PRE-CLINICAL CONGRESS 2015 EDITION

THE CUTTING EDGE:
NEWS AND NOTES FROM
THE BOARD OF GOVERNORS

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DON’T MISS THE NEXT EDITION OF THE CUTTING EDGE, ARRIVING TO YOUR INBOX IN DECEMBER 2015!

The issue will include the following stories and much more:

- Clinical Congress Participation Details
- Surgeon Human Interest Story
- Pillar Update: Quality
- Fascinating Facts from the College
- Did You Know? (Information about Reimbursement and Quality)
- On the Shoulders of Giants

Have an idea for a story to share? A little known fact? Have you taken a recent trip? Attended an exciting educational event? We want to know! E-mail msarap@msn.com or bsanders@facs.org.

Submission deadline is November 18, 2015.
The ACS Archives houses many interesting artifacts.

Here is an original letter from Oliver Wendell Holmes, dated March 10, 1869, and addressed to Frank H. Adams, Esq., Holmes’ student at Harvard. It is encased in a homemade box with a hinge. The letter and envelope are visible through the glass top of the box, while opening the hinge reveals the back of the letter and a typescript explanation of the provenance of this artifact as well as a transcription of the letter. The artifact was donated to the College by Richard A. Lynn, who received it from a former patient, Margaret Adams Brown, granddaughter of the recipient of the letter.
A MESSAGE FROM THE CHAIR

Fabrizio Michelassi, MD, FACS
Chair, Board of Governors

Dear Governors,

It is an exciting time to be a governor. The restructure of the Board of Governors has created a palpable enthusiasm among the governors of the 13 workgroups aligned along the 5 pillars of the College. Building on this enthusiasm, the Board of Governors Executive Committee has sought ideas from workgroups which would eventually lead to actionable projects and deliverables. As part of this process, which we named the AIMS process, the Executive Committee of the Board of Governors has charged each of the five pillars leads to create a list of projects and has facilitated conference calls between pillar leads and directors of the corresponding College Divisions to stimulate better integration and to vet the possibility of shared projects. The compilation of the pillar-centric AIMS and the AIMS created in conjunction with some of the Divisions has produced a robust list of projects. With this preliminary work done, the Executive Committee met in June in Chicago for a strategic planning meeting. During that meeting, the Executive Committee approved a final list of AIMS; catalogued the AIMS based on the projected time it would take to complete them (short-term: 6-12 months and long-term: longer than 1.2 months); and finally created an AIMS document that will inform the leadership of the Board of Governors for continuity of intent even when the current officers have superannuated.

The Board of Regents met at the beginning of June in Chicago to conduct the business of the College. The recent repeal of SGR was discussed and analyzed. Repeal of the SGR has been a legislative priority of the College for more than a decade. It was recognized that the repeal was achieved in part through the advocacy efforts of the ACS and other medical associations, as well as through Fellows’ participation in meetings with lawmakers and thousands of letters and calls to Capitol Hill. An initial discussion then followed on the future agenda for advocacy at the Federal and State level.

During the June meeting, the Regents approved two additional seats on the Board of Regents. These new seats are intended to expand the number of Regents representing specialties that are certified under the auspices of the American Board of Surgery (Critical Care surgery, Gastrointestinal surgery, General surgery, Pediatric surgery, Surgical oncology, Transplantation, Trauma and Vascular surgery). One new position will be filled in 2015, and the other in 2016. The Nominating Committee of the Board of Governors will be accepting nominations through September 10 and will convene in the Fall of 2015 to select the nominee for this year’s pending vacancy.

I hope you have already made plans to attend the Annual Clinical Congress in October. The Executive Committee is working on the agenda of the yearly B/G Business meeting and the Joint Session with the B/R on Sunday, October 4th. Every effort will be made to carve time for open discussion from the floor. The Tuesday night dinner promises to be again a great occasion to share in the recognition of the 2015 Surgical Volunteerism and Humanitarian Awards and it will give an opportunity to renew our camaraderie and friendship. On Wednesday morning, we will conclude our official business with the Adjourned Meeting.

See you in Chicago in October.
In case you didn’t catch the most recent issue of *ACS Surgery News*, congrats are in order for Luther Cobb, MD, FACS.

Dr. Cobb was installed as the 147th president of the California Medical Association (CMA), and this accomplishment was cited in the ACS Members in the News. Here is a link to his president’s speech: [www.cmanet.org/m/news/detail.dT/presidents-message-the-coming-year-and-beyond](http://www.cmanet.org/m/news/detail.dT/presidents-message-the-coming-year-and-beyond).
The American College of Surgeons held a regional skills course, Advanced Endoscopic Skills Training for Rural Surgeons, on May 8, 2015. This pilot course explored the feasibility of offering smaller, regional courses in order to increase accessibility to surgeons practicing in rural areas. Course participants came from North Dakota, South Dakota, Montana, Illinois, and Winnipeg (Canada).

The curriculum covered the topics of:

- Advanced polypectomy techniques
- Endoscopic dilation and stent placement
- Management of upper gastrointestinal hemorrhage
- Removal of esophageal foreign bodies

We previously conducted a needs assessment for rural surgeons across the country to assess the practice patterns and knowledge and skills gaps among surgeons in rural practice. Recognizing that there may be regional variation, we repeated a needs assessment among the surgeons practicing in rural regions in North Dakota and South Dakota. We asked them what procedures they most commonly perform and what topics they would be most interested in learning more about during a hands-on course.

As expected, a session on advanced endoscopy ranked among the most useful topics. This course utilizes a blended learning model whereby participants review online didactic material prior to the course for knowledge acquisition. This design allows the faculty and participants to focus the on-site activities to hands-on skill practice. The course was held in conjunction with the annual meeting of the combined North Dakota and South Dakota Chapters of the American College of Surgeons.
Looking forward, the American College of Surgeons will continue to evaluate educational strategies for continuing professional development. By creating course content and learning materials and providing technical support for regional courses, the College can facilitate institutions and regional ACS chapters in providing valuable learning opportunities to surgeons in their local areas.

General surgeons practicing in rural areas face unique challenges, including lack of access to continuing professional development activities and a sense of professional isolation. The rural surgeon’s scope of practice is broader than his or her urban counterpart’s; rural surgeons have the responsibility to cover urgent procedures that in other locations would be managed by surgical specialists. Endoscopic procedures make up approximately 50 percent of the procedures performed by rural surgeons, and many communities do not have gastroenterologists.

Given their remote locations, rural surgeons may not have the opportunity to interact with colleagues to keep up to date with new technology. New surgical technologies, devices, and practices are continuously being introduced into clinical practice. Exposure to continuous skills training will help clinicians maintain high quality and robust safety of care. While individuals may acquire knowledge through independent study (for example, web-based training, seminars), technical skills, such as those required by clinicians in surgical disciplines, are best acquired by mentored, experiential skills training.

Recognizing the need to improve access to ongoing skills training, the American College of Surgeons developed the Advanced Skills Course for Rural Surgeons. We have held this course annually since 2011 in conjunction with the American College of Surgeons Clinical Congress. While the rural skills course has consistently high attendance, the number of surgeons participating in this course has been relatively limited. Surgeons often cite time away from practice as a significant impediment to attending continuing professional development programs.

Looking forward, the Americal College of Surgeons will continue to evaluate educational strategies for continuing professional development. By creating course content and learning materials and providing technical support for regional courses, the College can facilitate institutions and regional ACS chapters in providing valuable learning opportunities to surgeons in their local areas.
To help ensure that surgical patients in the state of North Dakota have access to the care they need, the University of North Dakota School of Medicine and Health Sciences (UND SMHS) launched a Rural Surgery Support Program (RSSP) in July 2014. Governor Robert Sticca is chair of surgery at UND and organized the program along with director Mary Aaland, MD, FACS. An article in the July issue of the Bulletin of the American College of Surgeons details the real need for support for rural surgery programs and the process involved in originating and maintaining such a program. The purpose of the program is to stabilize surgical coverage in rural communities in need. The guiding principle is to meet the specific needs of the rural community, which are determined by invested community leaders, their surgeon(s), and the representatives from the RSSP. The program is flexible and can provide a range of support depending on the needs of each community. In the year since the RSSP began, both the initial response and the requests for use of the program have been impressive, reinforcing the authors’ belief that programs of this type can be very helpful and in some cases critical to stabilizing rural surgery practices. This program should provide impetus for similar efforts in other rural states and offers a template for organizing such efforts.

See the entire article from the Bulletin at http://bulletin.facs.org/2015/07/the-north-dakota-rural-surgery-support-program-providing-surgical-services-to-communities-in-need/
The Education Pillar is divided into three workgroups—the surgical training workgroup, patient education workgroup, and continuing education workgroup. These workgroups have had a strong start, focusing both on informative discussion and producing products valuable to Governors and Fellows at large. In addition to the workgroups, the Pillar has liaisons with several ACS committees within the Division of Education, including:

- Committee on Resident Education - Antonio Pavia, MD, FACS, Puerto Rico
- Committee on Medical Student Education - Deborah Loeff, MD, FACS
- Committee on Patient Education - Dennis Kraus, MD, FACS, New York
- Committee on Continuous Professional Development - Charles Bridges, MD, FACS, North Carolina
- Clinical Congress Program Committee - Diana Farmer, MD, FACS, California, and David Spain, MD, FACS, California
- Committee on Ethics - Karen Brasel, MD, FACS, Wisconsin
- Committee on Emerging Surgical Technology and Education - Joann Lohr, MD, FACS, Ohio

Continuing Education Workgroup
Chair: Mark Watson, MD, FACS
Vice-Chair: Daniel Dent, MD, FACS

The Continuing Education Workgroup is working with the ACS Division of Education to provide better value to ACS Fellows through the MyCME portion of the ACS website. CME needs for fellows in each state have been identified. Workgroup and Pillar leadership are working with Division of Education Leadership to help guide website design. The ultimate goal is that each ACS Fellow will have a CME profile such that the ACS MyCME site will assist the Fellows in identifying appropriate CME activities through ACS offerings, including the Clinical Congress, ACS Chapter meetings, and ACS online products like Selected Readings in General Surgery, JACS, and SESAP.
Patient Education Workgroup  
Chair: Terry Sarantou, MD, FACS  
Vice-Chair: Dennis Kraus, MD, FACS  

The responsibility of the workgroup is to review current ACS patient education products and work with the Patient Education Committee to expand available products; identify and develop best practices education products and programs; and identify potential links with ongoing patient education projects outside of ACS.

The patient education workgroup has identified that form of patient education and surgery is important. Patient’s serve as our new surgical partner. The workgroup sought to understand the implementation of reviewed proven care resources and developed a survey to determine the availability of patient education materials to the Fellows of the College for their patients. The survey was developed in 2014 and 2015 and queried the fellowship.

The survey comprised 36 questions and served as a needs assessment for the patient education workgroup and committee. It sought to ask how the American College of surgeons can support and enhance patient information and education. A link was placed in the Bulletin of the American College of Surgeons and the ACS Communities, and greater than 200 responses were received.

<table>
<thead>
<tr>
<th>Results of the 2014 Patient Education Survey</th>
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<tr>
<td><strong>Current practice</strong></td>
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<tr>
<td>• 50% refer patient to a website</td>
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<td>• 80% hand drawings</td>
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<tr>
<td>• 76% standardized print materials</td>
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<tr>
<td>• 7% computerized interactive materials</td>
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<tr>
<td><strong>What they want from the ACS</strong></td>
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<tr>
<td>• 85% very valuable/valuable for print and electronic resources</td>
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<tr>
<td>• 54% iPad apps</td>
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<td>• 58% On-line decision aids</td>
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<tr>
<td>• 69% skills training</td>
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<tr>
<td>• 80% patient education web portal that collated all specialty content</td>
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The workgroup will continue to evaluate patient education needs for Fellows and plans to communicate the patient education resources that are available with Governors and Fellows via the communities. Governors can work with their local chapter to disseminate information to the fellowship.

Surgical Training Workgroup  
Chair: Fred Luchette, MD, FACS  
Vice-Chair: Carol Scott-Connor, MD, FACS  

The surgical training workgroup has two products that are near completion. The first is a standardized letter of recommendation for 4th-year medical students applying to surgery, which has been developed with input from the ASE and APDS. It is in final phases, with hopes to pilot this year. The second is a group of modules with just-in-time teaching tips, aimed at the surgeon who does not have a full-time teaching practice and who is unable to attend in-person education CME. These modules will be released later this year, and will be available on the BOG website as well as through the ACS BOG Communities.
Devices that apply energy to tissue therapeutically have been in use for millennia. Cautery, the direct application of heat to tissue, has been in use since 3000 BC to destroy tumors and achieve hemostasis. At the beginning of the 20th century, William T. Bovie invented an instrument in which high-frequency alternating current (radiofrequency electrosurgery) is used to achieve effects similar to a knife, but in addition can coagulate tissue while cutting through it. It was introduced into surgical practice by Harvey W. Cushing and remains the most widely used energy-based device today with very little modification of its basic principles. In the 1940s, bipolar devices were introduced. Innovations such as the incorporation of cutting blades and real-time impedance measurement into bipolar instruments appeared over the next few decades.

After this relatively slow pace of innovation, the last two decades have seen an explosion in the type and availability of energy devices used by physicians of all specialties. Fueled by the minimally invasive “revolution,” which required new devices for tissue dissection and efficient control of larger vessels without suturing, there is now a vast array of devices that apply energy to tissues in clinical use throughout the world across all surgical specialties and operative approaches, including open, laparoscopic, robotic, and endoscopic. These devices use a variety of energy sources such as electric current at radiofrequency wave-length, mechanical energy at ultrasonic wave-length, and microwave energy. Without question, these technical innovations have enabled the advances in minimally invasive surgery, endoscopic interventional techniques, and percutaneous approaches to diseases that have greatly enhanced our ability to treat patients. However, this technological boon has also created a dizzying multitude of energy device platforms, configurations, generators, cost points, and vendors, and this complexity has increased the potential for injury.

Today’s surgeon encounters complex energy systems to be used after a short introduction by a specific vendor without any incentive or need to understand the fundamental principles of function and safety of the device. With the rapid increase in number, types, and forms of energy applications to tissue, the wide variety of indications and devices, and the complex environment in which they are used, the risk for complications and harm to patients and operators has become part of daily practice.

Injury and harm from electrosurgical devices in laparoscopic surgery is estimated to occur at a rate of one to two per 1,000 patients. These complications include unrecognized bowel injuries and major vascular injuries. Unrecognized thermal injuries to the intestine during laparoscopic surgery are difficult to detect and are therefore particularly dangerous with a significant associated mortality.

In response to this safety issue, SAGES created the FUSE (Fundamental Use of Surgical Energy) program to address this gap. Working in partnership with AORN, AAGL (American Association of Gynecologic Laparoscopists), and the AUA (American Urologic Association), the FUSE task force includes general surgeons with a variety of subspecialty practices, nurses, anesthesiologists, engineers, and gynecologists. As with the two other SAGES “Fundamentals” programs (FLS, or Fundamentals of Laparoscopic Surgery™, and FES, or Fundamentals of Endoscopic Surgery™), FUSE includes two components: a standardized curriculum for surgeons and allied health care professionals of all specialties and a certification test that meets high psychometric and accreditation standards. Success on the test will result in FUSE certification, documenting the basic knowledge that underlies the safe use of energy-based devices in the operating room.

Continued…
The curriculum includes 10 educational domains with a total of 63 educational objectives:

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<tr>
<th>Domains (10)</th>
<th>Learning Objectives (63)</th>
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<tr>
<td>1 Fundamentals of electrosurgery</td>
<td>7</td>
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<tr>
<td>2 Mechanisms and prevention of adverse events</td>
<td>20</td>
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<tr>
<td>3 Monopolar devices</td>
<td>4</td>
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<tr>
<td>4 Bipolar devices</td>
<td>5</td>
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<tr>
<td>5 Radiofrequency for soft tissue ablation</td>
<td>4</td>
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<tr>
<td>6 Endoscopic devices</td>
<td>4</td>
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<tr>
<td>7 Ultrasonic energy systems</td>
<td>5</td>
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<tr>
<td>8 Microwave energy systems</td>
<td>2</td>
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<tr>
<td>9 Energy devices in pediatric surgery</td>
<td>3</td>
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<tr>
<td>10 Integration with other medical devices</td>
<td>9</td>
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</table>

The content focuses on the fundamental principles required for safe and effective use of devices. For example, section two, Fundamentals of Electrosurgery, includes the types of currents used, correct nomenclature, explanation of physics (such as Ohm’s law as it is applied to electrosurgery), electrosurgical generators, differences in “coag” and “cut” waveforms, monopolar versus bipolar systems, isolated versus ground-referenced systems, active and dispersive electrodes, physical effects of temperature and alternating current on cells and tissue, resistive heating, and the different tissue effects (desiccation versus coagulation versus fulguration). Section two focuses on the safe use of electrosurgical devices, including direct and capacitative coupling, insulation failure, and prevention of and response to operating room fires. A similar emphasis on fundamental principles and safe application is used in the sections on specific devices, including monopolar, bipolar, radiofrequency ablation, microwave, and endoscopic devices. Additional sections deal with the special considerations for use of energy devices in pediatric patients and when used in patients carrying other medical devices such as pacemakers. The manual contains supplemental hands-on chapters describing how to set up “live” stations for demonstration and teaching surgical energy principles and safe practice.

FUSE
Supplied by Pascal R. Fuchshuber, MD, PhD, FACS

The material for the online educational curriculum is free and available by contacting these resources:

FUSE program: [www.fuseprogram.org](http://www.fuseprogram.org)
FUSE didactics: [www.fundamentals-didactics.com](http://www.fundamentals-didactics.com)
“This appointment has been a challenging and rewarding experience. The Portuguese Chapter will become stronger, and Portuguese FACS will participate more in ACS activities.”

Paulo Matos da Costa, MD, PhD, FACS, FRCS, is full professor of surgery at Faculdade de Medicina da Universidade de Lisboa (FMUL) and director of University Clinic (Surgery I) since 2009. He received his main surgical training with Prof. Veiga Fernandes in the department of Prof. Celestino da Costa at FMUL and University Hospital of Santa Maria (UHSM). In 1988, he obtained the Fellowship of the Colégio de Cirurgia Português in general surgery.

He was surgeon chief at the emergency department of the UHSM for 18 years. At this hospital, Dr. Costa served as attending general surgeon, and in 2003, he was nominated as director of service. During these last years, digestive oncology was his main field of action. Recently, he has been devoted to upper gastrointestinal (GI) surgery and research.

Dr. Costa was Visiting Professor of Surgery at the department of surgery, division of transplantation surgery, University of Pittsburgh School of Medicine and worked with Professor John Fung in May/July 1993. In November 1998, he was Guest Professor of Surgery at Klinik und Poliklinik fur Viszerale und Gefasschirurgie der Universitat zu Köln and worked with Professor AH Hölcsher. These experiences strongly contributed to his vision of academic surgery.

Before becoming a surgeon, he was involved in pharmacological research, studying in-cell calcium mechanisms of smooth muscle contraction and prostaglandins influence on some anti-hypertensive drugs effects. The time spent with his master, Prof. Toscano Rico, had an imprinting influence for life. His PhD thesis was focused on the esophagus-gastric-gallbladder emptying and the simultaneous bile and gastro-esophageal reflux evaluated by computerized gamma camera (new protocols for a dual energy functional acquisition and treatment of registered data were drawn and implemented). More recently, he came back to the bench for tutoring young surgeons in conducting their translation research in renal transplantation and inflammation.

He is deeply devoted and committed to the medical education and training of surgeons. As an academic surgeon, he was an elected representative of the Academic Surgical Group at the Scientific Council of FMUL in 2003 and served as chair of undergraduate surgical courses (4th-6th years). He was strongly involved in the educational reforms of his institution. The first surgical skills laboratory and the preregistration year (6th year) surgical rotations were established under his supervision.
Dr. Costa was a member of the steering committee for Research on Higher Education Policies, charged to state, “The learning outcomes for Portuguese medical graduates” (2005). During these years, he was the coordinator of a trans-European multi-institutional program to harmonize the preregistration year and enhance students’ mobility (Erasmus programme and Bologna statements), granted by a European Commission. He is a member of the Scientific Board of the Master Degree Course in Bioethics and is a faculty member of the Oncobiology Master Degree Course (FMUL). He got a Diploma in Medical Education at the University of Wales College of Medicine and FMUL (Master in Medical Education, 1997–2000). From 2001 to 2004 he was Rector at Universidade Atlântica (Oeiras – Lisboa).

Apart from his academic and hospital appointments, Dr. Costa served several scientific societies as member of their Boards.

Since 2002, he has been a Fellow of the American College of Surgeons, and, in 2010, together with Prof. Castro e Sousa and other FACS, he was a Founder of the American College of Surgeons Portuguese Chapter and became its Vice-President. Last year, during the Clinical Congress in San Francisco, CA, he was appointed as a Governor-at-Large of the College.

The Portugal Chapter will be enlarged to enhance the visibility of ACS programs. Networking inside the College is important to attract more colleagues. Young surgeons and residents (for the RAS-ACS) should be, and will be, one of his special targets, but senior surgeons, those who are surgical tutors and opinion leaders, must be engaged with ACS. Chapters of European countries should face common strategies to enlarge the recruitment for ACS Fellows.

“It should be possible to set up common scientific meetings and/or to allocate sponsored ACS thematic slots during national meetings, as has been the policy of the Chapter in recent years.”
August marks the “Community Year” in that the first of these communities was launched in August of 2014. Here we are in August of 2015, and I thought a few comments and questions might be in order.

At present, there are 109 Communities of various types. Many of these are closed Communities, which address committee work and have no need of general Fellow membership. We have about 23 Chapter Communities. These groups vary in activity from zero to moderate. Ohio, West Virginia, and Illinois are among those most active.

In the open Communities, General Surgery (9,100 discussion posts), Colorectal Surgery (1,400 discussion posts), GI Surgery (205 discussion posts), Rural Surgery (1,100 discussion posts), Women Surgeons (770 discussion posts), Trauma (432 discussion posts), Endocrine (415 discussion posts), Bariatric (310 discussion posts), and Breast Surgery (1,400 discussion posts) are among the most active. Young Fellows (217 posts) and RAS-ACS (273) have been surprises since we old folks thought those groups would especially like Communities. Perhaps they are reading the other Communities since they consider themselves surgeons and not members of a demographic group. My apologies to those Communities I didn’t report, but you can look up specifics within the system if you are interested in a particular Community.

Among the specialty-based Communities, like Breast, GI, and Colorectal, clinical discussions are the norm. What has been surprising is the lack of uniformity of approach to the same surgical case. Even recognized experts don’t agree. I wonder how this phenomenon relates to evidence-based decision making—whose evidence is the “right” evidence?

Generic Communities, like General Surgery, Women Surgeons, and Rural Surgery tend to discuss both clinical and social issues. The social issues cause lots of heat and light. I am waiting to see consensus. No wonder leadership is so cautious on social issues!

Our Fellows come from every viewpoint and are not shy to state those views.

Our “page views” per month have run from 110,000 per month to lows of 60,000 in the summer months. Library views have diminished, which may mean we need to pay attention to buffing up the usefulness and organization of the Community Libraries. We have between 500 and 700 unique posting individuals per month. Social media gurus say posters represent about 10 percent of users and are the most engaged members. So, by that reckoning, between 50,000 and 70,000 Fellows follow the Communities. Between 6,000 and 8,000 Fellows attend the Clinical Congress. What I like personally is that ACS Communities keep us thinking together on all the issues clinical and social in between the “big” in-person events.
Because of my position as editor, I’ve had considerable interaction with leadership over the course of this year. Generally, I think they find these Communities interesting and useful. Obviously, many of them read the postings, and it influences their approach to various issues. However, I don’t believe what is posted on the Communities is taken as an official polling of the membership since we don’t know exactly who is reading and why. It is more like an inference than a true reading of opinion.

So, I ask you: Has this platform been valuable? How do you see us improving its value? What would you like next August’s report look like?

I cannot conclude this report without giving my thanks to Drs. Hoyt and Turner as well as Jerry Schwartz (ACS Social Media Manager), Lynn Kahn (Director, Division of Communication), and Howard Tanzman (Director, Information Technology) as well as each of the editors and admins of the various Communities. Without their work and support this system would still just be an idea.
HOT TOPICS!
FROM THE ACS COMMUNITIES

The Cutting Edge presents its listing of “Hot Topic” threads and discussions from the various ACS Communities.

To search for information on any topic, simply go to ACS Communities>Browse All Communities>Enter the desired topic in the Search Box. We encourage all Governors to submit topics from their specific Communities for inclusion in future “Hot Topic” lists. These are the topics that really need response from as many of us as possible. We plan to include commentary on particularly important topics submitted by College Leadership and Fellows in future editions of this newsletter.

**Top Discussions**
- Open versus laparoscopic appendectomy
- Nonsurgical tx of appendicitis
- Volume versus quality debate
- Surgical leadership
- Tx of recurrent seroma
- ICU laparotomy
- Tx of duodenal perforation and trauma
- MOC
- Tx of esophageal food impaction
"I learned by practicing constantly as a medical student," said Terry Buchmiller, an assistant professor of surgery at Harvard Medical School and Harvard-affiliated Boston Children’s Hospital. “The nurses would let us take the extra suture that wasn’t used during an operation. They’d always slide it to the medical student so we could grab it and go back and just sit and doodle [with it] and tie knots at home.”

By now, knot-tying — and the many other steps indispensable to a successful surgery — is second nature to Buchmiller, who specializes in the delicate work required on small children, newborns, and, when necessary, fetuses in the womb.

But in the beginning, surgery was exactly as music had been.

For Buchmiller, 52, her calling came early, but it spoke with two voices, pulling her into two directions — medicine and music.

Growing up in Cupertino, Calif., she first picked up the violin at 7, spending hour upon hour practicing the scales and finger positions. By high school she’d performed in two symphonies. She was a music major in college, practicing five or six hours a day to master a piece: the perfect placement of her fingers, the just-so angle of the bow, the bouncing arpeggio stroke, the tremolo’s fluttering repetition. As a member of the Longwood Symphony Orchestra, the memory of those sessions is more a feature of action than reflection.
“At one point, in high school, I played three to four to five hours a day; during college, as a music performance major, sometimes five to six hours a day. So it was a tremendous amount of focus on that skill.”

But it was a focus held in balance. Buchmiller had taken up her pediatrician on his offer to follow him around and observe his work. She was 15 when she saw her first surgery, at the University of California at San Francisco. She was always fascinated by the ability to fix what ailed people.

“That interest never waned,” Buchmiller said. “I never had to decide what to do when I grew up.”

‘You walk in and there’s a performance, that one-time performance for that patient.’

Though the two may seem opposites, medicine and music have pulled her along instead of apart, Buchmiller said. The way of practice taught to her by music was mirrored in medicine: Break the complex down to its composite parts, practice those parts until they are second nature, and then put them together into a whole that has the potential to be greater than its parts.

“The traditional way surgery and music is taught, the way that I learned both, was to focus on the individual building blocks, each individual skill and then learn the big picture. Very scientific and very logical at the beginning and putting in the emotional part and the nuances only when your fingers know what to do, when your hands know what to do.”

Even after years of performing general surgery, there was still plenty to learn, as Buchmiller realized when she arrived at Children’s Hospital in 1995 to begin her fellowship in pediatric surgery.

“I could tie knots perfectly for a general surgeon, but now let’s try some on a baby. You’ve been through nine years of general surgery training and then you were told … well, that you had an opportunity to learn to be gentle all over again. That philosophy — because we do work on babies and children — that delicacy is paramount is something that is still ingrained in my head. Every time I go into the operating room, I still hear that voice from my mentor, and maintain a critical eye for not only my fellows’ and my residents’ hands, but mine as well.”

But medicine is more than craft. The surgical skills that seem important to her today aren’t physical tricks or manipulations of the scalpel, but qualities of mind: focus and teamwork.

“I think one is stamina. There’s no question that the ability to stay focused is a huge piece of surgery. This intense focus — I mean, hours can go by. Music may not [require] the same stamina, musical concerts are usually for a finite time, but I think the team-building skills are fairly similar.

“Whether or not you’re the head of a surgical team in the operating room or if it’s just you and a pianist, or you as part of a symphony orchestra, it’s a team.”
An operation requires a unit just as a symphony requires individual musicians. Each individual has to master specific skills, whether it’s administering anesthesia or playing certain notes, for the group to realize its goal.

“If you really look at the way a conductor rehearses a symphony, they break the parts down and they drill [musicians] in the parts and then, only when we know the mechanics of it, can the conductor really be free to put the whole together to make the music, interpret the music,” Buchmiller said.

“Our conductor’s always trying to embed in our … heads, ‘Please don’t wait until the last week to learn the notes because I want to make the music and I can’t make the music until you all really know the notes.’”

Years of playing the violin helped shape Buchmiller’s approach to medical training.

Then there are the notes of the operating room, individual acts by doctors and nurses and even by increasingly sophisticated machines, beeping and whooshing and tracing bright lines. These notes, punctuated, if all goes well, by the perfect knot, will never be played in quite the same way again, but the patient will live with them forever.

“You walk in and there’s a performance, that one-time performance for that patient,” Buchmiller said. “You want the scar to be beautiful, because the kids are going to have that for, God willing, 70 or 80 years.”
ACS Taste of the City, Fitness, and the Selfie Scavenger Hunt
www.facs.org/clincon2015/about/whats-new/member-engagement

Please note that attendees will be on the lookout for Governors this year, so be prepared! (See Selfie Scavenger Hunt for more information.)

Education
www.facs.org/clincon2015/about/whats-new/congress-program

Chicago Tourism
Information regarding things to see and do in Chicago, IL, can be found at the city’s official tourism page: choosechicago.com

Board of Governors (B/G)
Meeting Schedule
SATURDAY, OCTOBER 3, 2015
B/G Executive Committee Meeting
12:30–1:30 pm
B/G Pillar Meetings
Advocacy and Health Policy Pillar – 3:30–4:30 pm
Communication Pillar – 1:30–2:00 pm
Quality Pillar – 1:30–2:30 pm

B/G Workgroup Meetings
• Best Practices Workgroup – 2:30–4:00 pm
• Chapter Activities Domestic Workgroup – 1:30–3:00 pm
• Chapter Activities International Workgroup – 3:00–4:30 pm
• Continuing Education Workgroup – 4:00–5:30 pm
• Coalition Workgroup – 2:30–3:30 pm
• Fiscal Affairs (Committee to Study the) – 3:00–4:00 pm
• Health Policy and Advocacy Workgroup – 2:30–3:30 pm
WHAT’S HAPPENING AT THIS YEAR’S CONGRESS?
(CONTINUED)

• Newsletter Workgroup – 2:00–3:30 pm
• Patient Education Workgroup – 3:30–5:00 pm
• Physician Competency and Health Workgroup – 3:00–4:30 pm
• Surgical Care Delivery Workgroup – 2:30–4:00 pm
• Surgical Training Workgroup – 3:00–4:30 pm
• Surgical Volunteerism and Humanitarian Awards Workgroup – 1:30–3:00 pm
• Survey Workgroup – 2:00–3:30 pm

Canadian Regents/Governors Meeting
5:00–6:00 pm

International Governor Meetings
5:00–5:45 pm
• Region 14—Latin America Governors Meeting
• Region 15—European Governors Meeting
• Region 16—Asia and Australasia Governors Meeting
• Region 17—Middle East and North Africa Governors Meeting
  (Chapter Presidents will join the meeting from 5:30 to 6:30.)

SUNDAY, OCTOBER 4, 2015
Board of Governors Annual Meeting and Luncheon
7:45 am–2:30 pm
Convocation Robing
5:00–6:00 pm
Convocation Ceremony
6:00–8:00 pm
McCormick Place West
President’s Reception for New Fellows
8:00–9:30 pm

MONDAY, OCTOBER 5, 2015
Opening Ceremony
8:00–9:00 am
McCormick Place West
Nominating Committees of the Board of Governors and Fellows Meeting
9:00–10:00 am

Continued…
WHAT’S HAPPENING AT THIS YEAR’S CONGRESS? (CONTINUED)

TUESDAY, OCTOBER 6, 2015

Board of Governors Reception and Dinner (Black Tie)
7:00–11:00 pm

WEDNESDAY, OCTOBER 7, 2015

Board of Governors Adjourned Meeting
8:00–9:00 am

B/G Executive Committee Meeting
9:15–10:15 am

Annual Business Meeting of Members
4:15–5:15 pm
McCormick Place West
Mark Savarise, MD, FACS

In 2014, the AMA Current Procedural Terminology (CPT) Panel issued clarification regarding coding of removal of skin and subcutaneous lesions, both benign and malignant. The impetus for this was miss-coding excision of sebaceous cysts and melanoma. Nevertheless, some surgeons still code these procedures incorrectly. Recent posts in the ACS Communities have advocated for this erroneous practice.

Sebaceous cysts (inclusion cysts, follicular cysts, and so on) are epidermal structures, and excision should be coded from the integumentary section, excision – benign lesions (codes 11400-11446), even though they extend into the subcutaneous space. Conversely, lipomas and other tumors of the subcutaneous tissues are coded from the musculoskeletal section, based upon their location, size, and whether they are subcutaneous or intramuscular.

Likewise, melanoma, regardless of its depth, is a malignancy of the skin and should be coded from the integumentary section, excision – malignant lesions (codes 11601-11646). These codes are grouped by location and diameter of excision. The codes are valued to include simple (nonlayered) closure. For larger lesions, a more involved closure should be coded separately. The RVUs of the closure often exceed those of the excision.

Although it is tempting to use the musculoskeletal codes for some of these larger, deeper lesions, the recent AMA review has received the attention of payers, including Medicare. Claims filed with the wrong CPT codes associated with the ICD codes for these diseases could trigger audits and penalties.
Melissa Johnson’s epiphany happened in a hospital room 15 to 20 years ago, back when they called the place Sioux Valley Hospital and not Sanford Health.

A cancer nurse by training, she was standing in the room of a very frail, very elderly woman.

Surgeon Dr. Gary Timmerman bent low nearby, pulling up the covers for his patient, tucking her into bed, lingering there until he knew she had everything she needed.

“It was like, ‘Wow,’” Johnson recalls now. “I’ll be honest, I had never thought of surgeon as a possible career for me because, I mean, establishing a good relationship with your patient and having a good bedside manner ... those were important to me, and I didn’t think it was possible as a surgeon.”

Until that moment.

Ask her today, and Dr. Melissa Johnson will tell you it was a selling point in her decision to pursue a different career track – as a surgeon at the Veterans Affairs Medical Center in Sioux Falls. But just as important as that bedside manner now is the fact she also has signed on to help Timmerman run the newest residency program at the University of South Dakota Sanford School of Medicine, a five-year training exercise in general surgery meant to spread more such physicians across the rural landscape.

It’s the first new general surgery residency at a medical school in this country in the past decade. That it’s at USD says something about the clout and standing Timmerman wields among his medical brethren across the United States.

At 56, the Watertown native just finished a one-year reign as chairman of the American College of Surgeons’ Board of Governors – the first physician from this state to hold that prestigious and powerful position. It’s a role that took Timmerman to some of the most important legislative halls in Washington, D.C. It also made him a leading voice in a medical organization that counts 85,000 members globally and is the second largest organization of physicians in the world behind the American Medical Association.

He championed many initiatives with the Board of Governors – from standardizing recommendation letters for residency applicants to focusing on substance abuse within the profession. But Timmerman’s greatest glory for his home state might come from his leadership on the new surgery residency.

Continued...
Rebirth of residency

The USD medical school had such a program 30 years ago. It flourished from 1964 to 1984 under the leadership of Yankton’s Dr. Chet McVay.

But when the Graduate Medical Education Advisory Council looked across America in the mid-1980s and predicted that the 64,000 general surgeons practicing then would double by the year 2000, “they looked for what I call the low-hanging fruit to stop programs that were producing these surgeons,” Timmerman said.

USD’s program went away.

That big jump in surgeons never materialized. It had increased to 66,000 by 2000. Worse, what surgeons there were in rural America were dwindling, either because of retirement or the draw to specialized practices in urban settings.

In 1992, 45 percent of graduating general surgeons in America went on to fellowships training them as breast surgeons, vascular surgeons and other specialties. Today, 80 percent of surgeons specialize. Now, in a country that graduates 1,000 surgeons a year, only 200 go down the general surgical path, Timmerman said.

The problem with that, Johnson said, is that specialty surgeons are much less likely to enlist in the 24/7 rotation so necessary to trauma centers and rural hospitals.

“They don’t want to be taking calls overnight,” she said. “But without that, American hospitals can’t survive. If all your surgeons are getting subspecialties, then who’s left to provide that emergent care?”

Ben Jorgensen, Will Stinson and Derek Dirks are some of the surgical residents at the University of South Dakota Sanford School of Medicine. (Photo: Jay Pickthorn / Argus Leader)
The American College of Surgeons recognized the looming crisis. As it considered options to answer the shortfall, the idea of building more programs that specifically trained general surgeons floated to the surface. The question was, “where to create these programs?”

That’s when Timmerman’s hand went up.

In the mid-2000s, he saw 50,000 surgeries being performed annually at Sanford, Avera McKennan, the VA and the Avera Heart Hospital and lamented the fact that no one was learning from that work. “To me, it was volumes in a library, and nobody’s going in to read the books,” he said.

The federal government pays for residency training out of Medicare and Medicaid funding but doesn’t finance new programs unless existing ones go away. So Timmerman needed an investor, and Sanford Health stepped up with an initial pledge of $2 million to launch the five-year program.

With teaching and administrative assistance from surgeons including Johnson and Dr. Thavam Thambi-Pillai, the program took flight. It runs smoothly day-to-day now because of the heavy lifting of Amber Johnson, coordinator for the general surgery residency.

With three slots for each of the initial two classes, there are six medical school graduates in the mix now, with another three about to come on board. When the program finally gets to its fourth and fifth years, 15 future surgeons will be at some stage of training.

“I had no idea how many people would be interested in a brand-new program,” Timmerman said. “So guess how many people applied for the first six spots … where there was no proof we could even produce a surgeon? Close to 700, mostly from U.S. med schools, wanting and knowing that we’re going to train rural, community-based, broad-based general surgeons.”

The plan, of course, is that these future surgeons won’t just populate operating rooms in Sioux Falls and Rapid City, the only two communities in South Dakota the federal government doesn’t view as rural. While some candidates have expressed an interest in doing missionary work – that’s fine with Timmerman – the medical school has focused on students with Midwestern roots who are drawn to rural life.

Statistics show that up to 80 percent of medical students stay in the area where they do their residencies, said Dr. Mary Milroy, a general surgeon at the Yankton Medical Clinic and president of the South Dakota Medical Association.

“So I know with this program, when they’re selecting their residents, they’re picking people who say they want to practice in a rural setting,” Milroy said. “I’m extremely optimistic this is going to be a tremendous benefit to the state.”

Tremendous in a number of ways, Timmerman agreed. For one, when surgeons and hospitals in communities such as Winner, Spearfish, Huron or Brookings struggle with recruiting, there’s a good chance the residency program can help them.
With the blessing of the Accreditation Council for Graduate Medical Education and the American Board of Surgery, the medical school is allowed to send a third-year resident to one of those communities for “what is almost like a one-month job interview,” Timmerman said.

“So then that’s exactly where I want to go to those communities, go to those hospitals and say: ‘I’ve got three surgeons coming out. What would it take to put one in your community?’” he said. “Let those communities come up with a package, and let them make it look enticing. And most of these kids, most of them are Midwest people who are going to want to go back to rural medicine.”

Potential effect

The thing is – those communities will end up with more than a surgeon. They get a tremendous economic development boost as well, Timmerman said.

An Oklahoma State University study in 2010 found that a general surgeon practicing in rural America is likely to generate more than $1.3 million for a hospital. On top of that, an additional $1.4 million and 25.9 jobs are generated in the community in which the general surgeon practices.

So there is job, income and tax revenue creation there. And for people in rural South Dakota who have money, insurance and needs but don’t have access, “There is an answer,” Timmerman said.

Had he not been so heavily involved from a leadership standpoint in the American College of Surgeons, “I’m not sure this all would have happened,” Milroy said. “He had very good connections. He had passion. Somebody needed to really be the champion to make the surgical residency happen. It was Gary.”

What he hopes surgical residents get out of this program is more than just technology and techniques that come with operating room practice. There’s the humanity side as well, the one that Melissa Johnson saw in that elderly woman’s room so many years ago.

While renowned for his work in cancer surgeries — he was the first surgeon in the Upper Midwest to robotically perform a transhiatal esophagectomy — Timmerman said his students still need to understand and learn the difficult realities of limitations that exist.

Here’s the sad reality: He might be able to remove all of a patient’s cancer. The pathologist likely will confirm that. But low cure rates affiliated with, say, esophageal or pancreatic cancers “mean in five years it will come back in your lungs or your brain or your liver,” he said.

“So you can reassure your patients,” he continued. “But they live their remaining lives with the ghost in the back of their head that the cancer could come back, even though Timmerman said it’s gone. That’s sad. These med students need to understand that.”

He brings them into the room with him when he shares bad news, like a fly on the wall.

Continued…
“I’m not afraid to cry in front of my patients,” he said. “I’m not afraid to hold a hand ... to give a hug. They’ve got to see that we’re not these Teflon people that everything bounces off of.”

And when the sadness becomes too much, the stress of the job too burdensome, Timmerman likes to get in his car and head west toward Marion and the family farm passed down by his grandparents.

There, he might escape to simply mow the grass. Or to sit on a tractor and turn the soil in little four-acre plots that he plants with corn or soybeans or sorghum. They’re meant to attract deer and pheasants, but there’s little hunting that goes on here.

Instead, he’ll climb into a deer stand at sunrise and watch nature come alive. A seven-point buck can stroll by beneath him, and he probably won’t even notice.

“When I’m sitting in the silence or on the tractor, God puts epiphanies in my head that say, ‘You were worried about this; why didn’t you do that?’” he explained. “It lets me deal quietly, by myself without distraction, with issues that are really pertinent to patient care.”

Like how he’s going to get more surgeons into rural America. Or what else he could have done for a very frail, very elderly patient.

In the quiet or in the clatter, the answers always seem to come.

To Timmerman’s benefit. And to South Dakota’s as well.

“The opportunity to envision, design and implement a surgical residency program requires strong financial and cultural support. As you know, the Department of GME does not sponsor new resident programs with first year start-up costs or resident/faculty employment reimbursement. Our program was unselfishly sponsored by Sanford Health Systems which provided the necessary economics including construction expenses, simulation equipment, personnel and an undying system-wide “can do” attitude. Without that support, our program would likely still be my desire, not our reality.”

-Gary Timmerman, MD FACS
THE TIMMERMAN FILE

Name: Dr. Gary Timmerman
Age: 56
Hometown: Watertown

Family: Wife, Gena; two sons, Chris and Adam; daughter, Ashley Flynn

Occupation: General surgeon; chair of the Department of Surgery at the University of South Dakota Sanford School of Medicine; associate professor in the surgery department at the USD Sanford School of Medicine

Education: Bachelor’s degree, University of South Dakota; doctor of medicine degree, Washington University School of Medicine, St. Louis; general surgery residency, Rush Presbyterian St. Luke’s Medical Center, Chicago

Dr. Timmerman was the Chair of the Board of Governors from 2013 to 2014.
A TIMELESS JOB DESCRIPTION

“To eliminate that which is superfluous, restore that which has been dislocated, separate that which has been united, join that which has been divided, and repair the defects of nature.”

Ambroise Pare 1500–1590
SAVE THE DATE

September 1, 2015
2016 Resident Research Scholarships

October 4–8, 2015
Clinical Congress

October 12, 2015
2016 ACS/SVS/NHLBI

November 2, 2015
2016 Faculty Research Fellowships

November 16, 2015
2017 ANZ, Germany, and Japan Traveling Fellowships

December 15, 2015
2016 Oweida Scholarship
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