



WINTER 2016 EDITION

THE CUTTING EDGE:

NEWS AND NOTES FROM
THE BOARD OF GOVERNORS

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNEY

10

SAVE THE DATE

11

CONTACT US



AMERICAN COLLEGE OF SURGEONS

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FASCINATING FACTS FROM THE COLLEGE

Did you know that...?

- In 1913, the original Board of Governors consisted of surgeons who were invited to serve as the founders of the American College of Surgeons and were elected from among its own membership the first Regents.
- In the early years, the Governors were utilized individually to assist the Executive Director with local problems and as a body, to elect the Officers and the Regents.
- In 1950, when Dr. William L. Estes, Jr., was elected Chair of the Board of Governors, he urged the Regents to utilize the Governors in matters where a consensus of the Fellows might influence decisions. The Regents agreed, and from that time on, the Governors have been a vital and contributory force in administration.
- The American College of Surgeons is a democracy, with power and responsibility passing from the Fellows to the Governors to the Regents.

Duties of a Governor include the following:

Attend

- Attend the spring Leadership Summit (spring meeting attendance is not required for international Governors)
- Participate in Board of Governors meetings, Convocation, and Annual Meeting of Members at the Clinical Congress
- Attend Chapter or Specialty Society meetings

Communicate

- Provide bi-directional communication between the Board of Governors and your constituents
- Provide report to Chapter or Specialty Society and B/G Executive and Communications Committees
- Welcome new Fellows from your area/organization into the ACS
- Promote ACS Fellowship in state and specialty societies
- Engage new Initiates/Fellows

Participate

- Actively participate in a minimum of one Board of Governors Workgroup
- Complete Annual Survey
- Participate in local Committee on Applicants meetings and interviews
- Be an active participant in the Board of Governors online community site

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

FASCINATING FACTS FROM THE COLLEGE (CONTINUED)

How Are Governors Appointed?

Chapter Guidelines for Appointing a Governor

- Chapter Secretaries, with a copy to the Chapter Executive Director, will be notified via e-mail of a pending vacancy of Governor.
- The Chapter Secretary acquires nominations for Governor to be presented to the Chapter's governing body.
- The governing body will select two individuals from the nominations—one nominee for Governor and an alternate.
- The nominee and alternative's information is then forwarded to the Board of Governors Administrator. The American College of Surgeons (ACS) Division of Member Services has put together a form and requirements for this purpose.
- Include the nominee's CV. The alternate is not required to submit this item.
- These two names and accompanying information are then presented to the Nominating Committee of the Fellows for review and approval.

Specialty Society Guidelines for Appointing a Governor

- The Specialty Society Executive Director will be notified via e-mail of a pending vacancy of Governor.
- The Specialty Society Executive Director acquires nominations for Governor to be presented to the Chapter's governing body.
- The governing body will select two individuals from the nominations—one nominee for Governor and an alternate.
- The nominee and alternative's information is then forwarded to the Board of Governors Administrator. ACS Division of Member Services has put together a form and requirements for this purpose.
- Include the nominee's CV. The alternate is not required to submit this item.
- These two names and accompanying information are then presented to the Nominating Committee of the Fellows for review and approval.

Considerations for Appointing a Governor

- Open, deliberate, advertised nomination to the society or chapter membership.
- Outline and address issues of diversity (gender, race, geographic, rural/urban, academic/private) to promote equal opportunity for qualified candidates.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNEY

10

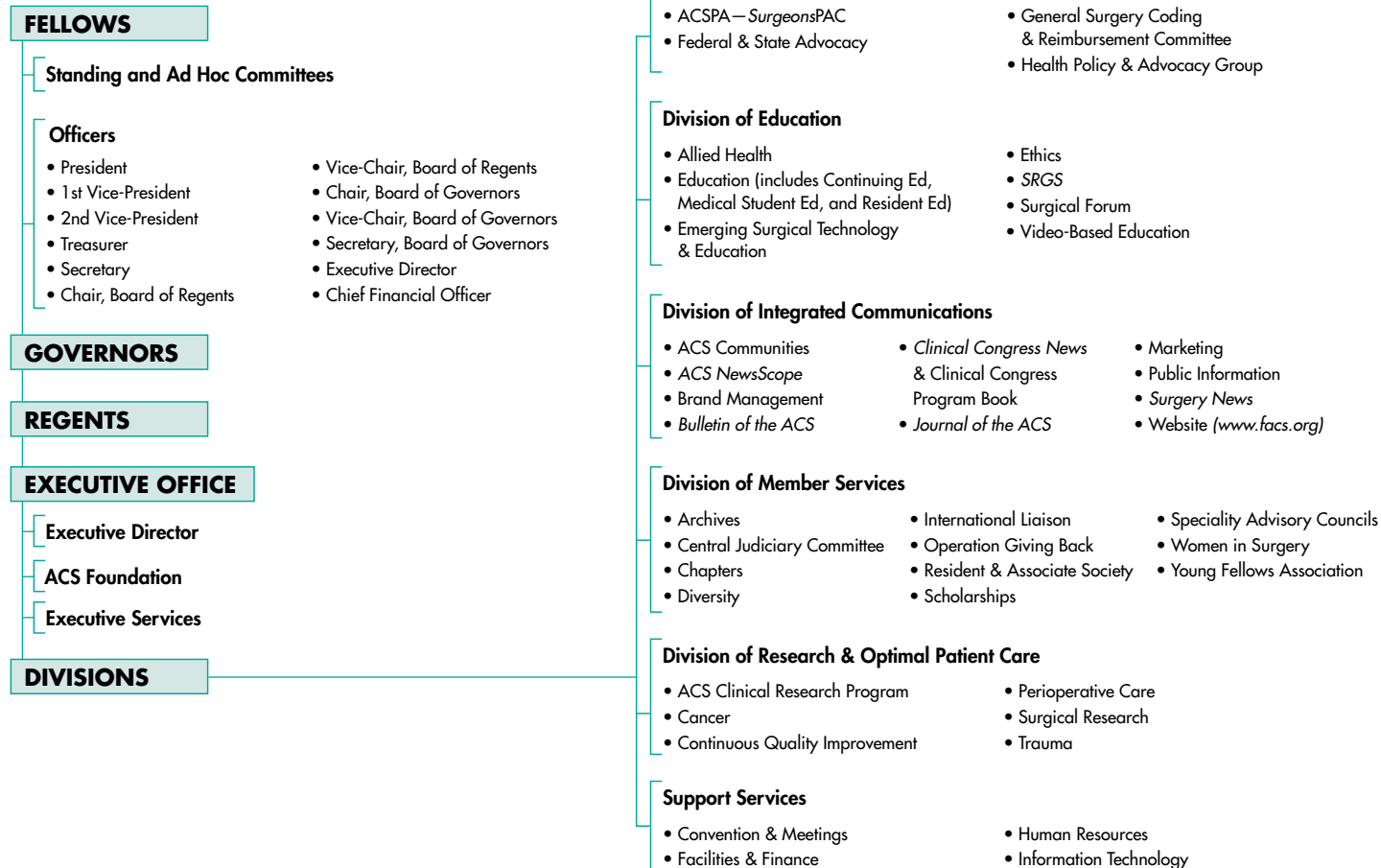
SAVE THE DATE

11

CONTACT US

FASCINATING FACTS FROM THE COLLEGE (CONTINUED)

American College of Surgeons — Organization Chart



1

FASCINATING FACTS FROM THE COLLEGE: GOVERNORS OF THE ACS

2

A MESSAGE FROM THE CHAIR

3

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL STORY

6

2016 LEADERSHIP & ADVOCACY SUMMIT

7

SRI LANKA: A VISIT HOME

8

HOT TOPICS! ... FROM THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF GIANTS": DR. CHARLES MCBURNEY

10

SAVE THE DATE

11

CONTACT US

MESSAGE FROM THE CHAIR OF THE BOARD OF GOVERNORS



Fabrizio Michelassi, MD, FACS
Chair, Board of Governors

Dear Governors and Fellows,

A lot has happened since we met in Chicago during the Annual Congress in October. At that time, Dr. Diana Farmer was elected to the position of Vice-Chair and Dr. Steven Stain to the position of Secretary of the Executive Committee of the Board of Governors, replacing Drs. Karen Brasel and James Denny, III, respectively, who ended their term as Governors. Two additional members of the Executive Committee superannuated: Drs. Kevin Behrns and Sherry Wren. To fill the vacated positions, four governors were elected to the Executive Committee: Drs. Daniel Dent, Francis Ferdinand, James Fleshman, and Susan Mosier. They were assigned the lead of the Education Pillar, Member Services Pillar, Communication Pillar and Advocacy Pillar, respectively. Dr. Diana Farmer continues as Quality Pillar Lead.

In addition, at the time of the Annual Congress, 60 new governors (56 domestic and 4 international) were elected. They represent 48 chapters and 12 surgical societies. In order to facilitate the onboarding of these new governors, the members of the Executive Committee and the staff of the Board of Governors have held two orientation webinars on December 17 and January 14, respectively. In addition, all new Governors have chosen a workgroup assignment and have begun working with their workgroups. The Executive Committee is planning a New Governor Networking and Orientation event to take place at the Leadership & Advocacy Summit on Saturday, April 9.

The workgroups of the five pillars have already started to meet via conference calls. Following is a summary of the work done so far by each Pillar:

Members Services Pillar

- ✓ The members of the Surgical Volunteerism and Humanitarian Awards Workgroup have tested a completely new nomination site in December and opened it to traffic in January. They have also engaged in outreach through communities, the Bulletin, Military Governors and Advisory Councils in order to increase awareness of these awards. Since the site has opened, there have been more than 20 nominations. The deadline to submit nominations is Monday, February 29, 2016.
- ✓ The members of the Chapter Activities Domestic Workgroup have started two initiatives: the RAS Representative Initiative and the Chapter Dashboard initiative. The goal of the former is to have an RAS representative on every domestic chapter council to facilitate ideas for programs, projects, and activities attractive to young Fellows. The goal of the latter is to design a dashboard intended to give a visual representation of the health of the Chapter.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

MESSAGE FROM THE CHAIR OF THE BOARD OF GOVERNORS (CONTINUED)

The dashboard would include finances, membership, advocacy, website, and other indicators of chapter viability. Finally, the Division of Member Services, and the Chapter Activities Domestic Workgroup, has welcomed the Division's new Manager for Domestic Chapters, Ms. Jennifer Connelly, CAE. Donna Tieberg will continue in the Division but in the role of Manager for International Chapters.

- ✓ The members of the Chapter Activities International Workgroup are in the process of setting up communities for four international regions as a first step towards individual International Chapter Communities. They have also created short videos on the value of being an international fellow. These videos could be used by international chapters as a tool to help recruit new fellows.

Education Pillar

- ✓ The members of the Continuing Education Workgroup have continued to work with the Division of Education to enhance the MyCME page of the ACS website. The goal is to make the MyCME page easier to navigate.
- ✓ The Patient Education Workgroup is analyzing last year's survey results for possible publication as well as working on a presentation and kit for chapters of available patient education materials.
- ✓ The members of the Surgical Training Workgroup are working towards completion of two products: a standardized letter of recommendation for applicants to surgery training programs and online education modules. The standardized letter of recommendation has been shared with the leadership of APDS and ASE. The APDS has formed a workgroup to gauge its potential utility to program directors and to

provide feedback. Four online education modules have been developed to assist educators with faculty development. The specific modules are (1) Teaching Millennials, (2) Giving Constructive Feedback, (3) Intraoperative Teaching, and (4) Clinical Teaching: The Teachable Moment.

Advocacy and Health Policy Pillar

- ✓ The members of the Health Policy and Advocacy Workgroup have had several conference calls intended to identify issues which may be worth analyzing in depth. So far these issues are: (1) Workforce shortage of general surgeons, (2) Bills defining policy and regulations for out-of-network plans, (3) The changing practice environment—private practice to employed surgeons, and (4) Videotaping of surgical procedures.
- ✓ The members of the Coalition Workgroup have gone through a similar process and have identified the following issues: (1) Merit-based incentive programs, (2) Concurrent surgery practices, and (3) Surgical training and credentialing over the course of a career.
- ✓ Both workgroups are planning to review these issues with the Division of Advocacy and Health Policy to better coordinate and synergize.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

MESSAGE FROM THE CHAIR OF THE BOARD OF GOVERNORS (CONTINUED)

Communication Pillar

- ✓ The members of the Survey Workgroup have begun work on the 2016 Governors survey and have created a list of topics for consideration. The 2015 Survey was summarized nicely by Dr. Mark Puls, Chair of the workgroup. Segments of the report will be uploaded to the Communities to stimulate discussion.
- ✓ The members of the Newsletter Workgroup have worked hard to prepare the winter quarterly Board of Governors Newsletter with the help of Ms. Betty Sanders and additional ACS staff. This is the fifth issue of the newsletter. The publication is well written and full of new and valuable information. We all owe a great debt of gratitude to the members of the Newsletter Workgroup.

Quality, Research, and Optimal Patient Care Pillar

- ✓ The members of the Best Practices Workgroup have completed guidelines on postoperative Ileus and are now in the process of updating the ACS NSQIP SSI prevention guideline and developing guidelines on management of post-op fever.
- ✓ Having just finalized the statement on "The aging surgeon," which was endorsed by the Board of Regents in October and has been published in the January issue of the *Bulletin*, the members of the Physician Competency and Health Workgroup are currently in the process of selecting new topics of importance: the impaired Surgeon; the disruptive surgeon; substance abuse and the surgeon; and environmental hazards and the OR: ergonomics, radiation, HIV, Hep C are some of the topics being vetted.
- ✓ The Surgical Care Delivery Workgroup is comprised of four subcommittees that carry out the workgroup's projects.

- Surgeon Workforce Subcommittee: Developing a checklist for new surgeons and surgeon employers to guide them in the transition to practice in any environment.
- Patient Access to Surgical Care Subcommittee: Reviewing and summarizing recent surveys published on the topic.
- Electronic Health Record (EHR) Subcommittee: Is in preliminary discussions with vendors regarding an EHR solution, a top concern among U.S. Fellows. Issues include meaningful use, disruption of physician workflow, and the ability to extract relevant quality data. Workgroup members believe the College should aggressively pursue the possibility of incorporating data from ACS NSQIP.
- Ambulatory Surgery Subcommittee: Created a document on ambulatory surgery guidelines, which is being vetted.
- Two subcommittees, Patient Access to Surgical Care (Panel Discussion) and Surgeon Workforce (Town Hall meeting), have been notified that their proposals for Congress sessions have been accepted for the 2016 Clinical Congress. Active planning is underway in each subcommittee for both sessions.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

MESSAGE FROM THE CHAIR OF THE BOARD OF GOVERNORS (CONTINUED)

Recognizing how hard it is for Governors to bring back important information from the Annual Clinical Congress to their respective Chapters and Specialty societies, the Communication Pillar, with the help of Ms. Betty Sanders, has created a Board of Governors Meeting Summary and slide deck. This summary and slide deck was sent to all Governors on January 25, 2016. If you have not received it, please contact Betty Sanders at bsanders@facs.org. Dr. Fleshman, Communication Pillar Lead, is interested in receiving your feedback on how to improve this material and make it more user friendly. The Executive Committee and I hope that this summary will facilitate your efforts at communicating back with your chapters and societies.

The Program Committee of the Division of Education has sent out an announcement soliciting applications for panels and sessions for the 2016 Clinical Congress. The online submission is available now and will stay open through March 2016. For more information or to submit your proposal, go to www.facs.org/clincon2016. This is a very competitive process, with over 300 applications received in 2015 and only 100 selected for the Annual Clinical Congress. If you or your workgroup are thinking of submitting a proposal, we would encourage you to begin the process now. Feel free to reach out to Diana Farmer or David Spain, B/G liaisons to the Program Committee, or Daniel Dent, Education Pillar Lead, for guidance. They can help you to generate the strongest proposals.

As mentioned earlier, the Surgical Volunteerism and Humanitarian Awards Workgroup has opened a completely new nominations website and it is seeking nominations for the awards to recognize exceptional volunteerism and humanitarian services of Fellows and Residents. These awards are given during the Board of Governors dinner on Tuesday night of the Clinical Congress. Please forward nominations to Brittanie Wilczak at ogb@facs.org by Monday, February 29, 2016. Also, should you have nominations of Fellows for one of the pending vacancies on the Board of Regents to be filled during the 2016 Clinical Congress, I encourage you to submit them to Ms. Sanders by Friday, February 26, 2016. The 2016 Nominating Committee of the Board of Governors (NCBG) will have the task of selecting nominees.

I hope to see all the domestic Governors (and the international Governors who can make it) at the Leadership Summit in Washington, DC, April 9–12. The leadership of the College is extremely grateful for our participation at the Summit and, as a token of appreciation, decided some time ago to waive the registration fee for Governors, understanding the commitment of time and resources that each one of us makes in leaving our practices to attend this yearly strategic meeting. The Summit will start with a Leadership Conference over the first two days and will conclude with the Advocacy portion during the last two days. Our presence to both components is extremely important to inform the leadership of the College on the pressing issues faced by all of us, helping crafting a strategy and bring our voices to Capitol Hill.

See you in Washington, DC.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY

Mark Savarise, MD, FACS

Colonoscopy is a procedure performed by many general surgeons, and it has generated more than its proportional share of questions and concerns about coding and reimbursement. This article addresses some of those issues.



Coding Issues:

Much of the confusion regarding colonoscopy coding arises from the dichotomy between screening and diagnostic colonoscopy. The difference between the two indications has gained more importance in recent years, especially after enactment of the Affordable Care Act (ACA), which mandated that insurers pay the full cost of screening examinations without collecting deductible or copayments from patients. Endoscopists saw an increase in the volume of screening examinations beginning in 2011 as a result of the ACA. Unfortunately, many also experienced an increase in calls from patients regarding their bills.

Screening colonoscopy is defined as a procedure performed on an individual without symptoms, for the purpose of testing for the presence of colorectal cancer or polyps. If a polyp or cancer is found during a screening exam, this does not change the screening intent.

Surveillance colonoscopy is a subset of screening, performed at an interval less than the standard 10 years from the last colonoscopy (or sooner, in certain high-risk patients), due to findings of cancer or polyps on the previous exam. Again, the patient is asymptomatic.

Diagnostic colonoscopy is done to evaluate symptoms, such as anemia, rectal bleeding, abdominal pain, or diarrhea.

A screening colonoscopy should be reported with the following ICD-10 Codes:

- Z12.11: Encounter for screening for malignant neoplasm of the colon
- Z80.0: Family history of malignant neoplasm of digestive organs
- Z86.010: Personal history of colonic polyps

If a polyp is found and removed at the same setting, these codes should still be listed as the primary diagnosis codes, followed by the appropriate ICD-10 code for polyp: D12.0-D12.9 (benign neoplasm of the colon or rectum, based on location).

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY (CONTINUED)

CPT codes for colonoscopy were all revised for 2015. There were several new CPT codes for interventional colonoscopy procedures, which were not valued for 2015, but all of these have been valued for 2016 and are reimbursed by Medicare and private insurance. With the 2015 revision, several clarifications were made:

- Colonoscopy is no longer defined as endoscopy beyond the splenic flexure; in order to be considered a colonoscopy, the examination must be to the cecum (or to the entero-colic anastomosis if the cecum has been surgically removed).
- All colonoscopy procedures now include the provision of moderate sedation.
- Incomplete colonoscopies not reaching the splenic flexure are reported as flexible sigmoidoscopies.
- Incomplete screening or diagnostic colonoscopies that reach beyond the splenic flexure but not to the cecum are reported with modifier -53. This allows future payment for a repeat examination before the usual screening interval.
- Therapeutic colonoscopies that are incomplete (the scope does not reach the cecum during a therapeutic procedure) are reported with modifier -52.

To add further confusion, the codes for reporting these procedures differ between Medicare and other payors.

For non-Medicare payors, we use the CPT conventions. Colonoscopy codes are found in the digestive section of CPT, codes 45378-45398 (codes 44388-44408, if performed through a stoma rather than the anus). CPT code 45378 is the base code for a colonoscopy without biopsy or other interventions. It does include brushings or washings, if performed. If a screening exam, modifier -33 (preventative service) is appended. This indicates to payors that the procedure should be reimbursed without regard to patient copay or deductible. This modifier can also be appended to therapeutic colonoscopies, such as 45385 (colonoscopy, with removal of tumor, polyp, or other lesion by snare technique). By using this modifier and the proper diagnosis codes, the endoscopist tells the payor that the diagnostic procedure is done for screening. The base value of the code is not subject to a copay, but the patient may be required to pay a copay on the additional value of the therapeutic procedure.

Medicare uses HCPCS codes for screening. For a patient of typical risk, the screening procedure is reported with HCPCS code G0121; for a patient at high risk, it is reported with HCPCS code G0105. Medicare has a separate modifier for situations where polyps are found and removed during a screening colonoscopy. In these situations, the correct CPT code is used (e.g., 45385), but with modifier-PT. The reimbursement policy is the same for Medicare as for other payors in this situation; only the coding differs. Each endoscopist should review the policies of their insurance providers to be certain of which system is used, especially for commercial insurers' Medicare Advantage plans.

In 2015, Medicare also stated that for patients undergoing screening colonoscopy and having sedation by an anesthesia provider, the copay and deductible would also not apply to the separate charge for anesthesia.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY (CONTINUED)

Reimbursement issues:

All endoscopy procedures have a “base” value for the diagnostic procedure, and incremental additional wRVU for additional diagnostic or therapeutic procedures (such as biopsy, snare polypectomy, stent placement, etc.). These increments are consistent among the different endoscopy families (EGD, sigmoidoscopy, colonoscopy). For colonoscopy, the base work Relative Value Units (wRVU) for the diagnostic procedure (CPT code 45378) is 3.36. The incremental wRVU of cold biopsy is 1.02, so the total wRVU of colonoscopy with cold biopsy by forceps is 4.38. When multiple procedures (such as snare polypectomy of one lesion and biopsy polypectomy of another) are performed at the same setting, the total wRVU would be the base wRVU and the sum of the incremental additional values.

Reimbursement for all colonoscopy procedures decreased substantially in 2016. This was not news to those involved in the valuation process at the AMA or in the government: it had been coming since 2011. The reasons for this, and the behind-the-scenes work on this one issue illustrate a great deal about the process of coding and valuation of physician services.

It had been widely recognized for several years that colonoscopy was increasingly being performed with the presence of an anesthesia provider. Most flexible endoscopy procedures had originally been described and valued with the inclusion of “conscious sedation,” a term that has become obsolete in medical practice.

Modern terms are “light sedation,” “moderate sedation,” and “deep sedation” (or general anesthesia). The introduction of propofol as a sedating agent changed the approach to procedural sedation. Studies reported that actual procedure times were significantly less than the times upon which the relative values for endoscopy had been based. Partly because of this data, CMS directed the AMA Relative Value Update Committee (RUC) to review all endoscopy codes. The RUC referred the entire code set back to CPT to reconsider the codes. Over the course of three years, beginning with upper endoscopy and enteroscopy, all of the codes were reconsidered, and a new code set was created. Colonoscopy codes were completed last, in time for valuation for the 2015 final rule from CMS.

The valuation process for endoscopy, and especially for colonoscopy, was contended at the RUC. Here, the GI societies that valued the new codes through the RUC survey process, proposed a modest reduction in value. The RUC disagreed and assigned value reductions between 4% and 23%. Prior to the 2015 final rule, the GI societies, along with the College, SAGES and ASCRS, appealed the ruling directly to CMS. This resulted in an additional year delay in revaluation. However, CMS ultimately agreed with the RUC valuation and enacted the new values for 2016. As a result, diagnostic colonoscopy, CPT code 45378, decreased 9% from 3.69 to 3.36 wRVU.

The colonoscopy code set still includes moderate sedation. Therefore, the endoscopist may not report an additional code for supervision of moderate sedation (99143-99150) or anesthesia (00740 or 00810). A second physician, other than the one performing the procedure, may report the codes for moderate sedation or anesthesia if he provides this service. At this time, there is no requirement for the endoscopist to report a reduced service (modifier -52) in this situation. However, this situation may change in the future, or further devaluation of the base endoscopy procedures may occur if the work of sedation is removed from the current valuation.

1

FASCINATING FACTS FROM THE COLLEGE: GOVERNORS OF THE ACS

2

A MESSAGE FROM THE CHAIR

3

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL STORY

6

2016 LEADERSHIP & ADVOCACY SUMMIT

7

SRI LANKA: A VISIT HOME

8

HOT TOPICS! ... FROM THE ACS COMMUNITIES

9

“ON THE SHOULDERS OF GIANTS”: DR. CHARLES MCBURNEY

10

SAVE THE DATE

11

CONTACT US

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY (CONTINUED)

Example

A 50-year-old patient without family or personal history comes for a screening colonoscopy and is found to have three polyps: a 10 mm polyp is removed from the cecum by snare technique after injection of saline to “lift” the polyp, a 5 mm polyp is removed from the descending colon by cold biopsy forceps, and a 5 mm polyp is removed from the rectum by cold biopsy forceps. The procedure is done with a CRNA providing moderate sedation.

Diagnoses:

- Z12.11: Encounter for screening for malignant neoplasm of the colon
- D12.0: Benign neoplasm of the cecum
- D12.4: Benign neoplasm of the descending colon
- D12.8: Benign neoplasm of the rectum

Note: it is important that the Z code is listed first.

Procedures:

- 45385-33: colonoscopy with snare polypectomy; modifier to indicate preventative screening procedure
- 45380-59: colonoscopy with biopsy, single or multiple; modifier to indicate distinct procedures

(Note: report only once, even if multiple polyps are removed by the same technique).

- 45381-51: colonoscopy with submucosal injection (any substance); modifier to indicate multiple procedures at the same setting
- The CRNA reports 99149-33: moderate sedation services, provided by a physician other than the physician performing the diagnostic service; modifier to indicate preventative screening procedure

Reimbursement:

- The endoscopist will be reimbursed 4.67 wRVU for colonoscopy with snare + 0.3 wRVU for the submucosal injection + 1.02 wRVU for the biopsy polypectomies for a total of 5.99 wRVU. The total reimbursement also includes practice expense RVU and liability RVU; the sum is multiplied by a conversion factor determined by the payor.
- The CRNA will be reimbursed at a rate determined by the payor, as the moderate sedation has not been assigned a relative value.
- The patient would be exempt from a copay for the value of the screening colonoscopy (3.36 wRVU) and the sedation. The patient would be responsible for a copay on the additional 2.63 wRVU from the therapeutic procedures.

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1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

“ON THE SHOULDERS OF
GIANTS”: DR. CHARLES
MCBURNEY

10

SAVE THE DATE

11

CONTACT US

INTERNATIONAL CAFÉ

Katsuhiko Yanaga, MD, PhD, FACS

Governor-at-Large and President, Japan Chapter

THE HONOR OF BECOMING AN ACS GOVERNOR

It gave me great pleasure to be named as a Governor-at-Large of the American College of Surgeons (ACS) in November 2013, and I remain to feel privileged to be one.

In Japan, Prof. Koichi Fujii was the first Governor to be named in 1992, followed by Prof. Kenji Sakurai, Prof. Yasuo Idezuki, Prof. Tatsuro Yamakawa, and Prof. Nobuhiko Tanigawa, making me the sixth Governor-at-Large from Japan.

The Japan Chapter of ACS was founded in March 1992 to encourage communication and exchange of knowledge and experience between the ACS and the Japanese surgeons, especially the Japan Surgical Society (JSS). At the beginning, the Congress President of JSS ran the Japan Chapter as the Chapter President on a yearly basis, but the term was extended to three years, allowing a significant position overlap with the Governor-at-Large from Japan to maximize the relationship between the two countries.

I graduated from Kyushu University, Fukuoka, Japan in 1979 and joined the Department of Surgery II, Kyushu University School of Medicine headed by Prof. Kiyoshi Inokuchi for one year. After an interview with Prof. Teruo Matsumoto who then was the Chairman of the Hahnemann Medical School during his stay at Kyushu University as a Visiting Professor, I was given an opportunity to work as a surgical resident in the United States for three years between 1980 and 1983, at Easton Hospital, Easton, PA for the first two years and at Hahnemann University Hospital and Crozer Chester Medical Center for one year.



Surgical resident Dr. Yanaga, PGY-1, at Easton Hospital, 1980

As a young surgical trainee, I enjoyed PGY1 to 3 surgical training in the United States, which was then pyramidal with no work-hour restrictions except for on calls not to exceed every other day and every other weekend. I still remember how exhausted I was at the end of Monday night after a long and busy weekend call which started from Saturday morning the week before. My hardest rotation was at Prof. Matsumoto's service at Hahnemann, starting at 5:30 am to collect patient data and coming home at 11:00 pm often without lunch or break to cover 100 patients every day. During that rotation, when I came home, I used to fall asleep in the bath tub, and skipped supper to go to bed, leaving me to eat only breakfast during weekdays.

During the three years, I met many surgeons in various specialties, not only general and vascular but also cardiothoracic, transplant, neurosurgery, gynecology, urology, orthopedics, and trauma. Most of them were board certified, confident, and willing to teach patient management and surgical techniques. They were trained at different programs, but all welcomed diligence, punctuality, and 'patient first' concept.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

INTERNATIONAL CAFÉ (CONTINUED)

After spending three years of busy but meaningful surgical rotation, I had to go back to Japan to engage in surgical research back in Kyushu University where my main interest was liver transplantation, because of the exposure to a lecture by Dr. Thomas E. Starzl at Allentown, PA, and fascination of open heart surgery during a cardiothoracic rotation. I established canine orthotopic liver transplant in the laboratory, and decided to apply for a transplant program at the University of Pittsburgh, where approximately one-half of clinical liver transplants in the world were performed. Probably because of my medical license in Pennsylvania and experience with liver transplants in large animals, as well as a sharp increase in clinical liver transplants in Pittsburgh, I was accepted to work as a clinical fellow under Dr. Starzl starting July 1986. I stayed in Pittsburgh for three years until June 1989 and returned to Fukuoka, where I was engaged in liver resections and the development of a liver transplant program under Prof. Keizo Sugimachi until 1998. I became a fellow of ACS in 1996, and even 20 years later, I still remember the excitement of the convocation at Moscone Center in San Francisco.

After spending two years at Matsuyama Red Cross Hospital, I moved to Nagasaki University School of Medicine, Nagasaki, Japan under Prof. Takashi Kanematsu in 2000 where I was engaged in starting an adult live donor liver transplant program for three years. In April 2003, I was then appointed to The Jikei University School of Medicine in downtown Tokyo in 2003 as the professor of surgery and division chief of digestive surgery, where I continue to serve to this day.



Dr. Yanaga at Convocation at Moscone Center, San Francisco, 1996



Katsuhiko Yanaga, MD, PhD, FACS in 2015

Thanks to the effort of my predecessors and previous as well as current officers, the Japan Chapter is now the second largest chapter with 357 members, which is increasing with initiates of 27 in 2013, 32 in 2014, and 24 in 2015. One of the reasons for successful recruitment of young Japanese surgeons to become initiates of FACS is successful invitation of distinguished guests from the ACS to our chapter business meeting, President Patricia Numann in 2012, President Brent Eastman in 2013, President Carlos Pellegrini in 2014, and Vice President Kenneth Mattox in 2015. With the strong support of our chapter from the ACS, we hope to extend our chapter activity and transpacific exchange of friendship with the United States as well as global communication with other chapters.

1

FASCINATING FACTS FROM THE COLLEGE: GOVERNORS OF THE ACS

2

A MESSAGE FROM THE CHAIR

3

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL STORY

6

2016 LEADERSHIP & ADVOCACY SUMMIT

7

SRI LANKA: A VISIT HOME

8

HOT TOPICS! ... FROM THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF GIANTS": DR. CHARLES MCBURNEY

10

SAVE THE DATE

11

CONTACT US

A COLORFUL STORY

Ronald D. Jaecks, MD, FACS
Governor, Oregon Chapter

Growing up as a pastor's son in small towns around the state of Wisconsin, from a young age on, I remember my mom dressing my brother and me in colorful suits for church. At age five, my favorite church clothes were a blue pastel suit and a very bright red vest. My outfit for the first day of first grade at a one-room schoolhouse in Eau Claire, WI, included bright orange pants. I refused to wear blue jeans because that would have been like everyone else. Also to be different, I grew my hair long—my open-minded father said, "OK, as long as you keep it neat." Now my patients protest if I cut my hair, and they expect to see me in living color!

Born and raised in Wisconsin, I was born a Packers fan. I dressed up and acted out the games with my brother as we listened to games on radio or watched them on TV. Now when I go to games in Green Bay or Packers games in visiting stadiums, the last three Packers Super Bowls, at our local Packers Bar, or even at home (much to my wife's bewilderment), I am the caped Super G-Force Man. Last year, while jogging to stay in shape to wear a body suit super fan costume, I was attacked by an owl. The story and my outfits were featured on the Rachel Maddow show and on local and national news shows. When the story made Anderson Cooper's Ridiculist, he was speechless and then played the clip again when he saw my white and gold suit. (Google Anderson Cooper Ridiculist Owl Capone!)



Dr. Superhero

At age 12, I became a magician performing for birthday parties, schools, and church events. I even performed at Loma Linda University Medical School at age 14, where I would eventually perform again when I was a medical student for our class-sponsored talent show. My show always included several colorful sequined costumes.

Since I was a child, I have dressed to complement the event. For example, when I go to the theatre, a character in the play will inspire what I wear. My wife, Kelli, recently starred as Roxy Hart in Salem's Pentacle Theatre production of Chicago. I attended 18 performances, and each night, I picked out a different character to inspire my outfit.

At my wedding, I greeted our guests in a "decoy" black tuxedo, and then when I appeared at the ceremony I was decked out in a gold-sequined tuxedo that was custom made for me in Hollywood.

As long as I remember, I have searched for color in boy's, and now men's, clothing. I have always been amazed that girls could dress in color, and boys were stuck with navy, browns, and greys. Our favorite activity when we travel is to seek out men's (and women's) fashion. When shopping several years ago in San Francisco, I was asked if I was going to wear the brilliant pants I was purchasing for a Halloween party. I said, "No, this is how I dress!" I returned to this shop during the 2014 Clinical Congress, and the owner remembered me and had several outfits in my size all ready for me to try on! This stimulated a light bulb moment for me! I could design my own clothing! I had just become friends with Vien To, a talented clothing designer in my town. We began designing and making colorful clothing for me to wear. Now we have a dream to make color available to men and boys everywhere! Stay tuned for this exciting business adventure!



Dr. Jaecks and his wife, Kelli

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNAY

10

SAVE THE DATE

11

CONTACT US

2016 LEADERSHIP & ADVOCACY SUMMIT

It won't be long before we head off to DC for this year's Leadership & Advocacy Summit. Below you will find the schedule of events as it relates to the Board of Governors.

The Board of Governors events are as follows:

- ✓ Saturday, April 9, 2016, from 12:30–1:30 pm
B/G Executive Committee Meeting
Executive Committee Members only!
- ✓ Saturday, April 9, 2016, from 1:00–2:00 pm
New Governor Orientation & Networking event
New Governors only!
- ✓ Saturday, April 9, 2016, from 2:00–2:30 pm
Pillar meetings (All B/G Pillars will meet as a group (see listing under "workgroup meetings" for your Pillar)
All Governors
- ✓ Saturday, April 9, 2016
Workgroup meetings (All B/G workgroups will meet EXCEPT for the Chapter Activities International Workgroup. For those Governors who reside internationally, we are working on setting up an international meeting, although it is not a requirement for International Governors to attend the Leadership Summit.)
All Governors

Meeting Name	Pillar	Time	Room
Best Practices Workgroup	Quality	4:00–5:30 pm	Congressional
Chapter Activities Domestic Workgroup	Member Services	4:00–5:30 pm	Longworth
Coalition Workgroup	Advocacy	4:00–5:30 pm	Dirksen
Continuing Education Workgroup	Education	2:30–4:00 pm	Cannon
Health Policy & Advocacy Workgroup	Advocacy	2:30–4:00 pm	Russell
Newsletter Workgroup	Communications	4:00–5:30 pm	Russell
Patient Education Workgroup	Education	4:00–5:30 pm	Cannon
Physician Comp & Health Workgroup	Quality	2:30–4:00 pm	Dirksen
Surgical Care Delivery Workgroup	Quality	2:30–4:00 pm	Longworth
Surgical Training Workgroup	Education	2:30–4:00 pm	Rayburn
Surgical Volunteerism Workgroup	Member Services	2:30–4:00 pm	Congressional
Survey Workgroup	Communications	4:00–5:30 pm	State

- ✓ Saturday, April 9, 2016 (evening)
Welcome Reception
All Governors
- ✓ Sunday, April 10, 2016, from 7:00 am–5:00 pm
Leadership Summit
All Governors

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNEY

10

SAVE THE DATE

11

CONTACT US

2016 LEADERSHIP & ADVOCACY SUMMIT (CONTINUED)



Washington, DC

Official DC Tourism site: <http://washington.org>**Registration:**

Please visit facs.org/advocacy/participate/summit-2016 to register for the meeting.

Please attend the subsequent **Advocacy Summit** if you are able. The **Advocacy portion** of the event begins on Sunday evening, April 10, at 6:00 pm with a dinner, but this event is not a Governor requirement and will require a separate registration fee. For questions regarding the Advocacy Summit, please contact Michael Carmody at mcarmody@facs.org or 202-672-1511.

①

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

②

A MESSAGE FROM
THE CHAIR

③

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

④

INTERNATIONAL CAFÉ

⑤

A COLORFUL
STORY

⑥

2016 LEADERSHIP &
ADVOCACY SUMMIT

⑦

SRI LANKA:
A VISIT HOME

⑧

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

⑨

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

⑩

SAVE THE DATE

⑪

CONTACT US

A VISIT HOME: HOW A MISSION TRIP TO SRI LANKA CAN CHANGE MY LIFE

It has been a story like John Steinbeck: "The Great Move West." Having been born in Sri Lanka, growing up in Nigeria and Zambia, going to high school in England, and then arriving for college in the U.S., the thought of returning to the land of my birth for a "mission trip" was exciting. This had been the work of the International Hepato-Pancreatico-Biliary Association (IHPBA); I was to be the representative from the U.S.

When I hear the words "mission trip," I think altruism, and I sometimes feel unjustified in using this term. I also feel that there are religious overtones that may or may not be problematic. Having grown up in the "emerging world" (I prefer this to the "third world," which can sound rather condescending), I wanted to build something lasting because of my connection to this country.

We arrived in Colombo at 6 am and I was quite jetlagged. However, I had to get my game face on and, in the humid weather of this island paradise, don my suit and head out for my series of talks at noon. A bus picked us up and I met up with the rest of the team, faculty from England, Scotland, and India—what an outstanding group of surgeons with such repute. I was clearly the least qualified of the group, but I had the home court advantage—this was the land of my birth.

Dhires R. Jeyarajah, MD, FACS
Governor, Americas Hepato-Pancreato-Biliary
Association (AHPBA)



Dr. Jeyarajah and colleagues

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

A VISIT HOME: HOW A MISSION TRIP TO SRI LANKA CAN CHANGE MY LIFE (CONTINUED)

We arrived at the College of Surgeons building, which was a converted beautiful Dutch-style house in the Colombo 7 section, one of the poshest in the city. The house was framed by bougainvillea bushes in all colors and had those colonial arches. We entered the packed theatre. There were approximately 100 trainees and faculty from all around the island, and we settled into three days of didactics and educational exchange. I had to give seven talks in that time! The exchange amongst the faculty was inspirational.

We heard a report from each of the five HPB sites on the island, and were impressed by the sheer honesty and desire to learn and make things better for the patients. The HPB faculty had all spent time aboard as part of their training and had excellent insight and skills. There was interest in any training opportunities that may exist abroad. My passion is education and I immediately realized that if we could train HPB surgeons, this was where the sustainability could blossom.

We spent a few additional days after the formal program on the island. It was wonderful to eat lots of traditional food that we cannot get outside of this place. There were little haunts that I remembered from the childhood that I also just had to visit.

Overall, this was a fabulous trip. I have a strategic plan moving forward to provide instruments for box trainers, set up sites for observership in the U.S., and work on faculty internet based conferencing. I feel that there is something sustainable that can be developed. It feels good to know that maybe in some small way, I can give back to the country of my birth.



In Sri Lanka

1

FASCINATING FACTS FROM THE COLLEGE: GOVERNORS OF THE ACS

2

A MESSAGE FROM THE CHAIR

3

DID YOU KNOW? CODING AND REIMBURSEMENT FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL STORY

6

2016 LEADERSHIP & ADVOCACY SUMMIT

7

SRI LANKA: A VISIT HOME

8

HOT TOPICS! ... FROM THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF GIANTS": DR. CHARLES MCBURNEY

10

SAVE THE DATE

11

CONTACT US

HOT TOPICS! ...FROM THE ACS COMMUNITIES

- ✓ Use of chaperones during patient exam
- ✓ Controversy about "Low-Volume Pledge"
- ✓ Board of Governors Survey
- ✓ Simultaneous colonoscopy and hernia repair
- ✓ Transfacial sutures for ventral hernia repair
- ✓ ABMS Certification of "Focused Expertise"
- ✓ Medical staff rules and regulations
- ✓ Physician reimbursement contracts and issues
- ✓ Bowel suturing techniques
- ✓ Surgical Educators training and education
- ✓ Idiopathic granulomatous mastitis
- ✓ Surgeon Writers Community startup



1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

"ON THE SHOULDERS OF GIANTS" DR. CHARLES MCBURNEY

Robert R. Nesbit, Jr., MD, FACS
Reprinted from the January 2016 Bulletin

The name McBurney (Charles McBurney, MD) is probably second only to that of Cushing (Harvey Cushing, MD, FACS) as a recognized name in American surgery. Dr. McBurney was born in Roxbury, MA; educated at Harvard College, Cambridge, MA, where he rowed crew; and received his medical degree from the College of Physicians and Surgeons (P&S) in New York, NY, in 1870. He trained at Bellevue Hospital, New York City, for 18 months and furthered his medical training in Europe, spending time with Christian Albert Theodor Billroth, MD, in Vienna, Austria. He returned to New York in 1873 and was a busy private practitioner until his retirement in 1905.

Dr. McBurney joined the faculty at P&S, taught anatomy and operative surgery, and became professor of surgery at age 44, though he stepped down five years later due to the demands of his practice. In 1888, he became surgeon-in-chief at the Roosevelt Hospital, New York, NY, where he said he had "the entire surgical service from one end of the year to the other" and "the number of operations is about twelve hundred annually."

He was noted for his clinical judgment, his teaching skills, and his expertise in trauma. In terms of technical operating skill, it was said that, "He was not a rapid performer with the scalpel, but exact, progressing without hesitation.... As a result, the patient's final sutures were placed and the dressings applied in as short a time as those of one who appeared to work much faster." Dr. McBurney was an early proponent of aseptic technique, and among his visiting observers was a young William W. Mayo, MD.

McBurney's tender point

In 1938, the journal *Medical Classics* cited 114 publications by Dr. McBurney, including case reports presented at meetings of the New York Surgical Society; but, of course, he is best known for his classic paper, "Experience with early operative interference in cases of disease of the vermiform appendix," published in the *New York Medical Journal*. This paper was published just three years after Reginald Fitz, MD, described and named appendicitis and recommended operation for perforation.

Dr. McBurney described the early clinical course of the disease, including tenderness at a point "almost exactly two inches from the anterior iliac spine, on a line drawn from the process through the umbilicus." Sir William Osler, MD, noted the importance of "McBurney's tender point" in the first edition of his text in 1893. Dr. McBurney advised that appendectomy was not necessarily easy to perform and stated his "strong feeling that it is well worthwhile for anyone who may have to do this operation to see it done at least once first."³ Five years later, he described the muscle-splitting incision that bears his name.

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNEY

10

SAVE THE DATE

11

CONTACT US

"ON THE SHOULDERS OF GIANTS" DR. CHARLES MCBURNEY (CONTINUED)

Consummate general surgeon

Dr. McBurney was a true general surgeon. In addition to his contributions to appendectomy, one of his most noted achievements was his description of a technique for repairing fracture dislocations of the shoulder (often a complication of attempts to reduce a dislocation).⁶ In 1898 he described sphincterotomy for impacted gallstones,⁷ and in 1901, Dr. McBurney was called to Buffalo, NY, to evaluate the postoperative condition of President William McKinley and was subsequently unfairly criticized for stating an overly optimistic prognosis.



Dr. McBurney operating at Roosevelt Hospital, 1901.

Charles McBurney was an astute observer, master surgeon, and role model for surgeons of all generations.

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1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNEY

10

SAVE THE DATE

11

CONTACT US

SAVE THE DATE

February 15, 2016

International Scholarships for Surgical Education

February 26, 2016

Nomination deadline for Officers of the College and Board of Regents

February 29, 2016

2016 Surgical Volunteerism Award(s) and Surgical Humanitarian Award Application Deadline

facs.org/ogb

April 9–12, 2015

Leadership & Advocacy Summit
Washington, DC

May 2, 2016

Dr. Pon Fund International Chapters Initiative Deadline
International Chapters only



1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US

CONTACT US

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Influence the Future of Surgical Care

ACS is a powerful, collective voice for the surgical profession. Together with our members, we have been influencing and propelling positive change in surgical care for over 100 years. Watch our new video where young surgeons discuss why now is the time to get involved and influence the next century. <https://www.youtube.com/watch?v=wABBsLujeJs>

1

FASCINATING FACTS
FROM THE COLLEGE:
GOVERNORS OF THE ACS

2

A MESSAGE FROM
THE CHAIR

3

DID YOU KNOW? CODING
AND REIMBURSEMENT
FOR COLONOSCOPY

4

INTERNATIONAL CAFÉ

5

A COLORFUL
STORY

6

2016 LEADERSHIP &
ADVOCACY SUMMIT

7

SRI LANKA:
A VISIT HOME

8

HOT TOPICS! ... FROM
THE ACS COMMUNITIES

9

"ON THE SHOULDERS OF
GIANTS": DR. CHARLES
MCBURNIEY

10

SAVE THE DATE

11

CONTACT US