2015 GOVERNORS SURVEY

208/273 (76.2%) Governors Responded to the 2015 Survey

Introduction

The 2015 Governor's Survey addresses multiple topics that have been identified as areas of concern for practicing surgeons. The survey work group led by *Drs. Mark W. Puls and David Welch* spent over two months determining which topics were most immediately relevant to the delivery of surgical care and almost the same amount of time designing questions that would most effectively provide useful answers. This document is a compilation of the entire survey and is divided into the five topics addressed by the survey and the results of each question within each topic. Each question consists of three parts; the question or subject addressed, the response data, and the initial interpretation of the data by members of the work group.

Document navigation:

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- Clicking on any element in the detailed table of contents will move to that element.

Report Sections

Contents

DEMOGRAPHIC QUESTIONS

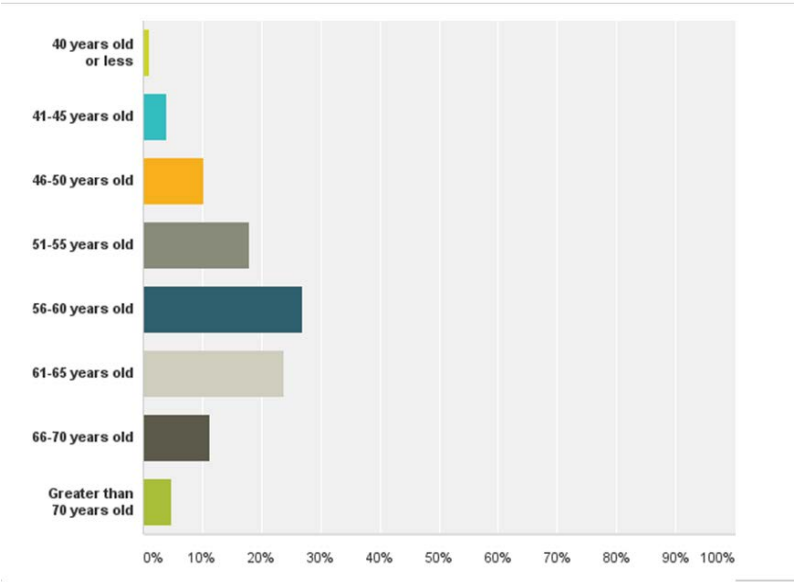
Question 1: What state do you practice in?

Data:

AL - 2	GA -4	MD -5	NH -1	SC -1	WY -1
AK - 1	HI -1	ME -1	NJ -3	SD -1	
AR -1	IA -1	MI -3	NM -2	TN -5	
AZ -1	ID -1	MN -1	NV -0	TX -13	
CA -13	IL -3	MO -4	NY -17	UT -1	
CO -3	IN -3	MS -1	OH -11	VA -7	
CT -3	KS -1	MT -1	OK -1	VT -1	
DC -0	KY -2	NC -4	OR -4	WA -3	
DE -1	LA -2	ND -1	PA -11	WI -0	
FL -8	MA -4	NE -1	RI -2	WV -1	

Question 2: What is your age?

Data:



Initial Interpretation: **Mostly representative of senior surgeons!**

Question 3: Are you an International, Canadian, or US Governor?

Data:

International Governor	17.4%
Canadian Governor	5.3%
US Governor	77.3%

Question 4: How would you best describe your surgical practice?

Data:

Specialty	No.
General Surgery –	90
Acute Care General Surgery –	48
Surgical Oncology –	42
Trauma Surgery –	38
Colon and Rectal Surgery –	31
Breast Surgery –	28
Endocrine Surgery –	26
Critical Care Surgery –	20
Other (please specify) –	18
Vascular Surgery –	15
Wound Care –	13
Bariatric Surgery –	12
Pediatric Surgery –	11
Cardiothoracic Surgery –	8
Otolaryngology –	8
Obstetrics and Gynecological Surgery –	7
Plastic and Maxillofacial Surgery –	5
Transplant Surgery –	5
Hand Surgery –	3
Neurological Surgery –	3
Orthopaedic Surgery –	2
Urological Surgery –	2
Ophthalmic Surgery –	1
Total	193

Initial Impression: Reasonable balance of surgical disciplines.

Question 5: Which best describes your surgical practice setting?

Data:

Answer choice	Response
Full time academic practice	48%
Full time hospital employed physician	15%
Governmental agency	4%
Private practice solo practitioner	10%
Private practice small surgical group	10%
Private practice multi-specialty group practice with primary care and surgical care	2%
Private practice multispecialty group practice with surgical care only	4%
Other	7%

Initial Interpretation: Skew toward academia, but reasonable representation of community practice (31%)

Question 6: Type of hospital, or hospitals, where you practice.

Data:

Answer choices	Responses
Academic, quarternary, or tertiary care facility	67%
Community hospital with >500 beds	6%
Community hospital with 250-500 beds	16%
Community hospital with 100-249 beds	12%
Community hospital with 50-99 beds	3%
Rural hospital with less than 50 beds	3%
Other	7%

ISSUES OF IMPORTANCE TO SURGEONS

Question 7: Top ten issues of concern

Data:

Issue	No.
CME/MOC	123
Readiness of a newly graduated surgical resident to assume independent practice	123
Medical Education	116
Physician reimbursement/Medicare/Medicaid	115
Funding GME	114
Competency assessment of practicing surgeon	109
Long-term workforce issues for general surgery/surgical specialties	105
Pay for Performance (P4P)	99
Electronic Med Rec	98
Professional Liability/Malpractice/Tort reform	93
ACA driven Reform	92
Public Reporting	88
Advocacy efforts at the state and national level	87
Enough surgeons to take call for general surgery and the surgical specialties	78
Over-specialization of the field of surgery	73
Regionalization of Surgical Care	69
Relationships and contracting with Hospitals/Managed Care Organizations/Accountable Care Organizations	69
Peer Review Issues	61
Trauma Care	60
Credentialing for new technology/Hospital privilege issue	44

There also was an option for Governors to write in an open response for other issues of concern:

Additional Concerns listed in "other"	No.
Practice related	
Access to surgical services	1
Lack of collegiality in practice	1
ICD-10 implementation	2
Coverage of rural areas - new grads want "lifestyle"	1
Marginalization of the general surgeon; being reduced from profession to occupation	1
Non-physician expansion and legislative effort impact on practice	1
Quality of care and outcomes	1
Reduced productivity due to increased burden of regulations	1
Setting standards of care	1
Burnout and wellbeing in surgery	2
Telesurgery	1
Education Related	
Unified Accreditation of Surgical and Surgical Subspecialties	1
Clinical Research Funding	1
Mentoring	1
Training residents in general surgery	1
ACS Related	
Involvement of international surgeons in ACS	1
The college is not helping the general surgeon	1
Too few general surgeons to replace retiring surgeons	1

Initial Interpretation: The top three issues have not previously had this level of priority and clearly reflect concern about the process and support of surgical training. There do not appear to be any specific issues that are really important to a specific age of Governor. No one issue jumps out as more highly prevalent for a specific age range.

Question 8: Issues the ACS is not currently addressing, or current issues to which the ACS should be spending more resources on:

The answers to this question can be found at the end of the survey under "FREE TEXT COMMENTS FROM GOVERNORS"

Question 9 (INTERNATIONAL GOVERNORS only): Surgical education, both for residents and practicing surgeons, has always been a major focus of the ACS. What can the ACS do to improve surgical education opportunities for your Chapter members?

Data:

There were 78 responses. Overall, the responses were positive, and requested that the ACS continue to provide educational activities and improve content and format. The responses placed a lot of emphasis on resident support, and involving resident participation at local chapters. (78 replies reviewed)

1. Surgical education (most common response)
    a. Respondents want ACS to provide more educational activities, CME and MOC products.
    b. The content of educational activities needs to include relevant CME topics that address new technologies, practice guidelines, and topics that cross all surgical disciplines.
    c. There were requests for more web-based, online education products. A video library of Podcasts was suggested. The format needs to be accessible, deployed to the Chapter, short, and modular.
    d. Courses need to be more frequent and available in more locations. Courses need to emphasize hands-on learning.
    e. Mock oral boards, and board preparation for residents and post-graduates
    f. CME credits for JACS readers
2. Chapter support
    a. Respondents requested that the above CME-MOC activities be deployed at the Chapter level with the ACS providing logistical and financial support to do so.
    b. Most respondents requested ACS financial support at the Chapter level for scholarships, resident attendance for Courses at the Clinical Congress, and mentorship.
    c. There were a few requests for reduced Clinical Congress registration fees for International attendees to mitigate unfavorable currency fluctuations.
3. Partnerships in educational endeavors
    a. With specialty societies, with the Royal College of Canada, and with the AORN.
4. Innovative ideas
    a. There were requests for Chapters to be able hold an annual “mini-congress” for those unable to attend Clinical Congress, with the ACS to assist in supporting this.
    b. Make it possible to attend Annual Congress expert sessions via internet.
5. Challenges for the future
    a. Education for transition from training to independent practice.
b. Acquiring and maintaining competency in “old” open procedures.

Initial Interpretation: Good news that International Fellows look to the ACS for quality educational products and wish to support the next generation of surgeons and future Fellows. Educational format can no longer rely on annual congress in-person attendance. Strong trend towards informatics based educational activities, allowing greater accessibility and flexible financing. Such trend would obviously favor international fellows to participate and communicate with American colleagues and experts.

Question 10 (INTERNATIONAL GOVERNORS only): Quality of surgical care has always been a major focus of the ACS. What can the ACS do to help your Chapter members improve the quality of surgical care in the area where you work?

Data:

There were 78 written responses to question 11.

1. There were two categories which had by far the most responses:
   a. ***Assistance in developing a quality assessment program*** that works in International nations, and can share databases and results on a regional (rather than American or worldwide) basis – 16 respondents
   b. ***Expand NSQIP availability*** **– 11 respondents**
2. There were several other categories of responses that were less frequent, but were important responses:
   a. Assistance in ***maintaining excellent quality resident training*** programs, consider training courses for program directors and teaching faculty- 5 respondents
   b. Have ACS Officers, or ACS surgical experts/educators ***attend surgical courses being put on in International sites*** (possibly at an International Chapter meeting) - 4 respondents
   c. Assure that ***"required" quality metrics are realistic*** and worthwhile - 3 respondents
   d. Help **improve EHR to track quality outcomes** - 2 respondents
3. ***Language barrier issues***:
4. Can NSQIP be translated into Spanish?
5. Can NSQIP risk calculator entries be in kg and cm as opposed to lbs and inches?

Initial Interpretation: Multiple opportunities for College to enhance its global presence and impact.

Question 11 (INTERNATIONAL GOVERNORS only): What provides the most value to you as a member of the ACS?

Data:

There were 79 written responses with five different categories of popular answers:

1. Being part of a **large, well respected surgical organization** that serves as the "voice of surgery" - 22 respondents
2. **Education** - 16 respondents
3. **Clinical Congress** - 14 respondents (If you combine Education and Clinical Congress together, this becomes the most common answer)
4. **Fellowship/Camaraderie/Networking** - 14 respondents
5. **Advocacy** - 11 respondents (This is a surprise to me. I wouldn't think International Governors would consider this as important)
6. **JACS** - 6 responses

Question 12 (INTERNATIONAL GOVERNORS only): What are the main reasons why more of your surgical colleagues do not join your Chapter?

Data:

The 82 responses are categorized below:

1. **Costs** - 21 respondents
2. Not enough perceived **value** - 15 respondents
3. Too many **competing surgical societies** - 12 respondents
4. **Time** constraints - 10 respondents
5. **Travel costs** associated with attending Clinical Congress (travel, hotel, registration, etc.) - 7 respondents
6. A difference in the **younger generation** - 7 respondents

Initial Interpretation: Not dissimilar from US responses obtained through the past few years.

Question 13 (INTERNATIONAL GOVERNORS only): Does your Chapter participate in the ACS Domestic/International "Chapter Partner Program"?

Data:

Yes 24%

No 76%

Question 14 (INTERNATIONAL GOVERNORS only): Would you like to have your Chapter partnered with a domestic Chapter in the ACS Domestic/International "Chapter Partner Program"?

Data:

Yes 73%

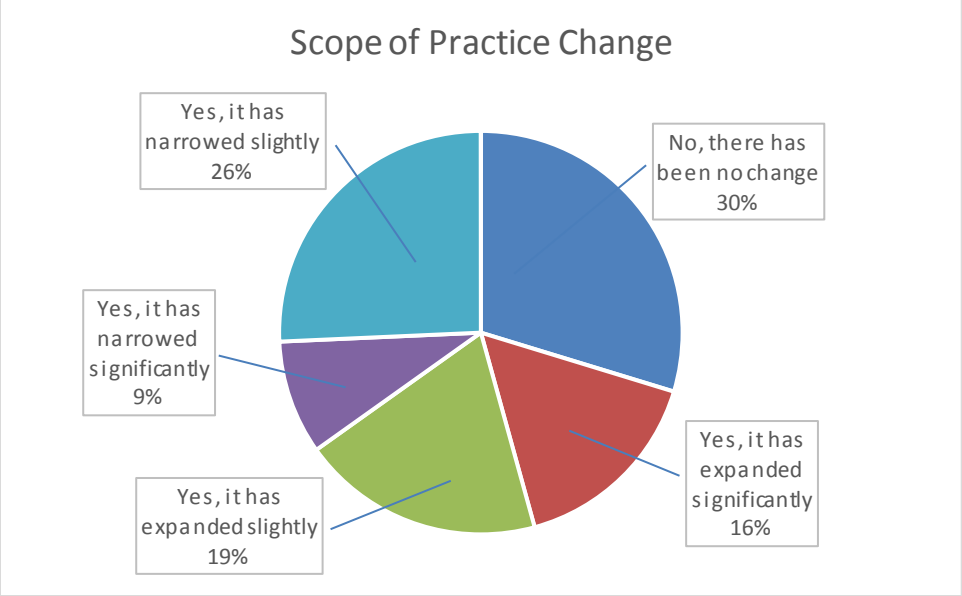
No 27%

Initial Interpretation: There's a great opportunity to get more participation in the ACS Domestic/International "Chapter Partner Program".

TOPIC I - SCOPE OF PRACTICE

Question 15: In the area where you practice, do you think that the scope of practice for your specialty has changed compared to five years ago?

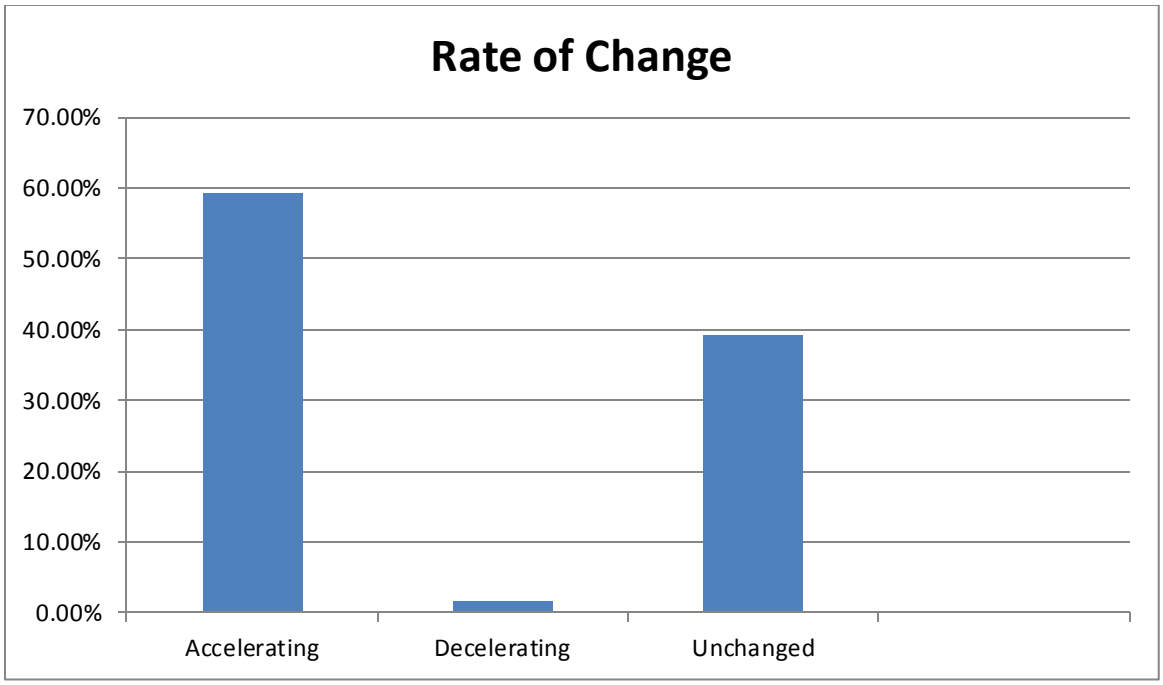
Data:



Initial Interpretation: Essentially 1/3 for each level of change suggests that the change is relatively local.

Question 16: Over the last three years, do you feel that the rate of change is accelerating, decelerating, or is unchanged?

Data:



Initial Interpretation: Interesting in light of the split of increase vs. decrease, again suggesting a more local (insurer? specialist infusion?) phenomenon.

TOPIC II - GRADUATE MEDICAL EDUCATION (GME) FUNDING

(US Governors only)

Question 17: GME funding was identified as a very important issue in the 2014 Governors Survey. Please complete the following statement:

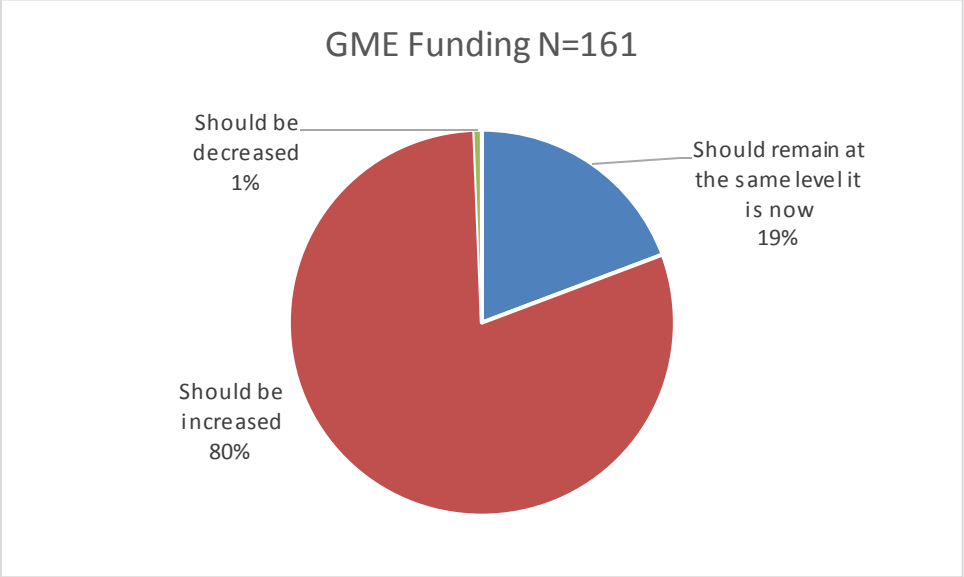
I feel that GME funding:

__ Should remain at the same level it is now

__ Should be increased

__ Should be decreased

Data:



Initial Interpretation: In light of political issues related to this it deserves much more discussion among Governors and Fellows. The older Governors seem more likely to favor current funding level.

Question 18: Which of the choices below do you think could be a viable alternative to supplement GME funding?

Data:

Medical insurance companies could help to supplement GME funding	117
Regional Sponsorship for Commit to Practice	86
State governments could help to supplement GME funding	84
Large hospital systems could help to supplement GME funding	75
Military support for commitment	68
The academic center or hospital which sponsors the residency program could supplement GME funding from their general fund	66

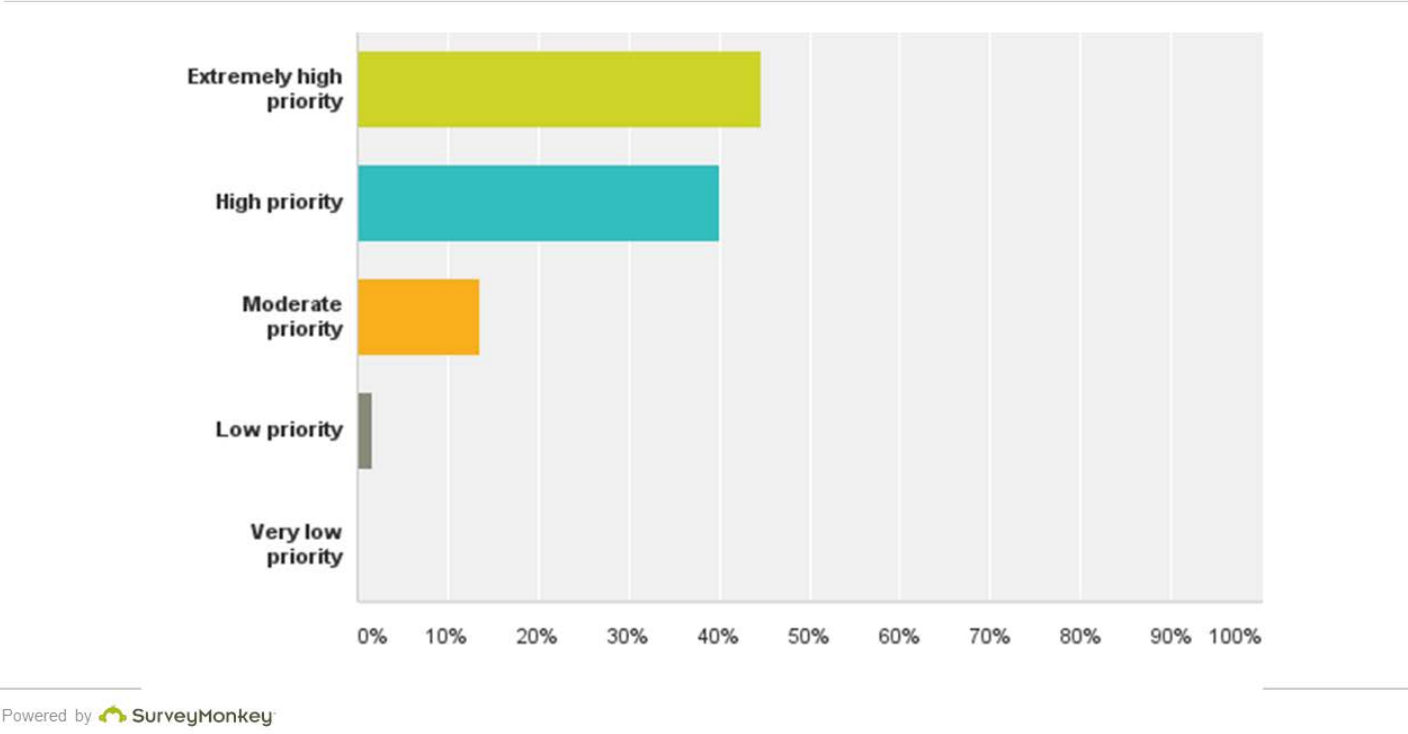
Governors also had the opportunity to write in any "other source" responses. Several themes emerged:

1. ACS to have a strong voice - to support continued funding, repeal ACA
2. Alternative payment sources –pharma, industry (mentioned by several people), legal settlements, shared model of payers of all of the stakeholders, donation ('public good')
3. Centralization of GME funds rather than to individual hospitals that provide GME training
4. Independent funding by large academic medical centers, teaching hospitals, large hospitals

Initial Interpretation: Very interesting that the least popular answer was "the academic center or hospital which sponsors the residency program could supplement GME funding from their general fund". Respondents certainly favor all of the other options more highly, especially medical insurance companies. It appears that respondents feel that the benefits from well-trained residents are very widespread, and that other areas that benefit (communities, regions, branch of military service, insurance companies, large hospital systems) should also contribute to the cost of training residents.

Question 19: In a list of ACS legislative agenda items, how high of a priority do you feel graduate medical education is?

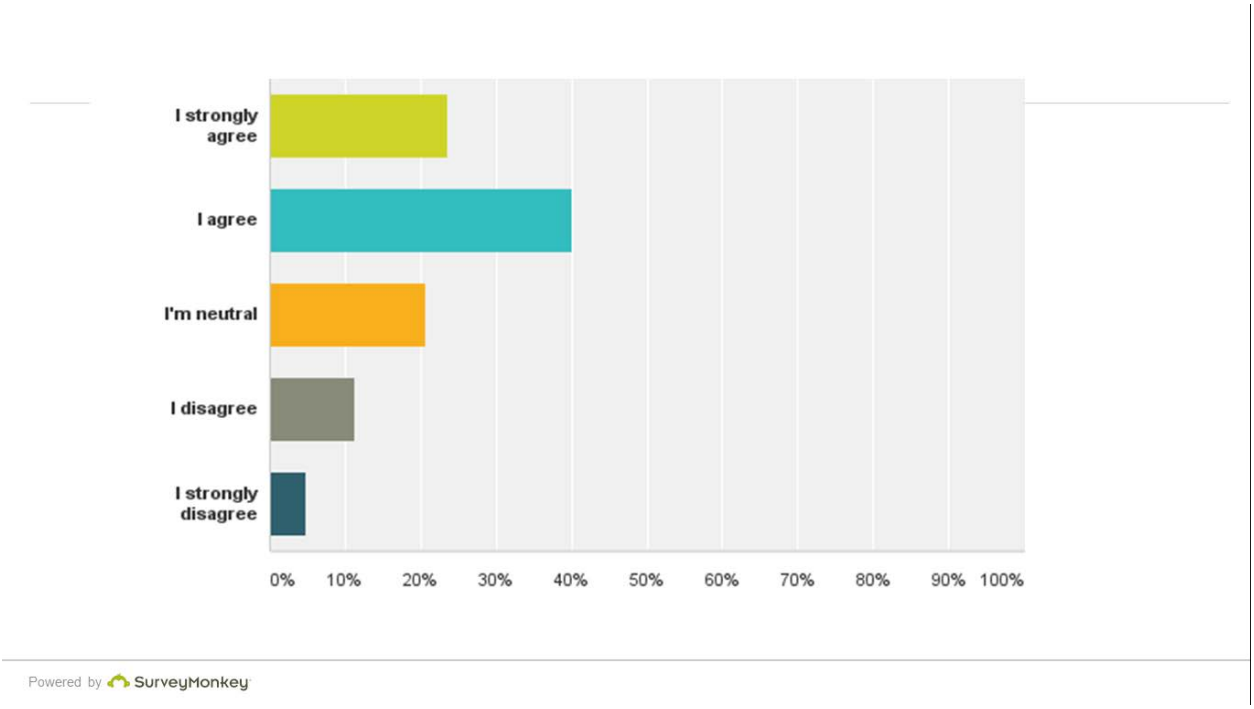
Data:



Initial Interpretation: It's very clear that ACS Governors feel this is an important issue for the ACS Washington Office to be addressing. This is one of the most unanimous answers in the survey.

Question 20: Do you feel that the ACS should function in an advisory role to determine which areas or regions need surgeons more than others, so that if GME funding is decreased nationwide, decisions could be made to preserve residency positions in areas of greater need?

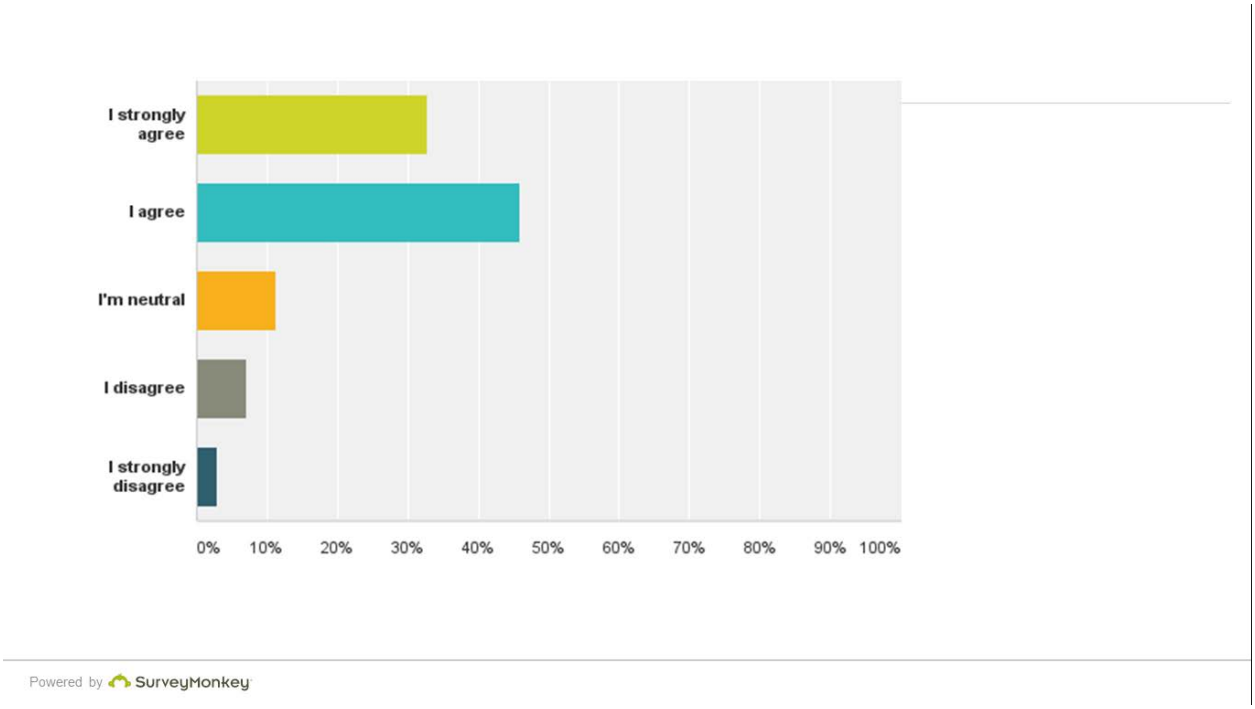
Data:



Initial Interpretation: It's clear that Governors feel that the ACS needs to be involved in the GME funding issue. From the standpoint of the ACS serving in an advisory role regarding preserving residency positions in areas of greater need, only 15.89% of Governors disagreed with this.

Question 21: Do you feel that the ACS should function in an advisory role to determine which type of surgeons are most needed, so that if GME funding is decreased nationwide, decisions could be made to preserve residency positions in surgical specialties of greater need?

Data:

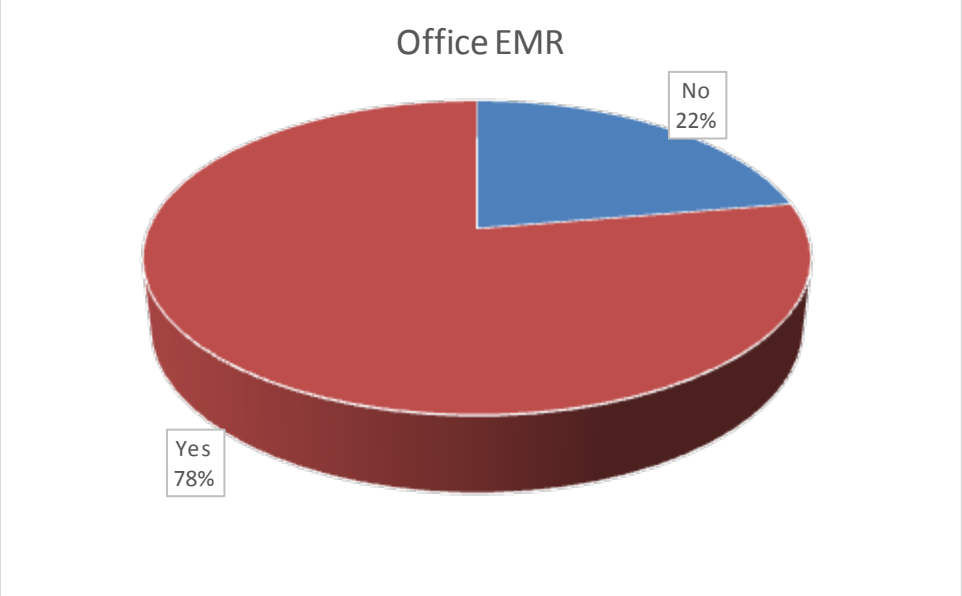


Initial Interpretation: There's even a stronger response here.

TOPIC III - CONCERNS WITH THE ELECTRONIC MEDICAL RECORD (EMR)

Question 22: Do you have an EMR in your office?

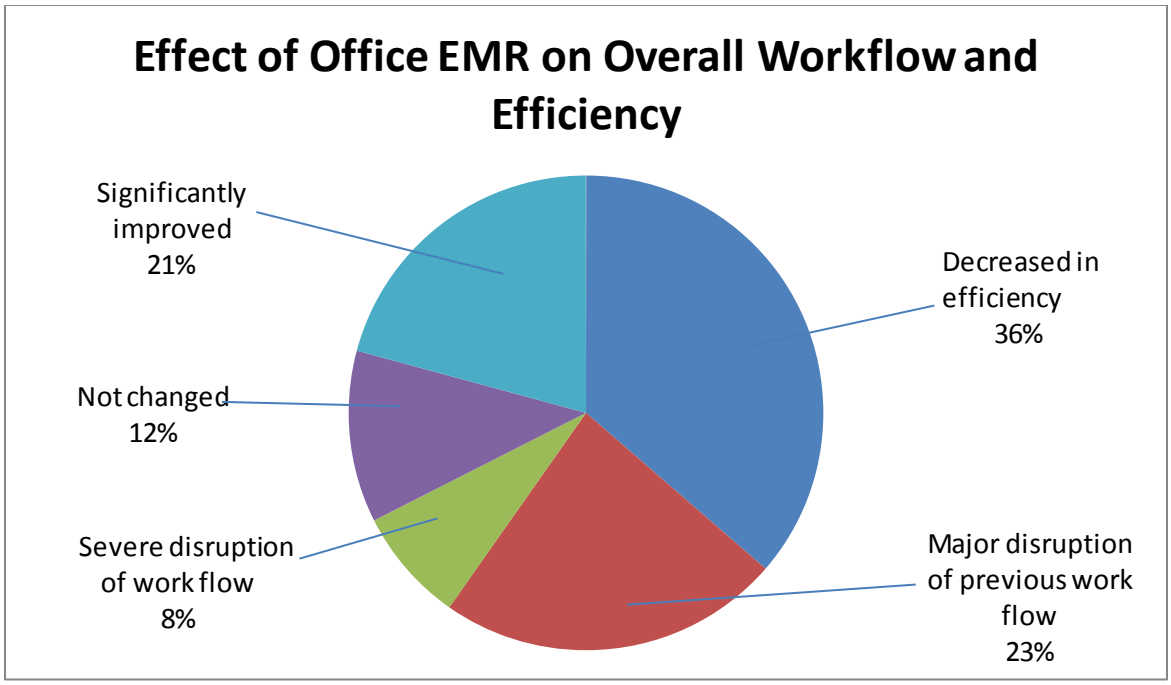
Data:



Initial Interpretation: Somewhat surprising that as many as 22% don't have an office EMR. That's quite a few that are paying the penalty. Some of these may be waiting for a better product.

Question 23: As a result of implementing an office EMR, my overall workflow and clinical efficiency has:

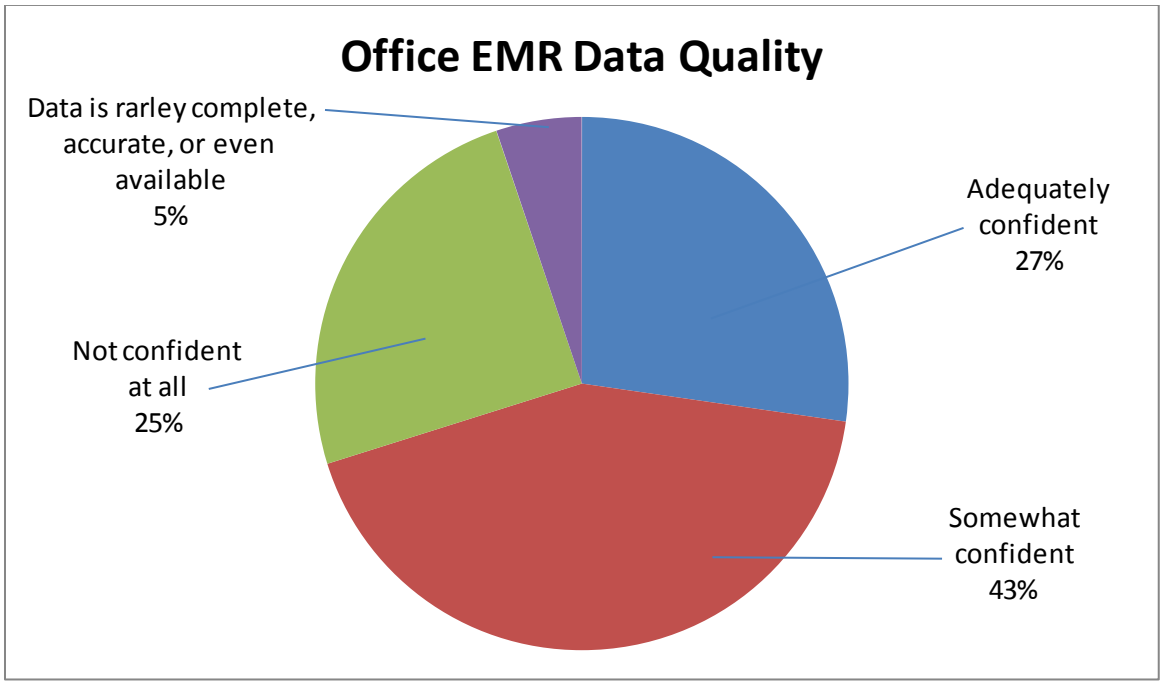
Data:



Initial Interpretation: Most Governors (36+23+8=67%) feel that their workflow and efficiency have decreased, however, 21% feel their workflow and efficiency have improved.

Question 24: How confident are you that the available information in your office EMR is current, complete, and accurate?

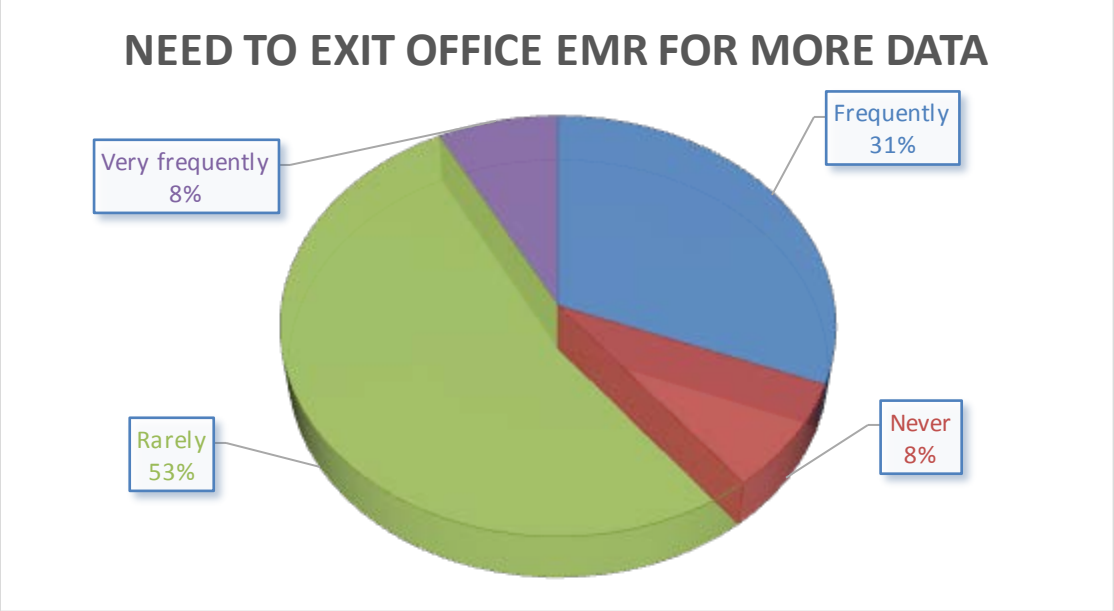
Data:



Initial Interpretation: Most Governors (27+43=70%) are confident of the office EMR data quality, however, 30% (25+5) are really struggling with the quality of the data.

Question 25: How often are you required to exit the office EMR and search through multiple data sources to obtain all of the information you need at that time?

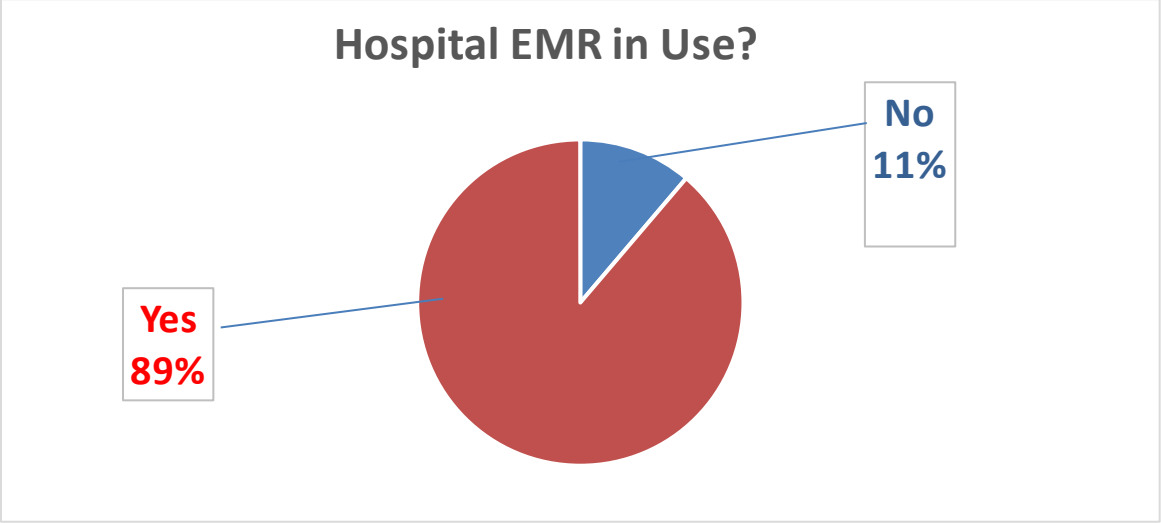
Data:



Initial Interpretation: Most governors (53+8=61%) don't have to exit the Office EMR often, but 8+31=39% do.

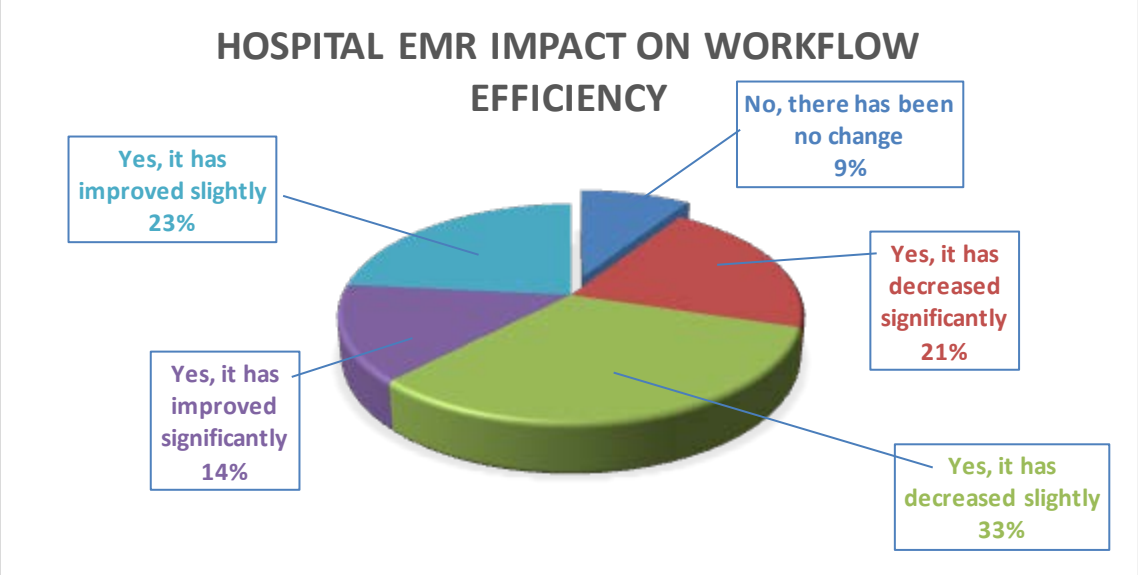
Question 26: Do you have an EMR in the hospital (or hospitals) where you work?

Data:



Question 27: Once you adapted to the use of the hospital EMR, have you noticed a change in your overall workflow and clinical efficiency?

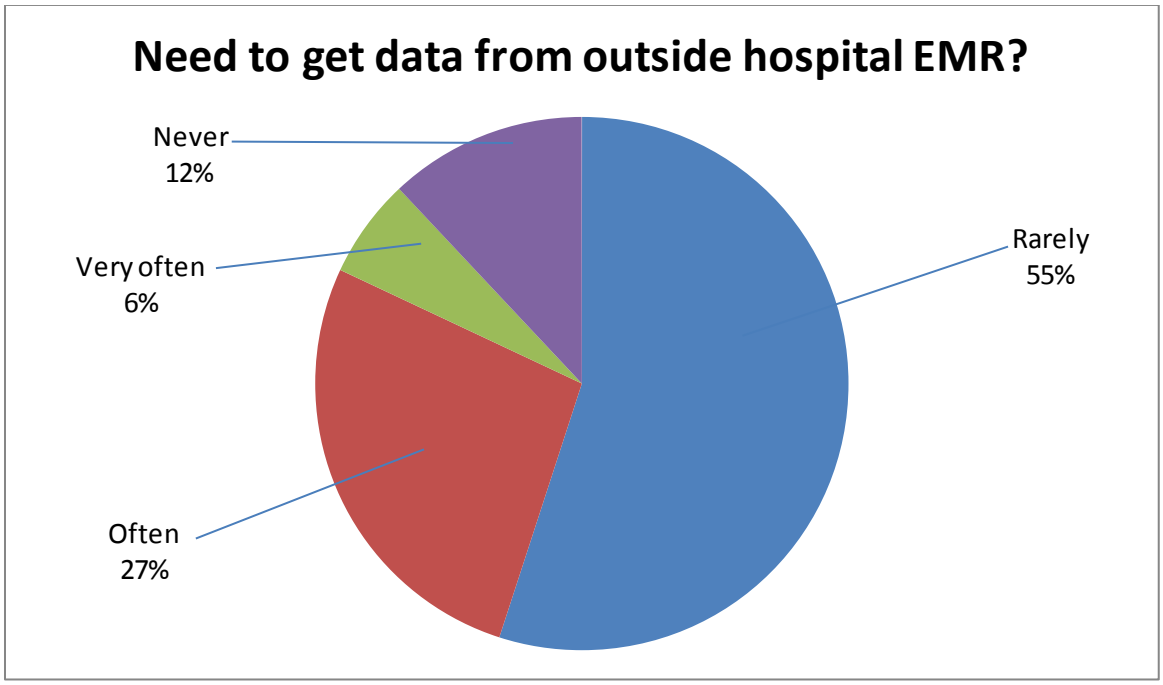
Data:



Initial Interpretation: A slight majority of governors (21+33=54%) feel that their workflow and efficiency have decreased. The efficiency and workflow has improved for 23+14=37%. When the results from this question are compared to the results from the similar questions directed toward the office EMR, it appears that governors are having a less difficult time with the hospital EMR when compared to the hospital EMR.

Question 28: How often are you required to exit the **hospital EMR** and search through multiple data sources to obtain all of the information you need at that time?

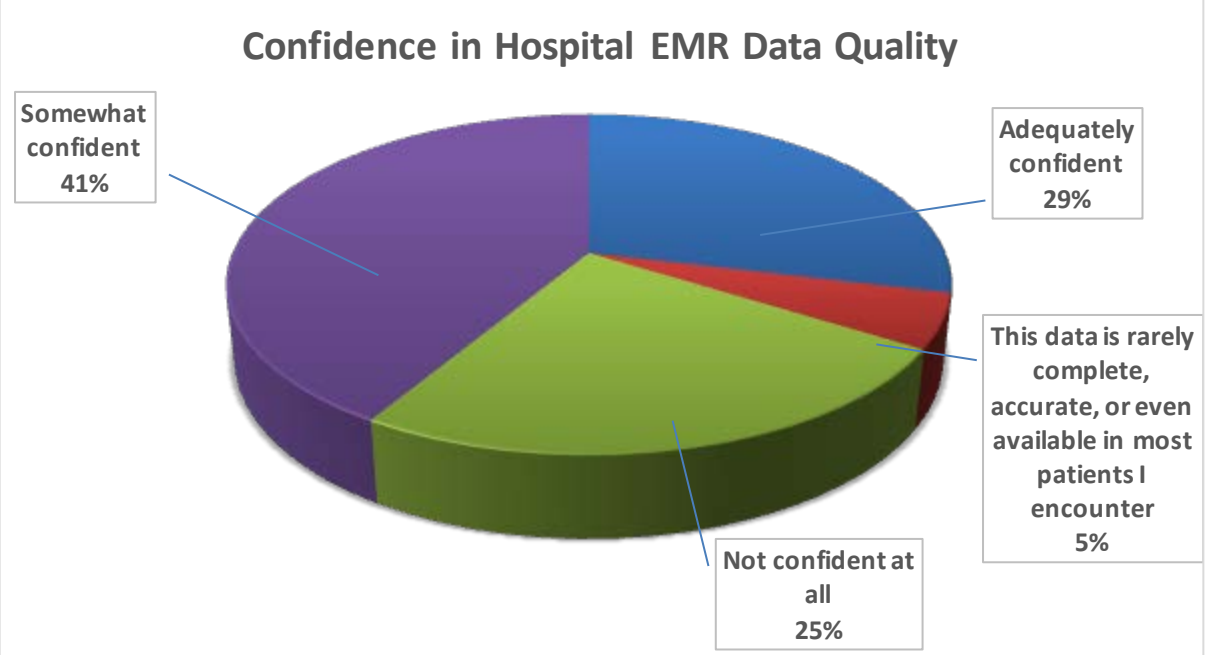
Data:



Initial Interpretation: The responses to this question are quite similar to the responses to the same question regarding office EMR.

Question 29: How confident are you that the available information in the hospital EMR is current, complete, and accurate?

Data:



Initial Interpretation: This is almost the exact same response as the similar question regarding office EMR.

TOPIC IV - CREDENTIALING FOR SURGICAL/ PROCEDURAL PRIVILEGES

Question 30: Are you experiencing more difficulty in being credentialed or re-credentialed for surgical/procedural privileges at your hospital or ambulatory surgery center?

Data:

Yes	17%
No	83%

Question 31: Are you being required to document a specific number of cases performed for specific procedures in order to be credentialed or re-credentialed for your surgical/procedural privileges?

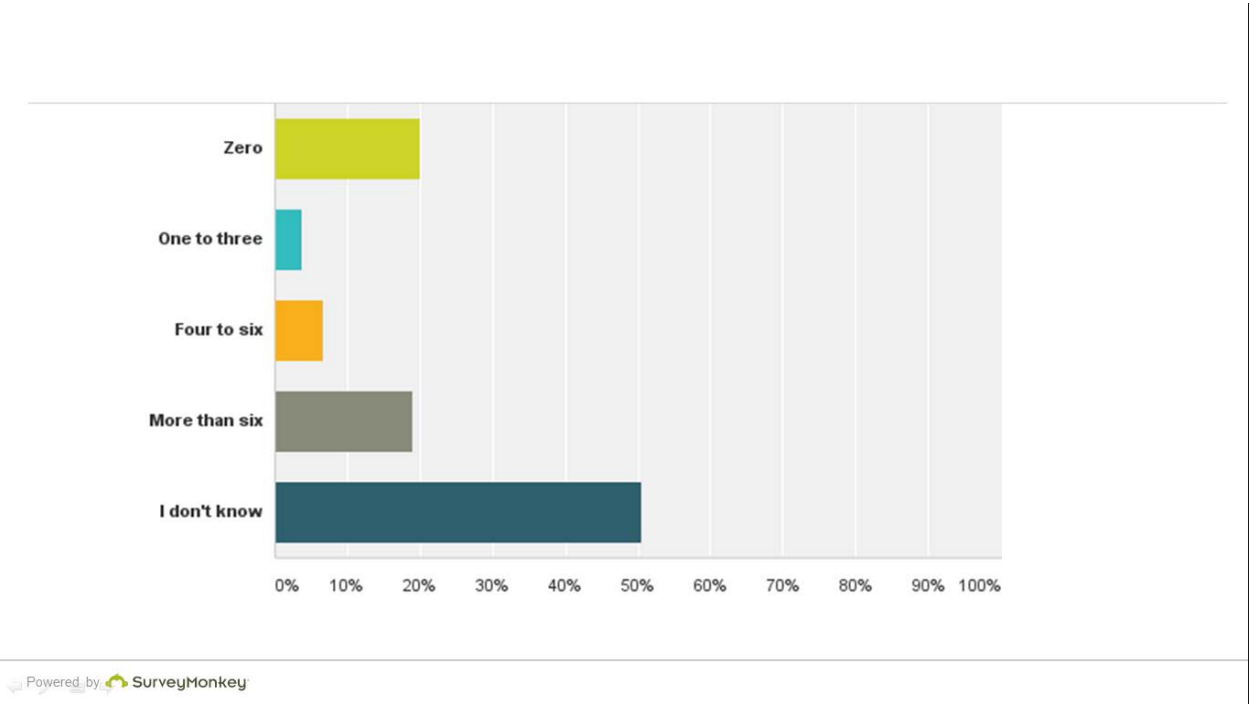
Data:

Yes	35%
No	65%

Initial Interpretation: Despite the fact that credentialing/re-credentialing was not a big issue for most Governors based on the response above, 35% are being required to document the number of cases or procedures.

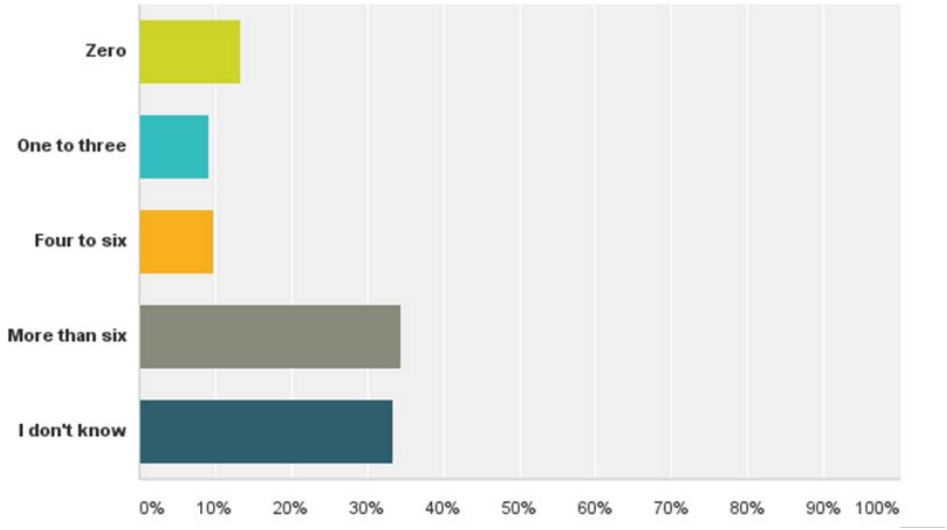
Question 32: For advanced surgical procedures (such as laparoscopic colorectal surgery, or pancreatic surgery), what is the ***current*** *threshold number* of cases, as determined by your hospital or medical staff, that is required to maintain privileges during a 2-year re-credentialing cycle?

Data:



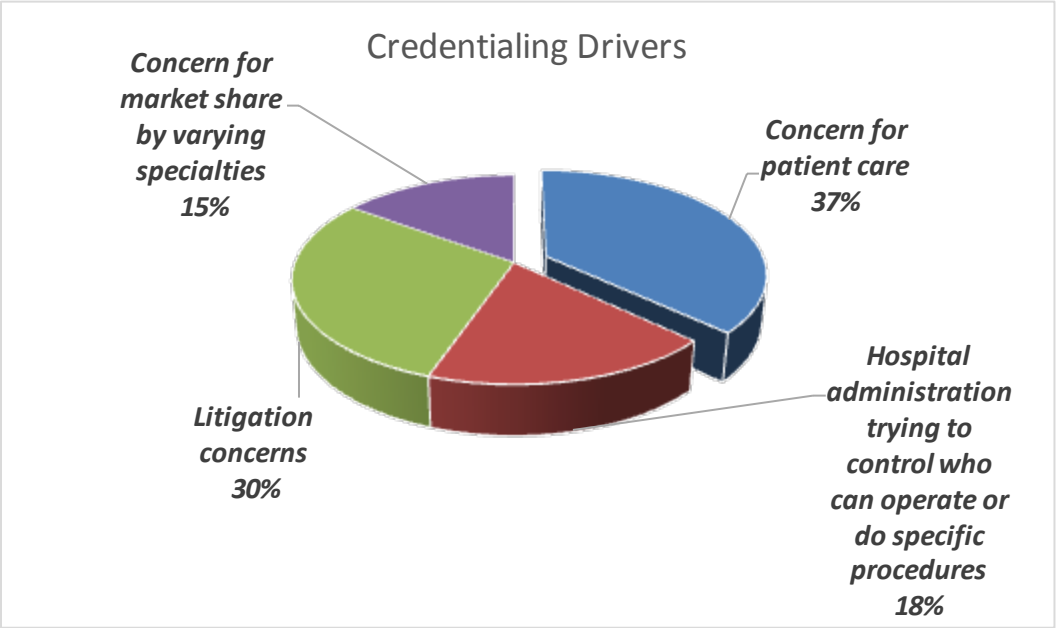
Question 33: For advanced surgical procedures (such as laparoscopic colorectal surgery, or pancreatic surgery), what should a hospital or medical staff *set as the threshold number of cases* required to maintain privileges during a 2-year re-credentialing cycle?

Data:



Question 34: What do you feel are the main driving forces behind the process of credentialing/re-credentialing for surgical/procedural privileges at your hospital?

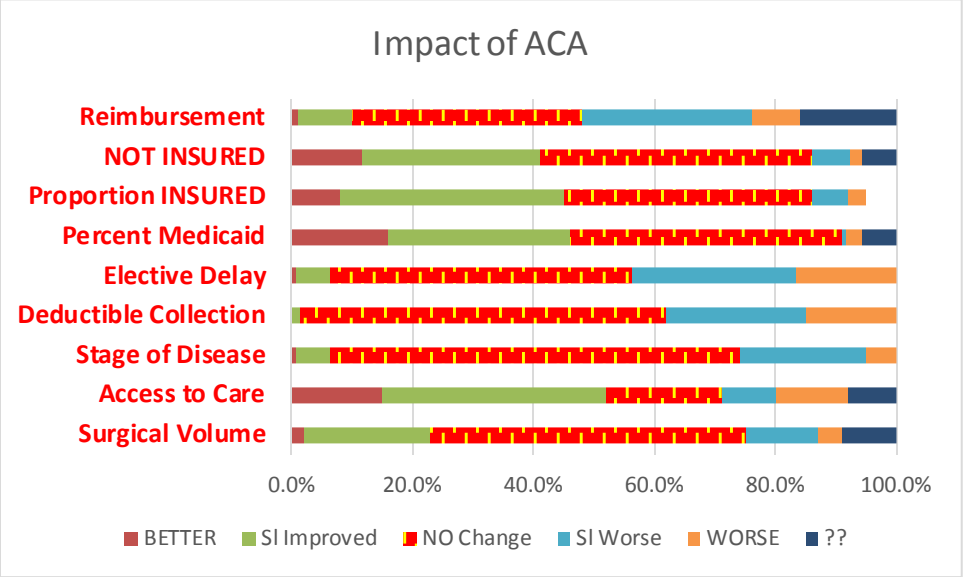
Data:



Initial Interpretation: Patient care is apparently assumed for the two thirds of institutions that reflect primary focus on *corporate wellbeing*!

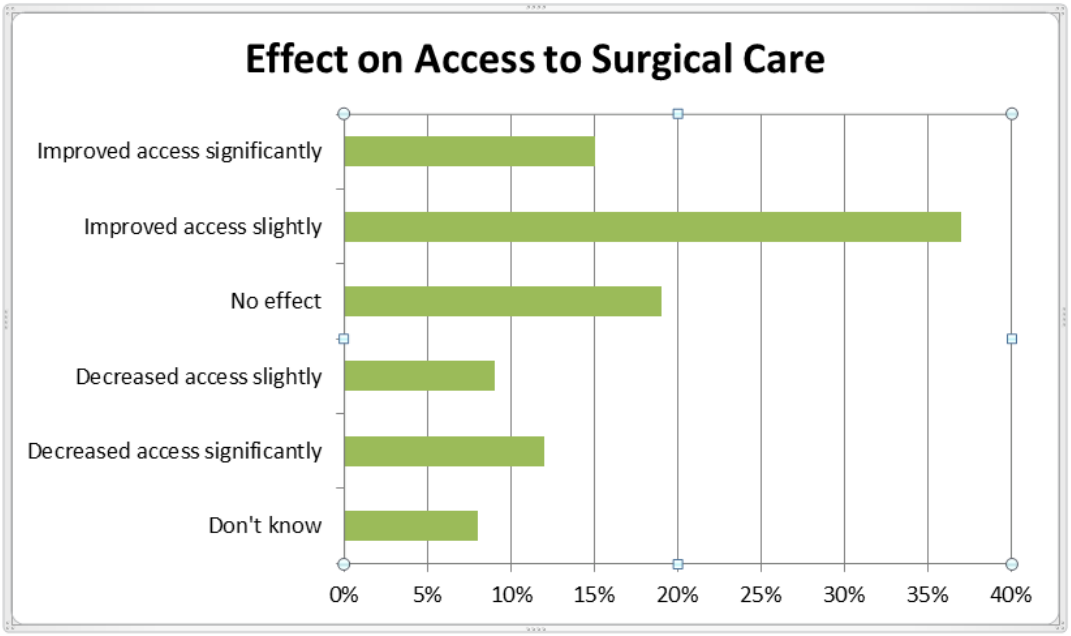
TOPIC V - THE EFFECTS OF THE AFFORDABLE CARE ACT

Summary graph: This summary graph is formatted with "no change" depicted as a speckled slider. To the left is improvement, to the right deterioration. It demonstrates decreased reimbursement, more coverage, but with limited benefits, and delay in surgical care.



Question 35: Do you feel the ACA has had an effect on the overall access to surgical care for patients nationwide?

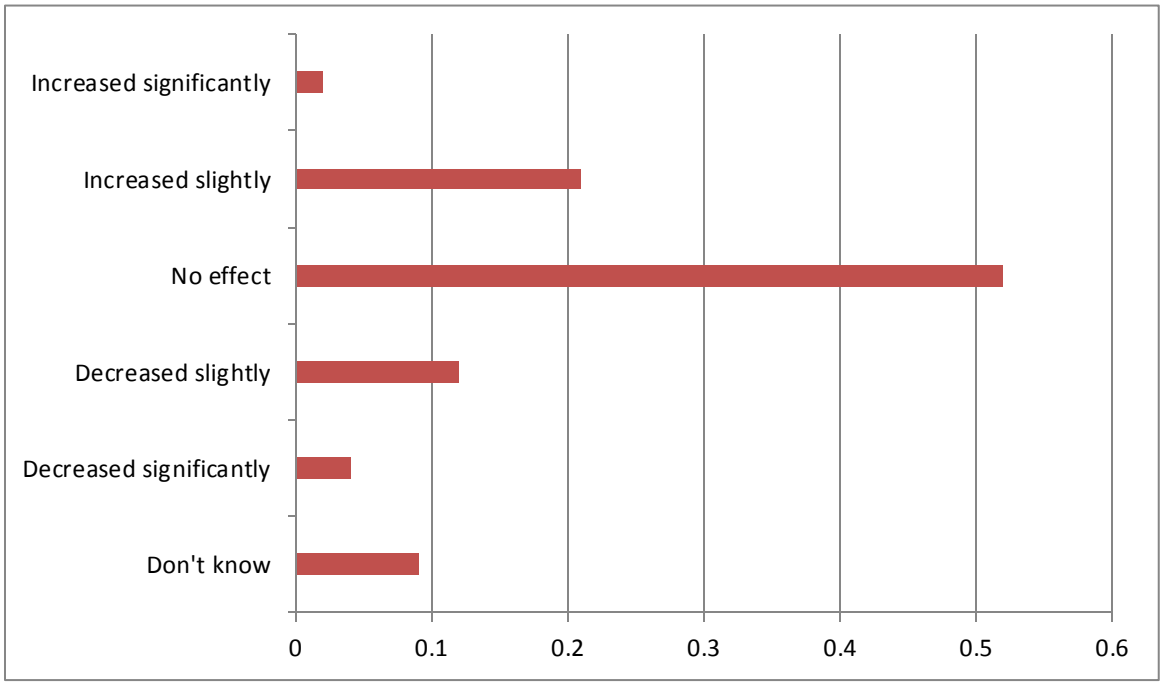
Data:



Initial Interpretation: A fairly high number (15+37=52%) of Governors responded that access to surgical care nationwide has improved, compared to 9+12=21% that said it decreased.

Question 36: Has the ACA had an effect on the surgical volume in your practice?

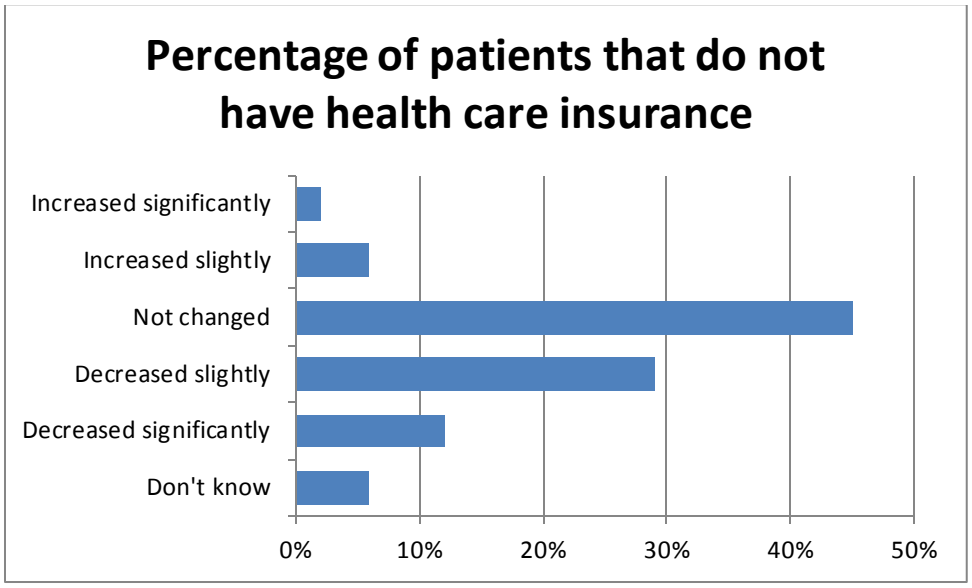
Data:



Initial Interpretation: For most governors, there has been no impact on their surgical volume. 23% (21+2) noted an increase, 16% (4+12) noted a decrease.

Question 37: Since the implementation of the ACA, the percentage of patients that I treat that do not have health care insurance has

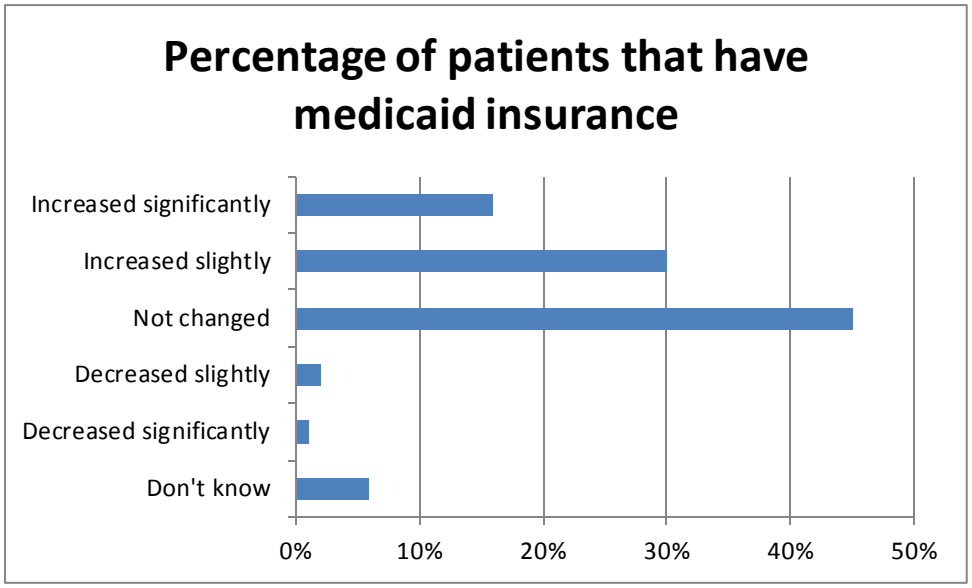
Data:



Initial Interpretation: More patients have health insurance.

Question 38: Since the implementation of the ACA, the percentage of patients that I treat that have Medicaid insurance has_____

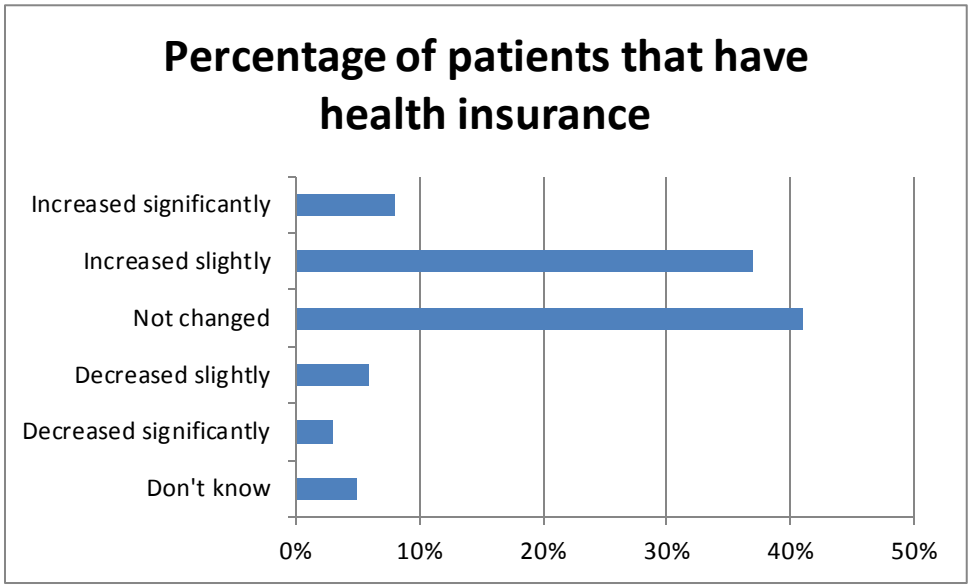
Data:



Initial Interpretation: Definite increase in patients with Medicaid.

Question 39: Since the implementation of the ACA, the percentage of patients that I treat that have health care insurance has

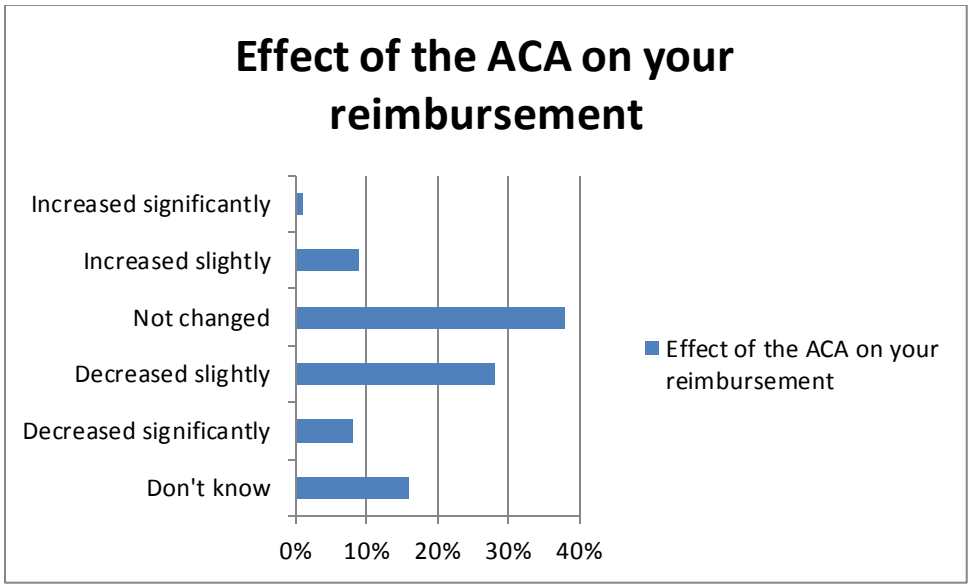
Data:



Initial Interpretation: Overall, an increase.

Question 40: Since the implementation of the ACA, has your reimbursement been effected?

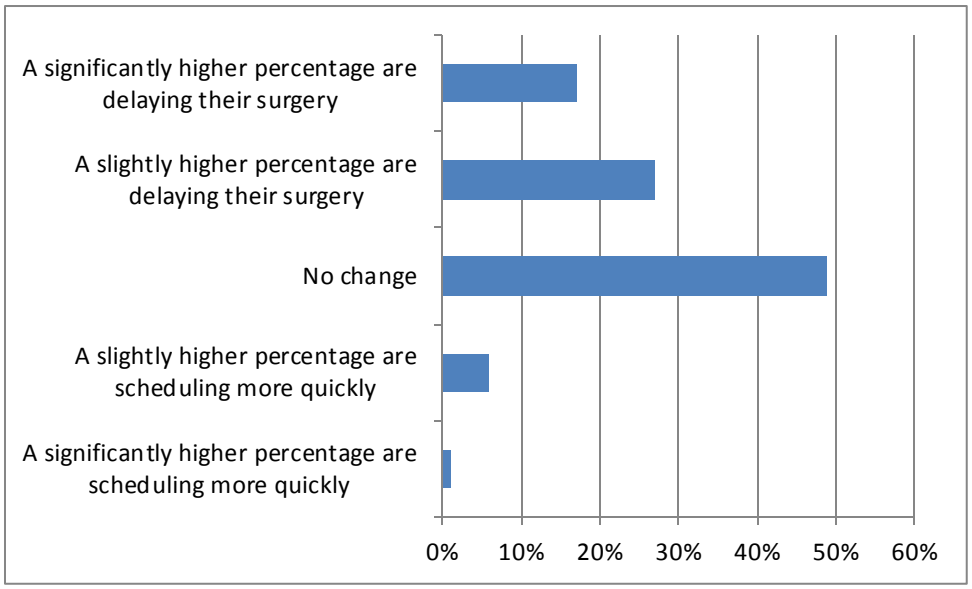
Data:



Initial Interpretation: Most responded "no change", but 36% (28+8) responded that their reimbursement decreased. This may have been a poor question. We didn't specify whether reimbursement referred to overall reimbursement to the practice, or reimbursement for each type of case. I suspect most of these answers were based on the reimbursement for each type of case.

Question 41: With changes in patient deductibles as a result of the ACA, do you think that there has been any change in your patient's decisions regarding elective surgical procedures?

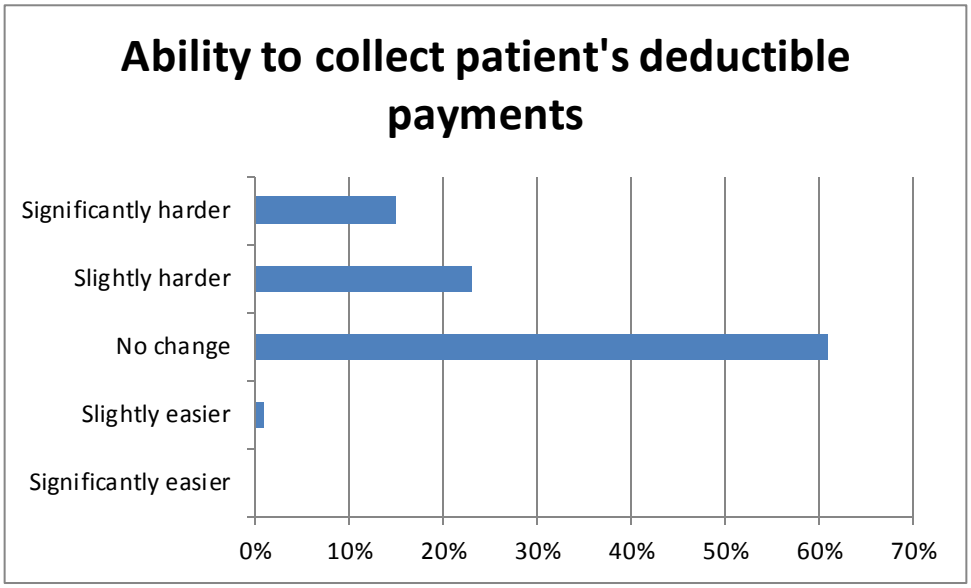
Data:



Initial Interpretation: A considerably higher number of patients are delaying their elective procedures.

Question 42: With changes in patient deductibles as a result of the ACA, have you noted any change in the ability of your practice to collect patient's deductibles?

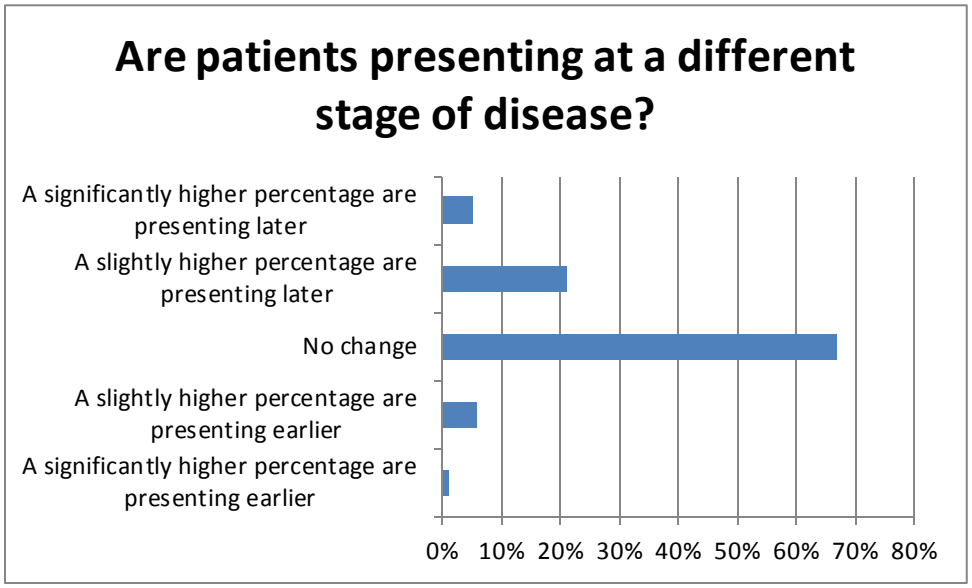
Data:



Initial Interpretation: It can be harder to collect deductibles.

Question 43: Since implementation of the ACA, do you feel that your patients are presenting at a different stage of disease?

Data:



No, there hasn't been any significant change	105
Yes, a significantly higher percentage of patients are presenting at a more advanced stage	8
Yes, a significantly higher percentage of patients are presenting at an earlier stage	1
Yes, a slightly higher percentage of patients are presenting at a more advanced stage	32
Yes, a slightly higher percentage of patients are presenting at an earlier stage	9

Initial Interpretation: There's somewhat of a trend for patients presenting at a more advanced stage.

FREE TEXT COMMENTS FROM GOVERNORS

"As a Governor, please list any pressing issues the ACS is not currently addressing, or current issues the ACS should be spending more resources on:"

The table below is an analysis of basic subjects covered in this list of comments. The table below that details the actual comments in a more generalized category.

Rank	Topic
1	MOC/PQRS 17 responses
2	GME 15 responses
3	None/Good job 14 responses
4	Miscellaneous 13 responses
5	CME 10 responses
6	Aging MD/competency 8 responses
7	Reimbursement 7 responses
8	College/Chapter 7 responses most negative comments
9	International chapters 5 responses
10	EMR 5 responses
11	Research 4 responses
12	Pt care 4 responses
13	Trauma 3 responses
14	Tort reform 3 responses
15	Young Surgeons 3 responses
16	General Surgery 2 responses
17	ACA 2 responses
18	Advocacy 2 responses
19	Burn out 2 responses

Specific Comments from Governors

Code	Comment
	Praise!
	Great survey, I remain proud and honored to serve the ACS.
	I think this survey was better designed than previous ones.
	I think the College is more aware of the current needs than ever in my career. The most serious problems are known by leadership
	I think the ACS is addressing the most pressing issues
	I think the ACS is doing a very good job in a difficult and challenging environment.
	Practice/Personal Support
	Tort reform should be a higher priority.
	The ACS should aid finishing surgery residents to pay back their huge loans which they incur to finish their schooling and training. · Especially when both spouses are doctors, the loan burden can be very large, in the hundreds of thousands of dollars, and preclude the young doctor(s) from purchasing a home, etc. It is like having a second mortgage. · The College has a very large amount of assets of which a tiny amount goes toward scholarships every year, compared with the overall amount. · The College should lead the surgical community to collect and utilize funds to aid worthy young surgeons to pay down their loans. This can be scholarship or other assistance. · So far, the College, nationally, has done nothing in this regard, while young surgeons, · When asked to be part of the ACS, respond with a question of "What can the College do for me, especially financially", which is the major issue on their minds when in this predicament. To not do something of substance in this area is to miss an important opportunity to demonstrate leadership to young surgeons.
	Support the general surgeon
	Respect surgeons who practice in non-academic centers
	Peer review processes
1.	I am concerned about how smaller community hospitals will find and keep general surgeons in the future. · It is becoming rarer to see graduating general surgeons be willing to work solo in a community environment, partly because they do not have back up if and when they need to be OOT for CME or vacation. · I'm afraid that almost all surgical care will eventually only be available at larger centers, meaning patients will have to travel 50-100 miles or more to get surgical care. · Also, general surgery re-imbursement needs to be looked at for what we call bread and butter surgery. With our residents graduating with so much debt, they are of course looking at working in surgical specialties that pay better for their specific procedures, so they can pay their bills.

	· There needs to be incentive for young surgeons to want to be general surgeons, and that needs to be at least partly financial incentive.
2.	Value based payments
3.	The controversy with MOC. The most frequent complaint I receive.
4.	Tort reform should be abandoned in favor of a patient compensation fund.
5.	Practice modification and/or Career Modification strategies for the Surgeon advancing in age and contemplating a transition process to retirement.
6.	ER Coverage - whether it should be required and whether it should be reimbursed
7.	Professional Ethical Standards as they relate to surgeons as employees of hospitals or third party payer contracts.
8.	Rural surgery - how to balance the needs of rural hospitals to provide surgery to remain financially viable, · And of patient's desire to remain close to home when possible, · With the expectations of work-life balance for the current (and future) generations of surgeons. · Also related, the # of surgical trainees pursing specialization vs "general surgery" - with the surplus of specialists who need/desire urban/subarban practice locations vs shortage of community/rural general surgeons
9.	Surgeon Ergonomics, Robotic Surgery
10.	Fully implementing the intent of the ACA -- that all persons living in the U.S. have access to quality health care in a timely fashion.
11.	The recertification process needs to be reevaluated in light of the implementation of MOC and P4P measures
12.	PQRS is a total waste of time. It is being addressed by the College but only to help surgeons complete it. The College needs to take a stand and just say NO to PQRS!
13.	Patient care
14.	The process for accessing cognitive impairment issues has been stifled because of politics. This is important, and the ACS needs to take a defensible stand, or indeed the gov't will
15.	Creating a means for public reporting of outcomes. · with increasing demands on surgeons (EMR, MOC etc) physician burnout rates will increase. · We may see many practicing physicians retire, thus burdening those that remain
16.	Peer review, parity in surgical manpower resources
17.	Re-entry programs after time off

18.	1MOC, Tort Reform
19.	1Setting standards of care, Governors should have decision making privileges
20.	Continue to try and provide meaningful changes to MOC
21.	The aging surgeon and maintaining competence...
22.	Patient Ownership… who owns the patient?
23.	Cost efficiency, standardization of practice, awareness and adoption of best practices
24.	Physician reimbursement
25.	Identifying those "experts" outside of surgery that try to grade, hinder, regulate or disenfranchise surgeons from their hard fought professional responsibilities
26.	The surgeon as a community leader for health
27.	Unbundling CPT codes
28.	Continued focus on the ACA and how this is impacting surgical practice and GME issues
29.	Turf battles in vascular surgery (IR and cardiology issues)
30.	Burnout training as discussed at the leadership summit in 4/15
31.	Getting NSQIP more widely adopted and recognized as the only quality metric for surgeon outcomes.
32.	The increasingly burdensome MOC Board Renewal. It is terribly onerous and just getting worse. I've contemplated allowing it to expire due to the ridiculous requirements (mostly time and money)
33.	Population health and transitioning of surgeons to new models of reimbursement
34.	Shared patient education resources.
35.	Negative impact of unreasonable burden of regulatory and reporting requirements on the profession of surgery.
36.	Impact of marketplace consolidation
37.	MOC MACRA Implementation
38.	When should a surgeon retire for skill reasons
39.	Dissemination of the practice guidelines the college has completed 2. Feasibility of lowering the cost of the annual dues and registration for the congress 3.Subsidy for authors of research papers that got accepted in the congress
40.	Transition to ICD-10 education
41.	Better enfranchisement of the young surgeon.
42.	Continue with efforts to make PQRS and meaningful use relevant to surgeons.
43.	Maintenance of competency during the entire career spectrum and acquisition of new surgical skills
44.	Competency and the aging surgeon
Education/Research	
45.	Bolster research funding for research consortia in acute care surgery and enhanced recovery surgical protocols.

46.	GME funding is essential
47.	2Key issue is resident education, surgical research, trauma research
48.	Assessing the quality of recent graduates and feeding that information back to their program directors.
49.	We should continue to push more for adequate funding of NIH extramural research both basic and clinical.
50.	Manpower to replace retiring surgeons and training for "rural" surgeons
51.	Reviving surgical resident autonomy
52.	GME training with particular emphasis on the concept of being a part of the professional society of general surgery. Training is intense with the reality of work hour restrictions which at times seems to silo the trainees time spent on the learning of the profession and minimal time being part of or thinking about the surgical profession.
53.	Distribution knowledge to the low economic country with lower payment.
54.	I am very concerned about having enough surgeons in the future. · There are many forces collaborating to decrease the total amount of surgery talent available to communities: increased number of people entering surgery who wish to have a more controllable lifestyle and therefore become employees or go into specialties with more regular hours and little call, lower age at retirement from active practice (I am an example!), increased specialization, etc. · We need to focus on ways to allow people to work at reduced hours if they need to and still maintain their skills, have ways that those who are out of practice for more than a few months ramp up quickly to return to practice, have ways actively practicing surgeons can learn new techniques without major disruptions in their practices, etc. · We have to think in a very different paradigm than the one I was brought up in, e.g., that one would go into practice and work continuously for 65-70 or more hours per week until one croaked at the OR table!
55.	Priority should be given to graduate education funding and increasing workforce numbers. · Expanding mentorship fellowship programs beyond residency to support newly trained surgeons integrate into private practice
56.	GME and residency education (more resources)
57.	Skill testing medical students applying for surgical training.
58.	Ensuring quality education of enough physicians and surgeons for future needs. More hands on courses to maintain technical skills for practicing surgeons and also skill labs for new procedures.
59.	Continuing medical education

60.	Increase surgical simulation programs. · Recognition of the ACS CME credits in all ACS Regions (14, 15, 16 and 17). · Economical and scientific support to the National / Regional Chapter Meetings. · I have often presented the NJ scholarship program to fund three surgeons per year for two years, in order to attract surgeons to "needy hospitals," in NJ. I think the ACS should do a similar program on a nationwide scale. · The debt of graduating residents is overwhelming for many. The ACS could really advance their cause and guarantee lifetime loyalty of young surgeons with this initiative. Please contact me for more information on how we did it in NJ..
61.	Making sure surgical students and residents educational curricula are complete and cover all educational needs to become a safe and competent surgeon
Quality Outcomes	
	My major interest is driving surgeons -- both general and specialty surgeons -- to focus on measuring outcomes after their interventions to determine whether surgeries improve quality of life, ability to return to work or school, satisfaction with appearance etc.
Advocacy	
62.	Statement on physician assisted suicide
63.	Regionalization of trauma centers and the recent proliferation of centers in financially advantaged locals. · This is impacting long standing inner city trauma centers that have relied on patients from these areas for financial survival.
64.	Gun Violence
65.	Delivery system reform
66.	Increasing diversity in the surgical work force.
67.	State wide/regional advocacy effort support
68.	Advocacy for bariatric surgery coverage- we are a canary in the coal mine- other fields to follow quality of care
69.	I encourage continued emphasis on surgeons becoming involved in advocacy at the chapter (grassroots) level.
70.	Nationwide trauma funding
EMR	
71.	I am thrilled that the ACS is beginning to address EMR problems. · This is currently a golden opportunity that is being missed. · We need interactibility of EMR with all other electronic data systems where our patient's data reside. · We need to be able to document our office visits without spending (my current) 3 hours each evening at the computer completing office visits.
72.	EMR complications and dangers

73.	Whereas I thought the ACS effort to improve/tweak EHR was the right thing, I am now coming to the conclusion that the premature computerization (THE most onerous result of the ACA) is literally destroying medicine as we knew it. · Forgetting my personal frustrations with it, the impact it has had on GME (residents spend ridiculous amounts of time on the computer and even perceive it as the "virtual patient") and NURSING care (the nurses spend more than half their shifts on those dopey rolling computers). · Perhaps the ACS should push back more forcefully that EHR and computerization should be rolled back. But I know, unfortunately, this is not likely to happen.
74.	EMR, while not an issue for me, is a HUGE issue for practicing surgeons. · MOC, similarly not an issue for me, is HUGE with them. FACS can get all the MOC credits they need with JACS - why don't you advertise this more??? · Finally, Governors should be mid-career, not elder statesmen. A deliberate effort should be made to recruit more junior people.
75.	I strongly believe that the Office EMR issue is the number one issue facing surgeons today. · I'm hopeful that the College would put significant resources into making the Office EMR a more functional and productive tool for practicing surgeons.
Chapter Activity	
76.	Support small chapters
77.	Strongly encouraging FACS members to join their local chapters. · Make it mandatory to join local chapters to continue being a FACS.
78.	The chapters are weak and do not represent the members interest. · There is no relationship with the COT and it functions as a distinct operation from the chapter and the Governor. Maybe this is not what you are asking about but it is my main concern.
International Support	
79.	Promotion of international activity
80.	International programs outside States
81.	More international presence at chapter activities. More quality training courses to international chapters
82.	Try to include more foreign expert surgeons in different surgical specialties and sub-specialties recommended by the different international chapters. · Please concern the price of the educational materials. · You can specify law priced edition for international chapters.
83.	To better scholarship to the Latin-American surgeons
College Relationships	

84.	The most pressing issue facing the College is lack of connection with the Fellowship at the grass roots level. · The chapter system is failing in many areas. · The only way to correct this is twofold: o require national officers and committee members to be active in their local chapters as a condition of their appointments; and o have the College collect chapter dues jointly with national dues.
85.	If the ACS wishes to increase membership, I would recommend they reduce the number of sponsors required to 2 or 3 - this would greatly increase international membership where the chapters have few members.
86.	The college is out of touch with its members. Reimbursements have fallen and patients insurance plans are very restrictive. The college has failed to address this.
87.	I don't see that the BOG shows any tangible results. We need measurable that we communicate to the rest of the ACS. I feel that we need to show these key issues and that we are trying to address them Need more private practice reps and less academicians that may not understand the minute to minute issues.
88.	Increasing diversity within the ACS membership

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