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Change was the catchword throughout our recent national election, as we all know. Regardless of political affiliation, the American electorate clearly is ready for less partisan bickering and more discussion about how to resolve the problems facing our nation. And, in light of the economic recession, we can anticipate that the government will start implementing new approaches to accomplishing that goal in the very near future.

Time for a makeover

All the signs have pointed for some time now to the fact that our health care system is one sector that is likely to undergo a profound transformation. A key element of this overhaul will be the development of a more reasonable payment system. This change must occur as soon as possible because the 18-month reprieve from Medicare physician payment cuts provided in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 expires at the end of this year. As you may recall, the American College of Surgeons was instrumental in achieving passage of MIPPA. This legislation eliminated the 10.6 percent Medicare physician reimbursement reduction that was slated for July 1, 2008, and replaced projected cuts for 2009 with a 1.1 percent increase. Without further congressional action, however, physicians will face an estimated 20 percent pay cut in January 2010.

Policymakers and physicians alike agree that the current Medicare payment system is unsustainable. The current system is riddled with multiple flaws, but perhaps the most widely maligned component is the sustainable growth rate (SGR). The SGR was devised in an effort to control spending growth by adjusting for the difference between actual expenditure increases and “targeted” growth. Under the SGR, the targeted rate is based on changes in the gross domestic product (GDP) and other factors. The problem is that actual medical spending growth continues to outpace SGR targets, largely because GDP growth has been well below health care increases for several years.

The College, the American Medical Association (AMA), and the medical and surgical specialty societies have repeatedly urged Congress to enact long-term solutions. Most experts agree that this is the year lawmakers are likely to pass these and/or other reforms.

Models for change

Policymakers are reviewing several reform models. Because you are likely to hear more about them throughout the year, now seems like an opportune time to outline some of these ideas.

Under an approach known as bundled reimbursement, payors would write a single check to cover an array of services. Many surgeons already are familiar with this concept because Medicare bundles payment for global surgical services and certain diagnostic imaging procedures. The Centers for Medicare & Medicaid Services (CMS) recently announced plans to identify opportunities to package more services together, and the Medicare Payment Advisory Commission (MedPAC) has recommended that Congress explore bundling options. Advocates claim that this methodology would provide incentives for all providers to better manage patient care and thereby reduce costs and improve outcomes. Before bundling is implemented more broadly,
however, CMS must address the composition of each bundle, how much Medicare will pay for each bundle, how payments will be risk-adjusted, and other issues.

A related concept, known as “gainsharing,” calls for hospitals to share with physicians the savings produced as a result of changes in care processes. Under this approach, all providers would be reimbursed through the same process as they are today, but institutions could also divide savings among the physicians who helped to produce them. Supporters maintain that this arrangement will offer all providers an incentive to deliver more cost-effective, high-quality service. One drawback is the fact that ongoing, sharable savings may be difficult to sustain. Furthermore, physicians could have difficulty accessing payments if hospitals control the funds, and Congress would need to change existing anti-kickback, self-referral, and other laws.

Another concept that has been extensively debated calls for enrolling patients in medical homes, which would be responsible for coordinating and managing all of the services provided to patient enrollees. Some experiments with patients who previously have had difficulty accessing appropriate care show that these arrangements lead to better outcomes and reduced waste. In addition, advocates say this approach could result in increased payments to physician practices serving as medical homes and thereby make generalist specialties more attractive to medical students and residents. However, questions remain about how to structure a medical home, what it must accomplish to qualify for bonuses, and whether the medical home concept should be limited to primary care physicians or applied to specialists who treat chronic conditions.

Pay for performance (P4P) continues to pique the interest of policymakers. Already considerable resources have been devoted to developing, reviewing, and endorsing quality measures. Furthermore, MIPPA requires CMS to present a plan to Congress for a value-based purchasing program for physicians, and CMS has initiated this process by holding listening sessions and soliciting comments. In some form or another, P4P or value-based purchasing, is going to happen.

Finally, some physician organizations, including the College, have suggested alternatives to the SGR that would avoid the exorbitant expense of outright repeal. As an example, a prototype that the College and the American Osteopathic Association have crafted calls for developing six separate growth targets for different types of services. This arrangement would help to eliminate the across-the-board payment reductions for all physicians, regardless of whether their specialty stayed within the targeted growth level.

Time for action

The College, the AMA, and the medical and specialty societies are discussing common concerns about these concepts and strategies for achieving long-term payment reform. During a recent meeting of leaders in the medical and surgical community, most attendees agreed to collaborate on a proposal that would assign separate expenditure targets to different types of services and implement the medical home concept, as long as it doesn’t take money away from the specialties. This plan would have the combined effect of easing payment inequities and fostering coordinated care. We also intend to encourage the government to pursue pilot projects to test other health care delivery and quality improvement models.

Change is coming, and the American College of Surgeons is positioning itself to ensure that the new health care system serves the professional interests of all surgeons and the well-being of all patients. As an important example, we recently released an ACS Statement on Health Care Reform (see December 2008 issue, page 5). I encourage each of you to think about what modifications you should be making in your practices in order to thrive in the coming years and how the College can help you to achieve that goal.

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Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
The 2009 Medicare fee schedule

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

On October 31, 2008, the Centers for Medicare & Medicaid Services (CMS) released the Medicare physician fee schedule final rule for 2009. This final rule responds to comments that the American College of Surgeons and other physician groups submitted regarding the proposed rule issued early last summer.

Some key provisions in the final regulation address the following issues of interest to surgeons: the conversion factor updates, effective dates for enrollment in the Medicare program, regulatory requirements of independent diagnostic testing facilities (IDTFs), the Physician Quality Reporting Initiative (PQRI), anti-markup provisions, incentive payments and shared savings programs, and potentially misvalued codes. In addition, the rule includes a section related to the provision of the Medicare Improvements for Patients and Providers Act (MIPPA), H.R. 6331, pertaining to electronic prescribing. To view the final rule, go to http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf.

The following article answers some questions surgeons may have about the final rule and the College’s views on its provisions.

What is the conversion factor for 2009?

The fee schedule update factor for 2009 is set at an average of 1.1 percent. In addition, MIPPA requires that budget neutrality adjustments previously applied to work relative value units (RVU) now must be applied to the conversion factor. Consequently, the conversion factor for 2009 will be $36.0666, compared with $38.0870 in 2008. Hence, the combined effect on total allowable charges for general surgery—taking into account all changes to work RVUs, practice expense changes, and MIPPA mandates—is expected to average approximately 2 percent.

How will the final rule affect Medicare billing privileges?

The final rule makes significant changes to the process for establishing an effective date for Medicare billing privileges for physician and nonphysician provider (NPP) organizations. CMS adopted an approach that established an effective date of billing for physicians, NPPs, and physician and NPP organizations—that is, whichever occurs later: the date of filing of a Medicare enrollment application or the date a physician, NPP, or physician and NPP organization first started furnishing services at a new location. Physicians, NPPs, and physician and NPP organizations may bill retroactively for services up to 30 days before the effective date of billing when the physician or NPP organization has met all other program requirements and when services were furnished at the enrolled practice location before the date of filing, and circumstances precluded enrollment in advance of providing the services.

Under the last set of rules, once enrolled, physicians could retroactively bill the Medicare program for services rendered up to 27 months before enrollment. In the proposed rule, CMS sought to change the initial Medicare enrollment date for physicians and NPPs to either the date that an enrollment application is approved by a Medicare contractor, or whichever occurred later: the filing date of the enrollment application that was later approved by a fee-for-service contractor or the date that an enrolled supplier first furnished services at a new practice location.

The College strongly opposed efforts to establish the initial enrollment date as the date on which a Medicare contractor approves an enrollment application. The College also recommended that CMS keep in place the concept of allowing retroactive billing for services rendered before enrollment in the Medicare program but change the time period for retroactive billing from 27 months to 12 months or another reasonable period of time.

Is CMS moving ahead with its plans to require physician offices that do diagnostic testing to enroll as IDTFs?
taining to publishing the names of reporting providers?

The final rule seeks to implement MIPPA requirements that CMS publish the names of successful reporters by posting the names of eligible professionals who have submitted data on the 2009 PQRI quality measures through the claims-based reporting mechanism or through registry-based reporting. It met one of the satisfactory reporting criteria for the 2009 PQRI, and received a PQRI incentive payment for covered professional services between January 1 through December 31. Thus, no names are likely to be listed on the CMS Web site until some point in 2010.

The regulation also makes clear that CMS intends to launch a Physician and Other Health Care Professional Compare Web site, beginning with a listing of the names of professionals who successfully participate in the 2009 PQRI, and expects to add more information to the site over time.

The proposed rule also called for possibly establishing a Physician and Other Health Care Professional Compare Web site, comparable to its existing Hospital Compare site, which allows the public to compare the performance of those and other providers. The College strongly urged CMS to proceed with the utmost caution in developing comparative information because reporting potentially inaccurate or misleading information could unintentionally harm both providers and patients. The ACS also strongly recommended that CMS consider alternative data sets for reporting, such as board certification, patient surveys, and participation in a clinical data registry.

Does the regulation contain provisions that would affect MIPPA’s incentives for electronic prescribing?

MIPPA provides for new incentive payments for health professionals who successfully prescribe electronically. The bonuses would be 2 percent in 2009 and 2010, 1 percent in 2011 and 2012, and 0.5 percent in 2013. The payments would not be available to professionals for whom the services subject to the electronic

What effect will the rule have on the 2009 PQRI?

In the final rule, CMS restated its intention of finalizing and publishing the detailed specifications for all 2009 PQRI measures on the agency’s Web site by December 31, 2008. The final rule also retains the option to participate in PQRI for the second half of 2009 under certain claims-based and registry-based reporting options. In the proposed rule, CMS called for extending PQRI through 2010 with the potential addition of 64 new measures and continuing the alternative reporting options started in 2008. Although the proposed regulation did not provide for incentive payments for reporting, MIPPA extends the PQRI through 2010 and includes 2 percent bonus payments for 2009 and 2010.

The College supported the continuation of the additional reporting options. The College also believes data registries are a critical resource in the evaluation of surgical care and health outcomes and appreciates the proposed extension of data registry reporting options and the proposed inclusion of measures from key repositories. The ACS also supported the option of reporting measures for 30 consecutive patients because reporting for consecutive patients may reduce opportunities for selective reporting.

Does the rule contain any provisions per-
prescribing performance measure total less than
10 percent of their Medicare allowed charges
during a reporting period. Under the final rule,
physicians and other eligible professionals may
use G codes to report the electronic prescribing
measure without any requirement to use
e-prescribing for controlled substances without
regard to final action that the U.S. Drug Enforce-
ment Administration may take on this subject.

In 2009, only physicians for whom the denom-
nator codes (mainly evaluation and management
[E/M] services) comprise at least 10 percent of
total Part B allowed charges will be eligible for
the e-prescribing incentive. CMS says that an
alternative eligibility criterion, based on sub-
mitting “a sufficient number of prescriptions
(as determined by the Secretary [of the U.S.
Department of Health and Human Services])
under Medicare Part D,” is infeasible for 2009.
However, in 2010, CMS will post the names of
successful 2009 e-prescribers on its planned
Physician and Other Health Care Professional
Compare Web site.

The College recommended revising the
e-prescribing measure to clarify that the 10 percent
requirement refers to the percentage of al-
lowed charges, rather than the percentage of
claims submitted. If CMS interpreted this
10 percent requirement to mean percentage of
claims submitted rather than percentage of
allowable charges, many surgeons would be ex-
cluded from receiving bonus payments because
the majority of their prescribing activity is
associated with procedure codes, not E/M codes.
Interpreting the requirement based on a per-
centage of allowable charges will be more inclusive,
because surgeons receive a significant percentage
of Medicare revenues from E/M codes.

In addition, the College recommended that the
Secretary use the discretionary authority provided
under MIPPA to exempt the e-prescribing of con-
trolled substances from the MIPPA e-prescribing
calculation.

Does the final regulation implement the
plans to revise the anti-markup rule?

CMS proposed to revise the anti-markup rule,
which was finalized last year in the 2008 physi-
cian fee schedule regulation but delayed until
January 1 because of unintended consequences.
According to the anti-markup rule, a physician
cannot mark up his or her cost when billing
for the technical component or professional
component of a diagnostic test not performed
in the “office of the billing physician or other
supplier.” In the final rule, CMS is adopting
an approach that incorporates both alterna-
tives in the proposed rule and described in
the paragraphs that follow. CMS is finalizing
Alternative 1 with some modifications, and re-
taining with some modifications the present site-
of-service approach described in Alternative 2.

Arrangements should first be analyzed using
Alternative 1. Thus, in instances where the per-
forming physician (the physician who supervises
the technical component, or performs the profes-
sional component, or does both) performs at least
75 percent of his or her professional services for
the billing physician or other supplier, none of
the services furnished by the physician on behalf
of the billing physician or other supplier will be
subject to the anti-markup provision. In other
words, a physician could furnish up to 25 percent
of his or her professional services through other
arrangements, such as acting as a locum tenens
physician, but could still only “share a practice”
for anti-markup rule purposes with one physi-
cian or other supplier.

If the performing physician does not meet the
“substantially all” services requirement of Al-
ternative 1, an analysis under the Alternative 2
requirements may be applied on a test-by-test
basis. CMS concluded that adoption of both Al-
ternatives 1 and 2 made it unnecessary to adopt
the exception related to physician organizations
that do not have any owners who have the right
to receive profit distributions. CMS retained the
January 1 effective date for the anti-markup
provisions, including changes made in the final
rule.

In the proposed rule, CMS described two op-
tions for revising the anti-markup rule. Under
the first alternative, CMS abandoned the site-
of-service approach and proposed that the anti-
markup provision apply in all cases where the
professional component or technical component
is either purchased from an outside supplier or
performed or supervised by a physician who does
not share a practice with the billing physician
or organization. However, more than two physicians are prohibited from sharing a practice for anti-markup purposes. CMS’ second alternative continued the existing site-of-service method for determining whether a physician shares a practice but expanded the definition of “office of the billing physician or other supplier” to include the entire building where his or her office is located.

The College recommended that CMS withdraw the proposed and delayed anti-markup provisions because they exceed the agency’s statutory authority in this situation. In the event that CMS refused to withdraw the proposed and delayed provisions, the College supported specific changes to the anti-markup policy, including allowing multiple physician relationships to be considered as sharing a practice, expanding the definition of “office of the billing physician or other supplier” to the entire building where the office of the billing physician is located, and exempting from the anti-markup rule diagnostic tests ordered by a physician in an organization that does not have any owners who have rights to receive profit distributions.

How does the rule affect the Stark law regarding self-referrals?

CMS proposed a Medicare physician self-referral statute or Stark law exception pertaining to incentive payments—also known as pay for performance—and shared savings, or gain-sharing. The pay-for-performance programs addressed in the proposed rules are those in which insurers pay hospitals for meeting certain quality standards. In gainsharing arrangements, hospitals share with physicians the cost savings achieved through efforts to reduce the cost of patient care. A pay-for-performance or gain-sharing program that involves payment from a hospital to a physician would create a financial relationship, and referrals by the participating physician to the hospital would violate the Stark law unless an exception applies.

In the final rule, CMS states that it received too few public comments pertaining to this section of the proposed rule for the agency to finalize an alternative that expands the proposed exception in any meaningful way. Therefore, CMS is reopening the public comment period to obtain additional information to create a workable exception.

The proposed exception to the Stark law set forth in the proposed rule is very narrow, and the numerous conditions and requirements included in the exception risk obviating the exception itself. Hence, the College fully supported the proposal to create the exception but recommended relaxing some of the safeguards to make the exception more workable. Specifically, the College supported the following requirements: physicians participating in the program must have access to items and supplies that they deem medically necessary, the program term shall have a minimum of one year and a maximum of three years, and hospitals must offer the opportunity to participate in the program to all physicians on staff or who practice in the specialty relevant to the program. The College opposed the proposed requirement that limited payments to physicians

“ The final rule makes significant changes to the process for establishing an effective date for Medicare billing privileges for physician and nonphysician provider organizations.”
by rebasing and scaling at the end of each year of a multiple-year program.

The College also recommended that CMS create an exception to the requirement that physicians participating in the program must do so in pools of five or more participants and that CMS create an exception to the program that would limit participation in the program to those physicians who are members of the hospital’s staff at commencement of the program.

**Does the final rule potentially address misvalued and Harvard-valued codes?**

The final rule responds to American Medical Association Relative Value Update Committee (AMA RUC) recommendations regarding certain potentially misvalued codes. CMS also indicates it will continue to work with the RUC, the Medicare Payment Advisory Commission (MedPAC), and the specialty societies on this issue. CMS acknowledges its proposed approaches are long term and will require time and collaborative effort to complete.

The proposed rule recognized both continuing concerns regarding misvalued services under the Medicare physician fee schedule and ongoing work by AMA RUC to address these concerns by creating a five-year review identification workgroup. The College supports the RUC’s efforts to identify and review potentially misvalued codes but objects to doing so in a fashion that is inconsistent with critical elements of past five-year review activities and the RUC’s long-standing, data-supported deliberative process. Specifically, the College opposes the RUC’s recent ad hoc review process that counters the cycle that CMS has established and used for the past 15 years and may not allow for public comment.

With regard to Harvard-valued codes, the final rule provides that CMS take no specific actions on codes that have never been reviewed by the RUC but may be potentially misvalued. Rather, the regulation calls for CMS’ continued work with the AMA RUC, MedPAC, and the specialty societies on this issue.

The proposed rule indicated that Harvard previously valued more than 2,800 codes that the RUC has never reviewed. According to CMS, these codes are potentially misvalued and should be reviewed by the RUC. The College supported reviewing a relatively small number of services that account for most allowable charges under Medicare; however, the ACS posited that reviewing all the Harvard-valued codes would require an inordinate amount of time and financial resources of the specialty societies that would conduct the surveys for review of these codes. In addition, the College said that CMS must be willing to consider, in an unbiased and objective manner, the possibility that a Harvard code’s work value may increase or decrease after undergoing reconsideration.

**Does CMS intend to update the process for determining the value of high-cost supplies?**

CMS has decided not to finalize the proposed process to update high-cost supplies of more than $150 at this time and not to revise the prices for identified supplies. CMS will consider the possibility of using an independent contractor to obtain accurate pricing information. A revised process will be proposed in future rulemaking. CMS proposed a process to update supplies that cost more than $150 every two years and listed the top 65 high-cost resource that needed specialty input for price updates.
A legacy of ensuring patient safety

Position of the American College of Surgeons on Restrictions on Resident Work Hours

presented to the Institute of Medicine Consensus Committee
March 4, 2008

American College of Surgeons Division of Education

The following report was developed by the American College of Surgeons Task Force on the Resident 80-Hour Work Week. This special Task Force was appointed by then-President of the ACS Gerald B. Healy, MD, FACS, FRCSI(Hon), and was chaired by L. D. Britt, MD, MPH, FACS. Members of the Task Force are listed at the end of this document. This report was presented to the Institute of Medicine of the National Academies, Committee on Optimizing Graduate Medical Trainee (Resident) Schedules to Improve Patient Safety, on March 4, 2008, in Irvine, California. Work of the Task Force was supported by the ACS Division of Education.
I. Key issues

The American College of Surgeons (ACS) has had a sustained emphasis on patient safety since its inception in 1913. As the umbrella organization for the house of surgery, the ACS represents the specialties of general surgery, cardiothoracic surgery, colon and rectal surgery, gynecology and obstetrics, neurological surgery, ophthalmic surgery, orthopaedic surgery, otolaryngology–head and neck surgery, pediatric surgery, plastic and maxillofacial surgery, urology, and vascular surgery. Patient safety is the overarching theme for all ACS initiatives for the 21st Century. As the threats to quality medical care and patient safety continue to mount, the ACS attempts to effectively address each challenge. Irrespective of the context, anything that is deemed potentially dangerous to a patient is expeditiously addressed by the ACS (such as surgical errors, fatigue of health care providers, and workforce issues), for it is incumbent on this professional organization to consistently advocate for the safety of the patient. Current initiatives focus on the use of contemporary principles of surgical education to address knowledge and skills, acquisition of new surgical skills and procedures, verification of knowledge and skills, simulation-based surgical education, and team training. Research in the aviation arena has proven that teams in which individuals may not have worked together may be at the highest risk for error, unless steps are taken to overcome this deficiency. In surgery, frequently these teams are composed of individuals who are unfamiliar with each other and thus must take extra care in preparing to perform a task such as an operative intervention. Acknowledging that communication failure is a leading source of adverse events in health care, the ACS has established courses and educational modules which address the importance of communication skills and related topics, including professionalism and ethics. In addition, the ACS is currently exploring the development of a potential methodology for improving the transfer of patient information (the patient hand-offs), which has become much more complex with the reduction of duty hours and the ever-changing group of caregivers interacting with any one patient. It is in this spirit that the ACS must emphasize the importance of critically evaluating resident duty hours in the broader context of patient safety and the quality of surgical care.

As we approach the ninth anniversary of the landmark report by the Institute of Medicine, To Err Is Human: Building a Safer Health System, there has been no evidence-based study linking surgery resident duty hours with improved patient safety. Although the effects of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour restrictions are still being assessed, there have been no peer-reviewed publications demonstrating enhanced patient safety or improved outcomes in surgical patients as a result of these restrictions. Medicare and Veterans Administration studies have not demonstrated improved outcomes following the implementation of the 2003 ACGME resident duty hour limitations. Furthermore, it is well known that the origin of the work hour restrictions was New York state. The hospitals with surgery training programs in the state of New York, which were subject to more stringent work hour restrictions for a longer period of time, also failed to demonstrate improvement in any of the patient safety measures in surgical patients. This is important given the fact that 15 percent of all U.S. residents are in New York. As mentioned previously, the literature does currently highlight concerns regarding increased transfer of patient care responsibilities (“hand-offs”) and possible medical errors associated with diminished continuity of patient care. With no objective data analyses documenting an association between surgery resident work hours and serious threats to patient safety, it would serve no meaningful purpose to arbitrarily recommend a further reduction of resident duty hours without first conducting rigorous, large-scale studies on the entire spectrum of issues impacting the safe care of surgical patients.

The combination of quality medical care, excellence in training, and patient safety has been the cornerstone of this nation’s health care system at every level, from undergraduate and graduate medical education to continuing medical education. The current emphasis by the ACGME on the six core competencies and the establishment of Maintenance of Certification (MOC) by member boards of the American...
Board of Medical Specialties (ABMS) are a testament to the continuous improvement process undertaken to ensure sustained quality health care, which is the underpinning of any patient safety initiative.

Optimum training of surgery residents requires a longitudinal, comprehensive curriculum that focuses on the cognitive elements, technical skills, and judgment that are critical to providing safe patient care. The educational process involves progressive transfer of responsibility from faculty to residents over a period of time. Achievement of expertise requires sustained deliberate practice, and retention of skills requires periodic reinforcement. Structured experiences in simulated environments are key to achieving the requisite skills. The surgical boards, academies, and residency review committees have worked together to develop standards and state-of-the-art curricula that are especially designed to address the aforementioned elements and promote patient safety. The educational goals are difficult, if not impossible, to address during limited experiences that do not permit appropriate coverage of the content and adequate interaction between faculty and residents. In particular, the diagnosis and management of emergencies may be severely compromised with significant restrictions on duty hours. These critical elements need to be considered and addressed in order to provide optimum patient care and to offer residents the requisite experiences for them to function as safe and effective members of the future work force.

Most surgeons and educators agree that the base of knowledge and skills required to be proficient practitioners has expanded rather than contracted in recent years. Further reduction in the hours available for training would be expected to translate into patients being cared for by less qualified surgeons. Many residents concerned about their readiness to enter practice are selecting subspecialty fellowship training in order to feel more prepared. Alternatively, the length of training programs could be expanded; however, this would be an additional deterrent to medical students considering surgery as a career, many of whom are already daunted by the prospect of five to seven years of surgical training and the overwhelming educational debt burden this creates. As surgery becomes a less attractive career option and increased subspecialization continues, the patients of this country will encounter increasing difficulties finding a surgeon and accessing quality care at the local level. Thus, the impending surgeon workforce shortage most likely would be exacerbated.

Our position is not speculative commentary. The adverse effects of reduced work hours have been featured in the medical literature in the United Kingdom and throughout Europe. The European Working Time Directive (EWTD) was initiated for the “protection of the clinical personnel against overwork for the benefit of patients.” With over a decade of experience with the EWTD, it has been considered by the greater medical community as a failure that has resulted in inadequately trained residents. The Association of Surgeons in Training (ASIT) at the Royal College of Surgeons of England highlighted that

Table I

| Scenario 1: Replace lost resident hours/FTEs with incremental new residents |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Provider        | FTEs (current)  | FTEs (incremental) | Current cost (at 80 hours) | Projected total cost (at 56 hours) | Incremental cost (% change) (at 56 hours) |
| Residents       | 411             | 176              | $24,872,322          | $35,424,009          | $10,551,687 (42%)          |
| Fellows         | 142             | 61               | $10,824,354          | $15,463,298          | $4,638,943 (43%)          |
| Total           | 553             | 237              | $35,696,676          | $50,887,306          | $15,190,630 (43%)          |

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the EWTD has been “severely detrimental” to surgical training. Observed reductions in index operative cases performed in a large study of surgical trainee logbooks were cited. ASIT also reported that EWTD resulted in suboptimal patient care within the current National Health Service (NHS) through poorly structured work patterns leading to cumulative fatigue, increased incidence of medical errors, and decreased continuity of care.

A recent communication from William E. G. Thomas, MS, FRCS, Chairman of Education for the Royal of College of Surgeons of England, has highlighted concerns regarding limited experiences of surgical trainees and inadequate focus on the whole patient, resulting from the severe work hour restrictions in the United Kingdom. He has cited a recent inquest on a patient who died in left ventricular failure and the surgical trainee involved in this patient’s care admitted to the coroner that he did not know how to manage this condition. A major enquiry into medical training in the UK has been led by Sir John Tooke, an educationalist. Sir John has made several recommendations to the government, such as not including training time in the work hour restrictions in view of the special educational needs of a procedural specialty like surgery. These experiences underscore the need for a well-rounded educational program for surgical residents that addresses cognitive elements, technical skills, and judgment, and is offered over an adequate period of time.

A reduction in duty hours may well need to be offset by expanding the number of residents in the system, or by adding physician extenders to care for the patients. Either way, the financial impact of reducing duty hours would likely be substantial. In a personal communication, H. Hunt Batjer, chair, department of neurological surgery, Northwestern University Feinberg School of Medicine, conveyed results of a financial analysis of what the costs would be for one tertiary medical center to provide the current level of care when duty hours are limited to 56 hours (see Tables I and II, pages 13 and 14).

### Table II

<table>
<thead>
<tr>
<th>Approaches to providing current level of care to compensate for the impact of proposed work hour restriction</th>
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<tbody>
<tr>
<td><strong>Scenario 2: Replace lost resident hours/FTEs with other health care providers</strong></td>
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<tr>
<td><strong>Provider</strong></td>
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<tr>
<td>Certified midwives</td>
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<tr>
<td>Physician assistants</td>
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<td>Clinical nurse specialists</td>
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<td>Nurse practitioners</td>
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<td>Registered nurse first assists</td>
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<td>Certified registered nurse anesthetists</td>
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<td>Faculty</td>
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<td><strong>Total</strong></td>
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*Note: Midlevel FTEs have been adjusted. (Midlevel providers work a 40-hour week and cannot replace resident FTEs working 56 hours on a 1 for 1 basis.)

| | **Current costs:** | **Projected costs:** |
| | | |
| | | $35,696,676 |
| | | $59,884,431 |
II. Statement of purpose

The mission of the American College of Surgeons is improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment. The ACS supports all efforts to enhance patient safety that include thoughtful, evidence-based evaluation of all the important contributing factors and the potential outcomes of such efforts. Areas of concern should not be addressed in isolation and without appropriate evidence; rather, they must be considered in the broader context of systems of patient care and surgical education, including continuity of care (hand-offs), a comprehensive curriculum to produce qualified surgeons, team training to enhance safety, costs to the health care system, and implications for access to high quality care for patients.

III. Questions and recommendations

A. Questions that should be addressed by the Institute of Medicine during its deliberations are as follows:

1. What is the optimal balance between required resident duty hours and rest periods that will ensure continuity of care and patient safety?
2. If duty hours are further constrained, how will training programs be able to provide the necessary volume and mix of clinical/operative activity to ensure that well-qualified surgeons are available to care for patients in the future?
3. Restricted duty hours will necessitate an increased number of hand-offs with critically ill patients. Will any gains in patient safety from less fatigued residents be overshadowed by the consequences of increased errors generally associated with hand-offs?
4. What are the unintended consequences of duty hour limitations on undergraduate medical education?
5. If further reduction of resident duty hours results in a need to extend the duration of training, who will provide the necessary graduate medical education (GME) funding?

B. Recommendations

1. A fully funded, multi-institutional study should be recommended by the Institute of Medicine to evaluate not only the impact of further reductions in duty hours but myriad other issues, including optimal duty hours to achieve curriculum objectives, to maintain continuity of care, and to address team training efforts. Discipline-specific outcome measures are needed in the areas of surgical patient safety and surgery resident education.
2. Effective team training initiatives need to be established with an emphasis on patient safety (similar to the crew resource management training concept utilized in the aviation industry).
3. Advanced information technology and simulation must be integrated in all aspects of surgical residency training and health care delivery in order to enhance educational experiences and ensure patient safety.
4. The chief surgical resident should be exempt from the duty hour limitation to allow a more realistic transition to a postgraduate career, and to acquire the knowledge and skills for practice, including full and independent patient responsibility.
5. The restrictive “cap” on CMS funded GME positions should be removed. The inability to increase residency training position(s) would be counterproductive to the current efforts to expand the undergraduate medical student pool in order to meet the future workforce needs.

IV. Executive summary

Patient safety in an environment with escalating challenges (including new treatment paradigms and technologies, along with a growing and aging population) cannot be achieved by arbitrarily decreasing resident work hours without thoughtful consideration of all issues impacting the care of the surgical patient. Rather, efforts should be focused on optimal utilization of information technology, electronic health records, telemedicine, and simulation to better support the health care system and residency education in surgery. Such initiatives are needed to facilitate reliable and safe hand-
offs, to streamline work, and to make training more efficient. Development of strategies to improve the system would do more to address quality and patient safety concerns than merely assuming that a reduction of working hours will improve safety.

Any initiative that calls for less exposure to the course of a patient’s illness must be examined closely. In July 2003, the Accreditation Council for Graduate Medical Education implemented new requirements that limited hours in all specialties to 80 per week, with continuous duty being limited to 24 hours. No evidence-based consensus has emerged regarding the optimal paradigm for surgical residents to avoid medical errors and enhance patient safety; further reduction of the resident work hours without careful study could result in deteriorating quality and more severe health care disparities than presently exist. Moreover, further reductions could cause irrevocable damage to a surgical residency training system that is already severely stressed and has many programs struggling to meet educational goals and obtain the necessary clinical/operative experiences to produce well-qualified surgeons.

Similar to other professions, mastery in surgery requires extensive and immersive experiences that extend over a substantial period of time. Also, the hallmark of the surgical professional is commitment to and responsibility for the continuum of care for the surgical patient. This critical sense of responsibility is inculcated in residents only through appropriate experiences that require sufficient duty hours. Commitment and mastery are respected symbols of this profession that will always be associated with hard work and dedication, and the highest level of patient safety and quality care can only be achieved by providing an immersive experience in surgical training.

Multi-institutional studies should be undertaken to fully understand the impact of further duty hour limitations before any changes to the current requirements are considered. As mentioned, these studies must also include all the other elements that impact safe care. Anything less could negatively impact the quality of care being provided to current and future surgical patients.

V. References

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Royal College of Surgeons of England. Personal communication with Josef E. Fischer. (1/22/08).
17. H. Hunt Batjer, Chair, Department of Neurological Surgery, Northwestern University Feinberg School of Medicine. Personal communication. (2/19/08).

Additional references


VI. Acknowledgments

ACS Task Force on the Resident 80-Hour Work Week

The American College of Surgeons Task Force on the Resident 80-Hour Work Week is composed of leaders of the ACS and the broad house of surgery who serve in key roles relative to the education and certification of surgeons. Specialties represented include general surgery, neurological surgery, obstetrics and gynecology, thoracic surgery, otolaryngology, urology, and pediatric surgery. Virtually all of the members have served as chairs, members, or ex officio members of the Residency Review Committees of the Accreditation Council for Graduate Medical Education. Furthermore, the vast majority have served as chairs or directors on the certification boards for their respective specialties. Finally, additional input was sought beyond the membership of the Task Force to confirm currency and broad representation from the house of surgery, and staff support for the Task Force was provided by the ACS Division of Education.

Chair:
L. D. Britt, MD, MPH, FACS
Brickhouse Professor and Chairman, Department of Surgery, Eastern Virginia Medical School, Norfolk, VA
Past-Chair, RRC—Surgery
Director, American Board of Surgery
Vice-Chair, Board of Regents, American College of Surgeons

Members:
H. Hunt Batjer, MD, FACS
Professor and Chairman, Department of Neurological Surgery, Northwestern University Feinberg School of Medicine, Chicago, IL
Chairman, American Board of Neurological Surgery
Past-President, Congress of Neurological Surgeons
Past-President, Society of University Neurosurgeons
Past-Chair, AANS/CNS Section of Cerebrovascular Surgery

Kirby I. Bland, MD, FACS
Fay Fletcher Kerner Professor and Chairman, Department of Surgery, University of Alabama at Birmingham, Birmingham, AL
Past-Chair, RRC—Surgery
Past-Director, American Board of Surgery

Josef E. Fischer, MD, FACS
William V. McDermott Professor of Surgery, Harvard Medical School
Surgeon-in-Chief and Chair, Department of Surgery, Beth Israel Deaconess Medical Center, Boston, MA
Past-Member, RRC—Surgery
Past-Chairman, American Board of Surgery
Chair, Board of Regents, American College of Surgeons

Norman Gant, MD, FACOG
Executive Director
American Board of Obstetrics and Gynecology, Dallas, TX
Professor and Past-Chair, Department of Obstetrics/Gynecology
University of Texas Southwestern Medical School, Dallas, TX
Past-Vice-Chair, RRC—Obstetrics/Gynecology
Member, National Academy of Science, Institute of Medicine (IOM)
Fellow, Royal College of Obstetricians and Gynecologists
(ad eundem)

**William A. Gay Jr., MD, FACS**
Executive Director, American Board of Thoracic Surgery,
Saint Louis, MO
Ex officio Member, RRC—Thoracic Surgery
Past-Director and Chair, American, Board of Thoracic Surgery
Executive Director, American Board of Thoracic Surgery

**Gerald B. Healy, MD, FACS, FRCSI(Hon)**
Healy Chair in Otolaryngology
Otolaryngologist-in-Chief, Children’s Hospital Boston
Professor of Otology & Laryngology, Harvard Medical School, Boston, MA
Past-Member, RRC—Otolaryngology
Past-Executive Director, American Board of Otolaryngology
President, American College of Surgeons

**Stuart S. Howards, MD, FACS**
Professor of Urology and Molecular Physiology and Biological Physics, Department of Urology, University of Virginia Hospital, Charlottesville, VA
Ex officio Member, RRC—Urology
Past-Trustee and Chairman, Examining Committee, American Board of Urology
Executive Secretary, American Board of Urology

**Carlos A. Pellegrini, MD, FACS**
Henry N. Harkins Professor and Chairman, Department of Surgery, University of Washington, Seattle, WA
Past-Chair, RRC—Surgery
Member, Appeals Panel, Accreditation Council for Graduate Medical Education
Director, American Board of Surgery
Member, Board of Regents, American College of Surgeons

**J. David Richardson, MD, FACS**
Department of Surgery, University of Louisville, Louisville, KY
Past-Vice-Chair, RRC—Surgery
Past-Chairman, American Board of Surgery
Member, Board of Regents, American College of Surgeons

**Ajit K. Sachdeva, MD, FRCSC, FACS**
Director, Division of Education, American College of Surgeons, Chicago, IL
Adjunct Professor of Surgery, Department of Surgery Northwestern University Feinberg School of Medicine
Member, Board of Directors of the Accreditation Council for Graduate Medical Education
Past Ex officio Member, RRC—Surgery, RRC—Colon and Rectal Surgery, RRC—Neurological Surgery, and RRC—Otolaryngology

**Dennis D. Spencer, MD, FACS**
Professor and Chair, Department of Neurosurgery, Yale University School of Medicine, New Haven, CT
Vice-Chair, RRC—Neurological Surgery
Vice-Chair, American Board of Neurological Surgery

**Patricia L. Turner, MD, FACS**
Assistant Professor of Surgery, Division of General Surgery, University of Maryland Medical Center, Baltimore, MD
Past Member, RRC—Surgery

**Thomas V. Whalen, MD, MMM, FACS**
Chair, Department of Surgery, Lehigh Valley Hospital, Allentown, PA
Vice-Chair, RRC—Surgery
Member, Board of Regents, American College of Surgeons

**STAFF:**
Patrice Gabler Blair, MPH,
Associate Director, Division of Education, American College of Surgeons

**ADDITIONAL CONTRIBUTORS:**
John L. Tarpley, MD, FACS
President, Association for Program Directors in Surgery
R. James Valentine, MD, FACS
Immediate Past-President, Association for Program Directors in Surgery

**George M. Fuhrman, MD, FACS**
President-Elect, Association for Program Directors in Surgery

**Joseph B. Cofer, MD, FACS**
Past-President, Association for Program Directors in Surgery

**John R. Potts, MD, FACS**
Past-President, Association for Program Directors in Surgery

**Richard C. Thirlby, MD, FACS**
Issues Committee Chair, Association for Program Directors in Surgery
Resident and Associate Society of the American College of Surgeons:

Position statement on further work hour restrictions

by Jacob Moalem, MD; Luke Brewster, MD, PhD, MA; and Ted James, MD, FACS

The following statement was developed by the Resident and Associate Society of the American College of Surgeons (RAS-ACS) and approved by the Board of Regents at its October 2008 meeting.

While the adoption and implementation of the 80-hour workweek by the Accreditation Council for Graduate Medical Education (ACGME) and its Resident Review Committees have had disparate effects on the various specialties within medicine, these regulations have had their greatest impact on surgical training programs. The restrictions on resident work hours have sparked the widespread overhauling of rotation and call schedules; hiring of physician extenders; and proliferation of resident cross-coverage, particularly at night.
Two years before the enactment of the duty-hour regulations in 2003, resident attendees at the American College of Surgeons Clinical Congress were surveyed about their opinions on resident work hours. Though the majority of residents at that time believed that some regulation of work hours would be beneficial, most believed that more than 80 hours would be required to train competent surgeons.1

We recently surveyed the RAS membership again, to assess whether their opinions had changed after a five-year “adjustment period.” Although surgical residents’ opinions on the subject reflected their adaptation to the regulations four years after the implementation of the ACGME’s regulations, their feelings had not changed dramatically. Representing 15 surgical specialties, nearly 600 respondents to the survey were evenly split on this issue: half thought that residents should work no more than 80 hours per week (in line with current regulations), and half still believed that more than 80 hours per week were needed for optimal surgical education. Only 3 percent believed that fewer than 60 hours per week would suffice to adequately train surgeons. Compared with their more junior colleagues, senior residents (postgraduate year four and higher) were more likely to think that more than 80 hours per week are necessary to train surgical residents. Moreover, nearly half of senior residents believed that the 80-hour work hour restrictions were, in and of themselves, a moderate or severe barrier to resident education (unpublished data). Clearly, surgical trainees, particularly senior residents, do not uniformly agree that the 80-hour workweek has been beneficial.

We have recently celebrated the 80-hour workweek’s fifth anniversary. In the time that has elapsed, numerous studies have attempted to relate the reduced work hours to patient outcomes. Some studies have demonstrated a decrease in attention lapses or medication errors in association with reduced work hours.2 To date, however, no peer-reviewed study has demonstrated improved patient safety or improved outcomes in surgical patients as a result of the duty hour limitations.3 In addition, there are no reliable national data that demonstrate a positive effect of the 80-hour work week on resident education or patient care.4 Conversely, multiple recent studies have raised serious concerns regarding the increased need for transfer of care responsibilities and decreased continuity of care that is necessary to accommodate the new work hour regulations.5,13 Specifically, studies have demonstrated adverse effects of decreased continuity of care on medication errors,5,10 communication errors,6,8,10,12 resident–patient relationships,9,13 and resident attitudes and professionalism.9

Beyond the impact on individual surgeons and patients, more global implications must also be considered. As the requisite knowledge base required of surgeons continues to expand, fewer and fewer trainees progress directly to practice. Thus, in an era when surgery is a decreasingly popular career choice among medical students14,15 and the burden of educational loans is peaking,16-18 many residents are lengthening their training period and accumulating debt during this pursuit of additional training. Lack of preparedness for the realities of independent practice is thought to have been a major contributing factor to more than 75 percent of U.S. graduating general surgical chief residents’ choices to pursue fellowship training in 2007.19 Further shortening of work hours could only be anticipated to augment this alarming trend.

The mission statement of the American College of Surgeons is in line with the putative mission of every surgical training program in this country: It is “dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.” Quality surgical training and care is founded on a longitudinal, comprehensive curriculum, which applies the six core competencies outlined by the ACGME to the care of the preoperative, intraoperative, and postoperative surgical patient. We believe that the increasing trend of graduating chief residents to pursue additional training is consistent with our survey results. As residents mature and the reality of independent practice becomes increasingly daunting, trainees thirst for opportunities to enhance their knowledge, skills, and readiness. With profound differences in scope of practice among medical and surgical specialties, and even among the various surgical specialties, we believe that perhaps uniform regulations should not be applied across the board.

As a subsidiary organization of the ACS, the RAS
fully supports any initiative designed to improve the care of surgical patients in this country, so long as it is evidence based and founded on a comprehensive study of all major contributing factors and possible ramifications. Although we readily acknowledge the concerns about resident fatigue and inefficiencies in our training programs, these issues should not be considered in isolation. We implore any regulatory body that is considering further restrictions on resident experiences to also consider the impact and consequences of such restrictions on (1) continuity of care, (2) burden on this country’s health care system, and (3) the overall quality of surgical training—and thereby on surgical care.

Acknowledgment

The authors wish to thank L. D. Britt, MD, FACS, Chair of the Board of Regents; Barbara Bass, MD, FACS, Regent of the College; and Peg Haar, Administrator in the College’s Division of Member Services, for their help in developing this position statement.

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continued on page 62
Surgery in Rural Zambia:
The rewards and challenges of treating patients in a resource-poor setting

by Kathryn M. Chu, MD, MPH
The evening heat was stifling as I slept in my modest mud house enveloped in my mosquito net. I was awakened by the nightwatchman knocking at the door to summon me to the hospital. In rural Zambia, we did not have telephones; therefore, I did not know what type of surgical problem had arrived. As I followed the light of the nightwatchman’s flashlight, I scanned the tall grass along the dirt path on the walk to the hospital, anxiously looking for snakes. On my arrival, I discovered a young boy who had been gored by a cow and now had an obvious evisceration. His small intestines, which were covered in dirt and leaves, were wrapped in a towel.

In fall 2006, I volunteered as a general surgeon for three months at Macha Mission Hospital (MMH) in rural Zambia, a southern African country. Zambia has a population of 11 million and is landlocked, bordered by eight countries. It is one of the poorest nations in the world, with a per capita income of $360 a year. Like its neighbors, Zambia suffers from a human immunodeficiency virus epidemic, with an estimated 16.5 percent of the population infected. The average life expectancy is 33 years, the lowest of any country in the world. Infrastructure is poor in Zambia, and few paved roads exist. The trip to MMH is a bumpy, dusty, six-hour adventure on poorly maintained dirt roads from the capital, Lusaka.

**Macha Mission Hospital**

MMH was founded in 1906 by two American female missionaries. Faith-based institutions support 50 percent of rural health care and 30 percent of health care overall. MMH serves a rural population of 140,000 and has more than 200 beds (see photo, this page). The hospital is divided into four wards: male, female, obstetrics, and pediatrics. Each ward holds approximately 75 patients in one large room (see photo, page 24). Overflow patients sleep on mattresses on the floor or the veranda. There are no dividers or curtains between beds, but if a patient is dying, a moveable screen is set up around him or her to allow for some privacy.

**Operating room conditions**

The surgical burden of disease was highly varied and included trauma, urologic, abdominal, and obstetric/gynecology cases. There are three operating rooms, although only one is equipped to perform major surgery. Each morning, patients sit outside the theater on wooden benches and wait their turn. I never heard a complaint, though some patients had to return several days in a row until they received treatment. Rubber sheets were placed on the operating table to protect it from bodily fluids.

For most procedures, I administered the an-
esthesia and performed the operation. Ketamine and spinal anesthesia were most commonly used. Pulse oximetry and an automatic blood pressure cuff were available. Supplemental oxygen was used only if absolutely necessary. Normal saline intravenous fluid was prepared by our laboratory and sterilized in reusable bottles. Abdominal surgery was ideally performed under spinal anesthetic, which gave moderately good relaxation (see photo, this page). This limited the amount of time for the procedure to approximately 90 minutes.

Gowns were made from heavy cloth and not waterproof, and a heavy rubber apron was worn underneath. In the midday heat, this became quite unbearable and I learned to operate quickly in order to keep from fainting. Sterile gloves were always in short supply and often only one size was available. Instruments were sterilized in an autoclave machine. Gauze was cut from large rolls and then sterilized. Hundreds of pieces were prepared daily for dressing changes on the wards. Sutures were donated from overseas and the supply was variable and limited. No surgical staplers were available. A few pieces of polypropylene mesh had been donated just before I arrived, and they were useful for inguinal herniorrhaphies.

While these donations were appreciated, much of what was sent was not useful. Cardiac pacing wires and an argon beam coagulator were among donations that could not be used. Many kindhearted indi-
individuals from resource-rich countries had sent costly equipment such as a laparoscopy tower and a video monitor. This type of equipment could not be properly maintained and once a single part was broken, the equipment as a whole was rendered useless. Disposable equipment was helpful but limited in supply. Monetary donations were the most practical because funds could be spent on medications and supplies manufactured locally, which were cheaper and supported the local economy.

Surgical burden of disease

Falls and injuries were common. During mango season, I cared for many young boys who had fallen out of trees while picking the ripe fruit and sustained ulnar or radial fractures. Patients paid 10,000 kwacha ($3) to be admitted to the hospital. In addition, they paid for supplies such as plaster and surgical procedures. Many waited days before undergoing closed reduction because their families could not find the money to pay. Femur fractures from motor vehicle accidents were also common. In developed countries, these fractures would be treated with intramedullary rods; however, in most of Africa, the definitive treatment is traction and bed rest. After 10 weeks, if the fracture site is not tender and a palpable callus confirms bony union, the traction is removed and weight bearing slowly initiated. Neither pneumatic compression boots nor subcutaneous heparin were available for deep vein thrombosis prophylaxis.

I diagnosed a 12-year-old boy, small for his age, with Hirschprung’s disease after he was brought in for intermittent abdominal distention and obstipation since birth. On abdominal X ray, his colon was dilated with paucity of air in the rectum. Like most rural African hospitals, MMH only had a radiology technician. Together, we performed the first (and probably the last) barium enema at MMH and confirmed a short segment of narrowed distal rectum and a dilated proximal colon (see photo, this page). A full thickness rectal biopsy demonstrated aganglionosis. In the U.S., this boy would have had a pull-through procedure. In rural Zambia, however, the options were limited. We were not equipped to perform a definitive operation at MMH. A diverting colostomy was impractical to care for in his village, nearly a day’s walk from any clinic. In my last few weeks, I learned that a pediatric surgeon was visiting from China and paid for the boy and his father to fly on a missionary plane to the University Teaching Hospital in Lusaka to receive care.

Burns were a common surgical problem. For several weeks I cared for an 18-year-old woman who had sustained burns over greater than 50 percent body surface area after being set afire by the first wife of her husband. (Polygamy, as well as extramarital relations, especially by men, are common in this part of Zambia.) Her infant daughter was also burned to death. We debrided and dressed the woman’s wounds in the operating room daily. I found a central line kit in the donation bin and placed a subclavian line for intravenous access and fluid resuscitation. In the U.S., this patient would have been intubated and placed on a narcotic drip for pain relief. We could do neither, however, and her constant crying in the ward was difficult for all. The patient succumbed to bacterial superinfection and dehydration within a few weeks.

Another complication arising in previously burned skin is the Marjolin’s ulcer, a type of squamous cell carcinoma. Women kneel over open fires to cook and suffer chronic burns in the pretibial area, which can develop into
One patient developed a Marjolin’s ulcer on a previous forearm burn. She underwent an arm amputation but was readmitted a few months later with recurrent tumor fungating from the amputation stump. Another woman developed a chest wall squamous cell carcinoma that was widely excised but then metastasized to her axillary lymph nodes. The nodes had grown so large she was unable to lower her arm beyond 90° (see photo, this page). I performed a metastasectomy but her tumor grew back within months. In the end, we were unable to provide any more treatment for either of these women except to palliate their pain. Chemotherapy was available at one hospital in the entire country and these women could not afford the journey, let alone the treatment.

I also cared for a young woman with a rectovaginal fistula. One year earlier, after a prolonged labor, her infant died during delivery. Shortly afterward, the woman began to pass stool through her vagina. This condition was socially devastating, as she could not keep herself clean. Her husband left her; her family forced her to stay in a separate room because of the smell. Obstetric fistulas are almost exclusively a problem of the developing world. They can develop from the bladder or rectum to the vagina. Obstetric fistulas are a result of inadequate obstetrical care and tend to occur in poor, rural women who are young primigravidas. After her repair, she returned to her village; however, I do not know if she was able to return to her husband or family. The success of social reintegration of former fistula patients is essentially unknown.

Endemic thyroid goiters were common (see photo, page 27). Many of these goiters were very large and cosmetically disfiguring. Given the lack of airway control in the operating room, I was reluctant to perform a lobectomy unless the goiter was causing airway symptoms. Also, if both lobes were enlarged, I did not perform a total thyroidectomy. Because thyroid function tests could not be performed at MMH and thyroid hormone replacement was not readily available, I did not
want to leave patients profoundly hypothyroid.

Zambia has been identified by the World Health Organization as having a critical shortage of health care professionals.③④ Volunteers fulfill a valuable purpose by giving temporary relief to those who serve long term. However, we volunteers are not a good solution for the long term. Recruiting more physicians who are Zambian nationals to the rural areas is a challenge. Many emigrate to Europe and North America for further training, improved salaries, and a better standard of living. A rural retention scheme—which offers increased salary, improved housing, and a car—has been implemented to encourage new medical graduates to practice for at least three years in rural Zambia.③

**Challenges in resource-limited settings**

MMH is staffed by only three physicians: two young Zambian doctors and a U.S. missionary physician. Each of these doctors tends to medical, pediatric, obstetric, and surgical patients in the clinics and on the wards. They perform all emergency surgery as needed; and before and after my stay, complicated elective surgical problems were referred to another district hospital that was difficult to access because of poor roads and infrequent transport. The nursing staff is extremely skilled and many have excellent clinical judgment. However, the patient-to-nurse ratio, especially at night, could be 50 to one. Family members often sleep underneath patients’ beds in order to care for them. They assist with feeding, bathing, and dressing changes. They also are essential in alerting the nursing staff to any acute change in status of their family member or any of the patients near them.

Infrastructure is poor and medications frequently out of stock. For example, one morning, two babies had been born prematurely. One was cyanotic and gasping; the other was very cold and lethargic. The ward had an oxygen tank and an incubator. Unfortunately, both babies required electricity, which had been cut that day for power line repairs. MMH had a generator, but it was broken. When I returned for evening rounds, both babies were dead. One mother sobbed silently as she rocked the dead infant. Although death is more common in this part of the world, the event reminded me that all people suffer from the loss of a loved one, regardless of how common its occurrence.

Health care in Zambia is directly limited by the patient’s ability to pay. There is no national health care system and private insurance is essentially nonexistent. Patients are not turned away for emergencies; however, they do not receive other services if they do not have money to pay. Many are also limited by lack of transport to a health care facility. Many people do not even have access to a hospital such as MMH and have to rely on a local clinic staffed only by a clinical officer with one to two years of training beyond secondary school or be treated by a local medicine man. MMH is one of the larger well-equipped hospitals; however, it still only provided basic surgical and medical services.
Dr. Chu is a part-time assistant professor in the department of surgery at The Johns Hopkins University, Baltimore, MD, and a surgeon for Médecins Sans Frontières/Doctors Without Borders.

Mothers waiting with their children outside a local clinic.

Specialty surgical care, pathology, and diagnostic radiology beyond X-ray and ultrasound are only available in Lusaka and therefore not accessible to most of the population.

Working at MMH as a general surgeon was a humbling experience. My skills as a surgeon were limited by available resources. In the U.S., I might be able to perform complex abdominal surgery, but only with a qualified anesthesiologist; excellent nursing staff; and the latest assortment of sutures, staplers, and bipolar and monopolar devices. I am also accustomed to calling on the expertise of surgical subspecialists, such as plastic surgeons, orthopaedic surgeons, gynecologists, and urologists. In Zambia, I had to rely on my own training and knowledge.

Like so many other countries in sub-Saharan Africa, access to health care in Zambia is limited by a lack of human resources, infrastructure, and finances. The training of more health care professionals is imperative. Currently, a cadre of Zambian clinical officers is participating in a three-year surgical residency training program to learn to perform basic surgical procedures. Long-term investments are likely to be most beneficial. Missionary doctors from resource-rich countries provide an invaluable service and give up lucrative lives in their home countries. However, most volunteers are not able to give such a lengthy commitment. Short-term volunteers should work through international or academic institutions to provide training and teaching, which will have a more sustainable impact on the health care system of resource-poor countries.

References


by Albert Bothe, Jr., MD, FACS; Linda M. Barney, MD, FACS; and Debra Mariani, CPC, Practice Affairs Associate, Division of Advocacy and Health Policy

This article summarizes changes in the 2009 Current Procedural Terminology (CPT)* that are relevant to general surgery and other surgical specialties. Be sure to read the guidelines of each section of the CPT book for any changes. It is also a good practice to update your charge sheet each year to ensure that you are using the most up-to-date codes for your practice. This information should be useful not only to surgeons but also to the office staff that performs coding functions. Be aware of the deleted codes, revised codes, new codes, and parentheticals that are included below a code or section of codes.

Hemorrhoidectomy

CPT has deleted three codes and created a new code so that the destruction of internal and/or external hemorrhoids can more accurately be reported. The three deleted CPT codes are 46934, Destruction of hemorrhoids, any method; internal; 46935, Destruction of hemorrhoids, any method; external; and 46936, Destruction of hemorrhoids, any method; internal and external. Replacing these three CPT codes is CPT code 46930, Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency). Deletion of the three codes referenced specifically, incision and excision codes, for the creation of the new code allows more precise coding for nonexcisional procedures. Code 46930 has a 90-day global period and is followed by a new parenthetical as follows: (Codes 46934–46936 have been deleted. For incision of external thrombosed hemorrhoid(s), use 46083; for destruction of internal hemorrhoid(s) by thermal energy, use 46930; for destruction of hemorrhoid(s) by cryosurgery, use 46999; for excision of hemorrhoid(s), see 46250–46262, 46320; for injections, use 46500; for ligation, see 46221, 46945, 46946; for hemorrhoidopexy, use 46947).
Laparoscopic heller myotomy

Surgical treatment via esophageal myotomy has been performed for correction of achalasia. Current CPT codes do not precisely describe the laparoscopic approach for an esophageal myotomy. CPT has created a new CPT code, 43279, Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed. Parentheticals were added to this code as follows: (For open approach, use 43330, 43331) and (Do not report 43279 in conjunction with 43280). Code 43279 has a 90-day global period.

Laparoscopic abdominal wall hernia repair

The CPT editorial panel accepted six new CPT codes to describe the levels of work associated with abdominal hernia repairs performed by laparoscopic techniques. The new codes all have a 90-day global period except for the new add-on code.

There is one revised add-on code, 49568, Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair). This code is not for use with the new laparoscopic codes.

New codes are as follows:

• 49652, Laparoscopy, surgical repair ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
  —49655, Incarcerated or strangulated
• 49656, Laparoscopy, surgical repair recurrent incisional hernia (includes mesh insertion, when performed); reducible
  —49657, Incarcerated or strangulated
  (Do not report 49652–49657 in conjunction with 44180, 49568.)

Integumentary system

Look for revisions to codes 11001, 11201, 11922, 15003, 15005, 15201, 15221, 15241, 15261, and 15341. These add-on codes have been revised to include the wording “or part thereof.” Under the Repair (Closure) section, all the Repair–Intermediate section (12031 to 12057) codes have been revised for consistency in terminology. The reference to “layer closure” has been revised to say Repair, intermediate. The last change in the integumentary system includes minor wording revisions to two codes in the Breast section (19296–19267) for brachytherapy.

Cardiovascular system

Two new codes, 35535 and 35570, have been established in the vein bypass subsection to report creation of bypass grafts for revascularization. Three new codes—35632, 35633, and 35634—have been established in the prosthetic bypass graft subsection to report creation of bypass grafts for revascularization of the celiac, the renal, and mesenteric arteries and treatment of chronic arterial occlusive disease.

Digestive system

A new code, 41512, has been established to report tongue base suspension, which utilized a permanent suture technique for treatment of snoring and obstructive sleep apnea. New code 41530 was established to report submucosal radiofrequency tissue volume reduction of the tongue base. Concurrently, Category III code 0088T, which previously described this procedure, has been deleted. There is a new add-on code in the Esophagus section under Endoscopy: 43273, Endoscopic cannulation of papilla with direct visualization of common bile duct(s) and/or pancreatic duct(s) (List separately in addition to code(s) for primary procedure).

Dr. Barney is associate professor and associate program director for general surgery, department of surgery, Wright State University Boonshoft School of Medicine, and member, Wright State Surgeons, Miami Valley Hospital, Dayton, OH.
**Male genital system**

New code 55706, Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance, has been established. This service was previously reported with code 0137T, which has been deleted.

**Nervous system**

There is revised text to each Stereotactic Radiosurgery Surgery (SRS) section in the Nervous System portion of the CPT book. There are five new codes in the Cranial section and code 61793 has been deleted. The five new codes are as follows: code 61796, Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion; add-on code 61797, each additional cranial lesion, simple (List separately in addition to code for primary procedure); code 61798, Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion; add-on code 61799, each additional cranial lesion, complex (List separately in addition to code for primary procedure); and add-on code 61800, Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure). There are two new codes in the Spinal section of SRS: Code 63620 describes SRS performed on one spinal lesion, and add-on code 63621 describes SRS performed on each additional spinal lesion and is reported in addition to code 63620.

**Evaluation and management codes**

See the revised coding guidelines for Critical Care Services for changes to evaluation and management codes. These changes are the result of further clarifications of the Neonatal and Pediatric Critical Care code revisions. Revisions were made to the Prolonged Services guidelines and codes 99354–99357 have been revised to indicate that these are intended to be reported with evaluation and management services in addition to any other physician services reported at the same session. Anticoagulant Management guidelines have been revised in tandem with the extensive editorial revisions in the Neonatal and Pediatric Critical Care section.

The guidelines in the Preventive Medicine Services section and codes 99381–99397 have been revised. Codes 99381 and 99391 were revised to exclude reference to immunization services. These services are separately reportable, as indicated in the introductory language that directs the use of codes 90465–90474 for immunization administration and vaccine risk/benefit counseling and 90476–90749 for reporting vaccine/toxoid products.
HIGHLIGHTS
of the
94th annual
CLINICAL
CONGRESS
At the 2008 Clinical Congress in San Francisco, CA, a wide selection of presentations covering subjects from education to practice to clinical considerations—in addition to poster presentations, papers sessions, and special-interest meetings—were offered. The meeting was attended by 14,397 participants, including 8,916 physicians; the remaining attendees included exhibitors, spouses, guests, and convention personnel.

Convocation

John L. Cameron, MD, FACS—a general and thoracic surgeon who specializes in the treatment of the alimentary tract and the Alfred Blalock Distinguished Service Professor of Surgery at The Johns Hopkins University School of Medicine in Baltimore, MD—was installed as the 89th President of the American College of Surgeons at the Convocation ceremonies that denoted the official opening of the Clinical Congress. (See sidebar on page 34 for a summary of his Presidential Address.)

Other officers installed during the Convocation were Jack W. McAninch, MD, FACS, as First Vice-President and Richard B. Reiling, MD, FACS, as Second Vice-President. Dr. McAninch is a professor of urology at the University of California–San Francisco and chief of urology at San Francisco General Hospital. Dr. Reiling is medical director of the Presbyterian Cancer Center in Charlotte, NC, and a past recipient of the College’s Distinguished Service Award.

Honorary Fellowship was conferred on the following five prominent surgeons: Jacques Brotchi, MD, PhD; Joaquim Gama-Rodrigues, MD, FACS; Gerald C. O’Sullivan, MB, BCh, FACS, FRCSGlas, FRCISI; Bernard Francisco Ribeiro, CBE, FRCSEng; and Russell Walker Strong, MB, BCh, FACS, FRCSEdin(Hon), FRACS, FRCSEng, FRACDS.

Named Lectures

This year for the first time, the Martin Memorial Lecture was combined with the American Urological Association Lecture; Peter Neupert, MBA, delivered his lecture—Translating the Power of Software for Optimal Patient Care—immediately following the Opening Ceremony on Monday morning (see photo, page 35). Also on Monday, The Phenotype of the Cardiothoracic Surgeon was presented as the John H. Gibbon, Jr., Lecture by Alden H. Harken, MD, FACS, and Alan R. Cohen, MD, FACS, presented The Origin and Evolution of Minimally Invasive Neurosurgery as the Charles G. Drake History

Dr. Cameron (left) conveys the Distinguished Service Award to Dr. Collicott.
During the Convocation ceremony on Sunday, 1,189 Initiates became Fellows, and Dr. Cameron delivered his Presidential Address about being a role model. Dr. Cameron asserted that surgeons will be role models—regardless of whether or not they want to be—because, he stated, “In the hospital, in the community, surgeons are looked upon as leaders. Their behavior is followed with special interest, almost scrutiny.” Because, he noted, good behavior among individual surgeons will be emulated and bad behavior criticized, he issued a charge to all attendees at the Convocation to be good role models.

Dr. Cameron remarked on what he perceives as one potential cause for the decline in surgical residency positions filled by U.S. medical graduates: the vocal, public complaining among surgeons regarding “decreased compensation, increased paperwork, and a perceived increase in obstacles they had to face to care for their patients.” He used this potential correlation to urge attendees “to behave in a fashion, as good role models, to portray to others the fact that [surgeons] are in the most desirable, most rewarding profession there is.”

To illustrate his point, Dr. Cameron provided examples of surgeons who, when the College was organized in 1913, could have been the ideal role model—that is, the first President of the College. He listed several possibilities, including William S. Halsted, W. W. Keene, John B. Murphy, and John C. Warren. Instead, Dr. Cameron noted, J. M. T. Finney was selected President, “not because he was a famous surgeon but because he represented what the organizers of the ACS felt was best of American surgery.” In other words, he was the perfect role model, with unyielding ethics and high moral standards and principles.

After providing a biographical sketch of Dr. Finney that demonstrated how he had become an ideal physician (as noted in his obituary upon his death in 1942), Dr. Cameron noted that Dr. Finney knew how important it was to be a role model, even before it was a coined term, as underscored by a passage from his autobiography: “How often do we see reflected, unconsciously perhaps, in students certain idiosyncrasies of their teachers…. We should conduct ourselves in such ways of thought and action as to make our influence count in the right direction.”

Note: Dr. Cameron’s speech will be published in its entirety in the March 2009 issue of the Journal of the American College of Surgeons.

2008 Clinical Congress:

Presidential Address focuses on being a role model
Awards, honors, celebrations

The 2008 ACS/Pfizer Inc. Surgical Volunteerism and Surgical Humanitarian Award winners were honored at a general session sponsored by the College’s Operation Giving Back program. Joseph A. Gurri, MD, FACS, and Bradley D. Wong, MD, FACS, received the volunteerism awards, and Guy D. Theodore, MD, FACS, was presented with the humanitarianism award (see photo, page 36).

Also Monday, Paul F. Nora, MD, FACS, was presented with the Fellows Leadership Society’s Distinguished Philanthropist Award in recognition of his extraordinary contributions in establishing the Nora Institute for Surgical Patient Safety at College headquarters in Chicago, IL (see photo, page 36).

James A. Anderson, MD, FACS, was presented with the 2008 Meritorious Achievement Award from the Committee on Trauma (COT) for his work as the Wyoming COT’s State Chair, Chief of Region 8, and Chair of the COT Rural Trauma Committee (see photo, page 36).

Christopher K. Breuer, MD, FACS, a surgeon-scientist focused on application of tissue-engineering techniques in pediatric surgery, was presented with the Joan L. and Julius H. Jacobson II Promising Investigator Award. His immediate objective is to perform the first phase I clinical trial approved by the U.S. Food and Drug Administration for evaluating the use of tissue-engineered vascular grafts.

Two National Safety Council Surgeons Awards for Service to Safety were conferred at the meeting (see photo, page 37). F. Carter Nance, MD, FACS, who had been unable to accept his award in person in 2007, was presented with his plaque, and C. William Schwab, MD, FACS, received the 2008 award for his “visionary leadership and steadfast commitment to firearm injury prevention and a distinguished surgical career marked by excellence in clinical care, prodigious research, and inspirational mentorship and training of young surgeons.”

The 2008 Owen H. Wangensteen Surgical Forum was dedicated to Patricia K. Donahoe, MD, FACS, a pediatric surgeon from Boston,
Edward M. Copeland III, MD, FACS, Chair, Board of Governors’ Committee on Socioeconomic Issues; Dr. Wong; Valerie W. Rusch, MD, FACS, Chair of the ACS Board of Governors; Dr. Gurri; Kathleen M. Casey, MD, FACS, Director of Operation Giving Back; Cathryn M. Clary, MD, vice-president of U.S. external medical affairs for Pfizer Inc.; and Dr. Theodore.

Edward M. Copeland III, MD, FACS (right), Chair of the Fellows Leadership Society, offers words of praise while presenting Dr. Nora with the Distinguished Philanthropist Award.

Dr. Anderson (left) receives the 2008 COT Meritorious Achievement Award. He is pictured with M. Margaret Knudson, MD, FACS, Vice-Chair of the COT.
MA, and the first woman to receive this honor (see photo, page 38). Residents honored with the Surgical Forum Excellence in Research Awards included Nasim Ahmadiyeh, MD, Brigham and Women’s Hospital, Harvard Medical School, MIT/Sloan School of Management, Boston, MA; Dieter Cadosch, MD, University of Western Australia, Perth; Aaron P. Garrison, MD, University of North Carolina, Chapel Hill; Deepak M. Gupta, MD, Stanford (CA) University; Matthew D. Katz, MD, Washington University School of Medicine, St. Louis, MO; Shahrooz Sean Kelishadi, MD, PhD, University of Maryland School of Medicine and Baltimore VAMC; Matthew D. Kwan, MD, Stanford (CA) University School of Medicine; Ugwuji N. Maduekwe, MD, Massachusetts General Hospital, Boston, MA; Ward M. Richardson, MD, University of Pittsburgh, Pittsburgh, PA; Susanna H. Shin, MD, M. D. Anderson Cancer Center, Houston, TX; and Vikram Sood, University of Michigan, Ann Arbor, MI (see photo, this page).

The 2008 Distinguished Service Award, the College’s highest honor, was presented to Paul E. Collicott, MD, FACS, Director of the College’s Division of Member Services (see photo, page 33). This award was given in recognition of his devoted service to the organization—including his role in developing the Advanced Trauma Life Support® (ATLS®) course and serving as ATLS course director, serving as a member of the COT and the General Surgery and Coding Reimbursement Committee, and as a member of the Board of Regents—and his 30 years of clinical activity as a peripheral vascular and trauma surgeon in Lincoln, NE, and as trauma director and chief of surgery at Lincoln General Hospital.

The International ATLS Meritorious Service Award was presented to Claus Falck Larsen, MD, MPA, FACS.

The Committee on Cancer Liaison recognized three Commission on Cancer State Chairs for outstanding performance and significant contribu-
Surgical Forum volume dedication: Dr. Donahoe (center) with Dr. Ashley (left), and Marshall Z. Schwartz, MD, FACS, surgeon-in-chief, department of surgery, St. Christopher’s Hospital for Children, Philadelphia, PA.

2008 COC State Chair Outstanding Performance Award winners, left to right: Dr. Dreyer, Dr. Kenady, and Dr. Recabaren.

Oweida Scholarship award: Dr. Breon (left) with Stephen E. Olson, MD, FACS, Chair of the Rural Surgery Subcommittee of the Advisory Council for General Surgery.

Dr. Singh, recipient of the Resident Award for Exemplary Teaching (center), pictured with (left to right): Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education; Dr. Cameron; Myriam J. Curet, MD, FACS, Chair, Committee on Resident Education; and Dr. Britt, Chair, Board of Regents.
Presentation of Best Scientific Exhibit. Dr. Spira (second from left) and Dr. Einav (second from right), co-authors of the winning exhibit, with (left to right) Regent Robin S. McLeod, MD, FACS; Regent Barbara L. Bass, MD, FACS, Chair of the Program Committee; and Dr. Bailey.

International Guest Scholars (IGS), and luncheon guests. Front row, left to right: Dr. Agarwal, Dr. Keck, Dr. Sauvat, Dr. Ademola, and Dr. Wong. Back row: Dr. Hotz, Dr. Barberousse, Dr. Singh, Dr. Sho, Dr. Yoshizumi, Dr. Fondevila, and Dr. Barrera.

Right: The IGS program birthday cake. (Photo by 1993 IGS Scholar Nobuyaso Kano, MD, PhD, FACS.)

Honored were James Recabaren, MD, FACS, California State Chair; Stephen Dreyer, MD, FACS, Nebraska State Chair; and Daniel Kenady, MD, FACS, Kentucky State Chair.

Timothy A. Breon, MD, FACS, a surgeon from Oskaloosa, IA, received the 2008 Nizar N. Oweida, MD, FACS, Scholarship at the Rural Surgeons meeting (see photo, page 38).

The sixth annual ACS Resident Award for Exemplary Teaching, which is sponsored by the Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives, was presented to R. Ramesh Singh, MBBCh (see photo, page 38). Dr. Singh completed his general surgery residency at the University of Virginia in Charlottesville, VA, and is currently a fellow in cardiothoracic surgery at the University of Colorado, Denver.

Case Managers in Multiple Casualty Incidents, co-authored by Ram M. Spira, MD, and Sharon Einav, MD, was named...
Members of the ATLS international community met to discuss pertinent issues related to the program. The ATLS program is in more than 40 countries worldwide.

Members of the Board of Regents (B/R) and ACS Officers met for their annual luncheon. Pictured (with their titles prior to the Congress) front row, left to right (all MD, FACS): Andrew L. Warshaw, Treasurer; Paul Friedmann, Second Vice-President; Gerald B. Healy, President; L. D. Britt, B/R Chair; John L. Cameron, President-Elect; Mary H. McGrath, First Vice-President; and Thomas R. Russell, Executive Director.

Middle row: Karen E. Deveney, Board of Governors (B/G) Secretary; Carlos A. Pellegrini; Charles D. Mabry; Richard J. Finley; Julie A. Freischlag; Robin S. McLeod; Barbara L. Bass; Howard M. Snyder III; Alden H. Harken; Raymond F. Morgan; and Valerie W. Rusch, B/G Chair.

Back row: H. Randolph Bailey; Michael J. Zinner, B/G Vice-Chair; Thomas V. Whalen; Bruce D. Browner; Karl C. Podratz; John T. Preskitt; Martin B. Camins; Mark C. Weissler; A. Brent Eastman; J. David Richardson; and Barrett G. Haik. Not pictured: Courtney M. Townsend, Jr., Secretary.
The Best Scientific Exhibit (see photo, page 39).

The International Guest Scholar program celebrated its 40th anniversary with a cake and welcomed its 2008 guest scholars, including the following: **Samuel A. Ademola, MSc, MB, ChB, FWACS, Ibadan, Nigeria; Amit Agarwal, MBBS, MS, Lucknow, India; Carlos M. Barberousse, MD, Montevideo, Uruguay; Juan G. Barrera, MD, Bucaramanga, Santander, Colombia; Constantino Fondevila, MD, PhD, Barcelona, Spain; Hubert G. Hotz, MD, Berlin, Germany; Germany Traveling Fellow Tobias Keck, MD, PhD, Freiburg, Germany; Frederique Sauvat, MD, PhD, Paris, France; Masayuki Sho, MD, PhD, Nara, Japan; Baljit Singh, MB, BCh, DPhil, FRCSEng, FRCSI, Oxford, U.K.; Kenneth Wong, MB, ChB, FRCSEd, Hong Kong, China; and Japan Traveling Fellow Tomoharu Yoshizumi, MD, PhD, Fukuoka, Japan (see photos, page 39).

**New this year**

A new system for arranging courses according to discipline- and theme-based tracks was introduced beginning with this year's Clinical Congress to focus specifically on the needs of various surgical specialties and learner groups. The tracks were as follows: Cardiopulmonary Surgery, Colon and Rectal Surgery, Ethics/Volunteerism, General Surgery, Geriatric/Palliative Care, Health Policy: Practice Management/Reimbursement/Liability Issues, Informatics, International, Neurosurgery, Obstetrics and Gynecology, Orthopaedic, Otolaryngology–Head & Neck Surgery, Pediatric Surgery, Plastic and Maxillofacial Surgery, Research/Biostatistics, Residents/Medical Students, Surgical Education/Core Competencies/Outcomes & Safety, Surgical Oncology, Trauma/Critical Care, Urology, and Vascular Surgery. The 2009 Clinical Congress will follow a similar format with the track system; however, note that each year the tracks will continue to be more defined and developed.

This year, Surgical Jeopardy, formerly held during the College’s annual Spring Meeting, convened during this year’s Clinical Congress as a standing-room-only event. Residents from various medical schools made up 24 teams of two each in this competition to test general and specialty surgical knowledge. The winning team, Lokesh Battha, MD, and Konstantinos Makris, MD, of Creighton University in Omaha, NE, were presented a plaque to commemorate their achievement.

Five new Town Hall Meetings, during which issues and news relevant to specific interest and practice areas were discussed, were held on Tuesday and Wednesday mornings and were hosted by the College’s Operation Giving Back program; the International Relations Committee; and the General Surgery, Vascular, and Cardiothoracic Surgery Advisory Councils. Meet the Professor Luncheons, informal gatherings where attendees had the opportunity to discuss a topic with experts in that given field, were also offered for the first time this year at the Clinical Congress. These 25 luncheons were very popular, with the hourlong afternoon sessions nearly sold out.

The papers sessions were reformatted this year to offer topic-specific sessions that incorporated the tracks system. Whereas the papers sessions in previous years were composed of approximately 20 papers presented in two sessions, the 2008 Clinical Congress hosted 13 papers sessions with approximately 100 papers presented.

Surgeons attending this year’s meeting were...
invited to participate in on-camera interviews for a multimedia presentation, “Why Surgery?”, meant to attract students to a career in surgery. This promotional piece—a joint project by the College, the Association for Academic Surgery, the Society of University Surgeons, and the Association of Program Directors in Surgery—will be available on DVD, as a video podcast, and via the College’s members-only Web portal, e-facs.org.

**College governance**

At the Annual Business Meeting of Members on Wednesday, where Dr. Cameron presided, Dr. Britt presented the Report of the Chair of the Board of Regents; Valerie W. Rusch, MD, FACS, presented the Report of the Chair of the Board of Governors; and Thomas R. Russell, MD, FACS, presented the Report of the Executive Director of the College; Sara L. Hartsaw, MD, FACS, presented the Report of the Chair of the Nominating Committee of the Board of Governors, during which the elected Regents and Board of Governors Officers were announced; and Mark A. Malangoni, MD, FACS, presented the Report of the Chair of the Nominating Committee of the Fellows and announced the nomination and election of Governors and Officers. It was also at this meeting that Dr. Collicott received his Distinguished Service Award, Dr. Breuer was presented with the Promising Investigator Award, and Dr. Singh was given the Resident Award for Exemplary Teaching.

The Past-Presidents of the College met for their annual luncheon. Pictured left to right, front row (all MD, FACS): M. J. Jurkiewicz; C. Rollins Hanlon; Gerald B. Healy; and Frank C. Spencer. Back row: R. Scott Jones; Edward R. Laws; Edward M. Copeland III; and LaSalle D. Leffall, Jr.

**Recipients of the College’s highest honor, the Distinguished Service Award, met for their annual luncheon. Pictured left to right, front row (all MD, FACS): Robert E. Hermann, Murray F. Brennan, and LaMar S. McGinnis, Jr. Back row: C. Thomas Thompson, Richard B. Reiling, Frank Padberg, and Josef E. Fischer.**
In addition to the Statement on Health Care Reform (see Board of Regents/Board of Governors section), three statements were approved by the Board of Governors during their Wednesday meeting, and were subsequently approved on Thursday by the Board of Regents: Statement on the Rationale for Emergency Surgical Call Support, Statement on Surgical Patient Safety, and Statement on the Uniform Emergency Volunteer Health Practitioners Act. (All three statements are published in this issue of the Bulletin; see pages 45, 47, and 49.)

New Officers-Elect
At the Annual Business Meeting of Members, new Officers-Elect were named. LaMar S. McGinnis Jr., MD, FACS, was named President-Elect and will begin his tenure as the 90th ACS President at the 2009 Clinical Congress in Chicago, IL. Dr. McGinnis is a general and oncologic surgeon and a clinical professor of surgery at Emory University in Atlanta, GA.

Kirby I. Bland, MD, FACS—chair of the department of surgery at University of Alabama–Birmingham—was named First Vice-President-Elect. Named as Second Vice-President-Elect was Karen E. Deveney, MD, FACS, Secretary of the Board of Governors.

Board of Regents/Board of Governors
At an unprecedented joint session led by Dr. Britt, Chair of the Board of Regents, and Dr. Rusch, then-Chair of the Board of Governors, Regents and Governors considered and debated a draft proposal of a formal ACS Statement on Health Care Reform. The meeting provided for a lively exchange of ideas, and the proposal was accepted after the Clinical Congress adjourned.

Newly elected to the Board of Regents were Dr. Malangoni—a general surgeon and chair and surgeon-in-chief of the department of surgery at MetroHealth Medical Center and professor of surgery at Case Western Reserve University in Cleveland, OH—and Dr. Rusch, who is chief of the thoracic service at Memorial Sloan-Kettering Cancer Center and professor of surgery at Cornell University Medical College, New York, NY. Elected to additional three-year terms on the Board of Regents were Charles D. Mabry, MD, FACS; Robin S. McLeod, MD, FACS; and Carlos A. Pellegrini, MD, FACS. The following Fellows were elected to the Board of Governors: Michael J. Zinner, MD, FACS, as Chair; Lenworth M. Jacobs, Jr., MD, FACS, as Vice-Chair; and James K. Elsey, MD, FACS, as Secretary. In addition, individuals voted onto Board of Governors Executive Committee included Timothy C. Flynn, MD, FACS; John M. Livingston, MD, FACS; Beth H. Sutton, MD, FACS; and Mitchell L. Willens, MD, FACS.
Statement on the rationale for emergency surgical call support

This statement was developed by the Board of Governors’ Committee on Socioeconomic Issues in collaboration with the Board of Governors’ Committee on Surgical Practice in Hospitals and Ambulatory Settings. It was approved by the Board of Governors and the Board of Regents in October 2008.

Issue
Compassion and our professional ethics mandate that all patients faced with a surgical emergency are provided care. The American College of Surgeons fully supports access for all Americans to emergency care, but major issues of surgical manpower and resource utilization represent a threat to continued access. The American College of Surgeons presents the following analyses and recommendations.

Historical perspective
Emergency surgical call serves to meet patient needs. The Emergency Medical Treatment and Active Labor Act regulations support this patient care by Medicare-participating hospitals and provide a funding stream to the hospitals by means of the Medicare system. By means of cost shifting and sharing the burden with other surgeons, surgical practices generally have been able to provide such service.

Current environment
Our population has aged steadily. The more elderly the population, the more health care required, both emergent and nonemergent. In addition, an ever-increasing population of indigent patients uses the emergency room as the sole avenue to medical care. At the same time, the number of surgeons produced by our graduate medical education programs has remained stable for nearly 30 years.* In general surgery, the ratio of surgeon to population has been steadily declining since 1985. Other specialties with even fewer providers feel they can no longer meet the community demands for their services.* As a result, there exists an increasing chasm between expectations for access to emergency surgical care and the surgeon workforce available to provide such care.

The College recognizes the need for emergency surgical care.† The hospital, mandated by the government, has entered into a contract with the community to provide care without

involving the actual care provider in the negotiations. The surgeon feels deeply obligated to care for all individuals who require care. However, the surgeon attempting to provide this care is forced to be practical in the face of increasing demands.

To provide this care, the surgical practice must remain fiscally viable, professionally attractive, and competitive in retaining and hiring colleague surgeons for the community. The challenges to this effort are many and varied. Emergency surgical care detracts from this ability to recruit in many communities because emergency call involves greater risks than care provided during elective, scheduled operations. Operations often must be accomplished under conditions that do not allow for standard preoperative preparations. These patients often have the highest risk for complications due to advanced disease states and associated risk factors. Patient expectations frequently reflect what can be expected with proper preoperative preparation and planning even when this is not the case. Such unrealistic expectations can lead to an increased malpractice risk. Being available for emergency call may appear innocuous, yet excessively frequent on-call duty has a negative impact on the surgeon’s time with family and the ability to provide community service outside of the profession.

Unfortunately, this surgical service is increasingly mandated without appropriate compensation. The obligation to provide care must be balanced by the means to do so; cost shifting to the surgeon is an unacceptable option.

**Recommendations**

The College recommends that health care payors and institutions commit necessary and appropriate support to surgeons for emergency coverage of surgical care.† Whatever the model chosen to provide this patient service, it must account for the disruption involved with being on call when actual service may or may not be required. Compensation for the service provided must be based on fair value for the risks involved and time allocated.
Statement on surgical patient safety

The American College of Surgeons regards patient safety as a top priority and strongly urges individual hospitals and health care organizations to develop guidelines to ensure optimal patient safety in the operating room. The use of a “team approach” has been shown to be highly effective.* However, this approach requires the engagement of all parties involved in the surgical process. Since lack of communication and failure to coordinate care are the most common causes of medical errors, the incorporation of team-based practice through institutional team training is desirable.

Each institution is encouraged to develop its own method of preoperative and postoperative briefing and debriefing (for example, http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf). Proper identification of the patient and procedure and confirmation of the consent form and the surgical site should be mandatory. If multiple separate procedures are scheduled, the checklist must be verified prior to each planned procedure. All relevant records and imaging procedures should be present. If any verification process fails to identify the correct site, patient, or critical items needed, the operating room activity should be halted at an appropriate time until verification and procurement are complete.

The American College of Surgeons recognizes that the use of computerized medical records and bar-coding of drugs and blood products are highly desirable throughout all perioperative areas. Computerized preference cards are encouraged to avoid multiple trips of support staff from the operating room during the procedure. It also is important that during each individual procedure there be a team-designated “no handoff time” when certain members of the team will not be changed. This process can be determined separately in each institution and by each

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surgical service involved. Safety mechanisms, as recommended by the American College of Surgeons and The Joint Commission—including, but not limited to, double-gloving, blunt-tip suture needles, neutral zones, and protective sharps devices—should be encouraged.† The American College of Surgeons condemns disruptive behavior from any member of the operating room team, as such behavior jeopardizes patient safety.

To enhance patient safety, it is the responsibility of the surgeon to oversee proper preoperative preparation of the patient; obtain informed consent; confirm with the team the diagnosis and agreed-upon operation; perform the operation safely and competently, including planning with the anesthesia professional the optimal anesthesia method for the patient; provide postoperative care of the patient, including personal participation in the direction of this care and management of postoperative complications should they occur; and disclose information to the patient or patient’s representative relative to the conduct of the operation, operative and pathological findings, procedure forms, and the expected outcome.

Statement on the Uniform Emergency Volunteer Health Practitioners Act

Background
In 2006, the National Conference of Commissioners on Uniform State Laws adopted a model bill to address the issue of health practitioners providing care during a declared emergency in states where they may not be licensed to practice. The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) was developed in response to the significant legal and licensing barriers to volunteer physicians and health care practitioners traveling to New Orleans, LA, and the Gulf Coast in response to the devastation of Hurricane Katrina.

In 2007, the American College of Surgeons’ Board of Governors’ Committee on Socioeconomic Issues and the Executive Committee of the Board of Governors discussed and endorsed the UEVHPA at its annual meeting and expressed that the Act should be aggressively and vocally supported by the College.

The purpose of UEVHPA
The UEVHPA establishes legal guidelines for recognizing other states’ licenses for physicians and health care practitioners who volunteer to provide assistance during the time of a declared emergency. Since federal provisions for interstate cooperation do not extend to most private practitioners, UEVHPA calls for the creation of a registration system that out-of-state practitioners may use either before or during a disaster. Upon successful registration, practitioners are expressly permitted to contribute their professional skills to existing organized disaster efforts. In addition, it addresses issues of workers’ compensation coverage and civil liability protections for physicians and other licensed health practitioners.

Why UEVHPA is important to surgery
Physicians are uniquely qualified to assist during disasters. In particular, surgeons, with their training in trauma and critical care, play a major role in our health care community’s response to most disaster situations.

This statement was developed by the Board of Governors’ Committee on Socioeconomic Issues in collaboration with Operation Giving Back. It was approved by the Board of Governors and by the Board of Regents in October 2008.
Properly trained volunteers are critical in such circumstances. By enacting the UEVHPA, state legislatures can have a positive impact on disaster-response effectiveness. Removing barriers that prohibit licensed surgeons and other qualified responders from traveling across state lines to voluntarily administer medically necessary care during disasters will ensure the citizens of their state access to high-quality surgical services in the event of a crisis. The American College of Surgeons’ Board of Regents supports enactment of the UEVHPA in the 50 states and the District of Columbia.
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Richard B. Reiling
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L. D. Britt
Chair
General surgery
Brickhouse Professor and chair, department of surgery,
Eastern Virginia Medical School
Norfolk, VA

H. Randolph Bailey
Colon and rectal surgery
Clinical professor and chief, division of colon and rectal surgery,
University of Texas Health Science Center
Houston, TX

Barbara L. Bass
General surgery
Chair, department of surgery,
Methodist Hospital
Houston, TX

Bruce D. Browner
Orthopaedic surgery
Gray-Gossling Professor and chairman, department of orthopaedic surgery,
University of Connecticut Health Center,
Farmington, CT, and director of orthopaedics,
Hartford Hospital
Hartford, CT

Martin B. Camins
Neurological surgery
Clinical professor of neurological surgery,
Mount Sinai Hospital and Medical School
New York, NY

A. Brent Eastman
General surgery
Chief medical officer, Scripps Health, and N. Paul Whittier Chair of Trauma,
Scripps Memorial Hospital, La Jolla, CA, and clinical professor of surgery,
University of California, San Diego
San Diego, CA

Richard J. Finley
General surgery
Professor and head, division of thoracic surgery,
University of British Columbia Faculty of Medicine
Vancouver, BC

Julie A. Freischlag
Vascular surgery
William Stewart Halsted Professor and surgeon-in-chief,
The Johns Hopkins Hospital
Baltimore, MD
Board of Regents

Barrett G. Haik  
Ophthalmic surgery  
Chair, department of ophthalmology,  
University of Tennessee Health Science Center,  
College of Medicine  
Memphis, TN

Charles D. Mabry  
General surgery  
Private practice  
Pine Bluff, AR,  
and assistant professor of surgery, practice management advisor to the chairman,  
department of surgery,  
University of Arkansas for Medical Sciences  
Little Rock, AR

Mark A. Malangoni  
Chair and surgeon-in-chief, department of surgery,  
MetroHealth Medical Center,  
and professor of surgery,  
Case Western Reserve University School of Medicine  
Cleveland, OH

Robin S. McLeod  
Colon and rectal surgery  
Professor of surgery and health policy, management, and evaluation,  
University of Toronto,  
and head, division of general surgery,  
Mt. Sinai Hospital  
Toronto, ON

Raymond F. Morgan  
Plastic surgery  
Milton T. Edgerton Professor and chair, department of plastic surgery,  
University of Virginia Health Sciences Center  
Charlottesville, VA

Carlos A. Pellegrini  
General surgery  
Henry N. Harkins Professor and chairman,  
department of surgery,  
University of Washington  
Seattle, WA

Karl C. Podratz  
Gynecology (oncology)  
Joseph I. and Barbara Ashkins Professor of Surgery,  
and professor of obstetrics and gynecology,  
Mayo Clinic  
Rochester, MN

John T. Preskitt  
General surgery  
Attending surgeon,  
Baylor University Medical Center  
Dallas, TX
Board of Regents

**J. David Richardson**
Vascular surgery
Professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine
*Louisville, KY*

**Valerie W. Rusch**
Chief, thoracic service, Memorial Sloan-Kettering Cancer Center, and professor of surgery, Cornell University Medical College
*New York, NY*

**Howard M. Snyder III**
Urology
Associate director of pediatric urology, The Children’s Hospital of Philadelphia, and professor of urology, University of Pennsylvania School of Medicine
*Philadelphia, PA*

**Mark C. Weissler**
Otolaryngology
Joseph P. Riddle Distinguished Professor of Otolaryngology, professor of otolaryngology–head and neck surgery, professor and chief of head and neck oncology, University of North Carolina Neurosciences Hospital
*Chapel Hill, NC*

**Thomas V. Whalen**
Pediatric surgery
Chair, department of surgery, Lehigh Valley Hospital
*Allentown, PA*
Can new patients find you? The ACS Surgeon-Finder can help

by Kathleen Heneghan, RN, MSN, Assistant Director, Patient Education Program; and Tanisha Woodson-Shelby, Patient Education Administrative Assistant, Division of Education

How do members of the public find a qualified surgeon? There are a number of ways, but the College offers a patient tool that makes the process easy. If they’re using the Google search engine, they can simply type “Find a Surgeon” into the search box and the first link that will come up is the American College of Surgeons. Potential surgical patients and the public can also access the “Find A Surgeon” search engine via the College’s “Patients as Partners” Web site at http://www.facs.org/patientseducation/ and via the “Patients” link on the homepage of the College’s public Web site at http://www.facs.org.

The ACS Find A Surgeon site has seen a 300 percent growth in usage since the Patient Education Committee initiated the Patient Education Web site in June 2006. The Find A Surgeon site has been receiving a range of 4,000 to 8000 visits per month by both the public and Fellows who have updated their online profiles. In addition to being accessible via Google, the College’s Web site, and the Patients As Partners Surgical Education Web site, patients are also referred to the Find A Surgeon Web site by the American Cancer Society and the National Cancer Institute’s “Live Help” site, as well as by several insurance companies.

The Find A Surgeon site has also been referenced in several lay magazines such as Vitality and Health Smart and the well-received book I Need an Operation...Now What? by Thomas R. Russell, MD, FACS, the College’s Executive Director. Dr. Russell’s many interviews about the content of his book for patients has resulted in references to the site being mentioned in major national daily newspapers like the New York Times, the Wall Street Journal, and USA Today.

The updated search engine allows the public to search for...
an ACS member by name, city, state, zip code, specialty, subspecialty, and areas of special interest (disease/procedure). The ability to search by area of special interest is the number one request of the public. When patients call the College for help in finding a surgeon, the request is very specific to the procedure that they need—for example, laparoscopic inguinal hernia repair or a thyroid operation. The ACS Find A Surgeon site now supports the public in finding ACS members in their geographic area who self-identify that specific procedure as a subspecialty. With more than 73 million Americans using the Internet as a source for health care information and the emphasis on patient empowerment, the College supports the public with an easily accessed, free, comprehensive resource to find a qualified surgeon.

Members of the College are encouraged to update their profile and take advantage of this member benefit. Members can update their profile by going to the College’s members-only Web portal at http://e-facs.org. If you have not accessed the portal before, your member ID is your membership number, and your last name is your password. Once logged in to e-FACS.org, click “My Profile” on the left-hand side of the homepage under “Quick Links.”

Members can include information about their practice site, medical school, residency, and fellowships and click through a list of subspecialties and areas of special interest. For example, a general surgeon can now identify if he or she focuses on breast disease/cancer, hernia procedures, bariatric procedures, and/or hand and wrist procedures. Other features on the “Edit Profile” section enable a detailed practice description including a means for linking to the surgeon’s practice Web site. The special interest and subspecialty lists are specific to each surgical specialty and were developed with guidance from the members of the College’s various Advisory Councils and members of the Patient Education Committee.

How will you know if this member benefit is helping you? Each time your page in the “Find a Surgeon” search engine is accessed, you will receive an automated e-mail with the subject line “Hard at Work for our Members—A Referral from the ACS.” If you do not wish to receive these e-mails, however, the response can be turned off by clicking the box on the automated e-mail.

If you would like to provide feedback regarding this site, contact Tanisha Woodson-Shelby at twoodson-shelby@facs.org or 312/202-5263.
The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at

* the 95th annual Clinical Congress, October 11–15, 2009, Chicago, IL

**Oral presentations**

- **Surgical Forum**
  Program Coordinator: Kathryn L. Matousek, 312/202-5336, kmatousek@facs.org
  (11 $1,000 Excellence in Research Awards were given in 2008)
  Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)

- **Papers Session**
  Program Coordinator: Beth Brown, 312/202-5325, ebrown@facs.org

**Poster presentation**

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

**Video presentation**

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

**Submission information**

- Abstracts are to be submitted online only
- Submission period begins November 3, 2008
- Deadline: 5:00 pm (CST), March 1, 2009
- Late submissions are not permitted
- Abstract specifications and requirements for each individual program will be posted on the ACS Web site at www.facs.org/education/. Review the information carefully prior to submission.
- Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.*
ACS Archives launches digital collections

The American College of Surgeons Archives announced the launch of its first samples of digital collections at last year’s Clinical Congress in San Francisco, CA. The link to the collections is now available on the Archives section of the ACS Web site at www.facs.org/archives, as well as on the History and Philosophy community page of the Web portal at http://efacs.org/history.

Fellows frequently come to the ACS Archives section of the Member Services booth at Clinical Congress, asking if ACS archival material is available online. As of the 2008 Clinical Congress, the Archives staff can say that, indeed, some of these materials are available online—however, the materials selected for online availability are just a small sampling of the wealth of materials found in the archives.

The College will celebrate its 100th anniversary in 2013. A committee of surgeon historians has been working on the centennial history for more than a year. The upcoming centennial has been the impetus behind getting some of the ACS collections digitized and made available online.

Olive Software arranged for the scanning, digitizing, and “segmentation” of the scanned materials, making them text-searchable. Fellows and associates should find much of interest on the site, and will get a feeling for the diverse types of materials that have been preserved and cataloged and made accessible in the ACS Archives.

Four categories of records from the ACS Archives appear in the digital collections, including one volume out of the 48 of the memoirs of Franklin H. Martin, MD, FACS, and one volume of the 26 ACS History Notebooks, along with its index, compiled by Eleanor K. Grimm, Dr. Martin’s secretary. Besides samples from these two collections, which serve both as artifacts and original source documents recording the history, two other categories of records are found in the digital collections: photos of all the ACS Boards of Regents, from the earliest extant until 2006, and all issues of the Clinical Congress Daily News (now the Clinical Congress News) that have been located from 1911 to 1979. On the Digital Collections link on the Archives site, researchers can perform an online search of names of Fellows who have been represented on the Board. With the
full-text issues of the Clinical Congress Daily News, users can search names, surgical techniques, diseases, issues affecting surgeons, international guest surgeons, examples of postgraduate courses in surgery throughout the years, and much more.

It’s also possible to browse through all these materials page by page. The plan is to gradually add more resources each year to the Digital Collections. Feedback about use of the site is appreciated, and recommendations of items to add in the future can be submitted by filling out the brief survey form provided on the site just below the link for the Digital Collections.

Free access to the archives and its collections remains primarily a member benefit. Because of the Archives’ small staff and limited resources, nonmembers must pay a small service fee for reference assistance. Nevertheless, researchers are welcome to visit and use the collections in person at ACS Headquarters in Chicago, IL.

For more information about the Archives, contact ACS Archivist Susan Rishworth at 312/202-270 or srishworth@facs.org.
Call for nominations for the ACS Board of Regents

The 2009 Nominating Committee of the Board of Governors has the task of selecting three nominees for pending vacancies on the Board of Regents to be filled during the 2009 Clinical Congress in Chicago, IL. One of these pending vacancies is a Canadian seat, which, in accordance with ACS Bylaws, must be filled by a Canadian surgeon. The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents:

• Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
• Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
• Recognition of the importance of their representing all who practice surgery

Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice. The College encourages consideration of women and other underrepresented minorities. Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents. Priority consideration should be given to representatives of general surgery. Note: Consideration of the surgical specialty does not apply to the Canadian seat.

Nominations should include one or two paragraphs on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 27, 2009.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Board of Governors, at psprecksel@facs.org.

Call for nominations for ACS Officers-Elect

The 2009 Nominating Committee of the Fellows has the task of selecting three nominees for the three Officer-Elect positions of the American College of Surgeons: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College.

• Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
• Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
• Recognition of the importance of their representing all who practice surgery

The College encourages consideration of women and other underrepresented minorities.

Nominations should include one or two paragraphs on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 27.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Fellows, at psprecksel@facs.org.
College seeks nominations for Jacobson Promising Investigator Award

The American College of Surgeons is accepting nominations for the fifth Joan L. and Julius H. Jacobson II Promising Investigator Award to be conferred in 2009. This award has been established to recognize outstanding surgeons engaged in research advancing the art and science of surgery and who have shown through their research early promise of significant contribution to the practice of surgery and the safety of surgical patients. The award is in the amount of $30,000, to be given at least once every two years. The College’s Surgical Research Committee administers the award.

Award criteria:
• Candidate must be Board-certified in a surgical specialty and must have completed surgical training within the past three to six years.
• Candidate must be a Fellow or an Associate Fellow of the American College of Surgeons.
• Candidate must hold a faculty appointment at a research-based academic medical center (military service appointments included).
• Candidate must have received peer-reviewed funding—such as a K-series award from the National Institutes of Health (NIH), Veterans Affairs, or National Science Foundation, or U.S. Department of Defense merit review—to support his or her research effort.
• Nomination documentation must include a letter of recommendation from the nominee’s department chair. Up to three additional letters of recommendation will be accepted.
• Only one application per surgical department will be accepted.
• Nomination documentation must include a NIH-formatted biosketch and copies of the candidate’s three most significant publications.
• Nominee must submit a one-page essay to the committee explaining why he or she should be considered for the award and discussing the importance of the research he or she has conducted/is conducting.

Special consideration will be given to surgeons who are at the “tipping point” of their research careers with a track record indicative of early promise and potential (such as degree program in research or K-award). Surgeon-scientists who are well established (for example, funded by NIH RO-1 grants) are not eligible for this award.

The recipient may be required to prepare and deliver a presentation on his or her research at the American College of Surgeons’ annual Clinical Congress following receipt of the award.

Nomination procedures
Nominations are accepted at any time, but to be considered for the award at this time, submissions must be e-mailed or postmarked no later than March 13, 2009. After compiling the necessary award criteria documentation in an electronic format, you may submit it via e-mail to Mary T. Fitzgerald at mfitzgerald@facs.org. Nomination materials can also be submitted on a CD-ROM and mailed to Ms. Fitzgerald at the following address: American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Applicants are encouraged to verify that all necessary documentation has been received before the March 13 deadline. For additional information, contact Ms. Fitzgerald by e-mail or call 312/202-5319.
Nominations sought for 2009 ACS volunteerism and humanitarian awards

The American College of Surgeons, in association with Pfizer Inc., is accepting nominations for the 2009 Surgical Volunteerism Awards and Surgical Humanitarian Award, as well as the newly created Surgical Resident Volunteerism Award.

The ACS/Pfizer Inc. Surgical Volunteerism Award is given in recognition of those surgeons committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities. This award is intended either for ACS Fellows in active surgical practice, whose volunteerism activities go above and beyond the usual professional commitments, or retired Fellows who have been involved in volunteerism during their active practice and into retirement. For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism in this case does not refer to pro bono or uncompensated care provided as a matter of necessity in most practices. Instead, volunteerism should be characterized by the prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gains.

The ACS/Pfizer Inc. Surgical Humanitarian Award is given in recognition of those surgeons who have dedicated a substantial portion of their career to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for a surgeon who has dedicated a significant portion of his or her surgical career to full-time or near-full-time humanitarian efforts rather than routine surgical practice. This effort may reflect a career dedicated to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received a compensation for this work does not preclude a nominee from consideration and, in fact, may be expected based on the extent of the professional obligation.

These volunteerism awards honor ACS Fellows who have made significant contributions to surgical care for the underserved through clinical care, education, implementation of training programs, research, advocacy, or other meaningful undertakings. Candidates for the volunteerism awards may have made these contributions in a domestic, international, or military setting. All surgical subspecialties are eligible for consideration.

Newly created for 2009 is the Surgical Resident Volunteerism Award. This award is intended for Resident Members of the College who have demonstrated an extraordinary commitment to addressing the unmet needs of surgical patients at home or abroad. Nominees for this award may have had extensive experience during their education in volunteer efforts, such as with international surgical missions or by working with free clinics in underserved areas or may have made substantive contributions to the burgeoning fields of surgical global health research and advocacy.

Nominations will be evaluated by the Socioeconomic Issues Committee of the Board of Governors, with final approval of award winners by the Executive Committee. Evaluation of nominees will take into consideration factors such as the sustainability of the volunteer’s work, the volunteer’s collaboration with health care teams in areas where he or she serves, and any demonstrated impact of the contributions made. Potential nominees should make note of the following:

- Supplemental materials should be kept to a minimum and will not be returned
- Self-nominations are permissible but require an outside letter of support
- Previous nominees may resubmit an updated application

The deadline for nominations is February 27, 2009.

The nomination forms are available in the “Announcements” section of the Operation Giving
American College of Surgeons Professional Association (ACSPA)

As of September 15, 2008, the ACSPA-SurgeonsPAC (http://www.facs.org/acspa/index.html) had raised $523,889—more than $200,000 above the total for the same period last year. In turn, political disbursements totaling $430,000 had been made to 110 candidates, leadership PACs, and party committees.

Among the College’s U.S. Governors, 42 percent contributed to the PAC, whereas 82 percent of the U.S. Officers and Regents contributed. The Treasurer stated that a very small percentage of the Fellows contribute to the PAC and stressed the importance of Fellows’ support of the PAC.

The fundraising potential within the membership remains largely untapped and there is still a great deal of work ahead. By membership numbers alone, there is no reason the ACSPA-SurgeonsPAC could not be in the top five among physician PACs.

American College of Surgeons

Board of Governors

The October 12, 2008, meeting of the Board of Governors (http://www.facs.org/about/governors/boardgv.html) included a two and one-half-hour joint session with the Board of Regents (http://www.facs.org/about/regents/regents.html) that was devoted to a detailed discussion of the draft ACS Statement on Health Care Reform. The statement will form the basis of the College’s interactions with Congress on health care policy during the next couple of years when major changes to the health care system will be under consideration. Comments from this meeting were used to modify the draft document, which was then finalized and distributed to key members of the College (http://www.facs.org/ahp/hcreform08.pdf).

The format of this meeting between the Governors and the Regents was considered very successful. In a vote taken at the October
15 meeting of the Board of Governors, there was unanimous support for continuing such a joint meeting in the future.

ACS Statements
The Board of Governors approved three statements generated by its liaison committees. The statements were subsequently approved by the Board of Regents and are published in this issue of the ACS Bulletin and posted on the ACS Web site.

- A statement supporting the passage in all 50 states of the Uniform Emergency Volunteer Health Practitioners Act, which would allow physicians to provide care in times of national disaster without the need for additional state licensure or liability coverage (see page 48)
- A statement on the rationale for emergency surgical call support that addresses the need for fair compensation for surgeons providing emergency care (see page 44)
- A statement on surgical patient safety that addresses issues of quality and safety in the care of the surgical patient in the operating room (see page 46)

The Board of Regents approved a Statement on All-Terrain Vehicle (ATV) Injuries. The statement was developed by the Committee on Trauma (COT) Subcommittee on Injury Prevention and Control to educate surgeons and others about ATV injuries and to encourage them to support ATV legislation in their respective states. Because of the increasing number of injuries and deaths related to ATV use, the ACS COT supports legislative and manufacturing efforts to improve safety and prevent injury. The statement will be published in a future edition of the Bulletin and subsequently posted on the College’s Web site.

Young Surgeons
The Committee on Young Surgeons (CYS) Membership Work Group has been developing proposals to create a national group of young surgeons with an organizational structure somewhat similar to the organizational structure employed by RAS. This group has been necessitated by the large number of young surgeons who want to be involved with CYS activities and programs. CYS membership is capped, and a structure that will accommodate a much greater number of potential volunteers needs to be developed. The CYS Membership Work Group hopes to finalize a proposal for presentation in February to the Board of Regents.

During the Clinical Congress in October 2008, CYS presented the Initiates Program. In addition, CYS co-hosted a program with RAS.

The next Joint Surgical Advocacy Conference will convene March 22–24 in Washington, DC. Sessions of interest to young surgeons will be presented.

Operation Giving Back (OGB)
Plans are under way to co-convene a forum on the potential role of the trauma community in national disaster response paradigms. The meeting, tentatively planned for November in Washington, DC, will be cosponsored by the ACS and the U.S. Department of Homeland Security (DHS).
A Disaster Responder Registry prototype, which will be considered as one element of a proposed national role of the ACS in collaborating with federal and state governments in times of disaster, is in development. The registry will be a topic for discussion at the planned ACS/DHS meeting.

In conjunction with the recent formal discussion on international surgical experience for residents, at the annual Association of Program Directors in Surgery meeting, a survey of program directors in general surgery has been developed and distributed. In addition, an expanded study of the interest of surgery residents in international experience has been submitted for publication.

As of September 15, 2008, there had been more than 1.5 million hits to the OGB Web site, with an average of 1,000 page views each day. The number of surgeons enrolled who have completed volunteer profiles continues to increase as well. The volume of information provided to surgical volunteers via the OGB Web site has necessitated the reorganization of the Resource Centers, including expanded information for all members of the surgical team.

HealthCareers (aka Job Bank)

As of September 15, 2008, there were 1,115 active jobs listed on the site with 307 posted resumes. The Job Bank is a valuable service for all of our members who are looking for an associate or a job. This service is free for our resident members.

Fellows of the College

The College leadership received and reviewed the analysis of the 2008 survey of the Board of Governors. The top five issues of concern to the Fellows of the College, as reported by the Governors, are listed below.

2. Professional liability/malpractice—for more information, visit http://www.facs.org/ahp/proliability.html
3. Health care reform—for more information, visit http://www.facs.org/ahp/index.html
4. Workforce issues—for more information, visit http://www.facs.org/ahp/views/workforce.html
5. Graduate medical education—for more information, visit http://www.facs.org/ahp/views/gme.html

Visit the College’s Web site at http://www.facs.org/ for details on other activities and initiatives of the American College of Surgeons.

Dr. Zinner is Moseley Professor of Surgery, Harvard Medical School; clinical director, Dana-Farber/BWH Cancer Center; and surgeon-in-chief, Brigham and Women’s Hospital, Boston, MA.
Surgeons Diversified Investment Fund—Market commentary 3Q2008

Published with this article, for your information, is the Surgeons Diversified Investment Fund (SDIF) third quarter 2008 performance report for the period ending September 30, 2008 (see pages 37-38).

Severe market turmoil this past quarter reflected loss of confidence in global capital markets, deleveraging, and panic selling. Notwithstanding this scenario, SDIF continues to believe in its asset allocation as the driver of success for a long-term investment portfolio. SDIF believes that upon the conclusion of the present consumer-led global recession, the potential exists for higher real returns in particular from emerging markets, commodities, and energy asset classes. The discussion of sector allocations is designed to help investors better understand SDIF’s investment objective. Fund holdings and sector allocations are subject to risk and may change at any time.

For the three-month period ending September 30, 2008, U.S. markets fell less than international and emerging markets contributing in large part to SDIF’s underperformance relative to its U.S.-based benchmark (the hypothetical, unmanaged, blended benchmark composed of 70 percent S&P 500 Index and 30 percent Lehman Brothers U.S. Aggregate Bond Index). During the third quarter period, SDIF had approximately 27 percent exposure to international and emerging equity markets versus the S&P 500 Index that contains no direct exposure to these markets. Thus, underperformance was driven by SDIF’s exposure to non-U.S. equities. In addition, energy and commodities exposure affected SDIF negatively as a result of expectations for a global recession. SDIF’s fixed income and real estate investment trust sectors were positive for the quarter, helping reduce its total quarterly decline of –10.11 percent versus the benchmark decline of –6.01 percent. Since inception, performance was –2.04 percent for SDIF and –1.29 percent for the benchmark.

Financial markets are always unpredictable, but investing for the long term and investing regularly (that is, dollar cost averaging*) can even out the ups and downs of the market while keeping one fully invested. Furthermore, studies indicate that diversification and asset allocation are the most important determinants of a portfolio’s long-term success. SDIF provides investors with a strong tool for such success.

If you have any questions, contact Savi Pai, SDIF President, at 312/202-5056 or spa@facs.org; Tom Kiley, SDIF Vice-President, at 312/202-5019 or tkiley@facs.org; or Dave Kelly, Business Development Associate, at 312/202-5485 or dkelly@facs.org. You may also visit www.surgeonsfund.com or contact SDIF directly at 800/208-6070 for more information.

* A plan of regular investing does not ensure a profit or protect against depreciation in a declining market. Since a dollar cost averaging plan involves continuous investment in securities regardless of fluctuating prices, you should consider your financial ability to continue purchases through periods of low price levels.

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:

- Trauma, Critical Care, & Acute Care Surgery—2009, April 6–8, 2009, Las Vegas, NV.
- Trauma, Critical Care, & Acute Care Surgery 2009—Point/Counterpoint XXVIII, June 8–10, 2009, Atlantic City, NJ.

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.
Surgeons Diversified Investment Fund’s third quarter 2008 performance report
If you have any questions, contact Savi Pai at 312/202-5056 or spai@facs.org; Tom Kiley at 312/202-5019 or tkiley@facs.org; or Dave Kelly at 312/202-5485 or dkelly@facs.org. These individuals are registered representatives available to discuss specific details regarding SDIF. You may also visit www.surgeonsfund.com or contact SDIF directly at 800/208-6070 for more information.
2009 Coding Workshop Series
for Surgeons and Their Staff

FT. LAUDERDALE, FL
FEBRUARY 26
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

FEBRUARY 27
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

ST. LOUIS, MO
MAY 14
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

MAY 15
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

CHICAGO, IL
JULY 9
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

JULY 10
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

LOS ANGELES, CA
AUGUST 27
2009 Introduction to CPT, ICD-9-CM, and Evaluation and Management Coding

AUGUST 28
2009 Surgical and Office-Based Coding and Reimbursement (Advanced)

For more information and to register, go to
http://www.facs.org/ahp/workshops/index.html
or contact
Debra Mariani,
Practice Affairs Associate,
tel. 202/672-1506,
e-mail dmariani@facs.org
NTDB® data points


by Richard J. Fantus, MD, FACS; and Avery B. Nathens, MD, PhD, FACS

The 2008 Annual Report of the National Trauma Data Bank® (NTDB), Version 8.0, is an updated analysis of the largest aggregation of trauma registry data that has ever been assembled. This year marks the first data collection under the new NTDB dataset, also known as the National Trauma Data Standard (NTDS). From 2004 through 2006, the NTDB Committee, supported by the U.S. Health Resources and Services Administration (HRSA), devised a uniform set of trauma registry variables and definitions. This work resulted in the NTDS, the new data dictionary for NTDB (http://www.ntdsdictionary.org/dataElements/datasetDictionary.html).

In total, the NTDB now contains more than 3 million records. The 2008 Annual Report is based on the first call for data under the NTDS. As this call was issued under a new data standard, only records with an admission year of 2007 were allowed, in contrast to past years’ annual reports that involved a five-year sliding window. In spite of limiting the call for data to a single year of discharge, an amazing total of 506,452 records made it through the validator and are the basis for version 8.0. This report also includes new features, including analyses by abbreviated injury scale (AIS) body region and geographic region (see graphic on this page). Also included are graphs showing the number of cases with injury severity score of at least 16 and number of complications submitted by facility.

The mission of the American College of Surgeons Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center registry data. The purpose of this report is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

Many dedicated individuals on the ACS COT, as well as at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, our goals in the coming years include improving
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.

**Dr. Nathens** is Canada Research Chair in Systems of Trauma Care, division head of general surgery and director of trauma of St. Michael’s Hospital, and medical director at Ontario Critical Program, Toronto, ON.

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A look at The Joint Commission

**Late NSQIP leader receives Ernest Amory Codman Individual Award**

The late Shukri F. Khuri, MD, FACS, has been honored by The Joint Commission for his leadership role in using performance measures to improve health care quality and safety. Dr. Khuri posthumously received the 2008 Ernest Amory Codman Award in the individual category in November.

At the time of his death on September 26, 2008, Dr. Khuri’s work in the field of surgical quality improvement and risk-adjusted surgical outcomes spanned more than 20 years. Dr. Khuri achieved national and international prominence in the fields of cardiac pathophysiology, cardiac surgery, medical informatics, quality improvement, and health policy research.

Named for the physician regarded in health care as the “father of outcomes measurement,” the Ernest Amory Codman Award showcases the effective use of performance measurement by health care organizations to improve the quality and safety of health care. The Joint Commission also recognizes an individual who has played a significant leadership role in promoting the use of performance measures to improve health care services and for providing major contributions to the development and testing of performance measures and the science and art of quality improvement.

For 16 years, Dr. Khuri oversaw the National Surgical Quality Improvement Program (NSQIP) in the Department of Veterans Affairs (VA). Recognized today as the model for continuous improvement in surgery, NSQIP is the first national, validated, outcome-based, risk-adjusted, and peer-controlled program for the measurement and enhancement of the quality of surgical care. Since the inception of NSQIP, 30-day postoperative mortality and morbidity have dropped by 47 percent and 43 percent, respectively. Dr. Khuri was also instrumental in implementing NSQIP in the private sector through collaboration with the American College of Surgeons. The American College of Surgeons created the ACS NSQIP and Dr. Khuri served on the advisory and steering committees.

Among his many notable accomplishments, in 1978 Dr. Khuri established the first automated data-management system in a surgical intensive care unit in the Northeast and chaired the VA Surgery Specific Interest Users Group, which developed the first clinical module in the VA’s Decentralized Hospital Computer Plan. Today, the electronic patient record in the VA is the most advanced...
The American College of Surgeons is pleased to announce its continued collaboration with the Southeastern and Southwestern Surgical Congresses, to develop and implement educational programs in the spring. The College looks forward to sponsoring half-day symposia at these prestigious events.

For more information, contact Julie Tribe, MS, Senior Manager, Educational Programs, Division of Education, at jtribe@facs.org or 312/202-5433.

For information on the ACS, visit www.facs.org or call 800/621-4111.

SAVE THE DATES!

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Southeastern Surgical Congress
FEBRUARY 7–10, 2009
Atlanta Marriott Marquis
Atlanta, GA
To register, visit www.sesc.org or call 800/558-8958

Southwestern Surgical Congress
MARCH 22–25, 2009
Hotel del Coronado
San Diego, CA
To register, visit www.swscongress.org or call 913/402-7102

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