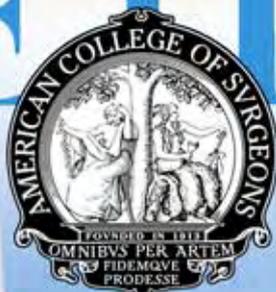


BULLETIN

AMERICAN COLLEGE OF SURGEONS



August 2010
Volume 95, Number 8

**Training
for a
rural
surgical
career**

**Community
Hospital**

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On the cover: The problem of a diminishing supply of rural surgeons is being addressed by Gundersen Lutheran Medical Foundation, which maintains a five-year program for residents pursuing careers in rural surgery (see article, page 11).

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Future meetings

Clinical Congress

2010 Washington, DC,
October 3-7

2011 San Francisco, CA,
October 23-27

2012 Chicago, IL,
September 30–
October 4

Letters to the Editor 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 J. 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.

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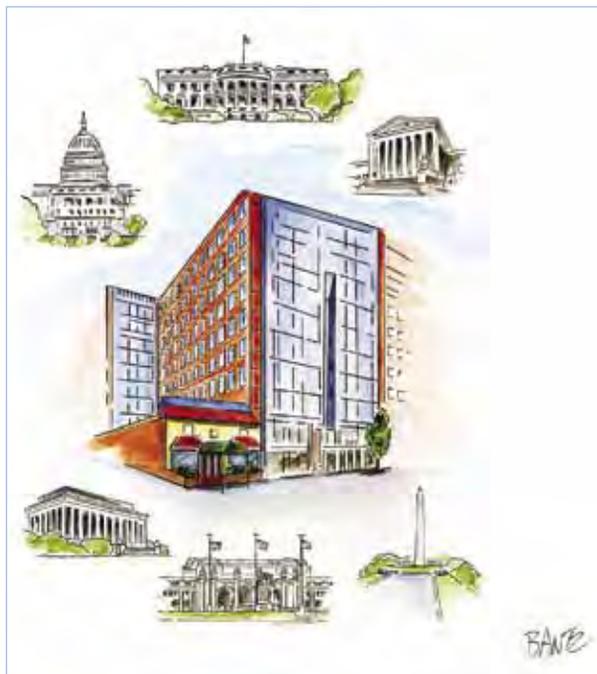
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

Looking forward

On June 3, the American College of Surgeons (ACS) commemorated the official grand opening of our newly constructed Washington, DC, office building at 20 F Street, NW. This milestone marks the culmination of more than nine years of planning and sends a powerful statement that the College is seriously committed to working with policy-makers and other organizations to develop a better health care delivery system.

In attendance at this event were 150 surgeons, including the members of the current Board of Regents, the Executive Committee of the Board of Governors, and the Officers of the College; Past-Presidents and Regents of the College; members of the Building Committee, and the officers of some of our chapters. (Members of the Building Committee and the Regents who served on the Board during the course of the effort to complete this project are listed on page 7.) Also on hand were key ACS staff members, other health care professionals, representatives of the federal government, and other individuals who have assisted in improving this organiza-



An artist's rendering of the new building.



“ The College’s centralized presence on Capitol Hill signals a new era in surgery. ”

tion’s visibility in Washington. The dedication of all these individuals over the course of the last several years is what made this project possible.

A necessary move

In light of more than two decades of increasing political involvement in how health care is delivered in this nation, the ACS has sought to play a more vigorous and influential role in Washington, DC. Moving our congressional and regulatory affairs staff in the Division of Advocacy and Health Policy from Georgetown to 20 F Street, NW, represents an investment in the future of surgery and the broader medical community. Indeed, the College’s centralized presence on Capitol Hill signals a new era in surgery—one in which a united surgical profession can speak with one voice about the issues that affect our patients and ourselves.

The 10-story, 165,000-square-foot Class A office building allows the College to hire more congressional and regulatory affairs staff and puts our advocates in an ideal physical location to interact with legislators and policymakers. Our staff occupies the top floor of the building, which includes meeting rooms large enough for the ACS to convene with other specialty societ-



The completed DC headquarters building at 20 F Street, NW.

ies to address issues of mutual concern, such as outcomes measurement, Medicare payment, liability, workforce shortages, patient safety, and so on. The remaining nine floors house the staff members of several other organizations, including the National Business Group on Health.

Details about the building

A visually appealing structure, the building is located on Capitol Hill and overlooks Union Station and Postal Square. The National Mall lies just to the south, along with the Senate and House office buildings, the U.S. Library of Congress, and federal agency headquarters. The building has a dramatic two-story glass entrance and atrium, as well as a 4,000 square-foot rooftop terrace. These spaces serve as ideal locations for hosting receptions and other gatherings with Members of Congress and their advisors. The facility also houses a state-of-the-art conference center equipped with two boardrooms and

a catering kitchen, making it an ideal location to facilitate interdisciplinary collaboration. In addition, the building has ample underground parking and a fully equipped fitness center.

Take the tour

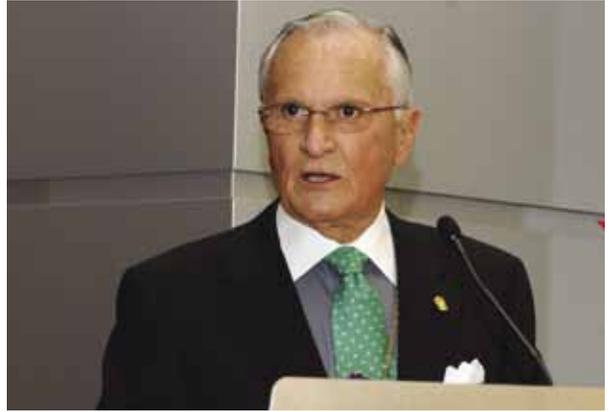
I encourage all surgeons who are planning to attend this year's Clinical Congress in Washington, DC, to stop by our new, state-of-the-art Washington, DC, Office and tour the facility. The College will host a free open house at 20 F Street, NW, from 8:00 am to 6:00 pm daily Sunday, October 3, through Thursday, October 7. Shuttle bus service between the Walter E. Washington Convention Center and the ACS Washington, DC, Office will be provided every hour on the hour until 5:00 pm.

The College's leadership is very excited about this new venture, which we anticipate will allow us greater access to legislators and policy-

continued on page 7



A. Brent Eastman, MD, FACS, at the opening ceremony.



LaMar S. McGinnis, Jr., at the opening ceremony.



At the grand opening ceremony (left to right): Edward M. Copeland III, MD, FACS; Mrs. Eastman; Gerald B. Healy, MD, FACS; Ms. Helen Darling of the National Business Group on Health; Dr. McGinnis; Dr. Eastman; and L.D. Britt, MD, FACS.



The facade of 20 F Street, NW, with the grand opening banner.



Members of the Building Committee and College officers gathered for the grand opening of 20 F Street, NW. Left to right (all MD, FACS): Dr. Hoyt, Dr. Britt, Andrew L. Warshaw, Dr. Eastman, Dr. McGinnis, Charles Mabry, J. David Richardson, Josef Fischer, Edward R. Laws, Martin B. Camins, and Kirby Bland.

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John Cameron, MD, FACS
Martin B. Camins, MD, FACS
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makers, so that we effectively can promote surgery's agenda. These are politically charged times, and surgeons must play an active role in looking out for the best interests of our patients. This new building represents a significant step toward achieving that goal.



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.

Recovery audit contractors: An update

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

Recovery audit contractors (RACs) are private organizations that the Centers for Medicare & Medicaid Services (CMS) hires to identify improper payments for Medicare Parts A and B services, as well as to collect overpayments or to return underpayments. Congress initially created the RAC program as a three-year demonstration project, which was subsequently expanded to a permanent, nationwide program. This article provides an update on the permanent RAC program, how surgeons are currently affected by RACs, the “blackout period” related to RAC activity in some states, and the expansion of the RAC program under the Patient Protection and Affordable Care Act.

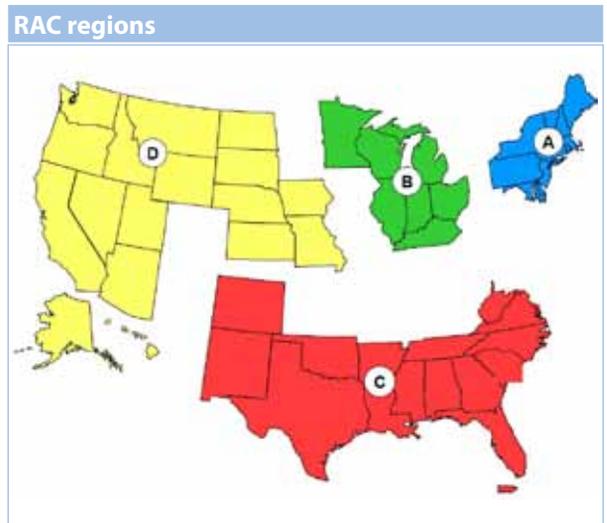
How does the permanent RAC program work?

The permanent RAC program became operational in all 50 states on January 1. Presently, the RAC permanent program focuses on traditional Medicare Parts A and B fee-for-service payments, and not on Medicare managed care or the prescription drug benefit. The RACs review claims on a post-payment basis by auditing a percentage of claims based on volume, using either an automated review, which requires no additional documentation, or a complex review, which does require further documentation. The RACs cannot review claims more than three fiscal years from the date the claim was paid, and they cannot review any claims paid before October 1, 2007. Rather than paying the RACs a specified upfront fee, CMS pays RACs using a negotiated contingency fee, typically a percentage of every improper payment that the RACs identify and recover.

For the purposes of the RAC permanent program, the nation is divided into four regions, with one RAC covering each area. The figure on this page shows all four regions.

How are surgeons currently affected by RACs?

RAC audits are limited to those particular claims



that are approved through the CMS “new issue review” process. All CMS-approved issues for review by a particular RAC are posted in advance on that RAC’s website, along with sample demand letters. Based on recent conversations that the College’s Division of Advocacy and Health Policy staff has had with CMS, three of the four RAC regions (regions B, C, and D) have CMS-approved issues pertaining to physicians for review; however, physicians in these states have received a minimal number of automated overpayment demand letters.

At press time, CMS also indicated that RACs are currently focusing primarily on hospitals and “durable medical equipment” suppliers. Surgeons should be aware, however, that physicians might receive requests from their hospitals to assist with RAC document requests if the physician’s hospital is audited by a RAC. CMS also has indicated that the RACs are only conducting automated reviews of physician claims at this time, but could move to complex reviews in the future. The ACS is closely monitoring the progress of RACs, and will notify College members if more physicians begin to receive RAC audit demand letters.

A list of each RAC region, the number of issues the RAC has approved for physician review as of press time, a link to the Web page listing the CMS-approved issues for RAC review, and the website and contact information for each RAC are outlined in Table 1 on this page.

What options are available to a surgeon who receives a RAC audit demand letter?

Surgeons have four options in responding to a RAC audit demand letter: (1) pay the overpayment amount via check, (2) allow recoupment of the overpayment amount from future Medicare payments, (3) request or apply for an extended repayment plan of the overpayment amount, or (4) appeal the overpayment. The time frames and process for appeal are set forth in the demand letter.

What types of health professionals make up the RACs' staff?

In addition to other professionals, each RAC must employ certified professional coders, nurses and/or therapists, and a physician contractor medical director (CMD). The CMDs for RAC regions A, B, C, and D are Eugene Winter, MD; Percival

Seaward, MD, FACS; James Lee, DO; and Ellen Evans, MD, respectively.

How are the protests against MACs affecting RACs?

As required by law, CMS has begun consolidating contracts with fiscal intermediaries (for Part A services) and carriers (for Part B services) into Medicare administrative contractors (MACs). The implementation period is from 2005 to 2011. Currently, protests against the MAC transition are occurring in six jurisdictions across the country. These protests will delay the transition to MACs in 17 states.

Before a RAC can begin auditing providers in a state, it must enter into a joint operating agreement with the MAC that covers that state, or with the appropriate carrier if the MAC transition has not yet occurred. Some RACs have chosen not to enter into joint operating agreements with outgoing legacy carriers when they are scheduled to transition soon to a MAC. The current MAC protests only contribute to the delay in the MAC transition and, as a result, the RAC rollout. Due to the protests, a blackout period will occur in each of the 17 affected states, during which the regional RACs will not take any enforcement or

Table 1. Physician issues approved for review and RAC contact information

Region	Physician issues approved for review	List of approved issues	RAC contact information
A	No physician audit issues approved at this time	http://www.dcsrac.com/issues.html	Diversified Collection Services, Inc. website: www.dcsrac.com e-mail: info@dcsrac.com
B	6 physician audit issues approved for review	http://racb.cgi.com/Issues.aspx	CGI Technologies and Solutions, Inc. website: http://racb.cgi.com/ e-mail: racb@cgi.com
C	8 physician audit issues approved for review	http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx	Connolly Consulting Associates, Inc. website: www.connollyhealthcare.com/RAC e-mail: RACinfo@connollyhealthcare.com
D	15 physician audit issues approved for review	https://racinfo.healthdatainsights.com/Public1/KnowledgeBasedAuthentication.aspx?ReturnUrl=%2fPublic%2fNewIssues.aspx Note: RAC Region D's list of approved issues is password-protected, with limited access to providers in this region.	HealthDataInsights website: https://racinfo.healthdatainsights.com e-mail: racinfo@emailhdi.com

Table 2. MAC jurisdictions under protest

MAC jurisdiction	States	MAC
Jurisdiction 2	Idaho, Oregon, Washington	National Heritage Insurance Corporation (NHIC)
Jurisdiction 6	Illinois, Minnesota, Wisconsin	Noridian Administrative Services, LLC
Jurisdiction 7	Arkansas, Louisiana, Mississippi	TrailBlazer Health Enterprises, LLC
Jurisdiction 8	Indiana, Michigan	National Government Services, Inc. (NGS)
Jurisdiction 11	North Carolina, South Carolina, Virginia, West Virginia	Palmetto GBA, LLC
Jurisdiction 15	Kentucky, Ohio	Highmark Medical Services, Inc.

auditing action against providers who operate in those states.

Most blackout periods will last for six months. In the 17 states involved, the regional RAC will stop sending correspondence for three months before and after the transition date. During the three months before the MAC transition, the outgoing legacy carrier will finalize all pending RAC actions for transfer to the incoming MAC. During the three months after the transition, the new MAC will focus on provider education and on establishing the joint operating agreement. CMS officials currently have no estimate on how long it will take to resolve the disputes in the six affected MAC jurisdictions.

The MAC jurisdictions and states affected by the RAC blackout period are outlined in Table 2 on this page.

How does the Patient Protection and Affordable Care Act affect the RAC program?

The health care reform legislation, the Patient Protection and Affordable Care Act (PPACA), expands the RAC program in several ways. Currently, the RAC program reviews services provided under Medicare Parts A and B. Pursuant to the mandates set forth in the PPACA, the RAC program will be expanded to Medicare Parts C and D, as well as to the Medicaid program, by December 31.

With respect to the Medicaid program, the PPACA requires all states to contract with at least one Medicaid RAC by December 31. The contractors' mission will be the same as that under the Medicare RAC program—to identify overpayments and underpayments, and to recoup

Medicaid overpayments or return underpayments. Like the Medicare RACs, Medicaid RACs will be paid a contingency fee; however, in the case of the Medicaid RACs, each state will be permitted to determine the amount of the contingency fee paid to the Medicaid RACs with which it contracts.

Where can I find more information about the RACs?

The CMS RAC website is <http://www.cms.gov/RAC/>, and the CMS e-mail address for RAC-related questions is RAC@cms.hhs.gov. 

**Training
for a
rural
surgical
career:**

**The reflections of two
Gundersen Lutheran
graduates**

by Karen Stein

**Community
Hospital**

In 2000, when Census data were last tallied,* approximately 21 percent of the U.S. population—or 59,061,367 people—lived in a rural area of the country.¹ Since then, the number has dipped slightly, to just under 20 percent.²

Similarly, the number of surgeons who practice in rural areas has been dropping. In rural locations in 2005, there were 4.48 general surgeons per 100,000 population.³ At this time, more than half of the practicing rural surgeons are older than 50 years, and as they retire, there is concern regarding who will replace them. Although “the federal government, through the Health Resources and Services Administration, offers various incentives to get primary-care physicians and dentists to work in places with ‘unserved, underserved, vulnerable, and disadvantaged populations’...general surgeons aren’t part of the program.”⁴ One indication of the seriousness of the situation: When the surgeons at Northern Cochise Community Hospital in Willcox, AZ, left the facility in 2004, emergency cases—which averaged to approximately 10 each month—had to be transported 82 miles by helicopter to Tucson, to the tune of \$14,000 per flight.⁴

Preparing surgeons for rural practice

Gundersen Lutheran Medical Foundation in LaCrosse, WI, perseveres as a mainstay in the surgical training of residents who largely pursue careers in rural settings. Among the 46 graduates of the five-year surgical residency program since it began in 1974, 66 percent elected to practice in towns with a population of less than 10,000.⁵ All 46 graduates have earned American Board of Surgery certification.

Because the only surgical specialty to sponsor a residency at Gundersen Lutheran is general surgery, residents are prepared for a full general surgical practice and competitive fellowships in various forms. In postgraduate years 1 and 3, residents spend one month exclusively in the intensive care unit to learn ventilator management, nutrition assessment, and invasive monitoring procedures.⁵ Specific, unique qualities of the program also lend themselves to a full general surgical education^{5,6}:

*At the time of this writing, the 2010 Census data had not yet been tallied.

- The Gundersen Lutheran Health System represents a multispecialty group practice with a 19-county referral area.

- Elective rotation in a medically underserved nation, in which the residents perform a high number of common surgical procedures in an isolated locale, has been added to the program.

- Surgical residents work with attending staff in the surgical specialties—including orthopaedics, neurosurgery, otolaryngology, plastic surgery, cardiothoracic surgery, and urology—in a one-on-one training setting when assigned to these sections.

- Graduates perform on average more than 1,200 major operations. Performance of specific procedures within specific specialty areas, such as the following, is required during the residency:

- Obstetrics and gynecology: Residents perform 25 cesarean sections and 20 hysterectomies, plus gynecologic oncology cases, over two months of the third year of residency

- Endoscopy: Residents complete a high-volume rotation over two months, including 150 colonoscopies and 50 upper gastrointestinal endoscopic procedures

- Trauma: Residents are trauma team leaders at a Level II ACS-verified trauma center in the fourth and fifth residency years, and all are active Advanced Trauma Life Support® instructors

- Minimally invasive surgery: The only sponsored surgical specialty fellowship at Gundersen Lutheran, residents perform 200 basic and 110 advanced laparoscopic procedures; surgical techniques can be honed at the facility’s dedicated skills laboratory, established in 1995

- Rural surgery: One-month rotations are available in two towns—one in Wisconsin, one in Iowa, both with populations of less than 8,000—during the fourth postgraduate year

The residents who pursue these rural surgery electives live in the community they serve and take call with the attending surgeons at the local hospitals. These residents assume responsibility for the care of all surgical patients—including nutrition and critical care needs. In addition, for those residents who have already decided to pursue a rural surgical career and know where they want to practice, the program makes arrangements for electives to be performed over the course of several months at the chosen institution—a setup that

helps the individual to become fully immersed in rural practice and to determine if he or she would best be served by honing particular skill sets in advance of joining the practice.⁶

Gundersen Lutheran graduates in rural practice

Part of the challenge of attracting surgical residents to a rural practice is sociocultural: small communities cannot match the cultural and academic offerings afforded by larger metropolitan communities.⁷ However, there are also substantial professional challenges in rural practice. These surgeons are expected to perform the operation that is needed at any given moment, but the “lower day-to-day volume” may lead to diminished confidence in the procedures that must be performed.⁸ In fact, many of the procedures rural surgeons are expected to perform are considered outside the scope of the general surgeon⁹—training in these procedures is emphasized to near-exclusion in otolaryngology, urology, orthopaedic, and obstetrics/gynecology programs, but “these subspecialists are far too few to serve the emergency needs of small communities throughout the U.S.”⁷ Thus, whereas the pressures related to resident work hours have generally led to “graduating residents with little useful experience in subspecialty areas,” compared with urban general surgeons, rural general surgeons have a broader scope of practice.³

For Kevin Riess, MD, a 2008 graduate, the decision to practice surgery in a rural setting was a foregone conclusion: Having grown up in Cloquet, a small Minnesota town, Dr. Riess had always had an interest in practicing in a similar type of community. Likewise, when Randel Stolee, MD, a 1992 graduate, was researching schools, he already wanted to pursue rural practice, and he believed that not all institutions offered a program that addressed this interest. Both Dr. Riess and Dr. Stolee note that the experience at Gundersen Lutheran is best encapsulated by the broad-based, hands-on learning experience in every subspecialty.

An important lesson in every case

Dr. Riess currently practices at the Duluth Clinic’s facility in Virginia, MN, one and one-half hours from Duluth. The clinic is in a town of 10,000 people, but serves approximately 20,000 people—the service area encompasses residents

“Whereas the pressures related to resident work hours have generally led to ‘graduating residents with little useful experience in subspecialty areas,’ compared with urban general surgeons, rural general surgeons have a broader scope of practice.”

who live up to two hours north to the Canadian border, one-half hour south, one hour to the east, and 20 minutes to the west.

He says the experience of shuttling among the various specialties during his residency was very rewarding, as it allowed him to develop a good working relationship with practitioners in these domains and provided him in-depth training and active participation in a wide range of procedures. He believes this experience strengthened his ability to provide patient care during his residency and after he had graduated, as it afforded him the knowledge base and skill set to confront myriad surgical challenges, including the issues that present with complex and trauma patients.

Furthermore, after specializing in laparoscopy/minimally invasive surgery during his training, Dr. Riess has found that his surgical colleagues are impressed with his knowledge of the procedures. The surgeons at Gundersen Lutheran are highly trained in minimally invasive surgery, be

it laparoscopic, endoscopic, or endovascular, he notes, adding, “During this exposure, I learned the importance of providing safe and effective surgery. If we felt there was a potential for increased risk in an open approach, we were taught to always do the right thing for the patient and do the less, and potentially safer, minimally invasive approach.”

However, Dr. Riess believes that every case was important to his education—even if the more complex cases afforded excitement and valuable teaching points, “even the smallest of cases, such as inguinal hernia surgery, could be a learning experience,” he says.

Although Dr. Riess learned valuable lessons in the operating room, many of his important lessons occurred outside the immediate environment of surgical procedures. For example, in clinic and wards, he learned the method for determining who requires surgery, when, and which type, not to mention making use of all the resources that surround him, from the medical literature to the surgical specialists to the nursing staff. In fact, he was particularly struck by the camaraderie and open dialogue among staff, nurses, and residents during his training—as well as their approachability and receptiveness to questions and issues.

“I was still in training when I found out where I was going to be working,” he notes, “and they still were responsive to my preparation for the future.” He also believes that his exposure to the many different specialties helped to increase his skills as a team player.

But it was the hands-on, rural-based learning in his fourth postgraduate year that has instilled in him the confidence to provide high-quality surgical care in hospitals that don’t have 24-hour access to subspecialty care. Because he is only one of a few surgeons in the area, he notes, “It has taught me how to balance my surgical practice with family life.”

Not enough Gundersen grads to go around

Dr. Stolee’s practice is at Sanford Meritcare Health System in Perham, MN—the town itself is populated by 3,000 people, but the facility’s service area includes 5,000 people. Dr. Stolee’s interest in rural practice was spawned from several factors: his desire to serve a population that is increasingly omitted from health care planning, to be able to perform the full breadth of a surgical practice, and

to live in an environment that best accommodated the well-being of his family.

Training in rotations in the various subspecialties provides a tremendous benefit, Dr. Stolee says, because while working one-on-one with an attending with an interest in teaching, residents simultaneously gain academic knowledge and surgical skills. “We were welcomed and treated so well,” he says, “and by the end of a rotation, we were able to perform a number of the operations: tonsillectomies, tracheotomies, facial plastic surgery, cesarean sections, hysterectomies, hip fractures, hemiarthroplasties, coronary artery bypass graft, thoracic procedures, burn wound procedures, vasectomies, nephrectomies, endoscopies, relief of epidural hematomas,” among so many others.

“A broadly trained surgeon has many more options than the more narrowly trained surgical specialist,” Dr. Stolee continues. “My practice has been varied, interesting, and stimulating as a result. For a rural surgeon to survive, it is mandatory to have that broad experience.”

As noted earlier, because of the wide range of procedures coupled with the potentially long lapses between performing them, self-doubt is not uncommon among this group. But Gundersen Lutheran addresses these concerns in its program. “Although they taught me everything I would need to know to compete in an urban practice,” Dr. Stolee says, “they also tailored the experience so I could be ready right away to practice independently.” He notes that this tailoring included teaching critical thinking skills so he could analyze the problems he would encounter as well as his own approach and preparedness. In fact, toward that end, residents are trained in surgical case log analysis and participate in Gundersen Lutheran’s National Surgical Quality Improvement Program process.⁶

“I was told that I would have to be my own worst critic and recognize when my skills or knowledge base would need to be amended,” Dr. Stolee adds. “The self-doubt is the voice that keeps us in check. Yet, we were girded with the confidence that we had been completely trained to be excellent surgeons with the capacity to grow with new techniques and knowledge.” Thomas H. Cogbill, MD, FACS, Gundersen Lutheran’s general and vascular surgery program director, taught Dr. Stolee that in the rural setting, there is no one aside from him who would be knowledgeable enough to judge

how well he performs an operation or provides patient care. For Dr. Stolee, this idea helps him to ensure quality care to his patients.

Dr. Stolee himself is encountering one of the major challenges that are endemic to rural practice: He has attempted to find partners for his busy practice, but he says, “It is getting very difficult at this point, as there are not enough broadly trained surgeons to handle a rural practice. Most residents graduate without ever performing a cesarean section, let alone being competent at them. Most surgeons who would come to join me need additional training to meet competency requirements even in something as basic as endoscopy.” He laments that “There aren’t enough Gundersen graduates to go around.”

One of the most important lessons Dr. Stolee learned at Gundersen Lutheran was that “A surgeon specializes in surgery, not operations.” This idea prepared Dr. Stolee for his surgical practice, which he describes as being about the total care of the patient, “from diagnosis, to decision, to operation, recovery, and rehabilitation”—this model ensures that his patients “aren’t just people with organs to be removed, but people with problems to be addressed” and that “they receive the quality and continuity of care that they deserve.”

But, most importantly, he notes, the broad training within rural surgery provides for an interesting and unique outcome: “You can never say, ‘It is not a surgical problem.’ In my practice, I am potentially the general surgeon, the gynecologist, the urologist, and the gastroenterologist. I can’t just punt the patient off to another specialist. I must work through the problem with a patient to find a solution as best it could be found.” □

References

1. U.S. Census Bureau. United States—Urban/Rural and Inside/Outside Metropolitan Area. Available at: http://factfinder.census.gov/servlet/GCT-Table?_bm=y&-geo_id=01000US&-box_head_nbr=GCT-P1&-ds_name=DEC_2000_SF1_U&-format=US-1. Accessed April 12, 2010.
2. Southwest Rural Health Research Center. Rural Healthy People 2010. Available at: <http://www.srph.tamhsc.edu/centers/rhp2010/default.htm>. Accessed April 12, 2010.
3. Heneghan SJ, Bordley James IV, Dietz PA, Gold MS, Jenkins PL, Zuckerman RJ. Comparison of urban and rural general surgeons: Motivations for practice location, practice patterns, and educational requirements. *J Am Coll Surg.* 2005;201:732-736.
4. Brown D. Shortage of general surgeons endangers rural America. *Washington Post.* January 1, 2009. Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2008/12/31/AR2008123103120.html>. Accessed March 20, 2010.
5. Cogbill TH. The general surgery residency at Gundersen Lutheran Medical Foundation: A tradition of training the complete general surgeon. *Am Surg.* 2009;75:739-742.
6. Hughes T. Rural general surgery training at Gundersen Lutheran. Available at: http://efacs.org/portal/page/portal/ACS_Content/ACS_COMMUNITIESSPECIALTIES/RURALSURG/Rural%20general%20surgery%20training%20at%20Gundersen%20Lutheran. Accessed April 26, 2010. [This is a password-protected site accessible with membership only.]
7. Hunter JG, Deveney KE. Training the rural surgeon: A proposal. *Bull Am Coll Surg.* 2003;88(5):13-17.
8. Sheldon GF. The Looming Challenge for Small Medical Practices: The Future Physician Shortage and How Health Care Reforms Can Address the Problem: Statement of the American College of Surgeons, presented by George F. Sheldon, MD, FACS, before the Committee on Small Business, U.S. House of Representatives. July 8, 2009. Available at: <http://www.facs.org/ahp/testimony/sheldontestimony0709.pdf>. Accessed March 20, 2010.
9. Zuckerman R, Doty B, Bark K, Heneghan S. Rural versus non-rural differences in surgeon performed endoscopy: Results of a national survey. *Am Surg.* 2007;73(9):903-905.

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Round-trip service:



Commentary

by Mary H. McGrath, MD, MPH, FACS

Editor's note: *The issues surrounding the subject of medical tourism have been previously addressed in the Bulletin (see April 2009 issue, pages 18 and 26), and continue to be of importance today. The following case and commentary appeared in the Agency for Healthcare Research and Quality (AHRQ) WebM&M.**

The case

A 70-year-old man with a long history of degenerative joint disease was experiencing increased symptoms in his left knee. He was referred by his primary care provider to an orthopedic surgeon who recommended a total knee replacement. The patient was eager for the surgery so he could return to his active lifestyle, but the elective procedure couldn't be scheduled for a couple of months. In addition to the delays with scheduling, the patient also became concerned about the costs associated with the surgery and his likely postoperative rehabilitation needs.

Based on a neighbor's recommendation, the patient explored alternate options and ultimately had his total knee replacement performed overseas. The surgery was scheduled within two weeks, at a fraction of the cost to the patient of domestic surgery, and provided a very satisfying experience overall. Approximately two weeks after the surgery, when the patient was back home, he developed acute pain and swelling in his surgically repaired knee. He contacted the U.S.-based orthopedic surgeon who originally saw him, explained the circumstances, and was told he could not be seen because "we didn't perform the surgery, so you should contact your operating surgeon." The patient was ultimately seen in the emergency department and received appropriate treatment for uncomplicated postoperative swelling.

*Reprinted with permission of AHRQ WebM&M. McGrath MH. Round-trip service. AHRQ WebM&M [serial online]. December 2009. Available at: <http://webmm.ahrq.gov/case.aspx?caseID=211>.

Dr. McGrath's commentary

The case presented has two improbable reasons for the patient to travel to another country for his joint replacement. If he lives in the U.S., it is unlikely that he would be subjected to a wait of several months or put on a queue to wait for surgery, although that might be a cause for medical travel in other industrialized nations. Second, his concern about the cost of postoperative rehabilitation would not be mitigated by traveling out of the country for surgery. In fact, problems with obtaining postoperative rehabilitation services are more likely to be exacerbated by medical travel. The outcome in the case also is improbable. Sadly, after a major operation involving a complex synthetic joint, it is unlikely that the difficulty is no more than postoperative swelling, to be addressed in one visit with no follow-up.

These particulars aside, the overwhelming advantage of joint replacement, or any medical procedure, done overseas is that the operation is less expensive.¹ This advantage has led increasing numbers of Americans to obtain overseas surgery, which makes the issue raised by this case increasingly relevant.

This case highlights the issue of continuity of care. Without arrangements for provision of postoperative care by a surgical team familiar with the patient, the type of implant used, technical aspects of the operation, perioperative infection precautions, and early postoperative stabilization, it is difficult to provide standard postoperative care. This patient developed a postoperative problem, but even absent this, he needs a physician to arrange and write orders for physical therapy to resume weight-bearing activities and encourage mobilization of the joint.

When consulted by a patient returning to the U.S. with local wound problems two weeks after surgery, the orthopedic surgeon's response is not simply because he or she is miffed that the patient chose to obtain surgery elsewhere. Rather, that surgeon is placed in a very difficult position medically, ethically, legally, and financially. He or she has no firsthand information about the procedure, such as the quality of the tissue closed around the prosthesis or the technique for attaching the ends of the device to the femur and tibia. He or she may be unfamiliar with the

specific device used (a device that may or may not be approved for use in the U.S.). If the situation looks problematic due to the possibility of infection or excessive swelling, the patient may be facing months of imaging studies, parenteral antibiotics, analgesics, and therapy. For a patient with health insurance, this may or may not be covered, depending on whether the policy covers the cost of care related to surgery that was not approved and covered initially. For a patient who is underinsured or uninsured, these costs would have to be paid out of pocket.

This last issue raises concerns regarding liability exposure, since a patient with an adverse outcome or a disappointing result, unable to pursue a successful legal claim against an offshore provider, may associate the poor outcome with the subsequent care provided in the U.S. Even if the case is uncomplicated, the U.S. surgeon who initiates postoperative care is agreeing to provide the long-term follow-up that is needed to meet the standard of care. This means that if the patient develops pain or mechanical problems with his knee prosthesis in the future, the U.S. surgeon would properly be responsible for ongoing care by virtue of having functioned as treating physician.

From a quality-of-care perspective, the potential argument for offshore surgery would be if the patient were unable to financially afford the operation here in the U.S. In this situation, the patient hopefully would be aware of the need for adequate follow-up care and the relative risk of complications with his procedure. The U.S. surgeon to whom he turns after his return would have an ethical obligation to treat a life-threatening problem. Few would insist that that surgeon is obliged to deliver non-emergent or long-term care for a patient returning from surgery abroad. Similarly, if the patient has health insurance, there is no consensus that U.S. insurance companies should have to cover follow-up care or costs associated with complications in patients who elect to have surgery abroad.

The big picture: Medical tourism in context

The roots of medical tourism lie in the practice of a modest number of Americans who, over the years, have had inexpensive cosmetic procedures while on vacation in foreign countries. Today,

the term is inadequate for the growing health care phenomenon of “outsourcing” or “offshore surgery.”

A consequence of escalating health care costs in the U.S., the global market for long-distance medical services is expanding. Several operational models are already in place. There is the outsourcing of hospital services such as transcription, insurance processing, and information technology to other countries with lower labor costs. Certain medical jobs are also moving offshore as low-wage foreign providers offer deep discounts on services like the real-time reading of radiographs.² Offshore surgery is seen as an opportunity for low- and middle-income Americans to have surgery for 20 to 25 percent of the cost in the U.S., often with surgeons who are U.S.-trained, may be U.S. board-certified, and who may be working in hospitals that are JCI (Joint Commission International) accredited.³

Growth in the global market is being driven by the complex and costly needs of an aging population, an increasing number of uninsured, the high cost of health care for U.S. companies, referrals by U.S. corporations and insurance companies, and aggressive marketing by hospitals in countries like India and Malaysia. With the building pressure for outsourcing surgical care, many questions are raised. These include quality and safety, the ability to assess competence, and the question of who will bear the responsibility for postoperative follow-up care. Other fundamental issues are legal redress, medicine’s relationship with big business, potential erosion of the American health industry by foreign competition, and consequences for the U.S. surgical workforce. Another debatable element of offshore surgery is the access overseas to services, organs, devices, and technologies still in clinical trials or unavailable in the U.S. due to regulatory constraints.⁴

The surgical procedures that lend themselves to offshore care are non-urgent, short-duration treatments that are expensive in the U.S. and appropriate for patients with less severe conditions.⁵ Orthopedic joint replacement surgery, some cardiac surgery, weight-loss surgery, cosmetic plastic surgery, dental surgery, and infertility treatments are those most frequently offered by the offshore hospitals seeking U.S. patients and offering lower prices.⁶ The countries able to offer these values are

developing nations that do not have the drivers that make American health care so expensive: cost of labor, cost of equipment and facilities, and the cost of pharmaceuticals and devices. The financial differences can be dramatic. For a hip replacement that might cost \$32,000 in an American hospital, the cost would be \$9,000 in India. A cardiac bypass costing \$100,000 in the U.S. costs about \$12,000 in Bangkok.⁷

With lower cost as the primary reason for medical travel, until recently most American participants have been uninsured or underinsured people trying to cope with large out-of-pocket costs.⁸ A relatively limited group, the number of individuals obtaining surgery under these circumstances is thought to have been 500,000 in 2009. This may change, however, as U.S. health care insurers and large employers look at the savings they could enjoy by providing a mechanism for their members or employees to travel for surgery.⁹ Promoted and facilitated by a burgeoning industry supporting medical travel, the logistics may become more manageable and the numbers of participants could increase rapidly. At this point, there are no solid estimates, but most economists predict a many-fold increase in medical travel over the next 10 years.¹⁰ The unknowns include the impact of health care reform in the U.S. in terms of the number of uninsured, limitations on covered benefits, and the regulation of the health insurance industry.

This patient’s experience illustrates several key points for those considering or advising others about medical travel:

- For patients without health insurance, the need for follow-up care must be calculated in the cost of the surgery.
- For patients with health insurance, the insurer’s policies about coverage of postoperative care need to be clear before proceeding.
- Even for straightforward interventions such as dental work or minimally invasive cosmetic surgery, follow-up is needed and complications can occur, and for more complex procedures, such as weight loss surgery, measures such as lap band adjustment are commensurately more complex and spread out over time.
- Patients who travel for advanced medical procedures available overseas but not adopted by U.S. surgeons pending outcome studies and clini-

cal trials should seek expert advice before going forward with these interventions.

- Any health insurer sending patients to a foreign country for surgery should guarantee that U.S.-based follow-up care is available, require credentialing and assessment of the providers in the foreign country comparable to that in the U.S., and ensure that patients have the same appeal and legal rights as they would in the U.S.

- Entities accrediting offshore facilities should consider the establishment of measures to ensure continuity of care and longitudinal care as necessary components of a safe organization.

From a policy perspective, offshore surgery has been described as a market correction for runaway health care costs in the U.S. Some postulate that it may force the health care industry in the U.S. to make the changes necessary to render health care affordable. While a popular argument, the types of procedures appropriate for medical travel (non-urgent, short-duration, costly, suitable for healthier patients capable of air travel) account for less than two percent of U.S. spending on health care. Moreover, from an operational standpoint, implementation of organized overseas programs will skim off from a U.S. hospital the most lucrative interventions with the best results, a practice unlikely to improve its bottom line.

The most pressing task for the American medical community is the education of patients who choose to travel abroad for medical care. Patients need to be informed that complications occur in a predictable number of interventions under any circumstances, that devices and treatments available outside the U.S. may not be subject to rigorous scrutiny, and, most importantly, that a surgical procedure is not an isolated event. The U.S. health care system recognizes this with global surgical fees that include up to four months of postoperative care. This, of course, contributes to the costs that make U.S. health care more expensive than offshore care. ¹⁰

References

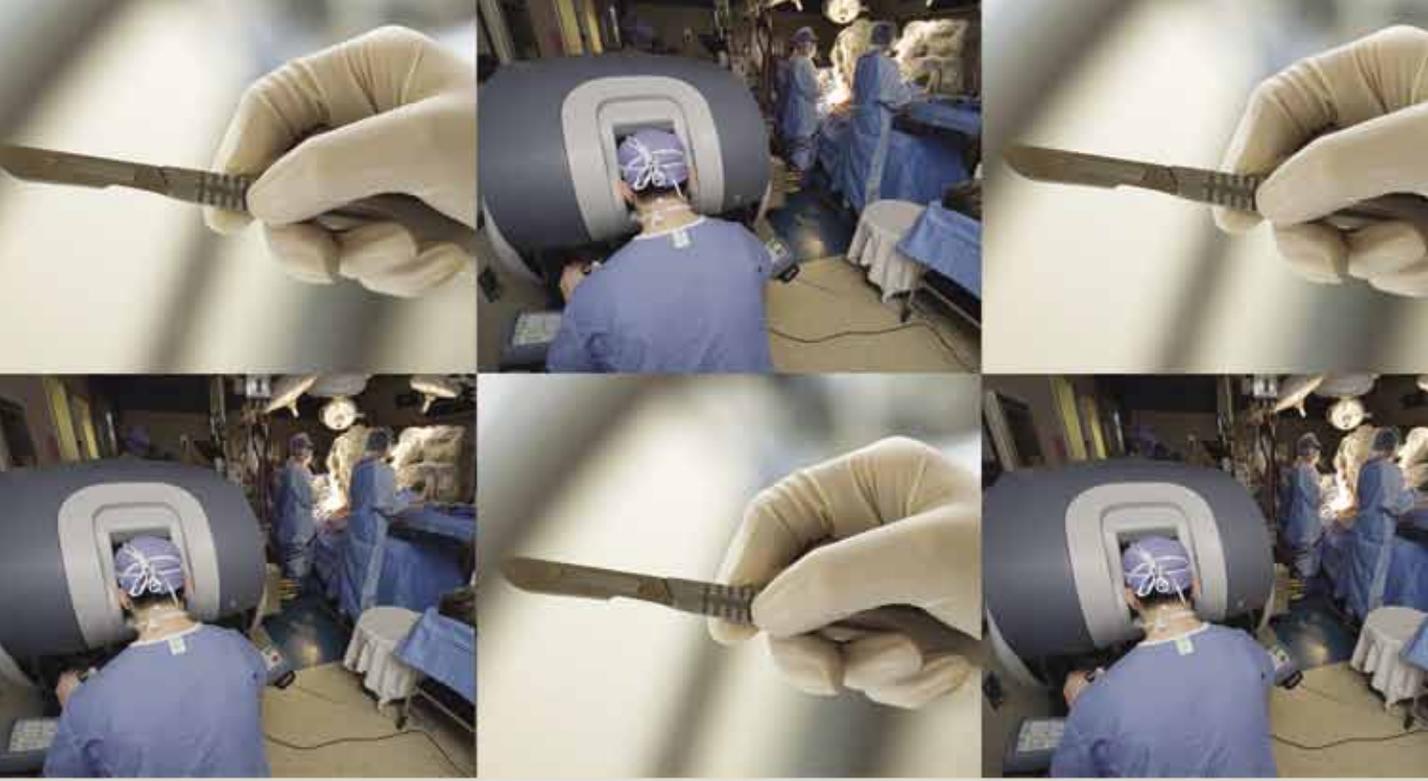
1. Milstein A, Smith M. Will the surgical world become flat? *Health Aff.* (Millwood). 2007;26(1):137-141.
2. Wachter RM. The “dis-location” of U.S. medicine—the implications of medical outsourcing. *N Engl J Med.* 2006;354(7):661-665.
3. Joint Commission International. Available at:

<http://www.jointcommissioninternational.org/about-jci/>. Accessed May 18, 2010.

4. Cortez N. Patients without borders: The emerging global market for patients and the evolution of modern health care. *Indiana Law J.* 2008;83:71-132.
5. Milstein A, Smith M. America’s new refugees—seeking affordable surgery offshore. *N Engl J Med.* 2006;355(16):1637-1640.
6. Horowitz MD, Rosensweig JA, Jones CA. Medical tourism: Globalization of the healthcare marketplace. *MedGenMed.* 2007;9(4):33.
7. Herrick DM. Medical tourism: Global competition in health care. NCPA policy report 304; 2007.
8. Horowitz MD, Rosensweig JA. Medical tourism—health care in the global economy. *Physician Exec.* 2007;33(6):24-26, 28-30.
9. Greider K. Outsourcing medical care—a better deal for business? *AARP Bull Today.* September 1, 2007.
10. Francis T. Medical tourism is still small. *Wall Street J.* May 6, 2008:D2. Available at: <http://online.wsj.com/article/SB121004330575669909.html>. Accessed May 15, 2010.

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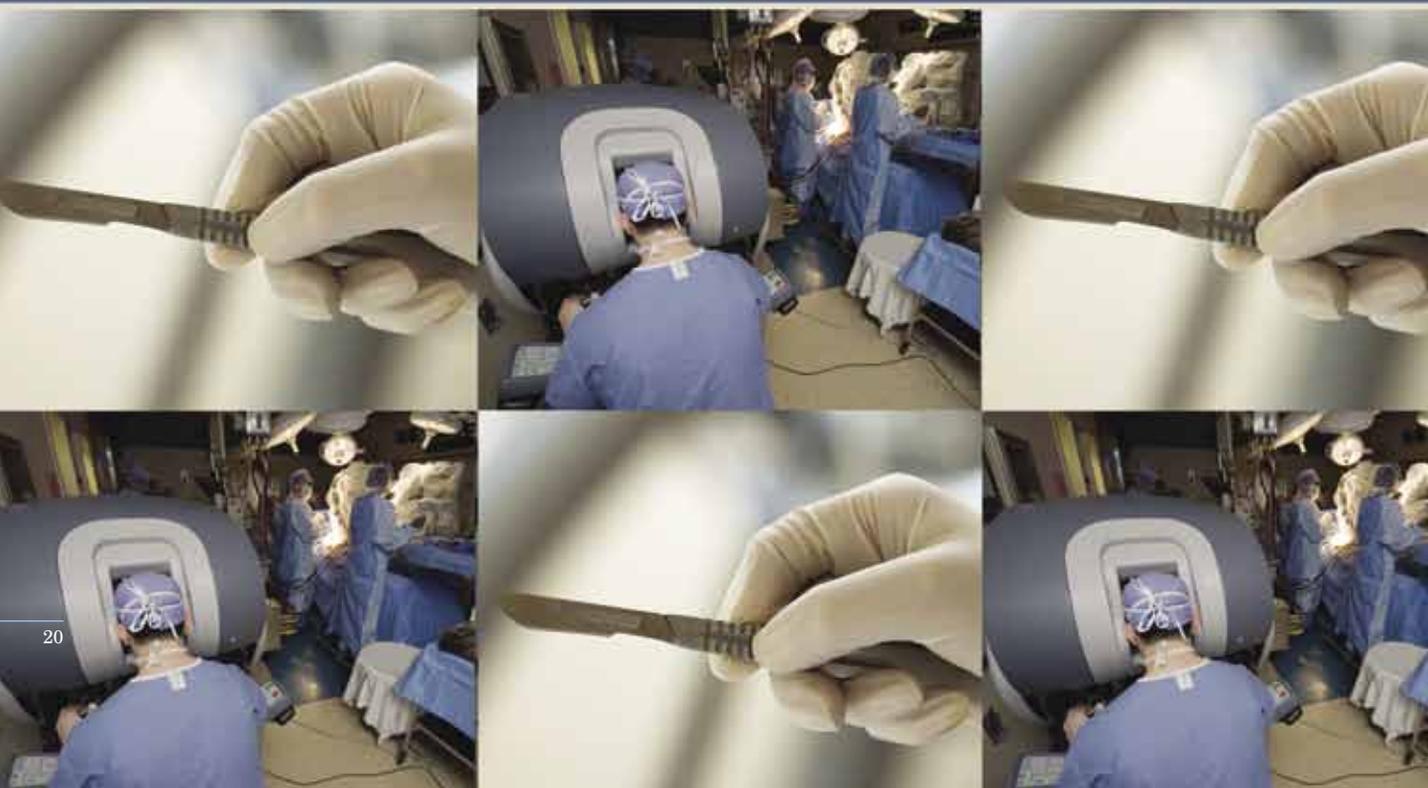




From scalpel to console:

A suggested model for surgical skill acquisition

by Christine S. Landry, MD; Elizabeth G. Grubbs, MD;
Jeffrey E. Lee, MD, FACS; and Nancy D. Perrier, MD, FACS



In 1987, a major revolution occurred in the practice of surgery: the advent and incorporation of minimally invasive laparoscopy, laparoscopic cholecystectomy in particular, into clinical surgical care. The technique was disseminated quickly, but the initial results were disastrous. The traditional surgical skills used in open surgery with three-dimensional visualization did not translate immediately to the skills needed to perform the operation with new instruments, while visualizing the procedure in only two dimensions on a computer screen. Furthermore, patient safety was not prioritized, and training was haphazard. The result was compromised outcomes.¹ Bile duct transactions, which had become a rarity in open cholecystectomy, were now commonplace with the advent of this new technology. Between 1993 and 1996, 629 trocar-related injuries were reported to the U.S. Food and Drug Administration, and many more likely occurred. Those reported injuries included more than 30 patients deaths, with nearly 500 vascular and visceral injuries.¹

Robotic surgery

Another surgical revolution is now under way: robotic surgery. As we embrace this new technology, we must balance surgical progress with safety and efficacy. In 1994, the American College of Surgeons' (ACS) Committee on Emerging Surgical Technology and Education established principles for the safe implementation of surgical technologies. Although the committee acknowledged that the process of evaluating new technologies should not impede their timely development or use, the committee emphasized the importance of establishing the value of a procedure prior to its widespread use on patients.² The purpose of this article is to describe what we believe is a safe means of surgical skill acquisition.

Safety—in the discipline of surgery—depends on interactions between people, machines, and working conditions. Performing safe procedures is the conglomeration of multiple learned skills and, thus, involves practice to achieve mastery.

Opposite: Robotic surgery photo copyrighted and used with permission of Mayo Foundation for Medical Education and Research, all rights reserved. Scalpel photo courtesy of istockphoto.com.

The learning curve for surgical procedures is considered to be the number of cases needed for a surgeon to reach the level of expert, and that further repetition of the procedure will not yield any additional improvement in surgical skills. Unfortunately, there are no standard guidelines regarding safety measures that shorten a surgical learning curve or make it less steep.

Surgeon learning

Several methods of learning can be utilized for continuous surgical education. One means is preceptorship, a form of training whereby an experienced surgeon supervises a procedure with the intention of guiding the learner in the acquisition of new skills. Preceptorship is distinctly different from proctorship, in which an observer is merely responsible for assessing skills and knowledge.³ Simulation training on technical skills and performing new procedures (first on cadavers) are reasonable options for instructing surgeons, but transferring the new skills into live patients is user-dependent, and does not directly correlate with technical training.

When training is inadequate for a procedure involving advanced technology, as was the case in early training on laparoscopy, failures occur. In complex procedures that involve both expertise and technical competence, systems interruptions are common. Most of these failures result from insufficient preparation. A recent retrospective review of closed malpractice claims supports the theory that most adverse events are due to systems malfunction.⁴ Of the 444 claims reviewed, 75 percent of errors arose intraoperatively, and system failures contributed to 82 percent of the adverse outcomes. The most frequent causes of adverse outcomes were inexperience and lack of technical competence.

Several authors have addressed the issue of how to systematically and safely introduce new technology and skills into surgical practice. Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College's Division of Education, proposed general principles for the safe introduction of new procedures after the period of residency and formal training.^{5,6} The principles are based on the level of evidence available to support a new procedure, the practice patterns of the surgeons,

and the needs of the community. Because practice patterns directly influence risk, practice guidelines have been suggested for achieving and maintaining certification.⁴ The incorporation of new devices into surgical practice should be disease-based, not a technology-driven application. Dr. Sachdeva proposed the idea that skill acquisition should extend to the entire surgical team, and not just the primary surgeon.⁶ Embracing the team approach is a mechanism by which multiple experienced surgeons can learn as a group and serve as preceptors to each other.

Jonathan Meakins, MD, FACS, well known for his contributions in patient safety, once stated, "...in many fly-by-night programs, the surgeon took the course on the weekend and had patients booked on the following Monday. This is not the way to do it, and it is unlikely that society will tolerate such a cavalier attitude."⁷ Prerequisites for introducing new surgical techniques should include the following: in-depth knowledge of the relevant disease process and its management gained through formal training and clinical experience, the acquisition of new skills, the development of appropriate support facilities, completion of a defined didactic educational program in the technology, assessment by a qualified surgeon experienced in the technology, and periodic monitoring of skills and outcomes. Furthermore, when a new technique becomes widely used, it must continue to be assessed and compared with alternative therapies to ensure efficacy and cost-effectiveness.²

Preceptorships

In 2006, surgeons in the Surgical Endocrinology Section at The University of Texas M.D. Anderson Cancer Center, Houston, TX, were encouraged by a senior mentor to explore the benefit to patients of posterior, retroperitoneoscopic adrenalectomy (PRA). The world expert in PRA is Martin Walz, MD, an experienced endocrine surgeon in Essen, Germany. The M.D. Anderson team, composed of three faculty surgeons and one surgical oncology fellow, traveled together to Essen for on-site observations of multiple PRAs performed by Dr. Walz and his surgical team.

In a PRA procedure, the adrenal gland is approached laparoscopically, from the posterior approach. The procedure requires a reorienta-

tion to the regional anatomy (which surgeons typically view anteriorly), modified patient positioning, and equipment that is typically unfamiliar to the surgeon. We introduced the technique into clinical practice as a team approach. This approach allowed each individual surgeon to learn, but each surgeon also served as a preceptor to the other team members, and allowed us to work together to solve problems as they occurred.

Results of our initial series of 62 cases were reported at the American Surgical Association's annual meeting in 2008.⁸ We had no perioperative deaths, and no reoperations were required; outcomes such as blood loss were acceptable for the complexity of the cases. When the patient population was divided into earlier and later cases, the median operating time did not differ significantly between the two subgroups. We believe that this finding resulted from a successful team approach, which allowed the risks of the learning curve to be flat because of the shared experience.

From our experience gained with the PRA procedure, we suggest that the model of group learning for skill acquisition can be used for the safe implementation of other modalities and procedures involving other organ sites. It is also suggested that this method is sufficient to fill in the gap when surgeons are serving as entrepreneurs, in order to push the envelope where no strong national precedent has been set—without compromising patient safety.

A model for introducing new technology

We then applied our model of group learning to the implementation of robotic surgery for transaxillary thyroidectomy. We became familiar with the literature on robot-assisted transaxillary endocrine surgical procedures, and then committed to exploring the technique. We identified a team consisting of experienced, dedicated endocrine surgeons, a biomedical engineer, and a technical support expert. With the approval of our department chair, we discussed access to, and availability of, our institution's robotic equipment (Intuitive Surgical Inc., Sunnyvale, CA) with the medical director of the minimally invasive new technology in the oncologic surgery group. All team surgeons acquired robotic

console skills after more than 10 hours each of simulation training and completion of online training modules. The group then traveled together to Seoul, South Korea, to learn the procedure from a surgeon, C.Y. Chung, MD, the individual with the most robotic transaxillary endocrine surgery experience in the world. We interacted with Dr. Chung's operating team, including nurses, fellows, and anesthesiologists, and we repeatedly observed operating room set-up, patient positioning, incision placement, instrument assignment, as well as operations. We then traveled to the robotic manufacturing headquarters in Sunnyvale, CA, to interact with the engineers of this device in order to master the equipment.

After returning to M.D. Anderson, we reviewed the open surgical dissection technique for transaxillary dissections, which is similar to the techniques of subcutaneous, skin-sparing mastectomy and axillary lymph node dissection. We re-mastered the anatomy of the lateral cervical approach. We then, as a team, performed robot-assisted dissections on multiple cadavers. We defined a best-practice algorithm that included each step of the procedure, and created a checklist to ensure safety and efficiency. We broke the procedure into responsibilities for three team members—designated console surgeon, field surgeon, and tower surgeon. All team surgeons developed competency in each role. To provide an efficient and concise means of communication, we created and memorized a technical vocabulary that defined what we meant by words such as extender, align, insert, deploy, and mount. Preparations for potential system failures were discussed, and strategies planned, to prevent collapses. We all became familiar with the instruments, whether or not they could be reused, and the cost of each item. All team members practiced emergency removal and deployment of the robotic devices. Dedicated operating room staff, including an anesthesiologist and a physical therapist, were identified, and the operating room personnel were prepared for the expectations pertaining to availability of light sources, bolsters, suction devices, retractors, and laparoscopic instrumentation.

Research aims were established, and data acquisition forms with definite endpoints were

designed. A commitment was made to employ the technique with continuous refinement. Patient selection criteria, with particular attention to landmark anatomy, were established. We performed the initial cases as planned, with a team consisting of console, field, and tower surgeons. A master log of outcomes was maintained, and periodically reviewed, by all team members.

Implementation

We believe that the model we followed can be applied by other surgeons in order to learn any robotic procedure. By following a well-defined process, surgeons can safely employ a new technology-based skill into clinical care. Techniques for overcoming obstacles to the delivery of safe surgical care have been designed by the ACS Committee on Emerging Surgical Technology and Education by learning from past failures.

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When new technology is involved, we should ask ourselves: Are we, as surgeons, following the principles of evidenced-based medicine? These include (1) defining the question and the problem, (2) searching for evidence, (3) applying the results, and (4) auditing the outcomes.

The safe implementation of new technology is a tremendous responsibility. William Mayo, MD, FACS, made a wise observation 100 years ago when he said, “There is no excuse today for the surgeon to learn on the patient.”⁹ Alexander Walt, MD, FACS, Past-President of the American College of Surgeons, has been quoted as saying, “The concept that one citizen will lay himself horizontal and permit another to plunge a knife into him, take blood, give blood, rearrange internal structures at will, determine ultimate function, indeed, sometimes life itself—that responsibility is awesome both in the true, and in the currently debased, meaning of that word.”¹⁰ We are reminded by James Jones, MD, that “As surgeons we, as fiduciaries, must balance technologic advancement and ethical responsibilities, a subject rarely broached in our data-driven surgical publications.”¹¹ 

References

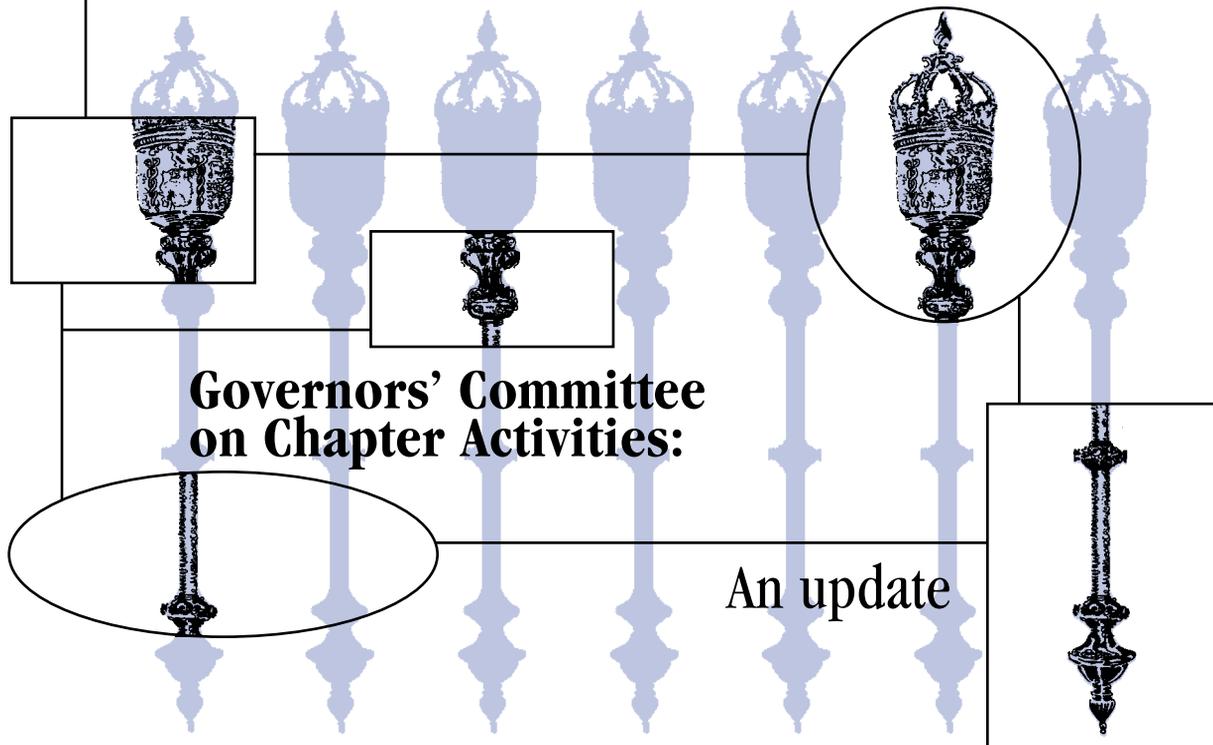
1. Bhojruyl S, Vierra MA, Nezhat CR, Krummel TM, Way LW. Trocar injuries in laparoscopic surgery. *J Am Coll Surg.* 2001;192(6):677-683.
2. Statements on Emerging Surgical Technologies and the Evaluation of Credentials. American College of Surgeons. *Bull Am Coll Surg.* 1994;79(6):40-41.
3. Zorn KC, Gautam G, Shalhav AL, Clayman RV, Ahlering TE, Albala DM, Lee DI, Sundaram CP, Matin SF, Castle EP, Winfield HN, Gettman MT, Lee BR, Thomas R, Patel VR, Leveillee RJ, Wong C, Badlani GH, Rha KH, Eggener SE, Wiklund P, Mottrie A, Atug F, Kural AR, Joseph JV. Training, credentialing, proctoring and medicolegal risks of robotic urological surgery: Recommendations of the society of urologic robotic surgeons. *J Urol.* 2009;182(3):1126-1132.
4. Rogers SO, Jr., Gawande AA, Kwaan M, Puopolo AL, Yoon C, Brennan TA, Studdert DM. Analysis of surgical errors in closed malpractice claims at four liability insurers. *Surgery.* 2006;140(1):25-33.
5. Helmreich RL, Musson DM, Sexton JB. In: Manuel BM, Nora PF, eds. *Surgical Patient Safety: Essential Information for Surgeons in Today's Environment.* Chicago, IL: American College of Surgeons; 2004.
6. Sachdeva AK. Acquiring skills in new procedures and technology: The challenge and the opportunity. *Arch Surg.* 2005;140(4):387-389.
7. Meakins JL. Innovation in surgery: The rules of evidence. *Am J Surg.* 2002;183(4):399-405.
8. Perrier ND, Kennamer DL, Bao R, Jimenez C, Grubbs EG, Lee JE, Evans DB. Posterior retroperitoneoscopic adrenalectomy: Preferred technique for removal of benign tumors and isolated metastases. *Ann Surg.* 2008;248(4):666-674.
9. Mayo WJ. Medical education for the general practitioner. *JAMA.* 1927;88:1377-1379.
10. Van Heerden J. Brothers. *Arch Surg.* 1997; 132(5):471-480.
11. Jones JW. Ethics of rapid surgical technological advancement. *Ann Thorac Surg.* 2000;69(3):676-677.

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Governors' Committee on Chapter Activities:

An update

by Kevin P. Lally, MD, FACS

The Board of Governors' Committee on Chapter Activities works to support the U.S., Canadian, and international chapters of the College. The activities of the committee are largely carried out by the four standing subcommittees, and the committee's focus is on improving chapter membership and function in support of the overall goals of the American College of Surgeons (ACS).

The International Activities subcommittee organized a strategic planning session at the Clinical Congress in October 2009. In addition to the international Governors, the session was attended by members of the International Relations Committee (IRC). A close working relationship with the IRC and focus on the role of the international chapters were widely agreed upon as important steps during the meeting. The group plans to focus on increasing international membership by developing recruiting strategies and expanding membership by young surgeons. Several members of the IRC will be working

with the Board of Governors' subcommittee on this item.

Other action items include the facilitation of international speakers, and working with the College to better coordinate activities and educational programs for international members. The Board of Regents also approved some changes regarding standardized requirements for international memberships. This change was necessary due to the differences in training around the globe.

The Meetings and Organization subcommittee is chaired by Gary L. Timmerman, MD, FACS. This subcommittee has been actively working on a new and revised checklist for chapter activities to help determine what defines a high-quality chapter. We planned to survey the chapters and use the feedback to provide more focused support for those chapters. This survey (<http://web.facs.org/chapterchecklst/default.htm>) was e-mailed to the chapters on June 4.

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Christian Charles Shults, MD
Michael E. Stark, MD, FACS
Gary L. Timmerman, MD, FACS
Bruce J. Waring, MD, FACS

added to the subcommittees, and they will be actively working on the issues outlined in this update. We hope to expand membership both nationally and overseas, and to expand chapter functions, especially in areas such as state advocacy. 

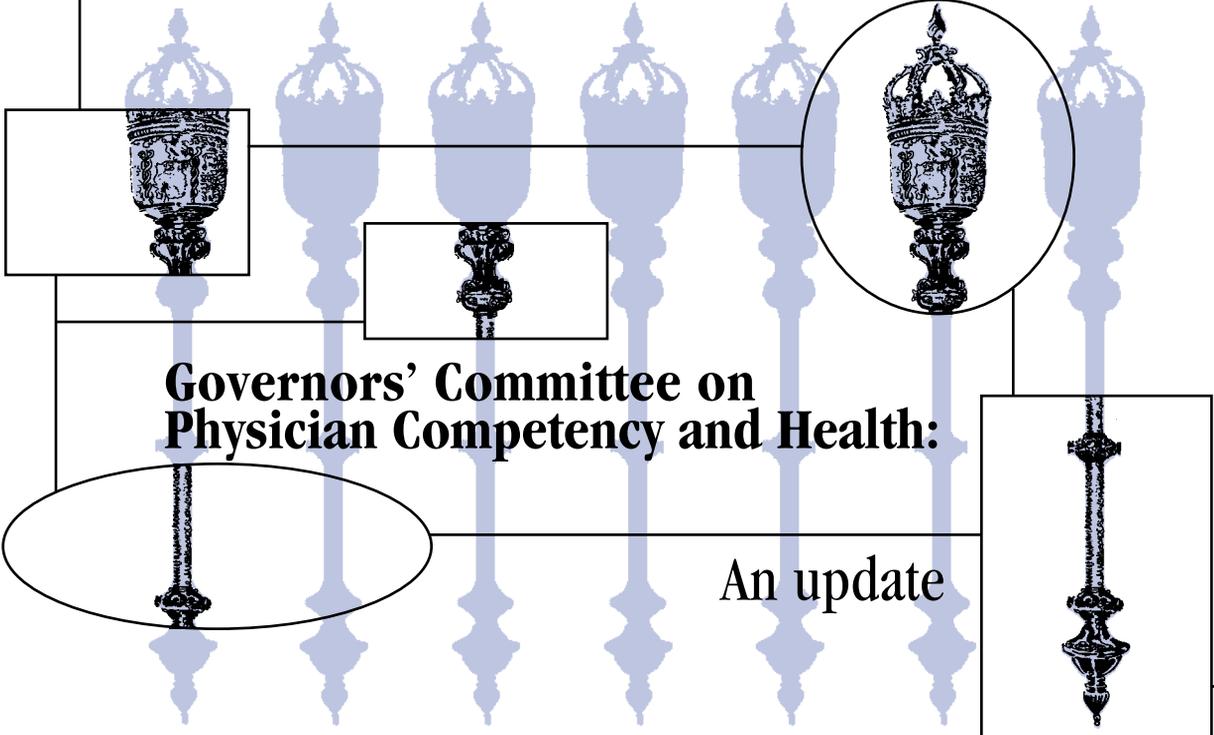
The subcommittee on Advocacy and Coalitions is chaired by John D. Nicholson, MD, FACS. This group worked actively to propose a chapter advocacy grant program that would be funded by the College. A number of chapters supported this proposal. The Board of Regents agreed that this is an important program and has authorized grants for up to five chapters to plan annual advocacy days at local state capitals. The subcommittee will be working with ACS staff to implement these grants. For more information on this program, refer to the Advocacy advisor column on page 33 of this issue.

Hilary A. Sanfey, MB, BCh, FACS, chairs the subcommittee on Membership and Diversity. This subcommittee is working with the Meetings and Organization subcommittee in an effort to expand membership and activity in the College by women and underrepresented minorities. The committee has also updated the College's online Speakers Bureau.

A number of new Governors have been

Dr. Lally is the A.G. McNeese Professor of Surgery and chairman, department of pediatric surgery, University of Texas Medical School at Houston, and the surgeon in chief, Children's Memorial Hermann Hospital, Houston. He is Chair of the Governors' Committee on Chapter Activities.





Governors' Committee on Physician Competency and Health:

An update

by John B. Hanks, MD, FACS

The Board of Governors' Committee on Physician Competency and Health has maintained an active position relative to the evaluation of the multiple issues influencing physician health and well-being. Over the last few years, under the capable and diligent leadership of Gerald J. Bechamps, MD, FACS, the committee has focused specifically on surgical career challenges that lead to substantial personal distress for the physician and his or her family. This year, the committee has continued to focus on this issue, and with the ongoing support of the College membership, intends to build on the very productive leadership of Dr. Bechamps and his colleagues for future endeavors.

Physician burnout and career satisfaction

A career in surgery, while often regarded as satisfying on a personal level, does not come without individual and family-related stress. In 2001, Lazar J. Greenfield, MD, FACS, published a study of the long-term consequences of stress

on academic surgeons at the University of Michigan, Ann Arbor, MI.¹ Using a quantifiable scale (specifically, the Maslach Burnout Inventory), this report analyzed more than 500 actively practicing surgeons who were either members of the Midwest Surgical Association or graduates of the University of Michigan Surgical Residency. Thirty-two percent of the actively practicing surgeons showed high levels of emotional exhaustion. Substantial levels of depersonalization and feelings of low personal accomplishment were also seen in this group. Younger surgeons were also very susceptible to burnout. A very strong association was made in this study between factors related to burnout and a desire for early retirement. Because of this report, the stage was set for continued evaluation of various surgical subspecialties, as well as nonsurgical fields, to determine burnout and its effect on the physician's well-being. Not only is personal health related to these findings, but this study also has significant implications for the physician workforce, if early

retirement is truly a result of factors relating to burnout—either perceived or real.

Dr. Bechamps, as Chair of the committee, recognized the possibility of using the American College of Surgeons to evaluate these findings within a larger population. All members of the College were sent an anonymous cross-sectional survey in June 2008. This survey evaluated demographic variables, practice characteristics, career satisfaction, burnout, and quality of life using standard and validated evaluation tools. Remarkably, 7,905 (32 percent of the College membership who were surveyed) responded to the questionnaire. More than 40 percent of responding surgeons demonstrated factors relative to burnout. Thirty percent screened positive for symptoms of serious depression, and 28 percent had a quality-of-life score below the population norm. Thirty-six percent of surgeons felt that their work schedule left enough time for personal family life, and only 51 percent would recommend that their children pursue a career as a physician or surgeon. This study represented the largest study of physician burnout conducted to date. As such, it represents a very valid evaluation of the results of a stressful career on physicians and their perceptions of their personal accomplishments.²

The committee will discuss factors related to burnout at the upcoming Clinical Congress in Washington, DC. Factors related to burnout and stress related to a career in surgery continue to be an issue that the College recognizes may affect as much as 30 percent of the workforce, with definable effects on individual performance, and, possibly, the entire overall workforce.

The impact of stress on surgical performance

While a career in surgery can impact a physician's perception of his or her environment, the impact of stress on surgical performance is an equally important factor. Quality and safety have become increasingly crucial elements of modern surgical practice. Intraoperative stress is recognized as a key component of surgical performance, and, therefore, should be managed effectively.

There is an increasing body of literature that evaluates the "systems approach" to modern

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surgical practice. This approach includes communication, teamwork, and decision making, all of which would be important determinants of performance in the operating room, and, as a result, affect ultimate patient outcome. It is commonly recognized that any of these elements may be compromised by acute mental stress experienced by the surgeon during an operation. Recent reports have attempted to delineate what the specifics of such stress may include. Dr. Arora and colleagues have reported that some of the key stressors that they have observed include complications related to laparoscopic surgeries, intraoperative bleeding, noise and other distractions in the operating suite, and time pressure, as well as equipment problems and procedural complexity.³ It may well be that, in an era with in-

creasing surgical complexity, economic attempts to maximize operating room time and utilization, as well as the burdens of resident teaching, all these issues may need to be analyzed—specifically, evaluation of ultimate patient outcomes as well as surgeon satisfaction. The extent to which these daily “episodes” of stress affect overall physician career satisfaction and, possibly, burnout are not well studied.

Continued efforts of the committee

The Committee on Physician Competency and Health has had a number of lively conversations, both at the Clinical Congress and via telephone conference, about where to go with future evaluation of these issues. There is a strong enthusiasm to pursue another survey, especially considering the success of the previous effort. It is important that a second survey include as many respondents as the previous survey, and that it examine more specific problem areas. Topics that have been suggested for this survey include issues of importance to surgical residents, or the younger surgeons, within the first several years of practice. Specific stress factors including financial debt, new technology, and productivity issues could also be evaluated. Additionally, there is some enthusiasm among committee members for issuing a formal request to the Board of Regents for a formal structure that would reside within the College and would support physician stress, and, perhaps, offer ways to alleviate issues that are contributory. This exciting possibility would necessarily entail in-depth discussion with College leadership. This would involve an analysis of issues related to the confidentiality of data, as well as scientific rigor, particularly if a diagnosis was suggested that may require a specific intervention.

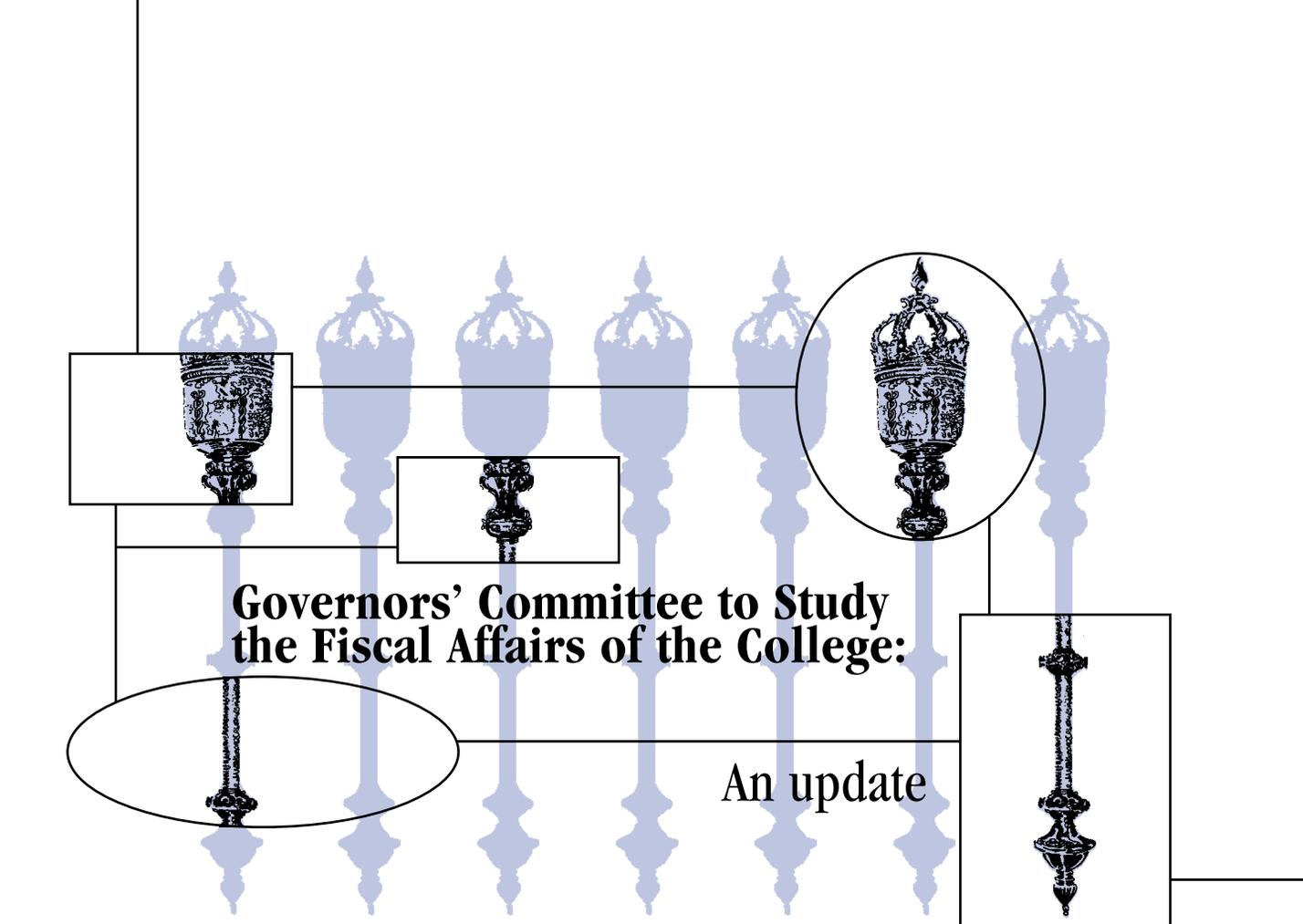
In conclusion, the Committee on Physician Competency and Health remains vitally concerned about the issues related to burnout, career satisfaction, and stress. These are important areas that concern the individual physician’s well-being, and ultimately affect the physician workforce and, most importantly, patient safety and optimal outcomes. The committee remains committed to pursuing these issues and making them a priority for College membership, and we look forward to the input

of the leadership, as well as the membership of the College, concerning our efforts. □

References

1. Campbell DA, Jr., Sonnad S, Eckhauser F, Campbell KK, Greenfield LJ. Burnout among American surgeons. *Surgery*. 2001;130:696-705.
2. Shanafelt TD, Balch CM, Bechamps GJ, Russell T, Dyrbye L, Satele D, Collicott P, Novotny PJ, Sloan J, Freischlag JA. Burnout and career satisfaction among American surgeons. *Ann Surg*. 2009;250:463-471.
3. Arora S, Sevdalis N, Nestel D, Woloshynowych M, Darzi A, Kneebone R. The impact of stress on surgical performance: A systematic review of the literature. *Surgery*. 2010;147:381-330.

Dr. Hanks is the C. Bruce Morton Professor and chief, division of general surgery, University of Virginia Health System, Charlottesville, VA. He is Chair of the Board of Governors’ Committee on Physician Competency and Health.



Governors' Committee to Study the Fiscal Affairs of the College:

An update

by James K. Elsey, MD, FACS

The Committee to Study the Fiscal Affairs of the College was established by the Board of Governors. In my capacity as Secretary of the Board of Governors, I serve as Chair of the committee, and as a member of the Finance Committee and the Compensation Committee of the Board of Regents. The committee meets several times each year to address the following significant responsibilities:

- Review the College's dues structure and recommend for approval, by the Board of Governors, any changes to the dues structure.
- Understand and monitor the College's financial matters in order to continue to ensure the overall financial integrity of the College. Specific areas that the committee concentrates their efforts on include reviewing the College's annual budget and resource allocations; reviewing the College's financial statements and related reports, including reports covering the investment activities of the College; reviewing

financial policies and procedures; reviewing any developed business plans; and soliciting the College membership as needed regarding the value of individual College programs and any dues changes. The work conducted regarding these efforts includes making recommendations as needed to appropriate bodies within the organizational structure of the College.

- Serve as the liaison body to communicate concerns or questions regarding College programs, dues structure, allocation of resources, and other financial matters from the Board of Governors to the Board of Regents, and vice versa.

Current activities

Over the last year, the committee has been actively engaged in a wide variety of important topics related to the fiscal activities of the College, including the following meetings:

- *Committee conference call meeting, April 28, 2009:* The committee discussed the roles and

responsibilities of the committee, including its role regarding the long-term dues strategy of the College. The committee received a detailed report from Andrew L. Warshaw, MD, FACS, the College's Treasurer, regarding the performance of the College's endowment investments, and minor changes made to the College's Statement of Investment Policies and Objectives.

The committee also received information regarding the dissolution of Surgeons Asset Management, LLC.

The committee reviewed the business plans provided to the Board of Regents for the proposed Disaster Management and Emergency Preparedness Course, the proposed Anatomically Based Surgery for Trauma Course, and an updated business plan regarding Selected Readings in General Surgery.

The committee also reviewed the 2009 Projection and 2010 Preliminary Budget and Forecast Parameters. The committee was updated on the progress of the 20 F Street Project (the new College office building in Washington, DC), and the recommendation for a vendor contract for the *Journal of the American College of Surgeons*.

- *Committee conference call meeting, August 5, 2009:* The committee received a detailed report from Dr. Warshaw regarding the performance of the College's endowment investments. Dr. Warshaw and College staff members Christian Shalgian, Director, Division of Advocacy and Health Policy, and Kristen Hedstrom, Assistant Director, Legislative Affairs, Division of Advocacy and Health Policy, provided detailed information about the College's current position regarding health care reform legislation.

The committee reviewed the business plan provided to the Board of Regents for the proposed General Surgery Review Course and reviewed an updated business plan regarding Selected Readings in General Surgery.

The committee was updated on the progress of the 20 F Street Project and provided an overview of the College's June 30, 2009, consolidated financial statements, which were to be independently audited by the College's audit firm during August and early September 2009.

- *Clinical Congress Committee meeting, October 10, 2009:* The committee received a

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Enrique Hernandez, MD, FACS
Brian D. Peyton, MD, FACS
A. John Popp, MD, FACS
Timothy D. Sielaff, MD, FACS
Randy Michael Stevens, MD
Andrew L. Warshaw, MD, FACS
Sherry M. Wren, MD, FACS

detailed report from Dr. Warshaw regarding the performance of the College's endowment investments.

The committee received an update on the *Selected Readings in General Surgery* product, and recommended that an electronic version of *Selected Readings in General Surgery* was needed.

The committee reviewed the College's audited consolidated financial statements for the year ended June 30, 2009, and related reports of the College's resource allocations and budget accountability.

- *Committee conference call meeting, January 25, 2010:* The Board of Regents requested on October 11, 2009, further discussion with the appropriate parties (including the Board of Governors) of the possible need to institute a member registration fee for future Clinical Congress meetings. The committee addressed this topic in order to provide information to the Board of Regents for their February 2010 meeting. The proposal included information compiled by the College's Division of Member Services, which outlined a variety of medical specialty organizations, their membership totals, annual dues amounts, and member as well as non-member annual meeting fees, in order to see where the College ranked in relation to

other medical specialty organizations.

After considerable discussion, the committee came to a consensus that the proposal was a reasonable approach to the decline in Clinical Congress revenues resulting from decreased exhibitor space rentals, exhibitor sponsorships, and satellite symposia. The committee also came to a consensus that a good starting point within the proposed \$125–\$175 member registration fee range would be \$150. The committee Chair communicated this recommendation to the Board of Regents' Finance Committee at their meeting on February 12, and it was ultimately approved by the full Board of Regents.

The committee also reviewed the initial proposed budget parameters for fiscal year 2011, with emphasis on the College's dues structure, and reviewed the committee's roles and responsibilities for the benefit of new committee members.

Focus for the future

One of the most significant responsibilities of the committee is to review the dues structure of the College, including reviewing dues revenue related to the development of the College's annual budget. The following outlines the history of the U.S. College Fellows dues:

1987: \$310 (from \$285 in 1986)
1988: \$330
1991: \$365
1992: \$375
2003: \$440

The committee continues to look forward to addressing and advising on the topic of College dues, as well as other significant College financial matters that arise in the future.

In conclusion, the Board of Governors' Committee to Study the Fiscal Affairs of the College very much appreciates the opportunity to provide members of the College with the most current information regarding the important activities of this committee. It is a great privilege to serve as Secretary of the College's Board of Governors and to serve as Chair of the committee. On behalf of the committee, I'd like to say thank you for the extraordinary efforts of the College's volunteer leadership team, the

College's Executive staff, and the College's Finance staff to steer the College down a sound financial track in these challenging economic times. □

Dr. Elsey is a vascular surgeon with Gwinnett Surgical Associates, Lawrenceville, GA. He is Secretary of the Board of Governors' Executive Committee, and Chair of the Governors' Committee to Study the Fiscal Affairs of the College.



Advancing advocacy with a day at the capitol

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

A very important part of any broad advocacy agenda involves face-to-face interaction with elected officials. Every year, representatives from thousands of organizations descend on Washington, DC, and state capitols to lobby an issue, to thank legislators for their support of a policy relevant to their profession, or to protest adoption of laws seen as detrimental to their cause.

Many medical and surgical associations sponsor annual lobby days to present the physician perspective on an issue. State medical societies commonly plan at least one lobby day per year, and sometimes they are joined by state specialty societies on this day. These efforts may be focused on one particular issue, such as opposing a physician tax on gross receipts, or on multiple significant issues that legislators are asked to address throughout a legislative session. In some cases, a state specialty society may have a particularly pressing issue to address. While a lobby day focused on one issue by a smaller society is more limited in scope and in number of physicians available to participate, it is no less necessary and effective in getting across the message. And in the case of the American College of Surgeons' Joint Surgical Advocacy Conference (JSAC) or the American Medical Association's National Advocacy Conference, hundreds of surgeons and other physicians travel to Washington, DC, for several days of issue briefings, advocacy training, and visits to Capitol Hill.

Sponsored by the College and 20 other national surgical societies, JSAC 2010, as it is informally referred to, commenced at the end of last month. This three-day conference provided an intensive introduction to the legislative process, as well as beginner and advanced advocacy training seminars, equipping surgeons with the skills and tools necessary to effect change both during their time in Washington, DC, and throughout the year at home. During visits to the Hill, surgeons were

given the opportunity to engage in practical application of their newly learned skills while meeting with their members of Congress. (A future issue of the *Bulletin* will contain a more comprehensive review of the JSAC.)

Planning the event

There are many components that go into planning a lobby day at the capitol, and the more work done upfront, the more effective the event will be, not only from the perspective of participants, but from those legislators being visited. No one likes to attend a disorganized event, so consider the following tips when organizing a lobby day.

- *Date of event.* The event should not conflict with other physician lobby days or large national clinical conferences; coordination among physician groups is essential in delivering a consistent physician message (it may make more sense to join with a coalition of physician groups for one big lobby day). Find a date on the calendar when the legislature is in session, and that falls before legislative deadlines. Also, consider a date that will allow for legislator education on the issue or issues—there is little point to having a lobby day when the legislature is not in session and legislators are not around.

- *Agenda.* Smaller lobby days may last for less than one full day, with participants meeting for breakfast and an issues briefing, picking up their information packets and “leave behinds” (handouts to leave with the legislators), and then spending the rest of the morning visiting with respective legislators. Following legislative visits, a lunch and debriefing can finish up by mid-afternoon, with everyone heading back to their hometowns soon after that. For a larger lobby day, it may be necessary to spend the morning in briefing sessions, with legislative visits following lunch, and then re-grouping later in the afternoon for a debriefing, and a reception in the early evening with legislators and legislative staff.

- *Issue focus.* Many lobby days focus on one or two specific issues, which emphasize the importance of these topics with legislators and reduce the complexity of conversations with legislators—simplicity is a virtue, especially when numerous nonphysician organizations are probably running around the capitol on the same day with their own agendas. A great visual cue for legislators occurs when physicians wear their lab coats, reinforcing the image of medical expertise when discussing the issue, and helping surgeons to stand out in the crowd.

- *Budget.* Sponsoring a lobby day at the capitol can be expensive, especially for smaller organizations with limited resources. Spreading the cost among coalition partners is a great way to plan a larger event and can include things such as food (meals, receptions), transportation (buses for participants or letting them drive in by themselves), setting up appointments with legislators, and media and public relations (brochures/programs, handouts, and issue fact sheets).

This is, of course, a very broad view of the factors that go into a lobby day at the capitol. It is not possible to go into all the specific details here; suffice it to say that ACS State Affairs staff members look forward to working with surgeons and College chapters to plan and implement a lobby day at the capitol. ACS Federal Legislative staff members are also available to assist chapters in facilitating Capitol Hill visits throughout the year. Contact Sara Morse, Manager of ACS Professional Association-SurgeonsPAC, in the ACS Washington, DC, Office at 202-337-2701 or smorse@facs.org for further information.

Chapter advocacy grant program

As a reflection of continuing support of the College for chapter advocacy efforts in their respective states, the Board of Governors Committee on Chapter Activities (GCCA) considered a proposal in October 2009 requesting the development and implementation of a chapter advocacy grant program to help support a lobby day at the capitol. This proposal was supported and signed by 27 ACS chapters, and was unanimously accepted by the Board of Governors. The Board of Regents approved this program in February 2010

Under this two-year Day at the Capitol grant program, ACS chapters may apply annually for

a grant for up to \$5,000 in a given year, with the stipulation that they will match one dollar for every two received. For example, a grant of \$5,000 would require a chapter match of \$2,500, for a total of \$7,500. After completing a grant application, the GCCA Subcommittee on Advocacy will review the applications and select the grant recipients. These recipients will be assigned a member of the State Affairs team to assist with the planning and on-site implementation of the event.

In those states where more than one ACS chapter exists, it is recommended that all the chapters come together in support of the grant application. Statewide advocacy requires a united surgical voice, which is best developed when diverse chapters are working together.

Once the Day at the Capitol program is completed, chapters will be required to provide a report to the ACS State Affairs office describing the event and its accomplishments, detailing ways in which the grant funds were spent, and assessing the overall completion of goals and objectives of the program. This report will be shared with the GCCA Subcommittee on Advocacy to further assess the grant program.

For further information on the Chapter Advocacy Grant Program, contact Jon Sutton, Manager of State Affairs in the Division of Advocacy and Health Policy, at jsutton@facs.org, or visit the College's state legislative Web page at <http://www.facs.org/ahp/statelegislation.html>. 

Dr. Greenfield receives the College's Jacobson Innovation Award for 2010

Lazar J. Greenfield, MD, FACS, of Ann Arbor, MI, is the 16th recipient of the Jacobson Innovation Award of the American College of Surgeons (ACS). The Jacobson Innovation Award—which honors living surgeons who have been innovative in the development of a new technique in any field of surgery—was presented to Dr. Greenfield on June 4, during a dinner that was held in conjunction with the ACS Board of Regents meeting in Washington, DC.

Established in 1994 through a gift from Julius H. Jacobson II, MD, FACS, a general vascular surgeon and pioneer in the field of microsurgery, and his wife Joan, the award is administered by the Board of Regents' Honors Committee of the American College of Surgeons.

An internationally recognized expert in vascular surgery, Dr. Greenfield was honored with the award in recognition



Dr. Greenfield

of his seminal contributions in the technical development of the Greenfield filter, a device that changed the technology associated with the pulmonary embolic complications of deep venous thrombosis. The

Greenfield vena cava filter is an implantable device inserted via a peripheral vein, and was designed to prevent blood clots from reaching the lungs—a condition otherwise known as pulmonary embolism. Filter devices are implanted in more than 10,000 patients annually who are at high risk for clotting, including some undergoing knee and hip-replacement surgery, and certain cancer and trauma patients. Since its introduction, the Greenfield filter has been implanted in more than 600,000 patients.

The filter is invaluable to immobile patients, since they are at highest risk of a blood clot due to the lack of movement. Clots that arise in the vein can break loose and travel to the lungs from other parts of the body (usually the leg), producing pulmonary embolism. Before the invention of the Greenfield filter, surgeons would try to prevent pulmonary embolism by surgically closing, partitioning, or clipping the inferior vena cava (IVC)—the vein that returns blood from the lower body to the heart—thereby stopping blood flow in the vein and forcing the blood to return to the heart through other veins. Moreover, these procedures usually led to massively swollen legs, among other problems. For instance, ligation of the IVC had a high operative mortality rate (up to 15 percent), and pulmonary

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Support® (ATLS®) Course—premiered in 1978? The ATLS program is now taught in more than 50 countries. Under the auspices of the ACS Military Committee on Trauma, the program has been conducted for U.S. military doctors in the U.S. and around the world. For further information, go to <http://www.facs.org/trauma/atls/history.html> on the College website.



Dr. Greenfield (far right) and his wife Sharon (second from right), with Dr. and Mrs. Jacobson.

embolism recurred in 6 percent of patients. The introduction of the Greenfield filter in 1973 provided the first effective method of trapping clots within blood vessels, while simultaneously preserving blood flow within the IVC. Although blood-thinners have proved effective at preventing blood clots, many people, especially trauma patients, cannot take these agents because they pose an increased risk of internal bleeding and death.

The impetus for developing the filter came from a surgical emergency Dr. Greenfield encountered in 1968, when he treated a 23-year-old patient who sustained multiple

fractures to both legs and the pelvis following a motorcycle accident and developed massive pulmonary embolism. Despite putting the patient on a heart-lung machine and applying the most aggressive surgical treatment of the time to remove numerous blood clots from the patient's lungs, the patient did not survive. Dr. Greenfield realized that a better method could be found for preventing pulmonary embolism. Two years later, he worked with Garman Kimmel, an oil-industry engineer and prolific inventor, to create an implantable filter for trapping blood clots before they could reach the lungs. The cone-shaped device con-

sists of six legs converging in the center that spans roughly an inch across the vena cava. It has tiny hooks that secure it in place in the blood-vessel wall, and corrugations in the legs to keep clots from slipping through. Clots that collect in the filter's conical nose almost always dissolve as a result of the continuous flow of blood, which has natural clot-dissolving properties.

Currently, there are eight filter designs, including the Greenfield filter, approved for use by the U.S. Food and Drug Administration. For many years, the Greenfield filter has served as the benchmark by which newer filters are mea-

Jacobson Innovation Award recipients

- 1994 Professor Francois Dubois**, Paris, France: Laparoscopic cholecystectomy.
- 1995 Thomas Starzl, MD, FACS**, Pittsburgh, PA: Liver transplantation.
- 1996 Joel D. Cooper, MD, FACS**, St. Louis, MO: Lung transplantation and lung volume reduction surgery.
- 1998 Juan Carlos Parodi, MD**, Buenos Aires, Argentina: Treatment of arterial aneurysms, occlusive disease, and vascular injuries by using endovascular stented graphs.
- 1999 John F. Burke, MD, FACS**, Boston, MA: Development and implementation of a number of innovative techniques in burn care, including the codevelopment of an artificial skin (Integra™).
- 2000 Paul L. Tessier, MD, FACS (Hon)**, Boulogne, France: Development and establishment of the surgical specialty of craniofacial surgery.
- 2001 Thomas J. Fogarty, MD, FACS**, Portola Valley, CA: Design and development of industry standard minimally invasive surgical instrumentation, especially for cardiovascular surgery.
- 2002 Michael R. Harrison, MD, FACS**, San Francisco, CA: Creator of the specialty of fetal surgery and developing techniques of fetoscopy for minimally invasive fetal technology.
- 2003 Robert H. Bartlett, MD, FACS**, Ann Arbor, MI: Pioneer in the development and establishment of the first extracorporeal membrane oxygenation (ECMO) program.
- 2004 Harry J. Buncke, MD, FACS**, San Francisco, CA: Pioneer in the field of microsurgery and replantation.
- 2005 Stanley J. Dudrick, MD, FACS**, Waterbury, CT: Innovator of specialized nutrition support and a pioneer in the field of clinical nutrition.
- 2006 Judah Folkman, MD, FACS**, Boston, MA: Pioneer in the field of angiogenesis.
- 2007 William S. Pierce, MD, FACS**, Hershey, PA: Pioneer in the conception and development of mechanical circulatory support and the total artificial mechanical heart.
- 2008 Donald L. Morton, MD, FACS**, Santa Monica, CA: Pioneered research efforts toward the development and clinical application of sentinel lymph node biopsy.
- 2009 Bernard Fisher, MD, FACS**, Pittsburgh, PA: Set a new course for the treatment of breast cancer by proposing that it is a systemic disease that metastasizes unpredictably and would best be treated with lumpectomy combined with adjuvant chemotherapy.

sured, because it has the best long-term record of any filter on the market—it has a recurrent pulmonary embolism rate of only 3 percent, and studies have shown it to be more than 95 percent safe and effective.

Dr. Greenfield received his medical degree from Baylor University College of Medicine, Houston, TX, in 1958, and completed his surgical training in general and thoracic surgery at the Johns Hopkins Hospital, Baltimore, MD (1958–1966). During his training, Dr. Greenfield spent two years conducting research at the National Heart, Lung, and Blood Institute of the National Institutes of Health, Bethesda, MD. He began his academic surgical career in 1966 as assistant professor of surgery and chief of surgical services at the Oklahoma City Veterans Affairs Medical Center at the University of Oklahoma Medical Center. In 1974, Dr. Greenfield was appointed the Stuart McGuire Professor and Chair at the Virginia Commonwealth University (VCU), Richmond, a post he held for 13 years. Following his work at VCU, Dr. Greenfield became the F.A. Collier Distinguished Professor of Surgery and chairman of the department of surgery at the University of Michigan in Ann Arbor, where he is currently professor emeritus of surgery.

Dr. Greenfield has been a Fellow of the American College of Surgeons since 1968. He is Editor-in-Chief of *Surgery News*, the College's monthly newspaper, and is Associate Editor of its members-only Web portal, www.e-FACS.org.

General surgery residency programs lack capacity to address shortage

Current residency programs do not have the capacity to address the growing shortage of general surgeons, according to survey research presented in May at the sixth annual Association of American Medical Colleges (AAMC) Physician Workforce Research Conference in Alexandria, VA.

In addition to expanding the existing 246 accredited general surgeon residency programs in the U.S., new training programs and an increase in funding will be required to meet the growing need for general surgeons, according to Anthony G. Charles MD, MPH, FACS, the study's lead researcher. Dr. Charles is an assistant professor of surgery in the department of surgery at the University of North Carolina, and a researcher at the American College of Surgeons Health Policy Research Institute, both located in Chapel Hill, NC. His presentation at AAMC was entitled *The Surgeon Shortage: Can We Solve the Surge in Residents Trained by Existing Residency Programs?*

"This shortage already poses a threat to hospitals in poor urban areas and rural hospitals that are generally dependant on surgical services for their survival," said George Sheldon, MD, FACS, a professor of surgery and social medicine in the department of surgery at the University of North Carolina and Director of the

ACS Health Policy Research Institute. "Among the ways to solve this problem are to develop new educational sites and new educational models. Above all, we need federal action to 'unfreeze' the funding for residency positions."

General surgeons perform a wide variety of procedures including appendectomies, cutting out cancerous tumors, and repairing the organs of trauma victims. Approximately 1,000 residents complete general surgery training annually in the U.S.—a number that has changed very little since 1980. In 2009, 909 residents became board certified general surgeons, according to the American Board of Surgery.

The overall number of general surgeons per 100,000 population has declined by 26 percent over the past 25 years. In addition, there is an increasing trend among general surgery residents to pursue surgical subspecialties rather than focus on general surgery. Given the present production level and retirement rate of general surgeons, the per capita supply of the general surgery workforce is expected to decline further over the next 15 years.

In November 2009, Dr. Charles conducted a Web-based survey to 246 residency programs accredited by the Accreditation Council for Graduate Medical Education to determine if these programs could expand enough

to address the shortage problem. Of the 123 program directors who responded, 80 percent reported having sufficient clinical and operative volume to accommodate an average increase of 1.9 residents per year.

Based on this response, Dr. Charles estimated that general surgery residency slots could potentially be increased to train up to 1,515 general surgery residents per year—a 33 percent expansion over the existing 1,137 approved chief resident slots. Given the five-year training intervals, it would take at least five years for this increase to have an impact on the shortage problem.

The research also found, however, that over the last five years, 71 percent of general surgery residents entered surgical clinical fellowships after completing their residencies.

"Even if we expand our current residency programs to full capacity, new programs and new models for surgical training will be needed, as will increased Medicare graduate medical education funding, if we are to produce enough new general surgeons to address the shortage," Dr. Charles said. He believes there has to be a commitment by the federal government to provide the resources that will help resolve this problem.

ANZ Traveling Fellowship for 2012 announced

The International Relations Committee of the American College of Surgeons (ACS) announces the availability of the Australia and New Zealand (ANZ) Traveling Fellowship. The purpose of this fellowship is to encourage international exchange of surgical science, practice, and education, and to establish professional and academic collaborations and friendships.

Basic requirements

The scholarship is available to a Fellow of the ACS, in most of the surgical specialties, who meets the following requirements:

- A major interest, and accomplishment in, basic sciences related to surgery
- Holds a current full-time academic appointment in the U.S. or Canada
- Under 45 years of age on the date the application is filed
- Enthusiastic, personable, and possesses good communication skills

Activities

The Fellow is required to spend a minimum of two or three weeks in Australia and New Zealand, and to engage in the following activities:

- Attend and participate in the annual Scientific Congress of the Royal Australasian College of Surgeons, in Kuala Lumpur, Malaysia, May 7–11, 2012
- Participate in the formal convocation ceremony
- Attend and address the ANZ Chapter meeting
- Visit at least two medical centers in Australia and New Zealand to lecture, and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and the President or designated representative of the Australia and New Zealand Chapter of the ACS. The surgical centers selected for a visit would

depend, to some extent, on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Australia and New Zealand.

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

Financial support

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

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

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

The closing date for receipt of completed applications is **November 15, 2010**. The successful applicant, and an alternate, will be selected and notified by March 2011.

Faculty research fellowships offered for 2011–2013

The American College of Surgeons is offering two-year faculty research fellowships, through the generosity of Fellows, chapters, and friends of the College, to surgeons entering academic careers in surgery or a surgical specialty. The fellowship award is \$40,000 per year for each of the two years, and is intended to assist a surgeon in the establishment of a new and independent research program. Applicants are required to demonstrate their potential to work as independent investigators.

Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College. The Franklin H. Martin, MD, FACS, Faculty Research Fellowship honors the founder of the College. The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico.

The Louis Argenta, MD, FACS, Faculty Research Fellowship, supported by Kinetic Concepts, Inc., is a one-year award in the amount of \$40,000 to help a surgeon establish an independent research program on wound care. All of the requirements outlined in this article that apply to the Martin and Carrico Fellowships, apply to the Argenta Fellowship—with the exception that the time period is for one year. The Argenta Fellow will attend and report at the 2012 Clinical Congress.

General policies covering the awarding of the American College of Surgeons Faculty Research Fellowships are:

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

- This award may be used by the recipient for support of his or her research or academic en-

richment in any fashion that the recipient deems maximally supportive of his or her investigations. The fellowship grant is to support the research of the recipient and is not to diminish or replace the usual, expected compensation or benefits. Indirect costs are not paid to the recipient or to the recipient's institution.

- Application for this fellowship may be submitted even if comparable application has been made to organizations such as the National Institutes of Health (NIH) or industry sources. If the recipient is offered a scholarship, fellowship, or research career development award from such an agency or organization, it is the responsibility of the recipient to contact the College's Scholarships Administrator to request approval of the additional award. The Scholarships Committee reserves the right to review potentially overlapping awards and adjust its award accordingly.

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

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

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

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

- The Fellow is expected to attend the Clinical Congress of the American College of Surgeons in 2013 to present a report to the Surgical Forum and to receive a certificate at the annual meeting of the Scholarships Committee.

The closing date for receipt of applications and all supporting documents is **November 1, 2010**. Application forms may be obtained from the College's website: <http://www.facs.org/member-services/acsfaculty.html>.

A look at The Joint Commission

New book examines how negative behavior affects patient safety and outcomes

No one in health care is immune to the negative consequences brought about by bad behaviors and the absence of civility. Inevitably, the quality of care that surgeons provide, and that their patients receive, can suffer. In his latest book for Joint Commission Resources (JCR)—the not-for-profit education, publishing, and consulting arm of The Joint Commission—practicing surgeon and best-selling author Michael S. Woods, MD, FACS, tackles the issues of disruptive and

intimidating behavior among physicians, nurses, and other health care providers, and how such behavior negatively affects patient safety and outcomes. *Civil Leadership: The Final Step to Achieving Safety, Quality, Innovation, and Profitability in Health Care* offers a common sense approach and business-savvy leadership advice for health care providers, but the lessons offered are also valuable for nonclinical staff, as well as patients.

In the book, Dr. Woods contends that “We can never

achieve the kind of quality and safety we should have without commitment to civility,” and ties the concept of civility to better employee and customer retention, higher patient satisfaction, and lower liability risks. The book covers topics such as the following:

- Relationship-based civil leadership
- The self-inflicted injuries of disruptive and uncivil behavior
- Relationship-based civil leadership as a health care business strategy
- Community, motivation, and the patient
- Why civility-driven, relationship-based care is important now
- Self-Inflicted Wounds: The Seven Common Leadership Mistakes® of physicians
- Standards for civility-driven behavior and professionalism

Civil Leadership: The Final Step to Achieving Safety, Quality, Innovation, and Profitability in Health Care includes a foreword from *The New York Times* best-selling author Marshall Goldsmith, who calls the book “wonderful” and its focus “critical” to “today’s changing workplace.”

Trauma meetings calendar

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

- **Advances in Trauma**, December 10–11, 2011, Kansas City, MO
- **Medical Disaster Response**, April 10, 2011, Las Vegas, NV

- **Trauma, Critical Care, and Acute Care Surgery 2011**, April 11–13, 2011, Las Vegas, NV

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons' website at <http://www.facs.org/trauma/cme/traumtgs.html>, or contact the Trauma Office at 312-202-5342.

So, You Want to Be a Surgeon...

Medical student guide to residency training

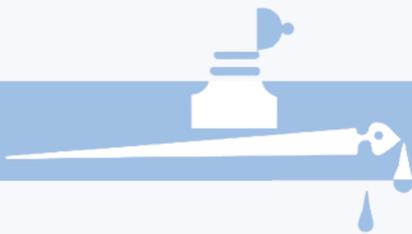
The online resource, *So, You Want to Be a Surgeon...A Medical Student Guide to Finding and Matching with the Best Possible Surgery Residency*, is now available on the American College of Surgeons Web site at:

<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.





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.

Why supporting UEVHPA is key

"10 questions and answers about disasters and disaster response" in the March 2010 issue of the *Bulletin* (*Bull Am Coll Surg.* 2010;95(3):6-13) is an excellent overview of what goes into responding to a disaster. The amount of assistance by Americans to the victims of the earthquake in Haiti demonstrates the continued willingness of our country to help those in need. Multiple agencies, including the American College of Surgeons, went from zero to 100 to mobilize relief efforts, in almost unprecedented time frames. The biggest obstacles to this relief effort were not related to the rescuers, but instead to the infrastructure and geography of Haiti itself, as pointed out in the article.

This is in stark contrast to relief efforts for the victims of 9/11 and Hurricane Katrina. In those instances, many relief efforts were shut down as soon as they were conceived, because of licensing and liability issues related to crossing state lines. Physician licensing is a state-by-state decision, with no reciprocity. Many physician rescuers who attempted to help at these homeland tragedies were simply turned away or given jobs that did not take advantage of their skills. It is unacceptable that a surgeon can help out in a neighboring country more easily than he can in a neighboring state. Although this article

was very informative, it did not mention that several states, with the help of the College, are trying to pass the Uniformed Emergency Volunteer Health Practitioner's Act (UEVHPA). This act will allow the creation of a single database to contact health care practitioners (it is not limited to physicians) during a disaster. Signing on to this database is voluntary, and will allow a physician's license and liability insurance to cover him while he helps those affected by the emergency. Because it involves state medical licenses, each state must pass its own version of the act. To date, only 11 states have passed such legislation. Many states considering this legislation are doing so at the direct request of ACS Fellows and Chapters. In Connecticut, we are working closely with our legislators to pass this important act, and several of us have already testified before our state congress. This can only be accomplished with support from politicians and the physician community. Please contact your legislator and support the UEVHPA in your state.

**Philip R. Corvo MD, FACS,
Stamford, CT
Past-President, CT Chapter
of the American College of
Surgeons**

National rural health service

I certainly agree with "Rural surgeons—We must grow our own" and "Rural surgeons—We must grow our own: A response" published in the April issue of the *Bulletin* (*Bull Am Coll Surg.* 2010;95(4):16-18,19). Mentoring, as well as early and continued exposure [to practicing medicine in rural environments] are important fertilizers to help "grow our own" rural surgeons. However, there is more to solving this shortage, especially as medical students and residents continue to be attracted to surgical subspecialties in increasing numbers. This likely has less to do with

the hope of financial gain than it does the search for a better lifestyle for themselves and their families.

I have practiced full time in academics, in a small private urban partnership, in the Veterans Affairs, a county teaching hospital, and, finally, solo in a 25-bed critical access rural mountain hospital in Northern California during my final four years in practice. Our little hospital needed better coverage and offered an income guarantee to help attract a surgeon.

There may be another, more direct, way to solve the problem of inadequate rural surgery coverage: aside from encouraging rural surgery rotations, we, as a profession, should foster the notion that rural health care can be stimulated through a system of national service—a national rural health service—for young, fully trained physicians and surgeons. It will become readily apparent to many of these young general surgeons that rural America offers a perfect setting and lifestyle to raise a family, and for a successful practice. And many surgeons may find that they will stay in that setting when their period of service is complete. Further, they will discover that modern rural surgery is far more sophisticated and connected than they ever imagined.

My four years practicing rural surgery were, arguably, my happiest years in practice.

**Lawrence A. Danto, MD, FACS
Northstar-Truckee, CA**

Difficult patients

My first reaction to the May 2010 issue of the *Bulletin*, which featured four articles on the theme of "Dealing with difficult patients" (*Bull Am Coll Surg.* 2010;95(5):10-23), is that, as stated in the American College of Surgeons' Fellowship pledge, the words "dealing with" should be changed to "caring for." This wording gives the concept a different perspective, and foregoes

blaming the patient. It is often the so-called “difficult patient” who survives, when the submissive and suffering good patient dies of natural causes or medical errors, because these difficult patients tend to have a fighting spirit.

Also, as I have learned, the best doctors are often criticized by patients, nurses, and family and learn from their mistakes, rather than make excuses and blame the patient. I always remember the patient who told me, when I was discharging him, that I was not getting a gift while all his other doctors were. When I asked why, he said, “Because you are always angry.” I said I was sorry, but I didn’t like what had happened to him or what I had to do to him. “Yeah, but you took it out on me.” Again, I said I was sorry, and he said, “Okay, I’ll give you a gift.” He didn’t need to tell me anything, or ever see me again, but he knew I was hurting and helped me become a better doctor.

The opposite of love is indifference, and, worse, rejection and abuse. The difficult patient is often seeking attention because they have never received it in a healthy and loving way from the authority figures in their life. Give them the love they need, and they will not be difficult, because you have let them know that you value them. I have watched difficult, self-destructive patients change over the months when I kept giving them return appointments, despite their behavior. They then realized somebody cared about them, and began to value themselves.

Humor can also break through the aura surrounding the difficult patient. When a frightened patient who didn’t want to enter the operating room met the staff and said, “Thank God all these wonderful people will be taking care of me.” I responded, “I’ve worked with them for years. They are not wonderful people.” Everyone laughed, and we became family.

I touch and hug my patients and ask them for a hug when I am hurting. We heal each other. I also tell them I prefer that they be responsible participants, and not patients, or submissive sufferers.

Yes, life is difficult, but if you truly care for patients, there is no need or reason for them to be difficult. So, learn from your mistakes and your difficult patients rather than blaming them, and your practice will improve and your malpractice suits will likely decrease, too.

**Bernie Siegel, MD, FACS
Woodbridge, CT**

I say find another physician. I fire these patients as fast as I can. Life is too short to deal with these people. I enjoy my practice and don’t need the hassle of trying to appease these troublemakers. Let someone else play “Marcus Welby.” I don’t need them screaming at my front office staff, or threatening to call the newspaper, or complaining about parking, or why their insurance is not covering their bills, or why my chairs are so hard/soft, or how I should change my practice to fit their schedule, or why I don’t allow cell phones in the exam room, and on and on and on.

**William J. Somers, MD, FACS
Columbus, OH**

Knowledge of anatomy key for residents

Dear Dr. Hoyt,

After reading your column in the May issue of the *Bulletin (Bull Am Coll Surg.* 2010;95(5):4-6), I am reminded of the occasion when I first met Robert (Bob) E. Hermann, MD, FACS. We were both residents in Cleveland in different programs, but we both attended the gross anatomy classes at Case Western Reserve University School of Medicine that were given especially for residents in surgery programs in Cleveland. This was an important opportunity to revisit the anatomy lab at a time in our training when

we could better appreciate the need for intimate knowledge of human anatomy.

In the years since I retired from a 40-year career in surgery at the Kaiser Permanente Medical Center in Panorama City, CA, I have volunteered in the gross anatomy lab at UCLA Medical School, helping first-year students in their introduction to the dissection of the human body. The amount of time now devoted to anatomy has significantly diminished during these years, and is of a different order of magnitude from when you and I were in medical school. UCLA Medical School offers more instruction, however, than what is offered at some schools where students do not go to the lab or even have a course in anatomy.

It has become apparent that some residents embarking on training programs in the various surgical fields have a weak understanding of anatomy, which probably is due to inadequate teaching of anatomy during their medical school years. To address this, the anatomy department at UCLA is now providing additional classes in anatomy throughout the four years of medical school, and additional opportunities to surgery residents at the Medical Center.

When you write about the importance of the Association of Program Directors in Surgery, which provides a forum to ensure that “surgery residents acquire the skills and knowledge they will need,” I think that it is paramount to address the possibility that some of the residents may be deficient in knowledge of anatomy, which could significantly impair their skills in their training. Identifying these individuals is important, but an even greater initiative would be to give all residents a chance to revisit the anatomy lab.

**Richard A. Braun, MD, FACS
Encino, CA**



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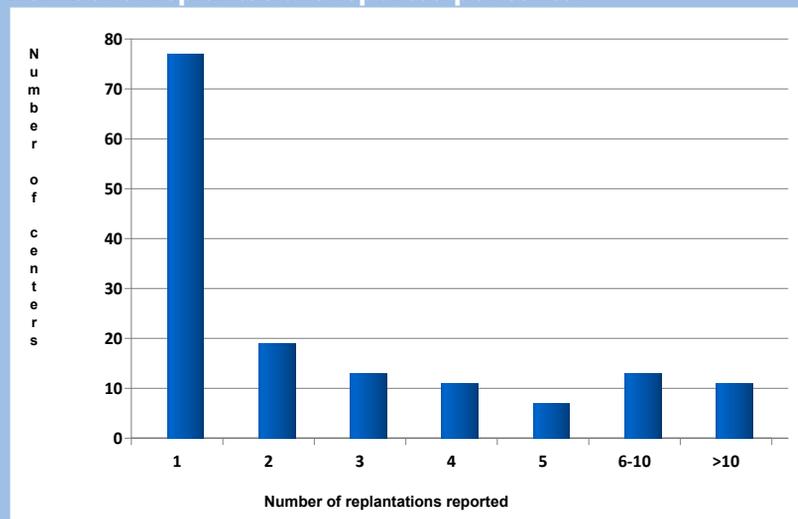
by Richard J. Fantus, MD, FACS; and John Fildes, MD, FACS

The English word “finger” has two meanings, even when referring to a single human hand. The first meaning refers to the four digits, not including the thumb; the second refers to any of the five digits of the hand. The first meaning of the word finger implies that the thumb is special. Many primates have opposable thumbs; however, the evolution of the fully opposable thumb is associated with *Homo habilis*, the forerunner of *Homo sapiens*. The opposable thumb has allowed the human species to develop fine motor skills, stone tools, and human functions such as the ability to write. The accidental loss of a thumb, or several fingers, would result in significant disability.

Microsurgery and replantation have evolved over the past 50 years, but they have their origins in the mid-1500s, when medical pioneers first developed techniques of vascular suture and vascular ligation. In the early 1900s, vascular surgery became a possibility, as a result of the experimentation efforts of Alexis Carrel, MD, and Charles Guthrie, MD. They performed transplantations and replantations of composite tissues, organs, amputated limbs, and kidneys in animals. In 1918, William H. Howell, PhD, and L. Emmett Holt, MD, developed heparin, which increased the

*Tamai S. *Plast Reconstr Surg*. 2009;124(12):(6 Suppl:e282-94).

Number of replantations reported per center



numbers and success rates of these types of operations performed in humans. The first monocular microscope was used for ear surgery in 1921 by Carl Nylen, MD, followed closely in 1923, with the first use of a binocular microscope by Gunnar Holmgren, MD. Over the next 50 years, with the development of the Zeiss operating microscope, suture materials, and microsurgical instruments, microsurgery became a part of several surgical disciplines.*

In order to examine the occurrence of replantations in the National Trauma Data Bank® research dataset 2008, admissions records were searched utilizing the International Classification of Diseases, Ninth Revision, Clinical Modifica-

tion (ICD-9-CM) procedure codes P84.2 (reattachment of extremity), including P84.21 through P84.24 (upper extremity), P84.25 through P84.28 (lower extremity), and P84.29 (other reattachment). A total of 508 incidents matched these P codes; 500 records had P codes for upper extremity, and seven records had P codes for lower extremity. These patients were 85 percent male, on average 36 years of age, had an average length of stay of 7.2 days, and an average injury severity score of 5.1, indicating that the majority of these were single-site injuries. The major mechanisms of injury categories for these records were machinery 212, cut/pierce 149, other specified 63, motor vehicle-related 21,

transport other 17, struck by or against 16, fall 8, and natural/environment 6. There were 151 centers that performed more than 500 replantations in 481 patients (these data are depicted in the figure on page 46).

Loss of a thumb, several digits, or part of an extremity—especially the arm—can have devastating consequences. Even though the field of prosthetics is progressing by leaps and bounds and is evolving as fast as advancements in modern technology allow, lower extremity prosthetics have outpaced the level of sophistication of currently available upper extremity prosthetics. With the lack of a suitable substitute that can provide for precise fine motor movements, replantation remains the mainstay for injuries involving the upper extremity,

especially the thumb. For this reason, the majority of replants involve the upper extremity, and, specifically, attempts to save the thumb. There is nothing more rewarding than to make rounds and have the patient give you the thumbs up.

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 website as a PDF file and a PowerPoint presentation at <http://www.ntdb.org>. In addition, information is available on our website 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 has been provided by Chrystal Price, data analyst, NTDB.

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

Dr. Fildes is chair, department of trauma, University Medical Center, Las Vegas, and director for general surgery, surgical critical care, and acute care surgery; professor of surgery and vice-chair, department of surgery; and chief, division of trauma/critical care, University of Nevada School of Medicine, Las Vegas. He is Trauma Medical Director for the American College of Surgeons.

Plan to attend daily panel sessions at 2010 Clinical Congress

The 2010 Clinical Congress, which will be held October 3–7 at the Walter E. Washington Convention Center in Washington, DC, will feature more than 100 panel sessions for all surgeons, including the following:

Monday, October 4

- Diverticulitis: Changing Management Paradigms
- Abdominal Catastrophes: Strategies to Optimize a Bad Situation
- Really Bad Biliary Emergencies: Using All Your Tools

Tuesday, October 5

- Colonic Emergencies
- Evolving Technologies and Procedures in Bariatric and Metabolic Surgery
- Prosthetic Material for Primary Inguinal Hernia Repair: Do We Need to Reconsider?

Wednesday, October 6

- Appendicitis Disasters: Options to Optimize Outcomes
- Infected Mesh: The Problem That Won't Go Away
- Surgical Management of Acute Pancreatitis

Thursday, October 7

- Inflammatory Bowel Disease Update
- Intraoperative Complications of Laparoscopic Surgery

To view the full list of panel sessions at the 2010 Clinical Congress, as well as the entire Scientific Program, visit <http://www.facs.org/clincon2010/index.html>. At that location, you can also register for the Clinical Congress and look for “Named Lectures” under the Scientific Program.

ACS Multimedia Atlas of Surgery

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Editors:

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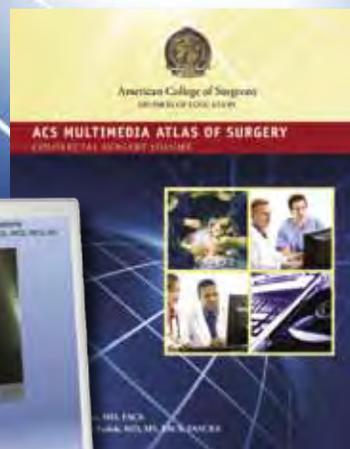
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Chapter news

by Rhonda Peebles, Division of Member Services

To report your Chapter's news, contact Rhonda Peebles toll-free at 888-857-7545, or via e-mail at rpeebles@facs.org.

New Jersey Chapter hosts annual socioeconomic meeting

On March 13, the New Jersey Chapter hosted its annual socioeconomic meeting in Monroe, NJ. David B. Hoyt, MD, FACS, the College's Executive Director, addressed the topic of health care reform. In addition, the program featured a session on risk management and future health care legislative priorities that was presented by Sen. Loretta Weinberg (D-37th District). (See photo, this page.)

Puerto Rico Chapter hosts Frederick Greene, MD, FACS

Last February, the Puerto Rico Chapter hosted its 60th annual meeting. The three-day education program featured presentations by residents and Fellows of the College. In addition, Dr. Greene represented the College at this year's event. (See photo, this page.)

Chapter anniversaries

Month	Chapter	Years
July	Southwest Missouri	58
	New Jersey	59
	Keystone, PA	58
	West Virginia	60
August	Georgia	60
	Hawaii	59
	Illinois	60
	Brooklyn-Long Island, NY	60
	Northwest Pennsylvania	60
	Rhode Island	57

Georgia Society of the ACS convenes 2010 advocacy meeting

On February 26, the Georgia Society of the ACS conducted its 2010 GSACS Advocacy Meeting. The two-day education program featured updates on federal and state health care legislation and regulation, as well as Georgia's trauma network and funding. In addition, John T. (Ted)



New Jersey Chapter, left to right: (all MD, FACS): Paul Carniol, President; Lewis Wetstein, Immediate Past-President; Steven Shikar; John Poole, Legislative Chair; Dr. Hoyt; Mark Moritz, Past-President; and Frank Padberg Jr., President-Elect.



Puerto Rico Chapter, left to right: Dr. Greene; Yvonne Baerga-Varela, MD, FACS, Education Program Chair; Ramon Sotomayor, MD, FACS, Immediate Past-President; and José Sorrentino, MD, FACS, Governor.



Georgia Society of the ACS: Addressing the advocacy conference attendees is Dr. Perry, who chairs the political action committee, SURGPAC.



Pakistan Chapter: Attendees at the Surgical Conference.

Perry, MD, FACS, Chair of the Georgia Composite Medical Board, presented Your Medical License: What You Don't Know Can Hurt You. (See photo, page 49).

Pakistan Chapter conducts national meeting

Together with the Society of Surgeons of Pakistan, the Pakistan Chapter convened the 2010 Joint National Surgical Conference, May 1–2, in Bhurban. (See photo, this page.)

West Virginia Chapter hosts 2010 annual meeting

Andrew L. Warshaw, MD, FACS, the College's Treasurer, attended the West Virginia Chapter's 60th annual meeting, which was held May 6–8, at the Greenbrier. In addition to presentations by Dr. Warshaw, the program also featured a session presented by Peter Rhee, MD, FACS, chief of trauma from the University of Arizona, Tucson, on trauma resuscitation. Also, to commemorate the Chapter's 60th anniversary, Richard Vaughan, MD, FACS, chair of surgery at West Virginia Uni-



West Virginia Chapter, front row, left to right: Alan Tracy, MD, FACS, President-Elect; James Carrier, MD, FACS, President; and Robert Gustafson, MD, FACS, Governor. Back row: Richard Vaughan, MD, FACS, Councilor; Eric Mantz, MD, FACS, Secretary-Treasurer; Sharon Bartholomew, Administrator; Roger King, MD, FACS, former Governor; Charles Lucente, MD, FACS, Chair, COT; and Gene Duremdes, MD, FACS, Councilor.

versity, Morgantown, delivered a short history of the chapter, and a call for fellowship that was written by Alvin L. Watne, MD, FACS, a former *continued on page 52*

Chapter meetings

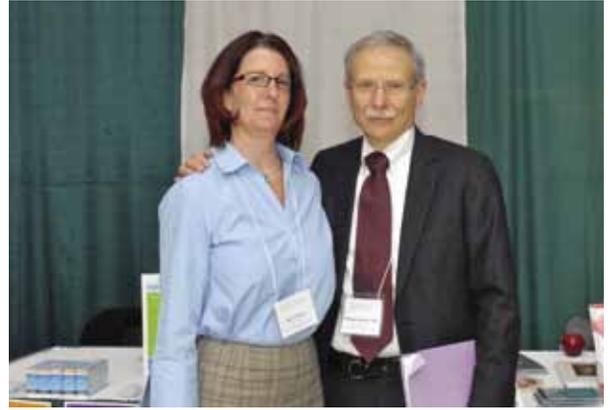
For a complete listing of the ACS chapter education programs and meetings, visit the ACS Web site at <http://www.facs.org/about/chapters/index.html>.

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

Date	Chapter	Location/information
August 7, 2010	Hawaii	Location: Queen's Medical Center, Honolulu, HI Contact: Gary Belcher, 808-586-8234 e-mail: gbelcher@hawaii.edu ACS Representative(s): LaMar S. McGinnis, Jr., MD, FACS
August 27–29, 2010	Georgia Society of the American College of Surgeons	Location: Grand Hyatt Atlanta in Buckhead, Atlanta, GA Contact: Kathy D. Browning, 404-625-1520 e-mail: info@georgiageneralsurgery.org ACS Representative(s): David B. Hoyt, MD, FACS
September 3, 2010	New Mexico	Location: Albuquerque, NM Contact: Sally Blackstad, 505-796-3430 e-mail: sblackstad@nmms.org
September 11–12, 2010	Kansas (CS)	Location: Wichita Airport Hilton Inn, Wichita, KS Contact: Gary Caruthers, 785-235-2383 e-mail: gcaruthers@kmsonline.org ACS Representative(s): David B. Hoyt, MD, FACS
September 18, 2010	Arkansas (CS)	Location: Crowne Plaza Hotel, Little Rock, AR Contact: Linda Clayton, 501-753-3500 e-mail: lindac92@comcast.net
September 22, 2010	Kentucky	Location: Hyatt Regency, Lexington, KY Contact: Linda Silvestri, 859-323-6346 e-mail: lsilv2@uky.edu
October 15, 2010	Oklahoma	Location: University of Oklahoma Health Sciences Center, Oklahoma City, OK Contact: Russell Postier, MD, FACS, 405-271-7912 e-mail: russell-postier@ouhsc.edu ACS Representative(s): L. D. Britt, MD, MPH, FACS
November 4, 2010	Maryland (CS)	Location: Sheraton Baltimore North, Towson, MD Contact: Kimberly Andrews, 443-849-2393 e-mail: kandrews@gbmc.org
November 5–6, 2010	Wisconsin Surgical Society—a Chapter of the ACS	Location: The American Club, Kohler, WI Contact: Terry Estness, 414-453-9957 e-mail: wisurgical@att.net ACS Representative(s): Mark A. Malangoni, MD, FACS
November 5, 2010	Connecticut (CS)	Location: Holiday Inn, Waterbury, CT Contact: Chris Tasik, 203-674-0747 e-mail: info@CTACS.org ACS Representative(s): David B. Hoyt, MD, FACS



New York Chapter, left to right (all MD, FACS): Peter D'Silva, Immediate Past President; Soumitra Eachempati, President; Dr. Deveney; Art Cooper, Legislative Committee Chair; Danielle Katz, Treasurer; and David Wormuth, Vice-President.



New York Chapter: Amy Clinton (left), Executive Director, and William Doscher, MD, FACS, represent the chapter at the Specialty Society Coalition.

Chapter President and Governor of the ACS. (See photo, page 50.)

New York Chapter meets for surgical symposium and advocacy

The New York Chapter conducted its 32nd annual surgical symposium on May 1, and Karen Deveney, MD, FACS, the College's Second Vice-

President, presented a talk on rural surgery and training (see photo, this page). Also on May 11, the chapter participated in the second annual Specialty Society Coalition, and held meetings with various local legislators (see photo, this page). Other specialties that participated in the coalition included ophthalmology, orthopaedic surgery, obstetrics-gynecology, and others.

***Surgery News* reports rise in number of uninsured in 2009**

The number of uninsured Americans rose last year, with 21 percent of all adults aged 18–64 years reporting that they were uninsured at the time that they were interviewed for the National Health Interview Survey, according to staff of *Surgery News*, the official newspaper of the American College of Surgeons.

That figure is up from

19.7 percent the previous year, and reflects a trend over the past decade of an increasing lack of health insurance, at least among adults, according to a survey by the National Center for Health Statistics, a part of the Centers for Disease Control and Prevention. Rates of coverage for children, on the other hand, have mostly improved.

Overall, 46.3 million people—

or 15.4 percent of the population—were uninsured at the time they were interviewed in 2009. A greater proportion of children than adults were covered by public health plans, which could explain the children's higher rate of coverage, according to the survey.

To learn more, visit <http://www.facs.org/surgerynews/>.