use of the fresh or frozen specimens which are to be preferred and fixed specimens. Many types of programs may be devised. The following procedure is suggested in the Manual of Hospital Standardization:

a. Present abstracted reports of selected cases.
ob. Present growths and microscopic pathology.
c. Correlate clinical and pathological findings.
d. Compare reports with the literature.
e. Summarize findings and conclusion.

The success of these conferences depends upon the pathologist and his teaching ability. The greatest educational value can be obtained, however, by utilizing members of the resident medical staff to aid in presenting the case reports and more especially to correlate these reports with the literature. The resident staff can also be utilized advantageously by making them responsible for the records of these meetings and by utilizing the material presented for subsequent group studies and comparisons of end-results.

7. An out-patient department with systematic follow-up clinic in which the resident, under proper supervision, may spend definite time. The importance of the outpatient department and its rôle in the training of the resident staff require little elaboration. Proper supervision, however, should be emphasized. In too many out-patient departments the major responsibilities are thrown on the resident staff without supervision of attending staff members. The teaching value of out-patient work is largely dependent upon the amount of interest displayed by heads of departments and members of the attending staff. Details as to the proper organization and conduct of the outpatient department of a hospital will be found on pages 53-55 of the Manual of Hospital Standardization.

Some hospitals, in which for various reasons an outpatient department could not or should not be maintained, possess all of the other requisites and facilities for conducting a graduate training program. In institutions of this type a follow-up clinic should be established and in this clinic the resident staff may profitably assume the major responsibility. The type of work done in the thorough manner in which the follow-up work is conducted, and the nature of the follow-up record.

In some hospitals where an out-patient department is not feasible because of local conditions, the follow-up clinic operating within the particular hospital could be supplemented by an affiliation with a neighboring institution in which the resident staff could participate in out-patient work during a part of the period of training. Most outpatient department wards welcome the additional help and mutually advantageous relationships might thus be established.

8. A medical library containing a wide range of standard textbooks, current medical journals and periodicals in sufficient number to provide for supplementary reading. Every scientific and teaching hospital should maintain a medical library which will provide the house staff and the attending physicians with a carefully selected, basic collection of the latest authoritative medical textbooks, current medical journals, and works of reference in the various branches of medicine and surgery. There has been published a revised list of current medical journals, textbooks, and monographs which has been prepared by the Department of Library Research of the American College of Surgeons in co-operation with the Library Committee.

9. Affiliation, if possible, with other educational institutions for the purpose of providing the resident staff with opportunity for collateral basic science study and study on the cadaver or animals, during the course of graduate training for surgery. A few hospitals in which residents are being trained at present are not affiliated in any way with a medical school or other educational institution, and these hospitals have made available facilities through which members of the resident staff are able to thoroughly review anatomy and pathology. Many hospitals have well developed laboratory facilities and other services but have not fully utilized them for teaching purposes. In most non-affiliated hospitals, however, the financial burden will preclude the development of local facilities for such training and this will necessitate an affiliation with existing basic science departments of other institutions for such training. The resident staff should spend a definite period of time in the study of gross and microscopic pathology, clinical radiology, and other basic sciences, such as anatomy and physiology. The problem of providing these services must be worked out in each individual case.

10. Assigned personal responsibility for active and personal supervision and direction of the resident staff. The resident staff should be adequately supervised. In many instances active and personal supervision and direction of the resident staff does not obtain, even though the organization has been outlined and responsible heads of departments have been designated. Often the administration assumes that the department head is carrying out his obligations and the department head assumes that the attending men on the surgical service are adequately fulfilling their duties, while actually no one sees to it that the
training program is carried out in detail and that existing possibilities are utilized to the fullest extent.

It is recommended that the surgical staff of every hospital which undertakes graduate training for surgery should appoint one surgeon or a committee of surgeons to be responsible for the program of graduate training for surgery in that hospital and to see to it that the resident staff is securing the full measure of training and experience.

11. Reports of actual work performed by the resident surgical staff and such reports by members of the medical staff as may be necessary to assure an equitable distribution of work, these reports to include additional educational activities offered by the hospital and participated in by the resident staff. A full knowledge of the extent and variety of the training being given to the resident staff may be had only from actual records. In hospitals in which the visiting staff does a considerable portion of the surgery this is particularly important and there should be a record of the actual work done by both the attending and resident staff in order to properly evaluate the service and training program. Inequities in the distribution of work on the surgical service, which may be detrimental to a particular group, may exist for long periods of time without the knowledge of the administrative or department head. In order that the volume and variety of work in general surgery or the surgical specialties may be known at all times there should be available a careful record of operations performed.

SELECTION OF APPLICANTS FOR GRADUATE TRAINING FOR SURGERY

1. Character. In its broadest interpretations, character involves many distinct qualities, but so far as the surgeon is concerned it may be summarized in one word—HONESTY. Character embraces ethics, conscientiousness, judgment, industry, and all other elements which make up the background of a surgeon. Honesty must be evidenced in all his relations with his colleagues, and especially with his patients. Honesty coupled with surgical judgment, learning, and technical skill, assures a proper balance in diagnostic and operative procedures. Therefore, the primary qualification in the selection of applicants is evidence of high character.

2. Preliminary Education. A college training, preferably culminating in a degree (A.B., A.M., B.S., B.S.C., Ph.D.). A cultural background is desirable since it gives the surgeon a better appreciation of the theory of medicine and enables him to use his knowledge more efficiently. This, however, cannot be insisted upon as a requirement in every instance at the present time.

3. Medical Education. Graduation from a medical school which is approved by the American Medical Association and the Association of American Medical Colleges.

4. Internship. An internship of one year or more in a hospital providing acceptable intern training. During the internship the candidate should receive either a general experience through well organized rotating services or a special training through a straight surgical service, before seeking graduate training for surgery.

5. Duration of Training. A period of at least two years, but preferably three or more years in graduate training for general surgery or a surgical specialty.

ACTIVITIES AND EDUCATIONAL PROGRAM

1. Members of the resident staff should devote adequate time to the study of gross and microscopic surgical pathology, clinical roentgenology and radiology, and the auxiliary basic sciences. The manner or method of accomplishing study in the basic sciences will be determined to a considerable extent by the type of institution, the volume of routine work, and the availability of these facilities. It is recommended that collateral study in pathology and the other basic sciences should be done so far as possible during a period in which the surgeon in training is relieved from the major portion of house responsibilities. Most hospitals connected with medical schools are confronted with the problem of providing an adequate resident staff to carry on the routine work, while other members of the staff devote the major share of their time to pathology and other basic science study. In some institutions the resident staff devotes half days during an assigned period of six months or a year to basic science study and/or research. The other half days are devoted to out-patient assignment or work on one of the less active services in the hospital. In hospitals which are not connected with medical schools, or whose affiliation is not of a nature to the basic science facilities of the medical school are available, it may be necessary to limit the work in the basic sciences to pathology and anatomy. This situation demands that a definite educational program for the resident staff be organized in the pathological department of the individual hospital, and the success or failure of the program will depend largely upon the pathologist. Under the circumstances outlined, collateral study may have to be pursued concurrently with the routine hospital work, in which event the administration and the medical staff must recognize their obligation to the resident staff in providing sufficient time for the added duties.

Affiliation with other educational institutions will be necessary in hospitals with limited pathological facilities and this may necessitate adding members to the resident staff or extending the time for the graduate training program, or both. A rearrangement or redistribution of responsibilities may effect the desired result, with mutual benefit to the hospital and to the resident staff.

In most instances the collateral work in roentgenology and radiology can be provided concurrently with the regular duties of the resident staff. It is only necessary for the radiologist to organize and carry out a teaching program.

2. The active surgical service should include a sufficient number of patients to provide opportunity for study and experience in the diagnosis and treatment of a variety of surgical conditions, during which time he should obtain sufficient operative experience under supervision to give him a reasonable degree of technical efficiency. The question as to what constitutes a sufficient number of patients and variety of surgical conditions is interpreted arbitrarily. There are several situations which may prevent the resident staff from securing a good, well-rounded training. In large institutions in which the various surgical specialties are departmentalized and segregated the program of training in general surgery may not include contact with some of the important surgical and pathological entities. This complex situation requires considerable thought and planning. Again there may not be opportunity for a well-rounded training in smaller hospitals which are not connected with medical schools and in which the size of the surgical service is limited. The importance of keeping records of all work done on the surgical service is again emphasized. Only by such a procedure can the scope of the work be fully appreciated and the teaching of the surgical staff be...
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amplified to cover situations with which the resident staff does not come in contact.

3. There should be an opportunity to observe autopsies on all patients who have died postoperatively or have died on the surgical service, and to carefully study the findings in correlation with the clinical history and course. Participation in the performance of autopsies should be possible. There must be the utmost cooperation between the management and the medical staff of the hospital in attempting to secure a continually increasing percentage of autopsies, the minimum number of which should be at least 25 per cent of all deaths. The incidence of autopsies in any hospital is good evidence of the scientific progress in the institution and of its scientific atmosphere. The time of the postmortem examination should be planned, so far as possible, so that the resident staff may attend or participate. A definite method of notification to all members of the resident medical staff usually exists in every hospital.

4. As much time as possible should be devoted to reading of scientific literature, past and current, under specific suggestion and supervision of his preceptor. It is advisable to have an organized activity in this respect, such as a "Journal Club," to serve as a stimulus and ensure the fulfillment of this step in his obligation. There are several methods of conducting a journal club, among them the following: Each member of the resident staff can be asked to make a complete and comprehensive review of the majority of the important articles contained in one or more current medical journals or periodicals. Although this alone may not guarantee a sustained interest, it may be supplemented by assignment of a specific topic or disease entity to one or more of the participants for a complete review of the related past and current literature. Through this means a few subjects can be covered intensively. Another method of stimulating current reading may be in conjunction with medical staff conferences, seminars, or research being done in the hospital, when reviews of the literature as they pertain to the problems under discussion may be applied to current clinical work in the hospital. A systematized, supervised plan for reading of medical literature should be arranged for each member of the resident staff in connection with the program of graduate training for surgery.

5. The surgeon in training should supplement his knowledge by anatomical dissections and study of the cadaver and animals. In graduate training for surgery it is advisable to supplement knowledge and experience by anatomical dissections on the cadaver and on animals. This requirement presents a problem, but with few exceptions it can be arranged satisfactorily. This work should be done under a preceptor.

6. The resident staff should be encouraged to participate in clinical or experimental research. Opinions differ as to the extent to which the resident staff should participate in research work. Only an occasional individual will produce or discover anything of lasting value to the medical profession, but the individual who undertakes and pursues a research problem under proper guidance derives something of worth which can be obtained in no other way. The pursuit of a clinical or experimental research problem involves new avenues of thought and approach, and incultates a commendable scientific attitude toward daily diagnostic problems.

7. An assigned period of time should be devoted to diagnostic and follow-up work in hospitals with an out-patient department. The place of a well organized out-patient department in the graduate training program has been referred to under the hospital requirements. An outpatient department conducted under the standards stipulated by the American College of Surgeons offers excellent opportunity for acquiring further knowledge and experience, particularly in case studies, differential diagnosis, and follow-up work. The latter particularly is of intrinsic value.

8. There should be active participation in medical staff and clinicopathological conferences and in the departmental meetings. This should be a studied participation and should consist of more than the brief presentation of a patient's history. The survey of graduate training facilities revealed the commendable fact that 70 or 80 per cent of the hospitals required attendance and participation in medical staff and clinicopathological conferences. Some question was raised as to the actual educational value to the resident staff of many of these conferences. Rearranged participation with preparation can be of definite educational value to all members of the medical staff. In some institutions several meetings a year are prepared and conducted entirely by the resident staff. The College has made an exhaustive study of the organization and the conduct of medical staff conferences and has worked out a plan through which the maximum benefit will accrue to the attending staff. The College urges the active participation of the resident staff in these conferences.

9. The resident staff should be encouraged to engage in some teaching activities. Educational programs for nurses, student and graduate, and other groups provide unlimited opportunities for these endeavors. These should be directed and guided activities. Varying degrees of responsibility may be given to the resident staff in respect to teaching opportunities, based upon the variation in types of hospitals and the proclivity and ability of the individual. It is believed that in many instances more responsibility for teaching could be given the resident with mutual benefit to the resident staff and the hospital. The study and review required of a teacher are stimuli which can be secured in no other manner. There are many possibilities for utilizing the resident staff in some teaching program, not only in hospitals connected with medical schools, but in those without such affiliation.

REPORTS OF PROGRESS—EXAMINATIONS

1. Records of all of the work and educational activities of each member of the resident staff should be maintained. In every phase of the graduate training program, the importance of keeping records and their value in maintaining an equitable distribution of work is manifest. Each member of the resident staff should keep a record of his progress and periodically submit for the consideration of his preceptor a prescribed summary of his work. Without such records the preceptor cannot have accurate knowledge of the scope of the training program over a given period of time, there can be no accurate comparison of educational programs in the various institutions, and further elaboration of minimum standards for training will be rendered more difficult. After the preceptor has evaluated the work from the standpoint of training and experience, a copy of the report should be filed in the hospital. In this manner the preceptor can arrange a better balanced program of training and experience for the resident.

An examination at the conclusion of the period of training is not only of value in ascertaining the knowledge and experience gained, but it is of great assistance in evaluating the instruction and training offered by the hospital.
Fundamental Principles -- Graduate Training for General Surgery and the Surgical Specialties

The Hospital
The hospital should provide:

1-a. A well organized medical staff with department chiefs or heads who are responsible for the organization and operation of the graduate training program.

b. Assigned personnel, responsible for active and personal supervision and direction of the resident staff.

2-a. Departmental conferences in general surgery and the surgical specialties at least weekly in which the resident should be permitted and encouraged to take an active part.

b. An active surgical service with a sufficient number of patients to offer opportunity for study and experience in the diagnosis and treatment of a variety of surgical conditions.

c. An outpatient department with systematic follow-up clinics in which the resident, under proper supervision, may spend definite time.

3-a. Adequate clinical laboratory and x-ray facilities under the full time supervision of an approved or accredited pathologist and radiologist respectively, with qualified technical assistants.

b. Other adjunct diagnostic and therapeutic facilities now considered essential for diagnosis and treatment.

c. Weekly clinicopathological conferences for the demonstration and study of surgical and post-mortem pathology.

d. Affiliation where necessary with other educational institutions to offer the resident staff opportunity for collateral basic science study and study on the cadaver or animals.

4. A medical library containing a wide range of standard textbooks, current medical journals and periodicals.

The Resident Staff
It is desirable that the resident staff should:

1-a. Devote adequate time to the study of gross and microscopic surgical pathology, clinical roentgenology and radiology, and the auxiliary basic sciences.

b. Observe and participate in autopsies on patients who have died postoperatively or on the surgical service, and study the findings in correlation with the clinical history and course.

c. Supplement clinical knowledge by anatomical dissections, study on the cadaver and animals, and/or other basic science study.

d. Participate in clinical or experimental research.

2-a. Obtain sufficient operative experience under supervision to provide a reasonable degree of technical efficiency.

b. Devote an assigned period of time to diagnostic and follow-up work in hospitals with an outpatient department.

3. Participate in medical staff and clinicopathological conferences, and in the departmental meetings.

4. Be responsible for some teaching activities, such as educational programs for student and graduate nurses, and other groups.

5. Devote as much time as possible to reading of scientific literature, past and current, under specific suggestion and supervision of preceptors.

Reports of Progress
1. Records of the work of the resident surgical staff should be kept by the hospital, and such other records as may be necessary to insure an equitable distribution of work, and to provide a basis for evaluating the scope of training.
HOSPITALS OF THE UNITED STATES AND CANADA APPROVED FOR GRADUATE TRAINING IN GENERAL SURGERY AND IN THE SURGICAL SPECIALTIES AS OF JANUARY 1, 1939*

The American College of Surgeons announces the following list of hospitals, affiliated hospitals, and other medical educational institutions which are participating in programs of training in general surgery and in the surgical specialties. These programs are graded as follows:

1. Fully Approved. The programs sponsored in these hospitals and/or other medical educational institutions are properly based on the fundamental requirements and are functioning acceptably.

2. Provisionally Approved. The programs in these hospitals and/or other medical educational institutions are properly based on the fundamental requirements, but for lack of time or other sufficient reasons are not fully meeting the requirements.

3. Not Rated. The programs in these hospitals and/or other medical educational institutions are not meeting the fundamental requirements.

If problems temporarily affect the eligibility of a hospital or other medical educational institution at the time the approved list is published, the rating of that particular institution may be deferred for further information and observation.

Each institution is considered for rating annually. An institution once approved will not necessarily always remain so. Ratings automatically cease on October 1, when new ratings are determined.

The purpose of the Approved List is obviously to encourage the proper correlation of activity in the field of graduate training in surgery and the surgical specialties; to promote where needed a co-operative effort between hospitals and other medical educational institutions so as to assure experienced guidance in educational programs in surgery; to expand opportunities for graduate training into a greater number of hospitals having acceptable facilities; finally, and most important, to provide sufficiently for the training of Junior Candidates and future Fellows according to existing requirements, which include:

Applicants for fellowship whose qualifying medical degree shall have been obtained after the date of January 1, 1938, shall be required to present evidence of having completed three years of hospital service in one or more acceptable hospitals, of which two years shall have been spent in training in surgery in hospitals approved by the American College of Surgeons.

In substance this means that until such time as there may be a sufficient number of opportunities for graduate training in general surgery and/or the surgical specialties which meet the requirements for approval for graduate training, the College will continue to specifically evaluate on merit the training of each individual candidate for fellowship.

An internship of at least one year, in a hospital providing acceptable interne training, is considered as a basic and fundamental requirement for graduate training. This internship may be of the rotating, mixed, or straight service type.

The Approved List is based on a minimum period of at least two years, preferably three or more years, with full time devoted to graduate training. Residence in the hospital or other medical educational institution is desirable. Where combined specialty fields are included, the minimum requirement for approval presupposes three years or more in training.

Due consideration was given to the provision of adequate basic science study as included in the graduate training programs and the close correlation of such study with clinical services in the various hospital departments. However, in recognition of the variation in existing opportunities and the wide divergence of opinion on this subject, it was considered that this requirement may be fulfilled through a variety of acceptable plans of collateral study. In the rating of institutions, serious attention was given to the setting aside of definite time for the satisfactory pursuit of basic science study.

The Approved List designates primarily the major hospital or other medical educational institution which originates and directs the program of graduate training in general surgery and/or the surgical specialties as enumerated, giving due credit to any affiliated institution which may co-operate in carrying it to completion. Thus a hospital which participates in a program to the extent of providing a period of clinical experience in residence appears on the list under the heading，“Affiliation for Graduate Training.” The Approved List does not include hospitals offering a period of clinical experience which is not properly correlated or co-ordinated through affiliation in a program of complete training. Medical schools have been included under the heading “Affiliation for Graduate Training” only in those instances where they participate in guiding and directing the graduate program, or where they provide facilities for basic science study. They have not been included if the affiliation is for under graduate teaching alone. In recognition of the current trend in developing graduate medical education on an academic basis, the list designates those institutions offering graduate degrees for which registration is optional or required.

There follows the list of hospitals and/or other educational institutions in the United States and Canada which are conducting Fully Approved and Provisionally Approved programs of graduate training in general surgery and/or the surgical specialties as of January 1, 1939. The asterisk (*) indicates provisional approval.
Because violence inflicted by guns continues to be a daily event in the United States and mass casualties involving firearms threaten the health and safety of the public, the American College of Surgeons supports:

1. Legislation banning civilian access to assault weapons, large ammunition clips, and munitions designed for military and law enforcement agencies

2. Enhancing mandatory background checks for the purchase of firearms to include gun shows and auctions

3. Ensuring that health care professionals can fulfill their role in preventing firearm injuries by health screening, patient counseling, and referral to mental health services for those with behavioral medical conditions

4. Developing and promoting proactive programs directed at improving safe gun storage and the teaching of non-violent conflict resolution for a culture that often glorifies guns and violence in media and gaming

5. Evidence-based research on firearm injury and the creation of a national firearm injury database to inform federal health policy
The benefits of attending an ACS Coding Workshop

by Jenny J. Jackson, MPH, CPC

Slightly more than half of physicians will agree on the same Current Procedural Terminology (CPT)* code for a given visit, and only 60 percent of professional coders will agree on the same code for a particular visit,” according to an article published by the Southern Medical Association in 2010. In the article, titled “Medical Decision Making: Guide to Improved CPT Coding,” author Jim Holt and colleagues discuss the intricacies of coding and the large margin for errors within medical practices.

To help navigate through these and other pitfalls of coding, each year the American College of Surgeons (ACS) hosts a series of two-day workshops on the application of changes to the CPT code set with an emphasis on codes that general surgeons commonly use. Expert instructors from the practice management consulting firm KarenZupko & Associates deliver practical explanations for each change, using real case examples and educational materials developed by the American Medical Association (AMA).

Who should attend an ACS Coding Workshop?

Surgeons, administrators, managers, coders, and reimbursement staff would all benefit from attending the workshops. Team attendance is highly encouraged, as it is vital to ensure accurate, complete, and consistent coding. Registration discounts are offered when three or more team members are enrolled at the same time. Moreover, if the physician is an ACS member, team members or practice employees may attend the workshop at the ACS member rate.

How often does coding change? Should I plan to attend a workshop each year?

Yes. Codes change frequently. In fact, the AMA updates the CPT code set annually. Improvements in coding constructs, additions of new technology, and changes to coding and reimbursement rules and payment policies make it necessary to attend a workshop annually.

What are the advantages of attending an ACS Coding Workshop?

When accurate coding is aligned with a clear understanding of payment policy rules, practices will begin to improve profit margins. Attending an ACS coding workshop increases participants’ knowledge of coding principles and helps them develop the skills needed to decrease coding errors and reduce the risk of an audit. The workshop also comprises information regarding the new codes for the year and audit trends and allows participants to practice accurate coding.

Additionally, attendees have the opportunity to share their different coding and practice management ideas, knowledge, experiences, and backgrounds with the group. Attendees also learn how their colleagues are handling coding, billing, and practice management issues.

What will I learn?

The topics discussed at an ACS coding workshop change annually due to the addition, deletion, and revision of the CPT code set. However, the focus of the first day of the workshop is on how to code correctly. Topics may include coding accurately for evaluation and management (E/M) services, reducing the risk of an audit, and new Medicare rules, regulations, and policies. These topics are addressed with an emphasis on their effects on surgical practices. Additionally, the instructors discuss how to appropriately apply coding and modifier guidelines to accurately report multiple procedure combinations. The Centers for Medicare & Medicaid Services’ Physician Quality Reporting Initiative, Electronic Health Record, and Electronic Prescribing Incentive Programs, which are updated annually, also are addressed.

The second day of the workshop is dedicated to surgical case coding. The instructor discusses the information that should be included in an

*All specific references to CPT codes and descriptions are © 2012 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.

ADDITIONAL ACS CODING RESOURCES
To assist surgeons in their efforts to address coding questions, the ACS also offers the following resources:

- The Coding Hotline (1-800-227-7911), hours of operation 7:00 am–4:00 pm Mountain Time. The coding hotline will answer five free coding questions a year for each Fellow of the ACS. For additional information on the ACS coding hotline, visit the ACS website, www.facs.org/ahp/coding/secoding.html.

- The Coding and Practice Management Corner (previously Socioeconomic Tips), a column in the Bulletin, provides tips on a range of reimbursement-related issues. The topics change monthly and in past years have included coding for hernia and other complex abdominal repairs, debridement, and sentinel lymph node mapping and its relation to biopsy. These and other articles can be found on the ACS website, www.facs.org/ahp/pubs/tips/index.html.

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Can I earn CME for attending a workshop?
Physician attendees are eligible to receive continuing medical education (CME) credits through the ACS. Physicians are eligible for 6.5 CME credits for each day of attendance. In addition, nonphysician attendees who are members of the American Academy of Professional Coders are eligible for 6.5 CEU credits for each day of attendance.

When and where will the next ACS coding workshops take place?
- April 11–12, Hyatt Chicago Magnificent Mile, Chicago, IL
- May 16–17, Wyndham Baltimore Peabody Court, Baltimore, MD
- August 22–23, Lowes Vanderbilt Nashville, Nashville, TN
- October 24–25, The Westin Las Vegas, Las Vegas, NV
- November 7–8, Hyatt Chicago Magnificent Mile, Chicago, IL

The dates and location change each year; visit the ACS practice management Web page for the most current dates and locations at www.facs.org/ahp/workshops/index.html.

How do I register?
The ACS offers a special price for members and their coding staffs. ACS Fellows and their staff members should be sure to have their ACS member number available and enter it for each person registering. ACS membership is not a requirement of attendance. To register for the two-day workshop, visit www.karenzupko.com/workshops/americancollegeofsurgeons/index.html or call 312-642-8310.

For hotel reservations, contact the hotel that is hosting the workshop using the number provided during the registration process, and then indicate that you are attending the “American College of Surgeons CPT Coding Course” for special pricing. The ACS also offers special airfare discounts on United by contacting ACS Travel Counselor Norma Velazquez at 800-456-4147 or ACSTravel@facs.org, or United Airlines at 800-521-4041 or online at www.united.com. When booking individual travel, be sure to indicate the name of the meeting and refer to the ACS file numbers provided at www.facs.org/ahp/workshops/travelinformation.html for any applicable discounts.

Editor’s note
Accurate coding is the responsibility of the provider. This article is intended only as a resource to assist in the billing process.
Joint Commission accreditation reaches 20,000 mark

The Joint Commission recently achieved a significant milestone—the accreditation or certification of 20,000 health care organizations with the addition of the Mercy Rehabilitation Hospital in Oklahoma City, OK. This occasion symbolizes the tremendous commitment to quality care and patient safety of the health care and administrative professionals at all accredited and certified health care organizations, including Mercy, which is dedicated to the treatment of patients with stroke, brain injury, and other debilitating conditions. In recent years, more institutions have sought Joint Commission accreditation; indeed, The Joint Commission experienced a 33 percent increase in the number of accredited and certified organizations between 2005 and 2012. As The Joint Commission marks this momentous accomplishment, the organization would like to take the opportunity to look at how it reached this point.

The Joint Commission's roots
The Joint Commission has its roots in the American College of Surgeons’ (ACS) Hospital Standardization Program, which evolved from the “end result system of hospital standardization” proposed by Ernest Codman, MD, FACS. Dr. Codman’s system of tracking the effectiveness of hospital treatments and using that information to improve patient care inspired his colleague, ACS Founder Franklin H. Martin, MD, FACS, to establish the ACS Hospital Standardization Program. As the program and the number of institutions seeking accreditation expanded, in 1951, the ACS and other health care associations agreed to establish what is now known as The Joint Commission.

The Joint Commission was founded to improve the safety and quality of health care for the public, but that goal would have been impossible to realize without the commitment of health care organizations in attaining accreditation and certification.

Seeking accreditation and certification from The Joint Commission is a voluntary choice and one that allows an organization to achieve the highest standards for quality and safety for the delivery of health care. Health care organizations awarded a Gold Seal of Approval for receiving accreditation and certification from The Joint Commission aspire to excel in providing the highest quality and value of care through compliance with state-of-the-art standards and survey processes.

Each time The Joint Commission has raised the bar on quality and patient safety, its accredited and certified organizations and the health care professionals in those organizations have met the challenge to the benefit of the patients and individuals they serve. As part of The Joint Commission’s accreditation

| The Joint Commission was founded to improve the safety and quality of health care for the public, but that goal would have been impossible to realize without the commitment of health care organizations in attaining accreditation and certification. |
and certification relationship, health care institutions have implemented important standards to improve patient-centered communications and bridge gaps in culture and language, as well as National Patient Safety Goals that address specific safety concerns, including infection prevention and medication safety.

**Commitment to quality**

The Joint Commission’s accredited and certified organizations are composed of health care institutions and clinical programs across the continuum of care. Hospitals, critical access hospitals, and providers of home care services make up the largest segments of institutions that seek Joint Commission accreditation to help strengthen patient safety and quality of care. In addition, The Joint Commission accredits laboratories, ambulatory care facilities, long-term care facilities, office-based surgery centers, and behavioral health care organizations. The Joint Commission also provides certification of health care staffing services and more than 2,400 organizations have earned Joint Commission certification in programs devoted to improving the care of patients with chronic diseases and conditions such as stroke, joint replacement, diabetes, and heart failure.

The accreditation and certification of 20,000 health care organizations of varying sizes and specialties operating in today’s complex health care environment is a reminder of the enduring importance of inspiring quality health care. Today, the end result system that Dr. Codman and the ACS founders envisioned remains an essential component of The Joint Commission’s mission to continuously improve health care for the public.

For information regarding Joint Commission accreditation and certification, visit www.jointcommission.org. For more information about the history of The Joint Commission and the role of the ACS in that history, visit www.jointcommission.org/assets/1/6/Joint_Commission_History_2012.pdf.
The “fiscal cliff”

by Richard J. Fantus, MD, FACS

There was public outcry, debate, and political maneuvering over the recent “fiscal cliff” that forced the country to face economic uncertainty in 2013. The U.S. economy has gone through 13 recessions since the Great Depression in 1929, the latest being the “Great Recession,” which started in December 2007 and continued through June 2009. These financial cycles have occurred throughout the history of the U.S. Unfortunately, recessions generally result in a rise in the unemployment rate and a rise in the suicide rate.

According to a Centers for Disease Control and Prevention (CDC) study titled Impact of Business Cycles on U.S. Suicide Rates, 1928–2007, business cycles may affect suicide rates, and it suggests that public health responses are a necessary component of suicide prevention during recessions. The study also revealed age-specific suicide rate responses to the cycles of an economic downturn. Specifically, suicide rates for those individuals between the ages of 25 and 64 rose during economic contractions.*

To examine the occurrence of self-inflicted injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2011, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Specifically searched were external cause of injury codes (E-codes) that fell into the category of self-inflicted manner/intent, based on the CDC’s recommended groupings for presenting injury mortality and morbidity data. (These data are located in appendix C of the NTDB Annual Report 2012.) A total of 11,747 records of self-inflicted injury were found; 9,532 records contained a hospital discharge status, including 4,424 patients discharged to home, 3,181 to acute care/rehab, and 645 sent to skilled nursing facilities; 1,282 died. These patients were 76.4 percent male, on average 38.7 years of age, had an average hospital length of stay of 6.7 days, an intensive care unit length of stay of 5.2 days, an average injury severity score of 11.2, and were on the ventilator for an average of 4.3 days. A breakdown of suicide by age demonstrates the greatest number of records between the ages of 25 and 64 (see figures, page 71). Of the 7,070 tested for alcohol, 59 percent were found to be positive.

Suicide is a serious public health issue that can be devastating and have long-lasting, harmful effects on individuals, families, and communities. An economic downturn presents the possibility of the loss of a job, the loss of income, the threat of foreclosure—any of which can negatively affect one’s self-

An economic downturn presents the possibility of the loss of a job, the loss of income, the threat of foreclosure—any of which can negatively affect one’s self-image and strain relationships with family and friends.

Taking the nation over the fiscal cliff could have yielded multiple risk factors, although suicide is generally not carried out in response to any one factor, but rather is often the result of a combination of many variables. There is an opportunity for prevention by reducing risk factors while promoting protective measures. For more information on suicide prevention, visit www.cdc.gov/violenceprevention/suicide.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. The NTDB Annual Report 2012 is available on the ACS website as a PDF file and as a PowerPoint presentation at www.ntdb.org. In addition, information regarding how to obtain NTDB data for more detailed study is available on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgement
Statistical support for this article has been provided by Chrystal Caden-Price, data analyst, NTDB.
The American College of Surgeons (ACS) is accepting applications for the 2014–2016 Clinical Scholars-in-Residence positions through March 15, 2013. The Clinical Scholars-in-Residence Program is a two-year on-site fellowship in surgical outcomes research, health services research, and health care policy. It was initiated in 2006 for the purpose of advancing the College’s quality improvement initiatives and to offer opportunities for residents to work on the ACS quality improvement programs. More specifically, Clinical Scholars perform research and practical projects relevant to ongoing work in the ACS Division of Research and Optimal Patient Care. The intent is to prepare residents for a career in academic surgery and surgical health services research.

About the program
The primary objective of the fellowship is to address issues in health care quality, health policy, and patient safety with the goal of helping the Clinical Scholar-in-Residence prepare for a research career in academic surgery. ACS Clinical Scholars have worked on projects and research using data from the ACS National Surgical Quality Improvement Program (ACS NSQIP®), the National Cancer Data Base, and the National Trauma Data Bank® to assist in guideline development and accreditation activities. Scholars are assigned to the appropriate group within the ACS based on their interests and the College’s needs.

In addition, participants earn a master’s degree in health services and outcomes research or health care quality and patient safety at Northwestern University during their two years at ACS headquarters in Chicago, IL. The goal of this aspect of the program is to educate clinicians to become effective health services and outcomes researchers. The health services and outcomes research curriculum focuses on how these issues are addressed within institutional and health care delivery systems, as well as in the external environment that shapes health policy. The program takes approximately two years to complete. All coursework is done at Northwestern University’s downtown Chicago campus, one block from the ACS headquarters. The ACS also offers a variety of educational programs that may benefit Clinical Scholars, including an Outcomes Research Course and the Clinical Trials Course.

The ACS assigns internal mentors to meet regularly with each Clinical Scholar and provides scholars with opportunities to interact with various surgeons who are affiliated with the ACS and the Division of Research.

by Karl Bilimoria, MD, MS; and Clifford Y. Ko, MD, MS, MSHS, FACS
The primary objective of the fellowship is to address issues in health care quality, health policy, and patient safety with the goal of helping the Clinical Scholar-in-Residence prepare for a research career in academic surgery.

and Optimal Patient Care. Because mentorship is one of the most important aspects of the fellowship, having guidance from multiple individuals from diverse backgrounds will provide the best opportunity for success. In addition, a core of ACS staff statisticians, research nurses, and project analysts serve as invaluable resources to the Clinical Scholars-in-Residency.

**Past successes**
Since its inception, surgical residents from throughout the U.S., including California, Connecticut, Colorado, Illinois, Louisiana, and Ohio, have participated in the Clinical Scholars program. These individuals note that they have had excellent, productive experiences that have been useful in launching their careers in academic surgery. With seven scholars having already completed the program and four scholars currently participating, the residents have demonstrated great dedication to outcomes research and the improvement of the quality of surgical care.

The ACS Clinical Scholars have presented their findings at numerous national meetings and have published in high-impact, peer-reviewed publications, in addition to having contributed a great deal to the ACS quality improvement programs. Furthermore, scholars have gone on to secure prestigious fellowships in several fields, including surgical oncology, pediatric surgery, and trauma/critical care and have subsequently earned academic faculty positions and become independently funded researchers.

**Apply now**
The 2014–2016 scholars will begin their work on July 1, 2014. Applications for these positions are due by **March 15, 2013**. Currently, applicants are required to have funding from their institution or other grant mechanism, although funding through the ACS is sometimes available.

For more information about the program and the application requirements, go to [www.facs.org/ropc/clinicalscholars.html](http://www.facs.org/ropc/clinicalscholars.html) or send an e-mail to clinicalscholars@facs.org. 

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**Deadline to claim CME credit for 2012 Clinical Congress**

Attendees of the 2012 Clinical Congress have until **March 31, 2013**, to claim their continuing medical education (CME) credits. After this date, the American College of Surgeons (ACS) Division of Education’s Program for the Validation of Surgical Knowledge and Skills will no longer accept CME claims for the 2012 Clinical Congress.

ACS members should go to [http://www.facs.org/clincon2012/cme.html](http://www.facs.org/clincon2012/cme.html) to access their “My CME” page and claim General Session CME credit online. To do so, go to My CME under Quick links, and click on the orange “Claim 2012 Clinical Congress Credit” button. When prompted, enter your username and password. The default login is your ACS membership number (username) and last name (password). Be sure to click on the “save” button at the bottom of each day’s CME course listing. Note that CME credit for Skills Courses, Postgraduate Courses, and Meet the Expert Luncheons have automatically been entered on member pages.

Before completing the “Global Evaluation,” remember to click on the “Summary” tab to ensure that all credits have been saved. After filling out the “Global Evaluation,” click on “submit,” and your credits will post to your “My CME” page. Log into the portal at efacs.org, click My Page in the menu bar, then select My CME. For more information, call toll-free, 866-918-4799.
Surgeons advocate in the AMA House of Delegates

by John H. Armstrong, MD, FACS, and Jon H. Sutton

The American Medical Association (AMA) Interim House of Delegates (HOD) meeting took place November 10–13, 2012, in Honolulu, HI. The American College of Surgeons (ACS) was well-represented with seasoned “veterans” testifying at reference committee hearings and voting on AMA policy (see sidebar, this page). The delegation succeeded in promoting College policy and ensuring that the AMA incorporated ACS positions into AMA resolutions, thereby strengthening the ACS voice in Washington, DC.

Actions of the HOD
• Principles for Physician Employment: These principles are designed to guide employed physicians and physician employers through the myriad potential challenges to professionalism and the practice of medicine that are likely to emerge from this arrangement. Topics discussed in the principles include conflict of interest, advocacy for patients and the profession, contracting, hospital medical staff relations, peer review, and performance evaluations. To access these principles, go to http://www.ama-assn.org/resources/doc/hod/ama-principles-for-physician-employment.pdf.

• Voluntary (Not Mandatory) Physician Enrollment in Medicare: Delegates agreed that the AMA should support every physician’s ability to voluntarily enroll or not enroll in Medicare and should uphold the right of patients to receive Medicare reimbursement for covered services provided by nonparticipating physicians.

• Affordable Care Act (ACA) Nondiscrimination of Health Care Provider Participation in Health Plans: Some specialty societies have expressed concern with regard to ACA statutory language that potentially expands scope of practice of non-physician health care professionals. The specific language states, “A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.” The AMA will actively pursue legislative and regulatory opportunities to repeal this clause.

ACS DELEGATION TO THE AMA HOD
• John H. Armstrong, MD, FACS, Delegation Chair; Surgeon General and Secretary, Florida Department of Health, Tallahassee, FL; and member, ACS Board of Governors
• Jacob Moalem, MD, FACS, AMA Young Physicians Section, professor of surgery, University of Rochester (NY) Medical Center
• Richard B. Reiling, MD, FACS, Chair, ACS Committee on Development
• Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, Chicago, IL, and adjunct associate professor of surgery at the Feinberg School of Medicine, Northwestern University, Chicago
Abuse of CPT (Current Procedural Terminology) Descriptors Related to Surgery: Several specialty and state medical societies brought forth a resolution urging the CPT Editorial Panel to retitle the section “Surgery” as “Surgery and Procedures” and to add the description of surgery in AMA policy to the section preamble. Whereas the resolution was referred to the AMA Board of Trustees, the College delegation encouraged resolution sponsors to meet with CPT Editorial Panel members to move forward on a solution outside the HOD.

Breast Reconstruction Public Education Initiatives: This resolution, which the HOD adopted, calls on the AMA to support education for breast reconstruction and its availability to physicians and breast cancer patients. Testimony emphasized the importance of cultural competence.

Surgical caucus
Review of HOD resolutions and reports, as well as Executive Committee elections, provided the substance for the Surgical Caucus’ business meeting. The following officers were elected to serve on the Executive Committee:

• Chair: Michael Simon, MD (delegate, American Society of Anesthesiologists), regional director, North American Partners In Anesthesia, Poughkeepsie, NY

• Chair-elect: Michael Deren, MD, FACS (chair, Connecticut and New England delegations), a general thoracic surgeon in private practice at Lawrence and Memorial Hospital, New London, CT; W. W. Backus Hospital, Norwich, CT; and Westerly Hospital, Westerly, RI; and currently a candidate for the AMA Board of Trustees

• Secretary: Lee Morisy, MD, FACS (delegate, Tennessee), Baptist Memorial Hospital, Memphis, ACS General Surgery Coding and Reimbursement Committee

• Treasurer: C. Bob Basu, MD, FACS (alternate delegate, American Society for Aesthetic Plastic Surgery), North Cypress Medical Center, Houston Northwest Medical Center

• Charles Drueck, MD, FACS, Swedish Covenant Hospital, Chicago, was recognized for his two years of service as chair of the Caucus and eight years of membership on the Executive Committee (see photo, page 74)

Two new Members-at-Large also were elected: Liana Pucas, MD, FACS, an otolaryngologist representing the American Academy of Otolaryngology–Head and Neck Surgery, for an open one-year term, and Jeffrey Kaufman, MD, FACS, a urologist representing the American Association of Clinical Urologists, for a three-year term.

The Caucus’ education session, Perioperative Focus: Your Voice in Advocacy, was well received. Speakers from the ACS, AMA, and the American Society of Anesthesiologists discussed their respective legislative agendas in light of national election outcomes and focused on physician influence during the lame-duck session of Congress.

Vote
The College’s delegation strives to represent the interests of ACS members through the AMA HOD. Delegation size is determined by the number of ACS members who are AMA members and who have selected the College as their specialty representative in the House. Fellows who are AMA members and have not yet “voted” for the College are encouraged to do so via the AMA password-protected ballot Web page: http://www.ama-assn.org/ama/pub/about-ama/our-people/the-federation-medicine/specialty-society-ballot.page.

The Delegation coordinates HOD action with the ACS Health Policy and Advocacy Group (HPAG) and works to connect the College’s many interests with the AMA. Fellows’ input is welcome. To share your views, contact Jon Sutton, the ACS delegation’s staff liaison, at jsutton@facs.org.

The delegation succeeded in promoting College policy and ensuring that the AMA incorporated ACS positions into AMA resolutions, thereby strengthening the ACS voice in Washington, DC.
Attend a 2013 Coding & Reimbursement Workshop

SAVE THESE 2013 DATES

MARCH 7-8
Encore at Wynn Las Vegas
Las Vegas, NV

APRIL 11-12
Hyatt Chicago Magnificent Mile
Chicago, IL

MAY 16-17
Wyndham Baltimore Peabody Court
Baltimore, MD

AUGUST 22-23
Loews Vanderbilt Nashville
Nashville, TN

OCTOBER 24-25
The Westin Las Vegas
Las Vegas, NV

NOVEMBER 7-8
Hyatt Chicago Magnificent Mile
Chicago, IL

• Office Coding and Profitable Practice Operations (THURSDAY)
• Mastering General Surgery Coding (FRIDAY)

NEW CASES for 2013!

Vein and thoracic surgical cases are featured this year — along with bariatric, breast, GI, skin cancer and trauma. Learn to apply modifiers correctly. Understand how to reduce delays and appeals.

Real case examples illustrate key documentation and coding principles — not vague theory. The workbook will serve as a useful, readable reference.

You’ll learn how to stay out of the auditor crosshairs for your evaluation and management coding.

Coding isn’t like riding a bicycle — once you’ve mastered cycling, you’ve got it down. Codes change, rules change, payers change — it’s a dynamic art.

These two workshops in combination will sharpen your ability to run your practice profitably and compliantly. Read signed reviews by workshop alums on our website.

* Earn CME credits!

OUR INSTRUCTORS

Mary LeGrand, RN, MA, CCS-P, CPC, consultant with more than three decades of nursing and administrative experience, including leadership positions on several national boards

Betsy Nicoletti, MS, CPC, author, speaker and consultant with over two decades engaged in coding education, billing, and accounts receivable management

To register visit www.karenzupko.com or call 312-642-8310

99% of the 2012 attendees would recommend the American College of Surgeons and KarenZupko & Associates workshops to a colleague!!

“Excellent course. The speaker was exceptional!! She was able to simplify the complicated areas for me, a new surgeon in practice.”
David J. Dupree, MD,
Dr. Chaagares and Dupree,
Shrewsbury, NJ

“I think the course was well presented and formatted. There was a lot of good information that will be useful for everyone.”
Sandra Kenning, RN, Kearney Clinic,
Kearney, NE

“As usual, excellent presentation. I will attend again.”
Mitzi Edge, Administrator,
The Breast Center, PC,
Marietta, GA
Call for nominations for ACS Secretary and Treasurer positions

The 2013 Nominating Committee of the Board of Regents (NCBR) will select nominees for the positions of Secretary and Treasurer of the American College of Surgeons (ACS). The Board of Regents approved this new open nomination process at its October 2012 meeting.

The NCBR will use the following guidelines when considering potential candidates:

• Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.

• Nominees must have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

• Members of the NCBR recognize the importance of achieving representation of all who practice surgery.

• The College encourages consideration of women and other underrepresented minorities.

All nominations must include a letter of recommendation, a current curriculum vitae, and a personal statement from the candidate detailing ACS service and the name of one individual who can serve as a reference. Any attempt to contact members of the NCBR by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification. Applications submitted without the requested information will not be considered.

The deadline for submitting nominations is Monday, May 6, 2013. Please submit nominations to secretaryandtreasurernominations@facs.org.

If you have questions, contact Barbara L. Dean, Director, Executive Services, and Senior Staff Liaison for the NCBR, at 312-202-5386.

Responsibilities of the Secretary and Treasurer

• The Secretary and Treasurer shall each serve an initial three-year term and may serve a maximum of two three-year terms.

• The Secretary shall oversee the minutes of the annual meetings of the members, give notices in accordance with the provisions of law and the Bylaws of the ACS, keep the records and corporate seal, and perform such other duties as may from time to time be assigned by the Board of Regents. The Secretary will attend the meetings of the Board of Regents and will work with designated staff members to ensure that the official minutes of meetings accurately reflect the discussion of the Board of Regents. The Secretary has the co-responsibility with the Executive Director to provide such oversight.

• The Treasurer shall oversee, in conjunction with the Chief Financial Officer, the funds of the College under the supervision of the Finance Committee and shall make such reports to the Finance Committee, the Executive Committee of the Board of Regents, and the Board of Regents as may be required. The Treasurer will attend the meetings of the Board of Regents and will have a reporting relationship to both the Finance Committee and the Executive Director. The College shall purchase a bond or insurance coverage ensuring the faithful performance of the duties of the office of Treasurer. In the absence or inability to act of the Treasurer, the duties of the Treasurer shall be performed by such person and in such manner as the Finance Committee may direct.
After a 10-year effort, the ACS archivists have completed a 54-page archival description of the 95 boxes of papers of ACS founder, Franklin Martin, MD, FACS, and his wife Isabelle.

The downloadable pdf description on facs.org/archives includes:

- Materials from Dr. Martin's early career, such as casebooks (1891–1917) and records of the Chicago hospitals and medical schools with which he was associated
- Martin's diaries and scrapbooks (1901–1934), which the Martins called their “Memoirs,” including 10 volumes documenting his experiences as Medical Director of President Woodrow Wilson’s civilian arm of the Council of National Defense
- Descriptions of Martin's correspondence and hundreds of sympathy notes from after his death
- And much more!

The personal papers of Eleanor K. Grimm, Martin's special assistant, are also available on facs.org/archives. They include more than 1,000 pages of her correspondence and photos with many more insights into the early history of the College and its early leaders, all free text searchable.

Also on the History and Archives page are links to our Digital Collections samples; all existing presidential addresses presented at the annual Clinical Congresses, including their dates and locations; Distinguished Service Award recipients; monthly highlights from the Archives featuring notable individuals or documents found in the archives; a brief history of the College, and more. Just click on “Online Resources.”

We hope that after viewing the Digital Collections you will return to the History and Archives page to complete a one-minute Web survey. Your feedback is important to us.

Contact Susan Rishworth, Archivist, at srishworth@facs.org for more information.
Stay current by using new ACS member e-mail forwarding benefit

The American College of Surgeons (ACS) is offering a new member benefit, an e-mail forwarding service that can point to any e-mail address anywhere and maintains a permanent efacs.org address for all electronic communications. The benefit ensures that all e-mail from the ACS is promptly sent to your current e-mail account and that the College can reach you for years to come, even if your employment changes due, for example, to retirement or moving on from a residency or fellowship program.

Go to http://efacs.org/emailforward to register for the benefit. (The e-mail address might include the first initial and last name, so, for example, the address for Dr. John Doe might be jdoe@efacs.org.) Registration for this service is quick, easy, and free.

For more information, contact the ACS Division of Member Services at ms@facs.org.

Webcast sessions of 2012 Clinical Congress now available

The webcasts of select 2012 Clinical Congress sessions are now available for on-demand viewing through the American College of Surgeons Division of Education. The webcasts may be used for self-assessment and continuing medical education (CME) credit. Purchasers of the sessions may choose from three packages:

• Complete Best Value Package, which allows the user to access all 36 webcast sessions from 2012 and 33 from 2011, including audio access to 46 select panel sessions from 2012
• Webcast Package, which provides access to all 36 webcast sessions from 2012 only
• Webcast Pick 12, which allows the purchaser to select 12 out of 36 webcast sessions from 2012


Connect with the College via social media!

Twitter.com/AmCollSurgeons
Twitter.com/ACSTrauma
Facebook.com/AmCollSurgeons
Facebook.com/ACSTrauma
Facebook.com/RASACS
YouTube.com/AmCollegeofSurgeons

Event Hashtag: #ACS100 identifies tweets related to the College’s centennial celebration, as well as highlights people and events from our 100-year history.

Social media questions?

For more assistance or if you have questions or comments about the American College of Surgeons’ social media sites, send an e-mail to socialmedia@facs.org.
Need to earn CME credit?

You’re reading articles every month in the Journal of the American College of Surgeons...

Why not get Maintenance of Certification self-assessment CME credit?

CONVENIENT ◆ FREE FOR FELLOWS AND SUBSCRIBERS
Each completed article receives 1 AMA PRA Category 1 Credit™

Track your CME online at the “My CME” page at www.e-FACS.org

Visit http://jacscme.facs.org for more information
The International Relations Committee of the American College of Surgeons (ACS) has announced the availability of the 2014 Traveling Fellowship to Germany. The purpose of this fellowship is to encourage international exchange of surgical science, practice, and education, and the establishment of professional and academic collaborations and friendships. The ACS Traveling Fellow will visit Germany and, as part of the exchange program, a German Traveling Fellow will visit North America.

**Basic requirements**
The Scholarship is available to an ACS Fellow in most of the surgical specialties who meets the following requirements:

- A major interest and accomplishment in clinical and basic science related to surgery
- Current full-time academic appointment in Canada or the U.S.
- Younger than 45 years of age on the date the application is filed
- Enthusiasm and personability with good communications skills
- Applicants with some German language skills are particularly encouraged to apply

**Activities**
The Fellow is required to spend a minimum of two weeks in Germany, during which he or she must complete the following:

- Attend and participate in the annual meeting of the German Surgical Society, which will be held in Berlin, Germany, March 25–28, 2014
- Attend the German ACS Chapter meeting during the society’s conference
- Visit at least two medical centers (other than the annual meeting city) in Germany before or after the annual meeting of the German Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and designated representatives of the German Surgical Society and the German ACS Chapter. The surgical centers that the Fellow will visit will depend to some extent on the special interests and expertise of the Fellow as well as any previously established professional contacts with surgeons in Germany. The Fellow’s spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction in addition to professional activities.

**Financial support**
The College will provide the sum of $6,000 (U.S.) to the successful applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society.

The Fellow must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and travel schedules. The Fellow will make travel arrangements in North America, thereby being allowed to take advantage of reduced fares and travel packages for travel in Germany.

The American College of Surgeons International Relations Committee will select the Fellow after review and evaluation of the applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained on the ACS website at http://www.facs.org/memberservices/acsgermany.html, or by sending an e-mail to the International Liaison Section, American College of Surgeons, at kearly@facs.org, or writing to 633 N. Saint Clair Street, Chicago, IL 60611-3211.

The closing date for receipt of completed applications and all supporting documents is April 1, 2013. The successful applicant and an alternate will be selected and notified by July 31, 2013.
Award-Winning DVD

This kit helps patients learn and practice the skills needed for optimal postoperative recovery at home. Program evaluation shows improved patient satisfaction, reduced complications, and lower expenditures.

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Ostomy Division of Education • Surgical Patient Education

Developed by the American College of Surgeons, Division of Education, in collaboration with American Society of Colon and Rectal Surgeons, the American Urologic Association, the Wound Ostomy and Continence Nurses Society, and the United Ostomy Associations of America.

This program has been funded in part by a grant from Coloplast Corp.
The American College of Surgeons’ (ACS) Division of Education and International Relations Committee have announced two international scholarships focused on surgical education. All 2013 application materials and supporting documents are due by May 1, 2013.

These scholarships will provide faculty members from countries other than the U.S. and Canada the opportunity to acquire new knowledge and skills in surgical education and training by participating in a variety of faculty development activities. The College anticipates that this experience will be useful in improving surgical education and training in the scholar’s home institution and country.

Educational opportunities
The two scholars will attend the 2013 ACS Clinical Congress, October 6–10 in Washington, DC, where they will participate in the Surgical Education: Principals and Practice course. Scholars also will participate in other sessions that address surgical education and training across the continuum of professional development, including the needs of practicing surgeons, surgery residents, medical students, and other members of the surgical team.

Following the Clinical Congress, scholars will visit two Level I ACS-accredited Education Institutes selected in advance based on their interest areas in surgical education and training. At the conclusion of the Clinical Congress and the visits to the ACS-accredited Education Institutes, scholars will be required to submit to the International Relations Committee and to the Division of Education a brief report outlining their experiences, specifically focusing on achievement of the objectives outlined in their scholarship application. The scholarships will facilitate the scholars’ involvement in subsequent collaborative ventures in education and training under the aegis of the ACS Division of Education.

Each scholarship provides a stipend of $10,000 to support travel and per diem expenses in North America, as well as the cost of courses undertaken at the 2013 Clinical Congress and for visits to ACS-accredited institutes. Clinical Congress registration and fees for attendance at the Surgical Education: Principles and Practices course will be provided gratis. Assistance will be offered to reserve affordable housing in Washington, DC.

Application requirements
Applicants must provide documentation of prior experience in surgical education and training, such as involvement in the development and evaluation of education modules, use of novel teaching and assessment strategies, or curriculum design. In addition, applicants must submit a one-paragraph description of their education philosophies, a list of specific educational goals and objectives for their visits, and evidence of support of these goals and objectives from the leadership at their home institutions. The Division of Education staff will review these documents as part of the selection process. At least five years of experience is required beyond completion of all training and fellowships. Scholarships must be used in the year awarded; they may not be postponed.

Full scholarship requirements for this program are available at http://www.facs.org/memberservices/issurged.html. The application for the scholarship may be accessed at the bottom of the requirements page. Questions should be directed to the ACS International Liaison at kearly@facs.org.
## Calendar of events

**MARCH 2013**

**Medical Disaster Response**  
March 18  
Caesars Palace, Las Vegas, NV  
Contact: Mary Allen, redstart@aol.com

**Trauma, Critical Care, and Acute Care Surgery**  
March 19–21  
Caesars Palace, Las Vegas, NV  
Contact: Mary Allen, redstart@aol.com

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**APRIL 2013**

**Metropolitan Washington, DC, Chapter**  
April 6  
Hyatt Regency Capitol Hill  
Contact: Jennifer Starkey, jennifer@acschapters.org, http://www.dcfacs.org/aws/ACS/pt/sp/DC_home_page

**113th Annual Congress of the Japan Surgical Society**  
April 11–13  
Fukuoka International Congress Center, Japan  
Contact: Katsuhiko Yanaga, MD, PhD, FACS, kyanaga@jikei.ac.jp

**2013 Leadership Conference and Advocacy Summit**  
April 13–16  
Mandarin Oriental Hotel, Washington, DC  
Contact: ACS Division of Advocacy and Health Policy, ahp@facs.org, 202-337-2701, http://www.facs.org/ahp/summit/index.html

**Chile Chapter**  
April 14–17  
Hotel Sheraton Convention Center, Santiago, Chile  
Contact: Ivan Alcoholad, MD, FACS, ialcoholad@alemana.cl, http://www.principal.acschile.cl/

**New Jersey Chapter**  
Joint 2013 Dublin Educational Pilgrimage with the Royal College of Surgeons of Ireland  
April 21–28  
Contact: Andrea Donelan, njsurgeons@aol.com, http://www.nj-acs.org/

**XXII International Course**  
Argentine Chapter of the American College of Surgeons  
April 26  
Salta, Argentina  
Contact: Rodolfo L. Faraco, MD, FACS, rfaraco52@gmail.com

**North Dakota and South Dakota Chapter**  
April 26–27  
Ramkota Hotel, Bismarck, ND  
Contact: Leann Benson, leann@ndmed.com

**Indiana Chapter**  
April 26–27  
ACS Headquarters, Chicago, IL  
Contact: Carolyn Downing, cdowning@ismanet.org, http://www.infacs.org/index.html

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**MAY 2013**

**Ohio Chapter**  
May 3–4  
Sheraton at Capital Square, Columbus  
Contact: Jennifer Starkey, jennifer@executive-office.org, http://associationdatabase.com/acs/pt/sp/OH_Home_Page

**Virginia Chapter Meeting**  
May 3–5  
Hilton Virginia Beach, VA  
Contact: Susan McConnell, smcconnell@ramdocs.org, http://www.virginiaacs.org/

**Australia and New Zealand Chapter**  
May 6–10  
SKYCITY/Crowne Plaza Convention Centre, Auckland  
Contact: Monique Whear, monique.whear@surgeons.org

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**FUTURE CLINICAL CONGRESSES**

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<th>Year</th>
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*Dates and locations subject to change.*