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Looking forward

Since President Barack Obama signed the Affordable Care Act in March, some surgeons have questioned why the American College of Surgeons and other medical and surgical organizations have been so quiet in voicing opposition to the legislation. The reason for our approach is to ensure that we can maintain a good relationship with policymakers and thereby have an opportunity to influence how the law is implemented.

The leadership of the College is attempting to react strategically, rationally, and in a cooperative fashion to the ACA and its incremental implementation. To this end, they and the staff of the Division of Advocacy and Health Policy, along with consultants from Health Policy Alternatives, gathered in Washington, DC, in August to discuss how we can play a meaningful role in the execution of various aspects of the ACA. Topics covered during the meeting included physician payment reform; regionalization, the surgical workforce, and graduate medical education (GME); quality; and expansion of health care coverage. In this column, I address the main concern that surgeons raise during the course of my conversations with them—payment reform under the ACA.

Payment reform

Although the ACA failed to address the problems associated with the sustainable growth rate (SGR), it does comprise provisions aimed at reforming the physician payment system in a way that will move the emphasis from essentially rewarding volume of services toward rewarding the quality and efficiency of services provided. The ACA and stimulus legislation passed in 2009 work together to achieve the following objectives:

- Increase preventive care, primary care, and use of medical homes
- Move away from pay for reporting to pay for performance
- Reduce payment for health care-acquired conditions and for preventable hospital readmissions
- Begin a pilot program for bundled payments
- Create accountable care organizations (ACOs)
- Establish a Center for Medicare and Medicaid Innovation (CMI)
- Provide funding for comparative effectiveness research and for health information technology

The College’s leadership believes that some of these provisions can, if implemented properly and with input from the surgical and medical specialty community, have a positive effect on our ability to provide our patients with high-quality and safe care. Addressed throughout the remainder of this column are some of the more controversial and innovative concepts related to payment reform.

ACOs

Of particular interest to the College’s leadership is the creation of accountable care organizations. The ACO model builds on similar initiatives that the Medicare program began implementing under President George W. Bush’s Administration. Starting in 2005, the Physician Group Practice Demonstration engaged 10 provider organizations and physician networks in...
a “shared savings” reform effort. Participants in the demonstration project receive all of their usual fee-for-service payments, as well as bonuses if their attempts to provide more coordinated care translate into slower risk-adjusted spending growth and improved outcomes. Subsequently, the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare Health Care Quality Demonstration, which is testing similar payment and quality improvement reforms in other delivery settings.

At least five different types of practice arrangements could serve as ACOs. These five prototypes are as follows:

- Integrated delivery systems, such as Kaiser Permanente, Group Health Cooperative of Puget Sound, and Geisinger Health System, which involve a common ownership of hospitals, physician practices, and, in some cases, an insurance plan.
- Multispecialty group practices, such as the Mayo and Cleveland Clinics, which generally own or have strong affiliations with local hospitals and contract with multiple health plans in their area.
- Physician-hospital organizations, such as Advocate Health, which are a subset of the hospital’s medical staff and often function like multispecialty group practices.
- Independent practice associations, consisting of individual physician practices that originally united largely to negotiate with health plans, but, over time, have started engaging in practice redesign, quality improvement initiatives, and the implementation of electronic health records (EHRs).
- Virtual physician organizations, which allow small, independent physician practices, many located in rural areas, to organize to develop disease registries, implement EHRs, share information, and provide coordinated, cost-effective care.

Regardless of practice arrangement, all ACOs would have certain set characteristics. They would all have “invisible enrollment.” Patients who receive most of their care from ACO-affiliated providers would not be formally enrolled in an ACO and could receive care from outside the ACO. All ACOs would be required to have a performance measurement instrument in place. They could receive a share of the savings if they can demonstrate that they provide more cost-effective care than non-ACOs provide. Initially, an ACO would not share in the losses if treatment of its patients cost more than expected, although they may eventually face some sort of penalty.

In addition, each ACO must have a formal legal structure that will allow it to receive shared savings payments and distribute them among providers. An ACO also must show that it can meet the quality and reporting standards that the Secretary of the Department of Health and Human Services is required to develop.

Whatever structure ultimately is adopted, the risk to providers must be minimized and the relationship with hospitals must be fair and equitable. We will work hard to better understand and influence this process and its implications for our Fellows.

**CMI**

A related provision in the ACA calls for establishing the new Center for Medicare & Medicaid Innovation, which will be charged with testing a variety of new payment and delivery models, including ACOs. The CMI also may examine other types of redesigned health care systems, including plans that pay salaries to physicians and other health care professionals, state-based all-payer models, and collaboratives of high-quality, low-cost health care institutions that develop and implement best practices.

**Bundling**

In addition, the ACA calls for further testing of bundled payments to hospitals, physicians, surgeons, and other providers who render services to a patient during the course of a treatment episode. In theory, bundled payments encourage restraint in the volume and intensity of services and provide an incentive for providers to collaborate. It also is assumed that bundling, combined with gainsharing, will strengthen hospital/physician partnerships and make institutions and providers equally accountable for delivering quality care.

Currently, CMS is conducting an acute care episode (ACE) demonstration project at five physician-hospital organizations. The pilot project is testing whether bundled payments improve
the quality of care and reduce the costs of 28 cardiac and nine orthopaedic inpatient surgical services.

The ACA takes this program one step further and establishes a five-year pilot program to examine the effects of providing a single payment for a bundle of inpatient and outpatient hospital-based services, including emergency room care. The bundled payment would cover hospital services, physician care, post-acute care services, and post-discharge care coordination. It would be tested on treatment for 10 chronic and acute patient conditions as selected by the Secretary of Health and Human Services.

The College’s role

CMS’ commitment to use its authority to encourage delivery system reforms may be at an all-time high, and it is imperative that the College and other advocates for surgery work with the agency to ensure that these reforms will have a positive effect on our nation’s patients. We need to use the information that is being culled through our National Surgical Quality Improvement Program and our cancer and trauma databases to demonstrate how hospitals can measure and improve their outcomes through comparative analysis. We need to help surgeons learn how to negotiate with ACOs to ensure their participation in shared savings, their ability to maintain referrals, and their ability to receive fair compensation for their services. We need to work with CMS to work out the details of gainsharing opportunities and to develop reasonable clinical protocols. The same goes for payment bundling.

To increase our ability to discuss these matters with policymakers, we plan to refocus our Division of Advocacy and Health Policy so that our regulatory and quality staff can more readily access the data they need to bring to the negotiating table. Furthermore, we are continuing to build collaborative relationships with both medical and surgical specialty societies to develop innovative solutions for all of medicine.

Granted, the reforms discussed here are far from a panacea for all that ails the Medicare payment system. Moreover, you can rest assured that the College fully intends to continue advocating for the repeal of the SGR and its replacement with a more reasonable methodology for calculating physician fees. However, we also must accept reality. The federal government has been working up to many of these reforms for the last decade. At the same time, the College has been building significant experience in quality measurement, which will prove invaluable in our meetings with policymakers and to our efforts to influence how various aspects of the ACA are implemented.

The ACA is the blueprint for a whole new health care delivery system for this country. It is up to us to do everything we can to make sure that the final structure is sound and equitable for surgeons and their patients.

David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
On July 13, the Centers for Medicare & Medicaid Services (CMS) released the final rule that sets forth the requirements for eligible professionals (EPs) to be considered meaningful users of certified electronic health records (EHRs) and, thereby, qualify for EHR incentive payments. These EHR incentive payments were created by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is part of the American Recovery and Reinvestment Act (Recovery Act) of 2009.

This article describes what an EP must do to show meaningful use of a certified EHR, the meaningful use measures and clinical quality measures on which an EP must report, and what it means for an EP to be certified.

What must an EP do to show meaningful use of certified EHR?

To show meaningful use of certified EHR, EPs must report on a core set and menu set of meaningful use measures, and must report on clinical quality measures as set forth by CMS. The measures making up the core and menu sets are described in detail later in this article.

What are the meaningful use measures on which an EP must report?

In the proposed meaningful use rule, CMS had outlined 25 objectives for EPs. However, in response to public comments arguing that the objectives and measures set the bar too high for most EPs, CMS revised the requirements in the final rule by splitting the objectives into a core set and a menu set. EPs must meet the 15 core set measures, and select and meet five of the 10 menu set measures. EPs must choose at least one of the population and public health measures from the menu set.

The core set objectives and measures for EPs are summarized in Table 1 on page 8.

The menu set of objectives and measures for EPs are summarized in Table 2 on page 9.

Many of the measurement levels for the specific objectives were reduced in the final rule. For example, the proposed rule would have required EPs to use computerized provider order entry (CPOE) for at least 80 percent of all orders. However, the final rule only requires the use of CPOE for medication orders, and for only 30 percent of unique patients with at least one medication in the patient’s medication list.

What are the clinical quality measures on which an EP must report?

EPs are also required to report on clinical quality measures in order to demonstrate meaningful use. In the proposed rule, CMS had required that EPs report on a core group of measures and a relevant specialty group of measures. CMS makes significant changes in the final rule to require that EPs meet three core set clinical quality measures: blood pressure level, tobacco status, and adult weight screening and follow-up (or three alternate core measures if these do not apply).

Alternate core measures include influenza immunization for patients older than age 50, weight assessment and counseling for children and adolescents, and childhood immunizations. If all six core and alternate core measures are inapplicable, an EP may report zeros for all six denominators.

In addition to the three core measures (and

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<th>Objective</th>
<th>Measures</th>
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<td>CPOE for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines</td>
<td>More than 30% of unique patients, with at least one medication in their medication list, have at least one order entered using CPOE. Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.</td>
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<td>Implement drug-drug and drug-allergy interaction checks</td>
<td>Functionality is enabled for these checks for the entire EHR reporting period.</td>
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<td>Generate and transmit permissible prescriptions electronically</td>
<td>More than 40% of all permissible prescriptions are transmitted electronically using certified EHR technology.</td>
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<td>Record patient demographics, including: preferred language, gender, race, ethnicity, and date of birth</td>
<td>More than 50% of all unique patients have demographics recorded as structured data.</td>
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<td>Maintain up-to-date problem list of current and active diagnoses</td>
<td>More than 80% of all unique patients have at least one entry, or an indication that no problems are known for the patient recorded, as structured data.</td>
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<td>Maintain active medication list</td>
<td>More than 80% of all unique patients have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.</td>
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<tr>
<td>Maintain active medication allergy list</td>
<td>More than 80% of all unique patients have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.</td>
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<td>Vital signs—record and chart changes in height, weight, and blood pressure, and calculate and display Body Mass Index (BMI); plot and display growth charts for children ages two to 20 years, including BMI</td>
<td>For more than 50% of all unique patients age two and older; height, weight, and blood pressure are recorded as structured data. Exclusion: Any EP who does not see patients age two or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.</td>
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<td>Smoking status, which is recorded for patients 13 years of age or older</td>
<td>More than 50% of all unique patients age 13 or over have smoking status recorded as structured data. Exclusion: Any EP who does not see patients 13 years or older.</td>
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<td>Implement one clinical decision support rule relevant to specialty or high clinical priority, along with ability to track compliance with that rule</td>
<td>Implement one clinical decision support rule.</td>
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<td>Report ambulatory clinical quality measures to CMS (if the EP is participating in the Medicare EHR incentive program) or the states (if the EP is participating in the Medicaid EHR incentive program)</td>
<td>For 2011, provide aggregate numerator, denominator, and exclusions through attestation; for 2012, submit clinical quality measures electronically.</td>
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<td>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request</td>
<td>More than 50% of all patients who request an electronic copy of their health information receive it within three business days. Exclusion: Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.</td>
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<td>Provide clinical summaries for patients for each office visit</td>
<td>Clinical summaries provided to patients for more than 50% of all office visits within three business days. Exclusion: An EP who doesn’t have any office visits during the reporting period.</td>
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<td>Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results) among providers of care and patient-authorized entities, electronically</td>
<td>Perform at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.</td>
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<td>Protect electronic health information created or maintained by certified EHR technology through the implementation of appropriate technical capabilities</td>
<td>Conduct or review a security risk analysis and implement security updates as necessary, and correct identified security deficiencies as part of the risk management process.</td>
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<td>Objective</td>
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<td>Implement drug formulary checks</td>
<td>The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period</td>
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<td>Incorporate clinical lab test results into certified EHR structured data</td>
<td>More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</td>
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<td>Exclusion: An EP who doesn’t order any lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period</td>
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<td>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach</td>
<td>Generate at least one reporting listing patients with a specific condition</td>
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<td>Send reminders to patients, per patient preference for preventive/follow-up care</td>
<td>More than 20% of all unique patients age 65 or older or age five or younger were sent an appropriate reminder during the EHR reporting period</td>
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<td>Exclusion: An EP who doesn’t have any patients age 65 or older or age five or younger with records maintained using certified EHR technology</td>
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<td>Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP</td>
<td>More than 10% of all unique patients are provided timely electronic access to their health information, subject to the EP’s discretion to withhold certain information (available to the patient within four business days of being updated in the EHR)</td>
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<td>Exclusion: Any EP that neither orders nor creates any lab results, problem lists, medication lists, or medication allergies during the EHR reporting period</td>
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<td>Use certified EHR technology to identify patient-specific education resources and provide those resources to patient if appropriate</td>
<td>More than 10% of all unique patients are provided patient-specific education resources</td>
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<td>The EP who receives a patient from another setting of care or provider of care, or believes an encounter is relevant, should perform medication reconciliation</td>
<td>The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP</td>
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<td>Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period</td>
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<td>Transition/referral of patient to another setting or provider of care; EP should provide summary of care record for each transition of care or referral</td>
<td>Summary of care record provided for more than 50% of transitions of care and referrals</td>
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<td>Exclusion: An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period</td>
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<td>Capability to submit electronic data to immunization registries or immunization information systems, and actual submission in accordance with applicable law and practice</td>
<td>Perform at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries, and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)</td>
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<td>Exclusion: An EP who doesn’t administer any immunizations during the EHR reporting period, or where no immunization registry has the capacity to receive the information electronically</td>
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<tr>
<td>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice</td>
<td>Perform at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies, and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)</td>
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<td>Exclusion: An EP who does not collect any reportable syndromic information</td>
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alternate core measures, if applicable), EPs will also have to select and report on three additional measures from a subset of clinical measures that are the most appropriate given the EP’s specialty. If these three additional selected measures have a value of zero in the denominator, then the EP will have to attest that all of the other clinical quality measures, if calculated by the certified EHR technology, would also have a value of zero to be exempt from reporting on additional measures.

CMS notes that the clinical quality measure requirements are simply a reporting requirement, and do not require a particular performance standard.

What does it mean for an EHR to be “certified?”

The Office of the National Coordinator for Health Information Technology (ONC) also released a final rule on July 13 that sets forth the EHR standards, implementation specifications, and certification criteria, which establish the required capabilities that EHR systems will need to satisfy, at a minimum, for EPs to qualify for incentive payments under the Medicare and Medicaid EHR incentive program.

The ONC is in the process of authorizing organizations, namely, ONC- Authorized Testing and Certification Bodies to test and certify EHRs to ensure that they comply with the adopted criteria, standards, and specifications.

When will I be able to purchase a certified EHR?

At the time of this printing, the ONC stated that it expects that the certified EHR products will be available and on the market by this fall.

To find out more about the meaningful use program, visit the CMS website at https://www.cms.gov/EHRIncentivePrograms/. This website is updated periodically with tip sheets and other information from CMS regarding the EHR incentive program.

In addition, more information, guidance, and resources will be offered by the ACS Division of Advocacy and Health Policy as implementation of the EHR incentive program continues to progress.
A challenging year

by A. Brent Eastman, MD, FACS

“Now is the age of anxiety” —W. H. Auden*

The October 2010 meeting of the American College of Surgeons (ACS) in Washington, DC, marked the end of my year as Chair of the Board of Regents. It was a good but challenging year, and unquestionably a time of great anxiety for surgeons.

In this same issue of the Bulletin, you will read an elegant summary by LaMar S. McGinnis, Jr., MD, FACS, of his year as President of the ACS (see pages 14–16). He nicely articulates not only many of the foundational principles of our College, but also the status of current programs. He speaks to our advocacy efforts of the past year. I agree with him, especially regarding the fact that we must strongly and proactively bring all of the resources of the College to bear on building a health care system that allows us to continue to provide the highest-quality, most cost-effective, and safe surgical care for our patients. We must be part of the solution at this time of great change.

We may all take pride in the superb job President McGinnis has done, not only in being completely involved in our efforts at home, but also in building “international bridges” with his wide-ranging travel abroad. I’m confident that President-Elect L.D. Britt, MD, FACS, will do the same in an exemplary fashion.

For me, the greatest gift of this year has been the exceptional collegiality and friendship among those of us privileged to be in leadership positions during this challenging time in the history of the ACS.

I have been honored to be a part of a board room team that includes Drs. McGinnis, Britt, and our extremely able new Executive Director, David Hoyt, MD, FACS, along with Michael J. Zinner, MD, FACS; Carlos A. Pellegrini, MD, FACS; and Andrew L. Warshaw, MD, FACS—respectively, Chair of the Board of Governors, Vice-Chair of the Board of Regents, and Chair of the Health Policy and Advocacy Group. The Executive Committee of the Board of Regents is further enriched by Regents Martin B. Camins, MD, FACS; Robin S. McLeod, MD, FACS; and Karl C. Podratz, MD, FACS.

All of our other ACS Officers have been extremely supportive, and, importantly, the viewpoint of our young surgeons has been brought forward by Mark Savarise, MD, FACS, Chair of our Young Fellows Association, and Joshua Broghammer, MD, Chair of the Resident and Associate Society. We are all supported by a talented, dedicated, and highly committed ACS staff in both Chicago, IL, and Washington, DC.

Last October, at the end of the Clinical Congress meeting in Chicago, IL, I was selected Chair by the Board of Regents, my peers for the last nine years, and I was deeply cognizant of the honor and responsibility this position entails. When I gave the Scudder Oration on Trauma at the meeting, I had the opportunity to talk about the field of surgery, which has been my passion, and, more importantly, to discuss the leadership that the College, through its Committee on Trauma, has provided in the care of injured patients here and around the world.

The New Year had a Wrenching Start with the devastating earthquake in Haiti on January 12. I have written about my experiences there with a team from my own hospital system, Scripps Health, San Diego, CA, in a recent Bulletin article.1 Dr. Hoyt and staff had set up an ACS Haiti support group and website immediately after the earthquake, and I was able to represent not only Scripps, but also the ACS.

Early in my tenure as Chair, I realized that one of the most important things I could do was to accept, whenever possible, every invitation to local chapter meetings. I have done so, traveling from my home in the southwest corner of the country to every other region, to large cities and to small towns. Meeting and becoming friends with so many of you has been another great gift to me as Chair of the Board of Regents.

We have tried hard to listen to, and hear, your concerns, constructive criticism, and sage advice, and your input has proven invaluable. It is obvious that the Fellows of the College in the U.S. wish us to provide leadership and solutions to ensure that the practice of surgery not only survives, but builds on its proud heritage under the Affordable Care Act (ACA), which was signed into law by President Barack Obama on March 23. To our Canadian colleagues, I convey my thanks for your support and insights from your own collective experience with Health Canada.

To that end, the ACS has led several recent initiatives, including the following:

- The third annual meeting of the Joint Surgical Advocacy Conference (JSAC) took place in Washington, DC (July 24–26). Approximately 350 surgeons representing all specialties and from all over the country met, participated in educational sessions, and then dispersed to Capitol Hill to meet with congressmen from their respective states for the explicit purpose of delivering the message about our concerns, and describing what surgeons can do to ensure the delivery of the highest-quality and most cost-efficient surgical care in this country. I had the opportunity to join surgeons from California, Kentucky, and Wyoming as we delivered our surgical message. I believe that message was united, welcomed, and well-received. Now we must deliver on our promise.

There were two other meetings coincident with the JSAC.

- The 2010 Leadership Conference for Young Surgeons and Chapter Leaders was held at the Hyatt Regency on Capitol Hill. Dr. Hoyt; Julie A. Freischlag, MD, FACS; Dr. Zinner; Dr. Warshaw; John Armstrong, MD, FACS; and I contributed to this meeting, along with some excellent “inside the beltway” Washington, DC, speakers, and many young surgeons and chapter leaders.

- The Surgical Coalition Meeting was held at 20 F Street. This group—created several years ago to address advocacy issues—ensures that the coalition has representation from virtually every surgical specialty, and anesthesiology. The ACS has taken a leadership role in the coalition, and this face-to-face meeting of surgeons from all specialties was crucial and positive. While surgeons may differ on tactical approaches, they are in total agreement with the fundamental principles as articulated in the ACS Statement on Health Care Reform, which is composed of the following:
  - Quality and safety
  - Patient access to surgical care (enabled by an adequate surgical workforce)
  - Medical liability reform
  - Reduction of health care costs
  - We agreed, in the strongest possible way, on the need for a permanent fix for the severely

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flawed formula that created the sustainable growth rate (SGR)
- The ACS Leadership Seminar: Health Reform from the Surgical Perspective, was held August 10–11, and included the Officers of the College, members of the Board of Regents, members of the Executive Committee of the Board of Governors, and members of the Health Policy and Advocacy Group. This meeting, which was exceedingly well organized by Dr. Hoyt and the Washington Office staff, had as its purpose the mapping of both short- and long-term strategies to ensure the sustainability and elevation to new levels of the practice of surgery in a changed health care environment. The format of the meeting was: formal presentations by outside experts, surgeon reactor panels, followed by whole group discussions. This process resulted in the following high-priority areas for aggressive ACS advocacy efforts:
  - Physician reimbursement
  - Quality issues
  - Medical liability reform
  - Regionalization, workforce, and graduate medical education issues
  - Expansion of cost-efficient health care coverage

The work product of this seminar—a draft of a white paper—was taken to the Joint Meeting of the Board of Regents and Board of Governors. What is clear at this point, and will be included in the final white paper, is that the ACS has an immense amount to offer in the current health care policy arena. Our history of evidence-based care—dating back to Ernest A. Codman, MD, FACS, a surgeon ahead of his time—and our current quality programs (for example, the ACS National Surgical Quality Improvement Program), our databases in trauma and cancer, our educational programs, our verification programs, and many others, are essential building blocks for optimal care of the surgical patient. We intend to write the book on that subject.
- On October 3, just prior to the Clinical Congress meeting in Washington, DC, we held the third annual Joint Meeting of the Regents and Governors of the College. The first two meetings in 2008 and 2009 were dedicated to creating our ACS Statement on Health Care Reform (available on the College website at http://www.facs.org/her/acs09hcr.pdf). Dr. Zinner and I conferred and consulted with our respective Executive Committees of the Board of Governors and the Board of Regents, as well as with Dr. Hoyt. We designed the agenda for this year’s meeting with a focus on how we can best help our fellowship deal with the changes we face under the ACA. A full report on that Joint Meeting will be shared with the entire Fellowship.

Finally, even though we have, out of necessity, been occupied this year with the challenges of health care reform, we have always been mindful of the College’s mission statement:

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.

Our advocacy efforts must ensure that we do everything in our power to affirm that our principles and the spirit of our mission statement are embedded in the policies that will govern health care in this country. Only then will we have fulfilled our obligation to our fellow surgeons and, more importantly, to our surgical patients.

Dr. Eastman is chief medical officer, Scripps Health, and N. Paul Whittier Endowed Chair of Trauma, Scripps Memorial Hospital, La Jolla, CA. He is also clinical professor of surgery-trauma, University of California, San Diego. Dr. Eastman is Chair of the Board of Regents.
Thoughts as I leave office

by LaMar S. McGinnis, Jr., MD, FACS

On my year as ACS President: One year ago, I was most privileged to be installed as the 90th President of our College. In addressing the new Fellows at last year’s Convocation during the Clinical Congress in Chicago, IL, I noted my unique position as one of only six community surgeons to have been so honored in our 96-year history. I chose the theme of Professionalism in the 21st Century, and I spoke about our College’s rich and cherished history, and of our many accomplishments in improving the safety and quality of surgical care for our patients. Together, we gloried in the current state of surgical science and technology, recognized the need for improvement in the delivery of surgical care to all of our citizens, recognized that change was in the wind, and sincerely hoped that our College could be a positive force in that change.

Over this past year, it has been my privilege to visit College chapters, national and international surgical societies, and other surgical colleges, and to interact with surgeons worldwide. It has been of great interest to me to learn about the commonalities of our interests and of our problems. Surgical science and technology are available around the globe in both mature and developing countries. Interest in further improving quality and safety, and in advancing surgical science and technology and its application, is universal.

Also, we all face similar problems: the ever-increasing cost of health care plagues all nations (if only health care costs could be viewed as an investment in human capital, rather than as a cost); extending quality care to all remains a challenge; surprisingly, liability issues are present virtually everywhere, including in China; physician shortages are either present or evolving worldwide; interest in general surgery is waning; bureaucratic government control over health care is ever-widening; and so on. Another trend that is having an effect on the practice of surgery around the world and leading us to rethink our traditional approach to the practice of our profession is the fact that women surgeons are now in the majority in health care almost everywhere.

The Affordable Care Act is now the law of the land, and the College is grappling with the enormity of change that will be upon us over the next decade. It is, indeed, regrettable that despite our positive entreaties and repeated offers, we have thus far not been included in the ongoing planning that will affect our own future so dramatically. This has been an historically true and inexplicable situation, yet it remains a sad commentary in these times of potentially epochal change in health care. Nonetheless, our College wishes to be proactive, and at the table, as needed change evolves that will inevitably have an impact on patients, positively or negatively. Our historic strengths in education, quality improvement based on data and
Evidence, standard setting, and professionalism will persist. We are attempting to be a logical resource for the development and testing of new systems for reimbursement, for new models for the delivery of surgical care, for comparative effectiveness research, for the systematic development of guidelines/pathways for surgical care, for outcome measures, and for the development and evaluation of other determinants of value. We are, in fact, essential in finding solutions to our workforce issues. We embrace true, well-grounded transparency. We are capable and eager to be engaged in positive change that will benefit patients and reduce health care costs. We remain convinced that quality and safety are essential keys in moving ahead, and that all citizens deserve access to safe, quality health care.

Surgical care is unique in health care. We are not interchangeable with other health care professionals. Surgical specialties are likewise each unique and special, yet we all share a common background and heritage, and follow certain surgical principles of care. Our College believes that the disciplines of surgery must collaborate to ensure the future of the calling that we each respect and love, and to ensure the best care for our patients.

In turbulent times, surgical professionals will remain true to our history, to our profession, to our patients, and to ourselves. Criticism without involvement will lead to a dead end. I want to thank all of you, my professional colleagues, for allowing me the inestimable privilege of serving as your President. I ask each of you to stay informed, to stay involved, and to stay an active participant in our College. Together we will make this a time of opportunity for improvement, and for the betterment of our beloved profession, by having a positive impact on surgical patient care. We are surgical professionals in this 21st century and we are needed, as always.

On 20 F Street, NW: A grand opening: As many of you are aware, the American College of Surgeons is rapidly approaching its centennial anniversary. Our history has been rich and our impact significant over time, with a focus on the delivery of safe, high-quality, ethical surgical care. Our interest in improving care in hospitals resulted in the formation of The Joint Commission, with major benefit to patients, physicians, and the institutions themselves. Our interest in improving the care of the injured patient resulted in the formation of our Committee on Trauma and all of its many byproducts, including the Advanced Trauma Life Support® course, which is recognized worldwide as the gold standard. Our interest in advancing the care of the cancer patient led to the formation of the Commission on Cancer and to more than 1,500 approved cancer programs. Approximately 80 percent of cancer patients are treated in these hospital programs with dramatic, measurable improvement in their care. Our databases in trauma and cancer are the largest in the world, and provide quality metrics for research and for optimal patient care. In addition, we have the American College of Surgeons National Surgical Quality Improvement Project as another clinical, risk-adjusted, data-driven source for quality improvement and associated cost reduction.

Our historic focus on surgical education and training has been broad, impactful, and increasingly focused on a continuum of learning and competence extending across the course of a surgeon’s career. This dedication to education is highlighted annually by our Clinical Congress, the largest single surgical educational endeavor in the world, which will be held in Washington, DC, this month for the first time since our founding in 1913. These comments are only broad strokes; there are many details and a variety of other activities included in the College’s portfolio.

Our 77,000 surgeon members worldwide have great reason for taking pride in the College (the largest surgical organization in the world), and for preserving and further enhancing its impact. Health policy and advocacy have become essential interests of this organization and a necessity in the 21st century, in a world that is more focused on activities within the beltway, and a vastly different world from that in which we surgeons are daily engaged.
The College built the magnificent building at 20 F Street, NW, on Capitol Hill—a truly prime location and a tribute to those with the foresight to enable this achievement.

Our College has a history endowed with architectural achievement—from the Nickerson Mansion, the John B. Murphy Auditorium, the former headquarters building at 55 E. Erie St., the former Washington Office location at 1640 Wisconsin Avenue in Georgetown, to our headquarters at 633 N. Saint Clair Street and now 20 F Street. Yet, while architecture and location are significant, what will really matter in the future is what is accomplished by our Fellows, staff, and other colleagues working within these structures. 20 F Street must follow our rich, productive, and impactful history.

It has been observed that progress has historically resulted from centers of trade, where interaction and exchange occur, specialization results, and collective intelligence leads to cumulative innovation. We need this building to house a free flow of impactful ideas that will result in progress in the delivery of value in safe, quality surgical care.

Over the last century, our lifespan has doubled, and childhood mortality has been reduced by three-quarters—these are monumental achievements. We know the role that modern surgery has played in this leap forward. We need this building to be “a center of trade” for cumulative innovation in the delivery of surgical care as impacted by health policy. This will be a center not only for pragmatic thought and application, but also for Socratic thought with persistent questioning, realizing that we are largely to blame for our own fate, that “the unexamined life is not worth living,” and that dogmatism should be assiduously avoided. Our College must be constantly looking ahead, and must be proactive and avoid being caught in a reactive posture, while continually focusing on the patient. “Aeger primo” (the patient first) must be our guide. We must not allow others to impede our historic focus on high-quality, safe surgical care delivered by available professionals following a code of professionalism, and adhering to our motto: “To Serve All with Skill and Fidelity.”

The American College of Surgeons Health Policy Research Institute and the Washington, DC, Office of our Division of Advocacy and Health Policy housed in this wonderful building will be a bastion for this important, essential, and ongoing activity.

Dr. McGinnis is senior medical consultant and advisor for the National American Cancer Society, and clinical professor of surgery, Emory University, Atlanta, GA. He is the 90th President of the American College of Surgeons.
The quest for sustainable trauma funding: The Georgia story

by Dennis W. Ashley, MD, FACS, FCCM

Floyd Medical Center in Rome, GA, was the first trauma center designated by the state 29 years ago. Despite much effort by multiple stakeholders, we still do not have an optimal statewide trauma system. The best description of the Georgia trauma system was coined by J. Patrick O’Neal, MD, director, division of emergency preparedness and response in the Georgia department of community health, as “islands of excellence in a sea of chaos.” Over the last 29 years, a total of 23 hospitals have been designated as trauma centers. Currently, Georgia has 16 hospitals that are state trauma centers designated by the Office of Emergency Medical Services and Trauma (OEMS/T), using the standards developed from the American College of Surgeons (ACS) verification criteria. There are four Level I, 10 Level II, one Level III, and one Level IV trauma centers. Two of the Level II trauma centers are pediatric only, while three of the four Level I centers have been recognized for their additional pediatric commitment.

Trauma center review

In 2001, the OEMS/T accomplished the first redesignation and review of trauma centers in the state. In 2002, the trauma centers received their first state funding in an annual appropriation of $754,000 to provide registry data to the state. This

was a significant development, as it allowed all trauma centers to purchase the trauma registry of the ACS, known as National TRACS (NTRACS) and standardize data reporting to the state office.

The first funding for actual patient care came in 2006, as a $1 million appropriation for uncompensated care, to be shared by all trauma centers. This was obviously an insufficient amount to support even one trauma center, and many of the centers were considering dropping their trauma center designation. Although much progress had been made with regard to trauma center designation and standardization of the trauma registry, there was no significant sustainable funding for trauma centers, emergency medical services (EMS), or trauma physicians. This lack of funding also prevented any statewide trauma injury data analysis or performance improvement projects, as the OEMS/T was grossly underfunded and could not provide the trauma centers any feedback on the state registry data. This prompted an outcry from the trauma community to Gov. Sonny Perdue and the legislators, noting that our state was in crisis and that immediate action was needed to save our trauma centers and develop a statewide system.

In response, the Georgia General Assembly created the Trauma Services Study Committee in 2006. This committee was composed of five members of the House of Representatives and five members from the Senate. They held five regional public meetings and heard testimony from state and national trauma experts. Their final report, released in the form of a white paper, concluded the following: the Georgia trauma death rate was 20 percent worse than the national average; only 30 percent of major trauma injuries in Georgia were treated at designated trauma centers; traumatic death rates in rural Georgia were much higher than in the urban areas; and Georgia’s trauma care providers (hospitals, surgeons, and EMS) delivered $250 million in uncompensated trauma care annually. The report recommended establishing a trauma fund, developing a statewide trauma system, and creating a trauma commission to provide oversight and accountability.

**Battle cry**

The committee report became a battle cry for the trauma provider and stakeholder community, as the above-average death rate translated into approximately 700 lives lost per year due to the lack of an organized system. Organized grass-roots efforts and focused communication strategies with the Georgia legislature culminated in the General Assembly passing S.B. 60 in 2007. This bill established the nine-member Georgia Trauma Care Network Commission (also known as the “Trauma Commission”) with five members appointed by the governor, two members appointed by the lieutenant governor, and two members appointed by the Speaker of the House. The bill identified system stakeholders and mandated EMS, trauma centers, and trauma physicians be represented on the Trauma Commission. The charge of the Trauma Commission was clear: Develop a statewide trauma system and formulas for the fair distribution of trauma funds to all stakeholders with regard to readiness costs and uncompensated care. Unfortunately, S.B. 60 came with no money allotted for the trauma fund. The Trauma Commission began holding monthly meetings, but was very limited in its function, as there was no funding. Simultaneously, Healthcare Georgia Foundation had contracted with a national trauma system financial consulting firm, Bishop + Associates, to assess the economics of the Georgia trauma system and to identify opportunities to stabilize and strengthen it for the decades ahead.

The Trauma Commission collaborated with Bishop + Associates to identify needs and assess the financial viability of Georgia’s trauma centers. Surveys were developed for trauma centers to evaluate their financial performance. Compared with national data, Georgia’s payor mix was lacking. In 2007, Georgia’s commercial insurance was 39 percent, versus 51 percent for the national norm, and the uninsured patient population was 25 percent versus 18 percent nationally. Readiness costs were also assessed by the

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1Report from the Joint Comprehensive State Trauma Studies Committee (unpublished legislative subcommittee report). 2006 Legislative Session of the Georgia General Assembly.

2Meeting results, Trauma Care Network Commission webinar, December 16, 2009.
survey for each trauma center. Readiness costs included all of the variables listed in Figure 1, this page. The total readiness cost for the four Level I trauma centers was $20,807,997, with an average cost of $5,201,999 per center. The total readiness cost for the 10 Level II trauma centers was $23,255,227, with an average cost of $2,225,245 per center. At the time of the survey, there were no Level III trauma centers in Georgia. In addition, treatment costs were assessed at $220,684,574; total trauma center cost (readiness and patient treatment) was $264,747,798; and the total patient care revenue was $193,999,255. The survey revealed a loss on trauma center operations of $70,748,543. It became obvious to health care providers that the trauma centers could not maintain the current level of participation without financial support from the state.

Governor Perdue responded to the Georgia trauma care financial crisis in January of 2008 by appropriating an initial one-time allocation of $58.9 million from the state’s general fund. The Trauma Commission had its funding—at least for one year. The overarching goal during that first year of funding was to stabilize and strengthen the existing trauma centers to prevent centers or physicians from dropping out of the system. Formulas were developed for distribution of funds to trauma centers and physicians based on readiness and uncompensated care costs. The Trauma Commission determined it could cover approximately half of the Level I trauma center readiness costs at $2.5 million per center, and $1.5 million for each Level II center. These funding formulas to determine readiness costs were fairly easy to develop, as they were based on the level of designation. Uncompensated care funding required a much more sophisticated approach, as there were many more variables involved.

### Treatment cost norms

According to S.B. 60, patients on the state trauma registry with no insurance were eligible for uncompensated care funding. To develop a fair and consistent approach for estimating costs for these patients, national trauma center patient treatment cost norms by injury severity were used for both community and academic trauma centers. These norms were developed over the past decade by the National Foundation for Trauma Care. In essence, the formula is composed of the number of patients multiplied by the cost norm for each level of injury severity.

This analysis was performed for each trauma center, and resulted in a total uncompensated care cost of $38,787,061 for all trauma centers. This process provided a way to calculate the percentage of uncompensated care each trauma center performed, and distribute uncompensated care funds to each trauma center based on these percentages. Therefore, all Level I trauma centers received the same compensation for readiness costs, as the designation standards for all Level I centers are the same. However, each Level I trauma center received a different amount of uncompensated care funding, as each center treated different volumes and severities of qualifying patients. The same formulas were used for the Level II centers. The Trauma Commission also set aside $4.1 million for Level I and Level II trauma centers in a competitive capital grants program. This allowed trauma centers to apply for funding for specific capital equipment or construction funds in regard to level of designation.

Trauma physician allocation for readiness was set at 25 percent of trauma center readiness costs. This was to ensure that physicians were compensated for being on call in a trauma center, as this was seen as a readiness cost to the center. The trauma physician uncompensated care component was set to 25 percent of trauma center uncompensated care distribution. As ac-

### Figure 1. Readiness cost variables

- Medical staff payments for trauma call
- Twenty-four-hour operating room staffing
- Higher staffing levels for lab/diagnostic services
- Ground or air transportation
- Support services
- Injury prevention
- Training of nurses and physicians
- Administrative infrastructure of trauma programs
- Physician extenders
- Verification process
- Trauma specific equipment
Figure 2. Six immediate goals

- Obtain permanent funding
- Maintain and expand trauma centers: Focus on South Georgia
- Strengthen EMS: Focus on rural regions
- Trauma transfer and communication center
- Trauma system infrastructure under Office of EMS and Trauma
- Assure exceptional accountability

Table 1. 2008 trauma fund allocation

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Percent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma center allocation</td>
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<td></td>
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<tr>
<td>Trauma center readiness costs</td>
<td>$17,888,539</td>
<td>30.4%</td>
</tr>
<tr>
<td>Capital grants for Level I and Level II trauma centers</td>
<td>4,148,602</td>
<td>7.0</td>
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<tr>
<td>Level IV trauma centers</td>
<td>200,000</td>
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</tr>
<tr>
<td>Uncompensated care costs</td>
<td>17,888,539</td>
<td>30.4</td>
</tr>
<tr>
<td>Total trauma center allocation</td>
<td>40,125,680</td>
<td>68.1</td>
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<tr>
<td>Trauma physician allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25% of trauma center readiness costs</td>
<td>5,962,846</td>
<td>10.1</td>
</tr>
<tr>
<td>25% of trauma center uncompensated care</td>
<td>5,962,846</td>
<td>10.1</td>
</tr>
<tr>
<td>Total physician allocation</td>
<td>11,925,693</td>
<td>20.2</td>
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<tr>
<td>EMS/prehospital allocation</td>
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<tr>
<td>EMS competitive grant program</td>
<td>4,000,000</td>
<td>6.8</td>
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<tr>
<td>EMS uncompensated care</td>
<td>1,479,945</td>
<td>2.5</td>
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<tr>
<td>GPS and automatic vehicle location system</td>
<td>996,452</td>
<td>1.7</td>
</tr>
<tr>
<td>Total EMS/prehospital allocation</td>
<td>6,476,397</td>
<td>11.0</td>
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<tr>
<td>Oversight and system development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma commission/system plan and development</td>
<td>375,000</td>
<td>0.6</td>
</tr>
<tr>
<td>Total oversight/development allocation</td>
<td>375,000</td>
<td>0.6</td>
</tr>
<tr>
<td>Total 2008–2009 Georgia Trauma Fund</td>
<td>$58,902,769</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Allocation of Trauma System Funding. Georgia Trauma Commission meeting, June 9, 2008. Printed with permission.

The actual physician trauma uncompensated care data was not readily available, it was estimated that for every dollar of cost for the trauma patient, approximately 25 percent was provided by the physician. None of these funding categories covered all the costs for physicians or trauma centers.

To address the prehospital point of the trauma system care continuum, EMS received $6.4 million, which included a competitive grant program for new ambulances in rural Georgia, an uncompensated care reimbursement program, and funding toward a GPS/automatic vehicle location system (see Table 1, this page).

After distributing funds from the one-time allotment for trauma care, the Trauma Commission worked on their second charge, which was to develop a statewide trauma system. This was developed through an aggressive assessment and planning process, including committed stakeholder input, ACS trauma system consultation, Georgia Health Policy Center economic analysis, the Healthcare Georgia Foundation report, and Trauma Commission monthly meetings and workshops. This intense and focused activity resulted in a five-year strategic plan consisting of 15 goals. The commission identified six immediate goals (see Figure 2, this page). Of these, the most important goal was to obtain adequate and permanent funding, as the $58.9 million was only a one-time allotment.

Awareness campaign

A public awareness campaign was started by the Hayslett Group of Atlanta, GA, that used media coverage, editorial support, marketing, and public engagement to promote trauma education and the need for a trauma system in the state. This resulted in a formal website (http://www.GeorgiaItsAboutTime.com), which serves as a repository for all state trauma system awareness information. The statewide media response was highly supportive of the issue, as all these efforts resulted in 500-plus print, broadcast, and Web reports spanning 49 newspapers and 19 television and radio stations. We were beginning to gain public awareness, as evidenced by a University of Georgia survey conducted in 2007 on the willingness of Georgians to pay for trauma care. The poll (N=500) noted that 66.7 percent were willing...
and if used appropriately, will lead to success. Each state must identify the need for trauma system development or improvement and translate this into their battle cry. For Georgia, this battle cry was the above-average death rate as compared with the national average. Once we identified our need, we were able to recruit multiple groups of stakeholders, as everyone can identify with developing a system that would save lives.

It is imperative that trauma surgeons do not try to develop a system or obtain funding on their own. It was not until our surgeons joined forces with EMS, the Georgia Hospital Association, the Medical Association of Georgia, nursing associations, the Georgia Chamber of Commerce, state and local governments, and, most importantly, the public, that we started to be heard at the state capitol. This allowed us to present a consistent, unified message that trauma system funding and development was important for all Georgians.

Acknowledgment

Many thanks to the Georgia Trauma Care Network Commission members for their dedication to trauma care in Georgia. The members include: Richard Bias, FACHE; Linda Cole, RN; Leon Haley, Jr., MD, MHSA, CPE, FACEP; Ben Hinson, EMT-P; William T. Moore; Joe Sam Robinson, MD, FACS; Kurt Stuenkel, MHA, FACHE; Kelli Vaughn, RN, MSN, CEN; and executive director, Jim Pettyjohn, BSN, RN.

Dr. Ashley is director of trauma and critical care, Medical Center of Central Georgia, and professor of surgery, Mercer University School of Medicine, Macon, GA. He is also chair of the Georgia Trauma Care Network Commission.
At no time in recent history has the need for physician leadership been more critical for our patients and our profession than the present day. Surgeons are often thrust into leadership roles with little or no training, simply because they are surgeons and, therefore, have the decisive personalities that successful leaders often possess. The words of Gen. George S. Patton, Jr., could easily be applied to surgeons: “Be willing to make decisions. That’s the most important quality in a good leader. Don’t fall victim to what I call the Ready-Aim-Aim-Aim-Aim syndrome. You must be willing to fire.”* Surgeons are ready-aim-fire people. They see a problem, analyze it, and make a decision that leads to an action. Then they move on to the next problem.

Surgeons have been preparing themselves for these leadership roles from their early years through the continuum of their practices in the present day, whether they realize it or not. However, formal training in leadership is often lacking during a surgeon’s education and, especially, during their surgical training.

There are many excellent texts on the subject of leadership, but in my opinion, one in particular stands out—On Leadership: Essential Principles for Success, by Donald J. Palmisano, MD, FACS.† In his book, Dr. Palmisano covers the essential principles for success, and stresses that success does not always translate into good leadership. He believes leadership involves three factors that his father, MAJ Dominic Palmisano of the New Orleans Police Department, once shared with him: “Do your homework, have courage, and don’t give up.”

Leadership in modern medicine

Whatever a surgeon’s practice environment is like today, get ready—it is going to change. The profession has already seen a tremendous shift from the private practice of medicine to an employed arrangement for many physicians, both surgeons and nonsurgeons. As physicians become less and less dependent upon fee-for-service payment, it is natural that physician loyalty will shift from patient to the “boss.” This change in perspective does not mean surgeons will provide care that is any different from what they currently provide, and it does not mean the quality of care will be any less. In fact, many policymakers believe that quality may even increase as a result of this change. With the introduction of the accountable care organization and the bundling of payments, the delivery of our services will be altered. As the nation transitions to these new systems, surgeon leadership will play a critical role in determining the future of surgical care.

Changes in payment methodologies are going to follow, or even force, these different alliances between physicians, hospitals, and payors. Beginning next year, all hospitals will be ranked publicly on their core measures, and on their hospital consumer assessment of health care providers and systems scores. Some surgeons and other physicians may argue the validity of such rankings, but other health care providers are already comfortable in this arena, given their experience with pilot programs. Debating the merits of these rankings is not the purpose of this article, but the fact that these studies are being brought into the health care marketplace signals that patient perception will likely be a factor in determining physician payment rates. The core measures—and more are likely to come—will also be used to factor these rankings. Again, this is an area where surgeons must be in leadership positions, where they must do their homework and express courage and determination.

Leading the bylaws development process

It is quite clear that nearly all surgeons will have to have privileges at some type of surgical facility, be it a hospital or a free-standing surgery center. The ownership of such a facility may vary from not-for-profit to for-profit or governmental. Each type of entity carries with it its own set of corporate and medical staff bylaws, rules, regulations, and policies, which define its governance structure and guide the day-to-day functioning

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*This quote has been variously attributed to George S. Patton, Jr. (http://www.englishforums.com/English/GeneralGeorgeSmithPattonWilling-Decisions/llqcm/post.html; accessed September 2, 2010), as well as T. Boone Pickens (http://www.boonepickens.com/thoughts/default.asp; accessed September 2, 2010).

of the organization. When changes external to the surgeon’s health care environment affect our practices, we must be ready to lead the changes within our institutions that will allow our facilities to be successful and accredited for payment purposes.

Whether or not surgeons are employees or if they are able to remain in private practice, they will be expected to comply with institutional bylaws. The surgeon’s medical staff bylaws define who they are as a body of physicians. They dictate how surgeons are organized to carry out their duties within the institution. They should define the organized medical staff’s (OMS) duties, responsibilities, and obligations to the governing body of the institution. These bylaws should protect the surgeon and grant them due process and confidentiality for any untoward events.

Physicians write their own bylaws, and many resources are available to help them accomplish this task. At press time, the American Medical Association (AMA) continued to offer the fourth edition of Physician’s Guide to Medical Staff Organization Bylaws. This guide serves as a good starting place, but it is not current with the new Joint Commission requirements of MS.01.01.01. The fifth edition of the AMA’s guidebook was in final proofing at press time and should be available this fall.

There are many other sources for generating bylaws, and it is important for surgeons to always conduct research before authoring these bylaws. An OMS should always hire its own independent legal counsel, especially if some other outside source is the originator of the proposed bylaws. (Many problems can be avoided by starting with good bylaws.)

The Joint Commission standard

The Joint Commission created Medical Staff Bylaws Standard MS.1.20 in 2004. There was much controversy in the hospital community about its intent and purpose, and concerns were also raised about the costs associated with changing existing bylaws. After several months of debate, The Joint Commission appointed a task force to study the issue. Representatives from the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, the AMA, the Federation of American Hospitals, and the National Association of Medical Staff Services were appointed to the task force. The task force represented physicians, hospital chief executive officers, trustees, and health care attorneys with extensive experience in medical staff bylaws and related issues. The task force held 12 meetings between January 2008 and March 2009. From this collaborative effort, new standard MS.01.01.01 emerged.

During deliberations conducted by the task force, it became clear that decisions regarding patients’ diagnoses and treatment should be made by physicians and other licensed independent practitioners, which include, for example, dentists and podiatrists who have been licensed by the state to diagnose and treat patients without clinical supervision. The role of physicians and other licensed independent practitioners within a hospital has two implications:

• From a legal perspective, these physicians and other licensed independent practitioners can be clinically overseen only by others who are licensed independent practitioners
• Their clinical decisions drive much of the rest of the hospital’s activities, from nursing care to diagnostic imaging to laboratory testing to medication use, and affect the hospital’s ability to provide high-quality, safe care to the patients it serves

Therefore, physicians and other licensed independent practitioners in the hospital form an organized medical staff, which has both the technical knowledge and the legal standing to provide clinical oversight of the clinical care and the performance of those with clinical privileges, and to evaluate and establish direction for their clinical care and decision making. The Joint Commission Standard LD.01.05.01, in the “Leadership” chapter, specifically requires that this OMS be “accountable to the governing body” to “oversee the quality of care, treatment, and services provided by those individuals with clinical privileges.”


The Joint Commission standards for hospital leadership outline three distinct leadership groups—the governing body, the chief executive and other senior managers, and the OMS—that must work together if the hospital is to reliably achieve high-quality, safe patient care. To enable this collaboration, the governing body and the OMS must mutually agree upon rules, procedures, and parameters that will guide their interactions. This is the rationale the task force gave for the changes in new MS.01.01.01, which requires that these rules, procedures, and parameters be included in a set of medical staff bylaws and rules and regulations that are adopted by the medical staff and approved by the governing body.

Within this context, the OMS is accountable for collecting, verifying, and evaluating each licensed independent practitioner’s credentials, and recommending to the governing body that an individual be appointed to the medical staff and be granted clinical privileges based on these credentials. Other medical staff and governing body activities related to the quality and safety of care include setting requirements for medical histories and physical examinations, terminating or suspending a practitioner’s medical staff membership or clinical privileges (including a process for challenging such action based on quality of care considerations), and directing medical staff departments. How these activities should be conducted, and the respective roles of the OMS and the governing body, are part of the agreement between the governing body and the OMS specified in the OMS bylaws, rules, and regulations.

The revised MS.01.01.01 provides more flexibility for governing bodies and medical staffs to determine what will be placed in the medical staff bylaws and what will be placed in other documents. The revised version also provides for notification by the OMS to the medical executive committee (MEC) when it wishes to propose a change to a rule, regulation, or policy directly to the governing body. At the same time, the MEC must provide notice to the OMS concerning proposed changes to rules or regulations (policy changes by the MEC do not require notification). Although disagreements in well-functioning organizations would be rare, the revised standard calls for a process to manage conflict, should it occur.

The Joint Commission anticipates that in those hospitals characterized by collaboration, cooperation, and communication between the governing body, the OMS, and the administration, few bylaws changes will be necessary. However, surgeons who practice in a hospital that is lacking in these areas must now take a leadership role. Surgeons must examine how each element of performance is addressed in the bylaws, and they should consult with legal counsel to determine any required amendments. On specific interpretations of the revised standard, surgeons can consult directly with the Joint Commission.

Dr. Gregory is a general surgeon in Muskogee, OK. He is a Governor of the College and Vice-Chair of the Board of Governors’ Committee on Surgical Practices.
As your skill set and success as a physician becomes apparent to patients, friends, and associates, the reason for that success becomes self-evident: hard work; integrity; attention to detail; self-confidence; genuine concern and affection for your fellow man; an ability to work through difficult, challenging, often emotionally charged events; and, at least to your admirers, all the while maintaining an air of composure and competency. These qualities make one a prime candidate for board trusteeship, be it corporate (public or private), a public charity, or a foundation. At first blush, the trustee invitation is humbling, and the candidate should feel honored. After that emotion passes, however, it is important to find quiet time to reflect and ponder several very important questions, because board trusteeship bears significant responsibility and commitment of time. These questions include the following:

- Why do I want to do this?
- Who will I be working with?
- Do I understand and believe in what they do?

If, after this self-assessment, the physician is still wanting to say yes to this position, the next thing the candidate must understand before accepting the role of a trustee is the role of the governing board and the responsibilities of trusteeship. The candidate should then ensure he or she has an understanding of the organizational structure and the lines of authority relative to the officers, board of trustees, committees, and, very importantly, the management team. It is important to always remember that boards and trustees are all about governing and oversight, and not about managing.

What will be the physician’s role as a trustee?

In defining the legal obligations of trustees, the courts have identified four general duties: duty of care, duty to make the entity productive, duty of loyalty, and duty of impartiality.

Duty of care

A trustee’s duty of care generally has two components:
- The duty to exercise care and good judgment with respect to actions and decisions
- The duty to monitor the affairs of the organization on an ongoing basis

Fulfilling the trustees’ and board’s responsibilities under duty of care includes the following:
- Being fully informed about the business of the organization
• Regular attendance at all board and committee meetings
• Attention to, and the full understanding of, all issues and material presented to the board
• Ensuring legal and ethical integrity, and Internal Revenue Service (IRS) compliance
• Requiring an annual audit with a report to, and review by, the board
• Understanding and monitoring the financials of the organization, which includes the following:
  —Balance sheet, which is also known as “the statement of the organization’s financial condition and net worth.”
  —Income statement, which is also known as the “profit and loss statement.”
  —Cash flow statement: this document outlines where the business got its cash, and what it did with it. This is also known as the “where got, where gone statement.”

Duty to make the entity productive
The duty to make the entity productive occurs when the candidate provides governance and oversight of all organizational affairs. It is important to remember that, with increasing federal and state oversight of board responsibilities and performance, the duty of governance and oversight will become even more important in the near future.

Duty of loyalty and duty of impartiality
For these two responsibilities, it is important that the candidate always act in the organization’s best interest. This can be accomplished by the following:
• Thinking of your role as a physician and the doctor/patient relationship
• Being an advocate of the patient and always doing what is in the best interest of the patient
• Giving the patient the best you have to offer
• Strict oversight of patient care
At this point, as a trustee, the organization is your patient.

Meeting with the organization’s leadership team
Once the physician has a general understanding of his or her duties as a trustee, it is important to meet with key individuals within the organization. It is suggested that candidates meet with the individuals in the following positions to gather even more information: the president of the organization, the chairman of the board, a current board trustee (particularly an acquaintance or friend, if possible), and the chief executive officer (CEO). It is important to meet with each individual privately, but the trustee candidate will likely want to ask each individual the same set of questions.

Begin by asking the individuals in each of these key roles to define the mission of the organization (or “is and does”), and its vision (or what it “strives to be or do”). The physician will also want to ask questions regarding the following topics:
• Positives and negatives of the organization.
• Major achievements, major problems.
• Is there a favorable relationship between the officers, board, and CEO?

When meeting with the chairman of the board of the organization, the physicians will want to focus on the board, the number of trustees, how they were selected, tenure, if there is directors and officers liability insurance, what the limit of that coverage is, and if all trustee votes are counted and if all trustees have an equal voice in the organization. The trustee candidate will also want to inquire about any problems within the board, and, as time permits, query the chairman of the board about the organization’s bylaws, specifically as they relate to the role of the board and trustees.

Legal and ethical integrity
It is important to remember that the overarching absolute of trusteeship is that the board and trustees must assume the responsibility of legal and ethical integrity. Because the board is ultimately responsible for ensuring adherence to legal standards and ethical norms, trustees must exhibit due diligence, commitment, and vigilance to keep their house in order. The organization’s reputation and public standing require the board and trustees take three concepts seriously: compliance, transparency, and accountability.

Compliance
The term compliance is simply shorthand for the regulatory and legal requirements imposed by government and regulatory bodies at local, state, and federal levels that are considered part of a board’s fiduciary responsibility.

Some failures in the governance and manage-
ment of tax-exempt organizations have captured the attention of the public state attorney general and the IRS, as well as that of the U.S. Senate Finance Committee. One of the most recognized pieces of recent legislation, the Sarbanes-Oxley Act, grew out of high-profile failures of corporate board oversight and dysfunctional accounting and auditing standards. Although Sarbanes-Oxley primarily affects publicly traded corporations and auditing firms, it has forced all boards and trustees to review, in detail, their own standards and practices.

Transparency

Part of the board’s fiduciary responsibilities, transparency describes the manner in which the board must act in providing accurate information about an organization’s financial condition and its revenue, and how it is expended. The information should also be open and clear on all compensation, especially executive compensation, and there should be strict adherence and proof of adherence to organizational policies and procedures.

Accountability

The board and trustees need to ensure the organization does the following:
- Adopts a code of conduct and ethical standards for trustees and officers
- Defines and avoids what constitutes possible conflicts of interest
- Maintains official records for the time periods required
- Develops and maintains up-to-date personnel policies and procedures
- Conducts annual audits of all revenues, assets, expenditures, and liabilities

Laws and regulations, IRS requirements, legislative committee inquiries, and accrediting organization standards are all likely to continue to require even more compliance, transparency, and accountability. The most effectively managed, governed, and highly respected organizations exceed, rather than meet, minimal standards and expectations.

In summary, as a trustee, it is imperative that the physician is satisfied that the board is functioning cordially, that governance is intact and adhered to, and that there is a prevailing spirit of confidence and a healthy relationship between the board and management. Be forewarned that subtle shifts in control can, and do, occur. The physician must be willing to give his or her time and full attention to thoroughly understanding all of the issues presented to the board.

Dr. McArthur is chairman and chief executive officer, Caldwell Foundation, Tyler, TX. He is a Past-President of the North Texas Chapter and a Past Vice-Chair of the Committee on Patient Safety and Quality Improvement.
The Board of Governors’ Committee on Surgical Practice in Hospitals and Ambulatory Settings has been quite active over the past year, due to a sizable conference call schedule and the annual meeting of the committee at the Clinical Congress, in Chicago, IL. One housekeeping suggestion of the committee was to shorten the name of the committee to the Committee on Surgical Practice. The Executive Committee of the Board of Governors recently voted and approved this name change.

The committee has been interested in a variety of issues that affect surgical practice, including: patient safety, surgical workforce concerns, emergency call, surgical practice structure, and the ability of graduating surgical residents to begin practicing.

**Patient safety**

The committee reviewed the Statement on Surgical Patient Safety that was approved by the Board of Regents and published in the *Bulletin* last year. The statement made recommendations about preoperative surgical site selection and the safety checklist, which was shown to improve safety in eight hospitals around the world. During the past year, the committee discussed various issues included in the statement and continued its support of the statement.

**Surgical workforce**

For four years, the committee has been concerned about the surgical workforce. With the population expanding and the increasing number of Baby Boomers aging, combined with the fact that the number of graduating surgical residents is not showing significant growth, while fewer surgeons are practicing broad-based general surgery, it does not appear that there will be an adequate number of general surgeons to manage future health care.
This issue is already a problem in rural areas, and it appears to be a problem in urban emergency rooms, as well. The committee supports the work of George Sheldon, MD, FACS, and the American College of Surgeons’ Health Policy Research Institute in addressing the surgical workforce problem. The committee is available to help in this area.

Emergency call

Given changes in surgical practice and in the general population, coverage of patients who need emergent general surgical care is changing. The committee has discussed this issue in detail, and it supports the efforts of the College in this area.

The committee particularly believes that surgeons practicing in these situations should be compensated fairly.

Surgical practice structure

The committee has expressed concern that private practice is diminishing, while hospital-employed surgery is increasing. The concerns of the committee will be discussed with surgeons at the 2010 Clinical Congress in Washington, DC, in a panel moderated by R. Phillip Burns, MD, FACS, the Past-Chair of this committee, and H. Earle Russell, Jr., MD, FACS. The title of the session is Perils, Pitfalls, and Benefits of a Surgeon As Hospital Employee. The goal of the panel is to provide factual information to help the practicing surgeon decide between private practice and hospital-employed surgery.

The committee will continue the discussion regarding hospital-employed surgeons with a panel at the 2011 Clinical Congress in San Francisco, CA, titled Surgeons As Hospital Employees. This session will include specific information regarding contracts.

The committee realizes that hospital-employed surgeons are part of a larger change in medicine. Presumably, accountable care organizations, in one form or another, will play a role in future health care. To this end, the Committee on Surgical Practice, along with the Committee on Socioeconomic Issues, will jointly sponsor a panel at the 2011 Clinical Congress addressing the 2011 version of accountable care organizations.

Are graduating residents ready to practice?

With the 80-hour workweek, and the societal push to deny residents the opportunity to operate independently during their residencies, there is a general perception by graduating residents and practicing surgeons that graduating residents are not ready to practice. The committee is particularly concerned about this issue. A survey is being developed to compile more information regarding this perception. If this perception is, in fact, a reality, the committee would like to work with others in the College to propose solutions to this problem.

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Joe B. Putnam Jr., MD, FACS
Melissa Michelle Rader, MD
H. Earle Russell Jr., MD, FACS
Peter Lloyd Rutledge, MD, FACS
Christopher M. Schlachta, MD, FACS

The committee is associate professor, department of surgery, Brigham and Women’s Hospital, Boston, MA, and Chair of the Governors’ Committee on Surgical Practice.

Dr. Swanson is associate professor, department of surgery, Brigham and Women’s Hospital, Boston, MA, and Chair of the Governors’ Committee on Surgical Practice.
The mission of the Socioeconomic Issues Committee is to identify societal and economic factors that affect the work and well-being of the Fellows and their ability to provide optimal care for their patients; to provide guidance to the Board of Governors regarding proposed actions that can promote the vitality, viability, and the future of the surgical profession; and to select surgical volunteerism and humanitarianism award recipients. Examples of the work produced by this committee include the American College of Surgeons (ACS) Statement on the Rationale for Emergency Surgical Call Support,* and the Clinical Congress Panel Session entitled The Surgeon’s Interaction with Industry. Organized by Michael Dalsing, MD, FACS, this panel addressed the potential conflicts of interest between surgeons and device vendors at a time when news headlines suggest that some surgeons may be influenced by gifts, favors, and cash inducements thinly disguised as research grants. Industry perspective was presented by Christopher White, general counsel of the Advanced Medical Technology Association (AdvaMed). Facing challenges from government and the private sector, AdvaMed made substantial revisions to its code of ethics in 2009. The current president of the American Academy of Orthopaedic Surgeons, John Callaghan, MD, FACS, addressed industry relations as interpreted by a surgical specialty whose members have constant involvement with high-tech instruments and implants. Patricia Turner, MD, FACS, provided the young surgeons’ view of industry relations; ACS Regent, Robin McLeod, MD, FACS, approached this topic from the ethics perspective; and Anton Sidawy, MD, FACS, discussed the impact on researchers.

Based on solicitation of its members, the committee proposed a panel for the 2011 Clinical Congress entitled The Role of the Surgeon in Design and Implementation of New Mechanisms of Collaborative Health Care Delivery. Mandated *

by the recently passed Affordable Care Act (ACA), the Centers for Medicare & Medicaid (CMS) will establish a center for innovation that will test, evaluate, and expand different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care in Medicare, Medicaid, and the Children’s Health Insurance Program. Simultaneously, private carriers are proceeding rapidly with innovative programs of their own to control expenditures. The impact of these programs on surgical providers is primarily speculative at this time, but the goal of this panel would be to inform surgeons of what lies ahead in these alternative payment models—specifically, how participation in development can benefit patients with surgical disorders and those who provide the surgery.

Nominations for the American College of Surgeons/Pfizer Inc Humanitarian and Surgical Volunteerism awards were higher this year than in the past, numbering 17 individuals for the Humanitarian Award and 22 for the Volunteerism awards (see Bull Am Coll Surg. 2010;95[9]:36-39). The committee evaluated each candidate in detail and made recommendations to the Executive Committee of the Board of Governors for recipients in each category. Evaluation of the nominees is certainly a humbling experience. Although a limited number of awardees are recognized annually, the service provided by all these individuals is something that every College member should be proud of. The award winners presented their work at a panel session at the 2010 Clinical Congress in Washington, DC, on Monday, October 4; the panel was co-sponsored by the committee and Operation Giving Back. The awardees were then honored at the Governors’ dinner on October 5.

During discussions this year, the committee identified several issues that would serve as a focus for the upcoming October meeting. Considering the substantial shift of surgeons to hospital employee status, committee members suggested opportunities for the College to assist Fellows as they consider this important decision. In particular, the suggestion was made that the committee should discuss the development of the modern surgeon as a leader in his or her hospital rather than simply an employee. Workforce supply issues remain a major concern of the committee, as the existing training structure is a long, multi-year program that is unable to provide a rapid solution to the growing surgeon in the U.S. The ACA mandates creation of a national health care workforce commission, and committee members have voiced concerns that the surgical workforce must be considered in earnest by this new commission. These topics and related issues were being compiled for the October 2010 committee meeting.

Dr. Zwolak is professor of surgery, Dartmouth-Hitchcock Medical Center, Lebanon, NH, and Chair of the Governors’ Committee on Socioeconomic Issues.
Building personal relationships with lawmakers is an essential tool in relaying surgery’s legislative concerns and priorities, and for ensuring that the profession’s key issues receive the necessary personal attention from elected representatives. Getting involved in campaigns for either state representatives and senators or for federal officials is an effective way to get to know the people who make decisions that directly affect surgical practice, and patients, on a daily basis.

Campaigns are a critical time when legislators have a heightened sensitivity to the topics their constituents deem important. Take advantage of this opportunity and volunteer for a campaign—it will ensure that your positions on policy are heard, and it will give you the chance to develop a rapport with your representatives. State and federal officeholders and their staffs are very aware of who contributes time, energy, and financial support to their campaigns. Due to the limited resources of a campaign, most funds are directed toward advertisements, mailings, and events, whereas volunteers are largely relied upon for executing the crucial day-to-day operations.

In fact, volunteers are an integral part of a campaign, so the greater visibility one has in a campaign, the stronger the relationship one can build with a representative and his or her staff. Once the election is over, this activity will afford you the contacts and credibility to serve as an expert on the issues critical to surgery and the surgical patient.

**Getting involved**

There are many ways to get involved in a political campaign that will yield great benefits in relationship building, and ultimately, in effectively advocating for the surgical profession.

- **Contribute financially.** It is a simple fact in American politics that most local and federal officials spend much of their time running for office. Today, more than ever, elections are an extremely expensive undertaking. Fundraising is a crucial and often arduous component of running for office. As a result, candidates and incumbents pay very close attention to dependable donors. Contributing financial support does not necessarily require large sums of money. Often, candidates appreciate and take note of the smaller, annual contributions from individual donors, which they grow to rely on as consistent and loyal support.

Facilitating a fundraiser for a group of local surgical colleagues is another effective strategy. There is always strength in numbers, and helping to organize groups of donors can go far toward strengthening relationships with lawmakers. One way to accomplish this would be to host a meeting with a candidate or your legislator at your home, and invite surgical colleagues and their spouses. It can also be helpful to invite legislators to tour your practice or hospital so he or she can get a firsthand look at how the laws being debated directly affect the practices in the areas they represent.

Contributing to political action committees (PACs) that are focused on health care issues and that provide financial support to candidates who serve on key committees and are in leadership positions is another crucial way to build relationships. At the state level, this could include an American College of Surgeons (ACS) chapter’s PAC or the state medical society PAC. From the federal perspective, the American College of Surgeons Professional Association (ACSPA)-SurgeonsPAC is a valuable and important component of the overall advocacy agenda for the College. To learn more about the ACSPA-SurgeonsPAC, go to [http://www.facs.org/acspa](http://www.facs.org/acspa). (Note: All financial contributions or fundraising efforts/amounts must be in compliance with...
state and federal election laws. It is important to be aware of the law before engaging in this type of activity.)

• Volunteer in the campaign office. Campaigns can always use another set of hands to assist with stuffing envelopes, addressing mailings, and making phone calls. Helping with these simple tasks goes a long way toward running a successful campaign. Working in a campaign office can provide insight into grassroots advocacy techniques, such as effective strategies for distributing materials, recruiting supporters, and mobilizing groups. In addition, spending time in campaign headquarters allows volunteers to become acquainted with the key issues and policies that the candidate is addressing, and provide opportunities to meet executive staff members and the candidate personally.

• Take to the streets. Canvassing neighborhoods; handing out flyers, letters, and yard signs (literature drops); and marching in parades are really effective ways to support a candidate. Elected officials value people who take to their feet to volunteer, to spread their name, and support them publicly. Attending town hall meetings, candidate debates, open houses, or other public forums also demonstrates personal dedication to advancing the right candidate who will act as a champion for surgeons and their patients.

• Offer expert advice. Campaigns often delegate their volunteers and long-time supporters to serve as advisors on panels, steering committees, or campaign cabinets. These committees are composed of professionals, advocates, and experts from a variety of fields, and are influential in shaping the message, position, and agenda for a candidate. Serving on a committee may even allow a volunteer access to writing and shaping policy, directing what stance or position the candidate should take on issues, and establishing the volunteer as a trusted resource. In a campaign, the individuals who serve on these boards and committees are some of the most important assets for a candidate, as they offer insight and knowledge into issues and policies that may be unfamiliar to the candidate. Board or committee members have greater access to the candidate, ensuring that they are able to share their expertise and strengthen the candidate’s ability to represent and serve the surgeons in their district.

Rewarding tasks

These volunteering strategies will help establish a rapport and working dialogue with policymakers, and will likely ensure that surgeons and surgical practice are represented accurately and effectively at every level of government. Candidates will appreciate the assistance volunteers provide to their campaign, and health care professionals will be able to build important connections and personal relationships with policymakers. In the end, this will help ensure a surgeon’s seat at the table and lend increased credibility to surgery’s legislative priorities.

For additional information on building relationships with policymakers, contact Charlotte Grill, LSW, State Affairs Associate, in the Division of Advocacy and Health Policy at cgrill@facs.org, or visit the College’s state legislative website at http://www.facs.org/ahp/index.html.
Pediatric surgeons: Subspecialists increase faster than generalists

by Stephanie Poley; Thomas Ricketts, PhD, MPH; Daniel Belsky; and Katie Gaul

Editor's note: The following is one of a series of columns initiated by the ACS Health Policy Research Institute (HPRI). The mission of the HPRI is to improve the understanding of surgical patient care from a policy perspective in order to educate the public, federal and state governments, health care consumers, and the policy community to enable advocacy for superior, efficient, and compassionate surgical patient care. The goal of the HPRI is to create a data-driven, knowledge-based program for examining issues related to surgical services, the surgical workforce, and public policies affecting surgery. The column will feature research data on topics of interest to Fellows and Members of the College.

Over the last three decades, the pediatric surgical workforce has expanded steadily, with a pronounced increase in the number of subspecialists. Still, many children across large geographic areas lacked access to any pediatric surgeons in 2006, and the nearly flat recent growth in pediatric generalist surgeons raises concern about future access.

Generalist growth slows

In 2006, there was one pediatric generalist surgeon for every 108,305 children up to the age of 19 in the U.S. This ratio represents a slight improvement from 25 years ago, but still signals a possible imbalance between the pediatric population and surgeons who are trained to treat them. Growth in the numbers of pediatric generalists reached a plateau by 2006, while pediatric surgical specialists expanded by nearly 24 percent in the last decade.

Pediatric surgical subspecialists have only been identifiable in the American Medical Association Physician Masterfile data since the early 1990s; many of these surgeons served the pediatric population prior to the addition of those specialty codes to the AMA Physician Masterfile survey. For this reason, it is difficult to assess change in this segment of the pediatric surgical workforce during the full 25-year study period; however, recent trends of strong growth in pediatric surgical subspecialties are evident (see Figure 1 on page 36). In all likelihood, these data underestimate the number of providers serving the pediatric population in all years. By 2006, there were 2.27 pediatric surgical specialists for every pediatric generalist surgeon in the U.S., and pediatric orthopaedic surgeons and ophthalmologists accounted for more 55 percent of all pediatric surgical subspecialists in 2006.

Pediatric surgeons cluster in urban areas

Overall, only 399 of the country’s 3,107 counties had any pediatric surgeons in 2006, and 28,774,439 children under the age of 19 lived in those counties. Just over half of the counties with pediatric surgeons (n=216) had a pediatric generalist surgeon, while pediatric specialist

Quick facts

Number of pediatric surgeons
1981: 464
2006: 2,474

Number of children (ages 0–19) per pediatric generalist surgeon
1981: 154,728
2006: 108,305

In 2006, only 399 (12.8 percent) of the 3,107 U.S. counties had a pediatric surgeon.

By 2006, there were 2.27 pediatric surgical specialists for every one pediatric generalist surgeon.
Figure 1. Pediatric surgical supply, 1981–2006

Table 1. County measures of pediatric surgical supply, 1981–2006

<table>
<thead>
<tr>
<th>Total number of counties</th>
<th>Percent of counties without a pediatric surgeon</th>
<th>Average county ratio of pediatric surgeons per 100,000 children 0–19 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>All counties: 3,107</td>
<td>94.2%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Urban: 838</td>
<td>80.5</td>
<td>60.0</td>
</tr>
<tr>
<td>Rural: 2,269</td>
<td>99.3</td>
<td>97.2</td>
</tr>
<tr>
<td>Midwest: 1,055</td>
<td>96.4</td>
<td>91.0</td>
</tr>
<tr>
<td>Northeast: 217</td>
<td>78.3</td>
<td>62.7</td>
</tr>
<tr>
<td>South: 1,391</td>
<td>95.3</td>
<td>88.5</td>
</tr>
<tr>
<td>West: 444</td>
<td>93.7</td>
<td>85.8</td>
</tr>
</tbody>
</table>

Surgeons were located in 371 counties. The distribution of pediatric surgeons is denser in more urbanized areas of the country; however, the magnitude of this varies from place to place and the difference in distribution between rural and urban areas is striking. Ninety-seven percent of rural counties lacked any pediatric surgeons in 2006, a small improvement from 1981, when 99.3 percent had none (see Table 1, this page). While it is clear that some previously underserved areas gained pediatric surgeons and that the average ratio of pediatric surgeons to children improved in both rural and urban areas between 1981 and 2006, geographic mal-distribution of the pediatric surgical workforce remains a significant issue in many parts of the
country, particularly for rural areas (see Figure 2, this page).

Large areas of the country, particularly in the midwestern and southern regions of the country, have no pediatric surgeons, and many states have only a few counties with any pediatric surgeons (see Figure 2). Three states—Montana, North Dakota, and Wyoming—have no pediatric generalist surgeons, and Hawaii has one to serve all of the islands.

**Data and methodology**

AMA Physician Masterfile data representing all licensed physicians were analyzed in six consecutive periods separated by five years each. Census Bureau population data for corre-
Table 2. Pediatric surgery specialty categories

<table>
<thead>
<tr>
<th>Specialty category</th>
<th>Included specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric General</td>
<td>Surgery</td>
</tr>
<tr>
<td>Pediatric Specialty</td>
<td>Surgery</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Neurological Surgery</td>
<td></td>
</tr>
<tr>
<td>Otolaryngology</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td></td>
</tr>
</tbody>
</table>

Corresponding years was used to calculate provider-to-population ratios at the county, state, and regional levels of analysis. Pediatric population was defined as the civilian population ages 0–19 years old. Providers with a self-reported primary or secondary specialty of one of seven pediatric surgical specialties including pediatric surgery, pediatric orthopaedics, pediatric ophthalmology, pediatric urology, pediatric neurological surgery, pediatric otolaryngology, and pediatric cardiothoracic surgery were included in the analysis (see Table 2, this page). When referring to pediatric surgical generalists, only providers with a primary or secondary specialty of pediatric surgery are discussed. Only providers who identified their practice type as direct patient care, were 69 years old or younger, and who reported a practice location within a U.S. county or county-equivalent (according to Federal Information Processing Standard [FIPS] codes) were included in the analysis.

Physicians were excluded from the analysis in a given year if they reported being in residency training, semi-retired, or if they reported their primary present employer was the U.S. government, locum tenens, medical school, or other non-patient care employment. For the purpose of this analysis, counties were defined by FIPS codes, regions were defined by the U.S. Census Bureau, and rural-urban was defined using the U.S. Office of Management and Budget’s core-based statistical area definitions for metropolitan and micropolitan areas.

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

Dr. Ricketts is professor of health policy and management and social medicine, University of North Carolina Schools of Global Public Health and Medicine, Chapel Hill, NC. He is Co-Director of the ACS Health Policy Research Institute.

Mr. Belsky is a PhD candidate in health policy and management at the University of North Carolina Gillings School of Global Public Health, Chapel Hill, NC. He was previously a graduate research assistant with the ACS Health Policy Research Institute.

Ms. Gaul is a research associate at the Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC, and the ACS Health Policy Research Institute.
Amilu Stewart, MD, FACS, honored with 2010 Distinguished Service Award

The Board of Regents of the American College of Surgeons (ACS) presented Amilu Stewart, MD, FACS, of Colorado Springs, CO, with the College’s 2010 Distinguished Service Award on October 3 during its 96th annual Clinical Congress in Washington, DC. The Board awarded Dr. Stewart the College’s highest honor for her dedicated service to the ACS and to the profession of surgery as a gifted and dedicated community surgeon and an active volunteer and leader.

Dr. Stewart currently serves on the admissions committee at the University of Colorado Health Sciences Center, Colorado Springs. She graduated from Thomas Jefferson University Jefferson Medical College, Philadelphia, PA (1965), and completed a residency in general surgery (1965–1970) at the University of Colorado Health Sciences Center. While completing her postgraduate training, Dr. Stewart also completed a transplant fellowship at the University of Colorado (1969).

Dr. Stewart’s academic career has been centered at the University of Colorado Health Sciences Center, where she was instructor in surgery and assistant professor of surgery (1972–1990). In addition to her work at the university, Dr. Stewart also served as a member of the surgical staff at both Penrose-St. Francis Health Systems (1972–2008) in Colorado Springs. At Penrose, Dr. Stewart also held the position of chief, department of surgery (1995). Prior to that time, Dr. Stewart served as emergency department director at Washington Adventist Hospital, Takoma Park, MD (1970–1972).

Since Dr. Stewart became a Fellow of the American College of Surgeons in 1974, her “tireless volunteer spirit” has resulted in “countless hours spent actively serving the College,” according to the ACS Board of Regents. She has served the ACS in a variety of activities, including as the Second Vice-President of the College (2003), as a member of the Board of Governors (1993–1999), and in leadership roles as Secretary (1996–1998) and Chair (1998–1999) of the Executive Committee of the Board of Governors. Dr. Stewart also served as a member of the former Board of Governors’ Committee on Ambulatory Surgical Care (now known as the Committee on Surgical Practice), its Committee on Surgical Infections and Environmental Risks (1995–1999), and she chaired the Governors’ Committee to Study the Fiscal Affairs of the College (1996–1998). On a local level, Dr. Stewart served as Councilor (1991), Treasurer (1993), and President (1995) of the ACS Colorado Chapter.

Additionally, she has represented the College on the Centers for Medicare & Medicaid Services’ Practicing Physicians Advisory Council (2002–2006), and as the ACS Delegate to the American Medical Association (1999–2008).

A founding member of the ACS Foundation, Dr. Stewart serves as Chair of the Foundation’s Corporate and Foundation Committee and is an organizer of its annual industry breakfast. Dr. Stewart concurrently serves as Secretary and member of the board of the ACS Foundation. Prior to her involvement with the Foundation, Dr. Stewart served as a member of the ACS Committee on Development (2000–2003, 2005–2007).

In addition to recognizing Dr. Stewart for her involve-
Governors’ committee addresses surgeon burnout

The American College of Surgeons (ACS) Board of Governors’ Committee on Physician Competency and Health sponsored a panel session during the Clinical Congress in Washington, DC, entitled Surgeon Burnout: Putting Out the Flames. Surgeon burnout and related stress in the hospital or clinic workplace has become an issue of increasing importance, particularly as it contributes to the declining surgical workforce. The committee recognized that there was very little data specific to surgeons and, in 2009, initiated a national survey of the members of the College. As one of the more successful surveys undertaken by the College (with responses from 7,900), the data gathered have generated a number of manuscripts.

Significantly, more than 40 percent of responding surgeons demonstrated factors relative to burnout. Thirty percent screened positive for symptoms of serious depression, and 28 percent had quality of life scores below the population norm. Only a minority of surgeons (36 percent) felt that their work schedule left enough time for personal family life, and 51 percent would recommend that their children pursue a career as a physician or surgeon.

The committee believes that a follow-up survey addressing specific issues is needed. This ensuing survey is being developed with Michael Oreskovich, MD, FACS; Tate Shanafelt, MD; and Gerald Bechamps, MD, FACS, whose experience was an important part of the initial survey. The survey should be appearing shortly and the committee members sincerely hope that all members of the College will contribute their experience to the survey.

The ultimate goal of the committee is to establish a resource center or area of expertise housed within the College, which can be easily and confidentially accessed, for surgeons dealing with issues of burnout, depression, or other stress factors for themselves or colleagues.

Did you know... THAT THE NEXT SET of ACS coding workshops will take place November 4 and 5 in Chicago, IL? The first course, Building Strong Coding Skills, intended for surgeons and coding staff who are new to coding or who have limited experience in this area, will take place November 4. Power Case Coding for Surgeons will be held November 5 and is designed for surgeons and staff with solid coding experience. For more information about this and other upcoming coding workshops, go to http://www.karenzupko.com/workshops/americancollegeofsurgeons/index.html#dates.

ment with the College, she is being recognized for her long and distinctive service to her surgical community. Dr. Stewart has been a leader of numerous surgical organizations, including president of the Western Surgical Association. She has also served as treasurer of the Colorado Medical Society (1975–1980) and the El Paso County Medical Society (1972–1975); and as president of the Colorado Springs Surgical Society (1985). Additionally, Dr. Stewart was one of the founders of the Colorado Physician’s Insurance Company in 1980; she served on the company’s board for 18 years.

As a retired surgeon, Dr. Stewart continues to give back to her community by volunteering to do office-based surgery at Peak Vista Community Health Centers, which provides primary care services to low-income, uninsured, and underinsured families within the Pikes Peak region of Colorado.

In acknowledgement of the positive leadership shown throughout her distinguished career and her continued and dedicated service to, and on behalf of, the College and the surgical community, the Board of Regents is pleased to recognize Dr. Stewart’s outstanding contributions by awarding her the College’s highest honor, the 2010 Distinguished Service Award.
The Affordable Care Act (ACA), the health care reform legislation that President Barack Obama signed into law this spring, contains numerous provisions that will affect surgeons and their patients. Now that the law has been enacted, the American College of Surgeons (ACS) and other surgical societies are attempting to influence how those measures are implemented and to encourage members of Congress to address issues that are not covered under the ACA. Charting a course for future surgical involvement in the health care reform process was the focus of this year’s Joint Surgical Advocacy Conference (JSAC).

Highlights of the 2010 JSAC included an overview of the ACA, comments from two members of Congress and a representative from the Centers for Medicare & Medicaid Services (CMS), a keynote address by a political analyst, and beginner and advanced advocacy training. Approximately 350 surgeons representing the ACS and 21 surgical specialty societies participated in the conference, which took place July 25–27 at the Hyatt Regency Washington (DC) on Capitol Hill. Most attendees also met with their senators and representatives on Capitol Hill to discuss their concerns regarding Medicare payment reform, medical liability reform, the surgical workforce crisis, and other issues.

Implementing the ACA

Shana Christrup, MPH, legislative and health consultant for Hart Health Strategies, a Washington, DC, advocacy consulting group, provided a timeline for implementation of provisions in the ACA that will affect surgeons and other providers. A summary of that schedule is as follows:

2010

• Adjust the payment for-
mula for misvalued physician services
- Authorize the Secretary of the Department of Health and Human Services (HHS) to publicly report hospital-acquired conditions
- Empower the HHS Secretary to establish medical reimbursement data centers
- Establish a patient-centered outcomes research institute
- Create a commission to study how to align workforce resources with patient needs

2011
- Provide 10 percent bonus payments to primary care physicians and general surgeons in health resource shortage areas
- Develop new imaging standards
- Tighten restrictions on physician self-referrals
- Redistribute unused post-graduate training slots to primary care
- Create a new Center for Medicare & Medicaid Innovation (CMI)

2012
- Encourage physicians to form accountable care organizations
- Establish a value-based purchasing program for acute-care hospitals
- Direct CMS to track and penalize hospital readmissions for certain conditions
- Require the HHS Secretary to submit a plan for a budget-neutral, value-based physician payment modifier
- Establish a new physician comparison website for Medicare beneficiaries

2013
- Establish a pilot program on payment bundling for hospitals, physicians, and post-acute care providers
- Implement requirement that drug, device, biological, and medical supply manufacturers report transfers of value made to physicians, medical practices, and/or teaching hospitals

2014
- Require prospective payment system-exempt cancer hospitals, and other institutions, to implement quality measurement reporting

2015
- Establish an Independent Payment Advisory Board (IPAB)
- Implement budget-neutral, value-based modifier for physician payment
- Decrease payments to non-participating Physician Quality Reporting Initiative physicians by 1.5 percent

CMS activities
Amy Hall, MPA, director of the CMS Office of Legislation, presented an update on the status of the agency’s efforts to implement the ACA. Ms. Hall noted that both the proposed rule for the 2011 Medicare physician payment and the regulation for the 2011 inpatient prospective payment system (IPPS) have provisions that respond to mandates in the ACA.

The Medicare physician fee schedule proposed rule calls for implementing the following provisions of the ACA: a general surgery incentive payment for major surgical procedures furnished in health professional shortage areas; a limited expansion of the multiple procedure payment reduction policy related to the technical component of certain imaging services; and new disclosure

JSAC meeting attendees comparing notes.
requirements for physicians furnishing positron emission technology, computed tomography, or magnetic resonance imaging services under the in-office ancillary services exception to the Stark self-referral regulations. (The Stark regulations, actually three separate measures, govern physician self-referral for Medicare and Medicaid patients.)

The IPPS interim final rule calls for updating acute care hospital rates by 2.35 percent. This update reflects a market basket increase of 2.6 percent for inflation minus a 0.25 percent reduction required under the ACA.

"Because these rules are so revolutionary, [stakeholders] are really taking the time to read through and comment on the rules," Ms. Hall said.

Ms. Hall also reported that CMS is in the process of creating the new CMI and a Center for Program Integrity (CPI). Under the ACA, the CMI will be charged with testing innovative payment and service delivery models to bring about a reduction in Medicare and Medicaid spending while preserving or enhancing quality of care. Meanwhile, the CPI is the product of organizational restructuring in CMS and is designed to more effectively ensure the financial stability of the Medicare and Medicaid programs.

In addition, Ms. Hall discussed the ACA provisions calling for the establishment of accountable care organizations. She assured JSAC participants that CMS recognizes that "not all [health care] providers are the same," and that the agency is committed to carrying out all of its tasks in a transparent way.

Members of Congress

Two members of Congress—Rep. Thomas E. Price, MD, FACS (R-GA), and Rep. Richard E. Neal (D-MA)—spoke about the ACA and what they and their colleagues need to do next. The congressmen agreed that Congress must directly address the problems associated with the use of the sustainable growth rate (SGR) in calculating Medicare physician payment. Congress needs to figure out a way to "divorce the SGR methodology from payment," Representative Price said.

Representative Neal also said that Congress needs to fix the SGR and emphasized the importance of maintaining the Medicare program. "Half the revenue for most hospitals comes from Medicare," he said. "The reason Medicare has worked is because we’re all in it."

In addition, Representative Neal said that he believes the ACA “has the potential to work” if it is implemented properly and if all Americans are buying into health plans. He further predicted: “There is not going to be a repeal of the health care reform law in the next two years because President Obama would never sign it.”

Representative Price said he opposes efforts to tie physician licensure to acceptance of Medicare and Medicaid. He also stated, “Quality ought to be defined by the specialties and not by Washington.”

Congressman Price urged surgeons to stay engaged in the political process. “Political involvement is imperative. Politics is everything in health care,” he said.
**Mid-term elections**

This year’s keynote speaker, Charlie Cook, a political analyst, *National Journal* columnist, and founder of the *Cook Political Report* newsletter, said that voters today are much less tolerant than the voters of other eras. They are more likely to oust incumbents who they believe are not doing their job adequately. Because “a mid-term election pivots on public sentiments about the party in power,” Mr. Cook predicts that Democrats will probably lose their majority in the House of Representatives, and may lose the Senate as well.

He based this forecast in part on the fact that “Blue State Democrats still love [President] Obama, but only kind of like congressional Democrats.” Furthermore, only 30 percent of independents say they think the nation is headed in the right direction, and 60 percent say it is going in the wrong direction. The people who voted for Sen. John McCain (R-AZ) are “pumped up and eager to vote” Republican, Mr. Cook added.

Mr. Cook attributes some of the voters’ unhappiness with Congress to the fact that it chose to pass costly health care reform legislation at a time when many people are experiencing economic hardships, and the national deficit is already at an all-time high. “There is no easy time to do health care reform, but that doesn’t mean there’s no bad time to do it,” he said. With the economy still unstable and unemployment figures still high, Mr. Cook believes this was the wrong time to pass health care legislation.

Even so, “Democrats may deserve to be thrown out of Congress, but I’m not entirely sure Republicans have proven worthy of being thrown in,” Mr. Cook added.

**Advocacy training**

This year’s JSAC attendees were able to participate in either beginner or advanced advocacy training workshops. Leading the program for surgeons with previous advocacy experience was Amy Showalter, a grassroots and political action committee (PAC) productivity expert and founder of The Showalter Group, Cincinnati, OH. According to Ms. Showalter, the most effective grassroots advocates serve as trusted authorities and advisors to their legislators. “You can’t just be in authority. You have to be an authority,” she said.

An advocate should “know your stuff and know yourself,” Ms. Showalter said. Be prepared to offer evidence that you are an authority on the matter, and know what the other side is saying. To build credibility, advocates should tell legislators and their staff what media outlets, groups, and institutions have sought their opinions on issues. She also said that effective advocates employ the following tactics:

- Show that they don’t gain at the legislators’ loss
- Avoid “powerless” speech
- Emphasize similarities with the legislators in terms of attitude, morality, socioeconomic status, and so on

Ms. Showalter also urged surgeons to tell a story about the topic at hand. Stories are twice as memorable as other types of communication. “A story can persuade and inspire where logic and reason fall flat,” she added.

Judy Schneider, a specialist on Congress at the Congressional Research Service (CRS), Washington, DC, presented information designed for surgeons.
who are new to the advocacy process. In addition to her role at CRS, Ms. Schneider is an adjunct scholar at the Brookings Institution Center for Public Policy Education. The beginner advocacy training session also was led by Keagan R. Lenihan, legislative director for Rep. Pete Sessions (R-TX).

AMA’s views

Peter W. Carmel, MD, FACS, president-elect of the American Medical Association (AMA), explained why the organization chose to support the ACA despite the objections of some members of the physician community. Dr. Carmel noted that the AMA’s purpose is to promote the interests of 900,000 physicians, and a community of that size cannot possibly reach unanimous agreement on highly complex and controversial issues. “At no time in my mind has physician opinion been more divided” than it was with regard to the ACA, he said. Nonetheless, “The AMA could not, in clear conscience, oppose legislation that expanded access to care to so many people.”

Now that the health care reform law has been enacted, the AMA and other medical and surgical organizations must work together to resolve the shortcomings in the legislation, Dr. Carmel said. A major problem that must be addressed is the continued use of the SGR. “Year after year, doctors are threatened with payment cuts because of the SGR, and year after year, practice costs have gone up,” he noted. “That legislative negligence is unacceptable. It’s time for the government to abandon this Ponzi scheme for once and for all.”

Business side of medicine

In addition, the JSAC featured concurrent sessions pertaining to the business side of modern surgical practice—one centered on contract negotiation, and one on practice management. The session on contract negotiation focused on contracts for on-call emergency care and with managed care organizations.

Ann M. Bittinger, Esq., a health law attorney based in Jacksonville, FL, noted that contracting for on-call emergency care arose in response to the federal Emergency Medical Treatment and Active Labor Act (EMTALA). Under EMTALA, tax-exempt hospitals must treat emergency patients or, if unable to provide appropriate care, transfer them to nearby, adequately equipped facilities. Likewise, on-call physicians must either provide stabilizing care or certify patient transfers to an appropriate medical center. Physicians who refuse to take EMTALA call face certain penalties, including exclusion from Medicare and a fine of up to $50,000.

To ensure that their emergency rooms are adequately staffed with specialists, hospitals have begun offering bonus payments to on-call physicians, leading to questions about whether supplying such compensation violates federal anti-kickback statutes. The HHS Office of the Inspector General (OIG) issued two advisory opinions on the matter. One indicates that on-call payments do not violate anti-kickback statutes if they are offered hospital wide and are provided as per diems, Ms. Bittinger said. The second advisory opinion said that on-call payments were acceptable because on-call physicians often provide medically necessary care to uninsured patients, many of whom cannot pay out of pocket for their care.

When negotiating for on-call payment, surgeons should...
make certain the contract meets the following criteria, Ms. Bittinger said: it is carefully tailored, it outlines tangible responsibilities, it describes the circumstances giving rise to the arrangement, it specifies the length of the agreement, it is signed by all parties, and it complies with the hospital’s bylaws.

Wes Cleveland, Esq., an attorney in the private sector advocacy group of the AMA, spoke about contracting with payors. Steps that physicians should take when deciding whether to contract with a managed care organization include the following, Mr. Cleveland said: identification of current and future plans in which they will be required to participate, the right to refuse to participate in certain plans, policies pertaining to the organization’s ability to recoup or recover overpayments, provisions affecting termination of the contract, and payment methodology.

He also discussed some of the problems associated with the physician ranking systems used by some managed care organizations. These shortcomings include questionable or nonexistent quality measure, limited or nonexistent risk adjustment, insufficient number of patient cases, and erroneous attribution.

Cheyenne Brinson, CPA, an instructor for KarenZupko & Associates, Inc., led the practice management session. Ms. Brinson uses her accounting experience to help practices build solid internal controls, reduce overhead, and increase revenue.

Congressional visits

Congressional affairs staff from JSAC-participating organizations provided an overview of the issues that surgeons should consider discussing with their elected officials during Capitol Hill visits.

Kristen Hedstrom, MPH, Assistant Director of Legislative Affairs in the ACS Division of Advocacy and Health Policy, urged surgeons to talk about Medicare payment reform. Ms. Hedstrom noted that Medicare physician payments will be cut by more than 23 percent on December 1, and an additional 6 percent will be cut on January 1, 2011, as a result of the SGR.

These significant reductions will jeopardize patient access to care. A recent survey conducted by a coalition of surgical societies showed that if these cuts are imposed, 37 percent of respondents will change their Medicare status to “nonparticipating,” and an additional 29 percent will opt out of the program entirely. Those remaining in Medicare indicated that they will make important changes in their practices, including limiting the number of Medicare patients they will see, Ms. Hedstrom said. For these reasons, surgeons were encouraged to ask their legislators to stop the 23 percent payment cut from taking effect December 1, increase payments in 2011 and future years to account for the growth in the cost of providing quality care, and repeal the SGR and establish a new baseline for reimbursement.

Katie Orrico, JD, director of the Washington, DC, office of the American Association of Neurological Surgeons, discussed the IPAB. She noted that this 15-member, administration-appointed board threatens the ability of the people’s elected representatives in Congress to make Medicare policy decisions. Ms. Orrico said surgeons should urge Congress to take immediate action to either repeal the IPAB or include one surgeon on the board. Other
issues Ms. Orrico addressed include liability reform, the workforce shortage, and trauma regionalization.

Joy Trimmer, director of government affairs for the American Academy of Otolaryngology-Head and Neck Surgeons, Alexandria, VA, recommended that surgeons urge their members of Congress to co-sponsor the Healthcare Truth and Transparency Act of 2010, H.R. 5295. This bill would provide increases in resources necessary to regulate health care advertisements and marketing. Ms. Trimmer also called upon JSAC participants to ask their elected representatives to support the Children’s Access to Reconstructive Evaluation and Surgery Act, which would ensure timely coverage for treatment of a child’s congenital or developmental deformity or disorder.

The night before their Capitol Hill visits, JSAC participants also had an opportunity to attend a political action committee (PAC) fundraiser at the Kennedy Center. During this event, the American College of Surgeons Professional Association (ACSPA)-SurgeonsPAC raised nearly $30,000.

**Participant reaction**

The surgeons who participated in a survey about their experience at the JSAC provided positive feedback. Andrew C. Bernard, MD, FACS, a trauma and acute care surgeon and assistant professor of surgery at the University of Kentucky College of Medicine, Lexington, attended his first JSAC this year. After the conference, he said, “The meeting demystified the legislative process for me. As a surgeon, I am used to making quick, definitive decisions based upon one thing: my patient’s needs. The legislative process is not definitive and involves many conflicting interests. Although I still find the legislative process somewhat frustrating, as least now I understand it, and understanding is the first step toward taking action.”
Young surgeons and chapter leaders take on today’s challenges

by Diane S. Schneidman, Manager, Special Projects, Division of Integrated Communications

“Now is a time of great challenges, but even greater opportunities,” A. Brent Eastman, MD, FACS, Chair of the American College of Surgeons’ (ACS) Board of Regents, said in his opening remarks at this year’s Leadership Conference for Chapter Leaders and Young Surgeons. “Change that improves the care of our patients demands all of our leadership—all of our involvement,” Dr. Eastman added.

Dr. Eastman’s remarks set the tone for this year’s Leadership Conference, which was designed to explore the concept of leadership from all angles and in all venues where surgeons should be playing leadership roles. The meeting took place July 24 at the Hyatt Regency Washington (DC) on Capitol Hill and was presented by the Young Fellows Association of the ACS.

Indeed, the medical and surgical professions are about to undergo major transformations in the near future due to the passage, earlier this year, of the health care reform package, the Affordable Care Act (ACA) (see related article, page 41). It is imperative that surgeons act to ensure that those changes are implemented in a way that serves the best interests of the profession and the surgical patient. “Managing change requires vision, skills, incentives, and a work plan,” Dr. Eastman said, attributing this observation to ACS Executive Director David B. Hoyt, MD, FACS.

The College’s leadership has sought to effect positive change for the surgical profession and patients by meeting with government officials to explain how their policies affect surgeons and their patients, Dr. Eastman said. “Your leaders have been coming to Washington as often as we can—as often as we’re invited,” he said. One important change that the College has been asking Congress to enact is the repeal of the sustainable growth rate methodology as a means of calculating Medicare payment rates for physicians. The College also is championing quality and safety improvements, patient access to surgical care, liability reform, and reduction of health care costs, Dr. Eastman noted.

Language of leadership

Wiley (Chip) Souba, MD, ScD, FACS, dean of the college of medicine and vice-president and executive dean of health sciences at Ohio State University, Columbus, spoke about the language of leadership. According to Dr. Souba, “The most powerful tool you have in your personal and professional life is language. The reason [surgeons are] not creating the future we want is because we don’t have mastery of the language of leadership.”

For language to serve as a transformational instrument, surgeons need to shift their focus from “being-centered” toward what is going on in their environment and who is affected by their actions. “Leadership in medicine has emphasized knowing, doing, and achieving,” Dr. Souba said. However, leadership in other arenas involves management of more external factors. According to Dr. Souba, the foundational pillars of leadership are as follows:

- Awareness: Being present in the moment; being mindful of limitations, distortions, blind spots, and filters
- Commitment: A dedication to something greater than oneself
- Integrity: Keeping one’s word
- Authenticity: Acting in ways that are consistent with one’s values and words

Leading organizations

As in the past, the Leadership Conference was divided into concurrent sessions for young surgeons and for chapter leaders. Kicking off the program for young Fellows, David Nielsen, MD, FACS, executive vice-president of the American
Academy of Otolaryngology-Head and Neck Surgery, spoke about leadership in organizations.

According to Dr. Nielsen, the power structures in professional associations are inherently more ambiguous than the power structures in for-profit corporations. Leadership in professional organizations is more diffuse and, therefore, requires consensus-building skills.

The ABCs of effective group leadership, according to Dr. Nielsen, are as follows:

- Authenticity: Speaking with one’s true voice
- Believability: Knowing the subject and displaying integrity
- Clarity: Clearly explaining goals, responsibilities, challenges, strategies, and expectations

Effective leaders also have high emotional intelligence (EI). “Intellect is responsible for 8 to 9 percent of success. Technical skill accounts for another 8 to 9 percent. The rest is EI,” Dr. Nielsen said.

Managing a surgical career

Herbert Chen, MD, FACS, and Lazar Greenfield, MD, FACS, spoke about handling the stress associated with running a busy surgical practice. “The key is time management,” said Dr. Chen, chief of endocrine surgery; vice-chairman, department of surgery; and professor of surgery at the University of Wisconsin, Madison.

Surgeons need to respect and redesign deadlines based on whether the target date is flexible, semi-flexible, or fixed, according to Dr. Chen. Surgeons should also compartmentalize their schedules, and maximize their time efficiency by working during down times and using technology effectively.

Dr. Greenfield, emeritus professor of surgery at the University of Michigan, Ann Arbor, advised young surgeons on dealing with frustration and burnout. “Anger destroys a surgeon’s image and effectiveness. [Frustrations should be addressed] like any lesion: treat, bypass, or excise,” Dr. Greenfield said.

Burnout is characterized by emotional exhaustion, depersonalization, and low achievement. Strategies for avoiding burnout and enjoying a successful career include maintaining a sense of curiosity, becoming an expert in an area of interest, experimenting to expand one’s horizons, cultivating family and community, and seeking professional help when necessary, Dr. Greenfield added. He advised young surgeons to “pay attention, work hard, and work smart.”

Leading a practice

Eric Whitacre, MD, FACS, and Paula Cozzi Goedert, Esq., spoke about handling and keeping the right practice management team, as well as the legal issues associated with hiring, reviewing, and firing employees.

“You need staff who can do things you don’t know how to do or can’t do, and you need staff who can help you with what you do know how to do,” Dr. Whitacre said. Most staff members are recruited through word of mouth, consultants, or advertisements. To keep a competent staff, surgeons need to offer opportunities for personal and professional growth. “The secret to attracting and keeping good employees is to care about them,” Dr. Whitacre said.

To avoid possible legal troubles, Ms. Goedert suggested that surgeons avoid any discussion of a potential employee’s personal life, including outside interests, family, and so on. Similarly, she said that annual reviews and termination interviews should center specifically on the employee’s ability to carry out his or her responsibilities. “If you focus on performance in your hiring, retention, and termination interviews you will be legally protected,” she explained.

Leading health systems

Paul A. Taheri, MD, FACS, president of faculty practice, Fletcher Allen Heath Care, part of the University of Vermont, and senior associate dean for clinical affairs and professor of surgery, University of Vermont, Burlington, spoke about physician leadership within health care systems. Dr. Taheri said physicians need to play leadership roles within health care systems because “the leadership sets the course for the overall enterprise,” and, therefore, institutes policies and programs that “eventually make it to the bedside.”

Dr. Taheri said leadership is an evolving concept. Under the
old model, leaders developed the vision for an institution, set performance standards, were selected for their intellectual acumen, and were control-oriented. Today’s leaders are expected to articulate the vision crafted by other members of the governing team, and inspire performance. They are selected for their EI, and set the tone for an empowered environment.

Physician leaders should project a sense of fairness, get things done, be forthright, and provide durable solutions, Dr. Taheri said. Successful leadership success, he added, is dependent upon integrity; delivering results; developing, integrating, and articulating the strategy, goals, and vision of the organization; ability to influence stakeholders; and good judgment.

**Chapter leaders program**

The program for chapter leaders began with a panel discussion about continuing medical education (CME) programming. Julie A. Freischlag, MD, FACS, an ACS Regent, discussed how chapters can help their members meet the new Maintenance of Certification CME requirements. Dr. Freischlag is the William Stewart Halsted Professor and director, department of surgery, Johns Hopkins University School of Medicine, Baltimore, MD.

In addition, Richard Reiling, MD, FACS, shared his views about ongoing investigations into funding for CME, and commented on future funding for chapters’ CME programs. Dr. Reiling is the medical director of Presbyterian Cancer Center, Charlotte, NC, and is the Vice-Chair of the ACS Foundation Board, which funds many ACS educational programs.

Chapter leaders also learned about the College’s expanded litany of resources designed to support state advocacy efforts. Jon H. Sutton, Manager, State Affairs, ACS Division of Advocacy and Health Policy, provided this information, along with tips for chapters seeking to engage in state-based legislative advocacy.

Additionally, Ms. Goedert spoke about chapter leaders’ fiduciary responsibilities. These charges relate to incorporation, insurance, records management, tax reporting, and contracting.

**Successful leadership**

During a session in which the young surgeons and chapter leaders regrouped, Donald Palmisano, MD, JD, FACS, a private practice general surgeon and clinical professor of surgery at Tulane University, New Orleans, LA, addressed the topic of physician leadership in the surgical community. Dr. Palmisano said, “A leader has courage, says [what the group is] going to do, and does it.” A leader also is decisive. Surgeons have an advantage here because that’s what they are trained to do, he added. Dr. Palmisano attributes his success to following some advice his father gave him when he was contemplating leaving medical school: “Do your homework, have courage, and don’t give up.”

In addition, successful leaders are skilled communicators, Dr. Palmisano said. They deliver a timely, well-crafted, and accurate message.

Dr. Palmisano encouraged the young surgeons to closely monitor and speak out on the government’s implementation of health system reform, particularly mandates for nationwide adoption of health information technology and the “elusive quest for quality and cost savings.” He called upon the attendees to get involved in their communities, hospitals, county and state medical associations, specialty societies, and national organizations.

**Town hall meeting**

The 2010 Leadership Conference concluded with a town hall meeting, during which the College’s leadership had an opportunity to listen and respond to the meeting participants’ concerns. Dr. Hoyt noted that the key missions of the College have been, and continue to be, to advance quality of care and to promote patient safety. “We are always at risk of being polarized over certain issues, but can come together over those key missions,” Dr. Hoyt said.

Dr. Eastman also stressed the importance of the College’s efforts to change the image of surgery. Too often, surgeons are seen as obstructionists, and as concerned only with their self-interests. The College and its consultants at Weber-Shandwick Worldwide—a respected international communications management firm—have developed a video
presentation designed to emphasize that surgeons are leaders in advancing safe and effective care, and are most qualified to treat a broad range of life threatening conditions.

Some surgeons expressed their concern that the College has been “too quiet” in speaking out against the ACA. Dr. Hoyt said, “I don’t think being angry [about the law’s shortcomings] is going to get us very far. I think [policymakers] are listening and that we will be in a position to influence how it is implemented.”

Dr. Eastman agreed, adding, “We need to move forward in a positive way.”

Christian Shalgian, Director of the ACS Division of Advocacy and Health Policy, further noted that, “We need to be strategic, or we’ll be dismissed.”

In addition, according to John Armstrong, MD, FACS, Chair of the Board of Directors of the American College of Surgeons Professional Association (ACSPA) political action committee (PAC), “We need to see grassroots action” and community engagement. Presently, only 4 percent of the eligible surgeons contribute to the ACSPA-SurgeonsPAC, which contributes to the campaigns of congressional candidates who support surgery’s legislative agenda.

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Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its February 12, 2010 meeting:

• A general surgeon from Newark, NJ, was admonished following charges that he violated the ACS Statement on the Physician Acting As an Expert Witness and the ACS Bylaws when he testified as an expert witness in a medical malpractice lawsuit.

• A general surgeon from Richmond, VA, was admonished following charges that he violated the ACS Statement on the Physician Acting As an Expert Witness and the ACS Bylaws when he testified as an expert witness in a medical malpractice lawsuit.

The following disciplinary actions were taken by the Board of Regents at its June 4, 2010 meeting:

• Steven A. Matzinger, MD, FACS, a general surgeon from Myrtle Beach, SC, had his Fellowship status placed on probation with conditions for reinstatement. This action was taken following disciplinary action by the South Carolina Board of Medical Examiners concerning his untruthful testimony in a civil matter, and his involvement with a conspiracy that provided monetary remuneration to him in exchange for referring potential medical malpractice clients to two attorneys and then offering favorable, disingenuous professional medical opinions in matters involving the attorneys’ clients.

• A general surgeon from Cape Girardeau, MS, had his full Fellowship privileges restored after a period of probation. The probationary period, which began in 2002, followed disciplinary action taken by the Missouri Board of Registration for the Healing Arts. This surgeon fulfilled the terms and conditions for restoration of his full Fellowship privileges with the ACS.

Definition of terms

Following are the disciplinary actions that may be imposed for violations of the principles of the College.

Admonition: A written notification, warning, or serious rebuke.

Censure: A written judgment, condemning the Fellow or member’s actions as wrong. This is a firm reprimand.

Probation: A punitive action for a stated period of time, during which the member (a) loses the rights to hold office and to participate as a leader in College programs; (b) retains other privileges and obligations of membership; (c) will be reconsidered by the Central Judicial Committee periodically and at the end of the stated term.

Suspension: A severe punitive action for a period of time, during which the Fellow or member, according to the membership status, (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the member’s name from the Yearbook and from the mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or member is returned to full privileges and obligations of fellowship.

Expulsion: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
The CSPS is a unique multidisciplinary coalition of seven professional organizations representing key members of the surgical team:

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

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

And why should you be interested?

- Because you want a caring perioperative workplace environment.
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- Because you want integrated teamwork and improved communication to result in better patient outcomes.
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For more information, visit www.cspsteam.org, or call the CSPS Administrative Director, Denise Goode, at 312-202-5700

CSPS and CSPSteam.org offer:

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

The American College of Surgeons (ACS) and the American Association for the Surgery of Trauma (AAST) announce a program that will provide supplemental funding totaling up to $75,000 per year to an individual who has received a Mentored Clinical Scientist Development Award (K08/K23) from the National Institute for General Medical Sciences (NIGMS). The award is directed at surgeon-scientists working in the field of trauma in the early stages of their research careers. This award supports a three-, four-, or five-year period of supervised research experience that may integrate didactic studies with laboratory or clinically based research.

This award program offers a means to facilitate the career development of individuals pursuing careers in trauma surgery research by enhancing salary support over and above that offered by the K08/K23 mechanism.

The application deadline is **October 12, 2010**. To apply, submit the complete K08 or K23 application simultaneously to NIGMS ([http://www.nigms.nih.gov/](http://www.nigms.nih.gov/)) and to Kate Early, the ACS Scholarships Administrator. Previously submitted applications and awards are not eligible for consideration. If applicants receive a K08 or K23 from NIGMS, their applications will undergo further review by a special committee for prospective supplemental funding. Funding begins July 1, 2011.

Awardees must be members in good standing of the College and eligible for membership in AAST. For further details, visit [http://www.facs.org/memberservices/research.html](http://www.facs.org/memberservices/research.html), or e-mail Kate Early at early@facs.org.

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In order to help hospitals prepare for performance measurement in the new health care environment, The Joint Commission is categorizing its performance measures—which include the Surgical Care Improvement Project (SCIP) measures—into accountability and non-accountability measures. This approach places more emphasis on an organization's performance on accountability measures—quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes (see sidebar, this page).* With this approach, the SCIP measures—which could include, for example, administering antibiotics within one hour of the first surgical cut, appropriate prophylactic antibiotics, and stopping antibiotics within 24 hours—meet the criteria for accountability measures. Non-accountability measures (for example, providing smoking cessation advice) are more suitable for secondary uses, such as exploration or learning within individual health care organizations, and are good advice in terms of appropriate patient care. The majority of The Joint Commission’s core measures are accountability measures; there are six non-accountability measures.

The Joint Commission first implemented its performance measurement and improvement initiative in 1998. The composites of these measures reflect the number of times evidence-based care was provided to patients, divided by the total number of opportunities to provide that care. Today, hospitals are required to collect and transmit data to The Joint Commission for a minimum of four core measure sets. In addition to SCIP measures, core measure sets include acute myocardial infarction, heart attack, heart failure, pneumonia, perinatal care, children’s asthma care, hospital-based inpatient psychiatric services, venous thromboembolism, and stroke.

Increasingly, performance measure data are being used

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for many purposes and, moving forward, will be the basis for much of Medicare’s value-based purchasing program and for public reporting purposes. The Joint Commission’s new approach will help hospitals prepare for the increasing reliance on attaining high performance on quality measures.

Hospitals accredited by The Joint Commission have significantly improved the quality of care provided to surgical care patients, as reflected by high levels of performance on the core measures. The need to “raise the bar” and advance performance measures that truly improve patient outcomes has been a priority for accredited hospitals and The Joint Commission for some time.

The Joint Commission has incorporated accountability measures into its ORYX® performance measure program and is working with all stakeholders to encourage them to adopt this approach and to remove non-accountability measures. Going forward, The Joint Commission will only adopt accountability measures for its ORYX program and is reviewing all the other current core measures (for example, perinatal care and hospital-based inpatient psychiatric services) and applying the accountability tests to them.

For more information regarding The Joint Commission’s accountability and performance measures, visit http://www.jointcommission.org/Library/WhatsNew/Accountability_Measures_FAQs.htm. To learn more about The Joint Commission’s performance measurement program, visit http://www.jointcommission.org/PerformanceMeasurement/.

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OCTOBER 2010 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
The woods are lovely, dark and deep.
But I have promises to keep.
And miles to go before I sleep.
—Robert Frost

Robert Frost’s poem, “Stopping by Woods on a Snowy Evening,” has something in common with the American College of Surgeons Oncology Group (ACOSOG) Z0011, a randomized trial of axillary node dissection in women with clinical T1-2 N0M0 breast cancer who have a positive sentinel node. For more than a century, the role of axillary lymph node dissection (ALND) in breast cancer control, as developed by William S. Halsted, MD, FACS, has been debated in surgical forums (“The woods are lovely, dark, and deep”). While the efficacy of ALND was never proven in a prospective clinical trial, it became standard of care since Dr. Halsted’s introduction.

The development of lymphatic mapping and the sentinel lymph node dissection (SLND) for early breast cancer by Armando Giuliano, MD, FACS, has been debated in surgical forums (“The woods are lovely, dark, and deep”). While the efficacy of ALND was never proven in a prospective clinical trial, it became standard of care since Dr. Halsted’s introduction.

The target accrual of the trial was 1,900 patients. Patients were followed for local, regional, and distant disease recurrence. Z0011 opened in May 1999, and was closed in December 2004 due to lower than expected accrual and recurrence rates. Nonetheless, 856 patients were protocol-treated and evaluable. At a median follow-up of 6.3 years, the local-regional recurrence rate was only 3.4 percent. There was no difference in this recurrence rate between the two treatment arms. Approximately 97 percent of the patients received systemic adjuvant therapy and whole breast irradiation.

While one can argue that the trial did not meet its accrual target, and therefore the reported outcomes and conclusions should be tempered, the trial offered evidence that the benefits of ALND were difficult to detect with 856 randomized patients. Lymph node analysis of the ALND arm showed that 27 percent of patients had additional metastases identified in the ALND specimen. Yet only 0.9 percent of node-positive nodal radiation. The primary endpoint was overall survival, and secondary endpoints were disease-free survival and loco-regional recurrence.

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patients who did not undergo ALND developed regional recurrence. Presumably, the SLND arm had a similar residual nodal disease left behind and a higher axillary recurrence could be expected but was not seen.

Adjuvant therapies for breast cancer include local radiation and systemic therapies. Both adjuvant therapies have proven to be effective for reducing breast cancer recurrence. The results of the Z0011 trial question the benefits of routine ALND for low-volume nodal metastatic disease. Each surgeon should read the Annals of Surgery publication and discuss the risks and benefits of ALND for low-volume nodal disease to their patients.

ACOSOG wants to express its deepest appreciation to the surgeons who enrolled patients and submitted follow-up data for many years. Surgical trials for early disease can take many years to generate enough events. The Z0011 surgeons clearly understood Robert Frost’s meaning of “miles to go before I sleep”; they are Robert Frost, who is “stopping by woods on a snowy evening.” Prospective surgical trials such as Z0011 require perseverance and the belief that multisite prospective trials are necessary to answer crucial surgical questions. ACOSOG continues to offer a rich portfolio of cancer trials that aim to change practice and improve the outcome of cancer patients. We invite surgeons to read the current open trials and consider them for your patients.

References


Oweida Scholarship availability announced

The Board of Governors of the American College of Surgeons is pleased to announce the availability of the 2011 Nizar N. Oweida Scholarship. The Oweida Scholarship, an annual award administered by the Executive Committee of the Board of Governors, was established in 1998 in memory of Dr. Oweida, a general surgeon who practiced in a small town in western Pennsylvania.

The purpose of the Oweida Scholarship is to enable young surgeons practicing in small communities to attend the Clinical Congress and benefit from the educational experiences it provides. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees.

Applications consist of a curriculum vitae, plus a one-page essay describing why the applicant characterizes his or her practice as serving a small community, and why he or she would like to receive the scholarship.

The deadline for receipt of application materials is December 15, 2010. For the complete requirements for this scholarship, visit http://www.facs.org/memberservices/oweida.html on the College’s website, or contact Kate Early at kearly@facs.org.
It is with great pleasure that I submit the report of my experiences as the 2010 American College of Surgeons Traveling Fellow to Japan. As a North American of Japanese descent, it was extraordinarily meaningful to be the recipient of this honor. Although I possess a reasonable grasp of basic Japanese customs and conversational language, I have always felt a significant void in my understanding of the Japanese academic, scientific, and medical cultures. With the invaluable assistance of Yasuhiro Kodera, MD, PhD, FACS, secretary of the 2010 Congress of the Japan Surgical Society and associate professor, department of surgery (II), Nagoya University Graduate School of Medicine, I was able to tailor a superb two-week curriculum that perfectly addressed my interests in colorectal surgical oncology and basic molecular cancer research. Needless to say, it was with tremendous excitement and anticipation that I ventured overseas with my wife and two children.

Osaka Medical College

My first academic stop in Japan was Osaka Medical College, in Takatsuki City in Osaka Prefecture. For two days, I enjoyed the kind hospitality of Junji Okuda, MD, PhD, FACS, associate professor and chief of staff, department of general and gastroenterological surgery, Osaka Medical College, who is widely considered to be one of the premier laparoscopic colorectal surgeons in Japan. His group has a very strong colorectal cancer volume, and I was amazed to learn that the practice is tailored such that more than 90 percent of their cases are performed laparoscopically (see photo, this page). It was a pleasure to observe him perform seemingly effortless minimally invasive low anterior resections. Dr. Okuda is clearly a strong innovator, as he showed me several instruments and devices that he had designed to match the specific needs of these complex procedures. I admit that I have already adopted a number of his “tricks” into my operative practice.

In addition to allowing me to observe his operations, Dr. Okuda generously availed himself to conversation and discussion the entire time that I was there. During a tour of the hospital, he

Dr. Shibata (second from right) and the surgical team of Dr. Okuda (far right) at Osaka Medical College, following completion of a laparoscopic-assisted low anterior resection.
demonstrated the various patient accommodations, and provided me with an explanation of the multi-tiered medical system in Japan, and of the differences with respect to postoperative length of stay, reimbursement, and medical litigation. As we struggle with health care reform in this county, it was interesting to gain insight into the Japanese government-based socialized health care system. We spent additional time watching surgical videos, discussing treatment philosophies, and, of course, family and sports. This was a truly an auspicious start to begin the fellowship, and I remain indebted to Dr. Okuda and his staff.

**Osaka University**

My next stop was the prestigious Osaka University, in Suita City in Osaka Prefecture, also known as “Handai,” where I was hosted by Masaki Mori, MD, PhD, FACS, chairman and professor, department of gastroenterological surgery, Graduate School of Medicine, Osaka University, and was afforded the treatment of a visiting professor (see photo, this page). Dr. Mori is a highly respected surgical scientist, and I looked forward to immersing myself in this unique academic environment.

I had the enjoyable opportunity to attend their weekly surgical research conference, during which the postgraduate fellows presented formal updates on their research progress. The speakers—much to their chagrin, I am sure—were kind enough to make their PowerPoint slides in English especially for my visit that day. It was greatly appreciated, as the talks were first-rate and represented a wide range of insightful research topics. One of Dr. Mori’s postgraduate fellows, who was very skilled in English, kindly served as my guide and translator for my entire visit, which represented an excellent balance between surgery and research.

I had the honor of observing Dr. Mori and his partner, Mitsu-gu Sekimoto, MD, PhD, associate professor, an accomplished laparoscopic surgeon, perform a minimally invasive low anterior resection for rectal cancer. The planes were very scarred, and it was with great interest that I observed the surgeons make use of 3-D fusion images of virtual colonography and computed tomography angiography as a high-tech intraoperative road map to precisely pinpoint them to the vasculature of interest.

I was also given an extensive tour of their laboratory research facilities. Housed in typically tight quarters was an army of highly motivated and dedicated surgical fellows performing clinical, basic, and translational research. The density of academic achievement and ambition was staggering, and was a testament to Dr. Mori’s leadership example. I also gained significant insight into the competitive challenges and difficulties faced by fellows and junior faculty as they hope to proceed through the ranks of academic surgery.

I was privileged to have a conference with Hideshi Ishii, MD, PhD, one of Dr. Mori’s most important scientific collaborators. Dr. Ishii provided me with a comprehensive overview of their exciting and cutting-edge stem cell research program. In turn, I discussed some of my interests in gene expression profiling and epidermal growth factor-like ligand signal...
transduction. We had a very productive exchange of ideas, and identified potential areas for future collaboration.

Discussions with respect to academic surgery and research continued into the evening, when Drs. Mori and Ishii kindly hosted my wife and I at a delightful Japanese-style dinner. It was with great surprise that I discovered that Dr. Mori had coincidentally spent time in the same Harvard-based laboratory research group in which I had completed my research fellowship. Further fueled by fine Japanese sake, we reminisced about mutual acquaintances and marveled at how academic surgery is truly a small world.

My visit with Dr. Mori at Handai was truly a unique and memorable experience. Additional thanks to Masataka Ikeda MD, PhD, assistant professor, who helped to organize my visit, and Ichiro Takemasa, MD, PhD, assistant professor, who generously provided me with a video of a skilled single-incision laparoscopic sigmoid colectomy.

Japan Surgical Society

This year, the annual Congress of the Japan Surgical Society was hosted in Nagoya, a port city in central Japan and the fourth most populated city region in the country. Although not touted as highly by travel guides compared to other destinations, we discovered a bustling city of outstanding food, shopping, and sightseeing, and it proved to be one of the highlights of our visit to Japan. The Congress was extremely busy, as it was attended by close to 13,000 Japanese and international surgeons, and consisted of an impressive number of presentations covering all aspects of surgery. Personal highlights of the conference included an International Symposium on the Strategy for Treating Liver Metastasis from Colorectal Cancer, Surgical Education and Training Around the World, and the Maestro’s Operating Theater: Colorectal Surgery. The latter was part of a thematic series featuring renowned surgeons presenting cases with embedded video emphasizing critical surgical principles of various procedures. This was a very effective component of the overall Congress program that epitomized the vision of the Congress president, Akimasa Nakao, MD, PhD, FACS, professor and chairman, department of gastroenterological surgery (II), Nagoya University Graduate School of Medicine—a charismatic and highly influential pancreatic surgeon (see photo, this page).

Attending several receptions allowed me to meet and/or reacquaint with a number of surgeons from all over Japan. Dr. Nakao hosted an unforgettable presidential dinner at a local restaurant specializing in the somewhat unlikely, but astonishingly delicious, Japanese-influenced Italian fusion cuisine. While being entertained by a world-renowned pipa (a Chinese string instrument) player and Japanese soprano, I had the opportunity to meet and converse with a number of surgeons from all over the world. In particular, I was able to meet the German Surgical Society Traveling Fellow, Moritz Koch, MD, vice-head section of surgical oncology, University of Heidelberg, Germany (see photo, this page). Other guests at our table included surgeons from New Zealand, Korea, and the U.S. That evening has already spawned an active research collaboration.

For my invited talk, Dr. Kodera had suggested that I try something controversial, to encourage participation from the almost exclusively Japanese audi-
ence. I delivered a presentation entitled Non-Radical Surgery Following Neoadjuvant Chemo-radiation for Rectal Cancer: Is It Safe?—which, as would be expected, successfully generated some lively discussion and commentary.

In summary, the Congress was an outstanding experience that appears to be developing into more of an international meeting, with English being recognized as an official second language. I am, once again, grateful to Dr. Nakao and Dr. Kodera for kindly treating me as a distinguished guest during this outstanding conference.

**Kyoto and Miyajima**

At the conclusion of the Congress, as had become customary during our trip, we sent off our bags with the courier service and headed off on the Shinkansen (bullet train) to the next destination of our adventure. Our next stop was Kyoto, the former imperial capital of Japan, where I had the pleasure of visiting a former research collaborator and surgeon, Fumiaki Sato, MD, PhD, associate professor, department of nanobio drug discovery, Kyoto University. We had the opportunity to catch up on our research directions and discussed potential collaborations with respect to the application of novel epigenomic array platforms. My family also made it a priority to visit some of the many famed temples, pavilions, and traditional gardens of this historic and beautiful city.

Finally, we made it a point to visit the island of Miyajima, which is located off the coast of Hiroshima. Miyajima, along with its shrine (a UNESCO World Heritage site), is ranked among the most beautiful destinations in all of Japan. It is characterized by a preserved Edo-era style town and the famous floating Torii gate. By good fortune, our visit to Japan coincided with the peak of the cherry blossom season, a breathtaking and highly symbolic time of year. All over Japan, we witnessed beautiful floral displays; however, in the setting of Miyajima, on a cloudless sunny day, they were truly at their pinnacle (see photos, this page).

**Tokyo—NCCH**

The final leg of the journey involved a two-day visit to the National Cancer Center Hospital (NCCH) in Tokyo. At the NCCH, I had the opportunity to meet and observe the operative techniques of Yoshihiro Moriya, MD, PhD, FACS, head,
colorectal division, who is internationally recognized as a leading authority on the application of lateral pelvic lymph node dissection for locally advanced rectal cancer (see photo, this page). Given that this is a treatment approach for which Western and Japanese surgeons harbor substantially differing opinions, it was with great interest that I participated in an afternoon-long session in which Dr. Moriya meticulously presented his vast and extensive experience in the management of locally advanced and recurrent rectal cancers. We had an animated discussion regarding a number of controversial issues, and Dr. Moriya graciously provided me with copies of several of his impressive videos. I also was able to observe Seiichiro Yamamoto, MD, PhD, perform a laparoscopic splenic flexure resection for a malignant polyp.

The gastroenterologists at NCCH are regarded as pioneers in the development of endoscopic submucosal dissection (ESD) and its application to both the foregut and hindgut. Fortunately, I had the opportunity to visit the endoscopy unit at NCCH and observe the performance of ESD for a hepatic flexure lesion. Takanisera Matsuda, MD, PhD, head, endoscopy division, and his partners Yutaka Saito, MD, PhD, and Takeshi Nakajima, MD, PhD (see photo, this page), were extremely gracious and accommodating in explaining the intricacies of their approach to patient selection and technique. I was impressed by their adept use of narrow band imaging and chromoendoscopy to delineate the nature of colorectal lesions.

Undoubtedly, one of the highlights of the visit was the opportunity to visit the division of carcinogenesis research and its chief, Toshikazu Ushijima, PhD (see photo, this page), an internationally prominent epigenetics cancer researcher. We had a lively discussion over mutual research interests, particularly with respect to determinants of epigenetic transcriptional regulation in cancer.

In a great gesture of hospitality, Dr. Ushijima invited me to dine with him at his favorite exclusive sushi restaurant immediately adjacent to the gates of the world famous, and enormous, Tsukiji Fish Market. The freshness and quality of the fish is unparalleled, and as somewhat of an enthusiast, this was the finest sushi meal that I have ever had. In between delicacies, I gained a great deal of insight into the complexities of Japanese grant funding mecha-
nisms. We further discussed the challenges of tissue collection protocols and translational collaborations, and reminisced about Boston, MA, where he had previously spent time at the Massachusetts Institute of Technology. As we parted, we agreed that we would arrange a visit to our institution, and I would return the favor of a meal at a top-notch American steakhouse. The rest of the day was spent sightseeing throughout the various museums and temples of Tokyo, and shopping and dining in the famed Ginza district.

Conclusions
As I reflect back upon this whirlwind tour of Japan, I am extremely grateful to my many hosts, who displayed tremendous hospitality and generosity. From a professional perspective, the experience of visiting prestigious Japanese medical centers exceeded my wildest expectations. My objectives of gaining new technical, medical, scientific, and cultural insights were completely fulfilled. That, combined with the opportunity to visit my ancestral homeland with my family, made this a priceless, once-in-a-lifetime experience. I very much look forward to maintaining and further fostering the new friendships and collaborations that I have made during this trip. I am indebted to the International Relations Committee of the American College of Surgeons for granting me this remarkable and unique opportunity.

Dr. Shibata is associate professor and chief of the section of colorectal oncology, department of gastrointestinal oncology, Moffitt Cancer Center, Tampa, FL

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The fall of mankind

by Richard J. Fantus, MD, FACS

Last month’s NTDB data points column (Bull Am Coll Surg. 2010;95(9):59-60) pointed out the increasing number of trauma records for patients age 75 and older that have been reported in the last several NTDB Annual Reports. Of those injured, falls were the leading mechanism, accounting for almost 84 percent of all injuries. This statistic is not surprising, as more than one-third of adults age 65 and over fall each year in the U.S., according to the Centers for Disease Control and Prevention’s report, Falls Among Older Adults: An Overview, as cited in Archives of Physical Medicine and Rehabilitation.

Falls are the leading cause of injury deaths among older adults, as well as the most common cause of non-fatal injuries and hospital admissions for trauma. Falls are also the single most common cause of brain injury in this population. Many elderly who fall, even if not injured, develop a fear of falling, and may self-limit their activity level, leading to reduced mobility and a higher risk of falling.

It is understandable that the aging process leads to a decrease in physiologic reserves, and the risk of serious injury from a fall therefore increases with age. Adults 75 years and older who fall are four to five times more likely to be admitted to a long-term care facility for a prolonged stay.

Figure 1, depicted on this page, shows one of the highest percentages of nursing home dispositions of any previous NTDB data points column. Over the past decade, fall-related deaths in older adults have risen significantly. In the year 2005, 15,800 people age 65 years and

Figure 1. Mechanism of fall (percent)

<table>
<thead>
<tr>
<th>Mechanism of Fall</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stairs/steps</td>
<td>10.91</td>
</tr>
<tr>
<td>Ladder/scaffold</td>
<td>1.54</td>
</tr>
<tr>
<td>Building</td>
<td>0.34</td>
</tr>
<tr>
<td>Hole</td>
<td>0.09</td>
</tr>
<tr>
<td>1 Level to Another</td>
<td>12.03</td>
</tr>
<tr>
<td>Same level slip/trip</td>
<td>47.78</td>
</tr>
<tr>
<td>Other unspecified</td>
<td>27.12</td>
</tr>
</tbody>
</table>

older died from injuries related to unintentional falls, while in 2004, 85 percent of deaths from falls occurred among people 75 years and older. Men are more likely to die from a fall, while women are 67 percent more likely to have a non-fatal fall. In 2003, women accounted for 72 percent of older adults who were admitted for hip fractures. In 2000, direct medical costs for elderly falls exceeded $19 billion, and as the population continues to age, these costs are projected to reach $54.9 billion by 2020 (http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html).

In order to examine the occurrence of falls in patients older than 74 years in the National Trauma Data Bank® research dataset 2008, admissions records were searched for age 75 and greater, utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) cause of injury codes for accidental falls E880 (stairs), E881 (ladder, scaffold), E882 (building), E883 (hole), E884 (one level to another), E885 (same level slip, trip), E886 (same level push, shove), and E888 (other unspecified). A total of 69,141 incidents matched this age range and at least one of these E codes; 63,896 records had discharge status recorded, including 17,461 discharged to home, 10,174 to acute care/rehab, and 32,037 sent to nursing homes; 4,224 died (these data are depicted in Figure 2 on this page). These patients were 68 percent female, on average 84.3 years of age, had an average length of stay of 6.4 days, and an average injury severity score of 9.44.

In order to protect their independence and reduce their risk of falling, older adults can take several of the following steps. They can exercise regularly; Tai chi, for example increases strength and improves balance. Older adults can ask their doctor or pharmacist to review their medications, including prescriptions and over-the-counter drugs, to reduce side-effects and interactions. It is also important for this population to see an ophthalmologist or an optometrist for an annual eye exam in order to optimize their vision, and allow them to see and avoid obstacles that could lead to a fall. At home, increase the ambient lighting and reduce hazards (such as throw rugs on wooden floors that may slip, and crowded hallways) that may lead to falls. These are a few simple solutions that can help prevent the “fall of mankind.”

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2009 is available on the ACS website as a PDF file and a PowerPoint presentation at http://www.ntdb.org. In addition, information is available on our website regarding how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal Manager, NTDB, at mmeal@facs.org.

Acknowledgment

Statistical support for this article has been provided by Chrystal Price, data analyst, NTDB.

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

by Rhonda Peebles, Division of Member Services

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

OH Chapter 2010 annual meeting
The Ohio Chapter conducted its 2010 annual meeting in Columbus, OH. In addition to the annual Residents Research Forum competition, new officers were elected (see photos, this page).

Brooklyn-Long Island Chapter hosts annual meeting
Sylvia Campbell, MD, FACS, visited the Brooklyn-Long Island Chapter on June 3, for the annual meeting and Young Surgeons’ dinner celebrating the 80th anniversary of the chapter. The event took place at the Garden City Hotel, Garden City, NY. Dr. Campbell gave a moving speech to the young surgeons about the importance of the College’s Operation Giving Back program for volunteerism (see photo, this page).

Alabama and Mississippi Chapters meet at Point Clear
The Alabama Chapter hosted its annual meeting June 11–12 at The Grand, located in Point Clear, AL. The day-and-a-half education program featured presentations by residents and surgeons from Alabama and Mississippi, and an annual dinner banquet. In addition, new officers were elected for the Alabama Chapter (see photo, page 72). The following residents won these awards:

- William Albert Maddox, MD, FACS, Memorial Cancer Award: Radical Prostatectomy for High-Risk Prostatic Cancer: A Single-Center Experience, by David L. Spencer, Jr., MD, School of Medicine/University of Mississippi, Jackson, MS.

- Columbus Doyle Haynes, MD, FACS, Memorial Trauma Award: Are We Delaying Ventriculostomy Placement for No Good Reason? What Is a Safe INR for Ventriculostomy Placement? by David Bauer, MD, School of Medicine/University of Alabama, Birmingham, AL.
• James Glenn Donald III, MD, FACS, Memorial Resident Paper Competition:
  Basic Science: Mitochondrial DNA Integrity and Endothelial Barrier Properties in Ex-Vivo Perfused Rat Lungs, by Joshua Chouteau, DO,* College of Medicine/University of South Alabama, Mobile, AL.
  Clinical Science: Minimally Invasive Parathyroidectomy: Use of Intraoperative PTH Assays after Two Preoperative Localization Studies, by Nicholas Smith, MD, School of Medicine/University of Alabama, Birmingham, AL.

**Metropolitan Chicago Chapter hosts Jeopardy game for residents**

The 2010 Metropolitan Chicago Chapter annual meeting and second annual Resident Jeopardy tournament were held on May 25.
Congratulations to Vijay Maker, MD, FACS, and the University of Illinois at Chicago Metropolitan Group Hospitals program, on earning the title of 2010 Resident Jeopardy champions (see photo, this page). Deborah Loeff, MD, FACS, Governor, served as coordinator for the tournament; Jeff Schaeder, MD, served as Jeopardy host; and Charles Drueck, MD, FACS; Richard Jorgensen, MD, FACS, Secretary-Treasurer; and Kenneth Printen, MD, FACS, served as judges. To view more photos of the tournament, visit the Metropolitan Chicago Chapter’s website at http://www.mccacs.org.

Chapter anniversaries

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