BULLETIN

AMERICAN COLLEGE OF SURGEONS

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An Orthopaedic Surgeon in Space

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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

Looking forward

Improving the care of the surgical patient has always been the mission of the American College of Surgeons. In fact, the founders of the ACS were among the first medical professionals to assert that quality can be objectively and scientifically measured, thus leading to improvements in patient care. This guiding philosophy resulted in the College's Hospital Standardization Program, the progenitor of today's Joint Commission.

Over the last 100 years or so, this organization has consistently modernized its means for monitoring and measuring quality of care. The Commission on Cancer (CoC) created the National Cancer Data Base (NCDB), and the Committee on Trauma (COT) developed the National Trauma Data Bank® (NTDB®). In addition, both the CoC and COT have set standards for accrediting oncology and trauma centers, and, more recently, the College has been accrediting bariatric and breast care centers. A little more than five years ago, the ACS took responsibility for bringing the National Surgical Quality Improvement Program (ACS NSQIP) into the private sector, so that hospitals across throughout the U.S. could start analyzing and comparing their outcomes.

The College has consistently demonstrated its commitment to quality and the surgical patient through its quality of care programs. They have been instrumental in helping us to objectively evaluate, define, and articulate the meaning of quality surgical care in the institutional setting.

> **"The College has consistently demonstrated its commitment to quality and the surgical patient through its quality of care programs."**

What's next?

In the spirit of looking forward, I believe we need to expand these efforts and determine what else we should do to ensure that surgical patients receive optimal care in a changing health care environment. What does quality mean today? How we do help institutions ensure that every surgical patient receives optimal care in the future?

The ACS Board of Regents, the Board of Governors, our Officers, and I believe the College needs to do more to maintain and further develop the organization's commitment to quality by helping surgeons and hospitals put the information that is being generated through ACS NSQIP to practical use. This program continues to gain widespread recognition as a surgical outcomes measurement and quality improvement instrument. Presently, 244 U.S. and six international hospitals participate in ACS NSQIP, which generates observed/expected (O/E) outcome ratios for 45 measures. Eligible institutions receive a PowerPoint presentation with auto-populated site-specific data and an individual hospital summary sheet containing all of the site's O/E data. ACS NSQIP participants also have access to the Participant Use Data File, which they are finding to be a valuable research tool.

Models in place

To make ACS NSQIP even more useful, I maintain that we should apply many of the same techniques that have worked well for our cancer and trauma programs. The NCDB is a joint program of the CoC and the American Cancer Society and produces outcomes data for more than 1,400 CoC-accredited cancer programs in the U.S. and Puerto Rico. About 70 percent of all newly diagnosed oncology cases are captured at the institutional level and reported to the NCDB. The repository now contains approximately 25 million records on all types of cancer. The data are tracked and analyzed to explore trends in cancer care, to create regional and state benchmarks for participating hospitals, and to serve as the basis for quality improvement. In addition, the CoC has launched the Rapid Quality Reporting

System, which provides real clinical time assessments of hospital-level performance using quality of cancer care measures approved by the National Quality Forum for breast and colorectal cancers.

With respect to trauma, the COT's Consultation/Verification Program assists hospitals in the evaluation and improvement of emergency care and provides objective external peer review of institutional capability and performance. The consulting team is composed of clinicians who are experienced in trauma care and assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features, as outlined in the College's *Resources for Optimal Care of the Injured Patient*.

The COT also recently launched the Trauma Quality Improvement Program (TQIP), which will use the NTDB to collect valid and reliable emergency care data, provide feedback to participating trauma centers, and identify institutional characteristics that lead to better outcomes. A short list of services TQIP provides include the following: annual in-person training sessions for registrars; automatic feedback on quarterly data transmissions to NTDB; and risk-adjusted O/E outcome benchmark reports, ranking individual facilities with other Level I and II centers.

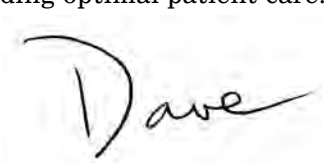
Under the leadership of Clifford Ko, MD, FACS, the ACS Division of Research and Optimal Care intends to extend these techniques to ACS NSQIP. Already, the program provides evidence-based expert-opinion guidelines on certain clinical issues, such as surgical site infection and thromboembolism. Because initiating and sustaining quality improvement efforts in the hospital setting can be challenging, we also have developed and published case studies illustrating how institutions have successfully implemented surgeon-led efforts to improve patient care and outcomes. Presently, we are in the process of developing a "risk calculator," which will help surgeons estimate patient risk factors based on type of operation, indications, unique physiological characteristics, and comorbidities.

At the same time as these tools are being further developed, we are also laying the groundwork for new initiatives that respond to what we are discovering to be the necessary components of high-quality care. For example, our experiences with the trauma and cancer programs, as well as ACS NSQIP, have demonstrated that quality improvement requires certain resources, leadership and governance structures, quality-focused processes, and so on.

Striving for improvement

A prominent role model for effective health care delivery, Geisinger Health System, has achieved its success largely through its sophisticated mechanisms for measuring outcomes and developing and applying evidence-based best practices. Geisinger uses various criteria to target certain services for redesign, specifically those specialties that affect the largest patient population, use the most resources, are marked by unjustified variations, or have observed outcomes farthest from expected performance.*

As the leading voice for quality in surgery, it is the College's responsibility to ensure that all institutions that provide surgical services have access to the same types of resources methodologies in place at Geisinger and other model health care providers. The goal of the College's programs aimed at filling this void is not to penalize low performers or to reward high performers; rather, it is to help all hospitals and their surgical care teams take the steps necessary to make progress in their quest to provide optimal care to their unique patient populations. We must help the providers at the bottom of the list move to the middle, and so on, up to the group of top performers. Similarly, high performers will need to do more than remain static, and will need to go on to bigger and better achievements. There is room for improvement at all institutions dedicated to providing optimal patient care.



David B. Hoyt, MD, FACS

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

*Paulus RA, Davis K, Steele GD. Continuous innovation in health care: Implications of the Geisinger experience. *Health Aff.* 2008;27(5):1235-1245. Available at http://content.healthaffairs.org/cgi/content/full/27/5/1235. Accessed February 19, 2010.

PQRI reporting in 2010

by Caitlin Burley, Quality Associate, Division of Advocacy and Health Policy

The Centers for Medicare & Medicaid Services (CMS) has continued the Physician Quality Reporting Initiative (PQRI) into 2010 as required under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). PQRI is the first CMS-crafted national program to link the reporting of quality data to physician payment. The incentive payment for those eligible professionals who successfully participate in the program is 2 percent of the total allowed charges for Medicare Part B professional services covered under the physician fee schedule and furnished during the reporting period.

How does one use the measure specifications manual?

The first step for implementing PQRI in your office is to use the 2010 PQRI *Measure Specifications Manual* to identify measures applicable for professional services for which a physician's practice routinely provides. The next step is to select those measures that make sense based upon prevalence and volume in the physician's practice, as well as their individual or practice performance analysis and improvement priorities. The 2010 PQRI *Measure Specifications Manual* can be found on the CMS PQRI Web site, *http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage*, or on the ACS PQRI Web site, *http://www.facs.org/ahp/pqri/index.html*.

This article outlines the process of claims-based reporting for PQRI 2010—in this case, perioperative measure #20: Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.

What is the description of the measure?

The measure specifications describe measure #20 as "Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)." This narrative gives a high-level description of measure #20.

What are the instructions?

The instructions explain when the measure should be reported and who should report it. According to the instructions, measure #20 should be reported every time the procedure is performed on patients 18 years and older, with the indications for prophylactic parenteral antibiotics. The instructions further state that "Clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure," clearly indicating who should report the measure. In addition, the instructions indicate that there is no diagnosis associated with this measure.

What is the "frequency?"

The frequency refers to how often the measure should be reported. Measure #20 should be reported each time an applicable procedure is performed during the reporting period (full or half-year).

What is the performance time frame?

The performance time frame for measure #20 is indicated as within one hour (two hours if fluoroquinolone or vancomycin) prior to surgical incision, or start of procedure when no incision is required.

How do I report measure #20 via claims?

The measure specifications for measure #20 indicate that it is a claims and registry measure, meaning it can be reported using either the

Table 1.

Measure #20: Surgical procedures for which prophylactic parenteral antibiotics are indicated

Surgical procedure	CPT code
Integumentary	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369
Le Fort fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35151, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
Spleen and lymph nodes	38115
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870
Small intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon and rectum	43880, 44025, 44110, 44111, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 51597
Anus and rectum	45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Hepatic surgery	47135, 47136, 47140, 47141, 47142
Biliary surgery	47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, peritoneum, and omentum	49215, 49568
Renal transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic surgery	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294

continued on next page

Table 1 (continued from previous page)	
Measure #20: Surgical procedures for which prophylactic parenteral antibiotics are indicated	
Surgical procedure	**CPT code**
Acoustic neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear implants	69930
Neurological surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
Cardiothoracic (pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
Genitourinary surgery	51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51920, 51925, 52450, 52601, 52630, 52647, 52648, 52649, 54401, 54405, 54406, 54408, 54410, 54415, 54416, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845
General thoracic surgery	19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35276, 35311, 35481, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 64746
Foot and ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737

claims-based *or* the registry-based method. This article looks at the claims-based method only. The Current Procedural Terminology (CPT)* codes and patient demographics identify the patients who are included in measure #20, otherwise known as the denominator. Beginning on page 51 of the *Measure Specifications Manual*, there is a listing of all surgical procedures and CPT codes that qualify patients as eligible to meet this measure's inclusion requirements (see Table 1, page 7 and this page). It is important to review the CPT codes associated with each measure reported. Also, please note that the included procedure codes may change from year to year, so review the 2010 measure specifications before beginning to report for this year.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.

What are the steps to be taken after identifying a patient in the denominator for Measure #20?

CPT II codes, or quality data codes (QDCs), are used to report the clinical action required by the measure on the claims form. For measure #20, there are four choices: 4047F, 4048F, 4047F with 1P, and 4047F with 8P. 4047F indicates the order for prophylactic parenteral antibiotics was given; 4048F indicates prophylactic parenteral antibiotic has been given; 4047F with 1P modifier indicates the order for prophylactic parenteral antibiotic was not given due to medical reasons; and 4047F with 8P modifier indicates prophylactic parenteral antibiotic was not given and the reason was not specified. Please note that both the CPT code and the appropriate CPT II code should be submitted on the same claim form.

It is important to note that for measure #20, Table 2 (this page) is included in the measure specifications and lists the antimicrobial drugs considered prophylactic parenteral antibiotics for the purposes of this measure. Code 4047F-8P should be reported when antibiotics from this table were not ordered.

Example claim form

CPT II codes can be reported on claim form CMS 1500 or via electronic form ASC X12N 837. Figure 1 on this page is an example of the CMS 1500 claim form.

Based on Figure 1, the following steps are listed for reporting via claims:

Step1: Look in the measure specifications for measure #20 to see if this procedure is listed in the table of surgical procedures for which prophylactic parenteral antibiotics are indicated. If so, continue to step 2.

Step 2: On the CMS 1500 claim form, the CPT procedure code 44120 is listed on line 1.

Step 3: On line 2, the CPT II code, 4047F, is listed, which indicates the order of prophylactic parenteral antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required). (Note: The CPT II code may be one of four options, as outlined earlier in this article.)

Step 4: Lines 3 through 6 are CPT II codes that correspond to other PQRI measures (#21, #22, and #23). Measures #21, #22, and #23 are often reported by eligible professionals

Table 2:

Measure #20: Antimicrobial drugs considered prophylactic parenteral antibiotics for the purposes of this measure

Ampicillin/ sulbactam	Cefotetan	Ertapenem	Levofloxacin
Aztreonam	Cefoxitin	Erythromycin base	Metronidazole
Cefazolin	Cefuroxime	Gatifloxacin	Moxifloxacin
Cefmetazole	Ciprofloxacin	Gentamicin	Neomycin
	Clindamycin		Vancomycin

Figure 1:

Procedure: 44120: Enterectomy, resection of small intestine; single resection and anastomosis—Example claim form

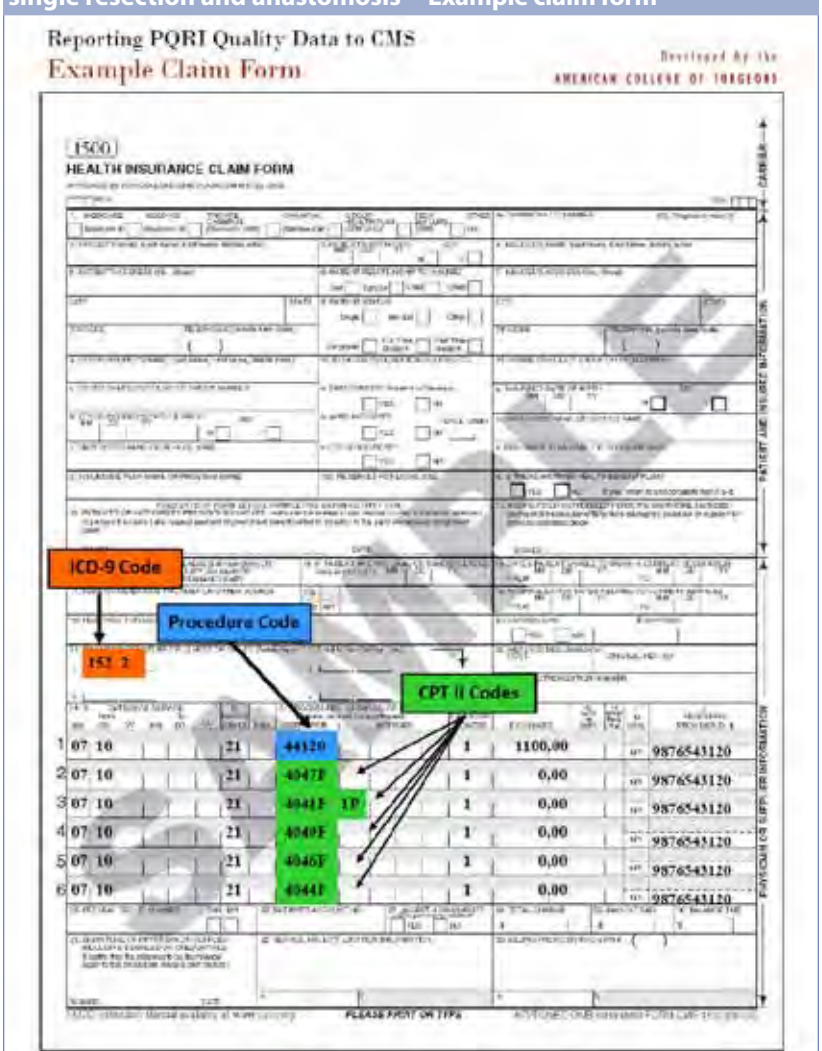


Table 3

PQRI 2010 reporting options matrix

		Claims-based methods	Registry-based methods	Electronic health record-based methods
Full-year period	Individual measures	At least three PQRI measures (one-two if less than three apply), for 80 percent of applicable Medicare Part B fee-for-service (FFS) patients of each eligible professional.	At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.
	Measures groups	One measures group for 30 Medicare Part B FFS patients. One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least 15 patients during reporting period).	One measures group for at least 30 patients (patients may include, but may not be exclusively, non-Medicare patients). One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least 15 patients during the reporting period).	
Half-year period	Individual measures	At least three PQRI measures (one-two if less than three apply), for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	
	Measures groups	One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least eight patients during reporting period).	One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least eight patients during the reporting period).	

when measure #20 is reported, because these four measures are perioperative care measures. CPT procedure code 44120 corresponds with these perioperative measures as well, so the CPT II codes are listed on the same claim form.

Step 5: Be sure billing software and the clearinghouse can correctly submit PQRI CPT II codes, or quality-data codes (QDCs).

Step 6: Regularly review the remittance advice notice from the carrier to ensure the denial remark code N365 is listed for each QDC submitted. This indicates that claims have made it to the CMS national claims history file.

Surgical practices that follow these steps should be able to successfully report via claims in PQRI 2010 to receive incentive payments. There are various ways to report for PQRI, and this article has only covered the claims-based method for individual measures. Please refer to the correct measure specifications manual if you choose another method. Table 3 on this page is a matrix that lists all 11 options for reporting in PQRI 2010.

For more background information regarding the PQRI program, visit the CMS PQRI Web site at *http://www.cms.hhs.gov/pqri/* and access the resources posted at *http://www.facs.org/ahp/pqri/index.html*. If you have any further questions regarding PQRI, contact Caitlin Burley, at cburley@facs.org. Ω

Surgical lifestyles

An orthopaedic surgeon in space:

An interview with Robert Satcher, MD, PhD

by Tony Peregrin, Associate Editor

Robert "Bobby" Satcher, Jr., MD, PhD, has gone where no orthopaedic surgeon has gone before: the International Space Station. Dr. Satcher, a specialist in child and adult bone cancer, became the first orthopaedic surgeon to orbit the earth last November as a member of the Space Shuttle *Atlantis* STS-129 crew. During the 11-day mission, Dr. Satcher, 44, performed maintenance on multiple robotic arms, hung up science experiments, and installed a 1,200-pound oxygen tank. He quickly discovered that the skills he possesses as a surgeon converted quite well to being an astronaut. "I basically drew from my experience as a surgeon, and the ability to multitask in a stressful environment," explains Dr. Satcher.

Overleaf: Dr. Satcher uses a high definition video camera at a window on the aft flight deck of Space Shuttle *Atlantis* during flight day three activities.

At the Shuttle Landing Facility at NASA's Kennedy Space Center in Cape Canaveral, FL, Dr. Satcher (left) and Mr. Bresnik on their way to join their fellow crewmates for an appearance on NASA Television.

Leading up to lift off

"[The] launch was amazing," wrote Dr. Satcher in his first Tweet from space. "7.7 million pounds of thrust, mach 25, microgravity in less than nine minutes! Awesome."

But how did the surgeon—who earned a PhD in chemical engineering from the Massachusetts Institute of Technology, and a medical degree from Harvard University School of Medicine—start down the path that would eventually lead him to outer space? "I think what initially sparked my interest was watching all of those Apollo missions as a kid," reveals Dr. Satcher. "And I think that spark was reinforced over the years by movies and television, like *Star Wars*, for example. As I got into medical school and residency, I did some research at University of California-San Francisco and NASA Ames [Research Center], looking at the effects of microgravity on bone homeostasis, and at that point I got a chance to meet some astronaut-physicians. That is when it occurred to me that I could actually apply to be an astronaut. I never thought that I would be selected, since there hadn't been any orthopaedic surgeons that were astronauts. I just decided to try and see what happens, and then I was fortunate enough to be selected."

Most recently, Dr. Satcher was an assistant professor at Northwestern University Feinberg School of Medicine in Chicago, IL, and he held an appointment as an attending physician in orthopaedic surgery at Children's Memorial Hospital, Chicago, IL, where he specialized in musculoskeletal oncology. He was also a member of the Robert H. Lurie Comprehensive Cancer Center and the Institute for Bioengineering and Nanotechnology in Advanced Medicine at Northwestern University. (Dr. Satcher has been on leave from Northwestern since he was accepted into the NASA program in 2004.) Currently,

STS-129 bench review at a contractor's clean room. Dr. Satcher (left) and astronauts Barry Wilmore and Leland Melvin review equipment for their upcoming space flight.

Dr. Satcher has an adjunct appointment at MD Anderson Cancer Center in Houston, TX.

Several months prior to receiving the invitation from the National Aeronautics and Space Administration (NASA), the organization started conducting background checks on Dr. Satcher—a positive indicator that he was being seriously considered for the NASA program.

"The FBI talks to your colleagues and family—NASA does that with everyone they are considering. I had been granted an interview four or five months prior to that, so I knew I was probably in the final running, and I had been discussing the possibility with my family and my wife, but you never really know until you get that call. I remember I was in clinic that day at Northwestern, right across the street from the American College of Surgeons, in fact. I think I was on the 12th floor of the hospital, and it was a pretty regular day. I was seeing people in clinic, and I got a call from a number I didn't recognize. I don't usually take calls from numbers I don't know, but for some reason I took that call, and it turned out to be NASA. And they said, 'You have been selected to be an astronaut—we'd appreciate your response within 48 hours.' I remember standing right outside a patient's room when I got the call and taking a few minutes to process what was said. But then I remembered I had to go back to work and finish clinic! I always knew becoming an astronaut was something I wanted to do and needed to do, and my family has been very supportive in terms of allowing me to pursue this dream."

Training for the mission

Dr. Satcher, the 23rd American physician to become an astronaut, was selected to join the NASA program in May 2004. In February 2006, he completed the astronaut candidate training, which included scientific and technical briefings, intensive instruction in Shuttle and International Space Station systems, physiological training, T-38 flight training, and water and wilderness survival training.

The most rigorous part of astronaut training, according to Dr. Satcher, was the extravehicular activity (EVA) training. EVA training is conducted in a neutral buoyancy lab, which is a large pool of water that actually mimics what it's like to be in the space shuttle and on the NASA space station. The trainees wear modified space suits that have been designed so that they float under water, which is similar to what astronauts experience while they are floating in orbit. The trainees work against the resistance of the pressurized suits—using muscles that are not typically utilized for movement—on tasks that are very detailed and complex. Each "run" lasts about six or seven hours and can be physically draining, as the suits typically weigh 300 pounds.

Dr. Satcher also flew to Japan to train with the Japan Aerospace Exploration Agency (JAXA), where he learned to operate the agency's robotic arm.

The space shuttle's robotic arms are not as refined as surgical robots, according to Dr. Satcher. "They are similar to a mechanical robot that makes and constructs cars. They are large, like a big crane, and they are not as precise as surgical robots, which are very precise. The main function of these robotic arms is to move around large pay-

loads, which can place objects within a centimeter or two of accuracy. Operating the robotic arms is very similar to arthroscopic surgery, in that you are viewing everything through monitors and using joysticks to move it around."

Dr. Satcher participated in three spacewalks. On the first spacewalk, he installed a spare antenna, hooked up cables and a handrail, and lubricated snares for a robot arm. As Dr. Satcher completed his tasks, fellow astronaut Randolph (Randy) Bresnik , also aboard the Space Shuttle *Atlantis,* famously observed, "It is a thing of beauty to see the good doctor at work. We have photographic evidence of the highest recorded orthopedic surgery—ever."

"We're actually very good friends," explains Dr. Satcher, with a good-natured laugh. "It felt great. I really appreciated the compliment. We have a lot of history together—we came in during the same class in 2004. He's a modest guy and has incredible talent. It was very nice of him to say that, and I know him well enough to know he meant it, so it was a great compliment, and at the same time it gave me a good laugh."

Parallel worlds

"I think the biggest parallel [between being a surgeon and being an astronaut] comes down to the ability to complete a complex procedure under what can often be stressful conditions," observes Dr. Satcher. "When you are operating, you are focusing not only on the immediate process at hand, but you are also thinking about coordinating equipment and the personnel, as well as things as subtle as the temperature of the room. All of this information goes into your decision-making process, and that approach is very similar to a spacewalk. You have to be thinking two to three steps ahead, and you have to keep the big picture in mind, in terms of what you need to accomplish, and what sort of impact it will have if you do not get the task done."

"This was really brought home to me on my first spacewalk," continues Dr. Satcher. "We were ahead of schedule, so we decided that we were going to do a reconfiguration of one of the platforms, even though it was tasked for a later spacewalk. The decision to do this was not easy, because if we didn't finish the task, it would have presented some problems for future spacewalks. Everything was going fine, and then we got to a point where there was a bolt that was stuck and we could *not* figure out how to loosen it. So, we're sitting out there at the end of the truss, [astronaut] Mike Foreman and I, looking at this bolt and trying to figure out how we are going to free it up. We thought about the tools that we had with us out there, and whether or not we needed to go back to the airlock to get other tools, and in real-time discussed it with each other and the ground. In the end, it took trying three or four different techniques, but we finally got the bolt unstuck. And it reminded me of being in the operating room, when you run into pinch points and

Dr. Satcher occupies the commander's station while using a communication system on the flight deck of Space Shuttle *Atlantis* during flight day three activities.

something doesn't go as you anticipated it would. You have to be able to think on the spot and quickly come up with, sometimes, two or three contingency procedures to solve the problem. The most important thing, in both instances, is to continue to keep thinking your way through it."

Dr. Satcher also served as a proxy scientist and worked with principle investigators on several experiments preselected by NASA, including analysis of the effects of outer space on the human immune system and on bone formation in mice.

Dr. Satcher participates in the mission's third and final session of EVA as construction and maintenance continue on the International Space Station. During the five-hour, 42-minute spacewalk, Dr. Satcher and Mr. Bresnik (out of frame) removed a pair of micrometeoroid and orbital debris shields from the Quest airlock and strapped them to the External Stowage Platform #2, then moved an articulating foot restraint to the airlock, and released a bolt on a starboard truss ammonia tank assembly (ATA) in preparation for an STS-131 spacewalk that will replace the ATA.

Back on Earth

Five additional space shuttle missions remain—all of them devoted to work on the space station, which will be kept running until at least 2015, according to NASA officials. At press time, Dr. Satcher had not been assigned to any of these missions, but if called upon, he is willing and eager to fill in as a substitute.

In the meantime, Dr. Satcher enjoys visiting schools and talking to students about his experiences. "Quite often, I am the first African-American astronaut they have seen," says Dr. Satcher. "And it is important for these kids to know that this is an option for them, that they have many options available to them as long as they are motivated and focused. I try to make it clear to them that they do anything as long they set their minds to it."

Dr. Satcher says his training as an astronaut has made him a better surgeon, perhaps most notably because the experience has sharpened his "situation-awareness" skills. However, his experience with the STS-129 crew left a lasting an impression on the orthopaedic surgeon in other important ways as well.

"When I went on my first spacewalk outside the space shuttle, my first thought was, 'What an amazing view.' I remember trying to capture a mental picture of what I as seeing, one that I would always have. The blue marble that is Earth and the pitch black of space were spectacular, and all of the colors are very vivid and bright. You can actually see the thin layer of atmosphere over the earth, and it is so thin! It looks like the layer of icing on a cake. All of the oxygen that we breathe is in that thin layer, and you can tell from that vantage point that it is most definitely a finite entity. It really brought home to me that it is so important what we do in terms of managing the planet and thinking of the planet as a resource. When you see the Earth on the backdrop of space, you see that there really isn't anything else out there close by, and we have to take care of what we have. Looking at planet Earth, you also notice that there are no borders between countries. If there is intelligent life out there, I imagine that's how they would see it—a planet without borders, all of us down here together." Ω

Rural surgeons—We must grow our own

by Paul J. Huffstutter, MD, FACS

The decline in the overall number of general surgeons is a growing concern in the public and surgical communities. The decline, which exceeds 25 percent, has been experienced in both urban and rural areas.[1] The demographic characteristics of the rural general surgeon workforce lead many physicians, as well as other health care researchers, to believe that the numbers will continue to decline in the future.[2] Quality rural health care will invariably suffer as a result of this reduction in rural surgeon numbers. The effect of decreased numbers of rural surgeons will not only impact the health care of rural communities, but also the financial viability of rural hospitals, and even the communities served by these hospitals.[3] Joseph B. Cofer, MD, and R. Phillip Burns, MD, have estimated the economic impact of a general surgeon on the net revenues of a hospital to be between $1.05 million and $2.4 million annually.[4]

Analysis of this rural surgeon shortage has revealed both assets and liabilities of a rural surgical practice, but has resulted in few meaningful solutions to the problem.[5] The establishment of specific rural surgery training programs is encouraging, but with unproven results.[6] Exposure during residency to rural surgery practices may influence more residents to choose practice in a rural setting.[7]

Looking within

I practiced for 29 years in a rural surgical practice, after having been recruited to this community by two well-trained, productive general surgeons. These individuals quietly went about their business of treating patients and were enthusiastic about their profession, with only a rare complaint. As these surgeons aged, the recruitment of young surgeons into this rural setting, for the most part, fell to me. During my 29 years at this facility, I was able to play a part in the recruitment of four general surgeons to our practice.

Based upon this experience, I have arrived at several opinions concerning the recruitment of rural surgeons, the cornerstone of which is "grow your own." After several early failed attempts to recruit new surgeons to our community, I concluded the best surgeons could not be enticed by money, early partnership, needs of the community, or various challenges.

Following these early failings, we began to look within our community. First, pre-med students from our county were given the opportunity to work at the hospital during the summer. Those interested in surgery were instructed in sterile techniques and operating room procedures, and then took on the role of surgical assistant. Our group chose not to discuss practice business, hospital politics, or the inevitable, ever-intrusive governmental controls on medicine. Conversely, we tried to point out the science of medical practice and the satisfaction of helping patients. The familiarity with peers and health care workers in the small rural setting was emphasized as an advantage. We attempted not only to discuss the science of surgery, but also to point out the importance of treating the patient and family members with courtesy and respect.

Emphasis was placed both on the entire spectrum of a rural practice, as well as the concept of a lifetime of learning. The relevance of undergraduate courses such as chemistry and biology were conveyed as part of the overall experience, and valuable time was reserved for answering each student's questions, and addressing their fears and aspirations.

Encouraged by some early success, the hospital joined our efforts by establishing a two-week summer program for juniors and seniors in our county's high schools, offering the students the opportunity to tour the hospital and see each department in operation. The program, titled "White Coats," became so popular that we had to restrict participation by evaluating the students' grades and personal compositions. As these students progressed to college, their progress was noted, and each was encouraged to return during the summer or holidays to work at the hospital, as well as to discuss any issues they might have concerning their education. At each step, the positive effect of a good and caring physician in the community was emphasized. Of approximately 70 of these students, 10 have completed medical degrees. One has become a neurosurgeon, one is a pediatrician, and another is a veterinarian/astronaut/physician. Six have become general surgeons, with four of these returning to practice with my group as partners. All are a credit to our profession.

Mentoring requires genuine interest

This history of surgeon recruitment I have outlined is probably best termed "mentoring." Mentoring is certainly not a new concept; however, with the escalating pressures placed upon today's general surgeons, its true meaning may have become diluted in our current environment. Mentoring requires genuine interest in the student, in their dreams, as well as a realistic appraisal concerning the difficulty and lengthy preparation for becoming a physician/surgeon. It requires some investigation into the student's or resident's current status, as well as their plans for reaching goals. In this aspect, mentoring is very much like the everyday practice of the general surgeon. The best of surgeons must not only take a personal interest in their patients, but also take the time to learn about each patient's expectations for their treatment, as well as to explain the benefits and risks involved.

As with the practice of surgery, the interest shown to patient or student alike must be genuine—or each group will quickly sense this lack of sincerity and react accordingly. Obviously, the most difficult requirement for successful mentoring is time—the time that must be taken from the surgeon's pressing issues of family, profession, and friends. However, there can be no substitute for time when establishing a relation-

ship that may or may not end with the decision to join a rural surgical practice.

The joy and fulfillment of mentoring has been eloquently outlined by various physicians, perhaps none more eloquently than Mitchell Goldman, MD, FACS, in his 2005 presidential speech, "Masters and Commanders," to members and guests of the Southern Association for Vascular Surgery. Dr. Goldman introduces his topic of mentoring by honoring his mentors, acknowledging their duties for criticism, as well as praise. Lamenting the decline of emphasis on mentorship, he explores the responsibilities of mentors as a catalyst for young minds, including the psychology and selflessness of true mentoring. Dr. Goldman outlines his experiences and structure for mentoring, concluding with a challenge to those who have no time or energy to mentor. I would recommend this address as required reading for all medical students, residents, and staff.[8]

Emphasize the positive

Upon retiring as an active surgeon, reflecting on my 29 years of practice as a rural surgeon has reaffirmed my decision to enter this rural environment and practice surgery. I have come to believe that if we are to continue to have well-trained rural general surgeons, we must spend time with the young people in our communities, exposing them to the profession in an encouraging and positive manner. They should be protected from the unimportant negativity that invades our profession, as well as from the fears that often fail to materialize; instead, we should expose them to the delights of helping others. We must be ready to encourage these young people through undergraduate school, medical school, and residency, as well as educate them on the many advantages of the practice of rural surgery. In short, rural surgeons must "grow our own." This burden falls squarely on the rural surgery community's shoulders, and not directly on the academic community, for its resolution.

The mentored high school students will enter college more enthusiastic to study and prepare for medical school. The mentored medical students will be better prepared during residency and have a better understanding of their ultimate goal. They will become better physicians, surgeons, and partners as the result of mentoring, with a deeper appreciation for our profession and its true goals. My advice to rural surgeons and rural hospitals alike: Look into your own community and "grow your own." Ω

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Rural surgeons—We must grow our own: A response

by Joseph B. Cofer, MD, FACS

Editor's note: *The author has served on the ACS Advisory Council for General Surgery and is an authority on rural surgery and national workforce issues.*

In the preceding article, Paul J. Huffstutter, MD, FACS, succinctly describes the increasing shortage of future surgeons providing general surgical care in the rural community setting. For a solution, he proposes that rural communities should "grow their own" through a formal mentoring process that identifies, and then nurtures, those young individuals within the community who show potential to develop into a surgeon.

I agree with his premise, and I congratulate him on his well-demonstrated success. I would also encourage all general surgeons, rural or urban, who are exposed to young lay persons or medical students, to follow Dr. Huffstutter's lead by taking the time and interest to encourage young people to explore, and understand, the joys of surgical practice. I believe that more surgeons should take the opportunity to spend time with, and mentor, medical students in their preclinical years. And I feel that successful mentoring of surgical residents by general surgical faculty can also make a difference by demonstrating the advantages of a general surgery practice. The shortage of general surgeons exists now, and is only going to increase, unless we can convince medical students to train in general surgery, and surgical residents to stay in general surgery.

Perceptions of negative lifestyle and income barriers regarding a general surgery practice continue to exist among trainees. A number of us feel strongly that adequate exposure to practicing general surgeons—especially rural surgeons—is sadly lacking in many of our training programs. To rectify this problem, I believe there should be rural surgery rotations established within general surgery training programs. We have implemented this change in Chattanooga, TN, and have found it to be very useful in helping a general surgery resident truly understand the benefits of a rural surgery practice.* Ω

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Medicare Physician Reimbursement:

Is the SGR's end in sight?

by **Shawn Friesen,**

Legislative Affairs Associate, Division of Advocacy and Health Policy

On December 19, 2009, President Barack Obama signed the Department of Defense appropriations bill (H.R. 3326) into law. Given the importance of passing a bill to fund America's military before adjourning for the year, congressional leaders determined the defense bill was the best vehicle for temporarily halting the 21 percent cut in the Medicare physician reimbursement that had been scheduled to take effect on January 1. The bill temporarily delayed the 21 percent cut until March 1, with the hope that Congress would use the two months in between to address Medicare's broken physician payment formula, known as the sustainable growth rate (SGR). Unfortunately, this hope was not realized, and on March 2, the President signed another temporary measure into law (H.R. 4691)—this one retroactively repealing the 21 percent cut that had taken effect and restoring Medicare payment rates for the month of March.

Urgent, yet temporary

The importance of these bills was underscored by the President's signature in both cases shortly after Senate passage of each bill. H.R. 3326 included a provision that prevented the cut in physician reimbursement and maintained the 2009 conversion factor of $36.0666 through the end of February. The January 1 deadline had been replaced with a March 1 deadline, at which point a 21 percent cut in the Medicare conversion factor was scheduled to take effect unless Congress again intervened. H.R. 4691, which was enacted on March 2, simply replaced the March 1 deadline with a new deadline of April 1, 2010.

As many readers may know, the scheduled 21 percent cut in reimbursement is a result of the SGR. The SGR was enacted as part of the Balanced Budget Act of 1997, which received the bipartisan support of Democratic President Bill Clinton and a Republican majority in Congress. The SGR set a target for Medicare physician spending that linked total spending to per capita growth in the gross domestic product (GDP). As a result, Medicare physician payments were tied to the GDP, and this linkage—along with a regulatory decision in the SGR's implementation to include physician-administered drugs in the calculation of Medicare

physician spending—set the stage for this new Medicare payment system's failure. To be fair, the system's failure was unforeseeable at the time, but after a few years of payment increases, Medicare payments to physicians were cut 5.4 percent in 2002, with additional reductions scheduled in every following year. Only congressional intervention has prevented those cuts from taking place.

Congress's passage of the delay last December, and again in March, followed the pattern set in previous years in which lawmakers provided a temporary reprieve from a broken Medicare payment system in need of reform. What was different about the actions—both in December and again in March—was the context in which they happened. First, these delays occurred in the midst of congressional consideration of health care reform legislation that could fundamentally alter how health care is delivered in the U.S. Second, both bills followed a concerted effort by some in Congress to finally enact the much-needed reform of Medicare's physician payment system.

A new context

On November 7, 2009, the House of Representatives, in a 220 to 215 vote, passed its version of health care reform legislation, the Affordable Health Care for America Act (H.R. 3962)—which the College supported. In supporting H.R. 3962, the College cited several of the bill's reforms, including measures to expand coverage, to help ensure patient access to surgical care, and to improve the nation's emergency care and trauma systems. In addition, the College offered its support for the bill because of the full and permanent SGR reform included in the Medicare Physician Payment Reform Act (H.R. 3961), which was introduced as a companion to H.R. 3962.

Following the House, the Senate passed its version of health reform legislation, the Patient Protection and Affordable Care Act (H.R. 3590), in a 60 to 40 vote on Christmas Eve, 2009. The College opposed the legislation. In a December 1, 2009, letter to Senate Majority Leader Harry Reid (D-NV), the College and 18 surgical organizations expressed opposition to the initial version of the bill, citing the following reasons: creation of an unaccountable Medicare board whose recommendations could become law without congressional action; budget-neutral payment increases for primary care and general surgery financed through payment cuts to other surgical specialties; an application fee for physicians to participate in Medicare; a tax on cosmetic surgical procedures; and the absence of medical liability reform. In addition, the letter highlighted the bill's failure to reform the broken Medicare payment system, as well as the lack of a pathway in the Senate to achieve the much-needed SGR reform that the College and the surgical community have been advocating as an essential component of health care reform legislation.

The December letter followed a November 4 letter to Senator Reid from the College and 19 surgical organizations, stating that the surgical community was prepared to oppose the Senate's health reform bill if it included a number of provisions in the Senate Finance Committee bill, the America's Healthy Future Act. The November and December letters were also preceded by a September 22 letter to the Senate Finance Committee Chairman Max Baucus (D-MT) from the College and 19 other surgical societies, stating that the organizations were unable support the bill before the Committee, while highlighting several concerns also mentioned in the letter to Senator Reid, and, again, stressing the legislation's lack of Medicare physician payment reform.

Before the Senate Finance Committee's passage of health reform legislation, the Senate Health, Education, Labor and Pensions (HELP) Committee had approved its own version of health reform legislation, the Affordable Health Choices Act, on July 15, 2009. Following the Finance Committee passage in October, Senators Reid, Baucus, and Christopher Dodd (D-CT), who had guided the legislation through the HELP Committee, worked to reconcile the Finance and HELP versions. It was during this period that the College offered comments in an effort to shape the Senate bill and achieve a pathway to reforming the SGR in the Senate. On November 18, 2009, the first version of H.R. 3590 was released, and the Senate voted to invoke cloture and move to consideration of the bill on November 21, 2009. This vote set the stage for the Senate's consideration, and ultimate passage, of the legislation in December 2009.

Throughout December, negotiations on health reform continued in the Senate. The legislation

passed by the Senate on December 24, 2009, was first released as a manager's amendment for consideration on December 19, 2009. The updated bill did include several improvements—namely, removal of budget neutrality, the application fee, and the cosmetic surgery tax. Nonetheless, the College remained opposed to H.R. 3590 because of the bill's failure to address the SGR, and because of several problematic provisions in the bill—most notably, the Medicare payment board, now called the Independent Payment Advisory Board (IPAB), which would now also be able to make policy recommendations about nongovernment health care spending.

While failing either to reform the SGR or to provide a pathway to Medicare payment reform in the Senate, the creation of an unelected Medicare board that would divest Congress of its authority over Medicare payment policy and shift this power to the executive branch would actually worsen the situation for surgical reimbursement in Medicare. On top of not reforming the SGR, the bill also included provisions that would create an unelected Medicare board that would divest Congress of its authority over Medicare payment policy and shift this power to the executive branch. Furthermore, the Medicare board, as envisioned in the Senate, could contain costs to the point of further undermining Medicare reimbursement for surgical care and potentially endangering Medicare beneficiaries' access to surgical care. It is for this reason that, in addition to advocating for Medicare payment reform, the College has played a key role in the effort to educate representatives, senators, and their staff members about the dangers of a board such as IPAB. Through the efforts of the College, patient organizations, other physician organizations, and other concerned stakeholders, numerous congressional staff members were contacted and, to date, 118 members of the House have publicly stated their opposition to such a board.

Progress and uncertainty

Health care reform also provided the setting for the greatest progress for achieving full-scale reform of the Medicare physician payment system since the cut of 2002. Twelve days after the passage of its health care reform bill, on November 19, 2009, the House passed the College-supported Medicare Physician Payment Reform Act (H.R. 3961) in a 243 to 183 vote.

H.R. 3961 includes the reforms that were included in an earlier version of the House bill, the America's Affordable Health Choices Act (H.R. 3200). H.R. 3200 had been passed by the House Committees on Ways and Means, Education and Labor, and Energy and Commerce in the months leading up to the release of H.R. 3961 and H.R. 3962 on October 29, 2009. H.R. 3961 would reset the budget baseline of the SGR and would replace the single spending target of the SGR with two spending targets based on type of service, which would be used to determine Medicare reimbursement for physician services. The first category of services would include all evaluation and management and office visits, and the second category would include all other services, including major surgical procedures. The bill would increase this annual target for growth to GDP plus 2 percent for the evaluation and management category, and to GDP plus 1 percent for the category for all other services. These provisions had been first released in June 2009, and the College had worked closely with the staff on the Ways and Means Committee and the Energy and Commerce Committee to address concerns regarding surgical reimbursement and preserving patients' access to surgical care.

Whereas the House considered legislation to reform and replace the SGR, the Senate considered the Medicare Physician Fairness Act of 2009 (S. 1776), which did not include the reforms outlined in H.R. 3961. Instead, S. 1776 would have reset the baseline and prevented Medicare payment levels from falling below 2009 levels. However, this measure failed to gain the support it needed to be considered by the full Senate, and on October 21, 2009, in a 47 to 53 vote, the bill failed to garner the 60 votes needed to invoke cloture. Senate Democrats and Republicans both cited the bill's cost as their reason for opposing the bill. At the time of consideration, S. 1776 was estimated to cost $210 billion over 10 years, ironically the same amount as H.R. 3961.

Unknown path ahead

Because of the enactment of the defense appropriations bill and H.R. 4691, the 21 percent cut in Medicare payments scheduled for January 1

was postponed until April 2010. Recognizing the continued need for legislative action on the SGR, the Senate took the step of adding a provision to the legislation to provide for an increase in the federal debt limit (H.J. Res. 45). While the provision did not directly address the threat of the 21 percent cut, it did exempt $82 billion from the statutory pay-as-you-go requirement that was included in H.J. Res. 45 for the purpose of addressing Medicare payments to physicians. This provision could set the stage for future consideration of Medicare physician payment provisions later in 2010.

Discussions regarding Medicare physician payments have also occurred in the context of legislation to promote economic growth and job opportunities. In fact, on March 10, the Senate approved the American Workers, State, and Business Relief Act of 2010 (H.R. 4213), which, in addition to measures extending certain tax provisions, also included a provision to extend current Medicare payment levels through the end of September. The House had previously passed a more narrowly crafted version of H.R. 4213 in December 2009. As a result, the House and Senate will need to need to resolve the differences between the House- and Senate-passed versions of H.R. 4213. Whether or not the Medicare payment issue will be resolved as part of those discussions before the scheduled cut on April 1 was unclear at press time.

In addition, the consideration for addressing Medicare physician payment cuts, either on a temporary or permanent basis, will certainly be affected by what costs the Congressional Budget Office (CBO) estimates will be associated with any Medicare payment legislation. With Congress moving to its consideration of the 2011 budget, CBO has indicated that a full repeal of the SGR could now be estimated to cost in excess of $300 billion.*

Even if Congress should agree to the Medicare payment extension through September, there has been no indication as to what action Congress might take to address future cuts either through other temporary measures or through full-scale and permanent Medicare payment reform. Earlier in 2010, there were rumors of consideration being given to a five-year temporary Medicare payment measure in the context of health care reform negotiations, and the $82 billion exempted under H. J. Res. 45 is the amount that would provide for measures freezing Medicare payments at 2009 levels through 2014.

The College continues to stress the need for a full and permanent Medicare payment reform, and has expressed strong concerns regarding the five-year approach, which would also expire the same year that the Medicare board (IPAB) would start issuing Medicare payment policies—should the Senate-passed bill become law.

The focus of America's surgeons

Over the past year, congressional efforts to reform the Medicare payment system have been undeniably shaped by the health care reform debate. While the effort to reform Medicare's payment system continues, 2009 marked the first time, since the creation of the SGR in 1997, that a congressional body has both considered and approved a measure to replace Medicare's broken physician payment system with a new methodology for Medicare reimbursement. In the near-term, America's surgeons are urged to call on their senators to follow the House's lead and enact much-needed reform of Medicare's payment system.

Even as Congress has continued to pass short-term measures to stop Medicare payment cuts, the College continues to advocate for lasting and permanent Medicare payment reform that will not only preserve, but also improve, Americans' access to quality surgical care. From the beginning, the College has consistently held that health reform's promise of greater access to care generally, and surgical care specifically, will mean little if Americans cannot find a qualified physician or surgeon to provide the care they need. Whether or not this promise will be realized rests in large part on whether or not America's elected representatives understand and appreciate the importance of ensuring that Medicare beneficiaries—and ultimately all Americans—can find a surgeon when they need one. Ω

*The Congress of the United States. Congressional Budget Office. *The Budget and Economic Outlook Fiscal Years 2010 to 2020*. January 2010. Available at: http://cbo.gov/ftpdocs/108xx/doc10871/01-26-Outlook.pdf. Accessed February 23, 2010.

Is the generalist surgeon obsolete?

The impact of the general surgeon shortage on global health

by Jeremy Hedges, MD, MPH; Kimberly A. Ruscher, MD, MPH; and Kathryn Chu, MD, MPH

Editor's note: *In 2009, the Resident and Associate Society of the ACS (RAS-ACS) sponsored an essay contest on the question, "Is the generalist surgeon obsolete?" Opposing positions were discussed by two previous authors (*Bull Am Coll Surg, *94[10]20-24), and the topic was debated at the 2009 RAS Symposium at Clinical Congress, in Chicago, IL. In this article, the RAS-ACS Issues Committee presents its final submission from this series—an essay on the global impact of the general surgeon shortage.*

The impending shortage of general surgeons has been well documented.[1] In the U.S., poor reimbursement rates, increasing medical school debt, and long work hours have contributed to a 26 percent decline in the overall number of surgeons over the past quarter century.[2] Thirty-two percent of general surgeons are older than 55 years, and thus many are poised to exit our profession.[3] According to the American Association of Medical Colleges, the average U.S. public medical school student graduates with $120,000 of debt, and a private school student graduates with $160,000 of debt—which could grow to more than $150,000 and $205,000, respectively, after the first three years of residency.[4] During lengthy general surgery training, this debt multiplies, leaving the young surgeon with a significant financial burden.

Fewer doctors are choosing general surgery as a career, and those who do tend to subspecialize.[2,5] At a time when fewer doctors become general surgeons, evidence of the global burden of surgical disease is demonstrating desperate surgeon shortages, disproportionately impacting developing countries. Surgery has recently been described as "the neglected stepchild of global public health" by Harvard professors Jim Kim, MD, PhD, and Paul Farmer, MD, PhD.[6] Although Drs. Kim and Farmer are infectious disease physicians, not surgeons, they are lobbying the public health community to scale up essential surgery services in resource-poor settings. While approximately 234.2 million major surgical procedures are performed worldwide each year, the poorest third of the world's population receives only 3.5 percent of

these operations. Meanwhile, three-quarters of these procedures are performed on the wealthiest third of the world's population.[7] There is a major disparity between state-of-the-art, expensive surgical care available in resource-rich countries and the lack of even basic services in poor countries.

The highest surgical burden of disease lies in Africa, where it is estimated to be 24 percent of the global volume; and most of that need is unmet.[8,9] With only one surgeon of any type for every 1 million people in Africa,[9] the sick person who finds a general surgeon, let alone a surgical specialist, is quite fortunate. Violence, injury, and obstetric emergencies are among the leading causes of mortality and morbidity, which could be mitigated through surgical intervention. Surgically treatable problems are estimated to account for up to 11 percent of the world's disability-adjusted life years.[10] In addition to this massive disease burden, there are other problems that are seriously debilitating (cataracts) or stigmatizing (obstetric fistula) this population.

Desperate surgeon shortages in developing countries are amplified by unstable political states, a paucity of medical schools and training programs, and the lure of higher salaries in developed countries.[11,12] The few surgeons working in developing countries confront an endless barrage of surgical pathology with little compensation, ill-equipped hospitals and operating suites, and with rare reprieve from continual "on-call" duties. Increasing evidence from the Disease Control Priorities Project, as well as evidence from recent literature, documents the tremendous number of years of life lost to death and disability from surgical pathology because of the inaccessibility of surgical care.[10,13]

Over the last several years, the surgical community has been debating the topic of whether the general surgeon is obsolete. Perhaps a better question for debate would be, "Who will replace the general surgeon in caring for the poor?" Increasingly, resource-poor countries are relying on expatriate surgeons to perform surgery or to train the local surgical workforce. For example, Ken Johnson, MD, FACS, a U.S.-trained general surgeon, has been working at a district hospital in Zambia for more than a decade. During the course of a single day, he performs a variety of cases such as caesarean sections, bowel resections, prostatectomies, and internal femur fixations. He is the only surgeon for the district; there are no surgical specialists. E.E. Moore, MD, FACS, and others, argue that the type of surgeon "who operated confidently and effectively on the neck, chest, abdomen, pelvis, and repaired any injured blood vessel" is disappearing from the American landscape.[14] Médecins Sans Frontières and other humanitarian organizations that provide surgical care during emergencies such as armed conflict and natural disasters in resource-poor environments are challenged to find broadly trained general surgeons.[15]

Perhaps a better question for debate would be, "Who will replace the general surgeon in caring for the poor?"

It is ironic that at a time when surgery is increasingly recognized as an important public health issue in developing countries, the number of surgeons with the appropriate breadth of training is decreasing. American surgeons are desperately needed to provide surgical services and train local providers worldwide, but the contribution they can make will depend on the relevance of their skills. Our surgical community must intentionally consider how to increase its impact on global health with surgeons adequately prepared to work in resource-limited settings. To accomplish this goal, attention must be given to establishing global surgery electives and residency tracks, similar to what has already been successfully accomplished by other specialties.[16] It is time to reflect, as a profession, on what contribution we want to make to medicine and public health before the general surgeon becomes extinct. Ω

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Dr. Hedges *is a PGY-5 general surgery resident at the University of Colorado Health Sciences Center, Denver. He is currently working and researching in Africa as a Harvard Traveling Fellow.*

Dr. Ruscher *is a PGY4 resident at the University of Connecticut, Hartford. She is Vice-Chair of the ACS Resident and Associates Society Issues Committee, and a member of the ACS Public Profile and Communications Steering Committee.*

Dr. Chu *is a surgical advisor for Médecins Sans Frontières-Brussels, and assistant professor in surgery and international health, Johns Hopkins University School of Medicine, Baltimore, MD.*

Lobbyists—Who needs them?

by Melinda Baker, Senior Associate, State Affairs, Division of Advocacy and Health Policy

The founding fathers made sure to include in the first amendment to the U.S. Constitution "the right to petition the government"—in other words, the right of citizens to lobby. These days, when partisanship and polarized politics seem to hold sway, the word "lobbyist" has become a dirty word. But what exactly is a lobbyist? Are they necessary?

Even President John F. Kennedy recognized the necessity of lobbyists. While a U.S. senator, he had this to say:

> Lobbyists are, in many cases, expert technicians capable of examining complex and difficult subjects in a clear, understandable fashion. They engage in personal discussions with Members of Congress in which they explain, in detail, the reasons for the positions they advocate.... Because our congressional representation is based upon geographical boundaries, the lobbyists who speak for the various economic, commercial, and other functional interests of the country serve a useful purpose, and have assumed an important role in the legislative process.*

Lending a helping hand

Legislators are asked to interact with every industry and community, and as they cannot be experts on every issue, lobbyists provide an essential education on important topics and issues. Without lobbyists, each state (as well as the federal government) would have to employ an entire staff, separate from their partisan staffs, to research every industry and every position. This staff would have to be quite large—according to the Center for Responsive Politics, in 2009 there were more than 13,000 registered individual lobbyists in Washington, DC.† Each state and many local governments would also have to expand their staffs. For example, in 2009, Illinois alone had 1,925 registered lobbyists.‡

There are two types of lobbyists: exclusive and contract. Exclusive lobbyists work only for one company or association. The College's Washington, DC, office employs four full-time lobbyists who advocate exclusively on behalf of the Fellows before Congress on issues ranging from quality to reimbursement to workforce. Contract lobbyists, by contrast, often have several clients and may be hired to lobby for a specific issue or congressional term, or to work with a particular individual or agency.

A lobbyist's reputation and credibility, whether he or she is an exclusive lobbyist or a contract lobbyist, are key to their success. Giving out misinformation to a legislator can quickly end a career. Despite reports of unethical lobbyists that may appear in the press, there are thousands more who are doing their jobs ethically and responsibly.

Chapters and lobbying

Should chapters hire a lobbyist to help advance their state advocacy initiatives? Ultimately, it comes down to time versus money. Does the chapter have the time to monitor legislation, establish and maintain relationships with policymakers, and effectively lobby surgery's position? On the flip side, hiring a lobbyist is an expense. Most contract lobbyists work on retainer—typically monthly, unless hired for a specific issue and a specific time period—and their fees can be steep. Conversely, an exclusive lobbyist is a staff member who receives a set salary and benefits.

If a chapter has the financial resources to hire a lobbyist, there are several things to keep in mind. Most importantly, make sure state lobby laws and the federal tax code permit the chapter to do this. There are differences between what a 501(c)(3) and a 501(c)(6) organization can do. Next, be sure to hire someone who can be trusted. In order to be an effective lobbyist, this person must

continued on page 48

*De Fouloy, C. 2008. *The Lobbyist's Book of Quotes*. Minneapolis, Minnesota: Kirk House Publishers.

†Center for Responsive Politics: Lobbyist Database. Available at http://www.opensecrets.org/lobby/. Accessed on January 27, 2010.

‡Illinois's Secretary of State, Index Department: Lobbyist List. Available at http://www.cyberdriveillinois.com/departments/index/lobbyist/lobbyistlist.txt. Accessed on January 27, 2010.

Kamangar Awards help create ethics training for residents

by Stuart D. Yoak, PhD

Surgeons grapple with some of the toughest ethical issues in medicine each day, such as, "Will this surgery truly benefit my patient who is facing a terminal illness?" or, "How much should I tell the patient's loved ones when the surgery did not go well?" and, "What is the best way to resolve disagreements among the health care team?"

These—and many similar questions—challenge surgeons across the country as they require developed skills in ethical decision making. The Kamangar Surgery Residents Training Program in Medical Ethics, launched in 2008 in collaboration with the College, is designed to help residency programs create ethics training initiatives that give residents experience in addressing real ethical issues in medicine, and to enable them to gain mastery in this challenging professional area.

Left to right: Dr. Klingensmith, Mr. Kamangar, and Dr. Kodner.

On Thursday, December 2, the 2009 Kamangar Award winners met for the Second Annual Directors' Meetings and Ethics Workshop at Washington University in St. Louis, MO. The 25 attendees represented 17 surgical residency training programs that were awarded Kamangar grants for the purpose of starting new ethics training programs or expanding existing programs at their institutions.

The Kamangar Surgery Residents Training Program in Medical Ethics is led by Ira J. Kodner, MD, FACS, the Solon and Bettie Gershman Professor of Colon and Rectal Surgery, Washington University School of Medicine, St. Louis, MO, and director of the Center for the Study of Ethics and Human Values at Washington University, St. Louis, MO; and Mary

Did you know... THAT NEARLY 250 hospitals are improving their quality of care by participating in the American College of Surgeons National Quality Improvement Program (ACS NSQIP)? ACS NSQIP employs a prospective, peer-controlled, validated database of clinical data—not claims data—to quantify 30-day risk-adjusted surgical outcomes, which allows valid comparison of outcomes among all hospitals in the program. For more information, visit *https://acsnsqip.org/login/default.aspx*.

Klingensmith, MD, FACS, professor of surgery, program director in surgery, and director of the Surgical Skills Laboratory at Washington University School of Medicine. Dr. Kodner welcomed the award winners and congratulated them on their commitment to developing an ethics training program at their institutions. He also introduced Mr. Parviz Kamangar, who shared his personal story as a grateful patient and his vision for this national ethics training program.

The first half of the Kamangar Surgery Residents Training Program in Medical Ethics Directors' Meeting focused on the model for medical ethics training developed and led by Dr. Klingensmith. She discussed a vision of creating a series of multidisciplinary meetings with residents, senior physicians, ethicists, administrators, chaplains, legal counsel, and many other health care professionals, where these individuals would explore key topics and challenge one another on critical ethical issues. Each session is devoted to topics and cases that present real ethical dilemmas for surgeons and the entire medical community. For the past eight years, Dr. Klingensmith and Dr. Kodner have organized these monthly, one-hour meetings, which are open to all. (The sessions include pizza and sodas, and have become known as the monthly "Surgery Ethics Pizza Rounds.")

Dr. Klingensmith and three other presenters also gave their unique perspectives on the medical ethics training series developed at Washington University. Nicholas Hamilton, MD, a surgery resident and clinical research fellow, discussed how residents were encouraged to bring real cases they encountered to the monthly meetings, and also how residents were given support to speak openly about their uncertainties in confronting ethical issues. Joseph F. Kras, MD, DDS, associate professor and director of education in the department of anesthesiology,

Mr. Kamangar

2009 Kamangar Award winners and workshop presenters.

shared his belief that inviting physicians and residents from other programs made the Surgery Ethics Pizza Rounds a dynamic exchange of views on complex ethical problems. Finally, the author, executive director and lecturer in professional ethics at Washington University, argued that one of the great strengths of the program was the effort given to clarify the ethics bottom line—a format developed in the ACS textbook, *Ethical Issues in Clinical Surgery,* edited by Mary H. McGrath, MD, MPH, FACS.

The afternoon workshop portion of the directors' meeting was devoted to sharing strategies for medical ethics training. Each of the award winners were asked to describe the process they intended to develop for their institution for training residents in ethical decision making. This interactive exchange helped participants learn from one another and further refine the plans they were developing.

The directors' meeting culminated with everyone attending a special session of the Washington University Surgery Ethics Pizza Rounds. In this combined session with residents and Kamangar Award winners, Jason Keune, MD, surgery resident and ACS Emerson Scholar in Residence, led the group in a discussion on the topic of elective surgical patients as living organ donors, and on the ethical aspects of clinical innovation.

Comments from the participants at the 2009 gathering uniformly demonstrate the important contribution of the program in helping launch ethics training. "I would like to convey my appreciation for the recent Kamangar directors' meeting in St. Louis, and to reiterate how excellent I felt the program was. I came back with many great ideas, and we are now in the final planning stages in order to effectively initiate our program," said Kamela Scott, MD, University of Florida College of Medicine, Jacksonville, FL. "I would just like to convey my thanks to you and your associ-

Kamangar Ethics Award winners 2009

Brigham & Women's Hospital
Harvard Medical School, *Boston, MA*
Stanley Ashley, MD, FACS,
Program Director

Cedars-Sinai Medical Center
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Farin Amersi, MD, FACS,
Program Director

Georgetown University Hospital
Washington, DC
Richard Holt, MD, FACS,
Program Director

Lehigh Valley Health Network
Allentown, PA
Michael Badellino, MD, FACS,
Program Director

Long Island Jewish Medical Center
New Hyde Park, NY
William Doscher, MD, FACS,
Program Director

Maine Medical Center
Portland, ME
James Whiting, MD, FACS,
Program Director

Naval Medical Center
Portsmouth, VA
Beth Jaklic, MD, FACS,
Program Director

New Hanover Regional Medical Center
Wilmington, NC
Thomas Clancy, MD, FACS,
Program Director

North Shore University Hospital
Manhasset, NY
Andrew Menzin, MD, FACS,
Program Director

Oregon Health and Science University
Portland, OR
Karen Deveney, MD, FACS,
Program Director

Pennsylvania State University
Hershey, PA
Peter Dillon, MD, FACS,
Program Director

Rush University Medical Center
Chicago, IL
Edie Chan, MD, FACS,
Program Director

St. John Hospital and Medical Center
Detroit, MI
Cheryl Wesen, MD, FACS,
Program Director

Texas Tech University
Health Sciences Center School of Medicine, *Lubbock, TX*
Ari Halldorsson, MD, FACS,
Program Director

University of Florida College of Medicine
Jacksonville, FL
Michael Nussbaum, MD, FACS,
Program Director

University of Maryland
Baltimore, MD
Patricia Turner, MD, FACS,
Program Director

University of Wisconsin
Madison, WI
Eugene Foley, MD, FACS,
Program Director

ates on an extremely valuable session which really worked for Nitin and myself," said William Doscher, MD, Long Island Jewish Medical Center, New Hyde Park, NY. "Awesome program. Came back very energized. Many thanks," said Andrew Menzin, MD, North Shore University Hospital, Manhasset, NY. "Thank you for hosting the Kamangar Medical Ethics Directors' Meeting and Workshop on December 3, 2009, and for your support. The sessions were informative and energizing. Our chief resident, Africa Wallace, MD, and I will begin tomorrow by discussing some of what we learned with our residents during this week's academic day," said Richard W. Holt, MD, Georgetown University.

In 2008, the Kamangar Surgery Residents Training Program in Medical Ethics awarded grants to 15 surgical residency programs from 10 different states. In 2009, the Kamangar program awarded grants to 17 surgical residency programs from 15 different states (see box, page 30). In just its first two years, the Kamangar ethics program has trained more than 1,280 residents nationally. This ongoing collaboration with the College is focused on building a successful national model for ethics training.

Plans for the 2010 Kamangar Surgery Residents Training Program in Medical Ethics are now under way. Announcements and a call for applications will go out later in the spring, with a due date for applications in July. For further information, please contact Dr. Kodner at IJKodner@aol.com, or 314-454-8567.

Dr. Yoak *is executive director and lecturer in professional ethics, Center for the Study of Ethics and Human Values, Washington University, St. Louis, MO.*

Emergency rooms treated 3.5 million MVAs in 2006

Approximately 3.5 million motor vehicle accident (MVA) victims were treated in emergency departments in 2006 for injuries ranging from scrapes and bruises to life-threatening trauma, according to the January 2010 *News and Numbers*, a statistical brief from the Health and Human Services' Agency for Healthcare Research and Quality (*http://www.hcup-us.ahrq.gov/reports/statbriefs/sb84.pdf*).

Nearly 44,000 people died in 2006 as a result of motor vehicle traffic accidents, and approximately 8,000 of the victims died in the emergency department. Roughly 85 percent, or 3 million, of the crash victims were treated and released. Some 321,000 were admitted or transferred to another acute care hospital for inpatient care. Also included in the federal agency's analysis:

- MVA-related emergency department visits resulted in admission to the hospital for care about half as often as nonMVA-related emergency visits. More than half (58 percent) were covered by private payors, compared with 34 percent of nonMVA-related visits.
- Sprains accounted for 44 percent of the injuries treated; superficial injuries, such as scrapes, accounted for 35 percent; open wounds, 10 percent; and head injuries accounted for 5 percent of the motor vehicle injuries. More serious injuries, such as internal injury of the thorax, abdomen, and pelvis, were considerably less common (2.6 percent).

The report uses statistics from the 2007 Nationwide Inpatient Sample, a database of hospital inpatient stays that is representative of inpatient stays in all short-term, nonfederal hospitals. The data are drawn from hospitals, which process 90 percent of all discharges in the U.S., and include all patients, regardless of insurance type or whether the patient was uninsured.

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Physician Reimbursement Systems

ACS Foundation receives educational grant for patient skill kit

The Surgical Patient Education Program of the Division of Education of the American College of Surgeons has developed a patient skill kit to better prepare surgical patients for their ostomy care post-discharge. An educational grant from Coloplast, Inc. will support the production and distribution of 30,000 of these kits to surgical patients.

The program provides patients with a comprehensive, interactive learning kit that supports them in adopting the knowledge and skills for self-care following discharge. Specifically, the College is launching the program with a skill kit for patients requiring an ostomy. Each kit will contain a simple ostomy simulator, sample pouches, measurement guide, scissors, instruction booklet with images to guide each step of skill acquisition, and a CD featuring a demonstration of each skill, as well as a list of additional resources and support groups. (The educational content also describes potential complications and risks.)

Skills education for ostomy patients was chosen for this initiative because patients with bladder and colon cancer require extensive life-adjustment and skills training for continued home management.

An estimated 120,000 patients require an ostomy procedure each year, and yet research indicates that patients are leaving the hospital unprepared for home care. Skills training reduces common complications such as skin breakdown, and patients who feel confident about their care and changing their appliance have significantly higher quality of life scores in comparison with those who are not confident in their skills.

In response to the program's launch, David B. Hoyt, MD, FACS, Executive Director of the American College of Surgeons, said, "The Surgical Skills Patient Education Program will improve outcomes of surgical care and will establish a national standard for patient surgical skills education that ensures all patients and their families have the opportunity to participate in their surgical care and competently perform the skills required for their home care."

The ostomy skills kit was developed in collaboration with all of the professional organizations that provide care to the ostomy patient, including the American College of Surgeons, the Wound Ostomy Continence Nurses Society, the American Society of Colon and Rectal Surgeons, the American Urological Association, and the United Ostomy Associations of America.

While the program is being launched with materials for ostomy procedures, kits will also be created for a vast array of surgical procedures. All patient kits and professional training guides will be accompanied by detailed evaluations to support enhanced clinical outcomes and ensure that the education and access that patients require to recover from their operation is effective.

Coloplast, Inc. is supporting this Surgical Patient Education Program through an educational grant. According to Kim Herman, Coloplast, Inc. vice-president of marketing, "Coloplast welcomes the opportunity to enhance the efforts of the ACS, and we applaud the educational mission. As the global leader in ostomy care, we are proud to support the production and distribution of the skill kits to help support ostomy patients, as well as the physicians and nurses providing clinical and educational services to each of these individuals."

"The philanthropic support of donors like Coloplast provides essential resources for the American College of Surgeons as it furthers its commitment to patient safety and patient education through new programs like the home care skill kit for ostomy patients," said Thomas R. Russell, MD, FACS, Chair of the American College of Surgeons Foundation.

The skill kit for ostomy patients will be available in mid-April. Surgeons may order the materials online through the American College of Surgeons Web site at *http://www.facs.org/patienteducation*.

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College to present leadership skills course in May

The American College of Surgeons invites surgeons who aspire to meet the challenges of exemplary leadership across all settings to join senior surgical leaders in a dynamic three-day course, Surgeons as Leaders: From Operating Room to Boardroom, to be held May 23–26, at the College headquarters in Chicago, IL.

Surgeons who will serve as faculty include: Layton F. Rikkers, MD, FACS, Chair; Bruce L. Gewertz, MD, FACS; Wiley W. Souba, MD, ScD, FACS; and Gayle E. Woodson, MD, FACS. A. Brent Eastman, MD, FACS, Chair of the Board of Regents, will be the keynote speaker. ACS Regent Julie A. Freischlag, MD, FACS, and Charles F. Rinker II, MD, FACS, will serve as specially invited faculty. Debra A. DaRosa, PhD, will serve as professional educator for the course.

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

For details and an application form, visit *http://www.facs.org/education/surgeonsasleaders.html*, or contact Alexandra Palinski at apalinski@facs.org or 312-202-5018.

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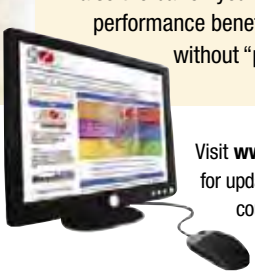

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A look at The Joint Commission

Annual report on hospital quality and safety shows steady improvement

The Joint Commission issued its fourth annual report in January. The report demonstrates how accredited hospitals in the U.S. have steadily improved the quality of patient care over a seven-year period, saving lives and improving the health of thousands of patients.

Improving America's Hospitals: The Joint Commission's Report on Quality and Safety 2009, provides scientific evidence of improvements in the care of patients. More than 3,000 Joint Commission-accredited hospitals contributed data to this report.

Five new measures were introduced in 2008, bringing the total number of Joint Commission measures covered in this report to 31. There are eight measures of care relating to heart attack, four relating to heart failure, nine to pneumonia, eight to surgical care, and two to children's asthma care.

Hospitals have steadily improved on individual surgical care performance measures over a four-year period. The complete results for the surgical care performance measures are outlined in the Figure on page 37.

Hospitals began collecting core measure data for Surgical Infection Prevention (SIP) with patient discharges beginning July 1, 2004. The SIP set subsequently transitioned to the Surgical Care Improvement Project (SCIP) effective July 1, 2006. All Joint Commission measures are submitted to the National Quality Forum (NQF) for review and potential endorsement. All SCIP measures have been endorsed by the NQF. The Joint Commission also works closely with NQF and other external entities in the ongoing identification and specification of additional core measure sets.

Not all hospitals deliver the same level of quality; some hospitals perform better than others in treating particular conditions and in achieving patient satisfaction. Quality, safety, and patient satisfaction results for specific hospitals can be found at *http://www.qualitycheck.org*.

Improving America's Hospitals: The Joint Commission's Report on Quality and Safety 2009, is available at: *http://www.jointcommission.org/Library/annual_report*. More information on the Surgical Care Improvement Project Core Measures is available at: *http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/SCIP+Core+Measure+Set.htm*.

Comprehensive general surgery review course slated for June

The first ACS Comprehensive General Surgery Review Course is scheduled to be held June 17–20, in Chicago, IL. The intensive four-day course will cover the essential content areas in general surgery, such as abdomen, alimentary tract, breast, endocrine, head and neck, oncology, pain management, perioperative care, skin and soft tissue, surgical critical care, trauma, vascular system, and other specialty-related areas.

The course Chair, John A. Weigelt, MD, FACS, along with a distinguished faculty, will use didactic and case-based formats for a comprehensive and practical review. Special course features include focused discussion sessions with faculty, a variety of self-assessment materials, and five additional monthly online modules following the course. Organized by the College's Division of Education, this course should be helpful in fulfilling the requirements for Maintenance of Certification, Part 2, and in preparing for recertification examinations.

For details, visit *http://208.250.24.72/education/reviewcourse.html*, or contact Alexandra Palinski at apalinski@facs.org or 312-202-5018. Registration forms will be accepted on a first-come, first-served basis until the course is full.

Figure. National performance summary, 2005–2008

All improvements or decreases in performance are statistically significant. Many of the smaller percentage improvements occurred within large patient populations, meaning that significantly more patients received a treatment. In some cases, performance was already quite high and there was less room for improvement. (The overall measure and rates are indicated in **bold**; the specific surgical procedures for each measure are indicated in regular type.)

Performance measure*	2005	2006	2007	2008	Improvement since inception (percentage points)
Surgical care					
Antibiotics within one hour before the first surgical cut††	**81.8%**	**86.6%**	**89.5%**	**93.5%**	**11.7**
For CABG surgery	85.2%	87.6%	89.5%	94.0%	8.8
For cardiac surgery (other than CABG)	83.8%	87.1%	89.0%	93.7%	9.9
For colon surgery	72.2%	78.0%	82.4%	87.6%	15.4
For hip joint replacement surgery	81.3%	86.9%	89.4%	93.4%	12.1
For hysterectomy surgery	82.4%	86.9%	89.8%	93.7%	11.3
For knee joint replacement surgery	85.1%	90.4%	92.5%	95.3%	10.2
For vascular surgery	75.2%	81.1%	85.3%	90.6%	15.4
Appropriate prophylactic antibiotics††	**N/A**	**N/A**	**94.9%**	**96.8%**	**1.9**
For CABG surgery	N/A	N/A	97.8%	98.7%	0.9
For cardiac surgery (other than CABG)	N/A	N/A	96.2%	99.1%	2.9
For colon surgery	N/A	N/A	75.7%	84.3%	8.6
For hip joint replacement surgery	N/A	N/A	98.0%	98.7%	0.7
For hysterectomy surgery	N/A	N/A	93.7%	96.1%	2.4
For knee joint replacement surgery	N/A	N/A	98.2%	98.8%	0.6
For vascular surgery	N/A	N/A	95.3%	96.6%	1.3
Stopping antibiotics within 24 hours††	**73.5%**	**79.1%**	**85.6%**	**90.5%**	**17.0**
For CABG surgery within 48 hours	69.7%	87.3%	89.7%	93.6%	23.9
For cardiac surgery within 48 hours (other than CABG)	62.7%	86.2%	89.7%	92.6%	29.9
For colon surgery	61.5%	65.3%	74.8%	80.4%	18.9
For hip joint replacement surgery	69.2%	74.9%	84.0%	89.8%	20.6
For hysterectomy surgery	88.0%	89.1%	90.2%	92.8%	4.8
For knee joint replacement surgery	69.5%	76.2%	85.4%	91.3%	21.8
For vascular surgery	65.0%	67.3%	77.0%	83.0%	18.0
Cardiac patients with controlled 6 a.m. postoperative blood glucose	**N/A**	**N/A**	**N/A**	**89.9%**	**N/A**
Patients with appropriate hair removal	**N/A**	**N/A**	**N/A**	**97.4%**	**N/A**
Beta blocker patients who received beta blocker perioperatively	**N/A**	**N/A**	**N/A**	**92.0%**	**N/A**
Prescribing VTE medicine/treatment	**N/A**	**N/A**	**87.2%**	**92.1%**	**4.9**
Receiving VTE medicine/treatment	**N/A**	**N/A**	**83.2%**	**89.6%**	**6.4**

* Results are determined by the number of times the hospital met the measure (such as giving aspirin before or after arrival for heart attack patients) divided by the number of opportunities (eligible patients) the hospital had during the year. Results are expressed as a percentage.

†† These surgical care measures report rates on seven specific surgical procedures, as well as the overall measure rate.
See Glossary for definitions

Improving America's Hospitals: The Joint Commission's Annual Report on Quality and Safety 2009

ACOSOG news

Changing multidisciplinary cancer treatment through ACOSOG trials

by David M. Ota, MD, FACS; and Heidi Nelson, MD, FACS

Early American College of Surgeons Oncology Group (ACOSOG) trials focusing on surgical questions such as diagnostic and regional lymph node staging were successful with enrollment and publications. While this focus was essential, ACOSOG has recognized the importance of balancing its list of procedure trials with multidisciplinary trials that incorporate systemic and radiation therapies.

Other cooperative groups have a multidisciplinary theme, but depend on surgeons primarily for referring patients for postoperative adjuvant therapy. ACOSOG relies on surgeons to provide leadership and decision making, and now incorporates reconstituted medical and radiation oncologist committees to bring added value to the surgeon-based cooperative group. This allows ACOSOG to continue to evolve by utilizing unique multidisciplinary teams recruited from national scientific leadership.

In the past two years there has been an emphasis in pragmatic growth for the ACOSOG Medical Oncology and the Radiation Oncology Committees. The chair of the current Medical Oncology Committee is Matthew J. Ellis, MD, FACS, professor of medicine and head, section of medical oncology, Washington University, St. Louis, MO (see Table 1, this page).

These members are actively engaged in ACOSOG trials, come from various multiple ac-

Table 1: Medical Oncology Committee membership

Matthew J. Ellis, MD, PhD Washington University School of Medicine, *St. Louis, MO*
Jordan Berlin, MD Vanderbilt University Medical Center, *Nashville, TN*
Emily Chan, MD, PhD Vanderbilt University Medical Center, *Nashville, TN*
Cathy Eng, MD MD Anderson Cancer Center, *Houston, TX*
Ramaswarmy Govindan, MD Washington University School of Medicine, *St. Louis, MO*
Axel Grothey, MD Mayo Clinic, *Rochester, MN*
Hedy L. Kindler, MD University of Chicago Medical Center, *Chicago, IL*
Craig Lockhart, MD Washington University School of Medicine, *St. Louis, MO*
Cynthia Xiuguang Ma, MD, PhD Washington University School of Medicine, *St. Louis, MO*
Robert R. McWilliams, MD Mayo Clinic, *Rochester, MN*
Alberto Montero, MD Sylvester Comprehensive Cancer Center, *Miami, FL*
Stacy L. Moulder, MD, MSCI MD Anderson Cancer Center, *Houston, TX*
Vincent J. Picozzi, Jr., MD Virginia Mason Clinic, *Seattle, WA*
Vered Stearns, MD Johns Hopkins School of Medicine, *Baltimore, MD*
Thomas E. Stinchcombe University of North Carolina Medical Center, *Chapel Hill, NC*
Anne M. Traynor, MD University of Wisconsin, *Madison, WI*
Andrea Wang-Gillam, MD, PhD Washington University School of Medicine, *St. Louis, MO*

ademic centers, and are a blend of senior and junior faculty.

The chair of the reconstituted Radiation Oncology Committee is Charles Thomas, MD, professor of radiation oncology and chair, department of radiation medicine, at Oregon Health and Science University (OHSU). (See Table 2, this page).

As with the Medical Oncology Committee, the Radiation Oncology Committee members are also engaged in ACOSOG trials, come from multiple academic centers, and are a blend of senior and junior faculty with a strong clinical and translational science background.

The impact of new oncology leadership to a surgeon-based cooperative group is apparent with current and future trials that focus on neoadjuvant and adjuvant designs. Examples of our neoadjuvant studies are ACOSOG Z1031 (neoadjuvant aromatase inhibitor therapy) for breast cancer, ACOSOG Z1041 (neoadjuvant chemotherapy trastuzumab) for breast cancer, and ACOSOG Z5041 (neoadjuvant erlotinib/gemcitabine for pancreas cancer). Neoadjuvant chemoradiation studies include ACOSOG Z6041 (rectal cancer) and ACOSOG Z4051 (esophageal adenocarcinoma). Intraoperative adjuvant brachytherapy (ACOSOG Z4032) and sublobar resection for NSCLC will soon be completed. Future unique neoadjuvant and adjuvant trials are in the ACOSOG pipeline.

Neoadjuvant design is particularly relevant to surgeons. Primary tumor regression can give surgeons options when resecting the tumors; notable examples are mastectomy to lumpectomy, and abdominal-perineal resection to local excision. Surgeons discuss the study with patients who ultimately must consent to either neoadjuvant therapy or surgery first. Specifically, neoadjuvant design allows surgeons to obtain consent for tumor tissue acquisition for future laboratory analysis or analysis for genome sequencing.

ACOSOG is expanding its scope of therapeutic trials,

Table 2: Radiation Oncology Committee membership

Charles R. Thomas, Jr., MD OHSU Knight Cancer Institute, *Portland, OR*
Ross A. Abrams, MD Rush University Medical Center, *Chicago, IL*
Thomas A. Buchholz, MD MD Anderson Cancer Center, *Houston, TX*
Laurie Cuttino, MD Medical College of Virginia, *Richmond, VA*
Thomas A. DiPetrillo, MD Tufts New England Medical Center, *Boston, MA*
Eli J. Glatstein, MD Abramson Cancer Center, *Philadelphia, PA*
Thomas E. Goffman, MD Cancer Intelligence & Research, P.C., *Norfolk, VA*
Chandan Guha, MD, PhD Montefiore Medical Center, *Bronx, NY*
Shalina Gupta-Burt, MD Kansas City Cancer Center, *Kansas City, MO*
Michael G. Haddock, MD Mayo Clinic, *Rochester, MN*
Bruce G. Haffty Robert Wood Johnson Medical School, *New Brunswick, NJ*
Michele Y. Halyard, MD Mayo Clinic, *Scottsdale, AZ*
Ruth Heimann, MD, PhD University of Vermont/FAHC, *Burlington, VT*
Dwight E. Heron, MD University of Pittsburgh Cancer Institute, *Pittsburgh, PA*
Charlotte D. Kubicky, MD, PhD OHSU Knight Cancer Institute, *Portland, OR*
Brian E. Lally, MD University of Miami, *Miami, FL*
Bo Lu, MD, PhD Vanderbilt University Medical Center, *Nashville, TN*
Mitchell Machtay, MD Case Western Reserve University, *Cleveland, OH*
Tracey Schefter, MD University of Colorado HSC, *Denver, CO*
Christopher G. Willett, MD Duke University Medical Center, *Durham, NC*

including systemic or regional adjuvant therapy procedures. We welcome our colleagues from medical and radiation oncology disciplines to help us answer important questions in cancer treatment. Francis Bacon, Sr., succinctly expresses the spirit of ACOSOG, in which a clinical trial begins by doubting current standard treatment, and then pursuing a trial design which provides data to support new treatment standard:

> If a man will begin with certainties, he shall end in doubts; but if he will be content to begin with doubts, he shall end in certainties.*

A multidisciplinary approach in a surgeon-based group offers unique strengths in bringing together correlative data with clinical data. We look forward to opening new studies in the near future, especially in this era of targeted therapy and diagnostics. Surgeon participation is critical to the success of improving cancer therapy.

*Wormald B.H.G. *Francis Bacon: History, Politics and Science, 1561-1626*.Cambridge and New York: Cambridge University Press; 1993.

***Dr. Ota**, of Durham, NC, and **Dr. Nelson**, of Rochester, MN, are ACOSOG Co-Chairs.*

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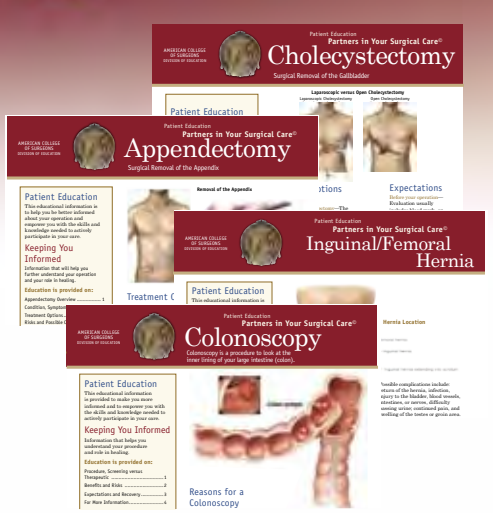

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Letters

The following comments were received regarding recent articles published in the Bulletin.

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.*

To serve and protect

I read with great interest the article titled "To serve and protect: An interview with a surgeon-SWAT cop" in the February issue of the Bulletin (*Bull Am Coll Surg*. 2010;95(2):10-14). As a fellow trauma surgeon and Fellow of the College, I am happy that Dr. Dennis has dedicated some of his practice to providing medical support to tactical teams in Illinois. Through the Illinois Tactical Officers Association (ITOA), I know many of these brave and selfless officers.

In 1989, David Rasumoff, MD, FACEP (now deceased), and myself formally started the first tactical emergency medical support (TEMS) program in the U.S., in conjunction with the National Tactical Officers Association (NTOA). David and I were both long-time SWAT police officers who had practiced medical support of our respective tactical teams in an informal way. This course evolved to become the national (and international) standard for the provision of TEMS. This course consisted of a 16-hour block of instruction for police officers, as well as emergency medical service (EMS) providers. It provided both didactic and hands-on tactical experience.

In 1990, my colleagues at the Uniformed Services University of Health Sciences (Baltimore, MD) began a federally sponsored TEMS course, the Counter Narcotics Tactical Operations Medical Support (CONTOMS) course. David and I were among the founding faculty and instructors for this week-long course. During the 1990s, and continuing into the new millennium, thousands of SWAT teams, police officers, and EMS personnel, nationally and internationally, were trained in TEMS. This decade also gave rise to many different TEMS-related training programs nationally. I personally participated in presentations to various Illinois teams and the ITOA in the 1990s and early 2000s.

As an offshoot of TEMS—and due to the evolution of more complex tactical threats in the 1990s and early 2000s—many departments nationally also began to train the patrol officers in emergency medical care in a military-like "buddy" system. The NTOA, CONTOMS, and other new programs also began to address the needs of non-SWAT patrol officers. Although the field is termed TEMS, the most important goal of the tactical provider, then and now, is to prospectively ensure the health, safety, and security of their team. (Nationally, TEMS providers are not only physicians, but also EMTs, nurses, and physician assistants, in some cases.)

We hope that more young health professionals like Dr. Dennis will continue to support our tactical teams, commensurate with their time available and their ability.

Richard Carmona, MD, MPH, FACS
17th Surgeon General of the U.S.
Tucson, AZ

Importance of conflict disclosure

I found the publication of the article "Dangers of postoperative opioids: Is there a cure?" (*Bull Am Coll Surg*. 2010;95[2]:21-22) without full conflict disclosure highly disturbing.

Although Dr. Stoelting has had an apparently prolific academic career, he is now president of the Anesthesia Patient Safety Foundation (APSF); no other affiliations are disclosed. A perusal of the APSF Web site reveals it to be largely industry-sponsored. This article contains a recommendation for the adoption of capnography for monitoring of patients receiving patient-controlled analgesia, without any supporting data. There may, or may not, be a connection to the fact that one or more of the donors to the APSF manufactures capnographic monitoring devices.

To my eyes, this article represents an industrial press release rather than a scientific endeavor. I personally do not believe it should have been published. I am not arguing that capnography in this setting is not appropriate; I am saying that such standards should be based upon non-biased research. Full disclosure would at least allow readers to judge this article in an appropriate manner.

Richard S. Goldstein, MD, FACS
Langhorne, PA

Authors' response

Dr. Goldstein raises two substantive issues: (1) the importance of full disclosure of possible conflicts of interest (in this instance, disclosure of corporate support of the APSF), and (2) the need for "non-biased research" to support patient safety recommendations. We agree that full disclosure is critically important for readers to properly evaluate published recommendations, regardless of their source.

For those not familiar with our unique function and structure, APSF is an advocacy organization guided by a unique partnership between multiple stakeholders (physicians, nurses, medical technicians, hospital administrators,

lawyers, insurers, regulators, patients, and the medical industry). APSF receives unrestricted donations from medical device manufacturers, including those that make capnometers. This should have been disclosed when our article was reprinted outside of the *APSF Newsletter*. We encourage readers to view our Statement on Industrial Relations at *http://www.apsf.org* (click on "About APSF").

Evidence-based standards should be supported by randomized controlled trials, although such studies are much more difficult and expensive, with rare occurrences of the dependent variable. Opioid-induced respiratory failure leading to death or brain damage fits this description. In such cases, evidence from randomized trials (if available) is important, but is neither sufficient nor necessary for acceptance of a new patient safety practice.[1] Indeed, pulse oximetry became a standard of care, not because of proof that it reduced adverse outcomes, but rather because it exhibited compelling benefits without significant harm. Similar reasoning would support the use of continuous monitoring of ventilation (capnography) in all clinical situations where patients receive potent opioids (or sedative-hypnotics).

To wait for incontrovertible proof of effectiveness before recommending a practice would be a potential prescription for inaction. Thus, clinical recommendations from a patient safety advocacy group are reasonable if the available evidence suggests that fewer patients would be harmed if such actions were taken. Admittedly, "only" a few hundred cases annually of serious patient harm from post-procedural opioid therapy can be discerned in existing event reporting systems and closed claims data. However, there is ample literature suggesting that the incidence of significant respiratory depression in patients in American hospitals receiving parenteral opioids ranges from 0.1 to 1 percent.[2] Thus, if only 1 percent of these events resulted in hypoxic brain injury, serious patient harm occurs at least 10 times more often than is reported (perhaps thousands of events per year).

With regard to prevention, there is emerging data suggesting that end-tidal carbon dioxide monitoring during PCA[3] or procedural sedation[4,5] provides warning of hypoventilation that is unrecognized by the treating clinicians.

APSF advocates for patient safety with the vision that "no patient shall be harmed by anesthesia." Thus, our recommendations focus on minimizing the risk to individual patients for rare adverse events. APSF does not intend for these recommendations to be standards, guidelines, practice parameters, or clinical requirements.

We recommend that continuous ventilatory monitoring (capnography) be utilized, especially when supplemental oxygen is administered to higher-risk patients (existing depressed level of consciousness or respiratory impairment, sleep apnea, or the very sick or elderly) receiving parenteral or neuraxial opioids.[6] Since surgeons are often the prescribing physicians, we believe this recommendation is important to share with our surgical colleagues.

Robert K. Stoelting, MD
President, APSF
Matthew B. Weinger, MD
Secretary, APSF

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NTDB® data points

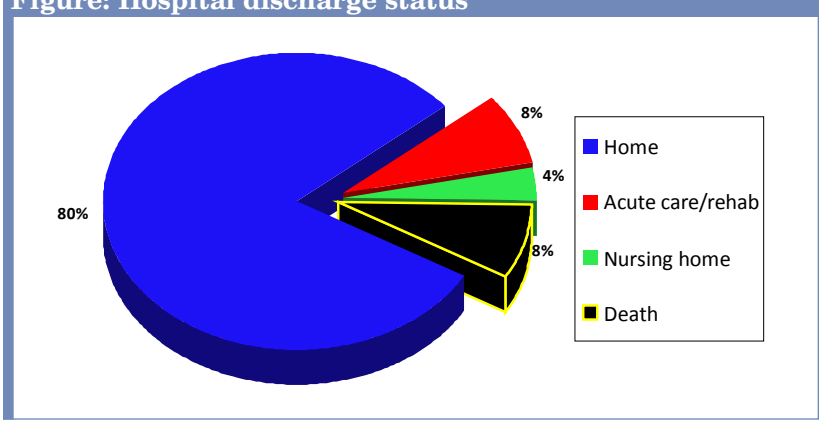
Children are our future

by Richard J. Fantus, MD, FACS

This month is National Child Abuse Prevention month, a time to encourage individuals and communities to support children and families while raising awareness about child abuse and neglect. In 1974, the first federal child protection legislation, the Child Abuse Prevention and Treatment Act, was enacted due to increasing public awareness of the need to ensure the welfare and safety of children. According to the Child Welfare Information Gateway Web site (*http://www.childwelfare.gov/preventing/preventionmonth/history.cfm*), Congress made a further commitment to identifying and implementing solutions to child abuse in the early 1980s by designating the week of June 6–12 as the National Child Abuse Prevention Week. In 1983, April was proclaimed the first National Child Abuse Prevention Month. Since then, child abuse and neglect awareness activities have been promoted across the country during April of each year.

Today, the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, is the federal agency responsible for providing child abuse prevention support for states, tribes, and communities throughout the country. The Office of Child Abuse and Neglect that resides within the Children's Bureau coordinates Child Abuse Prevention Month activities and provides national child abuse statistics each April. Additional information on this program is available at *http://www.childwelfare.gov/preventing/preventionmonth/*.

Figure: Hospital discharge status



Child abuse knows no boundaries. It crosses all socioeconomic levels, all ethnic and cultural boundaries, and is found in families from all religious backgrounds and with all levels of education.

The statistics on child abuse and neglect are staggering. In 2007, approximately 5.8 million children were involved in 3.2 million child abuse reports and allegations, with an estimated annual cost of more than 100 billion dollars. Child abuse is reported every 10 seconds in this country. Close to five children die each day as a result of child abuse, with more than 75 percent of those younger than four years of age. Those who do survive are at greater risk for teen pregnancy, juvenile arrests, developing alcohol abuse or drug addiction, and almost one-third will later abuse their own children (*http://www.childhelp.org/resources/learning-center/statistics*).

In order to examine the occurrence of child abuse in the National Trauma Data Bank® research dataset 2008, admissions records were searched utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) cause of injury code E967 (domestic abuse), E995.50 (child abuse, unspecified), E955.51 (child emotional/psychological abuse), E995.53 (child sexual abuse), E995.4 (child physical abuse), and E995.59 (other child abuse and neglect), with

an age range less than 18 years of age. 2,739 incidents matched these E codes, 2,371 records had discharge status recorded, including 1,911 discharged to home, 181 to acute care/rehab, and 89 sent to nursing homes; 190 died (these data are depicted in the figure on page 43). These patients were 57.1 percent male, on average 14 months of age, had an average length of stay of 6.8 days, and an average injury severity score of 11.3.

Children should not grow up in fear. They should have a nurturing environment in which they can develop, learn, and thrive. Linda Creed said it best in her lyrics for Whitney Houston's hit song, "Greatest Love of All": "I believe the children are our future."

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the *Bulletin*. The NTDB *Annual Report 2009* is available on the ACS Web site as a PDF file and a PowerPoint presentation at *http://www.ntdb.org*. In addition, information is available on our Web site regarding how to obtain NTDB data for more detailed study. 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 was 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 past-Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.*

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So,
You Want to Be a Surgeon...

Medical student guide to residency training

The online resource, *So, You Want to Be a Surgeon…A Medical Student Guide to Finding and Matching with the Best Possible Surgery Residency,* is now available on the American College of Surgeons Web site at:

http://www.facs.org/residencysearch

This online, contemporary version of the popular "Little Red Book" has proved to be an invaluable resource for medical students seeking opportunities in graduate medical education. The revised online version of this helpful reference includes a searchable database containing a complete list of accredited surgical specialty residency programs, as well as a section devoted to assisting students in choosing a residency program that is their best match.

For further information, contact Elisabeth Davis, MA, Education Research Associate, Division of Education, at 312-202-5192, or via e-mail at edavis@facs.org.

Chapter news

by Rhonda Peebles, Division of Member Services

BLIC and NSS host combined meeting

On December 2, 2009, the Brooklyn-Long Island Chapter (BLIC) and the Nassau Surgical Society (NSS) hosted their combined meeting, which featured an afternoon education program for nine specialties (cardiothoracic, general/vascular, neurological, ophthalmology, orthopaedic, otolaryngology, plastic, urology, and transplantation). The groups' combined education program, which was held in Uniondale, NY, began with a luncheon featuring the former U.S. Sen. Alfonse M. D'Amato and former Nassau County Executive Thomas Gulotta (see photo, this page).

BLIC and NSS, left to right: Margaret Chen, MD, FACS, BLIC Education Co-Chair; James Rucinski, MD, FACS, BLIC Vice-President; Teresa Barzyz, BLIC Administrator; Charles V. Coren, MD, FACS, BLIC President; Glenn Tepliz, MD, NSS Vice-President; Mr. Gulotta; Mr. D'Amato; Michael Setzen, MD, FACS, NSS Education Chair; Dean Pappas, MD, FACS, NSS Past-President; and Rajiv Datta, MD, FACS, NSS President.

2010 Leadership Conference and JSAC

The 2010 Leadership Conference is sponsored by the Young Fellows Association for Young Surgeons and Chapter Leaders. All ACS members are invited to join them on Sunday, July 25, for an educational program devoted to leadership topics. The Joint Surgical Advocacy Conference (JSAC) gives attendees from the surgical community the opportunity to join their peers in a collaborative advocacy effort. (See a copy of the ad for the conference, this page.)

The meeting will be held at the Hyatt Regency Washington on Capitol Hill, 400 New Jersey Ave. To reserve a room, call 1-888-421-1442 and mention the JSAC ($199/single/double).

A tentative schedule of events is as follows:

- Saturday, July 24, 5–7: Welcoming reception hosted by the Washington, DC, Chapter
- Sunday, July 25, all day: ACS Leadership Conference for Chapters and Young Surgeons, JSAC opening reception, and individual society briefings
- Monday, July 26: Congressional speakers and Capitol Hill reception
- Tuesday, July 27: Capitol Hill meetings (scheduled by ACS staff)

For more information or assistance, please contact the chapter hotline at 1-888-857-7545, or write to acschapters@facs.org.

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Chapter meetings

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

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

Date/time	Event	Information
May 01, 2010	New York (CS)	Location: Great Escape Lodge, Lake George, NY Contact: Amy Clinton (518) 283-1601 e-mail: NYCofACS@yahoo.com ACS Representative(s): Karen E. Deveney, MD, FACS
May 06, 2010 - May 08, 2010	West Virginia (CS)	Location: The Greenbrier, White Sulphur Springs, WV Contact: Sharon Bartholomew (304) 293-1258 e-mail: sbartholomew@hsc.wvu.edu ACS Representative(s): Andrew L. Warshaw, MD, FACS
May 07, 2010 - May 08, 2010	Ohio (CS)	Location: Hyatt Regency, Columbus, OH Contact: Brad Feldman, MPA, CAE, IOM (877) 677-3227 e-mail: brad@executive-office.org ACS Representative(s): David B. Hoyt, MD, FACS
May 07, 2010 - May 10, 2010	Chile	Location: Santiago, Chile Contact: Juan Eduardo Contreras, MD, FACS (562) 212-0426 e-mail: jec@rdc.cl ACS Representative(s): David J. Winchester, MD, FACS
May 10, 2010	Metropolitan Philadelphia (CS)	Location: Union League of Philadelphia, Philadelphia, PA Contact: MaryTherese Gallagher (717) 558-7850 e-mail: mgallagher@pamedsoc.org ACS Representative(s): A. Brent Eastman, MD, FACS
May 15, 2010	Northern California (CS)	Location: Marines Memorial Hotel, San Francisco, CA Contact: Annette Bronstein (650) 992-1387 e-mail: abronst230@aol.com
May 20, 2010 - May 23, 2010	Florida (CS)	Location: Ocean Reef Club, Key Largo, FL Contact: Brad Feldman, MPA, CAE, IOM (614) 505-7203 e-mail: brad@executive-office.org
May 20, 2010 - May 21, 2010	Michigan	Location: Crystal Mountain Resort, Thompsonville, MI Contact: Angie Kemppainen (517) 336-7586 e-mail: akemppainen@msms.org ACS Representative(s): LaMar S. McGinnis, Jr., MD, FACS
May 27, 2010	Vermont (CS)	Location: Mt. Mansfield Trout Club, Stowe, VT Contact: Jeanne Jackson (802) 847-9440 e-mail: jeanne.jackson@vtmednet.org
June 03, 2010	Brooklyn-Long Island (CS)	Location: Garden City Hotel, Garden City, NY Contact: Teresa Barzyz (516) 741-3887 e-mail: acsteresa@aol.com
June 10, 2010 - June 12, 2010	Alabama & Mississippi (CS)	Location: Point Clear Resort & Spa, Point Clear, AL Contact: Karen Roden (256) 355-6414 e-mail: kroden@surgicaldoctors.com
June 16, 2010 - June 19, 2010	Oregon & Washington (CS)	Location: Sunriver Resort, Sunriver, OR Contact: Alan Morasch, CAE (360) 859-4188 e-mail: alan@imc360.com

Chapters continue support for ACS Foundation

During 2009, 13 chapters contributed a total of $16,750 to the College's endowment funds. The chapters' commitments to the various funds support the College's pledge to surgical research and education. Chapters can contribute to several different funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Endowment Fund. The chapters that contributed during 2009 include:

Recipient of the R. Gordon Holcombe, MD, FACS, Chapter Award[*]: Louisiana

Governors Circle[†]: Arizona, Brooklyn-Long Island (NY), Florida, Illinois, Maryland, Nebraska, North Carolina, North Texas, Ohio, South Carolina, South Florida, Southern California.

Donors Circle[‡]: Indiana, Japan, Kansas, Metropolitan Philadelphia, South Dakota, Southwestern Pennsylvania, and the Wisconsin Surgical Society—a Chapter of the ACS.

[*]The R. Gordon Holcombe, MD, FACS, Chapter Award was established in 2004 for chapters that have contributed $100,000.

[†]Chapters that have contributed $25,000 are members of the Governors Circle of the Fellows Leadership Society (FLS).

[‡]Chapters that contribute at least $1,000 annually are members of the FLS Donors Circle.

Chapter anniversaries

Month	Chapter	Years
March	Brazil	58
	Southern California	58
	Massachusetts	56
	Nevada	45
	New Hampshire	58
	Puerto Rico	60
	South Dakota	58
April	Metropolitan Chicago	55
	Mississippi	57
	Oklahoma	60

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have the authority to negotiate on the chapter's behalf.

To identify potential lobbyists, it can help to contact other state specialty groups, as well as the state medical association, for recommendations. Whoever is hired will need to have a good relationship with the lobbyists from those organizations, because the medical community is a small world at the state level, and one that is built on personal relationships. Also, ask for a list of a prospective lobbyist's other clients to make sure there are no conflicts between what they are currently lobbying for and the interests of the chapter.

Finally, be specific about what services the lobbyist needs to provide. Clearly spell out in the contract, in detail, the chapter's expectations for the lobbyist—regular reports to the board, responsibility for producing written communication to the membership, carrying out advocacy initiatives, monitoring of legislative and regulatory issues, development and implementation of a lobby day at the capitol, and so on. In most states, lobbyists must be registered, and are required to submit periodic reports on their activity, and those organizations that hire them also may have to submit reports. Clearly indicate in the contract that the lobbyist is responsible for filing his or her report, and for providing copies of these reports to the chapter leadership in a timely manner.

Hiring a lobbyist can be a confusing process. For more detailed information and resources about hiring a lobbyist, contact Melinda Baker, Senior Associate, State Affairs, at mbaker@facs.org, or 312-202-5363. The chapter guidebook also has a section on advocacy and lobbying, and can be accessed at *http://www.facs.org/about/chapters/guidebook.html*.

Lobbying the government is an integral part of democracy in America—one that even the founding fathers recognized; and, as Charles de Gaulle, former French President, said, "…politics are too serious a matter to be left to the politicians."[*] Ω