A VIEW FROM THE COCKPIT:
Promoting aviation safety in the OR
On the cover: Adapting proven airline safety methods in the operating room could help to reduce medical errors, according to surgeon/pilot Richard C. Karl, MD, FACS. (See article on page 6.)
NEWS

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

Did you know...

Honorary Fellowship awarded to six prominent surgeons

Citation for Prof. Dario Birolini
L. D. Britt, MD, MPH, FACS

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Citation for Prof. Tehemton Erach Udwadia
John G. Hunter, MD, FACS

Citation for Prof. William Ignace Wei
Richard J. Finley, MD, FACS, FRCSC

A look at The Joint Commission: Safe Surgery Guide takes on major challenges to surgical safety

Members in the news

ACS nominee appointed to key federal board

From Surgery News: Stem cell ruling worries investigators

Letters

Trauma meetings calendar

Bulletin of the American College of Surgeons: Instructions to authors

NTDB® data points: “Eye see”
Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

ACS Foundation/Saint Louis University announce Scholar in Residence program

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

As our leadership has stated on numerous occasions, the mission of the American College of Surgeons (ACS) is to ensure that surgical patients have access to safe, effective, and affordable care that is delivered in an optimal environment. As Executive Director, one of my main goals is to focus more of the College’s resources on defining best practices and measuring relevant outcomes so that we can be a leading voice in the quality movement. The ACS National Surgical Quality Improvement Program (ACS NSQIP), the research carried out by our clinical scholars, and meaningful improvements in our cancer and trauma databases are key factors in our ability to achieve this vision.

Of course, no single organization can autonomously define and champion the changes that need to take place in the delivery of health care services in order to improve patient care. Hence, we must collaborate with other like-minded organizations to discover and promulgate best practices.

For this reason, I was pleased and intrigued when Mark Chassin, MD, MPH, MPP, president of The Joint Commission, approached Clifford Ko, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, and me early this year about the possibility of using ACS NSQIP data to study means of reducing surgical site infections (SSIs). After learning about how the project would work, the College’s leadership agreed that the ACS should work with The Joint Commission on this project. As a result, this initiative is being carried out through The Joint Commission’s Center for Transforming Healthcare in collaboration with the College.

About the center

The Center for Transforming Healthcare is Dr. Chassin’s brainchild and was established to evaluate and develop solutions to medicine’s most critical safety and quality problems. The center seeks to solve problems in health care through the application of the same Robust Process Improvement™ (RPI) methods and tools that other industries use to improve quality, safety, and efficiency. In addressing these problems, the center works with a cadre of leading hospitals and health systems that have considerable experience in the use of RPI methods and tools, such as Lean Six Sigma and change management, in the medical environment.

Using these paradigms, the Center identifies the most pressing safety issues, measures their effects, explores their causes, develops targeted solutions, and thoroughly tests the solutions in real-life, clinical situations. Once they are thoroughly tested, the solutions are publicly shared and included in the Center’s Targeted Solutions Tool™, which is a Web-based tool that allows Joint Commission-accredited organizations to customize solutions to best address their organization and specific causal factors. (This tool will be discussed in detail in the December issue of the Bulletin, in the “A look at The Joint Commission” column.) Other projects under way at the center focus on hand hygiene, hand-off communications, and wrong-site surgery.

The SSI project

The Joint Commission chose SSIs for its next endeavor because, according to the Centers for Disease Control and Prevention, SSIs account for approximately 25 percent of all health care-
associated infections in the U.S. each year, making them a major source of preventable patient harm and greater health care costs.

At least initially, the SSI project will center solely on colorectal surgery. We have chosen to focus on this specialty because ACS NSQIP data show that colorectal patients frequently experience SSIs. The SSI initiative encompasses all patients undergoing emergency and elective colorectal surgery, with the exception of trauma and transplant patients and patients under age 18. The project addresses preoperative, perioperative, and postoperative processes. Participating hospitals will be engaging all surgical and ancillary professionals and other hospital staff involved in these processes to identify the full spectrum of factors that contribute to SSIs, such as environmental cleanliness, surgical technique and tools, antibiotic usage, operating room traffic, patient education, and so on.

As the first step in this project, the College, The Joint Commission, and participating hospitals (see the box on this page) met August 18 and 19. At this conference, the participating hospitals identified the measures they will use to gauge their baseline performance and improvement over time. The primary measure will be the observed rate of patients with SSI within 30 days following their procedure. A secondary measure will be the observed rate of SSI compared with the expected rate as derived from the ACS NSQIP data.

Like other Six Sigma quality improvement projects, the SSI initiative will go through a five-stage process, know as DMAIC: Define, Measure, Analyze, Improve, and Control. The hospitals met again last month to report on the “Define” phase of the project and to prepare for the “Measure” phase.

### Participating hospitals

- Cedars-Sinai Health System, Los Angeles, CA
- Cleveland Clinic, OH
- Mayo Clinic, Rochester, MN
- North Shore-Long Island Jewish Health System, NY
- Northwestern Memorial Hospital, Chicago, IL
- OSF Saint Francis Medical Center, Peoria, IL
- Stanford Hospital & Clinics, CA

### An important project

The College’s collaboration with The Joint Commission on the SSI project is a natural fit in light of the fact that The Joint Commission grew out of the College’s own Hospital Standardization Program. Furthermore, this program will be invaluable as we continue to move forward to position the ACS as the leader in defining, measuring, and promulgating best practices for quality of care in surgery.

These types of collaborative endeavors serve as important opportunities to play a key role in the development of surgical protocols. The ACS will continue to work with other surgical and medical groups that have innovative ideas and to develop our own ground-breaking programs to ensure that the surgical patient continues to have access to safe, effective, and affordable care.

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**David B. Hoyt, MD, FACS**
A VIEW FROM THE COCKPIT:

Surgeon and pilot Richard C. Karl, MD, FACS, promotes aviation safety in the OR

by
Jeannie Glickson,
Communications Associate,
Division of Integrated
Communications
As a writer, Richard C. Karl, MD, FACS, likes a good metaphor. For years, he has used the metaphor of aviation and medical safety to point out that the health care field comes up short.

Dr. Karl speaks with some authority. He learned to fly airplanes before he became a surgeon; that’s when he developed a lifelong passion for flying. Later on, he discovered he also has talent as a writer.

In keeping with his multiple interests, Dr. Karl became an accomplished surgeon, aviator, and writer; and in 2002, Temple University Press published his honest, compelling book, *Across the Red Line*, which presents gritty, realistic, and poignant vignettes of surgical life. The book is about what happens “across the red line,” the line in hospitals that separates the operating rooms (ORs), patients, and the surgical team from the rest of the hospital and family and friends. The book reveals not only secrets of the OR, but also the spark and curiosity of a man fully engaged in his profession.

Following a surgical track

The son of an esteemed surgeon at Dartmouth-Hitchcock Medical Center in Hanover, NH, Dr. Karl attended undergraduate school at Cornell University in Ithaca, NY, and medical school at Weill Cornell Medical School in New York, NY. He completed his residency at Washington University in St. Louis, MO, and then joined the faculty at the University of Chicago, where he specialized in cancer. His life changed when he linked up in 1983 with the University of South Florida’s (USF) College of Medicine, which opened its doors in 1965. Dr. Karl helped establish the H. Lee Moffitt Cancer Center in Tampa, FL, and served as its founding medical director. He subsequently became the Connar Professor and chairman of the department of surgery. The Moffitt Center has become one of the nation’s premier centers for cancer treatment and research.

Appreciative of a “lucky life”

“I have had a very lucky life,” said Dr. Karl, who at age 64 looks back on 33 years as a surgical oncologist. In 2008, he retired after a decade as chairman, but continues to practice surgery. “I have enjoyed all the benefits of a great education and profession, and a wonderful wife and family. I’m lucky because I’ve always loved my work, and I’ve always managed to find balance in my life.”

When asked what makes surgical work most gratifying, he said it’s the patients “who are so brave and noble even in the face of deadly prognoses. In this job, you see all the frailties and fears, but also the strength, of human beings,” he added. “There’s also the friendship and camaraderie and respect among colleagues. Working at a university, you work with young people, who keep you young,” Dr. Karl said.
A writing career begins

His foray into writing began somewhat accidentally, when he became friendly with Eugene C. Patterson, editor emeritus of the St. Petersburg Times in Florida. A highly decorated World War II veteran, a Pulitzer Prize winner, and a former editor of the Washington Post, Mr. Patterson was one of the early staunch Southern supporters of the Civil Rights Movement in the 1950s and 1960s.

“We became friends, and I would often tell him stories from my life in medicine and aviation,” Dr. Karl said. “He suggested that I start writing down these stories, and he said he would consider publishing them in the newspaper if they were any good,” Dr. Karl added. “My first question to him was, ‘Should I take a writing course?’” “No!” the editor replied emphatically, so Dr. Karl began recording his observations, whether they were about practicing surgery, flying, or subjects in between.

As a result, Dr. Karl added writing deadlines to his schedule. He also began submitting unsolicited columns to the monthly Flying magazine, which began publishing just after Charles Lindbergh’s Atlantic flight in 1927.¹

“It’s the most widely read aviation magazine in the world,” Dr. Karl pointed out. “One day the editor of the magazine contacted me and said they would like to make me a contributing editor, which meant that I would get to write a monthly column.” He took on this new challenge, and as a result, for the past 10 years he’s written a column for Flying. “This experience has opened up all sorts of magnificent opportunities,” Dr. Karl said, “from flying a single engine airplane across the Atlantic, to getting a type rating in the Boeing 737.”

The daily human drama that surgeons and pilots experience provides him with a steady supply of story ideas. When he writes about a small bowel obstruction, he is reminded of a surgical aphorism (“the sun shall neither rise nor set on a small-bowel obstruction without an operation.”) He never tells a cancer patient that he “got it all,” he tells readers.² (“Recurrences are too common. We can’t be that arrogant,” he writes.) He reflects on the end of life, when “experience and carefulness and good intentions are impotent.”² In his Flying column, he questions the decision of Chicago Mayor Richard M. Daley to bulldoze Meigs Field, among “the most picturesque and useful landing strips anywhere in the world.”³

A surgeon in head and heart

Dr. Karl fits time in each day to write and think about flying, but in his head and heart, he is a surgeon, dedicated to working cooperatively with his colleagues and providing quality care to his patients, whether in the office, the emergency room, or the OR.

He insists that he has led a less stressful professional life than other surgeons and other health care professionals. “I have not had to deal with long hours of emergency call,” he said. “And I haven’t had to manage the stressful, on-call life of a pediatric surgeon.” (His brother Stephen Karl, MD, FACS, is a pediatric specialist in Sioux Falls, SD.) “I’ve been able to enjoy this cool life as an academic surgeon,” he said.

No doubt, it’s cool to be a pilot, too. Dr. Karl can’t suppress a smile as he recalls the phone call he received from a chief pilot of Southwest Airlines a few years ago. “He told me they were taking delivery of
a brand new Boeing 737, and asked me if my wife and I would want to join them.” This was a “no-brainer” for the surprised surgeon, who considered it one of those once-in-a-lifetime opportunities. “I got to fly this brand new plane from Seattle, where it was built, to Phoenix, and what a memorable experience that was. The inside of that new airplane smelled like a hundred new Corvettes!”

Dr. Karl knows the thrill of liftoffs and the assurance of a smooth landing. He is also keenly aware of aviation’s strong safety record and for a long time has been asking, “What can an operating room learn...from a cockpit?” A great deal, it turns out.

Six years ago, he worked with an advisory panel of physicians, nurses, clinicians, and commercial airline pilots to establish the Surgical Safety Institute (SSI). Its fundamental purpose is to advance the idea that lessons learned by the airline industry are relevant in the OR.

To err is human

In November 1999, the Institute of Medicine released the report, To Err Is Human: Building a Safer Health System, which estimated that as many as 98,000 patients die annually as the result of medical errors in hospitals. This level of fatalities is about equivalent to three jumbo jets crashing every week, according to Dr. Karl.

The U.S. airline fatality rate has steadily declined. In 2007 and 2008, 1.5 billion commercial passengers flew safely, with not one single airline fatality. During the same time, medical errors did not decline, and Dr. Karl believes the surgical field has not effectively addressed safety in the OR, where, he said, approximately half of all medical errors occur.

“When we talk about medical errors, we are speaking of bright, altruistic, hard-working, and well-meaning professionals who make mistakes,” he said. “They’re human, and they make unintentional human errors. We don’t have to replace the people. Reducing medical errors needs to focus on the system, not the individuals.”

Deadliest 20th century air disaster

On a foggy day in the Canary Islands in March 1977, a Pan Am Boeing 747 and a KLM 747 collided on a runway, killing 583 people, creating the single most deadly aviation accident of the 20th century. The seminal event was the result of a sequence of human errors, involving a problem with the communications system and an impatient senior pilot. Worldwide, the aviation industry responded with new prevention plans and a resolution of conflicts.

Aviation safety is the product of deliberate actions and an intense effort to correct safety flaws. After the Canary Island tragedy, the National Aeronautics and Space Administration conceived a program that addressed the factor of fatigue. The agency developed a new program called Crew Resource Management (CRM) (see box, page 10), which produces intense and focused communication, teamwork training, and operations designed to prevent stress and increase safety. Through this system, all commercial and military pilots must be trained to recognize factors like human fatigue and to resolve communication problems by speaking out and listening to team members. In 1979, the Federal Aviation Administration (FAA) mandated that all commercial airlines implement CRM. These efforts have resulted in safer skies.
“The airlines follow a step-by-step procedure that begins with the hiring process,” Dr. Karl said. “It used to be that the captain was very often autocratic, much like many surgeons of yesterday, and the rest of the crew were afraid to communicate or ask questions. But that has changed, and now the emphasis is on crew management and working together. For example, they don’t put people who don’t like each other on the same crew, among a variety of other policies that augment the safety culture.”

**Medicine is not there yet**

Aviation is safe, Dr. Karl maintains, but medicine isn’t there yet. On behalf of the SSI, Dr. Karl travels to hospitals, of all sizes, throughout the nation, urging, coaching, and training health care professionals to adopt traditions of the aviation industry. Initiatives for safer health care, he always warns, cannot be half-hearted or selective: “Hiring, training, and recurrent assessment techniques used in aviation may be useful in surgery, but the entire package must be implemented. It can’t be instituted in fragments. We examine policies for hiring and for discipline. We pay special attention to identifying latent factors that contribute to errors and delay their recognition and rectification.”

Dr. Karl has been a key advocate for using aviation standards in the OR, and his views have gained acceptance among many health care practitioners. “Clearly I am not the only guy to think of this,” he said.

As a result of Dr. Karl’s advocacy, and that of many others who concur with his views on medical care, many more health care professionals now think about aviation safety when they respond to public demands regarding reducing errors. In recent years, hospitals around the country have brought in professional pilots to talk with their health care professionals about air safety and how the same principles can be applied in medicine.
“They are great programs, but surgeons in particular seem to need a surgeon-to-surgeon-based course to really be effective,” Dr. Karl said.

“Poor communication lies at the heart of most medical errors,” said Dr. Karl. He recalled flying with a pilot who announced in the cockpit just before landing, “I think we’re landing on the middle runway.” That was obviously the case, and Dr. Karl said he wondered why the pilot was stating the obvious. He later realized that the pilot was actually verbalizing a thought that served as another checkpoint. It helped prevent a potential misunderstanding and possibly even a potential disaster.

Comparing airline, health care safety

Dr. Karl presents a system-wide guide to airline safety and points out the ways the medical field lags behind. In terms of safety, he said, it begins in the hiring process. Pilots are hired in a “codified fashion that often includes a scenario in a cockpit trainer to evaluate leadership skills,” he explained. In surgery, he pointed out, “letters of recommendation, an unstructured interview, and dinner at a local restaurant are common ways of assessing applicants.”

Surgery practices brief periods of “time out”—a term that Dr. Karl objects to on principle, because it “sounds like a break in the action, as if we are unsafe most of the time and take a break to ensure safety.” In aviation, decisions revolve around safety issues. “Safety is woven into the fabric of every flight,” Dr. Karl said. It is the most important part of any flight, he noted, exceeding personal needs or temporary embarrassment of individual crew members.

After being hired, airline pilots undergo a stringent orientation on the airline’s policies, procedures, culture, and history. Once they begin to fly, new pilots undergo 25 hours of FAA-required operating experience. Trained airmen assigned to new hires evaluate them for their flying ability and CRM techniques. In the surgery department, according to Dr. Karl, “traditionally, there has been little mentoring of new faculty.” Surgeons who are fully trained and board certified, he added, are given operative privileges and left unsupervised.

Aviation no longer has the steep hierarchy it once had. In medicine, that hierarchy continues to thrive, and the surgeon assumes all of the responsibilities. “The result,” he said, “is that many surgical crews don’t work well together.”

Airline pilots must follow strict rules about rest periods and are often subject to random drug and alcohol testing. In surgery, Dr. Karl noted, the only mandatory rest period in surgery is the 80-hour work week for resident staff.

Commercial aviation employs ongoing simulator training and ground school to train pilots, and captains are retrained every six months. During that training, captains learn about new policies, and gain knowledge by listening to each others’ experiences. Medicine has not developed this degree of competency maintenance program, according to Dr. Karl. New maintenance of competency policies may be on the horizon for surgical work, Dr. Karl said, but they are not nearly as well-developed as they are in aviation.

Medicine, he pointed out, relies on documentation rather than safe performance. Aviation has checklists for everything, and those tools are there to ensure that procedures are actually being followed. “Pilots don’t fill out a form documenting that they put the landing gear down. This is another fundamental difference in the two professions. We obsess about the documentation; aviation worries about getting the wheels down,” Dr. Karl said.

Surgeons handle emergencies based on their memory and what they learned in medical school. Flight emergencies are handled by a quick reference handbook. A “minimum equipment list” in an airplane contains the rules for decisions on whether a flight should continue. In surgery, Dr. Karl pointed out, most equipment, supplies, and environmental decisions are left to the surgeon’s discretion.

In aviation, there are no distractions below 10,000 feet, when only discussions regarding the safety of the flight are allowed. Compare this policy, Dr. Karl said, with the situation in most ORs, where irrelevant discussions take place all the time, even during the most critical moments of the procedure.

Achieving positive surgical outcomes

The Commercial Aviation Safety Team, created in the 1990s in the wake of several aircraft failures, brought the aviation industry together. From 1994 to 2006, the average rate of fatal ac-
Incidents decreased from .05 to .022 per 100,000 departures.7

Dr. Karl calls himself a “reformed former dictator” of the OR, and believes that some day medicine can achieve a similar rate of successful outcomes. Like most converts, he displays his zeal to enhance safety in the OR.

The SSI addresses the disparity between good medical intentions and unfortunate outcomes with a portfolio of diagnostic evaluations and evidence-based interventions. Dr. Karl sees his work and advocacy efforts as not only having an impact on, but actually changing, the hardest thing of all to change: tradition. A Johns Hopkins study showed that medical briefings actually reduced the perceived risk for wrong site surgery and improved collaboration among those in the OR.8 Dr. Karl reiterated a point made by James T. Reason, a psychology professor at the University of Manchester in England and a leading expert on human error. Addressing England’s Royal College of Surgeons, Professor Reason noted that physicians are generally trained to “get it right,” essentially eliminating the notion of error, which creates a big “sea change,” he said, when health care must work to eliminate human error.9

As a writer, Dr. Karl appreciates the power of a metaphor, but he realizes that metaphors have their limitations. Aviation safety can be an effective metaphor for surgical safety—but he concedes that in surgery there are more variables and more immediate decisions that the surgeon must make. Some hospital administrators have pointed out that surgery is more complex than aviation and requires more human interaction, which raises the possibility of human error. In Dr. Karl’s view, these arguments do not diminish the value of the aviation model. “I do know that it is harder to control bleeding from the back side of the portal vein than it is to land a 737 with an engine on fire,” he said.

A 1960s National Airlines television ad showed a flight attendant delivering the line that became a popular catchphrase: “Is this any way to run an airline?” she asked, and answered, “You bet it is.” Dr. Karl believes that the corollary line for the health care industry today would be, “Is this any way to run health care? No, it is not. We can do better.”

References
The American College of Surgeons (ACS) Foundation has a single mission: to promote voluntary philanthropy from Fellows and friends to advance the priorities of the College.

By matching the interests of our donors with the College’s needs and opportunities, philanthropy provides a “margin of excellence” to our programs. Gifts to the College can help cultivate the intellect and fresh ideas of young surgeons and assist them in exploring their interests, from clinical and basic science research to health policy, both in the United States and abroad.

The College administers numerous projects designed to help surgeons cope with the challenges of today’s value-driven health care environment and better serve the modern surgical patient. In addition, the College must invest in key initiatives such as clinical trials programs in order to achieve optimal outcomes and the best quality of life. Similarly, the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) requires investment, so that hospitals and surgeons can put the information generated through this initiative to practical use.

All of these programs are capital intensive, and dues dollars alone simply cannot fund them. Therefore, contributions to the ACS Foundation are crucially important to the College’s future, as well as to the future of surgery. Despite a challenging economic climate, a total of $2,176,567 was contributed in the 2009–2010 fiscal year to support current and future programs. We are grateful for your generosity.

The American College of Surgeons Foundation is recognized as a tax-exempt, not-for-profit organization. Contributions to the American College of Surgeons Foundation are tax-deductible to the extent allowed by law.
A Team Effort

The Board of Directors of the American College of Surgeons Foundation is grateful to everyone who made the past year a successful one. It is true that philanthropy is a “team effort” and a marathon; it is a product of collaboration with the College’s divisions and particularly with many committed volunteers. We are especially grateful for the service of the Foundation Board and Committee members listed on these pages. Amid competing duties and busy schedules, they provide the vital resources that make philanthropy happen: wealth, wisdom, and work.

Current gifts made by our Fellows and friends, program grants from foundations and corporations, and the estate and planned gifts from Mayne Heritage Society members ensure a more vital future for the American College of Surgeons. Thank you to those who commit their time and talent, as well as their treasure.

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A Culture of Philanthropy

Voluntary philanthropy is the backbone of the American not-for-profit sector, the purveyor of so many vital services in this country. To encourage and sustain voluntary giving, a distinctively American tax code has developed, with incentives for current and future philanthropy. The American College of Surgeons and its Foundation belong to the not-for-profit sector, and our benefactors can gain access to many of the same benefits of giving as they would by giving to arts, education, health care, or social service organizations.

While the American College of Surgeons Foundation has many constituencies—chapters, surgical specialty societies, philanthropic organizations, corporations, the Fellowship, as well as the College’s divisions and leadership—it has one client: the American College of Surgeons and its programs. The priorities articulated by ACS Executive Director Dr. David Hoyt are the framework for investment in the College: optimal patient care, professional education, and advocacy.

The Foundation provides funding for the College’s initiatives to improve quality of care, efforts that are of increasing relevance in today’s value-driven health care environment. More and more, health care professionals and providers are going to be judged on their outcomes. Initiatives such as the ACS NSQIP, and demonstrably successful programs in trauma and cancer, affirm the College’s leadership role in surgical practice innovation.

At the same time, extraordinary growth in knowledge and technology challenges the ability of busy surgeons to be current. The College’s education programs allow surgeons to maintain confidence in their skills and to preserve their professional identity. Much of the Foundation’s revenue—from Fellows and from philanthropic funding by organizations—is used to sponsor scholarships, fellowships, and other learning opportunities. In short, philanthropy to the College by the Fellowship isn’t exactly self-serving, but your gifts directly benefit the profession and its future.

Patient Education

Education programs that support patients and their families with the opportunity to learn and practice the skills needed for safe recovery are critical to the surgical patient, who is routinely required to administer complex care following discharge. The American College of Surgeons Division of Education’s Surgical Patient Education Program provides the knowledge and skills needed to support patients during their continued postoperative care.

The program was launched with a skills kit designed for patients requiring an ostomy. Each kit contains supplies, a CD and instruction booklet with images to guide each step of skill acquisition, and a list of additional resources and support groups. The educational content also describes the potential complications and risks of the procedure.

An educational grant from Coloplast Corp. is supporting the production and distribution of 30,000 kits to surgical patients through their surgeons. According to Kim Herman, Coloplast’s U.S. President, “Coloplast welcomes the opportunity to enhance the efforts of the ACS, and we applaud the educational mission. As the global leader in ostomy care, we are proud to support the production and distribution of the skills kits to help support ostomy patients, as well as the physicians and nurses providing clinical and educational services to each of these individuals.”

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

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

NOTE: The skills kit for ostomy patients is available to surgeons through the American College of Surgeons website at http://www.facs.org/patienteducation.
Guided by the principle that the future of surgery lies in the hands of the young surgeons who will develop into tomorrow’s leaders, the American College of Surgeons believes that the granting of scholarships is among the organization’s foremost responsibilities. Among the ACS scholarships awarded each year are International Guest Scholarships (IGS), which provide educational opportunities for surgeons chosen competitively from any country outside of North America and from applicants who demonstrate a commitment to teaching and research. The 2009 cohort of recipients is pictured below.

The Stavros Niarchos Foundation has established an endowment fund to support an IGS for candidates from Greece or of Greek heritage. The grant from the Niarchos Foundation, secured in collaboration with Fabrizio Michelassi, MD, FACS, Chair of the International Relations Committee (IRC), will help the IRC achieve its goal of increasing the number of IGS awards offered annually. Currently, eight to 10 scholarships are awarded annually, a number far short of the number of deserving candidates. The first Stavros Niarchos Foundation International Guest Scholarship is projected to be awarded in 2012.

“The generous support of the Stavros Niarchos Foundation will help the American College of Surgeons to nurture the commitment of additional promising surgeons and, in these times of international strife, will ultimately strengthen the collaborations between nations,” said Dr. Michelassi.
The American College of Surgeons Archives are a catalogued collection of the minutes, agendas, correspondence, and other meeting materials of the College’s governance and administration. With about 300 linear feet of material, the Archives room at the headquarters building in Chicago is an extraordinary research resource. The records housed in the Archives include paper-based materials, film, photographs, audio tapes, recordings, portraits, artwork, and artifacts. With the centennial year of the College approaching, archival material provides valuable insights to the College’s founding spirit.

Under the leadership of C. Rollins Hanlon, MD, FACS, the ACS Foundation undertook a campaign to raise funds for the preservation and reorganization of the collection. With the support of Fellows who have held the office of President of the American College of Surgeons, as well as those individuals who value the Archives, the campaign has passed the halfway mark toward its $250,000 goal. The Foundation wishes to thank the individuals and organizations who have participated in this important effort to render the College’s rich history more accessible to current users.

Contributors include: W. G. Austen, MD, FACS; James G. Chandler, MD, FACS; Dr. C. Rollins Hanlon; R. Scott Jones, MD, FACS; Maurice J. Jurkiewicz, MD, FACS; LaSalle D. Leffall, MD, FACS; LaMar S. McGinnis, MD, FACS; David G. Murray, MD, FACS; David L. Nahrwold, MD, FACS; and George F. Sheldon, MD, FACS. In addition, the Archives project has received a grant from the Dana Foundation, located in New York City.
Distinguished Philanthropist Award

The American College of Surgeons Foundation proudly acknowledges the philanthropy of individuals who have distinguished themselves through their extraordinary investment in the mission of the American College of Surgeons. We are pleased to honor them with the Distinguished Philanthropist Award.

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Dr. Oliver H. Beahrs (1992)
Dr. John Conley (1990)
Dr. Armand Hammer (1989)

* Deceased

Fellows Leadership Society

Philanthropy has been a tradition of the American College of Surgeons since its inception. In 1914, the leadership of the College initiated a campaign to secure gifts from members to establish an endowment fund. That spirit of giving continues today with gifts of all sizes from thousands of donors who support the numerous programs of the College through the ACS Foundation.

The Fellows Leadership Society recognizes Fellows and friends who have invested most loyally in the American College of Surgeons. Through their leadership in giving, members of the Fellows Leadership Society exemplify the philanthropic spirit of the College’s founders.

Recognition is provided based on cumulative giving history. Annual renewable membership is accorded to individuals whose contribution during a given fiscal year totals $1,000 or more. Categories of membership include:

Pinnacle Circle
*CUMULATIVE* gifts totaling $1,000,000 or more

Second Century Circle
*CUMULATIVE* gifts totaling $500,000–$999,999

Legacy Circle
*CUMULATIVE* gifts totaling $100,000–$499,999

Founders Circle
*CUMULATIVE* gifts totaling $75,000–$99,999

Presidents Circle
*CUMULATIVE* gifts totaling $50,000–$74,999

Regents Circle
*CUMULATIVE* gifts totaling $25,000–$49,999

Governors Circle
*CUMULATIVE* gifts totaling $10,000–$24,999

Donors Circle
*ANNUAL* gift of $1,000 or more

*We acknowledge all donor gifts received through June 30, 2010.*

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Estate Giving

Because of all the programs and activities the American College of Surgeons offers, not only for certified surgeons but for trainees and residents as well, I’ve always believed that it is the most important of the organizations I contribute to. I started contributing to the College soon after I became a Fellow in 1976. Now that I’m retired, I started looking to see where my assets would do the most good, and I decided to make a planned donation to the Mayne Heritage Society. When I gave my annual donation, I usually asked that the money be earmarked for surgical research programs, but with this planned donation, I thought it would be best to let the Board of Regents decide how best to use the money.

Besides being a regular contributor to the American College of Surgeons Foundation, I have been very active on several College committees. I served on the Committee on Trauma, the Committee for the Forum on Fundamental Surgical Problems, the Committee on Graduate Education, and the Young Surgeons Committee. These committees provided the “warm spots” for me within the College, and I’d like to see young surgeons have the same opportunities to be active participants in the College. Hopefully, this planned gift will help them to do so.

Martin C. Robson, MD, FACS, FRCS (Hon), FRACS (Hon), Retired Plastic Surgeon, Stuart, FL

Corporate Giving

Kinetic Concepts, Inc. (KCI) awarded an educational grant of $250,000 to the American College of Surgeons Foundation to support a research fellowship and a scholarship in honor of Louis Argenta, MD, FACS, of Wake Forest University Baptist Medical Center, Winston-Salem, NC. Both educational opportunities honor the role of Dr. Argenta in developing negative-pressure wound therapy in the early 1990s and his continued contribution to improving the care of surgical patients.

The Dr. Louis Argenta Faculty Research Fellowship will provide a one-year award annually for the next five years to help a surgeon establish an independent research program on wound care. The Dr. Louis Argenta International Guest Scholarship will be awarded in each of the next five years to a surgeon from a country outside North America to allow the awardee’s participation in the following year’s ACS Clinical Congress and the opportunity to visit academic institutions in the U.S. or Canada for further education in advancing wound care. The international scholarship helps honor the impact of Dr. Argenta’s fellowship in Paris and his membership in the International Society of Surgery.

“Dr. Argenta’s pioneering work created a real opportunity to globally change the standard of care in wound therapy,” said Catherine Burzik, KCI president and CEO. “The people of KCI are privileged to honor his accomplishments with an enduring commitment to research in this important area of medicine.”

Reaching New Constituents

In Spring 2010, leaders of the American College of Surgeons were honored at a reception at the home of Mrs. David Mahoney in Palm Beach, FL. This event evolved through the advocacy of Richard Lynn, MD, FACS, and his wife, Margrit, who is a long-time friend of Mrs. Mahoney. This event was the Foundation’s first regional outreach to build awareness and philanthropic support for ACS programs.

Dr. LaSalle D. Leffall, Jr., Past-President of the College, and Dr. LaMar S. McGinnis, Jr., current President of the College, spoke about the history and future trajectory of the College’s programs. Dr. Thomas R. Russell, Chair of the ACS Foundation Board of Directors, discussed the College’s role in health care reform and in ensuring high standards of patient safety. Also representing the College were Michael Zinner, MD, FACS, Chair of the ACS Board of Governors, and J. Patrick O’Leary, MD, FACS, executive dean of clinical affairs at Florida International University College of Medicine. Representing the ACS Foundation were Dr. Richard B. Reiling, Vice-Chair of the ACS Foundation Board, and Martin H. Wojcik, CFRE, Interim Executive Director.
The Mayne Heritage Society

When Earl Mayne, MD, FACS, concluded his surgical practice in 1948, many current Fellows of the American College of Surgeons were not born, much less active. Yet years after his passing, Dr. Mayne continues to have a profound impact on the College’s constituents and on best practice. Through his estate in 1944, Dr. Mayne established a trust that supported medical education scholarships for hundreds of individuals over many years. Eventually, proceeds from the Mayne Educational Fund reverted to the American College of Surgeons to support programs in the Division of Members Services.

Dr. Mayne, a native Iowan, worked his way through college and eventually medical school. He practiced in New York for many years and became a member of the Board of Governors of the American College of Surgeons. During his tenure on the Board of Governors, he decided that supporting the scholarly mission of the College was the best way to foster future progress in the surgical sciences. The value of Dr. Mayne’s gift to the College, received in 1994, now generates an income of several hundred thousand dollars annually. Dr. Mayne’s far-sighted generosity from decades ago ensures financing of education programs serving residents and Associate Fellows now and into the future.

In honor of Dr. Mayne’s philanthropic legacy, membership in the Mayne Heritage Society recognizes Fellows who have provided a bequest or planned gift to the College through their estates. Among other benefits, Mayne Heritage Society membership ensures that dues-exempt and retired Fellows continue to enjoy a rewarding relationship with the College. Mayne Heritage Society members are listed prominently in honor rolls in both the Foundation Annual Report and on the Foundation’s website, and are welcomed to the Fellows Leadership Luncheon and Hospitality Center during Clinical Congress. The leaders of the ACS Foundation encourage your consideration of a bequest to the College through your estate plan, a simple transaction with considerable impact on the future.

The Mayne Heritage Society

Dr. and Mrs. Neil C. Clements • Arizona
Dr. Benjamin L. Crue, Jr. • Colorado
Dr. and Mrs. Martin L. Dalton, Jr. • Georgia
Dr. and Mrs. Henry Gans • Florida
Dr. and Mrs. David E. Grambort • Arkansas
Dr. Peter S. Hedberg • Oklahoma
Dr. John C. Iacuzzo • New Jersey
Dr. and Mrs. Paul H. Jordan, Jr. • Texas
Dr. and Mrs. M. J. Juskiewicz • Georgia
The Estate of Harry E. Keig • Florida
Dr. and Mrs. Norman M. Kenyon • Florida
Dr. William W. Kridelbaugh • New Mexico
Dr. and Mrs. LaSalle D. Leffall, Jr. • District of Columbia
Dr. and Mrs. Joseph H. Lesser • California
Dr. and Mrs. Eric T. Lincke • Michigan
Dr. and Mrs. James V. Maloney, Jr. • California
Dr. and Mrs. Richard W. Martin • North Carolina
The Estate of Dr. Earl H. Mayne • New York
"Dr. Mary L. McKenzie • Florida
The Estate of Harold H. Metz • Pennsylvania
Dr. and Mrs. Henry A. Norum • California
Dr. and Mrs. Frank T. Padberg, Sr. • Illinois
Dr. Frederick W. Plugee IV • Maryland
Dr. and Mrs. Stuart M. Poticha • South Carolina
Dr. and Mrs. Richard B. Reiling • North Carolina
Dr. and Mrs. Martin C. Robson • Florida
Dr. and Mrs. Russell L. Ryan • Massachusetts
Dr. Amilu Stewart • Colorado
The Estate of Dr. Frank Stinchfield • New York
Dr. Hugh H. Trout III • Maryland
"Dr. and Mrs. Irving W. Varley • Washington
Dr. and Mrs. Alexander J. Walk • Michigan
The Estate of W. Merle Warman • West Virginia
Dr. and Mrs. Andrew L. Warnsh • Massachusetts
The Estate of Claude E. Welch • Massachusetts
Dr. and Mrs. David P. Winchester • Illinois
"Dr. A. Stark Wolkoff • Kansas
"Dr. and Mrs. Scott W. Woods • Michigan

† Deceased

www.facs.org/acsfoundation/
Friends of Tom Russell

The American College of Surgeons Foundation recognizes the generosity of those individuals whose donations have established the **Thomas R. Russell, MD, FACS, Scholarship Fund.** The Foundation Board of Directors (above) set a goal of $1 million, with income from the Fund to support the education and research aspirations of young surgeons. **Russell Scholars** will be selected annually to pursue development initiatives in the College. This special opportunity for philanthropy continues. Information is available through the members of the Board of Directors and the Foundation office.

American Society for Metabolic and Bariatric Surgery • Florida
American Society for Surgery of the Hand • Illinois
Mr. Leslie J. Armour • New Jersey
Dr. Nancy L. Ascher • California
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Dr. and Mrs. Thomas V. Whalen • New Jersey
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Ways to Give

The American College of Surgeons Foundation is a tax-exempt, not-for-profit organization whose sole mission is to promote voluntary philanthropy to support the College’s priorities. Contributions are deductible to the extent allowed by law.

Gifts may be directed to general support of the College’s programs in quality patient care, education and research, and outreach activities. Donors may also direct their gifts toward a specific program area, as outlined on the Foundation’s website: [www.facs.org/acsfoundation](http://www.facs.org/acsfoundation).

A variety of gifting vehicles is available to our benefactors:

**GIVING ONLINE**
Please visit [www.facs.org/acsfoundation](http://www.facs.org/acsfoundation) to donate with a credit card.

**GIFTS OF CASH**
You can donate through the mail by check or money order, payable to:

American College of Surgeons Foundation
633 N. Saint Clair St.
Chicago, IL 60611-3211

WHAT’S YOUR INSPIRATION?
For almost two years, physicians across the nation have watched Washington, DC, with much anticipation as to what was going to happen in the health care reform debate. In the spring of 2010, the anticipation ended with passage of the Affordable Care Act (ACA). Now, attention turns to the states as they are faced with the challenge of implementing the ACA by 2014. States are faced with the huge undertaking of carrying out the requirements set forth in the ACA, in addition to finding solutions to the additional challenges that arise every year, such as budget shortfalls, taxes, and additional health care issues beyond health care reform.

It may seem that the ACA was the only significant legislation introduced and passed in 2010, but, in fact, from January to mid-July, more than 180,000 bills were introduced in 46 states and the District of Columbia. The American College of Surgeons State Affairs staff tracked approximately 560 bills during the 2010 legislative session. The bills being tracked generally fall into five legislative priorities (see figure, page 24):

- Medical liability reform
- Trauma
- Scope of practice
- Uniform Emergency Volunteer Health Practitioner Act (UEVHPA)
- Uniform Accident and Sickness Policy Provision Law Repeal (UPPL)

The following article highlights a few of the issues that arose from the 560 tracked bills in 2010, as well as the impact to the states of the implementation of the ACA.

Affordable Care Act
Since the signing into law of the ACA earlier this year, state governments have been diligently working to figure out what provisions they need to implement and when they need to implement them. Not surprisingly, a large, complex health system reform law creates a large, complex planning and implementation process, and numerous organizations have developed resource websites to assist with this process.

For example, the National Governors Association (NGA) created a health care reform implementation resource center on its website.
(http://www.nga.org) that defines implementation issues by organizing them into four categories: Medicaid/Children’s Health Insurance Program, state-based health insurance exchanges, insurance regulations, and delivery system initiatives. It also provides a link to a page for the federal Department of Health and Human Services (HHS), which provides information for states on planning and implementation of health care reform.4

In addition to the NGA’s health care reform implementation center on its website, the State Consortium on Health Care Reform Implementation was formed by the NGA, National Academy for State Health Policy, National Association of Insurance Commissioners, and the National Association of State Medicaid Doctors to provide coordinated information and technical assistance to states regarding reform requirements. The Consortium also presents best practices and regulatory options for health care reform implementation in the states, some of which may also be available on consortium member’s own websites.

To gain a sense of what state governments need to address, HHS developed an implementation timeline, available in a seven-page document at the NGA website, http://www.nga.org/files/pdf/2010hhsimplementationtimeline.pdf. For 2010, there are 29 items that the state governments must address, including areas such as:

- Access to insurance for uninsured Americans with pre-existing conditions, and no discrimination against children with pre-existing conditions
- Prohibition of the dropping of coverage when people get sick

- Elimination of lifetime limits on insurance coverage
- Health insurance rate review to prevent unreasonable rate hikes

**Physicians and state implementation**

The American Medical Association (AMA) Advocacy Resource Center has developed an extensive state-specific health care reform implementation Web page available to AMA members and component medical societies to help them work with their respective state governments on ACA implementation. The Web page highlights and describes major provisions of the ACA, including the following:

- **Medicaid.** The ACA significantly expands those patients covered by Medicaid. As a result of the new law, Medicaid must cover all non-Medicare eligible individuals younger than 65 years of age with incomes up to 133 percent of the federal poverty level (FPL) based on modified gross income. Through this change, Medicaid is expected to cover an additional 16 million people by 2014.

- **Health insurance reforms.** The ACA reforms the health insurance marketplace in numerous ways. The ACA prohibits or restricts several of the most onerous health insurer practices, including rescission and pre-existing condition requirements. The ACA also requires the states and the federal government to determine when insurers’ rate increases are “unreasonable.” The medical loss ratio requirements in the ACA could be the most important market reform provision, and will have a profound effect on the health insurance marketplace for patients.

- **Health insurance exchanges.** The ACA authorizes state health insurance exchanges for the individual and small group markets. The American health benefit exchanges and small business health options program exchanges will start January 1, 2014. The exchanges will be open to all who need to purchase coverage in order to comply with the individual mandate, and those consumers who earn less than 400 percent of the FPL will receive subsidies.
to enable them to afford coverage. Also, the ACA establishes a high-risk fund to provide a bridge to the exchanges for uninsured individuals with pre-existing conditions.

- Public health initiatives. There are many public health initiatives contained in the ACA. These measures focus on wellness and prevention, as well as initiatives to improve the quality of health care. Much of the ACA public health provisions focus on promoting preventive services by requiring insurers to cover certain preventive measures, allowing insurers to create wellness incentive programs. In addition, the new law provides many opportunities for states to receive grants or participate in pilot programs on myriad issues, including childhood obesity initiatives, community transformation grants, and medical home pilot programs.

The bottom line in all of this is that there is a lot of work to be done between now and 2014 to implement the ACA at both the federal and state level. Surgeons should not only be aware of what is going on in their states with regard to the ACA, but they should also work with their colleagues to ensure that implementation of the ACA benefits both patients and the practice of medicine and surgery.

Medical liability reform

Due to a number of factors, the last few years have seen a significant decrease in the number of bills addressing large-scale Medical Injury Compensation Reform Act reforms. This is due, in large part, to the fact that 30 states now have some form of caps on noneconomic damages (which in some instances may be quite limited in application), and many states have enacted other significant reforms. For the remaining states with little to no reform, passing reform legislation will be difficult, due to unfavorable political climates in the states, or constitutional barriers that prohibit reform. Similar to 2009, most of the reform battles during 2010 took place in the courts, with physicians defending the importance of caps on noneconomic damages.

In 2009, Oklahoma was the first state to pass comprehensive reform legislation since 2006. During the 2010 legislative session, only Tennessee introduced reform legislation (H.B. 2887) that would have placed caps on noneconomic damages at $1 million. The bill saw little movement during the legislative session.

Medical liability reform was dealt two major blows in 2010, in the form of Supreme Court rulings. The Supreme Courts in Illinois and Georgia ruled caps on noneconomic damages to be unconstitutional. The ruling in Illinois represented the third time that the court has ruled that caps are unconstitutional in the state. The Georgia court ruled that caps on noneconomic damages were unconstitutional because the caps violated a plaintiff’s right to trial by jury. The Supreme Court of Kansas is expected to deliver a ruling on this issue in the near future.

Trauma

Of the 560 bills tracked by the ACS in 2010, 335 were related to various trauma issues. Distracted driving was an issue that most state legislatures tackled in 2010, with 31 states introducing distracted driving legislation. In fact, Iowa alone introduced 14 distracted driving bills. Distracted driving legislation was passed in Connecticut, Delaware, Georgia, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Nebraska, Oklahoma, Vermont, Washington, Wisconsin, and Wyoming. Now 36 states have some form of a texting-while-driving ban in place, while 13 states enforce a ban on hand-held cell phones.

Surgeons and coalition partners in Massachusetts joined with the College in supporting S. B. 2257, which is legislation to ban the use of all-terrain vehicles (ATVs) for riders under the age of 14. Hundreds of letters in support of this

States that have damage caps, primarily noneconomic:
Alaska, California, Colorado, Florida, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, Virginia, West Virginia, and Wisconsin

States that have constitutional bans on caps on noneconomic damages:
Arizona, Oregon, Pennsylvania, and Wyoming
bill were sent to legislators through the Surgery State Legislative Action Center (SSLAC), and many phone calls also were placed by Massachusetts Fellows and Residents, helping to pass the bill in the Senate and then the House. Years of consistent and strategic advocacy by this broad coalition of surgeons, child safety advocates, and the ACS and Massachusetts Chapter paid off when the governor signed the bill into law in late July. In addition to the key provision prohibiting children under the age of 14 from operating an ATV, the law also requires safety training for all ATV operators 18 years old and younger.

In 2009, Georgia saw major success in trauma funding when a “super speeder” bill (H.B. 160) was signed into law. The “super speeder” law adds an additional $200 fine for driving more than 85 mph anywhere in the state, and for driving 75 mph or more on a two-lane road, and was expected to generate approximately $23 million in fiscal year 2010. (For more information, refer to “State stats: Trauma funding in the states,” in the September 2010 issue of the Bulletin (Bull Am Coll Surg. 2010; 95[9]:29).

In 2010 the Georgia legislature also passed a significant piece of legislation that could go very far in protecting the state’s trauma system and trauma funds. This legislation, S.R. 277, is a resolution that proposes an amendment to the Georgia constitution that would impose an annual $10 trauma charge on certain passenger motor vehicle registrations in the state for the purpose of funding trauma care. S.R. 277 has been added to the November ballot to be voted on by the residents of Georgia. (See related article, “The quest for sustainable trauma funding: The Georgia story,” by Dennis W. Ashley, MD, FACS, FCCM; Bull Am Coll Surg. 95[10]:17-21).

The Alaska legislature passed legislation (H.B. 168) that provides for state certification and designation of trauma centers, and created a trauma fund to help compensate certified trauma centers. The funds are to be appropriated by the Alaska legislature.

Scope of practice

Nonphysician health care providers are becoming increasingly aggressive in their efforts to expand their scope of practice to include treatments, procedures, and authority inconsistent with their education and training, by pursuing legislative, regulatory, and administrative agendas. 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. As was the case in past years, 2010 saw a significant number of nonphysicians seeking the means to practice outside of their education and training, thus putting patients’ lives at risk.

In West Virginia, optometrists were seeking expansion through legislation (S.B. 230), which 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.” (For more information, refer to State Stats: Scope of practice overview, in the July 2010 issue of the Bulletin; Bull Am Coll Surg. 2010; 95[7]:62-63). The ACS, in conjunction with the American Academy of Ophthalmology and the Scope of Practice Partnership (SOPP), organized grassroots efforts and successfully defeated portions of the bill. The final version, signed by the governor, stated that an optometrist licensed in the state is prohibited from doing the following: performing surgery except as provided by the statute; using a therapeutic laser; using schedule II controlled substances; treating systemic disease; or presenting to the public that he or she is a specialist in surgery of the eye—nor may they use the term “optometric physician.”

New York faced three major scope-of-practice battles in 2010. The first was a continued legislative effort (A. 4656-A/S.B. 2937) from 2009 on behalf of the single-degree (DDS) oral and maxillofacial surgeons seeking the ability to perform cosmetic surgery including rhinoplasty, blepharoplasty, rhytidectomy, otoplasty, and liposuction. The New York legislature adjourned with little movement on the bill. The second scope-of-practice battle was on behalf of the podiatrists who introduced legislation (A.B. 2518/S.B. 2992) that would have expanded their scope from the foot to include the foot, ankle, and all soft tissues below the knee which govern the function of the foot and ankle. S.B.2992 was passed by the Senate in June, but was stalled by the Assembly.
In their respective states, with their licenses recognized in affected states for the duration of emergency declarations.


UEVHPA legislation in 2010 was introduced in Florida, Georgia, Illinois, Mississippi, New Hampshire, and Washington. As noted previously, this legislation was successfully enacted in Illinois and the District of Columbia.

Repeal of the UPPL

The Uniform Accident and Sickness Policy Provision Law (UPPL) is the state law that allows health insurers to deny reimbursement for services provided to patients for injuries incurred when an accident is a result of the insured’s intoxicated state or if the insured is under the influence of narcotics.4 The states that have repealed the UPPL are California, Colorado, Connecticut, District of Columbia, Illinois, Indiana, Iowa, Maine, Maryland, Nevada, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, and Washington. Virginia is a special case regarding the law, due to the fact that the state still has alcohol exclusion laws on the books, but insurers operating in the state do not include exclusions in their policies.

The ACS chapters of New York have been working to repeal the UPPL for many years, and this year finally saw great success when the No-Fault Intoxicated Driver Bill (S.B. 7845) was signed into law by Governor Paterson. S.B. 7845 requires insurance coverage for emergency medical services provided to a patient, regardless of whether he or she was injured by driving while intoxicated. (See related story, page 38.)

Miscellaneous

States continued to experience severe budget shortfalls this year, and a few of those desperate for funds sought solutions through unfair and arduous taxes on physicians, in an effort to bridge state budget deficits. In Washington, the state legislature introduced a bill (H.B. 3191) that

Naturopaths—health care providers focusing on natural remedies and the body’s ability to heal and maintain itself—also introduced legislation (A.B. 1370) that would have licensed them as naturopathic doctors, or NDs, although the legislation saw very little movement during the legislative session. It is expected that New York will see all three bills reintroduced in 2011.

Recently, legislative initiatives have been introduced to enact Truth in Medical Education (TIME) and/or Truth in Advertising (TIA). This legislation highlights the importance and need 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 semi-professional titles using the term “doctor,” patients are more confused now than ever before regarding the training and education of health care practitioners.

In Illinois, the legislature passed S.B. 3509, which created the Truth in Health Care Professional Services Act. As required by the bill, advertisements for health care services that name a health care professional must identify the type of license he or she holds pursuant to the definitions under his or her licensing act, and provide that the advertisement shall be free from any and all deceptive or misleading information. S.B. 3509 was signed into law by the governor in July. Arizona passed similar legislation (S.B. 1255), which requires advertisements with a health care professional’s name to identify the type of license the health professional holds, and under which the health practitioner is practicing.

UEVHPA

The Uniform Emergency Volunteer Health Practitioner Act (UEVHPA) is a piece of legislation that responds to a serious problem caused by a lack of uniformity in state laws, as was revealed during the horrific hurricane season of 2005. Passage of UEVHPA allows state governments to give reciprocity to other states’ licensees who are emergency services providers, so that covered individuals may provide services without meeting the disaster state’s licensing requirements. It recognizes a national registration system utilized to confirm that physicians and health practitioners are appropriately licensed and in good standing in their respective states, with their licenses recognized in affected states for the duration of emergency declarations.

would have added a state sales tax (of at least 6.5 percent) on elective cosmetic medical procedures. The bill passed swiftly out of the House Finance Committee before stalling in the full House.

For a second time in six months, Michigan’s governor recommended a 4 percent tax on gross physician services, intended to increase funds available to improve the Medicaid match. Michigan physicians were successful in defeating the proposed tax for the second time, by joining together and advocating with a unified and consistent message.

The Surgery State Legislative Action Center (SSLAC) was activated to assist Massachusetts surgeons to voice their opposition to efforts by the legislature to tie together physician licensure and reimbursement mandates for affordable health plans. Toward the end of the legislative session, amendments for quality improvement legislation were offered, but were defeated.

Looking ahead

It is always difficult to predict with any degree of certainty what future legislative sessions will bring, although trends do seem to carry over from one year to the next. As noted in this article, scope-of-practice issues will likely pop up in many states in 2011, with an increased focus on TIA/TIME legislation; and the potential for introduction of the UEVHPA in numerous state legislatures is also likely. Due to the passage of the ACA, all state legislatures will be faced with creating those structures and regulatory frameworks necessary for implementing various elements of health reform.

Regardless of what issues state legislators seek to address in 2011, the State Affairs staff in the Division of Advocacy and Health Policy is available to physicians and ACS chapters to provide advice and resources on the best way to address legislative and regulatory issues arising at the state level. For more information on state legislative issues, please contact Jon Sutton, Manager; State Affairs, at jsutton@facs.org; Charlotte Grill, State Affairs Associate, at cgrill@facs.org; or Alexis Macias, Regional State Affairs Associate, at amacias@facs.org.

References

Spotlight on a U.S. Army surgeon:

Interview with MAJ Jennifer Gurney, MD, FACS

by Mary Maniscalco-Theberge, MD, FACS
Editor's note: The following interview originally appeared in AWS Connections, Summer 2010, published by the Association of Women Surgeons (AWS). Reprinted with permission.

Jennifer Gurney, MD, FACS, assistant professor of surgery, Uniformed Services University of the Health Sciences, Bethesda, MD, is currently stationed at Landstuhl Army Regional Medical Center, Germany. During her 10 years of active duty, she has served in Operation Iraqi Freedom and Operation Enduring Freedom (Afghanistan). While in Afghanistan, her Forward Area Surgical Team (FAST) supported a Special Operations Task Force.

How did you get assigned to a Combined Joint Special Operations Task Force? I thought Special Forces were all men.

It was just random. Our FAST in Afghanistan was divided for split operations, and my half got assigned in support of a Special Operations Task Force. There are surgeons who go only in support of Special Operations—and they are all men.

What was the biggest challenge supporting a Special Forces Unit?

The biggest challenge was moving with the unit. We moved multiple times, and that required packing and unpacking all of the equipment and setting it up quickly to receive casualties with each move. In addition, another challenge was the down time. When we were busy, it was easier. When we had a five- to six-day lull, it could get frustrating—you needed to adjust to handling uncertainty; very busy versus very bored.

How far forward were you?

We were “out there” in support of the far forward units such as the Special Forces, Marine Units, and U.S. Army Civil Affairs, who worked directly with the small Afghan villages. Practically speaking, there was not a Post Exchange store to get things like personal toiletries. Thank goodness for anysoldier.com—they would send us stuff through the mail, like tampons, lotion, lip balm, and tons of other stuff.

What did you do for stress relief?

We would watch movies, exercise (sometimes watch the guys exercise), and talk.

What kept you sane?

My CRNA friend kept me sane. It was really great to have her there with me. In addition, while clearly forced to work outside of my zone of comfort, our team had to keep it together. The soldiers and other units were depending on us. The team looked to the general surgeon as the leader, so I always had to maintain a sense of control and composure, even in the most chaotic of situations.

I think it is actually harder on your family back home. I have been on both sides: deployed and...
plan to move the patients 4,000 miles. With different surgeons and different opinions—the system has to work like a team—communication is even more critical.

Another aspect of the far forward location is the support provided to the local nationals. Actually, most of our operative cases were on Afghans—the Afghan police, army, or local civilians. Also, we took care of a surprising number of children. It was very rewarding to be helping the local community medically. We were a very positive representation of the U.S., and the Afghans were very appreciative.

What advice do you have for other women who would deploy into an environment like one in support of Special Forces?

at home when my husband was deployed. When deployed you are focused, doing your job and taking care of the team and yourself, and you know you are okay. When you are the family member at home, though, because you don’t have the same type of intense mission and are mostly unaware of the situation, the stress or worry for your loved one is much greater.

What were the differences between the far forward units, Germany, and U.S. medical practice?

They are all different, especially with regard to the leadership and command. Very far forward, we were “the docs”—very patient-care focused, taking care of the injured—that was our primary mission and there was minimal paperwork, we just had to communicate with the higher echelons. As you move further to the rear, there is more paperwork, much more paperwork, as well as more Army requirements—even physical fitness tests.

Distance is also a factor. In a medical center, you just have to move the patient up [in] an elevator to another floor. Far forward, we would have to

Maintain your professionalism, be a leader, work hard, do not be afraid. Think of yourself as a surgeon first and a soldier second—your gender is not relevant. If you know that, then everyone around you knows that as well.

How have your deployments affected your practice as a teacher and surgeon?

Not a week will go by without referencing aspects of the care provided in relation to a far forward deployment. Specifically, things like damage control, learning from open cases (which are what you do a lot of far forward), and physical exam skills to make the diagnosis, as you do not have a lot of the technology far forward to help you make your diagnosis.

Supporting far forward units in Afghanistan and the Special Operations Task Force in remote areas, I was “out there”—it matured me very quickly and has helped shape me as a surgeon.

How have your deployments influenced your interactions with military patients?
They have changed my perception of how I saw the military. I went to a civilian medical school and had practically no exposure to the military prior to starting residency at Walter Reed Army Medical Center. Deployment opened my eyes to how unique the military is and how hard the soldiers work. Deployment definitely reinforced my commitment and belief that the soldiers, who volunteer to put themselves in harm’s way, deserve only the very best of care from committed physicians. When deployed, they work exceptionally hard under the worst of circumstances. With my combat patch on my shoulder, some patients react to me differently; they know that I know their sacrifices. It is interesting, though. I get to wear the Special Forces combat patch, and there are not many women who wear that patch. I will occasionally get stopped and questioned if I am authorized to wear their patch.

How did your residency prepare you for your deployments?

I feel very lucky to have trained at Walter Reed Army Medical Center. Since Walter Reed was the principal receiving hospital for the war during my residency, I saw combat causalities at the end of the line. I think my experiences during my residency did give me a different perspective on how I handled patients far forward, and the communication that I sent back.

In addition, residency prepared me well to problem-solve, assess a patient, and develop a plan. My residency pushed us. There was stress and pressure, so I felt ready. I feel that I was taught good, solid concepts, and my shock trauma experience gave me confidence. I felt as prepared as anyone could to be a sole general surgeon in an austere environment.

How did being deployed compare to your residency?

In my residency, I felt safe, both physically and because I had backup—there was always someone to call or bounce things off of.

Deployed, there was the threat to personal safety—which is frequently ignored at the time because there is a “job to do”—but retrospectively, I am very grateful not to have been hurt. In addition, there were the stresses of being on call for many months straight, the unknown of the number of patients, the severity of the injuries, and the overall tempo of the environment—occasionally there were a lot of unknowns and that was a little stressful. There would be times in a complicated abdominal case that I wished to have another general surgeon there with me. I was with an orthopaedic surgeon, who was overall a great partner, but not the same as a general surgeon!

What do you attribute your success to?

Good communication, working with the team, and training the team. One general surgeon cannot do it all. You really have to rely on the
team to do the initial resuscitation of trauma patients, if you are in the operating room. We had a well-developed mass casualty plan, triage system, whole-blood plan, and we rehearsed and we trained a lot during the quiet times. Our whole hospital was set up in tents or “B-huts” (depending on where we were), so everything was open and accessible. Commanders and soldiers would come and see patients, and they would see how our team worked together during traumas. They could see firsthand the excellent care we took of the casualties, and this instilled confidence in the units.

Was there a downside to your deployments?

Eating MRE (Meal, Ready-to-Eat) only during my deployment to Afghanistan (in Iraq the food was great!), minimal privacy, being away from home and family, times with no hot water, the cold, the heat, rocket attacks, mortars, the occasional gastrointestinal distress from the local food, bad smells, the bugs. There were lots of bugs—the bugs may have been the biggest downside.

Advantages of practicing medicine/surgery in the military?

I get to practice the type of surgery I want to practice. There is autonomy of practice, but also plenty of support. There are no restrictions in terms of cost for care of the surgical patient. I do not have to think about what insurance the patient has, reimbursement. Also, if I want to spend time explaining to a patient some aspect of their care for one hour, I can, as there is not the pressure to keep moving to generate more money. I really think that specialty care in the military is excellent, and I’m proud to be a part of it.

Do you think there is a glass ceiling in the Army for women surgeons?

No.

It sounds like you learned a lot from your deployments. How do you feel about future deployments?

Personally, I don’t look forward to deploying again, because of the obvious challenges of being away from home/family and the hardships of the environment. My deployments were also very hard on my mother, who worried constantly, which made me worry about her. Professionally, however, there is no greater honor and experience. Deployment is more rewarding than it is challenging. It is a great feeling be one of the many who contribute to getting a soldier home to their family. If there is going to be a war, then there need to be surgeons who are hard working, dedicated, and willing to commit themselves to the care of the combat casualty. Thankfully there are many.

The views expressed in this article are those of Dr. Gurney and do not reflect the official policy or position of the Department of the Army or the U.S. government.

Dr. Maniscalco-Theberge is deputy medical inspector, professional services, Office of the Medical Inspector, Veterans Health Administration, Washington, DC. She is a member of the AWS Clinical Practice Committee.
Nationally, disparities in surgical care are a combination of complex patient, social, and institutional factors. The relative contributions of access and timeliness of surgical care to these disparities is not clear. For some conditions such as cancer, disadvantaged populations may present with more advanced disease. For example, African-Americans, Native Americans, Hawaiians, Indians and Pakistanis, Mexicans, South and Central Americans, and Puerto Ricans are 1.4 to 3.6 times more likely to present with advanced (stage IV) breast cancer than non-Hispanic whites. In addition to clinical presentation as an explanatory variable for outcome differences, access to specialists, such as surgeons, may also contribute. For example, in the Community Tracking Study Physician Survey, P. B. Bach, MD, MAPP, and colleagues found that clinicians caring for African-American patients were less likely to report access to high-quality subspecialists, high-quality diagnostic imaging, high-quality ancillary services, and non-emergency hospital admission. These results indicate that race and ethnicity may dictate the quality of patient care as far as it is determined by location and access to providers.

Role of the ACS

In the American College of Surgeons’ (ACS) ongoing effort to improve the quality of care overall, focusing on disparities may be a fruitful target for interventions, as the overall quality of care will improve if we eliminate health care inequities. In addition to issues of access, outcomes are affected by factors such as race, ethnicity, primary language, and culture. Surgeons are increasingly concerned about patients’ outcomes, especially as public reporting and pay for performance initiatives promulgate. Traditionally, surgical procedures are viewed as discrete, episodic interventions in which all patients are treated equally.

However, racial and ethnic disparities in outcomes have been reported. Some studies have suggested that race is an independent predictor of poor outcomes following surgery. Using Medicare data on eight major cardiovascular and cancer procedures, John Birkmeyer, MD, FACS, and colleagues found that the African-American race was associated with an increased risk of death in seven out of eight procedures, even when adjusting for severity of illness. The effect of race on outcomes, however, was attenuated, when the effect of the hospitals at which patients were treated were controlled.† The structure of the hospitals in which disadvantaged populations receive care may lead to some of these outcome differences. The mitigation of health care disparities will be an important step to improve the overall quality of care in the U.S.

**Solutions to health care disparities**

Given the complexity of the health care disparities, we believe that a multi-pronged approach to eliminate surgical disparities in care, from access to outcomes, is necessary. Strategies on the national and local level will certainly differ. As there is an increasing focus on patient safety and the quality of surgical care, now is the time to address the issue of disparities in surgical care, as this reflects a defect in the overall quality of care.

Therefore, the ACS believes that ethnic and racial health care disparities have no role in a humane and just society, and are ethically and morally antithetical to the practice of medicine and surgery.

The College further promotes the principle that all patients deserve to be treated with respect and compassion, regardless of race, gender, creed, or religious beliefs. The ACS urges the Centers for Medicare & Medicaid Services and other agencies to include the factors of race, socioeconomic background, and educational level of patients into existing and future risk-adjustment methodologies for mortality and morbidity adjustment.

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Are E/M services reportable with a surgical procedure?

by Mary LeGrand, RN, CCS-P, CPC

As payors become more prone to denying payment for Current Procedural Terminology (CPT)* evaluation and management (E/M) codes billed as “incidental to another service,” surgical practices are seeking appeal assistance with increasing frequency. Practice staff members who handle appeals need to know when the denials are appropriate and whether they should appeal. If the service was coded appropriately, then the practice should appeal. If the case was not reported appropriately, however, it should be used as an educational opportunity with the surgeons and any staff member involved in the coding and billing process. (If incorrect, adjust the charge and document the reason as coding error for compliance monitoring.)

Global billing

CPT and Medicare reimbursement rules allow the reporting of an E/M service when the service is either a significant, separate service or leads to the decision to operate or perform a procedure. Medicare assigns global days to the surgical procedure codes. Some key points to keep in mind for global billing include the following:

• A minor procedure, for the purpose of global days, is a surgical procedure that has a zero- or 10-day global period.

A major procedure, for the purpose of global days, is a surgical procedure that has a 90-day global period. The number of days may vary by payors, but 90-day global periods are the most common and follow Medicare rules.

• Surgical procedures with no global days are typically indicated on the Medicare fee schedule as 000, meaning that the global period concept does not apply. Of course, add-on surgical codes do not have global days either. Since add-on codes are not reported independently, the concept of applying Modifier 25 or Modifier 57 does not apply to them.

The definition of the two modifiers, the rules, and a scenario for each follow.

Modifier 25

Modifier 25, Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service, is appended to an E/M service most common on the same day as a minor surgical procedure if the E/M is for a significant separate service. This situation typically occurs when a patient presents for evaluation of a condition and the surgeon decides to perform a minor surgical procedure. In these instances, append Modifier 25 to the E/M code and report in addition to the minor procedure.

• Scenario 1: E/M as significant service. A non-Medicare patient is seen in consultation for evaluation of a breast mass that was identified via a mammogram. The surgeon performs and documents an E/M service, as well as diagnoses a breast cyst, which the surgeon decides to aspirate. The surgeon aspirates three cc’s of fluid from the cyst during the same visit. In this case, the reason for the encounter was the E/M service; thus, the E/M is the significant service and is reported in addition to the aspiration of the breast cyst. A written report is sent to the physician who requested the consultation.

Because the patient is non-Medicare, the surgeon reports 9924x–25, Significant E&M service, consult, non-Medicare patient, and 19000, puncture aspiration of cyst of breast. Both services are reportable assuming the documentation supports the services. If denied, appeal on the basis that the E/M was the reason for the visit and the decision to perform the aspiration of the cyst occurred as a result of the E&M service.

• Scenario 2: E/M as separate service. The
same patient who had the breast cyst aspirated three weeks ago presents to the surgeon because the cyst has reappeared. At the same visit, the patient asks the surgeon to evaluate a skin lesion that has become increasingly bothersome and has started bleeding. The surgeon evaluates both the cyst and the new lesion. The surgeon re-aspirates the breast cyst and evaluates the new lesion.

The surgeon reports 9921x–25, Established patient visit linked to the new lesion diagnosis, and 19000, Puncture aspiration of the cyst linked to the breast cyst diagnosis. Both services are reportable, as the E/M service was for a separate condition than the aspiration of the breast cyst. If the claim is denied based on the E/M service that was not inclusive to the surgical procedure, the surgeon should appeal because the E/M is reported for a separate condition.

**Modifier 57**

Modifier 57, Decision for surgery, is appended to the E/M code when the surgeon evaluates a patient and determines that the patient requires a major operation that will be performed the same day or next day. The key here is that the decision-making E/M takes place and results in the decision for a major surgical procedure either the same day or the next day. Most typically, this E/M represents the urgent decision for surgery.

- **Scenario 1.** A 10-year-old female presents to the emergency room (ER) with complaints of lower right, lower quadrant pain, fever, nausea, and vomiting. The ER physician evaluates her and consults the general surgeon, as he or she suspects the condition might be acute appendicitis. The general surgeon evaluates the patient in the ER and, after reviewing all scans and labs, diagnoses acute appendicitis, confirms the concern of rupture, and makes immediate plans to take the child to the operating room for an open appendectomy. The surgeon reports the consultation service and appendectomy, appending Modifier 57 to the E/M to indicate that it was a decision-making service. Specifically, the surgeon reports 9924x–57, Outpatient consultation (decision for surgery), and 44960, Appendectomy; for ruptured appendix with abscess or generalized peritonitis.†

To receive payment, ensure all services are accurately reported and supported by documentation, and append Modifier 25 or 57 as appropriate, based on the CPT rules and the payor’s definition of major and minor procedures, if they are different than Medicare. Construct the appeal to indicate the E/M was the significant, separate, or decision-making visit, and thus should not be bundled into the surgical services. Also, link diagnosis or diagnoses codes appropriately to support the medical necessity of each service. Do not automatically write off any payor denials as incidental or inclusive without appeal. If the case was accurately documented and reported on the first claim submission, an appeal is warranted.

In addition, review payor contracts to ensure there is no hidden language indicating the bundling of an E/M with a surgical procedure. If this language is found, reconsider the contract with this payor. Also trend payor behavior, and if denials consistently track to one or two payors and there is no contract restriction, meet with the medical director and outline the concerns and increasing health care costs for the payor and the surgeon to construct appeals and overturn inappropriate denials. It may be necessary to request the payor to turn off an automatic edit that may be causing the inappropriate and automatic denial. Review insurance rules for your state, and if the payor continues to violate a contract or deny services without any sound coding foundation, consider reporting the insurer to the state insurance commissioner, the American Medical Association, the state medical society, and the American College of Surgeons, as appropriate.

†Under this non-Medicare scenario, the guidance suggests using a consultation code. This would not be appropriate in the Medicare context given that Medicare has eliminated the use of consultation codes, and similar visits should now use new or established patient visit codes. Note, however, that several private payors have followed Medicare’s lead and have also eliminated consultation codes. To avoid delays in payment, ensure that you are aware of your payor’s policy regarding consultation codes.

**Ms. LeGrand** is a consultant and speaker with Karen-Zupko & Associates, Inc. and teaches the Power Case Coding for Surgeons workshop sponsored by the ACS. Visit http://www.karenzupko.com for more information on the ACS 2010 coding workshop series.
The Uniform Accident and Sickness Policy Provision Law (UPPL), also known as the alcohol exclusion law, allows health insurers to deny reimbursement for services for injuries incurred when a patient is intoxicated or under the influence of any narcotic. In 1947, the National Association of Insurance Commissioners (NAIC) adopted UPPL as a model law and encouraged states to implement it into state policy. Following the NAIC’s lead, most states adopted UPPL into policy during the 1950s.

However, a major shift occurred in 2001, when the NAIC reversed their position and unanimously recommended that states repeal UPPL. To repeal this law, states must enact new legislation that prohibits the denial of coverage for individuals injured while under the influence of alcohol or narcotics. Since 2001, numerous organizations, including the American College of Surgeons (ACS) and the American Medical Association, have pledged their support for the repeal of the UPPL.

The UPPL law has had many negative consequences. For example, in states where the UPPL is still upheld, many trauma centers and trauma surgeons are reluctant to test a patient’s alcohol and toxicity levels because they are unwilling to jeopardize the patient’s insurance coverage. This practice is contradictory to the physician’s medical training and results in inaccurate and incomplete medical records for patients. In states with UPPLs, many patients do not receive the proper interventions from physicians because they were not tested for alcohol and narcotics. It has been demonstrated that trauma centers present an opportunity to provide alcohol counseling to the injured patients who are identified as problem drinkers. Alcohol is such a significant associated factor and contributor to injury that Level I trauma centers need to have a mechanism to provide interventions to identified problem drinkers.¹

Many benefits are associated with screening patients for alcohol and substances in trauma centers. A study at the University of Texas Southwestern Medical Center in Dallas found that when trauma patients are screened for alcohol problems and receive a brief 30-minute intervention consisting of education and counseling from a physician, they have 28 fewer drinks per week and are 48 percent less likely to be readmitted to a hospital than patients who do not receive such an intervention. The UPPL prevents hospitals from screening more patients and providing critical interventions that help patients address substance and alcohol abuse. The ACS recognizes how important it is to repeal UPPL so more patients in trauma centers can be properly screened and receive the comprehensive care they deserve.²

In 2010, several states made progress toward repealing their UPPLs, and in early August, New York Gov. David Paterson (D) signed the No Fault Intoxicated Driver Bill (S.B. 7845) into law. This bill requires insurance companies to compensate health care providers for emergency services provided to patients regardless of whether they were injured as a result of driving while intoxicated. This legislation will correct the inequity in insurance law in New York by ensuring that health care providers are fully compensated for the care they provide.

Nine states (Massachusetts, Michigan, Minnesota, New Mexico, New Hampshire, Oklahoma, Utah,
Vermont, and Wisconsin) never enacted a UPPL. Courts have ruled in favor of allowing insurance companies to deny insurance coverage in states that are silent on alcohol/drug exclusion laws. Virginia is an important exception. A review of policies by Ensuring Solutions, a research program within the George Washington Medical Center dedicated to reducing the ill effects of problem drinking and develop treatment options for people with alcohol problems, found that insurers operating in Virginia do not practice alcohol/drug exclusions. Virginia insurance companies are providing coverage to all clients involved in accidents while intoxicated, even though they are not required to do so by law.6

Figure 1 on this page depicts a map with the current status of UPPL repeal laws in the U.S.

The ACS and its chapters continue to encourage states to enact laws that would prohibit insurance companies from denying coverage to patients who receive medical care due to an injury that occurred while intoxicated. A formal statement on this is available at http://www.facs.org/fellows_info/statements/st-55.html. Surgeons and ACS chapters seeking further information should contact Charlotte Grill, State Affairs Associate, Division of Advocacy and Health Policy, at cgrill@facs.org.

References

Charity care among surgeons: Hours vary by specialty and practice type

by Caitlin Nelligan; Brad Wright; John Scarborough, MD; Stephanie Poley; Elizabeth Walker, MSPH; and Thomas Ricketts, PhD, MPH

Charity care is a crucial source of health care for the uninsured, particularly given the recent economic downturn and resulting losses in health insurance coverage. The provision of charity care is an increasingly important safety net for the public. However, relatively little is known regarding charity care provided by specialists such as surgeons. The Community Tracking Study (CTS) Physician Survey, administered by the Center for Studying Health System Change, is a unique source of information on the provision of uncompensated medical care as reported by physicians, and data from the CTS survey are the foundation of our study. *

Findings

Between 1996 and 2005, 82.4 percent of surgeons and 70.4 percent of nonsurgeons reported providing charity care. Surgeons reported providing 12.4 hours of charity care per month, compared with 6.7 hours among nonsurgeons. Among the surgeons who provided any charity care, general surgeons reported more hours per month than surgical specialists, with 17.9 hours per month versus 13.5, respectively.

Surgeons who provided charity care differed slightly with respect to practice characteristics from their counterparts who did not provide any charity care. Those surgeons who provided charity care were more likely to have an ownership stake in their practice and were more likely to be in a group practice (composed of three or more physicians). Neither age nor years in practice varied notably between the two groups, although women were less likely to provide charity care. Surgeons practicing in a group HMO were the least likely to provide any charity care (see table, this page).

Discussion

While surgeons surveyed for the CTS reported providing more charity care than other physicians, understanding the factors that influence their decisions regarding how much charity care to provide is important when considering strategies to improve access to specialty care among the uninsured.

It is important to consider the amount of patient-

### Provision of charity care by surgeon characteristics

<table>
<thead>
<tr>
<th>Practice ownership</th>
<th>Some charity care provided</th>
<th>No charity care provided</th>
</tr>
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<tr>
<td>Full owners (%)</td>
<td>45%</td>
<td>39%</td>
</tr>
<tr>
<td>Part owners (%)</td>
<td>33%</td>
<td>28%</td>
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</tbody>
</table>

### Surgeon practice type

<table>
<thead>
<tr>
<th>Practice type</th>
<th>Some charity care provided</th>
<th>No charity care provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (%)</td>
<td>37%</td>
<td>26%</td>
</tr>
<tr>
<td>Group HMO (%)</td>
<td>0.1%</td>
<td>12%</td>
</tr>
<tr>
<td>Medical school (%)</td>
<td>0.9%</td>
<td>11%</td>
</tr>
<tr>
<td>Hospital-based (%)</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Other (%)</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Total number of surgeons: 2,473 (527)

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Surgeons reported providing almost twice as many hours of charity care per month as did nonsurgeons.

General surgeons reported providing more hours per month of charity care than did surgical specialists.

Surgeons in a group practice were more likely to report providing at least some degree of charity care.

Data and methodology

Data for this analysis was obtained from the Community Tracking Study (CTS) Physician Survey, sponsored by the Robert Wood Johnson Foundation and conducted by the Center for Studying Health System Change. The survey—which is conducted to better understand how health care delivery in the U.S. is changing over time—uses the American Medical Association and American Osteopathic Association Masterfile data to sample active non-federal office- and hospital-based physicians practicing a minimum of 20 hours per week in direct patient care.

The CTS survey defines charity care as the number of hours in the past month that the physician provided free or reduced fee health care to a patient due to the patient’s financial need. In this context, charity care does not include discounted fee-for-service care or time spent providing services for which the physician expected, but did not receive, payment.

The data presented here combine all four rounds of the CTS (1996–1997, 1998–1999, 2000–2001, and 2004–2005). Physicians were considered surgeons if they were identified as practicing any one of 46 surgical specialties listed in the survey. (Residents and fellows were excluded from the analysis.)

Ms. Nelligan is currently enrolled in graduate studies in Madrid, Spain. She was formerly a research assistant for the American College of Surgeons Health Policy Research Institute at the Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC.

Mr. Wright is a predoctoral fellow at the Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC.

Dr. Scarborough is a general, trauma, and critical care surgeon at Duke Medical Center, Durham, NC, and a fellow of the American College of Surgeons Health Policy Research Institute.

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

Ms. Walker is a research associate at the Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC, and the project manager for the North Carolina Healthcare Quality Alliance.

Dr. Ricketts is professor of health policy and management and social medicine, University of North Carolina Schools of Global Public Health and Medicine, Chapel Hill. He is Co-Director of the ACS Health Policy Research Institute.
L. D. Britt, MD, MPH, FACS, a general and acute care surgeon from Norfolk, VA, was installed as the 91st President of the American College of Surgeons (ACS) during Convocation ceremonies that preceded the official opening of the College’s 2010 annual Clinical Congress in Washington, DC. A Fellow of the College since 1989, Dr. Britt is the Brickhouse Professor and chairman, department of surgery, Eastern Virginia Medical School, Norfolk, a position he has held since 1999. He is the first African-American in the country to have an endowed chair in surgery. Dr. Britt is currently also director of the American Board of Surgery.

Dr. Britt completed both a medical degree and a master’s degree in public health at Harvard Medical School and Harvard School of Public Health, respectively, in 1977. He undertook an internship in the department of surgery at the Washington University School of Medicine’s Barnes Hospital, St. Louis, MO, in 1978, before continuing his postgraduate medical training in 1979 at the W. Alton Jones Cell Science Center, Lake Placid, NY, where he studied cell culture. Dr. Britt also completed an assistant residency (1978–1979), as well as a research fellowship in the islet transplantation laboratory (1979–1981), at Washington University School of Medicine. From 1981 until 1984, he served as a surgery resident at University of Illinois, Chicago, followed by a clinical fellowship in trauma and critical care at the University of Maryland, Baltimore (1985–1986). Dr. Britt became a Diplomate of the American Board of Surgery in 1985, and, in 1987, he completed subspecialty certification in surgical critical care.

Known as an outstanding role model and educator, Dr. Britt is chair of Eastern Virginia Medical School’s council of clinical chairs and a professor in the university’s division of history of medicine, as well as distinguished professor of surgery at the Uniformed Services University of the Health Sciences, Bethesda, MD. In honor of his dedication and excellence in teaching, Dr. Britt has been the recipient of numerous national and institutional teaching awards, including the Robert J. Glaser Distinguished Teaching Award, the nation’s highest teaching award in medicine, which is given by the Association of American Medical Colleges in conjunction with the national medical honor society, Alpha Omega Alpha. His work in combat trauma care and community service has also been widely recognized.

As a Fellow of the ACS, Dr. Britt has been an active leader and participant in the work of the College for more than 20 years. He was ACS President-Elect from October 2009 to October 2010. A member of the Board of Regents since 2000, he served as Vice-Chair (2006–2008) and Chair (2008–2009) and Chair of its Executive, Finance, and Central Judiciary Committees. He was also a member of the Advisory Committee on Nominations for the Board of Regents (2008–2009). He has been a member of (1997–2003) and consultant to (2003–present) the College’s Committee on Medical Student Education and a member of the Committee on Surgical Education in Medical Schools (1999), the Health Policy Steering Com-
Did you know...

THAT SIR RICKMAN GODLEE, President of the Royal College of Surgeons of England, was awarded the first Honorary Fellowship in the American College of Surgeons during the first Convocation in 1913? In 1884, Sir Godlee became one of the first physicians to surgically remove a tumor of the brain. In addition to being a gifted surgeon, Sir Godlee was a linguist, a carpenter, a poet, a botanist, an ornithologist, and an oarsman, while his great knowledge of books made him an honorary librarian at the Royal Medico-Chirurgical Society of Medicine.

Since 1913, 424 internationally prominent surgeons have been named Honorary Fellows of the American College of Surgeons. For a complete list of Honorary Fellows, go to http://www.facs.org/archives/honoraryfellows.html.
Honorary Fellowship awarded to six prominent surgeons

Honorary Fellowship in the American College of Surgeons was awarded to the following six prominent surgeons from Turkey, France, England, India, Brazil, and China during Convocation ceremonies at this year’s Clinical Congress in Washington, DC:

- **Dario Birolini, MD, FACS.** Professor Birolini is a trauma surgeon and critical care specialist in São Paulo, Brazil.
- **Mehmet A. Haberal, MD, FACS, FICS(Hon).** Professor Haberal, Ankara, Turkey, is a renowned surgeon and humanitarian. He is being awarded Honorary Fellowship in absentia due to his detention in Turkey on allegations of anti-government activities.
- **Bernard Launois, MD, FACS.** Professor Launois, Rennes, France, is a professor of surgery at Université de Rennes.
- **Ralph John Nicholls, MA, MB, MChir (Cantab), FRCS(Hon Eng, Glas), EBSQ (Coloproctology), FRCP(Hon Lon), FASCRS(Hon).** Professor Nicholls, London, England, is an emeritus consultant surgeon, St. Mark’s Hospital, London; and visiting professor of colorectal surgery, Imperial College of Science, Technology, and Medicine, London.
- **Tehemton E. Udwadia, MBBS, FACS.** Professor Udwadia, Mumbai, India, is an emeritus professor of surgery at the Grant Medical College and J. J. Hospital, Mumbai.
- **William I. Wei, MBBS, FACS, FRCS(Edin, Eng), FRACS(Hon).** Professor Wei, Hong Kong, China, is regarded as one of the leading head and neck surgeons in Asia.

Presenting the Honorary Fellowships on behalf of the College were: L. D. Britt, MD, MPH, FACS, Norfolk, VA; Andrew L. Warshaw, MD, FACS, Boston, MA; Thomas E. Starzl, MD, PhD, FACS, Pittsburgh, PA; Stanley M. Goldberg, MD, FACS, Minneapolis, MN; John G. Hunter, MD, FACS, Portland, OR; and Richard J. Finley, MD, FACS, FRCSC, Vancouver, BC.

Sir Rickman Godlee, President of the Royal College of Surgeons of England, was awarded the first Honorary Fellowship in the College during the College’s first Convocation in 1913. Since then, 424 internationally prominent surgeons, including the six chosen this year, have been named Honorary Fellows of the American College of Surgeons. Following are the citations presented during the Convocation.

**Citation for Prof. Dario Birolini**

*by L. D. Britt, MD, MPH, FACS*

Mr. President, it is my distinct honor to present to you Prof. Dario Birolini of São Paulo, Brazil, for Honorary Fellowship in the American College of Surgeons (ACS). Professor Birolini is an internationally renowned trauma surgeon and critical care specialist.

Born in Fiume, Italy, Professor Birolini spent his entire adulthood in South America after the Birolini family moved from Italy to Brazil in 1951. Recognized early on as a talented student, Professor Birolini obtained his medical degree from the University of São Paulo School of Medicine. His thesis, Experimental Chemical Pancreatitis: Plasmatic, Muscular, and Body Composition Aspects, was given the highest grade possible (10/10). This allowed him to achieve the title of Doctor of Medicine at the university. After completing his residency at Hospital das Clínicas of the University of São Paulo, Professor Birolini concentrated his efforts on specialized care of the critically ill and injured. Early in his career, he started as a volunteer running the emergency care service of the Hospital das Clínicas.
1964, Professor Birolini was appointed staff surgeon of the surgical emergency service at the Hospital das Clínicas. Over a relatively short period of time, this honoree was appointed director of the Emergency Surgical Trauma Service at this facility, and was subsequently promoted to the academic position of professor of surgery at the University of São Paulo. Professor Birolini has held many posts at the university, including chairman of the department of surgery, vice-dean of the school of medicine, and president of the director board of the university hospital.

Although Professor Birolini has remained in São Paulo his entire career, his impact as a teacher, role model, investigator, and mentor has been felt throughout the world. He has been one of the major architects, both regionally and internationally, in the advancement of trauma management, emergency surgery, and critical care. For more than a quarter of a century, Professor Birolini ran a monthly course (the Annual Course of Urgency Surgery) every weekend for physicians and surgeons throughout Brazil to come and learn about urgent and emergency care. Professor Birolini, former governor of the Brazilian Chapter of the ACS, has established management algorithms and protocols for the entire nation after testing them in his own hospital and reviewing the outcome database.

The recipient of his country’s top awards, Professor Birolini has also received some of the highest honors internationally, including the ATLS Meritorious Service Award, given by the ACS Committee on Trauma. In 2007, he was chosen to be the Scudder Orator for the College’s 93rd Clinical Congress. In addition, Professor Birolini was recently made an Honorary Fellow of the American Surgical Association.

On a personal note, when I visited his home several years ago while attending a Pan-American trauma meeting in São Paulo, Professor Birolini was the consummate host. He is so revered in Brazil that it is difficult for me to believe that he is not the actual president of the country!

Professor Birolini clearly embodies all of the attributes expected of an Honorary Fellow of the ACS. Mr. President, it is my distinct privilege to present this consummate teacher, investigator, and master surgeon for Honorary Fellowship in the American College of Surgeons.

**Citation for Prof. Mehmet A. Haberal**

*by Andrew L. Warshaw, MD, FACS*

Mr. President, it is my distinct honor to present to you Prof. Mehmet A. Haberal, MD, FACS, FICS(Hon), of Ankara, Turkey, for Honorary Fellowship in the American College of Surgeons. Professor Haberal was born in Subaşı, a small village in eastern Turkey. He graduated from Ankara University Medical School (Turkey) in 1967, and received the title of general surgeon specialist in 1971. He had additional training at the Shriners Burns Institute in Galveston, TX, and at the University of Colorado in Denver, working with Thomas Starzl, MD, PhD, FACS. He performed the first living-related kidney transplant in Turkey that same year.

By 1980, Professor Haberal had established the Turkish Organ Transplantation and Burn Foundation and went on to develop hemodialysis centers throughout Turkey, which now perform about one-third of all of the dialyses in the country. In 1982, he was promoted to
professor of surgery and established the journal *Dialysis, Transplantation and Burns*. He organized the first Turkish Transplantation Society meeting in 1983, and was a founder of the Mediterranean Burns Club in 1984. That same year, he established the Middle East Dialysis and Organ Transplantation Foundation, which facilitated organ sharing and procurement throughout the Middle East. Subsequently, he built his own hospital for the care of burns and transplantation, supported by the Haberal Education Foundation, and has since built nine more hospitals throughout Turkey. He performed the first successful cadaveric liver transplant in Turkey, the first pediatric segmental liver transplant in Turkey, the first adult segmental liver transplantation in the world, and the first living kidney/liver transplantation from a living related donor in the world.

In 1993, he established Başkent University, which includes colleges of science and letters, law, economics and administrative sciences, engineering, medicine, health sciences, communications, design and architecture, fine arts, and dentistry, six vocational schools, and an English language preparatory school. This was followed by the establishment of a research center, a psychosocial and rehabilitation center, additional dialysis centers, and another scientific society (Middle East Burn and Fire Disaster Society). He has been an author or co-author of more than 1,400 Turkish and English scientific publications and six books. He has performed more than 1,800 kidney and 340 liver transplants. Dr. Haberal has received 26 national and international awards in the field of transplantation and medicine, including the Millennium Medal of the Transplantation Society. He is a Fellow of the American College of Surgeons and was made an Honorary Fellow of the American Surgical Association in 2003.

At present, Dr. Haberal has been held in detention for more than a year on allegations of anti-government activities. Support for Dr. Haberal, and calls for his release, have come from his colleagues around the world, from the Human Rights Committee of the Institute of Medicine, and from the American College of Surgeons. This awarding of Honorary Fellowship in the American College of Surgeons, made in absentia, recognizes Dr. Haberal’s unselfish devotion to his patients, medical science, and the educational processes, which have led to improvement of the welfare of citizens in his own country and throughout the Middle East.

**Citation for Prof. Bernard Launois**

*by Thomas E. Starzl, MD, PhD, FACS*

Mr. President, it is my distinct honor to present to you Prof. Bernard Launois, of Rennes, France, for Honorary Fellowship in the American College of Surgeons.

Bernard Launois is a “modest giant” of French surgery, who has been well-known to American surgeons for more than 40 years. His first lengthy experience in America began in late 1969 when, at the age of 38, he came to the University of Colorado for a two-year stint on the transplantation service of Thomas E. Starzl MD, PhD, FACS (author of this citation), where the first successful liver replacements had been performed. It was recognized immediately by his American peers that Professor Launois was a superb technical surgeon.
and had an unusual intellectual endowment that extended to sophisticated clinical research. At the time, the only kind of transplantation considered therapeutic was that of the kidney. However, the trickle of successful early liver replacements in Colorado was ongoing, and it was to this area of development that Professor Launois turned his most passionate interest.

After he returned to France as professor and chairman of surgery at the Université de Rennes (1972–1998), Professor Launois established one of the first two liver transplant centers in France (the other was in Paris, and was founded by Henri Bismuth, MD, FACS(Hon)). The Paris and Rennes programs were both outstanding successes. Before his retirement, Bernard compiled more than 1,200 liver replacements while contributing to the generic base of all kinds of transplantation (for example, his randomized trial of antilymphocyte globulin).

Liver transplantation was only one of Professor Launois’s accomplishments. His contributions to the techniques of hepatobiliary, pancreatic, and esophageal surgery have been no less notable. Examples of new trails blazed by Professor Launois include the first randomized trials of preoperative radiotherapy for cancer of the esophagus. His report in 1979 (Annals of Surgery) of the surgical management of duct cell carcinoma in the hepatic hilum was the first of its kind. He has been honored in his own country by numerous distinctions, including membership in the Académie Nationale de Médecine (French Academy of Medicine), one of the world's great learned societies.

Professor Launois also is a long-standing member of the Académie Nationale de Chirurgie (French Academy of Surgery). As president, he established a salaried fellowship that permits young American surgeons to spend a year in residence at the College de Médecine des Hôpitaux de Paris. In his cultivation of such international connections, he has spent significant periods in all of the populated continents. Exclusive of the U.S., the most fruitful and lengthy sabbaticals were in Australia (University of Adelaide); South Africa (Capetown), with John Terblanche, MB, ChB, FACS(Hon); and Canada (University of Calgary).

Citation for Prof. Ralph John Nicholls

by Stanley M. Goldberg, MD, FACS

Mr. President, it is with the greatest pleasure and honor that I present to you, and to the Fellowship of the American College of Surgeons, Prof. Ralph John Nicholls of London, England, for Honorary Fellowship in the American College of Surgeons. It is a great privilege to have the opportunity to honor an individual who has influenced the entire field of colon and rectal surgery throughout the world.

Professor Nicholls was edu-
cated at Cambridge University, England, and received his degree in medicine, with distinction, in 1967. Following his surgical training in London, he won the Alexander von Humboldt Research fellowship, which permitted him to study under Prof. Fritz Linder in Heidelberg, Germany. After this experience in Germany, he was appointed senior registrar for St. Mark’s Hospital, and shortly thereafter, he was appointed as a consultant surgeon at St. Mark’s and St. Thomas’ Hospitals in London. At St. Thomas’ Hospital, Professor Nicholls was encouraged to pursue his interest in colon and rectal surgery by the late Sir Hugh Lynn Lockhart-Mummery. At St. Mark’s Hospital, he matured under the tutelage of the late Sir Alan Parks.

In the late 1970s and early 1980s, he pioneered, along with Sir Alan Parks, the restorative proctocolectomy for patients with chronic ulcerative colitis. This innovative operation changed the lives of thousands of patients with chronic ulcerative colitis and familial adenomatous polyposis. His lifetime of research has been centered about the physiology of the ano-rectum.

For the last 32 years, Professor Nicholls has been a consultant surgeon at St. Mark’s Hospital, which is recognized as the mecca of colon and rectal surgery. During his tenure at this facility, he has been the dean of the school and clinical director. He has published 204 peer-reviewed papers, 48 book chapters, and four surgical text books. In addition, he has been the editor of the International Journal for Colorectal Disease, now Colorectal Disease, since 1998.

Professor Nicholls has held many leadership roles in surgical societies. In addition, he has been recognized by many surgical societies with honorary memberships, including the Royal College of Physicians and Surgeons of Glasgow and the Brazilian College of Surgeons.

In the recent past, Professor Nicholls has been instrumental in establishing the first certifying specialty board in surgery in Europe. Professor Nicholls and his lovely wife, Stella, have two sons, one daughter, and several grandchildren, whom they enjoy enormously. He is fluent in Italian, French, German, and that wonderful, vanishing language known as the King’s English.

He continues to teach and lectures frequently all over the world, and many prominent surgeons have had the pleasure of studying under Professor Nicholls. Recognized and acclaimed in the United Kingdom and internationally as a master surgeon, Professor Nicholls possesses a wonderful personality and has a strong commitment to professionalism and ethical behavior. The characteristics that have allowed Professor Nicholls to achieve the pinnacle of his chosen profession include a keen intellect, a wonderful sense of humor, the ability to communicate both orally (in four languages) and with the written word, and, most of all, his excellence in the operating theater. As one of his former students commented, “John was an inspiring figure with an agile mind who asked probing but very reasonable questions, and one who, in my experience, always encouraged research.”

Mr. President, it is with great pleasure that I present Prof. Ralph John Nicholls of London, England, for Honorary Fellowship in the American College of Surgeons.
Mr. President, it is a great pleasure to introduce Prof. Tehemton Erach Udwadia from Mumbai, India, for Honorary Fellowship in the American College of Surgeons. Put simply, Professor Udwadia has done more for the surgical health of Indian patients than any other surgeon in this vast subcontinent. He has done so by demonstrating that laparoscopic surgery is not just for the wealthy, but can be used in a cost-effective fashion to relieve suffering for all people, rich and poor.

Professor Udwadia was born in what was then known as Bombay, India. His father, a family physician, worked in the poorest areas of Bombay until the age of 84. His passion for the people and dedication to his profession rubbed off on his son. Professor Udwadia had the opportunity to receive an excellent education in Bombay, and ultimately pursued additional training in Liverpool before returning to India in 1963, where he has practiced for the last 48 years. Coupled with his father’s dedication to social justice was a desire to innovate, and to bring something new to surgery in India. This “disruptive streak” came out in his Storz Lecture delivered at the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) congress in 2001, as he quoted his undergraduate college motto, “You are not here to worship what is known, but to question it.” Question he did, indeed! In 1972, when faced with the inability to get even the simplest X-ray on a surgical ward, Professor Udwadia took to the laparoscope to diagnose intra-abdominal pathology. In 1972, 18 years before the video endoscopic revolution in general surgery, he received his first laparoscopic equipment, given to him by Dr. Karl Storz in Tuttingen, Germany. For the next 18 years, Professor Udwadia used this equipment to train 100 surgical residents in the performance of laparoscopic diagnosis, treating several thousand welfare patients in Bombay.

When laparoscopic cholecystectomy set the world on its ear, Professor Udwadia was ready. Working with industry, and a force of human will that few can match, he took laparoscopic surgery into small villages throughout India to perform procedures and train rural surgeons who were hungry to bring this new art to the benefit of their hard-working patients. With its ability to decrease infection and speed recovery, the benefits of laparoscopic cholecystectomy to the rural poor were even more dramatic than the benefits to an affluent patient. Using reusable equipment, he demonstrated a cost of approximately $20 per patient to perform laparoscopic cholecystectomy.

As is the case for many great leaders, especially those championing causes of the poor, Professor Udwadia was criticized for his work. Again quoting from his SAGES address, he said that his critics asked, ‘What right has a poor people who lack drinking water, sanitation, and primary health care to aspire to high technology surgery or even deserve it?’ To the economist, statistician, and hard-thinking realist, this question may make sense. To me, what makes sense is that during the entire history of surgery, from the dawn of mankind right up to the present, there have only been three patient-friendly revolutions: those brought about by asepsis, anesthesia, and minimal access surgery. I cannot passively accept that in one country, that in one world, there must forever and ever be perpetuated a class system with a second tier of humans fit only for second-
rate surgery. The poorest of the poor have as much right as anyone to less pain after operations, reduced medication, less morbidity, shorter hospitalization, and early return to home, family, and work.*

Professor Udwadia is a man of letters, the editor-in-chief of the Journal of Minimal Access Surgery, and a former editor-in-chief of the Indian Journal of Surgery. He has published 96 works in national and international journals, and he has traveled widely, giving more than 180 keynote addresses, plenary speeches, and paper presentations in various national and international congresses. He is the past-president of the International Federation of Societies of Endoscopic Surgeons. He is an honorary member of the Nepalese College of Surgeons, the Japanese College of Surgeons, the Brazilian College of Surgeons, and, probably the one he is the most proud of, the Association of Rural Surgeons of India. He is currently an emeritus professor of surgery at the Grant Medical College and J.J. Hospital in Mumbai, India.


Citation for Prof. William Ignace Wei

by Richard J. Finley, MD, FACS, FRCSC

Mr. President, it is a distinct honor to present to you Prof. William Ignace Wei of Hong Kong, the People’s Republic of China, for Honorary Fellowship in the American College of Surgeons. Born in Shanghai, China, Professor Wei and his grandmother emigrated as refugees to Hong Kong when he was nine years old. His family has instilled in him a strong work ethic and high ethical standards, which have allowed him to become the leading head and neck surgeon in Asia.

Professor Wei graduated from the faculty of medicine at the University of Hong Kong, where he received broad training in general and surgical subspecialties under the direction of Profs. G. B. Ong and John Wong. After completing this training in general surgery in 1983, he received specialty training in microsurgery at Melbourne University, and in otorhinolaryngology and head and neck surgery at the Institute of Laryngology and Otology, University of London, England. He received fellowships from the Royal College of Surgeons of Edinburgh in both general surgery and otorhinolaryngology.

In 1984, Professor Wei was appointed as a senior lecturer in the department of surgery at the University of Hong Kong. Through hard work, research initiatives, and innovative teaching techniques, he rose to become a full professor in the department in 1991. Professor Wei started the first academic otolaryngology and head and neck unit in South East Asia, at
Queen Mary Hospital and the University of Hong Kong. This initiative has blossomed into a large academic department, which has been responsible for teaching most of the academic head and neck otorhinolaryngologists in Asia.

Nasopharyngeal carcinoma is prevalent in Asia. Professor Wei has an international reputation for his basic and clinical research into the diagnosis and treatment of this often fatal disease. His research has led to new techniques for the reconstruction of previously non-resectable nasopharyngeal cancers using a maxillary swing approach to the central skull base. Professor Wei has been published in more than 200 international peer-reviewed journals, has written 25 book chapters, and has made more than 150 presentations to international societies. He has received numerous honorary fellowships and is actively involved in international editorial boards, as well as serving as the secretary-general of the International Federation of Otorhinolaryngology Societies. Professor Wei has recently been named by his peers as one of seven leading head and neck surgeons in the world.

Anyone who has ever met Professor Wei would describe him as a humble gentleman who is dedicated to his patients and students. For the past 15 years, he and his faculty have traveled to different parts of mainland China to provide up-to-date education to head and neck surgeons.

In addition, he brings speech therapists and his own patients with laryngectomies to these cities to help patients who have undergone total laryngectomy to speak again. This New Voice Club of Hong Kong has become the leader in speech rehabilitation for China.

Professor Wei has dedicated himself to his family and profession. He and his wife, Amy, have raised two children. Their son Rockson is a resident in general surgery, and their daughter Amy is a solicitor in Hong Kong. When Professor Wei has time, he collects first edition commemorative stamps, as well as antique scoops used by the Chinese for cleaning earwax.

Mr. President, Professor Wei has greatly improved the care of patients with head and neck cancer through innovative research and dedication to the education of patients, students, Fellows, and practicing otolaryngologists. I am honored to present Prof. William Ignace Wei for Honorary Fellowship in the American College of Surgeons.

A look at The Joint Commission

**Safe Surgery Guide takes on major challenges to surgical safety**

Recognizing that there is no single remedy that will improve the safety of surgery and other invasive procedures, a new *Safe Surgery Guide* takes a system-wide approach to challenges that pose the biggest threat to safe surgical care.

Serving as a multi-resource tool for surgeons, nurses, risk managers, medical staff, and other leaders in the health care setting, the *Safe Surgery Guide* addresses the major issues regarding surgical-related adverse events in health care organizations worldwide, including wrong site, wrong procedure, wrong patient surgery; retention of foreign bodies; anesthesia-related problems; surgical fires; medication errors; and postoperative infections.

The guide addresses other issues that may diminish or significantly impact the quality of care, including communication problems, distractions, overbooked operating rooms, and sharps injuries. The *Safe Surgery Guide* was developed by Joint Commission Resources, the education and consulting arm of The Joint Commission.

The guide’s system-wide approach advocates the completion of a sequence of steps by the entire multidisciplinary
team of health care professionals. The team, in conjunction with the patient and family, works together within a supportive health system for the patient’s benefit. The guide navigates users through the complex terrain of surgical care at each critical point in the process:

- Communication
- Hand hygiene
- Preparing the operating room or procedure area
- Preparing the patient
- Preparing the surgical team
- Completing the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™
- Monitoring the patient
- Avoiding problems in the operating room
- Cleanup of the operating environment
- Postoperative care

The Safe Surgery Guide gives organization leaders the ability to use a step-by-step process to standardize procedures for safe surgery practices, in turn contributing to reduced errors and associated costs. The guide’s tools can be used to educate staff on standardized procedures, positively affecting time management and organizational skills. The guide also offers solutions that address and fill the gap in information needed by organizations in ambulatory care and office-based settings.


International Surgical Week ISW 2011
August 28 – September 1, 2011, Yokohama, Japan
by the
International Society of Surgery ISS/SIC
“Exploring the Future of Surgery”

Congress President: Kenneth D. Boffard, South Africa
President LOC: Masahiko Watanabe, Japan

with its Integrated Societies
International Association of Endocrine Surgeons IAES
International Association for Trauma Surgery and Intensive Care IATSC
International Association for Surgical Metabolism and Nutrition IASMEN
Breast Surgery International BSI
International Society for Digestive Surgery ISDS

Deadline for the online submission of Abstracts: January 10, 2011

www.isw2011.org
Members in the news

Elliot L. Chaikof, MD, PhD, FACS, chief of vascular surgery at Emory University in Atlanta, GA, and a leader in the development of minimally invasive endovascular therapies for aortic aneurysms, carotid disease, and peripheral vascular disease, has been named chair of the Roberta and Stephen R. Weiner department of surgery and surgeon-in-chief at Beth Israel Deaconess Medical Center, Boston, MA. Dr. Chaikof holds secondary appointments as an adjunct professor in the School of Chemical and Biomolecular Engineering at the Georgia Institute of Technology, Atlanta, GA, and is a member of the faculty in the department of biomedical engineering.

Eugene N. Myers, MD, FACS, was the guest of honor at the fourth world congress of the International Federation of Head and Neck Oncological Societies held in Seoul, Korea, June 15-19. Dr. Myers gave the guest of honor lecture, entitled Defining the Role of the Head and Neck Surgeon in the Era of Chemoradiation. He also co-chaired the panel sponsored by the Brazilian Society of Head and Neck Surgery entitled Difficult Decisions in Head and Neck Surgery–2010.

James “Butch” Rosser, MD, FACS (see photo, right), has been selected as the first African-American president of the largest laparoscopy (minimally invasive surgery) society in North America. Dr. Rosser, a professor of clinical surgery at Morehouse School of Medicine in Atlanta, GA, helped pioneer the field of laparoscopic surgery and has traveled the globe teaching his “top gun” laparoscopic skills and suturing course to more than 5,000 physicians. Dr. Rosser also founded the not-for-profit Modern Day Miracle Inc. to train surgeons from underprivileged countries in minimally invasive surgery.

ACS nominee appointed to key federal board

Robert M. Zwolak, MD, PhD, FACS, has been appointed to serve on the Board of Governors of the Patient-Centered Outcomes Research Institute. The appointment was announced on September 23 by Gene Dodaro, the Acting Comptroller General of the U.S. and head of the U.S. Government Accountability Office. This past June, the American College of Surgeons nominated Dr. Zwolak and actively advocated for his appointment to this important commission.

Dr. Zwolak will serve as one of 19 governors for the Patient-Centered Outcomes Research Institute, which was created by the Patient Protection and Affordable Care Act to set the nation’s comparative effectiveness agenda and to improve Americans’ ability to access the highest quality, most effective medical treatments and health care services.

In addition to being a practicing vascular surgeon in New Hampshire, Dr. Zwolak serves on the ACS Board of Governors and the College’s Health Policy and Advocacy Group.

CALL FOR SUBMISSIONS

2011 Clinical Congress of the American College of Surgeons

The American College of Surgeons
Division of Education
welcomes submissions
to the following programs
to be considered
for presentation at

the 97th annual
Clinical Congress,
October 23–27, 2011,
San Francisco, CA

Oral presentations

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

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

Poster presentations

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

Video presentations

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

Submission information

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

*Accepted authors are encouraged to submit full manuscripts to JACS.
Some researchers studying human embryonic stem cells are surprised, disappointed, and even angry about the legal back-and-forth over the federal government policy on funding research using the cells, report staff of Surgery News, the official newspaper of the American College of Surgeons.

On August 23, a federal judge handed down a ruling that barred the use of federal funds for any research involving human embryonic stem cells. As a result of the temporary injunction, the National Institutes of Health (NIH) stopped accepting submissions of information on human embryonic stem cell lines for NIH review and has also suspended all review of embryonic stem cell lines. On August 31, the Justice Department asked for a stay of the lower court’s injunction, which was granted on a very short-term basis on September 9.

The September 9 temporary administrative stay granted by the U.S. Court of Appeals for the District of Columbia Circuit called on both parties to the suit to present information to the court by September 20.

To read more about recent legal developments affecting funding for stem cell research and the ramifications for investigators, go to http://www.facs.org/surgerynews.
The following comments were received regarding recent articles published in the Bulletin.

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

Local relief efforts in Haiti

Both my wife (Mary Ann Reynolds, MD) and I read the articles on Haiti in the June 2010 issue of the Bulletin (Bull Am Coll Surg. 2010;95[6]:6-20) with great interest. We went to Haiti in 1986 as volunteer physicians at the Hôpital Albert Schweitzer in Deschapelles, and have helped support them ever since. In every article we have read since the earthquake occurred, there has been very little reference to this established and well-run institution, which has been quietly caring for the Haitians for more than 50 years.

After the quake, this hospital took in all of the injured who reached them, and were able to carry on in a remarkable way. They have instituted many long-range and broad programs for the people living in the Artibonite Valley. They have always included local Haitians in the planning of these programs, and many of the programs are run by local Haitians.

Hopefully, Dr. Eastman, Dr. Ford, and others who are coordinating care in Haiti will consult with the very knowledgeable people at Hôpital Albert Schweitzer (http://www.hashaiti.org).

Harry E. Reynolds MD, FACS,
Boise, ID

Recovery audit contractors

Vinita M. Ollapally’s update on recovery audit contractors in the August 2010 issue of the Bulletin (Bull Am Coll Surg. 2010;95[8]:8-10) was interesting, informative, and memory-evoking. For me, the key point in the article is “Rather than paying the RACs [recovery audit contractors] a specified upfront fee, CMS pays RACs using a negotiated contingency fee, typically a percentage of every improper payment that the RACs identify and recover.” However, no comment is made about why the latter rather than the former is operative.

Paying a recovery contingency fee to RAC bounty hunters is, in my view, like paying the jury for a conviction (and nothing for an acquittal), and then paying the judge extra for every year he adds to the prison sentence. How impartial, fair, and reasonable determinations about physician “guilt” or “innocence” can possibly be made by RACs driven by such perverted incentives escapes me.

I am a retired ophthalmologist who was subjected to three of these audits some years back. I received threatening letters and phone calls, and I was offered the “easy way out” by just paying them around $7,000. I refused, fought them for months, and finally prevailed after a few hundred hours of personal and secretarial time and copying hundreds of pages of medical records. One service the auditors wanted to deny as “unnecessary, fraudulent, and abusive” was the very visual field that showed the first hint of loss in one of my glaucoma patients and made the diagnosis!

The third audit prompted my retirement from medical practice in February of 2001, so I actually have my fair-minded auditors to thank for almost 10 very happy years out to pasture. I’ll bet I have more company than I realize.

John K. Herpel, MD, FACS
Acworth, NH

Trauma meetings calendar

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

- Medical Disaster Response, April 10, 2011, Las Vegas, NV.
- Trauma, Critical Care, and Acute Care Surgery 2011, April 11–13, 2011, Las Vegas, NV.

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

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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.

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“Eye see”

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

The eye and the physiologic structures that make up the visual system are so incredible that a recent marketing campaign by a well-known cell phone manufacturer claimed it had an eye-popping “retina display.” The eye is a phenomenal one-inch spherical, camera-like structure that is capable of producing a continuous moving image with 576 megapixels of available data, without the need for replacing any memory cards. There is currently no consumer-level motion picture device available that comes anywhere close to capturing the amount of image data of the human eye. The lens of the eye focuses an image onto a light-sensitive membrane (the retina), where its photoreceptive cells act as transducers detecting photons of light and converting it to neuronal signals that are sent to the visual cortex. This complex visual system allows an individual to assimilate information from the environment.

For many, eyesight is an everyday, taken-for-granted part of life. It is not until one suffers an injury to this truly remarkable sensory organ that one gains a true appreciation for how important sight is in daily life. Of the 2.5 million eye injuries that occur annually, 75 percent of the injuries reported were male, according to the 2009 Eye Injury Snapshot project of the American Academy of Ophthalmology and the American Society of Ocular Trauma (http://www.aao.org/practice_mgmt/eyesmart/snapshot_2009_results.cfm.) A total of 44 percent of the eye injuries occurred in people between the ages of 18 and 45, another 20 percent in children younger than 12, and 8 percent in the 65 and older age group. Nearly half of these injuries occurred at home, with almost one-third caused by playtime activities or sports, while 20 percent were due to situations involving home repair or power tools. Accidents were reported as the cause of injury in more than 80 percent of these cases, while assaults accounted for 10 percent. In injuries involving motor vehicle crashes, 53 percent were not wearing seatbelts.

In order to examine the occurrence of major ocular injuries (excluding orbital and surrounding bony fractures) 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) injury codes 870–870.9 (open wounds of ocular adnexa) and 871–871.9 (open wound of eyeball). A total of 13,845 incidents matched these injury codes; 11,783 records had discharge status recorded, including 9,464 discharged to home, 891 to acute care/rehab, 1,052 sent to nursing homes; 376 died. These patients were
74 percent male, on average 37.3 years of age, had an average length of stay of 5.9 days, and an average injury severity score of 9.76.

Of interest is the location of occurrence of these major ocular injuries. Unlike the 2009 Eye Injury Snapshot project, which reported approximately 50 percent of these injuries occurring in the home, only one-quarter of the NTDB events took place at home, while almost half of these injuries took place in the street (which includes motor vehicle-related injuries, pedestrian, other transportation-related injuries, and assaults). These data are depicted in the figure on page 59.

Even though the ocular injuries in these patients with an average injury severity score of more than nine were most likely part of a larger injury complex, the two ICD-9-CM injury range codes selected represent significant ocular injuries. The magnitude of these injuries would, more often than not, require the on-site expertise of an ophthalmologist in order to treat, and hopefully preserve, vision.

Eyesight is an amazing physiologic phenomenon, and the best way to treat ocular injuries is to try to prevent them. Simple measures can be taken to prevent many of these injuries. When at work or while working around the house, wear American National Institute Standards approved (ANSI Z87.1 marked on the lens or frame) safety glasses, especially when using power tools. Before mowing the lawn, clear the area of any sticks or rocks. Always wear your seatbelt while riding or driving. After all, we want you to be able to look around at all those Kodak moments and be able to see what “eye see.”

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2009 is available on the ACS website as a PDF file and a PowerPoint presentation at http://www.ntdb.org. In addition, information is available on our website 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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**ACS Foundation/Saint Louis University announce Scholar in Residence program**

The ACS Foundation and Saint Louis University’s department of surgery and its Center for Sustainability have partnered with one of the world’s leading global manufacturing and technology companies—Emerson—to create the Emerson Sustainability Scholar in Residence.

The scholarship is intended for exceptionally qualified surgery residents (PGY 3) who are interested in advancing research and learning in the area of health care sustainability (defined as development that meets the needs of the present without compromising the ability of future generations to meet their own needs). The program requires a two-year commitment leading to a Master of Sustainability degree.

Applications are being accepted until December 7, 2010. Questions and requests for applications should be directed to Timothy Keane, PhD, director of the university’s Center for Sustainability, at tkeane@slu.edu.