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I am excited to have been selected to serve as the next Executive Director of the American College of Surgeons, and I look forward to getting to know the staff, the leaders, and as many Fellows as possible during the next few months.

There has never been a better time in medicine to deliver the highest quality surgical care. We can do more for our patients than has ever been possible in the past. However, we also have many complex and difficult issues facing us, and we have much work to do.

As I take over this responsibility, I am humbled by the comprehensive and transformative accomplishments Tom Russell has achieved over the last 10 years. As a salute to him, I would like to highlight some of the important things he accomplished during his 10 years of service and the values he used to lead us.

First, Tom gave a new face to the College’s leadership and to American surgery. His positive force of personality and enthusiasm for what we do every day as surgeons created an inspiring leadership model. Tom’s success rests on the fact that he truly believes surgeons strive for excellence in providing care for their patients, on an understanding of what surgeons need if they are to continue to achieve that end, and on the conviction that the College’s role is to provide support to its member surgeons to help them achieve that goal.

When I would run into Tom at a meeting, he would always be complimentary about my surgical colleagues and have something positive to say, or he would make some positive comment about our challenges and/or our accomplishments. His positive attitude may be his greatest legacy. His enthusiasm rubbed off on our member surgeons and encouraged them to share their ideas and to participate in our discussions and activities. Tom made them feel their voices were heard and that someone in leadership truly was listening. Participation by Fellows has never been stronger in College activities due to this openness.

Tom Russell is a steward of change. Change is not easy, and requires vision and follow through to bring it about. From developing the framework for the strategic plan he brought forth to the Regents for review and discussion, which determined how the College is now organized, to finding the leaders to carry out the plan, Tom believed in the importance of us moving forward as a profession.

Today, we are measuring quality outcomes and developing clinical trials like never before. We have embraced patient safety, educational reform, and even some limitations on the work we do. From these changes has emerged the value of teamwork, and we have broadened our attractiveness to young people and women in particular. We have seen educational and communications programs flourish, and activities focusing on professionalism, leadership development, and volunteerism have emerged in a way that is unparalleled in our College’s history. We have become an organization that offers something for everyone. Tom let people in.

Tom looked out for the individual surgeon and his or her practice in this complex world. He has stressed that surgeons have to work with the other members of the medical community in order to achieve what is best for our patients. He has supported what is best for surgeons by advocating for us on many difficult and challenging socioeconomic issues. He has built bridges throughout the house of medicine and among all players in the health care field. He is respected.
broadly as a thinker, a leader, and a collaborator in dealing with issues such as quality, effectiveness, tort reform, payment reform, and the surgical workforce—issues important to all surgeons. The new home for our Washington, DC, office and the focus on health policy will be critical to maintaining our leadership role. Along with our headquarters in Chicago, IL, our enhanced presence in our nation’s Capitol will make us ideally positioned to lead and advocate for surgery at the broadest level.

During the last 10 years, there have been several additional programs that owe their success to Dr. Russell’s leadership and his relationship with the Regents, the Governors, the Officers, the members, and the staff.

I have developed great admiration for all the previous Directors of the American College of Surgeons as I have learned what each of them has accomplished. The era of leadership under Tom Russell has brought us to the forefront of the modern world of medicine. He has set the tone for going forward, and attitude is everything.

Tom: On behalf of the Fellowship and the leadership, thanks for all that you have done.

To Fellows of the College: I promise I will work hard to continue this tradition. I welcome your thoughts, your ideas, expression of your fears, and your criticisms going forward.

Please don’t hesitate to contact me by mail, e-mail, or phone, and please stop by the office if you are in town.

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.
This article summarizes changes in the 2010 Current Procedural Terminology (CPT)* codebook that are relevant to general surgery and closely related specialties. This information should be useful not only to surgeons, but also to the office staff performing coding functions.

Please take special care this year to note that several CPT codes are intentionally out of numerical sequence. Resequencing is used to allow placement of related codes in appropriate conceptual locations, regardless of the availability of sequential numbers. The resequenced codes are identified with the “#” symbol and with a reference placed numerically as a means of directing readers to the location of the reordered code. For example, see CPT code 21554 in the 2010 CPT Professional Edition Codebook.

Integumentary system

CPT code 14300 has been deleted and replaced with codes 14301 and add-on code +14302. These codes have been established to more accurately distinguish extensive adjacent tissue transfer services from existing codes: CPT code 14301, Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm and +14302, Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure). Use 14302 in conjunction with 14301.

Musculoskeletal system

Throughout the musculoskeletal system subsection of the CPT Codebook there are numerous new codes and revisions in the “Excision” category for each body area related to soft tissue tumor excisions, including the following:

- Under “Head” there are five new codes and one revision; see codes 21011–21016.
- Under “Neck (Soft Tissues) and Thorax” there are three new codes and three revisions; see codes 21552–21558.
- Under “Back and Flank” there are four new codes and revisions in the “Excision” category for each body area related to soft tissue tumor excisions, including the following:
codes and two revisions; see codes 21930–21936.
- Under “Abdomen” there are five new codes and one revision; see codes 22900–22905.
- Under “Shoulder” there are three new codes and six revisions; see codes 23071–23078 and codes 23200–23220.
- Under “Humerus (Upper Arm) and Elbow” there are three new codes and five revisions; see codes 24071–24079 and codes 24150–24152.
- Under “Forearm and Wrist” there are new three codes and four revisions; see codes 25071–25078 and code 25170.
- Under “Hand and Fingers” there are three new codes and six revisions; see codes 26111–26118 and codes 26250–26262.
- Under “Pelvis and Hip Joint” there are three new codes and seven revisions; see codes 27043–27059 and codes 27075–27078.
- Under “Femur (Thigh Region) and Knee Joint” there are three new codes and four revisions; see codes 27327–27339 and codes 27329–27365.
- Under “Leg (Tibia and Fibula) and Ankle Joint” there are three new codes and eight revisions; see codes 27615–27634 and 27640–27647.
- Under “Foot and Toes” there are three new codes and six revisions; see codes 28039–28047, also 28171–28175.

There is a new CPT code for multi-layered dressings used for difficult lower leg wounds. It is 29581, Application of multi-layer venous wound compression system, below knee. Do not report 29581 in conjunction with 29540, 29580.

**Thoracic surgery**

CPT has created two new codes and revised one code. The CPT code 32560 now reads as 32560, Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax). The new CPT codes are 32561, Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day, and 32562, Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day. All three codes use the same parenthetical: (For chest tube insertion, use 32551). And all three codes have a zero-day global billing period.

**Cardiovascular system**

CPT has revised one code and created one new code to distinguish standard from radical ligation of perforator veins. The revised code is CPT code 37760, Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg. For endoscopic procedure, use 37500. The new CPT code is 37761, Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg. Do not report 37760, 37761 in conjunction with 76937, 76942, 76998, 93971. If you perform this procedure bilaterally, code 37761 with modifier –50 (Bilateral Procedure). For endoscopic ligation of subfascial perforator veins, use 37500.

**Digestive system**

CPT 2010 has two new codes for laparoscopic repair of paraesophageal hernias. CPT 43281, Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh, and CPT code 43282, Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh. For transthoracic paraesophageal hernia repair, use code 39520. For transabdominal paraesophageal hernia repair, use code 39502. Do not report 43281, 43282 in conjunction with 43280, 43450, 43453, 43456, 43458, 49568. These codes have a 90-day global period.

- **Bariatric surgery.** CPT has a new code for bariatric surgery, 43775, Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy). For open gastric restrictive procedure, without gastric bypass, for morbid obesity, other than vertical-banded gastroplasty, use code 43843. The code 43775 has a 90-day global period.
- **Colorectal surgery.** Two new CPT codes have been created to reflect the depth of the excision by replacing the deleted CPT code 45170 (Excision of rectal tumor, transanal approach). 45171, Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness), and 45172, Excision of rectal tumor, transanal approach; including muscularis pro-
pria (ie, full thickness). For destruction of rectal tumor, transanal approach, use 45190. Also in the Digestive System subsection for Anus under the heading “Excision,” see CPT codes 46200–46288. The section containing hemorrhoid procedures has been extensively revised and is resequenced. This section includes 14 revised codes.

Evaluation and management (E/M)

• Consultations: Inpatient and outpatient.
  The guidelines for consultations and inpatient consultations have changed.
  The consultation definition included within the introductory notes under the Evaluation and Management section subheading, “Consultations,” has been revised to outline the two circumstances under which consultations provided at the request of another physician or appropriate source may be rendered: (1) to provide an opinion and services for a specific condition or problem, or (2) to allow a determination to be made whether to accept the ongoing management of the patient’s entire care or for the care of a specific condition or problem (for example, transfer of care).
  Documentation of the written or verbal request for a consultation may be accomplished by either the consultant or by the requesting physician or other appropriate source.
  These new guidelines also clarify the reporting of services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility. Please review the new guidelines for Inpatient Consultations. The CPT Codebook explains how to code for certain circumstances that involve places of service.
  • Transfer of care. Services that constitute transfer of care (for example, services that are provided for the management of the patient’s entire care or for the care of a specific condition or problem) are reported with the appropriate new or established patient codes for office or other outpatient visits, domiciliary, rest home services, or home services.
  • Nursing facility services. All the codes under the Nursing Facility Services section of the E/M section have been revised to clarify the time component. The descriptor for each code has changed and now all end with the following sentence:

  Physicians typically spend __ minutes at the bedside and on the patient’s facility floor or unit.

Prolonged physician service

Guidelines under the Prolonged Physician Service Without Direct (Face-To-Face) Patient Contact have been revised (codes 99358 and 99359). There is clarification that prolonged services may be reported on a different date than the primary service to which it is related. Also, the add-on code status was removed from code 99358, Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (List separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient Evaluation and Management service).

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Dr. Barney is associate professor and associate program director for general surgery, department of surgery, Wright State University Boonshoft School of Medicine, and member, Wright State Surgeons, Miami Valley Hospital, Dayton, OH.
What surgeons should know about...

2010 changes to Medicare payment for consultation services

by Elizabeth Hoy, MHA, Assistant Director, Regulatory Affairs and Quality Improvement Programs, Division of Advocacy and Health Policy

The final rule on 2010 Medicare physician payment contains a significant change in billing practices for consultation codes. This article explains what surgeons and their billing staffs will need to do in order to comply with the rule. Other highlights of the regulation, which was published in the Federal Register on November 25, 2009, is summarized in the article on page 18 of this issue.

What did Medicare change about billing for consultation codes?

Beginning January 1, the Centers for Medicare & Medicaid Services (CMS) will eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for tele-health consultation G-codes) on a budget-neutral basis. To compensate for this change, CMS is increasing the work relative value units (RVUs) for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into practice expense and malpractice RVU calculations.

For inpatient consultations, physicians will bill an initial hospital visit or initial nursing facility visit code for their first visit during a patient’s admission to the medical institution. In lieu of outpatient consultation codes, physicians will bill either new or established patient office visit codes, depending on whether the patient has been seen for professional services within the practice in the last three years. You must comply with existing guidelines for coding and billing office visits.

The American College of Surgeons anticipates that most surgeons will do at least as well financially under these rules as under the previous system of consult codes, because of the increase in work RVUs for office and hospital visits and the impact of increases in RVUs for practice expense and medical liability. CMS estimates the combined effect of these changes will be approximately +1 percent in 2010 for general surgeons.

Medicare previously prohibited anyone but the attending physician from billing an initial hospital visit or initial nursing home visit. Has that changed?

Yes. CMS has created a modifier (–AI) to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient’s care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the –AI modifier to the initial hospital care or initial nursing facility care code, which will identify him or her as the admitting physician of record who is overseeing the patient’s care.

Subsequent inpatient care visits by all physicians will be reported as subsequent hospital care codes and subsequent nursing facility care codes. Additional outpatient care visits will be billed using established patient outpatient/office visit codes.

How do I choose which codes to bill?

Table 1 on page 10 shows the Current Procedural Terminology (CPT)* guidelines for selecting which level of consult code to bill. These are the codes previously used to bill for consultation services that will no longer be paid by Medicare. Table 2 on page 10 shows the guidelines for selecting which level of office visit to bill. These are the codes you will have to select from to bill.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.
### Table 1: CPT Evaluation and Management (E/M) services guidelines for consultations

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>History</th>
<th>Physical exam</th>
<th>Complexity of medical decision making</th>
<th>CPT estimate of time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Office consultation</td>
<td>pf</td>
<td>pf</td>
<td>str</td>
<td>15</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation</td>
<td>epf</td>
<td>epf</td>
<td>str</td>
<td>30</td>
</tr>
<tr>
<td>99243</td>
<td>Office consultation</td>
<td>det</td>
<td>det</td>
<td>low</td>
<td>40</td>
</tr>
<tr>
<td>99244</td>
<td>Office consultation</td>
<td>comp</td>
<td>comp</td>
<td>mod</td>
<td>60</td>
</tr>
<tr>
<td>99245</td>
<td>Office consultation</td>
<td>comp</td>
<td>comp</td>
<td>high</td>
<td>80</td>
</tr>
<tr>
<td>99251</td>
<td>Inpatient consultation</td>
<td>pf</td>
<td>pf</td>
<td>str</td>
<td>20</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient consultation</td>
<td>epf</td>
<td>epf</td>
<td>str</td>
<td>40</td>
</tr>
<tr>
<td>99253</td>
<td>Inpatient consultation</td>
<td>det</td>
<td>det</td>
<td>low</td>
<td>55</td>
</tr>
<tr>
<td>99254</td>
<td>Inpatient consultation</td>
<td>comp</td>
<td>comp</td>
<td>mod</td>
<td>80</td>
</tr>
<tr>
<td>99255</td>
<td>Inpatient consultation</td>
<td>comp</td>
<td>comp</td>
<td>high</td>
<td>110</td>
</tr>
</tbody>
</table>

pf = Problem focused  
epf = Expanded problem focused  
det = Detailed  
str = Straightforward decision making  
comp = Comprehensive  
low = Low complexity decision making  
mod = Moderate complexity decision making  
high = High complexity decision making

### Table 2: CPT E/M services guidelines for office and facility visits

<table>
<thead>
<tr>
<th>2010 proposed HCPCS</th>
<th>Description</th>
<th>History</th>
<th>Physical exam</th>
<th>Complexity of medical decision making</th>
<th>CPT estimate of time (minutes)</th>
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</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office/outpatient visit, new</td>
<td>pf</td>
<td>pf</td>
<td>str</td>
<td>10</td>
</tr>
<tr>
<td>99202</td>
<td>Office/outpatient visit, new</td>
<td>epf</td>
<td>epf</td>
<td>str</td>
<td>20</td>
</tr>
<tr>
<td>99203</td>
<td>Office/outpatient visit, new</td>
<td>det</td>
<td>det</td>
<td>low</td>
<td>30</td>
</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit, new</td>
<td>comp</td>
<td>comp</td>
<td>mod</td>
<td>45</td>
</tr>
<tr>
<td>99205</td>
<td>Office/outpatient visit, new</td>
<td>comp</td>
<td>comp</td>
<td>high</td>
<td>60</td>
</tr>
<tr>
<td>99211</td>
<td>Office/outpatient visit, established</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit, established</td>
<td>pf</td>
<td>pf</td>
<td>str</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit, established</td>
<td>epf</td>
<td>epf</td>
<td>low</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit, established</td>
<td>det</td>
<td>det</td>
<td>mod</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>Office/outpatient visit, established</td>
<td>comp</td>
<td>comp</td>
<td>high</td>
<td>40</td>
</tr>
<tr>
<td>99221</td>
<td>Initial hospital care</td>
<td>det or comp</td>
<td>det or comp</td>
<td>str or low</td>
<td>30</td>
</tr>
<tr>
<td>99222</td>
<td>Initial hospital care</td>
<td>comp</td>
<td>comp</td>
<td>mod</td>
<td>50</td>
</tr>
<tr>
<td>99223</td>
<td>Initial hospital care</td>
<td>comp</td>
<td>comp</td>
<td>high</td>
<td>70</td>
</tr>
<tr>
<td>99304</td>
<td>Nursing facility care, initial</td>
<td>det or comp</td>
<td>det or comp</td>
<td>str or low</td>
<td>25</td>
</tr>
<tr>
<td>99305</td>
<td>Nursing facility care, initial</td>
<td>comp</td>
<td>comp</td>
<td>mod</td>
<td>35</td>
</tr>
<tr>
<td>99306</td>
<td>Nursing facility care, initial</td>
<td>comp</td>
<td>comp</td>
<td>high</td>
<td>45</td>
</tr>
</tbody>
</table>
for consultation services beginning January 1. Select the office visit code that most accurately reflects the level of history, physical exam, medical decision making, and time involved in the consultation. In unusual circumstances, when a consultation extends beyond the usual service, you have the option of reporting one of the prolonged physician services codes (99354–99357 with face-to-face contact, or 99358–99359 without face-to-face contact).

How will this affect payment by non-Medicare payors?

CMS does not determine which services other third-party payors will recognize and reimburse. Some payors may choose to adopt the new CMS policy subsequent to this final rule. In cases where other payors do not adopt this policy, physicians and their billing personnel will need to take into consideration that Medicare will no longer recognize consultation codes submitted on bills, whether those bills are for primary or secondary payment.

If Medicare is the primary payor, physicians must submit claims with the appropriate visit code in order to receive payment from Medicare for these services. In these cases, physicians should consult with the secondary payors in order to determine how to bill those services to receive secondary payment.

If Medicare is the secondary payor, physicians and billing personnel will first need to determine whether the primary payor continues to recognize the consultation codes. If the primary payor does continue to recognize those codes, the physician will need to decide whether to bill the primary payor using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payor with the consulta-

<table>
<thead>
<tr>
<th>2010 proposed HCPCSMod</th>
<th>Description</th>
<th>2010 proposed total RVUs</th>
<th>2010 proposed pay (CF = 36.0666)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office/outpatient visit, new</td>
<td>1.08</td>
<td>$38.95</td>
</tr>
<tr>
<td>99202</td>
<td>Office/outpatient visit, new</td>
<td>1.87</td>
<td>67.44</td>
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<tr>
<td>99203</td>
<td>Office/outpatient visit, new</td>
<td>2.71</td>
<td>97.74</td>
</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit, new</td>
<td>4.19</td>
<td>151.12</td>
</tr>
<tr>
<td>99205</td>
<td>Office/outpatient visit, new</td>
<td>5.28</td>
<td>190.43</td>
</tr>
<tr>
<td>99211</td>
<td>Office/outpatient visit, established</td>
<td>0.53</td>
<td>19.12</td>
</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit, established</td>
<td>1.08</td>
<td>38.95</td>
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<tr>
<td>99213</td>
<td>Office/outpatient visit, established</td>
<td>1.82</td>
<td>65.64</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit, established</td>
<td>2.73</td>
<td>98.46</td>
</tr>
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<td>99215</td>
<td>Office/outpatient visit, established</td>
<td>3.68</td>
<td>132.73</td>
</tr>
<tr>
<td>99221</td>
<td>Initial hospital care</td>
<td>2.72</td>
<td>98.10</td>
</tr>
<tr>
<td>99222</td>
<td>Initial hospital care</td>
<td>3.70</td>
<td>133.45</td>
</tr>
<tr>
<td>99223</td>
<td>Initial hospital care</td>
<td>5.42</td>
<td>195.48</td>
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<tr>
<td>99304</td>
<td>Nursing facility care, initial</td>
<td>2.33</td>
<td>84.04</td>
</tr>
<tr>
<td>99305</td>
<td>Nursing facility care, initial</td>
<td>3.27</td>
<td>117.94</td>
</tr>
<tr>
<td>99306</td>
<td>Nursing facility care, initial</td>
<td>4.17</td>
<td>150.40</td>
</tr>
</tbody>
</table>

*This table assumes that Congress will enact a freeze on Medicare payment rates for 2010.*
tion codes, which will result in a denial of payment for invalid codes by Medicare as the secondary payor.

What are the new payment rates for E/M codes?

As proposed, this change will be implemented in a budget-neutral manner, meaning that it will not increase or decrease aggregate Medicare physician fee schedule expenditures. CMS will make this change budget-neutral for the work RVUs, by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes, and the work RVUs for initial hospital and facility visits by approximately 0.3 percent, to reflect the elimination of the facility consultation codes. CMS is also increasing the incremental work RVUs for the E/M codes that are built into the 10-day and 90-day global surgical codes.

CMS is also implementing changes to practice expense RVUs and medical liability RVUs. Table 3 on page 11 shows the national Medicare payment rates for these services in 2010, taking all these changes into effect.

Why did Medicare make this change?

According to the final rule, CMS is basing this change on the following points:

• The American Medical Association and specific national physician specialty societies have repeatedly claimed that physicians are dissatisfied with CMS documentation requirements and guidance that distinguish a consultation service from other E/M services, such as transfer of care.

• CPT’s instructions pertaining to the definitions of a consultation, transfer of care, and documentation requirements are unclear and ambiguous.

• A March 2006 report from the Office of the Inspector General indicated that Medicare allowed approximately $1.1 billion more in 2001 than it should have for services billed as consultations. Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions), resulting in improper payments.

• Beginning January 1, 2008, CMS ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits under the outpatient prospective payment system. CMS instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits.

• “The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient.”*

• “[T]he rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services.”*

How will this change affect 10-day and 90-day global payments?

In our response to the proposed regulations, the ACS argued that CMS should increase the bundled payments for postoperative visits occurring over a 10-day or 90-day global period. We argued that arbitrarily changing the work RVUs for some E/M codes without adjusting the E/M components of other procedural codes undermines the relative value scale on which physician payment is based. CMS agreed with this and increased the payments for these services. However, the increases in the payments for these 10-day and 90-day global services due specifically to this change are minor because visits are a relatively small proportion of the total global payment amount.

The role of civilian surgical teams in response to international disasters

by

Susan M. Briggs, MD, MPH, FACS
Historically, civilian surgeons have provided significant surge capacity, which has been critical to meeting medical needs during international disasters, both natural and man-made. Prior to the last decade, war and natural disasters were the most frequent international disasters requiring civilian surgical teams. In World War I, the fledgling American College of Surgeons and its founder, Franklin H. Martin, MD, FACS, played a major role in organizing the nation’s surgeons to aid in the war effort. American civilian surgical units were deployed in World War I more than two years before the arrival of U.S. combat troops, illustrating an appreciation of the necessity for medical preparedness in wartime. One of the first civilian surgical units was stationed at the Ambulance Americaine in Paris, France, under the leadership of George Crile, MD, FACS, and Harvey Cushing, MD.

During World War II, the U.S. War Department again asked academic institutions to organize surgical units that could be mobilized for active duty. The novel use in World War II of ancillary surgical groups that could be rapidly mobilized and sent to installations in need of additional surgical manpower has become a model for contemporary civilian and military disaster medical response.

Surgeons also have a rich history of medical response to man-made disasters other than war. On December 6, 1917, a French munitions ship and a Norwegian relief steamship collided in the harbor of Halifax, Nova Scotia. The explosion—the largest man-made explosion until the Hiroshima bomb—killed more than 2,000 individuals and injured more than 9,000. Teams of surgeons from the Northeast, including the renowned surgeon William E. Ladd, MD, provided much of the immediate medical relief. Dr. Ladd was so moved by the tragedy and the death of more than 500 children that he subsequently devoted all his energy to the care of children and the establishment of pediatric surgery as his specialty.

Challenges of disaster medical response

The demands of international disaster relief have changed over the past decade, both in the scope of medical care, the spectrum of threats, and the field of operations. Increasingly, civilian surgical teams are being asked to respond to complex international disasters, with a spectrum of threats ranging from war to natural and man-made disasters, including terrorism.

Many of today’s international disasters occur in austere environments. An austere environment is a setting where access, transport, resources, or other aspects of the physical, social, economic, or political environments impose constraints on the adequacy of care for the population in need. The provision of sophisticated surgical care in austere environments is a significant challenge for disaster providers.

Contemporary international disasters follow no rules. No one can predict the time, location, or complexity of the next disaster. All disasters, regardless of etiology, have similar medical and public health concerns. A consistent approach to international disasters, based on an understanding of their common features and the response expertise they require, is becoming the accepted practice throughout the world. This strategy is called the Mass Casualty Incident Response.

Similar to the ABCs of trauma care, Mass Casualty Incident Response includes four components: search and rescue, triage and initial stabilization, definitive medical care, and evacuation.

Surgeons are uniquely qualified to participate in all four aspects of disaster medical response because of their expertise in triage, care of critical patients, and rapid decision making. International civilian surgical disaster teams are designed and trained to provide specific functional areas of disaster care.

Clinical competencies, not titles, determine the role of civilian surgeons in international disaster relief. The complexity of today’s disasters demands civilian and military surgical partner-
generally include the following:

- A cadre of medical/surgical specialists
- Technical specialists knowledgeable in hazardous materials, structural engineering, heavy equipment operation, and technical search and rescue methodology
- Trained canines and their handlers

Search and rescue

In disasters involving large numbers of victims trapped in collapsed structures, the local response team may lack the technical equipment and expertise to facilitate extraction of the victims. Many countries, including the U.S., have developed specialized search and rescue teams as an integral part of their national disaster plans. Members of these teams, which receive specialized training in confined space environments, ships, which are key to effective international disaster response.

Triage and initial stabilization

Triage is the most important—and often the most psychologically taxing—mission of international disaster response teams, especially with disasters occurring in austere environments.
and involving a large number of casualties. Triage is the rapid categorization of victims at casualty sites by experienced medical personnel with knowledge of various injuries (for example, burns, blast and crush injuries, and exposure to hazardous materials). (See left-hand photo, this page.)

**Definite medical care**

The increasing need for multidisciplinary surgical teams to assist in international disasters is rapidly expanding due to the diversity and complexity of today’s international disasters. Disaster care is initially “minimally acceptable care” due to the large number and diversity of victims. Surgical care may be rendered at fixed or mobile facilities. Many countries have mobile field hospitals with the full spectrum of surgical care.

In the U.S., the National Disaster Medical System (NDMS) is part of the U.S. Federal Response Plan under the auspices of the Department of Health and Human Services. The NDMS has created three rapidly deployable international disaster teams, called International Medical...
Surgical Response Teams (IMSuRTs). Each team is sponsored by an academic trauma center: Massachusetts General Hospital, Boston, MA; Ryder Trauma Center, Miami, FL; and Harborview Medical Center, Seattle, WA.3,7

The IMSuRT teams are composed of multidisciplinary surgical specialists and designed to provide the full spectrum of medical care at the disaster site, especially in austere environments. Each team possesses a deployable, rapid assembly field hospital with the capacity for initial stabilization, operative interventions, critical care, and evacuation. The team logistical cache contains flexible and mobile equipment and supplies, including ventilators, monitors, ultrasound machines, blood, and pharmaceuticals.3,7

Evacuation

Evacuation can be useful in a disaster as a means of decompressing the disaster scene. Evacuation of victims with serious injured casualties to off-site medical facilities not only improves their chances of survival but also allows increased attention to the remaining casualties at the disaster site. (See right-hand photo, page 16.)

Conclusion

International disaster response presents unique challenges: geographic, organizational, ethnic, cultural, and political. Politics, more than a lack of personnel or the availability of supplies and equipment, often limit the effectiveness of international disaster response. The political players might include the affected country, other donor governments, international relief organizations such as the United Nations, and not-for-profit organizations. Too often the needs of the international relief organizations, not the medical needs of the disaster, dictate the international response, further complicating the disaster scene. Rapid assessment of disaster needs by experienced disaster responders should determine the need for civilian surgical teams to provide surge capacity.

Today’s civilian surgeons continue a century-old tradition of excellence in international disaster response. Good intentions alone do not constitute a successful disaster response. Surgeons must be clinically competent and understand the general principles of disaster response such as incident command, disaster triage, and decontamination. Intercultural effectiveness remains the ultimate key to successful international disaster response.

References


Dr. Briggs is associate professor of surgery at Harvard Medical School, and director of the International Trauma and Disaster Institute, Massachusetts General Hospital, Boston, MA.
The Centers for Medicare & Medicaid Services (CMS) released the Medicare physician fee schedule final rule for calendar year (CY) 2010 on October 30, 2009. This final rule enacts certain concepts set forth in the Medicare physician fee schedule proposed rule issued early last summer. The final rule also responds to comments that the American College of Surgeons and other physician groups submitted regarding the proposed rule.

This article summarizes key provisions of interest to surgeons and describes the College’s views on these provisions.
2010 conversion factor
The final rule states that the update to the physician fee schedule conversion factor (CF) is a little less than –21.3 percent for CY 2010. This results in a reduction in the current CY 2009 CF of $36,066 to the CY 2010 CF of $28,406. This 21.2 percent cut is required by the Balanced Budget Act of 1997, which established the sustainable growth rate (SGR) formula. However, at press time, Congress was expected to intervene to block this payment cut.

E/M codes for consultations
Effective January 1, CMS will eliminate the use of all evaluation and management (E/M) codes for consultations, directing specialists to instead bill office, hospital, and nursing home visit E/M codes for both new and established patients. However, CMS is also increasing the payment for office, hospital, and nursing home visit E/M codes to offset the change for disallowing consultation codes. For more information, see page 9 of this issue, “What surgeons show know about...2010 changes to Medicare payment for consultation services.”

Practice information survey
The final rule implements CMS’ proposal to use the American Medical Association (AMA) Physician Practice Information Survey (PPIS) in place of the AMA’s Socioeconomic Monitoring Survey (SMS) data and supplemental survey data to develop practice expense (PE) relative value units (RVUs). Based on comments recommending a transition due to the significant payment reductions for some specialties, CMS will transition to the PPIS data over four years. In our comments, the College fully supported the use of the PPIS to update practice expense RVUs. Implementation of the PPIS data to develop practice expense RVUs results in a slight increase in payment for surgeons.

The PPIS is a highly scientific and controlled survey instrument that expanded the SMS instrument. The College, along with the Government Accountability Office and the Medicare Payment Advisory Commission (MedPAC), recognized the need for CMS to update PE data. In its June 2005 Report to the Congress, MedPAC indicated that the data source that CMS uses to estimate total practice costs is dated and may not reflect current practice patterns. Up-to-date and accurate data are needed for all specialties. The report also notes that concerns have been raised regarding the use of the SMS data to derive PE RVUs. The SMS data represent practice costs from 1995 to 1999, and do not account for the increased costs that practices now face.

Physician-administered drugs and the definition of “physician services”
The final rule implements CMS’ proposal to remove physician-administered drugs from the definition of “physician services” for the purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years. CMS also finalized its proposal to remove physician-administered drugs from the calculation of allowed and actual expenditures for all prior years. This change would not affect the nearly –21.3 percent update for CY 2010, but would likely reduce the number of years in which physicians are expected to receive a negative update.

The College strongly supported CMS’ proposal to remove physician-administered drugs from the definition of “physician services” for the purposes of computing the SGR, and agreed that the inclusion of drugs has had a significant and disproportionate effect on the SGR system. Physician fee schedule rates are updated using the SGR formula, which requires that growth in total expenditures for physicians’ services be limited to sustainable levels. Under the SGR system, physicians’ services include items and services, specified by the Secretary of the U.S. Department of Health and Human Services, that are commonly performed by a physician or in a physician’s office. At the time that CMS decided to include physician-administered drugs in the definition of “physician services,” these drugs represented a much smaller volume of Medicare spending, but in subsequent years the growth in cost of physician-administered drugs has far outpaced growth in the cost of other physician services. As a result, CMS finalized its proposal to remove physician-administered drugs from the definition of physician services.

Advanced imaging services
Section 135 of the Medicare Improvements for Patients and Providers Act (MIPPA) requires that, beginning January 1, 2012, Medicare
payment may only be made for the technical component (TC) of advanced diagnostic imaging services for which payment is made under the fee schedule to a supplier who is accredited by an accreditation organization (AO) designated by the Secretary. “Advanced diagnostic imaging” is defined as diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography. MIPPA also required that by January 1, CMS designate AOs to accredit suppliers furnishing the TC of advanced diagnostic imaging services.

In the final rule, CMS stated that it still expected to meet the January 1 statutory deadline to designate AOs to accredit suppliers furnishing the TC of advanced diagnostic imaging services. In response to comments, CMS confirmed that ultrasound is specifically excluded by MIPPA from the accreditation requirement. CMS also stated that the agency would make certain that all AOs have provisions for reducing the accreditation burden and costs for small and rural suppliers. CMS also stated its belief that at least three entities would apply to become AOs for advanced diagnostic imaging services.

In the proposed rule, CMS had also indicated that the agency is reviewing and considering multiple attribution methodologies for assigning costs to be measured by the program. The College commented that the attribution methodologies used should be transparent. Specifically, we recommended that the entire algorithm used to generate the reports be in the public domain, along with clear plans for evaluating the impact of the reports. In addition, physicians should be closely involved with the program from the beginning, in order to review the methodology for creating the reports and to provide input.

**Resources use**

As required by MIPPA, CMS established, and is in the process of implementing, the Physician Resource Use Measurement and Reporting Program, using Medicare claims and other data to provide Medicare physicians with confidential feedback reports that measure their resource use. CMS previously stated that this would be a multi-year program. In the final rule, CMS moves forward with several aspects of Phase I of the program, including specifying the conditions, physician specialties, and geographic areas on which the program will focus, and the episode-of-care methodologies and cost-of-service categories that the program will employ.

In the final rule, CMS added diabetes to the episodes of care included in the program. The current list now includes:

- Congestive heart failure
- Chronic obstructive pulmonary disease
- Prostate cancer
- Cholecystitis
- Coronary artery disease with acute myocardial infarction
- Hip fracture
- Community-acquired pneumonia
- Urinary tract infection
- Diabetes

In response to comments, CMS also stated that the agency will offer the following:

- Paper and electronic delivery of feedback reports
- Investigation of the feasibility of capturing readmissions in the feedback reports
- The pursuit of further research to determine how to accurately attribute E/M services in surgical bundles for purposes of attributing patients to specific physicians or groups
- Investigation of the feasibility of using a Medicare-specific public domain episode grouper in the program

The College supports the use of physician feedback reports that measure resources used in furnishing care to Medicare beneficiaries. In addition, we recommended that CMS (or its contractor) develop algorithms for specialty-specific pathways, such as for surgery that would include the treatment of conditions such as hip fracture and appendicitis. The ACS also suggested that collaboration with the member boards of the American Board of Medical Specialties, as well as with the College and other professional organizations, could lead to integration of the Physician Resource Use Reporting process into the Maintenance of Certification process. This would bring government, payor, and physician needs into alignment and reduce the burden of data collection and reporting for physicians while helping to maintain and improve quality.
The College also believes that the attribution methodologies used should be risk-adjusted to prevent physicians from being penalized for caring for sicker patients. Risk adjustment should include the recognition that a patient population’s socioeconomic factors and co-morbidity affect a provider’s ability to achieve ideal patient outcome goals. These recommendations correspond with MedPAC’s guiding policy principles for the program.

**Physician Quality Reporting Initiative (PQRI)**

The final rule makes a number of changes to the PQRI. CMS finalized a proposal to move forward with electronic health records (EHR)-based reporting, but because the agency has not yet completed the 2009 EHR data submission testing process at this time, CMS cannot guarantee that qualified EHR vendors will be available for 2010 reporting. Nonetheless, CMS does anticipate continuing to offer claims-based reporting options for PQRI beyond 2010. CMS did not finalize a proposal to add a minimum patient sample size criterion for satisfactory reporting of data on individual quality measures, but did finalize a minimum patient sample size requirement of 15 and eight for 12-month and six-month reporting for measures groups, respectively.

CMS also finalized a proposal to allow eligible professionals to report on measures groups for any 30 patients, rather than a consecutive patient sample. In addition, CMS finalized a proposal that would allow physician practices of 200 or more eligible professionals to report PQRI measure data as a group. CMS also finalized its proposal to include the following three new measures applicable to surgery for 2010 PQRI:

- Cataracts: 20/40 or better visual acuity within 90 days following cataract surgery (registry)
- Cataracts: Complications within 30 days following cataract surgery requiring additional surgical procedures (registry)
- Perioperative temperature management (claims, registry)

**E-prescribing**

CMS finalized its plan to use a single numerator G-code for reporting e-prescribing events in 2010 (rather than the three current codes). The only applicable code for 2010 will be assigned at some point this year. At least one prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system. A new G-code will be assigned by CMS for 2010 and will be included in the measure specifications. The removal of code G8446 makes it difficult for surgeons to participate in the incentive program for 2010, because this code provided a means to report the prescription of controlled substances that cannot be e-prescribed due to Drug Enforcement Administration rules. CMS also finalized a proposal to allow three reporting mechanisms (claims, registry, and EHR-based) for 2010 e-prescribing. In addition, CMS finalized its proposal to permit certain group practices with 200 or more eligible professionals to qualify as a group for e-prescribing incentive payments, provided that the group has been selected to participate in the PQRI group practice reporting options.

To qualify for e-prescribing incentive payments, at least 10 percent of an eligible professional’s Medicare-allowed charges for services provided during the reporting period must be for services reported by the recognized denominator codes, which include codes for office and other outpatient services. In the final rule, CMS rejected requests to lower this 10 percent threshold. CMS also finalized a proposal to define a successful e-prescriber for 2010 as one who reports at least 25 e-prescribing events during the reporting period.

**Panel to review the work of the RUC**

CMS took no action in the final rule on MedPAC’s recommendation to establish a panel of experts separate from the AMA Relative Value System Update Committee (RUC) to review RVUs. CMS indicated that it will take comments into consideration as it continues to explore this issue. In its March 2008 Report to the Congress, MedPAC recommended that CMS establish such a group of experts to augment the RUC.

The College strongly opposes the establishment of such a panel and believes that the current RUC structure has adequate representation and applies a thoughtful and deliberative process for evaluating relative work RVUs. The College also believes that an additional panel could evolve into an extra layer of bureaucracy without adding real value to the process of determining work RVUs.
Potentially misvalued services
The AMA RUC is involved in an ongoing effort to identify potentially misvalued services through identifying codes with site-of-service anomalies, high intraservice work per unit time, and services with high-volume growth. Two of the issues addressed in the final rule of interest to surgeons include site-of-service anomalies and 24-hour stays.

Site-of-service anomalies
The final rule does not implement CMS’ proposal to change the work RVUs for certain codes with site-of-service anomalies; rather, CMS accepted the RUC-recommended work RVUs for these codes. In the proposed rule, CMS had expressed concern regarding the valuation methodology that the RUC used to review certain services, and that may have resulted in the removal of hospital days and the deletion or reallocation of office visits without extraction of the associated work RVUs from the valuation of the code. Accordingly, CMS proposed changes to several of the codes for which valuation has been adjusted to reflect changes in site-of-services. Specifically, CMS proposes to change the codes for which the AMA RUC review process deleted or reallocated preservice and postservice times, hospital days, office visits, and discharge day management services, but for which the agency believed the AMA RUC-recommended values do not reflect the extraction of the associated RVUs.

In its comment letter, the College strongly opposed CMS’ recalculation of work RVUs and supported the use of the RUC-recommended values for the codes at issue. We support the RUC’s thoughtful and deliberative process for evaluating codes, which uses standard physician work estimation surveys to set physician work RVUs relative to reference codes, both within and between specialties; and the College believes that CMS’ recalculation method discounts the key criteria that both Harvard and the RUC have used in making work RVU recommendations, namely, relative total work.

23-hour stay
The final rule does not finalize CMS’ proposal that would have disallowed additional E/M services to be billed for care furnished during the postprocedure period, when care is furnished for an outpatient service requiring less than a 24-hour hospital stay. Because CMS considers services that are performed in the outpatient setting and that require a hospital stay of less than 24 hours to be outpatient services, the agency believes that the use of inpatient E/M codes for services rendered in the postservice period for procedures requiring less than a 24-hour hospital stay would result in overpayment for preservice and intraservice work that would not be provided. Accordingly, CMS proposed to disallow inpatient E/M services for an outpatient service requiring less than a 24-hour stay.

In its comment letter, the College disagreed with CMS’ rationale and opposed the agency’s proposal regarding 23-hour stay because it would result in surgeons not being paid for the work they perform. The College’s letter also clarified that the phrase “23-hour stay” for many of the codes in question are not actually 24 hours or less, and all of the codes affected by the proposal require at least an overnight stay in a hospital. As a result, the services associated with these codes require additional work in a facility on the day of the procedure, combined with discharge services one or more days after the procedure. Therefore, because all of the codes at issue require at least an overnight stay, and because the standard of care requires a surgeon to follow up with the patient, the College opposed CMS’ proposal, and believes it is inappropriate for CMS not to recognize surgeons’ work while the patient is in the hospital. As a result of the comments CMS received regarding this proposal, the agency has decided to work with the RUC and the Current Procedural Terminology Editorial Panel on alternative E/M coding solutions.

Meeting the challenge—
A surgeon-centered quality program:

THE AMERICAN SOCIETY OF BREAST SURGEONS
MASTERY OF BREAST SURGERY PILOT PROGRAM

by
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Surgeons occupy a central role in the management of both benign and malignant breast disease. Breast cancer is the most commonly diagnosed cancer in women, with an estimated one in eight chance for an American woman to develop breast cancer during her lifetime. Numerous organizations have developed quality measures for breast cancer care, and although breast cancer care is multidisciplinary, many of the quality measures are the responsibility of the breast surgeon. However, no standard, readily accessible mechanism for surgeons to report adherence to these measures currently exists.

The American Society of Breast Surgeons (ASBrS) recently developed the Mastery of Breast Surgery Pilot Program, A Continuing Quality Improvement Initiative. It was developed in response to the urgent need for ongoing quality improvement in the practice of breast surgery. The goal of the program is to provide the surgeon with Web-based tools to document quality outcomes in patient care.

In December 2008, the ASBrS introduced the pilot phase of the program, which allows individual surgeons to report and receive feedback on a limited number of quality measures for open surgical procedures for benign or malignant breast disease. The program has met with remarkable success, with 709 physicians registered to participate. In the first 12 months of data collection, more than 380 surgeons have entered nearly 35,000 cases. The following is a description of the initial participation in the pilot program.

The pilot program

The pilot phase of the Mastery Program is open to all surgeons who meet the eligibility requirements, regardless of practice setting or volume of breast surgery. These criteria are based on recommendations of the Mastery of Breast Surgery Committee and approved by the board of directors of the ASBrS, and represent minimum requirements for surgeons caring for breast patients. Additional requirements may be added as further information becomes available on best practices in breast care. Board certification by the American Board of Surgery (ABS), its international equivalent, or the American Osteopathic Association is required, unless the surgeon has completed a breast surgery fellowship. Completion of a combined American Society of Breast Disease, American Society of Breast Surgery, Society of Surgical Oncology-approved breast fellowship also confers eligibility. Surgeons who were initially board certified, but have not recertified because of a more focused practice, are also eligible to apply.

Participation in the pilot program requires a minimum of eight hours of breast-specific AMA/PRA category 1 continuing medical education (CME) credits within the previous year, or 16 hours within two years prior to application. The CME credits can be obtained through a variety of courses, including education in breast surgical techniques, breast imaging, radiation physics, breast disease risk assessment, radiation or medical oncology, practice management for breast surgical practices, quality improvement, and public-reporting of quality measures programs. Breast-specific CME can also be obtained through attending breast disease-specific meetings and other surgical meetings.

Participating surgeons are required to enter data for a minimum of three months on three specific quality measures on all open breast surgical procedures for both benign and malignant disease. The simple, but critically important, surgeon-controlled quality measures include:

1. Was a needle biopsy performed to evaluate the breast lesion at some time prior to this procedure?1,2,3
2. Was the surgical specimen oriented?1,4,5
3. If a non-palpable lesion was localized with image guidance, was there intraoperative confirmation of its removal?1,6,7

It is expected that surgeons will continue to participate by entering data on all of their cases after the initial three-month period. Ongoing participation will maintain their standing in the Mastery of Breast Surgery Pilot Program as it grows and develops new quality measures.

Data entry

The Web-based Mastery data entry screen (see Figure 1, page 25) requires input of limited demographic data in addition to responses for the three quality measures. Although the patient’s
The name and date of birth are required fields, the surgeon may enter a self-generated number or even identifiers such as “x” or “y” in place of the patient’s name. The procedure that most closely matches the one performed is selected from a drop-down menu, or the surgeon can enter unlisted procedures in the “Other” space. For patients in whom all three quality measures have been met, three “Yes” clicks quickly complete the data entry. Frequently, a “No” response is appropriate but requires an explanation to be selected from a “Why not?” drop-down menu. There are valid clinical reasons why a needle biopsy might not be done prior to surgery. For example, the lesion might be too close to the skin, chest wall, or implant. Efforts were made to include in the drop-down menu the valid clinical reasons the quality indicator was not met, in order to provide meaningful data for analysis. Additional explanatory comments, if necessary, can be made for each of the measures in the “Other” space. Beside each quality measure are links that supply answers to frequently asked questions. In addition, links to references that support the validity of the quality measures appear beside all three measures. If any data is entered incorrectly, it can be corrected by selecting “View Cases/Edit” from the toolbar.

**Reports**

It is expected, as the program continues to develop and be refined, that many more quality reports useful to the surgeon will be available. Selecting “Reports” on the toolbar can currently access two reports. The “Summary of Procedures” report (Figure 2, page 27) allows the surgeon to compare the frequency of his or her operations with peers, for example, mastectomy rate. The “Summary of Quality Measures” (Figure 3, page 28) allows a comparison of how often the quality measures are met compared with the entire group. The reasons for variance from the quality measures may also be compared.

It is expected—and strongly encouraged—that the surgeon will continue to participate in the program by entering data on all of their open surgical breast cases.
Confidentiality of the data

All necessary legal work has been completed to allow surgeons to report on patients using a secure server and encrypted identification numbers. Each individual surgeon’s data is kept strictly confidential, and only the de-identified data is available to the ASBrS staff and appropriate committee and board members. The ASBrS will not make individual surgeon data available to the public, insurance companies, advocacy groups, credentialing bodies, or any other interested parties except in strict accordance with the Business Associate Agreement that must be signed to participate in the program. Nevertheless, the ASBrS cannot guarantee that it will not be forced to release data, including individual surgeon data, requested under the compulsion of a legally enforceable subpoena, search warrant, or court order.

Benefits of participation

It seems inevitable that surgeons will be required in the near future to document the quality of their work in order to obtain reimbursement. The ABS has recently recognized the Mastery of Breast Surgery Pilot Program as an acceptable quality initiative to meet the requirements of Part 4 (Evaluation of Performance in Practice) for ABS Maintenance of Certification. All surgeons who successfully fulfill the requirements of continuous case reporting for a minimum of three months, complete the Mastery application, and have the appropriate level of CME credits will receive a printed certificate attesting to their participation in the Mastery of Breast Surgery Pilot Program.

Current status

The program was designed to be inclusive of all surgeons who perform breast surgery because of the belief that community or rural general surgeons, regardless of the volume of breast cases, will benefit from participation in the program as much as will dedicated breast surgeons. Participants in the program represent a broad cross-section of surgeons throughout the U.S., with surgeons in the Northeast representing the largest group (31 percent). The majority of surgeons, 69 percent, are in private practice, 42 percent are in group practice, and 27 percent are in solo practice. Hospital-employed surgeons (21 percent) and academic surgeons (10 percent) comprise the remaining participants. Almost half of the surgeons (48 percent) limit their practice to breast surgery, and 76 percent devote at least half of their practice to breast problems. Most of the participants perform ultrasound (96 percent), ultrasound-guided office procedures (92 percent), and intraoperative ultrasound (90 percent). Seventy-one percent of the surgeons perform stereotactic-guided breast procedures. Many participate in other quality improvement programs.

Discussion

The Mastery of Breast Surgery Pilot Program was developed on a “proof of principle” basis—essentially a feasibility project. Could we design a Web-based, self-reporting program that would be user-friendly and allow the surgeon to report on open breast surgical cases, whether outpatient or inpatient? Could the data entry site be easily accessible and usable by the participant? Would surgeons be interested in participating in the program? Clearly the wide acceptance by surgeons, and the volume of data entered in a short period of time, answered these questions affirmatively.

The choice of the initial quality measures to launch this program was made after much discussion with members of the Patient Safety and Quality Improvement Committee and the Mastery of Breast Surgery Committee of the ASBrS. The initial three quality measures were selected for the pilot program, not only because of their importance in patient care, but also because they are under the complete control of the surgeon.

Breast surgery has become less invasive and more precise, with emphasis on procedures that minimize morbidity and deformity. The optimal approach for diagnosis is no longer excisional biopsy or needle-localized excisional biopsy, but percutaneous needle biopsy. After a tissue diagnosis is made and the results are determined to be concordant, appropriate surgical management can proceed, usually with a single operation. Performing a preoperative needle biopsy (quality
### Figure 2: Summary of Procedures

The table below provides a summary of procedures performed, divided into categories and presented with counts and percentages.

<table>
<thead>
<tr>
<th>Summary of Procedures</th>
<th>Your Total</th>
<th>All Members</th>
<th>Your %</th>
<th>All Members %</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>0</td>
<td>34902</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open surgical biopsy palpable lesion without image guidance</td>
<td>0</td>
<td>4119</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Open surgical biopsy following image guided localization</td>
<td>0</td>
<td>5587</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Nipple exploration with duct excision</td>
<td>0</td>
<td>1111</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Lumpectomy without image guidance</td>
<td>0</td>
<td>743</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Lumpectomy without image guidance and SLN only</td>
<td>0</td>
<td>1137</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Lumpectomy without image guidance and SLN followed by immediate ALND</td>
<td>0</td>
<td>254</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Lumpectomy without image guidance and ALND</td>
<td>0</td>
<td>182</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Lumpectomy with image guidance</td>
<td>0</td>
<td>3871</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Lumpectomy with image guidance and SLN only</td>
<td>0</td>
<td>5228</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Lumpectomy with image guidance and SLN followed by immediate ALND</td>
<td>0</td>
<td>591</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Lumpectomy with image guidance and ALND</td>
<td>0</td>
<td>331</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Re-excision of lumpectomy site (prior surgery by myself)</td>
<td>0</td>
<td>1609</td>
<td>0</td>
<td>5</td>
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<tr>
<td>Re-excision of lumpectomy site (prior surgery by another surgeon)</td>
<td>0</td>
<td>101</td>
<td>0</td>
<td>0</td>
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<td>2081</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
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<td>0</td>
<td>3784</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Total mastectomy and SLN followed by immediate ALND</td>
<td>0</td>
<td>938</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Modified radical mastectomy (without SLN procedure)</td>
<td>0</td>
<td>1210</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>SLN dissection (separate procedure)</td>
<td>0</td>
<td>422</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Axillary LN dissection (separate procedure)</td>
<td>0</td>
<td>465</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1138</td>
<td>0</td>
<td>3</td>
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</table>
measure 1) is consistent with the recommendations made by the International Consensus Conference II on Image Detected Breast Cancer: State of the Art Diagnosis and Treatment. The Mastery of Breast Surgery Pilot Program does not require the surgeon to perform the needle biopsy, but it does require that a physician, surgeon, or radiologist do a needle biopsy prior to the surgical procedure when appropriate.

Orientation of the surgical specimen (quality measure 2) allows the pathologist to assess the margins of the specimen to determine the adequacy of excision and allow precise re-excision if the margins are not clear. There are reasons why the surgeon would not orient a specimen—such as excising a benign lesion, lymph node procedures, or situations where orienting the specimen would add no value to subsequent management decisions. Specimen orientation will minimize deformity caused by excessive tissue removal from the breast when margin re-excision is necessary. The surgeon can orient the specimen or request the pathologist to do so in the operating room, but orientation is under the surgeon’s control.

Intraoperative confirmation of removal of an image-guided lesion (quality measure 3) is another part of precise, directed surgery that minimizes the risk of removing the wrong tissue or an inadequate amount of tissue. Intraoperative confirmation of excision of the lesion can be done by specimen radiograph, intraoperative ultrasound, palpation of the lesion,
immediate serial sectioning by the pathologist, or direct visualization of the surgical specimen by the surgeon. If the target lesion is a cluster of microcalcifications, a specimen radiograph must be done to confirm calcifications. Depending on the location of the targeted lesion within the specimen, more tissue can be removed to increase the likelihood of clear margins. Surgeons are responsible for verifying the targeted lesion has been removed before moving the patient from the operating table.

**Future directions of the program**

Self-reporting is a fundamental step in improving quality of care. It is evident that a mechanism for data collection is needed in the field of breast surgery, and breast cancer in particular. Through data collection and analysis, a method for defining and validating quality measures for breast surgical care can be established. Furthermore, through the development of a comprehensive reporting system, surgeons will be given the tools to improve the care given to each patient, improve their individual practice, and incorporate quality measures into daily practice.

The ASBrS will now transition the success of reporting on the initial quality measures in the pilot phase to a more robust program. Additional quality measures will be introduced with input from ASBrS members, reviewed by the Mastery Committee, and receive approval by the board of directors. There are plans to collect data specific to breast cancer, and to develop a more comprehensive and sophisticated quality reporting system. Mechanisms are currently under development that should allow surgeons to track their needle biopsy data for practice accreditation in ultrasound and stereotactic procedures. Plans are also under way to develop a series of “synoptic reports” for reporting breast procedures.

**Getting started**

Participation in the pilot program is free to members of the ASBrS at this time. Applicants who are not members of the ASBrS must submit an application fee. Nonmembers are encouraged to join the ASBrS and enjoy the benefits of membership.

For surgeons to participate in the pilot program, they are invited to go to the ASBrS Web site, http://www.breastsurgeons.org, to complete a brief registration form. They will then be given a link to a data collection software program for entering cases. The Web site has an online application form that must be completed, including reporting the required CME. Surgeons who attend the annual meeting of the ASBrS automatically meet the CME requirements.

There are links to the Mastery Program Web site on the ASBrS Web site for easy access to the program. All documents regarding the Mastery Program are available on the ASBrS Web site and the Mastery Web site. The documents include:

- Frequently asked questions (FAQ)
- Background and history of the program
- User agreement
- Participation agreement

**Dr. Laidley** is a breast surgeon at Breast Surgeons of North Texas, Dallas, TX.

**Dr. Whitacre** is director of the Breast Center of Southern Arizona, Tucson, AZ.
All queries received from participants are acknowledged by e-mail from the ASBrS, via a member of the Mastery Committee. The program has changed significantly in response to these questions and from other feedback from our participants. All queries are stored for reference to ensure continuity of answers, as well as to update the FAQ documents and brochures.

Acknowledgments

The authors wish to thank the members of the Mastery of Breast Surgery Committee for their dedication to the development and implementation of this project. The members of the committee are: Victor J. Zannis, MD, FACS, Breast Care of the Southwest, Phoenix AZ; Helen A. Pass, MD, FACS, assistant professor of clinical surgery, Lawrence Hospital, Bronxville NY; Richard E. Fine, MD, FACS, Advanced Breast Care, Marietta, GA; Arthur G. Lerner, MD, FACS, Dickson Cancer Treatment Center, White Plains NY; Lorraine Tafra, MD, FACS, Anne Arundel Medical Center, Annapolis MD; and John West, MD, FACS, Breast Care Center of Orange County, Orange CA. Special thanks go to ASBrS staff members Sharon Grutman and Christina Lucara, and to Jane Schuster, the executive director of the ASBrS, for their expert coordination and implementation of this project.

References


Highlights of the 95th Annual Clinical Congress
At the 2009 Clinical Congress in Chicago, IL, a wide selection of presentations covering subjects from education to practice to clinical considerations—in addition to poster presentations, papers sessions, and special-interest meetings—were offered. The meeting was attended by 13,869 participants, including 8,638 physicians; the remaining attendees included exhibitors, spouses, guests, and convention personnel.

Convocation

LaMar S. McGinnis, Jr., MD, FACS—a general and oncologic surgeon from Atlanta, GA, and a senior medical consultant and advisor for the National American Cancer Society and a clinical professor of surgery at Emory University, Atlanta, GA—was installed as the 90th President of the American College of Surgeons during Convocation ceremonies that denoted the official opening of the Clinical Congress (see photo, this page). (See the December 2009 issue of the Bulletin for the Presidential Address.)

Other officers installed during the Convocation were Kirby I. Bland, MD, FACS, as First Vice-President, and Karen E. Deveney, MD, FACS, as Second Vice-President. Dr. Bland, who became a Fellow in 1980, is chair of the department of surgery at the University of Alabama-Birmingham. In addition to his participation in various College committees, he has been a member of the ACS Board of Governors, a member and Vice-Chair of the Executive Committee of the Board of Governors, and a liaison for the Board of Governors’ Committee on Surgical Practice. Dr. Deveney, a Fellow since 1984, has served as Secretary of the Board of Governors. She is currently professor, department of surgery, Oregon Health & Science University, Portland, OR.

Honorary Fellowship was conferred on the following five prominent surgeons: Masaki Kitajima, MD, FACS, FRCS(Hon), FASA(Hon); Sir Bruce Edward Keogh, KBE, BSc, MD, FRCS, FESC, FETCS; Ingemar Ihse, MD, PhD, FRCS; Vicente P. Gutierrez, MD, MAAC, FACS; and Adelola Adeloye, MB, MS, FRCP(Edin), FRCS(Eng), FACS, FICS, FWACS, FMCS(Nig), FAS, FCOSCEA.

Named Lectures

As was the case last year, the Martin Memorial Lecture and the American Urological Association Lecture were combined for presentation during the Opening Ceremony of the Clinical Congress. Glenn D. Steele, MD, FACS, delivered his lecture, Re-engineering Systems of Care—Surgical Leadership, immediately following the Opening Ceremony on Monday morning (see photo, page 33). Also on Monday, The Intraoperative Myocardial Protection: Still Important? was presented as the John H. Gibbon, Jr., Lecture by William A. Gay, MD, FACS, and John E. Connolly, MD, FACS, presented Personal Reflections on the First 50 Years of Cardiovascular Surgery as the Charles G. Drake History of Surgery Lecture. The Excelsior Surgical Society Edward D. Churchill Lecture, which until 2008 had been presented at the ACS Spring Meeting, convened Tuesday with George F. Sheldon, MD, FACS, presenting The Surgeon Shortage: Constructive Participation during Health Reform. Other Named Lectures that convened Tuesday were the Scudder Oration on Trauma, during which A. Brent Eastman, MD, FACS, presented Wherever the Dart Lands: Toward
the Ideal Trauma System; and the Olga M. Jonasson Lecture, Leadership Development and Mentoring in the Age of Restricted Work Hours, presented by Karin M. Muraszko, MD, FACS. Wednesday’s Named Lectures included the Ethics and Philosophy Lecture, Can General Surgeons and Transplant Surgeons Work Together to Improve the Supply and Ethical Standard of Living Organ Donations? presented by Mark Siegler, MD, FACP; A Community Cancer Center Program: Getting to the Next Level, the Commission on Cancer Oncology Lecture, presented by Nicholas J. Petrelli, MD, FACS (see photo, this page); the I.S. Ravdin Lecture in Basic Sciences, where Michael T. Longaker, MD, FACS, delivered Reparative, Replacement, and Regenerative Medicine; the Herand Abcarian Lecture, The Little Engine That Did, offered by David Schoetz, MD, FACS; and Health Care Reform in the United Kingdom, the Distinguished Lecture of the International Society of Surgery presentation by Ara W. Darzi, MB, BCh, FACS.

**Awards, honors, celebrations**

The 2009 ACS/Pfizer Inc Surgical Volunteerism and Surgical Humanitarian Aware winners were honored at a general session sponsored by the College’s Operation Giving Back program. Edgar Rodas, MD, FACS, was presented with the humanitarianism award, and Douglas P. Grey, MD, FACS; William P. Schechter, MD, FACS; Glenn W. Geelhoed, MD, FACS; Vance J. Moss, MD, FACS; Vincent L. Moss, MD, FACS; and Awori J. Hayanga, MD, MPH, received the volunteerism awards (see photo, page 34).

Also Monday, Richard Reiling, MD, FACS, and Mrs. Elizabeth Reiling were presented with the Fellows Leadership Society’s Distinguished Philanthropist Award in recognition of their personal contributions, along with Dr. Reiling’s tireless work to raise philanthropic support on behalf of the College (see photo, page 34).

Dorry Segev, MD, PhD, FACS, an associate professor with the department of surgery at Johns Hopkins University, Baltimore, MD, was presented with the Joan L. and Julius H. Jacobson II Promising Investigator Award (see photo, page 35). Dr. Segev and colleagues conducted a large cohort study of the effects of cold ischemia time (CIT) on live donor outcomes demonstrating that the anticipated CIT resulting from cross-country kidney transport was safe. This procedure is now accepted as viable, has been performed numerous times, and has been included in both the U.S. and Canadian national kidney paired donation protocols.

The National Safety Council Surgeons Award for Service to Safety was conferred at the meeting. Martin R. Eichelberger, MD, FACS, was presented with his plaque for his undaunting...
commitment to the prevention and treatment of children’s injuries, and in recognition of his contributing influence on countless lives (see photo, page 35).

The 2009 Owen H. Wangensteen Surgical Forum was dedicated to Hiram C. Polk, Jr., MD, FACS (see photo, page 36). Residents honored with the Surgical Forum Excellence in Research Awards included Sonal Arora, MB, BS, MRCS, Surgical Education, Imperial College, London, UK; Elliott R. Brill, MD, Targeted Therapies, Memorial Sloan-Kettering Cancer Center, New York, NY; Benjamin S. Brooke, MD, Quality, Outcomes and Costs, Johns Hopkins University, Baltimore, MD; Bettina M. Buchholz, MD, Alimentary Tract, University of Pittsburgh, Pittsburgh, PA; Antoine L. Carre, MD, Plastic/Maxillofacial Surgery, Stanford University, Stanford, CA; Claudius Conrad, MD, PhD, Progenitor Cells and Cell-Based Therapies, Massachusetts General Hospital, Boston, MA; Amanda Feigel, MD, Vascular Surgery, Yale University School of Medicine, New Haven, CT; Georg N. Herlitz, MD, JD, Critical Care, University of Medicine and Dentistry, New Jersey-Robert Wood Johnson Medical School, New Brunswick, NJ; Onkar Khullar, MD, Cardiothoracic Surgery, Brigham & Women’s Hos-
The 2009 Distinguished Service Award, National Safety Council Surgeons’ Award for Service to Safety recipient Dr. Eichelberger (center), with, left to right: Dr. Eastman; John Fildes, MD, FACS, ACS COT Chair; M. Margaret Knudson, COT Vice-Chair; and J. Wayne Meredith, Medical Director, ACS Trauma Programs, Division of Research and Optimal Patient Care.

Joan L. and Julius H. Jacobson II Promising Investigator Award recipient Dr. Segev (center), with Mrs. Jacobson (left) and Dr. Jacobson.

The College’s highest honor, was presented to F. Dean Griffen, MD, FACS, a professor of clinical surgery and director of undergraduate surgical education at Louisiana State University Health Services Center, Shreveport (see top photo, page 37). This award was given in recognition of his staunch and devoted service as a Fellow of the American College of Surgeons, and for his leadership roles as Chair of the Board.

Pittsburgh, University of Pittsburgh Medical Center, Pittsburgh, PA; Douglas A. Murrey, Jr., MD, Urology and Reproductive Surgery, The Ohio State University Medical Center, Columbus, OH; and Robert Sucher, MD, Immunology, Transplantation, and Tissue Engineering, Innsbruck Medical University, Innsbruck, Tirol Austria (see photo, page 36).

The 2009 Distinguished Service Award, was presented to F. Dean Griffen, MD, FACS, a professor of clinical surgery and director of undergraduate surgical education at Louisiana State University Health Services Center, Shreveport (see top photo, page 37). This award was given in recognition of his staunch and devoted service as a Fellow of the American College of Surgeons, and for his leadership roles as Chair of the Board.
of Regents’ Committee on Patient Safety and Professional Liability, Vice-Chair of the Public Profile and Communications Steering Committee, President of the ACS Louisiana Chapter, and member of the ACS Board of Governors’ Committee on Professional Liability. Dr. Griffen is also acknowledged for his superb clinical activity as a Lieutenant Commander in the U.S. Navy, his service as a general-thoracic-vascular surgeon at the Highland Clinic in Shreveport, LA, and, most recently, his services as a clinical professor of surgery at Louisiana State University Medical Center in Shreveport. Dr. Griffen is further recognized for his leadership role with the American College of Surgeons in bringing to the attention of its membership—through his ground-breaking work on the ACS Closed Claims Study—insights into ways to improve surgical care and decrease liability through professional behavior, conducting numerous seminars, postgraduate courses, and mock trials at the Clinical Congress on the issues of liability and professionalism.

The Committee on Cancer Liaison recognized three Commission on Cancer State Chairs for outstanding performance and significant contributions to the Liaison Program in 2008. Honored were Daniel P. McKellar, MD, FACS, Good Samaritan Hospital, Dayton, OH; James J. Hamilton, Jr., MD, FACS, St. Francis Health Center, Topeka, KS; and Mary Milroy, MD, FACS, Avera Sacred Heart Hospital, Yankton, SD.

The 2009 Surgical Forum volume dedication recipient Dr. Polk (center) with Michael T. Longaker, MD, FACS (left), Chair of the Surgical Forum Committee, and Tien C. Ko, MD, FACS, a committee member.

Surgical Forum Excellence in Research Awards. Front row, left to right: Dr. Carre, Dr. Conrad, Dr. Feigel, Dr. Khullar, and Dr. Herlitz. Back row: Dr. Brill, Dr. Murrey, Dr. Brooke, Dr. Buchholz, Dr. Sucher, and Dr. Longaker. Not pictured: Dr. Arora and Dr. Malek.
Nathan C. Kanning, MD, a surgeon from Sandpoint, ID, received the 2009 Nizar N. Oweida, MD, FACS, Scholarship at the Rural Surgeons meeting (see photo, lower right, this page).

The seventh annual ACS Resident Award for Exemplary Teaching was presented to Susan Skaff Hagen, MD, a PGY-4 resident in general surgery at the University of Iowa Hospitals and Clinics. The award is sponsored by the Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives. Dr. Hagen was selected by an independent review panel of the Committee of Resident Education (see top photo, page 38).

“Improving Rural Maine’s Access to Emergency Trauma Services Through Telemedicine,” authored by Joan-Marie Pellegrini, MD, was named Best Scientific Exhibit (see bottom photo, page 38).

The International Guest Scholar program welcomed its 2009 guest scholars, including the following: Lohfa B. Chirdan, MBBS, FWACS, Jos, Nigeria; Paisarn Vejchapipat, MD, Bangkok, Thailand; Jaqueline Cruz Vargas, Oweida Scholarship recipient Dr. Kanning (left), with Stephen E. Olson, MD, FACS, Chair of the Rural Surgery Subcommittee of the Advisory Council for General Surgery.
Best Scientific Exhibit award recipient Dr. Joan-Marie Pellegrini (center), with ACS Regent Barbara L. Bass, MD, FACS (left), Chair of the Program Committee; and judge and ACS Regent Robin S. McLeod, MD, FACS. ACS Regent Carlos A. Pellegrini, MD, FACS (not pictured), also served as a judge.

Australia; Fernando Burdio, MD, Barcelona, Spain; Grant R. Christey, BSc, MBChB, FRACS, Hamilton, New Zealand; Patricio R. Andrades, MD, FACS, Vitacura, Santiago, Chile; and Germany Exchange Fellow Bjorn Brucher, MD, PhD, FACS, Tübingen, Germany (see photo, page 39).

The ACS Committee on Video-based Education sponsored a session to highlight outstanding surgical videos, which were nominated by prominent international surgeons and previously presented at various international meetings. At the conclusion of the session, chaired by Horacio J. Asbun, MD, FACS, members of the audience voted on the most outstanding video. The 2009 outstanding video was Laparoscopic Total Mesorectal Excision Based on the Recent Interpretation of Surgical Anatomy, presented by Yoshiharu Sakai, MD, from Kyoto, Japan (see photo, page 40).

New this year

A new format for the Clinical Congress Program Book was introduced at this year’s meeting, which included a larger trim size and an easy-to-read two-column format.

A Pocket Guide was also unveiled, which featured a convenient schedule of Sessions-at-a-Glance by Day as well as a Sessions-at-a-Glance by Track schedule. The tracks were as follows: Basic/Translational Research, Cardiothoracic Surgery, Colon and Rectal Surgery, Education/Outcomes & Safety, Ethics, General Surgery, Health Policy: Practice Management/
Reimbursement/Liability Issues, International, Neurosurgery, Obstetrics and Gynecology, Orthopaedic Surgery, Otolaryngology–Head and Neck Surgery, Pediatric Surgery, Plastic and Maxillofacial Surgery, Residents/ Medical Students, Surgical Oncology, Trauma/ Critical Care, Urology, Vascular Surgery, and Volunteerism. The 2010 Clinical Congress will follow a similar format with the track system; however, note that each year the tracks will continue to be more defined and developed.

Seven new Town Hall Meetings took place, during which issues and news relevant to specific interest and practice areas were discussed. The meetings were sponsored by the Advisory Council for General Surgery; the Advisory Council for Vascular Surgery; the Resident and Associate Society of the American College of Surgeons; the Advisory Council for Colon and Rectal Surgery; the International Relations Committee; the Advisory Council for Cardiothoracic Surgery; and the Committee on Emerging Surgical Technology and Education.

Meet the Expert Luncheons (formally known as Meet the Professor Luncheons), informal gatherings where attendees had the opportunity to discuss a topic with experts in that given field, were once again offered this year. These 30 luncheons (an increase of five expert luncheons over the previous Clinical Congress meeting) were once again very popular this year, and in fact, nearly sold out.

The Board of Regents approved the formation of the College’s 34th and 35th international chapters: the ACS Pakistan Chapter and the ACS Austria-Hungary Chapter. This brings the
total number of ACS chapters to 102: 35 international, two Canadian, and 65 U.S.

The Young Fellows Association (YFA) held its inaugural meeting during the Clinical Congress on Monday, October 12. Mark A. Malangoni, MD, FACS, a former Chair of the former Committee on Young Surgeons, provided the welcoming remarks at the meeting (see photo, page 42). The YFA consists of four workgroups: Advocacy, Communications, Education, and Member Services. Nearly 100 Fellows have joined a workgroup at this time. For more information, visit the new YFA Web page at http://www.facs.org/member services/yfa/.

The Scientific Papers abstract session offered topic-specific sessions that incorporated the tracks system. The 2009 Clinical Congress hosted 18 Scientific Paper Sessions with approximately 150 papers presented.

**College governance**

At the Annual Business Meeting of Members on Wednesday, where Dr. McGinnis presided, L.D. Britt, MD, FACS, presented the Report of the Chair of the Board of Regents; Michael J. Zinner, MD, FACS, presented the Report of the Chair of the Board of Governors; and Thomas R. Russell, MD, FACS, presented the Report of the Executive Director of the College. Henri R. Ford, MD, FACS, presented the Report of the Chair of the Nominating Committee of the Board of Governors, during which the elected Regents and Board of Governors officers were announced; and Linda G. Phillips, MD, FACS, presented the Report of the Chair of the Nominating Committee of the Fellows and announced the nomination and election of Governors. It was also at this meeting that Dr. Griffen received his Distinguished Service Award, Dr. Segev was presented with the Promising Investigator Award, and Dr. Hagen was given the Resident Award for Exemplary Teaching.

**New Officers-Elect**

At the Annual Business Meeting of Members, new Officers-Elect were named. L.D. Britt, MD, MPH, FACS, FCCM, was named President-Elect; he will begin his tenure as the 91st ACS President at the 2010 Clinical Congress in Washington, DC. Dr. Britt is a general and trauma surgeon from Norfolk, VA.

Richard J. Finley, MD, FACS, FRCSC—a general thoracic surgeon, and professor and head of the division of thoracic surgery at the University of British Columbia—was named First Vice-President-Elect. Named as Second Vice-President-Elect was Frederick L. Greene, MD, FACS, a general surgeon and chairman of the department of general surgery, Carolinas Medical Center, in Charlotte, NC.

**Board of Regents/Board of Governors**

The Board of Governors elected Rene Lafreniere, MD, FACS, Calgary, AB; Leigh A. Neumayer, MD, FACS, Salt Lake City, UT; and Marshall Z. Schwartz, MD, FACS, Philadelphia,
Dr. Lafreniere, a general surgeon, is professor of surgery, oncology, and anesthesia at the University of Calgary, AB. A Fellow of the College since 1989, Dr. Lafreniere has served on the Board of Governors (1998–2004), the Executive Committee of the Board of Governors (2001–2004; Vice-Chair, 2003–2004), the Program Committee (2003–2007), the Committee on Emerging Surgical Technology & Education (2004–2007), and the Committee on Development (2005–2007). Dr. Lafreniere served as Chair of the Committee on Operating Room Environment (2001–2002) and the Committee on Perioperative Care (2002–2003).

Dr. Neumayer, a general surgeon, is professor of surgery at the University of Utah; Jon and Karen Huntsman Presidential Professor of Cancer Research, Huntsman Cancer Institute; and co-director, Integrated Breast Program, Huntsman Cancer Hospital, all in Salt Lake City. A Fellow since 1994, Dr. Neumayer has served on the Committee on Medical Student Education (1996–2003; Chair 2001–2003); the Program Committee (2002–2004); the Advisory Committee on SESAP (2003–2005); the Committee for the Forum on Fundamental Surgical Problems (2003–2009); and the Women in Surgery Committee (2005–present).

Dr. Schwartz, a pediatric surgeon, is professor of surgery and pediatrics, Drexel University College of Medicine, Temple University School of Medicine, Philadelphia, PA. He is also surgeon-in-chief, chief of pediatric surgery, and director of the Pediatric Surgery Research Laboratory at St. Christopher’s Hospital for Children, Philadelphia. A Fellow since 1982, Dr. Schwartz served as Chair of the Advisory Council for Pediatric Surgery (2002–2008) and as Chair of Advisory Council Chairs (2004–2008).
YFA inaugural meeting. Dr. Malangoni (left) makes opening remarks. On the panel, left to right (all MD, FACS): Perry Shen, Immediate Past-Chair; Mark Savarise, Chair; Laurel Soot, Chair, Communications Work Group; Wayne Frederick, Chair, Education Work Group; and Sanjay Parikh, YFA Vice-Chair and Chair, Advocacy Work Group.

YFA Governing Council. Left to right (all MD, FACS): Adam Cohen; Dr. Savarise; Juan Paramo; Dr. Frederick, Cecelia Boardman, Michael Sutherland, Danielle Katz, Dr. Soot, Rob Todd, Steven Chen, Dr. Shen, Dinakar Golla, and Sanjay Parikh. Not pictured: Keith Amos, Nancy Baxter, and Patricia Turner.
Recipients of the College’s highest honor, the Distinguished Service Award, met during the Clinical Congress. Front row, left to right (all MD, FACS): LaMar S. McGinnis, Jr.; Paul E. Collicott; Murray F. Brennan; and David L. Nahrwold. Back row: Richard B. Reiling, Patricia J. Numann, Frank Padberg, and C. Barber Mueller.

He is a member of the Public Profile and Communications Steering Committee (2007–present).

A. Brent Eastman, MD, FACS, was elected Chair of the Board of Regents. A general, vascular, and trauma surgeon, Dr. Eastman is chief medical officer of Scripps Health and the N. Paul Whittier Endowed Chair of Trauma at Scripps Memorial Hospital, La Jolla, CA. He is also a clinical professor of surgery-trauma at the University of California, San Diego. In his role as Chair of the Board of Regents, Dr. Eastman will work closely with the ACS Executive Director and will chair the Regents’ Finance and Executive Committees.

Elected to additional three-year terms on the Board of Regents were H. Randolph Bailey, MD, FACS, Houston, TX; Bruce D. Browner, MD, FACS, Farmington, CT; Martin B. Camins, MD, FACS, New York, NY; Julie A. Freischlag, MD, FACS, Baltimore, MD; Raymond F. Morgan, MD, FACS, Charlottesville, VA; Karl C. Podratz, MD, FACS, Rochester, MN; J. David Richardson, MD, FACS, Louisville, KY; Mark C. Weissler, MD, FACS, Chapel Hill, NC; and Thomas V. Whalen, MD, FACS, Allentown, PA.

The Board of Governors reelected Michael J. Zinner, MD, FACS, Boston, MA, as Chair. Timothy C. Flynn, MD, FACS, Gainesville, FL, was elected Vice-Chair, and James K. Elsey, MD, FACS, Lawrenceville, GA, was reelected Secretary.

The Past-Presidents of the College and guests met during the Clinical Congress. Front row, left to right (all MD, FACS): John L. Cameron, C. Rollins Hanlon, and W. Gerald Austen. Back row: Dr. Russell; R. Scott Jones; LaSalle D. Leffall, Jr.; and Gerald B. Healy.
Members of the Board of Regents (B/R), the Board of Governors (B/G) Executive Committee, and ACS Officers met for their annual luncheon. Pictured (with their titles prior to the Congress) front row, left to right (all MD, FACS): Dr. Russell; Andrew L. Warshaw, Treasurer; Julie A. Freischlag; A. Brent Eastman, B/R Vice-Chair; L. D. Britt, B/R Chair; John L. Cameron, President; Valerie W. Rusch; LaMar S. McGinnis, Jr., President-Elect; and James K. Elsey, B/G Secretary.

Middle row: Michael J. Zinner, B/G Chair; Barbara L. Bass; John T. Preskitt; Charles D. Mabry; Martin B. Camins; Robin S. McLeod; Richard J. Finley; Mark A. Malangoni; Carlos A. Pellegrini; Richard B. Reiling, Second Vice-President; and Jack W. McAninch, First Vice-President.

Back row: Courtney M. Townsend, Jr., Secretary; Thomas V. Whalen; H. Randolph Bailey; J. David Richardson; Howard M. Snyder III; Karl C. Podratz; Raymond F. Morgan; Mark C. Weissler; Bruce D. Browner; and Lenworth M. Jacobs, Jr., B/G Vice-Chair.

Members of the ATLS international community met to discuss pertinent issues related to the program. The ATLS program is in more than 40 countries worldwide.
Also elected to the Board of Governors’ Executive Committee were Henri R. Ford, MD, FACS, Los Angeles, CA, and Lena M. Napolitano, MD, FACS, Ann Arbor, MI.

Clinical Congress 2010: Washington, DC
It’s never too early to start planning for the 96th annual Clinical Congress, scheduled for October 3–7, 2010, in Washington, DC—the first time the meeting has ever been held in the nation’s capital. ACS event planners said it was the ideal time to have the Clinical Congress meeting in Washington, DC, because the College is continually striving to have a more visible presence on Capitol Hill. Nearly all educational sessions will be held in the new, state-of-the-art Walter E. Washington Convention Center.

Where to find more information
These highlights include news items that have been discussed in more detail in previous issues of the Bulletin. Following is a list of where to find these articles.

September 2009
• Full description of the humanitarian achievements of Surgical Volunteerism Award recipients, page 31.
• Dr. Griffen’s Distinguished Service Award, page 29

November 2009
• Biography of Dr. McGinnis, page 36
• Citations for Honorary Fellows presented at the Convocation, page 38

December 2009
• Dr. McGinnis’ Presidential Address in its entirety, page 8
• Dr. Eastman selected as Chair, Board of Regents, page 26

A special luncheon was held during the Congress in honor of the Distinguished Lecture of the International Society of Surgery. Attending the luncheon were, left to right: Dr. Russell; Dr. Numann; Michael G. Sarr, MD, FACS; Dr. McGinnis; Lecturer Professor Lord Ara W. Darzi, MB, BCh, FACS; Ronald V. Maier, MD, FACS; and Carlos A. Pellegrini, MD, FACS.
LaMar S. McGinnis, Jr.
President
*General surgery*
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*Calgary, AB*

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Private practice  
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**General surgery**  
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**Plastic surgery**  
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*Charlottesville, VA*

Leigh A. Neumayer  
**General surgery**  
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*Salt Lake City, UT*

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

J. David Richardson  
**Vascular surgery**  
Professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine  
*Louisville, KY*
Valerie W. Rusch  
Chief, thoracic service, Memorial Sloan-Kettering Cancer Center; and professor of surgery, Cornell University Medical College  
*New York, NY*

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

Thomas V. Whalen  
*Pediatric surgery*
Chair, department of surgery, Lehigh Valley Hospital  
*Allentown, PA*

Marshall Z. Schwartz  
*Pediatric surgery*
Professor of surgery and pediatrics, Drexel University College of Medicine, Temple University School of Medicine; and surgeon-in-chief, chief of pediatric surgery, and director, Pediatric Surgery Research Laboratory, St. Christopher’s Hospital for Children Philadelphia  
*Philadelphia, PA*

Mark C. Weissler  
*Otolaryngology*
Joseph P. Riddle Distinguished Professor of Otolaryngology, professor of otolaryngology-head and neck surgery, and professor and chief of head and neck oncology, University of North Carolina Neurosciences Hospital  
*Chapel Hill, NC*
David B. Hoyt, MD, FACS, becomes ACS Executive Director

David B. Hoyt, MD, FACS, former chairman, department of surgery; executive vice-dean, school of medicine; and John E. Connolly Professor of Surgery, University of California, Irvine (UCI), Medical Center, has become the new Executive Director of the American College of Surgeons. The appointment of Dr. Hoyt, who is a former Medical Director of the College’s Trauma Programs, was approved and announced by the ACS Board of Regents at their October 15, 2009, meeting.

Dr. Hoyt succeeds Thomas R. Russell, MD, FACS, who has completed his second term and a full decade of service as Executive Director of the American College of Surgeons.

An ACS Fellow since 1987, Dr. Hoyt has been an active leader in a number of College activities. He has been involved with the work of the ACS Committee on Trauma (COT) since 1980, and was Chair of the COT 1998–2002. He is a member of the national faculty for the College’s Advanced Trauma Life Support® (ATLS®) course, and is a coordinator, instructor, and director of training for ATLS.

Dr. Hoyt was awarded the College’s highest honor, its Distinguished Service Award, in 2007. He was a member of the ACS Board of Governors’ Committee on Blood-Borne Infection and Environmental Risk, the Program Committee, and the Regents’ Committee on Informatics. He was also actively involved with the San Diego/Imperial County Credentials Committee for 12 years.

Prior to his position at UCI, Dr. Hoyt was The Monroe E. Trout Professor of Surgery and vice-chairman of the department of surgery at the University of California (UC), San Diego, CA; he was also on the staff at the Veterans Administration Medical Center in San Diego and at Thornton Hospital in La Jolla, CA.


A nationally recognized trauma surgeon, Dr. Hoyt has been president of the Pan American Trauma Society, the American Association for the Surgery of Trauma, the Shock Society, and the San Diego Society of General Surgeons. He has served as chairman of the Trauma Advisory Committee for the state of California’s Emergency Services Authority. Dr. Hoyt has received numerous recognition awards throughout his distinguished career, including the Trauma Service Award from the Society of Trauma Nurses and the Robert Danis Lifetime Research Award from the International Society of Surgery.

Dr. Hoyt’s research interests and past research experience have involved basic and clinical work in a variety of important areas related to trauma patients and trauma care systems, including cytokine regulation, the isolation of
trauma active peptides, trauma registries, violence prevention, crash investigation, and long-term outcomes research. He has been awarded several research grants from the National Institutes of Health as the principal or co-investigator for trauma-related research throughout his career, and has been the author or co-author of more than 480 publications. In addition, Dr. Hoyt holds membership on the editorial boards of the *World Journal of Emergency Surgery, Surgery, Journal of the American College of Surgeons, Journal of Trauma, Shock, and Open Access Emergency Medicine.*

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**College supports American Cancer Society screening mammography guidelines**

The American College of Surgeons strongly supports the current American Cancer Society’s (ACS) screening mammography guidelines that recommend women get a mammogram every year, starting at age 40. The College is supporting the ACS guidelines despite the recommendations from the U.S. Preventive Services Task Force stating that women should have regular mammograms once every two years beginning at the age of 50. The College believes the ACS guidelines have resulted in an effective approach toward dealing with the possibility of breast cancer and that women should continue to follow them in consultation with their physicians.

The federal panel’s position that regular mammography screening in women under the age of 50 may do more harm than good was dismissed by David P. Winchester, MD, FACS, Medical Director of the American College of Surgeons Cancer Programs, and chair of the National Accreditation Program of Breast Centers. Dr. Winchester was particularly concerned about the panel’s belief that mammography may cause an increased risk of false-positive results in younger women who have denser breast tissue, observing that “the term ‘unnecessary biopsy’ is misleading.” “In most cases,” he said, “biopsy—done by either surgeons or radiologists—is the reliable way to rule out cancer at any age.”

The College notes that the ACS has long recognized mammography as the gold standard for early detection of breast cancer, and encourages women to take an active role in partnering with their physicians to determine at what age, and at what interval, they should undergo screening mammography. The College agrees with the ACS that factors such as a woman’s family history of the disease, and her overall medical condition, are some of the issues that should be addressed, particularly for women who are known to be at an increased risk for developing the disease.

“Many surgeons in this country have the tremendous responsibility and privilege of caring for breast cancer patients each day. While recognizing that mammography is not perfect and supporting continuing research for improved methods, the surgical community believes that the American Cancer Society’s screening mammography guidelines offer an optimal approach to detecting breast cancer early, when it can be most successfully treated,” LaMar S. McGinnis, Jr., MD, FACS, President of the American College of Surgeons and former president of the American Cancer Society, said. “Mammography is a good and safe tool, which we will continue to improve. In the meantime,” he added, “let’s save lives as best we can. The lives of women, mothers, and grandmothers are invaluable. Our progress has been significant, and it will continue. Let us not confuse our patients and the public with mixed messages.”

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*JANUARY 2010 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS*
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.
Call for nominations for the ACS Board of Regents

The 2010 Nominating Committee of the Board of Governors has the task of selecting two nominees for pending vacancies on the Board of Regents, to be filled during the 2010 Clinical Congress in Washington, DC. The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents.

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

Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice. The College encourages consideration of women and other underrepresented minorities.

Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents. Priority consideration should be given to representatives of general surgery.

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 26.

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

For information only, the current members of the Board of Regents who will be considered for re-election are as follows: Barrett G. Haik, MD, FACS; and Howard M. Snyder III, MD, FACS.

Call for nominations for ACS Officers-Elect

The 2010 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College.

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

The College encourages consideration of women and other underrepresented minorities.

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Friday, February 26.

If you have any questions, please contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Fellows at psprecksel@facs.org.
Heller School Executive Leadership Program scholarships available

The American College of Surgeons is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management (http://heller.brandeis.edu/academic/execed/index.html) at Brandeis University, in Waltham, MA. The 2010 course takes place June 13–19, and the $8,000 award is to be used toward the cost of tuition, travel, housing, and subsistence during the period of the course and the post-course follow-up period.

Two 2010 scholarships are reserved for general surgeons and are fully funded by the College. In addition, the College is very pleased that a large number of the surgical specialty societies have partnered with the ACS to co-sponsor a scholarship for a member in good standing of both the College and his or her surgical society. The participating societies supporting scholarships are the American Association of Neurological Surgeons, the American Association for the Surgery of Trauma, the American Pediatric Surgical Society, the American Society of Breast Surgeons, the American Society of Colon and Rectal Surgeons, the American Society of Plastic Surgeons, the American Surgical Association, the American Urogynecologic Society, The Society of Thoracic Surgeons, and the Society for Vascular Surgery.

The American Urological Association (AUA) will also cosponsor a health policy scholarship with the College, via the mechanism of the AUA’s Gallagher Scholars program (visit www.AUAnet.org/Gallagher).

General policies covering the granting of the scholarships are as follows:

- The award is open to surgeons who are general surgeons or members in good standing of one of the listed societies and of the American College of Surgeons.
- The award is to be used to support the recipient during the period of the course and the period of service following. Indirect costs are not paid to the recipient or to the recipient’s institution.
- Applications for this scholarship consist of the following items:
  - The applicant’s current curriculum vitae
  - A one-page essay, discussing why the applicant wishes to receive the scholarship
- Application for this award may be submitted even if comparable application to other organizations has been made. If the recipient accepts a similar scholarship from another agency or organization, the scholarship will be withdrawn. It is the responsibility of the recipient to notify the Scholarships Section of the ACS, which administers this program, of competing awards.
- The scholarship must be used in the year for which it is designated. It cannot be postponed.
- The selected scholar is required to provide one year’s health policy-related assistance to the ACS and the cosponsoring society, attending meetings, reviewing applications, and so forth, as requested by either organization.
- A brief report of the scholar’s experiences and activities is due at the conclusion of the course and again at the end of the scholarship period. A simple accounting is also required.

The closing date for receipt of applications is February 1. All applicants will be notified of the outcome of the selection process by March 31. Questions may be directed to the ACS Scholarships Administrator at 312-202-5281. Requirements for the scholarships are available at: http://www.facs.org/memberservices/research.html.

Send applications for this scholarship to Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
Nominations sought for 2010 volunteerism and humanitarian award

The American College of Surgeons, in association with Pfizer, Inc, is accepting nominations for the 2010 Surgical Volunteerism Award(s) and the Surgical Humanitarian Award.

The ACS/Pfizer, Inc Surgical Volunteerism Award is given in recognition of those surgeons committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities. The awards for domestic, international, and military outreach are intended for ACS surgeons in active surgical practice whose volunteerism activities go above and beyond the usual professional commitments, or retired Fellows who have been involved in volunteerism during their active practice and into retirement. Surgeons currently in residency who have been involved in significant surgical volunteer activities are eligible for the resident award. Surgeons of all specialties are eligible for each these awards.

For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism in this case does not refer to pro bono or uncompensated care provided as a matter of necessity in most practices. Instead, volunteerism should be characterized by the prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gains.

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

Nominations will be evaluated by the Committee on Socioeconomic Issues of the Board of Governors, with final approval of award winners by the Executive Committee of the Board of Governors.

Potential nominees should make note of the following:

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

The nomination forms will be available for download from the “Announcements” section of the Operation Giving Back Web site during January and February at http://www.operationgivingback.org. Nomination forms can also be requested by mail, if preferred. Contact Uriah Melchizedek, Operation Giving Back Program Coordinator, with such requests or any questions.

Completed nomination forms should be addressed to the attention of Robert M. Zwolak, MD, FACS, Chair, Board of Governors’ Committee on Socioeconomic Issues, and can be submitted electronically, or by mail c/o Uriah Melchizedek, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; 312-202-5458; fax 312-202-5021; ogb@facs.org. All nominations must be received by Friday, February 26.
Did you ever wish you could be in 5 places at once?

NOW YOU CAN...95th Annual ACS Clinical Congress
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The ACS Clinical Congress is packed with valuable educational programming, but busy annual meeting attendees can’t be in five places at one time. The burning question has always been, “Which one to attend?”

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Includes 2009 Webcast sessions, 2008/2007 Webcast sessions AND audio sessions from 2009 Congress.

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In the last issue of the Bulletin (Bull Am Coll Surg. 2009;95(12):29), we discussed the role of the American College of Surgeons Oncology Group (ACOSOG) in promoting patient safety. We described how ACOSOG is charged with conducting clinical trials that ensure the safe introduction of effective new therapies. We also outlined, in brief, how the complex system of oversights and the team of patient advocates work together to safeguard patients enrolled in clinical trials. In this article, we provide a more in-depth examination of the ACOSOG patient advocates—who they are and what they do to contribute to the scientific effort of ACOSOG.

Who are patient advocates? Since ACOSOG is sponsored by the National Cancer Institute (NCI), we offer the NCI definition of the patient advocate as a starting point:

A person who helps a patient work with others, who [has] an effect on the patient’s health, including doctors, insurance companies, employers, case managers, and lawyers. A patient advocate helps resolve issues about health care, medical bills, and job discrimination related to a patient’s medical condition. Cancer advocacy groups try to raise public awareness about important cancer issues, such as the need for cancer support services, education, and research. Such groups work to bring about change that will help cancer patients and their families.

To examine the day-to-day contributions of patient advocates engaged in cancer trials, we invited Bettye Green, RN, the chair of the ACOSOG Patient Advocacy Committee, to offer her insights. We started by asking Ms. Green why, and how, a person decides to become a patient advocate, as well as what is required to become certified or credentialed.

“Just by desire, they decide they want to work with a researcher to find a cure for cancer,” said Ms. Green. “Once they decide to become a patient advocate, they voice that desire; they seek out and find the opportunities to work with researchers who work on cancer. There is no credentialing yet for patient advocates. There are colleges working on developing programs that would award degrees for advocacy, but they are not available at this time.”

We also enquired about the patient advocates who work with Ms. Green on the ACOSOG committee and about the role of the committee in promoting the science of ACOSOG.

“The Patient Advocacy Committee of ACOSOG is constituted with rich diversity,” said Ms. Green. “The 13 members of the committee are people from different backgrounds with different experiences and expertise. For example, the ACOSOG Patient Advocacy Committee includes Native Americans, African-Americans, Hispanics, women, men, old and young individuals. Folks are from different parts of the country and have experience in teaching, fundraising, and recruiting. All who serve ACOSOG have some personal connection with cancer so the desire to serve is strong.”

Ms. Green continued, “The job of ACOSOG patient advocates is to represent the patient at all steps along the ACOSOG decision-making process and to promote patient safety. To accomplish this aim, patient advocates are fully integrated into ACOSOG scientific committees and activities.”

Ms. Green explained that the process starts with the advocate reviewing the study...
idea or concept. They critically address the first key question, which is: will patients find the idea appealing enough to enroll into the trial?

If the answer is “yes,” the next step in the process is the Peer Review Committee. While the scientists are critically appraising the study methods and endpoints for what they need to learn from the study, the patient advocates on the committee are considering the logistics of the proposed methods. Will the study methods be something a patient can reasonably achieve?

Once a study is approved, the patient advocates work on the dissemination phase. “You need to reach out to patients in a culturally sensitive manner…and you have to reach out into the community,” explained Ms. Green. “The ACOSOG advocates train local advocates to reach communities to spread the word about trials, and they keep their eye on the accrual goal target.”

And finally, in order to put safety first during the conduct of the trial, patient advocates are part of the ACOSOG Data Monitoring Committee. “We are the patient at the ACOSOG table,” Ms. Green added.

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

### ACS leaders visit key senators

In the midst of the health care reform debate, leaders of the College traveled to Washington, DC, to meet with House and Senate congressional leaders, including Sen. Max Baucus (D-MT), Chairman of the powerful Senate Finance Committee. The December 9, 2009, meetings were held as part of the College’s long-term, strategic advocacy efforts to advance the College’s top legislative priorities within comprehensive health care reform. Pictured from left to right: A. Brent Eastman, MD, FACS, Chair of the ACS Board of Regents; Senator Baucus; LaMar S. McGinnis, Jr., MD, FACS, ACS President; and David B. Hoyt, MD, FACS, then incoming Executive Director of the College.
American College of Surgeons Professional Association (ACSPA)

As of September 15, 2009, the ACSPA-SurgeonsPAC (political action committee) raised $465,709. Forty-two percent of the U.S. Governors contributed $42,820, and 44 percent of the U.S. Officers and Regents contributed as well. PAC contributions were made to 45 candidates, leadership PACs, and party committees.

American College of Surgeons

Board of Governors

The Executive Committee of the Board of Governors held its five telephone conference calls scheduled for the year. In addition, two face-to-face meetings were held during the Clinical Congress in Chicago, IL.

The Board of Governors annual survey communicates the concerns and recommendations of the Fellows regarding major issues related to surgery to the College’s leadership. The results of the survey are presented to the Board of Regents as it considers future College endeavors. The top five issues of concern to the Fellows of the College in 2009, as reported by the Governors, are as follows:

- Health care reform
- Physician reimbursement
- Professional liability/malpractice
- Workforce issues
- Graduate medical education

The Board of Governors and the Board of Regents held a joint session during the annual business meeting of the Governors. The session focused on the College’s 2009 draft statement on health care reform. The draft was a major topic of discussion at both the business and adjourned meetings of the Board of Governors. The 2009 draft evolved, in part, from the 2008 ACS Statement on Health Care Reform, with added emphasis on medical liability reform. As the College did with its 2008 statement, it will use its finalized 2009 statement to form the basis of its interactions with Congress on health care policy. The finalized document was expected some time in November.
ACS Health Policy Research Institute (ACS HPRI)
The ACS HPRI is engaged in a variety of projects, including analysis of surgery workforce trends. The HPRI is also engaged in the development of an interactive atlas of the U.S. surgical workforce.


ACS Health Policy and Advisory Council
The Board of Regents approved the formation of a Health Policy and Advisory Council, which will be a subgroup of the Health Policy and Advocacy Group. The establishment of this council will allow for better outreach to, and input from, the Fellows on health policy matters. The council will be composed of Governors, Young Fellows, ACS Resident and Associate Society members, ACS Health Policy Scholars, and other Fellows with expressed interest or expertise in health care policy.

ACS National Surgical Quality Improvement Program (ACS NSQIP)
While important and substantial advances are being made in both the program’s technical and clinical aspects, the most progress has been achieved through the joint quality improvement efforts of a variety of different groups. The shared efforts with the Centers for Medicare & Medicaid Services (CMS) to develop ACS NSQIP-based performance measures, working with The Joint Commission to improve surgical safety, and collaborating with many surgical societies to further expand ACS NSQIP’s content and reach, are some examples of these joint quality improvement efforts. Overall, ACS NSQIP is reaching an important “tipping point” as the program’s proven technical aspects are advancing, clinical improvement is building on the expertise of internal initiatives, and surgical improvement efforts are being shared with organizations such as CMS, The Joint Commission, the Institute for Healthcare Improvement, and others.

Addition of “procedural skills” to the ABMS/ACGME core competencies
Since the American Board of Medical Specialties (ABMS) and the American Council for Graduate Medical Education (ACGME) defined the six core competencies several years ago, there has been widespread concern about the omission of technical skills from the list of competencies. The College addressed this gap by focusing specifically on technical skills through a variety of innovative competency-based educational programs that addressed psychomotor skills, cognitive skills, judgment, and teamwork. Leaders from across the surgical specialties have supported the notion of adding a seventh core competency to address technical skills, or have addressed this competency through approaches similar to the one adopted by the College. The ABMS and the ACGME appointed a Joint Task Force on Technical Skills to discuss this matter and develop appropriate recommendations. The Task Force unanimously endorsed inclusion of technical skills as a core competency, and named the new core competency “procedural skills.” Subsequently, the Board of Regents voted to approve the addition of procedural skills as the seventh core competency.

Journal of the American College of Surgeons (JACS)
Online and fax JACS CME submissions currently exceed 278,000 credits; the program is provided as a member benefit. The efficiency and economics of the JACS CME-1 program is beneficial to all members, especially in this time of heightened emphasis on Maintenance of Certification. It would benefit the ACS chapters to include information about the JACS CME-1 program for their members during their meetings.

New chapters
The Board of Regents approved the formation of the College’s 34th and 35th international chapters: the ACS Pakistan Chapter and the ACS Austria-Hungary Chapter. This brings the total number of ACS chapters to
HealthCareers (a.k.a. Job Bank)
As of September 2, 2009, there were 1,072 active jobs listed on the Web site, with 265 posted résumés. This is a valuable service for all members of the College.

Resident and Associate Society of the American College of Surgeons (RAS)
The RAS gave special recognition to Mark D. Boyer, MD, FACS, for his efforts on behalf of the Surgical Jeopardy program. Jacob Moalem, MD, FACS, hosted the first RAS Town Hall Meeting, during which the discussion focused on resident work hour restrictions. The RAS continues to focus on educational opportunities and is thankful for the fund that has supplied scholarships for the resident members. New ideas continue to be generated on how to increase those funds and offer new opportunities for deserving young surgeons.

Young Fellows Association (YFA)
The YFA held its inaugural meeting during the Clinical Congress on Monday, October 12, 2009. Mark A. Malangoni, MD, FACS, a former chair of the former Committee on Young Surgeons, provided the welcoming remarks at the meeting. The YFA consists of four workgroups: Advocacy, Communications, Education, and Member Services. Nearly 100 Fellows have joined a workgroup. Visit the new YFA Web page at http://www.facs.org/memberservices/yfa/.

Web portal
Top pages visited during the second quarter of 2009 included My Page, My Profile, My Cases, and My CME, closely followed by Member Services, Member Tools, and Member Benefits. The most visited communities were Minimally Invasive Surgery, Rural Surgeons, General Surgery, Breast Cancer Surgery, and Residents and Associate Fellows. The Communities & Specialties area of the portal continues to provide quality content targeted to main interests of members of the College.

Operation Giving Back (OGB)
In the past year, there have been nearly 23,000 unique visitors who have conducted more than 93,500 page views of the OGB Web site at http://www.operationgivingback.facs.org/. Since June, there have been 51 new volunteer opportunities posted to the Web site, with 196 opportunities currently, actively available.

Executive Director
Thomas R. Russell, MD, FACS, retired from his College position as Executive Director on December 31. Dr. Russell has been the College’s Executive Director for 10 years. During its business meeting in October, the Board of Governors expressed its appreciation for all of Dr. Russell’s accomplishments on behalf of surgery and patient care.

The Board of Regents met in Executive Session during the Clinical Congress and heard presentations from finalists for the position of Executive Director of the American College of Surgeons. After all candidates made their presentations, the Regents voted to approve the selection of David B. Hoyt, MD, FACS, of Orange, CA, as the next Executive Director of the College. The College welcomes Dr. Hoyt as he begins his new venture.

Dr. Zinner is Moseley Professor of Surgery, Harvard Medical School; clinical director, Dana-Farber/BWH Cancer Center; and surgeon-in-chief, Brigham and Women’s Hospital, Boston, MA.
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The American College of Surgeons does NOT provide your e-mail address to outside entities. E-mail addresses are used only for College communications.
A look at The Joint Commission

2009 Eisenberg Award recipients named

The National Quality Forum (NQF) and The Joint Commission presented the 2009 John M. Eisenberg Patient Safety and Quality Awards in October at NQF’s Annual National Policy Conference on Quality in Washington, DC.

The patient safety awards program, launched in 2002 by NQF and The Joint Commission, honors John M. Eisenberg, MD, former administrator of the Agency for Healthcare Research and Quality (AHRQ). Dr. Eisenberg was one of the founding leaders of the NQF and sat on its board of directors. In his roles both as AHRQ administrator and chair of the federal government’s Quality Inter-Agency Coordination Task Force, he was a passionate advocate for patient safety and health care quality, and personally led AHRQ’s grant program to support patient safety research. Honorees were selected in all five award categories, including a new international category.

The 2009 honorees, by award category, are as follows:

• **Individual achievement:** Gary S. Kaplan, MD, Virginia Mason Medical Center, Seattle, WA. Dr. Kaplan, a practicing physician, is credited for guiding Virginia Mason Medical Center through a transformation that explicitly placed the interests of the patient first. Introducing breakthrough changes derived from the Toyota Production System, Dr. Kaplan spearheaded the creation of the Virginia Mason Production System. The patient safety and quality achievements realized at Virginia Mason as a result of consistently applying these innovative methods have attracted the interest and attention of health care leaders nationally and internationally.

• **Research:** Tejal Gandhi, MD, Brigham and Women’s Hospital, Boston, MA. Dr. Gandhi has been instrumental in increasing knowledge and awareness of safety issues in the outpatient setting and in designing improvement strategies for this setting, particularly through the use of information technology. Her groundbreaking work to better understand the epidemiology of a wide range of ambulatory safety concerns is responsible for drawing national attention to safety issues and potential prevention in this important patient-care setting.

• **Innovation in patient safety and quality at the national level:** Michigan Health & Hospital Association (MHA) Keystone Center for Patient Safety & Quality, Lansing, MI. The MHA Keystone Center used a quality improvement collaborative to focus on interventions to improve patient safety and prevent harm in intensive care units (ICUs). Two of the interventions—eliminating central line-associated bloodstream infections (CLABSIs) and the Comprehensive Unit-Based Safety Program (CUSP)—have produced notable results in eliminating CLABSIs in Michigan ICUs. More than 1,800 lives have been saved, more than 140,700 excess hospital days avoided, and more than $271 million health care dollars have been saved in the five years since the interventions were first implemented.

• **Innovation in patient safety and quality at the local level:** Mercy Hospital Anderson, Cincinnati, OH. Mercy Hospital Anderson developed and implemented an automated Modified Early Warning System (MEWS), a simple scoring system that is applied to the physiological vital signs routinely measured by nurses. MEWS provides nurses with a tool to evaluate subtle signs that predict the patient’s likelihood of deterioration.

• **International:** Noreen Zafar, MD, FRCOG, Lahore, Pakistan. Dr. Zafar’s vision is to offer high-quality gynecological care and empower women to become good decision makers regarding their own health and
their family’s health. Dr. Zafar has worked independently to promote wellness among girls and women, without assistance from the government or any other outside support. She has overcome many social taboos in her quest, and has established health awareness programs related to precancer screening, teenage gynecological health, and reproductive health.

Dr. Zafar has initiated nearly a dozen campaigns under the umbrella of the Girls and Women Health Initiative, such as Say No to Osteoporosis, Beat Menopause, Prioritize Pink, Folic Acid Campaign, Women Matter, and The Pakistan Group for Pediatric and Adolescent Gynecology, in an effort to improve girls’ and women’s health.

Surgeons are eligible to receive the awards. In 2007, the individual category award was bestowed upon Darrell A. Campbell, Jr., MD, FACS, senior associate director and chief of staff, Henry King Ransom Professor of Surgery, University of Michigan Hospitals and Health Centers, Ann Arbor, MI.

Updated information for the 2010 Eisenberg submissions will be available February 1. To view past winners visit [http://www.jointcommission.org/PatientSafety/Eisenberg Award/#1](http://www.jointcommission.org/PatientSafety/Eisenberg Award/#1).

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**RESIDENCY ASSIST PAGE**

The Residency Assist Page of the American College of Surgeons offers a medium for program directors to acquire updates and advice on topics relevant to their needs as administrators and teachers.

Our goals are to offer practical information and approaches from summaries of published articles, invited editorials, and specific descriptions of lessons learned from program directors’ successful and not-so-successful strategies. Through the development of the Residency Assist Page, the ACS intends to support program directors and faculty by providing succinctly presented information helpful in addressing the challenges associated with administering state-of-art residency education.

[www.facs.org/education/rap](http://www.facs.org/education/rap)

For additional information, please contact Olivier Petinaux, MS, at elearning@facs.org, or tel. 866/475-4696
The American College of Surgeons
Division of Education
welcomes submissions
to the following programs
to be considered
for presentation at
the 96th annual
Clinical Congress,
October 3–7, 2010,
Washington, DC

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 2009)
  Accepted Surgical Forum abstracts will be published in
  the September Supplement of the Journal of the American College of Surgeons (JACS)

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

Poster presentation

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

Video presentation

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

Submission information

- Abstracts are to be submitted online only.
- Submission period begins November 2, 2009.
- Deadline: 5:00 pm (CST), March 1, 2010.
- Late submissions are not permitted.
- Abstract specifications and requirements for each individual program will be posted on
  the ACS Web site at [www.facs.org/education/](http://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.*
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” column written by former Executive Director Thomas R. Russell, MD, FACS.

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

The health care debate: We mean well but we are too timid

In “Does the U.S. have the best health care system in the world?” (Bull Am Coll Surg. 2009;94(7):8-15) there are four tables: (1) Health care system attainment, (2) Overall performance, (3) Life expectancy and health expenditures, and (4) Infant mortality rates. The article includes a section entitled “U.S. system is very good, but could be better” and it ends with “The U.S. has a high-quality health care system. We should do all we can to protect it as well as to improve it.”

In the tables we are ranked number 15 in attainment, and our overall performance rank is 37. The life expectancy of American newborns is 1.7 years less than the non-U.S. average, and less than each of 18 other nations. Our per-capita health care expenditure of 4,887 is the highest among 19 nations. In fact, it is more than double the average expenditure of 2,295 in the other 18 nations. The infant mortality rate in the U.S. is the highest among 16 nations. So where is the evidence that our system is very good? Even if one considers the positive evidence regarding our system (and I agree that there is such evidence), one cannot escape its high cost. Thus, the value of our health care system is abysmally low.

It is politically correct, but timid, to say, “The U.S. has a high-quality health care system. We should do all we can to protect it as well as to improve it.” Let us stop being timid and let us admit that our health care system is broken and inadequate. The evidence indicates that nations with single-payer or multiple-payer national systems are providing more value for their citizens than we are providing for most of ours. So, let’s stop primarily protecting the status quo. Let those of us who are privileged to practice surgery in this greatest of all nations lead in selecting changes that promise to be as beneficial as possible for our patients and the future of health care.

Health care reform is neither a Democratic nor a Republican issue, nor is it new. President Theodore Roosevelt was the first to propose universal health care, and President Richard Nixon had it among his highest priorities. Republican and Democratic presidents have been held down, much as the Liliputians successfully restrained Gulliver.

Reality indicates that sweeping, all-inclusive reform will not happen promptly. To start somewhere is required, and as part of this I offer three suggestions:

1. Initiate change within entities the government already controls. Centers for Medicare & Medicaid Services (CMS) patients often have limited access to care, and they face a billing morass. The federal government controls certain health care systems, e.g., Veterans Affairs, military; Public Health Service. The federal government also controls Medicare. Reform could promptly begin by allocating the required resources to government-controlled health care systems, giving Medicare patients access to these systems, and adapting these systems so that they could provide the positive aspects of existing nongovernment health care facilities.

2. Decrease costs by changing practice patterns. During my recent outpatient hernia repair in a voluntary hospital, and whenever I visit a doctor’s office, the number of paid people I encounter and the forms I complete are excessive and repetitive. Who knows how many CMS and Anthem Blue Cross billing and collection people handle the complicated, excessive paper work? There is clearly fat to be trimmed in practice patterns in hospitals and doctors’ offices.

3. Give physicians who have personal experience in the practice of medicine definitive leadership roles in advising the government. The merit of this suggestion is illustrated by the success of the Mayo Clinic, the Cleveland Clinic, and the Kaiser-Permanente systems. Well-selected medical practitioners have more to offer than administrators.

John R. Benfield, MD, FACS, Los Angeles, CA

Changes in practice patterns

Dr. Russell, we met in New Orleans at the lunch for Mark Puder, MD—the most promising investigator that year. Since that meeting, I have left my private practice of more than 20 years, for many of the reasons outlined by you in a recent column (Bull Am Coll Surg. 2009;94(6):4-5), for an employed position at Emerson Hospital in Concord, MA, this May. The scramble that private practice had become to make a living (including covering two hospitals, an office in a third location, fewer surgeons willing to care for all comers—especially trauma) led to a breaking point for me.

General surgery is an essential service and the sacrifices being made to provide it to my community, albeit professionally satisfying, became too demanding personally. Professionally, I wasn’t growing as a surgeon, either. It was all about
just doing, and there wasn’t enough time for reflecting on the process or the new abilities I should be developing to stay current with the technological advances. There was certainly a need for another body here, but in the right model there is time for peer review and education, and these things are perhaps more valued in this situation than in the eat-what-you-kill private practice.

There is more to surgery than the next case, and we need to have the flexibility in our practices to lead the way to better care for our patients. I don’t know that I have any specific solutions, but I know when I made my wish list of what my ideal practice would be like, my private practice didn’t resemble it in the least. This comes from a guy who developed the first Level III trauma center in Massachusetts and served as president of the medical staff for eight years, finishing my last two-year term last December [2008]. I don’t regret my early decisions about where and how to practice, but the ACS is doing well to recognize the changes in practice patterns and think about why it is happening.

Brian T. Callahan, Jr., MD, FACS
Concord, MA

Brian, Thank you for your recent communication and I do remember meeting you in New Orleans. Thank you so much for your comments about the article in the Bulletin regarding changing practice patterns. I really admire your ability to see the changes and make an adjustment in your private practice so that now you are in an employed position. I see more and more surgeons doing this, for the obvious reasons such as you have identified and that I have tried to write about. I congratulate you on your abilities to make this change after so many years in private practice. It is clear that there are some ways of practicing that are not sustainable, and the windows of opportunities are open now for many if they are able to change.

Thomas R. Russell, MD, FACS
Former Executive Director, ACS

Surgical tourism

The article on surgical tourism published in the April 2009 issue of the Bulletin is ironic, as surgeons have worked hard to provide accountability and efficacy to the health care process and costs (Bull Am Coll Surg. 2009;94(4):18). The institution of “surgery,” as opposed to “medicine,” is historically founded on the principle: one disease, one operation and one cure (for one fee, presumably).

General surgeon fees in this country are priced very reasonably, and hardly exceed fees for mechanic work or plumbing, based on my experience.

What underlies this rebellion on our patients’ part is not surgeon fees but the hospital charges. We know that these charges are driven by cost-shifting to cover shortfalls of Medicare funding for hospital care. I propose that such charges for non-Medicare or Medicaid individuals would be cut at least in half, if every patient simply paid for the services he or she received.

Is it ethical for surgeons, as a group, to participate without protest in a system that is detrimental to us and our working-age patients, when the public sees us as greedy co-conspirators, and when, in fact, the opposite is clearly the case?

F. A. Morfesis, MD, FACS
Fayetteville, NC

Surgical serious video games

Although the use of simulators in surgical education is a recently growing trend, the science behind these technologies is mature. Work-hour restrictions and decreased public and political tolerance for “never-event” and other potentially avoidable medical errors are creating a new paradigm for the training of the future generation of surgeons by increased non-bedside clinical training. As quality improvement lessons from the aviation industry are increasingly applied in operating rooms around the country, so, too, can the model of flight simulation training be applied to surgical education.

At last year’s Medicine Meets Virtual Reality Conference, several presentations described the current state of the art and the science behind the development of so-called serious video games, which are basically wholly computer-based surgical simulators. These programs have several distinct advantages over the more classic model of a simulation-center based model; specifically, these programs are portable, and as they do not require any additional equipment other than a personal computer, are cost-effective.

Dr. Jan Cannon-Bowers from the University of Central Florida stated that although video games are the most popular form of entertainment (more popular than movies and television combined), currently there are not many medical video games, and a lack of guidelines for their development. However, one of the key features of such games is that they provide “pattern building for adaptive expertise.” Dr. Cannon-Bowers went on to say that such simulators can provide variations on a theme for different scenarios, and even provide for “over-learning” of cognitive skills, making them automatic and subconscious, thus potentially helping to “take up the slack” regarding work-hour restrictions and the loss of clinical experiences.

Although funding of these projects remains an issue, by focusing on cognitive content, decision making, and role-playing instead of graphics, the development of these programs can be done for reasonable costs, especially within aca-
ademic environments where student programmers may be available. In addition to being used for resident education, these decision-making scenarios can also be used to assess competency. In fact, such digital case-based games are currently being developed for practicing surgeons.

In addition, in the future, these case-based scenarios will likely be linked with skills trainers, such as those currently commercially available, and will likely be in use in many surgery residencies across the country. Providing a case-based environment will help to contextualize skills-based learning, allowing students to practice the cognitive skills associated with the work-up, treatment, and even follow-up, as virtual patients can be seen for six-month follow-up immediately after the virtual procedure is completed. Thus, even continuity of care can be practiced before a student physician treats an actual live patient. Clearly, surgical video games will be a part of surgical education for the next generation of surgeons.

Stefan Holubar, MD
Associate Fellow, American College of Surgeons
Member, RAS-ACS
Education Committee
Rochester, MN

Resident issues

Thank you for addressing a serious shortcoming in our resident training programs—the practical business of medicine. As virtually every resident will verify, while we are well-trained in the complexities of caring for patients (as we should be, since this is our main focus), we cannot deliver that care if we cannot establish and run a financially viable practice. The articles by Nair, et al (Bull Am Coll Surg. 2009;94(6):15), Cooke, et al (Bull Am Coll Surg. 2009;94(6):19), and the comments by Dr. Russell are both appropriate and long overdue. I might point out that the ACS, on its Residency Assist Page, has published a “book” entitled Life after Residency; A Guide for the New Physician and Surgeon. This is also being distributed by Ethicon free of charge to all fourth- and fifth-year residents and surgical fellows. Expansion of this to include all physicians, regardless of specialty or field, would be admirable (and is needed). Congratulations on addressing a truly important subject; maybe this should be a regular part/subsection of the Bulletin.

Craig J. Schaefer, MD, FACS
Trappe, MD

As a former general surgery residency program director for more than 23 years, I would like to comment on the article by Moalem on residency training in the June 2009 issue of the Bulletin (Bull Am Coll Surg. 2009; 94;(6):12-14). Dr. Moalem states that patients today are “older and sicker than ever.” Older, maybe, but is there evidence that patients are sicker now than, say, 30 years ago? If so, please provide a reference.

I agree that the number of inpatients has declined. But I do not see how that results in more work for residents today. Back in the day, hernaorhaphy and cholecystectomy patients were not only admitted the day before surgery (necessitating a full history and physical by the resident), they also stayed in the hospital for five to seven days postoperatively. This created much more work, not less.

I agree that the demise of resident autonomy has contributed to the deterioration of residency training. However, something else is going on. Bell et al (Ann Surg. 2009;249:719-724) recently published data showing a distressing lack of resident exposure to many key operative procedures. For example, the mode (most common) number of common bile duct explorations reported by graduating chief residents in 2005 was one. For 63 of 121 types of procedures considered essential for graduating chief residents by a survey of program directors, the mode reported was zero cases.

In November 2008, one of the last cases I did before leaving the faculty of a residency program was insertion of a port for chemotherapy. In her fifth month of her PGY-1 year, the resident who scrubbed with me had not only never performed a subclavian vein cannulation, she had seen only one such procedure.

Today’s residents feel the need to take fellowships, and not just because they are looking for a niche. I believe many are not ready for independent practice and they know it. I am not sure if the solution is early differentiation into subspecialty tracks, but no doubt something needs to be done.

James E. Barone, MD, FACS, FCCM
Stamford, CT

I enjoyed reading the articles from young surgeons regarding the modern surgical lifestyle and the fate of the surgical generalist in the June 2009 issue of the Bulletin. It’s been painful for me to watch the decline of general surgery as a specialty to which a young doctor might aspire. I believe that much of the dissatisfaction with general surgery relates to the commitment young doctors have to lifestyle, and the difficulties that the general surgery community call presents in achieving that.

Two of the six general surgeons in my group have recently experimented with a modification of our usual call schedule. We take call every other day for two weeks, and then spend the next four weeks free of call responsibilities. Taking call every other day requires a change in one’s thinking if you are to survive it. The old idea of “eating what you kill” is not a part of our call service. Cases are handed off and assumed each morning. Rounding
in the morning is the responsibility of the on-call surgeon. It is a “shift mentality” service that requires you to accept the fact that your colleague can do as good a job as you can.

It is important to designate a period of time the day after call that is free of clinical responsibilities in order to recuperate. Communication is critical between my partner and me in order to provide continuity for the inpatients generated from the call service. It has been painful at times, but we have made adjustments that have made the situation tolerable. In fact, some of the new generation of doctors might find a version of the call service an acceptable lifestyle in the form of a surgical hospitalist. But the biggest revelation for me has not come from the time taking call. It has come from the time off call. The practice of general surgery without community call provides a very enjoyable lifestyle by anyone’s standards. The days are varied, yet predictable. One can wake up in the morning without worry of being interrupted by the emergency room or an urgent consult from the floor. There is never a need to cancel clinic appointments or add on cases that extend your operating room day into the evening. Most importantly to me, after 23 years of practice, there is no worry about completing a full day of surgery after working all night taking care of emergencies. The experience has convinced me that the only way general surgery can survive into the next generation of doctors is through the development of the surgical hospitalist.

The ACS should lead the way in providing guidelines for the development of the surgical hospitalist. The College is our only hope for competing in an employee contract, which a properly negotiated contract could have prevented.” Since all groups eventually dissolve (or turn over individuals), an exit strategy should be built into any contract; as the authors note, “both parties should be able to get out of the contract.” Restrictive covenants favor the employer at the expense of the employee (with a third party, the patient, not spoken for at all), and should be avoided at all cost.

The statement that “unfair non-compete covenants are typically not enforceable” is false. I was run out of a Midwest city by a restriction that specified a 25-mile radius around 12 hospitals scattered around a large metropolitan area of 1.5 million (essentially a 100-mile radius), which held up in District Court, but I somehow survived these severe restrictions long enough to overturn the decision on appeal two years later. Of interest, the legal profession believes that the client should have the right to see the attorney of their choice, so it is unethical to include a restrictive covenant in a contract among lawyers. Moreover, such a covenant not-to-compete between attorneys has never held up in a U.S. court-room. I believe that (at least on this issue) lawyers in this country are on a higher ethical plane than we doctors, who continue to “eat their young” using weapons such as “covenants against competition.”

William C. Cirocco, MD, FACS
Shawnee Mission, KS

An article published in the June 2009 issue of the Bulletin, titled “Building a surgical career” was interesting and well done (Bull Am Coll Surg. 2009; 94;(6):9-11). The article titled “Compensation, contracts and covenants: A surgeon’s guide to successful job negotiation,” published in the same issue (pages 15–18) also caught my attention, especially the section titled “Covenants to not compete.” I agree with the authors that “there is no such thing as a ‘standard’ contract.” Indeed, a “restrictive covenant” between physicians is illegal in several states (as noted by the authors) and should not be allowed in physician contracts.

Furthermore [I agree that], the “[AMA] and patients dislike restrictive covenants because they... prevent patients from following up with their physician of choice.” This is precisely why the ACS’ Committee on Young Surgeons brought this issue to the Board of Regents, resulting in ACS Position Statement 49 which reads, in part, “any restrictive covenant that interferes with the uninterrupted delivery of qualified surgical care to patients is considered unethical.”

Many general surgery program directors instruct their graduating chief residents not to sign a contract that includes a restrictive covenant. The old adage, “everything is negotiable” holds true. If a prospective employer demands the inclusion of a covenant not-to-compete in an employee contract, this should be a red flag not to enter into an association with that individual or group.

The authors state in the opening paragraph of the article that “it is only empathy from the colleagues we join that brings on a fair treatment throughout this process,” but later admit that “some end up trapped in a malignant practice, which a properly negotiated contract could have prevented.” Since all groups eventually dissolve (or turn over individuals), an exit strategy should be built into any contract; as the authors note, “both parties should be able to get out of the contract.” Restrictive covenants favor the employer at the expense of the employee (with a third party, the patient, not spoken for at all), and should be avoided at all cost.

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George N. Beito, MD, FACS
Kirkland, WA

George N. Beito, MD, FACS

William C. Cirocco, MD, FACS

Shawnee Mission, KS
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**Recent activities:**

- **The CSPS released a statement on violence in the workplace**
NTDB® data points

Annual Report 2009: A hip report

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

The 2009 Annual Report of the National Trauma Data Bank® (NTDB) is an updated analysis of the largest aggregation of U.S. trauma registry data that has ever been assembled. This is the second year that the data collection was undertaken utilizing the National Trauma Data Standard (NTDS) format. In an ongoing effort to improve the overall quality of the report, the “Validator’s” (previously reported in the September 2008 Bulletin) level of error checking of submitted files was increased by adding new data filters to weed out files with bad or missing data. In total, the NTDB now contains more than 3 million records. The 2009 Annual Report is based on 627,664 records—submitted by 567 facilities—from the single admission year of 2008.

A new aspect of this year’s report is an expanded section on facility information. This section includes information on registry inclusion criteria for participating hospitals. This information allows the reader to consider differences in case mix across hospitals while reading the report. For example, isolated hip fractures may or may not be captured by an individual trauma center based upon local, regional, or state inclusion criteria. The figure on this page illustrates a breakdown of facilities reporting hip fractures in their data submission.

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

Many dedicated individuals on the ACS COT, as well as at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, our goals in the coming years include improving data quality, updating analytic methods, and enabling more useful interhospital com-
parisons. These efforts will be reflected in future NTDB reports to participating hospitals, as well as in the Annual Reports.

Throughout the year, we will be highlighting these data through brief reports that will be published monthly in the Bulletin. The National Trauma Data Bank Annual Report 2009 is available on the ACS Web site as a PDF file and a Power Point presentation at http://www.ntdb.org. In addition, information is available on our Web site about 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.

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. He is Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.

Dr. Nathens is Canada Research Chair in Systems of Trauma Care, division head of general surgery and director of trauma of St. Michael’s Hospital, and medical director at Ontario Critical Care Program, Toronto, ON. He is also chair of the National Trauma Data Bank Subcommittee of the Committee on Trauma.