FEATURES

Executive Director’s annual report
David B. Hoyt, MD, FACS

Presidential Address:
ACS: A legacy of leadership
Bob Jasak

The ACS plays an active role in initial implementation of the ACA

A surgical mission to Cambodia: Delivering supplies and care
Elliott Brender, MD, FACS

DEPARTMENTS

Looking forward
Editorial by David B. Hoyt, MD, FACS, ACS Executive Director

Advocacy advisor
Resources for effective advocacy
Charlotte Grill, LSW, and Catharine Harris

HPRI data tracks
The aging surgeon population: Replacement rates vary
Elizabeth Walker, MSPH; Stephanie Poley; and Thomas Ricketts, PhD, MPH

On the cover: David B. Hoyt, MD, FACS, Executive Director, reports on the activities and accomplishments of the College throughout the past year (see article on page 6).
NEWS

Dr. Greenfield chosen as next ACS President-Elect 31

Did you know... 31

Report of the 2010 Australia and New Zealand Traveling Fellow 34
Nipun B. Merchant, MD, FACS

ACS Foundation/Saint Louis University announce Emerson Scholar in Residence program 38

Trauma meetings calendar 38

A look at The Joint Commission: Center for Transforming Healthcare releases targeted solutions tool 39

From Surgery News:
More minorities enrolling in medical school 41

NTDB® data points: Drive-through 42
Richard J. Fantus, MD, FACS

Chapter news 44
Rhonda Peebles

Bulletin index: Volume 95, numbers 1–12 46

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.
I want to again acknowledge the great job our leadership,..., volunteers, and staff, have done in implementing important strategies and initiatives that will ensure that our members can continue to provide optimal care for their surgical patients."

Advocacy and Health Policy

The College’s leadership and our advocacy staff worked tirelessly to ensure that the health care reform law, the Patient Protection and Affordable Care Act (ACA), would serve the best interests of surgical patients and the surgeons who provide their care by spearheading or signing on to seven letters to key legislators and to President Obama to voice our views about the legislation. In addition, the College supported a measure that offers a 10 percent bonus payment for major operations provided by general surgeons in health professional shortage areas and successfully sought inclusion of several important trauma-related provisions in the ACA. We also have encouraged Congress to enact legislation that would help to resolve issues not addressed in the ACA. For example, we have worked with organized medicine to stop multiple Medicare payment cuts resulting from the use of the flawed sustainable growth rate (SGR) formula. Additionally, we participated in a surgical coalition survey to assess the potential effects of the scheduled 21.2 percent cut in Medicare physician payment and issued a press release describing the findings of that survey, which generated significant media interest.

Furthermore, the College’s leadership has been developing strategies to ensure that the ACA is implemented in a way that accounts for the unique needs of the surgical patient. We have compiled an extensive list of priorities and an action plan for improving the ACA and successfully have nominated individuals to serve on the National Health Care Workforce Commission established under the ACA. Our representatives on that commission are Robert M. Zwolak, MD, PhD, FACS, who will serve on the Board of Governors, and Thomas Ricketts, PhD, MPH, Co-Director of the ACS Health Policy Research Institute, who will serve as a commissioner.

A highlight of the year was the opening of the new 20 F Street, NW, building in Washington, DC, which will contribute to our ability to influence health policy. To further enhance our advocacy efforts, the leadership has reviewed and approved plans to restructure our resources, including the addition of a part-time medical director position.

Research and Optimal Patient Care

The College’s programs aimed at improving the quality of surgical care delivered throughout our nation’s general hospitals, trauma centers, and cancer care facilities have continued to flourish.

Importantly, we have developed the second generation of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), and have contracted with the Centers for Medicare & Medicaid Services to evaluate merging ACS NSQIP information with the agency’s claims dataset for quality measurement. In addition, we worked with our communications manage-
ment firm, Weber Shandwick, to launch the Florida Surgical Care Initiative—a program intended to introduce ACS NSQIP in 100 Florida hospitals. That goal was met and surpassed in September.

Meanwhile, the Commission on Cancer surveyed 480 cancer programs and continued to make enhancements to the National Cancer Data Base. Furthermore, we have forged a stronger relationship with the American College of Surgeons Oncology Group (ACOSOG) and participated in efforts to renew its contract with the National Cancer Institute.

The Committee on Trauma (COT) has continued to uphold its legacy as one of the College’s most active and innovative groups. Among its accomplishments this year, the COT played a leading role in the College’s disaster relief efforts in Haiti, developed the Disaster Management and Emergency Preparedness (DMEP) course and published a manual for the course, began development of a DMEP e-learning program, and worked with the U.S. military to codify and document current joint theatre trauma system information.

Looking forward, we will need to establish an Office of Evidence-Based Medicine in order to start the process of guideline development. In addition, we will establish a new committee on quality within the next year.

**Education**

Our Division of Education has established a national and international leadership role in simulation-based surgical education and training, and is exploring a relationship with the U.S. Department of Defense to collaborate on simulation training. This division also took the lead in developing the College’s response to the Accreditation Council on Graduate Medical Education’s proposed new standards for resident duty hours.

In addition, we have developed several new didactic and e-learning programs and continued to enhance, expand, and more widely disseminate the College’s long-standing education programs.

**Member Services**

The College continued to make our products and services more user-friendly and meaningful for Fellows. Examples of these efforts include ongoing refinement of the ACS members-only Web portal, e-FACS.org; publication of an electronic newsletter for the Young Fellows Association; and the establishment of a Medical Liability Insurance Program with The Doctors Company, which offers ACS members a unique combination of coverage features, an aggressive claims defense, superior financial strength, and tangible economic benefits. This year the College undertook a general membership survey, the results of which will help to shape our activities going forward.

**Integrated Communications**

This year, the College and Weber Shandwick worked closely together to investigate, plan, and design a brand reputation building program for the College. Weber Shandwick also helped us to increase media coverage of studies published in the *Journal of the American College of Surgeons*, resulting in a 30 percent increase in significant media placements. We also undertook a total redesign of the public website (http://www.facs.org), scheduled for completion by the end of March 2011, and improved and expanded the ACS Facebook and Twitter pages.

**Conclusion**

I want to again acknowledge the great job our leadership (including the Board of Regents, the Officers, and the Board of Governors), volunteers, and staff, have done in implementing important strategies and initiatives that will ensure that our members can continue to provide optimal care for their surgical patients. On a personal note, I would like to extend my gratitude for the support and interest that these individuals have provided to me this past year. I look forward to our continued progress and success in 2011.

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.
I am pleased to submit this annual report on the American College of Surgeons’ (ACS) activities. This account is presented as I near the end of my first year as Executive Director of the ACS. I have included much detail so that each of you has a ready reference of this organization’s recent activities and accomplishments.

First, I want to express my thanks to the staff, volunteers, and leaders of this organization for all of their assistance throughout this transition. I also want to commend all of them for their continued dedication to serving the College’s Fellowship and to carrying out the College’s mission of ensuring that surgical patients have continued access to high-quality and safe care that is delivered in an optimal environment.

**Advocacy and health policy**

Without question, the health care reform package that was enacted in March has been a major source of conflict within the surgical and medical communities and, indeed, throughout the nation at large. The College’s leadership and the staff of the Division of Advocacy and Health Policy have worked tirelessly to ensure that the Patient Protection and Affordable Care Act (ACA) serves the best interests of the surgical patient. In fact, between November 4, 2009, and March 19, 2010, the College spearheaded or signed on to seven letters to key legislators and to President Barack Obama, in which we voiced our concerns about the legislation.

In addition, the College successfully sought inclusion of the following trauma-related provisions in the ACA:

- Establish three programs to award grants to qualified public, not-for-profit Indian tribal and urban Indian trauma centers
- Create a new grant program for trauma-related physician specialties and access to trauma services
- Reauthorize the Trauma-Emergency Medical Services program at $12 million for fiscal years (FY) 2010–2014
- Require the Secretary of the Department of Health and Human Services (HHS) to award at least four multi-year contracts or competitive grants for projects to improve regional coordination of emergency services
- Direct the HHS Secretary to expand and accelerate research on emergency medical care systems and emergency medicine
- Reauthorize emergency medical services for children demonstration grants for FY 2010–2014

The College led a letter-writing campaign on Capitol Hill to ensure that these trauma-related programs received adequate funding.

In addition, the ACS supported an ACA provision that offers a 10 percent bonus payment for major surgical procedures provided by general surgeons in health professional shortage areas. The College also supported removal of budget neutrality and the cosmetic surgery tax from the ACA.

Since the bill passed, the ACS has continued to correspond and meet with members of Congress and their health policy advisors to develop legis-
lation that address concerns that were not covered in the ACA, including payment reform. The College has also been strategizing and working cooperatively with other medical and surgical societies and members of the executive branch to make certain that the ACA and other laws and regulations that affect surgical practices are implemented in a fair manner that accounts for the unique needs of the surgical patient. More specifically, the ACS has conducted the following activities:

- Worked with organized medicine to halt multiple physician payment cuts due to the use of the flawed sustainable growth rate formula
- Provided feedback and recommendations to legislators and agencies regarding meaningful use of electronic health records (EHR), the Physician Quality Reporting Initiative (PQRI), and other issues affecting surgical care
- Compiled an extensive list of priorities and an action plan for improving the ACA
- Consistently educated and updated the College’s membership about changes to Medicare physician payment and other legislative issues
- Participated in a surgical coalition survey to assess the potential effects of the scheduled 21.2 percent cut in Medicare physician payment, and issued a press release describing the findings
- Co-sponsored the third annual Joint Surgical Advocacy Conference, attended by approximately 350 surgeons
- Successfully nominated individuals to serve on the National Health Care Workforce Commission established under the ACA. These individuals are Robert M. Zwolak, MD, PhD, FACS, who will serve on the Board of Governors, and Thomas Ricketts, PhD, MPH, co-director of the ACS Health Policy Research Institute, who will serve as a commissioner
- Wrote numerous letters to the Administration and Congress, a detailed, chronological list of which is available through the Division of Advocacy and Health Policy

I am pleased to report that the American College of Surgeons Professional Association’s political action committee (ACSPA-SurgeonsPAC) has continued to grow in terms of its contributions and influence. As of October 2010, the PAC raised $668,439 from 2,236 Fellows in 2010, bringing the total for the 2009–2010 election cycle to $1,286,173.

Looking forward, the ACS held a leadership meeting August 10–11 to discuss the College’s priorities for the future and the reorganization of resources to accomplish these objectives. As a result of this meeting, the College has prepared a proposal to reorganize and enhance our advocacy efforts. This plan was discussed and approved at the Board of Regents meeting in October. Consequently, we intend to make some changes to various committees, and we are seeking to fill a part-time medical director position in the Division of Advocacy and Health Policy.

Finally, the opening of the new 20 F Street, NW, building in Washington, DC, was a highlight of the year. The grand opening celebration on June 3 punctuated the importance of our ongoing advocacy efforts.

**Research and Optimal Patient Care**

The College’s programs aimed at improving the quality of surgical care delivered throughout our nation’s general hospitals, trauma centers, and cancer care facilities have continued to grow in stature, as well as quantity. We are expanding our overall quality improvement efforts in the following ways:

- Preparing to release the second generation of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP), which will address issues of concern specific to the various types and locales of participating hospitals (that is to say, urban versus rural, academic versus nonacademic, and so on)
- Collaborating with the Centers for Medicare & Medicaid Services (CMS) to develop surgical quality measures for hospitals and providers
- Contracting with CMS to evaluate merging ACS NSQIP information with the agency’s claims dataset for quality measurement
- Working with the Food and Drug Administration to evaluate the safety and quality of bariatric operations, including band procedures
- Collaborating with the American Geriatrics Society to fund an ACS Clinical Scholar to work on the evaluation and improvement of geriatric surgical care
- Working with the Centers for Disease Control and Prevention to develop surgical site infection (SSI) measures, guidelines, and EHR strategies
• Initiating the development of a surgeon-specific registry to address Maintenance of Certification (MOC), PQRI, and ongoing professional practice evaluation issues
• Collaborating with the surgical societies and boards to develop and expand ACS NSQIP, use of the ACS Case Log system, and the Bariatric Surgery Center Network (BSCN)—Accreditation Program
• Cooperating with The Joint Commission to develop and evaluate standards for colectomy SSI

In addition, the Division of Research and Optimal Patient Care is responsible for overseeing the ACS cancer and trauma programs. Both of these areas have made considerable strides in the last year.

The Committee on Trauma (COT) has continued success this year, including the following accomplishments for the last year are as follows:
• Scheduled survey of 480 cancer programs to be completed by the end of 2010
• Presented the Outstanding Achievement Award to 82 cancer programs
• Accredited 30 new cancer programs in 2009, with plans to approve 30 more in 2010
• Collaborated with three member organizations from the advocacy community—the Lance Armstrong Foundation, the National Coalition of Cancer Survivors, and the Cancer Support Community—to develop patient-centered initiatives
• Offered 10 online education portal webinars
• Received and reviewed 26 abstract submissions for the CoC Paper Competition
• Began beta testing the Rapid Quality Reporting System at 70 hospitals, with plans to roll out the program for voluntary participation by all CoC-accredited programs by the end of this year
• Released a participant-use file of data from the National Cancer Data Base (NCDB)
• CoC Clinical Scholar-in-Residence, Richelle Williams, MD, began her work with the NCDB
• Initiated data collection for the ProvenCare® Lung Cancer Collaborative

In addition, the ACS National Accreditation Program for Breast Centers (NAPBC) enjoyed continued success this year, including the following examples:
• Accreditation of nearly 300 breast centers by December
• Launch of an official NAPBC bimonthly electronic newsletter
• Ongoing revision of select NAPBC standards and the survey application record based on program feedback and survey experience
• Presentation of the first NAPBC workshops in May and November
• Collaboration with the National Consortium of Breast Centers, the American Society of Breast Disease, and the National Cancer Registrars’ Association to host NAPBC workshops in conjunction with their annual meetings
• Survey of 160 accredited centers, which showed that accreditation preparation has contributed to improved program operations and care coordination
• Media blitz coordinated by Weber Shandwick during Breast Cancer Awareness Month

Furthermore, the American Joint Committee on Cancer, which includes ACS representation, published the seventh edition of the Cancer Staging Manual, put the finishing touches on the e-staging tool, produced the second edition of the Cancer Staging Atlas, and developed 10 editorials for publication in the Annals of Surgical Oncology.

Finally, the College once again initiated a stronger relationship with the American College of Surgeons Oncology Group (ACOSOG) and participated in the grant renewal process. The College intends to visit with Harold Varmus, MD, director of the National Cancer Institute, to advocate for ACOSOG and to develop new opportunities to demonstrate how ACOSOG clinical trial findings can be applied to clinical practice.

The Committee on Trauma (COT) has continued to uphold its legacy as one of the College’s most active and innovative groups. Starting with its annual meeting in March, the COT underwent a restructuring process. The COT now has four areas of focus: education, quality, advocacy, and information/data.

With respect to education, this year the COT accomplished the following:
• Promulgated the Advance Trauma Life
Support® (ATLS®) program in seven countries: Malaysia, France, Nigeria, Paraguay, Uruguay, Slovenia, and Lebanon
• Began production on the ninth edition of the ATLS manual and developed an e-learning program for release with the ATLS manual
• Presented 2,292 ATLS courses and trained 20,437 health care professionals
• Released the third edition of Trauma Evaluation and Management with an accompanying student manual
• Published the Disaster Management and Emergency Preparedness (DMEP) manual and began development of a DMEP e-learning program
• Disseminated the Advanced Surgical Skills for Exposure in Trauma (ASSET) manual and presented 13 ASSET courses
• Published the second edition of the Advanced Trauma Operative Management (ATOM) manual and presented 99 ATOM courses
• Produced the third edition of the Rural Trauma Team Development Course (RTTDC) and presented 92 RTTDC courses
The COT was also responsible for carrying out the following quality-related activities:
• Conducted three trauma systems consultations
• Collaborated with other organizations on a trauma systems benchmarking project, and began development of trauma system metrics and creation of state monograph draft
• Worked with the U.S. military to codify and document current joint theater trauma system information
• Successfully submitted Emergency Medical Services (EMS) for Children Targeted Issues Grant as a subcontractor
• Submitted National Trauma Institute pre-proposal grant
• Developed new website tailored to meet the demands of different stakeholder groups
• Conducted 24 trauma center consultation visits and 118 verification visits; the COT has accredited a total of 335 trauma centers
• Leaders of the COT and the National Association of EMS Officials met to discuss mutual goals for patient safety, trauma system development, trauma center guidelines, and EMS issues
• Participated in the College’s Haiti disaster relief efforts by establishing a hotline for volunteers and by developing a Haiti case log
To heighten its advocacy efforts, the COT has formed an action committee that will include Edward E. Cornwell III, MD, FACS, and ACS advocacy staff.
In terms of information technology, the COT made the following advancements:
• Launched the Trauma Quality Improvement Program (TQIP) at 65 centers in the U.S. and Canada
• Scheduled the first annual TQIP training program
• Developed two TQIP case studies
• Issued the call for 2009 admissions National Trauma Data Bank® (NTDB®) data, resulting in 682 hospitals participating and the receipt of 682,036 records; the NTDB now contains more than 4 million records
• Completed MOC Part IV module
Going forward, the ACS needs to establish an Office of Evidence-Based Medicine and start the process of guideline development. In addition, a new committee will be formed in the next year to focus on quality. It will operate across divisions, with the purpose of defining the optimal resources for quality management of surgical programs. The participation of our education and advocacy programs will be essential to the success of these efforts.
Education
The ACS Division of Education has sought to link education with quality initiatives through systematic processes that involve gap analyses, implementation of innovative training programs, verification of knowledge and skills, and evaluation of performance and outcomes. In addition, this division has generated programs and products aimed at the establishment of education and training benchmarks and national standards. The staff have sought to broadly disseminate new information regarding innovative surgical education and training and to pursue liaisons with the U.S. Department of Defense, the Department of Veterans Affairs, other professional organizations, and the developers of surgical simulation technology. Examples of related achievements are as follows:
Establishment of a national and international leadership role in simulation-based surgical education and training
• Development of a national leadership role in the Council of Medical Specialty Societies
• Formulation of a response to the Accreditation Council on Graduate Medical Education’s proposed new standards for resident duty hours
• Participation in national dialogues relating to MOC continuing medical education requirements
• Implementation of collaborative programs at the annual meetings of the Southeastern Surgical Congress and the Southwestern Surgical Congress

New programs launched this past year are as follows:
• ACS Comprehensive General Surgery Review Course
  • Fundamentals of Surgery Curriculum
  • Surgical Education and Self-Assessment Program (SESAP) Sampler
  • Selected Readings in General Surgery Connect
• Beyond the Morbidity and Mortality Conference: Analysis of Surgical Errors and Complications in Contemporary Practice
• CD of the second edition of Ultrasound for Surgeons: The Basic Course
• Ostomy Skills Patient Education Program
  New education programs that began development this past year are as follows:
• ACS/Association of Program Directors in Surgery (APDS) Surgical Skills Curriculum, version 2
• ACS/APDS/Association for Surgical Education (ASE) Resident Prep Curriculum
• ACS/ASE Medical Student Simulation-based Surgical Skills Curriculum
• E-learning program on Preventing Errors and Near Misses in Surgery—Strategies for Teams and Individuals

In addition, the Division of Education continues to enhance, expand, and more widely disseminate the College’s longstanding education programs, including SESAP, programs on ethics, programs for surgeons and residents as teachers and leaders, communicating with patients, professionalism, and so on.

This division also is exploring a relationship with the Defense Department to collaborate on simulation training.

Member Services

The Division of Member Services continues to work with other areas of the College to develop meaningful products and services for members of the ACS. For example, the Division of Member Services presented the Leadership Conference for Governors, Chapter Officers, Young Surgeons, and Residents, in collaboration with the ACS Division of Advocacy and Health Policy. The Division of Member Services also worked on the following projects with the Division of Integrated Communications:
• Development of a marketing strategy, with assistance from Weber Shandwick
• Production of a recruitment and retention DVD
• Continued refinement of an ACS Web portal project
• Update of the Resident and Associate Society (RAS) portal page
• Refinement of the electronic and print catalog of member benefits on the ACS Web portal
• Development of Web-based surveys for the former Committee on Young Surgeons (CYS), the RAS, and ACS chapters
• Publication of a Young Fellows Association electronic newsletter
• Addition of more chapter websites and a Web-based chapter reporting system

Many of these initiatives were also carried out with the assistance of the College’s Information Technology (IT) support area.

Other activities were conducted with the assistance of the ACS Foundation and the Finance area, including dues comparisons and data analysis, the receipt of a $132,500 grant from Pfizer, Inc for Operation Giving Back (OGB), and the consolidation of the College’s scholarship program.

Other accomplishments with respect to member services are as follows:
• Refined RAS and career development scholarships, as well as Heller School curriculum at Brandeis University
• Substantially increased the number of Central Judiciary Committee reviews pertaining to irresponsible behavior of Fellows acting as expert witnesses
• Developed a collaborative plan for dues increase
• Initiated largest class of Fellows in eight years
• Continued to refine application process and fees for international Fellows
• Collaborated with COT and OGB on Haiti disaster response
• Increased chapter visitation and support programs
• Extensively researched and investigated Past-Presidents’ proposed professional liability program, resulting in the establishment of professional liability and member discounts through The Doctors Company
• Initiated general membership survey and study on surgeon “burnout”

Results of the membership survey are expected to be available later this year and will help to shape the basis of program focus going forward.

Integrated Communications

As indicated by the information provided about the other divisions of the College, the ACS Division of Integrated Communications has worked closely with other key areas of the College to update the organization’s member and public information programs. Other Division of Integrated Communications accomplishments are as follows:

• Worked closely with Weber Shandwick and the Division of Research and Optimal Patient Care to launch the Florida Surgical Care Initiative—a program intended to introduce ACS NSQIP in 100 Florida hospitals
• Collaborated closely with the Executive Director and Weber Shandwick to investigate, plan, and design a brand reputation plan for the College
• Undertook total redesign of the public website (http://www.facs.org), which is scheduled for completion by early March 2011
• Improved and expanded ACS Facebook page
• Negotiated and established business relationship with the Elsevier Society News Group, publisher of Surgery News, to sell advertising for the College’s public website and the Web portal
• Worked with Weber Shandwick to increase media coverage of studies published in the Journal of the American College of Surgeons, resulting in a 30 percent increase in significant media placements
• Developed and implemented plans for launching and promoting Surgical Palliative Care: A Resident’s Guide

Convention and Meetings

As always, the College’s Convention and Meetings area was responsible for the logistical, exhibition, technical support, and catering arrangements at all ACS-sponsored programs, including the Clinical Congress, in Washington, DC. This department also continues to provide management services for multiple surgical societies.

Specific accomplishments for the last year with regard to the Clinical Congress are as follows:

• Generated more than $2.5 million in exhibitor revenue for the 2009 Clinical Congress
• Launched an advertising and promotion/satellite symposia program for exhibitors, which generated more than $750,000—12 percent over budget
• Established an “Innovation Theater” on the exhibit hall floor so exhibitors could showcase their new products
• Implemented an online travel website for Clinical Congress attendees
• Worked with IT to further develop and implement a new Congress Manager database
• Secured substantially reduced (up to 40 percent lower) lodging rates for Clinical Congress attendees
• Generated more than 28,000 hotel room night reservations, representing more than $330,000 in commission paid to the ACS
• Coordinated arrangements for more than 910 ancillary, exhibitor, and ACS events and scientific sessions

This department was also responsible for the following internal accomplishments at the ACS headquarters and Washington Office:

• Arranged more than 650 internal meetings
• Negotiated cost savings of $620,000 on hotel rooms
• Created detailed training manuals for each meeting planner position in order to achieve efficiency and quality standards within the area
Arranged opening of the new Washington Office Conference Center and launched website for the facility

Launched marketing program for the Murphy Auditorium

During FY 2010, travel services issued 3,014 tickets, representing a 44 percent increase since the program’s inception in 2003, and saved the College more than $458,000 through negotiated contracts with United Airlines and Avis Car Rental.

In addition, the Association Management Services (AMS) program, launched in 2004, has continued to increase services and clients, leading to overall growth in the program’s contribution margin. Some examples are as follows:

- In the past year, AMS provided meeting, exhibitor, educational grant, and marketing support services for eight annual meetings
- Acquired the National Trauma Institute
- Renewed service agreements with six clients
- Increased net revenue from $59,962 in FY 2009 to a projected $229,245 in FY 2010

ACS Foundation

The College’s fundraising and development area—the ACS Foundation—has implemented new methods to encourage Fellows to make charitable donations to the organization. To increase annual giving, for example, the Foundation implemented the following strategies:

- Developed “segmentation” programs for the fall 2009 and spring 2010 mailed appeals, sending 75,000 customized pieces to potential donors in 23 constituencies
- Involved Annual Giving Committee volunteers in an assessment of loyal giving patterns and potential cultivation for larger gifts
- Launched a comprehensive outreach program to ACS chapters and surgical societies
  As a result of these efforts, the net revenue from annual donations increased more than $60,000, from $138,597 in FY 2009 to $198,759 in FY 2010.

The Foundation also has initiated a program to identify, engage, and inform major donors—those individuals willing to give more than $10,000. Related activities and accomplishments are as follows:

- Evaluated giving records and assessed inclination of Fellows; identified 120 prospective major contributors
- Began development of a comprehensive “moves management” system to ensure continuous donor pipeline, timely solicitation, and ongoing accountability for current and planned gifts
  - In FY 2010, 50 major gift prospects were engaged, including three solicitations of $100,000 or greater in New York, NY, and the San Francisco, CA, Bay area
- Negotiated a new International Guest Scholarship valued at $160,000
  - A total of $121,000 has been raised for the Archives Past-Presidents’ Campaign led by C. Rollins Hanlon, MD, FACS, and Fred Holzrichter
  - During its initial phase, $100,000 in donations have been contributed to the Thomas R. Russell, MD, FACS, Scholarship

The Foundation has increased its collaboration with divisions and programs across the College to secure funding from outside organizations and has begun incorporating donor recognition into the annual Medical Industry Breakfast. Examples of advancements made in the Foundation’s corporate and foundation relations are as follows:

- Raised $1,671,351 from organizations in FY 2009–2010—a 41 percent increase from the $1,187,950 raised the previous year
- Secured a commitment of $160,000 from the Stavros Niarchos Foundation to fund an International Guest Scholarship

In addition, the Foundation initiated an outreach and marketing campaign to promote bequests and planned gifts to support College priorities and is now sending a quarterly electronic newsletter to 30,000 Fellows. The e-newsletter is supplemented by three annual print newsletters sent to 6,500 donors. Furthermore, the Foundation initiated a quarterly online newsletter entitled Philanthropy at Work, which contains news of interest to donors. The Foundation received more than 200 online and print requests from Fellows for planned giving information, and inducted two new Mayne Heritage Society members.
Other activities

The College’s Finance and Facilities staff were instrumental in the ACS’s purchase, construction, and opening of the new Washington, DC, Office at 20 F Street, NW. Since then, this department has successfully leased out 44 percent of the rental space in the building, and has been working to close on the sale of the College’s previous Washington, DC, location in Georgetown. In addition, this department bid on and selected a new administrator of the staff’s 403(b) plan, and new independent auditors.

The College continues to be able to recruit and hire new employees. In the past year, we brought in 40 new employees, 11 of whom filled new positions. The College also provides staff members with important benefits, including educational and social programs; medical, dental, and life insurance; on-site health and wellness screening; yoga classes; and so on.

The College’s Information Technology support team played a key role in many of the activities mentioned throughout this report, including implementation of the new association management system (Aptify); enhancements to the Web-based ATLS management system, maintenance and expansion of the NAPBC administrative system for breast cancer, and development of the lung cancer data collection system for ProvenCare.

I believe a quality improvement rapid-cycle program will be of benefit to the College as a whole, and a proposal for a new position to lead this effort will be forthcoming.

Conclusion

As this report demonstrates, all divisions and support areas of the College are working together to expand and improve the ACS’ programs and services. In light of the passage of the ACA earlier this year, the College must continue to advance its advocacy and quality improvement efforts in order to ensure the integrity of the profession, and continued access to appropriate surgical care for our patients. Our volunteers, staff, and leadership have done a great job of developing and implementing important strategies and initiatives to that end.

Again, I am truly grateful for the ongoing support and interest that the Board of Regents, the Officers, the Past-Presidents, the Board of Governors, the loyal volunteers, and the ACS staff have provided to me these past months. I look forward to continuing to work with all of you to create a more dynamic and influential American College of Surgeons that is positioned to meet the challenges ahead.

Dr. Hoyt is Executive Director of the College.
President’s note: The following is a summary of the Presidential Address delivered by L.D. Britt, MD, MPH, FACS, during Convocation at the 96th annual Clinical Congress in Washington, DC. The full text of the address will be published in the February 2011 issue of the Journal of the American College of Surgeons.

"I enthusiastically dedicate this Presidential Address to the patient,” said L. D. Britt, MD, MPH, FACS, newly installed ACS President, to the College’s 1,467 Initiates on October 3, during the Convocation ceremony in Washington, DC. Framing his address with a historical perspective of both the Clinical Congress and the American Col-
College of Surgeons, Dr. Britt noted the historical benchmarks of the College, while acknowledging the importance of strong leadership in the past and the present day. “The American College of Surgeons has a legacy of leaders who put the interest of patients first,” Dr. Britt said, “even when such an emphasis conflicted with the economic best interests of the surgeon. It is a legacy that no amount of advertisement can create. Today, the American College of Surgeons has leaders who transcend gender, ethnicity, race, and professional/specialty orientation.”

Although Dr. Britt emphasized the importance of the College’s “legacy of leadership,” he urged the Initiates not to “bask in nostalgic euphoria” and he stressed the importance of adapting to change “without compromising [the College’s] core values.”

In speaking about the challenges surgeons will face over the next several months, Dr. Britt underscored the importance of access to quality health care, and the College’s role as a “beacon for quality care and patient safety” with “unwavering emphasis on professionalism and ethics.” He specifically noted the Advanced Trauma Life Support® course—which is celebrating its 30th anniversary this year—as a prototype for best practices in the management of the surgical patient.

“There has been no better steward of quality care and safety than the American College of Surgeons,” said Dr. Britt. “The American College of Surgeons has never needed any other authority to define its mission.”

Dr. Britt noted three ways the College—as well as the individual surgeon—“must fulfill their professional responsibilities to society.” These duties include ensuring excellent patient outcomes, wise resource allocation, and effective self-regulation.

“Whether we consider ourselves members of the ‘House of Surgery’ or citizens of the ‘Village of Surgery’ (where there are housing neighborhoods), we have an unbreakable contract with society to provide optimal care for the surgical patient,” said Dr. Britt.

In closing, Dr. Britt noted that “the gathering today marks the 100th year since the inception of the Clinical Congress, [and combined with] the fact that we are just three years shy of the centennial anniversary of the American College of Surgeons, it seems only fitting that we all renew our commitment to the original tenets of this great organization.” He called for everyone to demonstrate “the leadership that will be required” to meet the challenges of one of the “most turbulent and labile periods that this nation has faced.”

Dr. Britt delivering his Presidential Address.
When President Barack Obama signed the sweeping Patient Protection and Affordable Care Act of 2010 (ACA) on March 23, it signaled the dawn of a new era in health care delivery in the U.S. Even so, the next morning, health care delivery and financing in this nation felt pretty much the same as the day before. However, as the various provisions in the law move through multiple stages of implementation, the landscape of the U.S. health care system is slowly beginning to morph.

Many of the major provisions that are likely to change or impact the delivery of health care are scheduled to take effect over the course of the next few years. To ensure that surgical patients continue to receive high-quality care, the American College of Surgeons (ACS) has been working diligently to shift its advocacy focus from the legislative process toward the implementation and regulatory arena. This article provides an overview of some of the latest ACA implementation developments, and offers a look forward to consider how the implementation of several major provisions of the ACA will likely affect surgeons and their ability to provide care to their patients.

**Commissioning commissions**

On September 23, the Obama Administration named the members of the Patient-Centered Outcomes Research Institute (PCORI). The PCORI, as outlined in the ACA, is responsible for evaluating the comparative effectiveness of medical and surgical treatments for various medical conditions. The 21-member PCORI comprises the director of the Agency for Healthcare Research and Quality, the Director of the National Institutes of Health, and 19 appointees.
The ACS is pleased that the Administration has appointed Robert Zwolak, MD, PhD, FACS, to the PCORI for a renewable six-year term. Dr. Zwolak is a vascular surgeon at Dartmouth-Hitchcock Medical Center and professor of surgery at the Dartmouth Medical School, Hanover, NH. The ACS supported Dr. Zwolak’s nomination to the PCORI, and believes that his expertise and commitment will bring a much-needed surgical perspective to the Institute.

The PCORI is expected to play a critical role in the development of a national comparative effectiveness agenda. Providing input to the PCORI on research priorities and the effectiveness of procedures under investigation will be an important activity for the College, as it could have a lasting effect on Medicare coverage and payment policies—policies that are typically replicated in private pay markets.

In another move to meet deadlines set under the ACA, on September 30, the Obama Administration named the 15 members of the National Health Care Workforce Commission. The ACS is extremely disappointed that no surgeon was appointed to the Commission. However, the ACS is continuing to push for surgical representation on the workforce commission in future calls for nominations. In addition, the ACS is pleased that the Administration appointed Thomas Ricketts, PhD, MPH, co-director of the ACS Health Policy Research Institute, to the workforce commission for a three-year term. Dr. Ricketts is a professor in the department of health policy and management at the University of North Carolina, Chapel Hill, Gillings School of Global Public Health, and serves as the deputy director for policy analysis at the Cecil G. Sheps Center for Health Services Research. With a growing dearth of general surgeons across the country and current and impending shortages in other surgical specialties, Dr. Ricketts’ expertise on workforce issues will prove invaluable to the workforce commission.

**CMMI**

A controversial and vague provision of the ACA calls for creating a new body referred to as the Center for Medicare & Medicaid Innovation (CMMI). The CMMI is responsible for developing and testing different payment and delivery model alternatives with a budget of $10 billion through 2019. With this broad charge, exactly what types of alternatives the CMMI will pursue is unknown. However, the law also directs the CMMI to focus part of its efforts on several areas, including the following:

- Primary care reform and “patient-centered medical home models”
- Direct contracting with surgeons, physicians, and other providers (for example, through risk-based comprehensive payment or salary-based payment models)
- Care coordination between providers of services and suppliers that move providers away from fee-for-service-based payments toward salary-based payment
- Creation of appropriateness criteria and corresponding payment variations for physicians who order advanced diagnostic imaging services
- Dissemination of quality and efficiency best practices in the delivery of health care
- Exploration of electronic monitoring by specialists, including intensivists and critical care specialists for facilitating inpatient care
- Delivery of certain outpatient care (such as outpatient physical therapy) without the referral of a physician or involvement of a physician in the development of a plan of care

On September 27, Richard Gilfillan, MD, was named acting director of the CMMI. At the time of his appointment, Dr. Gilfillan was director of performance-based payment policy at the Centers for Medicare & Medicaid Services (CMS). Previously, he held various positions at the Geisinger Health System and Health Plan, including having served as president and chief executive officer of the Geisinger Health Plan and executive vice-president of Insurance Operations for Geisinger Health System, Danville, PA.

In order to ensure that patients have access to quality surgical care, the ACS continues to provide input to these and other bodies tasked with redesigning the health care system. As the CMMI commences its efforts, the ACS will work to ensure that the “innovations” that the CMMI pursues are complementary to efforts of the College to improve quality and efficiency in surgery.

**Utility of a value-based payment modifier**

Perhaps one of the most worrisome provisions in the ACA is the one that requires the Secretary of the Department of Health and Human Services (HHS) to apply a separate, budget-neutral pay-
ment modifier (the “value-based payment modifier”) to the Medicare fee-for-service physician fee schedule payment formula, based on quality and geographic variations in the delivery of care. The payment modifier is slated to be phased in from January 1, 2015, through January 1, 2017. This mechanism is intended to better distribute payments between geographic areas.

Although the modifier is not scheduled for implementation until 2015, CMS has already signaled (via the 2011 physician fee schedule proposal rule) an intention to link the value-based payment modifier to the Resource Use Reports (RUR) program that it had initiated even before the passage of the ACA.

In its response to the physician fee schedule proposed rule submitted in August, the ACS made clear that this organization believes it is premature for CMS to rely too heavily on the RUR program in developing the congressionally mandated payment modifier. The ACS stated that the development of an accurate and fair value-based payment modifier will be extremely challenging, especially given the difficulties of attributing care to a single physician and the effects of delivering complex care involving teams of physicians. The RUR program itself is in an early stage, and relatively few physicians have currently received the feedback reports. The ACS also expressed serious concern regarding the budget-neutral nature of the value-based payment modifier.

Many health policy experts believe that Congress may alter or eliminate the value-based payment modifier provision. The ACS continues its work to ensure that policymakers and legislators are aware of the negative consequences of imposing such a modifier on the physician fee schedule payment formula. The first problem lies with the proposed connection between the modifier and the RUR program. The value-based payment modifier is still in its infancy, and it is unclear at this stage how it will be implemented, especially in light of the problems attributing care to a single physician and the effects of delivering complex care involving teams of physicians. The provision also requires an unrealistic and unachievable timeline, and given the lack of appropriate data for use in the program, could result in physicians being financially penalized under an instrument that is neither well-designed nor equipped with the appropriate inputs. If implemented, this would then provide perverse financial incentives in the name of quality of care while doing nothing to improve the health of patients.

**Accountable care organizations**

One of the most widely debated provisions in the ACA calls for the creation of accountable care organizations (ACOs). The ACA section that alludes to these entities is actually titled the Medicare Shared Savings Program.

The concept of ACOs is not particularly well-defined, and ACOs can come in a variety of formats. According to the legislation, several different types of ACOs could participate in the Medicare Shared Savings Program, including the following:

- Physicians and other professionals in group practices
- Physicians and other professionals in networks of practices
- Partnerships or joint venture arrangements between hospitals and physicians and health care professionals
- Hospitals employing physicians or other professionals
- Other groups that the HHS Secretary deems appropriate

CMS is expected to issue a notice of proposed rulemaking in late 2010 or early 2011 to further detail the shared savings program and the requirements to become an ACO. While CMS has not yet provided much information about what this guidance will contain, the legislation also contained several criteria that ACOs must meet to participate in the program, including the following examples:

- A formal legal structure to receive and distribute the savings
- A minimum of 5,000 beneficiaries assigned to the ACO
- An agreement to participate in the program for at least three years
- A defined leadership and management structure, including clinical and administrative systems
- Processes to promote evidence-based medicine, coordinate care, and report data to evaluate

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DECEMBER 2010 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
quality and cost measures (which might include the Medicare Physician Quality Reporting Initiative [PQRI] electronic prescribing incentive program, and electronic health record [EHR] incentive program)

- Demonstrate that it has met “patient-centeredness criteria” as determined by the HHS Secretary

In a related move, CMS scheduled a joint public workshop in cooperation with the Federal Trade Commission and the HHS Office of the Inspector General to tackle the many legal issues that complicate the creation of ACOs. The workshop took place October 5, and focused on how the creation and functioning of an ACO and physician participation in an ACO can implicate antitrust laws, the Civil Monetary Penalty law, the federal anti-kickback statute, and Stark self-referral laws and regulations. In advance of the workshop, the ACS submitted comments outlining the need for the respective government agencies to provide explicit protections for physicians participating in ACOs and clear guidance on avoiding legal liabilities for engaging in well-intentioned activities incentivized under the ACA. In addition, the ACS expressed the need for these government entities to create a level playing field in the context of these laws and regulations in order to increase the ability of ACOs to provide their assigned beneficiaries with high-quality coordinated care.

In preparation for the proliferation of ACOs and the bundled payment mechanisms that will likely accompany many of the ACOs’ activities, the ACS has engaged its relevant committees and workgroups, including the Health Policy and Advocacy Group and General Surgery Coding and Reimbursement Committee, to ensure that surgeons are well-positioned to provide care to their patients in these alternative payment models.

Independent Payment Advisory Board (IPAB)

Throughout the health care reform debate, the ACS regularly voiced its opposition to the creation of an unelected, unaccountable board charged with making broad cuts to Medicare services and, possibly, patient access to care. As presented in the legislation, the IPAB continued to maintain elements that the College found to be counterproductive to the goal of creating a more efficient health care delivery system, particularly in the context of the flawed Medicare physician payment formula.

The IPAB is not expected to directly affect rates until 2015. However, the ACS remains concerned that without an open and transparent legislative process, Medicare beneficiaries and the physicians who provide their care will be subject to arbitrary cuts that will inhibit the ability of patients to access necessary care. The ACS has continued to make these concerns known and will pursue opportunities to correct the misguided policies set forth in this section of the ACA.

Just the beginning...

The provisions described in this article represent just the tip of the iceberg in the implementation of the ACA. There will doubtless be continued appointments, rulemaking, and opportunities to make improvements to these and other measures. Because of the flurry of activity, the ability of physician organizations to provide timely input and expertise at all levels of policymaking will be imperative. Because of long-range planning and the commitment of Fellows, the ACS is poised to do exactly that.

For more information regarding the implementation of the ACA, visit http://www.facs.org/ahp/regulatory.html or contact Bob Jasak, Assistant Director for Regulatory and Quality Affairs, at bjasak@facs.org or 202-672-1508.

Mr. Jasak is Assistant Director, Regulatory and Quality Affairs, Division of Advocacy and Health Policy, Washington, DC.
A surgical mission to Cambodia: Delivering supplies and care

by Elliott Brender, MD, FACS
In March of 2008, I received a letter from Edward Copeland III, MD, FACS, Past-President of the American College of Surgeons (ACS), inviting me to participate in a People Ambassadors Program in Vietnam and Cambodia, with other members specializing in surgery, in November of that year. In the letter, Dr. Copeland mentioned 3rd Field Hospital, where I was stationed during the Vietnam War. I was the chief of emergency services at 3rd Field Hospital from June to November 1972. Intrigued by Dr. Copeland’s proposal, I decided to go. My brother, William Brender, MD, FACS, a board-certified plastic and hand surgeon, decided to go as well.

2008 visit

At the last minute, Dr. Copeland was replaced by Thomas H. Witchii, MD, an orthopaedic surgeon. Dr. Witchii asked us to bring donations for the Cambodian and Vietnamese surgeons, such as old journals, used surgical textbooks, and so on. (Dr. Witchii brought nails for fracture repair.) I did not have any old journals or textbooks, but I did produce a video entitled Avoiding Complications During Laparoscopic Cholecystectomy. The video is unique, in that it shows actual recorded errors made during surgery. In the early days of laparoscopic surgery, everybody recorded their cases, because one could. In-line video recorders were a part of the laparoscopic setup. I was able to collect a series of laparoscopic errors from my colleagues, as I was chief of surgery at our local hospital, and tapes were routinely reviewed as part of the morbidity and mortality process. I presented my findings to the Southwest Surgical Congress in 1991. The general conclusion of the audience was that routine taping was extremely damning to the surgeon when errors occur, and that tapes are discoverable as evidence. Routine taping of laparoscopic procedures was discontinued shortly thereafter. I burned 20 discs to donate to the Cambodian and Vietnamese surgeons.

To my chagrin, on arrival in Cambodia, I learned there was no laparoscopic surgery at all. Although my DVDs were of academic interest, they were of little practical value. Also, now that Dr. Witchii was in the leadership role, the focus was primarily orthopaedic. My training is in general surgery.

We did meet Theavy Mok, MD, a plastic and general surgeon at the Khmer Soviet Friendship Hospital (also called the Russian Hospital), and Gunther Hintz, MD, a plastic surgeon who runs a nongovernment organization called Medicorps. Dr. Hintz facilitates getting supplies to where they are most needed.

So, I asked them, “As a general surgeon, what can I bring that will be of value?” And I was told “mesh.” Hernias are very common problems, and they occur worldwide. Due to poverty, most people did not have their hernias repaired until they incarcerated or strangulated (see photo, page 23). When they were repaired, commonly they were repaired without mesh, and recurrence was a problem.

Mesh was something I could obtain. Having been in practice almost 30 years, I knew enough people that I could call in a few favors. Upon my return home, I contacted MAP-Ethicon, an organization that provides medical device products to
physicians who volunteer their services overseas, and after submitting the proper 501(c)3 paperwork provided by Dr. Hintz, the mesh and suture arrived on my doorstep. I now had enough suture and mesh to do 200–250 hernia procedures. It is customary to use antibiotics for prophylaxis. I was referred to Project Hope, who provided me with appropriate antibiotics for 50 cases.

2009 visit

Dr. Mok invited us to be guest speakers at the 2009 Cambodian Surgical Society meeting, and I prepared presentations titled Hernia Repair in the 21st Century and What is Realistic for Cambodia. My brother planned to discuss the topic of awake hand surgery.

Two weeks before returning to Cambodia, I attended the 2009 Clinical Congress meeting in Chicago, IL, to review the latest techniques. At this meeting, I solicited the aid of LifeCell, Gore, and Davol. LifeCell supplied 50 sheets of AlloDerm, which arrived the day before our scheduled departure. Luckily, I had very large suitcases. I would carry one full of supplies, another full of antibiotics; my brother would carry a second bag, also full of supplies.

Supplies in hand, we arrived in Phnom Penh, Cambodia, on November 11, 2009. We were thrilled to learn, as we were deplaning, that one of Dr. Mok’s relatives was a head customs agent, and we were processed through the ambassador’s line, bypassing everybody in line.

Dr. Mok’s primary hospital, the Khmer Soviet Friendship Hospital, is the “county” hospital for Phnom Penh. At the hospital, my brother was shown complex hand injuries, many as a result of traumatic nerve damage. I was shown hernias of all sizes and shapes. We scheduled as many operations as possible within our allotted operating room (OR) time over the next several days.

During our first full day, we attended the opening ceremonies of the Surgical Society Meeting, followed by repairing the hernias that were scheduled the day before. I think we did four cases that day, two more the next day, two more at Dr. Mok’s private clinic and OR the day after that, and a laparoscopic cholecystectomy that afternoon at the International University Hospital. My brother performed nine plastic surgery procedures.

A lot can happen in a year. In November 2008, there were no laparoscopy surgeries at all, as the International University Hospital had not been built. Since the completion of the hospital and with the purchase of laparoscopic equipment, the anesthesiologists estimated that they did about 30 laparoscopic cases.

Working in a foreign OR is a very interesting and challenging experience. Through years of training, one expects a certain protocol related to scrubbing, drying hands, gowning, gloving, draping, time out, and finally, the surgery itself. Sometimes, things are done very differently than one initially anticipates. After a chlorhexidine scrub (same as back home), the surgeon’s hands are sprayed with alcohol, supposedly to further disinfect and help evaporate the water, but my hands were still wet—not minor wet, but major wet. I asked for a towel and was handed a lap sponge. “A little weird,” I thought as I dried my hands on the sponge, as I am accustomed to using a towel. Incidentally, lap sponges are reused. They are washed after each case, placed in a container, and steam sterilized. One batch I encountered was green-stained, but I was assured it was OK and the green was not Pseudomonas.

As for gowning, gloving, and draping, I discovered that gowns were all wet, and that the folding technique is not what I’m accustomed to. Unfolding the gown was a challenge. Gloving is a pretty standard process—one opens the gloves, and the physician either puts them on or asks...
the nurse for assistance. As for draping, no small
towels are used to drape field, only big sheets.
No cover drapes and no drapes with pockets are
used. If a surgeon is in need of a pocket, he or she
makes one with towel clips. Bovies are reused.
The handle portion is placed in a sterile glove.
The tip is steam sterilized and a hole is punched
through the glove to attach the Bovie tip into the
handle. The surgeon does fumble a bit working
the buttons, and handles that would normally be
disposed of after one use in the U.S. are reused.

Lighting at this facility can also be a challenge.
Only one overhead light is used, and as the fix-
ture does not have handles, an assistant has to
focus the light for the surgeon. A second light
is available, but, in this case, no extension cord
was readily available and the electrical outlet was
located on the opposite side of the OR. Finally,
we made the decision to move the table in order
to get adequate light. Additionally, surgical in-
struments are old and dull, and needleholders
tend not to hold onto the needles. These are all
difficult challenges, but the experienced surgeon
gets the job done despite these conditions. But I
must give my Cambodian colleagues great praise.
It is amazing what they can get done despite their
lack of resources.

All and all, the mission was a wonderful suc-
cess. We were able to deliver more than 70 pounds
of mesh, suture, and antibiotics worth more than
$100,000, with the ability to repair more than 200
hernias. I have been in communication with Dr.
Mok, and he is using the mesh and getting excel-
ent results. Since my return, additional suppli-
ers have come forward with more donations, so
there is little doubt that I will be returning to
Cambodia next month, in January 2011.

Dr. Brender is clinical
professor of surgery,
University of Califor-
nia, Irvine.
Advocacy advisor

Resources for effective advocacy

by Charlotte Grill, LSW, State Affairs Associate; and Catharine Harris, Congressional Affairs Assistant, Division of Advocacy and Health Policy

Several advocacy resources and websites are available to Fellows of the American College of Surgeons (ACS) that provide a wide range of information and tools that may be useful to surgeons who want to get involved and become effective advocates at the state and federal levels. ACS state and federal legislative affairs staff use these resources to assist Fellows in learning about current legislative action, contacting elected officials, and reaching out to broadcast media in order to increase the College’s overall advocacy and policy efforts.

State-level resources

• Tracking state legislation online. CQ Statetrack is an easy-to-use website that gives Fellows the opportunity to view ACS priority legislation throughout the U.S. Surgeons can carry out searches and submit queries to identify specific legislation by state, topic, or date. Furthermore, an interactive component on this website uses a U.S. map to create personalized legislative searches using keywords, dates, or the legislative priorities and topics identified by the ACS. In addition, Fellows can sign up to receive customized e-mails to monitor important state regulatory developments. To access this website, visit the ACS portal (http://efacs.org), and click on the “Advocacy” tab to get to the Advocacy and Health Policy page. Scroll down and click on “Find out what bills the College is tracking” to launch the program.

• Surgery State Legislative Action Center (SSLAC). The SSLAC website is a straightforward and easy way to facilitate grassroots advocacy and to mobilize surgeons to contact their state and federal elected officials, as well as members of the media.

A shared advocacy effort of 13 national surgical specialty societies and the College, the SSLAC engages surgeons from a variety of backgrounds to become involved in the legislative process and support initiatives that will enhance both the quality of care and access to care for the surgical patient. The SSLAC allows surgeons to find their elected officials and obtain relevant information on upcoming elections and candidates. In addition, important Action Alerts are posted through the SSLAC website, and surgeons are directed to the site to send letters to their legislators on a variety of bills and issues. For more information visit http://sslac.capwiz.com.

• State Advocacy Representative (StAR) Program. In 2003, the College began working with ACS State Chapter Presidents and Administrators to recruit individuals to serve in its StAR program. Those individuals participating as StARs work with ACS as the point people to carry the College’s message and agenda to their state legislature. The job of the StARs is to be the “eyes and ears” of the College at the state level, and they are encouraged to contact State Affairs staff when important legislation is introduced or surgical initiatives are proposed. StARs participate in conference calls several times a year to exchange information with the College and each other, providing an early warning system to states where legislation may not yet have been considered, but could be introduced. Currently, 133 StARs are enrolled, with representation in virtually every state.

Advocacy resources at the federal level

• ACSPA-SurgeonsPAC. Established in 2002, ACSPA-SurgeonsPAC—the political action committee of the American College of Surgeons Professional Association— influences the composition of Congress by contributing to Democratic and Republican candidates who understand the needs of surgeons and surgical patients. This allows the College to build vital relationships with the senators and representatives who vote on issues that affect the surgical practice environment. For example, the ACSPA-SurgeonsPAC enabled the College to have a seat at the table during the health reform debate. Although the law has
flaws, the College’s involvement ensured that important provisions, such as general surgery bonuses, reauthorization of funding for trauma and emergency systems, and a pediatric specialty loan repayment program, were included in the final law. The ACSPA-SurgeonsPAC depends on personal contributions from U.S. Fellows of the College to continue to build the College’s clout on Capitol Hill. For more information, visit http://www.facs.org/acspa_pac/.

Joint Surgical Advocacy Conference (JSAC). The JSAC takes place annually in Washington, DC. During this conference, surgeons from across various specialties come together to learn about current legislation affecting their practices and patients, attend beginner or advanced advocacy training and continuing medical education courses, and hear from members of Congress and the administration. The JSAC concludes with meetings involving surgeons and their members of Congress or congressional staff to discuss issues of importance, such as the sustainable growth rate, medical liability reform, trauma funding, and the surgical workforce crisis. The fourth annual JSAC will take place March 27–29, 2011, at the JW Marriott hotel in Washington, DC.

ACS Grassroots Network. The ACS Grassroots Network is a one-stop shop where members of the College may contact their senators and representatives at the federal level, receive information about current legislation affecting surgical patients and practices, and access other federal advocacy information. The site contains pre-drafted, template e-mails regarding specific pieces of legislation, which surgeons can sign and send to their legislators or edit with their personal touches. It is important for federal legislators to know where surgeons—as constituents and experts in their field—stand on the issues. Becoming a member of the ACS Grassroots Network is an easy way to ensure that your voice is heard on Capitol Hill. Log on to http://www.capitolconnect.com/acspa/ with your ACS user name and password to become a member of the Grassroots Network.

There are many ways for ACS members to get involved in state and federal advocacy. The College has committed numerous resources to help surgeons become advocates for their patients and their profession, and these instruments have become vital to the College’s advocacy and legislative work. Surgeons and ACS chapters seeking additional information should contact Charlotte Grill, State Affairs Associate, at cgrill@facs.org, or Alexis Macias, Regional State Affairs Associate, at amacias@facs.org. For questions regarding federal advocacy, contact Catharine Harris, Congressional Affairs Assistant, charris@facs.org.
Previous analysis by the American College of Surgeons’ (ACS) Health Policy Research Institute (HPRI) has found that growth in the surgical workforce over the past 25 years has been fueled by expansion in surgical subspecialties, including orthopaedic, plastic, thoracic, and obstetrics/gynecology. Despite this overall growth, the number of new surgeons entering the workforce may not be sufficient to replace surgeons nearing retirement. The training pathways and demographic makeup of each subspecialty varies, calling for different strategies to address surgery workforce shortages.

Differences across specialties

Using data from the 2009 American Medical Association (AMA) Physician Masterfile and the American Board of Medical Specialties (ABMS), 137,426 physicians were classified as surgeons. For the purpose of this analysis, only surgeons under the age of 70, working in direct patient care, were included (see “Data and methodology” section in this

Approximately one-third of all surgeons are older than age 55, but differences across specialties are noteworthy (see Figure 1, page 27). Dermatologic surgeons are the youngest subspecialty group, with a median age of 43 and 18 percent over the age of 55. Thoracic and urologic surgeons are the oldest subspecialty groups, with median ages of 52 and 51, respectively. Thirty-nine percent of thoracic surgeons and urologic surgeons are over the age of 55. Orthopaedic, ophthalmic, and plastic surgeons also have median ages of 50 years old or older, with 34 to 37 percent of surgeons in those groups over the age of 55.

**Rural surgeons tend to be older**

For all specialties, the median age of surgeons in rural areas is older than that of surgeons in urban areas (see Figure 2, page 27). Rural urologic surgeons have the highest median age of any group. The greatest difference in median age between urban and rural surgeons is in dermatologic surgery, with a difference of 6.5 years. The smallest differences in median age between urban and rural areas are in plastic and thoracic surgery, with a difference of just one year between the median age of rural surgeons in these specialties and their urban counterparts.

The age distribution of surgeons in rural areas is uniform across all age groups. By contrast, in urban places there is a concentration of specialty surgeons between the ages of 35 and 54, and of general surgeons between the age of 35 and 44 (see Figure 3, this page). These patterns may reflect more recent efforts to increase the production of general surgeons, whereas an increase in the number of surgical specialists occurred earlier, in the 1980s and early 1990s. Even with this group of younger surgeons, the number of new surgeons who are necessary for replacing those nearing retirement age appears disproportionate, particularly...
in rural areas and for general surgery.

Examining age patterns by U. S. Census Bureau region, only modest differences emerge in the age profile of surgeons (see Figure 4, page 28). A slightly higher proportion of surgeons in the West are over the age of 55 (35 percent), while the Midwest has the lowest percentage of surgeons over the age of 55 (32 percent). Overall, a lower percentage of general surgeons are over the age of 55 when compared to specialty surgeons.

**Implications**

An earlier ACS HPRI study of surgeon demographics over time concluded that the growth of general surgeons has failed to keep pace with population." This analysis highlights the variations in age structure of the surgeon workforce by specialty, census region, and rural or urban status. The age structure of different surgeon

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**Surgery specialty categories**

<table>
<thead>
<tr>
<th>Specialty category</th>
<th>Included AMA specialties</th>
<th>Included ABMS certifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Surgery</td>
<td>Colorectal Surgery, Proctology</td>
<td>Colon &amp; Rectal Surgery</td>
</tr>
<tr>
<td>Dermatologic Surgery</td>
<td>Dermatologic Surgery, Procedural Dermatology</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Neurological Surgery, Pediatric Neurological Surgery, Endovascular Surgical Neuroradiology</td>
<td>Neurological Surgery</td>
</tr>
<tr>
<td>Obstetrical &amp; Gynecological Surgery</td>
<td>Gynecology Oncology, Gynecology, Obstetrics &amp; Gynecology, Obstetrics, Critical Care Medicine OB/GYN</td>
<td>Obstetrics &amp; Gynecology, Gynecologic Oncology</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>Hand Surgery - Orthopedics, Adult Reconstructive Orthopedics, Foot &amp; Ankle Surgery, Musculoskeletal Medicine, Pediatric Orthopedics, Orthopedic Surgery, Sports Medicine, Orthopedic Spine Surgery, Orthopedic Trauma</td>
<td>Orthopedic Surgery</td>
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<tr>
<td>Ophthalmic Surgery</td>
<td>Ophthalmology, Pediatric Ophthalmology</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Head &amp; Neck Surgery</td>
<td>Head &amp; Neck Surgery, Otology/Neurotology, Otology, Otolaryngology, Pediatric Otolaryngology</td>
<td>Otolaryngology, Pediatric Otolaryngology, Neurotology</td>
</tr>
<tr>
<td>Urologic Surgery</td>
<td>Urology, Pediatric Urology</td>
<td>Urology, Pediatric Urology</td>
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groups may be influenced by many factors, including the relative duration of training for each specialty group, placement opportunities, work schedule, and call hours. To best address the aging surgeon workforce and increase the number of new surgeons entering the workforce, the underlying sources of this age variation should be explored further.

Data and methodology
As previously stated, this analysis is based on the 2009 AMA Physician Masterfile data representing all licensed physicians and ABMS data on board certifications. Physicians with a self-reported primary specialty of surgery were included in the analysis. Additional physicians were identified as surgeons and included in the analysis based on their ABMS board certification information, with surgical specialty groups defined as shown in the table on page 29.

Only physicians who identified their practice type as direct patient care, were 69 years old or younger, and who reported a practice location within a U.S. county or county-equivalent (for example, Federal Information Processing Standard [FIPS] codes) were included in the analysis.

Physicians were excluded from the analysis in a given year if they reported being in residency training, semi-retired, or if they reported their primary present employer was the U.S. government, locum tenens, medical school, or other nonpatient care employment.

Counties and county equivalent areas were those identified by modified FIPS codes, and regions were those defined by the U.S. Census Bureau. The rural and urban classification of counties was defined using 1996 Metropolitan Statistical Areas, constructed by the U.S. Office of Management and Budget. Surgeons with missing age data were excluded from age calculations and figures.

Quick facts

<table>
<thead>
<tr>
<th>One-third of all surgeons are over the age of 55.</th>
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<tbody>
<tr>
<td>Thoracic and urologic surgeons are older, on average, than other surgical subspecialists.</td>
</tr>
<tr>
<td>Dermatologic surgeons are younger, on average, than other surgical subspecialists.</td>
</tr>
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<td>Rural surgeons are older, on average, than their urban counterparts.</td>
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</tbody>
</table>

Ms. Walker is the project manager for the North Carolina Healthcare Quality Alliance, and a former research associate for the American College of Surgeons Health Policy Research Institute, Chapel Hill, NC.

Ms. Poley is a research associate at the Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC, and research coordinator for the ACS Health Policy Research Institute.

Dr. Ricketts is professor of health policy and management and social medicine, University of North Carolina Schools of Global Public Health and Medicine, Chapel Hill. He is co-director of the ACS Health Policy Research Institute.
Lazar J. Greenfield, MD, FACS, a vascular surgeon from Ann Arbor, MI, was named President-Elect of the American College of Surgeons (ACS) during the Annual Business Meeting of Members held Wednesday, October 6, during the Clinical Congress in Washington, DC.

Dr. Greenfield has been a Fellow since 1968, and has been active in the governance of the College. He is Editor-in-Chief of Surgery News, the College’s monthly newspaper, and is Associate Editor of its members-only Web portal, http://www.e-FACS.org.

Dr. Greenfield received his medical degree from Baylor University College of Medicine, Houston, TX. 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, he 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 FA.

Did you know... THAT THE ACS HEALTH POLICY RESEARCH INSTITUTE (HPRI) has released a Surgery Workforce Atlas that shows surgeon shortages across the U.S.? The interactive, Web-based map from the HPRI shows, county-by-county throughout the U.S., where shortages of surgeons and other physicians threaten patient access to timely, safe, high-quality, and affordable care. The Surgery Workforce Atlas made its debut during the College’s 96th annual Clinical Congress in Washington, DC. The ACS HPRI is already working on a second version of the atlas that will feature all of the surgical subspecialties, overlay facilities such as hospitals and ambulatory surgery centers, and offer visual displays using alternative geographic units including hospital referral regions. The atlas may be found at http://www.acshpri.org/atlas.
Coller Distinguished Professor of Surgery at the University of Michigan in Ann Arbor, where he is currently professor emeritus of surgery.

Dr. Greenfield has served on the ACS Committee on the Operating Room Environment (1990–1993, 1998–2000) and on the Board of Regents’ Communications Committee (2001–2005). He was First Vice-President of the College (2000–2001), and currently serves on the Public Profile and Communications Steering Committee.

This past June, Dr. Greenfield became the 16th recipient of the Jacobson Innovation Award of the ACS.

The Vice-Presidents-Elect were also named during the Annual Business Meeting of Members. Patricia J. Numann, MD, FACS, of Syracuse, NY, is First Vice-President-Elect, and Robert R. Bahnson, MD, FACS, Columbus, OH, is Second Vice-President-Elect.

Dr. Numann, a general surgeon, is professor emeritus at the State University of New York, Syracuse, NY. A Fellow of the College since 1974, Dr. Numann has served as Second Vice-President (1999–2000), as Chair of the Nominating Committee of the Fellows (1994–1995), and as a Board Member of the Advisory Committee for General Surgery (1999–2002). She also currently serves as Director of Fundamentals of Surgery Curriculum™.

Dr. Bahnson, a urologic surgeon, is professor and chairman of the department of urology, and the Dave Longaberger Chair in Urology, The Ohio State University College of Medicine, Columbus. A Fellow of the College since 1990, Dr. Bahnson has served on the Board of Governors (2004–2010), as a Member of the Board of Governors’ Committee on Physician Competency and Health (2006–2010), as Vice-Chair of the Program Committee (2008–2010), and as Chair of the Advisory Council for Urology (2007–2011).
The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at the 97th annual Clinical Congress, October 23–27, 2011, San Francisco, CA

**Oral presentations**

- **Surgical Forum***
  Program Coordinator: Kathryn L. Matousek, 312-202-5336, kmatousek@facs.org
  (12 $1,000 Excellence in Research Awards were given in 2010)
  *Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)*

- **Scientific Papers***
  Program Coordinator: Kay Anthony, 312-202-5325, kanthony@facs.org

**Poster presentations**

- **Scientific Exhibits**
  Program Coordinator: Rhoby Tio, 312-202-5385, rtio@facs.org

**Video presentations**

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

**Submission information**

- Abstracts are to be submitted online only.
- Submission period begins after December 1, 2010.
- Deadline: 5:00 pm (CST), March 1, 2011.
- Late submissions are not permitted.
- Abstract specifications and requirements for each individual program will be posted on the ACS website at www.facs.org/education/. Review the information carefully prior to submission.
- Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.*
It was indeed an honor to serve as the 2010 American College of Surgeons (ACS) Australia and New Zealand (ANZ) Chapter Traveling Fellow. Travelling to the land Down Under; meeting colleagues, trainees, and surgical leaders from Australia and New Zealand; and exchanging ideas in scientific and social settings was an unparalleled experience for me. Perhaps just as important, I had the opportunity to develop what will hopefully become lasting friendships and collaborations for future interactions.

My journey began as my wife and I traveled to Perth, where the 2010 annual Scientific Congress of the Royal Australasian College of Surgeons (RACS) was held. After a long flight from Nashville, TN, to Los Angeles, CA, followed by crossing the international dateline, we finally arrived in Brisbane, Australia.

**Developing a Career in Academic Surgery Course**

One day prior to the commencement of the Scientific Congress, the second annual Developing a Career in Academic Surgery course, run jointly by the Association of Academic Surgery (AAS) and the Academic Section of the RACS, was held. Spearheaded by Richard Hanney, MB, BS, FRACS, from the RACS in collaboration with members of the AAS, this course has been a tremendous success. Since there is no pure model for academic training or promotion in the Australian health care system, the course focuses on providing young surgeons, trainees, and students insights into careers in academic surgery, and provides them an opportunity to directly interact with more established surgeons in an effort to help inspire and recruit potential academic surgeons.

My presentation was titled **Building an Academic Career Pathway: Opportunities, Obstacles, and Getting Past Them.** All in all, this course was an ideal forum for interaction and motivation for young, aspiring academic surgeons.

**RAS Congress, Perth**

The Scientific Congress is organized by specialty-based scientific sessions. Prior to my arrival, John Buckingham, MB, BS, FACS, FRACS, President of the ANZ Chapter, assisted in facilitating my trip by putting me in touch with several of the conveners responsible for organizing the meeting’s various scientific programs. They, in turn, arranged for my participation in their respective sessions based on the themes of their scientific program, as well as my clinical and research interests.

Christobal Saunders, MB, BS, FRACS, FRCS, a breast surgeon from Freemantle, Western Australia, organized the surgical oncology session. One of the sections in this forum was combined with the breast cancer session and focused on new techniques in diagnosis and management of breast cancer. I gave a presentation titled **Molecular Imaging and Prediction of Tumor Response,** based on some of our research on in vivo imaging of cellular proliferation, apoptosis, and drug delivery to tumors.

I also participated in the colorectal session, which was organized by Professor Cameron Platell, MB, BS, PhD, FRACS. One of the sessions in this forum focused on translational colorectal research. During this session, I was asked to speak about some of our recent work on **An Experimentally Derived Metastasis Gene Expression Profile Predicts Recurrence and Death In Colon Cancer Patients** in which we identified 34 gene profiles derived from a liver metastasis mouse model and advance human colorectal cancers that are highly predictive of good or poor prognosis in Stage II and III colon cancer patients.

The hepatopancreatobiliary (HPB) session was organized by Dr. Andrew Mitchell, MB, BS, FRACS, a hepatobiliary surgeon from Perth. During this session, I gave a presentation titled **Current Approaches to**
Management of Pancreatico-enteric Neuroendocrine Tumors. During the HPB sessions, Andrew Biankin, MB, BS, PhD, FRACS, BMedBc, a pancreatic surgeon from Sydney, also gave a presentation titled Pancreas Cancer Genome Project. He has generated multimillion-dollar funding from the International Cancer Genome Consortium as the principal investigator for this project in Australia. This project really highlights the significant advances in the quality of research occurring in Australia. With our mutual interest in pancreatic cancer, we instantly bonded and spent a significant amount of time discussing our research and potential future collaborations.

In addition to the presentations given at these scientific programs, I had the privilege of delivering the ACS keynote lecture, titled Progress in Pancreas Cancer Management: Not an Oxymoron, which describes some of the significant advances made in the understanding of the molecular and genetic progression of pancreatic cancer, which have resulted in potential novel therapies.

Immediately following this, Professor Buckingham hosted the luncheon of the ANZ Chapter members. 2010 marked the twenty-fifth anniversary of the ANZ Chapter and was celebrated by all the participants with a very large and wonderfully decorated cake. I had the opportunity to address the chapter members, as well as Prof. Ian Gough, MB, BS, FACS, FRACS, President of the Royal Australasian College of Surgeons, and LaMar S. McGinnis, Jr., MD, FACS, President of the American College of Surgeons, during this session. I was able to express my gratitude for their support of this fellowship, and highlight the importance of this wonderful professional interchange. Dr. Buckingham then made an exciting announcement: starting next year, in addition to an ACS member traveling to the RACS meeting, an Australian fellow will be selected as a traveling fellow to the U.S. and the Clinical Congress, further enhancing the vibrant association between the ANZ Chapter and the ACS.

**Sydney**

After the RACS meeting, my wife and I traveled to Sydney where our children joined us. We had the opportunity to see many of the sites, including Sydney Harbour, where the iconic Sydney Opera House and the Harbour Bridge are featured prominently. Our hosts included several friends, such as Dr. Hanney and Stan Sidhu, MB, BS, PhD, FRACS, who demonstrated tremendous hospitality. Dr. Hanney took us to Cottage Point which, while within the Sydney city limits, feels like an oasis that could be found miles away from a major urban city. Dr. Sidhu had our entire family over to his house, where we met his wonderful wife and four lovely children, and we even played Australian-rules football. On Mother’s Day, his amazing wife made us a spectacular Sunday dinner.

In Sydney, Dr. Sidhu had arranged for me to visit the Royal North Shore Hospital, where I was hosted by Jaswinder Samra, D. Phil, FRACS, and Tom Hugh, MD, FRACS, two very busy HPB surgeons. I toured the facilities, attended their HPB tumor board and their multi-disciplinary GI conference, and spent time with them in the operating room, discussing the similarities and differences in the management of many of the complex cases they presented. I also met with Prof. Ross Smith, MD, FRACS, and toured the laboratory facilities there. We discussed our respective research and exchanged various ideas to further both of our work. I was invited to speak at their surgical grand rounds, and my presentation was titled New Paradigms in Cancer Treatment: From Bench to Bedside and Back Again. My time at Royal North Shore Hospital highlighted the quality, depth, and breadth of the clinical work being done there.

While in Sydney, I then spent time with Dr. Biankin. He first took me to Bankstown Hospital, where I participated in their gastrointestinal tumor board and was asked to give a presentation titled Current Approaches to Management of Pancreatico-enteric Neuroendocrine Tumors. At that point, I participated in their ward rounds and saw many of their postoperative patients. It was interesting to see that early discharge management is more difficult in Sydney, as they do not have a formal system for skilled home nursing care. Therefore, patients tend to stay in the hospital until they are more fully recovered.

Dr. Biankin then took me to the Garvan Institute, a free-
standing facility with a focus on biomedical research that is currently undergoing a multi-million-dollar expansion. Dr. Biankin’s laboratory is located at this facility, where he also runs the Pancreas Cancer Genome Project. While at the institute, I interacted with several members of Dr. Biankin’s laboratory and established several potential collaborations. I was also invited to speak at the institute’s research seminar, where I gave a presentation based on my laboratory research, titled Src Signaling in Pancreas, to the community of scientists. This was truly a pleasure spending the afternoon with them and discussing their thoughts about their training as it compared with training in the U.S., and also their aspirations and concerns regarding pursuing an academic career.

During my stay in Melbourne, I also met with several other colleagues and visited other medical centers. I met with Tony Burgess, PhD, from the Ludwig Institute for Cancer Research, New York, NY, with whom we have an ongoing collaboration of our colorectal cancer genetic profiling work.

Peter MacCallum Cancer Centre (or “Peter Mac” as it is commonly referred to) is the only hospital in Australia dedicated solely to cancer care. It is one of the foremost cancer facilities in Australia and is staffed by renowned scientists and clinicians. I was hosted there by Ben Thomson, MB, BS, FRACS, an HPB and upper GI surgeon. I attended the HPB tumor board, and, because of my interest in molecular imaging metrics for therapeutic response, I also visited their outstanding imaging center. They have a tremendous facility and have done cutting-edge work with Gallium scanning, which has just now become available in the U.S. I also toured their laboratories, and spent time with Wayne Philips, PhD, one of their leading scientists, discussing our respective research and the differences in research funding between our two nations.

One of the most memorable meetings I had was with Professor Robert Thomas, MB, BS, PhD, FRACS. He was previously the chief of surgical oncology at Peter Mac and now works for the Health Ministry for the State of Victoria. The state and federal government have committed almost $1 billion (AU) to create a comprehensive cancer center in Melbourne. This center will be a combined effort between several institutions, including Royal Melbourne Hospital, Royal Women’s Hospital, Peter Mac, the Ludwig Institute, and others to combine state-of-the-art clinical care, research, and clinical trials to provide optimal cancer care.

I spent an entire morning with Professor Thomas and Dr. Mann in a stimulating discussion about the forward-thinking change that had to occur in the mindset and culture of many of these institutions to bring these resources together. We talked at length about the structure of comprehensive cancer centers in the U.S. as well as their vision for this comprehensive center.

After a whirlwind tour of visiting many different institutions in Perth, Sydney, and Melbourne, it became quite apparent that the clinical care and research in Australia is second to none. Despite many
similarities to the U.S., there are also dramatic differences in the way our Australian colleagues practice surgery. Health care delivery is essentially a two-tier public and private system. The worldwide economic downturn has affected many of the public hospitals, leading to significant cuts in resources for physicians to facilitate their practices. Therefore, most academic surgeons engage in a parallel private practice to supplement their income. As in the U.S., with these added clinical responsibilities, many academic surgeons continue to struggle with the time and financial constraints associated with their academic pursuits. Previously, most trainees in Australia had to go oversees to pursue additional research training. However, there has been tremendous growth for several centers of research excellence, and for academic mentors who can provide high-quality training for young surgeons, allowing them more opportunities to obtain high-quality research training within Australia.

In summary, I would like to thank the ACS and the ANZ Chapter for providing this once-in-a-lifetime experience for my family and me. My trip to Australia was full of professional and personal development and adventure. It allowed me to establish important clinical and basic science collaborations, and it promoted an intense exchange of ideas. I know many of the friends that I met during this trip will be lifelong colleagues. I am indeed indebted to the ACS for this generous opportunity.

**Dr. Merchant** is associate professor of surgery, Vanderbilt University Medical Center, Nashville, TN.
The American College of Surgeons (ACS) Foundation and Saint Louis University’s department of surgery and its Center for Sustainability have partnered with one of the world’s leading global manufacturing and technology companies—Emerson—to create the Emerson Sustainability Scholar in Residence.

The scholarship is intended for exceptionally qualified surgery residents (PGY 3) who are interested in advancing research and learning in the area of health care sustainability (defined as development that meets the needs of the present without compromising the ability of future generations to meet their own needs). The program requires a two-year commitment leading to a Master of Sustainability degree. The first year of the program will be structured within the Center for Sustainability, while the second year will offer more opportunities for independent, mentored scholarship.

**Objectives**

The objectives of the program include the following:

- Immerses the surgery resident in collaborative learning environments to foster discovery focused on critical sustainability-related issues facing the medical profession
- Provides the resident with the experience and analytical skills needed to evaluate the complex nature of sustainability-related challenges
- Leads the health care industry in proactive initiatives designed to integrate sustainability best practices into the patient care framework.

**Program**

The candidate may work with health care faculty and clinicians at multiple universities in the St. Louis area to develop a comprehensive program of learning. The program will include the following:

- Research opportunities and collaborations with faculty from multiple disciplines at St. Louis University and members of the St. Louis Regional Higher Education Sustainability Consortium
- Participation in ongoing sustainability-related programs and events across the region
- Regular reporting of research findings to ACS staff at the Chicago, IL, headquarters on initiatives regarding sustainability
- A teaching appointment in St. Louis University’s department of surgery, with opportunities to teach students and residents about the importance of sustainability to the future of health care
- Input in the planning and convening of public forums fostering an exchange of ideas on critical topics in sustainability, health care, and business

Through the generous support of Emerson, the scholar will receive a salary and full health benefits, as well as full tuition scholarship to the two-year Master of Sustainability program at the university.

Applications are being accepted until December 14, 2010. Questions and requests for applications should be directed to Timothy Keane, PhD, director of the university’s Center for Sustainability, at tkeane@slu.edu.

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**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:

- **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](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312-202-5342.
A Look at The Joint Commission

Center for Transforming Healthcare releases targeted solutions tool

Joint Commission-accredited hospitals now have access to an interactive tool that simplifies the process for solving the most persistent health care quality and safety problems within the health care system. The Targeted Solutions Tool™ (TST), which encapsulates the work of The Joint Commission Center for Transforming Healthcare, provides a step-by-step process to measure performance, identify barriers to excellent performance, and implement proven, customized solutions.

The first set of targeted solutions, created by eight of the country’s leading hospitals in collaboration with the center, is for improving hand hygiene. At the start of the project in April 2009, the participating hospitals were surprised to learn that their rate of hand hygiene compliance averaged 48 percent. By June 2010, they had reached an average rate of 82 percent—a rate that had been sustained for eight months. Many other small, medium, and large hospitals across the country worked with the center to test the efforts of the original eight hospitals, and provide guidance on the development of the solutions that are now available through the TST. These hospitals are experiencing gains similar to those of the original eight.

The advanced process improvement methods used by organizations participating in the center’s pilot program have been simplified via the TST, and are now available to all Joint Commission-accredited organizations. Organizations do not need statistical data analysis capability or specialized performance improvement expertise to use the TST; the center designed the self-paced tool to be clearly understood and used by an organization’s staff so that no new resources are required to utilize it. The easy-to-use TST is not just a checklist. It provides instantaneous data analysis, which saves the organization time and resources. The TST, which is confidential in nature, is accessible for free via an accredited organization’s Joint Commission Connect™ extranet site.

The TST is not a quick fix. Successful execution of the tool requires commitment, regular and reliable measurement, courage to honestly recognize where processes are failing, and the discipline to implement solutions.

As issues such as wrong site surgery, surgical site infections, and hand-off communications are tackled by the center, the solutions developed by these projects will eventually be incorporated into the TST. Surgeons and other health care staff will have access to these solutions, which are expected to be available through the TST next year.

The Surgical Site Infection (SSI) Project was launched in August in collaboration with the American College of Surgeons (ACS) and uses data derived from the ACS’ National Surgical Quality Improvement Program (NSQIP). The scope of the SSI project is focused on colorectal surgery and colorectal procedures, which are often associated with SSIs as reported by NSQIP hospitals.

For more information regarding the Center for Transforming Healthcare and the TST, visit http://www.centerfortransforminghealthcare.org.
The National Ultrasound Faculty of the American College of Surgeons has developed “Ultrasound for Surgeons: The Basic Course, 2nd Edition” on CD-ROM for surgeons, surgical residents, and anyone interested in ultrasound imaging.

The 2nd Edition includes:
♦ Updated graphics using 3-D medical modeling developed by NASA researchers to teach ultrasound and rapidly demonstrate key ultrasound skills
♦ Targeted clinical applications are highlighted, including Head and Neck, Breast, Vascular, Abdominal, Thoracic, Critical Care/Trauma, Foreign Objects, and Fractures
♦ Cue Cards to view and print to prompt learners on three commonly performed scans
♦ Easier navigation and support of the CD-ROM
♦ Four CME credits available

The CD-ROM provides the learner with basic education and training in ultrasound imaging as a foundation for specific clinical applications.

To purchase the NEW edition, go to www.acs-resource.org or call 888-711-1138.
From *Surgery News*

**More minorities enrolling in medical school**

Data released October 13 by the Association of American Medical Colleges (AAMC) indicate that more minority students—notably Hispanic males—enrolled as first-year medical students in 2010, report staff of *Surgery News*, the official newspaper of the American College of Surgeons.

The number of black/African-American and American Indian first-year medical students also grew this year, and every U.S. region saw increases in medical school enrollment diversity, said AAMC president and chief executive officer Darrell Kirch, MD, at a press briefing.

Improved diversity will help communities meet their health needs, especially with the increased need for physicians triggered by the Affordable Care Act, Dr. Kirch noted. He also said that efforts to expand medical school enrollment will make it possible to add 7,000 more annual graduates.


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**The United States Atlas of the Surgical Workforce**

- Interactive maps of the ratio of surgeons to population
- County-level and state-level ratios
- Rural-urban comparisons

[www.acshpri.org/atlas](http://www.acshpri.org/atlas)

Now Available
There are two seasons in Chicago: winter and road construction. Now that it is December, all but the last few construction barricades have been removed to make room for the snow.

This past road construction season has been especially challenging. Many major highways were the subject of large construction projects concurrently, and commuting for many people was extremely challenging. Unfortunately, in addition to long travel times and delays that are often associated with construction zones, so is an increased opportunity for highway work-zone injuries.

The U.S. Department of Transportation’s Federal Highway Administration takes this problem seriously and is actively pursuing work-zone safety through a combination of approaches that include engineering, education, enforcement, and coordination with local agencies. One such engineering feat was the utilization of portable “Jersey” barriers (known as K-rails in the western states) in construction work zones. These modular steel reinforced concrete barriers, developed at Steven’s Institute of Technology in Hoboken, NJ, stand three tall and are designed with soft sloping sides to minimize vehicle damage from incidental contact as well as prevent vehicles crossing over into oncoming traffic.

The soft slope of the concrete allows the vehicle’s tires to ride up the wall lifting and position the vehicle back to its original direction of travel, thus avoiding contact with workers, vehicles, or property that may be located on the other side of the barrier.

In 2008, there were 2.4 million people injured, and 37,261 people died, on the U.S. roadway system. This number is lower than previous years and, overall, there has been a continued downward trend in fatalities on our nation’s roads. In 2007, the fatality rate dropped to 1.37 deaths per 100 million miles of travel, down from 5.50 fatalities in 1966. Work zone injuries account for approximately 2 percent of roadway injuries, and fatalities with more than 80 percent of those injuries involving the motorist. In 2008, there were 40,000 work zone injuries and 720 fatalities. To put this into perspective, there is one work zone injury every 13 minutes and one fatality every 10 hours (http://safety.fhwa.dot.gov/wz/facts_stats). However, it is important to remember the innocent construction worker. Road construction is a demanding and labor-intensive job, and the last thing a worker wants to do is dodge cars while also performing their daily tasks.

In order to examine the occurrence of workers injured in highway work zones in the National Trauma Data Bank® research dataset 2008, admissions records were searched utilizing the International Classification of Diseases, Ninth
Revision, Clinical Modification (ICD-9-CM) cause of injury codes for E815.7 (other motor vehicle traffic crash involving collision on the highway—pedestrian), and E815.9 (other motor vehicle traffic crash involving collision on the highway—unspecified person). A total of 219 records matched these injury codes; 174 records had discharge status recorded, including 132 discharged to home, 15 to acute care/rehab, and 17 sent to nursing homes; 10 died (these data are depicted in the figure on page 42). These patients were 68 percent male, on average 31.5 years of age, had an average length of stay of 6.9 days, and an average injury severity score of 12.61.

When drivers approach a work zone, it is important that they remember to slow down, obey the lane configurations, and respect the workers. Imagine how it would be if you were to see your patients in an office that had a 45 mile per hour drive-through running in between the examination rooms!

Throughout the year, we highlight these data through brief reports that can 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.
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.

North Carolina Chapter recognizes Richard Reiling, MD, FACS

During the North and South Carolina Chapters’ meeting July 9–11 in Myrtle Beach, the North Carolina (NC) Chapter presented Richard Reiling, MD, FACS, with the chapter’s Most Honored Surgeon award. Dr. Reiling, who currently serves as the medical director of the Presbyterian Cancer Center in Charlotte, as well as Vice-Chair of the College’s Foundation, has served in many leadership positions in the Ohio and NC Chapters, as well as for the College and the American Medical Association. In addition, last year, the College presented Dr. and Mrs. Reiling with the Distinguished Philanthropist Award, and in 2004 Dr. Reiling received the College’s Distinguished Service Award, the College’s highest achievement. (See photo, this page.)

Chapter anniversaries

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<td>December</td>
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<td>Missouri</td>
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Delaware Chapter publishes new newsletter

Beginning summer 2010, the Delaware Chapter reintroduced its quarterly newsletter. For a copy of the newsletter, or for subscriber information, please contact Kristi Walters, Executive Director, at 302-943-1856, or via e-mail at defacs@ymail.com.

*Denotes Resident membership in the College.
Georgia Society of the ACS hosts Surgical Olympics
The Surgical Olympics event was held Saturday, August 28 as part of the Georgia Society annual meeting. The winning team—all residents—hailed from the Atlanta Medical Center in Atlanta (see photo, page 44).

New Chapter in Portugal formed
The Board of Regents approved the formation of the Portugal Chapter on October 2. The Portugal Chapter is the 36th international Chapter of the College, bringing the total number of ACS chapters to 103 (65 U.S. chapters and two Canadian). Francisco Castro Sousa, MD, PhD, FACS, the Governor representing Portugal, was responsible for developing the new Chapter. The officers of the Portugal Chapter include: Dr. Castro Sousa, President and ACS Governor; Antonio Carlos Saraiva, MD, PhD, FACS, President-Elect; Paulo Costa, MD, FACS, Vice-President; Jose Crespo Mendes de Almeida, MD, FACS, Secretary; and Jose Manuel Ferreira Coelho, MD, FACS, Treasurer (see photo, page 44).

Chapter meetings
For a complete listing of the ACS chapter education programs and meetings, visit the ACS website 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.

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<th>Date</th>
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<tr>
<td>January 12, 2011</td>
<td>Delaware (CS)</td>
<td>Location: John H. Ammon Medical Education Center, Newark, DE Contact: Kristi Walters, 302-943-1856, e-mail: <a href="mailto:defacs@ymail.com">defacs@ymail.com</a></td>
</tr>
<tr>
<td>January 20, 2011</td>
<td>South Florida (CS)</td>
<td>Location: Miami City Club, Miami, FL Contact: Bill Bouch, 305-687-1367, e-mail: <a href="mailto:wtbouck@bellsouth.net">wtbouck@bellsouth.net</a> ACS Representative(s): Mr. Christian Shalgian</td>
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<tr>
<td>January 21, 2011</td>
<td>Louisiana (CS)</td>
<td>Location: Shreveport, LA Contact: Janna Pecquet, 504-841-0145, e-mail: <a href="mailto:janna@laacs.org">janna@laacs.org</a> ACS Representative(s): David B. Hoyt, MD, FACS</td>
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<td>January 21, 2011</td>
<td>Southern California (CS)</td>
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</tr>
</tbody>
</table>
Author index

A

ALKHATIB, JASMINE, and BRASEL, KAREN, and HOLLANDS, MICHAEL J., and CHAPLEAU, WILL, ATLS® inaugurates course in Malaysia, 95, 5:33
ASHLEY, DENNIS W., The quest for sustainable trauma funding: The Georgia story, 95, 10:17
AVERY, NAILA, and FANTUS, RICHARD J., NTDB® data points: IPV, 95, 3:51

B

BAKER, MELINDA, Advocacy advisor: Developing a successful coalition, 95, 2:25
− Advocacy advisor: Grassroots, grasstops, and...Astroturf? 95, 6:35
− Advocacy advisor: Lobbyists—Who needs them? 95, 4:27
BANKS, JOHN B., Governors’ Committee on Physician Competency and Health: An update, 95, 8:27
BARNEY, LINDA M., and MARIANI, DEBRA, and BOETHE, ALBERT, Jr., What surgeons should know about...Current Procedural Terminology changes for 2010, 95, 1:6
BELSKY, DANIEL, and GAUL, KATIE, and POLEY, STEPHANIE, and RICKETTS, THOMAS, HPRI data tracks: Pediatric surgeons: Subspecialists increase faster than generalists, 95, 10:35
BELSKY, DANIEL, and RICKETTS, THOMAS, and POLEY, STEPHANIE, and GAUL, KATIE, HPRI data tracks: Surgical deserts in the U.S.: Counties without surgeons, 95, 9:32
BITTNER, JAMES G. IV, The meaning of “surgeon” in the mountains of Honduras, 95, 9:19
− and HAYANGA, J. AWORI, and POWELL, ANATHEA, C., and BUCK, DONALD W. II, Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training, 95, 7:21
BOTHE, ALBERT, Jr., and BARNEY, LINDA M., and MARIANI, DEBRA, What surgeons should know about...Current Procedural Terminology changes for 2010, 95, 1:6
BRASEL, KAREN, and HOLLANDS, MICHAEL J., and CHAPLEAU, WILL, and ALKHATIB, JASMINE, ATLS® inaugurates course in Malaysia, 95, 5:33
BRENDER, ELLIOTT, A surgical mission to Cambodia: Delivering supplies and care, 95, 12:21
BRIGGS, SUSAN M., The role of civilian surgical teams in response to international disasters, 95, 1:13
BRITT, L. D., Citation for Prof. Dario Birolini, 95, 11:44
BROGHAMMER, JOSHUA A., Health care policy and advocacy: A call to arms for residents and associates, 95, 7:10
BUCK, DONALD W. II, and BITTNER, JAMES G., and HAYANGA, J. AWORI, and POWELL, ANATHEA, C., Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training, 95, 7:21
BURLEY, CAITLIN, What surgeons should know about...PQRI reporting in 2010, 95, 4:6
BURNS, KARYL J., and DANKO, RUDOLPH, and JACOBS, LENWORTH M., Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa, 95, 6:23

C

CASEY, KATHLEEN, and MELCHIZEDEK,
Author index

URIAH, Fellows honored for volunteerism, 95, 9:36
CASTLE, SHANNON, A blessing and a curse, 95, 9:20
CHAPLEAU, WILL, and ALKHATIB, JASMINE, and BRASEL, KAREN, and HOLLANDS, MICHAEL J., ATLS® inaugurates course in Malaysia, 95, 5:33
CHU, KATHRYN, and HEDGES, JEREMY, and RUSCHER, KIMBERLY A., Is the generalist surgeon obsolete? The impact of the general surgeon shortage on global health, 95, 4:24
COFER, JOSEPH B., Rural surgeons—We must grow our own: A response, 95, 4:19
COOKE, DAVID T., Health care policy and the future of surgery, 95, 7:7
–and MERY, CARLOS M., and LIEPERT, AMY, The modern history of U.S. health care reform: A primer for practicing surgeons, residents, and associate fellows, 95, 7:15
CRUZ VARGAS, JAQUELINE, Report of the 2009 International Guest Scholar, 95, 6:45

D

DARKO, RUDOLPH, and JACOBS, LENWORTH M., and BURNS, KARYL J., Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa, 95, 6:23
DEHMER, JEFFREY J., and NELSON, JENNIFER S., and RAMAN, SHANKAR R., and SANTRY, HEENA P., Modern surgical communication and the practice of surgery, 95, 7:33
DUNN, GEOFFREY P., Dealing with the difficult family: Lessons from palliative care, 95, 5:16

E

EASTMAN, A. BRENT, A challenging year, 95, 10:11
–Haiti impressions: January 23–26 and January 28–February 3, 2010, 95, 6:10
ELSEY, JAMES K., Governors’ Committee to Study the Fiscal Affairs of the College: An update, 95, 8:30

F

FANTUS, RICHARD J., NTDB® data points: Children are our future, 95, 4:43
–NTDB® data points: Double McTwist 1260, 95, 6:59
–NTDB® data points: Drive-through, 95, 12:42
–NTDB® data points: The fall of mankind, 95, 10:67
–NTDB® data points: Going downhill, 95, 7:83
–NTDB® data points: Older and thinner, 95, 9:59
–and AVERY, NAILA, NTDB® data points: IPV, 95, 3:51
–and FILDES, JOHN, NTDB® data points: “Eye see,” 95, 11:59
–and NTDB® data points: How old is old enough? 95, 2:39
–and NATHENS, AVERY B., and FILDES, JOHN, NTDB® data points: Another national chapter, 95, 5:43

FILDES, JOHN, and FANTUS, RICHARD J., and NATHENS, AVERY B., NTDB® data points: Another national chapter, 95, 5:43

FILDES, JOHN, and WEIRETER, LEONARD, J., Jr., Experience in Haiti allows College to better prepare for future crises, 95, 9:15
FINLEY, RICHARD J., Citation for Prof. William Ignace Wei, 95, 11:50
FLINT, LEWIS, and FRYKBERG, ERIC, and WEIRETER, LEONARD, 10 questions and answers about disasters and disaster response, 95, 3:6
FRIESSEN, SHAWN, Medicare physician reimbursement: Is the SGR’s end in sight? 95, 4:20
FRYKBERG, ERIC, and WEIRETER, LEONARD, and FLINT, LEWIS, 10 questions and answers about disasters and disaster response, 95, 3:6
G

GAUL, KATIE, and BELSKY, DANIEL, and RICKETTS, THOMAS, and POLEY, STEPHANIE, HPRI data tracks: Surgical deserts in the U.S.: Counties without surgeons, 95, 9:32

GAUL, KATIE, and POLEY, STEPHANIE, and RICKETTS, THOMAS, and BELSKY, DANIEL, HPRI data tracks: Pediatric surgeons: Subspecialists increase faster than generalists, 95, 10:35

GIULIANO, ARMANDO, and OTA, DAVID M., and NELSON, HEIDI, ACOSOG news: Node biopsy vs. full lymph node dissection for breast cancer, 95, 10:58

GLICKSON, JEANNIE, Surgical lifestyles: A view from the cockpit: Surgeon and pilot Richard C. Karl, MD, FACS, promotes aviation safety in the OR, 95, 11:6

GOLDBERG, STANLEY, M., Citation for Prof. Ralph John Nicholls, 95, 11:47

GREGOR Y, JAY A., Leadership opportunities in a more institution-based health care environment, 95, 10:22

GRILL, CHARLOTTE, State STATs: Repeal of the UPPL, 95, 11:38

– and HARRIS, CATHARINE, Advocacy advisor: Resources for effective advocacy, 95, 12:25
– and MORSE, SARA, Advocacy advisor: Building relationships through campaign work, 95, 10:33

GRUBBS, ELIZABETH G., and LEE, JEFFREY E., and PERRIER, NANCY D., and LANDRY, CHRISTINE S., From scalpel to console: A suggested model for surgical skill acquisition, 95, 8:20

H

HANLON, C. ROLLINS, In memoriam: Paul F. Nora, MD, PhD, FACS, 95, 2:26

HARKEN, ALDEN and RUSSELL, THOMAS R., and HARKEN, TABETHA R., and RUSSELL, KATHRYN W., Surgical megafauna, 95, 3:24

HARKEN, TABETHA R., and RUSSELL, KATHRYN W., and HARKEN, ALDEN and RUSSELL, THOMAS R., Surgical megafauna, 95, 3:24

HARRIS, CATHARINE, and GRILL, CHARLOTTE, Advocacy advisor: Resources for effective advocacy, 95, 12:25

HAYANGA, J. AWORI, and POWELL, ANATHEA, C., and BUCK, DONALD W. II and BITTNER, JAMES G., Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training, 95, 7:21

HEDGES, JEREMY P., Surgical volunteerism, 95, 9:21

– and RUSCHER, KIMBERLY A., and CHU, KATHRYN, Is the generalist surgeon obsolete? The impact of the general surgeon shortage on global health, 95, 4:24

HEDSTROM, KRISTEN, Health care reform becomes law—with room for improvement, 95, 6:21

– and MAA, JOHN, College advocates for ensuring quality eye care for America’s veterans, 95, 9:8

HEYROSA, MARY GRACE, A gift to yourself, 95, 9:22

HOLLANDS, MICHAEL J., and CHAPLEAU, WILL, and ALKHATIB, JASMINE, and BRASEL, KAREN, ATLS® inaugurates course in Malaysia, 95, 5:33

HOY, ELIZABETH, What surgeons should know about...2010 changes to Medicare payment for consultation services, 95, 1:9

HOYT, DAVID B., Executive Director’s annual report, 95, 12:6

– Looking forward, 95, 1:4 (Dr. Russell’s achievements); 2:4 (vision for the future); 3:4 (health care reform); 4:4 (expansion of ACS quality improvement programs); 5:4 (ACS’s relationship with the Association of Program Directors in Surgery); 6:4 (ACS disaster response); 7:4 (surgical workforce shortage); 8:4 (new ACS Washington, DC, Office building); 9:4 (resident duty-hour requirements); 10:4 (accountable care organizations); 11:4 (collaboration with The Joint Commission on surgical site infection study); 12:4 (overview of accomplishments in 2010)

HUFFSTUTTER, PAUL J., Rural surgeons—We must grow our own, 95, 4:16

HUGHES, CHRISTOPHER DAVID, Finding my own Lambaréné, 95, 9:23

HUNTER, JOHN G., Citation for Prof. Tehemton Erach Udwadia, 95, 11:49

J

JACOBS, LENWORTH M., and BURNS, KARYL J., and DARKO, RUDOLPH, Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa, 95, 6:23

JASAK, BOB, The ACS plays an active role in initial implementation of the ACA, 95, 12:17

KAFAARANI, HAYTHAM, and MÖLLER, MECKER G., and PRABHAKARAN, SANGEETHA, and MELIS, MARCOVALERIO, Addressing workforce issues with foreign medical graduates, 95, 7:27

KANNING, NATHAN C., Report of the 2009 Oweida Scholar, 95, 3:38

KANNING, NATHAN C., Report of the 2009 Oweida Scholar, 95, 3:38
LAIDLEY, ALISON L., and WHITACRE, ERIC B., and SNIDER, HOWARD C., and WILLEY, SHAWNA C., Meeting the challenge—A surgeon-centered quality program: The American Society of Breast Surgeons Mastery of Breast Surgery Pilot Program, 95, 1:23

LALLY, KEVIN P., Governors’ Committee on Chapter Activities: An update, 95, 8:25

LANDRY, CHRISTINE S., and GRUBBS, ELIZABETH G., and LIEPERT, AMY, and LIEPERT, AMY, and LEGRAND, MARY, Socioeconomic tips: Are E/M services reportable with a surgical procedure? 95, 11:36

LEE, JEFFREY E., and BETH G., and LANDRY, CHRISTINE S., and LANDRY, CHRISTINE S., and PERRIER, NANCY D., From scalpel to console: A suggested model for surgical skill acquisition, 95, 8:20

Lee, Jeffrey E., and PERRIER, NANCY D., and LANDRY, CHRISTINE S., and GRUBBS, ELIZABETH G., From scalpel to console: A suggested model for surgical skill acquisition, 95, 8:20

LeGRAND, MARY, Socioeconomic tips: Are E/M services reportable with a surgical procedure? 95, 11:36


MACIAS, ALEXIS, State STATs, Trauma funding in the states, 95, 9:29

–and SUTTON, JON H., 2010 state legislative wrap-up, 95, 11:23

MANISCALCO-THEBERGE, MARY, Spotlight on a U.S. Army surgeon: Interview with MAJ Jennifer Gurney, MD, FACS, 95, 11:29

MARDIS, ELAINE, and OTA, DAVID M., and NELSON, HEIDI, ACOSOG news: Translational science in ACOSOG trials, 95, 5:39

MARIANI, DEBRA, Socioeconomic tips: General equivalency mapping helps convert ICD-9-CM codes to ICD-10-CM, 95, 3:31

–Socioeconomic tips: Practice management resources for the surgeon’s office, 95, 5: 30

–and BOETHÉ, ALBERT, Jr., and BARNEY, LINDA M., What surgeons should know about...Current Procedural Terminology changes for 2010, 95, 1:6

McARTHUR, MICHAËL S., Physicians and surgeons as board trustees: Be careful what you wish for, 95, 10:26

McFEE, ARTHUR S., In memoriam: J. Bradley Aust, MD, FACS, 95, 6:37

McGINNIS, LaMAR S., Jr., Thoughts as I leave office, 95, 10:14

McGRATH, MARY H., The difficult or disruptive surgical patient: Practical strategies for diagnosis and management, 95, 5:10

–Round-trip service: Commentary, 95, 8:16

MELCHIZEDEK, URIAH, and CASEY, KATHLEEN, Fellows honored for volunteerism, 95, 9:36

MELIS, MARCOVALERIO, and KAFAFARANI, HAYTHAM, and MÖLLER, MECKER G., and PRABHAKARAN, SANGEETHA, Addressing workforce issues with foreign medical graduates, 95, 7:27

MERCHANT, NIPUN, B., Report of the 2010 Australia and New Zealand Traveling Fellow, 95, 12:34

MERY, CARLOS M., and LIEPERT, AMY, and COOKE, DAVID T., The modern history of U.S. health care reform: A primer for practicing surgeons, residents, and associate fellows, 95, 7:15

MÖLLER, MECKER G., and PRABHAKARAN, SANGEETHA, and MELIS, MARCOVALERIO, and KAFAFARANI, HAYTHAM, Addressing workforce issues with foreign medical graduates, 95, 7:27

MORSE, SARA, Improve your advocacy skills by attending the 2010 JSAC in July, 95, 2:7

–Who said that midterm elections aren’t interesting? 95, 6:31

–and GRILL, CHARLOTTE, Advocacy advisor: Building relationships through campaign work, 95, 10:33

NAHRWOLD, DAVID L., In memoriam: Harris B Shumacker, Jr, MD, FACS, remembered, 95, 3:34


–NTDB® data points: The 2009 Annual Pediatric Report: How old is old enough? 95, 2:39

NATHENS, AVERY B., and FILDES, JOHN, and FANTUS, RICHARD J., NTDB® data points: Another national chapter, 95, 5:43

NATUZZI, EILEEN STACK, Bullets, betel nut, and bacteria: Medicine in the Solomon Islands, 95, 3:16

NELLIGAN, CAITLIN, and WRIGHT, BRAD, and SCRABOROUGH, JOHN, and POLEY, STEPHANIE, and WALKER, ELIZABETH, and RICKETTS, THOMAS, HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type, 95, 11:40

NELSON, HEIDI, and GIULIANO, ARMANDO, and OTA, DAVID M., ACOSOG news: Node biopsy...
vs. full lymph node dissection for breast cancer, 95, 10:58
NELSON, HEIDI, and MARDIS, ELAINE, and OTA, DAVID M., and ACOSOG news: Translational science in ACOSOG trials, 95, 5:39
NELSON, HEIDI, and OTA, DAVID M., ACOSOG news: Patient advocates: “Our job is purely about patient safety,” 95, 1:57
NELSON, HEIDI, and OTA, DAVID M., and WILKE, LEE GRAVATT, ACOSOG news: Promoting patient safety through peer review, 95, 3:45
NELSON, JENNIFER S., and RAMAN, SHANKAR R., and SANTRY, HEENA P., and DEHMER, JEFFREY J., Modern surgical communication and the practice of surgery, 95, 7:33
NICOLETTI, BETSY, Socioeconomic tips: Billing for E/M services during the global period, 95, 7:64
–Socioeconomic tips: Practically speaking: Reducing your audit risk, 95, 9:30
OLLAPALLY, VINITA, 2010 Medicare Physician Fee Schedule final rule contains important changes, 95, 1:18
–What surgeons should know about...Meaningful use of electronic health records, 95, 5:7
–What surgeons should know about...The meaningful use final rule, 95, 10:7
–What surgeons should know about...Recovery audit contractors: An update, 95, 8:8
OTA, DAVID M., and NELSON, HEIDI, ACOSOG news: Patient advocates: “Our job is purely about patient safety,” 95, 1:57
–ACOSOG news: Changing multidisciplinary cancer treatment through ACOSOG trials, 95, 4:38
OTA, DAVID M., and NELSON, HEIDI, and GIULIANO, ARMANDO, ACOSOG news: Node biopsy vs. full lymph node dissection for breast cancer, 95, 10:58
OTA, DAVID M., and NELSON, HEIDI, and MARDIS, ELAINE, ACOSOG news: Translational science in ACOSOG trials, 95, 5:39
OTA, DAVID M., and WILKE, LEE GRAVATT, and NELSON, HEIDI, ACOSOG news: Promoting patient safety through peer review, 95, 3:45
PEEBLES, RHONDA, Chapter news, 95, 3:54, 4:46, 6:62, 8:49, 10:70, 12:44
PEREGRIN, TONY, Checklists for success inside the OR and beyond: An interview with Atul Gawande, MD, FACS, 95, 5:24
–Surgical lifestyles: An orthopaedic surgeon in space: An interview with Robert Satcher, MD, PhD, 95, 4:11
–Surgical lifestyles: To serve and protect: An interview with a surgeon-SWAT cop, 95, 2:10
PERRIER, NANCY D., and LANDRY, CHRISTINE S., and GRUBBS, ELIZABETH G., and LEE, JEFFREY E., From scalpel to console: A suggested model for surgical skill acquisition, 95, 8:20
POLEY, STEPHANIE, and GAUL, KATIE, and BELSKY, DANIEL, and RICKETTS, THOMAS, HPRI data tracks: Surgical deserts in the U.S.: Counties without surgeons, 95, 9:32
POLEY, STEPHANIE, and RICKETTS, THOMAS, and BELSKY, DANIEL, and GAUL, KATIE, HPRI data tracks: Pediatric surgeons: Subspecialists increase faster than generalists, 95, 10:35
POLEY, STEPHANIE, and RICKETTS, THOMAS, and WALKER, ELIZABETH, HPRI data tracks: The aging surgeon population: Replacement rates vary, 95, 12:27
POLEY, STEPHANIE, and WALKER, ELIZABETH, and BELSKY, DANIEL, and NELSON, JENNIFER S., and RICKETTS, THOMAS, and GIULIANO, ARMANDO, and POWELL, ANATHEA C., Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training, 95, 7:21
PRABHAKARAN, SANGEETHA, and MELIS, MARCOVALERIO, and KAAFARANI, HAYTHAM, and MÖLLER, MECKER G., Addressing workforce issues with foreign medical graduates, 95, 7:27
RATTAN, RISHI, Volunteerism is not enough, 95, 9:25
REGNIER, STEPHEN, J., Surgical lifestyles: Heart and soul: A surgeon rebuilds his life after a cardiac crisis, 95, 3:14
REISMAN, NEAL R., Risk management perspective on the difficult patient and family, 95, 5:20
RICKETTS, THOMAS, and BELSKY, DANIEL, and GAUL, KATIE, and POLEY, STEPHANIE, HPRI data tracks: Pediatric surgeons: Subspecialists increase faster than generalists, 95, 10:35
RICKETTS, THOMAS, and BELSKY, DANIEL, and GAUL, KATIE, and POLEY, STEPHANIE, HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type, 95, 11:40
RICKETTS, THOMAS, and POLEY, STEPHANIE, and GAUL, KATIE, and BELSKY, DANIEL, HPRI data tracks: Pediatric surgeons: Subspecialists increase faster than generalists, 95, 10:35
RICKETTS, THOMAS, and NELLIGAN, CAITLIN, and WRIGHT, BRAD, and SCARBOROUGH, JOHN, and POLEY, STEPHANIE, and WALKER, ELIZABETH, HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type, 95, 11:40
RICKETTS, THOMAS, and POLEY, STEPHANIE, and NELLIGAN, CAITLIN, and WRIGHT, BRAD, and SCARBOROUGH, JOHN, and POLEY, STEPHANIE, and WALKER, ELIZABETH, HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type, 95, 11:40
RUSCHER, KIMBERLY A., and CHU, KATHRYN, and HEDGES, JEREMY, Is the generalist surgeon obsolete? The impact of the general surgeon shortage on global health, 95, 4:24
RUSCHER, KIMBERLY A., and SANTIN, BRIAN J., Do more requirements make a better surgeon? 95, 7:40
RUSSELL, KATHRYN W., and HARKEN, ALDEN and RUSSELL, THOMAS R., and HARKEN, TABETHA R., Surgical megafauna, 95, 3:24
RUSSELL, THOMAS R., and HARKEN, TABETHA R., and RUSSELL, KATHRYN W., and HARKEN, ALDEN, Surgical megafauna, 95, 3:24
SANTIN, BRIAN J., and RUSCHER, KIMBERLY A., Do more requirements make a better surgeon? 95, 7:40
SANTRY, HEENA P., Second annual RAS essay contest: Volunteerrism, 95, 9:18
–and DEHERM, JEFFREY J., and NELSON, JENNIFER S., and RAMAN, SHANKAR R., Modern surgical communication and the practice of surgery, 95, 7:33
SCARBOROUGH, JOHN, and POLEY, STEPHANIE, and WALKER, ELIZABETH, and RICKETTS, THOMAS, and NELLIGAN, CAITLIN, and WRIGHT, BRAD, HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type, 95, 11:40
SCHENK, WILLIAM P., Preparing for the Maintenance of Certification examination, 95, 9:11
SCHNEIDMAN, DIANE S., JSAC focuses on the future of surgery in the aftermath of the ACA’s passage, 95, 10:41
–Surgeons respond to the needs of a broken nation, 95, 6:6
–Young surgeons and chapter leaders take on today’s challenges, 95, 10:48
SCHWARTZ, GARY, Surgical volunteerism objective: Symbiosis, 95, 9:26
SHIBATA, DAVID, Report of the 2010 Japan Traveling Fellow, 95, 10:60
SHULMAN, IVAN, On the importance of role models: The views of a senior surgeon, 95, 2:15
SNIDER, HOWARD C., and WILLEY, SHAWNA C., and LAIDLEY, ALISON L., and WHITACRE, ERIC B., Meeting the challenge—A surgeon-centered quality program: The American Society of Breast Surgeons Mastery of Breast Surgery Pilot Program, 95, 1:23
STARZL, THOMAS E., Citation for Prof. Bernard Launois, 95, 11:46
STEIN, KAREN, Training for a rural surgical career: The reflections of two Gundersen Lutheran graduates, 95, 8:11
STEvens, LAURIE A., Responding to the difficult patient, 95, 5:12
STEWART, AMILU, ACS Foundation to sponsor medical industry panel at Clinical Congress, 95, 9:46
SUTTON, JON H., Advocacy advisor: Advocacy with a day at the capitol, 95, 8:33
–College advocacy agenda advances through the AMA, 95, 7:72
–A cut above the rest: Surgical Caucus turns 20, 95, 5:37
–Issues and policies addressed at the AMA Interim HOD meeting, 95, 2:28
–Report on the 2010 AMA HOD meeting, 95, 9:41
–and MACIAS, ALEXIS, 2010 state legislative wrap-up, 95, 11:23
SWANSON, RICHARD S., Governors’ Committee on Surgical Practice: An update, 95, 10:29
TADLOCK, MATTHEW D., Pacific Partnership: A U.S. Navy resident’s experience on the USNS Mercy in Southeast Asia, 95, 2:17
W

WALKER, ELIZABETH, and RICKETTS, THOMAS, and NELLIGAN, CAITLIN, and WRIGHT, BRAD, and SCARBOROUGH, JOHN, and POLEY, STEPHANIE, HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type, 95, 11:40

WALTERS, ALEXIS, Midwest surgeon leaders engage in advocacy development at conference, 95, 7:69

–State STATs: Medical liability reform and the states, 95, 3:29
–State STATs: Scope of practice overview, 95:7:62
–State STATs: The UEVHPA: An update, 95, 5:28

WARSHAW, ANDREW L., Citation for Prof. Mehmet A. Haberal, 95, 11:45

WEINGER, MATTHEW B., and STOELTING, ROBERT K., Dangers of postoperative opioids: Is there a cure? 95, 2:21

WEIRETER, LEONARD, J., Jr., and FILDES, JOHN Experience in Haiti allows College to better prepare for future crises, 95, 9:15

WEIRETER, LEONARD, J., and FLINT, LEWIS, and FRYKBERG, ERIC, 10 questions and answers about disasters and disaster response, 95, 3:6

WEST, MICHAEL A., Governors’ Committee on Surgical Infections and Environmental Risks: An update, 95, 9:27

WHITACRE, ERIC B., and SNIDER, HOWARD C., and WILLEY, SHAWNA C., and LAIDLEY, ALISON L., Meeting the challenge—A surgeon-centered quality program: The American Society of Breast Surgeons Mastery of Breast Surgery Pilot Program, 95, 1:23

WILKE, LEE GRAVATT, and NELSON, HEIDI, and OTA, DAVID M., ACOSOG news: Promoting patient safety through peer review, 95, 3:45

WILLEY, SHAWNA C., and LAIDLEY, ALISON L., and WHITACRE, ERIC B., and SNIDER, HOWARD C., Meeting the challenge—A surgeon-centered quality program: The American Society of Breast Surgeons Mastery of Breast Surgery Pilot Program, 95, 1:23

WRIGHT, BRAD, and SCARBOROUGH, JOHN, and POLEY, STEPHANIE, and WALKER, ELIZABETH, and RICKETTS, THOMAS, and NELLIGAN, CAITLIN, HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type, 95, 11:40

Y

YOAK, STUART D., Kamangar Awards help create ethics training for residents, 95, 4:28
Subject index

A

ACCESS TO CARE (see WORKFORCE ISSUES)
ACCOUNTABLE CARE ACT (see LEGISLATIVE AND GOVERNMENT ISSUES: FEDERAL)
ACCREDITATION (see THE JOINT COMMISSION)
ADVOCACY AND HEALTH POLICY (see also: AMERICAN COLLEGE OF SURGEONS: Advocacy and Health Policy and LEGISLATIVE AND GOVERNMENT ISSUES)

–Advocacy advisor: Advancing advocacy with a day at the capitol (Sutton), 95, 8:33
–Advocacy advisor: Building relationships through campaign work (Grill, Morse), 95, 10:33
–Advocacy advisor: Developing a successful coalition (Baker), 95, 2:25
–Advocacy advisor: Grassroots, grasstops, and...Astroturf? (Baker), 95, 6:35
–Advocacy advisor: Lobbyists—Who needs them? (Baker), 95, 4:27
–Advocacy advisor: Resources for effective advocacy (Grill and Harris), 95, 12:25
–Midwest surgeon leaders engage in advocacy development at conference (Walters), 95, 7:69

AMERICAN COLLEGE OF SURGEONS

Activities
–Comprehensive general surgery review course slated for June, 95, 4:36
–Looking forward (Hoyt), 95, 2:4, 4:4, 5:4, 8:4, 12:4
–Report on ACSPA/ACS activities, October 2009 (Zinner), 95, 1:59
–Report on ACSPA/ACS activities, February 2010 (Zinner), 95, 6:52
–Report on ACSPA/ACS activities, June 2010 (Zinner), 95, 9:51

Advocacy and Health Policy
–2010 Leadership Conference to be held in July, 95, 2:37
–ACS leaders visit key senators, 95, 1:58
–College advocacy agenda advances through the AMA (Sutton), 95, 7:72
–College advocates for ensuring quality eye care for America’s veterans (Maa, Hedstrom), 95, 9:8
–Improve your advocacy skills by attending the 2010 JSAC in July (Morse), 95, 2:7
–JSAC focuses on the future of surgery in the after-math of the ACA’s passage (Schneidman), 95, 10:41

American College of Surgeons Foundation
–ACS Foundation receives educational grant for patient skill kit, 95, 4:33
–ACS Foundation/Saint Louis University announce Emerson Scholar in Residence program, 95, 12:38
–ACS Foundation/Saint Louis University announce Scholar in Residence program, 95, 11:60

American College of Surgeons Oncology Group (ACOSOG) (see also CLINICAL TRIALS)
–ACOSOG news: Changing multidisciplinary cancer treatment through ACOSOG trials (Ota, Nelson), 95, 4:38
–ACOSOG news: Node biopsy vs. full lymph node dissection for breast cancer (Ota, Nelson, Giuliano), 95, 10:58
–ACOSOG news: Patient advocates: “Our job is purely about patient safety” (Nelson, Ota), 95, 1:57
–ACOSOG news: Promoting patient safety through peer review (Wilke, Nelson, Ota), 95, 3:45
–ACOSOG news: Translational science in ACOSOG trials (Ota, Nelson, Mardis), 95, 5:39

American College of Surgeons Professional Association
–Report on ACSPA/ACS activities, October 2009 (Zinner), 95, 1:59
–Report on ACSPA/ACS activities, February 2010 (Zinner), 95, 6:52
–Report on ACSPA/ACS activities, June 2010 (Zinner), 95, 9:51

Annual meeting (see AMERICAN COLLEGE OF SURGEONS: Clinical Congress)

Archives
–Presidential Addresses available on archives site, 95, 6:41

Awards
–Amilu Stewart, MD, FACS, honored with 2010 Distinguished Service Award, 95, 10:39
–Dr. Greenfield receives the College’s Jacobson Innovation Award for 2010, 95, 8:35
–Fellows honored for volunteerism (Casey, Melchizedek), 95, 9:36
–Nominations sought for 2010 volunteerism and humanitarian award, 95, 1:55

Bulletin of the American College of Surgeons
–Instructions to authors, 95, 3:47, 5:41, 7:81, 9:57, 11:57
–Correction, 95, 2:30
Letters, 95, 1:66, 4:41, 8:43, 11:56

Chapters

Chapter news (Peebles), 94, 3:54, 4:46, 6:62, 8:49, 10:70, 12:44

Clinical Congress

2010 Clinical Congress Preliminary Program, 95, 7:45

ACS Foundation to sponsor medical industry panel at Clinical Congress (Stewart), 95, 9:46

Clinical Congress panel to address surgeon burnout, 95, 9:44

Highlights of the 95th annual Clinical Congress, 95, 1:31

Official notice: Annual Business Meeting of Members, American College of Surgeons, 95, 9:36

Plan to attend daily panel sessions at 2010 Clinical Congress, 95, 8:47

Surgical professionalism panels offered at Congress, 95, 7:78

Development (see AMERICAN COLLEGE OF SURGEONS: American College of Surgeons Foundation)

Disciplinary actions

Disciplinary actions taken, 95, 2:35, 6:57, 10:53

Education

ACS Foundation receives educational grant for patient skill kit, 95, 4:33

Executive Director

David B. Hoyt, MD, FACS, becomes ACS Executive Director, 95, 1:50

Executive Director’s annual report (Hoyt), 95, 12:6


Fellows and Members (see also AMERICAN COLLEGE OF SURGEONS: Awards)

ACS nominee appointed to key federal board, 95, 11:53

JACS Editor-in-Chief named president-elect of ASA, 95, 7:67

Members in the news, 95, 3:41, 7:67, 11:53

Spotlight on a U.S. Army surgeon: Interview with MAJ Jennifer Gurney, MD, FACS (Maniscalco-Theberge), 95, 11:29

Governors, Board of

Governors’ committee addresses surgeon burnout, 95, 10:40

Governors’ Committee on Chapter Activities: An update (Lally), 95, 8:25

Governors’ Committee on Physician Competency and Health: An update (Hanks), 95, 8:27

Governors’ Committee on Socioeconomic Issues: An update (Zwolak), 95, 10:31

Governors’ Committee on Surgical Infections and Environmental Risks: An update (Swanson), 95, 10:29

Governors’ Committee to Study the Fiscal Affairs of the College: An update (Elsey), 95, 8:30

Health Policy Research Institute

HPRI data tracks: The aging surgeon population: Replacement rates vary (Walker, Poley, Ricketts), 12:27

HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type (Nelligan, Wright, Scarborough, Poley, Walker, Ricketts), 95, 11:40

HPRI data tracks: Pediatric surgeons: Subspecialists increase faster than generalists (Poley, Ricketts, Belsky, Gaul), 95, 10:35

HPRI data tracks: Surgical deserts in the U.S.: Counties without surgeons (Belsky, Ricketts, Poley, Gaul), 95, 9:32

Honorary Fellowships

Citation for Prof. Dario Birolini (Britt), 95, 11:44

Citation for Prof. Mehmet A. Haberal (Warshaw), 95, 11:45

Citation for Prof. Bernard Launois (Starzl), 95, 11:46

Citation for Prof. Ralph John Nicholls (Goldberg), 95, 11:47

Citation for Prof. Tehemton Erach Udawadia (Hunter), 95, 11:49

Citation for Prof. William Ignace Wei (Finley), 95, 11:50

Honorary Fellowship awarded to six prominent surgeons, 95, 11:44

Journal of the American College of Surgeons

JACS Editor-in-Chief named president-elect of ASA, 95, 7:67

Officers and Staff

ACS Officers and Regents, 95, 1:46

Call for nominations for ACS Officers-Elect, 95, 1:53, 2:34

David B. Hoyt, MD, FACS, becomes ACS Executive Director, 95, 1:50

Dr. Fildes named Trauma Medical Director, 95, 5:32

Dr. Greenfield chosen as next ACS President-Elect, 95, 12:31

Dr. Rotondo named Chair, ACS Committee on Trauma, 95, 5:32

L. D. Britt, MD, MPH, FACS, installed as 91st President of the ACS, 95, 11:42

Thoughts as I leave office (McGinnis), 95, 10:14

Operation Giving Back (see VOlunteerism)

Presidential Address

Presidential Address: ACS: A legacy of leadership, 95, 12:15

Presidential Addresses available on archives site, 95, 6:41

Regents, Board of

Call for nominations for the ACS Board of Regents, 95, 1:53, 2:34

A challenging year (Eastman), 95, 10:11

Resident and Associate Society of the Amer-
can College of Surgeons (RAS-ACS) (see also EDUCATION AND TRAINING and YOUNG SURGEONS)

- Addressing workforce issues with foreign medical graduates (Kaafarani, Möller, Prabhakaran, Melis) 95, 7:27
- A blessing and a curse (Castle), 95, 9:20
- Do more requirements make a better surgeon? (Santin, Ruscher), 95, 7:40
- Finding my own Lambaréné (Hughes), 95, 9:23
- Health care policy and the future of surgery (Cooke), 95, 7:7
- Is the generalist surgeon obsolete? The impact of the general surgeon shortage on global health (Hedges, Ruscher, Chu) 95, 4:24
- The meaning of “surgeon” in the mountains of Honduras (Bittner IV), 95, 9:19

Scholarships/fellowships
- 2010 ACS Japan Traveling Fellow selected, 95, 2:30
- 2010 Health Policy Scholars announced, 95, 7:76
- 2010 International Guest Scholars selected, 95, 2:30
- 2010 Japan and German Exchange Travelers announced, 95, 7:75
- 2011 Traveling Fellowship to Germany announced, 95, 2:32
- ACS resident research scholarships are available, 95, 7:80
- ACS Traveling Fellowship to Japan available, 95, 3:43
- ANZ Traveling Fellow selected for 2011, 95, 6:41
- ANZ Traveling Fellowship for 2012 announced, 95, 8:39
- The Clowes ACS/AAST/NIGMS Mentored Clinical Scientist Development Award available, 95, 10:55
- College announces Clinical Scholars Program, 95, 3:41
- College seeks nominations for 2010 Jacobson Promising Investigator Award, 95, 2:33
- Faculty research fellowships offered for 2011–2013, 95, 8:40
- Germany Traveling Fellow selected for 2011, 95, 9:44
- International Guest Scholarships available for 2011 (95, 6:50)
- Martin, Carrico, and Argenta Fellowships awarded by College, 95, 6:42
- Oweida scholarship availability announced, 95, 10:59
- Report of the 2009 International Guest Scholar (Cruz Vargas), 95, 6:45
- Report of the 2009 Oweida Scholar (Kanning), 95, 3:38
- Report of the 2010 Australia and New Zealand Traveling Fellow (Merchant), 95, 12:34
- Report of the 2010 Japan Traveling Fellow (Shibata), 95, 10:60
- Resident Research Scholarships for 2010 awarded, 95, 6:43

Statements
- Statement on health care disparities, 95, 11:34
- Statement on high-performance teams, 95, 2:23

Trauma (see also TRAUMA)
- 2010 COT Residents Trauma Papers Competition winners announced, 95, 7:65
- ATLS® inaugurates course in Malaysia (Brasel, Hollands, Chapleau, Alkhatib), 95, 5:33
- Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa (Jacobs, Jr.; Burns; Darko), 95, 6:23
- Dr. Fildes named Trauma Medical Director, 95, 5:32
- Dr. Rotondo named Chair, ACS Committee on Trauma, 95, 5:32
- NTDB® data points: The 2009 Annual Pediatric Report: How old is old enough? (Fantus, Nathens), 95, 2:39
- NTDB® data points: Annual Report 2009: A hip report (Fantus, Nathens, MD), 95, 1:71
- NTDB® data points: Another national chapter (Fantus, Nathens, Fildes), 95, 5:43
- NTDB® data points: Children are our future (Fantus), 95, 4:43
- NTDB® data points: Double McTwist 1260 (Fantus), 95, 6:59
- NTDB® data points: Drive-through (Fantus), 95, 12:42
- NTDB® data points: “Eye see” (Fantus, Fildes), 95, 11:59
- NTDB® data points: The fall of mankind (Fantus), 95, 10:67
- NTDB® data points: Going downhill (Fantus), 95, 7:83
- NTDB® data points: IPV (Fantus, Avery), 95, 3:51
- NTDB® data points: Older and thinner (Fantus), 95, 9:59
- NTDB® data points: Thumbs up (Fantus, Fildes), 95, 8:46
- Trauma meetings calendar, 95, 2:37, 3:46, 6:57, 7:66
CANCER (see also AMERICAN COLLEGE OF SURGEONS: American College of Surgeons Oncology Group)

College supports American Cancer Society screening mammography guidelines, 95, 1:51
Meeting the challenge—A surgeon-centered quality program: The American Society of Breast Surgeons Mastery of Breast Surgery Pilot Program (Laidley, Whitacre, Snider, Willey), 95, 1:23
NAPBC now surpasses 100 accredited centers mark, 95, 2:31

CLINICAL TRIALS (see AMERICAN COLLEGE OF SURGEONS: American College of Surgeons Oncology Group and SURGICAL RESEARCH)

Comprehensive general surgery review course slated for June, 95, 4:36
Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa (Jacobs, Jr.; Burns; Darko), 95, 6:23
Preparation for the Maintenance of Certification examination (Schecter), 95, 9:11
Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training (Buck II, Bittner IV, Hayanga, Powell), 95, 7:21
Training for a rural surgical career: The reflections of two Gundersen Lutheran graduates (Stein), 95, 8:11

EDUCATION AND TRAINING (see also AMERICAN COLLEGE OF SURGEONS: Resident and Associate Society (RAS-ACS) and YOUNG SURGEONS)

Comprehensive general surgery review course slated for June, 95, 4:36
Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa (Jacobs, Jr.; Burns; Darko), 95, 6:23
Do more requirements make a better surgeon? (Santin, Ruscher), 95, 7:40
From scalpel to console: A suggested model for surgical skill acquisition (Landry, Grubbs, Lee, Perrier), 95, 8:20
Kamangar Awards help create ethics training for residents (Yoak), 95, 4:28
Looking forward (Hoyt), 95, 9:4
Preparing for the Maintenance of Certification examination (Schecter), 95, 9:11
Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training (Buck II, Bittner IV, Hayanga, Powell), 95, 7:21
Training for a rural surgical career: The reflections of two Gundersen Lutheran graduates (Stein), 95, 8:11

ETHICS

Kamangar Awards help create ethics training for residents (Yoak), 95, 4:28
Statement on health care disparities, 95, 11:34

EVIDENCE-BASED MEDICINE (see QUALITY OF CARE)

GLOBAL HEALTH CARE (see also MEDICAL TOURISM and VOLUNTEERISM)

Development of the Medical and Surgical Simulation Institute: Accra Ghana, West Africa (Jacobs, Jr.; Burns; Darko), 95, 6:23

GUIDELINES AND STANDARDS (see THE JOINT COMMISSION)

HEALTH CARE REFORM (see also PAY FOR PERFORMANCE and REIMBURSEMENT)

Health care policy and advocacy: A call to arms for residents and associates (Broghammer), 95, 7:10
Health care policy and the future of surgery (Cooke), 95, 7:7
Health care reform becomes law—with room for improvement (Hedstrom), 95, 6:21
JSAC focuses on the future of surgery in the aftermath of the ACA’s passage (Schneidman), 95, 10:41
Leadership opportunities in a more institution-based health care environment (Gregory), 95, 10:22
Looking forward (Hoyt), 95, 3:4
The modern history of U.S. health care reform: A primer for practicing surgeons, residents, and associate fellows (Mery, Liepert, Cooke), 95, 7:15
Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training (Buck II, Bittner IV, Hayanga, Powell), 95, 7:21
Surgery News reports rise in number of uninsured in 2009, 95, 8:52

HEALTH CARE DISPARITIES
Statement on health care disparities, 95, 11:34

HISTORY (see AMERICAN COLLEGE OF SURGEONS: Archives)

IN MEMORIAM
In memoriam: J. Bradley Aust, MD, FACS (McFee), 95, 6:37
In memoriam: Paul F. Nora, MD, PhD, FACS (Hanlon, Russell), 95, 2:26
In memoriam: Harris B. Shumacker, Jr., MD, FACS, remembered (Nahrwold), 95, 3:34

INFORMATICS
Modern surgical communication and the practice of surgery (Santry, Dehmer, Nelson, Raman), 95, 7:33
What surgeons should know about...The meaningful use final rule (Ollapally), 95, 10:7
What surgeons should know about...Meaningful use of electronic health records (Ollapally), 95, 5:7

THE JOINT COMMISSION
A look at The Joint Commission: 2009 Eisenberg Award recipients named, 95, 1:63
A look at The Joint Commission: Annual report on hospital quality and safety shows steady improvement, 95, 4:36
A look at The Joint Commission: CMS approves continued deeming authority, 95, 3:49
A look at The Joint Commission: Center for Trans-forming Healthcare releases targeted solutions tool, 95, 12:39
A look at The Joint Commission: Helping hospitals meet future performance measurement expectations, 95, 10:56
A look at The Joint Commission: Joint Commission International celebrates a milestone, 95, 2:36
A look at The Joint Commission: New book examines how negative behavior affects patient safety and outcomes, 95, 8:41
A look at The Joint Commission: Preventing violence in health care facilities, 95, 9:49
A look at The Joint Commission: Revised medical staff bylaws standard approved, 95, 6:51
A look at The Joint Commission: Safe Surgery Guide takes on major challenges to surgical safety, 95, 11:51
Looking forward (Hoyt), 95, 11:4

LEADERSHIP
2010 Leadership Conference to be held in July, 95, 2:37
College to present leadership skills course in May, 95, 4:35
Leadership opportunities in a more institution-based health care environment (Gregory), 95, 10:22
Physicians and surgeons as board trustees: Be careful what you wish for (McArthur), 95, 10:26
Young surgeons and chapter leaders take on today’s challenges (Schneidman), 95, 10:48

LEGISLATIVE AND GOVERNMENT ISSUES (see also MEDICARE/MEDICAID and REIMBURSEMENT)
–Who said that midterm elections aren’t interesting? (Morse), 95, 6:31

Federal
–The ACS plays an active role in initial implementation of the ACA (Jasak), 95, 12:17
–Health care reform becomes law—with room for improvement (Hedstrom), 95, 6:21
–Looking forward (Hoyt), 95, 10:4

State
–2010 state legislative wrap-up (Macias, Sutton), 95, 11:23
–State STATs: Medical liability reform and the states (Walters), 95, 3:29
–State STATs: Repeal of the UPPL (Grill), 95, 11:38
–State STATs: Scope of practice overview (Walters), 95, 7:62
–State STATs: Trauma funding in the states (Macias), 95, 9:29
–State STATs: The UEVHPA: An update (Walters), 95, 5:28
LIFESTYLES
Surgical lifestyles: Heart and soul: A surgeon rebuilds his life after a cardiac crisis (Regnier), 95, 3:14
Surgical lifestyles: An orthopaedic surgeon in space: An interview with Robert Satcher, MD, PhD (Peregrin), 95, 4:11
Surgical lifestyles: To serve and protect: An interview with a surgeon-SWAT cop (Peregrin), 95, 2:10
Surgical lifestyles: A view from the cockpit: Surgeon and pilot Richard C. Karl, MD, FACS, promotes aviation safety in the OR (Glickson), 95, 11:6

MEDICAL TOURISM
Round-trip service: Commentary (McGrath), 95, 8:16

MEDICARE/MEDICAID (see CURRENT PROCEDURAL TERMINOLOGY and REIMBURSEMENT)
MENTORSHIP
On the importance of role models: The views of a senior surgeon (Shulman), 95, 2:15

MILITARY SURGERY (see also TRAUMA)
Spotlight on a U.S. Army surgeon: Interview with MAJ Jennifer Gurney, MD, FACS (Maniscalco-Theberge), 95, 11:29

OPERATION GIVING BACK (see VOLUNTEERISM)
OUTCOMES
College announces Clinical Scholars Program, 95, 3:41
Outcomes research course scheduled for November, 95, 9:47

PATIENT COMMUNICATION
Dealing with the difficult family: Lessons from palliative care (Dunn), 95, 5:16
The difficult or disruptive surgical patient: Practical strategies for diagnosis and management (McGrath), 95, 5:10
Responding to the difficult patient (Stevens), 95, 5:12
Risk management perspective on the difficult patient and family, (Reisman), 95, 5:20

PERFORMANCE MEASUREMENT (see THE JOINT COMMISSION and MEDICARE/MEDICAID and QUALITY OF CARE)
PERIOPERATIVE CARE
Dangers of postoperative opioids: Is there a cure? (Stoelting, Weinger), 95, 2:21

PRACTICE MANAGEMENT (see also CURRENT PROCEDURAL TERMINOLOGY and REIMBURSEMENT)
Socioeconomic tips: Practice management resources for the surgeon's office (Mariani), 95, 5:30
What surgeons should know about...The meaningful use final rule (Ollapally), 95, 10:7
What surgeons should know about...Meaningful use of electronic health records (Ollapally), 95, 5:7

PROFESSIONAL LIABILITY
State STATs: Medical liability reform and the states (Walters), 95, 3:29

PROFESSIONALISM (see also EDUCATION AND TRAINING and ETHICS)
Dealing with the difficult family: Lessons from palliative care (Dunn), 95, 5:16
The difficult or disruptive surgical patient: Practical strategies for diagnosis and management (McGrath), 95, 5:10
Responding to the difficult patient (Stevens), 95, 5:12
Risk management perspective on the difficult patient and family, (Reisman), 95, 5:20

QUALITY OF CARE (see also HEALTH CARE REFORM)
Checklists for success inside the OR and beyond: An interview with Atul Gawande, MD, FACS (Peregrin), 95, 5:24
College to present leadership skills course in May, 95, 4:35
Looking forward (Hoyt), 95, 4:4
Statement on high-performance teams, 95, 2:23
What surgeons should know about...PQRI reporting in 2010 (Burley), 95, 4:6

REGULATORY ISSUES (see LEGISLATIVE/GOVERNMENT ISSUES)
REIMBURSEMENT (see also CURRENT PROCEDURAL TERMINOLOGY, MEDICARE/MEDICAID, and PRACTICE MANAGEMENT)
2010 Medicare Physician Fee Schedule final rule con-
tains important changes (Ollapally), 95, 1:18
Medicare physician reimbursement: Is the SGR’s end in sight? (Friesen), 95, 4:20
Socioeconomic tips: Are E/M services reportable with a surgical procedure? (LeGrand), 95, 11:36
Socioeconomic tips: Billing for E/M services during the global period (Nicoletti), 95, 7:64
Socioeconomic tips: General equivalency mapping helps convert ICD-9-CM codes to ICD-10-CM (Mari-ani), 95, 3:31
Socioeconomic tips: Practically speaking: Reducing your audit risk (Nicoletti), 95, 9:30
What surgeons should know about...2010 changes to Medicare payment for consultation services (Hoy), 95, 1:9
What surgeons should know about...Recovery audit contractors: An update (Ollapally), 95, 8:8
RESIDENTS (see AMERICAN COLLEGE OF SURGEONS: Resident and Associate Society of the American College of Surgeons (RAS-ACS) and EDUCATION AND TRAINING and YOUNG SURGEONS)
RURAL SURGERY
Rural surgeons—We must grow our own (Huffstutter), 95, 4:16
Rural surgeons—We must grow our own: A response (Cofer), 95, 4:19
Training for a rural surgical career: The reflections of two Gundersen Lutheran graduates (Stein), 95, 8:11

SCHOLARSHIPS AND FELLOWSHIPS (see also AMERICAN COLLEGE OF SURGEONS: Scholarships)
ACS Foundation/Saint Louis University announce Emerson Scholar in Residence program, 95, 12:38
ACS Foundation/Saint Louis University announce Scholar in Residence program, 95, 11:60
Heller School Executive Leadership Program scholarships available, 95, 1:54

SCOPE OF PRACTICE
College advocates for ensuring quality eye care for America’s veterans (Maa, Hedstrom), 95, 9:8
State STATs: Scope of practice overview (Walters), 95, 7:62

SURGICAL RESEARCH
College announces Clinical Scholars Program, 95, 3:41
College seeks nominations for 2010 Jacobson Promising Investigator Award, 95, 2:33
Dr. Greenfield receives the College’s Jacobson Innovation Award for 2010, 95, 8:35

From Surgery News: Stem cell ruling worries investigators, 95, 11:55

TRAUMA (see also AMERICAN COLLEGE OF SURGEONS: Trauma and MILITARY SURGERY)
10 questions and answers about disasters and disaster response (Frykberg, Weireter, Flint), 95, 3:6
Emergency rooms treated 3.5 million MVAs in 2006, 95, 4:31
Experience in Haiti allows College to better prepare for future crises (Fildes, Weireter, Jr.), 95, 9:15
Haiti impressions: January 23–26 and January 28–February 3, 2010 (Eastman), 95, 6:10
Looking forward (Hoyt), 6:4
Pacific Partnership: A U.S. Navy resident’s experience on the USNS Mercy in Southeast Asia (Tadlock), 95, 2:17
The quest for sustainable trauma funding: The Georgia story (Ashley), 95, 10:17
The role of civilian surgical teams in response to international disasters (Briggs), 95, 1:13
State STATs: Trauma funding in the states (Macias), 95, 9:29
State STATs: The UEVHPA: An update (Walters), 95, 5:28
Surgeons respond to the needs of a broken nation (Schneidman), 95, 6:6

VOLUNTEERISM (see also GLOBAL HEALTH CARE)
A blessing and a curse (Castle), 95, 9:20
Bullets, betel nut, and bacteria: Medicine in the Solomon Islands (Natuzzi), 95, 3:16
Experience in Haiti allows College to better prepare for future crises (Fildes, Weireter, Jr.), 95, 9:15
Fellows honored for volunteerism, (Casey, Melchizedek), 95, 9:36
Finding my own Lambaréné (Hughes), 95, 9:23
A gift to yourself (Heyrosa), 95, 9:22
Haiti impressions: January 23–26 and January 28–February 3, 2010 (Eastman), 95, 6:10
HPRI data tracks: Charity care among surgeons: Hours vary by specialty and practice type (Nelligan, Wright, Scarborough, Poley, Walker, Ricketts), 95, 11:40
The meaning of “surgeon” in the mountains of Honduras (Bittner IV), 95, 9:19
Nominations sought for 2010 volunteerism and humanitarian award, 95, 1:55
Pacific Partnership: A U.S. Navy resident’s experience on the USNS Mercy in Southeast Asia (Tadlock), 95, 2:17
Second annual RAS essay contest: Volunteerism (Santry), 95, 9:18
Service as transformation: Girls on the run (Powell), 95, 9:24
Surgeons respond to the needs of a broken nation (Schneidman), 95, 6:6
A surgical mission to Cambodia: Delivering supplies and care (Brender), 95, 12:21
Surgical volunteerism (Hedges), 95, 9:21
Surgical volunteerism objective: Symbiosis (Schwartz), 9:26
Volunteerism is not enough (Rattan), 95, 9:25

W

WOMEN IN SURGERY
Spotlight on a U.S. Army surgeon: Interview with MAJ Jennifer Gurney, MD, FACS (Maniscalco-Theberge), 95, 11:29

WORKFORCE ISSUES
Addressing workforce issues with foreign medical graduates (Kaafarani, Möller, Prabhakaran, Melis) 95, 7:27
From Surgery News: More minorities enrolling in medical school, 95, 12:41
General surgery residency programs lack capacity to address shortage, 95, 8:38
HPRI data tracks: The aging surgeon population: Replacement rates vary (Walker, Poley, Ricketts), 12:27
HPRI data tracks: Pediatric surgeons: Subspecialists increase faster than generalists (Poley, Ricketts, Belsky, Gaul), 95, 10:35
HPRI data tracks: Surgical deserts in the U.S.: Counties without surgeons (Belksy, Ricketts, Poley; Gaul), 95, 9:32
Is the generalist surgeon obsolete? The impact of the general surgeon shortage on global health (Hedges, Ruscher, Chu) 95, 4:24
Looking forward (Hoyt), 94, 7:4

Y

YOUNG SURGEONS (see also AMERICAN COLLEGE OF SURGEONS: Resident and Associate)