FEATURES

The ACS Case Log System: 2009 update
Tyler Hughes, MD, FACS; Howard Tanzman; and M. Michael Shabot, MD, FACS

Health care reform: We all have a dog in this hunt
Andrew L. Warshaw, MD, FACS

Amputee network provides peer support
Lola Butcher

Governors’ Committee on Surgical Infections and Environmental Risk: An update
Vijay K. Maker, MD, FACS

Governors’ Committee on Physician Competency and Health: An update
Gerald J. Béchamps, MD, FACS

DEPARTMENTS

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

What surgeons should know about...
Selling a medical practice 101
Charles D. Mabry, MD, FACS; and Vinita M. Ollapally, JD

In compliance
Preparing for the switch to HIPAA 5010 and ICD-10-CM
Debra Mariani, CPC

On the cover: The ACS Case Log System enables surgeons to easily maintain their personal case log, and to compare their results against the aggregated results of thousands of other surgeons. See story, page 10. (Photos courtesy of istockphoto.)
NEWS

F. Dean Griffen, MD, FACS, to receive 2009 Distinguished Service Award 29

Official notice: Annual Business Meeting of Members, American College of Surgeons 29

Fellows honored for volunteerism 31

Germany Traveling Fellow selected for 2010 35

COT accepting submissions for 2010 Resident Trauma Papers Competition 35

Survey reveals that residents view DHR a hindrance in training 36

Report on the 2009 AMA HOD meeting 37

Jon H. Sutton

The Doctors Company announces membership dividend 38

Clinical trials methods course scheduled for November 39

ANZ Traveling Fellowship for 2011 announced 41

The Clowes ACS/AAST/NIGMS Mentored Clinical Scientist Development Award available 43

Report of the 2009 Japan Traveling Fellow
Lorenzo Ferri, MD, FACS 44

A look at The Joint Commission: New approach to sterilization 51

Report on the ACSPA/ACS activities: June 2009
Michael J. Zinner, MD, FACS 52

Letters 59

Trauma meetings calendar 61

NTDB* data points: Trespassers beware
Richard J. Fantus, MD, FACS 63

The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
The surgeons who will be best able to adapt to these changes and maintain their professional viability are those who develop the capacity to be cooperative, considerate, and compassionate leaders of patient-centered multidisciplinary teams.

Averting errors

Multiple studies have shown that coordinated care leads to improved patient safety. The primary contributor to the nation’s understanding of medical error was the Institute of Medicine’s report *To Err Is Human*, which is about to mark its 10th anniversary. This seminal report shows that medical mishaps occur not because a single health care professional experienced a lapse in judgment, but because the fragmented state of our health care system creates an environment in which information is poorly communicated, or easily misplaced.

A decade later, little has changed. Surgical patients continue to receive care through highly complex, and often fragmented, organizational structures. Their care also involves a heterogeneous mix of professionals, including a diagnosing physician, a surgeon, an anesthesiologist, a perfusionist, surgical residents, surgeon assistants, and any number of nurses and providers of follow-up care. Furthermore, different people take over these various patient care functions as shifts change. Consequently, outcomes are affected, not only by the capabilities of the operating surgeon, but also by how cohesively the team interacts and how carefully hand-offs are made.

Armed with this awareness, policymakers have sought to develop incentives for the provision of more coordinated care. Policymakers, and most of the medical and surgical establishment, believe that team-based approaches to care will result in fewer redundancies and errors.

Treating chronic conditions

The American population is aging, and as a result, the focus of health care is shifting from the provision of episodic treatment of acute illnesses, to the provision of ongoing care for long-term health problems. Common chronic conditions afflicting Americans, particularly the elderly, include hypertension, heart disease (including heart attack), diabetes, arthritis, lung disease (such as emphysema and pulmonary obstruction), cancer, and depression. Moreover, many senior citizens

---

contend with more than one of these health care issues.

Well-coordinated care is critically important for patients with chronic illnesses, particularly those individuals with multiple health problems. Every physician, nurse, surgeon, pharmacist, and other health care professional involved in the treatment of patients with chronic diseases needs to know what tests have already been done, which drugs have been prescribed, which procedures have been performed, and so on.

**Responding to advances**

Accelerating the push toward team-based approaches to care are the many medical and technological advances that have emerged in recent decades, as well as our rapidly expanding understanding of molecular biology and genetics. For instance, many screening procedures can now be conducted by radiologists. In addition, many patients with certain forms of breast, colon, prostate, and other cancers often can be treated more effectively, and less invasively, with radiation, chemotherapy, and medical interventions.

Due to the growing awareness of how genetics affect an individual’s predisposition to medical conditions, physicians have started testing earlier for disease systems in certain patients, and are advising patients on the precautions they should take to ward off potential illness. Hence, more diseases can be averted or thwarted before they morph into acute conditions.

**The team**

Under these circumstances—the renewed emphasis on improving safety, treating chronic illnesses, and using new technology and scientific advances to cure and prevent illness—surgeons who want to maintain viable practices must expand their horizons and adopt patient-centered, multidisciplinary approaches to care. Surgeons need to thoroughly understand disease processes and to serve as pivotal players on patient management teams.

Surgeons are well-suited to lead these multidisciplinary teams because we are trained prognosticators, perform cost-effective treatment, and are instrumental in the development and execution of clinical trials. We also have experience in the effective management of advanced disease conditions and outcomes evaluation. Together, these skills and this knowledge make us ideal coordinators of care.

The most important members of these teams, however, will be the patients. Indeed, effective control of chronic conditions depends on collaboration between patients and their clinicians. Patients and health care professionals must work together to set goals, develop treatment plans, and determine who will be able to assist patients in managing their day-to-day health care and personal responsibilities.

To best lead patient-centered health care teams, surgeons will need excellent communication and interpersonal skills—competencies often ignored or undervalued in previous eras. We need to listen to input from nurses, anesthesia professionals, residents, surgical assistants, and other physicians. We must open the lines of communication with our patients and their loved ones, explaining in plain language the benefits and risks of various treatment options, and what went wrong, should an adverse event or complication arise.

Most surgeons realize that surgical practice is going to be much different in the years to come. The surgeons who will be best able to adapt to these changes and maintain their professional viability are those who develop the capacity to be cooperative, considerate, and compassionate leaders of patient-centered multidisciplinary teams. They will foster these personal attributes not out of self-interest, but to ensure that their patients are protected from unnecessary risk, and that they receive optimal care.

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.
While health care is less affected by economic ups and downs compared to other industries, health care is not completely immune to a slowing economy. Physicians in private practice must manage the financial pressures of a small business, a constantly changing regulatory landscape, and the challenges of recruiting and maintaining physician and staff talent. In addition, it is clear that the Obama Administration is placing much greater emphasis on health information technology, quality, and efficiency—and these are areas that can present additional challenges to physicians who are struggling to thrive during this economic downturn.

To handle these increased pressures, many physicians in private practice are taking precautions, such as postponing purchasing new equipment and holding off on recruiting new physicians and staff. Some physicians are increasing their practice efficiency by using midlevel providers, such as physician assistants, to cover their growing workload, and by improving their business practices and revenue cycle activities. Others have chosen to sell their practices to a larger group or hospital and retire; sell their practices to a larger group or hospital and become an employee of that organization; or keep their practices, but enter into an employment relationship with a hospital for supplemental funds. Although the trend of physicians selling their practices and/or entering into employment relationships with hospitals, health systems, or large groups is nothing new, the current economic downturn could accelerate what many see as a growing cultural change among physicians.

The process of selling a practice and/or becoming an employed physician can be complicated, and often requires much time and preparation.

**Why sell?**

Physicians make the choice to sell their practices or contract with hospitals for a variety of reasons, and there are myriad issues to consider in determining whether or not to sell a practice. Some physicians who sell their practices to a large group or hospital, and subsequently become employees of that organization, do so because they seek a different quality of life and work/life balance, and moving to an employed or large group situation can provide relative job security and semi-regular hours with less financial pressure. Other physicians no longer want the responsibility for the business side of medicine, and they would prefer to spend more time caring for patients, and less time running a business. These physicians choose to work in a hospital, health system, or large group because the management responsibilities are handled by experts who deal daily with contract negotiations, the purchasing of supplies, and other services required to ensure the smooth, efficient, daily operation of the practice.

In addition, physician employees may no longer be required to deal with billing and fighting for reimbursement. Larger corporations may also have more leverage when negotiating payment contracts with health maintenance organizations and other third-party-payors. Some physicians may see leaving private practice as a financial opportunity, as hospitals are increasingly seeking coverage for the uninsured, and more hospitals are paying physicians for on-call coverage.

Physician employees can also leave increasingly complex regulatory and compliance issues to others who are trained in monitoring and ensuring that the organization is compliant with new regulatory developments. In addition, when faced with the decision of whether or not to invest in an expensive electronic medical records (EMR) system, some physicians may choose to join a hospital, health system, or large group because often these organizations have already purchased, transitioned to, and maintain cutting-edge health information technology.

Physicians who are employed, or are part of...
a large group, are also not required to manage unhappy staff members and staff complaints, or deal with the hassles of being a landlord and maintaining the office building. Many physicians consider selling their practices to a larger group as a way to add partners, if recruiting physicians to their own group or solo practice has been challenging. Others choose to sell, rather than close, their practice upon their retirement.

How should a physician prepare for the sale?

One of the most important ways to prepare for the sale of a medical practice is to start the planning process early. Many advisors suggest planning at least two years in advance, but the amount of time needed to organize the office and files, identify the correct buyer, and negotiate and close the deal could vary, depending on the practice and the market. It is also important to hire an experienced team, which typically includes a health care attorney, an accountant, a financial advisor, and possibly a practice consultant to represent the physician throughout the selling process. A property appraiser may also be required, if real estate will be included in the sale of the practice.

In the years and months leading up to the sale, it is important for the office to avoid lowering productivity, which could result in losing patients and staff. If this occurs, the value of the practice at the time of the sale could be diminished. However, it is also important to notify colleagues, staff, and patients of the sale at the right time, if notification is required. For example, if the physician sells his or her practice to a larger group or hospital, and the physician becomes an employee of that organization, the physician often stays on in the same location with the same patients, and the employees of the practice will also become employees of the larger group or hospital. If a physician sells his or her practice upon retirement, the employees will have to adapt to a new employer and new terms and conditions of employment, and will need to ensure that patients will be cared for by a new provider. On the other hand, if the physician does not sell his or her practice, but decides to enter into an employment relationship with a hospital for supplemental funds, the new relationship typically will not affect the practice’s existing employees or patients, but will also provide services to the hospital for an additional salary guarantee.

Also, a good knowledge of all overhead expenses—ranging from medical and office supplies to lawn care costs—is essential in determining the practice’s net worth (the worth minus the expenses).

Other steps that a physician may take in preparing to sell his or her practice include, but are not limited to, preparing a promotional package, cleaning the office, and being prepared for potential buyers to examine practice information such as finances, active patients, office hours, employees, and managed care contracts.

How should a physician choose the right buyer?

Selecting an appropriate buyer is one of the most important factors in the success or failure of the sale of the practice. If a physician sells his or her practice to a large group or hospital, and if the physician continues in practice as an employee of the large group or hospital, that organization’s care philosophy should fit with the physician’s practice philosophy, vision, and values. For example, not-for-profit hospitals have a charitable mission to fulfill, which often takes precedence over profitability. As a result, it might be difficult for some physicians to adapt to a not-for-profit hospital’s way of thinking. In this situation, it is also valuable to know what kind of marketing and developmental resources the hospital would commit to the practice, and whether the practice would be relocated.

In addition, it is important to know whether the physician’s practice can use the hospital’s EMR system, and what would be required for the transition. It can also be useful to speak with other physician colleagues who work for organizations that are potential buyers, in order to learn more about working for the organizations and to narrow the field of prospective buyers. Also, a physician should choose a buyer that is a market share leader, rather than one that is capital-strapped and struggling to stay in business.

SEPTEMBER 2009 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
These are just a few of the many issues related to choosing the right buyer, if a physician sells his or her practice and continues as an employee of the larger organization. Other factors could come into play, based on the type and location of the practice for sale, as well as the overall goals of the physician selling the practice. It should be noted that some of the issues above are not relevant if a physician sells his or her practice, and then retires or does not remain as an employee of the larger organization.

What are the components of a medical practice valuation?

Medical practice valuation, which involves assigning a dollar value to the practice, is one step in the process of selling a practice. A professional, independent party should appraise the practice value regardless of whether the physician selling is going into retirement or will continue as an employee of the buyer. The practice value is usually the sum of tangible assets, intangible assets, and accounts receivable. Tangible assets are relatively straightforward in terms of assessing their value. These include fixtures, medical equipment, exam tables, desks, chairs, and other furniture. Tangible assets value also includes the real estate assessment, if the practice owns, rather than rents, the building where the practice is located. These assets are less valuable than intangible assets, because often real estate is not involved, and usually most of the office tangible assets have depreciated considerably.

Intangible assets, also known as goodwill, typically comprise the greatest contribution to the practice, but are also much more difficult to assess in terms of value. There are two types of intangible assets: practice goodwill and professional goodwill. Practice goodwill is institutional in nature. It is associated with the practice as a business structure and includes, but is not limited to, intangible elements such as operating procedures and policies, trained and assembled support staff, salaries, overhead, an established client base and accompanying patient records, computer systems and library resources, practice history, history of malpractice, degree of dependence on referrals and basis for referrals, third-party payor participation and mix, other issues with payors such as audits or malpractice, and revenue history (over the past several years, but especially over the past 12 months).

The practice location and demographics are also relevant because often the harder it is to start a practice from scratch in a particular location, the easier it is to sell that particular practice. In fact, sometimes buying a practice is the easiest and least expensive way for a new physician to enter a particular market.

The second type of intangible asset is professional in nature, also known as professional goodwill. This is the intangible value associated with the practitioner’s personal knowledge, experiences, and reputation, after deduction for a reasonable salary consistent with such knowledge, experience, and reputation.

In the health care industry, accounts receivable can also make up a significant portion of the value of a practice. Accounts receivable refers to the money that is due to the practice from services provided prior to the sale. At the time of the sale, there are typically five to six months’ worth of services that have been provided that have yet to be collected, because of a delay in reimbursement from third-party payors.

It is imperative from the start of negotiations that the physician selling his or her practice has a good idea of the true value of the practice’s tangible and intangible assets, including the value of property owned, accounts receivable, and the perceived value to the community and their referring doctors. A good understanding of the value of the practice, along with a practice valuation prepared by an experienced independent third party, will provide significant bargaining leverage.

What is the difference between a stock and an asset sale?

There are two ways a physician can sell a practice: a hospital (or other organization) can purchase stock in the entity that owns the practice, or it can purchase the assets of the practice. There are advantages and disadvantages to each type of sale, and it is important that a health care attorney and an accountant correctly structure the deal and its terms. In the case of a stock sale,
all corporate assets transfer from the seller to the buyer, and the buyer also assumes the liabilities of the practice. The seller must be honest and disclose all known liabilities, but there is always the risk that the buyer will be responsible for future malpractice suits and other complaints not yet filed at the time of the sale. One major advantage for buyers in the case of a stock sale is that all contracts, deals, or agreements that exist in the practice are honored if the entire stock is purchased. Accordingly, contracts with third-party payors remain intact, which assures uninterrupted cash flow. Also, if the practice is paying a low rent for a long-term space, that agreement will remain unchanged. Despite the fact that such agreements are kept in place, most buyers avoid stock sales and prefer asset sales.

In the case of an asset sale, only assets enumerated in the asset purchase agreement are sold. The buyer will be required to obtain new provider numbers, which may not be available on the day of the sale. Although this could create a lag or a gap in payment for the buyer, the buyer will not be responsible for any liabilities or overpayments due back to the payor. In addition, in the case of an asset sale, the landlord is usually able to terminate the lease and negotiate a new lease at a potentially higher rate.

What is important to keep in mind regarding the terms of the sale contract?

In addition to the deal structure, it is also important that the agreement address all relevant terms necessary for a sale. If, after the sale, the physician will continue in the practice as an employee of the buyer, the financial expectations should be clear in terms of how compensation will be determined. Many hospitals avoid large base salaries in favor of productivity-based compensation arrangements, so the physician should understand whether the compensation is reasonable when considering the specific market conditions and the past performance of the practice. It should also be clear whether the hospital will do the physician’s billing, and what the hospital’s expectations are for productivity. In addition, it is recommended that non-negotiable items are discussed early on in the process. For example, if the physician traditionally takes 30 days a year off, and an afternoon off once a week, and he or she is not willing to take less time off, that should be made clear during the initial negotiations. Setting the lines in the sand from the beginning will lead to easier negotiations later. The agreement should also include a provision that would allow the physician to return to private practice if one or both parties are unhappy with the deal. An unwind provision may be tied to specific financial or developmental milestones, or can simply be exercisable by either party if it determines that the arrangement is undesirable.

Dr. Mabry is a general surgeon practicing in Pine Bluff, AR, and assistant professor of surgery and practice management advisor to the chairman, department of surgery, University of Arkansas for Medical Sciences, Little Rock, AR. He is a Regent of the College.
The ACS Case Log System: 2009 update

by Tyler Hughes, MD, FACS;
Howard Tanzman, ACS Director of Information Technology;
and M. Michael Shabot, MD, FACS
Since the days of John Hunter, surgeons interested in advancing the profession have kept records of their outcomes. Most surgeons have kept such notes, or logs, of their cases as a means of tracking and improvement. These data are so important that for decades, the American College of Surgeons and the American Board of Surgery (ABS) have used logs to assess the breadth and depth of a surgeon’s training and experience.

Until the development of the ACS Case Log System (also known as the Practice-Based Learning System), these records have been laborious to maintain. Additionally, paper-based records were difficult to analyze and were not uniform in format, so it was nearly impossible for a practicing surgeon to compare his or her results with those of others. The ACS Case Log System is changing that—with nearly 1 million cases entered since October 2005, surgeons can now quickly and easily maintain their personal case log, and confidentially compare their results against the aggregated results of thousands of other surgeons. The Case Log System has continued to evolve over time. In this report we will describe the current status, capabilities, and uses of the Case Log System.

**Why use the Case Log System?**

The Maintenance of Certification (MOC) process is easier to manage with the Case Log System. Instead of spending time chasing paper, classifying cases, and filling in the ABS case experience form, a surgeon can electronically transfer all of his or her case data to the ABS with a few mouse clicks. And the study for ongoing education is streamlined with a surgeon’s knowledge of his or her most common cases and their outcomes. This allows the surgeon to assess educational needs more precisely.

There are other practical reasons for surgeons to keep a standardized log of their cases. Patients are self-informed now, more than ever, and they expect more information from a surgeon than in the past. They want to know not only the published results of the procedures, but their own surgeon’s personal experience and outcomes. The Case Log System allows surgeons to confidently and accurately state their overall experience, infection rate, complications, and overall outcomes.

Surgical groups can use their logs to better understand the nature of their practice, and whether their complication rates are higher or lower than case log aggregate averages, or when compared with the ACS National Surgical Quality Improvement Program (NSQIP) data. These groups can stay ahead of the curve in quality discussions with payors and hospital credentialing committees.

Responding to a survey of users of the Case Log System, surgeons gave several key reasons for why they participate in the program (see Figure 1, this page).

**Practice-based learning and improvement**

Lifelong learning is not only a competency mandated by the ABS, it is a way of life for sur-
Figure 2. The practice-based learning and improvement cycle

Figure 3. American Board of Surgery online recertification application

<table>
<thead>
<tr>
<th>Summary of Operative Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOLLOWING IS A SUMMARY OF PROCEDURES REPORTED OVER THE PERIOD.</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Abdomen-biliary</td>
</tr>
<tr>
<td>Abdomen-hemla</td>
</tr>
<tr>
<td>Abdomen-spleen</td>
</tr>
<tr>
<td>Alim Tr-large Int</td>
</tr>
</tbody>
</table>
Using the system for credentialing, re-credentialing, and privileging purposes

Medicare and The Joint Commission regulations governing hospitals require proof of current clinical experience and competence for credentialing, re-credentialing, and privileging. The Case Log System records the facility where each procedure was performed, and provides for aggregation of cases over surgeon-specified time periods for reporting purposes. Surgeons who practice at multiple hospitals and ambulatory surgical centers especially benefit from this, as the Case Log System provides combined reports of experience to satisfy all possible credentialing and privileging needs.
Ease of use

The original version of the Case Log System released in 2005 to the membership was designed to be quick and user-friendly. These qualities have always been a key goal for the Case Log System designers. On average, a case can be entered in less than two minutes. Software engineers work with practicing surgeons on ways to make the Web and handheld application easy to use and practical. Even surgeons who consider themselves “computer illiterate” can master the Case Log System in a short time. The pages are set up in a logical fashion, with many embedded aids to speed data entry (see Figure 4, page 13).

To enter a new case, a surgeon needs only to click on the “Create” tab. The entry form appears quickly. A minimum of demographic information on the patient is requested and the surgeon can choose how much of this he or she needs.

In this age of coding, every detail of assigning codes can be a chore. Fortunately, the system has a series of short cuts that makes this easy. Both the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT)* coding systems are embedded in the software. The system automatically remembers each surgeon’s most

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2008 American Medical Association. All rights reserved.
common codes and puts them in a “Hot list” available for selection with a single click of the mouse (See Figure 5, page 14). The surgeon can also change awkward “code language” into “nicknames” so that the coding terminology is more familiar.

To assist in coding, the “Suggest a Code” feature lists the typical CPT (procedure) codes applicable to a given ICD-9-CM diagnostic code (see Figure 6, page 14). CPT code modifiers and their definitions are also available.

For those individuals who may have already created a computerized case log, the ACS Case Log System has an import function that can convert records to Case Log System format. A surgeon with hundreds or thousands of cases logged over the years can instantly transfer them, and begin using the ACS Case Log System reporting and confidential case comparison features (see Figure 7, page 14).

<table>
<thead>
<tr>
<th>Table 1. Procedure-specific complications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Colonscopy</strong></td>
</tr>
<tr>
<td>Bowel perforation</td>
</tr>
<tr>
<td>Failed completion of colonoscopy</td>
</tr>
<tr>
<td>Inadequate bowel prep</td>
</tr>
<tr>
<td>Bleeding from biopsy or polypectomy site</td>
</tr>
<tr>
<td>Aspiration</td>
</tr>
<tr>
<td>Perforation at polypectomy site</td>
</tr>
<tr>
<td>Pneumoperitoneum</td>
</tr>
<tr>
<td>Sedation-related complication</td>
</tr>
</tbody>
</table>
Devices supported for user entry

These days, most surgeons carry some sort of smart phone or personal digital assistant (PDA) device for communication purposes, and to access information. To provide maximum flexibility for your individual workflow, the Case Log System is available on a variety of platforms:

• Internet access via a personal computer
• Palm handhelds, including smart phones
• Pocket PC (Windows Mobile), including smart phones
• iPhone (under development, anticipated availability by the end of 2009)
• Blackberry (under development, anticipated availability by the end of 2009)

System usage

Use of the Case Log System continues to grow at a rapid rate. The number of cases entered into the system has been doubling each year, and will exceed 1 million cases in the fall of 2009 (see Figure 8, page 15).

A broad spectrum of inpatient and outpatient cases are well represented in the Case Log System, including:

• Colonoscopies (>65,000 cases)
• Hernia (>55,000)
• Cholecystectomy (>50,000)
• Upper GI endoscopy (>35,000)
• Breast procedures (>45,000)
• Appendectomy (>20,000)
• Colectomy (>16,000)
• Bariatric procedures (>9,000)
• Excise lesion (>8,000)
• Biopsy/excise lymph node (>7,000)
• Pediatric cases (>60,000)

What data are included in the Case Log System?

The Case Log System tracks approximately 20 data points for each case. These data points include some minimal demographic information, procedure dates, diagnosis and procedure codes, comorbid conditions, complications, and outcomes. Complications and comparative reports are specific for many of the procedures. Examples of procedure-specific complications are listed in Table 1 on page 15.

What kind of reports does the Case Log System generate?

The Case Log System provides many pre-defined reports. In addition, you can download your data into Excel and perform additional analysis as desired. The Case Log System pre-defined reports include:

• Procedures by Frequency. This report provides a basic count of procedures performed, and is the most popular report generated from the Case Log System.
• Comorbidities by Frequency. This report provides counts of the comorbid conditions in a surgeon’s case mix.
• Post-Op Occurrences by Frequency. This report provides counts of a surgeon’s complications.
• Comparative Reports. These reports show a surgeon’s results grouped by CPT code, including the comorbid conditions, American Society of Anesthesiologists (ASA) class, postoperative occurrences, and outcomes. They also provide a comparison against the aggregate of the other Case Log System users, and for certain procedures, a comparison against data from the NSQIP.
• Outcomes by Frequency. This report provides counts of 30-day outcomes tracked in the system (death and unplanned return to the operating room).
• Wound Infections. This report provides wound infection rates.

**What about the Health Insurance Portability and Accountability Act of 1996 (HIPAA)?**

Surgeons and patients are concerned about the security of sensitive patient data. The Case Log System protects the data physically and legally. All data are encrypted during transfers, and no one except the individual surgeon is allowed access to their own data. As part of the Case Log System registration process, there are two “click-thru” agreements. The first defines the ownership of the data as follows:

• Surgeon owns all identifiable data
• College owns de-identified aggregate data (excludes patient and surgeon IDs)

The second click-thru agreement is a Business Associate Agreement which, under HIPAA regulations, allows you to input protected health care information into the system.

In this way, the data is the surgeon’s alone, and the surgeon does not have to worry that anyone else is tracking his or her results. Patients can be assured the same level of privacy.

**How do I get started?**

In order to access the system, you must be a member of the ACS. First, you must register for the system by visiting [http://www.acscaselogregister.org](http://www.acscaselogregister.org). A user ID and password are required to access the ACS members-only Web portal. There is information on this page to assist you, if you have questions regarding your user ID and password. Once you have registered for the system, you can directly access the Case Log System at [http://www.acscaselog.org](http://www.acscaselog.org).

**Conclusion**

The era of outcomes-based medicine is here to stay. Surgeons throughout history have been outcomes-based individuals, but until now, they have not had access to the kind of technology necessary to create a personalized outcomes-based system in order to improve patient care, surgeon education, and MOC. The ACS Case Log System does all this and more, and is free to members of the College. Register to use the system, and add your cases to the nearly 1 million already logged. Through honest reporting and analysis, surgeons will lead the way in the quality debate, instead of being led by those who have never experienced the burden of being responsible for a patient’s life.

---

**Dr. Shabot** is system chief medical officer, Memorial Hermann Healthcare System, and adjunct professor, University of Texas Health Science Center, Houston, TX. He is a Past-President of the ACS Southern California Chapter.
HEALTH CARE REFORM:
We all have a dog in this hunt

by Andrew L. Warshaw, MD, FACS

Editor’s note: The following article appeared as a column in the Spring 2009 newsletter of the Massachusetts General Hospital (MGH) Surgical Society. The column is reproduced here with permission.

My newsletter column has always been about us—what is going on in the MGH department of surgery. This one is a departure: it is about you and the world of surgery. Unless you have been working yourself into a tunnel-visioned stupor, you know that big changes are in store for health care, health systems, and compensation for doctors. The Obama Administration has health care reform near the top of its priorities; the economy can’t afford the steady climb of health care costs; the uninsured are a growing problem; and primary care physicians want both greater control of the patient and a bigger share of the health care dollar—at the expense of surgical specialists. What it comes down to is that you will be either a player or a victim. With regard to coming changes, you can make it happen, watch it happen, or ask “what happened?” There are lots of new systems under consideration—the medical home, bundling, episodes of care, accountable care organizations, among others—and surgeons are at risk of being at the tail-end of control in these systems. At this point we can only be sure that the near future will be different, perhaps within months.

In addition to fee schedules, surgeons have critically important concerns about a growing surgical workforce shortage and patients’ access to surgical care. We worry, or should worry, about the challenges to choosing a career in surgery: lifestyle, debt, increasing subspecialization, and the cost of graduate surgical education. While surgeons are retiring earlier, it takes up to eight years after medical school to train a new surgeon for replacement.

Our message must get to our legislators: surgeons want to be part of devising the formulas for restructuring the health care system. We want to be at the table with primary care physicians, business leaders, and insurers. We all have a dog in this hunt.

We get access to the process as individuals, and through our organizations, by developing active relationships with our elected representatives.
Sending an e-mail or a letter is worth something, but meaningful recognition by the representative takes face time, and face time is earned by helping them. The first order of business for an elected official is to get re-elected, not to pass legislation. They face an overwhelming number of issues (bills), and the ones most likely to get attention are those affecting their friends (read: supporters), those who contribute time and money to their re-election.

Many medical and surgical organizations have political action committees (PACs), which contribute funds to legislators. These political contributions should not be construed as buying specific votes, but rather as helping to build a positive relationship by keeping a friend in office. When the American College of Surgeons was considering forming a PAC, some of its leaders were resistant to the idea of “paying to be heard.” Now the American College of Surgeons Professional Association (ACSPA)-SurgeonsPAC has raised more than a million dollars in its third election cycle (2006–2008), greatly increased the access of ACS lobbyists to Capitol Hill offices, and attracted many members of Congress to speak at our meetings. Our concerns are being heard. Nonetheless, only 4 percent of the eligible ACS Fellows contributed during the last cycle. Think of what power we have left untapped thus far.

There are many PACs that include surgeons, whether attached to a surgical subspecialty (neurosurgery, orthopaedics, and so on) or a state, or regional, PAC. Each of these has its agenda, and a surgeon may be conflicted as to which should receive his or her contribution. Remember that the specialty PACs usually have a focus on the special issues of that constituency. The SurgeonsPAC of the ACS is the big umbrella which carries the power of the 75,000 ACS Fellows and lobbies for the issues which are common to all surgeons, skirting those which divide us. We may not agree on abortion, gun control, or same-sex marriage, but we are united on the desired role of surgeons in a new health care system, the need to be fairly compensated, support for graduate medical education and research, and medical liability reform.

The ACS has also taken the lead in forming a coalition of surgeons and surgical PACs. In March, the Joint Surgical Advocacy Committee (JSAC) brought 450 surgeons of all stripes together in Washington for training in methods of political advocacy, and for visits to their congressional representatives and senators. In May, the ACSPA-SurgeonsPAC hosted a conference of surgical PACs in Louisville.

The College has coalesced its advocacy think tank into a new Health Policy and Advocacy Group (which I chair) to prioritize and develop positions on issues important to the Fellows, including health care reform, Medicare and other compensation issues, quality and safety, workforce, and access to surgical care. The committee works with the ACS Health Policy Research Institute and reports directly to the ACS Regents. Its home base will be in the new ACS building currently under construction on Capitol Hill.

My message is simple: know the issues and get involved. One five-minute call each week to deliver a message to one of your senators or your representative, added up over, let’s say, 50,000 surgeons, will generate 2,500,000 calls to Congress per year—don’t you think that will be heard? Get to know your legislators; attend their fundraising events. Become a face they recognize.

Michael Dunn, a political involvement consultant in Washington, DC, cites what he purports to be an old Chinese proverb: “A man can sit for a very long time with his mouth open waiting for a roast duck to fly in.”
Early in his career as an orthopaedic surgeon, American College of Surgeons Regent Bruce D. Browner, MD, FACS, recognized that a patient experiencing limb loss might benefit from speaking with someone who had faced the same situation. He started keeping a list of patients willing to help.

“As our amputees would get better and start to return to life, we would ask them informally, ‘Would you be willing, in the future, to speak to another amputee?’” said Dr. Browner, who now serves as director of the orthopaedics department at Hartford (CT) Hospital and is a professor at the University of Connecticut Health Center’s department of orthopaedic surgery. “When we had somebody facing an amputation or who had just gone through a traumatic amputation, we would call one of these people who we thought would be a good fit and arrange a meeting.”

Such peer support, he said, provides a perspective that a patient’s health care team cannot offer. “We can tell them about the process—‘Here’s what I’m going to do, here’s how long it will take to heal, here are some of the complications that can come up,’” said Dr. Browner. “But we can only, in a third-person fashion, tell them what it’s going to be like to be an amputee, whereas another amputee who has actually lived through this and knows the day-to-day details of facing all these issues can provide so much more information.”

Seeing the value of these interactions is why Dr. Browner is so enthusiastic about the work of a nationwide initiative—the National Peer Network (NPN) program developed and sponsored by the Amputee Coalition of America (ACA)—to provide that same type of support that Dr. Browner has provided to his own patient base.

Standardized in 2001, the NPN program is currently coordinated through health care facilities and 250 support groups in 46 states, said Patricia J. Isenberg, chief operating officer of the ACA. Through this program, more than 1,000 civilians and veterans with limb loss have been trained to serve as peer visitors.

Douglas G. Smith, MD, professor of orthopaedic surgery at the University of Washington, Seattle, served as medical director for the amputee coalition from 2000 to 2008.

“Having helped run an amputee service and care for individuals with limb loss since 1989, I have seen first hand the value of amputees helping, listening to, and educating other amputees,” he stated in a letter of support for the peer visitor network. “Many new amputees have stated
that a peer visitor program was one of the most helpful events during their hospitalization and rehabilitation.”

**Why the peer network is needed**

Approximately 1.7 million Americans are currently living with limb loss and some 185,000 new amputations are performed each year, according to the ACA. Despite advancing technology and surgical techniques, the rate of new amputations is expected to grow dramatically because of the diabetic and obesity epidemics. Dr. Browner said the number of people living with major limb loss in the U.S. is expected to triple by 2050.

The ACA, organized in 1986, is a not-for-profit organization that represents people who have experienced amputation or are born with limb differences. The coalition provides a wide range of advocacy, support, and education services. Its central tenet is as follows: To achieve their highest potential, people with limb loss must take the lead in decisions regarding their own care—and that requires knowledge based on education.

As every surgeon who has performed amputations knows, some people with limb loss experience considerable challenges, including pain, decreased mobility, difficulty in adjusting to new roles, body image issues, and financial burdens.

The Limb Loss Research and Statistics Program, a collaboration of the ACA and the Johns Hopkins Bloomberg School of Public Health, published the results of a 2006 survey of 954 people with limb loss. The survey’s findings include the following:

- Almost 30 percent of people with limb loss had a depressed mood at the time they responded to the survey.
- Depressive symptoms are two to four times greater in people with limb loss than in the general population.
- Almost half of the survey respondents reported significant anxiety or depression in the two years following a lower-extremity amputation.

The goal of peer support is to help the patient with limb loss learn that others experience similar feelings of loss and grief, and to provide information about what it’s like to perform daily activities after an amputation. The peer understands problems that might arise in the months and years after an amputation and can serve as a source of encouragement as the patient returns to normal activities after the surgery.

Dr. Browner said peer visitors may also help patients during their decision-making process. “When a patient is faced with the decision of whether to have an amputation or try for a limb salvage, they really have very little concept of what it’s going to be like to live with an amputation,” he said. “And even in that terribly pressurized, traumatic situation, it can be beneficial for them to have another amputee come in.”

He recalled an older patient whose chronic bone infection forced her to choose whether to have a limb reconstructed or to proceed with an amputation. He arranged for two visitors—a patient in the process of a limb reconstruction and a woman who had undergone an amputation—to speak with the patient. “As a result of that process, she decided to go for the amputation,” he said.

**How the network works**

The success of the ACA’s peer visitation network is limited only by the amount of money available to conduct trainings. There is certainly a need for the service. Although there are more than 1,000 peer visitors, that pales in comparison to the 180,000 amputations performed each year—even though there is a steady supply of amputees who wish to volunteer for the network.

“We have many more people who want to be peers than we can have training,” Isenberg said. “If we had more funding, we could have three times the number of trainings.”

The program, partially supported by the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention, serves as its own recruiter. Ms. Isenberg noted that of those amputees who have had a peer visitor, at least 75 percent want to be trained to serve as a peer visitor because the experience has proven so beneficial.

The ACA trains two types of peer visitors: adults (civilians and veterans) who have adjusted well to limb loss and are living life fully, and

---

parents who have adapted successfully to life with a child born with limb difference or who has undergone amputation.

Peer visitors are certified by the coalition after they successfully complete a full-day training course that includes information about the recovery process, communication activities, role play, games, brainstorming, and case studies designed to prepare them for various situations they may encounter as a volunteer visitor.

In addition to matching peer visitors to patients who need their support, the NPN provides information, training, and technical assistance to more than 250 volunteer-led amputee support groups in the country. Some groups are social or recreational, whereas others focus mostly on education, but they all exist to help amputees adjust to life.

Peer visits may be conducted in person, or by telephone, e-mail, or standard mail, Ms. Isenberg said. Many patients live in locations too remote for the visit to be conducted in person, and some patients prefer the anonymity or control that comes with a phone call or e-mail exchange rather than a face-to-face visit. Whenever possible, patients are matched with peer visitors by age, gender, type of limb loss, and extent of limb loss. The patient controls the timing of peer visits.

“We think it is very important to have contact prior to, and just after, surgery,” Ms. Isenberg said. “But limb loss is a lifelong experience, so there are going to be different times when people need support. A year out, patients may experience pain or depression or adjustment difficulties that a peer visitor can help with.”

Currently, the ACA receives most requests for a peer visitor from family members, but Ms. Isenberg thinks that might change if more physicians and therapists were aware of the service. Family members are often overwhelmed with the responsibilities and stress associated with the patient’s medical emergency and they tend to stumble upon information about the peer network during a frantic Internet search for information and resources.

“We wish more referrals would come from health care providers because that would be one less thing that family members have to deal with at a time when they are most vulnerable,” she said.

Adapted for military use

Unfortunately, as Jeffrey Gambel, MD, learned shortly after the war in Afghanistan started in 2003, the willingness of a person with limb loss to support another patient does not guarantee that person will make a good peer visitor.

Dr. Gambel is a physiatrist—a specialist in physical medicine—and a rehabilitation physician at Walter Reed Army Medical Center, Washington, DC, where many of the war wounded are sent for care. As the public became aware of the serious injuries U.S. soldiers were experiencing, people with limb loss—both Washington, DC, area residents and those traveling to the area for business or vacations—started calling to offer their help.

“Through the goodness of their hearts they would call and say, ‘I want to come in and cheer up the guys and show them that life with major limb loss is not the end of the world. They have a future, and I can use myself as an example,’” said Dr. Gambel, who serves on the ACA’s medical advisory board.

The sheer number of offers from strangers lending a hand presented its own challenge for Walter Reed personnel, but the quality of the peer interaction presented an even bigger problem.

“Many individuals would come by and say ‘I’m here for the afternoon, and I’m an amputee, and let me tell you about myself, and let me tell you about myself, and let me tell you about myself,’” Dr. Gambel recalled. “Here’s someone who just got blown up, has been overseas, is on a lot of medication, and is just re-acquainting with loved ones—and here is this one-way conversation taking place with the person and the family.”

The Walter Reed staff quickly reached out to the ACA for help to develop a group of trained peer visitors to help patients facing limb loss or acclimating to life after amputation.

“The program is vital to our success as an organization and will hopefully have lasting effects in terms of our patients’ injury recovery and successful community reintegration,” Paul F. Pasquina, MD, chairman of the department of orthopaedics and rehabilitation at Walter Reed, said in a letter supporting the peer network.

The first training at Walter Reed occurred in 2004, and new training sessions are now conducted at least once a year. The result: More
than 100 ACA-certified peer amputee visitors are now an integral part of Walter Reed’s program.

“Even though they are volunteers, we consider them part of our health care team, in the sense that they can do some things that none of us can do. They can speak and listen from the vantage point of someone who has actually lived major limb loss and has had to adjust to it and go on with their lives,” Dr. Gambel said. “They have instant credibility.”

The training session underscores what Dr. Gambel calls “the mantra”—a peer amputee visit is about the person being visited, not about the visitor. The training educates peer visitors on listening skills, stages of recovery, and the appropriate boundaries of a peer visitor’s interaction.

“You’re not there to advise people medically. Or just because you have a particular prosthesis you like, you’re not there to market that to the individual,” he said. “You’re there to support the person and the family in the situation that they find themselves in right now. Mostly your job is to listen.”

With two wars in progress, Walter Reed has approximately 200 patients with major limb loss at any given time, Dr. Gambel said. He estimates that 20 percent to 30 percent of the peer visitors come regularly—a couple times a week.

“It’s not a drive-by or coming here just so they can say ‘I was at Walter Reed,’ or ‘I’m helping our injured service members,’” he said. “They form relationships and they become support for months and years.”

Peer visits are also made available to family members. According to Dr. Gambel, when patients are in the intensive care unit, too sick to have a peer visit, their worried family members may benefit from talking with a person with limb loss.

“Often the family members want to talk to a peer amputee visitor to get a sense of what to expect,” he said. “They value that.”

Of course, many of the injured soldiers have recovered sufficiently that they have moved back into college and jobs around the country, but their ties to the people who saved their lives remains strong.

“They often will stay in contact with us and the staff, but particularly with some of the peer visitors that they developed strong—probably lifelong—friendships with,” Dr. Gambel said.

The Walter Reed staff found that the ACA’s peer visitor training, developed with civilians in mind, needed tweaking to be appropriate for his military patients. At the ACA, Ms. Isenberg adapted the standard program to meet the needs of military patients.

**Special needs of military amputees**

In the general U.S. population, major limb loss is often caused by diabetes, vascular disease, or cancer, and many people lose their limbs late in life, after they have retired from work or stopped participating in activities that require agility and mobility. By contrast, military amputees most frequently are young and accustomed to being very active.

“These are people who are in very good shape, are jumping out of planes and playing sports, who want to get back to that type of lifestyle,” Dr. Gambel said. “Our whole program is geared toward supporting the maximum potential of our younger amputees for people with major limb loss and their families.”

Walter Reed’s program, in partnership with the ACA, has been so successful that it has been introduced at Brooke Army Medical Center in Fort Sam Houston, TX, and the Naval Military Hospital in San Diego, CA. Dr. Pasquina said the hospital’s patient satisfaction survey for veterans with amputations, covering 32 different types of services, consistently shows that peer visitation ranks among the top five services most valued by the patients.

That’s why Dr. Browner hopes to see other surgeons learn about the ACA’s peer network.

“It’s a tremendous service, and it makes sense to me to connect the amputee coalition and its peer visitation program to the surgeons who do the amputations, so that they can support their patients,” he said.

**Ms. Butcher** is a freelance writer in Springfield, MO.
Governors’ Committee on Surgical Infections and Environmental Risk: An update

by Vijay K. Maker, MD, FACS

The Safer Surgery 2008: Current Evidence and Continuing Challenges session—presented at the 2008 Clinical Congress in San Francisco, CA, by the Surgical Infections and Environmental Risk Committee, along with two other College committees—was well attended, and received excellent feedback and reviews by the Fellows. The committee has had a busy and productive year, greatly benefiting from increased communication through multiple webcasts and teleconferences from the leadership as well as through the Fellowship. With greatly increased national recognition of the importance of the role of surgical infections and environmental risks, our committee will be presenting the following three panel sessions at the Clinical Congress in October 2009 in Chicago, IL.

• Blood Transfusions in Surgery: 2009
• Bedside Surgical Procedures: The “Invisible” Risk to Patient Safety
• Bugs Are Winning the Resistance Battle—The Surgeon’s Responsibility

These sessions represent current surgical challenges and will address the solutions to improve patient care. In line with the same theme and mission of our committee, the following seven new topics are being researched continued on page 43

Dr. Maker is program director in surgery, University of Illinois, Metropolitan Group Hospitals Residency in General Surgery, and chairman, department of surgery at Advocate Illinois Masonic Medical Center, Chicago. He is Chair of the Governors’ Committee on Surgical Infections and Environmental Risk.
In the previous biannual report of the Committee on Physician Competency and Health, we provided this committee’s mission statement, which emphasizes the promotion of maintenance of physical and mental wellness in the Fellows of the American College of Surgeons. To that end, the committee conducted an informal survey of ACS Governors attending a Clinical Congress, which revealed potential and significant issues related to professional satisfaction, well being, and the delivery of safe and competent care to our surgical patients.

The ACS, through our committee, and in contractual arrangement with the Mayo Clinic Institutional Review Board and its biostatistics department, initiated and financially supported a more formal, anonymous, cross-sectional survey to all Fellows of the College who had registered their e-mail address via the American College of Surgeons’ Web site. The survey solicited more than 24,900 surgeons, and 7,905 (32 percent) completed the survey. The objectives of the survey were to measure burnout and quality of life among surgeons, evaluate personal and practice characteristics of surgeons, and determine any relationship between specific personal and practice characteristics among surgeons.

Burnout is defined as a syndrome of emotional exhaustion and depersonalization that leads to decreased effectiveness at work. Burnout and physical and mental quality-of-life issues were measured using validated instruments. Of the practicing surgeons responding to the survey, 40 percent were considered burned out and 28 percent had a quality of life score more than one-half standard deviation below the population norm. Similar findings among residents being trained under the 80-hour workweek rules were reported in a presentation at the 2008 Clinical Congress (personal communication, Jacob Moalem, MD, Chair, Resident and Associate Society of the ACS, March 13, 2009). In that presenta-
tion, emotional exhaustion in surgical residents was seen due to the development of more cross coverage, and continuous stress was apparent at work and due to constant home call. In addition, a sense of depersonalization developed in residents whose patients no longer identified the resident caring for them, and likewise residents routinely cared for patients they did not know because of the many handoffs. Burnout was the single greatest predictor of career satisfaction among surgeons, with wide variation in the level of career satisfaction and specialty choice.

Another analysis of these self-reported data included a validated depression scoring tool. Among those surveyed, 8.9 percent reported having made a major medical error in the last three months, although more than one-half of these errors did not result in any adverse patient outcome. Among these surgeons, 70 percent attributed their error to individual rather than system-level factors. Burnout and depression remained independent predictors of reporting a recent major medical error on multivariable analysis that controlled for other personal and professional factors.

The survey and the statistical analysis of this data have been submitted for publication in the near future. At the upcoming Clinical Congress in Chicago, IL, the committee is sponsoring a panel session entitled Stress and Burnout Among Surgeons: Understanding and Managing the Syndrome, scheduled for Wednesday, October 14. In this panel session, we will discuss analysis of the ACS survey, administration interventions for counseling and mentoring, how adverse patient events interact with the Medical Practice Acts (the laws and regulations that control an individual’s state medical license), and professional intervention and rehabilitation.

For the future, formal studies and surveys need to be done to assess burnout among surgical residents in training, determine how to identify and relieve surgeon stress, and determine how to support surgeons when medical errors occur. We also need to identify and promote societal and professional intervention for colleagues in need. To help those who seek assistance for themselves or their colleagues, all 50 states have developed programs for impaired physicians in conjunction with the American Medical Association's Center for Physician Health and Wellness.

---

Dr. Béchamps is in private practice as a general surgeon at the Winchester Surgical Clinical, Winchester, VA. He is Chair of the Governors' Committee on Physician Competency and Health.

---


Preparing for the switch to HIPAA 5010 and ICD-10-CM

by Debra Mariani, CPC, Division of Advocacy and Health Policy

Earlier this year, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for switching from the Health Insurance Portability and Accountability Act (HIPAA) 4010A1 standard to HIPAA 5010. In addition, the U.S. Department of Health and Human Services (HHS) issued a final rule for transitioning from the ninth edition of International Diagnostic Classification code sets (ICD-9-CM) to ICD-10 code sets. This article summarizes the specific changes that will occur in order for surgical practices to remain in compliance with HIPAA rules when submitting claims.

HIPAA 5010

The 5010 (005010) standard includes improvements to the current 4010A1 standard used for HIPAA-compliant electronic transfers of claims data. Practices that are already submitting electronic transactions, including filing claims and receiving remittances, will have to upgrade to the 5010 standard. HIPAA originally included a section on administrative simplification, and mandated the adoption of regulations for privacy, security, unique health identifiers, and electronic transactions and code sets. The electronic transactions named by HIPAA were as follows:

• Health claims or equivalent encounter information
• Health care payment and remittance advice
• Eligibility for a health plan
• Health claim status
• Referral certification and authorization
• Enrollment and disenrollment in a health plan
• Health plan premium payments

The transactions were to be used by covered entities (defined as health care providers, payors, and clearinghouses) when conducting specific administrative transactions electronically. The original version of the transactions named in HIPAA is version 4010 (004010) and subsequently was updated to 4010A1 (004010A1). These transactions were developed by the Accredited Standards Committee X12 (ASC X12). ASC X12 continuously updates its standards and implementation guides for transactions, in order to better meet the needs of the health care industry.

Improvements in the HIPAA 5010 transactions include clearly defined instructions, reduced ambiguity among common data elements, and elimination of redundancies. Because the 4010A1 version of the transactions is named in a federal rule, the regulatory process must be followed in order to upgrade to the 5010 version. CMS published the final rule making 5010 transactions mandatory on January 16. The following is the timeline for implementing the 5010 standard:

January 1, 2009–December 31, 2009: Vendors develop claims processing and practice management software and upgrades. Now is the time to contact vendors and start preparing for the transition.

January 1, 2010–December 31, 2010: Vendors and carriers will test their 5010 software and systems.

January 1, 2011–December 31, 2011: Medicare will accept electronic claims submitted with 5010 and the current 4010 HIPAA standards. This is the time to test new upgrades.

January 1, 2012: Your carrier will no longer accept claims submitted using the 4010 standard.

October 1, 2013: CMS switches to the ICD-10 code set. (This transition is described later in this article.)

Now is the time for surgical practices to start preparing for implementation of HIPAA 5010. The College recommends taking the following steps to ensure compliance:

• Discuss the new compliance standards with your current practice management system vendor. This could be the largest expense for most practices, although depending on the specifics in the vendor contract, system upgrades may be viewed as an aspect of maintenance.

• Discuss the new compliance standards with your current practice management system vendor. This could be the largest expense for most practices, although depending on the specifics in the vendor contract, system upgrades may be viewed as an aspect of maintenance.
Practices should review their contracts to determine whether regulatory updates are also considered part of maintenance. If a contract does not mention whether there is a charge for upgrades, be sure to find out whether the present system will be able to accommodate the 5010 transactions. If not, the practice will most likely need to purchase new software or a new system. Vendors should be well aware of everything that is involved for keeping individuals compliant.

- Talk to clearinghouses or billing services, if you use either one, as well as health insurance payors. If a practice’s present software uses a clearinghouse, the practice will be responsible for ensuring that it can upgrade to accommodate 5010 transactions. If not, you may have to renegotiate your provider contract or electronic data interchange (EDI) agreement. Practices should also find out when they can start testing these transactions, once upgrades are in place.
- Identify changes to data reporting requirements. There may be changes to make regarding how your practice reports; for example, you will no longer be able to use a PO. Box number or lockbox address for the billing provider address.
- Identify potential changes to existing practice work flow and business processes.
- Identify staff training needs. Staff training, as always, is crucial for a smooth transition. The training should be focused on understanding the transaction changes, learning the practice management system changes, collecting and reporting new data, and learning any new work flow processes.

Practices should be currently preparing for the switch to HIPAA 5010. Practices that wait too long could experience transaction rejections and payment delays.

For additional resources, visit the following Web sites:
- http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp
- http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm
- World Health Organization: http://apps.who.int/classifications/apps/icd/icd10online/

ICD-10-CM

On January 15, 2009, HHS announced that starting October 1, 2010, ICD-10-CM will replace ICD-9-CM as the HIPAA-adopted code set. This deadline has been pushed back and will now take effect October 1, 2013. Because this transition to ICD-10-CM comes on the heels of 5010 standard upgrades, practices should be asking their vendors questions regarding the upgrade to ICD-10 while preparing for 5010. Your office will have to work with each payor and vendor to see how this change will affect the continuity of service.

ICD-10-CM will comprise a total of 68,100 codes that are three to seven characters in length, versus the 14,000 codes that are three to five characters in length currently used in the ICD-9-CM code set. In addition, HHS has developed the ICD-10 Procedure Coding System (PCS) for use by hospitals. There are 87,000 ICD-10-PCS code sets, compared with the 4,000 procedural codes hospitals now use. Current Procedural Terminology (CPT)* codes will still be used to identify procedural services in physician offices and outpatient settings.

ICD-10-CM and the transaction upgrades will allow HHS to support full-quality reporting, pay for performance, and bio-surveillance. Practices should develop an education and training program for surgeons and coding staff. Education for coders should occur closer to the implementation date, and each physician will have to work continued on page 64

Resources
- Centers for Medicare & Medicaid Services: http://www.cms.hhs.gov/ICD10/
- National Center for Health Statistics: http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm
- World Health Organization: http://apps.who.int/classifications/apps/icd/icd10online/

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2008 American Medical Association. All rights reserved.
F. Dean Griffen, MD, FACS, to receive 2009 Distinguished Service Award

The Board of Regents of the American College of Surgeons has named F. Dean Griffen, MD, FACS, of Shreveport, LA, the recipient of its highest honor, the College’s 2009 Distinguished Service Award. Dr. Griffen will received the award during the College’s 2009 Clinical Congress in Chicago, IL.

Dr. Griffen is currently a professor of clinical surgery and director of undergraduate surgical education at Louisiana State University Health Sciences Center, Shreveport.

The Board will recognize Dr. Griffen with this award in appreciation of his staunch and devoted service as a Fellow of the American College of Surgeons, and for his leadership roles as Chair of the Board of Regents’ Committee on Patient Safety and Professional Liability, Vice-Chair of the Public Profile and Communications Steering Committee, President of the ACS Louisiana Chapter, and member of the ACS Board of Governors’ Committee on Professional Liability.

Dr. Griffen is also acknowledged for his superb clinical activity as a Lieutenant Commander in the U.S. Navy, his service as a general-thoracic-vascular surgeon at the Highland Clinic in Shreveport, LA, and, most recently, his services as a clinical professor of surgery at Louisiana State University Medical Center in Shreveport.

Dr. Griffen is further recognized for his leadership role with the American College of Surgeons in bringing to the attention of its membership—through his ground-breaking work on the ACS Closed Claims Study—insights into ways to improve surgical care and decrease liability through professional behavior, conducting numerous seminars, postgraduate courses, and mock trials at the Clinical Congress on the issues of liability and professionalism.

In granting the award to Dr. Griffen, the College also cites its “admiration of his natural leadership, integrity, vision, and service as a role model to surgeons both in the private and academic sectors, and his work in highlighting the issues of professionalism as a means of safer surgical practice. It is in recognition of his continued and dedicated...
service to and on behalf of the American College of Surgeons and the surgical community, that the Board of Regents is pleased to present Dr. Griffen this year’s Distinguished Service Award.”

Dr. Griffen received his medical degree in 1965 from Louisiana State University, New Orleans, and served as a general rotating intern (1965–1966) at Louisiana State University Medical Center, Shreveport. He completed a general surgery residency at Louisiana State University Medical Center in 1970, before serving in the United States Navy (1970–1972), reaching the rank of Lieutenant Commander, aboard the USS Franklin Delano Roosevelt, Mayport, FL, and at the Millington Naval Hospital, Millington, TN. Dr. Griffen became a Diplomate of the American Board of Surgery in 1972.

After completing postgraduate training, Dr. Griffen devoted his career as a surgical educator to Louisiana State University, Shreveport, serving as clinical instructor of surgery (1972–1975), clinical assistant professor of surgery (1975–1978), clinical associate professor of surgery (1978–1992), and clinical professor of surgery (1992–2007). He has been a professor of clinical surgery at Louisiana State University, Shreveport, since 2007.

Additionally, from 1972 until 2007, Dr. Griffen was a private practice surgeon, specializing in general, thoracic, and vascular surgery, at the Highland Clinic, Shreveport, during which time he and his partners introduced and pioneered the double-stapling technique for low rectal reconstruction. Dr. Griffen is also a staff surgeon at Christus Schumpert Highland Hospital, Willis–Knighton Medical Center, and Louisiana State University Medical Center, all in Shreveport.


Additionally, Dr. Griffen is Vice-Chair of the Public Profile and Communications Steering Committee (2006–present) and has been Chair of the Committee on Patient Safety and Quality Improvement (2002–2006), a member of the Health Policy Steering Committee (2007–present), and a liaison to the Program Committee (2003–2007). He has also been active within the College’s Louisiana Chapter, having served as Vice-President (1990), President-Elect (1991) and President (1992) of the chapter and a member of the chapter’s Credentials Committee (2000–2005). He currently serves on the chapter’s Board of Directors. Dr. Griffen also serves as the American College of Surgeons representative on the steering committee of Doctors for Medical Liability Reform.

Fellows honored for volunteerism

The Governors’ Committee on Socioeconomic Issues is pleased to announce the 2009 recipients of the American College of Surgeons/Pfizer, Inc, Surgical Humanitarian Award and Surgical Volunteerism Awards, including the newly established category for residents. The committee received nominations for many exceptional individuals, once again demonstrating the substantial commitment of the Fellows of the College to the care of the underserved. The awards will be presented at the Clinical Congress in October in Chicago, IL.

**Edgar Rodas, MD, FACS**, of Cuenca, Ecuador, will be awarded the Surgical Humanitarian Award (see photo, this page). Following his graduation from the University of Cuenca’s medical school, Dr. Rodas spent a year volunteering aboard the SS *Hope* with the not-for-profit organization Project Hope. Upon returning to Ecuador, he embarked on a long and illustrious surgical career that has been characterized by service. Whether leading surgical missions to deliver care to the underserved in rural Ecuador, or working to establish a branch of the not-for-profit organization, Interplast, in the country, his devotion to those in need is exemplary. In 1990, he founded the Cinterandes Foundation, a not-for-profit organization that promotes human development. Cinterandes launched a mobile surgery program in 1994, after constructing a van equipped with an operating room, allowing doctors to deliver care to areas that were previously inaccessible. Building on the foundation of that program, the Cinterandes Foundation introduced additional programs in nutrition, immunization, and maternal health, to ensure recipients would receive a full spectrum of necessary care.

Dr. Rodas’ commitment to public service has extended to the highest levels of government, where he was appointed Minister of Health for Ecuador. For his lifetime of effort to bring comprehensive surgical care to the underserved in Ecuador, Dr. Rodas will receive this year’s Surgical Humanitarian Award.

**Douglas P. Grey, MD, FACS**, and **William P. Schecter, MD, FACS**, of San Francisco, CA, founders of the not-for-profit organization Operation Access, will be jointly awarded the Surgical Volunteerism Award.
for their domestic outreach efforts (see photos, this page). Drs. Grey and Schecter are longtime friends and colleagues who serve as chief of vascular surgery at Kaiser Permanente San Francisco Medical Center, and chief of surgery at San Francisco General Hospital, respectively.

At a Clinical Congress in the early 1990s, Drs. Grey and Schecter were inspired by a speaker who questioned why surgeons weren’t more involved in caring for the underserved in the U.S., and they decided to address that challenge in their own community. In 1993, they co-founded Operation Access, a not-for-profit organization that mobilizes an entire network of medical volunteers, referring community clinics, and hospitals to provide donated outpatient surgeries and specialty care to the uninsured and underinsured.

Since its inception, Operation Access has had a positive impact on the health, quality of life, and ability to work of thousands of low-income patients lacking access to surgical care. Their program has proven effective both clinically and financially, and is considered a model for surgical care delivery to the underserved in the U.S. For their success in providing surgical care to those individuals in greatest need in their community, Drs. Grey and Schecter are this year’s recipients of the Surgical Volunteerism Award for domestic service.

Glenn W. Geelhoed, MD, FACS, of Washington, DC, will be awarded the Surgical Volunteerism Award for international outreach in recognition of his devotion to providing surgical care and education throughout the world (see photo, page 33). Each year, Dr. Geelhoed assembles six to eight surgical missions, with teams of medical students, residents, and physicians. Over the course of his career, he has led more than 200 such missions to Africa, Asia, the South Pacific, and South America, and has inspired countless others to take up the mantle.
As a Senior Fulbright Scholar in 1996, he undertook the necessary research and service to develop the African Regional Research Program.

Since 1975, his academic base has been George Washington University, where he is professor of international medicine. Dr. Geelhoed is currently developing an international health center and international medical education program for the university. For his tireless efforts in working with countless surgeons to provide surgical care and education all across the globe, and his vast influence on generations of like-minded surgeons, Dr. Geelhoed is to be awarded this year’s Surgical Volunteerism Award for international service.

**Vance J. Moss, MD, FACS, and Vincent L. Moss, MD, FACS,** of Upland, PA, will jointly receive the Surgical Volunteerism Award for military service in recognition of their contributions in Afghanistan (see photo, this page). After joining the U.S. Army Reserve Medical Corps during their residencies, the Moss brothers were mobilized in 2005 for Operation Enduring Freedom, and deployed domestically to treat soldiers returning from Iraq and Afghanistan. After learning about the lack of surgical and medical care available to Afghan civilians, they began organizing a surgical mission to Afghanistan. With the support of an independent organization, Medical Teams International, the Mosses established contacts in Afghanistan to identify areas that were most in need of surgical care, secured transportation, security, and translators.
In January 2006, they flew to Kabul to undertake their first mission. After demonstrating their commitment to a humanitarian mission with a focus on treating women and children, they were granted access to regions controlled by the Taliban and local warlords. The success of this first mission resulted in a return visit the following year. The Moss brothers remain committed to Afghanistan while here in the U.S., arranging for an eight-year-old boy and his father to travel to New York City in order to complete surgical treatment started on one of the missions.

Currently, the Mosses are in private practice in New Jersey. For service to their country that inspired surgical outreach to civilians in one of the most remote and dangerous areas of the world, Drs. Vince and Vance Moss are the 2009 recipients of the Surgical Volunteerism Award for military service.

Awori J. Hayanga, MD, of Superior, MI, will receive the inaugural Surgical Volunteerism Award for resident service for his founding role, and ongoing work, with the Reuben J. Williams (RJW) Foundation (see photo, this page). Born and raised in Kenya, Dr. Hayanga left Africa to pursue a medical education in Europe. He moved to the U.S. to begin surgical training at Johns Hopkins University Hospital, and later he moved to the University of Michigan, where he served as the administrative chief resident. During residency, Dr. Hayanga co-founded the RJW Foundation, which is committed to improving the delivery of surgical care in resource-poor settings through enhancing surgical education and fostering networks of academic medical institutions in sub-Saharan Africa, Europe, and the U.S. The foundation incorporates curriculum development and research into a variety of areas, including epidemiology, health delivery, policy, and education, and has established a distinguished lecture series that has attracted chairs of surgery from several prestigious institutions to the University of Nairobi. Dr. Hayanga intends to return to Kenya after his residency as the first academic general thoracic surgeon in east and central Africa. Recognizing the remarkable accomplishment of founding, and successfully administering, the RJW Foundation during his residency and for his commitment to improving the delivery of surgical care to some of the world’s most vulnerable citizens, Dr. Hayanga will be presented the Surgical Volunteerism Award for resident service.

The exceptional contributions made by Dr. Rodas, Dr. Grey, Dr. Schecter, Dr. Geelhoed, Dr. Vance Moss, Dr. Vincent Moss, and Dr. Hayanga will be formally recognized at the annual Board of Governors dinner on Tuesday, October 13, during the annual Clinical Congress in Chicago, IL. Congress at-
attendees are invited to hear these physicians speak about their inspiration and work at the panel session on volunteerism (PS06)—which will convene Monday, October 12, 9:45 am–1:00 pm—and to meet them and others dedicated to surgical volunteerism, in all its many forms, at a volunteer networking reception later that evening.

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

Germany Traveling Fellow selected for 2010

Gregory J. Landry, MD, FACS, associate professor of surgery, Oregon Health & Science University, Portland, has been selected as the 2010 ACS Traveling Fellow to Germany.

As the Germany Traveling Fellow, Dr. Landry—a vascular surgeon—will participate in the annual meeting of the German Surgical Society in Berlin, Germany, April 20–23, 2010. He will attend and participate in the ACS Germany Chapter meeting during that event. Dr. Landry will also travel to several surgical centers in Germany, with assistance from mentors provided by the German Surgical Society and the Germany Chapter. He looks forward to meeting with colleagues who share his interest in peripheral vascular disease and functional outcomes of vascular surgical patients.

The application deadline for the 2011 Traveling Fellowship to Germany is April 1, 2010. The requirements will be published in a future edition of the Bulletin and will be posted to the College’s Web site, http://www.facs.org/memberservices/acsgermany.html.

COT accepting submissions for 2010 Resident Trauma Papers Competition

Papers are now being accepted by the ACS Committee on Trauma (COT) for the 2010 Resident Trauma Papers Competition, which will be held during the COT’s annual meeting, March 10–12, 2010, in Las Vegas, NV.

The Resident Trauma Papers Competition is open to general surgery residents, surgical specialty residents, and trauma fellows. The papers should describe original research in the area of trauma care and/or prevention, categorized as either Basic Laboratory Research or Clinical Investigation. Papers should be sent to the appropriate ACS state/provincial chair. A list of chairs is available at http://www.facs.org/trauma/ regional.html.

The papers competition is funded by the Eastern and Western States COT, Region 7 COTs, Wyeth Pharmaceuticals, the National Trauma Institute, and the American College of Surgeons.

The dates of regional competitions will vary, but the deadline for submission of papers to the COT region chiefs is November 13, 2009. Further information can be obtained on the ACS Web Site at http://www.facs.org/trauma/traumapapers.html, or by contacting Bridget Blackwood in the ACS Trauma Office at 312-202-5380 or bblackwood@facs.org.
Survey reveals that residents view DHR a hindrance to training

Results of a survey published in the July issue of the *Journal of the American College of Surgeons* show that a large subset of surgical residents consider duty hour regulations (DHR) a significant barrier to their surgical education, and express a desire for flexibility to work longer hours than current restrictions allow.

The implementation of DHR in 2003 was intended to address resident fatigue and improve patient safety. Prior to implementation, residents often worked 100 hours or more weekly; currently, residents are limited to an 80-hour workweek. Although studies have shown that residents are getting more sleep and their personal lives are improved, the effect of DHR on case load, academic performance, and board examination performance is still poorly understood. The effect of DHR on patient care also remains uncertain, and there is evidence to suggest that there has been an increase in communication errors as a result of frequent patient handoffs.

“We were surprised to find that nearly half of surgical residents believe work-hour restrictions are actually an impediment to their training,” said Jacob Moalem, MD, department of surgery, University of Rochester Medical Center, NY, and Chair of the Resident and Associate Society (RAS) of the American College of Surgeons. “Our current system limits educational opportunities for surgeons who are expressing a desire and a need to learn more in a compact time frame. Senior surgery residents should be given the chance to control their own schedules as they continue to refine their technical skills and transition into independent practice.”

An Internet-based survey was electronically distributed to all RAS Members of the College. The first question asked respondents to rate the impact of DHR on their education as “no barrier,” “minimal barrier,” “moderate barrier,” and “significant barrier.” For analysis, the first two choices were grouped and retitled “no barrier,” and the latter two choices were grouped and called “barrier.” The second question asked respondents how many hours they considered ideal for their postgraduate year in their program. Choices provided were <60 hours, 60 to 80 hours, 80 to 100 hours, and >100 hours per week.

Of 599 respondents, 41 percent believed that DHR were a considerable or moderate barrier to their education. Fewer than one-third of residents reported that their education was not hindered by DHR. Another 27 percent stated that DHR were a minimal barrier to their education.

A small majority of residents (52 percent) reported that the ideal number of hours for their training was 60 to 80, in line with the current DHR. Forty-three percent believed that 80 to 100 hours per week would be ideal.

The belief that DHR represented a substantial or moderate barrier to education was correlated with the belief that the ideal DHR should be greater than 80 hours per week (p < 0.0001). Furthermore, the likelihood that residents and Fellows considered DHR a barrier to their education was highly related to their level of training (p=0.03). First- and second-year residents were more than twice as likely to believe that DHR were not a barrier to education (p=0.0003 and p=0.006, respectively).

Conversely, the proportion of residents who believed that DHR substantially interfered with their education peaked as they approached graduation. Compared with only 7 percent of junior residents, 32 percent of residents in or beyond their seventh postgraduate year reported that DHR were an important barrier to their education (p = 0.006).

Report on the 2009 AMA HOD meeting

by Jon H. Sutton, Manager of State Affairs, Division of Advocacy and Health Policy

Delegates expecting a robust discussion of health system reform were not disappointed at the American Medical Association (AMA) annual House of Delegates (HOD) meeting in Chicago, IL. Contributing to that debate was a one-hour address by President Barack Obama, who made his case for reform to the HOD during the June 2009 meeting. He was warmly greeted by those in the crowd, and while many were not in complete agreement with some of the president’s proposals, delegates felt he candidly presented his views on the issues requiring attention.

After almost nine years of service as a delegate, Charles Logan, MD, FACS, retired from the ACS Delegation. He engaged fully in AMA HOD activities on behalf of the College, including his role as reference committee chair during tenacious pay-for-performance debates, where he demonstrated plain-spoken and stalwart support for the College’s agenda.

Issue highlights

Highlights of the HOD meeting included the following:

• Resolution 110—Public Option Health Insurance. Sponsored by more than 15 state medical societies, Resolution 110 would originally have directed the AMA to oppose public option proposals that could result in the elimination of the private health insurance market. After long and robust debate on the matter, the HOD finally adopted a resolution that outlines the AMA support of health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

• Resolution 203—Right to Privately Contract. An emotional issue for many delegates, Resolution 203 would have made the right to privately contract the highest advocacy priority of the AMA. After considerable testimony, the resolution was amended and adopted to direct the AMA to include in its top advocacy priorities the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so, and regardless of the payor within the framework of free market principles.

• CMS Report 8—Patient-Centered Medical Home (PCMH). The AMA Council on Medical Service presented a report on the patient-centered medical home. Most significantly, the recommendations in this report reinforced the notion that payments associated with the PCMH model not be subject to a budget neutrality offset in the Medicare physician payment schedule. This is consistent with the position taken by the physician specialty community as it advocates in favor of health system reform.

• Financial relationships with industry in continuing medical education (CME). The issue of industry financial support for CME has, over the past couple of years, achieved a high
level of scrutiny, and as a result the AMA Council on Ethical and Judicial Affairs developed a report (CEJA Report 1) in 2008 that was referred back for further work. During the discussion of the June 2009 report, the council was complimented for presenting a much-improved report to the HOD. However, significant concerns still exist, particularly the definitions of ethically preferable and ethically permissible. As such, the CEJA Report 1 was referred back for further consideration.

Surgical Caucus of the AMA

The Surgical Caucus of the AMA, which met during the HOD meeting, continues to operate smoothly under the management of the College. This meeting’s educational session—Health Care Reform and the Surgeon—was presented by Thomas Russell, MD, FACS, ACS Executive Director, and Kristen V. Hedstrom, Assistant Director of Legislative Affairs in the College’s Division of Advocacy and Health Policy.

Elections

As reported in the June 2009 issue of the Bulletin (page 55), Richard Reiling, MD, FACS, ran for re-election to the AMA Council on Medical Education. A well-coordinated campaign managed by John Armstrong, MD, FACS, and the support of numerous surgical specialty societies and delegates helped Dr. Reiling achieve re-election in the first round of voting.

A number of Fellows ran for election to AMA positions. Barney Maynard, MD, FACS, a urologist from Indiana, ran for the AMA Board of Trustees, but, in a tough multi-candidate race, was not successful. Raj Ambay, MD, a plastic surgeon from Wisconsin, was successful in his election bid to be the Resident Trustee on the AMA Board of Trustees, and Michael Deren, MD, FACS, of Connecticut, was re-elected to the AMA Council on Constitution and Bylaws.

In other election news, several surgeons were successful in races for the Young Physician Section (YPS) Governing Council. Patricia Turner, MD, FACS, was elected to serve as Speaker of the YPS Assembly; Steven Chen, MD, FACS, was elected to be the Assembly’s Alternate Delegate to the HOD; Ravi Goel, MD, an ophthalmologist from New Jersey, was elected Chair-Elect; and Dawn Buckingham, MD, FACS, assumed the Chair position.

For further information on the annual 2009 AMA HOD and surgical involvement in this meeting, contact jsutton@facs.org.

The Doctors Company announces membership dividend

The Doctors Company, the official medical malpractice insurance provider for members of the American College of Surgeons, has approved a dividend to reward members of the College for their loyalty and dedication to advancing and protecting the practice of good medicine.

Effective with policy renewals on or after July 1, the dividend credit will provide a premium reduction of 5 percent for eligible members of the ACS professional liability insurance program. The Doctors Company’s multi-year dividend has returned approximately $60 million to members in the past three years. Other member benefits include aggressive claims defense strategies, innovative patient safety tools and programs, and excellent service. The company also offers the unique Tribute® Plan, a career award at retirement, which rewards physicians for their dedication to providing superior patient care.

The Doctors Company is the largest national insurer of physician and surgeon medical liability with 45,000 member physicians.

For more information regarding the 2009 dividend distribution, visit http://www.thedoctors.com/dividend.
Clinical trials methods course scheduled for November

The American College of Surgeons’ Surgical Research Committee is sponsoring the ninth Clinical Trials Methods Course November 13–17 at ACS headquarters in Chicago, IL. A new component this year—course didactics, including two added basic statistics lectures—will be based on four successfully conducted clinical trials published in the literature. The four clinical trials will be distributed ahead of time to all participants.

This course is recommended for surgeons who plan to engage in clinical research at a leadership level. It includes concepts and development of skills in the design, implementation, and analysis of randomized clinical trials; observational studies; the use of large administrative databases; meta-analysis; funding mechanisms and budget development; outcomes (medical, patient-centered, cost); and dissemination of results. Participants work in small groups mentored by a surgeon and a biostatistician to develop a protocol.

It is suggested that interested surgeons reserve a spot early, because the course is limited to 50 participants and is only offered every other year. It is important to note that preference is given to members of the American College of Surgeons.

Visit [http://www.facs.org/cqi/src/clintrial.html](http://www.facs.org/cqi/src/clintrial.html) for online registration, additional information about the course, a preliminary course schedule, and a list of faculty members. For more information, contact Mary Fitzgerald at 312-202-5319, or mfitzgerald@facs.org.

WHAT SURGEONS SHOULD KNOW ABOUT..., from page 9

Most of the factors outlined in this article are relevant when a physician becomes an employee of the buyer after the sale. A physician who is retiring, or not continuing with the practice as an employee of the buyer, should consider other issues, including contract terms that maximize the favorable tax implications for the physician selling the practice, and arrangement for the retention of medical records as required by federal and state law. Also, sometimes physicians who sell or leave a practice are required to sign a noncompete agreement so that he or she cannot open another practice that would compete with the practice he or she sold, thereby diminishing its value.

Regardless of whether the physician is selling because he or she is planning to retire or move away, or whether the physician will continue to practice as an employee of the buyer, the agreement should assure that the transaction is compliant with state and federal anti-kickback and self-referral legislation, antitrust laws, state corporate practice of medicine laws, state certificate of need laws, and state fee-splitting laws, if applicable.

Unless specific reasons exist for a speedy sale, it is best not to be pressured into a quick deal. Taking time to thoroughly research and study potential buyers works in the physician’s favor. Also, carefully reviewing all aspects of the contract, particularly with experts, will smooth the path as the sale process progresses. Again, it is important to hire an experienced health care attorney, accountant, and financial advisor to provide advice throughout the sale process, as this article does not address the entire range of issues that could be relevant to the sale of a specific practice.

This article is intended to be a general introduction to the issues related to selling a medical practice. This article does not constitute legal, accounting, or financial advice or opinion. It should not substitute for advice from a health care attorney, accountant, or financial advisor who knows the facts related to your specific practice.
As a body representing all of surgery, the College:

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

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

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

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

Here are some of the many benefits being a member of the College affords you:

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

Information on becoming a member of the College and an application form are available online at www.facs.org/dept/fellowship/index.html

or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800-293-9623, or via e-mail at chicks@facs.org.
The International Relations Committee of the ACS announces the availability of the Australia and New Zealand (ANZ) Traveling Fellowship. The purpose of this fellowship is to encourage international exchange of surgical science, practice, and education, and to establish professional and academic collaborations and friendships.

Basic requirements
The scholarship is available to a Fellow of the American College of Surgeons, in most of the surgical specialties, who meets the following requirements:
- A major interest, and accomplishment in, basic sciences related to surgery
- Holds a current full-time academic appointment in the U.S. or Canada
- Under 45 years of age on the date the application is filed
- Enthusiastic, personable, and possesses good communication skills

Activities
The Fellow is required to spend a minimum of two or three weeks in Australia and New Zealand, and to engage in the following activities:
- Attend and participate in the annual Scientific Congress of the Royal Australasian College of Surgeons, in Adelaide, Australia, May 3–6, 2011
- Participate in the formal convocation ceremony
- Attend and address the ANZ Chapter meeting
- Visit at least two medical centers in Australia and New Zealand to lecture, and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and the President or designated representative of the Australia and New Zealand Chapter of the ACS. The surgical centers selected for a visit would depend, to some extent, on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Australia and New Zealand.

His or her spouse is welcome to accompany the chosen applicant. There will be many opportunities for social interaction, in addition to professional activities.

Financial support
The College will provide $8,000 to the chosen applicant, who will also be exempted from registration fees for the annual Scientific Congress. He or she must meet all travel and living expenses. Senior chapter representatives will consult with the Fellow about the centers to be visited in Australia and New Zealand, the local arrangements for each center, and other advice and recommendations regarding travel schedules. The Fellow is urged to make his or her own travel arrangements in North America, due to the likely availability of reduced fares and packages for travel in Australia and New Zealand.

The ACS International Relations Committee will select the Fellow after reviewing and evaluating the final applications. A personal interview may be requested prior to the final selection.

Applications for this traveling scholarship may be obtained from the College’s Web site, http://www.facs.org/memberservices/research.html, or by writing to the International Liaison, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is November 16, 2009. The successful applicant, and an alternate, will be selected and notified by March 2010.
NEW! ACS MULTIMEDIA ATLAS OF SURGERY
Colorectal Volume. This DVD and accompanying book provide an interactive demonstration of 26 colorectal surgery procedures, both laparoscopic and open. Especially designed to address the cognitive element of surgical procedures, each procedure is presented in a step-wise fashion, offering expert commentaries that highlight specific nuances and actions to be taken to prevent errors. Upcoming volumes include Pancreas Surgery and Hernia Surgery.

NEW! PROFESSIONALISM IN SURGERY, 2nd Edition: This DVD presents an additional 12 new vignettes that depict professionalism challenges faced by surgeons in everyday practice, as well as possible courses of action in the context of the core competency of professionalism. The vignettes are ideal for teaching purposes and CME credit is available.

NEW! ACS SURGERY RESIDENT OSCE: This program provides a tool to assess the entry-level knowledge and skills of PGY-1 surgery residents to deliver safe care to surgery patients with critical and life-threatening conditions. It includes a CD-ROM manual with all the materials needed to administer the OSCE, and a DVD that provides a gold standard performance of each clinical scenario. This project was supported by grant number U18 HS12021 from the Agency for Healthcare Research and Quality.

NEW! PATIENT SAFETY 2008 CD. This CD features patient safety sessions from the 2008 Clinical Congress.

BASIC ULTRASOUND COURSE CD: This CD provides a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications and is available for CME credit.

PRACTICE MANAGEMENT for Residents and Young Surgeons: This series of three CDs covers important topics such as mechanics of setting up or running a private practice, essentials of an academic practice and career pathways, and basics of surgical coding. CME credit is available.

ADDITIONAL CDs, including the Bariatric Surgery Primer and Personal Financial Planning and Management for Residents and Young Surgeons.

DVDs AVAILABLE AT NO CHARGE, including Disclosing Surgical Errors: Vignettes for Discussion, and Communicating with Patients About Surgical Errors and Adverse Outcomes, each supported by a grant of the Agency for Healthcare Research and Quality.

VIDEO-BASED EDUCATION SESSIONS: Select video sessions from the Clinical Congress are available on CD/DVD. The ACS Video Library contains narrated videos, donated by the authors.
The Clowes ACS/AAST/NIGMS Mentored Clinical Scientist Development Award available

The American College of Surgeons and the American Association for the Surgery of Trauma (AAST) announces a program that will provide supplemental funding of up to $75,000 per year to an individual who has received a Mentored Clinical Scientist Development Award (K08/K23) from the National Institute for General Medical Science (NIGMS). This award is directed at surgeon-scientists working in the field of trauma in the early stages of their research careers. The award supports a three-, four-, or five-year period of supervised research experience that may integrate didactic studies with laboratory or clinically based research.

This award program offers a means to facilitate the career development of individuals pursuing careers in trauma surgery research by enhancing salary support over and above that offered by the K08/K23 mechanism.

The application deadline is October 12, 2009. To apply, submit the complete K08 or K23 application simultaneously to NIGMS and to Kate Early, the ACS Scholarships Administrator. Previously submitted applications and previously granted awards are not eligible for consideration. If applicants receive a K08 or K23 from NIGMS, their applications will undergo further review by a special committee for prospective supplemental funding. Funding begins July 1, 2010.

Awardees must be members in good standing of the College and eligible for membership in AAST. For further details, visit http://www.facs.org/memberservices/research.html, or e-mail Ms. Early at kearly@facs.org.

COMMITTEE ON SURGICAL INFECTIONS..., from page 24

Members of the Governors’ Committee on Surgical Infections and Environmental Risk

Vijay K. Maker, MD, FACS, Chair
Michael A. West, MD, FACS, Vice-Chair
Marianne E. Cinat, MD, FACS
John Fildes, MD, FACS
Henri R. Ford, MD, FACS
Donald E. Fry, MD, FACS
Linwood R. Haith, Jr., MD, FACS
John C. Hendricks, MD, FACS
Jan K. Horn, MD, FACS
Rao R. Ivatury, MD, FACS
M. Margaret Knudson, MD, FACS
Edward J. Quebbeman, MD, FACS
Leonard M. Randolph, Jr., MD, FACS
Andrew W. Saxe, MD, FACS
Francis J. Scarpa, MD, FACS
Donald J. Scholten, MD, FACS
Joseph J. Sferra, MD, FACS
Michael J. Sutherland, MD, FACS
Beth H. Sutton, MD, FACS
Stephen Michael Warren, MD

for the Clinical Congress in Washington, DC, in 2010:

- Prevention of Infection 2010 and Beyond: Let Us Not Forget the Patient
- Myths and Facts in Surgical Environment
- Infected Implants: How Do I Handle ‘Em?
- Vacuum-Assisted Wound Care: To Suck or Not to Suck
- Hospital-Acquired Infections: Can We Win the Battle?
- What Leads to Never Events: Perfect Storms or Black Swans
- Surviving Systemic Inflammatory Response Syndrome—2010 and Beyond

The program chair continues to represent the ACS at the National Advisory Council of the Joint Commission on Blood Transfusion and Utilization. Our committee has accepted the charge of producing a white paper summarizing the College’s stance on this important issue.

Thank you for all the input from Fellows, and we welcome your suggestions through 2010 and beyond.
Report of the 2009 Japan Traveling Fellow

By Lorenzo Ferri, MD, PhD, FACS

As I planned for the three weeks I would spend in Japan in April 2009 as the American College of Surgeons Traveling Fellow, I reflected on my clinical practice and research interests to identify gaps that my Japanese colleagues could help fill. Ultimately, I came up with a general theme for my visit: “Stage-Directed Therapy for Malignancies of the Foregut.”

As a thoracic surgeon specializing in esophageal and gastric cancer, I had significant exposure to this concept through my training under John Wong, MBBS, FACS, and Simon Law, MBBChir, FACS at the University of Hong Kong, China.

Nonetheless, I was intrigued by the remarkable success in treatment of gastric and esophageal cancer reported in manuscripts from Japan, be they technical achievements such as endoscopic submucosal dissection (ESD) for early tumors and extended lymphadenectomy for more advanced tumors, or the use of adjuvant chemotherapy. Could the improvements in survival rates in Japan compared with the survival rates of this disease in North America be due solely to a difference in histological disease or stage migration? As a fervent supporter of D2 celiac dissection, I could not believe that this was the case, and so I was compelled to investigate these improvements at the source.

Accordingly, I organized my trip to visit centers that have embraced the concept of stage-directed therapy and have distinguished themselves in the treatment of foregut malignancies. For early cancer treatment, I visited two endoscopy units in Tokyo—the National Cancer Centre Hospital and Toranomon Hospital—headed by Takuji Gotoda, MD, and Noahisa Yahagi, MD, respectively. For advanced disease, I visited Mitsuru Sasaki, MD, FACS, of Hyogo University Medical Centre; Harushi Osugi, MD, at Osaka City University Hospital; and Harushi Udagawa, MD, FACS, at Toranomon Hospital.

Fukuoka—Japanese Surgical Society annual meeting

During the first stop in my quest for stage-directed therapy of upper gastrointestinal (GI) malignancies, I attended the annual congress of the Japanese Surgical Society in Fukuoka—the capital of Kyushu. As I
traveled to my hotel from the airport, I was welcomed by my first sighting of the famed *sakura*, as I had fortunately timed my visit with the short-lived, but truly breathtaking, cherry blossom season. The following day I presented a talk during the international travel grant session, titled Exploring the Role of Systemic Inflammation in Thoracic Cancer Metastasis, an overview of my basic science laboratory investigation into the cancer cell–inflammation cross-talk in cancer progression. At that session, I discovered that my Teutonic equivalent, the German Surgical Society traveling fellow Jan-Hendrick Egberts, MD, PhD, from the University Hospital of Schleswig-Holstein in Kiel, has a similar central research theme. After our presentations, we discussed potential collaborative efforts between our respective laboratories.

During the meeting, I took advantage of this important date in the Japanese surgical calendar to catch up with old friends and to make many new ones, as well. One of my previous surgical oncology fellows, Hidefumi Nishimori, MD, had returned to Japan to work in one of the premier esophageal programs in northern Japan, Prof. Masao Hosokawa’s center at Keiyukai Sapporo Hospital in Hokkaido. Not only did we discuss, at length, future collaborative efforts, including exchanging cancer cell lines and access to each other’s tissue banks, Dr. Nishimori also introduced me to the famed Fukuoka ramen noodles, best experienced at a roadside food stall (see photo, page 44).

The conference was well attended and highly successful due to the organization of conference president Prof. Masao Tanaka of the Kyushu University (see photo, this page), who hosted an excellent opening reception where I had the opportunity to meet many surgeons from across Japan.

Although most of the presentations at the annual congress were in Japanese, the posters and slides were often in English or presented in a manner that was comprehensible to all, irrespective of country of origin. Furthermore, the many video sessions at the conference ensured that non-Japanese speakers could participate and learn from our Japanese colleagues.

I was astounded by the sheer number of sessions, often offered simultaneously, dedicated to gastric and esophageal surgery. Clearly my decision to come to Japan was a good one. After four days in Fukuoka, I packed my bags to head north-east to Osaka where I would meet up with my wife, Alison Breen, at Kansai airport as she travelled from Montreal to join me in the middle week of my 21 days in the land of the rising sun.

**Kansai Area–Osaka and Hyogo**

We were greeted at the airport in Osaka by Dr. Osugi, head of gastroenterological surgery at the Osaka City University Graduate School of Medicine, and his wife Hideko, for what would become a week of incredible and unparalleled hospitality in a country that
takes this virtue seriously. The Osugis brought us to a hotel that they had arranged for our stay in the Kansai area, one which proved to be a central starting point for the week that lay ahead.

The first day I visited Professor Sasako, previously of the National Cancer Center Hospital (NCCH) in Tokyo, but currently the chair of surgery at Hyogo College of Medicine Hospital. Professor Sasako is widely regarded as a pioneer in extended lymphadenectomy and is an integral part of the Japanese Clinical Oncology Group organizing committee for randomized controlled trials investigating all aspects of treatment for gastric cancer, be it surgical (for example, D2 versus D1 celiac lymphadenectomy, transhiatal versus left thoraco-abdominal for cardia cancers) or chemotherapy (for example, adjuvant S1 for resected gastric cancer). He is a true leader in gastric surgery and I was fortunate to spend a day visiting his program and to witness him perform a trademark D2 dissection (see photo, this page). We discussed the role of neo-adjuvant chemotherapy in gastric cancer, as well as the differences in treatment paradigms of this disease between North America and Japan.

Although our group at McGill University has embraced routine neoadjuvant/adjuvant perioperative chemotherapy, followed by resection with extended D2 lymphadenectomy for gastric adenocarcinoma, the standard for much of North America consists of up-front resection and adjuvant chemoradiotherapy. It was refreshing to speak with one of the true promoters of extended lymphadenectomy and hear his viewpoint on the subject, particularly the reasons behind the failure of the Dutch trial to show a clear benefit of D2 dissection. I look forward to discussing these topics with Professor Sasako in further detail as I proceed with the design of clinical trials within our own group at McGill.

I returned to Osaka for the following two days to reside more proximally in the GI tract, namely in the esophageal surgery department at Osaka City University Hospital, led by
Professor Osugi (see photo, page 46). An internationally recognized leader in thoracoscopic extended lymphadenectomy for esophageal cancer, Professor Osugi had previously invited me to visit his impressive center, and the ACS traveling fellow program offered me the perfect opportunity to take him up on this offer.

Professor Osugi has successfully applied minimally invasive techniques to a procedure few thought amenable to this approach, en-bloc three-field esophagectomy. Indeed, his technique was initially met with skepticism from the esophageal surgical establishment in Japan. However, after witnessing Professor Osugi’s technical wizardry in skeletonizing both recurrent nerves within the chest, I can easily see how he has been able to convert many Japanese surgeons to the thoracoscopic approach, including Professor Udagawa, whom I would visit later in my trip.

Professor Osugi has a remarkable team that, during the procedure, works like a symphony in full swing, as if one head were controlling three sets of hands. I felt somewhat embarrassed showing him videos of some of my own minimally invasive esophagectomy cases, and promised him to show him a more refined technique when I invite him to Montreal. To aid me in this endeavor, he gave me as a gift (one of many from him and his wife) a patented “Osugi retractor” that he developed for this procedure, an instrument I have since used in Montreal.

During my visit, I gave a talk to the Osaka City University Department of Surgery on one of my recently closed trials, titled Peri-operative Taxane-Based Chemotherapy for Adenocarcinoma of the Esophagus, Gastro-esophageal Junction, and Stomach: Early Results from a Phase II Trial. After my talk, the surgical team including Dr. Lee, Professor Osugi’s partner, hosted my wife and me at a Korean barbeque. We were treated to the “cardiothoracic
special,” a title that may conjure images of a two-pound cheese steak in North America, but in Osaka, a city with a large Korean population, this represents eating delicately grilled bovine heart, aorta, and trachea. I think I may still be trying to digest the trachea.

My wife and I spent the rest of the week in Kyoto, enjoying the cherry blossoms in full bloom. We were fortunate to have scheduled this portion of the trip at the height of this incredibly beautiful season, in the city that most Japanese believe to be synonymous with cherry blossoms. Although I did not visit a hospital in Kyoto, I couldn’t resist the urge to buy a chef’s knife as sharp as any scalpel I have ever used, at a store called Aritsugu—an establishment that has been the purveyor of fine knives to the discerning Japanese chef for over 400 years.

We returned to Nara to spend the weekend with Professor Osugi and his wife Hideko in their remarkable traditional Japanese home, complete with tatami mats. As we made a concerted effort not to discuss surgery, I learned as much about Japanese culture during this weekend with Harushi and Hideko as I have about medicine. (see photo, page 47). Alison and I are truly grateful for the incredible hospitality that the Osugis provided us, and we look forward to hosting them in Canada in the near future.

**Tokyo–Toranomon Hospital and NCCH**

I returned to Tokyo to visit the Toranomon Hospital, a center renowned across Japan for the management of esophageal disease. Indeed, it is at this hospital that Drs. Hiroshi Akiyama and Masahiko Tsurumaru established and popularized extended lymphadenectomy for esophageal cancer, a technique used routinely throughout Japan but sparingly in North America. Although I currently perform three-field lymphadenectomy for mid and upper esophageal cancers, I can think of no greater place than Dr. Akiyama’s institution to witness this procedure performed to perfection. Indeed, Professor Udagawa (see photo, page 47), the present head of esophageal surgery at the Toranomon Hospital, has not only continued Akiyama and Tsurumaru’s legacy, he has also improved upon it by...
adding the minimally invasive approach. I witnessed Professor Udagawa perform two thoracoscopic esophagectomies during my time with him, and I can honestly state that I have never seen a finer lymph node dissection in the neck or chest anywhere in the world. He has truly perfected this technique, and I was impressed with the attention he and his team paid, not only to the dissection of lymph nodes within the patient, but also to the surgical specimen once it had left the body. Long after the patient had left the operating theatre, all members of the surgical team remained to dissect every lymph node from the specimen into discrete numbered packages according to the original map designed by Dr. Akiyama (see photo, page 48). Through the combination of thorough in-situ dissection, as well as careful examination of the specimen, retrieval of more than 80 lymph nodes is not uncommon at the Toranomon Hospital.

Professor Udagawa and his team treated me to an incredible Kaiseki–style meal in Ginza, where we continued our discussion on neoadjuvant treatment of esophageal cancer.

Moving from maximally to minimally invasive procedures, I moved on to the area of nonsurgical treatment of foregut malignancies by visiting two of the pioneers of endoscopic resection. Professor Gotoda, of the NCCH, and Professor Yahagi, of Toranomon Hospital, were both instrumental in the development of ESD at the end of the last millennium. This technique involves a significantly greater degree of complexity than endoscopic mucosal resection (EMR), but, unlike EMR, this technique adheres to surgical oncology principles by providing a pathology specimen with a measurable deep and circumferential margin for any size lesion. Although EMR is widespread in North America, ESD is rarely performed here, despite these clear benefits.

As I embarked from my hotel to the NCCH, I realized that my tourist’s map did not include the NCCH. However, my limited navigation skills were not required, as I had learned that the hospital is directly across the street from the famed Tsukiji fish market—the world’s largest—and my olfactory senses proved as useful as any global positioning system device. I spent two days within Professor Gotoda’s endoscopy unit at the impressive NCCH, and witnessed numerous ESD procedures. This technique requires specialized equipment.
that is passed through the operating channel of a standard gastroscope. Professor Gotoda (see photo, page 49) has developed one of the most widely used tools for this procedure, a needle knife with an insulated tip (the IT knife) that enables a safe dissection of the submucosa from the muscularis propria.

Dr. Yutaka Saito, a technically gifted endoscopist in Dr. Gotoda’s unit, performed a difficult ESD for a mid-esophageal squamous cell carcinoma during my visit. I met frequently with Dr. Gotoda and members of his team, including Dr. Saito, and we discussed at length the development of this technique, as well as the possibility of expanding the indications to cases highly pertinent to Western surgeons. Along those lines, Dr. Gotoda showed me images of a recent case of long segment Barrett’s with high-grade dysplasia for which he had performed ESD in a patient from Britain.

For the final sojourn of my trip, I returned to the Toranomon Hospital to visit the endoscopy unit headed by Professor Yahagi (see photo, this page). This extremely busy unit performs over 800 ESD procedures annually and is widely considered, along with the NCCH, as one of the premier centers for this technique. During my two-day visit I witnessed more than 10 ESD procedures for early tumors of the esophagus, stomach, and colon. I was greatly impressed by the coordination of all members of Dr. Yahagi’s team, which made these difficult procedures appear effortless. As with Dr. Gotoda at the NCCH, Dr. Yahagi has been instrumental in the development of advanced endoscopic equipment for mucosal incision and submucosal dissection, including the flex knife and dual knife. It was interesting to compare and contrast the differences in technique between these two gifted pioneers of ESD. In developing the McGill Endoscopic Submucosal Dissection program, I have incorporated a portion of what I learned from both endoscopists.

**Conclusion**

Upon returning to Montreal, I reflected on my incredible trip to Japan and realized that I had completed a once-in-a-lifetime experience. I am deeply indebted to the many people I met, and am grateful to the International Relations Committee for choosing me as the 2009 ACS Traveling Fellow to Japan. I look forward to continuing my friendship with the surgeons and endoscopists I met during the ACS traveling fellowship to this remarkable country, and am certain that the lines of scientific and clinical collaboration that we have already initiated will last for many years to come.

*Dr. Ferri* is assistant professor of surgery and oncology, McGill University, Montreal, PQ.
A look at The Joint Commission

New approach to sterilization

With an increased focus on the prevention of health care-associated infection, it is important for surgeons to understand whether or not the sterilization process used on their instruments is adequate enough to protect their patients from infection.

The Joint Commission has been discussing common and proper use of steam sterilization with multiple professional and trade organizations. A few decisions have been made that will affect the interpretation of standards, as well as the survey process. This new approach may be of particular interest to surgeons in fields with a high rate of instrument reuse, such as ophthalmology.

According to the steam sterilization position statement issued in June by The Joint Commission: Based on discussions with experts in the field, professional organizations, and government organizations, The Joint Commission has decided to refocus its survey efforts on all of the critical processes included in sterilization. If a complete and effective process of sterilization is used, it will be considered an effective sterilization method. Therefore, surveyors will review the critical steps of disinfection and sterilization to determine if the process is appropriate.

Previously, the selection of a sterilization method was a primary focus during a survey. Now surveyors will be looking more closely at all aspects of the sterilization method or cycle. According to the statement the surveyors’ activities will include the following:

• Observe instruments from the time they leave one operating room, to the time they are returned to the next.
• Ask health care workers to provide the manufacturers’ instructions for instrument sterilization, and to describe and demonstrate how instruments are being cleaned and decontaminated according to those written instructions.
• Observe the cleaning of instruments. Rinsing is rarely enough to properly remove soil from instruments; meticulous cleaning is necessary.
• Verify that staff members are wearing appropriate personal protective equipment.
• Observe the sterilization process. The surveyor will ask for the manufacturer’s instructions for the following items: the sterilizer, wrapping or packing, and the instruments.
• Review sterilization logs. Surveyors will be seeking information related to parametric, chemical, and biological indicators.
• Observe the return of instruments to the sterile field, and verify that they are being protected from recontamination.


If you have a question for The Joint Commission, fill out the standards online submission form, available at the following Web site: http://jcwebnoc.jcaho.org/SigSub/onlineform.asp.
American College of Surgeons
Professional Association (ACSPA)

As of May 18, 2009, the ACSPA-SurgeonsPAC (political action committee) raised $226,613. The average donation amount from 823 Fellows and staff was $275. ACSPA leaders’ contributions included the following:

• U.S. Governors: 26 percent donated on average $407
• U.S. Regents and Officers: 30 percent donated on average $669

Political disbursements were made to 45 candidates, leadership PACs, and party committees. The ACSPA-SurgeonsPAC will continue its education and outreach programs, and will focus efforts on increasing participation at the local level. Peer-to-peer fundraising remains a critical component of a successful PAC, and PAC leadership will continue to work to foster these efforts.

American College of Surgeons
Board of Governors (B/G)

The Executive Committee of the Board of Governors held three of the five telephone conference call meetings scheduled for this year. A sixth meeting will occur during the Clinical Congress in October in Chicago, IL.

Two B/G webcasts were held in 2009. The first webcast was held February 6, and the second webcast was held June 5. The webcasts are scheduled in conjunction with the Board of Regents meetings held in Chicago.

The Executive Committee and B/G committee chairs are currently planning the 2009 joint session of the Governors and the Regents. It is anticipated that the topics of interest will focus on workforce issues, health care reform, and payment reform.

ACS Health Policy Research Institute (HPRI)

In order to provide a dynamic and up-to-date location for information about the ACS HPRI, a Web site is being developed by HPRI staff. The Web site’s content will include in-
information about the HPRI purpose, staff, current projects, publications, and news. The site will be developed in a manner that is consistent with the appearance of the other ACS Web pages, and will link to the ACS Web site.

The HPRI cosponsored a Surgery Workforce Meeting on April 29, in Washington, DC, in conjunction with the fifth annual Association of American Medical Colleges Physician Workforce Conference. Invitations were sent to all of the ACS Advisory Councils, the American Board of Medical Specialties Surgery Board, and many professional societies, in which a representative was requested to attend the meeting. The meeting was attended by approximately 25-30 invited representatives from professional societies, education and training organizations, and health workforce researchers interested in the collection and analysis of data on the surgical workforce.

The meeting was lively and productive. Much of the discussion centered on the future of rural surgery, the problem of the diminishing general surgery workforce, and the changing culture of the surgical profession as a new generation of surgeons enters the workforce.

**Review Course for General Surgery**

The Board of Regents approved the initiation of a new, free-standing Review Course for General Surgery. Because of the comprehensive nature of the board recertification examination in general surgery, most surgeons take steps to prepare for the examination, whether it is to refresh overall knowledge of general surgery, or to affirm knowledge and cognitive skills used every day. To help meet this need, the College is designing a comprehensive (24-hour) course that provides a broad review of the essential content areas in general surgery. The course will use a variety of contemporary education strategies, including case-based activities, lectures, sessions with an audience response system, and online modules posted following the course.

**Advocacy**

The Board of Regents approved additional appointments to the newly formed Health Policy and Advocacy Group. The Group’s goal is to consider how it can best serve the College for expert response queries on behalf of surgeons, and for policy development. Andrew L. Warshaw, MD, FACS, is the Group’s Chair.

In response to the Senate Finance Committee’s proposal on health care delivery system reform, the College was joined by 14 other surgical specialties in sending a detailed comment letter addressing issues such as budget neutrality, sustainable growth rate reform, Physician Quality Reporting Initiative, quality improvements, health information technology, and comparative effectiveness. Following the letter’s submission, the ACS secured a meeting with key Senate Finance Committee staff to discuss, in further detail, surgery’s reaction to the proposal.

The College was one of two physician organizations sitting before the Senate Finance Committee at a roundtable discussion on the topic of reforming America’s health care delivery system. The roundtable was the first in a series of three planned roundtables in the Finance Committee’s effort to craft comprehensive health care reform legislation. The other discussions will focus on extending insurance coverage and the financing of full-scale health reform, respectively.

The College was among a select group of physician organizations invited to meet with Sen. Max Baucus (D-MT) to discuss progress on health reform legislation and Medicare payment reforms. The College also participated in three closed-door meetings with key members of Senator Baucus’ staff to discuss progress on health care reform legislation.

The College served as the lead organization in brokering a meeting between the physician community and the House Ways and Means Committee Chair, Rep. Charles Rangel (D-NY). Representatives from the College and other organizations expressed the physician community’s shared position regarding the implementation of innovative
payment reforms, the need to remove barriers to reform—such as Stark Laws and antitrust restrictions, the impact of defensive medicine and the need for liability reform, and the importance of establishing a national workforce policy to address the growing workforce challenges in medicine.

The College released a statement expressing support for President Barack Obama’s proposed plan to address Medicare’s broken physician payment system within his budget outline. The initial outline would stop a 21.5 percent cut in Medicare payments in 2010, and would set a new budget baseline in 2010, preventing Medicare payments from falling below current levels. In the statement, ACS Executive Director Thomas R. Russell, MD, FACS, expressed the College’s interest and desire to work with the new Administration on reforming the Medicare payment system. The statement also expressed the College’s long-standing commitment to improve patient outcomes, and highlighted the successful efforts of the ACS Commission on Cancer as one successful model for policymakers.

John T. Preskitt, MD, FACS, a general surgeon in private practice at Baylor University Medical Center in Dallas, TX, and member of the ACS Board of Regents, testified at a hearing of the U.S. House of Representatives Committee on Small Business. Dr. Preskitt discussed how the ACS National Surgical Quality Improvement Program (ACS NSQIP) could be a helpful model for the budget’s proposed expansion of hospital quality improvement (QI) efforts. In discussing QI and efforts to limit hospital readmissions, Dr. Preskitt stressed the importance of risk adjustment to account for variations in patient acuity. He also expressed the College’s concerns regarding the president’s proposal to limit physician ownership and investment opportunities in physician-owned specialty hospitals.

The College joined with 30 other organizations in sending a letter to the Senate and House Budget Committees. The letter expressed support for including in the budget resolution the resources needed to enact comprehensive health reform legislation, and requested the committees to consider the long-term savings that such reforms could achieve in their resolutions. The letter specifically asked the committees to work outside their typical 10-year budget window and account for the savings that would be achieved by a restructuring of the health care system.

The College issued a strong statement on surgical workforce challenges for a Senate Committee on Finance hearing. The College also offered several recommendations for addressing workforce shortfalls, and warned Congress about the potential negative effects of proposals that would finance increased reimbursement for primary care through reduced payments for other physician services, including surgical care. More specifically, the ACS noted that such actions could threaten patient access to surgical care and discourage medical students and residents from pursuing careers in surgery.

The College continues to meet regularly with the staff of key committees and representatives regarding its Statement on Health Care Reform and its position regarding issues that are being discussed in this context. The College continues to stress Medicare physician payment reform as an essential component of health system reform. In addition, the College continues to express its opposition to budget-neutral payment increases for primary care that would require corresponding payment cuts for other physician services, including surgical care.

The College had numerous conversations with staff members of various senators and representatives to discuss the value of ACS NSQIP in improving patient surgical outcomes. In addition, the College discussed ACS NSQIP and its relation to H.R. 1, the American Recovery and Reinvestment Act of 2009. The College continues to be in regular contact with the staff of Senators Baucus and Conrad, who are working to develop broader comparative effectiveness legislation.

On behalf of the College, Dr. Russell nomi-
nated Karen R. Borman, MD, FACS, and Ronald D. Castellanos, MD, FACS, to serve second terms on the Medicare Payment Advisory Commission (MedPAC). Dr. Russell highlighted the important contributions that Dr. Borman has made to MedPAC’s work, and expressed the importance of preserving her unique surgical perspective as a MedPAC Commissioner. Dr. Russell also underscored Dr. Castellanos’ unique perspective as the only physician in private practice who serves on the panel.

The College recently led an effort to gain inclusion of trauma-related legislation in health care reform. The College, along with its trauma and emergency care colleagues, worked with trauma champion Sen. Patty Murray (D-WA) on three bills that would address trauma and emergency care. Senator Murray has indicated to the College that she will request the inclusion of these three bills in the health care reform package, and the College will continue to work with her staff on these bills as this process continues. The following is a list of the three bills:

• National Trauma Center Stabilization Act
• Improving Emergency Medical Care and Response Act
• Authorizing the Emergency Care Coordination Center (ECCC)

The Trauma-EMS program has not received funding since FY 2005. The College has asked for $12 million for FY 2010 in the Labor, Health & Human Services, and Education Appropriations legislation—$4 million more than authorized for FY 2010. Due to the lack of funding of this vital program, the College is asking for the amount authorized in PL. 110-23 for FY 2008, in order to provide sufficient resources for re-establishing the program. The College is working hard to collect data and patient stories describing what has been lost as a result of the lack of funding for the Trauma-EMS program.

The College, along with trauma and emergency care colleagues, developed a legislative agenda for the 111th Congress to address the trauma and emergency care issues across the country. The College is also working on the following legislation:

• Mitigating the Impact of Uncompensated Service and Time Act (H.R. 1678)
• Access to Emergency Medical Services Act (H.R. 1188/S. 468)
• Health Care Safety Net Enhancement Act (H.R. 1998)
• Emergency Volunteer Health Care Professions Protection Act

At the grassroots level, the College is working on its soon-to-be-launched Grassroots Network, which will provide its members with an opportunity to get actively involved in surgery’s advocacy efforts. Simultaneously, the College is working to launch a patient-centered grassroots advocacy platform to engage and motivate patients in our efforts to ensure health care policy that preserves and promotes quality surgical care and access.

There are approximately 180,000 bills introduced every year in state legislatures. In order to cull out those of particular interest to surgeons, the College uses an online service called CQ State Track. This year, 731 bills were identified as fitting within our search parameters, developed from a list of state legislative priorities. Surgeons who are interested in staying abreast of the state legislation that the College is monitoring may use a feature of this tracking service on the Advocacy page of the College’s Web portal. A map of the U.S. allows users to click on an individual state to get an overview of pending regional legislation. Information available through the tracking service includes bill numbers, titles, sponsors, abstracts, scheduled hearings, and notes added by College staff. If the College is asking surgeons to take action on a particular bill, a link to the Surgery State Legislative Action Center is provided.

ACS NSQIP

As approximately 50 percent of the hospitals in the U.S. have less than 100 beds, the ACS NSQIP has initiated a pilot program to
foster participation in the rural/small hospitals in the U.S. In addition to appropriate pricing for these hospitals to join the ACS NSQIP, there will be program enhancements that decrease the burden of data collection for these hospitals, as well as enhancements that specifically target the types of procedures performed in these rural/small hospitals.

**Trauma consultation/verification program for hospitals**

As of May 8, 2009, there were 286 ACS verified trauma centers. The most common deficiencies continue to be performance-improvement related. A resource manual for site reviewers is under development, and an online credentialing program for reviewers is being considered.

**Education**

A special ACS task force was appointed to review the Institute of Medicine Consensus Committee Report on resident duty hours, and to assist in developing a response from the College on behalf of the house of surgery. The College prepared a comprehensive response for the Accreditation Council for Graduate Medical Education (ACGME). The response has been submitted to the ACGME, and discussions with a variety of organizations are ongoing to address this important issue.

The College has continued to provide national and international leadership in simulation-based surgical education. A broad range of educational programs and products involving simulation have been developed and launched. Simulations of various types have been incorporated into definitive educational programs and products to support teaching, learning, and assessment. Collaboration across the surgical specialties and with other national organizations, universities, and federal entities is actively being pursued.

At the 2009 Clinical Congress, 116 panel presentation sessions in various tracks will cover a broad range of important and timely topics in general surgery and the surgical specialties, as well as critical nonclinical topics. Twelve didactic postgraduate courses will be offered, including the extremely successful General Surgery Review Course. Fourteen skills courses will also be offered.

Enhancements continue to be made in *Selected Readings in General Surgery*. An international version will be made available to reach new markets.

The Fundamentals of Surgery curriculum continues to be extremely well received. Additional case scenarios have been added with the goal of making 94 case scenarios available in the 11 modules of this curriculum. The entire program was scheduled for completion by June 2009, and will be available for the incoming cohort of surgery residents.

The second edition of *Professionalism in Surgery: Challenges and Choices* includes 24 vignettes, and is the definitive educational resource for professionalism in surgery. It is being used for resident education at institutions across the country, and by practicing surgeons who have found this to be a very useful resource.

Special certificates based on verification levels continue to be provided to attendees for participation in postgraduate courses at the Clinical Congress. For 2009, 18 courses will offer Level I Verification, nine will offer Level II Verification, and two will offer Level III Verification. This program provides specific outcomes information and documentation that can be used in credentialing and privileging.

A total of 3,017 College members claimed continuing medical education (CME) credit for the general sessions attended at the 2008 Clinical Congress. CME credit information earned from the spectrum of programs offered by the College is seamlessly transferred to the respective “My CME” page of the individual surgeon. A system is being developed to transfer the CME credit information from the “My CME” page to the American Board of Surgery, upon request of the surgeon, for Maintenance of Certification (MOC). This will be an additional member benefit that will help
surgeons in meeting the MOC requirements. The new patient education Find a Surgeon Web site has been enthusiastically embraced by both patients and members. On average, 772 member profiles are viewed daily by patients. College members have responded positively to the increased public visibility and many have updated their profiles.

**ACS Advisory Councils for the Surgical Specialties**

All of the Advisory Councils continue to propose educational programming for the Clinical Congress, and to formulate programming that would benefit the wide spectrum of surgical attendees at the Clinical Congress. In addition to panel discussions and courses, several Advisory Councils have submitted recommendations for Town Hall Meetings and Meet-the-Expert luncheons.

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

In conjunction with its centennial, the 11,000-member Special Libraries Association conducted a poll on the 100 most influential journals in biology and medicine of the century. *JACS* was the only surgery journal to be named to this prestigious list.

Online and fax *JACS* CME submissions currently exceed 252,000 credits; the program is provided as a member benefit. The efficiency and economics of the *JACS* CME-1 program is beneficial to all members, especially in this time of heightened emphasis on MOC.

**HealtheCareers (Job Bank)**

As of May 11, 2009, there were 1,128 active jobs listed on the Web site, with 338 posted résumés. This is a valuable service for all members of the College.

**Resident and Associate Society (RAS)**

After the RAS position statement on further work-hour restrictions was published in the January 2009 issue of the *Bulletin* (pages 19–21), it generated much interest in the surgical community. At the Association of Program Directors meeting in Utah, RAS leadership was asked to forward the position statement to the ACGME to include in its research on the subject of work-hour restrictions as it lobbies Congress on this important topic.

**Young Fellows Association (YFA)**

The Board of Regents approved the formation of a new group, the Young Fellows Association (formerly the Committee on Young Surgeons), which is modeled after the Resident and Associate Society. This new group will be composed of Fellows who are age 45 or younger, and all young Fellows will be encouraged to participate in the YFA via four work groups: Advocacy, Communications, Education, and Member Services.

**Communications**

The ACS Web portal continues to be used by more and more surgeons, as reflected in the first-quarter visitor statistics for 2009. The portal received more visitors in the first quarter of 2009 than in any other quarter. The portal now contains 43 communities, of which 12 are specialty communities, and nine are subspecialty communities under the category General Surgery. The remainder of the communities focus on areas of special interest, such as minimally invasive surgery, rural surgery, international surgery, and surgical patient safety, to name a few. Portal communities include robust information that is of great educational value to Fellows, Associate Fellows, Resident Members, and Medical Student Members in all specialties.

**Operation Giving Back (OGB)**

Seven ACS/Pfizer Humanitarian and Volunteerism Award winners were selected for 2009. They are:

- Surgical Humanitarian Award nominee: Edgar Rodas, MD, FACS
- Surgical Volunteerism Award domestic co-nominees: Douglas Grey, MD, FACS, and William Schecter, MD, FACS
- Surgical Volunteerism Award international nominee: Glenn Geelhoed, MD, FACS
• Surgical Volunteerism Award military co-nominees: Vance Moss, MD, FACS, and Vincent Moss, MD, FACS
• Surgical Volunteerism Award resident nominee: Awori Hayanga, MD
(See related story on page 31.)
Since the last report, there have been more than 8,000 unique visitors who have conducted nearly 34,000 page views of the OGB Web site, http://www.operationgivingback.facs.org/. There have been 30 new volunteer opportunities posted on OGB, for a total of 187 actively available opportunities. The number of surgeons enrolled (by means of completing a volunteer profile) in the “My Giving Back” feature of the OGB Web site exceeds 1,250. There are 53 international partner agencies and 41 domestic partner agencies.
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” column written by Executive Director Thomas R. Russell, MD, FACS.

Letters should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to sregnier@facs.org, or via mail to Stephen Regnier, Editor, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

**Single-payer systems**

In his Letter to the Editor (Bull Am Coll Surg. 2008;93(12):43), Sherif Emil, a fellow member of the College and of Physicians for a National Health Program (PNHP), lamented Dr. Russell’s refusal to accept a single-payer system now. Although Dr. Russell doesn’t need my assistance, I think there is common ground between the ACS and PNHP to bring about the goals and principles of both organizations—call me naive if you want to. In addition to Medicare for all, advocated by Dr. Emil, create optional luxury items and restrictions, and affordability comparable to other developed nations. President Obama is setting an example of civil discourse and respect for diverse opinions and ideas, all while promoting real change. We could do worse than to follow in his footsteps on the road to real reform of health care.

Jerry Frankel, MD, FACS, PNHP board member, Houston, TX

I would like to strongly support Dr. Emil’s Letter to the Editor. A single-payer national health insurance will eventually have to be enacted. To believe in “market competition” to lower health care costs is a fallacy. Patients select physicians or hospitals by other criteria than cost, and often these are also neither readily available nor can be predicted. To evaluate insurance programs is beyond the average person because of the many state-dependent clauses and rules.

Adequate insurance coverage also is only one part of the problem. An overall reduction in health care costs requires addressing not only insurance costs but also the pharmaceutical industry, as well as physician and patient attitudes and expectations.

To illustrate the point: some years ago, the Michigan Medical Society reported insurance over-heads of 2.3 percent for Medicare, versus 10 percent to 26 percent for private insurers. We should mandate generic drugs. The U.S. Food and Drug Administration needs to be more thorough before allowing marketing of new medications, and their assessment should include cost-benefit analysis.

From my perspective as a retired surgeon and now longtime hospice physician, I ask the following questions: How many of us, physicians and patients alike, are dazzled by state-of-the-art technology when a simpler procedure may be just as effective? How often do we physicians propose and patients desire a desperate treatment just “because it might help for a while?” And how often do we bow to the patient’s wishes, even though we realize their futility, or feel too pressed for time, and thus take the “easy” way out? In short, decreasing health care costs requires a comprehensive approach.

Last, but not least, we have to overcome our almost paranoid aversion to anything even remotely smacking of “socialism.” Both Great Britain and Canada have universal health care and neither of these two countries has turned communist yet. We often hear about these “poor” Canadians who cannot wait for their procedure and have to come to the U.S. and pay for it. I also have met some poor Canadians who cannot afford this, and who were pleased to have received high-standard care at home. Though some had to wait, those who became symptomatic were moved up the line. And what value can be placed on one’s peace of mind, knowing that if one ever gets ill, one will be taken care of.

I would like to close by quoting John Stuart Mill: “Laws and social arrangements should place the happiness of every individual as nearly as possible in harmony with the interest of the whole... and to establish in the mind of every individual an indissoluble association between his own happiness and the good of the whole.” It is in this sense that we should apply our commitment to beneficence, nonmalfeasance, autonomy, and justice.

Klaus Hergt, MD, Cheboygan, MI

**Ethical issues**

I was encouraged by “ACS-developed curriculum is becoming a centerpiece of training in ethics,” which was published in the March 2009 issue of the Bulletin (Bull Am Coll Surg. 2008;94(3):11–17). I agree with Ira Kodner, MD, FACS, that “Young people are hungry for the opportunity to think about the ethical values of the surgical profession.” The ethics curriculum of Dr. Kodner and Mary Klingensmith, MD, FACS, at Washington University School of Medicine in St. Louis, MO, should help fulfill this need.

However, as stated in the article, “Another challenge is to uncover
evidence that teaching ethics is a valuable use of an institution’s financial and clinical resources.” Medicine is both an art and a science. I would encourage a prospective, long-term, longitudinal scientific study to test if teaching ethics at the graduate level can modify behavior. Studies can, and should, be done.

George Bohigian, MD, FACS, St. Louis, MO

Resident work hour restrictions

Some time ago, I was waiting on an international flight back to the U.S. The check-in representative told me that since the plane got in late the night before, that same crew would have to rest the required time, delaying the flight by two hours. I did not complain. Who wants an exhausted pilot dozing away as we crossed the ocean? Why would I complain about work requirements from the regulatory panels that address air safety? I was reminded of the resident hours situation we confront daily in academic surgical practice. Was I applying different personal safety standards to air travel than to my own practice? Have we not been repeatedly confronted by how much more safe it is to fly than to be a surgical patient? Have we not been repeatedly challenged that anesthesia has gotten so much safer, but progress in surgery so much less impressive? Then I remembered what was bothering me.

I read with great interest and in retrospect, the presentation had little impact on the recommendations of the Institute. It might be useful to query why the position of the College had so little effect.

It seems the concerns of the surgical education community relative to work hour restrictions have centered on how we get things done as we are now doing them with fewer resident hours to apply, and how we get surgeons trained in effectively less contact time. Our first reaction is that the regulation is not needed. Then we get specific about the impact of such foolishness. The horrifying response always seems to involve hiring more residents or physician extenders. Otherwise, safety is compromised. Of course, any prediction that something will cost more money in health care today means it just cannot be done. Then again, we might be forced to extend resident training years to assure the public that their surgeons have had adequate experience. Given the tally of resident debt and the need to pay them so poorly for yet more years, this extension is most unlikely to happen. I would like to address these issues separately.

The majority of the approximate 5,000 hospitals in the U.S. have no residents and deliver the majority of surgical care to the public. The outcome of surgical care may not be meeting the accelerated path of safety of other industries, but we know and the public knows that the quality of surgical care in the U.S. is better than ever, getting better all the time, and is the source of great confidence and pride for the public and the surgical practice community. It is not clear that patient safety cannot be ensured in settings without perpetual and dense resident coverage. How is it possible to provide surgical care even when there are no residents? Apparently in those settings without teaching, there is a strong professional relationship between nurse providers and surgeons to guarantee collaborative care, information exchange, and continuity of care. Patient safety and quality in the main are exemplary with absolutely no need for resident involvement. The large majority of residents trained in academic health centers go on to staff these hospital settings and seem to do very well.

Should we not start with a viable and realistic care model and then look for the best ways to include trainees into this safe, collaborative, continuous setting of surgical care? That model would involve the successful example in community practice modified to meet the needs of education. Rather than considering the work of residents as an isolated quantum, it would seem better in the current challenge to regulate hours that we look more at work redesign rather than cries of desperation and looming collapse of the academic programs. In other examples, when labor became too expensive, labor-saving measures were found to keep the industrial operation in play. History is also instructive in medicine itself. Predictions were dire that phlebotomists, electrocardiograph technicians, laboratory staff, and steadily increasing paraprofessional assistants might make medical students less than prepared.

There were grave predictions 30 years ago that the requirement of attending surgeons to actually be present in the operating room would make it impossible to ever train an independent surgeon again. The surgeons graduating from these circumstances are, in fact, superb. Furthermore, the basic notion of supervision has been greatly eroded in favor of personal responsibility of the attending surgeon to be the prime patient contact and advocate insinuating residents and students into care in ways that are neutral to outcome. We are in the midst of a massive work rede-
sign already. Perhaps adding the work hour requirements to the list is not too much of a burden and might lead to a very happy solution.

Can we really not train someone to be a surgeon in five years working 80 hours or even 60 hours a week? I submit that we can. In order to do so means that residents need to be on high utilization services working on the cases we expect them to master and not on services with insufficient volume and excessive work unrelated to the educational task. Residents should be working with faculty who are trained to pass on surgical skills and knowledge with facility in the context of ongoing patient care. That faculty should be rewarded for educational outcomes as well as paying patient volume. Residents should be comfortable in the operating room because they are well versed beforehand in the skills needed by exercises in simulation. There is no way to waste time with ill-prepared faculty, ill-prepared residents, and exorbitant waits for the opportunity to work in the actual surgical setting in a way that is constructive toward prompt and effective competence. Residents should not be burdened with administrative tasks or anything that resembles personal service to attending physicians. They should know exactly what they are expected to do and their days and nights should be organized to advance toward those expectations.

Administrators must realize that our residents are not discharge coordinators and the hospital information system must meet the needs of residents and not vice versa. The information system must capture the reality of patient status, past care, and treatment plan in a way that is understandable immediately to the oncoming team. Continuity of care is needed more than ever; that continuity is electronic and not word of mouth from fallible memory.

It is fortunate that the electronic display of air traffic is sufficient to assure air safety without the air traffic controllers staying around 80 hours a week. There is, frankly, no doubt that we can train residents to graduate as effective, competent, and compassionate surgeons in five years. There is no doubt this training can be done in a work environment that is recognizable to the community surgical setting to which most of our residents are destined. And there can be no doubt that those surgeons will be effective in the surgical settings they eventually will populate. Finally, there can be no doubt this can be done meeting the expectations of our public during and after training.

I am so impressed by the work of my colleagues on the position statement. I know how hard we all work to ensure safety and quality education of the next iteration of surgeons for our communities. However, perhaps we are missing some obvious approaches in a time when we are confronting so many changes in our practices. There seems little value in just balking and forecasting doom. Let us just get busy to redesign our programs, using examples from far and wide. Those examples in industry, human performance science, private medicine, and other countries are abundant. Surely we must adapt them remembering our national medical objectives and responsibilities. But there is no reason to declare that it cannot be done. That message of despair is surely not one that the College really wants to send. We can do it and we will.

Ronald Merrell, MD, FACS, Richmond, VA

Trauma meetings calendar

The following continuing medical education course in trauma is cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

- **Disaster and Mass Casualty Management 2009**, December 10, Kansas City, MO.
- **Advances in Trauma** 2009, December 11–12, Kansas City, MO.
- **Medical Disaster Response 2010**, March 21, 2010. Las Vegas, NV.
- **Trauma, Critical Care, and Acute Care Surgery, 2010**, March 22–24, 2010. Las Vegas, NV.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
Identify and Fill Practice Knowledge Gaps with a Subscription to SRGS

“If you read these issues, passing board examinations would be no problem.”
—Academic surgeon

Selected Readings in General Surgery (SRGS) synthesizes 18 subject-specific topics in the surgical literature in a three-year cycle, including

- Respiratory and cardiac management of surgical patients/noncardiac thoracic surgery
- Pediatric surgery
- Gastrointestinal surgery, a four-part series
- Vascular surgery, a three-part series
- General oncology
- Trauma, a two-part series

SRGS is published by the American College of Surgeons Division of Education.

For subscription and CME program details, visit www.facs.org/srgs/, e-mail srgs@facs.org, or call 800/631-0033.

Take advantage of the optional CME program to help fulfill Maintenance of Certification (MOC) requirements.

- Each issue of SRGS contains a self-assessment test. Participants can earn 10 AMA PRA Category 1 Credits™ for each test that is successfully completed. Eight issues are included in a 12-month subscription.
- Demonstrating a commitment to continual professional growth and learning through CME is one of the requirements of the American Board of Surgery (ABS) MOC program.
- SRGS CME credit can be used to comply with Part 2 of the ABS MOC program: Lifelong learning and self-assessment through continuing education and periodic self-assessment.
NTDB® data points

Trespassers beware

by Richard J. Fantus, MD, FACS

My home state has been the nation’s rail hub for more than 150 years. Illinois leads the nation in volume of freight carried (519 million tons) on more than 7,343 miles of track, with an average of 1,200 trains per day passing through the Chicago region (http://www.createprogram.org/PDF/Illinois%20Railroads_September2008.pdf). As a result, there are railroad tracks, trestles, rail yards, and railway equipment scattered throughout the state and all of these are considered to be private property. Walking on them, or playing on them, is illegal and considered trespassing. The Federal Railway Administration of the U.S. Department of Transportation categorizes an injury that results in death during this illegal act as a railway trespass fatality. Each year, there are approximately 500 railway trespass fatalities nationwide (http://safetydata.fra.dot.gov/OfficeofSafetypublicsite/Publications.aspx).

A preliminary 2008 report was released this June on the top 15 states for railway trespass fatalities (http://www.oli.org/statistics/trespassing_state.htm). It comes as no surprise that Illinois is near the top of this list, and is second only to California in the number of pedestrian rail trespass fatalities for 2008.

In order to examine the occurrence of railway trespass injuries in the National Trauma Data Bank® research dataset 2007 admissions (formerly called research dataset 8.0), records were searched utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification cause of injury code E800 –E807 (railway accidents ) with the fourth digit .2 (to identify injured person as the pedestrian).

194 incidents matched these E codes and of these, 173 records had discharge status recorded, including 89 discharged to home, and 30 to acute care/ rehabilitation; 26 were sent to nursing homes, and 28 died (these data are depicted in the figure on this page). These patients were 81.4 percent male, and on average, 36.4 years of age. They had an average length of stay of 14.8 days, and an average injury severity score of 21.1. Of those tested or suspected for alcohol, more than 60 percent tested positive.

Trains have an enormous mass and can take up to one mile or more to stop. Therefore, it is easy to understand the long length of stays, high injury severity scores, and mortality when an object like this strikes a pedestrian. Consequently, there...
are a few activities to avoid: never walk, run, ride a bicycle, or operate an all-terrain vehicle down a train track; never hop aboard railway equipment; and do not fish or bungee jump from railroad trestles. Remember that railways, yards, trestles, and tracks are private property, so trespassers beware.

The full NTDB Annual Report Version 8.0 is available on the ACS Web site as a PDF and a PowerPoint presentation at http://www.ntdb.org.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

**Acknowledgment**

Statistical support for this article has been provided by Chrystal Price, data analyst, NTDB.

**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.

---

**COMMITTEE ON PHYSICIAN COMPETENCY AND HEALTH, from page 26**

with legislation in their Medical Practice Act or through professional society memberships. The Federation of State Physician Health Programs Inc. (http://www.fspphp.org) has 42 member states and is an excellent resource. Michael Oreskovich, MD, FACS, is a regional director of that organization and is a member of our committee.

In fulfilling another aspect of the committee’s mission, the ACS has been represented at the National Alliance for Physician Competency, a voluntary organization of many stakeholders across many disciplines trying to find uniform language, the definition of competency, and agreement in answering the question: “How will the health care system determine, measure, evaluate, and assure the public of a physician’s competence throughout the course of his or her professional career?” A document called Guide to Good Medical Practice USA (available at www.GMPUSA.org), which is similar to the U.K.’s National Health Service document, has been adopted with the emphasis that it is a guide for medical schools, residency programs, and licensing and certification boards, but is not a standard.

Finally, as I complete my term as an ACS Governor from Virginia and Chair of this committee, I want to thank all the members for their input and support. In particular I want to acknowledge the outstanding contribution made to this survey and its analysis by Tait Shanafelt, MD, and his colleagues at the Mayo Clinic, and to Charles Balch, MD, FACS, from Johns Hopkins University, for coordinating and championing our efforts in this endeavor to be published and delivered in seminars.

---

**IN COMPLIANCE, from page 28**

on his or her documentation. Diagnoses will have to be clear; an “unspecified” diagnosis will not get your claims paid.

ICD-10-CM will have the same organizational properties as ICD-9-CM, such as the rubric system, index conventions, tabular conventions, inclusion terms, notes, and the neoplasm table. Some of the anticipated benefits of ICD-10-CM include an improved documentation profile and a reduction in nonspecific coding. Physicians will have clearer code choices and clearer reimbursement guidelines.

It is important to start devising a plan now to begin implementation of HIPAA 5010 and ICD-10-CM, by calling your vendors and checking on your current software. Constant monitoring and communication of all the steps outlined in this article should help with a smooth transition for surgeons’ offices.