Medical tourism: The new world of health care globalization
FEATURES

The problem of self-determination of professionalism and ethics 8
Henry Buchwald, MD, PhD, FACS

ACS-SQA surgical patient experience of care survey design project: A progress report 14
Elizabeth W. Hoy, MHA

Medical and surgical tourism: The new world of health care globalization and what it means for the practicing surgeon 18
James A. Untt, MD, FACS

Statement on medical and surgical tourism 26

Residents salute their mentors 28

My mentor: The Mac of all mentors: Jack McAninch, MD, FACS 29
David Aaronson, MD

My mentor: Growing under a watchful eye: John W. C. Entwistle III, MD 30
Angela Mouhlas, MD

My mentor: The right track: A tribute to John D. Mellinger, MD, FACS 31
James G. Bittner IV, MD

My mentor: Guerilla rounds: In memory of Erwin F. Hirsch, MD, FACS 32
Anathea Powell, MD

DEPARTMENTS

From my perspective 4
Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director

What surgeons should know about... 6
The NCDs for “never events”
Vinita Ollapally, JD

Advocacy advisor 33
Lobby laws
Melinda Baker and Kristen V. Hedstrom

On the cover: The growing industry of medical tourism raises concerns about safety and quality issues that patients may encounter if they seek health care services outside the U.S. (see article, page 18, and statement, page 26).
CSPS issues statement on violence in the workplace 34
CSPS to co-convene symposium in May 36
New College Web site centers on E-prescribing Incentive Program 36
The Tennessee Chapter’s strategic planning experience 38
Gayle Minard, MD, FACS; and Wanda M. Johnson
Chapter leadership 39
John T. Preskitt, MD, FACS
ACS leadership to host interactive Webcast Town Hall Meeting 42
ANZ Travelling Fellow selected for 2010 42
Report of the 2008 ACS Traveling Fellow to Germany 43
John F. Renz, MD, PhD, FACS
A look at The Joint Commission: Preventing technology-related health care errors 51
AWS announces availability of two fellowships 52
ACS to present course on leadership skills 52
Trauma meetings calendar 52
Bulletin of the American College of Surgeons: Instructions to authors 53
NTDB® data points: How complicated is it? 55
Richard J. Fantus, MD, FACS
Chapter news 58
Rhonda Peebles

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.
The College promptly issued a press release responding to the budget plan, applauding efforts to address Medicare’s broken physician payment system and the overarching goals of expanded access, improved quality, and reduced spending growth.

Research and HIT

As anticipated, President Barack Obama has moved quickly regarding the development of plans to reform the U.S. health care delivery system. Related provisions in the American Recovery and Reinvestment Act (ARRA) of 2009 and in the President’s budget proposal could significantly alter the way in which surgeons run their practices and are reimbursed for their services. Hence, the College has offered swift and proactive responses to these plans for change.

From my perspective

Research and HIT

The ARRA, also known as the economic stimulus package, contains several provisions pertaining to health care, most of which are centered on advancements in research and technology. The American College of Surgeons’ advocacy staff and consultants examined this bill before Congress passed it, and I submitted comments to House Speaker Nancy Pelosi (D-CA) and Senate Majority Leader Harry Reid (D-NV) outlining our position.

To begin, the ARRA contains considerable language pertaining to “comparative effectiveness research” (CER), which is defined as (1) comparative analysis of items, services, and procedures used to prevent, diagnose, and treat illness; and (2) work conducted through clinical registries, clinical data networks, and other electronic means for purposes of generating outcomes data. The Act states that a significant portion of the $1.1 billion in CER funding—$400 million—is to be used to “accelerate the development and dissemination of CER.”

The College largely supports the law’s allocation of funds to speed efforts to compare clinical outcomes in an unbiased manner. Furthermore, the ACS is pleased to note that the information gathered and examined through a newly established Federal Coordinating Council for CER will not be used, as stated in the Act, to “mandate coverage, reimbursement, or other policies for any public or private payer.”

To further advance outcomes research as a means of promoting safer, higher-quality, better-coordinated care, the law invests $20 billion in the health information technology (HIT) infrastructure, including the expansion of existing clinical registries and quality improvement tools. The College has requested that some funds be allocated to the ACS National Surgical Quality Improvement Program—the only risk-adjusted, validated instrument for measuring surgical outcomes.

The legislation also provides financial assistance to physicians for the acquisition and implementation of HIT. The ACS supports Medicare and Medicaid bonus payments of $40,000 to $65,000 through 2016 to physicians who switch to interoperable electronic medical records (EMRs). Nonetheless, we have concerns about making the availability of these funds contingent on participation in a quality improvement program, and we have reminded lawmakers that the adoption of interoperable HIT may precede an individual’s ability to participate in a reporting system.

Because surgeons who fail to comply with the new HIT requirements by 2015 will be penalized—a mandate that the ACS opposed—the College urges its members to put modernized record-keeping systems into place as soon as possible.
The ACS Committee on Informatics recommends consulting with the Certification Commission for Healthcare Information Technology (CCHIT), (http://www.cchit.org). CCHIT is an independent, not-for-profit organization that defines a set of functions for EMR systems and certifies products that meet those levels of functionality.

**Insurance and payment reforms**

Soon after the President signed the ARRA, his Administration released its fiscal year 2010 budget proposal, which seeks to create a $634 billion reserve fund over the next decade to finance expanded health insurance coverage and other health care investments. Approximately half of the reserves would be generated by increasing taxes on couples filing jointly who earn more than $250,000 annually and on individuals earning more than $200,000 per year. The remainder of the funding would be derived from Medicare and Medicaid savings.

Of particular relevance to physicians, the budget proposal includes $329.6 billion “to account for additional expected Medicare physician payments” over the next 10 years. If adopted by Congress, these funds would effectively eliminate the deficit in Medicare physician payments as well as scheduled payment cuts of 40 percent over the next seven years.

Furthermore, the budget package iterates the Administration’s willingness to “support comprehensive, but fiscally responsible, reforms to the payment formula.” Importantly, the proposal signals a willingness to modify the sustainable growth rate formula and to move toward a system in which physicians are rewarded for providing high-quality care.

Included in the Medicare and Medicaid savings proposals are restrictions on physician-owned hospitals and requirements for the use of radiology benefits managers. Other provisions aimed at reducing Medicare spending are as follows: competitive bidding for Medicare Advantage plans, bundled payments for hospital and post-acute care services, reduced payment for hospital readmissions, reduced payment for home health services, increased Medicaid drug rebates, increased Part D drug premiums for higher income beneficiaries, and Medicare program integrity efforts.

The American College of Surgeons promptly issued a press release responding to the budget plan, applauding efforts to address Medicare’s broken physician payment system and the overarching goals of expanded access, improved quality, and reduced spending growth. We affirmed our willingness to work with the Administration on meaningful adjustments to the current physician payment system. We also stated our belief that health care reform should encourage and reward surgeons for choosing the optimal treatment and should reduce spending by eliminating waste and inefficiencies.

**A new era**

At press time, Congress had just begun its review of President Obama’s budget proposal, and the College has been at the table for key deliberations, including small stakeholder meetings with the Senate Committees on Finance and Health, Education, Labor, and Pensions. Most likely, lawmakers will markedly change the budget proposal before it passes as legislation. Nonetheless, we clearly are entering a new era in the delivery of health care services—one in which there will be considerable emphasis on outcomes reporting, the use of interoperable EMRs, bundled payments, and coordinated care.

Some surgeons have contacted me to voice their concerns about the proposed reforms and the means of financing these changes. Although their frustrations are understandable, this organization would be ill-served if we focused solely on areas of disagreement. To help the College advance its mission of providing optimal care to surgical patients, we intend to continue to offer proactive responses as new policies are developed and to be a constructive participant in efforts to create a more sustainable, high-quality health care system.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

Thomas R. Russell, MD, FACS

APRIL 2009 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
What surgeons should know about...

The NCDs for “never events”

by Vinita Ollapally, JD, Senior Regulatory Associate, Division of Advocacy and Health Policy

On January 15, the Centers for Medicare & Medicaid Services (CMS) finalized three national coverage determinations (NCDs) that deny Medicare coverage of certain surgical or invasive procedures, including the following: (1) surgery on the wrong patient, (2) surgery on the wrong body part, and (3) wrong surgery performed on a patient. This article is intended to help surgeons become familiar with the specifics of the NCDs.

What are Medicare NCDs?

Medicare NCDs set national policy on whether and under what conditions Medicare will cover an item or service.

What are “never events”?

“Never events” are identified in the National Quality Forum’s list of 28 Serious Reportable Events. The Deficit Reduction Act of 2005 directed the Secretary of the U.S. Department of Health and Human Services to identify acute medical conditions that are (1) high in cost, high in volume, or both; (2) identified through International Classification of Diseases, Ninth Revision, Clinical Modification coding as complicating conditions or major complicating conditions, when present as secondary diagnoses on claims, and/or in a higher-paying Medicare-severity diagnosis related group; and (3) reasonably preventable through the application of evidence-based guidelines. Whereas CMS has determined through previous rulemaking that some of these conditions are nonreimbursable hospital-acquired conditions, CMS has chosen to address the three conditions mentioned previously through the NCD process instead.

How are surgical and other invasive procedures defined under the new NCDs?

Surgical and other invasive procedures are defined as operative procedures in which skin or mucus membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures—such as biopsy, excision, and deep cryotherapy for malignant lesions—to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology* and other invasive procedures, such as percutaneous transluminal angioplasty and cardiac catheterization.

How is it determined that an operation was performed on the wrong patient?

A surgical or another invasive procedure is considered to have been performed on the wrong patient if that procedure is inconsistent with the correctly documented informed consent for that patient.

How is it determined that an operation was performed on the wrong body part?

An operation is considered to have been performed on the wrong body part if it is inconsistent with the correctly documented informed consent for that patient. It encompasses not only procedures on the wrong appendage or organ, but also operations on the wrong location on the body, including the wrong side or at the wrong level (spine). If a surgeon operates on a different body part than the one identified in the informed consent as a result of an emergency situation that arises in the course of the procedure and/or because of circumstances that preclude obtaining informed consent, the action will not be deemed an operation on the wrong body part. It is also not considered to be an operation on the wrong body part when there are changes in the opera-

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2008 American Medical Association. All rights reserved.
tive plan upon surgical entry into the patient resulting from the discovery of pathology in close proximity to the intended site when the risk of a second operation outweighs the benefit of patient consultation, or when there is discovery of an unusual physical configuration (for example, adhesions or spine level/extra vertebrae).

How is “wrong surgery” defined under the NCD?

A surgical or other invasive procedure is considered to be the wrong surgery if it deviates from the correctly documented informed consent for that patient. As with wrong body part determinations, it is not considered “wrong surgery” when actions taken in emergency situations occur in the course of an operation and/or under circumstances that preclude obtaining informed consent. In addition, changes in the plan upon surgical entry into the patient (as described in the paragraph defining wrong body part surgery) are not considered to be wrong surgery performed on a patient.

For more information about the new NCDs, go to the following sites:

- For surgery on the wrong patient: http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=221
- For surgery on the wrong body part: http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=222
- For wrong surgery performed on a patient: http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=223

What is the College’s position on NCDs?

The College maintains that it is inappropriate for CMS to use the NCD process to address surgery on the wrong patient, surgery on the wrong body part, and wrong surgery performed on a patient. Instead, the ACS supports developing a clear payment policy outlining circumstances under which claims related to surgery would result in nonpayment from Medicare. For example, if a physician’s failure to use commonly accepted patient safety practices resulted in surgery on a wrong body part, a Medicare carrier might deny partial or full payment for the service claim.
Only in literature and in the theater is the human embodiment of evil given an identity; a personification; a self-awareness; and even a boastful, commanding presence. Thus, Iago, in Shakespeare’s *Othello*, with pride proclaims:

> Divinity of Hell! When devils will the blackest sins put on, they do suggest at first with heavenly shows, as I do now... I’ll pour this pestilence into his ear.¹

In 19th century opera, villainy is given even a stronger identity, and villains are given arias to sing. Thus, in Verde’s *Othello*, the brilliant text of Arrigo Boito has Iago stating:

> I believe in a cruel god, who has created me in his image and whom, in hate, I name.²

In Puccini’s *Tosca*, based on the novel by Victorien Sardou, libretto by Luigi Illica and Giseppe Giacosa, the arch villain, the police chief Scarpia, is also given an aria to proclaim his credo of lust and evil:

> I am gripped by desire. I pursue what I desire, take my fill and throw it away.³

In real life, however, evil people don’t publicly state that they are evil, and I doubt most believe that they are. In our surgical microcosm of the world, I believe there are few, if any, truly evil and corrupt people—but there are those who are totally self-absorbed and self-serving, even ruthless, and who place their own ambitions above concern for their patients or above fair play for their professional associates.

How can we as surgeons in the community we serve rely on self-determination to set the standards for ethics and professional conduct in surgery?
The search for guidelines

Can we rely on guidelines to help us meet the self-challenge of determining our principles for behaving honorably in our professional lives and ethically in general? “Do unto others as you would have done unto you”4 is an impeccable guideline. Unfortunately, it is often corrupted in daily affairs to “Do unto others before they can do unto you,” or “Do unto others as others have done unto you.” This guideline is, nevertheless, a sound first principle for the start of self-determination in our professional lives.

Seneca was the originator of many of the world’s great aphorisms. Shakespeare provides an English translation of one of Seneca’s most quoted guidelines for professional conduct:

This above all: To thine own self be true, And it must follow, as the night the day, Thou canst not then be false to any man.5

Ironically, Shakespeare gives these lines in Hamlet to Polonius—a pretentious fool.

Why, as surgeons, should we not turn to the Oath of Hippocrates,6 the essence of which has been summarized by many in the admonition, “Primum, non nocere,” or, “First, do no harm”? Primarily, that precept is not found in the Oath of Hippocrates. It may well be a Latin translation of Hippocrates, but from his Epidemics, Book 1, Section XI, Hippocrates states:

Declare the past, diagnose the present, foretell the future; practice these acts. As to diseases, make a habit of two things—to help, or at least to do no harm.7

Secondly, the Hippocratic Oath disallows the profession of surgery: With the statement “I will not cut persons laboring under the stone,” there goes biliary tract surgery and urology.

More to the point, we surgeons, as a rule, do harm in order to do good. By advice, drugs, chemotherapy, and radiotherapy, as well as operative intervention, we can do damage instead of, or as well as, offer benefits to our patients. By open,oscopic, or natural orifice surgery, we extirpate, manipulate, or perform some other tissue damage to achieve a potential salutary goal. Many times, we harm but do not even accomplish good. We need to accept the fact that we may have to do harm in order to offer our patients the opportunity to be cured or ameliorated of their ills.

In 1803, Sir Thomas Percival published a thesis entitled, “A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons.”8 According to Percival, physicians should “unite tenderness with steadiness and condescension with authority, as to inspire the minds of their patients with gratitude, respect, and confidence.” In 1847, these words were essentially repeated in the first Code of Medical Ethics of the American Medical Association (AMA), adopted at the first AMA Convention in Philadelphia of 268 physicians from 22 states.9

The AMA Code of Medical Ethics has undergone multiple revisions. In 1958, the Code was reduced to 10 Principles of Medical Ethics10; in 1980, to seven principles11; and expanded to nine principles in 2001.12 The work of the AMA was supplemented in 1973 by the Patient’s Bill of Rights published by the American Hospital Association, which emphasizes full disclosure of diagnoses, prognoses, treatment options, and the patient’s right to refuse treatment.13

Outside of the U.S., the World Medical Association has published eight separate declarations of ethics, including the Declaration of Geneva and the International Code of Medical Ethics in 1948, and the Declaration of Helsinki in 1964.14,15 The latter focused on the principle of informed consent for volunteers in biomedical research and was an outgrowth of the Nuremberg Code, issued after the trial of Nazi doctors who had experimented with Jewish prisoners in concentration camps during World War II.16

The AMA Code of Medical Ethics, similar codes, and the various medical oaths that have been promulgated over time all have in common a social compact not only among physicians but among physicians, patients, and society. By the 1847 AMA Code, the AMA set licensing requirements and minimal education standards and promised to drive out the unscrupulous from the ranks of medical practitioners.9 In the 1958 Principles of Medical Ethics, Section 10 states:

The honored ideals of the medical profession imply that the responsibilities of the physician
extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.  

In the 1980 Principles, Principle VII states that: “A physician shall recognize a responsibility to participate in activities contributing to an improved community.”

The Principles of 2001 reiterate the idea from 1980 and add, as Principle IX: “A physician shall support access to medical care for all people.”

The American College of Surgeons was founded in 1913. The Fellowship Pledge of the ACS reiterates the ethical principles of the AMA Code and closes the circle to the precept of “Do unto others as you would have done unto you,” by the pledge, “I promise to deal with each patient as I would wish to be dealt with if I was in the patient’s position, and I will respect the patient’s autonomy and individuality.”

A subtle transformation of emphasis from ethics to professionalism was initiated by the American Board of Medical Specialties Task Force on Competence and published by the Accreditation Council for Graduate Medical Education in 2002. This current credo, though not as poetic as those of the past, may be as good as we are going to get in the 21st century. We periodically grade our residents on these principles of professionalism, summarized as follows:

- Demonstrates respect, compassion, and integrity
- Demonstrates responsiveness to the needs of patients that supersedes self-interest
- Demonstrates commitment to excellence and ongoing professional development
- Demonstrates a commitment to ethical principles as pertaining to patient confidentiality, informed consent, and business practice
- Demonstrates sensitivity

**Personal autonomy and administocracy**

In order for self-determination to guide us in achieving professionalism and ethics in medicine, we must have personal autonomy. Surgeons tend to be individualists and to espouse individual responsibility. Our years of training prepare us for this autonomy. We acquire a base of knowledge and the insight to apply facts and rational supposition to patient care. We obtain skills and have learned the art of being gentle with a firm and steady hand. We are sobered by death and bad outcomes. We are taught by the vagaries of human nature. We acknowledge our fallibility and our power to do harm. Ours is a profession where decisions are singular and responsibility is particular. Thus, when a surgeon reaches professional maturity, that individual has achieved personal autonomy.

Yet, of the wide circle of freedom, we are allowed only a small arc, and that arc is narrowed daily by the administrative policies of academia, hospitals, insurance companies, and government. Several years ago, I coined the term “administocracy” to epitomize top-down control of money, resources, and opportunities by all these forces that restrict the autonomy of the clinician and academic. Unfortunately, administocracy has or is gaining control of our medical schools, our teaching and community hospitals, our income, and our ability to provide health care. We are being reduced to “vendors” of health care; this status is not a firm base for the autonomy necessary for self-determination in our profession.

**The individual and the group**

Today, most decisions are made by a group—an elected legislative body, an appointed judicial body, or an ad hoc team of consultants. This structure is true in government, in industry, in universities, and certainly in health care. There is comfort in the rule of the majority. Yet, in all these affairs of governance, there is a head, a president, or a chief executive officer, and the achievements, as well as the place in history of these organizations, are identified with that leader, for good and for ill.

The same is true for ethics and codes of morality. For the most part, dicta for appropriate conduct are written by groups that at times meet in conclave for generations. However, the great revelations in the changes in the course of moral behavior are brought about by individuals.

Has history taught us to rely on the judgment of the group in terms of ethics—in our case, in
professional ethics for the surgeon—or the judgment of individuals, or neither? The dilemma of individual choice is nowhere better illustrated than when personal judgment is in conflict with the recommendations of the group and is in discord with those of a respected leader. This conflict can occur in decisions and interactions between surgeon and patient, surgeon and colleagues. What code of conduct exists for us as surgeons to respond to these challenges? In the final analysis, the challenge for self-determination must rest precisely on the self.

Conflict of interest

Self-determination of professional conduct and ethics today is intimately enmeshed with the concept of “conflict of interest.” (Author’s note: I have examined this topic elsewhere in an editorial that informs much of my discussion here.20) The term “conflict of interest” is generally employed in a derogatory sense—an expression of implied wrongdoing. It is considered dishonorable to be tarred with the brush of conflict of interest; even to undergo investigation for conflict of interest is negatively perceived. There are various definitions for conflict of interest, but the expression is generally used in the narrow sense of involving access to money or the opportunity for financial gain. Was Honore de Balzac (1799–1850) correct when he stated that behind every great fortune, there is a crime?21 Would it not be more scientifically sound to view the potential of conflict of interest from a less narrow, more encompassing perspective? Is the perception of conflict of interest not present when promotion, career advancement, favorable media notoriety, or public recognition are concerned? Of all these inducements, money may, for some, be the least tempting. Arnold S. Relman, the legendary editor of the New England Journal of Medicine, basically agreed with this premise, noting the following:

We recognize that in some sense, authors may be affected by conflicts of interest even when no commercial considerations are involved. Competitive pressures and concerns about research grants, peer recognition, or academic advancement may adversely influence behavior. Connections with investigator-owned businesses, therefore, may simply be another form of a pre-existing problem.22

The workplace

For the surgeon, the workplace is the hospital in which the surgeon holds privileges; for the academic surgeon, the workplace is the hospital and the university. In 1986, Ross, in an article entitled, “Academic Research and Industry Relationships,” stated the following:

The potential for great personal enrichment is responsible for the university’s concern that the individual scientist will divert energy from the pursuit of new knowledge to that which has a practical application and will generate dollars. Vannevar Bush put it well when he said ‘applied research drives out the pure.’ This is a legitimate concern. Scientists are people, and people are subject to temptation. To use epidemiological terminology, we could say that the fraction of the population who will be susceptible to temptation is proportional to the potential for financial reward.23

A. Bartlett Giamatti took up this theme as well, concluding that “the university is the only entity that can enter into arrangements for cooperative research.”24 In essence, the individual is to entrust himself or herself to the institution that governs his or her workplace and its judgment, not his or her own judgment, in ascertaining where conflict of interest exists and what rules should be imposed to oversee this aspect of professional conduct.

Funding agencies

Definition and regulation of conflict of interest by funding agencies have, as a rule, followed the principles set down by the National Institutes of Health (NIH), in particular the 1989 NIH Guide for Grants and Contracts, which states:

Growing expressions of public concerns suggest that NIH ought to limit possibilities for

Vannevar Bush was scientific advisor to President Franklin D. Roosevelt.

actual or apparent financial conflicts of interest by investigators in research and development projects funded by NIH extramural awards.... NIH therefore intends to take steps to develop appropriate guidance for such relationships.... Guidelines should also recognize special conditions under when restrictions should be waived to permit investigators with unusual skills and expertise to conduct studies which might otherwise be proscribed.25

Points of interest and emphasis in this statement are the definition of conflict of interest in monetary terms, primary concern with extramural awards, and an escape clause for certain investigators.

The 1989 NIH statement has subsequently been modified and supplemented by conflict of interest policies set by the individual institutes—a discussion beyond the scope of this essay. Also, the NIH has had to deal with various internal conflict of interest situations, often first revealed in the media, concerning Cooperative Research and Development Agreements and other financial arrangements between NIH institutes and industry, unreported NIH personnel consultative arrangements with industry, and the partial funding of large NIH trials by industry.

Thus, funding institutions, as well as the individual, can have great difficulty in navigating this arena. They seek to find the best applicants and the most scientific and socially promising projects. More often than not, these individuals will be those who demonstrate the ability for professional advancement, who attract public recognition, and who are offered opportunities to make money. Certainly, no one would propose a safe cadre of career researchers consisting of individuals who pledge themselves to remain anonymous, never to accept advancement, be devoid of attachment to their research, and, preferably, have no ideas of their own but perform as surrogate investigators for basic wages.

Presentations and publications

It is common practice today, indeed mandated, that all presentations and publications are preceded by listing the authors’ financial and industry consultative relations. This acknowledgment is called “Disclosure of Potential Conflict of Interest” or just “Conflict of Interest Statement.” In going through this exercise, it is best to reveal any monetary connection with industry, granting sources, patents, company ownership, and so on. (The official conflict of interest policy of the Journal of the American Medical Association is so inclusive as to occupy nearly a page of print.26) Unfortunately, the more such connections an individual has, the less will his or her work be considered free of bias. In a sense, this litany is protective for the individual, but it can also be used against the individual.

To perform scientific research that will be presented and published, an investigator needs money. There is not enough money to go around from public agencies to fund even a small fraction of worthwhile research, in particular focused drug or device research and trials. If research money comes from the NIH or another external funding agency, that funding source is accepted today without further questions by the publishers of scientific literature, even though these agencies are burdened by their own mandates and politics that, in the broader sense, pose a potential for conflict of interest. On the other hand, if the research is funded by industry, it is, prima facie, subject to suspicion. In a presentation or a publication, the funding source of the former is “credited” whereas the source for the latter is “disclosed.”

Conclusions

Does self-determination of professionalism and professional ethics belong to the past? Are we today too confined by our institutions and society to determine moral conduct for ourselves? Do we welcome our limitations and restrictions and take comfort in the security they provide? Is the surgeon of the present and the future not the individualist represented by the surgeon of the past? These are complex questions for a complex world. There may be no easy answers, or even partial answers, to these questions. It is important, however, that these questions are continually being asked and, in the asking, framed to project concepts of self-determination and self-challenges.
In these reflections, there is hope for truth and for progress. The Talmud poses four self-challenges expressed as the following four questions of self-determination:

Have I lived honorably on a daily basis?
Have I raised the next generation?
Have I set aside time for study?
Have I lived hopefully?

Author’s note: The information herein was published, in modified format, as a book chapter in Professionalism & Ethics in a Surgical Practice (Frezza EE, ed. Woodbury, CT: Cîné-Med; 2008.)

References

27. The Babylonian Talmud. Tractate Shabbat; 31a.

Dr. Buchwald is professor of surgery and biomedical engineering and Owen H. and Sarah Davidson Wangensteen Chair in Experimental Surgery Emeritus at the University of Minnesota, Minneapolis.
ACS-SQA
surgical patient experience of care survey design project:
A progress report

by Elizabeth W. Hoy, MHA,
Assistant Director, Regulatory Affairs and Quality Improvement Programs, Division of Advocacy and Health Policy
The American College of Surgeons, representing the Surgical Quality Alliance (SQA), has been working with the American Institutes for Research (AIR) and Westat to develop a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey centered on patient experiences of surgical care. This article provides background information on why the College and SQA decided to get involved in this project, updates readers on the status of that undertaking, and offers an overview of the types of information gathered through the CAHPS studies. In the coming months, the Bulletin’s “What surgeons should know about...” columns will discuss the ACS-SQA Surgical CAHPS project.

CG-CAHPS’ primary care focus

The Agency for Healthcare Research and Quality (AHRQ) launched the CAHPS program in 1995 as a public-private initiative using standardized surveys of patients’ experiences with ambulatory and facility-level services. AHRQ developed the surveys through a public-private partnership with researchers at Harvard University, The RAND Corporation, Research Triangle Institute, Westat, and American Institutes for Research. Since then, CAHPS surveys have become the most widely used instruments of their type in the U.S., achieving widespread adoption by the Centers for Medicare & Medicaid Services, state Medicaid programs, and private health plans. More than 55 million enrollees currently are covered through health plans that rely on CAHPS.

Furthermore, in October 2006, the Ambulatory Quality Alliance (AQA) endorsed the use of the Clinician & Group CAHPS (CG-CAHPS) survey instrument for all purchasers, providers, and payors interested in measuring patient experience of care at the physician or group practice level. The surgical societies reviewed this survey and reached a general consensus that the questionnaire did not adequately measure and reflect the quality of surgical care. By emphasizing all care received from a physician in the last 12 months and using a response scale that ranged from “always” to “never,” the survey clearly was geared toward primary and chronic care. Moreover, the CG-CAHPS survey did not contain key domains of quality in the surgical episode, such as informed consent, shared decision making, postoperative follow-up care, and anesthesia care.

ACS and SQA step in

After review and consultation, the ACS contracted with AIR and Westat on behalf of the SQA to develop a survey that would properly assess patient experiences in surgical care. AIR and Westat have extensive experience working on other CAHPS instruments and are following all AHRQ guidelines and protocols for developing a CAHPS survey. The goal at the end of the project is to submit the survey instrument to AHRQ and receive the CAHPS trademark and, thus, make available to the health care marketplace a reliable, valid measure of surgical patient experiences.

A total of 11 surgical specialty societies and one surgical board (see box on this page) supported the project financially, provided technical input to the questionnaire design, and recruited surgical practices to participate in field testing the questionnaire. The College also received a generous grant from the United Health Foundation to support instrument development.

Sponsors of the Surgical Patient Experience Survey

**Specialty societies**
- American Academy of Ophthalmology
- American Academy of Orthopaedic Surgeons
- American Academy of Otolaryngology–Head & Neck Surgery
- American College of Osteopathic Surgeons
- American College of Surgeons
- American Society of Anesthesiologists
- American Society of Colon & Rectal Surgery
- American Society of Plastic Surgeons
- American Urological Association
- Society for Vascular Surgery
- Society of Thoracic Surgeons

**Surgical board**
- American Board of Orthopaedic Surgery

**Foundation**
- United Health Foundation
Survey development

To increase the likelihood that AHRQ would add the surgical survey to the CAHPS family of national standard survey instruments, the ACS-SQA project followed the CAHPS consortium survey development protocol. This approach involves the following five phases, each of which builds on the previous step to ensure the development of an instrument that measures aspects of care that are meaningful and for which patients are the best source of information:

• **Review the literature.** These activities focused on identifying existing surveys related to surgical care, relevant topics to cover in a survey of surgical care, and issues pertinent to survey administration and appropriate survey design characteristics, such as response scales. AIR reviewed 930 abstracts and identified 18 different instruments covering 14 topics related to surgical care.

• **Conduct focus groups.** AIR then conducted six focus groups in two geographic locations with a broad mix of patients who had undergone surgery within the previous six months. Using a structured protocol that included open-ended questions, ranking exercises, and prompted recall, AIR tested the relevance of the topics identified in the literature review and examined common experiences across surgical patients.

• **Develop questions/survey items.** The findings from these two activities were reviewed by the technical advisory panel representing surgical society participants, and a set of approximately 70 questions were developed. These questions were crosswalked with the existing CAHPS surveys to ensure comparability wherever possible. Draft survey instruments in English and Spanish were developed for cognitive testing with patients.

• **Test questions on patients.** To ensure that patients can accurately answer the questions in the survey and that patients are appropriately interpreting the intent of the questions, all CAHPS surveys are subject to cognitive testing. This process consists of two-hour, one-on-one interviews with patients who have undergone surgery within an appropriate time frame. Patients answer the draft survey based on their experience and “think aloud” about how they determine their answers. Researchers conducting the testing also use a

### Composites and questions in the Surgical Patient Experience Survey

#### Presurgical communication
- Surgeon/staff gave you enough information
- Surgeon/staff gave you easy-to-understand instructions
- Surgeon listened carefully to you
- Surgeon encouraged you to ask questions

#### Perioperative care
- Surgeon visited you before surgery
- Visit made you more calm and relaxed
- Surgeon visited you and discussed outcome of surgery before you left the facility

#### Postsurgical follow-up
- Surgeon/staff explained to you what to expect during recovery
- Surgeon/staff warned you of symptoms requiring immediate medical attention
- Surgeon/staff gave you easy-to-understand instructions about what to do during recovery
- Surgeon made sure you were physically comfortable
- Surgeon spent enough time with you
- Surgeon treated you with courtesy and respect

#### Office staff
- Staff was as helpful as you thought they should be
- Staff treated you with courtesy and respect

#### Shared decision making
- Surgeon told you there was more than one way to treat your condition
- Surgeon asked which way you prefer to treat condition
- Surgeon talked about the risks and benefits of treatment decisions

#### Using diagrams
- Surgeon/staff used diagrams, models, videos to help explain surgery
- Diagrams, models, videos helped you understand

#### Anesthesia care
- Anesthesiologist encouraged you to ask questions
- Anesthesiologist answered questions clearly
- Anesthesiologist made you feel more calm
series of structured follow-up questions to clarify patients' understanding. AIR conducted 30 interviews in two rounds of cognitive testing—20 in English and 10 in Spanish.

- Conduct field testing. After revising the instrument based on cognitive testing results, the psychometric properties of the questionnaire were tested in a large-scale field test. The test encompassed 33 practices across nine specialties and included responses from nearly 2,750 patients in 18 states. With these results, the researchers were able to examine the reliability and validity of the questionnaire and use factor analysis to develop clusters of questions (composites) that reliably describe domains/topics of patient experience of surgical care.

This survey development process began in August 2007 and analysis of the field test data and final revisions to the instrument were completed in November 2008. The final version of the survey has 35 questions, plus seven questions designed to determine patient demographics for analysis and risk adjustment. Some questions, such as those assessing provider communication skills, are very similar to questions in other CAHPS surveys; however, they use a scale of “definitely yes” to “definitely no”—rather than “always” to “never”—reflecting the more episodic nature of surgical care. Other questions in the new survey are unique to this instrument and reflect the special quality concerns of surgical care, such as postsurgical follow-up and instructions.

** Purposes and status **

This questionnaire may be used for quality improvement purposes by individual surgeons or health care delivery systems, as part of Maintenance of Certification, or as part of a public reporting initiative. In addition to the participating specialty societies and surgical board, ACS staff has received a number of inquiries about the new instrument from large academic medical centers, other surgical boards, and the American Board of Medical Specialties.

The final step in the survey development process is to submit the new questionnaire and documentation of its development and testing to the AHRQ for review and permission to use the official CAHPS trademark. This approval will ensure that the ACS-SQA questionnaire becomes the national standard for measuring patient experience of surgical care and will provide a mechanism for establishing and monitoring appropriate survey administration procedures. It is also anticipated that some surgical specialties will develop supplemental questions over time to reflect the unique aspects and concerns of surgical care for their patients.

For further information about the surgical patient experience of care instrument, contact Caitlin Burley, Quality Associate, Division of Advocacy and Health Policy, at cburley@facs.org.
Medical and Surgical Tourism:
The new world of health care globalization and what it means for the practicing surgeon

by James A. Unti, MD, FACS

In this issue of the Bulletin, the leadership of the American College of Surgeons has published a Statement on Medical and Surgical Tourism (see page 26). The statement addresses a number of concerns about this new industry and some of the safety and quality issues that patients may encounter if they seek health care services outside of the U.S. On June 16, 2008, the American Medical Association adopted its own first set of guidelines on medical tourism to help ensure the safety of patients who are considering traveling abroad for medical care.1 The American College of Surgeons’ statement and the American Medical Association’s guidelines together provide an important set of principles for consideration by patients, employers, insurers, and other third-party groups responsible for coordinating such travel outside of the country.

Medical tourism is a rapidly growing, worldwide industry, and its continued expansion could have significant implications for health care delivery in the U.S.2 It is important to distinguish medical tourism today from the traditional model of international patient travel. In the traditional model, patients generally journeyed from less developed nations to major medical centers in more highly developed countries. They would do so to receive services that were not typically available in their own communities. Wealthy individuals and dignitaries have often traveled great distances to seek out the best treatments, frequently coming to the U.S. for care that for many years was perceived to be second to none. Individuals in upper social classes have a long history of traveling abroad, seeking spas, mineral baths, innovative therapies, and fair climates such as those of the Mediterranean with the hope of improving their health.3 Individuals lacking health insurance coverage and individuals with insurance seeking services that weren’t covered by their payor plans have crossed borders for care that was simply more affordable. Typically, the services sought were of limited medical complexity. Common examples include elective, cosmetic surgical procedures and various types of dental care. Still others
have traveled for reasons of privacy, to circumvent delays associated with long waiting lists, to obtain services for which access was restricted, or because the desired care was illegal in their homeland country.4,5

Worldwide shortages of donor organs for transplant have created global commercial opportunities in the international organ trade. Often referred to as “transplant tourism,” this form of medical tourism has little in common with the emerging industry that is being broadly promoted today. In transplant tourism, patients travel on their own to obtain organs through the organ trade or through other means that contravene the regulatory framework of their countries of origin.6 Many clinical and bioethical concerns surround this trade, and the unavailability of sufficient amounts of verifiable data has led to numerous superficial and often inadequate assessments of this exceedingly complex issue.7

Reproductive outsourcing is another specialized form of medical tourism. Legal and policy limitations in many countries have created a global environment where, in a rising number of instances, individuals and couples must travel elsewhere to procure fertility procedures that are unavailable back home.8 Sometimes referred to as “reproductive tourism,” circumstances are created in which pregnancy is initiated in one location using the services of a fertility doctor, and parturition occurs at another (typically back home). The jargon term “procreation vacation” has been used, and certainly, assisted conception is one of the most contentious areas of present-day medicine. Such services have many associated bioethical, legal, and other safety issues and these matters become even more complicated when travel to foreign lands is involved.9 Pregnancy termination presents another area with many concerns. Like transplant tourism, determining both the demands and the outcomes for these services is complicated by virtually nonexistent domestic record keeping and an unclear understanding of the size and scope of the industry.

It is highly recommended that the reader take a moment to access the Internet and perform a simple search of just a few of the innumerable medical tourism Web sites to obtain a full appreciation of what is being marketed to the health care consumer today.

The new model of medical tourism

The newer, more popularized concept of medical tourism refers to the model in which patients not only travel across national borders to receive health care services, but they typically travel from more highly economically developed countries to less developed ones. In this circumstance, the term provides neither an accurate reflection of the reality of the patient’s situation nor characterizes the types of advanced medical care that is being delivered in the countries of destination.10 The image of the typical medical tourist in the new model is one of an individual who jets around the world to a foreign land to receive complex, sophisticated, and often serious medical or surgical care.

Because so much of the care that is actually provided is of a procedural or surgical nature, the term “surgical tourism” may be more accurate in many cases. Imagine a patient leaving the U.S. along with a family member or other companion and flying off to some exotic locale halfway around the world to receive a needed surgical treatment. Following treatment, the “tourist” experiences personal medical attention in a luxurious setting with first-class accommodations and subsequently has the chance to enjoy a vacation for a short while before returning home. Figure 1 (pages 20–21) provides a list of some of the more common surgical procedures that are being promoted by the medical tourism industry.*

At first glance, the imagery being promoted by the industry seems very enticing, and it may be compatible with the delivery of certain procedures that are not associated with serious or potentially life-threatening medical conditions. Add to this imagery the fact that all of the costs for both the tourist and the companion—the medical and surgical care, the airfare, the accommodations, and the extra time for the vacation—are covered by the tourist’s employer-sponsored health insurance. Why? The real answer has nothing to do with improved quality, greater safety, or better clinical outcomes. It simply has to do with costs.

From their viewpoint, domestic payors see savings that are significant enough to justify their actions. They believe that they are con-
tributing positively to our nation’s health care system by making overall care more affordable and accessible.

The Table on page 22 provides some examples of cost comparisons that have been promoted throughout the medical tourism industry. Prices for medical services in countries like India may be as low as 10 percent of the corresponding prices in the U.S., and obtaining such services in other countries like Thailand and Singapore could result in cost-savings of as much as 80 percent.2,11-13 Medical centers in developing countries are able to provide services at such reduced pricing largely because of their lower economic status. Significantly lower fixed costs, pharmaceuticals, employee wages, and administrative expenses—and the virtual absence of litigious medicolegal climates in these countries—allow them to have substantial advantages. For example, the professional liability insurance premium for a surgeon in India has been estimated to be only 4 percent of the premium for a similarly practicing surgeon in New York.14

Figure 2 on page 23 lists many of the countries that are involved in the medical tourism industry outside of the U.S. Increasing numbers of facilities, agencies, and even countries are marketing their advantages. Tourist destinations in a number of highly developed nations—such as Belgium, Canada, Germany, Israel, and Italy—are trying to attract foreign patients, claiming to offer modern care that is more attentive to patient preference, service, and satisfaction.

**Figure 1. Common surgical treatments promoted by medical tourism agencies**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac and vascular surgery</td>
<td>Aortic aneurysm repair, Atrial septic defect repair, Cardiac valve replacements: aortic and mitral, Carotid endarterectomy, Coronary artery bypass grafting, Femoropopliteal bypass surgery, Varicose vein treatments</td>
</tr>
<tr>
<td>Cosmetic and plastic surgery</td>
<td>Abdominoplasty, Blepharoplasty, Breast augmentation/reduction, Cosmetic skin refinishing and body contouring, Face lifts and implant surgery, Liposuction, Rhinoplasty</td>
</tr>
<tr>
<td>Dentistry and oral surgery</td>
<td>Bridges and implants, General dentistry procedures, Orthodontic procedures, Endodontic procedures; root canal surgery, Tooth veneers</td>
</tr>
<tr>
<td>Ear, nose, and throat surgery</td>
<td>Bronchoscopy, Cochlear implants, Nasal septoplasty and reconstruction, Sinus surgery, Tonsillectomy and adenoidectomy, Tympanoplasty and tube insertion</td>
</tr>
<tr>
<td>General, colorectal, and oncologic surgery</td>
<td>Bariatric surgery: banding and bypass, Bowel surgery: colectomy and other procedures, Breast surgery: biopsy, lumpectomy, mastectomy, Cholecystectomy, Gastrointestinal endoscopy: upper and lower, Hemorrhoidectomy, Herniorrhaphy, Laparoscopic surgery</td>
</tr>
</tbody>
</table>

**Establishing legitimacy**

To address potential quality and safety concerns, facilities in underdeveloped countries have sought to improve their reputations by becoming recognized through accreditation. The Joint
Figure 1 (continued). Common surgical treatments promoted by medical tourism agencies

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>Treatment of brain tumors</td>
</tr>
<tr>
<td></td>
<td>Treatment of spine disorders</td>
</tr>
<tr>
<td></td>
<td>Skull base surgery</td>
</tr>
<tr>
<td>Obstetrics and gynecology</td>
<td>Gynecologic laparoscopy</td>
</tr>
<tr>
<td></td>
<td>Hysterectomy: abdominal and vaginal</td>
</tr>
<tr>
<td></td>
<td>In vitro fertilization and intrauterine insemination</td>
</tr>
<tr>
<td></td>
<td>Tubal ligation and reversal</td>
</tr>
<tr>
<td>Ophthalmologic surgery</td>
<td>Cataract surgery</td>
</tr>
<tr>
<td></td>
<td>Cornea alteration procedures</td>
</tr>
<tr>
<td></td>
<td>Glaucoma treatments</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>Ankle fusion</td>
</tr>
<tr>
<td></td>
<td>Arthroscopic and arthroplasty procedures</td>
</tr>
<tr>
<td></td>
<td>Carpal tunnel release</td>
</tr>
<tr>
<td></td>
<td>Back procedures: disectomy, laminectomy, spinal fusion</td>
</tr>
<tr>
<td></td>
<td>Hip replacement and resurfacing</td>
</tr>
<tr>
<td></td>
<td>Knee replacement</td>
</tr>
<tr>
<td></td>
<td>Shoulder surgery</td>
</tr>
<tr>
<td>Transplant surgery</td>
<td>Organ transplantation: heart, kidney, liver, lung</td>
</tr>
<tr>
<td>Urologic surgery</td>
<td>Cystoscopy</td>
</tr>
<tr>
<td></td>
<td>Genitourinary prosthetic implant surgery</td>
</tr>
<tr>
<td></td>
<td>Prostatectomy</td>
</tr>
<tr>
<td></td>
<td>Testicular cancer surgery</td>
</tr>
</tbody>
</table>

Commission—through its international arm, the Joint Commission International (JCI)—and the Trent International Accreditation Scheme in the U.K. have responded to these needs and have already accredited a number of centers around the world. The International Society for Quality in Health Care in Ireland (formerly headquartered in Australia), another organization whose mission is to drive continual improvement in health care quality worldwide, actually accredited JCI’s own standards in August. A recent review of the JCI’s Web site reveals 219 organizations in 35 countries that have received accreditation to date. In addition to accreditation, many of the tourist agencies that cater to this market make declarations about the certifications and training of their associated physicians. Many claim that their physicians have either received training in the U.S. or maintain U.S. board certification.

It must be pointed out that the accrediting guidelines applied internationally are not necessarily equivalent to those used to evaluate programs in the U.S. Many of the guidelines have been developed to complement the differing legal, cultural, and religious climates of the various countries involved. In some instances, they may defer to local laws and customs, and this deference makes it difficult to fairly compare hospitals in different countries or regions with each other.

An important point for all practitioners to understand is that the entire medical tourism phenomenon is being driven purely by economic marketplace forces, and so far its rapid growth has occurred largely outside of the view and control of organized medicine. Equally important is the fact that, to date, no verifiable statistics regarding the true magnitude of this industry actually exist. Much of what is known consists of information that has been disseminated though news articles published in the lay media and through industry-led marketing on tourism agencies’ Web sites.

Healthcare Tourism International was started in 2006 with a declared mission of upholding and improving the reputation of the medical tourism industry. It is headquartered in Los Angeles, CA, but also maintains offices in India, Singapore, and Ecuador. Through its associated not-for-profit service, Healthcare Trip Inc., it has assumed accreditation responsibilities for many of the major groups involved in the trade, including hotels, booking agencies, and other
nonclinical resource entities. Medical Tourism Association is an independent group established in West Palm Beach, FL, that promotes itself as an objective resource for transparency, communication, and education. This association has offices around the world as well. According to the association’s Web site, the founder is an attorney who previously was in charge of United Group Programs Inc., a national third-party administrator for many self-funded employee medical benefits plans.

So what significance does this new industry actually have for the practicing surgeon? Perhaps it is best to answer this question at several levels.

### The significance for our health care system

For our nation’s health care system, the degree to which medical tourism has an impact may be proportional to the extent to which it grows. It essentially is a marketplace reaction to the high costs that are stressing our current system and amounts to the international outsourcing of medical and surgical care for relief. Advances in communication capabilities, the speed and safety of travel, and medical technology availability around the world have allowed its development. But the tipping point may be the fact that the payors of health care in this country are now beginning to give it greater support. Insurance companies such as Aetna and Blue Cross/Blue Shield of South Carolina, and third-party administrators like United Group Programs Inc., have already begun programs to reimburse some treatments performed outside the U.S. Other insurers either are contemplating or are developing plans as well.

Even more notable is the fact that, in 2006, a bill was introduced for the first time in a U.S. state legislature (H.B. 4359 in West Virginia) to allow state employees to go overseas for surgery. A similar bill was introduced in 2007 in the Colorado General Assembly (H.B. 07-1143). Neither of those legislative proposals passed, but one cannot predict the fates of similar proposals in the future. The U.S. Senate has taken notice of these

### Table.

Cost comparisons between the U.S. and three tourist destination countries for selected surgical procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>U.S. insurer’s cost ($)</th>
<th>U.S. retail cost ($)</th>
<th>India ($)</th>
<th>Thailand ($)</th>
<th>Singapore ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angioplasty</td>
<td>25,704–37,128</td>
<td>57,262–82,711</td>
<td>11,000</td>
<td>13,000</td>
<td>13,000</td>
</tr>
<tr>
<td>Gastric bypass</td>
<td>27,717–40,035</td>
<td>47,988–69,316</td>
<td>11,000</td>
<td>15,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Heart bypass</td>
<td>54,741–79,071</td>
<td>122,424–176,835</td>
<td>10,000</td>
<td>12,000</td>
<td>20,000</td>
</tr>
<tr>
<td>Heart-valve replacement</td>
<td>71,401–103,136</td>
<td>159,326–230,138</td>
<td>9,500</td>
<td>10,500</td>
<td>13,000</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>18,281–26,407</td>
<td>43,780–63,238</td>
<td>9,000</td>
<td>12,000</td>
<td>12,000</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>9,591–13,854</td>
<td>20,416–29,489</td>
<td>2,900</td>
<td>4,500</td>
<td>—</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>17,627–25,462</td>
<td>40,640–58,702</td>
<td>8,500</td>
<td>10,000</td>
<td>13,000</td>
</tr>
<tr>
<td>Mastectomy</td>
<td>9,774–14,118</td>
<td>23,709–34,246</td>
<td>7,500</td>
<td>9,000</td>
<td>12,400</td>
</tr>
<tr>
<td>Spinal fusion</td>
<td>25,302–36,547</td>
<td>62,778–90,679</td>
<td>5,500</td>
<td>7,000</td>
<td>9,000</td>
</tr>
</tbody>
</table>

Source: See reference 11. (U.S. rates include at least one-day hospitalization.)
Figure 2. Frequently cited countries with medical tourism destinations outside the U.S.

<table>
<thead>
<tr>
<th>Africa</th>
<th>Asia &amp; the Middle East</th>
<th>Europe</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>China</td>
<td>Belgium</td>
<td>Australia</td>
</tr>
<tr>
<td>Tunisia</td>
<td>India</td>
<td>Czech Republic</td>
<td>Barbados</td>
</tr>
<tr>
<td></td>
<td>Israel</td>
<td>Germany</td>
<td>Cuba</td>
</tr>
<tr>
<td>The Americas</td>
<td>Jordan</td>
<td>Hungary</td>
<td>Jamaica</td>
</tr>
<tr>
<td>Argentina</td>
<td>Malaysia</td>
<td>Italy</td>
<td></td>
</tr>
<tr>
<td>Brazil</td>
<td>Singapore</td>
<td>Latvia</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>South Korea</td>
<td>Lithuania</td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>Philippines</td>
<td>Poland</td>
<td></td>
</tr>
<tr>
<td>Costa Rica</td>
<td>Taiwan</td>
<td>Portugal</td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>Turkey</td>
<td>Romania</td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>United Arab Emirates</td>
<td>Russia</td>
<td>Spain</td>
</tr>
</tbody>
</table>

Source: Adapted from reference 10.

In the end, the fact that Americans are traveling out of the country for surgical care is a symptom of, and not a solution to, our health care system’s affordability problems. Rather, it is a way to get around the problem without actually fixing it. And longer term, the consequences could be detrimental since actual needed health care dollars are being redirected out of the system itself. The loss of even a small number of profitable insured patients could actually end up endangering the viability of many local programs and institutions that provide necessary services. Such a circumstance could eventually be devastating to us all.

The significance for the surgeon

For the practicing surgeon, a number of potential issues arise, and the nature of these issues actually depends on the position and the circumstances of the individual surgeon in the marketplace. Many of our own surgical colleagues who are capable, well trained, and respected may be on the receiving end of medical tourist travel.
Some surgeons are becoming licensed in more than one country and they may actually be beneficiaries in this new industry. For surgeons who aren’t, however, there may be an initial pushback at the idea of taking care of a patient who has had surgery overseas and returns afterwards for follow-up care. Problems may be encountered with the availability and adequacy of medical records, continuity of care, and the need to deal with potentially serious clinical complications. Questions may arise regarding reimbursement for services, especially in view of the fact that the surgeon performing the follow-up services wasn’t the one who performed the original procedure. In some respects, there may be unsettled feelings toward payors that are willing to readily send patients away for care, thus eliminating potentially significant revenue sources for the local surgeon, and then are expecting the surgeon to pick up and deliver care afterwards that may be associated with much lower levels of compensation.

One must remember that although physicians do have rights to decline nonemergent care when other treatments are available, if a patient presents with a problem and the surgeon is competent to diagnose and treat that problem, then he or she should do so irrespective of where the patient may have received prior care. Such care could have just as easily been delivered at a facility down the road, somewhere in a nearby town or city, or at a major referral center within the region. Patients should not be punished for going elsewhere just because they tried to do what they thought was best for their own situation at the time their decision was made.

For our patients, safety, quality, and convenience become greater issues. Most patients would prefer to have major surgery in their local community, near loved ones, or at a regional medical center if it were a feasible or reasonable option. In fact, the vast majority of patients would not likely be able to participate in medical tourism because age and comorbidities would prevent them from doing so. However, there are patients who feel pressured to balance their health needs against other considerations, and at times medical concerns may be subordinated to other issues. These patients may actually access overseas treatments if their payor plans make it more affordable and are able to demonstrate adequate safety and quality.

The problems that can occur do not surface when everything goes right, however. And good, objective data with which to make sound decisions are lacking. Infectious complications with unusual pathogens are possible, the contraction of illnesses because of unsafe blood-banking processes can occur, and circumstances in which records are inadequate or incomplete could be harmful if they are truly needed. A lack of coordination of care could be detrimental if it is not prepared for and arranged ahead of time. Despite what the industry promotes, many of the more serious procedures are not so easy to recover from, and the idea of a vacation on the beach or a sightseeing tour may not be even desirable by many during the immediate postoperative period. Such notions don’t seem to be at all compatible with the reality of the situation.

Many other postoperative complications, such as deep vein thrombosis and possible pulmonary emboli, are very real and dangerous, especially because their incidence is enhanced by immobility and prolonged flight travel. And the mechanisms for legal recourse in most underdeveloped countries are almost nonexistent, leaving patients without any ability to take legal actions if the need to do so were to arise. This circumstance would likely be unappreciated until it became too late to make a difference.

The Statement on Medical and Surgical Tourism drafted by the American College of Surgeons was developed with the patient’s interests in mind. It is important that individuals considering health care services outside the U.S. become informed of the potential risks and complications as well as the medical, social, cultural, and legal implications of receiving such treatment. It is also important that they are not forced to seek such care by their payor plans and that their right to seek care without restriction be maintained. Surgeons should keep all of these matters in mind as they interact with and provide care to their patients.

References
2. Forgione DA, Smith PC. Medical tourism and its impact on the U.S. health care system. J Health


Dr. Unti is a Medical Associate at the American College of Surgeons’ Nora Institute for Surgical Patient Safety in Chicago, IL.
Statement on medical and surgical tourism

This statement was developed by the Committee on Perioperative Care and approved by the Board of Regents at its February 2009 meeting.

Medical tourism is a term denoting travel across international borders for the express purpose of receiving medical care.

Residents of the U.S. may choose to pursue medical care abroad for a variety of reasons, including a real or perceived lack of services available at home; limitations imposed by payors or regulatory agencies on access to certain specialists, treatment protocols, equipment, or services; prolonged waiting periods; lower costs of care; and personal reasons, such as a desire to travel.

Medical care outside the U.S. involves a number of risks. Some of the intangible risks include variability in the training of medical and allied health professionals; differences in the standards to which medical institutions are held; potential difficulties associated with treatment far from family and friends; differences in transparency surrounding patient discussions; the approach to interpretation of test results; the accuracy and completeness of medical records; the lack of support networks, should longer-term care be needed; the lack of opportunity for follow-up care by treating physicians and surgeons; and the exposure to endemic diseases prevalent in certain countries. Language and cultural barriers may impair communication with physicians and other caregivers. Finally, compensation for liability associated with injury may be difficult to obtain.

The American College of Surgeons has adopted the following position with respect to medical tourism.

1. The ACS encourages patients to seek care of the highest quality and supports their rights to select their surgeons and health care institutions without restriction.
2. The ACS encourages its Fellows to assist all patients in reaching informed decisions concerning medical care, whether at home or abroad.
3. The ACS advises patients to consider the medical, social, cultural, and legal implications of seeking medical treatment abroad prior to deciding on a venue of care. In the event of proven medical liability for injury, viable
means for the recovery of damages should be in place. Patients should be aware that many of the means for legal recourse available to citizens in the U.S. are not universally accessible in other countries.

4. The ACS encourages patients electing to receive treatment abroad to seek care at health care institutions that have met the standards for accreditation established by recognized accrediting organizations. Examples of recognized accrediting organizations include The Joint Commission International (U.S.) and the Trent International Accreditation Scheme (U.K.). Patients should be aware, however, that accreditation standards are not uniform and that standards set locally can vary from place to place around the world.

5. The ACS encourages patients electing treatment abroad to seek care from surgeons and anesthesiologists certified in their specialties through a process equivalent to that established by the member boards of the American Board of Medical Specialties.

6. The ACS encourages patients receiving treatment abroad to obtain a complete set of medical records prior to returning home so that the details of their care are immediately available to their physicians and surgeons in the U.S. Follow-up care at home should be organized prior to travel whenever possible.

7. The ACS encourages patients contemplating medical tourism to understand the special risks of combining long international flights and certain vacation activities with anesthesia and surgical procedures.

8. The ACS opposes the imposition of provisions for mandatory referral of patients by insurers to health care institutions outside the U.S., unless such provisions are clearly and explicitly stated in the insurance contract and accepted by the subscriber. The ACS opposes the addition of provisions for mandatory referral abroad for patients with insurance contracts already in force, absent the subscribers’ fully informed consent. In any circumstance, mandatory care abroad should be verifiably equivalent in quality to care available in the U.S.

9. The ACS supports the view that payors referring patients for mandatory treatment abroad should be responsible for the coordination and reimbursement of follow-up care in the U.S., including the management of postoperative complications, readmissions, rehabilitation, and long-term care.
The following articles are the second installment in a series of brief essays the Bulletin will publish in the coming months under the theme “My mentor.” These essays are the result of efforts made by the Resident and Associate Society (RAS) of the American College of Surgeons in launching its first essay contest asking residents, fellows, and new faculty to describe in 500 words or less the role that a mentor has played in their development.

In this series, you will read what several outstanding surgical trainees who responded to the contest have to say about the individuals who have mentored them. Through this series, members of the College and other Bulletin readers will learn about 10 extraordinary mentors who have provided both personal and professional guidance for their mentees at various stages of their training.

The leadership of the RAS believes that these mentors are more than just role models—they are pillars of strength and good examples for future generations of surgeons who are attaining technical and clinical skills, while also advancing their interest in research, education, and outreach in an increasingly challenging health care environment. The winner of this year’s essay contest will be announced at the 2009 Clinical Congress in Chicago, IL.
I’m lucky to have had the opportunity to work with Jack McAninch, MD, FACS, at the University of California, San Francisco (UCSF), as a urology resident. He is a true role model who exemplifies professionalism and has delivered outstanding patient care for more than 30 years. Dr. McAninch has tremendously impacted my career path, as I now am greatly interested in pursuing a fellowship in his area of subspecialty, trauma and reconstruction.

My first experience with Dr. McAninch came at the San Francisco General Hospital, operating on a young man shot multiple times in the abdomen. The patient was unstable at presentation, intubated, and brought to Operating Room 1 for exploratory laparotomy by chief of surgery, William Schecter, MD, FACS. We were called intraoperatively to come and evaluate the patient, who was noted to have had gross hematuria. Dr. McAninch requested I perform an on-table intravenous pyelogram to assess the kidneys and ureters for function and evidence of injury. In true Dr. McAninch fashion, he asked me how much intravenous contrast I should give. My response was unfortunately incorrect and his classic admonishment quickly came: “You can’t not know that!” I laugh about it now, but it certainly made me strive harder during my residency to know as much as possible about patient care.

Dr. McAninch and I ultimately identified a polar injury to the left kidney and were able to perform a successful renorrhaphy.

Anyone who knows “Dr. Mac,” or just simply “The Mac,” finds him to be warm and caring. He is a gentleman and a scholar. He has published hundreds of journal articles and literally has written the book on Traumatic and Reconstructive Urology. I have had the pleasure of working on a publication with him and found his mentorship incredibly helpful. He has passed on to me his thirst for knowledge and attention to patient care.

In addition, he has instrumentally encouraged our residents at UCSF to be members of the American College of Surgeons. This encouragement has allowed me to participate in ACS programs and learn about ongoing health policy actions in the ACS Bulletin. As a result, I have embarked upon a health policy fellowship at UCSF and stimulated my interest in health policy as a component of my career.

I will always cherish the time I have spent with Dr. Mac in and out of the operating room. I couldn’t have asked for a better role model during my surgical training. I would count myself lucky if I earn a tenth of the respect Dr. Mac has from his peers and love from his patients.

Dr. Aaronson is a urology resident in the department of urology at the University of California–San Francisco.
Growing under a watchful eye: John W. C. Entwistle III, MD

by Angela Mouhlas, MD

Until my third year of surgical residency, I didn’t grasp the concept of a true surgical mentor. My “mentor” was the person that I had to have two scheduled conversations with a year. The conversation always led to reading more and figuring out my destiny, preferably sooner than later. As the end of my third year was approaching, the haze of my unknown future was lifted. I had fallen in love with cardiothoracic surgery. This epiphany was the product of one of the finest surgeons and teachers, John W. C. Entwistle III, MD.

It didn’t start off blissful; I remember reading my evaluation from him, stating that I needed to learn to play well with others. I was crushed. I couldn’t even remember the positive comments and I never would. I could only recall that last statement—and recall how the senior fellow had antagonized me. In the weeks to come, we would talk, and in the end, I would grow into a more confident, determined surgery resident. In hindsight, it’s the constructive criticism and avenue of communication that is the foundation for a mentor-mentee relationship.

On paper, the rotation length was a few months, but my operative experience under his watchful eye has continued for more than a year. There is no greater smile on my face, or twinkle in my eye, than when I get the call from him saying that he has cases, if I am interested. There are few instances in my mind that stand out in my surgical career, but all are with him. I remember being post-call on my birthday, but found myself in the operating room, opening the chest for a heart transplant. The amount of time he took for me to understand the anatomy and the patience he showed for me to learn proper surgical technique was truly an experience I never forgot. I soon learned it just wasn’t that case—it quickly became all cases.

Fellowship is all about finding the right fit. For me, it was finding the next-best fit. If there was any way to stay and be his fellow, I wouldn’t have blinked an eye. I found myself on interviews looking for someone like him—someone who would challenge me maximally, who I had to work for, who would never give me an inch on my own, and, lastly, someone whom I could ask for advice when I couldn’t find my way. I believe my first word to him on match day was the invitation to come with me, so he could orchestrate my transformation into a thoracic surgeon.

This essay is a dedication to my mentor: for his gift of time, teaching, and patience that has allowed me the space to grow and achieve. I’ve learned that even though I will leave in a year, he will still be the person who taught me the fundamentals, the core of who I will become. He showed me what it means to be a true mentor and I thank him from the bottom of my heart.

Dr. Mouhlas is a fifth-year postgraduate general surgery resident at Drexel College of Medicine, Hahnemann University Hospital, Philadelphia, PA.
Omaha, NE, is a railroad town, which ensures that it’s on the right track. This city played a historic role in the triumphant westward expansion of the U.S. and, consequently, in its unprecedented national growth and prosperity. To me, John Mellinger, MD, FACS, is like Omaha, in that he represents an extraordinary station along my Iron Road to professional and personal expansion and success.

Professional growth during surgical training is imperative and best engineered by a dedicated, tireless mentor. Dr. Mellinger not only functions as the chief of the section of gastrointestinal surgery and program director of the general surgery residency at the Medical College of Georgia, but he serves an even more vital role—mentor. To his credit, he avoids merely driving everyone down the same track. Instead, individual students, residents, and faculty choose their own track as Dr. Mellinger stokes the furnace, flips the switches, and throws the brakes to ensure each ends up on the right rail for their desired destination. He conducts his mentorship with impressive enthusiasm and undeniable class while offering an unparalleled model of persistent professionalism. All the individuals who work with or around him grow into genuinely respectful and exceptionally competent surgeon physicians.

Although professional development is critical, it occurs in conjunction with significant personal maturation, a progression that should not be overlooked. Well aware of this concept, Dr. Mellinger energetically fosters the personal growth of all learners. He accomplishes this worthwhile goal through various means, including invitations to his home, participation in extracurricular activities with students and residents, team-building exercises, faith-based opportunities, and an open-door policy for professional and personal issues. In addition, resident personal development is an important point of discussion during required biannual review sessions. In essence, Dr. Mellinger serves as an exceptional model of professionalism but, perhaps more importantly, provides a genuine representation of all the best humanity has to offer.

Although benefits of mentorship are great, few are tangible; yet, Dr. Mellinger strongly believes that the finest mentors become increasingly less valuable as the learners mature and prosper. He reminds me that true mentorship is not measured by the length of the curriculum vitae but rather in humility and the reflected glory of others. Again, these are examples of wise counsel and deep appreciation for his primary role—that of mentor.

As I embark on my surgical journey, I recall Promontory Summit, where driving of the golden spike signified completion of the transcontinental railroad. The joining of westbound tracks from Omaha and eastbound tracks of the Union Pacific Railroad established a means for growth and prosperity. As a general surgery resident, I drive to reach my own Promontory Summit, the end of one line and the beginning of the next. Such a journey is only possible with the tireless inspiration and support of a celebrated mentor. Therefore, I feel it is imperative to pay homage to the railroad town, furnace feeder, switch operator, and brake man who provides me with a point of embarkation, a well-fed fire, and an iron-clad direction—thank you, Dr. Mellinger. I hope to be half the mentor to others that you are to me.

My mentor

The right track:
A tribute to John D. Mellinger, MD, FACS

by James G. Bittner IV, MD

Errata: In the “My mentor” series published in the March Bulletin, the photos of John Mellinger, MD, FACS, and Erwin Hirsch, MD, FACS, were mistakenly reversed. The Bulletin editors regret the error. The essays by Drs. Bittner and Powell are republished here with the correct photos.

Dr. Bittner is a general surgery resident, department of surgery, Medical College of Georgia School of Medicine, Augusta, GA.

Dr. Mellinger
Only a few weeks after graduating from the Boston EMS Academy as an emergency medical technician (EMT), my truck responded to a working fire in the southern part of the city. Flames poured from the upper level of the house and the noise was overwhelming, with screaming and rushing sounds of fire and water. We took two of the most badly burned patients and made our way to Boston City Hospital (BCH) as quickly as possible. Erwin Hirsch, MD, the director of the BCH trauma service, met us at the trauma doors. Unfazed and commanding, he directed the patients into the trauma rooms and oversaw the resuscitation efforts. As a naïve and inexperienced EMT shaken by the anguish of the fire, to me, he seemed larger than life during those moments, a reassuring presence that medicine could help the suffering.

Almost five years later to the day, I arrived on the surgical floor at the old BCH, now the Harrison Avenue campus of Boston Medical Center, in the short white coat of a Boston University medical student. Dr. Hirsch was no different than I remembered from the ambulance; he still suffered no fools and his priorities remained patient care and education. Dr. Hirsch reminded us at every opportunity that BCH offered the highest standard of care and that all patients who came there, no matter their socioeconomic status, should be given that care. His intensive care unit (ICU) rounds were legendary for the fear they inspired; no resident dared be unprepared for “guerilla rounds.” Past an age when most attendings would be thinking of retiring, Dr. Hirsch was not only still actively working, he was still taking frequent trauma call. He was notorious for roaming the halls at odd hours while on call, and we always knew he was nearby if we needed him.

As gruff and “guerilla” as he could be, the other side of his devotion to medicine was his devotion to the people in his life and those of the hospital. At the wedding of one of his former residents, he beamed with pride when he saw her so happy. When a Boston EMS member was admitted to the hospital, he personally watched over the care and fiercely protected the member’s privacy. And on most of the nights he took call, he could be found in the ICU break room, counseling chief residents on their career plans.

As a student, I simply thought of these things as “Dr. Hirsch-isms”; now, during surgical residency, these lessons of professionalism, lifelong learning, and compassion keep me both grounded and vigilant. Eleven years after I met him in the parking lot of BCH, he remains larger than life in memory. Dr. Hirsch—husband, father, Viet Nam veteran, Naval officer, surgeon, and mentor to countless doctors, nurses, EMTs, and paramedics—died in a boating accident on May 23, 2008. BCH, and those of us he trained, will never be the same.
Advocacy advisor

Lobby laws
by Melinda Baker, State Affairs Associate, and Kristen V. Hedstrom, Assistant Director, Legislative Affairs, Division of Advocacy and Health Policy

Over the last few years, headlines questioning the ethics of state legislators, governors, and members of Congress and their interactions with lobbyists have become more and more commonplace. The profession of lobbying also grabbed state and national attention as, during his election campaign, President Barack Obama ran on a platform of “cleaning up Washington.” Once he was elected, laws were strengthened in an attempt to curb unethical practices by both legislators and lobbyists and made understanding the new rules and guidelines critical for anyone in regular communication with a legislator.

It is important to understand that advocacy is not always the same as lobbying. Likewise, lobbying can be defined in a number of ways and may be subject to different rules from state to state. Lobbying by a 501(c)(3) or a 501(c)(6) tax-exempt organization is legal, but before embarking on any kind of advocacy initiative as an organized group, the group leaders must examine their state and local lobbying laws as well as the Internal Revenue Service (IRS) regulations.

The IRS has not clearly defined what it considers to be lobbying activities, but generally, it is considered lobbying when contacting legislators and their staff members (by phone, in writing, or in person) to discuss pending or proposed legislation and regulations. This broad definition of lobbying also has been extended to newsletters and other types of member communications when a particular publication contains information about current or pending legislation or regulations—especially if members are encouraged to contact their elected officials.

There are distinct differences between what is permissible at a state or local level and what is acceptable at the federal level. Remember, it’s the branch of government involved in the efforts that determines which laws—state or federal—should be followed, not the locale of the event. For example, hosting an event for a local U.S. congressman is regulated by federal laws, whereas hosting the same event for a state representative would be regulated by state law. If, however, an event includes both the congressman and the state representative at the same time, the state law applies to the state representative and the federal law applies to the federal representative.

The complexity of these laws and regulations should not prohibit or deter individual surgeons or ACS chapters from becoming involved in legislative and political processes. However, chapter leaders should plan to obtain expert legal advice before engaging in certain legislative and political activities. In particular, chapter leaders should consult the Chapter Guidebook compiled by the College’s Division of Member Services (http://www.facs.org/about/chapters/guidebook.html) and/or seek advice from a tax attorney/advisor with questions about lobbying and political expenditures. Fellows and chapter leaders may also contact the College’s Division of Advocacy and Health Policy for information about lobbying regulations.

State laws

State and local laws vary, so always check with your state as to what constitutes lobbying and any reporting requirements. Different states regulate lobbying through different offices. Because some state lobbying laws are less strict than others, it is critical to know what activities are permitted. For example, you may be barred from giving a cup of coffee to a state senator in one state, whereas other states allow unlimited gift giving. In another state, you may be allowed to discuss pending legislation with an elected official without registering as a lobbyist—or, you may only be able to talk about general issues or answer direct questions put to you by the official. The bottom line is that it is prudent to check on the law before you do anything.

continued on page 56

APRIL 2009 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
CSPS issues statement on violence in the workplace

The Council on Surgical & Perioperative Safety (CSPS) has agreed on many safe surgery principles concerning the safe care of surgical patients and the promotion of a caring workplace environment for the entire perioperative team. One of these principles is that violence in the workplace must not be tolerated under any circumstances. Thus, the CSPS proposed a Statement on Violence in the Workplace that was approved in October 2007.

The CSPS is a unique, multidisciplinary coalition of seven professional organizations whose members (more than 250,000 members representing more than 2 million health care practitioners) are involved in the care of surgical patients. The mission and vision of the CSPS is to promote excellence in patient safety in the surgical and perioperative environment. The CSPS envisions a world in which all patients receive the safest surgical care provided by an integrated team of dedicated professionals.

Voting members from the following organizations serve as the CSPS board of directors: the American Association of Nurse Anesthetists, the American Association of Surgical Physician Assistants, the American College of Surgeons, the American Society of Anesthesiologists, the American Society of PeriAnesthesia Nurses, the Association of periOperative Registered Nurses, and the Association of Surgical Technologists.

The goals of the CSPS are as follows:

- Raise awareness of surgical patient safety and perioperative workplace environment issues
- Serve as an expert knowledge resource on surgical patient safety
- Collaborate with external organizations to advocate for surgical patient safety and a caring perioperative workplace environment
- Provide or facilitate joint educational opportunities for members of the perioperative/surgical team
- Endorse, support, and utilize quality research initiatives in surgical patient care

The Statement:

The mission of the CSPS is to promote excellence in patient safety in the surgical and perioperative environment. Creation of a violence-free culture of mutual respect, dignity, and fairness among individuals and professional disciplines is essential for the teamwork and communication necessary for patient safety.

The Occupational Safety and Health Act of 1970 mandates that all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. Violence in the health care environment is of growing concern. Nurses at particularly high risk. Of every 10,000 full-time nurses, 25 were injured in workplace assaults in 2000. Injuries due to workplace assaults occur in only two of every 10,000 employees in most private-sector industries. These statistics represent only a portion of the incidents because many health care workers believe that workplace assaults are part of the job and do not report them.

Definitions

- Workplace violence includes, but is not limited to, intimidation, threats, physical attack, property damage, and sexual harassment.
- Intimidation includes, but is not limited to, stalking or engaging in actions intended to frighten and coerce.
- Threat is the expression of intent to cause physical or mental harm.
- Physical attack is unwanted or hostile physical contact such as hitting, fighting, pushing, shoving, or throwing objects.
- Property damage is intentional damage to property.
- Sexual harassment is “unwelcome advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when submission to or rejection of this conduct explicitly or implicitly affects a person’s employment or education, unreasonably interferes with a person’s work or educational...
performance, or creates an intimidating, hostile, or offensive working or learning environment.”

Risk factors for violence
The risk factors for violence vary from hospital to hospital depending on location, size, and type of care. Common risk factors for hospital violence include the following:

- Working directly with volatile people, especially if they are under the influence of drugs or alcohol or have a history of violence or certain psychiatric diagnoses
- Working when understaffed, especially during meal times, visiting hours, and when on call
- Transporting patients
- Long waits for service
- Overcrowded, uncomfortable waiting rooms
- Working alone
- Poor environmental design
- Inadequate security
- Lack of staff training and policies for preventing and managing crises with potentially volatile patients
- Drug and alcohol abuse
- Access to firearms
- Unrestricted movement of the public
- Poorly lit corridors, rooms, parking lots, and other areas

Position
It is the position of the CSPS that

- Violence or the threat of violence in the workplace must not be tolerated under any circumstances.
- Violence directed toward members of the perioperative health care team interferes with the provision of safe, competent, and ethical care.

- The responsibility for providing a perioperative practice environment free of violence is shared among the organization, members of the perioperative health care team, patients, and their families.
- Organizations should implement policies that support violence-free workplaces through a comprehensive workplace violence prevention program including education and training in violence prevention.
- The confidentiality of the individuals involved should be taken into consideration but not interfere with an aggressive approach to the issue.

Recommendations
The CSPS recommends that all health care organizations establish a health and safety committee to monitor, address, and evaluate violence through a comprehensive workplace violence prevention program, which includes the following criteria:

1. Creation and dissemination of a policy on workplace violence, including the following provisions:
   - Stipulating “zero tolerance” for violence.
   - Communicating expectations to all individuals providing and receiving services in the facility.
   - Ensuring that no employee who reports an incident will experience reprisal.
   - Requiring prompt reporting and leadership evaluation of records of incidents to assess risk and progress toward establishing a violence-free environment.

2. Perform a comprehensive and confidential analysis of all workplace violent events to determine the following:
   - If the cause(s) of a violent event are individual and/or system issues
   - The priority of potential solutions or changes
   - The timely implementation of individual and/or system improvement/process improvement actions
   - The success in reducing violence based on evaluation of outcomes

3. Maintain a comprehensive plan for ensuring effective safety and security measures.

4. Require management commitment and employee/staff involvement.

5. Provide access to support services for victims of violent incidents.

6. Assist victims through the legal process.

7. Establish worksite analysis to view facilities records, trends, workplace security, and surveys for staff to identify hazards.

References
CSPS to co-convene symposium in May

The CSPS and Joint Commission Resources Inc. are cosponsoring a symposium—Improving, Enhancing, and Sustaining Positive Patient Outcomes—to convene May 8–9 in Chicago, IL, at the Sheraton Chicago Hotel and Towers.

The target audience for this symposium is surgeons, anesthesiologists, nurse anesthetists, perianesthesia and perioperative nurses, surgical physicians’ assistants, surgical technologists, pharmacists, and all others who provide care and services within the surgical area. The conference goals of increased teamwork and improved communication translate to better patient outcomes, which are topics of interest to business leaders (such as chief executive officers and chief financial officers) and risk management professionals.

At the end of the conference, participants will be able to describe the current state of perioperative safety and prioritize strategies for improvement within their respective organizations; analyze the methods presented to determine which would most effectively enhance the interdisciplinary care model at their organization, evaluate and apply interdisciplinary approaches designed for specialty patients/situations, examine tenets of and advocate for medication safety in the perioperative area, and investigate causes of surgical/anesthesia errors as a means to develop preventive processes.

To register for the symposium and for more information, visit http://www.jcrinc.com/Conferences-and-Seminars/Perioperative-Safety-Symposium/1512/. For more information on the CSPS, visit http://www.cspsteam.org/, or contact Denise Goode at dgoode@facs.org.

New College Web site centers on E-prescribing Incentive Program

The American College of Surgeons has created a Web site to educate members about the Centers for Medicare & Medicaid Services’ 2009 E-prescribing Incentive Program.

The Web site includes an introduction to the electronic prescribing program, a discussion of frequently asked questions, and resources for surgeons who want to participate.

The Doctors Company is devoted to helping doctors avoid potential lawsuits. For us, this starts with patient safety. In fact, we have the largest Department of Patient Safety/Risk Management of any medical malpractice insurer. And, local physician advisory boards across the country. Why do we go this far? Because sometimes the best way to look out for the doctor is to start with the patient. Our medical professional liability program has been sponsored by ACS since 2002. To learn more about our program for ACS members, call (800) 862-0375 or visit us at www.thedoctors.com.
Motivated by the presentation by John T. Preskitt, MD, FACS, ACS Regent, regarding strategic planning at the March 2008 ACS Leadership Conference, the Tennessee Chapter’s then-President Tony Haley, MD, FACS, and then-President-Elect Dr. Minard determined that the chapter should try the strategic planning process to evaluate and guide its activities. They agreed to have a strategic planning session for Tennessee Chapter leaders early in the 2008 association year. Dr. Preskitt agreed to facilitate the session, and Rhonda Peebles, of the ACS Division of Member Services, agreed to attend and assist.

Planning the session
As a first step, a conference call was held with Drs. Haley, Minard, and Preskitt, along with Ms. Peebles and Ms. Johnson. The purpose of the call was to discuss the following questions: Who should be invited to participate in the strategic planning session? How long should the session last? What materials should be distributed to the participants before and during the session? What is the desired outcome of the session?

• Strategic planning session participants. The Tennessee Chapter’s governing body is the Executive Council. It is composed of the following: President, President-Elect, Vice-President, Past-President, six Councilors (two from each of the grand divisions of the state), Chair of the Committee on Trauma, Chair of the Cancer Committee, Young Surgeons’ Representative, a Surgical Resident, Governors-at-Large, and the Chairman of the Tennessee Surgical Quality Consortium. Any specialty governors, members of the American Board of Surgery, and others who are involved in national surgical leadership positions are routinely asked to serve on the Council as ex-officio members. Obviously, these individuals would be invited to participate in the strategic planning session.

Some thought was given to inviting other surgeons from around the state to participate, considering that perhaps having a representative from each surgical training program would be helpful, or perhaps including leaders of the surgical specialty societies would enhance the discussion. In the end, it was agreed that a larger group would be unwieldy for this type of meeting and, furthermore, those who had not been involved in the chapter would be less prepared for a strategic planning endeavor.

• Length of the session. Whereas some strategic planning sessions are stretched out over a weekend or even a longer period of time, the group agreed that a determined council could accomplish its task in one day. It was agreed to have dinner as a group the night before the strategic planning session. There was no agenda and no plan to have formal discussions at the dinner; it turned out, however, that the dinner provided a good platform to begin discussions about potential future goals and objectives of the chapter.

• Session materials. As the strategic planning session facilitator, Dr. Preskitt provided the session materials. In order to understand the chapter’s structure and functions, certain information was provided to him: Executive Council listing, breakdown of chapter membership by specialty, membership trends, and financial summaries.

• Desired outcome. Establishing the chapter’s vision, mission, and priorities were among the desired outcomes of the strategic planning session. Dr. Preskitt emphasized that these must be summarized in a written document—an operating plan—that would change over time as the strategic planning process continued from year to year.

The day arrives
Dr. Preskitt provided an outline and led a discussion describing the qualities of good chap-
ters. These qualities include sustainable leadership, especially young surgeons; strong administrative structure; strong member enthusiasm; and worthwhile member services. He discussed the characteristics of leadership, noting the importance of having a vision.

Strategic planning was defined as a systematic way of planning to establish goals, set priorities, allocate resources, assign tasks, and measure success. Dr. Preskitt stressed that it is not a prediction of the future; not a smooth, linear process; and not a substitute for good judgment.

Strategic planning includes developing a mission statement, a vision, conducting a SWOT (strengths, weaknesses, opportunities, and threats) analysis, setting goals, and agreeing on priorities. A written strategic plan must be developed.

- A mission statement describes what a group does and why it does it. The ACS Mission Statement was reviewed as an example.
- A vision statement describes the future state of the organization as envisioned by the group’s leaders.
- The SWOT analysis iden-
tifies internal strengths and weaknesses and external opportunities and threats.

- The leadership must agree on priorities and how to accomplish goals and objectives.

By the end of the session, the Tennessee group would have a strategic plan written by one person that ultimately would be reviewed by everyone. From that draft, an operating plan will be finalized and reevaluated every year.

**Mission statement**

As the mission statement was discussed and drafted, the following concerns were expressed:

- Lack of participation by specialty surgeons and other specialty groups
- The increasing number of surgeons not joining the College
- Development of a strong resident and young surgeon initiative

It was noted that the chapter had interviewed applicants during the annual meeting in an effort to introduce young surgeons to the chapter and ACS very early in their careers so that they would recognize the relevance of membership. This approach required rearranging the chapter’s activities throughout the year to meet the College’s required deadline for reports on the interviews.

The Tennessee Chapter adopted the following mission statement:

> The Mission of the Tennessee Chapter, ACS, is to improve the health of the people of Tennessee and the Southeastern Region of the United States by promoting the ethical practice of the art and science of surgery.

**Vision statement**

As the group discussed its vision for the chapter, the following concerns about the chapter were voiced:

- It must be an advocate for patients and for surgeons
- It must be the leader in defining and promoting surgical quality of care and patient safety, especially through the National Surgical Quality Improvement Program (NSQIP) project
- It must promote membership and the relevance of the ACS
- Its leaders should assume the responsibility of promoting the chapter itself and the College to medical students, residents, and practicing surgeons
- The NSQIP Consortium will achieve multiple benefits by establishing the chapter as a leader in promoting quality with the public and among other health care associations
- It should improve its Web site and provide templates for contacting elected officials
- It should take back control of surgical standards of practice [from payors, hospital administrators, and so forth]

The group agreed on the following vision statement:

> The Tennessee Chapter is dedicated to
>   - the promotion of membership
>   - the provision of advocacy for surgeons and patients
>   - the education of surgeons and surgical residents
>   - the ultimate improvement and measurement of patient care and safety

The chapter provides a network for the Fellows who reside in the state and serves as their liaison to the American College of Surgeons.

**SWOT Analysis**

The third step in the strategic planning process was the SWOT analysis. Following is the SWOT analysis the Tennessee Chapter developed.

- **Strengths:**
  - Leaders
  - Cohesive core group
  - Annual meeting
  - NSQIP
  - Trauma program/system
- **Weaknesses:**
  - Consistent core group (need more widespread participation)
  - Lack of specialty representation
  - Leadership too “academic”
  - Education programs are weak for practicing physicians
  - Not enough participation by young surgeons
  - Perceived lack of relevance
  - Outdated Web site
  - Ineffective lobbying efforts
  - Chapter finances
  - No participation by Regents
- **Opportunities:**
  - Reach out to practicing surgeons to provide information they need such as practice management and responding to changes in emergency room call contracts
  - Educate members about surgeons’ worth to a hospital and community
  - Create public education
materials about Fellows
—Use Internet and new technology
—Welcome affiliates, including operating room nurses
—Use Cap Wiz for Tennessee advocacy initiatives
—Focus on leadership in quality care issues and concerns
—Increase revenue from vendors at annual meeting
—Promote general surgery as a career to medical students and promote College membership
—Expand council for specialty representation
• Threats:
—Malpractice costs and other damaging personal aspects of litigation
—Splintering of general surgery
—Workforce shortage
—Safety net hospitals and surgeons threatened because of uninsured
—Outside interference in practice
—Hospitals hiring surgeons for emergency department call and other positions
• Goals

After considerable discussion, the group agreed on the following goals:
1. Increase membership
   —Target young surgeons (residents and those just beginning practice) and practicing surgeons
   —Address relevancy issues in areas of education and within the health care community
   —Publicize chapter’s leading role in quality
   —Control the message
2. Promote the chapter as a leader in promoting quality/optimal care
   —Promote NSQIP within Tennessee hospitals and ultimately enroll 30 hospitals
   —Make reporting of data part of annual meeting within three to five years
   —Publicize the chapter’s work with NSQIP
3. Increase advocacy
   —Increase subspecialty participation within the chapter and on the council by inviting subspecialty representation (neurosurgery, urology, ear-nose-throat, and so forth)
   —Participate with Tennessee Medical Association specialty coalitions and Committee on Legislation
   —Create and send a new newsletter (similar to ACS NewsScope, with bulleted items and links to Web sites for members of Congress and Tennessee legislators)
   —Work toward tort reform by educating legislators this year and plan to draft and/or support legislation within the next two years with the Tennessee Medical Association
   —Address and publicize workforce issues such as emergency department coverage
   —Educate legislators and the community about patient access problems and reimbursement issues, including care for the uninsured
   —Monitor and support legislative activity to maintain the helmet law, to repeal Uniform Accident and Sickness Policy Provision Law
   —Work with the Tennessee Committee on Trauma on any issues relating to the trauma system
4. Revamp chapter annual meeting
   —Expand program committee and its functions to redesign the educational sessions
   —Keep the positive aspects (fun, family, entertainment)
   —Involve program directors with a defined role
   —Be more proactive in getting residents to submit papers
   —Offer a special residents session
   —Sponsor medical students
   —Hold the meeting in a city or resort every third year and meet at state parks otherwise
   —Continue to invite a College representative to present a “town hall” session
   —Add a resident representative to the program committee and one or more of the program directors
   —Look for creative ways to increase revenue
   —Use SurveyMonkey.com to vet the program content to the executive council
   —Eventually publish best practices from NSQIP
   —In the future, offer webinars/teleconferencing
5. Improve communication
   —Improve Web site by providing more relevant and current information
   —Include information about NSQIP and strategic plan
   —Appoint an officer-level webmaster

Follow-up activities/current status
A plan was drafted and approved by the executive council and work has begun on the assigned tasks.

Measures of success
As the year progresses, the council will monitor its progress toward achieving the goals
that resulted from the strategic planning session. The council will measure its success using the following three benchmarks:

- Improved financial status
- Increased participation in annual meeting
- Increased participation in advocacy issues

**Conclusion**

The Tennessee Chapter admittedly is brand new to the strategic planning process, and the desired outcomes are certainly not guaranteed. However, the council is already realizing one of the benefits of strategic planning—the cohesive, focused, goal-oriented approach to fulfilling our responsibilities as chapter leaders.

**Dr. Minard** is President of the Tennessee Chapter.

**Ms. Johnson** is Executive Director of the Tennessee Chapter.

---

**ACS leadership to host interactive Webcast Town Hall Meeting**

Michael J. Zinner, MD, FACS, Chair of the Board of Governors, invites all members of the College to participate in an interactive Webcast Town Hall Meeting with the College’s leadership on June 5, from 5:00 pm to 6:00 pm (CST). The webcast will feature brief presentations delivered over live streaming Internet video by leaders from the Board of Governors and Board of Regents. Questions sent via e-mail during the webcast will be answered live by the panel.

Agenda and access instructions will be available in May.

---

**ANZ Travelling Fellow selected for 2010**

Nipun B. Merchant, MD, FACS, associate professor of surgery at Vanderbilt University Medical Center, Nashville, TN, has been selected as the Australia and New Zealand (ANZ) Chapter of the ACS’ Travelling Fellow for 2010.

As the Travelling Fellow, Dr. Merchant will participate in the annual Scientific Congress of the Royal Australasian College of Surgeons in Perth, Australia, May 4–8, 2010. He will attend the ANZ Chapter meeting during that congress and will then travel to several other surgical centers in Australia and New Zealand.

Dr. Merchant is an academic surgical oncologist who has been building up a clinical and laboratory research program that focuses on colorectal and pancreatic tumor biology.

The application deadline for the 2011 ANZ Travelling Fellowship is **November 16, 2009**. The requirements for the 2011 Travelling Fellowship will appear later this year in the Bulletin and will be posted on the Scholarships page of the College’s Web site at [http://www.facs.org/memberservices/research.html](http://www.facs.org/memberservices/research.html).

---

Dr. Merchant
It was 1:27 am on Thursday, September 25, 2008, as my wife Geraldine C. Diaz, DO, and I settled into a familiar booth at our local International House of Pancakes. I had just completed the donor operation, back-table, and orthotopic liver transplant of a 10-month-old, 7 kg girl. My wife performed the anesthesia for this case and we were exhausted. In three hours, we had to have our two children, mother-in-law, and ourselves packed and ready for an international flight to Germany. We were about to embark on what would become a highlight of our academic careers, and we didn’t even yet know it.

The American College of Surgeons’ Traveling Fellowships are an extraordinary opportunity to interact with colleagues on a range of clinical and research interests while touring a foreign country. Sponsored by the ACS International Relations Committee, fellowships are currently offered in Japan, Germany, and Australia/New Zealand. My initial interest in the Germany Fellowship was purely academic, as reflected in the title of my presentation at the 2008 Clinical Congress, “Comparison of Extended-Donor Criteria Liver Allograft Utilization, Including Adult-to-Adult Living-Donor Liver Transplantation, Between Europe and North America.” Having previously been to Germany for surgical conferences, I saw this fellowship as a chance for detailed study of two different organ allocation systems that would culminate in an academic report. To that end, dutifully arranged for a whirlwind tour of every major university performing liver transplantation in Germany, with one day allotted to each university/city pair. This fellowship promised to be a once-in-a-lifetime opportunity to personally meet many of the thought leaders of transplantation in Germany, but only upon completion of the journey would
I truly appreciate the essence of the fellowship.

**Annual Congress of the German Society of Surgery**

The Traveling Fellow is expected to attend the Annual Congress of the German Society of Surgery. This was the 125th meeting of the Deutsche Gesellschaft für Chirurgie that is organized as a weeklong event very similar to the ACS’ Clinical Congress. The meeting was held the week of April 22, 2008, in Berlin. The unexpected illness of a family member limited me to attending only the meeting in Berlin with immediate return to the U.S.; the university tours were postponed to a later date.

In Berlin, I participated in a roundtable discussion of residency work-hour restrictions chaired by Prof. Ernst Klar, MD, chief of transplantation at University Hospital Rostock, and my host for the Fellowship, Prof. Norbert Senninger, MD, chairman of the department of surgery and chief of transplantation at University Hospital Münster. I am very thankful to both for their invitation and hospitality during my visit. At that discussion, I delivered a 20-minute presentation, Work Hour Limits: How We Do It at the University of Arizona. This presentation was followed two days later by a 30-minute lecture, Utilization of Expanded-Donor Criteria Liver Allografts, that I delivered at a session hosted by the president of the German Society of Surgery, Prof. Rainer Arbogast, MD. Afterward, I had an enjoyable discussion on extended-donor criteria liver allograft utilization with Prof. Wolf Bechstein, MD, chief of transplantation at University Hospital Frankfurt. My schedule was booked by the meeting each day whereas evenings were spent visiting the Berlin Wall and Checkpoint Charlie and touring the trendy Kurfürstendamm, a retail hub similar to New York’s Madison Avenue. On the last evening, I attended a large gala with Professor Senninger, where I had the honor of meeting numer-
ous German colleagues from a variety of surgical specialties. The 2008 Annual Congress of the German Society of Surgery was an outstanding educational event on par with the ACS Clinical Congress. Of particular note was the difference in vendor representation with respect to food and beverages that were plentiful at the European event. The contribution of my host, Professor Senninger, cannot be overemphasized. He was invaluable as a guide, counselor, mentor, critic, and friend. As I departed Berlin, I eagerly anticipated my return in September 2009 to complete my university tours.

**September return to Germany**

Assembled at the gate one year later, we were ready to go back to Germany. Geraldine, our two sons (Peter, age 4 years, and John, age 18 months), and my mother-in-law Rogelia Diaz awaited our flight to Germany. I have chosen to travel with my family whenever possible, as they erratically see me at home. For this trip, traveling with my wife was a unique professional opportunity, as she is board-certified in anesthesia and critical care. Her expertise as leader of our liver transplant anesthesia group at the University of Arizona was relayed in advance to each center we were scheduled to visit in Germany. Every center accepted our offer to perform combined surgery/anesthesia grand rounds on a variety of topics related to adult and pediatric liver transplantation. Working side-by-side with my wife, literally, in building a liver transplant program has required the help of an army of individuals. Our itinerary again necessitated someone to assist us with our two sons, and I am very thankful my wonderful mother-in-law could join us.

**Frankfurt**

Our arrival at Frankfurt revealed a marvelous Sunday afternoon. Germany had been blessed with an Indian summer of temperatures in the high 70s and brilliant sunshine. The itinerary called for a three-hour drive via the autobahn to Münster; however, we elected to take scenic back roads with many stops along the Westfalia countryside. Almost seven hours later, we arrived at our hotel to prepare for our first visit. The selection of Münster as our initial visit was deliberate. Here we could spend time with Professor Senninger and review our travel plans as well as any additional suggestions. Münster is a medieval university city of roughly 280,000. The center of town is marked by the Dom St. Paul, a massive cathedral initially constructed in the 13th century and impeccably restored after World War II. The cathedral contains a functional astronomical clock that is more than 400 years old.

The university hospital is an inspiring facility mating traditional architecture with state-of-the-art technology (see photos on pages 43 and 44). Our guide for a tour of the hospital and laboratories was Heiner Wolters, MD, privatdozent and leader of Professor Senninger’s transplant team (see photo, page 44). I was fortunate to meet Torge Mees, MD, and Prof. Hans-Ullrich Spiegel, MD, and tour their laboratories. Our
conversation focused on hepatic microvascular circulation following ischemia reperfusion injury. I also had the opportunity to meet Prof. Hartmut Schmidt, MD, medical director of liver transplantation at Münster and an international expert on Wilson’s disease. We toured his laboratory and discussed the performance of combined heart-liver transplantation as well as the current organ shortage in Germany. During the hospital tour, I had the opportunity to review a patient in evaluation for combined heart-liver transplantation with the entire cardiac and hepatic transplant teams in attendance. Later in the day, my wife delivered grand rounds on anesthetic management of combined heart-liver transplantation and I delivered a lecture on extended-donor criteria hepatic allograft utilization.

The children and their grandmother returned from a visit to the Münster Zoo just as we arrived at the hotel. That evening, we enjoyed spirited conversation with the Münster transplant team on liver allocation in Germany as the guests of Professor Senninger at the Pinkus Mueller Brewery, an authentic German eatery. The Renz clan had enjoyed a wonderful first day, but we were already behind, as Hannover, the next day’s visit, was more than 150 km away.

**Hannover**

Hannover was an important stop on my schedule—it is not only one of the largest abdominal organ transplant programs in Germany, with extensive experience in pediatric and combined liver/thoracic-organ transplantation, it is also the institution of Rudolph Pichlmayr, MD, FACS(Hon), FRCSEng(Hon), a pioneer in hepatic surgery and mentor to many of Germany’s current leaders in transplantation. The current chiefs of Hannover, Hamburg, Regensburg, Mainz, Halle, Leipzig, Kiel, and Berlin-Charité all were trained by Dr. Pichlmayr. Our arrival was late, hampered by a driving rain that had caused accidents and slowing on the autobahn. The chairman of surgery and chief of transplantation, Prof. Jürgen Klempnauer, MD, greeted us in his office and provided a tour of the state-of-the-art hospital and new scientific research facility dedicated to Professor Pichlmayr (see photo on page 45). The new research facility provides seamless integration of scientific, medical, and surgical research interests. My wife met with Prof. Siegfried Piepenbrock, MD, and toured the intensive care units. Later, we combined grand rounds on simultaneous heart-liver transplantation and Geraldine and I presented a description of our program using allografts from human T-cell lymphotrophic virus seropositive donors to more than 60 attendees from the departments of surgery and anesthesiology.

The day also provided a brief opportunity to view the Maschsee, a large artificial lake encircled by the sprawling Eilenriede Forest within Hannover. The evening ended with a discussion of Hannover’s extensive experience of more than 40 combined liver-lung transplantations during dinner at the central train station.

Because my younger son was having difficulty adapting to the
time change, we would spend nights traveling the autobahn to the next city, only to begin with an early morning grand rounds. Typically our talks and tours would end in the early afternoon and we would return to our hotel just as our two sons were waking up and preparing to play. Driving the autobahn late at night was exhilarating. It is true there are segments with no signed speed limits, but the majority of the autobahn has a posted speed limit that is strictly enforced. In addition, there are numerous automated speed sensors that photograph your license plate and later send a citation, as I would discover weeks after our trip had concluded.

**Hamburg**

Our third stop was Hamburg. The day began with plentiful sunshine and warm temperatures providing ample opportunity to enjoy this magnificent city. My wife and I began the day at 6:30 am with grand rounds on split/reduced/living-donor liver transplantation. This itinerary was particularly relevant, as Hamburg enjoys preeminence in the field of reduced-organ and pediatric liver transplantation. I spent the morning with Professor Björn Nashan, MD, PhD, chairman of the department of surgery and chief of transplantation (see photo on page 46), discussing partial-organ allografts, and received a tour of the adult and pediatric hospitals and a beautiful new research facility by Jorg-Matthias Pollack, MD, assistant professor of surgery and member of the transplant team. Dr. Pollack is an exceptional young faculty member who practices transplantation surgery in addition to heading a funded research laboratory while overseeing surgical research and medical student education. Meanwhile, Geraldine attended walk rounds in the surgical intensive care unit as a guest of Prof. Alwin E. Goetz, MD, PhD, chairman of the department of anesthesiology, and toured their research facilities.

With our responsibilities completed by noon, Geraldine and I were back at the hotel to enjoy a wonderful day with our children. Hamburg is a blend of architectural beauty and cultural diversity that reminds me very much of San Francisco, CA. We enjoyed the city skyline via a canal boat tour of the Binnenalster, one of two lakes within the city, and had a relaxing outdoor dinner along the Jungfernstieg, a central boulevard for local commerce. Premium shopping was the call for my wife and mother-in-law at the Hanse Viertel Galerie Passage, while my sons and I checked out the InterCity Express bullet trains at the Hamburg Hauptbahnhof as well as an awesome family-owned toy store adjacent to the station.
Berlin

The following day was Re-Unification Day, a national German holiday, so there would be no university visits on this day. I assumed this holiday was comparable to our Fourth of July—I was wrong. In search of a parade, I inquired of our hotel concierge, who was bleak in his recommendations for activities in Hamburg. “Try Berlin” was his recommendation, as he noted, “If anything is going on, it will be there.” And so, there we went: another 300 km away at night.

By now, I was hankering for a good night’s rest, so we selected the Holiday Inn in the center of town. The next two days in Berlin did not disappoint. Re-Unification Day was celebrated at the foot of the Brandenburg Gate, with more than 100,000 Berliners enjoying concerts, outdoor activities, and delicious food. It was then that I realized the enormity of this city. Its beauty, character, and depth easily rival other European capitals. While in Berlin, we enjoyed the Tiergarten, Berlin’s equivalent of Central Park in New York; the Berlin Zoo; and the museums of Schloss Charlottenburg. Particularly interesting is the Kaiser Wilhelm Memorial Church that was devastated by World War II bombing but has been converted to a monument on the atrocities of war.

Reinvigorated by our stay in Berlin, it was now time to travel south to Bavaria to complete our visits at Munich and Regensburg. We divided the long trip into two days that permitted time to relax at the country farmhouse of one of my mentors, Prof. Christoph Broelsch, MD, PhD. I have had the pleasure of knowing Professor Broelsch since 1992, when I was asked by Prof. Jean Emond, MD, to be his guide during a faculty visit to the University of California at San Francisco. Since then, we have collaborated regularly on projects pertaining to living-donor and pediatric liver transplantation. Indeed, Professor Broelsch was my sponsor for this fellowship. It was certainly a highlight for my family to spend a day on his beautiful farm just outside Celle in Western Germany and enjoy an authentic German dinner including delicious homemade pumpkin soup and stone-oven baked sweetbread, prepared by Professor Broelsch’s wife, Bianka (see photo, page 47).

Just before our departure, an interesting event occurred that would fundamentally change our itinerary. I had asked Professor Broelsch if we could walk the countryside where I could bounce off him some research ideas I had about expanding the donor pool in the U.S. “Of course” was his reply, “let’s enjoy a cigar!” Before I could respond, my four-year old son replied: “I would like a cigar!” This was a code word between my son and I that Professor Broelsch did not recognize: whenever I have to go to some obligatory meeting or event where he cannot attend, I promise him that as soon as he is “old enough to smoke a cigar,” he can join me. Quick to accept the professor’s offer of a junior cigar, there we went to stroll the countryside, but, more importantly, I now had a permanent attaché for all my future meetings and visits.
Munich

We arrived in Munich to begin the last segment of our journey. This was my first visit to the Bavarian capital that was just recovering from Oktoberfest. Brilliant sunshine and warm temperatures complemented this breathtaking city. Picturesque courtyards, fountains, gardens, and traditional Bavarian motifs abound (see photo, page 48). The city is energetic and open very late into the night. The costs for food and lodging are similar to such expenses in New York, Paris, or London, but there is a clean, efficient public transportation system that permits easy travel. I spent the morning at the University Hospital Munich, a quaternary referral center equivalent to any North American medical facility, as the guest of Prof. Karl-Walter Jauch, MD. The focus of our discussion was pediatric liver transplantation, which is becoming less centralized in Germany. The discussion could have extended much longer, but Professor Jauch wisely encouraged me to enjoy the city; I did so with my family, participating in a walking tour of medieval cathedrals and museums within the Marienplatz, the heart of Old Town.

The next morning, the subject of pediatric liver transplantation was revisited in the format of combined anesthesia/surgery grand rounds, followed by several case discussions. We planned to stay longer; however, Professor Jauch, upon hearing that our next stop was Regensburg, advised us to be certain to appropriate sufficient time to explore the ancient city.

Regensburg

Driving through the German countryside during the light of day, we appreciated the transition from Munich to Regensburg. Regensburg hugs the Danube River and was largely untouched during World War II. Regensburg originated as a Celtic settlement in approximately 500 BC and retains the traditional city plan of a stone wall encircling an enormous central church, the Dom St. Peter, the home of Pope Benedict, as well a Stone Bridge crossing the Danube that has served the city for more than 800 years. The modern University Hospital complex (see photo, this page) is located atop a hill outside of town with magnificent country views. Our hosts for this visit were Stefan Farkas, MD, PhD, and Marcus Sherer, MD, PhD, associate professors of surgery and members of the transplant team headed by Prof. Hans J. Schlitt, MD, chairman of the department of surgery and chief of transplantation. My wife was hosted by Christoph Wiesenack, MD, from the department of anesthesiology.

We enjoyed a tour of the medical and research facilities as well as a spirited discussion on the management of advanced hepatocellular carcinoma with Prof. Edward Geissler, MD, chief of surgical research and an expert on the pharmacology of sirolimus. My wife engaged in an interesting debate with the chairman of anesthesiology, Prof. Bernhard Graf, MD, on the role of antifibrinolytics during liver transplantation. This discussion was followed by combined grand rounds on pediatric liver transplantation at the request of the chairs of surgery and anesthesiology.

Later that night, we attended a wonderful dinner hosted by
Marcus Scherer at Bischofs-hof, a traditional German beer garden that originated as an ecclesiastical academy in 1810 with a brewery dating to 1649. These gatherings had become the hallmark of our trip: newfound friends from the fields of anesthesiology and surgery enjoying a fantastic meal of local cuisine as we share stories of our personal and professional lives (see photo, this page).

Reflections on the fellowship

As we left Regensburg after midnight for the 300 km drive to Frankfurt to catch our early morning flight home, the essence of this once-in-a-lifetime experience was apparent. The many new faces I now have the privilege of calling friends and colleagues have left a lasting impression on my work, research, and personal life. Already opportunities for collaboration have emerged and will continue to expand as I prepare the scientific report of the fellowship for submission to the Journal of the American College of Surgeons. This remarkable opportunity to interact with colleagues who at times use very different techniques to address the same fundamental questions of clinical medicine and research is a highlight of my academic career.

As the ACS’ 2008 Traveling Fellow to Germany, I visited six academic centers, lecturing on the topics of pediatric liver transplantation, split/living donor liver transplantation, combined liver-thoracic organ transplantation, and utilization of extended-donor criteria liver allografts. This journey encompassed more than 1,500 km of travel by land within Germany during a period of 11 days.

I am very thankful to the membership of the American College of Surgeons and the International Relations Committee for the privilege of being your Fellow. There are also many individuals who I would like to recognize: Foremost are Professor Senninger of the University Hospital Münster; Kate Early of the International Relations Committee of the ACS; and my sponsor, Professor Broelsch, for their council in all facets of planning and execution. I also would like to thank Profs. Jürgen Klempnauer, Björn Nashan, Karl-Walter Jauch, and Hans Schlitt, as well as their clinical and administrative staffs, for their hospitality during each of my university visits. I am indebted to Profs. Rainer Gruessner, John Hughes, and Khalid Khan of the University of Arizona department of surgery for covering my clinical responsibilities during the fellowship as well as the University of Arizona department of anesthesiology for permitting my wife to attend with me. Lastly, I would like to thank my family for their endurance, love, and sacrifice.

Acknowledgment

I am particularly grateful to Camilla Regler for coordinating my visit and arranging my itinerary.

Dr. Renz is a professor of surgery at the University of Arizona, Tucson.
A look at The Joint Commission

Preventing technology-related health care errors

Technology is often touted as the “cure” for health care, but a new Joint Commission Sentinel Event Alert warns that implementation of technology and related devices is not a guarantee for success and may actually jeopardize the quality and safety of patient care.

The Alert urges greater attention to understanding when a technology may (or may not) be applicable, choosing the right technology, understanding the impact technology can have on the quality and safety of patient care, and attempting to quickly fix technology when it becomes counterproductive. The Alert makes clear that the overall safety and effectiveness of technology in health care ultimately depend on its human users and that any form of technology can have a negative impact on the quality and safety of care if it is designed or implemented improperly or is misinterpreted.

The Alert notes that there are very little data on the number of errors directly caused by the increasing combined use of health information and devices. However, root cause analysis of errors shows that computerized medication orders and automated dispensing cabinets for medications are frequently involved. In addition to specific recommendations contained in the Alert, The Joint Commission urges health care organizations to use the Information Management accreditation standards to improve patient safety while using technology. As technology is so common in health care—from admitting patients to the operating room to ordering and administering medication—any Joint Commission accreditation standard can be tied to technology.

“Innovations in technologies and information systems are vitally important to improve health care quality and safety, but we must be mindful of the safety risks and preventable errors that these implementations can create or perpetuate” says Mark R. Chassin, MD, MPP, MPH, president, The Joint Commission. “The strategies contained in this Alert give organizations and caregivers guidance that can help prevent patient harm and maximize the beneficial impact of these innovations.”

The Alert notes that the implementation of technology can threaten care and patient safety when the following occurs:

• Clinicians and other staff are not included in the planning process
• Providers do not consider the impact of technology on care processes, workflow, and safety
• Technology is not fixed when it becomes counterproductive
• Technology is not updated

To reduce the risk of errors related to health information and technology, The Joint Commission’s Sentinel Event Alert recommends that health care organizations take a series of 13 specific steps, including the following:

• Look for possible risks in how caregivers perform their work and resolve these issues before putting technology into place
• Involve the caregivers who will ultimately use the technology
• Train everyone who will be using the technology and provide frequent refresher courses
• Make clear who is authorized and responsible for technology—from putting it into use to reviewing safety
• Continually seek ways to improve safety and discover errors

Other strategies for reducing technology-related errors include avoiding distractions for staff using technology, monitoring and reporting errors and near misses to find the causes, and protecting the security of information.

The warning about preventing technology-related errors is part of a series of Alerts issued by the Joint Commission. Previ
ous Alerts have addressed anticoagulants, wrong-site surgery, medication mix-ups, health care-associated infections, and patient suicides, among others. The complete list and text of past issues of Sentinel Event Alert can be found on the Joint Commission Web site at www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_42.htm.

AWS announces availability of two fellowships

The Association of Women Surgeons Foundation, together with Ethicon Endo-Surgery Inc. and Genomic Health Inc., have announced the availability of two fellowships. A $25,000 grant for each fellowship will be awarded to two qualified and approved applicants. A grant request addressing one of the following disciplines is required: oncology, bariatrics, new and innovative minimally invasive surgery, or surgical education. The deadline for grant submissions is May 15. For a detailed schedule and application information, visit http://www.WomenSurgeons.org/ or contact Info@WomenSurgeons.org.

ACS to present course on leadership skills

The American College of Surgeons invites surgeons who aspire to meet the challenges of exemplary leadership across all settings to join senior surgical leaders in a dynamic, three-day course, Surgeons As Leaders: From Operating Room to Boardroom, to convene June 28 to July 1.

Faculty includes Layton F. Rikkers, MD, FACS, Chair; Bruce L. Gewertz, MD, FACS; Wiley W. Souba, MD, ScD, MBA, FACS; and Gayle E. Woodson, MD, FACS. L.D. Britt, MD, MPH, FACS, Chair of the Board of Regents, will be the keynote speaker; and Charles F. Rinker II, MD, FACS, will serve as special invited faculty. Debra A. DaRosa, PhD, will serve as professional educator for the course.

Organized by the College’s Division of Education, the course will help surgeons to (1) exhibit the attributes of a leader; (2) use consensus development and vision to set, align, and achieve goals; (3) build and maintain effective teams; (4) cultivate leadership capacities to move groups forward; (5) change culture, resolve conflict, and balance demands within the larger environment; and (6) evaluate leadership opportunities.

The course will take place at the ACS headquarters in Chicago, IL. For details and an application form, visit http://www.facs.org/education/surgeonsasleaders.html, e-mail apalinski@facs.org, or phone 312/202-5018. The application deadline is May 1.

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 11–12, 2009. Kansas City, MO.

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.
Submission of manuscripts

Electronic submission is encouraged; send files via e-mail to sregnier@facs.org. Submissions will be acknowledged and sent to appropriate reviewers.

If you are sending the manuscript on diskette or other hard copy of materials, forward these items prepaid, at the author’s risk, to:

Stephen J. Regnier, Editor
Bulletin of the American College of Surgeons
American College of Surgeons
633 N. Saint Clair Street
Chicago, IL 60611-3211

Manuscripts are accepted for consideration on the understanding that they are intended for publication solely in the Bulletin of the American College of Surgeons and that they are not under review nor have been published or committed for publication elsewhere. If a paper has been prepared for presentation at a meeting, this information should be noted on the cover letter accompanying the manuscript. All manuscripts are subject to editorial modification and revisions necessary to bring them into conformity with Bulletin style and publication-readiness.

Style and format

Manuscripts should be no more than 3,200 words in length, excluding tabular material or illustrations. Manuscripts should be composed of seven to nine pages in Microsoft Word—doublespaced and with one-inch margins. Please turn off tracked changes before sending the document. Manuscripts submitted as PDF will be returned to the author with the request that a Word document be submitted instead.

Give full names of authors and their degrees, academic or professional titles, professional affiliations, and complete addresses. Specify to whom galley proofs are to be sent.

References should be listed numerically in the text, with full citations to appear on a separate page at the end of the text of the article. Please be sure to keep the references separate; do not use the feature in Word that automatically generates footnotes.

References should follow American Medical Association style guidelines. Following are some examples:


All manuscripts should include a brief biography (including employer name, position title, and city and state) and a photo of each author. Each photograph must be a head shot/portrait in JPG or TIF format, at least two inches wide, and at least 300 pixels per inch. Do not submit the photos in a Word document,
as this affects the publishing quality. If preferred, submission of a hard copy of photos (minimum passport size) is acceptable.

**Tables/illustrations**

Figures, tables, and/or other illustrations are welcomed as long as they add significantly to the author’s discussion in the text. Data display should be called a “Table” when presenting precise numerical values that show item-to-item comparisons; the term “Figure” should be used when presenting patterns or trends or illustrating comparisons in text.*

Displays that present lists of any kind (such as names of board members or checklist items) should be called “box.” Photos should be referred to in text as photos, not figures.

Drawings (including graphs and charts) should be created either in MSWord, PowerPoint, or as a JPG, TIF, or PDF file, with lettering large enough to be legible after necessary reduction. If camera-ready art is supplied in lieu of an electronic file, be sure that the original is clean, clear, and will be legible when reduced. A separate page with legends for the illustrations should be supplied. Tables submitted with the manuscript should be on separate pages at the end of the manuscript. Be sure to label the tables and illustrations clearly and be sure to refer to their placement in the text of the article.

Photographs or other illustrative art, if supplied in an electronic (JPG, TIF, or PDF) format, should have a resolution of no less than 300 pixels per inch, or at least 1200 pixels in width. Anything less than that may not reproduce at publishing quality. Photographs and illustrations pasted into a Word document are discouraged, as they do not always print at ideal resolution. Please provide captions for photographs on a separate page.

**Galley proofs**

Authors will receive galley proofs (as a Word document) of their edited manuscript for their review in advance of the scheduled month of publication. Galleys may include queries from editorial staff.

Before publication, revised proofs must be returned either as a Word document with any edits indicated using the tracked changes function or as a list of requested changes to the editors. Authors of feature articles will have the opportunity to see a PDF of the article in magazine format that reflects any changes made to the document during the galley stage. After viewing the PDF, authors may only request changes to text that is currently outdated or presents egregious errors; all other edits will be rejected at that time.

**Inquiries**

Inquiries regarding potential articles for consideration, deadlines, the submission of manuscripts, author proofs, or style should be directed to Stephen J. Regnier, Editor, *Bulletin of the American College of Surgeons*; or Linn Meyer, Director, Division of Integrated Communications, via e-mail at sregnier@facs.org or lmeyer@facs.org, or by mail at American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; 312/202-5331; fax 312/202-5021.

NTDB® data points

How complicated is it?

by Richard J. Fantus, MD, FACS

Not all patients are created equal in their constellation of signs, symptoms, comorbidities, disease entities, or incidence of complications. In an era of medicine where it seems—as deemed by governmental payors—that it is unacceptable for certain complications to occur and therefore they will not be reimbursed, it is paramount that the trauma community has a handle on what is the true incidence of various complications in the traumatized patient population. What is the expected incidence of ventilator-associated pneumonia in a population of acutely traumatized patients with significant head injury? How about the incidence of pulmonary embolus in a select group of multiply traumatized patients with an overall injury severity score of greater than or equal to 25 and an abbreviated injury score of three for lower extremity? With large numbers of records and quality data, it may be possible to answer questions such as these that remain unanswered or currently have answers with little or inexact supporting data.

In the Annual Report for 2008, one of the new analyses involves the number of complications reported and submitted by facility (see graphic on this page). However, almost 60 percent of the half-million records submitted to the National Trauma Data Bank® (NTDB) had no indication of whether the patient had hospital complications and, therefore, complication information was considered missing for these records.

The new National Data Standard has raised the bar for the level of quality of data submitted. Because standard data definitions and uniform registry field specifications were created and the validator data-screening tool was implemented, several previous concerns related to past years’ data submissions have been eliminated. However, there is still significant room for improvement. In order to get a better understanding of complication rates in the trauma patient, one has to be diligent in capturing and reporting these occurrences if or when they occur. Only then will we be able to answer the question: How complicated is it?

The full NTDB Annual Report Version 8.0 is available on...
the ACS Web site as a PDF 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.

**Dr. Fantus** is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago, IL. He is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.

**ADVOCACY ADVISOR, from page 33**

**Federal laws**

In an effort to increase transparency on federal lobbying activities, the Lobbying Disclosure Act of 1995 (LDA) received a major overhaul with the passage of the Honest Leadership and Open Government Act in late 2007. Although the updated provisions are directed at professional lobbyists, surgeons—especially surgeons who have frequent contact with their members of Congress—should be familiar with the basic restrictions and the accompanying internal House and Senate rules that outline the ethical standards for members of Congress and their employees (http://senate.gov/reference/resources/pdf/RL31126.pdf).

The updated LDA now defines a professional lobbyist as an individual who makes more than one lobbying contact (written or verbal) to a member of Congress, congressional staff, or senior agency official and spends a minimum of 20 percent of his or her time on these activities during a three-month period. A practicing surgeon will rarely, if ever, meet this threshold.

However, a surgeon who is lobbying his or her members of Congress and their staff should always follow the new House and Senate ethics rules pertaining to gift giving and travel. In general, members of Congress and their staff may not accept gifts or travel of any value, including meals, provided by private parties. The House and Senate rules include several exemptions, such as allowing food of nominal value and permission to continue receiving gifts from family and friends. However, these exemptions also have strict requirements, so you should always check the rules before making a purchase of any kind for a member of Congress or staff.

If you are going to be advocating as an individual, remember that you have the right and the civic responsibility to contact legislators. Surgeons are encouraged to regularly communicate with their elected officials, advising them on issues and concerns related to the health care profession.
The Executive Committee on Video-Based Education, through the Division of Education and Ciné-Med, has developed the interactive Multimedia Atlas of Surgery. Each volume presents a comprehensive list of surgical procedures, featuring:

- Narrated surgical video
- Didactic presentations
- Medical illustrations
- Expert commentary
- Foreword by Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, American College of Surgeons

Pricing:

All 26 chapters
- DVD-ROM with book and online access, $270
- 1-year online subscription: $180

Individual chapters:
- $35 each (CD-ROM)
- $20 each (1-year online subscription)

Published by Ciné-Med®

To order, call 800/633-0004 or visit www.cine-med.com
Chapter news

by Rhonda Peebles, Division of Member Services

**Virginia Chapter announces new scholarships for surgical residents**

The Virginia Chapter has established the VA-ACS Humanitarian Surgical Resident Travel Scholarship Program. This program was established to offset travel expenses for residents in Virginia who are interested in participating in programs to deliver surgical care as part of humanitarian missions to underdeveloped countries. The following three residents were selected to receive the $500 travel scholarship in 2009:

Sharline Z. Aboutanos, MD* (see photo, right), will be a part of the VCU Health System department of plastic surgery’s annual surgical mission trip to Guatemala City, Guatemala; the trip is sponsored by Operation Kids.

Chris Campbell, MD,* will travel to Giridih Jharkhand, India, with Physicians for Peace.

Jayme Stokes, MD* (see photo, right), will travel to Samoa, where he will provide ultrasound education to the physicians and nurses in the local hospitals as well as participate in the general surgery service at one of the hospitals.

All three scholarship recipients will be invited to give a brief presentation about their experiences at the Virginia Chapter’s 2010 annual meeting, which will convene April 23–25, 2010, at the Hotel Roanoke in Roanoke, VA. For more information, contact Jeffrey S. Young, MD, FACS, Virginia Chapter President, at jsy2b@virginia.edu, or Craig S. Derkay, MD, FACS, Chair, Humanitarian Surgical Resident Travel Scholarship Committee, at Craig.Derkay@chkd.org.

**Louisiana Chapters hosts first resident Surgical Jeopardy Bowl**

During its 2009 annual meeting, held January 16–18 in New Orleans, the Louisiana Chapter hosted its first Surgical Jeopardy Bowl. Four teams of two residents—representing Ochsner Health Systems, Louisiana State University (LSU)-New Orleans, LSU-Shreveport, and Tulane—competed. Members of the winning team from LSU-Shreveport received a cash prize provided by Pediatric Surgery of LA and the New Orleans Surgical Society (see photo, this page).

**New York chapters will head to state capital**

On May 12, members of all the chapters in New York will head to Albany for surgery’s annual Lobby Day. For more information and/or
### Chapter meetings

For a complete listing of the ACS chapter education programs and meetings, 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</th>
<th>Chapter</th>
<th>Location/contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 18</td>
<td>New York (CS)</td>
<td>Location: Hotel Thayer, West Point, NY Contact: Amy Clinton, 518/283-1601, <a href="mailto:NYCoFACS@yahoo.com">NYCoFACS@yahoo.com</a> ACS representative: L. D. Britt, MD, FACS</td>
</tr>
<tr>
<td>April 24–26</td>
<td>Virginia (CS)</td>
<td>Location: Hilton VA Beach Oceanfront, Virginia Beach, VA Contact: Susan McConnell, 804/643-6631, <a href="mailto:smconnell@ramdocs.org">smconnell@ramdocs.org</a> ACS representative: Kristen Hedstrom, Division of Advocacy and Health Policy</td>
</tr>
<tr>
<td>April 25–26</td>
<td>Turkey (CS)</td>
<td>Location: Istanbul, Turkey Contact: Cemalettin Topuzlu, MD, FACS, 91-212-347-6300, <a href="mailto:ctopuzlu@gmail.com">ctopuzlu@gmail.com</a></td>
</tr>
<tr>
<td>May 2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 3–7</td>
<td>Chile</td>
<td>Location: Hotel Sheraton Convention Center, Santiago, Chile Contact: Juan E. Contreras P., MD, FACS, 56-2-264-1878-2640472, <a href="mailto:americoll@terra.cl">americoll@terra.cl</a></td>
</tr>
<tr>
<td>May 4–6</td>
<td>Iran</td>
<td>Location: Razi Convention Center, Tehran, Iran Contact: Heshmatollah Kalbasi, MD, FACS, 0098-21-8808-1469, <a href="mailto:h_kalbasi@yahoo.com">h_kalbasi@yahoo.com</a></td>
</tr>
<tr>
<td>May 7–9</td>
<td>West Virginia (CS)</td>
<td>Location: The Greenbrier, White Sulphur Springs, WV Contact: Sharon Bartholomew, 304/293-1258, <a href="mailto:wvacs@labyrinth.net">wvacs@labyrinth.net</a> ACS representative: J. David Richardson, MD, FACS</td>
</tr>
<tr>
<td>May 8–9</td>
<td>Ohio (CS)</td>
<td>Location: Hyatt Regency Cleveland at the Arcade, Cleveland, OH Contact: Brad Feldman, MPA, 877/677-3227, <a href="mailto:ocacs_exec@ohiofacs.org">ocacs_exec@ohiofacs.org</a> ACS representative: Stephen R. T. Evans, MD, FACS</td>
</tr>
<tr>
<td>May 8–9</td>
<td>Southwestern Pennsylvania</td>
<td>Location: Nemacolin Woodland Resort, Farmington, PA Contact: Dianne Meister, 412/321-5030, <a href="mailto:dmeister@acms.org">dmeister@acms.org</a></td>
</tr>
<tr>
<td>May 16</td>
<td>Northern California (CS)</td>
<td>Location: Marines Memorial Hotel, San Francisco, CA Contact: Annette Bronstein, 650/992-1387, <a href="mailto:abronst230@aol.com">abronst230@aol.com</a></td>
</tr>
<tr>
<td>May 21–22</td>
<td>Michigan (CS)</td>
<td>Location: Shanty Creek Resorts, Bellaire, MI Contact: Angie Kemppainen, 517/336-7586, <a href="mailto:akemppainen@msms.org">akemppainen@msms.org</a> ACS representatives: John L. Cameron, MD, FACS</td>
</tr>
<tr>
<td>May 22–25</td>
<td>Florida (CS)</td>
<td>Location: Ginn Hammock Beach Resort, Palm Coast, FL Contact: Bob Harvey, 904/637-0943, <a href="mailto:bharvey@hgmnet.com">bharvey@hgmnet.com</a> ACS representatives: Thomas R. Russell, MD, FACS; and L. D. Britt, MD, FACS</td>
</tr>
<tr>
<td>June 2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 13–16</td>
<td>Washington and Oregon (CS)</td>
<td>Location: Campbell’s Resort, Chelan, WA Contact: Lynette Hazard, 503/494-3074, <a href="mailto:hazardl@ohsu.edu">hazardl@ohsu.edu</a></td>
</tr>
</tbody>
</table>
to participate, contact Amy Clinton, Executive Director, NY Chapter, at 518/283-1601 or at NYCoofACS@yahoo.com.

**Chapter execs convene for conference calls and webinars**

As of January, the chapter executives can participate in conference calls and webinars that will help with chapter-related management activities. The first conference call was devoted to continuing medical education accreditation procedures; more than 20 chapter executives participated. The following future sessions have been planned:

- **May 13** ACS Products—The Case Log System
- **June 16** Roundtable Discussion—Noncommunicative Volunteers
- **August 4** The Chapter Exec’s Role in Strategic Planning (with Wanda Johnson)
- **September 23** Roundtable Discussion—Recruitment Techniques and Tools
- **October 6** ACS Products for Residents (with Peg Haar)
- **November 10** Roundtable Discussion—Programs for Young Surgeons That Work
- **December 6–7** Chapter Execs’ Winter Learning

For more information about these learning activities, call the chapter hotline at 888/857-7545, or visit the chapter Web page at [http://www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html).

**Chapter anniversaries**

<table>
<thead>
<tr>
<th>Month</th>
<th>Chapter</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>Brazil</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Southern California</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Massachusetts</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Nevada</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>New Hampshire</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Puerto Rico</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>South Dakota</td>
<td>57</td>
</tr>
<tr>
<td>April</td>
<td>Metropolitan Chicago</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Mississippi</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>Oklahoma</td>
<td>59</td>
</tr>
</tbody>
</table>