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and the future of surgery
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Richard J. Fantus, MD, FACS

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

For the past few years, concerns about a physician workforce shortage have been mounting. Within surgery, we have grown particularly troubled by the fact that fewer physicians are choosing to enter into general surgery practice and to provide the breadth of services that our patients in underserved regions of the U.S. need.

It behooves the American College of Surgeons as a professional organization to request that the federal government assume responsibility for correcting some of the problems that have contributed to this imminent crisis. However, our profession must also intervene and take actions that will encourage more young physicians to pursue general surgery training and to provide care to underserved patients.

The workforce shortage

Most members of our profession and health policy analysts agree that the U.S. is facing a looming medical workforce crisis and that there will be a particular dearth of general surgeons in the near future. The reality is that for the past few decades, fewer and fewer young physicians have been going into general surgery. In 1981, the American Board of Surgery (ABS) provided certification for 1,047 general surgeons graduating from accredited training programs. By 2008, the ABS had certified only 909 general surgeons, and today there are approximately 4 percent fewer general surgeons than there were a decade ago, according to George F. Sheldon, MD, FACS, Director of the ACS Health Policy Research Institute.1,2

This decline has translated to a 20 percent decrease in the number of surgeons per population over the past 10 years, when we account for the fact that the number of general surgeons completing residency has remained stagnant over the last 10 years while, at the same time, the U.S. population has increased by 25 million.

Rural Americans, who comprise 20 percent of the population, currently are bearing the brunt of the surgical workforce shortage.3 In 2006, 95 percent of the 925 counties lacking a general surgeon were classified as nonmetropolitan areas.

Of course, developing benchmarks or ideal ratios of surgeons to population has proven to be a challenging proposition. In 1980, the Graduate Medical Education National Accreditation Council recommended 4.7 general surgeons per 100,000 people as the minimum acceptable ratio. In 2004, the health care research and consulting firm Solucient recommended at least 6.01 general surgeons per 100,000 population nationally.3

No matter how one measures it, the evidence shows that not enough young people are going into general surgery. Most of us are all too familiar with the deterrents that discourage medical students and residents from pursuing a career in surgery. The prospects of lower payment coupled with higher practice costs, increased liability premiums and the heightened threat of lawsuits, more on-call time and less time for patient care, an uncertain financial future and enormous debt after leaving residency training are all factors that discourage young people from entering surgery. Furthermore, many individuals now go on to enter one of the more lucrative and less time-consuming general surgery subspecialties.

The proportion of general surgeons pursuing
post-residency fellowship training has increased from approximately 55 percent to 70 percent since 1992.4

Advocating for improvements

The ACS has developed several proposed measures that may prove useful in alleviating the surgical workforce shortage. Foremost is the need to support existing residency programs and to promote the development of new ones, particularly in rural areas. Furthermore, it is important to develop appropriate supports and incentives for medical students who are interested in pursuing a surgical career while also eliminating the disincentives that push medical students away from surgery.

To these ends, the College has sought to encourage Congress to adopt the following policies:

• Preserve Medicare funding for graduate medical education (GME) and eliminate the residency funding caps
• Fully fund residency programs through at least initial board eligibility
• Include surgeons under the Title VII health professions programs, such as the National Health Service Corps, so that they are eligible for scholarships and loan assistance in return for a commitment to generalist practice following training
• Alleviate the burden of medical school debt and promote rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas
• Extend medical school loan deferment to the full length of residency training for surgeons
• Allow young surgeons who qualify for the Economic Hardship Deferment to use this option beyond the current limit of three years into residency

The College advocated for Congress to include these types of provisions in the health care reform legislation that President Barack Obama signed into law on March 23. Whereas the focus of the Patient Protection and Affordable Care Act is on improving the primary care workforce, the ACS succeeded in ensuring the inclusion of several provisions that take the first steps toward addressing the surgical workforce problem. They are as follows:

• Provide a 10 percent bonus payment for procedures provided by a general surgeon practicing in a Health Professional Shortage Area (HPSA) beginning January 1, 2011.
• Establish a loan repayment program for pediatricians and pediatric surgeons who agree to work full-time in their specialty for at least two years. The program would pay up to $35,000 per year for each year of service for a maximum of three years.
• Redistribute unused GME residency slots by increasing the number of positions in states with the lowest resident physician-to-patient ratios.

While the College welcomes these legislative improvements to the resident training system, they fall short of actions necessary to secure a stable surgical workforce in the future.

New Jersey surgeons respond

To bring about meaningful change, the surgical profession needs to continue to provide policymakers with viable solutions to the workforce crisis. One chapter of the ACS has developed an innovative program aimed at addressing the general surgeon workforce shortage in that state.

Through an initiative led by Michael A. Goldfarb, MD, FACS, the New Jersey Chapter of the ACS has received a commitment from Building Hope, a not-for-profit foundation established by Sallie Mae, to provide $150,000 annually for the next two years to fund a debt forgiveness program for general surgeons. The goal of this pilot program is to stimulate the recruitment and retention of up to three qualified general surgeons at community hospitals in HPSAs throughout the state.

Under this program, each surgical resident who signs a two-year commitment to serve as a general surgeon at a community hospital approved by the New Jersey Chapter will be eligible to receive the lesser of $50,000 per year or one-half of their total student indebtedness. Recipients will still be permitted to negotiate their salaries directly with the hospital.

According to Dr. Goldfarb, chairman and program director, department of surgery, Monmouth Medical Center, Long Branch, NJ, the state of New Jersey has had great difficulty retaining general surgeons. He polled program directors there and found that 145 surgeons completed their training in New Jersey every five years,
but only seven general surgeons remained in the state after completing their residency. “Because of this program, in two years we’ll have six more surgeons staying in the state,” Dr. Goldfarb noted.

My hat’s off to Dr. Goldfarb and the entire New Jersey Chapter of the ACS for developing this program. If this program succeeds, it could very well serve as a model for other chapters and states to implement, or even as the basis for a federal program. It demonstrates the sort of proactive response the surgical profession needs to offer to ensure that patients continue to have access to surgical care.

Reference


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.
HEALTH CARE POLICY
and the future of surgery

by David T. Cooke, MD
Once a year, the Communications Committee of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) is given the opportunity to contribute to an issue of the Bulletin. The RAS-ACS contributions to this issue discuss in-depth, current concepts that have significant relevancy to residents, Associate Fellows, and practicing Fellows. This year’s RAS-ACS contributions expand upon the themes of last year’s issue, “Building a surgical career,” and address the following question: In order to be clinicians who are integral to the surgical community, what information or skills do young surgeons need to learn—specifically, the things that are not taught or openly discussed during residency? The current socioeconomic environment requires surgeons to have an understanding of health care policy, and as a result, the theme of this year’s RAS-ACS special section of the Bulletin is “Health care policy and the future of surgery.”

It is critical that surgeons become active in the development of health care policy. The keys to becoming active and involved include understanding the nuanced issues related to health care policy, and learning how to become involved.

The dominant health care policy issue today is health care reform. On March 23, President Barack Obama signed the Patient Protection and Affordable Care Act into law, ensuring the nation will see sweeping changes in health care coverage. Such changes may affect how surgeons care for their patients, and/or are reimbursed for their services. Therefore, it is important that our voices are heard, in order to assist in the evolution of health care reform legislation. However, health care policy is not just limited to redefining health insurance coverage; there are other questions that need to be addressed, including:

- Are we equipped as an industry and nation to handle the upcoming physician shortage? And what is the role of international medical graduates (IMGs) to alleviate the upcoming physician shortage?
- How are the advancing health information technology and Web 2.0 (which include social networking Web sites such as Facebook and Twitter) going to impact health care reform?
- How do we teach residents to become participants in drafting health care policy?
- How does the College advocate for its membership?

This RAS-ACS section of the Bulletin places the current health care policy debates front and center. Our first contribution comes from the Chair of the RAS-ACS, Joshua A. Broghammer, MD. In his article, “Health care policy and advocacy: A call to arms for residents and associates,” Dr. Broghammer challenges us to become involved with the health care policy process. In addition, he highlights the four key principles that the College has determined to be essential in any health care reform legislation: (1) quality and safety, (2) patient access to surgical care, (3) medical liability reform, and (4) reduction of health care costs. Dr. Broghammer also describes, in detail, the College’s recent history of advocacy regarding each of these principals.

The article, “The modern history of U.S. health care reform: A primer for practicing surgeons, residents, and associate fellows,” discusses the history behind the development of the Medicare and Medicaid programs, and, perhaps more importantly, it exactly defines Medicare and Medicaid. The authors describe the “near misses” of comprehensive health care reform since 1964, including efforts by Presidents Richard Nixon, Ronald Reagan, and Bill Clinton. The article also provides a timeline for the current race for health care reform, spearheaded by President Obama’s Administration.
“Preparing surgeons for a seat at the health care policy table: A proposal for a longitudinal health care policy curriculum during surgical training” is a bold treatise that seeks to redefine surgical education. The authors describe in detail a potential curriculum that would prepare surgical residents to become advocates for, and contributors to, the shaping of health care policy—without sacrificing their clinical education.

In the article, “Addressing workforce issues with foreign medical graduates,” the authors address the growing, but less publicized, problem of the pending surgeon shortage. International medical graduates (IMGs) could potentially be an ideal solution to the surgical shortage, especially in underserved areas such as rural America. But there are sensitive health care policy issues that may serve as an impediment to utilizing the unique skill sets of IMGs, such as the immigration laws governing J-1 visas, and the ethics behind the concept of a “brain drain,” which is the siphoning off of medical talent from other nations.

In “Modern surgical communication and the practice of surgery,” the authors discuss the incorporation of new modes of communication, such as Web 2.0 and electronic health records (EHRs), into surgical practice. The 2009 American Recovery and Reinvestment Act mandates the use of EHRs for all health care facilities and providers. Yet there are issues in regard to EHRs concerning the accuracy of documentation and privacy. The authors discuss these issues, and describe the College’s initiatives and bold strides into new millennium communication.

The final article in this section is sponsored by the RAS-ACS Issues Committee. Each year, this committee presents an important topic that will be debated during the RAS-ACS Symposium at the upcoming Clinical Congress—this year, in Washington, DC. This article, “Do more requirements make a better surgeon?” provides surgeons with a teaser for the spirited debate that will occur at the Clinical Congress meeting. The article—and ensuing debate—will address the following question: With the growing diaspora of prerequisites, credentialing requirements, board certifications, and licensing exams, are we providing the public with an improved surgical product, or are we merely discouraging and eroding the morale of our current surgical workforce? Although the article is an introduction to the RAS-ACS Symposium, it is apropos to the health care policy theme of this section of the Bulletin. After all, as the authors astutely point out, many of these requirements were mandated, not requested.

The RAS-ACS is proud to present our special section of the Bulletin. This section not only helps us understand the subtleties of health care policy, it also illustrates the College’s commitment to the education and mentorship of surgical residents and associate fellows.

**Dr. Cooke** is assistant professor of clinical surgery, division of cardiothoracic surgery, University of California, Davis, Medical Center, Sacramento. He is the Chair of the RAS-ACS Communications Committee.
Health care policy and advocacy:
A call to arms for residents and associates
by Joshua A. Broghammer, MD

As quickly as medical discovery and advancements in care occur, so do developments in the health care policy front. Recent events in the political arena have created a tumultuous maelstrom of bill proposals, amendments, legislative committee meetings, and a presidential health care summit, which, following more than a year of partisan and intra-party debate, culminated in the Patient Protection and Affordable Care Act (H.R. 3590), which was signed into law. Despite the reality that health care reform is now law, general public disillusionment with how the law will impact society and with the government’s ability to implement the law continues—regardless of political party affiliation. A recent Newsweek poll of 1,009 Americans solicited the public’s opinion on the government’s handling of the issue of health care reform. President Barack Obama’s approval rating was 39 percent; the Congressional Democrats’ rating, 27 percent; and the Congressional Republicans’ rating, 21 percent.1 Health care reform continues to be the Sisyphean boulder on the backs of the American people and our political system.

Generation “why?”

Legislative politics has traditionally struggled with engaging younger generations to participate in the process. This same paradigm exists in getting residents and young surgeons involved in health care advocacy. Many Baby Boomers have accused Generation X and Generation Y of being different, although evidence to the contrary exists.2,3 Those individuals graduating from the new regimen of an 80-hour work week are often challenged on their personal commitment to patient care, devotion to career, and professional focus. These challenges persist, despite the fact that work-hour restrictions were not requested by, but imposed on, residents due to circumstances surrounding their predecessors. The end results of the work-hour restriction are questionable, but what is generally agreed upon is that educational time is more limited, and contact time with faculty has been reduced.4 This further strains the dissemination of knowledge, especially in the political arena. Opportunities
for political mentorship and simple water cooler conversation about current health care advocacy efforts are rightly pushed aside for discussions on patient care, educational issues, and disease management.

More challenging is the fact that many residents are not even equipped with the vocabulary to carry on the conversation. Trainees tackling their daily tasks of rounding, operating, and caring for patients are left limited time to remain well-versed on the political front. Without guidance from their faculty, many trainees are left unaware of the reasons why awareness of current health care advocacy efforts is necessary, and, more importantly, why these efforts require the involvement of young surgeons.

**An appeal to residents and associates**

It cannot be emphasized enough that the involvement of young surgeons is crucial to the current political process of health care reform. Any reform put into action today will have little effect on senior policymakers from the major medical societies, or on those in Washington, DC. The impact will be felt by the current youth in medicine, who will live and practice for years in the environment created by current health care policy, and will have to contend with future ramifications of any potential new legislation.

The Balanced Budget Act of 1997 helped to enact Medicare’s sustainable growth rate formula (SGR). An oversimplified description of the SGR is that it ties the physician payment rates for Medicare-related services to the growth of the economy. When this legislation was enacted, the economy was performing well, but it has since declined, while health care costs and expenditures have soared. The SGR addresses this financial shortfall by reducing overall physician payments in an attempt to maintain fiscal neutrality. The impact couldn’t have been more profound. Since 2002, there has been a planned Medicare cut associated with every fiscal year. Congress has stepped in to prevent the cuts, but it has avoided addressing the baseline flaw in the SGR formula. Even while cuts have been averted, the largest fee increase has been only 1.5 percent. Many years have seen a 0 percent to 0.5 percent increase. With health care costs far exceeding the rate of inflation, the SGR has resulted in a sharp decline in physician reimbursements for Medicare-related care.

A 21.2 percent cut in Medicare, which was scheduled to take place on January 1, was temporarily stayed for 60 days in late December 2009, and on March 1 was stayed again for an additional 30 days (which expired April 1). Unfortunately, at press time, a permanent solution to this issue was not yet available. Legislators have been paralyzed to the point of inaction. Fear that a permanent repeal of the SGR will result in accusations of increasing government financial debt and burdening future generations are juxtaposed by the premise that allowing Medicare cuts to occur will create an impending crisis, leaving a large section of American seniors with a lack of health care coverage and access to physician care. As a result, the myriad patchwork fixes continue, with no future plans in sight for overhauling the system.

The impact of the SGR is far-reaching. In previous years, where cuts have been actually allowed to take affect for short periods of time, physicians responded by cutting appointments to new Medicare patients. Some practices even dealt with the crisis by temporarily closing their doors, having been unable to cover the operating costs of their practice. On a national level, patients could suffer severely, with potentially few doctors remaining enrolled as Medicare participants. Only after graduation from residency and upon joining my practice did I realize the scope of this issue. Medicare covers 35 percent to 40 percent of my own practice’s patient population. Like many other groups, a 21 percent decrease in reimbursement would cripple our practice, requiring employee layoffs, a reduction in patient access, and limiting of surgical services. It is ironic that legislation that was enacted while I was college, and had remained relatively unknown to me through 10 years of medical training, now stands poised to severely transform my ability to provide care in the profession I have grown to love. Many of my own residents have asked me, “How can I afford to spend time keeping up with everything going on in Washington?” My response is simple: “How can you afford not to?”
The College’s role in health care reform

The mission statement of the College is, “The American College of Surgeons is dedicated to improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment.” The College, representing more than 77,000 members, has been instrumental in supporting these issues in Washington. However, the plea for simple improvements in physician reimbursement alone will fall upon deaf ears in Washington, DC, and does not actually satisfy our duty as surgeons. It is our obligation as health care providers to participate in the reform process, assure patient access to quality surgical care, and continue to advocate for our patients’ rights. In general, the public trusts physicians to carry out this task. In a Gallup poll of 992 Americans, 77 percent felt confidence in physicians to recommend the right course of action for health care reform. Comparatively, the President scored 49 percent, Democratic congressional leaders scored 37 percent, Republican congressional leaders scored 32 percent, while health insurance companies inspired the least confidence, with a 26 percent rating.9 The ACS 2009 Statement on Health Care Reform is an eight-page document detailing the College’s position on issues related to health care policy.9 The College adheres to the tenets of its mission statement by promoting four key principles that any health care reform bill must comply with, and they are as follows:

1. Quality and safety. The College has been deeply rooted in the history of patient safety, beginning with its development of the Minimum Standard for Hospitals, published in 1917, and with the creation of the Joint Commission on Accreditation of Hospitals in 1951, which is known today as The Joint Commission.10 Since that time, various College programs seek to improve the delivery of surgical care in America. The ACS National Surgical Quality Improvement Program (NSQIP) helps to avert surgical complications, improve patient safety, and deliver quality care. In addition, by reducing complications, millions of dollars are saved in health care costs. Other issues supported by the College include responsible use of physician quality data and public reporting that is accurate, risk adjusted, peer reviewed, and developed with surgeon participation.

2. Patient access to surgical care. The College’s Operation Patient Access is a program that has been formed by a coalition of surgical groups with the goal of addressing the pending surgeon shortage and preventing limitation of access to surgical care.11 During the 1980s and 1990s, various policymakers predicted a surplus of physicians entering the workforce. As a result, several steps were undertaken to reduce the number of doctors graduating per year.12 No one could predict the size and scope of the pending surgeon workforce crisis that now looms near in the profession’s future. Nearly a third of rural hospitals expect to lose a general surgeon within two years, while a third of rural hospital administrators are looking to hire a surgeon.13 By 2012, a predicted 40 percent of trauma surgeon positions at Level I and Level II centers will remain unfilled.14 These are just some of the factors that threaten a patient’s ability to gain access to potentially lifesaving surgical treatment.

3. Medical liability reform. Medical liability reform has been demonstrated to be beneficial in several states, and, thus, it is supported by the College. Caps on noneconomic damages help to draw physicians to states with lower malpractice premiums, reduce budgetary expenditures in

Additional ACS resources for health care advocacy

The ACS has a variety of resources available to help educate, disseminate information, and activate the surgical workforce in the area of health care policy reform. For more information, visit:

- American College of Surgeons main health care reform page: Available at: http://www.facs.org/hcr/index.html
- American College of Surgeons Division of Advocacy and Health Policy: Available at: http://www.facs.org/ahp/index.html
- American College of Surgeons Operation Patient Access: Available at: http://www.operationpatientaccess.facs.org
health care costs, and improve patient access to care.15 States lacking noneconomic caps create a disincentive for surgeons to practice in a region, resulting in a lack of surgical availability. Other components of liability reform include alternatives to litigation, protection of physicians working in disaster situations, and protection of those physicians adhering to evidence-based guidelines.

4. Reduction of health care costs. The College seeks to improve the quality of surgical care delivery, thereby reducing complications and decreasing health care costs. In addition, evidence-based guidelines will eliminate waste, cut costs, and improve health care system efficiency. New forms of physician payments are also supported, provided they are voluntary, sustain a viable workforce of surgeons, and improve patient care.

Differing needs for residents and associates?

The current political climate has centered on patient access to quality care, and providing reasonable health care coverage. However, there are a number of issues that remain unaddressed in the prevailing conversation. The increasing debt carried by medical students is severely impacting the choice of medical training, practice location, and overall job satisfaction. Recent data from the American Medical Association states the average debt from the class of 2009 is $156,456. Over the last 20 years, private schools have raised tuition an average of 50 percent, with public institutions increasing fees by 133 percent.16 This issue, coupled with decreasing physician reimbursements, threatens to deter quality individuals from entering the medical profession. The effect of education debt can be alarming, with 32 percent of academic surgeons choosing not to recommend their career choice to their children or to medical students.17

The College stands in support of loan forgiveness programs and expansion of the National Health Service Corps to include surgical disciplines with anticipated workforce shortages.9 This is an important first step, but further action must be taken to address the indebtedness of American medical graduates.

There is an overall lack of discussion regarding funding of resident training. The Balanced Budget Act of 1997 enacted caps on Medicare’s Direct Graduate Medical Education payments used to cover the cost of resident education.18 Since that time, however, the number of graduating residents has remained largely stagnant. Hospitals and residencies have attempted to address the issue via funding sources from private grants and internal institutional monetary sources. This overall lack of focus on resident funding fails to help address the pending surgical workforce shortage, which will impact access to effective and quality surgical care.

How to get involved

The time to get involved is now. The College is a unique organization, and through the Resident and Associate Society (RAS) you can become part of the solution. It is one of the few medical organizations that is inclusive, rather than exclusive; if one wants to participate, they can. The RAS Issues Committee helps to address matters of health care policy. There is also the RAS liaison program, which puts a RAS representative in each institution with resident trainees. At the local level, identify mentors active in health care policy and find out how you can help them. Participating in your local ACS Chapter meeting or medical society is a great way to seek out those individuals. Become active in your institution by volunteering for hospital and medical school committees. Contact your local state and national representatives to let your voice be heard. The College sends its members legislative alerts and updates, which make this process easy.

Summary

The College supports the efforts to provide universal access to quality, timely, and affordable surgical care. President John F. Kennedy once said, “There are risks and costs to a program of action. But they are far less than the long-range risks and costs of comfortable inaction.”19 It is imperative that, as patient advocates and practitioners of the art of surgery, we let our voices be heard on this matter. The issue of health care reform is both complex and diverse, requiring thorough debate. Like many major movements throughout history, this issue also requires action, perseverance, and courage.
References


Dr. Broghammer is assistant professor, department of urology, University of Kansas Medical Center, Kansas City. He is Chair of the RAS-ACS.
The modern history of U.S. health care reform: A primer for practicing surgeons, residents, and associate fellows

by Carlos M. Mery, MD, MPH; Amy Liepert, MD; and David T. Cooke, MD

It is clear that the current U.S. health care system is in need of reform. According to the Council of Economic Advisors, by 2040, health care expenditures will be 34 percent of the gross domestic product (GDP), with Medicare and Medicaid spending nearly 15 percent of the GDP In addition, nearly 54 million Americans who would not qualify for Medicare will be uninsured. However, throughout our country’s history, there have been multiple attempts to restructure our health care system. Nearly 100 years ago, President Theodore Roosevelt and his Progressive Party unsuccessfully lobbied for national health insurance. Since Roosevelt’s presidential run in 1912, our nation has seen the enactment of the Medicare and Medicaid programs signed into law by President Lyndon B. Johnson on July 30, 1965, followed by a series of health care reform “near misses.” This multi-part article chronicles the development of Medicare and Medicaid, highlights some of the near misses in health care reform since enactment of that legislation, and outlines the timeline of the current health care debate.

The Medicare and Medicaid programs

by Carlos M. Mery, MD, MPH

Medicare is a federally sponsored health insurance program that covers the medical needs of Americans 65 years or older, those under 65 years of age with certain disabilities, and those...
with end-stage renal disease. The program consists of four parts. Part A (hospital insurance) is provided to all eligible individuals premium-free, and provides coverage for inpatient care, skilled nursing facilities, hospice care, and some home health services. Part B (supplementary medical insurance) is a voluntary program in which eligible individuals pay a monthly premium in exchange for coverage of physician fees, outpatient services, and other costs not covered by Part A. Part C, the Medicare+Choice program (now called Medicare Advantage), was added to Medicare in 1997 to allow beneficiaries to receive their benefits from private health insurance plans that include at least the current benefit package offered by Parts A and B. Part D, signed into law in 2003, is the prescription drug benefit plan for Medicare beneficiaries, and is administered by private companies with oversight by the Centers for Medicare & Medicaid Services.

Medicaid is a program jointly funded by the federal and state governments to assist states in providing medical assistance to people with low income. Each state decides the eligibility criteria, the type of services to provide, the rate of payment, and the administration of the program.

The Medicare and Medicaid programs have their developmental roots in the health insurance programs introduced by Germany in 1883 and Great Britain in 1911. From 1912 to 1920, the American Association of Labor Legislation, a private multidisciplinary reform organization, initiated a movement to try to enact “sickness insurance” in the U.S. on a state-by-state basis. This insurance would include cash compensation and coverage of medical bills for sick workers. Despite initial support for the initiative in several states, by 1920 the measure was defeated in every state in which it was raised. The defeat was mainly due to the political climate; the resistance of states to undertake what, at the time, were perceived as costly social measures; and a lack of endorsement from the American Medical Association (AMA).

Several studies published during the 1920s and 1930s highlighted the high costs of medical care and the need for medical insurance by the states. This led to an attempt by President Franklin D. Roosevelt to incorporate a national health care provision as part of the 1935 Social Security Law. However, the measure failed again.

The discussion over the issue of health care insurance continued over the next decade, to no avail. In 1945, President Harry S. Truman strongly endorsed the creation of a federally based national health insurance program. The result of this endorsement, the Wagner-Murray-Dingell bill, was debated, and eventually failed, secondary to opposition from multiple sources, including a difficult political post-war climate and the growing influence of private insurance companies.

By 1951, more than half of patients admitted to hospitals in the U.S. had some form of private medical insurance. In the 1950s, in an effort to gain more support, health reformers limited the idea of national health insurance to elderly individuals, as they represented a high risk for private insurance companies. As a significant compromise, the Kerr-Mills bill was passed in 1960, creating the Medical Assistance for the Aged program. According to this program, the federal government would give matching funds to the states in order to provide medical assistance to those elderly deemed in need by each state. However, after more than three years, only 32 of the 50 states had created Kerr-Mills programs.

The Kerr-Mills bill was insufficient to provide complete health care for the elderly. In 1961, President Kennedy endorsed the creation of a Medicare bill proposing coverage of hospital costs for the elderly. However, given the presence of a mild recession and the lack of support by Congress, he decided to postpone the introduction of the bill. In 1964, after Kennedy’s assassination, President Johnson made health care reform a priority. By then, the issue of national health insurance had gained public support, due to sharp decreases in personal income and greatly increased medical needs of the elderly.

After much debate, three alternative options emerged:

1. Medicare, proposed by the Administration, would be a government-funded program similar to the private insurance programs, providing coverage for hospital costs of the elderly.
2. The AMA-proposed “Eldercare,” an expansion of the Kerr-Mills state-run program, including drug coverage.
3. A third proposal, by Rep. John Byrnes (R-WI), was the creation of a voluntary health insurance program that would cover medical and
hospital costs, funded in part by the beneficiaries and in part by the government.

The AMA proposal was eliminated, and a bill was drafted incorporating both the Medicare provisions (Part A) and Byrnes’ proposal (Part B). In July 1965, the bill was passed in both chambers and was signed into law as Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act.

Since its creation, Medicare has expanded to cover a greater portion of the population. In 1972, Medicare eligibility was extended to include individuals younger than 65 years of age with long-term disabilities and any individuals with end-stage renal disease.

In 1983, in an attempt to limit hospital medical costs, Medicare introduced the prospective payment system based on diagnosis related groups (DRGs). Under this system, a fixed amount is paid to the hospital for each patient stay based on a particular DRG, regardless of the actual amount of money spent. The hospital therefore absorbs the loss or makes a profit.

Similarly, since 1992, physicians are paid based on relative value units assigned for each procedure or intervention. In 1998, Medicare introduced the controversial sustainable growth rate formula (SGR) in an attempt to control costs. The SGR sets a target of expenditures on physician payments each year based on the GDP. If the actual spending surpasses the spending target for that year, reimbursement rates are decreased. Actual spending has surpassed the spending target every year since 2002, prompting cuts to physician reimbursement every year. As a result of pressure from the AMA and other medical organizations, including the American College of Surgeons, Congress has postponed these cuts every year. Recently, a bill was passed by the House of Representatives to eliminate the accumulated SGR debt and create a better system for physician reimbursement, but similar language failed to pass the Senate.

Near-misses
by Amy Liepert, MD

Although the enactment of the Medicare and Medicaid programs is the most tangible result of health care reform in this country, there are other notable attempts and near-misses that have occurred since the Johnson administration.

One such attempt was the Comprehensive Health Insurance Act (CHIP). CHIP was introduced to Congress and the American public on February 6, 1974, by President Richard Nixon during his presidential address. The need for a national health insurance act, at that time, was based on data that showed 25 million uninsured Americans, and health care costs that had increased 20 percent over the previous two-and-a-half years.

CHIP included three major programs: employee health insurance, assisted health insurance, and improved Medicare. The proposal was to make one of these three plans available to every American, but also to maintain voluntary participation. The employee health insurance program was designed to build on existing employer-sponsored plans, with government subsidies to help the self-employed and small businesses. This portion of the plan was designed to build upon a cost structure shared by employers and employees—which is often considered the historical design of health care in the U.S. The assisted health insurance program was designed for low-income earners who were not eligible to participate in the other two programs. Costs for this portion of the plan were split between federal and state funding. The improved Medicare portion of the plan was to be built on the existing Medicare system for people aged 65 and older, but would include additional benefits.

CHIP was designed to provide identical benefits to every American, without any exclusion. In addition, it was designed to include coverage for mental illness, alcoholism, drug addiction, nursing home care, and home health services. Children’s services were to be covered, including preventive care up to age 6, as well as eye and hearing exams, and dental care up to age 13.

The design of the program was such that yearly costs per family were limited. Per-family maximum out-of-pocket expenses were not to exceed $1,500, and would be adjusted down for lower-income families. The improved Medicare program had an annual maximum amount of $750. The costs projected by the General Accounting Office were $6.9 billion, plus additional costs during the transitional period to be divided between the federal and state governments, and were in addition to the costs of existing programs. On an individual level, the employee health insurance program was estimated to cost each individual employee
$150 per year and each employer $450 per year per employee.

The progression of this bill moved at a positive rate through Congress; however, it could not overcome the political debacle of the Watergate scandal. By the time Gerald Ford was elected President, the economy was facing another potential recession, and the political climate was unfavorable for a large piece of social legislation such as this.

In the mid-1980s, a modification to health care came in the form of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985. This law, signed by President Ronald Reagan on April 7, 1986, focused on Americans who lost their insurance due to separation from employment.

A requirement was included in this large bill for insurance eligibility to continue for 18 months after separation from employment. Pre-existing conditions were covered without waiting periods, and the new insurance plan was required to provide comparable benefits to the previous plan. The premium was to be paid in full by the employee, and lack of payment resulted in immediate cancellation. An additional requirement mandated that any premium adjustments applicable to the previous employer would also apply to the individual. Extension to the 18-month limit was granted only for disability or multiple events. After the term of COBRA coverage, the enrollee must either be covered by another employer or purchase his or her own personal policy.

This piece of legislation was designed as a bridge, providing insurance for those in between jobs. However, COBRA still left certain groups of people at risk for not receiving insurance coverage, including people working at a small business with fewer than 20 employees, people who lost their employment and for whom new employment was not available within 18 months, or individuals who could not pay for private insurance after job loss.

While these gaps are widely criticized, the design of the bill was to provide an option for employees and their families in the circumstances of job loss, death, disability, or other major life event.

A decade after the COBRA legislation was enacted, President Bill Clinton’s Administration attempted health care reform in the form of the Health Security Act of 1993. The Health Security Act would have used a complex system to develop universal health care by using private insurer competition, mandates for employers as well as individuals, and by requiring heavy government oversight and regulation. Central to its structure was that the federal government would provide oversight of national standards for cost, quality, and benefits. A major component of this oversight was through the creation of a National Health Board.

The states were to organize their own regional alliances, in order to provide universal coverage.

Three cost-sharing options were built into the Health Security Act. The first option—the low cost sharing option—was equated to a health maintenance organization-type system, in which users would be required to pay a small co-pay for outpatient care. The higher cost sharing option was equated to a fee-for-service system, in which an individual would pay a $200 annual deductible and co-insurance up to $1,500; families would have an annual $400 deductible with a maximum of $3,000 out-of-pocket expenses. The third option was the combination cost sharing option, which was equated to a preferred provider organization. As part of this plan, a $10 co-pay would be necessary for in-network visits, along with a 20 percent co-insurance for any out-of-network service.

Under the proposed Clinton plan, each American would have been issued a health security card and would have been allowed to choose their own insurance from their local alliance or corporate alliance. Supplemental insurance could be purchased by each member. This did remain an employer-based insurance plan, with each employer required to pay a major portion for all employees, with the payment adjusted based upon the employee’s work commitment. However, the adequate amount of votes were not garnered for the plan.

Where are we now, and how did we get here?

by David T. Cooke, MD

After the failure of the Health Security Act, major health care reform was essentially tabled until the 2008 presidential election, when both major party candidates ran with the promise of meaningful health care reform prominent in their platforms. In 2009, President Barack Obama submitted his 2010 budget to Congress. President Obama requested that Congress reserve $600 billion via changes in income tax deductions for health care reform initia-
tives over 10 years, and asked Congress to develop the specifics of health care reform legislation.

In June of that year, Democrats in the House submitted a bill that included a government-run insurance plan, or “public option,” with penalties on businesses that did not provide health insurance for their employees. Concurrently in the Senate, both the Senate Finance Committee and the Health, Education, Labor and Pension Committee prepared versions of these bills. On July 15, 2009, the Health Committee passed a bill that included a public option, with a requirement that employers with more than 25 workers would provide insurance coverage or pay an annual penalty fee to the government.

During his address to a joint session of Congress in September, President Obama increased estimates of 10-year costs for reform from $600 billion to $900 billion, expressed an interest in curbing the costly practice of defensive medicine, and reaffirmed his belief that health care in this country needs dramatic and lasting overhaul. Two days after President Obama’s address to Congress, several surgical organizations, including the American College of Surgeons, signed a letter addressed to Senate Majority Leader Harry Reid (D-NV) and the Speaker of the House Nancy Pelosi (D-CA), urging Congress to make medical liability reform a core component of any health care reform legislation.

In October, the Senate Finance Committee approved legislation backed by Sen. Max Baucus (D-MT). The Baucus Plan, per the Congressional Budget Office (CBO), would most likely diminish health care expenditures and reduce the federal budget. The plan would tax expensive premium or “Cadillac” health plans, and require businesses with 50 or more employees to reimburse the government for costs incurred by workers who purchase their own health insurance. The bill in its original form did not contain a public option. However, after the bill left committee, Senator Reid announced his intention for the bill to contain a public option, but it would also have a provision that would allow states to opt out of the public option.

On November 7, 2009, the U.S. House of Representatives passed its bill by a 220 to 215 vote. The concurrent House bill, containing a public option, would cover 36 million uninsured Americans and eliminate any policies excluding individuals with pre-existing conditions from insurance plans. According to the CBO, the House bill would drop deficits by $109 billion over the span of a decade.

During the month of December, debate within the Senate led to a modification of its bill’s public option. In a new proposal, individuals between the ages of 55 and 64 could buy in to Medicare, and the federal agency known as the Office of Personnel Management could negotiate with insurance companies to offer national health benefit plans. However, the proposal for Medicare expansion was eliminated after opposition from Sen. Joseph Lieberman (I-CT). On December 24, the Senate passed the health care bill by a party line vote of 60 to 39.

At first glance, the passage of the Senate bill appeared to be a historic vote, bringing the nation closer to the elusive holy grail of comprehensive health care reform. Debate continued concerning how the House and Senate bills could be reconciled. However, on January 19 of this year, Republican candidate Scott Brown won the special election in Massachusetts to fill the Senate seat made available by the demise of Sen. Edward M. Kennedy (D-MA). Senator Brown’s victory eliminated the 60-vote Democratic filibuster-proof majority. Senator Brown’s election, for a seat once held by Senator Kennedy, is ironic, as Senator Kennedy referred to comprehensive health care reform as the “cause of my life.”

The race to reform health care hit a yellow flag, as other national issues became more prominent, specifically, the economy and high unemployment rates. The yellow flag was changed to green when, on February 25, President Obama hosted a bipartisan health care summit at the Blair House, in Washington, DC. At that meeting, and during press conferences following the summit, an up or down, or “reconciliation,” vote on health care legislation was considered, which would require a simple majority vote, and avoid a potential partisan filibuster. On March 17, the CBO concluded that the health care reform legislation being considered would cost approximately $940 billion dollars over ten years, but would also reduce the deficit by $138 billion over the same time period. Four days after the release of the CBO’s report, the House passed, with a 219 to 212 vote, the Senate health reform bill, H.R. 3590—the Patient Protection and Affordable Care Act.12 On March 23, President Obama signed the bill into law in a packed ceremony in the East
Room of the White House, marking the enactment of the most significant social legislation since the Johnson Administration.

In conclusion, from Theodore Roosevelt, to the creation of Medicare and Medicaid, to multi-party attempts by Presidents Nixon and Clinton, modern health care reform has seen modest gains and numerous near misses. Now—although we have reached a monumental milestone—it is unclear if there is a final destination to the road to comprehensive health care reform. This article should read as a primer to help surgeons begin to understand the complicated history of health care reform in this country, and possibly spark interest in becoming an informed participant in the health care reform debate.

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Dr. Mery is a resident in cardiothoracic surgery, University of Virginia, Charlottesville, VA. He is a member of the RAS-ACS Communications Committee.

Dr. Lipe rt is a resident in general surgery, University of Utah, Salt Lake City, UT. She is a member of the RAS-ACS Communications Committee.

Dr. Cooke is assistant professor of clinical surgery, division of cardiothoracic surgery, University of California, Davis Medical Center, Sacramento. He is Chair of the RAS-ACS Communications Committee.
Preparing surgeons for a seat at the health care policy table:

A proposal for a longitudinal health care policy curriculum during surgical training

by Donald W. Buck II, MD; James G. Bittner IV, MD; J. Awori Hayanga, MD, MPH; and Anthea C. Powell, MD

Health care reform has been a topic of heated debate for many years. Recently, this debate reached a fever pitch. On March 21, 2010, Congress passed the Patient Protection and Affordable Care Act (H.R. 3590), which will overhaul America’s health care system over the next 10 years. Despite holding a critical position within the health care system, physicians often feel excluded from policy-related discussions. It is unclear whether this omission is a result of personal choice, or a direct reflection of a limited understanding of health care policy. This lack of health care policy knowledge is understandable, given that current medical education omits formal health care policy training. As a result, most trainees navigate the medical education maze with little or no exposure to the concepts of managed care, insurance coverage, medical coding, or billing until they join the workforce as staff surgeons.

Educating residents in health care policy

In this era of health care reform, it is critical for surgical trainees to understand the basic framework of health care policy and delivery. As the inconclusive, national debate reaches a crescendo, even President Barack Obama has acknowledged that meaningful health care reform can only occur with the support of physicians. He effectively charged physicians to serve as leaders of progress toward coordinated, reasonable, outcome-driven care. A recent survey of 991 physicians from various specialties (21 percent surgeons) revealed most respondents (78 percent) agreed that physicians have a professional obligation to address health care policy issues. Most responding surgeons (70 percent) also agreed with this statement.

In order to improve our understanding of health care policy, formal education must begin in medical school and continue throughout residency. Currently, there are only a handful of medical schools in the country that offer integrated health care policy curricula. In these centers, students learn the basics of biological and physical sciences, and take courses in managed care, insurance systems, and health care economics. Similarly, very few hospital systems offer a dedicated health care policy component to their residency education programs. Despite the recent endorsement of the core competencies by the Accreditation Council for Graduate Medical Education (ACGME), only a small number of medical schools and residency programs have successfully implemented health care policy education as a required curricular component.

While it is impossible to incorporate every aspect of health care policy, and the proposed reforms, into the current medical education system, it is
important to discuss the concepts that are central to the foundation of the current system, fuel the reform debate, and ultimately impact our future as health care providers. One of the biggest factors driving the reform agenda involved access to care. Despite spending more on health care than any other country in the world, an estimated 46 million Americans remain uninsured, or under-covered, creating a significant financial burden on individuals, health care facilities, the economy, and health care providers. The role of the government has also generated numerous questions, including the impact of governmental control on patient–physician privacy, practice standards, and the definition of what care is available, what care is delivered, and how it is financed. Other important concepts related to health care policy and reform include the right to health care, as well as fairness, efficiency, cost, and quality of care.

Health care policy and reform have a direct impact on every aspect of a surgical career, including practice patterns, financial foundations, and future career directions. Surgeons must coordinate patient care effectively in various health care delivery systems, consider cost-effectiveness and risk-benefit analyses of disease management, and advocate for patient safety and broad system reform. Despite potential constraints inherent to the current training paradigm, surgical trainees need to become educated in health care policy and delivery in the form of systems-based practice.

Goals of health care policy education

The ACGME’s core competencies established the importance of learning systems-based practice. However, compliance with ACGME directives obligates training programs to overcome inherent educational challenges. Instruction in systems-based practice is hampered by the lack of robust and valid teaching and evaluation tools. Additionally, residency programs that decide to implement health care policy curricula must balance this education with duty-hours restrictions. Albeit time-consuming, a formal curricular initiative focused on the various facets of health care policy and delivery would offer trainees opportunities to understand health care policy and delivery, and to translate that understanding into effective advocacy for both patients and system reform.

Some institutions have made the decision to broaden medical student and resident education to include health care policy and systems-based practice. In all cases, these formal curricular initiatives have generated interest among trainees, established a correlation between exposure to health care policy training and future involvement in advocacy efforts, and produced trainees more proficient in systems-based practice. For example, the Pennsylvania State University College of Medicine, Hershey, PA, instituted an elective health care policy and legislative awareness course designed to inform medical students on policy issues and provide practical experience in legislative assignments. The authors of the course outlined components of a successful curricular initiative and concluded that medical schools should provide students with a basic understanding of the health care system, and impress upon them the importance of individual and collective advocacy.

Putting such ideas into practice, the University of New Mexico School of Medicine, Albuquerque, piloted an elective 16-credit course for medical students designed to introduce health care policy topics at an early stage in training. The institution also extended the offering to residents, using the clinical situations of ward practice. In this novel approach, teams of residents identified systems problems affecting care during an individual rotation, collected data about problems, and proposed specific solutions. In one example, an inpatient team became frustrated by slow discharges and identified gaps in social work coverage as the root cause. All affected patients were indigent or without private insurance. Using supportive financial data, the team advocated successfully for the allocation of two additional social work positions to facilitate discharges. Although this time and labor-intensive project may be difficult to replicate on surgical services, the program serves to highlight how daily issues that arise on individual rotations can be leveraged by surgery departments, in order to provide health care policy education in real time.

In an effort to address the gap in systems-based practice, George Washington University, Washington, DC, established a three-week Residency Fellowship in Health Policy (RFHP) designed specifically for residents. The RFHP exposes residents to health care policy issues, provides
practical experience with health care legislation, and fosters a personal commitment to health care policy and system reform. The innovative course covers five broad content areas of health care policy (33 didactic and 14 practical sessions). Participants’ exit surveys revealed a high level of overall satisfaction with the RFHP and a significant improvement in overall understanding of health care policy. Compared with pre-fellowship attitudes, more residents who completed the exit survey reported being interested in further practical experience with health care policy following residency (40 percent before RFHP versus 70 percent after RHFP, p<.001). While the aims and achievements of the RFHP are commendable, only two (1.5 percent) surgical residents over a three-year period took advantage of the fellowship. The authors do not cite a specific reason for so few surgical resident participants, but the unique challenges of surgical training likely play a role.

On a larger scale, Dartmouth-Hitchcock Medical Center, Lebanon, NH, instituted a two-year Leadership Preventive Medicine Residency (DHLPMR) to attract and develop residents across disciplines who desire to lead health care policy change and improve health care delivery. Participants of DHLPMR earn a Master in Public Health degree, which includes practical experience designed to improve health care delivery for a defined population of patients. Additionally, DHLPMR trainees complete a longitudinal public health experience with a governmental public health agency. Since its inception, graduates of DHLPMR have initiated various substantive improvements to local, regional, and statewide health care delivery systems. This program allows residents a chance to effect change in an environment to which they are accountable, ultimately improving the health of a select population of patients by leading change in systems-based practice.

Surgical residents interested in the DHLPMR program may participate during dedicated research time or after residency training. Across the spectrum of surgical specialties, most training programs allow residents to take dedicated research time for one to three years during residency. During this time, surgical residents are not only conducting traditional basic science research, but are now also participating in clinical or health systems research, and/or obtaining additional degrees, such as a Master in Public Health or Public Policy. Other examples include the Brigham and Women’s Hospital Center for Surgery and Public Health, Boston, MA, which offers a two-year postdoctoral fellowship in surgical health services research, and The Robert Wood Johnson Foundation Clinical Scholars program, which offers two years of funded, protected graduate level study, and research in public health problems at one of four major U.S. academic medical centers. The University of Michigan, Ann Arbor, requires that surgery residents engaged in dedicated research activities also complete an online, one-year curriculum written by MDcontent and designed to educate physicians on health care administration.

In the preceding examples, academic and policy institutions recognized the value of health care policy training and supported implementation of large-scale curricular initiatives. Unfortunately, these programs can present logistical difficulties and pose financial challenges for many surgical programs and residents. However, a large-scale initiative is not required to achieve the benefits of health care policy training. Individual residency programs in family medicine, internal medicine, pediatrics, urology, and radiology have established successful health care policy training initiatives. For example, the Mallinckrodt Institute of Radiology, St. Louis, MO, developed a five-week didactic curriculum relevant to health care policy and radiology practice. Prior to initiation of the curriculum, all radiology residents described their baseline knowledge of health care policy as “weak.” Following the course, interest in curriculum topics and perception of their importance and relevance to radiology practice increased among those residents who participated. In addition, almost half of participants (42 percent, 13 of 31) felt motivated to pursue further health care policy education, and 61 percent (19 of 31) developed interest in administrative issues and in radiology organizations.

Although educators recognize the need for teaching health care policy and advocacy in residency training, few well-developed surgical residency curricula exist. Even so, leaders in surgical education, practice management, and public health should consider combining their efforts to
design and implement a standardized, validated, resident-focused curriculum with both didactic and experiential components. A complete health care policy and advocacy curriculum could address at least five of the six ACGME core competencies, including patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Perhaps more importantly, such a definitive curriculum could supply residents with the tools they need to both navigate the health care system and to advocate on behalf of their patients and profession.

Proposal for a longitudinal health care policy curriculum

A longitudinal curriculum—delivered over a rotating period of time during residency training—provides advantages over the stand-alone options described above. First, it takes advantage of protected resident education time already carved out in many residency schedules to meet ACGME requirements. Second, a longitudinal curriculum does not require residents to utilize elective or dedicated research time, which is in short supply in the emerging era of combined training. Third, a curriculum designed by the individual department could be tailored to the specific needs of the residents and take advantage of both intradepartmental support and resources from the larger hospital and medical school infrastructure. Fourth, a curriculum rotating over a period of one or more years can repeat topics for reinforcement as well as change material/lecturers to highlight new areas and/or new approaches. Finally, this approach can centralize disparate topics previously taught independently, such as practice management (for example, coding and reimbursement), electronic health records (EHRs), advocacy and leadership skills, and so on, into one program that meets core competencies and resident needs in a cohesive and meaningful manner.

We propose the development of a longitudinal curriculum, both didactic and experiential, that incorporates elements of the approaches men-

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**Figure 1**

HEALTH CARE POLICY CURRICULUM DEVELOPMENT

- Needs Assessment of Individual Department
- Survey of Existing Departmental, Institutional, and Community Resources
- Develop Didactic and Experiential Curriculum
- Implementation

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**Figure 2**

RESIDENCY LONGITUDINAL HEALTH CARE POLICY CURRICULUM

- Didactic Curriculum
- Web Resource
- Experiential Curriculum

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**Figure 3**

- Rotation Specific Modules
  - Billing, Coding
  - Industry Relations
  - Electronic Medical Records
  - Public Health

- Leadership
  - Professional Development
  - Management

- Faculty—Trainee Relationships
  - Accessibility, Formative Feedback, Curricular Evaluations
tioned here and suggestions from the ACGME, in order to provide more comprehensive and relevant health care policy education than what is currently available. The first steps to developing this curriculum are a needs assessment—with input from departmental administration, faculty, and residents—and a survey of existing resources. These assessments allow the curriculum to be relevant to the individual department and avoid duplication of effort (see Figure 1, page 24).

The centerpiece of such a curriculum, given the large volume of sometimes unfamiliar information that residents must assimilate, is a repeating series of one-hour lectures covering core areas (see Figure 2, page 24). These lectures may be drawn from core areas such as health care structure and politics, surgical practice specifics, health disparities, advocacy, ethics, and legal issues. In order to capitalize on existing resources, lecturers and reading material may be culled from the surgery department and from partnerships with the hospital administration, schools of medicine and public health, and organizations such as the American College of Surgeons. Utilizing existing Web resources for residents can extend the course to cover the inherent scheduling uncertainties of surgical departments. A Web-based library may be made available on a departmental or school intranet with syllabi, PowerPoint files and/or video files of lectures, files of relevant papers, links to Web sites and e-books, and a discussion forum.

Each rotation may provide part of the experiential curriculum. The faculty of each department and rotation may be surveyed to understand available systems resources and practice models such as private practice, academic, public or Veterans Affairs hospital, use of EHRs, data collection for quality improvement or outcome research projects, technology-rich departments (such as minimally invasive or robotic divisions), and other resources.

Based on rotation-specific resources, each rotation can develop its own “mini” policy education curriculum. For example, in real-time, a public hospital rotation could discuss health care access issues, while a private, minimally invasive rotation could address working with product vendors. And individual faculty members could mentor residents as they rotate through the specific practice setting. These discussions have particular relevance in the outpatient clinic setting. Instead of simply focusing on the clinical needs of the patient, residents could discuss the billing method of the surgeon or practice during the outpatient experience.

Developing and implementing both didactic and experiential components of a formal health care policy curriculum will require departmental commitment and an upfront investment of time and labor. The developed curriculum will require ongoing evaluation, as health care policy continues to evolve and departmental needs change. The fruits of this labor, however, may be a more comprehensive and relevant policy education for surgical residents. This education is becoming essential for surgeons to fully understand health care practice and to continue to be advocates for our patients. Decisions are made by those who show up, and we must ensure that the surgeons

Dr. Buck is a plastic surgery resident at Northwestern University, Chicago, IL. He is the RAS member of the ACS Advisory Council for Plastic and Maxillofacial Surgery. He is also a member of the RAS-ACS Executive, Education, and Communications Committee.

Dr. Bittner is a general surgery resident at the Medical College of Georgia School of Medicine, Augusta, GA. He is Vice-Chair of the RAS-ACS Education Committee.
of today and tomorrow are not only present at the health care policy table, but prepared as clinicians, leaders, and advocates.

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**Dr. Hayanga** is administrative chief surgical resident, University of Michigan. Ann Arbor. He is Chair of the RAS-ACS Education Committee.

**Dr. Powell** is a general surgery resident at New York University, New York, NY. She is Vice-Chair of the RAS-ACS Communications Committee and a member of the Advisory Council of Operation Giving Back.
Addressing workforce issues with foreign medical graduates

by Haytham Kaafarani, MD, MPH; Mecker G. Möller, MD; Sangeetha Prabhakaran, MD; and Marcovalerio Melis, MD

For most of the past 25 years, medical workforce studies have typically predicted a surplus of specialists and a shortage of primary care physicians.1,2 In 1981, the Graduate Medical Education National Advisory Committee calculated a physician surplus of 145,000 by the year 2000, and called for restricting the number of slots in medical schools, as well as the number of international medical school graduates (IMGs) admitted into the country.3

In 1988, the Council on Graduate Medical Education (COGME) also predicted excessive growth in the specialties (including surgery), and a surplus of approximately 80,000 physicians by the year 2000.2 In 1992, to constrain the perceived oversupply of specialists and a shortage of generalist physicians, the COGME recommended increasing from 30 percent to 50 percent the number of graduates entering practice as generalists, and reducing from 70 percent to 50 percent the number of specialists. The COGME also recommended limiting the number of residency positions to 110 percent the number of graduates of U.S. medical schools, thereby stemming the influx of IMGs.2 This policy became known as the “110:50:50 rule,” and remained in use, for the most part, for medical and surgical education plans for the following decade. Meanwhile, various experts predicted that the managed care revolution of the 1990s would further reduce the need for physicians.1 Acknowledging these positions, the Balanced Budget Act of 1997 (Public Law 105-33) capped the number of residency slots qualified for federal funding.1,2

During the last decade, however, new methods of calculating physician supply and demand suggested that restraints imposed on the production of medical professionals would lead to shortfalls in physician supply. In a landmark article in 2002, Richard Cooper, MD, and colleagues predicted a deficit of 50,000 physicians by 2010, and 200,000 by 2020.4 Additionally, they noted a pronounced association between average income and demand for specialty care, and projected that the need for specialists will rise faster than the demand for generalists. Since the American population is aging, assuming that age-specific, per capita use of surgical services will remain constant, in 2003, David Etzioni, MD, MSHS, and colleagues projected a 14 percent to 47 percent increase in the demand for all surgical services.5

These new approaches to predict physician supply were received by medical education policy advisors, who now acknowledge that the U.S. is headed toward a physician shortage. In 2005, the Association of American Medical Colleges and the COGME agreed that physician shortfalls are likely to occur by 2020. This shortage was estimated at 85,000 to 96,000 physicians.6 However, a physician shortage is already evident in facilities caring for the nation’s most vulnerable populations: trauma centers, emergency departments (ED), and rural health facilities.

In June 2006, the Institute of Medicine reported on the most relevant issues facing the nation’s emergency care system, highlighting key problems, including a shortage of specialists who will
take emergency call. According to the American College of Emergency Physicians, nearly three-quarters of EDs have inadequate on-call specialist coverage. A study conducted on behalf of the American Hospital Association showed that neurosurgeons, orthopaedic surgeons, general surgeons, and plastic surgeons are specialists in short supply for ED on-call panels. This shortage is marked for general surgery. The number of general surgeons per 100,000 inhabitants has declined steadily by almost 26 percent during the past 25 years (from 7.68/100,000 population in 1981 to 5.69/100,000 in 2005). The decline has been most discernible in urban areas (from 8.04 to 5.85, −27.24 percent) than in rural areas (from 6.36 to 5.02, −21.07 percent). However, rural areas continue to have significantly fewer general surgeons than urban areas.

At this time, in rural areas, shortage of surgeons is not only a perceived issue, but constitutes a dramatically quantifiable problem. In 2005, in North Carolina, 22 counties had no general surgeons and, between 2000 and 2005, 53 other counties experienced a decline in the number of general surgeons. It is safe to assume that these issues, currently seen in emergency care and in rural areas, will soon spill over into the broader American population.

Historically, IMGs have played a vital role in health care delivery in the U.S. Some 40 percent of primary care programs in the U.S. are already dependent on immigrant physicians, and a full two-thirds of international graduates serve in hospitals that provide a disproportionate share of care for the poor in the country. In this article, we will analyze how IMGs may be used at this time to address the impending shortage of surgeons, and what would be advantages and potential pitfalls of this strategy.

**Incorporation of IMGs in the U.S.: Challenges and available solutions**

Incorporation of IMGs in the U.S. medical system is a long and complicated process. IMGs willing to practice surgery in the U.S. face several challenges, but the first and foremost difficulty is gaining access to a residency program. In theory, once an IMG becomes certified by the Educational Committee of Foreign Medical Graduates (ECFMG), he or she can then apply through the National Resident Matching Program (NRMP) for a categorical position in a residency program. For a number of reasons, however, this option does not generally work for IMGs pursuing a surgical career in the U.S.

In order to become competitive for the NRMP, most IMGs need to build up competitive curriculum vitae and become more familiar with the U.S. medical system. Several venues have been used in the past to reach these twofold goals. Generally, IMGs participate in observership rotations in a clinical setting before applying to a residency program. Observerships provide IMGs with invaluable knowledge of U.S. medical practice settings, and with U.S. physicians who can serve as mentors and references. Some IMGs start as research fellows, or gain further nonclinical education in the U.S. (for example, MPH or PhD degrees). A small number of IMGs spend a few years in a clinical fellowship not accredited by the Educational Council for Graduate Medical Education, and then (in order to become board-eligible) complete a residency.

In some states, such as Florida, ECFMG-certified IMG surgeons have been working as surgical assistants for private and semi-private hospitals where surgery residents are not available; some of them later may become able to compete for surgical positions. Most of these experiences provide some degree of clinical exposure in the U.S. prior to starting a residency, introduce the IMG to U.S. physicians who can serve as references, and smooth the transition of living in a new country with a different culture.

However, to an IMG surgeon willing to practice in the U.S., savvy guidance is required to navigate through these preliminary steps. Some institutions have recently started to organize this transition process. In 2006, the ECFMG launched a free service, called IMG Advisors Network (IAN). The aim of the IAN is to provide IMGs with advisors who can answer questions about living and working in the U.S., facilitate application to GME positions, and, eventually, mentor in the subsequent career after residency.

The Global Observership Program and the William J. Harrington Medical Training Program for Latin America and the Caribbean (both at University of Miami) provide IMGs with the opportunity
for research and clinical rotations in different specialties (including surgery). In only two years of activity, the Global Observership has accepted applicants from China, Egypt, France, Germany, Ghana, India, Italy, Korea, and Saudi Arabia. The Harrington Program offers internships and residency positions in internal medicine to Latin American medical graduates. Most of the applications have been received from Brazil, Colombia, the Dominican Republic, Ecuador, Mexico, and Peru.

The Washington University program has developed an eight-week clinical experience for IMGs in a tertiary care teaching hospital. This track helps identifying those IMGs with better chances to succeed, and provides them with enough experience to successfully integrate into a U.S. residency. The Louisiana state licensing board has approved a short-term training permit or other postgraduate training program for IMGs, who may rotate for a period not exceeding 90 days in Louisiana hospitals, as per board discretion.

Further development of similar programs would be beneficial in integrating IMGs into the surgical training system. However, local programs, although important and significant, will not be sufficient to streamline admission of IMGs to residency programs across the country, and should rather be coordinated at a nationwide level. A recent article by Kamal Itani, MD, FACS, and colleagues suggests allocating dedicated residency spots to IMGs to ensure a stable supply of highly qualified IMG residents, rather than the current unstable and fluctuant acceptance of IMGs in surgical residency programs. Such a change can easily help (1) eliminate the anecdotal belief that the reputation of a residency program is negatively affected by the presence of IMGs, (2) improve the selection process during the match process rather than eliminate most IMGs’ applications in the first screening, and (3) reverse any internalized feeling of inadequacy that IMGs may develop over time because of repetitive incidents of discrimination.

Upon entering surgical residency in the U.S., the IMG faces additional unique challenges on the linguistic, cultural, and discriminatory levels that could also be better handled on a system-wide level. The linguistic difficulties typically encountered are not only related to clearly expressing oneself in formal English, but also struggling to understand slang and colloquialisms of both patients and fellow care providers, and to differentiate the regional differences in dialect and body language of diverse patients and co-workers. Both the cultural and linguistic difficulties can be greatly reduced by introducing formal cultural awareness systems programs in surgical residencies and formal mentor-mentee pathways to mutually improve the cultural integration and training experiences of IMGs during residency years. Providing resources through the ECFMG or GME to IMGs from non-English-speaking countries to encourage them to improve their pronunciation, use of colloquialisms, and accent reduction could be another way to ease their transition.

Courses in American history and culture could also benefit the IMGs during their transition. Visa restrictions constitute one of the major obstacles for assimilating IMG surgeons into the U.S. Most IMG residents are currently in the U.S. on a J1 visa, sponsored by ECFMG. This visa presents several problems. First, the J1 visa, for purpose of graduate medical education or training, can be maintained for a maximum of seven years. This duration limit forces many IMGs to choose between pursuing research during residency or fellowship after completion of their studies. Second, the visa stamp needs to be renewed in the country of origin every year. The potential for lengthy security checks repeated every year has already unnecessarily put in jeopardy the careers of many IMGs. Third, in accordance with Section 212(e) of the Immigration and Nationality Act, all J-1 exchange visitors are automatically obligated to return to their country for an aggregate of at least two years. This rule is one of the major obstacles for IMG surgeons to be used as workforce in the U.S. at the end of their training.

According to the Conrad State 30 J1 Visa Waiver program, the two-year requirement can be waived in exchange for the IMG’s agreement to work for three years in a designated health professional shortage area or medically underserved area. However, the Conrad program provides for the approval of only 30 J1 visa waivers for each U.S. state. The issue is further complicated by the fact that each U.S. state, by regulation, has enacted its own specific requirements that a foreign physician must meet to qualify for consideration for inclusion in this program.
The two-year requirement was created to emphasize the role of the U.S. in preventing the "brain drain" from developing countries. If one examines the number of physicians per capita per country, the fact that the brain drain theory does not apply to many of the main IMG exporting countries becomes obvious. For example, countries such as Argentina, Greece, Italy, Lebanon, or Russia have more than three physicians per 1,000 people, and thus have an oversupply of physicians. For comparison purposes, the U.S. has fewer than 2.5 physicians per 1,000 people. The brain drain concern from such exporting countries is simply unfounded. In view of the previously noted workforce projections suggesting a large physician and surgeon shortage in the U.S. in the near future, requiring IMGs from these so-called physician-oversupplied countries to return home and serve their own communities is irrational from both the U.S. and the exporting country’s perspectives. We suggest a policy aimed at facilitating the stay of IMGs from high physician/capita countries. This would be relatively easy to achieve if the ECFMG started selective granting of J versus H visas to IMGs based on their country of origin, rather than the “one-size fits all” policy currently prevailing in visa-sponsoring for IMGs seeking surgical training in the U.S.

Following completion of training and attainment of a visa with working permit, more obstacles are ahead for those IMGs seeking an academic career. The majority of research awards and grants are not available to individuals on temporary visas. Candidates must be U.S. citizens or must have been admitted for permanent residence by the time of the award. A new National Institutes of Health (NIH) grant, the Pathway to Independence Award (K99/R00), was introduced in 2006 and made available to temporary visa holders. NIH decided to offer this award to non-U.S. citizens with the explanation that scientific research is a global enterprise: “The Pathway to Independence Award seeks to attract the best and brightest individuals conducting research in the U.S., regardless of citizenship.” If this is true for the K99/R00 award, the NIH could make all of its awards available to non-U.S. citizens. Although the challenge for all is to identify the best and the brightest within the current system—some of them are certainly IMGs.

Incorporation of IMGs in the U.S.: Advantages

Throughout history, IMG surgeons have made, and continue to make, important contributions to the field of surgery in the U.S. In general, IMGs are talented, knowledgeable, and motivated, and some possess a level of expertise or prior training that is not commonly found among some U.S. graduates. In several countries where technology is not readily available, medical students rely only on their clinical knowledge to reach a diagnosis. Graduates of some Latin American medical school programs are trained during medical school to meet the social needs for primary care physicians, having to go through a year of internship, followed by a year of social service as rural doctors, prior to entering specialty residency programs. This requirement provides these surgery residents with field experiences, opportunities, and responsibilities that are not available to graduates of some standard medical schools in the U.S.

Many surgical residents from European countries have been educated under different work hour regulations and trained in specialized tracks early in their training, an area of current adaptation for U.S. surgery residents. For U.S. surgical departments, it may be advantageous having IMG residents and/or faculty. The faculty involved in evaluating and training IMGs may find that mentoring these residents may be as rewarding, if not more so, as mentoring U.S. graduates. By mentoring IMGs, faculty may expand and enhance their own skills in evaluation, feedback, and teaching. The rewards and gratification of seeing an IMG succeed as a brilliant resident, fellow, or practicing physician may become significantly rewarding for the faculty member.

Successful IMG staff surgeons can share their personal and medical training backgrounds, and facilitate collaboration with international colleagues to broaden the experiences of U.S. faculty, resulting in a more creative and effective teaching and collaborative research. Their academic contributions, international networking, and clinical expertise obtained in a different training model might invigorate the national research enterprise. These faculty members could become effective role models for minority U.S. medical students and residents, and relate to patients.
of similar cultural or linguistic backgrounds.\textsuperscript{10,27}

In summary, because of their diverse background, IMGs may offer new perspectives about medical care, creativity, and improvisation when resources are scarce, and may possess innate skills to better understand cross-cultural issues among their patients.\textsuperscript{10} Availability of IMGs willing to work in the U.S. should be considered an asset for our health care system. As discussed previously in this article, a shortage of surgeons is already apparent, and many IMGs are more willing than U.S. medical school graduates to practice in remote, rural areas through the J1 visa waiver requirements.

In an era when most graduating surgeons are pursuing specialized training and we face the shortage of general surgeons, many of the IMGs who already have been practicing general surgeons in their native countries and have graduated from Accreditation Council for Graduate Medical Education-accredited residencies in the U.S. could help serve areas with surgical needs.

Final considerations

The road to integrating IMGs into the U.S. graduate medical education and health care system is steep and has obstacles, but once those obstacles are overcome, IMGs can potentially serve as a safety net for the shortage of surgeons in the U.S. We need to strike a balance between the national goal of attracting the highest-quality IMGs to stay in the U.S. and the global responsibility of mitigating any brain drain from exporting countries with desperate need for physicians. However, the authors suggest that the ECFMG should become more flexible with both the duration and the ease of switching between clinical and research J visas, in order to allow academically oriented IMGs to pursue research during residency, mature clinically, and become competitive for fellowships without the restraints of visa expiry. Similarly, the quota of IMGs eligible for participation in the Conrad program should be increased, or adjusted on a yearly basis, according to the need for generalists and specialists in underserved areas.

Predicting the future need of the medical workforce has historically been a difficult task. An increase in the number of positions available in medical school and residency programs may increase the surgeon supply in the long term. However, with few uncomplicated measures, IMGs could be used as a reservoir of surgeons to fill in, real-time, the medical needs of the U.S. population.

References


Dr. Kaafarani is a resident in general surgery, Tufts Medical Center, Boston, MA; a member of the RAS-ACS Communications and International Medical Graduates Committee; and the RAS-ACS representative to the ACS Quality and Safety Committee.

Dr. Möller is assistant professor of surgery, division of surgical oncology, University of Miami, Miami, FL. She is Chair of the RAS-ACS International Medical Graduates Committee, member of the ACS-RAS Communication Committee, and is the ACS-RAS liaison to the ACS International Relations Committee.


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**Dr. Prabhakaran** is a resident in general surgery, University of North Dakota School of Medicine and Health Sciences, Grand Forks, ND. She is a member of the RAS-ACS Communications and International Medical Graduates Committees, and Editor of the RAS-ACS e-newsletter.

**Dr. Melis** is assistant professor, division of surgical oncology, New York University School of Medicine, New York, NY. He is a member of the RAS-ACS Communications Committee, and a member of the Association for Academic Surgery Global Affairs Committee.
Modern surgical communication and the practice of surgery

by Heena P. Santry, MD; Jeffrey J. Dehmer, MD; Jennifer S. Nelson, MD; and Shankar R. Raman, MD, MRCS

As is the case with the business world and with society in general, how surgeons communicate with one another, with patients, and with the bureaucracy governing surgical practice has changed tremendously in the last 20 years. With the emergence of computers, the Internet, and, more recently, new media, surgical communication has evolved dramatically.

The term “new media” refers to digital communication, as opposed to traditional paper and verbal communication. It includes electronic versions of the health record (EHR) and mail (e-mail). Web 2.0, which includes social networking sites such as Facebook and Twitter, is the most modern form of communication and allows for real-time updates, interaction, and user-generated information exchange. The College has embraced new media on behalf of its Fellows (see sidebar, pages 34–35). With rampant growth of communication tools, surgeons today are challenged in many ways beyond the traditional scope of practice. This article will explore the benefits, challenges, and policy implications of advanced technology, new media, and Web 2.0.

New media and the surgeon’s image

New media has linked patients and surgeons in a variety of innovative ways. Social networking sites educate the public and stimulate discussion on a range of surgical topics. Blogs (Web-based multimedia journals containing personal reflections, comments, and links posted by the “blogger”) and microblogs (essentially, condensed versions of blogs limited by word count or byte-size) offer surgeons the chance to be heard by a much broader audience than their patients and colleagues. Finally, the Internet provides a relatively inexpensive means of promoting one’s surgical practice and attracting new patients. Embracing these new modes of communication, however, has resulted in the blurring of traditional norms governing the surgeon-patient relationship and society’s view of surgeons.

Social networking sites such as Facebook and MySpace allow users to connect virtually to one another and share thoughts, interests, and photos through online posts. As recently described by Pauline W. Chen, MD, FACS, “Historically, doctors
The American College of Surgeons and new media

Fourteen years ago, all communications from the American College of Surgeons were paper-based. As medical practice has embraced Internet technology and new media, so, too, has the College. The College’s movement into Web 2.0 is progressing rapidly.

The College’s first presence on the Internet came in 1996, with the launch of its Web site (http://www.facs.org). Originally consisting of a few pages and with just 60 files online, the Web site currently contains more than 8,000 files (including HTML text, graphics, and PDF files) and generates 2 million hits per month. The College’s Web site makes specific resources freely available to the general public to promote and support the delivery of high-quality surgical care.

The College’s Patients As Partners in Surgical Care program (http://www.facs.org/patienteducation/) provides medically accurate and up-to-date information on surgical diseases and procedures in order to empower patients “with the knowledge and skills to participate in [their] surgical care.” Through this section of the ACS Web site, patients can also find a surgeon who is a Fellow of the College and be directed to the professional organization that will verify board certification and facility accreditation. Once a patient is certain of a planned procedure, this online tool provides resources on how to prepare for surgery and explains the entire perioperative process.

The full text of all College publications, including the downloadable planner for the Clinical Congress, can also be accessed online by members and other interested individuals. The College’s members-only Web portal contains “mirror images” of these publications and many other materials, making them available to all of the College’s audiences. Additionally, some of the College’s most robust resources for volunteerism (http://www.operationgivingback.facs.org/) and advocacy (http://www.facs.org/acspa/index.html) can be accessed through both its Web site and Web portal.

In 2006, the College stepped beyond the Web 1.0 Web site and launched the members-only Web portal, e-FACS.org, a first-of-its-kind professional networking and resource site specifically for surgeons. All facets of membership maintenance and renewal can be handled online through e-FACS.org. Members can search and enroll online for the College’s numerous educational offerings and coding workshops, and tools intended only for members of the College—such as the CME tracker and the Case Log System—are available only through the Web portal.

A major feature of the portal is that it allows members to join “communities” based on similar interests. The portal also provides users access to key features relevant to modern regulation of surgical practice. The portal’s My CME feature provides a convenient way to track continuing medical education credits and a simple way to generate evidence of participation. The portal’s Case Log System (which uses a separate login for additional security) uses the validated National Surgical Quality Improvement Project (NSQIP) risk-adjustment variables in a database where members can enter each of their cases and any adverse outcomes, with all of the relevant factors that have been proven to influence outcome. These data can ultimately be blindly compared with those of other surgeons performing the same procedures. These networking and data-tracking opportunities, as well as exclusive access to videos, podcasts, discussion forums, and other useful features, have contributed to the portal’s growing popularity since its 2006 inception. The portal attracts more and more users every month; between 2008 and 2009, the number of unique users rose by 13 percent and produced more than 200,000 unique page views.

Beyond the Web, e-mail blasts have been aggressively used by the College since it first launched its hugely popular ACS NewsScope in 1999, with approximately 45,000 member in-boxes receiving it weekly in 2010. E-mail blasts are also a key way to keep members informed of issues in need of urgent attention. For example, numerous e-mail blasts were sent to members during the debate on health care reform, and such communications will continue to be sent as details of this legislation—as related to surgeons and their patients—become clear.

Another example of how the College is using “special alert” e-mails were the eight e-mail blasts that were sent during the three weeks following the Haiti earthquake. Those communications served as both a recruitment
tool for potential volunteers, and as a regular update mechanism for keeping members abreast of the rapidly changing situation on the ground for Haitians, and for those deployed to assist in the recovery efforts related to the disaster.

The Resident and Associate Society of the American College of Surgeons (RAS-ACS) also uses an e-mail software program to disseminate its e-newsletter, RAC-ACS News. The e-newsletter provides an every-other-month account of ongoing RAS-ACS activities and programs, and details information and opportunities that are likely to be of interest to Resident Members and Associate Fellows of the College. Likewise, the Young Fellows Association disseminates quarterly e-mail newsletter, YFA e-News, to practicing young surgeon members of the College.

The College’s most recent advances in modern surgical communication have been numerous, and they are expected to also grow in popularity in the future. Both live and archived webinars are frequently utilized to replace in-person seminars on a variety of topics ranging from Cancer Staging Updates to New CMS Policy of Consultation Coding. In February and June 2009, the College’s Board of Governors held their first two live webcasts, allowing members to discuss important issues challenging the safe and effective practice of surgery. These formal, yet virtual, professional exchanges are furthered more informally on the College’s Twitter account, with nearly 500 followers (http://twitter.com/amcollsurgeons), and Facebook group (http://www.facebook.com/#!/group.php?gid=36660331571), with more than 650 members.

The College has shown no signs that it is abandoning traditional media, and has clearly mastered the use of Web 1.0 to communicate with a majority of its members, while its Web 2.0 products are continuing to grow. As Linn Meyer, Director of the College’s Division of Integrated Communications, puts it, “The College is committed to using every single communications tool that makes sense for all demographic groups that are part of the College’s membership.”

erred on the side of saying little or nothing about themselves, positioning themselves as a “blank slate” against which patients could freely discuss concerns.”2 However, surgeons who participate in Web-based social networking are revealing themselves to a wide audience, including friends, colleagues, and, possibly, patients. Privacy settings vary from one site to another and access to personal information—whether posted by the surgeon or by virtual “friends”—is variable. Recently, Sachin Jain, MD, wrote about the complexities of accepting a “friend request” from a patient and how social networking sites make “clinicians’ attitudes and activities increasingly visible.” Like Dr. Chen, Dr. Jain writes about the “importance of maintaining professional distance” that is so emphasized in medical training, and on how exposure of one’s personal life on the Internet can shorten this distance.3 It is evident that surgeons who engage in social networking sites push the boundaries of their professional relationships when their personal information is shared intentionally or unintentionally with present or future patients. The medical profession is still grappling with the moral and ethical challenges of online social networking, but the current norm appears to be that physicians should maintain the long espoused notion of professional distance.

Blogs and microblogs allow surgeons to share personal anecdotes, the details of which can cross the traditional lines of medical etiquette. Whether used as a therapeutic outlet for their stressful work experiences or to solicit the input of colleagues on a challenging case, when surgeons share seemingly anonymous patient information or lessons learned through mistakes, issues of patient privacy and medicolegal liability arise. Twitter, a microblogging tool, allows users to send short messages, called “Tweets,” to the author’s “followers” or as open-access. Live updates from the operating room allow patients, family members, and the public unique access to surgery, thus raising public awareness of procedures and potentially eliminating the fear of the unknown for those following Tweets about a loved one’s procedure. However, intraoperative Tweeting also raises concerns about the surgeon’s focus on the operation. Similarly, while it may also comfort patients under local anesthesia to Tweet during procedures, it might distract the surgeon, whose
every action is under the scrutiny of any number of followers in the blogsphere.4

New media has also transformed patients into consumers, rather than passive recipients, of surgical care, thus putting even greater pressure on the image cultivated by surgeons. Traditionally, a patient sought care for elective surgical problems based on a referral from their own physician, and occasionally, by word of mouth. However, with the Internet, patients can now research surgeons based on expertise, as well as outcomes and bedside manner. There are countless Web sites, such as angieslist.com, ratemds.com, and vitals.com, where patients rate and review their surgeons, much like they would review a restaurant or gadget. With Web sites ranking patient satisfaction, the pressure on physicians is enormous. It is possible that reimbursement might someday be tied to patient satisfaction; medicine is already becoming a consumer-driven industry.

In response to this trend, many surgeons have already become savvy Internet marketers, cultivating for themselves an online image through social media and individual Web sites to attract patients to their practices. This trend has been especially pervasive in specialties such as cosmetic, vein stripping, and bariatric surgery, where controversy exists in the medical and lay community regarding medical necessity. There are companies whose only service is creating Web sites marketing surgical services with tag lines such as, “The truth is that most specialists in your position have a Web site that fails to harness the power of the Internet to help your business grow.”5

Surgeons will have to define the rules of Internet conduct, and organizations such as the American College of Surgeons may need to add specific language related to online presence into their codes of ethical behavior.

Caring for the “e-patient”

The traditional surgeon-patient relationship has also been challenged by the new type of patient born of the Internet and new media. This so-called e-patient is technology-savvy and derives medical knowledge from various online resources for health care decision making.6 The Pew Internet and American Life Project reports that, in 2009, approximately 61 percent of Ameri-
regard to the timeliness of response. In theory, non-urgent issues might best be handled over e-mail—but who is responsible for triaging e-mails for acuity when a physician is not always at his or her inbox? Texting allows for acquisition of information without mandating an immediate response, but will text messages limited to just a few words be appropriately interpreted? It remains to be determined what issues can be safely managed over e-mail or via texting, and what type of compensation and liability is associated with such physician-patient interaction that is devoid of real-time feedback.

Interacting with the e-patient generates unprecedented medicolegal and ethical concerns for surgeons. Agreed-upon guidelines for the profession are lacking. At issue are not only the traditional boundaries of the surgeon-patient relationship, but also patient safety.

Electronic health records

While surgeons have had to adapt to a new style of patient, they have also had to adapt to a new kind of record keeping, one that is now mandated for all health care facilities and providers by the 2009 American Recovery and Reinvestment Act (ARRA).\textsuperscript{10} The ARRA incentivizes eligible providers in the form of cash payments for those who demonstrate “meaningful use” of certified EHR technology beginning in 2011. However, the ARRA also established penalties in the form of reduction in Medicare payments for those who do not use certified technology by 2015.

An EHR is an electronic health record that contains streamlined, easily accessible, and legible patient information. It includes digitized storage systems for radiological images, computerized provider order entry (CPOE), electronic charting of progress notes, operative dictations, and vital signs. As of April 2009, fewer than 2 percent of acute care hospitals have a comprehensive EHR system, with only 17 percent of surveyed physicians using electronic records of any sort.\textsuperscript{11} Since publication of the landmark Institute of Medicine report \textit{To Err Is Human: Building a Safer Health System} in 2000, there has been a push to improve patient safety.\textsuperscript{12} ARRA provides the funds for development and implementation of information technology as a means of ensuring patient safety.

Barriers to EHR implementation include cost, lack of user training, privacy concerns, and technical difficulty merging systems within, and across, institutions. These issues, particularly cost, are heavy burdens on the 78 percent of physicians who practice in groups of eight or fewer.\textsuperscript{13} Furthermore, having faster access to more comprehensive records does not necessarily improve the quality of the care delivered. Increasing reliance on technology, combined with growing time constraints, has led to a new phenomenon dubbed “clinical plagiarism,” in which cutting and pasting from the EHR often substitutes for a thorough history and physical.\textsuperscript{13} Nevertheless, the forces pushing for improved technological integration of patient data for the goal of improved outcomes and efficiency will continue.

An ideal system would be one in which all of the pertinent information for a patient (past history, medications, allergies, family history, labs, images) could be found in one place that is easily accessible and updated in real time. This information could potentially be something patients could carry with them. Time spent searching for, and awaiting, old records from referring institutions would be drastically reduced, thus improving continuity of care and reducing duplicate tests. Automated algorithms in the EHR could improve processes of care and patient safety with triggers for screening tests, follow-up, and treatment protocols. For example, CPOE has been shown to reduce medication errors and harmful drug interactions.\textsuperscript{14} The EHR can also enable less burdensome billing and coding and reduce potential for over- or under-billing by quickly identifying key portions of procedures or consultation visits.\textsuperscript{15} Lastly, de-identified data from EHRs can greatly enhance opportunities for comparative effectiveness research, the results of which will have major implications for best practice guidelines. These benefits notwithstanding, patient privacy is a significant concern. With sensitive information regarding transmissible diseases or mental health disorders incorporated into the EHR, the security of these data will be paramount in the development of any integrated system.
Telemedicine

New media technologies have also enabled surgical health care delivery via video conferencing, satellite technology, and information-transfer over the Internet. A major goal of telemedicine is to expand access to health care for patients in remote or rural areas and appropriately triage patients when local resources cannot serve their medical needs. By allowing specialists to consult, monitor, and even perform interventions from a distance, telemedicine has great potential. A recent report documented the lives saved, as well as substantial cost savings, due to avoidance of transfer for non-life-threatening emergencies in a telemedicine system connecting rural sites to a Level I trauma center. However, a study evaluating the use of telemedicine in monitoring intensive care unit patients demonstrated that many physicians are reluctant to embrace this new technology. Without the support of practitioners and a preponderance of evidence, it will be difficult to develop the infrastructure necessary to use telemedicine effectively.

Although skepticism has slowed research on the utility and safety of telemedicine, the practice of telemedicine is growing, especially in rural areas. Some U.S. states, such as Texas, as well as private insurers, have implemented teleconferencing to connect patients and doctors. Online consultations, lacking the benefit of a physical exam, however, are not the same as an in-person visit. Practices that offer this service include lengthy disclaimers on their Web sites, but the medicolegal implications for the surgeon treating patients remotely are unclear. There are no precedents on the standards for granting remote treatment privileges or licenses to practice medicine virtually across state lines.

Conclusion

The implications of the new media and Web 2.0 are profound. In her blog entry, “Medicine in the Age of Twitter,” Dr. Chen notes there are no evidence-based guidelines to direct doctors in the use of social media. There is fear that surgeons may overexpose themselves through new media and modern marketing. However, it is possible that increased familiarity between surgeon and patient may strengthen relationships and improve outcomes. There is fear that e-patients overexposed to medical information may place unwarranted demands on surgeons. Nevertheless, educated and empowered patients raise disease awareness and promote health care participation. While implementation of the EHRs may be costly and procedurally burdensome, if used appropriately, they may improve the efficiency and quality of care. Similarly, while patients in all geographic areas, and with various levels of communication savvy, are entitled to have access to the highest level of care, when medical advice is being given remotely via e-mail, text messaging, or telemedicine, liability and reimbursement are a significant concern.

The uncertainties notwithstanding, new media is here to stay. Surgery has always been a specialty of technical and technological evolution. While
regulatory issues will undoubtedly play a role, surgeons’ enthusiasm will largely determine the speed of this communication evolution. With thoughtful and carefully planned use of new media, surgeons will continue to be leaders in the implementation of new technology in the pursuit of providing the highest quality of patient care.

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Dr. Nelson is a resident in general surgery, University of North Carolina Hospitals, Durham, NC, and a member of the RAS-ACS Communications Committee.

Dr. Raman is a resident in general surgery, Bronx-Lebanon Hospital Center, Bronx, NY, and a member of the RAS-ACS Communications Committee.
Do more requirements make a better surgeon?

by Brian J. Santin, MD; and Kimberly A. Ruscher, MD, MPH

Editor's note: At the 2010 ACS Clinical Congress in Washington, DC, the ACS Resident and Associates Society Symposium will engage members in debating the question, “Do more requirements make a better surgeon?” This article introduces this debate’s broad themes. In future issues of the Bulletin, resident winners of the essay competition on this topic will have their viewpoints published.

Many faculty recall the old days of living and breathing surgery for five years of training, while residing within the hospital, and, upon completion, being awarded the honor and the title of surgeon. It is unclear what the current surgical trainee will eventually remember as the old days. In recent years, the number of prerequisites, competencies, tests, and certifications trainees must complete, as well as those required by surgeons seeking recertification, has grown significantly. In 20 years, will we remember working only 80 hours in the hospital or office, yet going home to complete documentation? Many members of this generation of trainees were introduced to the era of increasing requirements in 2004 and 2005 by an additional licensing exam, the United States Medical Licensing Exam Step 2—Clinical Skills. Beginning this year, residents are required to complete the Fundamentals of Laparoscopic Surgery (FLS) course to become board-eligible. Is this increase in documentation and other requirements supported by evidence? What has been the nidus for this growth?

The changing face of surgical education

From the time of William S. Halsted’s 1904 description of surgical education as an apprenticeship of “graded responsibility,” the dynamic balance of clinical and didactic education has remained a topic of debate.\textsuperscript{1,2} Apprenticeship-style programs were the norm dating back to 1755, wherein physicians endured five years of training, and if their mentors deemed them as competent, they were granted a certificate.\textsuperscript{2} This was followed by a more lax period in the early 19th century, with apprenticeships lasting for two years and certificates awarded to anyone willing to pay the required fees.\textsuperscript{2}

In his review of surgical education in the first half of the 20th century, John O’Shea, MD, emphasizes the complete lack of any “system of evaluating either the value of surgical education or the competence of the prospective surgeon.” Did the lack of regulation or professionalism in surgical education during this time period result in an inferior breed of surgeons? Certainly not universally. The career of Jere Crook, MD, from Tennessee, would argue against an inferiority claim. Dr. Crook was not only one of the founding members of the Southern Medical Association, but he also performed the first appendectomy for perforated appendicitis in 1902.\textsuperscript{2}

In his presidential address to the Southern Surgical Association, James O’Neill, Jr., MD, FACS, stated, “Our standards and regulations have stifled innovation and creativity in the design of educational programs in surgery, an unintended consequence in the quest for quality.” He also stated that as the Accreditation Council for Graduate Medical Education (ACGME) is being confronted with new variables (for example, work hour limits), the apprenticeship model is now being significantly modified and potentially destroyed. Dr. O’Neill stated, “It is ironic that we have seen a number of new challenges and disruptive changes in surgical education at a time when surgical education in America and the status of surgical practice is the envy of the world.”
**The way it used to be**

Herbert Fred, MD, MACP, described the beginning of his surgical education nearly 55 years ago as “the days when the internship ingrains discipline, stimulates a taste for continual self-education…these are the days when good patient care and the education of the intern are all that matter.” Before 1900, the sole purpose of many medical training programs—many of which were attended by the brothers Mayo—emphasized the importance of patient contact. In fact, it was made adamantly clear that didactic education would be neglected in favor of more practical purposes. It was in these times that the apprenticeship was the predominant model through which many early surgeons were trained.

Edward M. Copeland III, MD, FACS, in his Presidential Address at the ACS Convocation in 2006, confirmed the paradigm he trained under. “If a test is ordered, know the result. If a tube is inserted, be sure it works. Talk to the patient—it is amazing what they know. When practical, check on inpatients at least twice a day. Instill teamwork among health care professionals—ensure that the physician who assumes the care of your patient is well informed. When in the operating room, be prepared for the unexpected,” Dr. Copeland said.

Early in the era of the apprenticeship model, there was a lively debate regarding who should drive change in surgical education. Elmer Brown, in an address on American Standards of Education, asked why legislatures should incorporate institutions, giving them the right to grant degrees. Over time, various organizations were created to oversee medical education, and the Liaison Committee for Graduate Medical Education was founded in 1971. This group was replaced in 1981 by the Accreditation Council for Graduate Medical Education (ACGME).

With the development of the ACGME core competencies (professionalism, patient care, medical knowledge, practice-based learning and improvement, systems-based practice, and interpersonal skills) has come the requirement of documentation of these competencies. Many surgeons believe that these competencies are not new to the surgical education model, but rather have always been learned from exposure to, and close-working relationships with, faculty. Is it the fact that we must document these competencies that is causing such a stir?

Steven Wexner, MD, has pointed out that maybe none of the changes from the old-school mentality would even be an issue if surgeons weren’t so stubborn. Recall that surgeons once rejected hand washing, when it was proposed by Ignaz Semmelweis, a Hungarian-born surgeon. Is that same stubbornness now leading to the resistance to the Maintenance of Certification (MOC) process? While it is clear that merely attaining continuing medical education credits is inadequate for demonstrating surgical competence, an expanded recertification process could detour surgeons from continuing to practice. There exists a fine balance between a plan for recertification that is sufficient, yet not too onerous. Will the MOC designed by the American Board of Surgery (ABS) adequately address this issue?

**Scope and goals of the paradigm change**

Overall, the goal of increasing requirements is ensuring patients undergo safe, high-quality surgery. This goal is not limited to surgeons and the ABS, of course. Hospitals are responsible for credentialing physicians to perform procedures and tasks. Other stakeholders, such as insurers, have begun requiring minimum numbers of procedures in a specific time period to be credentialed for reimbursement.

What is the goal of this paradigm change? And with so many stakeholders pursuing similar goals, who is responsible for determining the scope and characteristics of these efforts? In their *Journal of the American Medical Association (JAMA)* commentary, “Improving the Quality of Health Care,” J. Frank Wharam, MB, BCh, BAO, MPH, and Daniel Sulmasy, OFM, MD, PhD, discuss these stakeholders and outline various obligations. In the discussion concerning pay for performance as a means to providing consistent, quality care, they raise the question of whether the efforts seem more like rewards for data than for achieving better outcomes. James Castle, president and chief executive officer of the Ohio Hospital Association, believes we “should focus on the desired outcome—providing high-quality...
care, [and] not on how to achieve that goal.” Yet at the same time, Mr. Castle recognized that “Accredited organizations need the flexibility to design...processes in a way that meets their unique needs.”11 In a similar vein, for surgical trainees and young surgeons, what is more important—documentation of the attainment of learning, or the constant striving to become the best surgeon possible?

The new training paradigm

The most significant change to surgical education in the past 100 years is likely duty hour restrictions. It is believed that while the ACGME lacked data to support the hour limit of 80, their rationale was intuitively biased—a well-rested resident will inherently make fewer mistakes.2 Studies have shown mixed results on the outcomes of the duty hour restriction. In his 2008 presidential address to the Western Surgical Association, Merrill Dayton, MD, claimed, “Faculty believe that resident education has been compromised because of loss of continuity of patient care and, most important, that patient care has deteriorated or worsened.”9 It isn’t much of a stretch to think that attending surgeon work hour restrictions would have a devastating effect on patient access to care.12

After surveying nearly 600 surgical residents, members of the Resident and Associate Society of the American College of Surgeons released a position statement, later endorsed by the ACS Board of Regents, stating further work hour restrictions are not supported by trainees. The statement’s primary author, Jacob Moalem, MD, FACS, said, “We are young doctors who are trying to learn and master our fields, and as our survey clearly showed, the closer we get to graduating, the more we wish that our works hours were less restricted. We’re deluding ourselves if we think cutting hours further is going to provide the answer.”13,14 The position statement suggests policymakers should examine differences in scope of practice between medical and surgical fields.

In response to this change, residency programs have developed intricate systems to monitor hours and to ensure compliance.2 Yet, residents have resisted strict monitoring. Is this, like early resistance to handwashing, an example of stubbornness? Residents in one hospital system have been slow to adopt the use of the Northwestern Online Surgical Quality Improvement (NOSQI) system, a Web-based morbidity and mortality event tracking system. The program requires 10 minutes to enter data at any Northwestern University Hospital (Chicago, IL) computer, yet underreporting by residents has been a challenge to the success of the system. In 2007, Karl Bilimoria, MD, then a resident at Northwestern, encouraged residents to think of the need for reporting events as a “systems issue” to overcome their reluctance to participate.15 Should we be aggressively monitoring compliance, or should we be spending this time on education?

Karen Horvath, MD, FACS, believes that “With the rising complexity of health care...surgical education has added more and more onto residents’ backs until they were pretty much maxed out before the 80-hour workweek was implemented.”16 She further states that “We need to sit down and assess all of these many things we are doing—and maybe decide that some of them don’t need to be done anymore...the system does not have infinite capacity.” Should the Residency Review Committee for Surgery allow developmental educational models to be piloted?2

The FLS course may pave the road for further documentation of technical proficiencies, and experts have evidence to support such requirements. The support of Gary Dunnington, MD, FACS, for simulation laboratories has previously been cited by one of the authors of this article (Santin): “With advancing technologies, the cost of the operating room has made the methodical, high-quality teaching with a patient present increasingly more difficult and expensive.... Airlines have been doing this kind of training for years. Pilots often spend hundreds of hours in front of a flight simulator before ever making their first flight and now our residents will have a similar experience, using a high-tech model of a human torso, abdomen, or hand.”17

Could residency programs benefit from additional requirements focused on specific deficits? One of the core competencies, interpersonal communication, often is not addressed specifically in most programs. A few studies support the inclusion of formal communication training in surgical training, as current methods are inefficient,
or nonexistent, and may result in compromised patient care.18,19

Who is running the ship?

In 2003, a medical center in Florida attempted to override medical staff bylaws and deny physician leaders’ abilities to moderate staff membership, peer review, clinical privileges, and quality assurance. Litigation progressed to the state’s Supreme Court, which, in 2008, upheld the rulings of the lower courts by claiming the medical center would have “almost absolute power in running the affairs of the hospital, essentially without meaningful regard for the recommendations or actions of the medical staff.”20 This case exemplifies how nonphysician entities have attempted to steer the ship of health care without regard for physician insight, and offers an example that could have transformed the national stage of medical staff bylaws. Is the physician’s relative lack of leadership training a weakness?

Should we have leadership training as well?

A group from the University of Kentucky reported in the Journal of Surgical Education in 2008 that “As the complexity and the scope of health care industry have grown, the physician’s role as a leader in the marketplace has been marginalized. Without formal training in leadership skills, many physicians are not equipped to lead in this marketplace.”21 Are factors and entities outside of our control beginning to have more of an impact on how we need to be trained in order to remain a viable entity within our own field of study?

Can we not regulate ourselves? Cyril Chantler, MD, in a JAMA editorial, reflected on “whether physician self-regulation can survive under the increasing pressure for accountability and transparency in the regulation of the medical profession.”22 He further mentions that “Others have suggested a need to redefine medical professionalism given the changing roles of physicians and the increasing expectations of the public, and this in turn will have an effect on regulation.”

The history of surgical education demonstrates that surgeons are indeed responsive, thoughtful leaders. Recent examples of this include a survey published in the Journal of the American College of Surgeons in 2009, titled, “Effects of Increased Vascular Surgical Specialization on General Surgery Trainees, Practicing Surgeons, and the Provision of Vascular Surgical Care.” In the article, graduates from the Greenville Hospital System, Greenville, SC, general surgery residency program responded to a survey with overwhelming support of the continued inclusion of vascular surgery experience in the curriculum.23 In response to the results of this survey, and after reviewing the significant impact vascular surgery exposure during general surgery training had on graduates, the authors concluded that vascular surgery should remain in general surgery training.

Where do we go from here?

Medicine has always been a quilt sewn of many pieces—it is composed of business, industry, and science. In this quilt’s creation, are we forgetting the most crucial piece—the patient’s well-being?24 Economists have argued that prevention rarely saves money when compared to therapeutic care, once all variables are taken into consideration.24 In a parallel rationale, do additional prerequisites for trainees and those seeking recertification really just serve as preventive measures?

Dr. O’Shea hypothesized that surgical education needs to balance educational freedom with the ability to evaluate each surgeon’s competency within their realm of practice. Furthermore, he states that future “successful programs will be receptive to the individual goals and personal constraints of those trainees who do not aspire to careers as surgical teachers or researchers, and who will continue to make up the bulk of the surgical workforce.”1 Ironically, education freedom is a concept originally embraced by Halsted well over a hundred years ago.1

In the late 1920s, Hawthorne Works, a manufacturing facility in Chicago, IL, attempted to identify ways to improve productivity by studying workers under different intensities of light. The plant workers were told about the experiments beforehand. The data from the study revealed that the workers’ productivity did, in fact, improve during the study period. The study concluded that an improvement was identified simply because those being studied knew they were being studied; the lighting in the facility was never changed. Nothing changed, except notifying the workers that they
were being studied. This has become known as the Hawthorne Effect.\textsuperscript{25} Are all of these attempts to improve patient care really just examples of this same phenomenon? We know we’re being monitored, so the data will naturally improve.\textsuperscript{11}

References

3. Fred H. These are the days: The internship revisited. Tex Heart Inst J. 2007;34(3):328-335.
An Important Note to Clinical Congress Attendees

As we all know, the state of the economy is having a negative impact on many sectors of our society and on the business community across the country. Not-for-profit professional organizations like the American College of Surgeons are not immune from these national economic trends.

For more than 90 years, the College has been one of a very few medical societies that has been able to offer its members annual meeting attendance at no cost. In past years, the ability to offer free registration for the Clinical Congress has been possible because revenue from exhibitor fees has, in large part, offset meeting expenses. Unfortunately, financial constraints on commercial entities that exhibit at national conventions like the Clinical Congress, coupled with rising labor, convention space rental, audiovisual, and other meeting costs, are resulting in declining revenue and are affecting the bottom line for this premier national educational event.

As a result, after careful and thoughtful review of current trends and their negative impact on the College’s ability to continue to offer this outstanding educational opportunity, the Board of Regents, in consultation with the Executive Committee of the Board of Governors, has decided to apply a nominal registration fee to partially offset rising meeting costs. The new registration fee will be implemented for the first time for the 2010 Clinical Congress.

The fee structure for Fellows and Associate Fellows is:

- Register on or before August 16: $150
- Register between August 17 and October 2: $200
- On-site registration: $275

The fees for other attendees will be increased and are listed on the last page of the Preliminary Program. Surgeons who will be initiated into membership in the College, however, will not be charged a fee.

Fortunately, given the scale of the Clinical Congress, the registration fee structure is very modest and substantially less than fees at other national meetings. This new policy will allow the College to continue to provide the highest quality educational programming possible for members and other attendees at the Annual Clinical Congress.

CANCELATION AND CHANGES TO SESSIONS OR COURSES:
The American College of Surgeons reserves the right to cancel or change any of the scientific sessions or courses listed in this preliminary program. Please check the College’s Web site at:
for the most current information.

Due to space limitations, we are not able to include the more than 100 new and exciting SCIENTIFIC PANEL SESSIONS that will be held at this year’s Clinical Congress. For a full and up-to-date listing of all the Scientific Panel Sessions, refer to the ACS Web site at:
http://web2.facs.org/cc_program_planner/Program_Sessions_2010.cfm?SessionType=PA
Dear Colleagues,

This year for the first time, the nation’s capital will serve as host for the American College of Surgeons 96th annual Clinical Congress, which is scheduled for October 3–7, 2010, at the Walter E. Washington convention center in Washington, DC. Under the leadership of the Program Committee, chaired by Barbara L. Bass, MD, FACS, and the Division of Education, the Scientific Program of the Clinical Congress has been revitalized. The 2010 Clinical Congress program includes a wide array of timely and important topics that are essential to delivery of surgical care of the highest quality.

The broad-ranging Panel Sessions, which include experts from across the surgical specialties and nonsurgical disciplines, will focus on key clinical and nonclinical topics in surgery and related fields. The Named Lectures will be delivered by renowned experts. The Didactic and Skills-Oriented Postgraduate Courses will especially focus on important domains and help attendees advance their knowledge and acquire new skills. Experiential, hands-on learning will be used to achieve the objectives of skills courses.

The Scientific Program for the Clinical Congress will also include a large number of high-quality Scientific Papers, strong Surgical Forum Sessions, timely Video-Based Education Presentations, and excellent posters. These sessions will be complemented by Meet-the-Expert Luncheons and Town Hall Meetings. Attendees will be able to obtain certificates of verification following their participation in Postgraduate Courses, and additional certificates will be provided for participation in specific sessions, to address requirements for Maintenance of Certification, Maintenance of Licensure, privileging, and credentialing. The Clinical Congress Program has been arranged in thematic tracks that address content of interest to all surgical specialties as well as specialty-based tracks that address the learning needs of various specialty groups.

The outstanding educational program, which includes special opportunities to address regulatory requirements and interact with experts, and the ability to reconnect with professional colleagues make the 2010 Clinical Congress an essential meeting for all practicing surgeons, surgical residents, and members of surgical teams. On behalf of the American College of Surgeons, I would like to extend to you our warmest invitation to join us in Washington, DC, for the 96th Clinical Congress, which will have as its theme Surgical Professionalism in the 21st Century. We will look forward to seeing you at the meeting.

With best wishes,

A. Brent Eastman, MD, FACS
Chair, Board of Regents
American College of Surgeons

ACS PROGRAM COMMITTEE

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MBA, FACS, Gainesville, FL

Staff:
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Chicago, IL
Julie A. Tribe, MS Ed., Chicago, IL
Katie M. Anthony, Chicago, IL
What’s New in 2010?
- Meeting held in Washington, DC, at the Walter E. Washington Convention Center
- Open House at the College’s new building.
- Washington Marriott Wardman Park to serve as Headquarters Hotel
- Current and timely Health Policy topics

Cancellation of Sessions
The American College of Surgeons reserves the right to cancel any of the scientific sessions listed in this Program Planner. The information in this Program Planner is preliminary. Check the College’s Web site at www.facs.org for updates.

Goal
The Clinical Congress is designed to provide individuals with a wide range of learning opportunities, activities, and experiences that will match their educational and professional development needs.

Objective
By the conclusion of the Clinical Congress, participants should gain and be able to apply the knowledge to improve their current practice, research, and care of surgical patients.

Accreditation
The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

CME Credit
The American College of Surgeons designates this educational activity for a maximum of 51* AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

* A maximum of 37 AMA PRA Category 1 Credits™ for nonticketed sessions only, including evening video sessions.

CME Certificates
On-site claiming of CME credits will be available at the My CME booth located in the Walter E. Washington Convention Center, October 4–7, 2010. Physicians are responsible for claiming CME credit for Clinical Congress. Claims for CME credit for this event will be accepted until March 31, 2011.

Scientific and Technical Exhibitions
The Scientific Exhibition is a forum of more than 325 exhibits presenting completed research, research in progress, and case reviews. Innovative surgical practices and teaching methods will also be presented. The Scientific Exhibits will be located in Hall A-B of the Walter E. Washington Convention Center. Hours are 9:00 am–4:30 pm, Monday through Wednesday.

The Technical Exhibition comprises more than 200 companies displaying their products and services. The exhibition provides an excellent opportunity to explore the surgical marketplace by comparing products firsthand and planning purchases. The Technical Exhibits will be located in Hall A-B of Walter E. Washington Convention Center. Hours are 9:00 am–4:30 pm, Monday through Wednesday.

Opening Ceremony
Monday, October 4, 8:30–9:00 am
Walter E. Washington Convention Center
The Canadian and American national anthems are presented, along with a short video highlighting the new President’s theme for the year. The President presides and introduces the College Officers and Regents, Honorary Fellows, Past-Presidents, the recipient of the Distinguished Philanthropist Award, Special Invited Guests from national and international health care organizations, and the International Guest Scholars. The Martin Memorial Lecture, sponsored by the American Urological Association, follows immediately.

Annual Business Meeting of Members
Wednesday, October 6, 4:15–5:15 pm
Walter E. Washington Convention Center
- Reports from the Chair of the Board of Regents, the Chair of the Board of Governors, and the Executive Director
- Presentation of the Resident Award for Exemplary Teaching and the Joan L. and Julius H. Jacobson II Promising Investigator Award
- Reports of the Nominating Committee of the Board of Governors and the Nominating Committee of the Fellows, and introduction of the President-Elect

Key to Session/ Course Codes
ME Meet-the-Expert Luncheon
NL Named Lecture
PG Postgraduate Course
PS Panel Session
SC Skills Course
SE Scientific Exhibit
SF Surgical Forum
SP Scientific Paper
TH Town Hall Meeting
VE Video-Based Session
The scientific program, scheduled in discipline- and theme-based tracks, will focus specifically on the needs of various surgical specialties and learner groups.

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Named Lectures

MONDAY, OCTOBER 4

**NL01 8:30–9:30 am**
Opening Ceremony/Martin Memorial Lecture: Regenerative Medicine—New Approaches to Health Care

**PRESIDING OFFICER:** L. D. Britt, MD, MPH, FACS, Norfolk, VA
**INTRODUCTOR:** TBD
**LECTURER:** Anthony Atala, MD, FACS, Winston-Salem, NC

Introduction of Honorary Fellows, recipient of the Distinguished Philanthropist Award, officers, Regents, Past-Presidents, and special invited guests.

Martin Memorial Lecture, established in 1946 to honor Franklin H. Martin, MD, FACS, founder of the College

Sponsored by the American Urological Association

**NL02 9:45–10:45 am**
John H. Gibbon, Jr., Lecture: The STS and VA Cardiothoracic Surgical Databases—Their Role in Quality Improvement, Research, and Health Care Policy

**PRESIDING OFFICER AND INTRODUCTOR:** Frank W. Selkoe, MD, FACS, Providence, RI
**LECTURER:** Frederick L. Grover, MD, FACS, Aurora, CO

Sponsored by the Advisory Council for Cardiothoracic Surgery

**NL03 2:30–3:30 pm**
Charles G. Drake History of Surgery Lecture: Surgery for Cardiovascular Anomalies in Infants—Personal Reflections

**PRESIDING OFFICER AND INTRODUCTOR:** John L. D. Atkinson, MD, FACS, Rochester, MN
**LECTURER:** Denton A. Cooley, MD, FACS, Houston, TX

Sponsored by the Advisory Council for Neurological Surgery

TUESDAY, OCTOBER 5

**NL04 10:00–11:00 am**
Excelsior Surgical Society Edward D. Churchill Lecture: From Excelsior Society to the Present—What Will Be Expected of Us?

**PRESIDING OFFICER AND INTRODUCTOR:** David V. Feliciano, MD, FACS, Atlanta, GA
**LECTURER:** Thomas R. Russell, MD, FACS, San Francisco, CA

Sponsored by the Advisory Council for General Surgery

**NL05 11:30 am–12:15 pm**
Scudder Oration on Trauma: Vascular Trauma Revisited

**PRESIDING OFFICER AND INTRODUCTOR:** Michael F. Rotondo, MD, FACS, Greenville, NC
**LECTURER:** David V. Feliciano, MD, FACS, Atlanta, GA

Sponsored by the Committee on Trauma

**NL06 2:45–3:45 pm**
Olga M. Jonasson Lecture: Women in the Professions

**PRESIDING OFFICER AND INTRODUCTOR:** Hilary A. Sanfey, MB BCh, FACS, Springfield, IL
**LECTURER:** Nina Totenberg, Washington, DC

Sponsored by the Women in Surgery Committee

WEDNESDAY, OCTOBER 6

**NL07 9:45–10:45 am**
Ethics and Philosophy Lecture: Is There a Role for Race in Science and Medicine?

**PRESIDING OFFICER AND INTRODUCTOR:** Robin S. McLeod, MD, FACS, Toronto, ON
**LECTURER:** Clive O. Callender, MD, FACS, Washington, DC

Sponsored by the Committee on Ethics

**NL08 11:30 am–12:30 pm**
Commission on Cancer Oncology: Immunotherapy and Gene Therapy for Patients with Cancer

**PRESIDING OFFICER AND INTRODUCTOR:** Stephen B. Edge, MD, FACS, Buffalo, NY
**LECTURER:** Steven A. Rosenberg, MD, PhD, Bethesda, MD

Sponsored by the Commission on Cancer

**NL09 2:30–3:15 pm**
I. S. Ravdin Lecture in Basic Sciences: Cancer Immunotherapy—Where Are We Heading?

**PRESIDING OFFICER AND INTRODUCTOR:** T. Forcht Dagi, MD, MPh, Mts, FACS, FCCM, Newton Centre, MA
**LECTURER:** Ian Frazer, MB, Chb, MD, Woolloongabba, Australia

Sponsored by the Committee on Perioperative Care

**NL10 2:30–3:30 pm**
Herand Abcarian Lecture: Radical Reform or Gentle Tweaking?—The Cure to Challenges in Resident Education

**PRESIDING OFFICER AND INTRODUCTOR:** Patricia L. Roberts, MD, FACS, Burlington, MA
**LECTURER:** Richard K. Reznick, MD, MEd, FACS, FRCS, Toronto, ON

Sponsored by the Advisory Council for Colon and Rectal Surgery

**NL11 3:00–4:00 pm**
Distinguished Lecture of the International Society of Surgery: Ethics and Errors in Surgery

**PRESIDING OFFICER AND INTRODUCTOR:** Ronald V. Maier, MD, FACS, Seattle, WA
**LECTURER:** Alberto R. Ferreres, MD, MPH, PhD, JD, FACS, Buenos Aires, Argentina

Sponsored by the International Society of Surgery
Postgraduate Courses

Postgraduate Courses and Fees
Only registered meeting attendees may purchase postgraduate course tickets. Seating capacities are limited, and ticket requests will be filled on a first-come, first-processed basis. All courses require a ticket for admission. Postgraduate course tickets may also be purchased on site in Washington, DC, subject to availability. No refunds for postgraduate courses will be accepted after Thursday, September 30, 2010. However, tickets may be exchanged for another course prior to the start of the course and only if room is available.

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<tr>
<th>DESCRIPTION OF FEE CATEGORIES</th>
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<tbody>
<tr>
<td>FELLOW:</td>
<td>A surgeon who is a Fellow of the College</td>
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<tr>
<td>NON-FELLOW:</td>
<td>A practicing physician who is not currently a member of the College</td>
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<td>RAS:</td>
<td>Associate Fellows, Resident Members, Medical Student Members, and Affiliate Members of the College</td>
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<tr>
<td>NON-RAS:</td>
<td>A physician in training or member of the surgical team who is currently in an accredited training program or working in a surgical-related setting, but has no affiliation with the College</td>
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ACS System for Verification of Knowledge and Skills
The Board of Regents of the American College of Surgeons has approved a five-level model for verification and documentation of knowledge and skills by the Division of Education, following participation in the educational programs of the College. The model provides a framework for designing and implementing educational courses, based on principles of contemporary surgical education, and permits provision of appropriate documentation to the attendees.

The postgraduate didactic and skills courses offered at the Clinical Congress have been assigned verification levels based on the requirements of each level.

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<td>Verification of satisfactory completion of course objectives</td>
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<td>III</td>
<td>Verification of knowledge and skills</td>
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<td>IV</td>
<td>Verification of preceptorial experience</td>
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<td>V</td>
<td>Verification of demonstration of satisfactory patient outcomes</td>
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### Postgraduate Courses

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<td>Fundamentals of Breast Imaging for the General Surgeon</td>
<td>$290</td>
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<td>NA</td>
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<td>$370</td>
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<td>Techniques in the Management of Venous Disease in the 21st Century</td>
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<td>Surgeons as Effective Communicators: Sharpening Skills for Critical Moments</td>
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<td>Thyroid and Parathyroid Ultrasound</td>
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<td>Building Strong Coding Skills (Basic Course)</td>
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<td>Power Case Coding for Surgeons (Advanced Course)</td>
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<td>Getting Out of Trouble during Open Vascular and Endovascular Procedures</td>
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<td>General Surgery Review Course</td>
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<td>Challenging Surgical Emergencies: What to Do in the Middle of the Night</td>
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Please register online for any of these Postgraduate Didactic or Skills-Oriented Courses.
### Postgraduate Skills-Oriented Courses

#### SC01 Surgical Education: Principles and Practice
- **6 credits, Verification Level I**
- **Track:** EDU
- **Saturday, October 2**
- 9:00 am – 4:30 pm
- **Chair:** Anne T. Mancino, MD, FACS, Little Rock, AR
- **Co-Chair:** Guy F. Brisseau, MD, FACS, FRCS, Halifax, NS
- Sponsored by the Committee on Continuous Professional Development

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#### SC02 Fundamentals of Breast Imaging for the General Surgeon
- **4 credits, Verification Level I**
- **Track:** GEN
- **Sunday, October 3**
- 7:30 am – 11:45 am
- **Chair:** Darius S. Francescatti, MD, FACS, Chicago, IL
- Sponsored by the National Ultrasound Faculty

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#### SC03 Ultrasound Course for Residents
- **5 credits, Verification Level II**
- **Track:** RES/MED
- **Sunday, October 3**
- 7:30 am – 1:00 pm
- **Chair:** Amy C. Sisley, MD, FACS, Baltimore, MD
- **Co-Chair:** Sarah B. Murthy, MD, FACS, Baltimore, MD
- Sponsored by the National Ultrasound Faculty and the Program Committee

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#### SC04 Flexible GI Endoscopy for General Surgeons
- **8 credits, Verification Level II**
- **Track:** GEN
- **Sunday, October 3**
- 8:00 am – 5:30 pm
- **Chair:** Jeffrey M. Marks, MD, FACS, Cleveland, OH
- **Co-Chair:** Brian Dunkin, MD, FACS, Houston, TX
- Sponsored by the Committee on Emerging Surgical Technology and Education

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#### SC05 Humanitarian Surgery: Surgical Skills Training for the International Volunteer Surgeon
- **6 credits, Verification Level I**
- **Track:** HUM
- **Sunday, October 3**
- 8:30 am – 4:30 pm
- **Chair:** Sherry M. Wren, MD, FACS, Palo Alto, CA
- **Co-Chair:** Kathleen M. Casey, MD, FACS, Newport, RI
- Sponsored by Operation Giving Back

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#### SC06 Fundamentals of Laparoscopic Surgery
- **4 credits, Verification Level I**
- **Track:** GEN
- **Sunday, October 3**
- 8:00 am – 12:30 pm
- **Chair:** Brent D. Matthews, MD, FACS, St. Louis, MO
- **Co-Chair:** Daniel J. Scott, MD, FACS, Dallas, TX
- Sponsored by the Committee on Emerging Surgical Technology and Education

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#### SC07 Laparoscopic Colon and Rectal Surgery
- **Lectures Only:** 6 credits, Verification Level I
- **Track:** CRS
- **Sunday, October 3**
- 9:00 am – 4:30 pm
- **Lectures and Hands-On Lab:** 9 credits, Verification Level II
- **Sunday, October 3:** 9:00 am – 4:30 pm
- **Monday, October 4:** 10:00 am – 2:30 pm
- **Lab:**

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### SC07 High-Risk Breast Cancer Management from A to Z
- **4 credits, Verification Level I**
- **Track:** GEN
- **Sunday, October 3**
- 12:30 – 4:45 pm
- **Chair:** Nora M. Hansen, MD, FACS, Chicago, IL
- **Co-Chair:** Megan K. Baker, MD, FACS, Charleston, SC
- Sponsored by the Program Committee

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For registration and more information, go to [www.facs.org](http://www.facs.org)
SC08 Funding Your Research
6 credits, Verification Level I
TRACK: BTR
Monday, October 4
10:00 am–5:30 pm
CHAIR: Leigh A. Neumayer, MD, FACS, Salt Lake City, UT
CO-CHAIR: Robert W. Thompson, MD, FACS, St. Louis, MO
Sponsored by the Surgical Research Committee
FEE FELLOW...$340 NON-FELLOW ......$395
RAS ........... $105 NON-RAS............. $135

SC09 Techniques in the Management of Venous Disease in the 21st Century
6 credits, Verification Level I
TRACK: VAS, GEN
Monday, October 4
10:00 am–5:30 pm
CHAIR: Joann M. Lohr, MD, FACS, Cincinnati, OH
CO-CHAIR: Robert M. McLafferty, MD, FACS, Springfield, IL
Sponsored by the Advisory Council for Vascular Surgery
FEE FELLOW...$340 NON-FELLOW ......$395
RAS ........... $105 NON-RAS............. $135

SC10 FAST Ultrasound Skills Course
4 credits, Verification Level II
TRACK: GEN, TRA
Monday, October 4
1:00–5:15 pm
CHAIR: Dan A. Galvan, MD, FACS, Palmyra, PA
CO-CHAIR: Heidi Frankel, MD, FACS, Hershey, PA
PREREQUISITE: Completed basic ultrasound course.
Available options to meet the prerequisite are:
1. Completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons.
3. Completion of a comparable course elsewhere. Please include either a CME Certification or a Certificate of completion with your registration. Equivalent ultrasound courses are subject to approval by the National Ultrasound Faculty.
Sponsored by the Program Committee
FEE FELLOW...$400 NON-FELLOW ......$460
RAS ........... $120 NON-RAS............. $160

SC11 Ultrasound Instructors Course
4 credits, Verification Level III
TRACK: GEN
Monday, October 4
1:00–5:15 pm
CHAIR: Reid Adams, MD, FACS, Charlottesville, VA
PREREQUISITE: Formal application required. E-mail skillscourses@facs.org for application form.
Sponsored by the National Ultrasound Faculty
FEE FELLOW...$525 NON-FELLOW ......$605

SC12 Single-Port Laparoscopic Surgery
LECTURES ONLY: 3 credits, Verification Level I
Tuesday, October 5
7:30 am–12:15 pm
LECTURES AND BASIC OR ADVANCED HANDS-ON LAB: 6 credits, Verification Level II
Tuesday, October 5
7:30 am–4:30 pm
TRACK: GEN
CHAIR: Deborah A. Nagle, MD, FACS, Boston, MA
CO-CHAIRS: James K. Elsey, MD, FACS, Lawrenceville, GA
Paul G. Cuccillo II, MD, FACS, Philadelphia, PA
Sponsored by the Program Committee
FEE FELLOW...$400 NON-FELLOW ......$460
RAS ........... $120 NON-RAS............. $160

SC13 Ultrasound in the Surgical ICU
8 credits, Verification Level II
TRACK: GEN
Tuesday, October 5
8:00 am–5:30 pm
CHAIR: Heidi M. Frankel, MD, FACS, Hershey, PA
CO-CHAIR: Amy Sisley, MD, FACS, Baltimore, MD
PREREQUISITE: Completed basic ultrasound course.
Available options to meet the prerequisite are:
1. Completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons.
3. Completion of a comparable course elsewhere. Please include either a CME Certification or a Certificate of completion with your registration. Equivalent ultrasound courses are subject to approval by the National Ultrasound Faculty.
Sponsored by the National Ultrasound Faculty
FEE FELLOW...$895 NON-FELLOW ... $1,030
RAS ........... $270 NON-RAS............. $360
**SC14** Vascular Ultrasound: Current Applications and Laboratory Management
7 credits, Verification Level III

**TRACK:** VAS
Tuesday, October 5
8:30 am–5:00 pm

**CHAIR:** David C. Han, MD, FACS, Hershey, PA

**CO-CHAIR:** R. Eugene Zierler, MD, FACS, Seattle, WA

**PREREQUISITE:** Completed basic ultrasound course.

Available options to meet the prerequisite are:
1. Completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons.
3. Completion of a comparable course elsewhere. Please include either a CME Certification or a Certificate of completion with your registration. Equivalent ultrasound courses are subject to approval by the National Ultrasound Faculty.

**Sponsored by the National Ultrasound Faculty**

**FEE**
FELLOW .... $395  NON-FELLOW ...... $495
RAS ....... $125  NON-RAS .......... $175

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**SC15** Surgeons as Effective Communicators: Sharpening Skills for Critical Moments
6 credits, Verification Level I

**TRACK:** EDU, GEN
Tuesday, October 5
10:00 am–5:30 pm

**CO-CHAIR:** L. D. Britt, MD, MPH, FACS, Norfolk, VA

**CO-CHAIR:** Thomas R. Gadacz, MD, FACS, St. Petersburg, FL

**Sponsored by the Division of Education**

**FEE**
FELLOW..... $340  NON-FELLOW ...... $395
RAS ....... $105  NON-RAS .......... $155

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**SC16** Surgical Palliative Care: Basic Clinical Skills Course
6 credits, Verification Level I

**TRACK:** GEN, ONC
Wednesday, October 6
8:00 am–3:30 pm

**CHAIR:** Geoffrey P. Dunn, MD, FACS, Erie, PA

**CO-CHAIR:** David E. Weissman, MD, FACP, Milwaukee, WI

**Sponsored by the Task Force on Surgical Palliative Care**

**FEE**
FELLOW..... $340  NON-FELLOW ...... $395
RAS ....... $105  NON-RAS .......... $155

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**SC17** Thyroid and Parathyroid Ultrasound
7 credits, Verification Level II

**TRACK:** GEN, OTO
Wednesday, October 6
8:00 am–4:30 pm

**CHAIR:** Robert A. Sofferman, MD, FACS, Burlington, VT

**PREREQUISITE:** Registrants must have completed the CD-ROM course, Ultrasound for Surgeons: The Basic Course, 2nd Edition. The CD-ROM may be ordered online, by phone, or by a mail-order form. Please visit [http://www.facs.org/education/usCDROM.html](http://www.facs.org/education/usCDROM.html) for details.

**Sponsored by the Committee on Emerging Surgical Technology and Education and the National Ultrasound Faculty**

**FEE**
FELLOW .. $1,300  NON-FELLOW ... $1,495
RAS .......... $390  NON-RAS ............ $520
Postgraduate Didactic Courses

PG18 Building Strong Coding Skills (Basic Course)
7 credits, Verification Level I

TRACK: HP
Saturday, October 2
8:00 am–4:30 pm
CHAIR: Albert Bothe, Jr., MD, FACS, Danville, PA
CO-CHAIR: John T. Preskitt, MD, FACS, Dallas, TX
Sponsored by the General Surgery Coding and Reimbursement Committee

FEE
FELLOW......$390  NON-FELLOW ......$450
RAS ..............$120  NON-RAS.............$155

PG19 Benign Anorectal Disease
6 credits, Verification Level I

TRACK: CRs
Saturday, October 2
9:00 am–4:30 pm
CHAIR: W. Donald Buie, MD, FACS, FRCSC, Calgary, AB
CO-CHAIR: Kirsten B. Wilkins, MD, FACS, FASCRS, Edison, NJ
Sponsored by the Advisory Council for Colon and Rectal Surgery

FEE
FELLOW......$340  NON-FELLOW ......$395
RAS ..............$105  NON-RAS.............$135

PG20 Power Case Coding for Surgeons (Advanced Course)
7 credits, Verification Level I

TRACK: HP
Sunday, October 3
8:00 am–4:30 pm
CHAIR: Mark T. Savarise, MD, FACS, Sandpoint, ID
CO-CHAIR: Albert Bothe, MD, FACS, Danville, PA
Sponsored by the General Surgery Coding and Reimbursement Committee

FEE
FELLOW......$405  NON-FELLOW ......$470
RAS ..............$125  NON-RAS.............$165

PG21 Getting Out of Trouble during Open Vascular and Endovascular Procedures
6 credits, Verification Level I

TRACK: VAS
Sunday, October 3
9:00 am–4:30 pm
CHAIR: Thomas C. Bower, MD, FACS, Rochester, MN
CO-CHAIR: Darren B. Schneider, MD, FACS, San Francisco, CA
Sponsored by the Advisory Council for Vascular Surgery

FEE
FELLOW......$340  NON-FELLOW ......$395
RAS ..............$105  NON-RAS.............$135

PG22 General Surgery Review Course
12 credits, Verification Level II

TRACK: GEN
Monday, October 4
10:00 am–5:30 pm
Tuesday, October 5
8:00 am–3:30 pm
CHAIR: John A. Weigelt, MD, FACS, Milwaukee, WI
VICE-CHAIR: Eugene F. Foley, MD, FACS, Madison, WI
VICE-CHAIR: Robert C. McIntyre, Jr., MD, FACS, Aurora, CO
Sponsored by the Division of Education in collaboration with the Southeastern Surgical Congress and Southwestern Surgical Congress

FEE
FELLOW......$700  NON-FELLOW ......$805
RAS ..............$210  NON-RAS.............$280

PG23 Practice Management: Pay for Reporting
4 credits, Verification Level I

TRACK: HP
Tuesday, October 5
8:00 am–12:15 pm
CHAIR: Christopher K. Senkowski, MD, FACS, Savannah, GA
CO-CHAIR: Pamela A. Howard, MD, MBA, FACS, Little Rock, AR
Sponsored by the General Surgery Coding and Reimbursement Committee

FEE
FELLOW......$290  NON-FELLOW ......$335
RAS ..............$90  NON-RAS.............$115

PG24 Challenging Surgical Emergencies: What to Do in the Middle of the Night
6 credits, Verification Level I

TRACK: GEN, TRA
Wednesday, October 6
8:00 am–3:30 pm
CHAIR: Michael J. Sise, MD, FACS, San Diego, CA
CO-CHAIR: Charles M. Ferguson, MD, FACS, Boston, MA
Sponsored by the Advisory Council for General Surgery and Committee on Trauma

FEE
FELLOW......$340  NON-FELLOW ......$395
RAS ..............$105  NON-RAS.............$135

6 credits, Verification Level II

TRACK: VAS
Wednesday, October 6
8:00 am–3:30 pm
CHAIR: Joseph L. Mills, MD, FACS, Tucson, AZ
CO-CHAIR: Linda M. Harris, MD, FACS, Buffalo, NY
Sponsored by the Advisory Council for Vascular Surgery

FEE
FELLOW......$390  NON-FELLOW ......$450
RAS ..............$120  NON-RAS.............$155

For registration and more information, go to www.facs.org
Meet-the-Expert Luncheons

Discuss selected topics with experts over an informal lunch. Cost for each luncheon is $45. The luncheons will be from 1:15 to 2:15 pm.

**MONDAY, OCTOBER 4**

| ME101 | Primary Hyperparathyroidism with Martha A. Zeiger, MD, FACS |
| ME102 | Changing Paradigms in the Treatment of Diverticulitis with Jeffrey L. Cohen, MD, FACS |
| ME103 | Laparoscopic Colectomy: Tips and Tricks with James W. Fleshman, MD, FACS |
| ME104 | Alternatives in Treatment of Anorectal Fistula Disease with Herand Abcarian, MD, FACS |
| ME105 | Navigating an Academic Career with O. Joe Hines, MD, FACS |
| ME106 | Vascular Surgery Databases with Jens Eldrup-Jorgensen, MD, FACS |
| ME107 | Discussion of Interesting Pancreas Cases with Mark P. Callery, MD, FACS |
| ME108 | Using Ultrasound in Thyroid and Parathyroid Operations with Allan Siperstein, MD |
| ME109 | Tricks and Traps of Neuromonitoring for Thyroidectomy with Gregory W. Randolph, MD, FACS |

**TUESDAY, OCTOBER 5**

| ME201 | Diverticulitis with David J. Schoetz, MD, FACS |
| ME202 | Thyroid Cancer with Nancy D. Perrier, MD, FACS |
| ME203 | Pilonidal Disease with Thomas H. Bascom, MD |
| ME204 | Managing Thoracic Outlet Disease with Robert W. Thompson, MD, FACS |
| ME205 | Treatment of Barrett’s Esophagus: Medical vs. Surgical with John G. Hunter, MD, FACS |
| ME207 | Robotic Laparoscopic Surgery with Pier C. Giulianotti, MD, FACS |
| ME208 | Anal Fistula Disease with Clyde N. Ellis, MD, FACS |
| ME209 | Evaluation and Acute Care of the Severly Injured Patient with Ronald V. Maier, MD, FACS |
| ME210 | Difficult Ostomies with Harry T. Papaconstantinou, MD, FACS |
| ME211 | How to Escape Abdominal Disasters with David M. Mahvi, MD, FACS |

**WEDNESDAY, OCTOBER 6**

| ME301 | Crohn’s Disease with Fabrizio Michelassi, MD, FACS |
| ME302 | Novel Treatments for Hemorrhoids with H. Randolph Bailey, MD, FACS |
| ME303 | Anal Dysplasia: What to Do? with Bard C. Cosman, MD, FACS |
| ME304 | Current Therapy in Thoracoabdominal Aortic Aneurysm Repair with Charles W. Acher, MD, FACS |
| ME305 | Liver Resection for Cancer with Yuman Fong, MD, FACS |
| ME306 | Appendicitis or Surgical Disease with Rodney J. Mason, MD, FACS |
| ME307 | Can a Low Volume Pancreas Surgeon Still Operate? with Thomas J. Howard, MD, FACS |
| ME308 | NOTES: What’s the Hype? with Eric S. Hungness, MD, FACS |
| ME309 | Current Status of Minimally Invasive Parathyroidectomy with Sally E. Carty, MD, FACS |
| ME310 | Thyroid Cancer: When to Do Lymph Node Dissection with Quan-Yang Duh, MD, FACS |
| ME311 | Teaching Old Dogs New Tricks: The Challenge of Introducing New Procedures into Your Surgical Practice with Craig S. Derkay, MD, FACS |
Special Interest Sessions

Please note, these are non-CME designated sessions, unless otherwise indicated.

Sunday, October 3

Medical Student Program
Session I: 12:00 noon–6:00 pm
The Division of Education invites students from all four years of medical school to attend the Clinical Congress and to participate in a program designed specifically for medical students who may be interested in pursuing a career in surgery. Additional sessions are scheduled on Monday and Tuesday. Students must be enrolled in a U.S., Canadian, or international allopathic or osteopathic medical school in order to participate. For additional information, please contact Ms. Laura Meyer at 312-202-5335 or laurameyer@facs.org. Please register online at www.facs.org.

Resident and Associate Society Symposium
1:00–4:00 pm
RAS Symposium 2010: A Great Debate “Do More Requirements Make a Better Surgeon?”
Training and certification requirements are constantly changing. When will they end? How much should it take to maintain credibility in your field? Who is setting the standards and how are they measuring performance outcomes? Are there evidence based reasons for recertification? Are we going to continue to prove our credentialing to government agencies?
Do we have objective evidence that additional exams and skills tests reduce mortality and morbidity? Join us for this lively debate and panel discussion.
For additional information, please contact Ms. Peg Haar at 312-202-5312 or phaar@facs.org.

Monday, October 4

Surgery Resident Program
Essential Skills for Surgical Practice: A Primer for Residents
10:00 am–4:00 pm
Surgery residents from all postgraduate year levels are invited by the Division of Education to participate in a special program designed to assist surgery residents with essential nonclinical issues they face during residency training and the transitional period to their posttraining career. For additional information, please contact Ms. Cheryllyn Sherman at 312-202-5424 or csherman@facs.org. Please register online at www.facs.org.

Meet-the-Expert Luncheons
1:15–2:15 pm
Cardiothoracic Surgery in the Future: Technology Overview for Residents and Medical Students
5:30–9:00 pm • Fee: $25 (includes dinner)
COURSE DIRECTORS:
Daniel L. Miller, MD, FACS, Atlanta, GA
James I. Fann, MD, FACS, Stanford, CA
This course will introduce surgery residents and medical students to conventional and less invasive procedures that are available to cardiothoracic surgeons today and provide information about new technologies and the integrated cardiothoracic surgery training programs. The primary focus of the session will be hands-on experience with specific cardiothoracic surgical procedures. Participants will experience and have the opportunity to perform these procedures using surgical simulators. The program will be taught by surgeons who are leaders in conventional and less invasive cardiac and general thoracic surgery.
Sponsored by the American College of Surgeons, the Society of Thoracic Surgeons, and the American Association for Thoracic Surgery. Please refer to the registration section of the ACS website at www.facs.org.
Tuesday, October 5

Town Hall Meetings
7:00–7:45 am
TH01: The Future of General Surgery
TH02: Using NSQIP to Improve Your Surgical Outcomes: An Update of New Advances
TH03: Palliative Care: What Does It Mean for Surgeons?
TH04: Health Care Reform: Are We Neglecting the Future of Surgery?
TH05: What Is the Value of Accreditation?

Polishing Your Interview Style: Preparing for the NRMP Match
8:00–9:45 am
This session will be moderated by Kim Agretto, C-TAGME, Past-President of the Association of Residency Coordinators in Surgery. For more details regarding this session, please refer to the ACS 2010 Clinical Congress website.

2010 Excellence in Research Award Distribution/Surgical Forum Dedication
How to Be Successful in the Competitive World of Grant Writing
2:30–5:45 pm
The Committee for the Forum on Fundamental Surgical Problems will distribute awards for excellence in research in the following categories: alimentary tract, critical care, genetic determinants of disease and outcomes, geriatric surgery, orthopaedic surgery, plastic/maxillofacial surgery, quality, outcomes and costs, surgical education, targeted therapies, urology, and vascular surgery. In addition, the 61st volume of the Owen H. Wangensteen Surgical Forum will be dedicated to Frank W. LoGerfo, MD, FACS, Boston, MA. Introduction will be made by C. Keith Ozaki, MD, FACS, with remarks from Dr. LoGerfo immediately following. The session will then proceed with the scientific presentations as scheduled.

Medical Student Program
Session III: 1:00–6:00 pm
For a brief description of this program, please refer to the Sunday schedule.

Meet-the-Expert Luncheons
1:15–2:15 pm

Posters of Exceptional Merit Presentation
1:15–2:15 pm
All attendees are invited to join in a lunchtime tour and discussion of the Posters of Exceptional Merit, facilitated by Barbara L. Bass, MD, FACS, Chair of the Program Committee. More than 325 posters will be on display at the Clinical Congress, but only a select few are designated Posters of Exceptional Merit. Come hear the authors of these distinguished works present their research and answer questions, prior to the judges awarding one poster the title of Best Scientific Exhibit.

Chapter Showcase
2:00–4:30 pm
“How We Do It”
This year’s Chapter Showcase will feature several “how we do it” sessions. Chapter-management topics will be presented by Chapter leaders and staff, including:
- managing membership databases for dues, registration, and communications
- rescuing “at risk” Chapters
- planning for successful leadership transitions
All Chapter leaders are invited to attend—Presidents, Presidents-Elect, Secretaries, Editors, and Chapter staff. In addition, specialty society leaders who have an interest in association-management topics are welcome to attend. Please join us for a program that will help strengthen your Chapter’s activities.

Seventh Annual Rural Surgeons Meeting and Oweida Scholarship Presentation
4:15–5:45 pm
This session opens with the recognition of the 2010 Nizar N. Oweida Scholarship recipient, Fernando A. Navarro, MD, FACS, a practicing rural general surgeon, in Norway, ME.

The Rural Surgery Subcommittee of the Advisory Council for General Surgery’s mission is “To improve the patient’s access to quality surgical care in the rural setting by identifying and addressing the needs of surgeons in this unique environment.” Meeting this mission requires regular and ongoing communication between rural surgeons and the leadership of the College. Members of the Rural Surgery Subcommittee, together with other leaders of the American surgical profession, will comprise a panel designed to hear and respond to your input. In this era of health care reform, it is crucial that rural general surgeons speak for our patient constituency in a manner that the College’s leadership can understand, and then to transmit clearly to policy makers. This is not the time to sit quietly on the sidelines and let the contributions of rural general surgeons to the overall health care of their communities be overlooked. Please attend and contribute to this open forum.

Wednesday, October 6

Town Hall Meetings
7:00–7:45 am
TH06: Policy, Presence, and Political Action
TH07: International Relations Committee
TH08: The Relevancy of Cancer Staging

The ACS Response to the Haiti Earthquake and Lessons Learned
1:15–2:15 pm
Open Microphone Session—please refer to the Clinical Congress website for more details.

Meet-the-Expert Luncheons
1:15–2:15 pm

Thursday, October 7

Town Hall Meetings
7:00–7:45 am

JULY 2010 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
Air Transportation

ACS has arranged special meeting discounts on United Airlines. These special discounts are available by booking with United directly (independently or through a travel agent). Be sure to reference the ACS file number below to obtain the special fares. Area/Zone fares based on geographic location are also available with no Saturday night stay required. Minimum stay (two nights); seven-day advance purchase required. Zone fares are not available through online ticket purchase; please call United Airlines at:

United Airlines
800-521-4041
8:00 am–10:00 pm ET
ACS File: 501CR
www.united.com

Purchase your ticket online at united.com and receive a discount off the lowest applicable fares.

International Attendees

Visa Information

International Fellows, guest physicians, and meeting attendees: Please be aware that the process of obtaining a visa to attend meetings in the U.S. takes much longer than in the past. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting. For detailed information regarding the Visa Waiver Program (VWP), please visit the U.S. Homeland Security Web site at http://travel.state.gov/visa/temp/without/without_1990.html#.

You may request a letter from the College welcoming you to the meeting if you feel this will be helpful by contacting the International Liaison Section via e-mail at: postmaster@facs.org or by fax at: 312-202-5021.

International Travel Packages

In an effort to improve the level of services provided to our international attendees, ACS has appointed ESA Voyages of Paris as the official international travel provider. Working directly with corporate travel departments and your preferred travel agent, ESA will provide full service travel packages for international guests. Packages include full-service air inclusive or ground-only travel packages to fit the needs of both individual travelers and groups. All of the packages include hotel stay, daily American breakfast, airport transfers in Washington, DC, travel assistance during the meeting, and on-site registration material delivery coordination.

For additional information regarding international travel packages, please visit www.esavoyages.fr or contact:

Yves Grandjean
8 rue de Malabry
92350 Le Plessis Robinson
Phone: (33) 1 41 28 13 00
Fax: (33) 1 46 32 66 21
E-Mail: esa@esavoyages.fr

Car Rental

Avis is designated as the official car rental company for the 2010 Clinical Congress. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

Avis Reservations
800-331-1600
www.avis.com
AWD Number: B169699

Affiliate Group Functions

Groups planning a social function or business meeting to be held in conjunction with the Clinical Congress will need to make arrangements through ACS. For more information and to request function space, please contact Carrie Balzer, ACS Convention and Meetings, at cbalzer@facs.org.
Who Should Attend and What’s Included?

Registration is open to all physicians and individuals in the health care field and includes a name badge, program book, and entrance to the exhibits and all sessions, other than postgraduate courses and Meet-the-Expert Luncheons. To review the full registration policies and submit your 2010 Clinical Congress registration, please visit our Web site at http://www.facs.org/clincon2010/registration/index.html.

Registration questions:

Should you have any questions regarding Clinical Congress registration, please contact Registration Services. PHONE REGISTRATIONS ARE NOT ACCEPTED.

E-MAIL: registration@facs.org
PHONE: 312-202-5244
FAX: 312-202-5003

REGISTRATION LOCATION AND HOURS

<table>
<thead>
<tr>
<th>Location</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walter E. Washington Convention Center—Hall A</td>
<td>Sunday, October 3 7:00 am–6:00 pm</td>
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<tr>
<td></td>
<td>Monday, October 4 7:00 am–5:00 pm</td>
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<tr>
<td></td>
<td>Tuesday, October 5 6:30 am–4:00 pm</td>
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<tr>
<td></td>
<td>Wednesday, October 6 6:30 am–4:00 pm</td>
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<tr>
<td></td>
<td>Thursday, October 7 7:30–10:00 am</td>
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<tr>
<td>Marriott Wardman Park Hotel* (Advance Registration only)</td>
<td>Sunday, October 3 7:00 am–6:00 pm</td>
</tr>
<tr>
<td></td>
<td>Monday, October 4 7:00 am–5:00 pm</td>
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</tbody>
</table>

*The Marriott Wardman registration location will handle Advance Registration only. If you require on-site registration, ticket changes, or purchases, please visit On-Site Registration at the Walter E. Washington Convention Center during the times listed above.

REGISTRATION FEES AND CREDENTIALS

<table>
<thead>
<tr>
<th>Category</th>
<th>On or Before 8/16</th>
<th>8/17 – 10/2</th>
<th>On Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS Fellow (2010 dues paid)—</td>
<td>$150</td>
<td>$200</td>
<td>$275</td>
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<tr>
<td>Initiate</td>
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<td>No Fee</td>
<td>No Fee</td>
</tr>
<tr>
<td>Associate Fellow</td>
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<td>$275</td>
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<td>Resident Member</td>
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<tr>
<td>Medical Student Member</td>
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<td>No Fee</td>
<td>$15</td>
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<tr>
<td>Affiliate Member</td>
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<td>$95</td>
<td>$170</td>
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<td>Guest Physician*</td>
<td>$610</td>
<td>$660</td>
<td>$735</td>
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<tr>
<td>Resident Nonmember (with verification letter)†</td>
<td>$45</td>
<td>$45</td>
<td>$75</td>
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<tr>
<td>Medical Student Nonmember (with verification letter)†</td>
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<td>$25</td>
<td>$35</td>
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<td>Hospital Administrator (non-physician)*</td>
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<td>$575</td>
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<tr>
<td>Hospital Purchasing Agent*</td>
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<tr>
<td>Medical Association Personnel*</td>
<td>$350</td>
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<td>$475</td>
</tr>
<tr>
<td>Nurse Nonmember*</td>
<td>$350</td>
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<tr>
<td>Surgical Assistant Nonmember*</td>
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<td>$400</td>
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<td>Surgical Technician Nonmember*</td>
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<td>Allied Health Other</td>
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<tr>
<td>PhD Nonmember*</td>
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<tr>
<td>Commercial Press</td>
<td>$550</td>
<td>$600</td>
<td>$675</td>
</tr>
</tbody>
</table>

Commercial Representatives may obtain the commercial registration form by e-mailing a request to rsanders@facs.org.

—Retired Fellows fall under the ACS Fellow registration category for the Clinical Congress. Applicable registration fees apply.

*Nonmembers who pay the applicable registration fees will have their membership application fees waived if they apply for membership by December 31, 2010. The American College of Surgeons is pleased to offer discounted registration fees for residents and medical students. Please submit a letter verifying your educational status with the completed registration form to expedite processing. Residents should obtain a letter from their program director; students should contact their department chairs.

†Resident and Medical Student Membership

The College has membership opportunities for medical students and residents. Medical students must be attending a U.S., Canadian, or international allopathic or osteopathic medical school. There is a one-time fee of $20, which covers all four years of medical school. Membership will expire upon graduation from medical school. Residents enrolled in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or surgeons in surgical research or fellowship programs acceptable to the American College of Surgeons are eligible for Resident Membership. The application fee of $20 is waived for first-year residents. Annual dues thereafter are also $20. Nonmember medical students and residents that register for this meeting and meet the appropriate membership category requirements will be contacted to affirm their membership status.

Printable registration forms are available on the Web site.
In recent years, many non-physician health care providers have increased their efforts to expand their scope of practice to include treatments, procedures, and authority inconsistent with their education and training, through legislative, regulatory, and administrative means. If scope-of-practice expansions are inconsistent with the education and training a provider group receives, or are not coupled with safeguards—such as practice protocol arrangements with a physician who provides oversight of the care provided—the safety and quality of health care delivered to patients is compromised.

On the state level, scope-of-practice issues remain one of the top five state legislative priorities for the College. Over the course of many years, the College has worked with many state coalitions to educate legislators regarding the differences in education and training between medical doctors, doctors of osteopathy, and other health care professionals. In addition, the College has adopted statements related to scope of practice and the definition of surgery (these statements, ST-40 and ST-11, can be accessed at the following Web site: http://www.facs.org/fellows_info/statements/statement.html).

Expansion efforts

Numerous bills and proposals expanding the scope of practice for nonphysician providers are introduced each legislative session across the country in state houses or via the rulemaking authority of regulatory boards (see figure, this page). Commonly seen scope-of-practice expansions include independent prescriptive authority, independent practice, diagnostic and/or surgical authority, and other care privileges for which a nonphysician provider may not be educated or trained to safely and effectively provide.

Numerous examples exist of scope legislation the College has tracked over the years, including: podiatrists looking to expand their scope to operate above the foot, including the ankle, calf, and sometimes the knee; single-degree (Doctor of Dental Surgery) dentists interested in performing surgery on adjacent structures, including injections such as Botox and dermal fillers; physical therapists seeking to see patients independent of a medical referral from a physician; and optometrists seeking to expand their scope by including authority to dispense medicated lenses or perform surgery with lasers or scalps.

An example of scope-of-practice expansion legislation was introduced during the 2010 legislative session, when West Virginia optometrists sought expansion privileges that would have authorized optometrists to use lasers to perform glaucoma eye surgery; perform injection procedures; and advertise as, and refer to themselves as, “optometric
physicians.” After considerable debate, the final version of S.B. 230 signed into law stated that an optometrist licensed in the state may not do the following: perform surgery except as provided in the statute; use a therapeutic laser; use Schedule II controlled substances; treat systemic disease; or present to the public that he or she is a specialist in surgery of the eye or use the term “optometric physician.”

*Truth in medical education/truth in advertising*

Recently, legislative initiatives in a number of states have been implemented that include efforts to enact Truth in Medical Education (TIME) and/or Truth in Advertising (TIA) bills. This legislation highlights the importance for health care providers to clearly and honestly state their level of training, education, and licensure—on a name badge, in Internet or print advertising, and so on. Due to the explosion of professional and semiprofessional titles utilizing the term “doctor,” patients are often misled regarding the training and education of health care practitioners—and patients deserve to have this information when selecting a health care provider.

*Scope-of-practice partnership*

For medical organizations, coalitions form an important strategic component for dealing with difficult scope-of-practice issues at the state level. For many years, physician groups have come together as an organized front with specialty organizations, and they have stood together to uphold patient safety. One effective coalition was formed in 2006, when the College, in conjunction with the American Medical Association (AMA), various specialty organizations, and state medical societies, came together to create the Scope of Practice Partnership (SOPP). The purpose of the SOPP is to focus the resources of organized medicine to oppose nonphysician scope-of-practice expansions that threaten the health and safety of patients. The SOPP accomplishes its goals by a combination of legislative, regulatory, and judicial advocacy, as well as programs focused on information, research, and education. For example, the SOPP was recently involved in West Virginia’s optometric scope expansion effort, and supports TIME/TIA legislative initiatives.

The SOPP has created various resources that are used to address scope expansion legislation. One tool is the Scope of Practice Data Series, consisting of 10 modules that provide in-depth analysis on the education, training, and qualifications of various nonphysician providers. Another useful educational tool is the AMA geographic mapping initiative, which has been successful in addressing access to care arguments in scope of practice expansion efforts. This tool provides a clear visual comparison between the geographic practice locations for physicians and nonphysician health care practitioners, allowing legislators to determine for themselves the veracity of claims that scope expansion will increase access to care.

*Ongoing support for patient safety*

Scope-of-practice debates have serious implications for patient care, particularly as demand for health care services increases. The College is committed to ensuring patients are receiving the highest quality of care from properly trained and educated providers, and will continue to be dedicated to protecting patients by tracking scope-of-practice legislation and teaming with the SOPP.

Questions or comments about scope-of-practice issues may be sent to Alexis Walters, Regional State Affairs Associate, at awalters@facs.org.
Billing for E/M services during the global period

by Betsy Nicoletti, MS, CPC

Surgeons know that most services provided during the global period are not separately reportable (that is, payable) but, rather, are included in the global surgical payment for the surgical procedure performed. However, some services performed during the global period may be separately reported and paid. This article addresses evaluation and management (E/M) services that may be paid during the global period. E/M services that are eligible for payment during the global period include any services that meet the criteria for use with modifier –24, –25, or –57.

Modifier –24 is appended to an E/M service during the global period to indicate that the E/M service was unrelated to the surgery. It is for an unrelated E/M service provided by the same physician during a postoperative period. For example, a surgeon performs a hernia operation that has a 90-day global period on June 15. On July 29, the patient calls the office, concerned about a breast lump. The office visit for that service is correctly reported as an established patient visit with modifier –24, and a diagnosis of breast lump, clearly unrelated to the hernia operation. Modifier –24 is used when the original procedure had a 10- or 90-day global period. There would be no reason to use it for an E/M service after a procedure with 0 global days, because no follow-up is included in the payment for those procedures.

Modifier –25 is appended to an E/M service on the same day as a surgical procedure, with 0 or 10 global days to indicate that on the day of the procedure, a separate, significant E/M service was also performed. The Centers for Medicare & Medicaid Services (CMS) manual and the National Correct Coding Initiative (NCCI) both state that payment for deciding to perform a procedure is included in the payment for the procedure. An E/M service is only paid in addition to a procedure if significant, extra work was medically necessary, performed, and documented. For example, a patient who presents with skin tags or actinic keratoses for destruction would not require a separate E/M service. A patient who presented in a follow-up for a planned procedure, such as a biopsy or excision, would not require a separate E/M service. It would be appropriate to bill an E/M service for a patient who is seen in the hospital for a question of gastrointestinal bleeding with anemia. It would be necessary to evaluate the patient’s condition before deciding to do an endoscopic procedure. The same diagnosis is permitted.

Append modifier –57 to an E/M service to indicate that a major surgical procedure is planned for that day or the next day, and that it was during this visit that the surgeon decided to operate. For this purpose, a major operation is defined as one with a 90-day global period. The payment for a major surgical procedure includes reimbursement for all of the E/M services provided, beginning the day before the procedure, unless the visit was the one at which the surgeon decided to perform the surgery, and the patient is taken to surgery that day or the next. Do not use it if the surgery is scheduled for a later date. The E/M service may be an admission or consult, an office visit, or whatever category of code accurately describes the service.

These three modifiers—modifier –24, –25, and –57—bypass the payors’ claims editing systems and allow physician payment for services during the global period. It is important to understand the circumstances in which to use them from both a financial and a compliance perspective.

Did you know... that if every member of the American College of Surgeons Professional Association (ACSPA) contributed only $100 to the ACSPA-SurgeonsPAC (political action committee), it would be the largest medical PAC in the country and would be more than double the size of the trial lawyers’ PAC? For more information about the ACSPA-SurgeonsPAC, please visit http://www.facs.org/acspa_pac.

The Committee on Trauma (COT) announced the winners of the 33rd annual Residents Trauma Papers Competition at its annual meeting in Las Vegas, NV. The competition is open to surgical residents and trauma fellows. Submissions describe original research in the area of trauma care and/or prevention in one of two categories: basic laboratory research or clinical investigation. The competition is funded by the Eastern and Western States COTs, Region 7 (Iowa, Kansas, Missouri, and Nebraska), the National Trauma Institute, and the American College of Surgeons.

Submissions begin at the state or provincial level, and winners are then judged at regional competitions. Each region is then eligible to submit two abstracts to a panel of COT judges, who make the final selection for presentation at the Scientific Session of the COT meeting.

This year, 15 oral presentations were given at the session, which was moderated by M. Margaret Knudson, MD, FACS, Vice-Chair of the
COT and Chair of the COT Regional Committees. Each of the 15 presenters received a prize of $500, with an additional $500 awarded to the second-place winners in each category, and an extra $1,000 was awarded to the two first-place winners.

The oral presentations were given by these winners from the following COT regions: Chad M. Patton, MD, MS, Burlington, VT (Region 1); Arash Farahvar, MD, PhD, Rochester, NY (Region 2); CPT Ian R. Driscoll, MD, Washington, DC (Region 3); Thomas M. Schmelzer, MD, Charlotte, NC (Region 4); Angela L.F. Gibson, MD, PhD, Madison, WI (Region 5); Shnil K. Shah, DO, Houston, TX (Region 6); Christopher J. Cooper, MD, Columbia, MO (Region 7); John C. Eun, MD, Denver, CO (Region 8); Chirag Patel, MD, Phoenix, AZ (Region 9); Philibert Y. Van, MD, Portland, OR (Region 10); Ryan T. M. Mitchell, MD, BSc, Winnipeg, MB (Region 11); Barbara Haas, MD, Toronto, ON (Region 12); Captain Suzanne M. Gillern, MD, Washington, DC (Region 13); Guillermo Jose Borjas Salas, MD, Camarinas, Venezuela (Region 14); and Andrew B. Martin, BHB, MBCHb, Eliebeana, Australia (Region 16).

The 2010 final winners are as follows:

- **First Place, Basic Laboratory Research**: Angela L.F. Gibson, MD, PhD, Madison, WI (Region 5): Expression of an hBD-3 Transgene in Keratinocytes Using an Ex-Vivo, Non-Viral Strategy Produces an Antimicrobial Human Skin Substitute.
- **Second Place, Clinical Investigation**: Barbara Haas, MD, Toronto, ON (Region 12): Survival of the Fittest: Overcoming Survivor Bias in Evaluating the Transfer Process.
- **Second Place, Basic Laboratory Research**: Arash Farahvar, MD, PhD, Rochester, NY (Region 2): Transplantation of Glial-Restricted Progenitor Cells following Traumatic Brain Injury in the Rat.
- **Second Place, Clinical Investigation**: Thomas M. Schmelzer, MD, Charlotte, NC (Region 4): Vancomycin Intermittent Dosing versus Continuous Infusion for Treatment of Ventilator-Associated Pneumonia in Trauma Patients.

In addition to the oral presentations, the COT is pleased to announce that a poster session was added to the competition this year, with two first-place awards in the Basic Laboratory Research and Clinical Investigations categories. The participants in this inaugural poster session were as follows:

Dipan C. Patel, MD, Providence, RI (Region 1); Tyler J. Kenning, MD, Albany, NY (Region 2); Brian P Smith, MD, Philadelphia, PA (Region 3); Eric L. Long, MD, Macon, GA (Region 4); Thomas Sitzman, MD, Madison, WI (Region 5); Sasha D. Adams, MD, Houston, TX (Region 6); Jacob A. Quick, MD, Columbia, MO (Region 7); Todd W. Costantini, MD, San Diego, CA (Region 9); and Captain Danielle B. Holt, MD, Honolulu, HI (Region 13).

- **First Place, Basic Laboratory Research**: Dipan C. Patel, MD, Providence, RI (Region 1): Neutrophil Mechanosensing Regulates Effector Functions.
- **First Place, Clinical Investigation**: Tyler J. Kenning, MD, Albany, NY (Region 2): A Comparison of Hinge Cranietomy and Decompressive Cranietomy for the Treatment of Malignant Intracranial Hypertension: Need for Cranial Revision and Long-Term Clinical Outcomes.

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**Trauma meetings calendar**

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

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

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

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ Web site at [http://www.facs.org/trauma/cme/traumtgs.html](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312-202-5342.
JACS Editor-in-Chief named president-elect of ASA

Timothy J. Eberlein, MD, FACS, Editor-in-Chief of the Journal of the American College of Surgeons (JACS) and head of the department of surgery and director of the Alvin J. Siteman Cancer Center at Washington University School of Medicine and Barnes–Jewish Hospital, St. Louis, MO, has been elected to the top leadership post of the American Surgical Association (ASA). Dr. Eberlein is president-elect for the 2010–2011 year, and he will serve as president in 2011–2012.

Dr. Eberlein is the Bixby Professor of Surgery and the Spencer T. and Ann W. Olin Distinguished Professor at Washington University School of Medicine, and surgeon-in-chief at Barnes–Jewish Hospital. His research activities focus on tumor immunology and immune therapies, and he is an actively practicing breast surgeon. His bibliography of more than 300 titles includes original reports in peer-reviewed journals and contributions to many textbooks and monographs.

Before joining Washington University in 1998, Dr. Eberlein served as the Richard E. Wilson Professor of Surgery at Harvard Medical School, Boston, MA; and chief of the division of surgical oncology and vice-chairman for research in the department of surgery at Brigham and Women’s Hospital in Boston.

Dr. Eberlein is the recipient of numerous honors and awards, including the Hench Award from the University of Pittsburgh, PA, and the Sheen Award from the American College of Surgeons. In 2004, Dr. Eberlein was elected to the Institute of Medicine of the National Academy of Sciences.

Members in the news

David Chiu, MD, FACS, was awarded the Millesi Award during the Third Symposium on Peripheral Nerve Surgery, organized by Vienna’s Millesi Center for Peripheral Nerve Surgery. Dr. Chiu received the award for his life’s work in nerve surgery, particularly for his contributions to the research of peripheral nerves. Dr. Chiu is a professor of surgery (plastic surgery) and neurosurgery, and director of hand fellowship at New York University, NY.

Mimis Cohen, MD, FACS, professor and chief of plastic, reconstructive, and cosmetic surgery, University of Illinois, Chicago, was elected president of the American Society of Maxillofacial Surgeons.

Patrick J. Gullane, CM, MB, FACS, FRCSC, FRACS(Hon), FRCS(Hon), has been unanimously elected as an honorary fellow of the Royal College of Surgeons of England. Dr. Gullane, otolaryngologist-in-chief, University Health Network, department of otolaryngology–head and neck surgery, Toronto General Hospital, ON, was also selected to formally address the association’s diplomats during the meeting.

F. Michael Minch, MD, FACS, has been selected by the Tennessee Medical Association to serve as president-elect for 2010, and subsequently as president of the association in 2011. Dr. Minch, now retired, specialized in vascular surgery among diabetic patients.
What is the CSPS?

The CSPS is a unique multidisciplinary coalition of seven professional organizations representing key members of the surgical team:

- American Association of Nurse Anesthetists
- American Association of Surgical Physician Assistants
- American College of Surgeons
- American Society of Anesthesiologists
- American Society of PeriAnesthesia Nurses
- Association of periOperative Registered Nurses
- Association of Surgical Technologists

The CSPS envisions a world in which all patients receive the safest surgical care provided by an integrated team of dedicated professionals.

And why should you be interested?

- Because you want a caring perioperative workplace environment.
- Because you are concerned about the safety of your patients.
  - Because you want integrated teamwork and improved communication to result in better patient outcomes.
  - Because you care!

For more information, visit www.cspsteam.org, or call the CSPS Administrative Director, Denise Goode, at 312-202-5700

CSPS and CSPSteam.org offer:

- 18 Safe Surgery Principles, with online resources and literature covering topics from sharps safety to adequate rest periods
- A statement on violence in the workplace and downloadable slides of the topic, available to national organizations interested in promoting patient safety
- Valuable information for surgical patients: Go to “I’m a Patient” on CSPSteam.org
- Partnerships for safety, such as the Joint Commission Resources, Inc. and the cosponsored national conference on perioperative care and safety—Improving, Enhancing & Sustaining Positive Patient Outcomes—last year
- A Speaker Bureau offering audiences presentations on Violence in the Workplace and the Transfer of Patient Care
Midwest surgeon leaders engage in advocacy development at conference

by Alexis Walters, Regional State Affairs Associate, Division of Advocacy and Health Policy

The American College of Surgeons held the inaugural Midwest Regional State Advocacy Conference in April, at the College’s office in Chicago, IL. The meeting provided more than 20 chapter leaders, governors, administrators, and executive directors from seven chapters (including Illinois, Metro Chicago, Indiana, Iowa, Michigan, Minnesota, and Ohio) the opportunity to network, learn how to structure their chapter to maximize advocacy efforts, explore innovative ways to motivate chapter members, identify best practices for communicating with legislators, and consider programs on building effective legislative messages and coalitions.

The conference was held as a part of the College’s ongoing effort to enhance and support chapter advocacy in the Midwestern states. Alexis Walters, the Regional State Affairs Associate (and also the author of this article) was hired last September to work primarily with the chapters in Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, and Wisconsin. The goal of this position is to assist with the many varied aspects of state advocacy, including tracking and monitoring legislation, creating action alerts on proposed legislation to encourage Fellows to contact their legislators or take some other type of action, providing advocacy presentations at annual meetings or other appropriate venues, working directly with chapter councils to develop an advocacy infrastructure to support chapter advocacy initiatives, assisting with the planning of lobby days or other advocacy conferences, and preparing testimony for state legislative hearings.

Program highlights

Throughout the day-and-a-half conference, various topics were covered by a wide array of speakers. These presenters—who included College staff members, chapter Executive Directors, surgeon advocacy leaders, and staff members from the Illinois State Medical Society and the American Medical Association—represented a number of content perspectives.

At the beginning of the meeting, College staff members were available to provide attendees with an overview of the numerous College resources available to Fellows, such as the Surgery State Legislative Action Center (SSLAC) and the Advocacy page of the College’s Web portal. The SSLAC is a Web site used by ACS staff and Fellows...
to assist with grassroots advocacy efforts. Fellows can utilize the SSLAC to access state and federal representatives, contact legislators, track elections, and contact members of the media. The Web portal features a summary of the 400 pieces of legislation the College has been tracking throughout the 2010 legislative session, along with various other tools, including the opportunity for Fellows to network on advocacy via the advocacy message board.

Attendees were introduced to numerous state advocacy programs that can easily be implemented by the chapters. Kathy Browning, Executive Director of the Georgia Society of the American College of Surgeons; Brad Feldman, Executive Director of the Ohio Chapter; and Melinda Baker, ACS Senior State Affairs Associate, all discussed advocacy programs that could be instituted at the state level. These programs included state lobby days, “Doctor for the Day” programs, community health fairs, political action committee fundraisers (within state legal guidelines), and advocacy newsletters to establish regular communication with chapter members. Ms. Browning stressed that chapters can “start out small, but please start!”

Of particular interest for attendees was the question-and-answer session with Illinois State Sen. Kwame Raoul. Senator Raoul spoke about the importance of visiting with state and federal legislators in-district, as well as at the State house level.

“Anyone who thinks that legislators sit in their office and think of solutions—that’s bunk! I get to hear from people that have problems and have solutions,” Senator Raoul stated, when addressing the importance of meeting with legislators. Senator Raoul also placed an emphasis on the value of hearing personal stories from constituents, and provided several examples of how a personal story from a constituent had directly impacted the passage of legislation in the Illinois Senate.

After Senator Raoul covered effective methods to communicate with legislators, Ms. Browning spoke to the group regarding how to prepare an effective message to send to a legislator. During her presentation, Ms. Browning outlined five steps for developing a message, including:

- Identifying a target audience
- Identifying what will move the target audience
- Presenting your solution
- Presenting results of your position
- Explaining what makes you different from the “other side”

Philip Corvo, MD, FACS, an Alternate Governor for the Connecticut Chapter, closed out the conference by presenting ways to motivate chapter members. His presentation included a handout titled “Checklist for a Successful Chapter,” which included having a dedicated council with a common goal, collaboration with specialty societies, the formation of both a Membership Recruitment Committee and a Young Surgeons Committee, and a reminder to always have fun with your chapter members.

At the conclusion of the program, attendees were tasked with a challenge: pass along the importance of advocacy to at least one Fellow. Subinoy Das, MD, FACS, of the Ohio Chapter, accepted the challenge and added, “I was impressed with the quality and organization of the staff of the ACS and their devotion to protecting the welfare of our patients who need surgery. This conference has inspired me to increase my participation in supporting our state legislators on issues vital to the practice of surgery, and has given me many valuable tools to effectively and efficiently advocate for my patients.”

While the Midwest Regional State Advocacy Conference was focused on a geographically defined group of individuals, the advocacy development information covered during the conference is universal in application. All surgeons can benefit from a basic knowledge of advocacy, and by supporting their respective chapter advocacy activities.

For more information on the topics discussed in this article, including copies of handouts or presentations, contact Alexis Walters, Regional State Affairs Associate, at awalters@facs.org or 312-202-5446.
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College advocacy agenda advances through the AMA

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

The American College of Surgeons has developed a multifaceted approach to meeting the needs of patients and surgeons. The College’s organizational structure reveals a wide range of programs and services—education, research and optimal patient care, member services, advocacy and health policy, communications, and public relations—all focused on implementing the mission of the College.

Advocacy and health policy development, through federal legislation, state legislation, and regulation across all levels of government, is an essential role for the College. A seasoned staff in Washington, DC, and in Chicago, IL, carry out the College’s advocacy agenda by assisting Fellows in advocating for surgical issues, nurturing relationships with legislators and their staff, monitoring and responding to proposed regulations, providing expertise in policy development and legislative strategy, and communicating with Fellows about the critical elements of health policy issues.

Beyond the realm of government, the College influences health policy in other ways, such as participation in surgical coalitions focused on specific issues, and involvement in private sector quality initiatives like the Surgical Quality Alliance. Further, the College works within the American Medical Association (AMA) House of Delegates (HOD) to shape AMA policy.

Why is participating in the AMA’s policymaking process so important to advancing a surgical agenda? Perception is reality; policymakers turn to the AMA first when they are looking for information on health care policy, because the AMA is a well-known organization that is often viewed as representing the physician community as a whole. Strategically, it never hurts to have the backing of the AMA for advancement of surgical issues; when policymakers hear the same or similar answers to their questions from multiple sources, it helps to reinforce that message and enhances the legitimacy of a position or policy.

The College in the HOD

Currently, the College’s delegation to the AMA HOD effectively represents the College with six delegates, making it one of the larger national specialty societies in the HOD. In the past 10 years, the delegation has grown from one delegate to six, with additional representation in the Young Physicians Section and the Resident and Fellow Section. The College also provides the administrative infrastructure for the Surgical Caucus of the AMA, helping to enhance the broader voice of surgery within the HOD.

The size of a society delegation is determined by the number of common members (belonging to both AMA and the society) who vote for that society to represent them in the HOD. Every year, AMA members are reminded that they can vote at the AMA’s Web site for their specialty representation within the AMA. Many Fellows in the AMA do not take advantage of this opportunity to select the College to represent them at the HOD; in fact, they do not vote at all, significantly restricting the potential size of the College’s influence. If Fellows in the AMA took the three minutes that is required to vote for the ACS, the delegation would easily double or triple in size, and could become the largest society delegation in the HOD. Fellows who are AMA members should access the AMA’s specialty ballot Web site (which is password protected) via the following link: http://www.ama-assn.org/ama/no-index/about-ama/11232.shtml—and vote for the ACS!

Policy impact in the HOD

For the last 10 years, the ACS has introduced—either on its own or in coalition with numerous surgical specialty societies—resolutions calling for the adoption of policies that are important to surgeons. As a result, the following resolutions are now AMA policy:
Patient safety principles in office-based surgery
- Expert witness qualifications and expert witness affirmation statement
- Support for passage of the Uniform Emergency Volunteer Health Practitioners Act
- Investigation of solutions to on-call and emergency workforce issues
- Support for payment for ultrasound and other diagnostic services when performed by a qualified physician
- Study and support of disaster preparedness education and training in medical schools, graduate medical education programs, and continuing medical education

These policies have significantly helped to enhance surgery’s agenda on a wide range of issues, and have contributed to greater collaboration between the AMA and surgery.

Elections

Another way to influence policies through the AMA is to elect surgeons to various AMA councils. For example, the College regularly endorses surgeons running for various positions within the AMA. Five years ago, the College nominated Richard Reiling, MD, FACS, an ACS delegate to the AMA, for the Council on Medical Education. He was successfully elected to this council, and was re-elected for a second term last year. As a result of his position on this council, Dr. Reiling has served as a representative to the National Board of Medical Examiners, and now serves as vice-chair of the Board of Directors of the Accreditation Council for Continuing Medical Education.

Advocacy conference

Meeting with members of Congress is an integral part of advocacy, and many physician organizations plan advocacy events in Washington, DC. The College, along with many other national surgical societies, sponsors the Joint Surgical Advocacy Conference (this year scheduled for July 25–27.) For more information, go to http://www.facs.org/ahp/jsac2010.html.

Each year, during the spring, the AMA holds a National Advocacy Conference (NAC). This year, the ACS delegation to the HOD participated, for the first time, as a delegation to the NAC. Delegates used this opportunity to emphasize the need for the repeal of the sustainable growth rate with members of Congress.

Policy opportunities

The AMA House of Delegates met June 12–16, in Chicago, IL. The College’s delegation prepared for an active meeting of resolution review, testifying at reference committees, and advancing the College’s positions on a variety of issues. The consequences of federal health system reform dominated the meeting.

In addition, the College endorsed the campaigns of a number of surgeons: Peter Carmel, MD, FACS, for AMA president-elect; Steven Chen, MD, FACS, for Young Physicians Section delegate; Charles Hickey, MD, FACS, for re-election to the Council on Constitution and Bylaws; Peter Lund, MD, FACS, for the Council on Medical Service; and Thomas Peters, MD, FACS, for the Council on Science and Public Health. Results of this election and actions taken at the meeting will be reported in the Bulletin, in a future AMA HOD update.

The College delegation always welcomes input from Fellows who are AMA members. If you have comments or suggestions e-mail them to Jon Sutton, Manager, State Affairs, at jsutton@facs.org.
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2010 Japan and German Exchange Travelers announced

The International Relations Committee of the American College of Surgeons has established an exchange program with the Japan Surgical Society and the ACS Japan Chapter.

In early April, David Shibata, MD, of the H. Lee Moffitt Cancer Center, Tampa, FL, attended the annual meeting of the Japan Surgical Society in Nagoya, and visited several other Japanese surgical centers.

The Japan Exchange Traveler, Akihiko Soyama, MD, PhD, of Nagasaki University, Nagasaki, has been selected to attend the College’s Clinical Congress in Washington DC, in October. Dr. Soyama will give a presentation at the Congress and will tour several surgical institutions in North America. Dr. Soyama’s research concerns living-donor liver transplantation and hepatocellular carcinoma.

The German Surgical Society and the ACS Germany Chapter have also developed a similar exchange program with the College. Gregory J. Landry, MD, FACS, of the Oregon Health & Science University, Portland, was originally scheduled to attend the German Surgical Society’s annual meeting in Berlin in late April, but due to the volcanic eruptions in Iceland that month, he is now scheduled to make the trip to Germany in 2011, along with the next ACS Traveling Fellow.

His German counterpart, Prof. Thorsten Vowinkel, MD, of the University of Münster, will attend our Clinical Congress and choose several surgical sites to visit with the guidance of his mentors at home and in the U.S. Dr. Vowinkel’s research focuses on inflammation and defining the roles of blood cell types in the pathogenesis of inflammation.
2010 Health Policy Scholars announced

Fourteen surgeons were selected to attend the Leadership Program in Health Policy and Management that took place last month at Brandeis University, Waltham, MA. Each scholarship included participation in the weeklong intensive course, followed by a year’s service in a health policy-related capacity to the College and the surgical specialty society co-sponsoring the awardee.

• ACS Health Policy Scholar for General Surgery: Steven D. Schwaitzberg, MD, FACS, Harvard Medical School, Boston, MA.

• ACS Health Policy Scholar for General Surgery: Jacob Moalem, MD,
FACS, University of Rochester School of Medicine and Dentistry, Rochester, NY.

• ACS/American Academy of Otolaryngology–Head & Neck Surgery Health Policy Scholar: Saurin Popat, MD, FACS, FRCSC, Delaware Medical Group, Buffalo, NY.

• ACS/American Association of Neurological Surgeons Health Policy Scholar: Fred G. Barker II, MD, FACS, Massachusetts General Hospital, Boston, MA.

• ACS/American Association for the Surgery of Trauma Health Policy Scholar: Christopher K. Senskowski, MD, FACS, Memorial Health University Medical Center, Savannah, GA.

• ACS/American Pediatric Surgery Association Health Policy Scholar: Aviva L. Katz, MD, FACS, Children’s Hospital of Pittsburgh, PA.

• ACS/American Surgical Association Health Policy Scholar: Steven M. Steinberg, MD, FACS, Ohio State University Medical Center, Columbus, OH.
Every year, the ACS Clinical Congress focuses on issues vital to surgeons and their patients. The 2010 Clinical Congress, which will be held in Washington, DC, October 3–7, will concentrate on both current and imminent challenges for surgeons based on the theme Surgical Professionalism in the 21st Century.

Many free panel sessions at the Clinical Congress will advance the discussion of surgical professionalism, including the following:

• The Surgeon’s Interaction with Industry
• Quantity vs. Quality: How to Decide if Major Surgery Is Right for Your Older Patient
• Unconscious Bias: Diagnosis, Treatment, and Prevention
• Acute Care Surgery: Quality Improvement, Ethics, Finances, and Workforce
• Data-Based Strategies to Reduce Your Chance of Being Sued
• Common Problems and Quality Outcomes: Surgical Care for the Terminal Patient
• Making the OR Safe: The Role of High Performance Teamwork
• Latin American Day 2010: Safety and Quality Issues for the Surgeon
• Surgeon Burnout: Putting Out the Flames
• Implication for Access to Care and Surgical Practice: The Patient Protection and Affordability Care Act (Pl 111-148)

The online reservation system for hotel accommodations during the 2010 Clinical Congress is now open. For more information or to make hotel reservations, go to http://www.facs.org/clincon2010/hotel-travel.html, or refer to the 2010 Program Planner.
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ACS resident research scholarships are available

The American College of Surgeons is offering two-year resident research scholarships for July 1, 2011, through June 30, 2013. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty. American College of Surgeons’ Resident Research Scholarships are supported by the generosity of Fellows, chapters, and friends of the College, to encourage residents to pursue careers in academic surgery.

General policies
The policies for granting of the American College of Surgeons Resident Research Scholarships are as follows:

• The applicant must be a Resident Member of the College who has completed two postdoctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarship is awarded (July 1, 2011), and shall not complete formal residency training before June 2013. Scholarships do not support research after completion of the chief residency year.

• The scholarship is awarded for two years, and acceptance of it requires commitment for the two-year period. The award is to support a research plan for the two years of the scholarship, July 2011 through June 2013. Priority will be given to the projects of residents involved in full-time laboratory investigation. Study outside the U.S. or Canada is permissible. Renewal of the scholarship for the second year is required and is contingent on the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Section of the College by May 1, 2012.

• Application for these scholarships may be submitted even if comparable application to other organizations has been made. If the recipient is offered a scholarship, fellowship, or research award from another organization, it is the responsibility of the recipient to contact the College’s Scholarships Administrator to request approval of the additional award. The Scholarships Committee reserves the right to review potentially overlapping awards and to adjust its award accordingly.

• The scholarship is $30,000 per year; the total amount is to support the research of the recipient and is not to diminish or replace the usual or expected compensation or benefits of the recipient. Indirect costs are not paid to the recipient or to the recipient’s institution.

• The scholar is expected to attend the Clinical Congress of the American College of Surgeons in 2013 to present a report on the research as part of the Surgical Forum, and to report and receive a certificate at the annual meeting of the Scholarships Committee.

• Approval of the application is required from the administration (dean or fiscal officer) of the institution. Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor who will be supervising the applicant’s research should be submitted. Only in exceptional circumstances will more than one scholarship be granted in a single year to applicants from the same institution.

The closing date for receipt of completed applications and all supporting documents is September 1, 2010.

Application forms may be obtained from the College’s Web site at http://www.facs.org/memberservices/research.html, or upon request from the Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
Submission of manuscripts

Electronic submission is encouraged; send files via e-mail to sregnier@facs.org. Submissions will be acknowledged and sent to appropriate reviewers.

If you are sending the manuscript on diskette or other hard copy of materials, forward these items prepaid, at the author’s risk, to:

Stephen J. Regnier, Editor  
Bulletin of the American College of Surgeons  
American College of Surgeons  
633 N. Saint Clair Street  
Chicago, IL 60611-3211

Manuscripts are accepted for consideration on the understanding that they are intended for publication solely in the Bulletin of the American College of Surgeons and that they are not under review nor have been published or committed for publication elsewhere. If a paper has been prepared for presentation at a meeting, this information should be noted on the cover letter accompanying the manuscript. All manuscripts are subject to editorial modification and revisions necessary to bring them into conformity with Bulletin style and publication-readiness.

Style and format

Manuscripts should be no more than 3,200 words in length, excluding tabular material or illustrations. Manuscripts should be composed of seven to nine pages in Microsoft Word—doublespaced and with one-inch margins. Please turn off tracked changes before sending the document. Manuscripts submitted as PDF will be returned to the author with the request that a Word document be submitted instead.

Give full names of authors and their degrees, academic or professional titles, professional affiliations, and complete addresses. Specify to whom galley proofs are to be sent.

References should be listed numerically in the text, with full citations to appear on a separate page at the end of the text of the article. Please be sure to keep the references separate; do not use the feature in Word that automatically generates footnotes.

References should follow American Medical Association style guidelines. Following are some examples:


All manuscripts should include a brief biography (including employer name, position title, and city and state) and a photo of each author. Each photograph must be a head shot/portrait in JPG or TIF format, at least two inches wide, and at least 300 pixels per inch. Do not submit the photos in a Word document,
as this affects the publishing quality. If preferred, submission of a hard copy of photos (minimum passport size) is acceptable.

Tables/illustrations
 Figures, tables, and/or other illustrations are welcomed as long as they add significantly to the author’s discussion in the text. Data display should be called a “Table” when presenting precise numerical values that show item-to-item comparisons; the term “Figure” should be used when presenting patterns or trends or illustrating comparisons in text.*

Displays that present lists of any kind (such as names of board members or checklist items) should be called “box.” Photos should be referred to in text as photos, not figures.

Drawings (including graphs and charts) should be created either in MSWord, PowerPoint, or as a JPG, TIF, or PDF file, with lettering large enough to be legible after necessary reduction. If camera-ready art is supplied in lieu of an electronic file, be sure that the original is clear, clean, and will be legible when reduced. A separate page with legends for the illustrations should be supplied. Tables submitted with the manuscript should be on separate pages at the end of the manuscript. Be sure to label the tables and illustrations clearly and be sure to refer to their placement in the text of the article.

Photographs or other illustrative art, if supplied in an electronic (JPG, TIF, or PDF) format, should have a resolution of no less than 300 pixels per inch, or at least 1200 pixels in width. Anything less than that may not reproduce at publishing quality. Photographs and illustrations pasted into a Word document are discouraged, as they do not always print at ideal resolution. Please provide captions for photographs on a separate page.

Galley proofs
 Authors will receive galley proofs (as a Word document) of their edited manuscript for their review in advance of the scheduled month of publication. Galleys may include queries from editorial staff.

Before publication, revised proofs must be returned either as a Word document with any edits indicated using the tracked changes function or as a list of requested changes to the editors.

Authors of feature articles will have the opportunity to see a PDF of the article in magazine format that reflects any changes made to the document during the galley stage. After viewing the PDF, authors may only request changes to text that is currently outdated or presents egregious errors; all other edits will be rejected at that time.

Inquiries
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NTDB® data points

Going downhill

by Richard J. Fantus, MD, FACS

Last month’s column reported on the exciting sport of snowboarding and its related injuries. However appealing that sport may seem, alpine skiing remains, by far, the most popular snow sport, and accounts for approximately two-thirds of those individuals on ski slopes. Ski technology made a major advancement in the mid-1990s with the development of “carved” or “shaped” skis. Taking a page from the snowboarder’s playbook, ski manufacturers realized that by narrowing the ski in the center, similar to the design of a snowboard, it would lend itself to easier turning, as well as make it easier for beginners to learn how to ski. Today, almost all skis are designed this way. That design enhancement, along with improved binding systems, ski leashes, slope design, grooming, and improved signage, has led to a significant reduction in ski-related injury. For the most part, skiing is safe. Ski injury studies were first reported in the 1970s, and, since that time, injury rates have decreased approximately 50 percent, to two injuries per thousand skier days, a rate that is fairly consistent worldwide (http://www.ski-injury.com/specific-sports/alpine).

In order to examine the occurrence of skiing-related injuries in the National Trauma Data Bank® research dataset 2008, admissions records were searched utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) cause of injury code E885.3 (skiing), E884.9 (jump), and E847 (lift or tow with chair or gondola). A total of 20,197 incidents matched this E code; 17,345 records had discharge status recorded, including 14,597 discharged to home, 1,603 to acute care/rehab, and 859 sent to nursing homes; 286 died (these data are depicted in the figure on this page). These patients were 71 percent male, on average 34.9 years of age, had an average length of stay of 4.4 days, and an average injury severity score of 8.8. Of the 4,782 tested for alcohol, more than 30 percent were found to be positive.

When skiers head to the slopes, they should try and stay on piste (on the trail or route), watch out for tree wells (an area of loose snow around the trunk of a tree which becomes surrounded by deep snow), know their physical limits, and make sure the only beverage consumed on the ski slope is hot chocolate. Going downhill
is hard enough to take when you are sober.

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

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