Surgeons
Diversified Investment Fund

SDIF:
One year later
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
From my perspective

Members of the College and of other surgical societies frequently contact me here at our headquarters in Chicago or approach me at meetings to discuss the challenges of surgical practice in the 21st century. As you all know, the ongoing threat of payment cuts, encroachment from other health care professionals, the emergency workforce shortage, rising liability premiums and practice expenses, and other negative trends are causing many surgeons real financial and emotional pain. Indeed, these problems have precipitated so much disillusionment and dissatisfaction that some surgeons are opting to retire early or to enter into another line of work.

After hearing so many negative “war stories” from surgeons in the trenches, I found it refreshing to recently speak with a surgeon who has managed to not just to survive but to keep moving ahead during these turbulent times. Kent Kessler, MD, FACS, is a general/vascular surgeon practicing in rural Kentucky. He and his partners recognize that surgical practice today differs from what it used to be and have made adjustments not only in where and how they deliver care but also with regard to their attitudes and expectations.

I found his insights and suggestions so impressive that I wanted to write a column summarizing what he has done. Then I realized that it would be impossible for me to present his findings and recommendations any more clearly than he could, so I asked him to submit the following commentary for publication in the Bulletin (see pages 4-5). I anticipate that many readers will find Dr. Kessler’s strategies for diversification and growth useful in their own practices.

“I anticipate that many readers will find Dr. Kessler’s strategies for diversification and growth useful in their own practices.”

I have heard from many surgeons who engaged in similar exercises. Dr. Kessler is just one example from whom we can all learn.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
How a rural general surgeon remains competitive

by Kent J. Kessler, MD, FACS

The front page of the June edition of Surgery News, the official newspaper of the American College of Surgeons, features an article summarizing comments surgeons made during an open forum at the College’s Spring Meeting this past April in Las Vegas, NV. These surgeons, who are from all areas of the U.S., talked about the exact same issues that are affecting my partners and me in our four-person practice in Richmond, KY. I recently had a conversation with Dr. Russell, who thought it would be useful to the membership if I provided some insights into how my partners and I are coping with these challenges.

My background

I have been in the private practice of general/vascular surgery in Richmond for the past 11 years. I completed my residency at Good Samaritan Hospital in Cincinnati, OH, where I received wonderful training in general, vascular, endoscopic, and laparoscopic procedures. My training more than adequately prepared me to step into a busy practice. Unfortunately, what it didn’t prepare me for was the various political and socioeconomic issues revolving around the practice of general surgery.

Never in my wildest dreams would I have thought that declining reimbursement, malpractice insurance, and emergency room coverage would become such contentious issues at this point in my career. When I first started to practice, most of the patients presenting to the emergency department (ED) had private insurance, and the call coverage was not that busy. Now, the vast majority of patients presenting to our ED are uninsured or insured via Medicaid. Furthermore, the volume of surgical patients coming through the ED has more than doubled. The fiscal realities of this situation are obvious. My malpractice insurance premium has increased by two to three times the amount I used to pay, and reimbursement steadily declines each year. Therefore, I am very empathetic with regard to the comments some of the participants made at the Spring Meeting’s open forum with respect to decreasing reimbursement, ED call coverage, and rising office expenses. I experience the same dilemmas each and every day.

How we survive

So, how do my partners and I remain competitive in the present practice environment? First of all, my group is fairly aggressive, and we have built relationships with multiple hospitals and referring physicians to support our practice. We have several rural clinics where we provide our services, and we try our best to provide good care to patients in the local communities and good service to the referring physicians. We also perform a wide variety of general/vascular procedures and take on endoscopic cases to supplement our operative caseload. In addition, we have invested heavily in technology, including several quality ultrasound machines, vascular laboratory equipment, and a mammotome biopsy machine, so that we can perform operative and nonoperative procedures in our office. We also participate in a physician-owned surgery center, where we perform outpatient procedures. In short, we try to remain diversified both in our location and in the scope of services we offer in order to remain competitive. We have not been successful yet in convincing the local hospitals where we take ED call to reimburse us for our time spent doing so, but this is an ongoing issue.

It is interesting to observe that the current challenges in surgery are forcing many older surgeons into retirement, while the younger surgeons are left with feelings of “dashed expectations.” All general surgeons need to wake up to the reality that we are in a new practice environment and we must change the way we practice in order to remain competitive. We must diversify our sources of practice income and where we offer our services. At the same time, we must continue to provide...
the best-quality care possible. I also think that the future will dictate that general surgeons form larger groups to benefit from economies of scale and to more adequately negotiate with insurance carriers.

**A balanced life**

I would also recommend that surgeons as a group develop and nurture personal interests outside of surgery. When all you deal with is medicine and its related issues, you can quickly become frustrated, angry, tired, and depressed.

Life is not all about surgery. Find an outside interest. Do something different. Participate in your community and in faith-based activities. Most importantly, participate in your families. The only way to be a good surgeon is to be a good physician. The only way to be a good physician is to be a good person. One of the ways to be a good person is to be a good spouse and parent. Stay involved with your family, and the problems you experience in the medical profession will seem minuscule. I find great satisfaction in spending time with my wife Ellen, our three children, and our German Weimaraner. I also take pleasure in various outside interests, such as gardening, fishing, and caring for a large purple martin colony.

**ACS can help**

The leadership at the American College of Surgeons seems to be very aware of the problems we are facing. I would like for the American College of Surgeons to continue to aggressively lobby members of Congress about such issues as reimbursement rates, medical liability reform, and ED coverage. I would also like to see the College explore the possibility of negotiating with one or two companies that can provide members with good-quality, electronic medical recordkeeping systems at a reasonable cost. Because I do not trust the government to implement a fair pay-for-performance system, I encourage the ACS to work with other stakeholders to ensure that it becomes and remains a fair and equitable method of reimbursement. Lastly, I applaud the College’s recent efforts to launch the Surgeons Diversified Investment Fund.

You know the situation must be pretty bad when the American College of Surgeons has a town forum at the Spring Meeting and surgeons see it as an opportunity to vent their frustrations. Are we going to step up to the plate and change the system from within, or are we going to continue to have annual “gripe” sessions? Although we may not all agree on whether the College provides the best representation to general surgery as a whole, it certainly could be a lot worse. Why don’t the 43,000 eligible members of the College try something different? Let’s participate in one of the oldest traditions in American society—something for which physicians, quite frankly, have a terrible track record—and support our political action committee (PAC). Let’s all donate $250 to $500 apiece to the American College of Surgeons Professional Association’s SurgeonsPAC and lobby our representatives in Congress just as hard as the trial attorneys do. My own check has been written and delivered.

Each and every day when I go to work, I ask myself if this is really what I want to do, and each and every day when I realize what a difference I can make in the lives of my patients if I perform my job to the best of my ability, the answer is “yes.” We can complain about the situation or we can do something about it. Let’s do something. Get involved, write to your legislators, keep delivering high-quality compassionate care, and, most importantly, stick together.

*Dr. Kessler is a general/vascular surgeon practicing in Richmond, KY.*
On July 11, Rep. Pete Sessions (R-TX) introduced the Medicare Physician Payment Reform Act of 2007 (H.R. 3038), which would repeal the sustainable growth rate (SGR) formula used to calculate the Medicare fee schedule conversion factor update. As the College and the American Osteopathic Association have advocated, H.R. 3038 would replace the SGR with the service category growth rate (SCGR). Unlike the SGR, the SCGR would recognize the different types of services that physicians provide and establish separate payment levels for each category. In this way, the SCGR would provide incentives for the continued provision of preventive and chronic care services to Medicare patients without penalizing other service categories, such as major surgical procedures, that have experienced little or no growth in volume.

One of the SGR’s many flaws is that it sets a target for the growth in Medicare spending for physician services. Whenever spending on physician services exceeds the SGR target in one year, the surfeit costs must be recouped in future years, leading to across-the-board cuts in physician reimbursement rates. These reductions occur regardless of whether the spending for particular types of services has stayed within the limits imposed by the SGR. For example, over the last several years, the growth in spending on major surgical procedures has remained consistently lower than spending in other service categories, yet surgeons have continued to experience the same threats of payment reductions.


On July 12, the Centers for Medicare & Medicaid Services (CMS) published a proposed regulation outlining Medicare physician payment policy changes for 2008. The notice states that the Medicare fee schedule conversion factor still is slated for an estimated 9.9 percent reduction effective January 1, 2008. Other provisions in the proposal that may interest surgeons are as follows:

• The work adjuster that is applied to relative work values would change from –10.1 percent in 2007 to –11.8 percent in 2008 (a 1.7% drop in payment), primarily because of a proposed 32 percent increase in work values for anesthesia services.
• The geographic practice cost indices, which are reviewed every three years, would be revised to reflect new data on resource cost differences among localities. The most significant decreases are expected in northern California, where Santa Clara, for example, will see an estimated 4.63 percent reduction in payment. The largest proposed increase is estimated at 2.17 percent in Miami, FL.
• The multiple procedure payment reduction, under which payments for additional operations performed by the same physician during the same operative session are reduced 50 percent, would now be applied to Mohs surgery.
• An expanded list of clinical and structural measures would be incorporated into the Physicians Quality Reporting Initiative (PQRI).
However, no new measures would be used until the National Quality Forum endorses them or the AQA adopts them. Without congressional action, no funding is available to continue this year’s policy of providing a bonus payment to physicians who report the PQRI measures.

Assuming Congress halts the 9.9 percent cut in the fee schedule conversion factor, the combined effect of all the proposed payment policy changes on the surgical specialties in 2008 would be relatively minor. Most surgical specialties—including general, orthopaedic, plastic, and vascular surgery, as well as obstetrics-gynecology and urology—would experience a 1 percent net decrease in Medicare income. Colorectal surgery would see no net effect, whereas cardiac, general thoracic, hand, and neurological surgeons would be subject to the greatest decline (2%). Ophthalmologists and otolaryngologists would experience modest net increases of approximately 1 percent.

The proposed regulation may be viewed on the CMS Web site at http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1200867&intNumPerPage=10. At press time, the College was drafting comments about the proposal; public comments were due on August 31.

CMS disseminates NPI information

CMS began disseminating National Provider Identifier (NPI) information to physicians via the Internet on August 1. CMS has decided that any data that were submitted but not required in order to obtain a NPI may be disclosed in response to queries. Providers may delete this information by submitting another NPI application form and completing only the required fields. CMS had originally intended to make NPI information available to physicians via the Internet effective June 28 but delayed implementation so physicians would have time to update or delete information before its release. For more information, visit http://www.cms.hhs.gov/NationalProvIdentStand.

State health systems report available

The Commonwealth Fund’s Commission on a High Performance Health System recently released Aiming Higher, a report that follows up on the group’s 2006 report, A National Scorecard on U.S. Health System Performance. Aiming Higher compares the performance of state health systems, focusing on 32 indicators such as access, quality, avoidable hospital use and costs, equity, and healthy lives. The report presents overall rankings and scores for each factor. The Commonwealth Fund anticipates that states with low ratings in a performance indicator will use the report to begin a dialogue with higher-ranking states to develop methods of improving quality across the U.S. The report can be accessed at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551.

Two days before the Commonwealth Fund released Aiming Higher, the Agency for Healthcare Research and Quality issued findings from a similar project, State Snapshots, which can be accessed at http://statesnapshots.ahrq.gov/statesnapshots/index.jsp.
It has been said that there is no true preparation for a disaster. Authorities in the trauma community would disagree. In most sophisticated trauma systems, various scenarios are played out in rehearsed simulations, and these scenarios are varied to better prepare the first responders and health care personnel, should the real event occur.

Such was the case in the city of New Orleans, LA. Our city has been supported by a sophisticated level I trauma center at the Medical Center of Louisiana in New Orleans (MCLANO) since the mid-1990s. Long before the official designation of Charity Hospital as a level I trauma center, MCLANO had been one of those urban hospitals that managed thousands of injured patients on a yearly basis. Charity Hospital was as prepared as any facility could be prepared to manage a disaster, be it of a natural origin (related to weather or earth) or produced by man (thermal-nuclear, conflagration, mass transportation interruption, mechanical, terrorist, or other).

In fact, the trauma system in New Orleans had staged a simulation entitled Hurricane Pam in the spring of 2005, four months before the behemoth Katrina devastated New Orleans and.

**Surgery in a disaster:**

Assessing the lessons of the Katrina event

by

J. Patrick O’Leary, MD, FACS
the coastal regions of Louisiana, Mississippi, and Alabama. Hurricane Pam was a class 5 storm that almost exactly predicted the course that Katrina would follow. The simulation was extensive, almost exhaustive, and the performance of the system was deemed acceptable with several areas of critique that stimulated appropriate modifications in the overall plan. All seemed to be ready for the hurricane season.

**Surgeons in disaster systems**

Disasters differ from one another not only by the locale in which they occur but also by the rapidity of the onset. In certain circumstances, the prodrome for disaster would be the time from the identification of the potential destructive force and its actual occurrence. They also differ in terms of the nature of the destructive force, be it an explosion (no warning), an earthquake (minimal warning), or a weather-based event (longer prodrome). In addition, other factors have an impact on the magnitude of the destruction such as duration of such an occurrence and the magnitude, not only with regard to the violence of the event but also the surface area over which the destructive force is deployed. Disasters also differ by their effect on victims and survivors in the proximity and also in the magnitude of the lingering effect after the disruptive force has passed.

In any system preparing for a disaster, surgeons play a critical role. All disasters are a local event, but it is often true that coping with the effect of the disaster must involve a regional or even national response. Surgeons must become involved in all areas of the preparation and execution of the plan. Planning for the response to a disaster needs to occur long before the event. Simulations of the various types of events that could occur in a locale should involve all of the groups that can affect the response to the disaster. With each simulation, every level of response must be critically analyzed with brutal honesty, and the assessment of the execution must be presented and critiqued. After such an exhaustive evaluation, more planning is in order. It is only through this type of exhaustive preparation that loss of life can be minimized when the real disaster occurs.

In the midst of the disaster, the surgeons' role moves from the passive, introspective, intellectual person assessing the situation into a creature of action. The first assessment of the event should be of the resources that can be immediately applied to the event. Next comes a triage of patients and personnel, and this translates into the beginning of the intervention phase. Resources are applied where they can be of the most value and the valuable time of the health care providers is applied where they can have the greatest benefit to the largest number of individuals.

**The intervention phase**

The intervention phase is punctuated by ingenuity, creativity, and efficiency. As the intervention phase matures, stabilization of the situation should be anticipated. A detailed reassessment of the situation may identify other areas where triage, intervention, and stabilization should be addressed. At all phases, documentation of the events is critical. This documentation can be as pedestrian as writing on the patient’s bandages the early assessment of the injuries and what treatment has been instituted. Patients should be evacuated from areas of highest risk as soon as feasible. It is often important to plan evacuation of medical staff to complement the evacuation of patients who are in need of in-transit care. After the time of most critical intervention, a time of closure should be planned for patients and caregivers to deal with the emotional stress.

**The assessment phase**

One of the most critical parts of reaction to a disaster is the assessment phase. The assessment should clearly identify the resources that can be applied in the management of the catastrophic event. Categories that must be assessed include type and number of personnel available, issues of security, and communications with individuals at ground zero and outside of the zone of maximal effect. The assessment should also include the availability of food and water as well as other supplies, including medical supplies. In addition, the situation should be evaluated for the presence or absence of electrical power, matters of sanitation, and whether transportation is available, be it by land or air.

In the assessment of the aftermath of Katrina, there were clearly two phases. As the hurricane passed over the Gulf Coast, New Orleans was lashed by winds consistent with the class 3/class 4
hurricane that Katrina had become and the torrential rains that accompanied the hurricane. In comparison to the overall damage done by this storm, the injury to New Orleans was relatively small. The hurricane had reached class 5 proportions during its course over the warm waters of the Gulf of Mexico and it was the storm surge that peaked at about 32′ that truly devastated the Gulf Coast of Mississippi and parts of Alabama. As the surge rushed inland up to 15 miles, the devastation was immediate and death, where it occurred, was quick. On the Gulf Coast of Louisiana, the surge overcame many levees on the peripheral defense of the state and then was channeled via industrial and intercoastal waterways as though through a funnel until it crashed into the levees in immediate proximity to New Orleans and along the shore of Lake Pontchartrain. Many of these levees were breached and water poured into the city. With a sizable proportion of the landmass of the city being lower than sea level, even when the sea was not agitated, torrential waters now poured into the city. Trillions of gallons of water settled over the landscape, rendering transportation in the city impossible except by boat.

**Hurricane Katrina**

The Katrina event began on the evening of Sunday, August 28, 2005, and the skies began to clear on Monday afternoon. Although the flooding had already begun in certain areas of the city, the central business district where the hospitals were located did not begin to see water in the streets until Monday evening. By Tuesday morning, the water was already several feet deep throughout the central city. In the Louisiana State University (LSU) School of Medicine, located adjacent to the hospitals, the water finally peaked at approximately 6′ deep during the latter part of the week. In the assessment of the assets available to health care professionals in the immediate time after the water’s intrusion, there probably were enough personnel at Charity Hospital and the Veterans Affairs Hospital—where members of the LSU department of surgery were stationed—to care for the approximate 700 patients at risk.

Electrical power at Charity Hospital failed in the early Monday morning hours during the peak onslaught of the hurricane. The emergency auxiliary power came online and then failed when a short in the primary diesel generator occurred in the third hour of its operation. A number of smaller gasoline generators were mobilized and were used in the most critical areas of the hospitals. The majority of these generated power for the ventilators in the intensive care units. Ultimately, these also failed when fuel supplies were exhausted.

It should be mentioned that heroism was commonplace during the hurricane and flood that followed. These heroes were average people who really didn’t seek out to be heroes but they were. Heroes were found among the faculty, house staff, and staff of these facilities, among friends and families of patients, and even some of the patients themselves. Everyone did what was necessary to protect patients. Everyone contributed. Doctors pushed gurneys and carried patients downstairs. Nurses fanned patients when the air conditioning failed and some of the janitorial staff collected fuel from sunken vehicles so that gas-powered generators could continue to run and deliver electrical power to the respirators. Occasionally, in the most dire of circumstances, individuals commandeered stranded vehicles (specifically box-bed trucks) for the movement of patients to sites of relative safety.

Security was severely challenged as gunfire resounded throughout the city. Some former military individuals were deputized and the security force performed admirably in these dismal circumstances. Medical supplies were damaged when winds blew out windows and drugs were in short supply as looters ransacked the pharmacies in several of the facilities. Food supplies dwindled as the event continued. Most of the hospitals had enough food to provide for the patients and staff for three days, but before patients were evacuated, some of the facilities had been under duress for more than six days.

Communications were reasonable within the first 24 hours and then began to fail. Firstly, communications failed because electrical power was not present to recharge batteries and then it failed as more and more individuals began to use those few frequencies that remained open. The most reliable way to reach the outside world was using ham radio operators who stood by their radios beginning on the second day after the hurricane and continuing until the weekend when all patients were ultimately evacuated. Sanitation was also a
problem, but this was ultimately solved by placing plastic liners into five-gallon buckets with an attachable lid. Gallons of bleach were distributed. When a small amount of bleach was added to the improvised toilet after each use, the stench was reduced. Much more elaborate apparati failed to perform adequately.

Although there are many parts of New Orleans below sea level, there are also many places that are much higher. Flooding never occurred in the French Quarter or along the Mississippi levee system running to the west from the downtown district. Flooding occurred in the eastern end of St. Charles Avenue, but there were some parts of St. Charles well above water. There was very little flooding to the west side of the 17th Street Canal, the area of the city known as Metairie, and the south end of the Causeway, a 24-mile bridge spanning Lake Pontchartrain and ending on the north shore of the lake adjacent to a major interstate road that was also undamaged. These areas represented the embarkation points as survivors and patients were moved from the area of flooding out to other medical facilities. Ambulances transported patients across the lake to the interstate system and then to Baton Rouge and ultimately to Lafayette. Patients who reached safety from the Louis Armstrong Municipal Airport were evacuated to various sites across the country. Other individuals found a variety of different modes of transportation and spread out across the southern part of the state of Louisiana, many of whom ended up in the few principal cities to the west.

Katrina’s call for surgeons

Although there was some evidence of surgical intervention within the hospitals in the city, much of the work done by surgeons was triage and stabilization. Multiple specialties—from geriatrics to pediatrics and from psychiatry to surgery—were represented at these hospitals. A number of internists and critical care specialists were present. The surgical interventions provided to these patients ranged from consultation to stabilization of wounds, critical care management, and intravenous access both superficial and deep. The most elaborate surgical procedure performed (that I am personally aware of) was the reattachment of an arm that had been partially amputated at Earl K. Long Charity Hospital in Baton Rouge.

Lessons learned

The lessons learned are multiple and worthy of exhaustive study. In this disaster, the hurricane was an event and carried with it great sorrow, but the flood was the real catastrophe. The effects were long and lingering, and the loss of life and property was horrendous. At the most recent count, at least 1,084 deaths in the area have been directly attributed to the storm. Communication failed and this failure was, in part, related to the failure of electrical power. The timing and coordination of the relief effort were probably not optimal, but the magnitude of the event was unprecedented in modern history. No one could have ever anticipated the degree of destruction present. The other and probably most important lesson learned was about the depth, the magnitude, and the resilience of the human spirit. Despite horrendous conditions, those in harm’s way worked to save lives and minimize human suffering in ways that will become legend. Each in his or her own way was a hero in the truest sense of the word!

Dr. O’Leary is the Isidore Cohn, Jr., Emeritus Professor and emeritus chairman of surgery at Louisiana State University Health Sciences Center in New Orleans. He is also executive associate dean for clinical affairs, Florida International University College of Medicine, Miami, FL.
The key concept for the ACSPA-SurgeonsPAC

Patient access to timely, effective surgical care is at the heart of the message. There is a growing crisis in the provision of surgical services as the effective number of surgeons declines as a result of a fixed number of training slots, greater narrowing of the scope of surgical practice with subspecialization, earlier retirement of surgeons, and the influence of lifestyle issues on career choice. The result has been a steady relative decline in the number of surgeons available to serve a growing population, stress on emergency call schedules, and the closing of trauma centers. (See Figure 1, page 13). Contributing to the problem of an insufficiency of surgeons has
Figure 1: Physicians per 100,000 population

![Figure 1: Physicians per 100,000 population](image)

Table: Impact of the resource-based relative value scale with inflation

<table>
<thead>
<tr>
<th>Procedure</th>
<th>% Change, 1989–2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract</td>
<td>–69.3%</td>
</tr>
<tr>
<td>Total knee</td>
<td>–50.7</td>
</tr>
<tr>
<td>Total hip</td>
<td>–56.6</td>
</tr>
<tr>
<td>Carotid artery endarterectomy</td>
<td>–50.1</td>
</tr>
<tr>
<td>Transurethral resection of the prostate</td>
<td>–46.6</td>
</tr>
<tr>
<td>Partial mastectomy</td>
<td>–25.2</td>
</tr>
<tr>
<td>Colostomy</td>
<td>–25.8</td>
</tr>
<tr>
<td>Laminectomy</td>
<td>–62.4</td>
</tr>
<tr>
<td>Hernia</td>
<td>–37.3</td>
</tr>
<tr>
<td>Coronary artery bypass graft</td>
<td>–54.0</td>
</tr>
</tbody>
</table>

been the simultaneous increase in the cost of liability insurance in our litigious society and the significant decline in compensation for surgical services under the Medicare fee schedule.

Reimbursement under the Medicare fee schedule remains a major, ongoing problem for surgeons. The flawed formula governing payments—the sustainable growth rate (SGR)—holds total Medicare payments to a fixed total tied to the gross domestic product by bundling major surgical services, which are not increasing, with the cost of nonsurgical services (evaluation and management services, office visits, chemotherapy drugs), which are growing rapidly. As a result, surgeons have been facing an annual cut of approximately 5 percent. (See Table, right.)

Political action has staved off these cuts up to the present time, but the temporary fixes leave us facing a 10 percent cut in January 2008 and 5 percent more per year for at least seven years. The estimated cost of fixing the SGR outright would exceed $250 billion, a pill that Congress has been unwilling to swallow. Nonetheless, bills have been introduced that could bring about a significant, long-term improvement instead of the yearly legislative brinksmanship of the recent past. One important solution currently being entertained would give surgeons a separate conversion factor for Medicare services so that we would no longer be affected adversely for growth in other medical sectors over which we have no control. Surgeons need to be on the scene to move these fixes forward; we cannot afford to be passive spectators while competing interests work against us.

Surgeons need to speak out about numerous other issues as well, including sustained funding for graduate medical education, increased training positions to ensure that patients will continue to have access to surgical care, and support for a health care system that affords near-universal coverage. Manifestly, we must continue to emphasize the oppressive costs of the current tort system for resolving liability questions—costs that are passed on to the patient in large part and are driving many surgeons out of practice.

SurgeonsPAC is a critical tool for informing legislators about these problems and securing
a seat at the table to craft and influence solutions for addressing them. Congressional offices are bombarded by lobbyists and special-interest groups, some of which are antithetical to or at least competitive with our aims. Since the institution of the ACSPA-SurgeonsPAC four years ago, our access to congressional offices has markedly improved. Our message is reaching legislators’ ears with increasing ease and frequency—a very real and important measure of success. We have helped to elect five ACS Fellows to Congress, and the rate of success for all candidates we have supported has been 85 percent.

If, in addition to the education and advocacy efforts of the PAC, every surgeon were to set aside five minutes per week to call his or her senator or representatives to weigh in on important issues, the roar of the crowd (50 calls per year from each of 50,000 surgeons = 2.5 million annual calls to Congress) would be powerful indeed.

Although ACSPA-SurgeonsPAC is not the only surgical PAC in Washington, DC, it is important to note that only ACSPA-SurgeonsPAC can speak for all of surgery on the issues that are common across subspecialties. SurgeonsPAC does work closely with other surgical specialty PACs and recognizes the critical role they play for their constituents. There is a defined need for both the ACSPA-SurgeonsPAC and the others.

With ACSPA membership in the ballpark of 45,000 members (the size of an entire ballpark, indeed), the potential of the SurgeonsPAC is staggering. Relative to ACSPA membership, the support for the PAC has been modest (in 2006, 3% of ACSPA members contributed an average of $315). We have the membership and capacity to become the biggest medical PAC in Washington, but after four years, we still have much room to grow. (See Figure 2, this page.)

Political action on behalf of surgeons and their patients must be viewed as an ongoing, continuous effort with long-term goals to be achieved in increments. There will always be new endpoints as well as changing and evolving strategies. Surgery’s political pressure must be steady and ever-growing. The competition for attention and political gains is omnipresent; surgery cannot afford to be off the playing field.

Members of the ACSPA who would like further information on how they can get involved in the ACSPA-SurgeonsPAC are encouraged to contact Sara Morse, Manager of ACSPA-SurgeonsPAC, at 202/672-1512 or smorse@facs.org. They also may visit the PAC’s Web site at www.facs.org/acspa by clicking on the ASCPA-SurgeonsPAC logo. An ACSPA user ID and password are necessary to enter the Web site.

Dr. Warshaw is the Chair of the Board of Directors of the ACSPA-SurgeonsPAC. He is also the W. Gerald Austin Professor of Surgery at Harvard Medical School and the surgeon-in-chief and chairman in the department of surgery at Massachusetts General Hospital, Boston.
Do barrier drapes reduce surgical site infections?

by Nathan L. Belkin, PhD

The intensity of the pressures to control and contain health care costs is accompanied by the need for the surgical community to consider the cost-to-benefit ratio of practices that have become ingrained in surgical technique. Such practices continue to be performed even though they may not influence the outcome of the procedure. One of these practices is the use of barrier surgical drapes.

**Barrier drapes and SSI**

The use of surgical gowns and drapes evolved as a standard of practice more than a century ago. Their main function was to protect the sterile field from microbial invasion. It was in 1939 that Devenish and Miles first questioned the effectiveness of the readily permeable material of which the surgical gowns were made. Having observed that blood and saline were penetrating the sleeve to the skin of the forearm, they reasoned that bacteria from the forearm could similarly pass from the surgeon to the patient. As a solution, it was suggested that the sleeves be made of a fabric that had been treated with a rubber coating on both sides. Although this rendered the material to be impervious, its use was not generally adopted because of its discomfort.

Subsequently in 1952, William C. Beck, MD, FACS, warned the surgical community that although the material that was being used for the gowns and drapes may have been considered to be a satisfactory bacteriological barrier when it was dry, it lost that capability once it became wet.

For some time thereafter, most operations were still performed with gowns and drapes made of the traditional, readily permeable material. Lacking scientific evidence to justify the use of a more expensive barrier fabric, the community awaited the publication of a study to support its use.

The results of the first published study were reported by Joseph D. Moylan, MD, FACS, in 1980. His findings indicated that whereas the rate of infection with reusable nonbarrier materials was 4.42 percent, the incidence of a surgical site infection (SSI) with the disposable barrier fabrics was reduced to 1.98 percent.

However, Dr. Moylan subsequently acknowledged that “additional matched clinical studies are necessary so that with better understanding of barrier characteristics, laboratory bench tests can be correlated to wound infection rates.”

Nevertheless, although the study’s findings were not conclusive, their use mushroomed the use of the barrier-quality disposable products. In addition to igniting the heated reusable versus disposable controversy, their use was further skewed by a reimbursement system that made any single-use disposable a profit generator, as this item was reimbursed at cost plus patient charge. Thus, the concern for the patient’s welfare and the possibility of reducing the incidence of a surgical wound infection were totally overshadowed.

**Sources of infection**

The major contributing factors to the incidence of SSI have been described by Harold Laufman, MD, PhD, FACS, as the “5 Ds” and defined as follows:

- Discipline of the surgeon
- Defense mechanism of the patient
- Drugs (prophylactic antibiotics)
- Design of the surgical suite
- Devices, of which surgical gowns and drapes are but one category of the hundreds of items used.

Thus, those cases that are performed on body sites that are considered “clean” should have a low risk of infection because they would come primarily from contamination external to the body (exogenous). Therefore, if barrier materials were to be expected to have the greatest effect on reducing infections, it would be in those procedures.

The largest and most frequently cited study that reports rates of infection in class I clean procedures is the analysis done by Peter J. E. Cruse, MB, FACS, FRCS. This most comprehensive study covered a period of 10 years with all the procedures performed with gowns and drapes made of “usual cotton.” Particularly noteworthy is that of the 47,054 clean procedures with gowns and drapes both made of a nonbarrier reusable material, the incidence of SSI was 1.5 percent.8

In a commentary on the preoperative measures to prevent complications, Dr. Cruse stated the following:

In the final analysis, two factors determine the development of infection: the dose of contamination and the resistance of the patient. Resistance depends most on adequate nutrition. Contamination can be introduced from exogenous sources such as the surgeon’s hands or air and droplet contamination or it can be endogenous, originating from the patient’s bowel flora, urinary tract, biliary tract and elsewhere. Endogenous contamination is far more important than all the exogenous factors combined yet paradoxically, the aseptic religion is aimed at the satan of exogenous contamination.7

**Defining a barrier**

Up to this time, although manufacturers of both reusable and disposable fabrics made claims about the barrier capabilities of their products, the results of their proprietary tests could not be correlated. In the interim, under the leadership of Harvey R. Bernard, MD, FACS, and Dr. Beck, the American College of Surgeons’ Board of Governors Committee on the Operating Room Environment challenged industry to develop a test method that would simulate the stresses to which a material would be subjected under what they astutely described as “usual conditions of use.”8

With the emergence of the era of preventing the hazards associated with the transmission of bloodborne pathogens, whatever “strikethrough” of materials that may have been tolerated in the past was no longer acceptable. With a pressing need for a test, a standard was established under the auspices of the American National Standards Institute and the Association for Advancement of Medical Instrumentation.9

The standard classifies a barrier’s performance capability at four levels, three that are tested with water. Barrier drapes, on the other hand, must be made of a class IV fabric that is required to pass a test when challenged by surrogate blood and at a level of pressure of two pounds per square inch.10

**Protection for the patient**

What was not considered in requiring this level of protection for the patient are the advances in surgical technique and changes in the marketplace that may antiquate the need for a drape to be made of an expensive class IV barrier fabric. For example, consider the following:

- If the surgical gown protects the surgeon, it simultaneously protects the patient from the surgeon. This being the case, from whom or what does the class IV barrier-quality drape protect the patient?
- With the trend toward small incisions and minimally invasive procedures, how vital is it to use a drape made of a class IV barrier fabric that has been challenged by surrogate blood?
- A survey of draping practices found that almost two-thirds of respondents use incise drapes.11

If, as Dr. Laufman has stated, “the area that particularly requires impermeability is the area around the fenestra, or the peri-incisions area,”12 why is it necessary for the drape to be made of the most expensive class IV barrier-quality materials?

- If a drape is to be considered an item of protective clothing for the patient, should it not be chosen based on the same factors (that is, the level of exposure anticipated for the patient) that were used to choose the surgeon’s gown?
- Data released by the American Hospital Association indicate that 16,700,000 (61%) of the 27,200,000 surgical procedures reported for 1997 were performed in hospitals on an outpatient ba-
sis.13 With an increasing number of procedures also being performed in office surgery centers and freestanding ambulatory surgery centers, how vital is it for drapes to be made of the most expensive and costly class IV barrier-quality materials?

**Conclusion**

The Centers for Disease Control and Prevention (CDC) maintains that “There are limited data that can be used to understand the relationship of gown or drape characteristics with SSI risk. The wide variation in products and study designs make interpretation of the literature difficult.”14

The CDC’s position is further supported by a recently published review of experimental, clinical, and epidemiological studies of gowns and drapes in which the authors concluded that the studies were “of limited relevance because of methodological flaws and product improvements.”15

The fact of the matter is that there is no real, empirical evidence demonstrating the influence of patient drapes made of a class IV barrier-quality fabric on the outcome of a surgical procedure. As Ronald L. Nichols, MD, FACS, has observed, “A practice cannot be justified on the basis of anecdotal experience or commercial interests; it must be evaluated by its influence on the outcome of surgical procedures and supported by scientific facts.”16

As evidenced by a review of the literature, the need for an unbiased, statistically valid conclusive research on the influence of barrier drapes on SSI remains. Until such data become available, the need cannot be indisputably defended.17

**References**


**Dr. Belkin** retired in 1991 after 40 years in research and development of surgical textiles. He lives in Largo, FL.
As of June 30, the Surgeons Diversified Investment Fund (SDIF) net assets were approximately $43.5 million. SDIF’s total return since the inception date of September 22, 2006, to June 30, 2007, was 12.63 percent. SDIF’s return can be compared against the return of 11.73 percent for the combined index of the S&P 500 Index/Lehman Brothers U.S. Aggregate Index* during the same period. Current performance may be lower or higher than the quoted past performance, which cannot guarantee future results. Share price, principal value, and return will vary and you may have a gain or loss when you sell your shares.

SDIF was created in September 2006 to help ACS members and affiliated organizations develop a healthy financial future. SDIF provides busy surgeons and organizations with access to a professionally managed, diversified investment program. SDIF is a no-load, open-end, asset allocation mutual fund that seeks to provide long-term capital appreciation and income through the fundamental investing principles employed by the endowment fund of the College—asset allocation, diversification, and rebalancing.

Asset allocation is the discipline of combining asset classes—stocks, bonds, and cash—to achieve an optimally balanced portfolio. Asset classes, considered alone, may vary greatly in performance and risk potential. By combining them in a diversified portfolio, one can seek an ideal ratio of risk versus reward. For instance, adding bonds to a 100 percent stock portfolio may lower return potential and possibly reduce volatility by an even greater margin. (See Figure, this page.)

Diversification and rebalancing are two additional investment principles used by SDIF. Diversification can help to manage risk and may increase return potential by ensuring that a portfolio remains invested in a variety of sub-asset classes, each of which will exhibit performance variations over time. Rebalancing is the process of returning to the original allocation. Over time, a portfolio’s diversified asset allocation will shift as certain investments outperform others. Rebalancing keeps a portfolio focused on specific objectives and prevents the risk level from moving too far in one direction or another. Rebalancing can be one of the hardest things to do, as it is counterintuitive: you must sell your winners and buy more of your losers in order to get back to your target allocation. Busy professionals may lack the time to rebalance regularly and consistently. SDIF rebalances to the determined allocation at least quarterly.

Figure: Asset allocation

*The S&P 500 Index/Lehman Brothers U.S. Aggregate Index reflect an unmanaged portfolio of 70 percent S&P 500 Index and 30 percent of Lehman Brothers U.S. Aggregate Index.
Targeted allocation
SDIF invests, on average, 70 percent of its securities in equities and 30 percent in fixed income. The asset allocation for SDIF is actively managed. In February, the investment advisor recommended to adjust the allocation by shifting 3 percent from small cap stocks to large cap stocks. In June, the investment advisor recommended to adjust the allocation by reducing 1 percent of large cap value equities, 1 percent of large cap growth equities, and 2 percent from international equities, to add a 4 percent emerging market component. See the Table at right for an illustration of these changes.

SDIF currently invests in exchange-traded funds (ETFs), which hold a portfolio of common stocks or other securities designed to track the performance of a particular index. ETFs differ from traditional index funds in that their shares are listed on a securities exchange and can be traded throughout the day. When SDIF has accumulated net assets of at least $100 million, it intends to retain additional investment sub-advisors in the equity and fixed-income markets to achieve SDIF’s investment objective and to invest in securities other than the ETFs.

How to invest
SDIF is available to be used as an investment vehicle in individual accounts, such as traditional individual retirement accounts

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<th>U.S. equity</th>
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<td>8%</td>
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<td>Large cap growth stocks</td>
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<td>Energy stocks</td>
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| International equity | 25 | 25 | 23 |

| Emerging market | N/A | N/A | 4 |
| U.S. fixed income | 30 | 30 | 30 |

| Total | 100% | 100% | 100% |

Disclosure
An investor should consider the investment objectives, risks, and charges and expenses of SDIF carefully before investing. SDIF’s prospectus contains this and other information about SDIF and should be read before investing.

Performance numbers have been positively affected by fee waivers and/or expense reimbursements. Without such fee waivers and/or expense reimbursements, performance numbers would have been lower. Returns for SDIF are before taxes and are net of all expenses and advisory fees. All index returns listed herein also include the reinvestment of dividends, distributions, and interest (total return). The returns shown do not reflect the deduction of taxes a shareholder may pay on the redemption of SDIF shares or SDIF distributions.

Target allocations are subject to change. As a result of SDIF investing in other funds, an investor will pay a proportionate share of the expenses charged by the underlying funds invested in. In addition, SDIF is subject to the same risks as the underlying exchange traded funds that it invests in, including, among others, interest rate risk, credit/default risk, market risk, international investment risk, derivatives risk, management risk, and liquidity risk.

SDIF is distributed by Ultimus Fund Distributors, LLC, 225 Pictoria Dr., Suite 450, Cincinnati, OH 45246; 513/587-3400.
A program of regular investing does not ensure a profit or protect against depreciation in a declining market. Because a consistent investing program involves continuous investment in securities regardless of fluctuating prices, you should consider your financial ability to continue to purchase through periods of various price levels.

Risks
SDIF is subject to the same risks as the underlying ETF that it invests in, including interest rate risk, credit/default risk, market risk, international investment risk, derivatives risk, management risk, net asset value risk, and liquidity risk. Investing in the underlying ETFs indirectly through the fund, an investor will incur not only a proportionate share of the expenses of the ETFs held by SDIF, but also a share of the expenses of SDIF Diversification and rebalancing neither ensure a profit nor eliminate the risk of experiencing investment losses. For a more complete discussion of the risks associated with an investment in SDIF, obtain a copy of the current prospectus and read it closely before investing.

More information
For more information about SDIF or regarding the waived minimum, contact Savitri Pai at 312/202-5056 or spai@facs.org or Tom Kiley at 312/202-5019 or tkiley@facs.org. Both individuals are registered representatives available to discuss specific details regarding SDIF. You may also visit the Web site at www.surgeonsfund.com or call 800/208-6070.

Visit http://www.surgeonsfund.com/fundinfo/performance.html for performance information current through the most recent quarter-end. Performance information through the most recent month-end can be obtained by calling 800/208-6070. SDIF’s prospectus may be obtained by downloading it from SDIF’s Web site.

The American College of Surgeons hopes that many of you will explore this new investment opportunity it is providing for its members. It is anticipated that this service will be of assistance in alleviating some of the financial pressures that members all face.

†A program of regular investing does not ensure a profit or protect against depreciation in a declining market. Because a consistent investing program involves continuous investment in securities regardless of fluctuating prices, you should consider your financial ability to continue to purchase through periods of various price levels.

(IRA), Roth IRAs, simplified employee pension IRAs, simple IRAs, rollover IRAs, beneficiary/inheritied IRAs, profit-sharing plans, and regular personal investment accounts. SDIF can also be used as an investment vehicle in institutional accounts, such as associations, foundations, societies, chapters of the American College of Surgeons, hospital and university retirement plan platforms, surgical group practice plans, and others.

The suggested minimum investment to participate in SDIF is $25,000, but waivers of the minimum are possible. The minimum investment has been modified for Medical Student Members ($500), Resident Members ($1,000), and Associate Fellows ($2,500) of the College. For those who find it appropriate, an automatic investment plan is also available.

Like a model ship in a bottle, a Jaguar is being restored in the basement of an eye surgeon in Philadelphia, PA. It’s not a basement garage, but a regular basement with normal doors and stairs that lead to the ground floor of the house. It makes for a fun bit of conversation when children come to visit.

“They see this car and I say, ‘Oh, I’ve been building that for years—I can’t wait until I’m done so I can drive it out,’” said Michael A. DellaVecchia, MD, PhD, FACS, director of the emergency department at Wills Eye Hospital in Philadelphia.

The residential Jaguar—one of four automobiles Dr. DellaVecchia is currently restoring—is parked in the basement because its owner likes to use an amazing range of technical skills to solve problems. He needed a place to work on the car; the basement was available, and the only barrier was a retaining wall that separated the garage from the basement. Naturally—that is, if you’re Dr. DellaVecchia—the solution was to redesign the wall.

“I modified the wall so it could be taken apart,” he said, “and then I pushed the car into the basement and put the wall back up.”

A drive to fix things
Dr. DellaVecchia’s first car, purchased when he was in graduate school, was a used Volkswagen Bug, considered worthless by its former owner, a fellow student, and sold to him for a dollar (required to transfer deed of ownership); the second, a 1962 red Jaguar with approximately 100,000 miles on the odometer. He bought it in the mid-1970s, during his pathology residency, for something like $800.

“Partly I was going to restore it and partly I was going to just drive it around,” he said. “I bought it and became sort of depressed over the purchase because it was the first time in
my life I bought something that wasn't really necessary.”

But friends intervened to nurture his relationship with the car. Originally, Dr. DellaVecchia did not have access to a garage, so that first Jaguar was parked on the street. New friends came calling.

Longtime friend Richard Showalter said of Dr. DellaVecchia, “I grew up in the same neighborhood and I used to go over and help him work on his cars.”

Then a Jaguar mechanic befriended Dr. DellaVecchia and informed him that just one old car was no good. He advised that buying a “spare car” as a source of parts would reduce downtime for the car being refurbished.

“Lo and behold, that’s what I did and, the next thing I know, I had four Jaguars in various states of disrepair,” he said.

An inventor by nature, Dr. DellaVecchia owns a machine shop—two lathes, a drill press, other mechanical tools, design software, and so forth—that allows him to make parts for the automobiles on occasion.

He currently has four Jaguars in various stages of rehabilitation. Three of them are XK-Es, dating back to a golden era between 1961 and 1974. A two-seater E-type is credited with revolutionizing sports car design, says Dr. DellaVecchia.

Growing up in southwest Philadelphia, Dr. DellaVecchia is the only child of parents who emphasized education. They had both stopped school after fourth grade, and they wanted something different for their son.

And he wanted something different for his parents. Although the family did not own a car for most of Dr. DellaVecchia’s youth, he celebrated a career milestone by taking care of that.

“When I got out of residency, I wanted to buy my father a really nice car,” he said. “Dad had his nice V12L Jaguar in southwest Philly.”

That car, like the others he has purchased over the years, was bought for a good price because it needed some work. The total he paid for all his Jaguars was $8,000. He does not restore them for investment purposes, but rather as a hobby that he devotes a few hours to each week.

“I can put on my iPod and ‘read’ or listen to a lecture while I’m working on the car,” he said.

Dr. DellaVecchia belongs to a Jaguar club, and although he showed his refurbished vehicles in the past, he no longer makes time for that. Although he is not actively in the market for additional cars, he is open to the possibility of adding to his collection. He enjoys them and so do his friends.

Mr. Showalter, whose wedding celebration featured two DellaVecchia autos—a sports car and a 1958 sedan—laments that the ophthalmologist does not spend enough time cruising around in the eye-catching automobiles.

“The biggest problem Mike has is he works too hard. He never has time to drive them,” he said. “His dedication to his work is unbelievable.”

**A physician who knows physics**

When they were in high school together, Richard Matkevich said, it was pretty clear that Dr. DellaVecchia was going to be a high achiever.

“We kind of knew he was destined for something big,” said Mr. Matkevich, a buyer for Lockheed-Martin and one of Dr. DellaVecchia’s many long-time friends. “I figured he would be a scientist.”

That was correct, although his career pushed beyond science. Using academic scholarships to pay for his education, Dr. DellaVecchia earned a bachelor’s degree in physics from LaSalle University and master’s and doctorate degrees in biomedical science and engineering from Drexel University.

From there, he went to Temple University School of Medicine, where he completed residencies in anatomical pathology, clinical pathology, and ophthalmology.

In fact, Dr. DellaVecchia is one of very few people to do three medical residencies on top of a doctorate in biomedical engineering. That mix of training and experience has served him well.

With dozens of research publications among his credits, Dr. DellaVecchia holds four patents. He has helped start companies, directed laboratories, advised state and federal emergency preparedness agencies, and served as a consultant to the U.S. National Aeronautics and Space Administration.

Throughout his career, he has taught ophthalmology, pathology, and engineering at his alma maters and other Philadelphia-area universities. In 2003, he moved into academic medicine full-time as director of the emergency department at Wills Eye Institute at Thomas Jefferson Uni-
University, considered one of the most advanced eye centers in the world.

Wills Eye Institute, one of the few hospitals in the country that has a 24-hour dedicated eye emergency room, draws patients from a wide region. Many of them have suffered a degree of trauma that requires the special expertise available at Wills.

Although he enjoys teaching and supervising residents, as well as the challenge of emergency room medicine, the Philadelphia location of Wills Eye is an added bonus to this lifelong Philadelphian who completed 18 years of higher education in three universities in one city.

“I ended up as director of the world-renowned emergency department within 10 minutes of where I was born and raised,” he said.

A few evenings and Saturdays each month are devoted to his private practice. “I didn’t want to abandon my patients, so I have a small, old-fashioned, almost country-type practice,” he said. “It’s just me and the patients.”

That means Dr. DellaVecchia serves as receptionist, billing clerk, and head of the information technology department.

“I have a lot of computerized technology so when a patient calls [and the call is missed], I know it and I can track them down,” he said. “So I call back and schedule an appointment.”

The private practice is not for extra income so much as to provide continuity of care for long-time patients and people they want to refer. Dr. DellaVecchia refers to the practice of giving back to the community, a theme that his old friends took note of a long time ago.

“His parents were always trying to make him a better person and he returned that by taking care of all the old folks in the neighborhood,” Mr. Matkevich said.

Even though he was trained as a pathologist and eye specialist, Dr. DellaVecchia was called upon for all sorts of medical advice in the neighborhood where he grew up.

“He knew people needed help, and he likes helping people out,” Mr. Showalter said.

The past is the present

It may not be the sleek design or the luxury mystique of old Jaguars that attracted Dr. DellaVecchia to his primary hobby so much as it was the collection of moving parts that needed to be set right. His friend Mr. Matkevich sees a pattern in the surgeon’s professional and pleasure pursuits.

“It all ties in together with [his interest in] the intricate details and the meticulous ways of doing things,” he said.

That is why, when he does not want to crawl under a car, Dr. DellaVecchia relaxes by repairing an old watch. He learned the skill by serving as a needed apprentice to his grandfather, who fixed watches as a part-time business.

“I remember as a small boy he would pick me up and place me on the kitchen table where he repaired his watches,” Dr. DellaVecchia said. “And he would have me put the little screwdriver in the little slots of the pocket watches so he could take them apart.”

Thus, his grandfather, who had poor eyesight, exposed his young grandson to two activities that have come to define his life.

“That was my first experience in repairing mechanical things,” he said. “And now that I look back on it, it was my first contact with a patient who was visually compromised.”

Starting with pocket watches inherited from his father and grandfather, Dr. DellaVecchia has collected at least 25 watches of different types in recent years.

“Because they are so old, pocket watches are generally kind of compromised,” he said. “You find ones that are in various states of disrepair, so you have to cannibalize other ones to get them working.”

In that way, fixing a watch gives the same satisfaction that restoring a luxury automobile does. He calls mechanical pursuits “therapeutic,” a distraction from working to save a patient’s eyesight.

“If something breaks, if something doesn’t work, if you get a bad outcome, it’s just metal,” he said. “And then on those days when you get it all running right, turn the key, go out for a nice drive…it’s worth the effort.”

Ms. Butcher is a freelance writer in Springfield, MO.
Program for Accreditation of Education Institutes continues to grow

By Carlos A. Pellegrini, MD, FACS; Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education; and Kathleen A. Johnson, EdM, Senior Manager, ACS Program for Accreditation of Education Institutes and Experiential Learning Programs
On June 6, the Program for Accreditation of Education Institutes added eight more institutions to the growing consortium of level I ACS-accredited education institutes (see box, this page). This was the third set of accreditation decisions made by the Accreditation Review Committee. Decisions are based on the review of the completed applications and surveyors’ reports. By the end of June, the College had accredited 18 level I Comprehensive Education Institutes and interest in the program remains strong. Applications for accreditation were recently requested by 13 new institutions.

This program was officially unveiled at the 2005 Clinical Congress in San Francisco, CA.

The vision of the Program for Accreditation of Education Institutes is to create a consortium of ACS-approved regional education institutes that offer practicing surgeons, surgical residents, medical students, and members of the surgical team a spectrum of educational opportunities, including those that address acquisition and maintenance of skills and focus on new procedures and emerging technologies.

The College is committed to providing accredited education institutes opportunities to develop new curricula and share experiences. Collaborative education, research, and development will also be pursued. The College hosted a meeting of the surgical directors of the accredited education institutes in March in order to establish common goals, the pursuit of which will benefit all the accredited institutes.

For information about the ACS Program for Accreditation of Education Institutes or how to apply for accreditation, contact Kathleen Johnson at kjohnson@facs.org or 312/202-5276, or Maura Boyle at mboyle@facs.org or 312/202-5535.

For a roster of Review Committee members, see the last update on the Program for Accreditation of Education Institutes in the March issue of the Bulletin (page 34).

**NEW ACS-accredited education institutes, as of June 2007**

- Louisiana State University Health Sciences Center–New Orleans Learning Center  
  *New Orleans, LA*

- Penn State Milton S. Hershey Simulation Center  
  *Hershey, PA*

- Mayo Clinic Multidisciplinary Simulation Center  
  *Rochester, MN*

- Northwestern Center for Advanced Surgical Education  
  *Chicago, IL*

- Department of Surgery Education Institute at Stanford  
  *Stanford, CA*

- Baystate Simulation Center  
  *Springfield, MA*

- University of Michigan Clinical Simulation Center  
  *Ann Arbor, MI*

- Maryland Advanced Simulation, Training, Research, and Innovation Center  
  *Baltimore, MD*

**Dr. Pellegrini** is Henry N. Harkins Professor and chair, department of surgery, University of Washington, Seattle, and a member of the Board of Regents.
ACS Fellows honored with 2007 Surgical Volunteerism Awards

Following careful consideration of another extraordinary field of nominees, the American College of Surgeons’ Governors’ Committee on Socioeconomic Issues has announced the recipients of the 2007 American College of Surgeons/Pfizer Medical Humanities Initiative (ACS/PMHI) Surgical Volunteerism Awards. The dedication to caring for the underserved that is demonstrated so consistently by Fellows of the College is a source of tremendous pride and admiration to us all.

This year, for the first time since the inception of the awards, the ACS/PMHI Surgical Volunteerism Award will be given in all three possible categories: domestic, international, and military.

Sylvia D. Campbell, MD, FACS, of Tampa, FL, will be awarded the Surgical Volunteerism Award for domestic outreach in recognition of a career defined by giving back to her local community. Dr. Campbell began volunteering at the Judeo Christian Health Clinic while a surgical resident at Tampa General Hospital, and her commitment to the clinic has grown over the ensuing 27 years as a volunteer and board member and in her current role as president of the board of directors. She has cared for thousands of patients in this role and further increases the impact of the clinic by recruiting

In accordance with Article I, Section 6, of the Bylaws, the Annual Business Meeting of Members of the American College of Surgeons is called for seven-thirty o’clock in the morning of Thursday, October 11, 2007, at the Ernest N. Morial Convention Center, La Nouvelle C, New Orleans, LA.

This session constitutes the annual business meeting of the Members, at which time Officers and Governors will be elected and reports from officials will be presented. Items of general interest to the Members will also be presented. Members are respectfully urged to be present.

Courtney M. Townsend, Jr., MD, FACS
Secretary
American College of Surgeons
August 1, 2007
other volunteers and raising funds to support its mission. In addition to this extraordinary level of commitment in her own community, Dr. Campbell also volunteers annually in Haiti, has been involved in efforts to build and sustain a school in Uganda, and traveled with the Florida Department of Health to Mississippi for nine days to provide care immediately after Hurricane Katrina.

Van C. Knowles, MD, FACS, of Albany, GA, has been selected as the recipient of the Surgical Volunteerism Award for his international outreach over the past quarter-century in Karakonam, South India. Since 1983, Dr. Knowles has made a commitment to this community that has culminated in the creation of a 500-bed multidisciplinary hospital and clinic with 14 operating rooms, a staff of 500, and an associated nursing and medical school complex. For his dedication to this effort, the facility has been named the Van Knowles Surgical Complex. Dr. Knowles is currently developing training programs for residents in general surgery; ear, nose, and throat; obstetrics-gynecology; ophthalmology; and public health. As president and chief executive officer of the Southwest Georgia Medical Mission Team that has been involved with Karakonam for the past two decades, Dr. Knowles has inspired by example, overseeing outreach projects, procuring necessary funding, and, of course, forming a lasting and meaningful relationship with the people of Karakonam.

Col. Thomas G. Crabtree, MD, FACS, of Kailua, HI, will be the first recipient of the Surgical Volunteerism Award for volunteer work performed while serving as an active-duty military surgeon. Distinguished by his ability to bring about innovative collaborations between military medicine, not-for-profit organizations, and government
agencies, Dr. Crabtree has been involved in the creation of several important surgical outreach programs. Among these is the Pacific World Care Project, a unique public-private partnership that provides treatment for children with severe craniofacial deformities throughout the Pacific Rim. While deployed in Iraq, Dr. Crabtree volunteered to create and staff a number of rural outreach clinics that provided primary care services and specialty referrals for hundreds of Iraqi citizens. These clinics remain in operation today, staffed by an array of international volunteers. In addition, he annually volunteers with Operation Smile during his available leave time, serving in nine countries to date with this organization.

The exceptional contributions made by Dr. Campbell, Dr. Knowles, and Dr. Crabtree will be formally recognized at the annual Board of Governors dinner on Tuesday, October 9, during the Clinical Congress in New Orleans, LA. We invite you to hear them speak about their inspiration and work at the plenary session on volunteerism (GS08)—which will be held on Monday, October 8, from 10:00 am to 12:00 noon—and to meet them and others dedicated to surgical volunteerism in all its many forms at a volunteer networking reception later that evening.

Full details on these events will be available in the Clinical Congress Program Book and on the Operation Giving Back Web site at www.operationgivingback.facs.org.

Dr. Pierce honored at Jacobson Award dinner

William Schuler Pierce, MD, FACS (back row, right), was presented with the thirteenth Jacobson Innovation Award of the American College of Surgeons during a dinner ceremony on June 8 in the College’s newly renovated John B. Murphy Memorial Auditorium.

Pictured with Dr. Pierce are his wife, Peggy Pierce (front row, right); Thomas R. Russell, MD, FACS, Executive Director of the College (center); and Julius H. Jacobson III, MD, FACS, and Joan L. Jacobson, who sponsor the award.

Trauma meetings calendar

The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:
• Advances in Trauma, December 7–8, Kansas City, MO.
• Trauma, Critical Care, & Acute Care Surgery–2008, March 24–26, 2008, Las Vegas, NV.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
Approximately 100 ACS Chapter Leaders and Young Surgeon Representatives gathered in Washington, DC, June 3–6, for the 2007 ACS Leadership Conference, where they learned how to enhance their leadership skills and influence health policy. Providing the attendees with this information were members of Congress, surgeon leaders, ACS staff, and other Washington insiders. The College’s Divisions of Advocacy and Health Policy and Member Services coordinated the presentation of the 2007 ACS Leadership Conference.

**Keys to success**

ACS President Edward M. Copeland III, MD, FACS—the Edward R. Woodward Professor and chair, department of surgery, University of Florida, Gainesville—provided the keynote address at the meeting. His speech focused on lessons in leadership that he has learned during his distinguished career, including the following observations:

- The closer you get to being history, the more you learn to appreciate it.
- It is essential to encourage and practice behaviors that enhance patient safety. If a test is ordered, know the result. If a tube is inserted, be sure it’s working. Talk to the patient. Be prepared for the unexpected.
- The friendship and respect of peers cannot be overstated. Be collegial with associates. Err on the side of inclusiveness, not exclusiveness.
- It is best to maximize your potential without hurting others. Remember, a career lasts a long time.
- By striving to make those around you successful, your success will grow.
- Sometimes you need to mentally change places with your colleagues. Try to see the situation from the other person’s perspective, and be the spokesperson for your colleagues’ opinions.
- It’s important to maintain an open-door policy, but you also need to protect time for yourself.
- You can learn as much from the mistakes of others as from their successes.
- To maintain your sense of optimism, investigate every negative event for its positive impact.
- It’s good to develop an outside interest in something besides operating in which you can succeed and compete.
- Good judgment needs to be combined with influence and patience.
- The art of “skillful neglect” eliminates 50 percent of the problems a department head experiences.
- It is a privilege to have the
life of another person placed in your hands. It is a unique privilege to train those individuals who assume the responsibility for the lives of others.

**Pay for performance**

A prominent political topic discussed during the meeting was reimbursement and the movement toward pay for performance (P4P). Frank Opelka, MD, FACS, Chair of the ACS Patient Safety and Quality Improvement Committee and Chair of the national Surgical Quality Alliance (SQA), led a panel discussion on this concept, also known as value-based purchasing. According to Dr. Opelka, the movement toward P4P stemmed from several factors, including rising health care costs, gaps in care, the decreasing capacity for employers to offer health insurance benefits, and the increasing number of uninsured Americans.

To play an influential role in the development of P4P, the surgical community needs to generate valid outcomes measures, Dr. Opelka said. These measures should demonstrate the observed versus expected ratios for the entire operative team (not just the surgeon) and should be risk-adjusted. Under a value-based model, surgeons will need to provide evidence that they are providing “the right care at the right time for the right reason,” Dr. Opelka added. He noted that the College formed the SQA to arrive at measures that account for the unique nature of surgical services.

Debra L. Ness, MS, president of the National Partnership for Women and Families, provided the consumer perspective, asserting that the existing health care system is failing patients. Costs are out of control, quality is inadequate, and information is scant. Furthermore, as health care spending outpaces inflation, more businesses are being forced to shift insurance costs to their employees, with the money coming out of wages and benefits. As a result, many working Americans have a hard time meeting their financial responsibilities. “Medical bankruptcies account for about 50 percent of all personal bankruptcies,” according to Ms. Ness.

Furthermore, patients have a “50-50 chance of getting the right care,” Ms. Ness said. Medical errors occur too frequently, variations in quality are evident across populations, and racial disparities continue to exist, she added.

To resolve these problems, the health care system needs greater transparency, payment reforms, and increased use of health information technology (IT). Transparency will lead to better quality of care because “what gets measured and publicly reported improves more and faster,” Ms. Ness said. Payment reform is necessary because “the current system has enormously perverse incentives,” rewarding volume instead of outcomes, she added. Health IT is essential for quality measurement and for comparative effectiveness research that will lead to evidence-based medicine and clinical guidelines.

James Cowan, MD, MPH, head of clinical programs and operations for Aetna, Inc., provided the payor’s perspective. Dr. Cowan noted that currently, “good care” is defined on the basis of whether outcomes match expectations, medical science is applied, and resources are used efficiently. Presently, payors rely on claims-based performance measures. However, “claims-based measurement does not measure many aspects of clinical care,” such as a patient’s weight and blood pressure, and therefore it has limited accuracy, he said. In order to implement P4P, more definitive methods of measuring quality are needed. “We need your help to make this work well,” Dr. Cowan added.

Julie Lewis, Associate for Quality Programs, ACS Division of Advocacy and Health Policy, explained the Physician Quality Reporting Initiative (PQRI), which the Centers for Medicare & Medicaid Services (CMS) was preparing to launch at the time of the meeting as a likely precursor to P4P. “The PQRI is the first national program linking reporting to payment for physicians,” Ms. Lewis said. Physicians who participate in the PQRI pilot project, which is in effect July 1 through December 31, 2007, receive a bonus of up to 1.5 percent of their allowed charges for all claims reported during that six-month period.

The 74 quality measures used in the PQRI were developed by physicians’ groups and represents a great collaborative effort, Ms. Lewis noted. The American College of Surgeons developed six measures that are applicable to many surg-
cal specialties. Other surgical and medical organizations that contributed to the development of the measures include the American Academy of Ophthalmology, the Society of Thoracic Surgeons, and the American Medical Association’s Physician Consortium for Performance Improvement.

Members of Congress

Over the course of the meeting, seven members of Congress spoke about health system reform, reimbursement, liability, and other legislative issues of concern to surgeons.

All of the representatives who participated in the meeting agreed that the current health system is in critical need of reform and that the nation cannot continue operating under the status quo, but they differ in their opinions about how best to resolve the problems. Rep. Pete Sessions (R-TX) said the main argument is over whether the nation should adopt a single-payor or consumer-driven system. “I happen to be one of those who don’t believe universal health care that follows a single-payor model would be good at all,” he said. Instead, he favors a consumer-driven approach that would provide tax cuts and incentives for people to pay for their care. “People need affordable care with an emphasis on prevention,” RepresentativeSessions added.

Other members of Congress echoed Representative Sessions’ views on health system reform. Rep. Charles Boustany, MD, FACS (R-LA), said, “We should open the insurance market and open it widely.” He also said he believes consumers should have access to information that will help them to make wise decisions about their care. “Families should be able to take control of their health care” and should be given incentives to invest in health savings accounts.

Similarly, Reps. Tom Price, MD, FACS, and Phil Gingrey, MD, both Republicans representing congressional districts in Georgia, endorsed a consumer-driven system. “A government-run system would be a disaster for medicine,” Representative Price said.

However, other members of Congress, including Pete Stark (D-CA), Chair of the House Ways and Means Subcommittee on Health, question the effectiveness of a market-driven system. “I don’t think it will save us money to go with a market-driven system,” Representative Stark said. Instead, he favors incremental movement to a universal health care system that builds on Medicare.

Reps. Earl Pomeroy (D-ND) and Bart Gordon (D-TN) stopped short of offering any specific proposals regarding health system reform and in-
stead encouraged the meeting participants to offer suggestions to their members of Congress. “When it comes to health care, you’re the experts,” Representative Pomroy said. “We have got to figure out how we heal a system that is unsustainable in its current condition. We can all agree on that,” he added.

Members of Congress also expressed their concerns about Medicare reimbursement and the use of the sustainable growth rate (SGR) to calculate updates, agreeing that the methodology is ill conceived. Several members of Congress, however, said that the 9.9 percent reduction in physician Medicare payment scheduled to take effect in January 2008 probably will be delayed. “My suspicion is we will kick the can down the road another year or two,” Representative Price said. He also said that the long-term fix to the SGR is fundamental reform of the Medicare payment system.

Representative Stark also predicted that the 9.9 percent payment reduction was unlikely to occur next year. “We’ll probably postpone cuts in their entirety for a couple of years. It’s a zero-sum game at this point,” he said.

“We should eliminate the SGR all together,” Representative Pomroy said. “This has become a problem too big to fix.”

Most of the Congressmen also suggested that expanded use of electronic medical records and quality measures would be useful in reducing costs, improving patient safety, and making the move to P4P. “Electronic medical records are hugely, hugely important, and the President has pushed for [their use throughout the nation],” Representative Gingrey observed. “They save lives and save money” by reducing the likelihood of errors.

The health care system needs to be more efficiently run, and health IT is one possible mechanism for achieving that goal, added Representative Gordon, who chairs the House Committee on Science. However, at this point, there are concerns about the interoperability of IT systems and patient privacy.

Representative Stark and other members of Congress who spoke at the meeting also noted that physicians should receive some reimbursement for making the move for electronic medical recordkeeping. “Then maybe we can start a P4P system” and more accurately measure quality of care, he added.

“Quality is extremely important,” Representative Price added. However, he warned that it is very important to consider who is defining it. “Only specialty societies can define quality,” he added.

In addition, the members of Congress addressed the emergency surgical care issue. Representative Sessions noted that, “Our emergency rooms are back up with people who don’t have insurance,” and this reality is putting financial strains on the entire health care system.

To help reduce the trends that are affecting patients’ ability to receive quality emergency care, Representatives Sessions and Gordon have introduced the Access to Emergency Services Act of 2007, H.R. 822. The bill calls for the creation of a national bipartisan commission to examine the factors impeding the delivery of care in U.S. emergency departments, Representative Gordon explained. In addition, the legislation calls for increasing physician payments for services provided to Medicare beneficiaries under the Emergency Medical Treatment and Active Labor Act.

The congressmen also discussed medical liability reform. Representative Gingrey said he has introduced a bill containing provisions that are similar to those in California’s Medical Injury and Compensation Reform Act. He is looking for bipartisan support to ensure passage of the legislation. Representative Gordon said that he has supported medical liability reform bills in the past, but did not get the sense that the Congress was making any real effort get the law enacted. “We have to think outside the box on this,” Representative Gordon said. “Let’s look at what is going on in the states” to find alternatives.

In addition to addressing issues of concern to surgery, the representatives gave the meeting participants some advice about how to talk about their concerns to their elected officials during meetings and on political advocacy in general.

Representative Price said that surgeons should always start their conversations with a focus on the patient, using phrases such as “I can’t take
care of my patients because...,” or “My patients can’t get proper care because....”

“The most important component [of political advocacy] is to make sure that you know your member of Congress and that your member knows you and what you do,” Representative Sessions added.

“Be patient with us. We welcome your advice,” Representative Stark said.

**Inside Congress**

Judy Schneider, a policy analyst with the nonpartisan Congressional Research Service, reprised her entertaining and educational presentation from the 2005 Leadership Conference. Once again, she provided insights into how Capitol Hill operates and how surgeons can influence the legislative process.

“Congress was not created to pass law, but to prevent bad law from getting enacted,” according to Ms. Schneider.

Three factors drive Congress —policy, politics, and procedure. “The Senate is a very political chamber,” Ms. Schneider said, adding that committee chairs are often selected on the basis of seniority, rather than knowledge of policy. Fortunately, “The committee system is not as integral to the [Senate's] legislative process as you would think,” Ms. Schneider said. “Most work is done on the Senate floor.”

On the Senate floor, all senators are equal. “The Senate lives and dies by two words: unanimous consent,” Ms. Schneider said. Debate on the Senate floor ends when the chamber is able to invoke closure, which process “entails 60 senators voting to tell you to shut up,” she added.

“As unimportant as the committee system is for the Senate, that’s how important it is in the House,” Ms. Schneider added. “The House lives and dies by rules and procedures.” In the House, she said, committee and subcommittee hearings often are staged “to get America riled up.” As a result, we now witness “celebrity hearings” on a regular basis. “America responds to celebrity. I’m not saying it’s right or wrong, but it’s a statement of fact,” Ms. Schneider noted.
Most importantly, representatives are sent to Washington to develop policies that serve the interest of the constituents of their districts. “House members have to do the right thing for the people back home,” Ms. Schneider said. “If you don’t tell them what to do, somebody else will,” she added.

Ms. Schneider encouraged the meeting participants to be resolute in their discussions with members of Congress and to not be intimidated by their power. “Most [senators and representatives] are very average people whom we have asked to do a very difficult job,” she added.

**ACS advocacy staff**

Christian Shalgian, Manager of Congressional Affairs in the ACS Division of Advocacy and Health Policy, briefed the participants on the issues being discussed in Congress that are of greatest concern to this organization.

Topping the list is Medicare reimbursement for physicians’ services and the scheduled 9.9 percent reduction in payment beginning in January 2008. According to Mr. Shalgian, Medicare physician payment will be cut 41 percent between 2008 and 2016 if the SGR remains in place, adding that Congress has the following three options for addressing the pay cut: Do nothing and let the reduction go into effect, stop the cut in 2008 and for another year or two thereafter, or enact full-blown reform. While the latter alternative may seem most appealing, overhauling the Medicare reimbursement system will cost the nation $250 billion, he said. The College’s message on Medicare payment is that Congress should stop the pay cut and enact large-scale reform to preserve patient access to quality care.

One mechanism for replacing the SGR that has received widespread consideration in Congress, CMS, and the Administration is pay for performance. “This is not going away. We are not going to be able to stop this train,” Mr. Shalgian said, noting that CMS is already setting the stage for P4P through pilot testing of the PQRI.

Other federal issues of concern to the College include stagnant funding for cancer research, the expense surgical practices will incur when adding health information technology, funding for graduate medical education, trauma systems development, the overburdened emergency workforce, medical liability reform, and expanded scope of practice for nonsurgeons, Mr. Shalgian said.

Mr. Shalgian offered further advice for those meeting participants who were planning to visit their legislators’ Capitol Hill offices during the conference. He warned that many meetings will take place with a senator’s or representative’s health aides, rather than with the actual member of Congress. “Do not dismiss congressional staff,” Mr. Shalgian said. These are the people who often tell the member how to vote.

He also told participants to follow up on their visits to Capitol Hill. “[Advocacy] is all about relationships—relationships with staff and members of Congress,” Mr. Shalgian said. “You want them to use you as a resource for information on health policy.”

Jon Sutton, Manager of State Affairs, and Melinda Baker, State Affairs Associate, Division of Advocacy and Health Policy, presented an overview of state legislative issues. Specific state-level matters of concern to the College at this time include changing requirements for maintaining state licensure, certificate of need requirements for surgeons who operate ambulatory surgical centers, liability, provider taxes, and expanded scope of practice for nonphysicians, Mr. Sutton said.

Ms. Baker explained how the ACS State Affairs staff can help chapters and College members bring about change at the state level. First, they are available to speak at chapter meetings on specific issues as well as advocacy skills. State Affairs staff also can be instrumental in planning a day at the state capital, developing and promoting a position on a bill, and preparing testimony, Ms. Baker added.

**Leadership development**

In addition to the sessions on advocacy and health policy, the conference comprised three concurrent sessions on various aspects of leadership skills.

During one workshop, Stephen R. T. Evans, MD, FACS, professor and chair, department of surgery, Georgetown University Hospital in Washington, DC, talked about change in institutional environments. According to Dr. Evans, change entails conquering technical
and adaptive challenges. Technical challenges are tangible and amenable to authoritative expertise and standard operating procedures. Adaptive challenges, which represent 90 percent of the obstacles that leaders face, are more complicated and call for changing people’s values, attitudes, and behaviors. These transformations require experimentation, discovery, and adjustment, Dr. Evans said.

To effectively bring about change, leaders should make observations, ask questions, offer interpretations, and take action. Dr. Evans noted that surgeons often skip the middle steps and go directly from making observations to taking actions. Effective leaders “let the issue ripen,” he said. They ask what’s on other people’s minds, gauge how deeply people are affected by the problem, and consider what other authorities are saying and doing.

Surgeons have the potential to be effective leaders because they are intelligent, tenacious, hard-working, empowered, high-profile individuals, Dr. Evans said. Furthermore, they identify and fix problems every day. On the other hand, some surgeons possess characteristics that work against their viability as change leader. They consider themselves among the intellectual elite and see the world as black and white. These individuals are often seen as too busy, resistant to change, dissatisfied with their careers, and egocentric, he noted. The strongest leaders, according to Dr. Evans, demonstrate personal humility and professional will. They are driven to make their institutions or organizations great, and they attribute success to those around them and failure to themselves.

“Real leadership—the kind that surfaces conflict, challenges long-held beliefs, and demands new ways of doing things—causes pain,” Dr. Evans warned. “When people feel threatened, they take aim at the person pushing for change. As a result, leaders often get hurt both personally and professionally,” he said.

Mary E. Maniscalco-Theberge, MD, FACS, a general surgeon in Reston, VA, and Past-President of the Metropolitan Washington Chapter of the College, and John H. Armstrong, MD, FACS, of University of Florida, Gainesville, addressed the issue of engaging young surgeons in the profession. “We as leaders need to be passionate about what we do,” including efforts to bring young people into the fold, Dr. Maniscalco-Theberge said.

Today’s surgeons of the future are members of Generations X (born between 1965 and 1977) and Y (born between 1978 and 1995), she said. Members of Gen X focus on productivity in the workplace, are motivated by time off, have a low sense of loyalty to the company, view money as a means to an end, and value time with their families. They thrive on change, work fast, are straightforward, are not intimidated by authority, do not like structure, multitask, and achieve goals on their terms. They want “direction without dictation,” Dr. Maniscalco-Theberge observed.

Members of Gen Y have been raised during times of considerable prosperity and globalization, and their parents, mostly Baby Boomers, showered their children with attention and high expectations. As a result, members of Gen Y tend to have a great deal of self-confidence. Because they grew up in the computer age, they are fluent in technology. They expect structure in the workplace,
acknowledging and respecting chain of command; prefer to collaborate; and are highly tolerant of social and cultural differences. They like clear instructions and deadlines and thrive on their mentors’ approval, Dr. Maniscalco-Theberge said.

In short, the members of the generations just entering or considering a future in surgery are very different from the surgeons who are heading the departments of surgery, looking for younger partners, or training residents. “It’s not the way it’s always been, and we need to get over it,” Dr. Maniscalco-Theberge said. “We cannot make them be like us, but we can all have the same shared goal of providing the best patient care,” she added.

“In many senses, we are herding cats,” in the effort to engage young members of the profession, Dr. Armstrong said.

Before an organization or institution can effectively recruit new members, it needs to know itself, Dr. Armstrong said. Ask some basic questions: What does your organization do? What’s your focus? What is your “brand”? Who do you serve? Dr. Armstrong suggested conducting market research to find out what the organization’s members and prospective members think about the organization.

To build and sustain membership, an organization needs to forge a relationship with its members. The strength and longevity of this connection depends on the organization’s ability to communicate with members, offer meaningful activities, and create a community of trust. “Recruitment is only the beginning. Retention is where the rubber meets the road,” Dr. Armstrong added.

In addition, Patricia A. Clark of Communication Strategies in Ogden Dunes, IN, led a session on how surgeons can communicate effectively with the media and the public. Some tips that Ms. Clark provided include the following:

• Have an objective in mind before responding to any question.
• Anticipate difficult questions and be sure you understand the question before answering. Ask for clarification if necessary.
• Before answering a question, correct any misinformation, misstatement, or incorrupt assumptions on the part of the individual posing the query.
• Don’t be afraid to say, “I don’t know.”
• Monitor your body language and maintain eye contact.
• Be succinct and direct.
• Be a good listener.
• Avoid jargon.

Other events
The program also included a reception on Capitol Hill. Sen. Jack Reed (D-RI) spoke at that gathering, welcoming the surgeons to Washington and providing words of encouragement for their efforts on Capitol Hill.

Subsequent to the meeting, the College awarded the Arthur Ellenberger Award for Excellence in State Advocacy to Andrew L. Warshaw, MD, FACS, from Boston, MA, for his many years of advocating for patients and for the surgical profession. Traditionally, this award is presented during the Leadership Conference; however, Dr. Warshaw was unable to attend the meeting because of scheduling conflicts.

Finally, the meeting concluded with the chapter leaders and young surgeons visiting the Capitol Hill offices of the respective members of Congress to advocate on surgery’s behalf.

Papers being accepted for 2008 Resident Trauma Papers Competition

The ACS Committee on Trauma (COT) is now accepting papers for the 2008 Resident Trauma Papers Competition, which will be held during the COT’s annual meeting March 13–15, 2008, in Washington, DC.

The Resident Trauma Papers Competition is open to general surgical residents, surgical specialty residents, and trauma fellows. The papers should describe original research in the area of trauma care and/or prevention, categorized as basic laboratory research or clinical investigation. Papers should be sent to the appropriate ACS state/provincial chair. The list of chairs’ names can be found at http://www.facs.org/trauma/regional.html.

The papers competition has been funded by the Eastern and Western States COTs, Region 7 COTs, Wyeth Pharmaceuticals, and the American College of Surgeons.

Deadline for submission of papers to the region chief is November 14, 2007. Further information can be obtained on the ACS Web site at http://www.facs.org/trauma/traumapapers.html or by calling Bridget Blackwood, ACS Trauma Programs Coordinator, at 312/202-5380 or e-mail bblackwood@facs.org.
CALL FOR SUBMISSIONS

2008 Clinical Congress of the American College of Surgeons

✧ The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at

✧ the 94th annual Clinical Congress, October 12–16, 2008, San Francisco, CA

Oral presentations
✧ Surgical Forum
  Program Coordinator: Kathryn L. Matousek, 312/202-5336, kmatousek@facs.org
  (12 $1,000 Excellence in Research Awards were given in 2007)
✧ Papers Session
  Program Coordinator: Beth Cherry, 312/202-5325, echerry@facs.org

Poster presentation
✧ Scientific Exhibits
  Program Coordinator: Kay Anthony, 312/202-5385, kanthony@facs.org

Video presentation
✧ Video-Based Education
  Program Coordinator: GayLynn Dykman, 312/202-5262, gdykman@facs.org

Submission information
✧ Abstracts are to be submitted online only
✧ Submission period begins November 1, 2007
✧ Deadline: 5:00 pm (CST), March 1, 2008
✧ Late submissions are not permitted
✧ Abstract specifications and requirements for each individual program will be posted on the ACS Web site at www.facs.org. Review the information carefully prior to submission.
✧ Duplicate submissions (submitting the same abstract to more than one program) are not allowed.
American College of Surgeons Faculty Research Fellowships available

The American College of Surgeons is offering two-year Faculty Research Fellowships, the Franklin H. Martin and the C. James Carrico Faculty Research Fellowships. They are offered through the generosity of Fellows, chapters, and friends of the College to surgeons entering academic careers in surgery or a surgical specialty. The fellowships are intended to assist a surgeon in the establishment of a new and independent research program.

The Franklin H. Martin Faculty Research Fellowship is named to honor the founder of the American College of Surgeons. It is awarded to the highest-ranked applicant. The C. James Carrico Faculty Research Fellowship honors the late Chair of the Board of Governors and is designated for an applicant demonstrating excellence in trauma and critical care research.

Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years—July 1, 2008, through June 30, 2010—to support the research.

General policies covering the granting of the American College of Surgeons faculty research fellowships are as follows:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools. Preference will be given to applicants who directly enter academic surgery following residency or fellowship.

- This award may be used by the recipient for support of his/her research or academic enrichment in any fashion that the recipient deems maximally supportive of his/her investigations. The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient’s institution.

- Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College’s scholarships administrator to request approval of the additional award.

- The College encourages the applicant to leverage the funds provided by this fellowship with time and monies provided by the applicant’s department. Formal statements of matching funds and time from the applicant’s department will promote favorable review by the College.

- Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor supervising the applicant’s research effort must be submitted. This approval would involve a commitment to continuation of the academic position and of facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.

- The applicant must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.

- A minimum of 50 percent of the fellow’s time must be spent in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.

- The recipient is expected to attend the Clinical Congress of the American College of Surgeons in 2010 to meet with the Scholarships Committee, to present a report to the Surgical
Forum, and to receive a certificate at the Annual Business Meeting of Members.

The closing date for receipt of applications is November 1, 2007. Application forms may be obtained upon request from Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, or from the College’s Web site, www.facs.org.

New Resident Research Scholars named

Shortly after the announcement of the selected 2007 Resident Research Scholars, two of them declined their scholarships. The Scholarships Committee is pleased to announce that these two scholarships will instead be awarded to Nicholas J. Panetta, MD, and John Frederick, MD. Their awards will run from July 2007 through June 2009.

Dr. Panetta is a general surgery resident from University of South Florida in Tampa. His research project, Enhanced Osteogenic Differentiation of Adipose-Derived Mesenchymal Cells, will be conducted at Stanford University in California.

Dr. Frederick, who anticipates a career in general surgery, is from the Hospital of the University of Pennsylvania, Philadelphia. His research project is Endothelial Progenitor-Directed Neovascularogenesis for Myocardial Ischemia.

Rural trauma meeting will convene at Congress

The Ad Hoc Rural Trauma Committee of the American College of Surgeons Committee on Trauma will hold its third annual International Meeting on Rural Trauma on Sunday, October 7, from 1:00 to 5:00 pm at the Hilton New Orleans Riverside.

The meeting is open to anyone with an interest in rural trauma care and education, but please note that funds are not available to help defray travel costs.

The goals of the meeting are to present information on the ACS Rural Trauma Team Development Course®️, to solicit information on similar courses, and to foster mutual interests in rural trauma care and education. The agenda has not been finalized as of press time.

If you are interested in additional information regarding this meeting, contact Bridget Blackwood at 312/202-5380 or bblackwood@facs.org.
Two new Named Lectures to debut at Clinical Congress

At this year’s Clinical Congress in New Orleans, LA, two new Named Lectures will be introduced: The Olga M. Jonasson Lecture and the Herand Abcarian Lecture.

The Committee on Women’s Issues, friends, colleagues, and women in surgery throughout the country want to honor the memory of Olga Jonasson, MD, FACS, who died in August 2006. Dr. Jonasson was a true pioneer and trailblazer. She was a leader in academic surgery, exemplified by her becoming the first woman chair of surgery in the history of the U.S. In addition, she was a devoted teacher and mentor to countless numbers of surgeons, both men and women. This lectureship will be a testimony to leadership and education in surgery and a reflection of the capacity of women to reach academic pinnacles. Nancy L. Ascher, MD, PhD, FACS, of San Francisco, CA, will deliver the Olga Jonasson Lecture, which will convene Tuesday, October 9, from 3:00 to 4:00 pm.

At the request of the Chicago Society of Colon and Rectal Surgeons, the Herand Abcarian Lecture was approved by the Board of Regents in October 2006. Herand Abcarian, MD, FACS, is a colon and rectal surgeon who has been a Fellow of the American College of Surgeons since 1974; he is the former chairman of the department of surgery and remains the Turi Josefsen Professor of Surgery at the University of Illinois College of Medicine in Chicago. He is a member of more than 20 professional associations and is a well-published author. This lectureship is not limited to the surgical specialty of colon and rectal surgery but addresses issues of relevance to the surgical community at large and focus on emerging issues in surgery. Thomas R. Russell, MD, FACS, Executive Director of the College, will deliver the inaugural Herand Abcarian Lecture on Wednesday, October 10, from 2:00 to 3:00 pm.

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Go to the College’s “members only” Web portal at www.efacs.org
Dr. Copeland to present at end-of-life care symposium

In *Final Exam: A Surgeon’s Reflections on Mortality*, Pauline W. Chen, MD, FACS, writes, “…in a society where more than 90% of us will die from a prolonged illness, physicians have become the final guardians of life, charged with shepherding the terminally ill and their families through the intricacies of the end. Most patients and their families fully expect physicians to be able to comfort and provide that support. For doctors, this care at the end of life is...our final exam. Unfortunately, few doctors are up to the task.”

As keynote lecturer, Dr. Chen will join ACS President Edward M. Copeland III, MD, FACS, at The Art of Medicine at the End of Life, a continuing medical education (CME) symposium designed to meet the educational needs of physicians. This conference will expose physicians to the cultural, spiritual, and practical aspects of the physician-patient relationship at the end of life.

Scheduled for November 2 at the University Club of New York in Manhattan, this highly interactive course is the first annual symposium created through a collaboration between the Cunniff-Dixon Foundation, the University of South Florida College of Medicine, and the H. Lee Moffitt Cancer Center and Research Institute. The course will use short, didactic lectures, discussions, and case presentations to enhance physicians’ understanding, comfort levels, and skill in dealing on a more personal level with terminally ill patients. In addition, diligent follow-up with course participants will endeavor to gauge changes in physician-patient interactions that enhance the overall quality of patient care.

The learning objectives for the course are as follows:
• Prepare patients and their families for the transition to the end of life
• Implement a strategy to provide a more personal and informed level of patient care and thus enhance the quality of life for terminally ill patients
• Recognize the appropriate time to suggest palliative care or hospice for terminally ill patients and facilitate the process
• Anticipate common ethical and legal issues that arise in the context of end-of-life medical care
• Apply an understanding of the psychiatric aspects of mortality to improve the quality of interactions with terminally ill patients and their families
• Recognize and accommodate the needs of patients and families from various cultures and religions coping with the end of life

For detailed course information and to register, visit the course Web page at www.cme.hsc.usf.edu/artofmedicine. For additional inquiries, contact Maria Uravich, CME Specialist in the University of South Florida Health Office of Continuing Professional Development, at muravich@health.usf.edu or 813/974-6682.
Ovarian cancer is GCF’s focus for Gynecologic Cancer Awareness Month

During September, Gynecologic Cancer Awareness Month, the Gynecologic Cancer Foundation (GCF) continues its educational efforts to alert women to the symptoms of ovarian cancer, as September also is Ovarian Cancer Awareness Month.

In June, GCF released a recently formulated consensus statement of ovarian cancer symptoms that was written by GCF along with the Society of Gynecologic Oncologists and the American Cancer Society. The statement is endorsed by 38 national ovarian and gynecologic cancer advocacy organizations (see text box, page 45).

Gynecologic oncologists recognize the critical need to share this information across the surgical specialties as a means to enhance early diagnosis of ovarian cancer. The nonspecific nature of ovarian cancer symptoms results in women with ovarian cancer presenting to a variety of providers in the surgical specialties, most commonly general surgeons and colorectal surgeons. In addition, surgeon-educators play an important role in disseminating information to the next generation of surgeons, thereby passing on the knowledge of ovarian cancer symptoms to future physicians and educators.

The consensus statement on ovarian cancer symptoms is the culmination of a 10-year effort among ovarian cancer survivors and advocacy organizations to encourage the medical community to conduct the research necessary to debunk the myth that ovarian cancer is a “silent killer.”

“This agreement on common symptoms of ovarian cancer hopefully will lead to earlier diagnosis when a cure is more likely,” said Barbara Goff, MD, of the Gynecologic Foundation and the lead author of much of the research that contributed to the development of the consensus statement. “We know that when women are diagnosed in stage I of the disease, it is 90 percent curable. Unfortunately, until now there has been no agreement on common symptoms, allowing women to go undiagnosed, despite visits to the doctor, until it was too late.”

As noted in the statement, women with these symptoms that are new, persistent, and occur almost daily for more than a few weeks should be evaluated, preferably by a gynecologist. A pelvic and rectal exam should be performed with follow-up with a transvaginal ultrasound and CA125 test if the examination arouses suspicion of ovarian cancer.

It is estimated that more than 22,000 women will be told they have ovarian cancer this year and more than 15,000 will die from this deadly cancer. Ovarian cancer ranks fifth in cancer deaths among women. At present, approximately 80 percent of these cancers are not diagnosed in their early stages, leading to a reduced chance of survival.

In May, GCF conducted a nationwide poll (n=700) to determine how best to make women aware of this new consensus regarding ovarian cancer symptoms. The poll revealed that although women agree that it is important to know the symptoms of ovarian cancer, 65 percent say that they do not know enough about the disease. More than 90 percent of the women polled say that they get their most valuable health information from friends or family and their personal experience with a disease. Advertising by advocacy organizations such as GCF, brochures in medical offices, and the Internet also rank high as sources of health information for women.

After the poll was conducted, a front-page article about the ovarian cancer symptoms consensus statement published in The New York Times sparked national media coverage.* The overwhelming response to the news story was positive. However, a few physicians expressed

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Ovarian Cancer Symptoms Consensus Statement

Historically ovarian cancer was called the “silent killer” because symptoms were not thought to develop until the chance of cure was poor. However, recent studies have shown this term is untrue and that the following symptoms are much more likely to occur in women with ovarian cancer than women in the general population.12 These symptoms include:

- Bloating
- Pelvic or abdominal pain
- Difficulty eating or feeling full quickly
- Urinary symptoms (urgency or frequency)

Women with ovarian cancer report that symptoms are persistent and represent a change from normal for their bodies. The frequency and/or number of such symptoms are key factors in the diagnosis of ovarian cancer.5 Several studies show that even early-stage ovarian cancer can produce these symptoms.26

Women who have these symptoms almost daily for more than a few weeks should see their doctor, preferably a gynecologist. Prompt medical evaluation may lead to detection at the earliest possible stage of the disease. Early stage diagnosis is associated with an improved prognosis.

Several other symptoms have been commonly reported by women with ovarian cancer.23 These symptoms include fatigue, indigestion, back pain, pain with intercourse, constipation, and menstrual irregularities. However, these other symptoms are not as useful in identifying ovarian cancer because they are also found in equal frequency in women in the general population who do not have ovarian cancer.1

References

4. Vine MF, Ness RB, Calingaert B, Schildkraut JM, Berchuck A. Types and duration of symptoms prior to diagnosis of invasive or borderline ovarian tumor. Gynecol Oncol. 2001;83:466-471. Level III

[Editor’s note: Level II refers to evidence from a well-designed case control study. Level III refers to retrospective studies or descriptive series.]

Although proof that earlier recognition of symptoms improves outcomes does not yet exist, there is little to be lost and much to be potentially gained by increasing awareness of ovarian cancer symptoms that might lead to earlier medical evaluation and intervention. Although population screening with CA125 and ultrasound has the potential to lead to many false-positive results, their use in the evaluation of a symptomatic woman represents appropriate medical care.

In addition to stressing the need for women to be aware of the symptoms of ovarian cancer, the importance of receiving care from a gynecologic oncologist once ovarian cancer is suspected also was emphasized. There is a growing body of evidence that primary staging surgery performed by a gynecologic oncologist improves the outcome for women with ovarian cancer.

Adherence to treatment standards, optimal debulking rates, and overall survival have all been shown to be significantly improved when primary surgery is performed by a gynecologic oncologist in data from national, international, and regional retrospective studies.
Recent analysis of Surveillance Epidemiology and End Results data shows that the five-year, disease-specific survival for epithelial ovarian cancer is 50 percent. Optimal surgical debulking remains the most significant factor that affects survival in ovarian cancer. Given these challenging facts, specialists in the field of gynecologic oncology continue to develop new surgical approaches for women with advanced disease. Recent trends include using more radical approaches to tumor debulking. For disease in the upper abdomen and chest cavity, this change in approach has been facilitated by collaborations between gynecologic oncologists and their colleagues in general, hepatobiliary, and thoracic surgery. These new partnerships continue to advance the quality of surgical care, and thus improve survival for women with advanced ovarian cancer.

GCF will continue its outreach to women about the symptoms of ovarian cancer and the advantages of seeking care from a gynecologic oncologist during Gynecologic Cancer Awareness Month in September and throughout the year.

“The GCF is committed to providing women with the latest information about gynecologic cancers,” said Karl C. Podratz, MD, PhD, FACS, ACS Regent and GCF chairman. “By making women aware of the symptoms of ovarian cancer and encouraging them to seek care from a gynecologic oncologist when ovarian cancer is suspected, we hope to reduce the burden of disease from this heretofore deadly cancer.”

Patients who seek more information should be directed to GCF’s Women’s Cancer Network and www.wcn.org.
An important goal of the American College of Surgeons Oncology Group (ACOSOG) is to improve the care of the cancer patient by reducing treatment morbidity. To this end, ACOSOG is conducting a radiofrequency ablation (RFA) trial for nonsmall cell lung carcinoma (NSCLC) in patients who are poor candidates for surgical resection. This procedure has become feasible because the technology of ablation devices has improved significantly in the last decade. For example, monitoring the ablation temperature is now possible during the procedure.

Furthermore, screening computed tomography (CT) scans are more commonly done to detect early disease and smaller tumors are being identified. The imaging also allows assessment of the intrathoracic ablation zone and placement of the ablation instrument. Positron emission tomography (PET) imaging is available to assess residual and early recurrent disease after intrathoracic ablation has been performed. Lastly, RFA offers an opportunity to treat NSCLC in patients who are at high risk for postoperative complications following local resection. In many ways, RFA parallels in situ ablation of malignant liver tumors, preserving liver function and avoiding major hepatic resections.

A major limitation and concern with in situ ablation of malignant tumors is the inability to pathologically assess the margin of the ablation zone. Although relatively smaller tumors are selected for ablation, methods to monitor the ablation zone and the heat-sink effect of adjacent large blood vessels can limit the ability to achieve a complete ablation. This result leads to residual disease and local recurrence.

For these reasons, patient selection is important, weighing the risks of operative resection versus residual disease after ablation. As ablation procedures develop for malignant solid tumors, there is a need for well-designed prospective clinical trials. Patient eligibility criteria, credentialing, and imaging methods to detect residual or recurrent disease are essential components of an ablation trial.

ACOSOG protocol Z4033, a pilot study of RFA in high-risk patients with stage IA NSCLC, addresses many of the issues regarding new ablation procedures for solid tumors. Patients who present with low cardiopulmonary function are at high risk for complications after right lobectomy or sublobar resection. Such patients may not be eligible for radiation therapy, which can compromise already inadequate pulmonary function. This is a phase II, single-arm study. The primary endpoint is overall survival at two years. Local recurrence is defined as recurrence within the same lobe of hilum (N1 node) or progression at the ablated site after treatment effects have subsided.

Secondary objectives include the following: (a) assess regional or distant recurrence, (b) assess local recurrence in the ablated lobe, (c) determine the number of procedures deemed to be a technical success, (d) assess for procedure-specific morbidity and mortality, (e) assess the utility of immediate post-RFA PET scan in assessing local recurrence and overall survival, and (f) determine the effect of RFA on pulmonary function.

The trial will enroll 55 patients. Specific eligibility criteria are suspicious lung nodule for clinical stage I NSCLC, tumor size 3 cm or smaller by CT scan measurements, and one major criteria or two minor criteria from the following lists:
Major criteria:
• Forced expiratory volume in 1 second (FEV1) ≤ 50%
• Diffusion capacity for carbon monoxide (DLCO) ≤ 50%

Minor criteria:
• Age > 75 years
• FEV1 51 percent to 60 percent predicted
• DLCO 51 percent to 60 percent predicted
• Pulmonary hypertension
• Poor ventricular function (ejection fraction ≤ 40%)
• Resting arterial pO2 ≤ 55 mmHg
• pCO2 > 45 mmHg
• Modified Medical Research Council dyspnea scale > 3

Final registration for Z4033 requires the following:
• Tumor must be biopsied before the final registration
• Tumor must be noncontiguous with vital structures such as trachea, esophagus, aorta, aortic arch branches, and heart and accessible via percutaneous transthoracic route
• Suspicious mediastinal nodes must be assessed with fine needle aspiration

There is a credentialing process defined in the protocol. All treating physicians must have performed at least 25 image-guided lung procedure biopsies and 10 RFA ablation procedures. Reimbursement for patient enrollment is $2,500.

The trial is open to interventional radiologists and surgeons who meet these qualifications. Because of the limited enrollment as well as highly technical skills required for the procedure, the trial is open to 20 sites.

Z4033 is an excellent example of a prospective approach to study novel procedures. Multiple sites are necessary in order to assess the new procedure and reduce single institution bias. ACOSOG is committed to careful prospective studies of new procedures to determine if patient safety and cancer control are at risk. Our future trials will emphasize new procedures that reduce treatment morbidity.

Thoracic surgeons or interventional radiologists who are interested in participating in this trial should contact Isa Lamerton, Z4033 research coordinator, at isa.lamerton@duke.edu.

Dr. Ota and Dr. Nelson are ACOSOG Group Co-Chairs.

RAS to host quality initiatives symposium at Clinical Congress

Every year, during the College’s annual Clinical Congress, the Resident and Associate Society (RAS) sponsors a symposium focusing on a timely topic targeted at surgical residents, young surgeons, and Fellows. This year’s symposium, entitled Pay for Performance and Surgical Quality Initiatives: Will the Generalist and Surgical Training Survive in the New Paradigm?, will convene in New Orleans, LA, on Sunday, October 7, from 1:00 to 4:00 pm. The aim of the session is to examine surgical quality initiatives and their potential impact on both resident training and the practice of surgery in the future.

ACS Secretary Courtney M. Townsend, Jr., MD, FACS, chairman of the department of surgery at the University of Texas Medical Branch in Galveston, will discuss pay for performance and its potential pitfalls from the “con” perspective. ACS Regent Barbara L. Bass, MD, FACS, chair of the department of surgery at Methodist Hospital in Houston, TX, will discuss pay for performance and its potential advantages for the patient and the surgeon from the “pro” perspective. Hari Nathan, MD, Chair of the Issues Committee of the RAS, will provide a resident’s perspective on this topic. A representative from the Centers for Medicare & Medicaid Services will also participate on the panel.

Attendance is open to all RAS members, as well as students and Fellows. An open-microphone discussion will promote audience participation in the symposium.

The Congress will afford you with a prime opportunity, regardless of your specialty area, to advance your knowledge in the traditional surgical areas as well as learn about the latest innovations in surgery. The entire program, complete with online registration, can be viewed online at:


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American College of Surgeons Professional Association (ACSPA)

As of May 11, the political action committee (PAC), ACSPA-SurgeonsPAC, raised $204,366 for the current election cycle. Telephone fundraising continues to be a major component of the PAC’s fundraising efforts. Contributions have been made to 35 candidates, leadership PACs, and party committees.

Of the 216 U.S. members of the Board of Governors, 43 (20%) made contributions averaging $413. The names of all leaders who contributed to the PAC, and those who donated $1,000 or more in 2007, will be listed at the PAC booth during the Clinical Congress in October in New Orleans, LA.

The Board of Regents voted to continue membership for one year in Doctors for Medical Liability Reform (DMLR). Continued membership in DMLR beyond one year is contingent on credible liability reform.

ACS Foundation

From January 1 through May 15, the Foundation received 740 gifts totaling $589,873. This compares favorably with the same period last year.

American College of Surgeons

Surgical Education and Self-Assessment Program (SESAP)

The Board of Regents approved the continuation of SESAP for another three-year cycle with the development of SESAP 14. SESAP has been a premier educational resource for practicing surgeons and surgical residents for 36 years. During the cycle of SESAP 13, concerted efforts were made to implement several major changes. Additional enhancements will be made to SESAP 14 to make it even more useful as a self-assessment and review program.

Statements

The Board of Regents approved an ACS Statement on the Surgical Workforce. The statement
notes the College’s concern that access to surgical care is eroding in many U.S. communities and is most evident and widespread in rural areas, trauma centers, emergency departments, and increasingly in urban and suburban communities. Although policymakers have devoted considerable discussion to developing solutions for a predicted shortage of generalists, little attention has been devoted to surgical workforce limitations. The ACS supports measures it believes the federal government should take in order to ensure access to surgical specialty care. The policy statement was published in the August issue of the Bulletin and subsequently posted on the ACS Web site.

The Board of Regents approved a Statement on Sharps Safety. The statement will be published in a future issue of the Bulletin and posted on the ACS Web site.

Committee on Women’s Issues

The Board of Regents approved a name change for the Committee on Women’s Issues, now to be called the Women in Surgery Committee. The Board also approved the following revised mission statement for the committee: “To promote recruitment and retention of Fellowship within the American College of Surgeons among women in the surgical specialties; to aid in the development of and enhance the leadership roles for women surgeons within the American College of Surgeons as well as other surgical and medical organizations.”

Scholarships

The Board of Regents approved three new shared health policy scholarships. The scholarships will be cosponsored with the American Society of Breast Surgeons, the American Surgical Association, and the American Pediatric Surgical Association from 2008 to 2010.

Physician Quality Reporting Initiative (PQRI)

In December 2006, Congress passed legislation linking a 1.5 percent Medicare physician payment bonus to reporting Medicare quality data through the PQRI. Physicians will voluntarily report on relevant quality measures for services provided between July 1 and December 31, 2007. In the PQRI, 74 physician performance measures are available; all were developed with physician involvement.

The College has recruited 34 surgical practices to participate in a project that will collect information on their experiences following the PQRI. The purpose of the program is to improve the College’s effort to educate all its Fellows about PQRI requirements and operations.

Surgical Quality Alliance (SQA)

The SQA convened a group of interested surgical specialties in a Patient Experience Workgroup to examine current patient satisfaction surveys for their relevance to surgical care and to determine the parameters of a surgical survey. The workgroup concluded that there is a need for a surgery-focused patient satisfaction experience survey and that any instrument developed should be applicable across all surgical specialties and settings.

A request for proposals for developing this survey instrument was released in May with plans to award a contract by July. The project will be completed by January 1, 2008. The College will serve as the project leader for this endeavor, but all surgical and anesthesia specialties are being encouraged to participate, and financial support is being sought from private health insurance plans.

After the survey is developed, it will be submitted to the Agency for Healthcare Research and Quality for endorsement as an official Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Upon approval, it will be the only CAHPS survey instrument for surgical care and will be publicly available. CAHPS surveys are not proprietary and can be used by anyone interested in measuring patient experience.

Medicare physician payment issues

The Medicare Trustees annual report issued on April 23 estimated that Medicare fee schedule payments will be reduced across the board by 9.9 percent on January 1, 2008, unless
Congress intervenes. Projected cuts between 4.8 percent and 5.4 percent will occur annually through 2016.

The Medicare Payment Advisory Commission (MedPAC) released two reports with implications for Medicare physician payment policy. In its annual report to Congress, MedPAC recommended an increase in 2008 Medicare payments based on practice cost inflation minus productivity growth. This would produce an estimated 1.7 percent increase in the Medicare fee schedule conversion factor, rather than the estimated 9.9 percent cut that is scheduled to take effect. The second report was mandated under the Deficit Reduction Act of 2005 and examined possible options for replacing the sustainable growth rate (SGR) system.

The College hosted a briefing for press and congressional staff about the challenges already facing surgery under Medicare and the potential impact of MedPAC’s recommendations on surgical care in the future. The briefing also outlined an alternative proposal endorsed by the College and the American Osteopathic Association in which service-specific expenditure targets could replace the current SGR system if Congress is unwilling to provide the estimated $265 billion that would be required to eliminate expenditure targets entirely.

**Surgical practice in hospitals**

Revised hospital conditions of participation (CoP), effective June 1, 2004, raised havoc in teaching hospitals by requiring the surgical informed consent to include the name of any residents (or nonphysician staff) participating in a surgical procedure and describe precisely which portions of the procedure they would personally perform. The College—along with the Association of American Medical Colleges, the American Medical Association, and the American Hospital Association—pointed out the realities of working with residents. In April, a further revision of the CoP created an exception for operations in which residents perform parts of the procedure.

The Centers for Medicare & Medicaid Services (CMS) outlined its plans to comply with a congressional mandate to select at least two high-volume or high-cost complications occurring in hospitals that could increase Medicare hospital payment through higher diagnosis-related group assignment or outlier payments, and to establish procedures under which those increased payments would not be made. The College reviewed the proposal and submitted its official comment. The revised payment policy, which pertains to hospital payments only, will take effect October 1, 2008.

**Ambulatory surgery centers (ASCs)**

The College supported H.R. 1823, the Ambulatory Surgical Center Payment Modernization Act of 2007, which would provide a more equitable payment system for ASCs and follow a MedPAC recommendation to modify the ASC procedures list. In a proposed rule issued by CMS, payments would be made to ASCs at only 62 percent of the 2008 Hospital Outpatient Prospective Payment System (HOPPS) proposed rate. H.R. 1823 would provide a payment rate of 75 percent of the HOPPS.

**Trauma**

The House passed H.R. 727, the Trauma Care Systems Planning and Development Act of 2007, with the Senate following suit. President Bush signed the bill into law and it is now public law 110-23. This legislation reauthorizes the Health Resources and Service Administration (HRSA) Trauma-EMS program through fiscal year (FY) 2012 with an authorization level of $12 million for FY 2008, $10 million for FY 2009, and $8 million for FY 2010–2012.

The President’s FY 2008 budget was released on February 5. As in the past two years, no funding was proposed for most trauma-related programs, among them, HRSA’s Trauma-EMS program. The College, along with several other organizations, sent letters to the House and Senate appropriations committees supporting $12 million for the HRSA Trauma-EMS Program.

The College sent a letter to the chair of the House Defense Appropriations Subcommittee in support of the U.S. Army Institute of Surgi-
ed Research to increase scientific knowledge related to trauma, burns, and all aspects of trauma research. The knowledge and information amassed through the National Trauma Institute, coupled with the new therapies that have been developed, will benefit military personnel and have powerful far-reaching benefits for trauma care in civilian settings.

Emergency care

The College, along with the American Association of Neurological Surgeons and the American Academy of Orthopaedic Surgeons, developed a legislative agenda to address the ongoing surgical workforce crisis in emergency departments across the nation. The College is approaching other surgical specialty societies for input and support, and will then enlist a member of Congress to sponsor this agenda.

The College supports H.R. 1233, Mitigating the Impact of Uncompensated Service and Time Act of 2007. Introduced to help alleviate the financial burden placed on physicians who are federally mandated to provide emergency care, this legislation would amend the Internal Revenue Service code of 1986 to allow them to partially offset the cost of providing uncompensated care that is required under the Emergency Medical Treatment and Active Labor Act. Board-certified physicians providing these services could take a tax deduction equal to the Medicare fee schedule payment.

MedPAC heard testimony in April regarding the future workforce of physicians and clinical practitioners. Following that testimony, J. Wayne Meredith, MD, FACS, and ACS staff met with MedPAC staff to present information on general trends in surgical workforce issues and on the growing problem of specialty emergency call coverage, in particular.

Once Voice Against Cancer (OVAC)

As a member of OVAC, the College continues to call for increased funding for cancer research and programs through the National Institutes of Health (NIH), the National Cancer Institute (NCI), and the Centers for Disease Control and Prevention (CDC). The FY 2008 funding process started with President Bush submitting a budget that again calls for cuts in federal funding for medical research and calling for flat funding for the NIH and CDC along with cuts to NCI of more than $111 million. The College will continue to call for increased funding for cancer research and programs.

Scope of practice

The College opposes H.R. 1665, the Medicare Hearing Health Care Enhancement Act of 2007. If enacted, this legislation would grant an inappropriate expansion in the scope of practice of audiologists. As written, it would provide direct access to audiologists for Medicare beneficiaries “without regard to any requirement that the individual...be under the care of (or referred by) a physician.” The College sent a letter to members of the House stating its strong opposition to this legislation. The letter stated, “While we agree that all Medicare beneficiaries deserve timely access to health care professionals and their services, this legislation would remove the physician from the most crucial segment of any patient consultation—initial evaluation and diagnosis.”

Transplants

The House passed H.R. 710, the Living Kidney Organ Donation Clarification Act. H.R. 710 was introduced to clarify existing law regarding paired kidney donations. Paired donations enable a kidney transplant candidate and an incompatible living donor to be matched with another incompatible pair; the paired donation enables two living kidney transplants that otherwise would not have occurred. The College sent letters of support for H.R. 710 to the House Energy and Commerce Committee. The bill also has the support of the American Society of Transplant Surgeons and the American Society of Transplantation.

Practice management and coding

The 2007 series of basic and advanced coding workshops has been scheduled. Two workshops—one basic and one advanced—were scheduled for May, July, and September in Baltimore, MD, Chicago, IL, and St. Louis, MO, respectively.
The availability of the free Coding Hotline for Fellows has previously been highlighted at all ACS coding workshops and practice-management courses and in a number of issues of ACS NewsScope. For the first part of 2007, the hotline has averaged close to 500 calls a month from Fellows and their office staff.

The College continues its sponsorship of practice management teleconferences presented by Economedix. The teleconferences are scheduled through December 12.

**Education**

The College has made a significant impact at the national level through its new and innovative educational programs, products, and resources. These have served the needs of the members well. The College is now poised to build on these achievements to stay ahead of the national trends and mandates. The educational needs of practicing surgeons, surgical residents, medical students, members of the surgical team, and surgical patients will continue to be addressed through comprehensive educational approaches that are based on principles of contemporary surgical education and state-of-the-art technology. Efforts will continue to address the educational needs of the College's members, to help them provide the highest quality of surgical care and to support their efforts to remain competitive in the ever-changing milieu of surgical care.

**Journal of the American College of Surgeons (JACS)**

Online and fax continuing medical education submissions to JACS currently exceed 122,700 credits as a member benefit. Hits to the JACS Web site average 81,492 a month.

**Continuous Quality Improvement (CQI)**

Scheduled educational activities in the area of CQI include the following:

- The third biennial Outcomes Research Course, scheduled for November 14–16, 2008, at ACS headquarters
- The Clinical Trials Methodology Course, scheduled for November 9–13, 2007, at ACS headquarters (this course will be shortened to accommodate participant and faculty schedules)
- The next Young Surgical Investigators Conference is scheduled for March 7–9, 2008, at the Bethesda North Marriott Hotel and Convention Center in Maryland.

**National Surgical Quality Improvement Program (NSQIP)**

NSQIP program statistics as of June included the following:

- 157 enrolled sites
- 188 applications received
- 100 additional sites interested

In April 2006, the multispecialty model became available to all ACS NSQIP hospitals interested in collecting data from the following 10 subspecialties: general, vascular, urology, neurosurgery, orthopaedics, otolaryngology, plastic, thoracic, gynecology, and cardiac.

The NSQIP Surgical Care Improvement Project (SCIP) module has been developed and is currently being tested with CMS. CMS approved the ACS NSQIP multispecialty model's sampling methodology as an appropriate sample of cases to meet the CMS SCIP requirement. Hospitals participating in the multispecialty model may use the SCIP module to collect and report their SCIP data through the ACS NSQIP Web site. Once testing is finalized, the module will become available to participating sites.

NSQIP continues to work with surgical specialty societies to develop additional modules. The pediatric NSQIP planning committee has made significant progress in the development of a pediatric NSQIP module that will include general, vascular, and subspecialty surgeries. The module will also include neonates and trauma patients.

The Joint Commission has agreed to acknowledge hospitals that participate in the ACS NSQIP program on its Quality Check Web site through the awarding of a Special Quality Award Merit Badge. The merit badges recognize achievements by health care organizations that go above and beyond accreditation, are national in scope, and relate to the delivery of high-quality health care.
American College of Surgeons Bariatric Surgery Center Network (ACS BSCN)

The ACS BSCN accreditation program is entering into its third year. The College recognizes and commends those facilities that implement defined standards of care, document their outcomes, and participate in periodic reviews and verifications of their programs in bariatric surgery.

Commission on Cancer (CoC)

The Online Education Center for Cancer Programs debuted in May 2006 with 10 programs. An additional nine new topics were added in February 2007 to include the following:

- Tumor, Nodes, and Metastases (TNM) cancer staging for physicians for breast and colorectal cancer
- TNM cancer staging for cancer registrars for breast, colorectal, and lymphoma cancer
- Collaborative staging for cancer registrars for breast, colorectal, lung, and prostate cancers
- Medical radiation physics for surgeons

In June 2007, the CoC launched a new Web conference program aimed at presenting focused education to CoC constituents on new and emerging projects and activities that affect approved cancer programs. A calendar of programs is in development with six topics scheduled for presentation with repeat sessions planned for alternate time zones. These one-hour programs will include 45 minutes of didactic presentation followed by 15 minutes of Q & A and will be free of charge.

Arthur Ellenberger Award

This year’s recipient of the Arthur Ellenberger Award is Andrew L. Warshaw, MD, FACS. Dr. Warshaw has spent many years of his surgical career advocating for patients and for the surgical profession and was instrumental in creating and expanding the ACSPA-SurgeonsPAC.

Surgical Volunteerism Award

In conjunction with Operation Giving Back, the Board of Governors Committee on Socioeconomic Issues solicited the College’s membership for nominations for the American College of Surgeons/Pfizer Medical Humanities Initiative Surgical Volunteerism Award. The committee, and subsequently the Executive Committee of the Board of Governors, selected the following individuals to receive awards: Sylvia D. Campbell, MD, FACS, of Tampa, FL; Van C. Knowles, MD, FACS, of Albany, GA; and Thomas G. Crabtree, MD, FACS, of Kailua, HI. (See related story on page 27 of this issue.)

Operation Giving Back (OGB)

Traffic to the OGB Web site has surpassed 2.3 million hits. In addition, the number of surgeons who have contributed to the demographic compilation of surgical volunteers has reached 689, an increase of 50 percent over a four-month period. Continued outreach to volunteer agencies offering opportunities for surgeons has resulted in the growth of the database to include 84 partner agencies—39 domestic and 45 international.

A distinguished group of professionals representing expertise in domestic and international volunteerism, medical philanthropy, surgical academia, and socially responsible industry have accepted invitations to join an advisory group that will help guide the strategic direction of the OGB initiative.

Plans are under way to coordinate an opportunity for the College and participants at the 2007 Clinical Congress to contribute to the renewal of the medical infrastructure of New Orleans. “ACS Project New Orleans” will be conducted in partnership with the New Orleans chapter of Habitat for Humanity and incorporated into the week’s social program. Details will be made available on the College’s Web site and via other communication tools related to the Clinical Congress.

Resident and Associate Society (RAS)

Gregory S. Cherr, MD, Chair of the College’s Resident and Associate Society, outlined RAS’ recent accomplishments. Four recipients were selected to receive the second annual RAS-ACS Leadership Award. Recipients of the award will attend an ACS course of their choosing. The courses are intended to engage young surgeons.
and enhance skills in leadership, communication, education, or research. The selected recipients are Neal R. Barshes, MD, of Houston, TX; Awori J. W. Hayanga, MD, of Baltimore, MD; Gerald S. Lipshutz, MD, of Los Angeles, CA; and Arezou T. Yaghoubian, of Woodland Hills, CA.

RAS conducted a survey of the College’s younger members relative to the future of the College and strategic planning. The survey revealed medical malpractice, patient safety, and reimbursement as the top issues of concern.

It was noted that there is still the perception that the College is not responsive to its younger members. It was suggested that the College develop mentorship programs that focus on recruitment and retention.

Other accomplishments of RAS include the following:

• Formed the International Medical Graduates Committee
• Enhanced RAS-ACS Web portal community
• Submitted Bulletin articles regarding the future of surgery
• Planned the RAS-ACS Symposium for Clinical Congress, entitled, Pay for Performance and Surgical Quality Initiatives: Will the Generalist and Surgical Training Survive in the New Paradigm?
• Continued collaboration with Committee on Young Surgeons

HealthCareers (Job bank)

As of May 16, there were 785 active jobs listed on the HealthCareers site with 88 posted résumés. This valuable service to all College members is complimentary to the resident members.

Committee on Young Surgeons (CYS)

Under the leadership of Juan Paramo, MD, FACS, the CYS has reinstituted its newsletter that is sent to all of the College’s Fellows who are aged 45 or younger. The CYS E-News will be distributed electronically each quarter. The CYS has been working on the Initiates Program for the 2008 Clinical Congress in San Francisco, CA. The proposed title is The Wards to Wall Street: What Every Surgeon Should Know about Financial Planning and Asset Management.

Chapter Activities

The 2007 Chapter Officers and Young Surgeons Leadership Conference was held in June in Washington, DC, for the fifth consecutive year. The conference yielded record attendance.

Advisory Councils for the Surgical Specialties

As of May 16, half of the 12 Advisory Councils for the Surgical Specialties had held their interim meetings. Several advisory councils will conduct mailings to program directors highlighting the ACS membership benefits available to resident members, and encouraging 100 percent participation from all programs as well as participation from the residents in each program.

The Advisory Council for General Surgery will increase its educational program proposals for future Clinical Congresses. All of the advisory councils continue to propose educational programming that will benefit the varied surgical attendance at the Clinical Congress.

ACS Web portal, e-FACS.org

Traffic to the College’s Web portal continues to grow. The constant addition of new content, resources, and tools, as well as changes made to the portal as the direct result of user feedback, are major reasons for its growing success.

To highlight a few changes, in an effort to help visitors find information and electronic tools more quickly, the portal’s home page has been redesigned and a Google search engine has been added. A Quick Links box has been added to the home page to provide direct access to pages that are viewed frequently, for example, Clinical Congress information, the Case Log System, and so forth.
Q. What is the Online Education Center?
A. An educational resource providing Webcast presentations for cancer program staff, physicians, and administrators.

Q. What is the Benefit of Using the Center?
A. It helps enhance your facility’s educational resources, while providing support, education, and training related to CoC and AJCC requirements.

WEBCASTS — Convenient, Self-Directed Distance Learning 24/7/365

- Fee-based sessions are hosted online in their entirety. (Staff from CoC-Approved Cancer Programs receive a 25% discount.)

- Dynamic learning environment is provided through synchronized audio and slides with written transcripts.

- Key topics include:
  - CoC Cancer Program Standards
  - Data and Quality Improvement
  - Cancer Staging
  - Stereotactic Breast Biopsy Accreditation

To Learn More, Visit the Online Education Center for Cancer Programs.

www.facs.org/cancer/webcast

Sponsored jointly by the Commission on Cancer and the American Joint Committee on Cancer

The CoC is a multidisciplinary program of the American College of Surgeons.
A look at The Joint Commission

The 2008 National Patient Safety Goals

The Joint Commission has released its 2008 National Patient Safety Goals and related requirements for each of its accreditation programs and its Disease-Specific Care Certification Program. The goals and requirements, recently approved by The Joint Commission’s board of commissioners, apply to the nearly 15,000 health care organizations accredited and certified by The Joint Commission.

Major changes in this sixth annual issuance of the National Patient Safety Goals include a new requirement to take specific actions to reduce the risks of patient harm associated with the use of anticoagulant therapy and a new goal and requirement that address the recognition of and response to unexpected deterioration in a patient’s condition. The new anticoagulant therapy requirement addresses a widely acknowledged patient-safety problem and becomes a key element of the goal: Improve the safety of using medications. It is applicable to hospitals, critical access hospitals, ambulatory care and office-based surgery settings, and home care and long-term-care organizations.

The new goal and requirement regarding the deteriorating patient will ask hospitals and critical access hospitals to select a suitable method for enabling caregivers to directly request and obtain assistance from a specially trained individual if and when a patient’s condition worsens. Each of the foregoing new requirements has a one-year phase-in period that includes defined milestones. Full implementation is targeted for January 2009.

In addition, an existing requirement to ensure the timely reporting of critical test results has been extended to the Long Term Care Accreditation Program. Furthermore, for all programs, the requirement that addresses hand hygiene also has been expanded to permit use of the World Health Organization Hand Hygiene Guidelines as an alternative to the Centers for Disease Control and Prevention hand hygiene guidelines.

Finally, the requirement to limit and standardize drug concentrations that is part of the goal to improve the safety of using medications will be retired as a National Patient Safety Goal, but organization compliance will continue to be evaluated as part of the Medication Management standards.

“The 2008 National Patient Safety Goals seek to focus the efforts of health care organizations on the priority areas where the opportunities for improving patient safety are greatest,” says Dennis S. O’Leary, MD, president of The Joint Commission. “Consistently putting these requirements into action will benefit millions of patients.”

The development and annual updating of the National Patient Safety Goals and associated requirements continue to be overseen by an expert panel that includes widely recognized patient safety experts, as well as nurses, physicians, pharmacists, risk managers, and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings. Each year, this sentinel event advisory group works with The Joint Commission to undertake a systematic review of the literature and available databases to identify candidate new goals and requirements. Following a solicitation of input from practitioners, provider organizations, purchasers, consumer groups, and other parties of interest, the advisory group determines the highest-priority goals and requirements and makes its recommendations to The Joint Commission.

The full text of the 2008 goals and requirements for all accreditation programs is posted on The Joint Commission Web site at www.jointcommission.org. Compliance with the requirements is a condition of continuing accreditation or certification for organizations accredited or certified by The Joint Commission.
Membership in the American College of Surgeons?

HERE’S WHY IT’S IMPORTANT:

AS A BODY REPRESENTING ALL OF SURGERY, THE COLLEGE:

• Provides a cohesive voice addressing societal issues related to surgery.
• Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
• Is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients.
• Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

THERE IS STRENGTH IN NUMBERS.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to shape the College’s agenda for the future.

If you aren’t a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain that status and consider getting involved in the work of the College.

Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

HERE ARE SOME OF THE MANY BENEFITS BEING A MEMBER OF THE COLLEGE AFFORDS YOU:

• Free registration at the Clinical Congress
• Access to the College’s free coding consultation hotline
• Subscription to ACS NewsScope, the College’s weekly electronic newsletter
• Subscription to the Bulletin of the American College of Surgeons
• Subscription to the Journal of the American College of Surgeons
• Access to all College-sponsored insurance, credit card, and other helpful programs
• Free posting of resume on ACS Career Opportunities
• Access to Surgeons Diversified Investment Fund

Information on becoming a member of the College and an application form are available online at www.facs.org/dept/fellowship/index.html or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800/293-9623, or via e-mail at chicks@facs.org.
NTDB® data points

The “University of Injury”

by Richard J. Fantus, MD, FACS, and Jake Fantus, Chicago, IL

Fall is rapidly approaching and as the season changes, collegiate sports begin. According to the National Center for Education Statistics—Digest of Education Statistics: 2005, close to 17 million students attend more than 4,000 colleges across the U.S. each year (http://nces.ed.gov/programs/digest/d05/tables/dt05_213.asp). For the past 25 years, the National Athletic Trainers’ Association and the National Collegiate Athletic Association (NCAA) have collaborated to create the largest ongoing collegiate sports injury database in the world. This database houses information on sport’s specific injuries that have occurred during NCAA sporting events, which includes 380,000 student athletes annually (http://www.nata.org/collegiateinjurystats07/factsheet.pdf). Along with sanctioned collegiate sports, a great number of students participate in intramural and recreational sporting activities, as for many students, sports can be a welcome diversion from the day-to-day educational grind. With millions of students participating in various sporting activities, someone is bound to be injured.

In order to examine the occurrence of college-age individuals involved in sports-related injuries in the National Trauma Data Bank® Dataset 6.2, we used the International Classification of Diseases, Ninth Revision, Clinical Modification cause of injury code E 917.0, injury in sports without subsequent fall (struck by hockey stick, puck, or a thrown ball), and E 917.5, object in sports with subsequent fall (knocked down during sporting event), along with E 849.4, place of injury for recreation and sport; age parameters were set between 18 and 22 years old. This search yielded 1,911 records with discharge status recorded. Among the patients in this dataset, 1,738 were discharged to home, 156 sent to acute care/rehabilitation, and seven sent to nursing homes; 10 died. These data are depicted in the figure on this page. Among victims, 85 percent were male and on average 19.5 years of age; average length of hospital stay was 2.7 days, and average injury severity score was 8.5.

Going to college broadens a student’s horizon, allows development of interpersonal skills, prepares one for future employment or advanced degrees, and results in a feeling of accomplishment. For many, a part of the college experience is participation in sports. Fortunately, the number of injuries we found was small. Please remember when it is time for those of you with college-bound high school students to go on college visits, be sure to take a pass on the University of Injury.

Throughout the year, this column will provide brief monthly reports. The full NTDB Annual Report Version 6.0 is available on the ACS Web site as a PDF file and a PowerPoint presentation at http://www.ntdb.org.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.
With Group Savings Plus®, ACS members can get more from their auto and home insurance.

Savings of up to $327.96 or more a year on auto insurance* with a special group discount and other discounts**

12-month Rate Guarantee (not six, like some other insurers offer)

Help when you need it with 24/7 Enhanced Emergency Roadside Assistance*** and 24-hour claims service

Added benefits for added security including Identity Theft Protection and Auto Accident Forgiveness***

These are just some of the benefits of the Group Savings Plus program for members of The American College of Surgeons. They could be significantly more than your current provider offers. So call us right now for a FREE rate quote on auto and home insurance.

Get more. Save more.

Call today to find out just how much more.

Call 1-800-524-9400, go to www.libertymutual.com/lm/acsfellows or visit a Liberty Mutual office near you.

Please mention group #100128.

*Figures based on a March 2007 sample of auto policyholder savings when comparing their former premium with that of Liberty Mutual’s group auto and home program. Individual premiums and savings will vary. **Discounts and credits are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. ***Emergency Roadside Assistance Service applies to auto policyholders and is provided by Cross Country Motor Club of Boston, Inc., Boston, MA or through Cross Country Motor Club of California, Inc., Foster, MA. Accident Forgiveness coverage subject to terms and conditions of Liberty Mutual’s underwriting guidelines and varies by state. Please consult a Liberty Mutual specialist for specific details. Coverage provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA. A consumer report from a consumer reporting agency and/or a motor vehicle report, on all drivers listed on your policy, may be obtained where state laws and regulations allow. ©2007 Liberty Mutual Insurance Company. All Rights Reserved.
To report your Chapter’s news, contact Rhonda Peebles toll-free, at 888/857-7545, or via e-mail at rpeebles@facs.org.

**New York Chapter honors Dr. Patricia Numann**
In April, the New York Chapter presented its first Distinguished Service Award to Patricia Numann, MD, FACS. Dr. Numann was recognized for her many contributions to surgical education, mentoring, and surgical leadership (see photo, right). In addition to its scientific education program, which was presented at the Sagamore Resort on Lake George, NY, the annual business meeting was convened and new officers were elected (see photo, below).

**Florida Chapter recognizes Dr. Phillip Andrews**
At its annual meeting in late May, the Florida Chapter conducted an extensive education program, and during the two-day event, the Chapter presented its distinguished Raymond H. Alex-
ander, MD, Award to Phillip E. Andrews, MD, FACS. The Florida Chapter presents this award to recognize outstanding dedication and service to the medical profession in the field of surgery, as exemplified by the devoted and unselfish life of Dr. Ray Alexander. Among Dr. Andrews’ numerous medical association affiliations, many that he has served on their respective boards of directors, he served as President of the Florida Chapter from 1996 to 1998, and as president of the Lee County Medical Society in 1994; he has also held the office of Secretary/Treasurer in both of these organizations. In addition, he is active on the boards of many local and civic organizations.

Chapter meetings

For a complete listing of the ACS chapter education programs and meetings, please visit the ACS Web site at [http://www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html).

(CS) following the chapter name indicates that the ACS is providing AMA PRA Category 1 Credit™ for this activity.

<table>
<thead>
<tr>
<th>Date/Time</th>
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<tr>
<td><strong>October 2007</strong></td>
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| October 19–20      | Wisconsin                  | Location: The American Club, Kohler, WI  
Contact: Terry Estness, 414/453-9957; wisurgical@execpc.com |
| October 31         | Maryland (CS)              | Location: Sheraton Baltimore North Hotel, Towson, MD  
Contact: Kim Andrews, 443/849-2393; kandrews@gbmc.org  
ACS representative: Gerald B. Healy, MD, FACS |
| **November 2007**  |                            |                                                                                                 |
| November 3         | Delaware (CS)              | Location: Delaware Art Museum, Wilmington, DE  
Contact: Dianna Garvey, 302/658-7596; dmg@medsocdel.org  
ACS representative: Edward M. Copeland III, MD, FACS |
| November 3–4       | Arizona (CS)               | Location: Resort Suites Scottsdale, Scottsdale, AZ  
Contact: Joni Bowers, 602/246-8901; jonib@azmedassn.org  
ACS representative: Paul Friedmann, MD, FACS |
| November 10        | New Hampshire              | Location: Mount Washington Resort Hotel, Bretton Woods, NH  
Contact: Donald Eberly, MD, FACS, 603/526-5260; dae@nlsurgeons.org  
ACS representative: Monica Morrow, MD, FACS |
| **December 2007**  |                            |                                                                                                 |
| December 1         | New Jersey (CS)            | Location: Parsippany Hilton, Parsippany, NY  
Contact: Art Ellenberger, 973/239-2826; njacschapter@yahoo.com  
ACS representative: Gerald B. Healy, MD, FACS |
| December 2–5       | Philippines                | Location: EDSA Shagri-La Hotel, Mandaluyong City, Philippines  
Contact: Bienvenido S. Gaddi, MD, FACS, bsgaddi@yahoo.com |
| **January 2008**   |                            |                                                                                                 |
| January 17–18      | Southern California (CS)   | Location: Santa Barbara Biltmore Hotel, Santa Barbara, CA  
Contact: C. James Dowden, 323/937-5514; cjdowden@pachell.net |
| January 18–20      | Louisiana (CS)             | Location: The Ritz Carlton–New Orleans, New Orleans, LA  
Contact: Janna Pecquet, 504/733-3275; pecquet@LAACS.org |
## Chapter anniversaries

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<td>Keystone (PA)</td>
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<td>West Virginia</td>
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<td>August</td>
<td>Georgia</td>
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<td>Brooklyn–Long Island, NY</td>
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<td>Rhode Island</td>
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## New CME training in palliative care offered by NCI

The National Cancer Institute (NCI) estimates that there are more than 10.5 million cancer survivors living in the U.S. and more than 500,000 of these individuals will die from cancer each year. To address the education needs of cancer health care providers, the NCI is releasing a new palliative and end-of-life care self-study curriculum.

The Education in Palliative and End-of-Life Care for Oncology (EPEC™-O) CD-ROM and DVD is a comprehensive multimedia program developed for health professionals, including physicians, physician assistants, nurses and nurse practitioners, therapists, and social workers. The curriculum, featuring slides and case study videos, provides the following:

- Knowledge and skills necessary to provide state-of-the-art palliative interventions for cancer patients
- Educational tools and materials to use in teaching palliative care core competencies
- An opportunity for physicians and nurses to earn continuing education (CE) credits through the American Society of Clinical Oncology and the Hospice and Palliative Nurses Association

### CME for physicians and CE for nurses

The American Society of Clinical Oncology is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education (CME) for physicians. The American Society of Clinical Oncology designates this educational activity for a maximum of 32.5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The Hospice and Palliative Nurses Association is approved by the California Board of Registered Nursing (provider number CEP7976) as a provider for continuing education for nurses. This educational activity is approved for a maximum of 31 nursing contact hours.

To order your free copy of the EPEC-O CD-ROM and DVD, please call NCI’s Cancer Information Service toll-free at 800/4-CANCER (800/422-6237) or visit www.cancer.gov/publications.

To access EPEC-O promotional materials, please visit www.ncipoet.org/PromoToolsEPECO.cfm.

The EPEC-O curriculum was developed by the EPEC Project at Northwestern University with major funding from NCI and supplemental funding from the Lance Armstrong Foundation. The American Society of Clinical Oncology and the Oncology Nursing Society are among the professional organizations partnering with NCI to disseminate the EPEC-O curriculum.