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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.
Ensuring that surgical residents are adequately trained to provide the highest quality care upon entering into practice has always been one of the College’s central goals.

Development of new standards

The newly proposed standards reflect the ACGME’s effort to balance recommendations in the 2008 Institute of Medicine (IOM) report, Resident Duty Hours: Enhancing Sleep, Supervision, and Safety, and comments from the medical and surgical education community, including the ACS. Recommendations in the IOM report that were of greatest concern to the College are as follows: (1) further restrict resident work hours, particularly the continuous duty period; (2) restrict extended duty to a maximum of 16 hours, unless a five-hour nap is provided, after which residents may continue for up to nine more hours for a total of 30 hours; and (3) set maximum frequency of in-hospital night duty at four consecutive nights, followed by a minimum of 48 hours off duty. The College’s perspective on the IOM report and existing ACGME guidelines were summarized in an article published last September in Surgery.†

To develop its proposed changes, the ACGME commissioned a 16-member task force to review relevant research, hear testimony from the IOM and other interested parties, and draft new standards. The panel received written comments from more than 100 medical and surgical organizations, including the American College of Surgeons.

ACS comments

The College also convened a Task Force on Resident Duty Hours, which was charged with reviewing the ACGME’s planned changes and their potential effects on resident training and patient care. Chairing this workgroup were L.D. Britt, MD, FACS, ACS President-Elect, and Carlos A. Pellegrini, MD, FACS, Vice-Chair of the ACS Board of Regents. As the roster on pages 6 and 7 indicates, task force members represent training programs from all regions of the nation and the broad scope of surgical specialties.

At press time, the College was putting the final touches on formal comments regarding the
ACGME’s proposed modifications. Four of the ACGME’s revisions are of particular concern to the ACS. They are as follows:

- **Supervision.** The ACGME proposes that supervising faculty delegate some care to residents, and that senior residents or fellows serve as their supervisors. The proposed ACGME requirements also would mandate that training programs adhere to three classifications of supervision based upon a resident’s knowledge and skills. Needless to say, first-year postgraduate (PGY-1) trainees would be subject to more direct forms of supervision.

  The ACS, of course, supports any effort to ensure proper supervision of residents and agrees that the level of supervision should be based on patient care needs, as well as on residents’ cognitive and technical competence. However, the College maintains that specialty- and institution-specific nuances of appropriate supervision must be carefully defined and managed to achieve optimal supervision. For example, senior residents may be unable to assume any additional supervisory responsibilities because of their caseloads, duty-hour limitations, and rotation patterns. Thus, substantial additional human resources will be needed to meet the proposed ACGME requirements, and those personnel may be unavailable within surgery departments or certain institutions. Without adding other staff, many training programs will find it challenging to maintain quality, and some will be forced to close at a time when the nation already is experiencing workforce shortages.

- **80-hour workweek.** The ACGME proposes to maintain the requirement of a maximum of 80 duty hours per week averaged over four weeks. The College supports this decision, but also maintains that 80-hour workweeks should be the absolute minimum for surgical residents. The ACS notes that surgical education and training must include sufficient experience in the full spectrum of elective and emergency cases. The College also asserts that surgeons must have command of both cognitive knowledge and technical skills, and that acquiring these competencies entails exposure to certain experiences and training over time. Therefore, any further duty-hour reductions would necessitate lengthening the years of surgical training, which would inevitably discourage trainees from entering surgery and further exacerbate the workforce shortage.

- **Maximum duty period.** The College supports the ACGME requirement that permits intermediate and senior residents to remain on-site for four hours beyond the 24 hours of continuous duty to ensure effective continuity of care. However, the College has grave concerns about the ACGME’s plan to impose a 16-hour duty limit on PGY-1 residents. Without a substantial increase in human resources to replace the residents, this limit would negatively affect patient safety and continuity of care. Even with additional resources, this requirement necessitates the use of night-float systems, which may be inappropriate for some residency programs. Furthermore, the strict 16-hour cap may well have the unintended consequence of eroding residents’ professional commitment to their patients. In addition, this requirement probably will result in work being transferred from PGY-1 residents to intermediate and senior residents, which will increase their workload and potentially negatively affect patient care. Moreover, this restriction will prohibit adequate preparation of PGY-1 residents for subsequent training, and transfers of care will disrupt the structure of residency training.

- **Inhospital on-call frequency.** The ACS opposes the ACGME’s proposed requirement of a maximum inhospital on-call frequency of every third night without averaging, because it will preclude any flexibility in providing resident coverage in the event of illness, personal emergencies, and vacations. Such flexibility is critically important for all surgical specialties because of rapid, unexpected changes in patients’ conditions. In addition, residents will be unable to enjoy the benefits of having two consecutive days off, which are made possible only through averaging.

A vital task

The College supports the ACGME’s proposed changes to other aspects of the duty-hour standards and commends the council for its comprehensive, thoughtful, and thorough examination of the work-hours issue. Furthermore, we are continued on page 7
### Members of the ACS Task Force on Resident Duty Hours

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>L.D Britt, MD, MPH, FACS</td>
<td>Chair, Brickhouse Professor and chairman, department of surgery, Eastern Virginia Medical School, Norfolk, and ACS President-Elect</td>
</tr>
<tr>
<td>Carlos A. Pellegrini, MD, FACS</td>
<td>Co-Chair, Henry N. Harkins Professor and chairman, department of surgery, University of Washington, Seattle, and Vice-Chair, ACS Board of Regents</td>
</tr>
<tr>
<td>Stephen A. Albanese, MD</td>
<td>Professor and chairman, orthopedic surgery, State University of New York Health Science Center at Syracuse, East Syracuse</td>
</tr>
<tr>
<td>H. Hunt Batjer, MD, FACS</td>
<td>Professor and chairman, department of neurological surgery, Northwestern University Feinberg School of Medicine, Chicago, IL</td>
</tr>
<tr>
<td>Patrice Gabler Blair, MPH</td>
<td>Associate Director, ACS Division of Education, Chicago, IL</td>
</tr>
<tr>
<td>Kirby I. Bland, MD, FACS</td>
<td>Fay Fletcher Kerner Professor and chairman, department of surgery, University of Alabama at Birmingham</td>
</tr>
<tr>
<td>Joshua A. Broghammer, MD</td>
<td>Assistant professor of urology, University of Kansas Medical Center, Kansas City, and Chair, ACS Resident and Associate Society</td>
</tr>
<tr>
<td>Brian B. Burkey, MD, FACS</td>
<td>Section head, head and neck surgery and oncology head and neck institute, Cleveland Clinic, OH, and adjunct professor, department of otolaryngology, Vanderbilt University Medical Center, Nashville, TN</td>
</tr>
<tr>
<td>Michael Coburn, MD, FACS</td>
<td>Professor and interim chair, Scott department of surgery, Carlson-Smith Chair in Urology Education, and urology residency program director, Baylor College of Medicine, Houston, TX</td>
</tr>
<tr>
<td>Ralph G. Dacey, Jr., MD, FACS</td>
<td>Henry G. and Edith R. Schwartz Professor and chairman, department of neurological surgery, Washington University School of Medicine, St. Louis, MO</td>
</tr>
<tr>
<td>A. Brent Eastman, MD, FACS</td>
<td>N. Paul Whittier Chair of Trauma, Scripps Memorial Hospital, La Jolla, CA, and Chair, ACS Board of Regents</td>
</tr>
<tr>
<td>Mark L. Friedell, MD, FACS</td>
<td>Academic chairman, department of surgical education, Orlando Regional Medical Center, FL</td>
</tr>
<tr>
<td>Larry C. Gilstrap III, MD</td>
<td>Chair emeritus, department of obstetrics, gynecology, and reproductive sciences, University of Texas at Houston Health Sciences Center, and clinical professor, department of obstetrics and gynecology, University of Texas Southwestern Medical Center, Dallas</td>
</tr>
<tr>
<td>Robert J. Havlik, MD, FACS</td>
<td>James J. Harbaugh, Jr., Professor of Surgery, director, cleft and craniofacial surgery, and chief of plastic surgery, Riley Hospital for Children; and vice-chief, section of plastic surgery, Indiana University School of Medicine, Indianapolis</td>
</tr>
<tr>
<td>Gerald B. Healy, MD, FACS</td>
<td>Healy Chair in Otolaryngology, otolaryngologist-in-chief, Children’s Hospital Boston, professor of otology and laryngology, Harvard Medical School, Boston, MA, and Past-President of the ACS</td>
</tr>
<tr>
<td>Stuart S. Howards, MD, FACS</td>
<td>Director of clinical studies core, professor of urology and molecular physiology and biological physics, and chief of division of pediatric urology, University of Virginia School of Medicine</td>
</tr>
<tr>
<td>Shepard R. Hurwitz, MD, FACS</td>
<td>Professor of orthopaedics, University of North Carolina Health Care System, Chapel Hill</td>
</tr>
<tr>
<td>Mark S. Juzych, MD</td>
<td>Associate director, Kresge Eye Institute, and professor, department of ophthalmology, Wayne State University School of Medicine, Detroit, MI</td>
</tr>
<tr>
<td>Michael O. Koch, MD, FACS</td>
<td>John P Donohue Professor of Urology, and chairman, department of urology, Indiana University School of Medicine, Indianapolis</td>
</tr>
<tr>
<td>Irving L. Kron, MD, FACS</td>
<td>S. Hurt Watts Professor and chairman, department of surgery, University of Virginia Health System, Charlottesville, VA</td>
</tr>
<tr>
<td>LaMar S. McGinnis, Jr., MD, FACS</td>
<td>Senior medical advisor, American Cancer Society, Atlanta, GA, and ACS President</td>
</tr>
<tr>
<td>David R. Nielsen, MD, FACS</td>
<td>Executive vice-president and chief executive officer, American Academy of Otolaryngology, Alexandria, VA</td>
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<tr>
<td>David W. Purke II, MD, FACS</td>
<td>Executive vice-president and chief executive officer, American Academy of Ophthalmology, San Francisco, CA</td>
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pleased to be able to offer our views on this controversial issue, because ensuring that surgical residents are adequately trained to provide the highest quality care upon entering into practice has always been one of the College’s central goals.
Earlier this year, the American College of Surgeons (ACS) was alerted to a series of events that occurred within the Veterans Affairs Palo Alto Health Care System (VAPAHCS) in California that had tragic outcomes for numerous veterans. More than 100 veterans treated at the facility suffered varying levels of vision loss after receiving care for glaucoma by optometrists without the adequate involvement of ophthalmologists.

The College is extremely concerned about nonphysician practitioners providing medical care without having the appropriate training, experience, or skills. Whereas we recognize that the partnership between physicians and allied health care providers is important to the continuum of care for patients, we believe it is essential that the VA system immediately develop, standardize, and implement appropriate safety and quality procedures throughout the system to prevent this unfortunate outcome in the future.
**What happened in Palo Alto**

In California, the state legislature has considered a number of bills introduced to expand the scope of practice for optometrists. In 2008, a law was passed to allow optometrists to begin treating glaucoma patients by prescribing medication under special certification standards, and consulting an ophthalmologist when appropriate. In January of 2009, a patient who had been followed by the optometry service at VAPAHCS since 2005 was seen for the first time by the ophthalmology service. This patient suffered significant visual loss due to poorly controlled glaucoma, a condition that could no longer be corrected with surgical intervention.

This event prompted an investigation in February of 2009 of 381 additional cases, which revealed the following: Seven veterans had progressed to blindness that could have been prevented, 16 veterans had experienced progressive visual loss, and 87 veterans were at high risk of losing their sight. At issue is whether the optometry department failed to follow existing VA policy, which requires them to consult with ophthalmologists on glaucoma cases. Of these veterans, 86 had their care transferred to the ophthalmology department. The VA formally informed seven of the patients that improper care might have caused their blindness. Three have filed lawsuits—one has been settled, and another is proceeding to trial.

**The legal challenge**

After being informed of the deficiencies in his care, an 87-year-old World War II veteran followed the instructions provided by the VA and filed a grievance with the federal government in a timely fashion. When he failed to receive a response after six months, he retained legal counsel to file a tort complaint asserting medical negligence. A federal answer filed in June refuted his claims, and the case is currently proceeding to trial. At the time of the initial reporting of the event and subsequent filing of the lawsuit, the events at the Palo Alto VA have been reported extensively in the media, and further litigation may follow pending the outcome of this case.

**The revised VA policy**

Ultimately, the chief of optometry at VAPAHCS was placed on administrative leave, and subsequently retired in 2009. A formal internal inquiry was undertaken, and in March the VA Undersecretary for Health, Robert Petzel, MD, issued a Health Information Letter outlining greater collaboration between optometry and ophthalmology as equal partners at VA facilities nationally, and calling for a joint collaborative peer review—without disclosing the specific contributing causes of the events at Palo Alto.

Of perhaps greater concern is the fact that policies and legislation had existed prior to this event, but failed to protect the veterans at risk of losing their eyesight. Introducing a “new” policy without clearly addressing the contributing problems may prove insufficient in preventing this problem from occurring again at this, or another, VA facility elsewhere in the country. The American Academy of Ophthalmology, the ACS, and the American Medical Association have written to Dr. Petzel to express concern that the steps taken are likely inadequate, and, specifically, that an enforcement policy is not included in the document.

**The national implications**

An added level of complexity that this case reveals is the lack of standardization in credentialing requirements that currently exist throughout the VA system nationally. The VA system is unique in allowing health care providers to practice in one state with certification from a different state, rendering them exempt from compliance with local state standards. The chief of optometry at the VAPAHCS had actually been licensed in the state of Washington, where optometrists may treat glaucoma without additional certification, and he did not possess the additional training or certification proposed by the California law passed in 2008. Currently, the finalization of new certification standards for optometrists in accordance with the 2008 law is being conducted by the California Department of Consumer Affairs and the Secretary of State. This confusing variation regarding oversight, competency, and creden-
tialing within the VA highlights the conflict between state and federal laws and policies, and so, ultimately, action in both Washington, DC, and state legislatures may be necessary to address this loophole in the credentialing process in the VA system.

**NEXT STEPS**

The concerns this case raises are echoed by the recent exposure of 1,812 veterans to possible infection through improperly sterilized dental equipment at the John Cochran VA Medical Center, St. Louis, MO, and are inconsistent with the important efforts of physicians and nurses across the country who labor each day to deliver high-quality care at VA facilities.\(^9\)

The ACS recognizes the need to work together with our optometry colleagues, but we also have a professional obligation to ensure the proper oversight and transparency in this investigation. The VA did not involve the American Academy of Ophthalmology as an equal partner in the drafting and development of the Health Information Letter. Currently, concern among health care professionals continues, particularly due to the fact that the findings of the investigation at Palo Alto have not been disclosed to the public, and because the possibility remains that a full understanding of the mistakes made in this case remain concealed.

A change in culture will likely be necessary, as it is especially curious that in an institution where clinicians are salaried, there was a disincentive to the optometrists to work with the ophthalmologists more closely, in an effort to deliver the best care possible. The ACS will remain committed to implementing the necessary steps to protect the eyesight of veterans across the country.\(^{10}\)

**References**


**Dr. Maa** is assistant professor, department of surgery, University of California, San Francisco, CA.
Preparing for the Maintenance of Certification examination

by Willam P. Schecter, MD, FACS

Medicine is a profession, and “profession” is a word that is derived from the Latin word “profession,” meaning a public declaration with the force of a promise. Virtually all professions share certain characteristics: mastery of a body of knowledge, specific duties toward the individuals and the society it serves, self-government, self-regulation, and service—even if the service comes at some personal cost to the members of the profession. The Maintenance of Certification (MOC) examination of the American Board of Surgery (ABS) is a mechanism for the profession of surgery to assess ongoing mastery of a specific core body of knowledge by diplomates of the board.

The American Board of Medical Specialties, of which the ABS is a member, as well as the Accreditation Council for Graduate Medical Education, have adopted the six general competencies of quality patient care as a method of assessing the members of the medical profession (see Table 1, page 12).¹ Medical knowledge is the second of the six competencies, and the MOC exam directly assesses medical knowledge. The American College of Surgeons’ Code of Professional Conduct lists lifelong learning as an essential element of professional conduct for surgeons.² The MOC exam both assesses, and stimulates, lifelong learning activities.
The MOC exam and the MOC process

The MOC process is composed of four main parts (see Table 2, this page), and maintenance of cognitive expertise is an especially critical part of this process. This particular component of the MOC process is assessed by the MOC exam.

Modular or core body of knowledge?

There is a legitimate and, at times, highly emotional, debate regarding the question of a modular MOC exam (which only examines diplomates in their field of practice), versus a global examination of a core body of knowledge. The arguments on both sides of this debate have recently been reviewed. The ABS struggled with this question and has decided that, at present, a global examination is most appropriate. There are a number of reasons for this decision, including:

- The majority of the ABS directors are of the position that all surgeons—regardless of their practice pattern—should maintain a core body of knowledge relevant to surgical practice.
- A modular exam would compete with, and devalue, a Certificate of Special Competence or other board certificates requiring fellowship training for admission to the exam. For example, how would an individual distinguish a surgeon who elects to recertify only in critical care from a fellowship-trained surgeon with a Certificate of Special Competence in critical care?
- The number of recertifying diplomates in many fields would be relatively small, calling into question the psychometric validity of such an exam.
- The cost of writing and administrating a large number of modular examinations would be exorbitant.

Requirements for admission to the exam

The requirements for admission to the MOC exam are as follows:

- The MOC exam may first be taken three years prior to certificate expiration
- Submission of a written application
- Submission of a 12-month operative log (either the ABS Operative Report or the ACS Case Log are acceptable).
- Complete the components of the MOC process (see Table 2, this page).

Table 1. The general competencies for quality patient care

1. Patient care
2. Medical knowledge
3. Interpersonal and communication skills
4. Professionalism
5. System-based practice
6. Practice-based learning and improvement

Table 2. The Maintenance of Certification process

Part I  Professional standing (unrestricted medical license, hospital privileges, references)
Part II  Lifelong learning and self-assessment
Part III  Cognitive expertise
Part IV  Evaluation of performance in practice

Content of the MOC exam

The content of the MOC exam is based on the Surgical Council on Resident Education (SCORE) patient care curriculum. You can access this curriculum by going to the ABS website (http://www.absurgery.org), click on “Publications,” and then click on “SCORE Patient Care Curriculum.” Alternatively, you can write to the ABS and request a copy of the SCORE curriculum. According to the ABS website, “The outline consists of 28 organ system-based categories. Each category is further separated into diseases/conditions (broad and focused) and operations/procedures (essential-common, essential-uncommon, and complex). A total of 700 topics (diseases, conditions, operations, and procedures) are listed. The outline encompasses the fundamental body of surgical care....”

How is the MOC exam designed?

There are 2,251 questions that were used on previous examinations. Each year, additional new MOC exam questions are written by the MOC exam committee members (all active directors of the ABS) and consultants to the MOC exam committee, which includes selected ABS diplomates who have scored well on recent MOC examinations. The names of the members of the MOC exam committee, and the current consultants to
The consultants to the MOC exam committee deserve the medical profession’s gratitude, as they do a tremendous amount of work that is not compensated and, quite often, goes unrecognized.

The ABS staff, under the direction of Jo Buyske, MD, FACS, develops a draft exam consisting of approximately 50 percent pool questions (questions from previous exams) and 50 percent new questions. The draft is then reviewed by the committee of exam consultants and the chair of the MOC exam committee. The questions are reviewed for content, accuracy, and relevance to the practicing surgeon. Questions with poor performance from previous exams, incorrect answers, or lack of relevance are discarded.

The second draft of the exam is then reviewed by the MOC exam committee, using the same criteria. Dr. Buyske; Tom Biester (the ABS director of psychometrics); and Andrew Jones, PhD (the ABS associate director of psychometrics), serve as resources for the MOC exam committee, but the final decisions are made by the committee.

How is the exam graded?
The exam is not graded on a curve. There is a statistical equating of the difficulty of the exam to achieve equity with prior exams. Theoretically, every examinee can pass the exam. Following the exam, questions deemed to have poor statistical performance are discarded. The MOC exam committee chair reviews problematic questions and decides either to retain or discard them, with input from the ABS staff.

Where is the exam conducted?
The MOC exam is conducted at the Pearson Professional Examination Centers. There are approximately 250 centers nationwide, three in Canada, and three overseas (the UK, Germany, and Jordan). The U.S. military surgeons deployed in Iraq and Afghanistan are also able to take the MOC exam, which is computer-based.

What is the failure rate?
The overall failure rate for the MOC exam is 5.9 percent. The failure rates for 10-, 20-, and 30-year recertifying diplomates is 3.1 percent, 6.4 percent, and 11.2 percent, respectively. Only 1 to 1.5 percent of MOC examinees fail to pass the exam after multiple attempts. In other words, it is possible to pass the MOC exam as long as a physician prepares for it.

Preparing for the exam
If you are actively engaged in the lifelong learning and self-assessment competence of the MOC process, you are automatically preparing for the exam. I recently completed the Surgical Education and Self-Assessment Program (SESAP). It is an excellent tool to prepare for the examination. You get 60 hours of continuing medical education (CME) credit, which is automatically downloaded to the CME section of the College’s Web portal. (We all owe John Weigelt, MD, FACS, and his hard-working committee a debt of gratitude for this excellent educational tool.) SESAP contains a large number of questions, and it can be challenging to answer some of them, especially since they seem never-ending. One strategy is to complete five to 10 questions per day.

I read the Selected Readings in General Surgery religiously as a resident, and then stopped, in favor of journals and other academic activity. Last year, I began the cycle again. If you haven’t seen the Selected Readings in a while, take a look at them. Lewis Flint, MD, FACS, has done a spectacular job taking over the Selected Readings from Robert N. McClelland, MD, FACS. There are 20 multiple-choice questions at the end of each monograph.
The questions at the end of each module are helpful in focusing your study, and physicians receive CME credit automatically downloaded to the “My CME” section of their page on the ACS Web portal, which makes it easy to document lifelong learning and self-assessment.

Like all of you, I keep current by attending grand rounds and selected weekly conferences, including the Annual Clinical Congress and various national, regional, and local meetings. I regularly read the New England Journal of Medicine, the Journal of the American College of Surgeons, and other journals, including the Journal of Trauma, the Archives of Surgery, and the Journal of Critical Care Medicine.

I also read a standard surgical textbook over the year, prior to my 10- and 20-year MOC exams. Reading these textbooks was beneficial because I reviewed areas of surgery where my experience was limited, and I think it made me a better surgeon. When I joined the ABS as a director six years ago, Frank Lewis, MD, FACS (the ABS executive director), informed me in June 2004 that I had to recertify prior to beginning my duties in September of that year. I had four weeks to study for both the general surgery and critical care exams, and failure was not an option. I didn’t have time to re-read a textbook, but I answered 60 questions a night for the entire month of July. Fortunately, I passed. I certainly don’t recommend this method of study. If you prepare diligently, you will pass, as the data indicate. Every physician has a study method that works best for them.

**Statement of gratitude**

It has been both an honor and pleasure to serve as a director and as chair of the ABS MOC exam committee. My time as an active director ended in June of this year. I can assure you that the ABS will continue to work hard to ensure that the MOC exam is fair and relevant, and that the method of exam construction and grading is transparent. Many thanks to all of you for allowing me to fulfill this important responsibility on your behalf.

**References**


Dr. Schecter is professor of clinical surgery, University of California, San Francisco, and chair, Maintenance of Certification examination committee, American Board of Surgery.
Fifty years ago, when Hurricane Katrina battered New Orleans, LA, and other parts of the Gulf Coast, many Fellows of the College wanted to help the health care professionals and patients who were trapped in the floodwaters. These potential volunteers turned to the American College of Surgeons (ACS) for support in their efforts to provide disaster relief services. Unfortunately, the College was inadequately prepared or positioned to direct these volunteers to the appropriate agencies.

The College learned an important lesson from that experience: this organization comprises many willing volunteers, and it is our responsibility to make certain they know how they can best offer their services when disaster strikes. Since then, the ACS Committee on Trauma (COT) has developed programs that are designed to ensure that the College and its mem-

Experience in Haiti allows College to better prepare for future crises

by John Fildes, MD, FACS, and Leonard J. Weireter, Jr., MD, FACS
bers can more effectively respond to national and international crises. These methods were put to the test when the 7.0 force earthquake struck Haiti earlier this year, and more than 950 surgeons attempted to enlist in relief efforts.

ACS Executive Director, David B. Hoyt, MD, FACS, summarized the College’s efforts to assist surgeons who wanted to help the people of Haiti in his “Looking forward” column published in the June issue of the Bulletin (Bull Am Coll Surg. 2010;95[6]:4-5). Whereas this organization proved that it has become much more effective at responding to disasters, our experience in Haiti also taught us which techniques are working and which ones need improvement.

The COT’s Ad Hoc Committee on Disaster and Mass Casualty Management is seeking to ensure that the College can “turn on a dime” when catastrophe strikes, and has a game plan for responding to mass casualty events. To this end, the COT is developing a concise operational template to guide ACS relief activities in the future. This strategic plan comprises the following steps:

▲ Immediately launch an internal and external communications program. Start sending out press releases in conjunction with the American Association for the Surgery of Trauma and other regional and national trauma organizations, expressing sympathy for the victims and explaining what the groups intend to do to provide relief.
Ongoing electronic updates aimed at the College membership and the public will follow, with frequency to be determined at a later point in time. Also provide educational information for members who are planning to deploy, including clinical, cultural, and logistical information.

▲ Support and educate Fellows who want to participate in disaster relief efforts. The College will be better able to direct Fellows to the activities where they do the most good for victims, using the hierarchy of volunteers illustrated in the figure on page 16. Under this paradigm, all ACS Fellows would be expected to take the COT’s Disaster Management and Emergency Preparedness Course, so they can adequately respond to future natural and man-made catastrophes, wherever and whenever they may occur. The next level of volunteers would participate in hospital planning activities, the next in regional planning, and the highest level of volunteers would be deployable to the disaster site. These highest-ranking volunteers would have established relationships with government, military, university, or faith-based organizations that have teams of health care professionals who are ready to deploy immediately after disaster strikes. The second and third layers of Fellows are those who are unable to contribute their skills to a disaster relief project but can work with their regional societies and hospitals to donate money, supplies, and their hospital space.

The College would take responsibility for helping surgeons locate and deploy with government-based and nongovernmental organizations. We anticipate that the memorandum of understanding with the U.S. Navy that Kathleen Casey, MD, FACS, Director of Operation Giving Back (OGB), secured for the ACS during the Haiti crisis will be useful toward building future relationships with government-based disaster relief programs.

▲ Mobilize an electronic case tracking system. Surgeons who have deployed would use this technology to catalog their experiences, so that the College could keep track of what types of operations are being performed, and what could be done to improve outcomes for the victims. For example, a modification of the ACS Case Log System was tailored for use in Haiti at the request of several physicians and surgeons who were on the ground there. The College also would maintain a registry of volunteers.

The ACS Executive Director, the executive staff of pertinent College divisions, and the leadership of the COT and OGB would be responsible for coordinating these activities. These individuals responded swiftly to the earthquake in Haiti and, because of what we learned from that experience, they will be even better equipped to effectively react to future disasters.

Dr. Fildes is chair, department of trauma, University Medical Center, Las Vegas, and director for general surgery, surgical critical care, and acute care surgery; professor of surgery and vice-chair, department of surgery; and chief division of trauma/critical care, University of Nevada School of Medicine, Las Vegas. He is ACS Trauma Medical Director.

Dr. Weireter is the Arthur and Marie Kirk Family Professor of Surgery at Eastern Virginia Medical School, and medical director, shock trauma center, Sentara Norfolk General Hospital, Norfolk, VA. He is Chair of the ACS COT’s Ad Hoc Committee on Disaster and Mass Casualty Management.
A selfless desire to help others often inspires people to seek careers in medicine. While every day in surgical training is marked by tireless service to patients, the needs—whether medical or socioeconomic—of those most underserved in our own backyards and abroad are easily forgotten during the daily rigors of becoming a surgeon. This year’s annual American College of Surgeons Resident and Associate Society (RAS) Essay Contest is on the topic of volunteerism. RAS members were asked to describe, in 500 words or less, a domestic or international volunteer experience that has shaped them personally or professionally. We are pleased to share the top essays from these selfless young surgeons who have taken time out of their busy lives to help others. The author of the winning essay will receive an award at the annual RAS business meeting on October 3 during the Clinical Congress in Washington, DC.

Dr. Santry is assistant professor of surgery, trauma and surgical critical care, University of Massachusetts Medical School, Worcester, MA. She is Secretary of RAS-ACS, a member of the RAS-ACS Communications Committee, the RAS-ACS liaison to the ACS Women in Surgery Committee, and the RAS-ACS representative to the ACS General Surgery Advisory Council.
As the clouds lifted, I could barely discern the lush rugged mountains coming into view. The aged school bus I boarded many hours before in Tegucigalpa now climbed slowly out of the humid Honduran capital via the tortuous Pan-American Highway and into the cooler, forest-covered mountains. Eventually, the bus arrived in San Marcos de Colón, a Honduran village in Departamento de Choluteca near the Nicaraguan border. It is here that I would be privileged to serve such kind and appreciative people.

This mountain village is physically and socially isolated from any formal health care delivery system in Honduras. The people of San Marcos de Colón are largely reliant on foreign medical missions to supply their health care services, physicians, and pharmaceuticals under governmental bureaucratic oversight. In fact, many young villagers have never seen a physician, due to inaccessibility and cost.

The school bus parked in front of a cement-block school house where a large group of students dressed in blue and white government-issue uniforms, parents, and others stood waiting for the American health care providers and missionaries. The beauty of the impressive mountains gave way to the imposing needs of so many underserved people. Behind the bus stopped the mobile medical unit, a well-equipped trauma bay on wheels complete with basic radiography, ultrasonography, and laboratory capabilities. This tool affords otherwise inaccessible or expensive medical and surgical care to people living in remote locales. While sitting on the bus, I never realized that such a tool could impact the lives of so many people. During the trip, I would perform various surgical procedures, including abscess drainage, necrotizing fasciitis debridement, Shouldice herniorrhaphy (sorry, no mesh available), long bone reduction and splinting, trauma resuscitation, and cutaneous neoplasm excision.

More important than the operative experience would be the chance to witness firsthand the physical and spiritual needs of an underserved people. While my surgical training adequately prepared me for these basic operative procedures, only through service to those most in need, regardless of barriers to health care including nationality, sociopolitical status, and religious beliefs, could I learn such an important lesson about what it means to be a surgeon.

After stepping off the school bus to begin what would ultimately be two wonderful weeks in San Marcos de Colón, I could not have imagined the lessons I would learn. One of the most important would be the understanding that those trained in the discipline of surgery are blessed with the clinical acumen and technical skills necessary to impact a huge number of lives, wherever and whenever such needs arise. Despite ever-present health care needs at home, my glimpse of the mounting medical needs of underserved people abroad would help me realize that surgeons can and should be involved in medical missions, through faith-based organizations or the American College of Surgeons’ Operation Giving Back. Either way, I now understand that being a surgeon means I need to go and bear witness to the needy, render compassionate care to the underserved, and remember whatever I do to the least of these....

Dr. Bittner is a general surgery chief resident, Medical College of Georgia, Augusta, GA. He is Vice-Chair of the RAS-ACS Education Committee.
When I met “Blessing,” she was sitting on a gurney in Evangel Hospital’s makeshift preoperative area, eyeing me with the distrust of a three-year-old toward a stranger. Not only a stranger, but a white one: far different than everyone else in central Nigeria.

Blessing had been diagnosed with Hirschsprung’s disease during a hospitalization a year prior that had left her with a colostomy. She had recovered well, and now that her family had raised enough money, was at Evangel for her definitive operation. In the U.S., her operation would be done by a pediatric surgeon; here, in a land with few specialists, it would be done by Evangel’s single general surgeon and me.

On the day that Blessing left the hospital after an uneventful recovery, I walked from her room over to the preoperative area where we had met, and was faced with a Nigerian resident, Sumi, wheeling a patient into the room. The patient, a young man in his twenties, had been shot at close range with a shotgun. His abdomen and chest were riddled with pellet wounds. He was rapidly going into respiratory distress, and Sumi started to ventilate him with a mask, then looked at me and asked, “What should we do?”

At Evangel, trauma is a daily occurrence. In a city with frequent violent crime, swarms of motorcycles, and innumerable car accidents, there is every kind and severity of injury. Many of the doctors training at the hospital, however, have had little, if any, formal training in trauma. I had, and Sumi knew that.

The surgeon walked in as we were putting a chest tube into the patient, and with a rush of air his breathing improved, but his abdomen was getting bigger as his blood pressure dropped. We rushed him to the OR, packed his bleeding liver, and brought him back to the ICU. With our limited resources we fought to keep him alive: hand-bagging since there was no ventilator, taking manual blood pressures. He died later that afternoon. When I walked outside to tell his family, I was met by more than 40 people crying.

Sumi explained, “The whole village comes, because the one who doesn’t come is the one who put the curse on him. No one wants to be blamed for the death, so they all come.”

Evangel, like many hospitals in the developing world, is forced to care for a wide variety of surgical issues without the luxury of specialists. Like Blessing’s surgery, some are elective, and go well. Many are emergent, and some, like in any hospital, die—“cursed” or not. Evangel’s physicians have been equipped to deal with them all by learning from those who visit. I was able to offer my relatively limited knowledge, but in the past year, multiple surgeons have spent time training the physicians there. The value of my visit, and of others, is not really in things we did while we were at Evangel, but in any knowledge we were able to leave behind.

Dr. Castle is a research fellow, department of pediatric surgery, Childrens Hospital, Los Angeles, CA.
A monolithic monument of gritty volunteerism erupts from an otherwise rural Kenyan landscape—Tenwek Hospital. This facility has 300 beds, five operating rooms, primary care for nearly a million people, and a surgery referral center for many more. Flash back in time, and the same hillside reveals a derelict dispensary, a few beds—and not one physician. Pleas for help from overwhelmed nurses fell on deaf ears. Surgeons too busy, practices too lucrative. Some 20 years passed before a young, talented doctor left America to confront seemingly insurmountable infirmities through work woven with the bonds of sacrifice. Today, I step into that same hospital, and Dr. Ernie Steury’s legacy. Being the only physician and surgeon at Tenwek for 14 years, he was on call nightly, without reprieve from raw and frequent human need. Ralph Waldo Emerson described selfless surgeons like Dr. Steury as “…brave men who work while others sleep.” All of this without compensation, for the people he treated were peasant farmers. I find his example inspiring in an era when lifestyle and reimbursement drive career choices.

I followed Dr. Steury’s footsteps to this far corner of Africa because I have seen too much. I’ve seen suffering without recourse. In the slums of Haiti, desperate surging crowds were controlled by armed militia while a youthful me assisted physicians inside a securely walled compound. A man cast words on me that I have never escaped, “In Haiti, physicians are as gold. Do not forget us.” English abolitionist William Wilberforce poignantly reminds that, “Having heard all of this, you may choose to look the other way…but you can never say again that you did not know.”

To take suffering seriously, I must consider the 2 to 3 billion people without access to essential surgery, agreeing with Albert Schweitzer that we all must carry our share of the misery which lies upon the world.

This afternoon at Tenwek, I met a cachetic 51-year-old man unable to swallow his own saliva, one of several such cases I’ve seen today, as esophageal cancer is endemic in western Kenya. He declined the sedation, which he could not afford, and allowed me to dilate, then stent his obstructing tumor. Afterward he gulped down a ceremonial cup of water, a luxury he had not recently known, and said in broken English, “Thank you for helping me.” His gratitude granted me pause in the midst of a busy day, knowing that those words are reward enough for doing this work.

The eminent British surgeon, Dr. Paul Brand, who spent much of his career serving the poor, summarizes volunteerism and its rewards well: “Because of where I practiced medicine, I never made much money at it. But I tell you that as I look back over a lifetime of surgery, the host of friends who once were patients bring me more joy than wealth could ever bring. It’s strange, those of us who involve ourselves in places where there is the most suffering look back in surprise to find that it was there that we discovered the reality of joy.”

Surgical volunteerism
by Jeremy P. Hedges, MD, MPH

Dr. Hedges is a PGY6 general surgery resident, University of Colorado, Denver.

—Jeremy P. Hedges, MD, MPH

I remember the day I was perusing the American College of Surgeons’ volunteerism website, and discovered an opportunity with the Global Medical Foundation to volunteer in the Philippines. I was filled with excitement, and I knew this was my chance to fulfill a promise that I had made 11 years earlier while visiting the Philippines. Rejected from medical school for yet another year, I promised myself that when I became a physician I would return to this country and share my skills and knowledge.

Volunteering has given me an opportunity to see the world more vividly. Returning from a mission trip, I experience all aspects of my life differently. Journal entries from my trip remind me that the complaints we have in our operating rooms seem trivial compared to the obstacles faced in foreign hospitals. There was never a shortage of insects in the operating room, and on one occasion a cat even visited us through an open window. I laugh to think of that happening in one of our hospitals.

I would love to infuse every physician I meet with the excitement I feel when I share my volunteer experiences. It’s like a kid describing her first visit to Disneyland. I was in awe that we had performed an open cholecystectomy under a spinal through an incision the size of my hand.

Although you donate your skills without monetary compensation, what you receive is priceless. Caring for individuals who would otherwise receive no medical attention is both gratifying and humbling. The first day of our mission involved seeing 37 patients, some of whom had traveled for days. Local doctors would not operate on them because they did not have money to pay for surgery. The goiters were larger than anything I had ever have seen in residency. Some patients—like the one-year-old with an ostomy for Hirschsprung’s, and the elderly woman with the parotid mass—we knew we could not help.

I am continually inspired to do more with my life by my volunteer experiences. I have found myself surrounded by amazing people who use their hard-earned vacations, spend their own money, and travel across the world to help strangers. They care for people whom they may not even be able to communicate with outside of a heartfelt smile or comforting touch. I am reacquainted with the truth that the simplest actions can have the greatest impact.

I discovered after being accepted to medical school that this process demanded so much. I have incurred a large amount of debt and sacrificed my youthful years to education and training. At times, my personal relationships and physical health have been casualties to the process. Volunteering is a gift I have given to myself. It has helped to revitalize my passion for medicine. It is a treasure I hold close to my heart. It warms me and helps me make it through the challenges that come with being a surgeon. Volunteering is, and will always be, an essential part of my medical career.

Dr. Heyrosa is a colorectal fellow, Lehigh Valley Hospital, Allentown, PA.
I was expecting to smell burning when the plane landed. I’d smelled that smell before: in Belize, in Costa Rica, in Mexico, Honduras, Panama, and even in India.

It is a smell like none other: an odor that I’d convinced myself was a purer kind of incense, an olfactory witness to the realness of my experience. It is dirt and earth and necessity wrapped into an invisible reminder of where you are. Later, in India, when I finally found out that, in fact, this beautiful burning smell was really smoldering garbage, I refused to believe it, and maybe I still do.

Regardless, when the plane landed, I expected to smell burning.

Instead what I found was mountains and sunrise and breathlessness in minimal oxygen at the two miles of La Paz’s elevation. I quickly realized that my expectations I’d brought with me (as carry-ons, of course, because I can’t afford to check them now) would be useless. I was carrying with me reminders of previous missions, previous lands and people and memories, and I guess I thought I’d make Bolivia fit in that puzzle.

We were 30 strong: surgeons, residents, and students, nurses, anesthesia, and support staff. We came to perform a week’s worth of emergency and essential surgeries in a rural, underserved community in eastern Bolivia. We traveled the countryside in beaten-up buses, drivers barely speaking behind mountains of cocoa leaves stuffed in their cheeks, and despite the hazards of back-road travel in South America, we grounded our operations at San José de Chiquitos. Through the course of a week, we performed 41 operations, from emergency appendectomies, to giant goiter thyroidectomies, to cholecystectomies, to several minor orthopaedic and gynecologic procedures. Shedding three times our body weight in sweat beneath our gowns, side-by-side next to local Bolivian physicians, we were able to facilitate an exchange of techniques and ideas about surgery, and about the best way to care for this population.

In the end, I left knowing that we performed an essential role in addressing this community’s surgical needs. But this is the least of it. The real challenge comes, for all of us, in refusing to be complacent. It doesn’t take a stretch of the imagination to realize that the burden of surgical disease cannot be adequately addressed by counting our gallbladders. On these international trips, if we really want to serve our patients, we must look to what got these people to the operating room in the first place, what steps might be implemented to prevent these conditions, and how we can institute such steps in the future through education and collaboration. We need to take the operating room to the streets, and unless we focus at least as much on education, empowerment, and access issues within the populations we serve, we will be doing little more than pouring water on the fire. It is a vital and important and commendable role, certainly, but one that will never adequately stop the pile of trash from burning.

Finding my own Lambaréné

by Christopher David Hughes, MD, MPH

Dr. Hughes is a surgical resident, University of Connecticut, and a Paul Farmer Global Surgery Research Fellow, Children’s Hospital, Boston, MA.
On the morning after the New York City Marathon, during my surgical oncology research fellowship, I stood on a blacktop in suburban Maryland with the other coaches for Potomac Elementary School’s Girls on the Run program, watching the girls run their laps. When I started volunteering for Girls on the Run, a program that uses the love of running to teach healthy choices and to build self-esteem in elementary school girls, I was dubious of my assigned geography. My volunteer experience has always been with the poor and sick. Potomac is an area known as much for its money as it is for its sprawling horse estates; these girls were far from underserved.

To add to my disquiet, I was very caught up in being a woman surgeon and an Ironman triathlete, and in wanting the girls to get something from me and these experiences. The girls, ages 9 through 12, took these hard-earned things for granted; I was frustrated and confused in the early weeks and didn’t feel much of use to them.

About halfway through the season, I ran a very disappointing race at the New York City Marathon. However, back at the Potomac blacktop that morning after the race, it didn’t matter to the girls what had happened in New York; all that mattered was that I ran, I finished, and I was back at practice with them. Their simple, unqualified acceptance was a turning point; I stopped feeling so much like I had to be a certain way for the girls, and instead was more able to focus on them. Practice became more enjoyable as each girl’s unique personality emerged through a lens no longer heavily clouded by self-reflection.

Near the end of the season, on a Boston-cold morning, the girls were unusually animated, talking about a recent incident of bullying. As we talked about the issue, I found myself really listening to them and contributing to the discussion. After the serious conversation, we needed some fun, so we played their favorite game: Duck Duck Goose. We sat in a circle and played, all of us, including the coaches. From the smallest third grader to the most confident fifth grader, they sat anxiously on their heels, geese waiting to give chase. For 30 glorious minutes, all of us were kids again, and the game was the only thing that mattered. That day, finally, we were all in the same place, a place where real communication could begin.

Whatever the Potomac girls learned from me, I may have gotten more from them. The girls and school may not have fit my romantic ideals of volunteering with those who need it the most. In spite of that contrast, or perhaps because of it, the experience reminded me that the transformational power of service comes when we step outside of ourselves, meeting others without ego or artifice, and instead, with honesty and openness to different realities.

Sometimes all you need is a good game of Duck Duck Goose.

Dr. Powell is a general surgery resident at New York University School of Medicine, New York. She is Vice-Chair of the RAS-ACS Communications Committee. She is also RAS Liaison to the ACS Women in Surgery Committee and the Governors’ Committee on Socioeconomic Issues, and RAS Representative to the Operation Giving Back Advisory Council.
While I was volunteering in rural Haiti during the rainy season, a pregnant woman with placental abruption came to our hospital, hemorrhaging, with a hemoglobin of 5 g/dL. She became coagulopathic in the operating room, and we rushed her to the ward for further resuscitation. In dry weather, and save any flat tires on the unpaved mountain roads, whole blood takes six hours to arrive. Despite the valiant efforts of the surgeon and staff, the patient died as the driver walked into the ward with the blood.

The week before, a bus overturned on the road. Selfless witnesses transported nearly 30 surviving passengers to our hospital. Although our efforts were well-coordinated, without ultrasonography or a surgeon, triaging was difficult. Unstable patients died. We sent those with open fractures or suspected internal injuries over the same rocky road to hospitals three to four hours away. Their outcome is unknown.

Without an anesthesiologist, ultrasound machine, closed-ventilation operating room, clean water, continuous electricity, reliable supply of scrub brushes, or blood bank, most local surgeons choose not to work in such an environment. Haitian surgeons visit for days at a time. U.S. surgeons visit for one or two weeks, but only perform scheduled procedures with little estimated blood loss and treat emergencies. I have a deep respect for the surgeons I worked with for overcoming obstacles to provide care. But I am frustrated by the apparent limiting of responsibility to the operating table. This is not what surgical volunteerism should look like.

The U.S. surgeon’s response to a resource-poor setting should be to direct resources into the area. With the increasingly broad role nonsurgeon clinicians play in treating surgical disease abroad, volunteer surgeons must focus on creating a sustainable, safe infrastructure that functions even when they are not present. Developed world health care professionals are taken more seriously than their developing world counterparts. Though this is lamentable, it is reality. Thus, we have a larger responsibility to hold national and international forces accountable to provide lifesaving surgical resources.

For many years, conventional wisdom held that volunteer surgery was suited to short-term, high-volume endeavors. However, truly addressing the global burden of surgical disease demands more. Though more than 90 percent of the world’s surgical burden is in developing countries, and surgical mortality can be up to 10 times higher than in the U.S., many global health advocates do not see safe surgery as a cost-effective intervention in the resource-poor setting. It is left to surgeons, therefore, to create an enduring framework that treats the entire spectrum of surgical disease.

Following this expanded vision of volunteerism, surgeons and surgeons-in-training, among many others, have coordinated the donation of an ultrasound, training of staff, creation of potable water, trials of chemotherapy, and discussion with the Red Cross to organize a blood bank in town. These are small, still-evolving steps toward surgical infrastructure, but they include invaluable efforts by surgeons working exclusively from the U.S., as well as volunteering in Haiti.

Dr. Rattan is a resident at Tufts Medical Center, Boston, MA.

It is a popular misconception that volunteer health care services are purely altruistic. At best, the relationship between the patients and providers at a volunteer clinic or mission is symbiotic: patients without access to care are provided with free, quality health care, and providers gain experience improvising in subpar clinical situations and the immeasurable gain from their contribution to society. At worst, they can be classified as iatrogenic injuries, where lack of follow-up can be more detrimental than the absence of care. Often the transient nature of such services offers minimal long-term aid, without the resources or training necessary to sustain a health care infrastructure. It turns out you also need fishing rods and bait to teach a man to fish.

In reality, all parties do in fact benefit, but there are compromises along the way. The utilitarian nature of such efforts certainly justifies their existence, and I, for one, would testify to this fact. During medical school in the Bronx, I witnessed firsthand patients being evaluated and receiving prescriptions from students volunteering on the weekend. For the most part, these were patients who would otherwise congest inner-city emergency rooms for routine health care maintenance, certainly benefiting themselves and relieving the stress on the public health care system and taxpayers. Was follow-up regular? Did patients end up in the emergency room anyway? Were medical errors committed due to limited attending supervision? Significant problems, but many antihypertensive and hypoglycemic agents were dispensed and unquantifiable cardiac events prevented.

My experience volunteering on a pediatric surgical mission as a third-year resident epitomized for me this tenuous equilibrium: cutting-edge colorectal procedures were performed on children with devastating congenital defects. Having an anus where one was lacking is certainly a price-less gift, but what happens when anal stenosis develops at the anastomosis, and the only health care within 200 miles is a midwife? Perhaps the preexisting colostomy was in fact a blessing in disguise. But no complaints from me—I hadn’t assisted on a posterior sagittal anorectoplasty and don’t know if I will ever again, so all parties left happy.

I’m packing now for a week in Nigeria, where I think the relationship will be well-balanced. Ambulatory general surgery procedures will be performed by board-certified surgeons with Accreditation Council for Graduate Medical Education-accredited resident assistance, and follow-up will be within the first two postoperative weeks as it routinely is, thanks to part of the team remaining behind. We’ll have to improvise supplies and manpower shortages, but hernia defects that might have incarcerated will have quality repairs with the finest Food and Drug Administration-approved mesh. Hopefully, the operations we perform will be minimally different from operating here in New York; I just hope no one is counting work hours.

Ideally, local physicians could be trained to perform the procedures volunteer surgeons have to offer for a long-term impact, but that is rarely the case. Nonetheless, short-term benefits are priceless to both the patient and the health care provider in a truly unique symbiotic relationship.

Surgical volunteerism—objective: symbiosis
by Gary Schwartz, MD

Dr. Schwartz is a fourth-year general surgery resident at St. Luke’s-Roosevelt Hospital Center, New York, NY.
During the 2009 Clinical Congress in Chicago, IL, the Surgical Infections and Environmental Risks (SEIR) Committee of the Board of Governors continued to implement its mission of presenting well-designed clinical and cost-effectiveness research on surgical infections and environment risks.

Three well-attended panel symposia titled Minimizing Risk in Bedside Surgical Procedures, Bugs Are Winning the Resistance Battle: The Surgeon’s Responsibility, and Blood Transfusions in Surgery were presented. Feedback from the Division of Education indicated that attendees found these topics timely and directly useful to practicing surgeons. Based, in part, on questions from the session on current transfusion practices, committee members continue to develop a position statement and guidelines for blood and blood component transfusion.

The committee will again present several panel symposia at the forthcoming 96th Clinical Congress to be held in Washington, DC. This year’s topics emphasize current problems encountered in delivering inpatient and outpatient surgical care. The panels, to be presented on Monday and Wednesday, respectively, are titled Hospital Acquired Infections: Can We Win the Battle? and Infected Mesh: The Problem That Won’t Go Away.

The committee’s leadership changed during the past year, when Vijay Maker, MD, FACS, retired after several highly productive years as Chair. The former Vice-Chair, Michael A. West, MD, PhD, FACS, was selected as the new Chair for his last year as a Governor, and Linwood R. Haith, Jr., MD, FACS, will serve as committee Vice-Chair.

The committee’s primary focus has recently shifted from addressing infections and blood-borne pathogens to a broader consideration of surgical infections and environmental risks. The shift in focus is timely, with increasing
administrative scrutiny of infectious complications and enhanced awareness of the hazardous nature of the operating room environment. The SEIR Committee has responded proactively to this expanded role and broadened the topics submitted to the Program Committee for possible presentation at the 2011 Congress in San Francisco, CA. Four panel topic proposals were submitted:

- Early Diagnosis of Surgical Infection: The Next Frontier
- Adverse Patient Safety Impact of Operating Room “Noise Pollution”
- Perioperative Normothermia: What Is It? Why Is It Important? How Do We Achieve It?
- The Hidden Cost of Adverse Environmental Ergonomics

The committee is hopeful that highlighting provocative, but often ignored, topics such as noise pollution and ergonomics in the operating room will result in thoughtful consideration of how we, as surgeons, interact and are acted upon by the environment in which we work. We welcome input and suggestions from all Fellows of the College to enhance patient and surgeon safety.

Members of the Governors’ Committee on Surgical Infections and Environmental Risks

Michael A. West, MD, PhD, FACS, Chair
Linwood R. Haith, Jr., MD FACS, Vice-Chair
Dennis W. Ashley, MD, FACS
Marianne E. Cinat, MD, FACS
Donald E. Fry, MD, FACS
Jan K. Horn, MD, FACS
Rao R. Ivatury, MD, FACS
Joshua M.V. Mammen, MD
Ernest E. Moore, Jr., MD, FACS
Edward J. Quebbeman, MD, FACS
Leonard M. Randolph, Jr., MD, FACS
Andrew W. Saxe, MD, FACS
Donald J. Scholten, MD, FACS
Joseph J. Sferra, MD, FACS
Nathaniel J. Soper, MD, FACS
Michael J. Sutherland, MD, FACS
Beth H. Sutton, MD, FACS

Dr. West is professor and vice-chair, department of surgery, University of California, San Francisco, CA, and chief of surgery, San Francisco General Hospital. He is Chair of the Governors’ Committee on Surgical Infections and Environmental Risks.
Each year, trauma accounts for 37 million emergency department visits and 2.6 million hospital admissions across the nation. Trauma surgeons across the country know that excellent trauma care is sustained by an excellent trauma system, which, in turn, is dependent upon the funds allocated to that system. States across the nation are looking to implement or improve their statewide trauma systems to better serve communities and patients, yet many of the states that boast a statewide system are not supported by state funding. However, many states have set up various financial systems that fund trauma systems across the state.

State breakdown

Forty-two states have recognized the importance of a statewide trauma system. Alabama, California, the District of Columbia, Idaho, Michigan, New Jersey, Rhode Island, South Dakota, and Vermont are the remaining states that do not have a trauma system in place. Of the states with a statewide system, only 24 have some form of state funding in place. States collect and allocate funds for the state trauma system in a variety of ways, including the following: 13 states fund the trauma system through fines and fees on moving violations; seven states issue additional fees on motor vehicle registration, license plates, or driver’s license renewal; six states have implemented an excise tax on cigarettes; four states collect fees from criminal penalties; and five states allocate money from the state’s general revenue (see figure, this page).

Legislative efforts

During the 2010 legislative session, six states—Alaska, Florida, Georgia, Michigan, New Mexico, and Tennessee—introduced legislation that would have allocated funds to the state trauma system. Alaska and Georgia were the only states to see trauma funding success during the 2010 legislative session.

The Alaska legislature passed legislation (H.B. 168) that provides for state certification and designation of trauma centers, and created a trauma fund to help compensate certified trauma centers. The funds are to be appropriated by the Alaska legislature. Proving the impact that one surgeon can have on state advocacy, the state’s American College of Surgeons Committee on Trauma Chair, Regina Chennault, MD, FACS, played a critical role in championing this legislation through the legislative process.

Georgia is another state that has seen legislative success in trauma system funding. In 2009, the Georgia legislature passed “super speeder” legislation (H.B. 160) that was expected to generate approximately $23 million in fiscal year 2010 for the state’s trauma care network. The super speeder bill adds an additional $200 fine for driving over 85 mph anywhere in the state, and for driving 75 mph or

Practically speaking: Reducing your audit risk

by Betsy Nicoletti, CPC

How can a surgical practice decrease its audit risk? The stock answer is: by implementing a comprehensive and robust compliance program, by attending coding education classes annually, and by keeping abreast of new regulations. But what specific activities and inquiries should a surgical practice make within its own compliance work plan?

We often advise surgical practices to employ a three-pronged strategy: analyze and check your practice’s use of modifiers, compare all the physician’s evaluation and management (E/M) coding profiles with one another and with industry benchmarks, and pay attention to hot topics related to surgical billing.

Check your practice’s use of modifiers

Modifiers tell the payor the circumstances surrounding the provision of care, but do not change the description of the Current Procedural Terminology (CPT)* code to which they are appended. Surgeons use modifiers –24, –25, and –57 on E/M services to indicate that the service should be paid in addition to the global surgical payment. Since these modifiers bypass the claims editing system, and allow a physician to be paid separately from the global payment, their use is monitored by payors. An unusual use of modifiers that impacts payment will increase the chance of a payor audit. Payors will pay these claims initially; each claim is adjudicated and paid (or not) based solely on the information on the claim. Later, however, the payors, both private and governmental, will analyze the composite paid claims data. A higher-than-average use of modifiers will attract attention, and not the kind of attention a surgical practice wants. General surgeons appended modifier –24 to 3.11 percent of their E/M services; modifier –25 to 3.84 percent of their E/M claims; and modifier –57 to 1.71 percent of their E/M services, for claims submitted to Medicare according to the most current data available.1 If a practice finds a significantly higher usage of these modifiers, staff should review the notes to be sure they follow CPT and Medicare rules.

Compare and monitor E/M coding profiles

It’s oft-repeated advice to analyze E/M profiles, and many groups routinely collect this data. What do we do with this data? First, be sure to show the physicians the results, comparing each physician’s profile with all the other physicians in the group, as well as the national and state Centers for Medicare and Medicaid utilization data. Where to get the CMS data? KarenZupko & Associates E & M Analyzer tool compares a practice’s E/M coding patterns against general surgery-specific state and national code utilization figures, using CMS’ most recently published claims database. Go to http://www.karenzupko.com for more information.

Once a comparison of the practice’s code usage has been conducted—what is the next step? Do something with the results. Instead of performing random audits, focus audit efforts on codes that are over- or underrepresented. If the documentation doesn’t support the code selected, and the physician coding profile varies significantly from the norm, provide increased coding education for the physician and increase the number of audits. Physicians need feedback: show them their results, payor requests, and comparative data frequently.

Pay attention

It is important to be aware of the following hot topics to reduce the compliance risk:

• Location of service errors. For the exact same service (for example, a CPT code), payors...
pay physicians more for the service when it is performed in a non-facility setting, such as a physician office, rather than in a facility setting, such as an ambulatory surgical center, outpatient department, emergency department, or inpatient hospital. Incorrectly reporting the place of service as performed in the office will result in collecting more than the practice is entitled to collect.

- Incorrect diagnosis codes. Submitting a claim to Medicare for an E/M service prior to a colonoscopy screening is a significant error. Medicare does not pay for this as a separate and distinct service. Reporting an incorrect diagnosis code in order to receive payment would be considered purposefully collecting money from the Medicare program to which a practice is not entitled. Cigna, one Medicare administrative contractor (MAC), has a local coverage determination policy that explicitly states:

A provider preparing to perform a screening colonoscopy cannot also bill for a pre-procedure visit to determine the suitability of the patient for the colonoscopy. These E/M services, to include consultations, are not separately payable. While the law specifically provides for a screening colonoscopy, it does not also specifically provide for a separate screening visit prior to the procedure. Although no separate payment can be made for these visits currently, the fee schedule payment for all procedures, including colonoscopy, contains payment for the usual pre-procedure work associated with it. This reflects the principle that each procedure has an evaluative component.‡

Once the decision to operate is made, a surgeon may not bill for a subsequent visit for the purpose of completing a history and physical. After the decision for the operation is made, an E/M service scheduled for the purpose of doing a history and physical, completing paperwork, and obtaining informed consent may not be billed separately. Payment for those activities is included in the payment for the surgical package. This visit would be easy to identify by analyzing paid claims data, searching for an E/M service between an initial visit and the operation, and matching it with the same diagnosis code.


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.

There were 133,796 surgeons in active, post-residency practice in the U.S. in 2006, yielding a national surgeon-to-population ratio of 44.7 surgeons per 100,000 persons. Like all physicians, surgeons are distributed unevenly across the U.S., with more located in urban centers and fewer in rural communities (see Figure 1, page 33). In 2006, 30 percent (925) of the 3,107 U.S. counties lacked any surgeons, and nearly 9.5 million Americans lived in those counties.

Geographic distribution

Counties without surgeons are concentrated in the rural parts of the country: 95 percent of the 925 counties without a surgeon in 2006 were classified as nonmetropolitan by the Office of Management and Budget (OMB). Places without surgeons are also unevenly distributed regionally; just under one-third of counties nationally, and about that proportion in the Midwest, South, and West, lacked a surgeon in 2006, while only 4 percent of the counties in the Northeast did not have a surgeon in that year.

Most counties without surgeons are recognized as being underserved for primary care by the Bureau of Primary Health Care’s health professional shortage area (HPSA) designations. Of the 925 counties without a surgeon in 2006, 84 percent were classified as either a whole or part-county primary care HPSA. Physicians and psychiatrists practicing in HPSAs are eligible to receive Medicare bonus payments for professional fees.

Small and disadvantaged counties

Counties without hospitals are unlikely to have surgeons, particularly general surgeons, as their services depend on technology and staff that are associated with hospitals. Yet, 50 percent of counties without surgeons (467) do have hospitals, the majority of which are critical access hospitals (CAHs) (see Figure 2, page 34). CAHs are small rural hospitals in relatively isolated areas that provide inpatient and 24-hour emergency services, and receive enhanced reimbursement from Medicare and Medicaid in many states. In 2006, 433 CAHs were located in counties without a surgeon. The distribution of surgeons is also tied to population. Maintenance of a surgical practice depends on a minimum patient volume, and the economic activity necessary to support a hospital or surgical center. Counties without surgeons are one-tenth the size of those with one or more surgeons, on average (mean population 10,247, as compared with 132,856; see Table 1, page 34). A total of 89 percent of counties without a surgeon had populations of less than 10,000 people. Some larger communities lacked surgeons as well. Fifty-seven counties without surgeons (6 percent) had populations of 25,000 or more, the largest of which contained 54,476 persons.

The volume of surgery for counties with and without surgeons also varies: Counties without surgeons have one-quarter the number of inpatient surgeries (516/100,000 versus 2,042/100,000), and one-third the rate of outpatient surgeries (2,041/100,000 versus 6,012/100,000). Counties...
without surgeons have lower per capita incomes ($25,198 as compared with $28,227) and slightly higher proportions of their populations living below the federal poverty level (16 percent as compared with 14 percent). The proportion of persons aged 65 and older are, on average, slightly higher in counties without surgeons (17 percent as compared with 14 percent).

How many is enough?
Developing benchmarks, or ideal ratios, of surgeons-to-population is challenging given the highly specialized nature of many surgeons’ practices, and the tendency of specialist providers to cluster around facilities in large urban centers. Standards do exist for general surgery. The 1980 Graduate Medical Education National Accreditation Council (GMENAC) report recommended 4.7 general surgeons per 100,000 population as the minimum acceptable ratio.† In 2004, the health care research and consulting firm Solucient issued a report recommending a minimum 6.01 general

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surgeons per 100,000 population nationally, and slightly different ratios for counties within each Census Region. Figure 3 on page 35 plots the ratios of general surgeons to population (in 1,000s) for all counties with population of 400,000 or less (95 percent). The diagonal lines mark the GMENAC and Solucient recommended minimum per capita supply benchmarks. Counties marked with an “x” are rural counties and those marked with an “*” are urban counties.

Discussion

The supply of surgeons in the U.S. is very uneven, and this creates potential problems for access to surgical services. A substantial number of Americans must travel to the next county, or beyond, to receive necessary or lifesaving surgical treatment. While we know, anecdotally, that there is some degree of regionalization and sharing across facilities as generalist surgeons refer to subspecialists, less is known about whether this is an effective and sufficient strategy for meeting the surgical needs of these communities. Further research is needed to answer this question, and to understand the effects of the distribution of surgeons on the health of Americans.

A substantial portion of our country can be characterized as surgically underserved, despite several programs designed to help sustain health care services in underserved communities through enhanced reimbursement. For many areas, these initiatives may not be sufficient to supplement a surgical practice. Understanding the characteristics of these communities and the dynamics of their local health care systems is important when considering new policies aimed at increasing their surgical workforce, or developing alternatives to satisfy unmet surgical needs.

Data and methodology

American Medical Association Physician Masterfile data representing all licensed physicians were analyzed for 2006. Census Bureau population data for the corresponding year were used to calculate provider-to-population ratios at the county, state, and regional levels of analysis.

Providers with a self-reported primary specialty of surgery, as identified in Table 2 on page 35, were included in the analysis. 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

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Table 1. Population characteristics of counties with and without surgeons

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>1+ Surgeons</th>
<th>No Surgeons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean county population, 2006</td>
<td>132,856</td>
<td>10,247</td>
</tr>
<tr>
<td>Mean population change 2001–2006</td>
<td>6,485</td>
<td>161</td>
</tr>
<tr>
<td>Mean income per capita (2005)</td>
<td>$28,227</td>
<td>$25,198</td>
</tr>
<tr>
<td>Mean % of population in poverty, 2005</td>
<td>14.1</td>
<td>16.1</td>
</tr>
<tr>
<td>Mean % ages 65+, 2006</td>
<td>14.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Mean % ages 0-19, 2006</td>
<td>26.4</td>
<td>25.1</td>
</tr>
<tr>
<td>Mean % White, 2006</td>
<td>79.7</td>
<td>80.6</td>
</tr>
<tr>
<td>Mean % African-American, 2006</td>
<td>9.1</td>
<td>7.8</td>
</tr>
<tr>
<td>Mean % Hispanic/Latino, 2006</td>
<td>7.2</td>
<td>7.3</td>
</tr>
<tr>
<td>Mean % American Indian, 2006</td>
<td>1.6</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Population characteristics from the U.S. Census Bureau County Characteristics File for 2006 as reported in the 2007 Area Resource File.
were excluded from the analysis in a given year if they reported being in residency training, semi-retired, or if they reported their primary present employer was the U.S. government, locum tenens, medical school, or other nonpatient care employment. For the purpose of this analysis, counties were defined by FIPS codes regions by the U.S. Census Bureau, and rural-urban defined using the U.S. OMB’s core-based statistical area definitions for metropolitan and micropolitan areas.

Population characteristics come from the U.S. Census County Characteristics File for 2006 and, in the case of income per capita and persons living in poverty, from the Census Regional Economic Information System for 2005 as reported in the Health Services and Resources Administration (HRSA) Area Resource File (ARF). County-level measures of health services infrastructure and utilization come from the American Hospital Association Annual Survey 2005, as reported in the ARF. Counts of federally qualified health centers are reported in the ARF from HRSA data for 2006. Counts of CAHs come from the Flex Monitoring Team website (http://www.flex-monitoring.org/) and include hospitals certified as CAHs as of 2006.

**Table 2. Surgery specialty categories**

<table>
<thead>
<tr>
<th>Specialty category</th>
<th>Included specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Surgery</td>
<td>Colorectal Surgery, Proctology</td>
</tr>
<tr>
<td>Dermatologic Surgery</td>
<td>Dermatologic Surgery, Procedural Dermatology</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Neurological Surgery, Pediatric Neurological Surgery, Endovascular Surgical Neuroradiology</td>
</tr>
<tr>
<td>Obstetrical &amp; Gynecological Surgery</td>
<td>Gynecology Oncology, Gynecology, Obstetrics &amp; Gynecology, Obstetrics, Critical Care Medicine OB/GYN</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>Hand Surgery–Orthopaedics, Adult Reconstructive Orthopaedics, Foot &amp; Ankle Surgery, Musculoskeletal Medicine, Pediatric Orthopaedics, Orthopedic Surgery, Sports Medicine, Orthopaedic Spine Surgery, Orthopaedic Trauma</td>
</tr>
<tr>
<td>Ophthalmic Surgery</td>
<td>Ophthalmology, Pediatric Ophthalmology</td>
</tr>
<tr>
<td>ENT Surgery</td>
<td>Head &amp; Neck Surgery, Otology/Neurotology, Otology, Otolaryngology, Pediatric Otolaryngology</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>Thoracic Surgery, Pediatric Cardiothoracic Surgery</td>
</tr>
<tr>
<td>Urologic Surgery</td>
<td>Urology, Pediatric Urology</td>
</tr>
</tbody>
</table>
Fellows honored for volunteerism

by Kathleen Casey, MD, FACS, Director, Operation Giving Back; and Uriah Melchizedek, Program Coordinator, Operation Giving Back

The Board of Governors’ Committee on Socioeconomic Issues is pleased to announce the recipients of the 2010 American College of Surgeons (ACS)/Pfizer, Inc Surgical Humanitarian Award and Surgical Volunteerism Awards. As in previous years, the committee received a large number of exceptional nominees, reflecting the substantial commitment of the Fellows of the College to the care of the underserved.

Richard S. Bransford, MD, FACS, of Kijabe, Kenya, has been selected to receive the 2010 ACS/Pfizer, Inc Surgical Humanitarian Award, in recognition of more than three decades of service in Africa, primarily at Africa Inland Church (AIC) Kijabe Hospital.

Dr. Bransford graduated in 1967 from the Johns Hopkins University School of Medicine, Baltimore, MD, and, following residency, served two years in the U.S. Air Force. He earned a degree in Tropical Medicine from the Prince Leopold Institute of Tropical Medicine in Antwerp, Belgium, in 1976.

After brief periods as a missionary surgeon in the Democratic Republic of Congo and the Comoros, Dr. Bransford and his wife and five children moved to Kenya, where he began more than three decades of service at AIC Kijabe Hospital, first as a staff surgeon, and later as the program director of pediatric rehabilitation surgery.

In 1998, Dr. Bransford co-founded the Bethany Crippled Children’s Centre (BCCC) adjacent to the hospital. A 30-bed facility with a pediatric ward and operating room, the BCCC treated children suffering from a wide range of conditions, including burn contractures, hydrocephalus, spina bifida, cleft palate and palates, club feet, polio, scoliosis, hypospadias, cerebral palsy, and muscular dystrophies. In 2004, he co-founded BethanyKids at Kijabe Hospital, a 67-bed hospital that has become widely known in Africa as a referral center for disabled children and is supported by a network of 14 outreach clinics across Kenya.

Dr. Bransford has also provided surgical care during disasters and crises elsewhere in Africa, including in Rwanda, Somalia, southern Sudan, and Zaire.

For a career dedicated to improving surgical care in Africa, especially for children, Dr. Bransford will receive this year’s Surgical Humanitarian Award.

Samuel B. Broaddus, MD, FACS, of Portland, ME, will be awarded the Surgical Volunteerism Award for international outreach, in recognition of his commitment and significant contributions toward improving surgical care in Haiti.

After completing a urology residency at the Medical

OFFICIAL NOTICE

Annual Business Meeting of Members, American College of Surgeons

In accordance with Article I, Section 6, of the Bylaws, the Annual Business Meeting of Members of the American College of Surgeons is called for 4:15 o’clock in the afternoon of Wednesday, October 6, 2010, at the Washington Convention Center, Washington, DC.

This session constitutes the Annual Business Meeting of the Members, at which time Officers and Governors will be elected and reports from officials will be presented. Items of general interest to the Members will also be presented. Members are respectfully urged to be present.

Courtney M. Townsend, Jr., MD, FACS
Secretary
American College of Surgeons
September 1, 2010
Center Hospital of Vermont, Dr. Broaddus spent two years teaching trans-urethral prostate surgery to general surgeons in mission hospitals in St. Lucia, Egypt, Pakistan, Sri Lanka, and Thailand. He solicited donations of fiber optic resectoscopes and collected and shipped them to each hospital at his own expense, so that the technique could be continued after his departure. He later served as a visiting professor at hospitals in Thailand and Vietnam, the latter under the auspices of the not-for-profit organization Friendship Bridge.

Haiti has been his main passion, however, and he has volunteered there often over the past 16 years. Each year from 1994 to 1998, Dr. Broaddus spent two weeks at the Albert Schweitzer Hospital in central Haiti, performing urological surgery where there was no urologist. Since 2002, he has volunteered with Konbit Sante, a Maine-based medical not-for-profit, working in partnership with Haitian physicians at the Justinien Hospital in Cap Haitien with a mission to improve basic health care in northern Haiti. For the last eight years, he has led an annual surgical mission to this 250-bed teaching hospital operated by the Haitian Ministry of Health, and through his efforts, surgical infrastructure and surgical residency training have seen marked improvements.

In 2008, Dr. Broaddus conducted a comprehensive needs assessment of surgical services at Justinien Hospital, including

Dr. Bransford with a patient in Africa, where care for children with disabilities is nearly nonexistent.

Dr. Broaddus and a Haitian boy (status post-nephrectomy) after the 2010 earthquake, Justinien Hospital, Cap Haitien, Haiti.
surgical postgraduate education, and co-authored a groundbreaking situation analysis of these services. This report is the first of its kind in northern Haiti, and is viewed as a model for understanding surgical needs in other resource-poor countries. After the January 2010 earthquake, Dr. Broaddus led a seven-person surgical response team from Konbit Sante to Cap Haitien to provide emergency surgical care to injured Haitians.

For his tireless service, critical research, and ongoing advocacy for Haiti, he is the recipient of this year’s Surgical Volunteerism Award for international outreach.

COL Michael W. Cruz, MD, FACS, of Tamuning, Guam, will be awarded the Surgical Volunteerism Award for military service, in recognition of his work with the Ayuda Foundation. While serving with the Guam Army National Guard, Dr. Cruz co-founded the Ayuda Foundation to address the vital health needs of neighboring Pacific Islanders.

For the past 16 years, the Ayuda Foundation has organized medical missions to the islands of Micronesia, providing a wide range of programs. The foundation organizes surgical teams and containers of supplies to provide relief to hospitals struggling with a backlog of surgical cases and a lack of infrastructure.

To improve the training of local medical personnel, the foundation secured a grant from the Robert Wood Johnson Foundation to build medical libraries in 12 Pacific Island
hospitals, complete with computers and Internet access. To date, seven of the libraries have been completed, with the rest expected to be finished by December.

The foundation has provided critical surgical relief during natural disasters in the region, as in the aftermath of Typhoon Chataan in 2002. The Ayuda Foundation also conducts nonsurgical medical programs, including an HIV/AIDS education team and its Island Girl Power program, providing health and safety education for girls aged seven to 14.

In addition to his work with Ayuda, Dr. Cruz is the incumbent Lt. Governor of Guam, and has served tours of duty with the National Guard in Iraq, Philippines, Cambodia, and Afghanistan. During his deployment in Afghanistan, he provided clinical assistance and medical education to Afghani surgeons.

For his dedication to humanitarian surgery during his service in the U.S. National Guard, Dr. Cruz will be recognized with the Surgical Volunteerism Award for military service.

T. Peter Kingham, MD, of New York, NY, is this year’s recipient of the Surgical Volunteerism Award for outreach during residency.

Dr. Kingham graduated from the school of medicine at State University of New York, Stony Brook, in 2001, and is currently finishing a surgical oncology fellowship at Memorial Sloan-Kettering Cancer Center, New York, NY, where he will join the faculty of the hepatopancreato-biliary division in the fall of 2010.

During his residency, Dr. Kingham has spent a significant amount of time volunteering in South Africa, Malawi, and Mexico. In 2007, he co-founded Surgeons OverSeas (SOS), with the mission of saving lives in developing countries by improving surgical care. Since its creation, SOS has assisted in improving medical infrastructure in developing countries, most notably in Sierra Leone. Its programs have included assisting the Sierra Leonean Ministry of Health in developing a surgical residency program, which will produce the first surgical resident in the country in 30 years, the creation of a mass casualty disaster training course, and sending surgical missions and supply containers.

Through its activities, SOS has created a model of surgical development that it will share with other organizations in order to collaborate in improving medical infrastructure around the world. As the president of SOS, Dr. Kingham assumed responsibility for program management, strategic planning, leading the board of directors, and fundraising—all while pursuing his surgical training.

For these impressive accomplishments and his commitment to improving surgical care within global health, Dr. Kingham will be awarded the Surgical Volunteerism Award for outreach during residency.

The extraordinary contributions made by Dr. Bransford, Dr. Broaddus, Dr. Cruz, and Dr. Kingham will be formally recognized at the annual Board of Governors dinner on Tuesday, October 5, during the annual Clinical Congress in Washington, DC. We invite you to hear them speak about their inspiration and work at the panel session on volunteerism, PS108, to be held on Monday, October 4, 9:45 am–1:00 pm, and to meet them and others dedicated to surgical volunteerism in all its many forms at a volunteer networking reception later that evening.

Full details on these events will be available in the Clinical Congress Program Book and on the Operation Giving Back website at http://www.operationgivingback.facs.org.
EXAMINE THE ETHICAL UNDERPINNINGS OF THE ISSUES YOU FACE EVERY DAY

A case-based educational resource for surgeons at all stages of their careers, **ETHICAL ISSUES IN CLINICAL SURGERY** has all the components needed to help surgeons and residents examine the ethical underpinnings of clinical practice and address the ethical issues they face every day caring for their patients.

*Ethical Issues in Clinical Surgery* was developed by the Committee on Ethics of the American College of Surgeons.

**TOPICS**
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- Confidentiality
- Professional obligations of surgeons
- End-of-life issues
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**FEATURES OF EACH CHAPTER**
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There are two versions of the book: one for course instructors and practicing surgeons that has CME credit available, and one for use with residents.

Pricing and ordering information can be found at [http://www.facs.org/education/ethicalissuesinclinicalsurger.htm](http://www.facs.org/education/ethicalissuesinclinicalsurger.htm) or by calling 312/202-5335.
The annual meeting of the American Medical Association (AMA) House of Delegates (HOD) took place June 12–16 in Chicago, IL, with more than 530 delegates and paired alternate delegates participating in a range of policy review activities: reference committee hearings on resolutions and reports, state and specialty society caucus meetings, and informal discussions. In addition, elections for AMA council and officer positions created considerable buzz regarding the AMA leadership’s impact on health system reform and the future of the organization.

Health policy highlights

More than 166 resolutions submitted by state and national specialty societies and 71 reports from AMA councils and the AMA Board of Trustees were on the HOD agenda. To facilitate deliberations, eight reference committees convened for hearings on each resolution and report (similar to those in a legislative body), with testimony provided by any physician who is an AMA member. Each reference committee has a particular theme, including medical service/practice, legislation, medical education, public health, AMA governance and finances, and science and technology.

The most significant issues from a surgical perspective centered on the following:

• Health care reform physician payment models. Policy was adopted calling for the AMA to work with the Centers for Medicare & Medicaid Services and other payors to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs. Guidelines would be developed for health care delivery payment systems that protect the patient-physician relationship, and the AMA would make available to members access to legal, financial, and ethical information, tools, and other resources to enable physicians to play a meaningful role in the governance and clinical decision making of evolving health care delivery systems.

• Assuring patient’s continued access to physician services. The HOD strongly directed the AMA to immediately formulate legislation for an additional payment option in the Medicare fee-for-service program that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule, and in a manner that does not forfeit benefits otherwise available to the patient.

• Financial relationships with industry in continuing medical education (CME). The AMA Council on Ethical and Judicial Affairs presented its third iteration of a report to provide ethical guidance for physicians and the medical profession with respect to industry support for CME. Once again, the HOD sent the report back to the council due to impractical and burdensome guidelines.

• Breast screening mammography guidelines. Considerable testimony was presented on this resolution, calling for physicians and patients to continue to follow the guidelines of the American Cancer Society regarding screening mam-
mography and patient breast self-examination, instead of the recommendations made by the U.S. Preventive Services Task Force. The resolution also directed the AMA to encourage government panels and task forces dealing with specific disease entities to have representation by physicians with expertise in those issues. After plenty of discussion and support from the College, the issue of recommending one set of screening mammogram guidelines was referred to the AMA Board of Trustees for a decision, and the suggestion of physician expertise on government panels and task forces was adopted.

- Endorsement of the WHO Surgical Checklist. The AMA Medical Student Section asked the HOD to endorse the World Health Organization (WHO) Surgical Checklist as a highly effective tool for reducing morbidity and mortality. Many surgical societies, including the College, testified to the value of a surgical checklist and highlighted the well-developed policies and checklists being utilized in the U.S.—and emphasized that the WHO checklist is probably more relevant to developing and least-developed countries. The issue was finally referred to the AMA Board of Trustees for decision.

Elections

As noted previously, elections took center stage at this meeting of the HOD, with an unusually large number of physicians running for president-elect and for the Board of Trustees. With regard to the president-elect position, three physicians ran for the privilege to serve, including Peter Carmel, MD, FACS, pediatric neurosurgeon from New York; Joseph Heyman, MD, an obstetrician/gynecologist from Massachusetts; and Edward Langston, MD, a family physician from Indiana. Dr. Carmel was subsequently elected by the HOD.

For Board of Trustees, eight candidates vied for four seats, with one of those seats held by an incumbent. When the dust had settled, Joseph Annis, MD, an anesthesiologist from Austin, TX, was re-elected to his seat. The other three new members of the board are Barbara McAneny, MD, an oncologist from New Mexico; Stephen Permut, MD, a family physician from Pennsylvania; and Carl Sirio, MD, a critical care physician from Pennsylvania.

Surgical Caucus

The Surgical Caucus of the AMA met for a short business meeting, followed by an educational session entitled On The Cutting Edge of Surgical Patient Safety—Crew Resource Management. This well-received program focused on system methodologies for high-reliability organizations, including better teamwork, communication, and care processes.

A highlight of the Surgical Caucus was a celebration of its 20th anniversary. One of the founders of the caucus and its first chair, Grant Rodkey, MD, FACS, reflected on the history of the caucus, how it evolved over the years to embrace anesthesiology and emergency medicine, and the impact it has had on the development of policy within the HOD. For a more complete description of the caucus and its accomplishments over the years, see the May 2010 Bulletin article, “A cut above the rest: Surgical Caucus turns 20.” (Bull Am Coll Surg. 2010;95[5]:37-38.)

ACS delegation

The American College of Surgeons (ACS) was well-represented by a cohesive team of delegates, working throughout the HOD to formulate responses to health policy proposals, carrying forward the College’s positions, and serving as a unifying voice among the surgical specialty delegations. David B. Hoyt, MD, FACS, Executive Director of the ACS and an Alternate Delegate, shared his observation with ACS leadership: “Time and time again, I heard compliments about the ACS delegates and staff and their knowledge, effectiveness, and respect for how we presented our case.”

For further information on 2010 AMA HOD meeting, contact Jon Sutton, Manager, State Affairs, Division of Advocacy and Health Policy, at jsutton@facs.org, or visit the AMA website at http://www.ama-assn.org/ama/pub/meeting/index.shtml.
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or recruit your ideal candidate

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• Read career advice:
  Access articles about landing your
dream job
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info@healthecareers.com
for more information.
Germany Traveling Fellow selected for 2011

Ali Khoynezhad, MD, FACS, associate professor of surgery and director of thoracic aortic surgery at Cedars-Sinai Medical Center in Los Angeles, CA, has been selected as the 2011 ACS Traveling Fellow to Germany.

As the Germany Traveling Fellow, Dr. Khoynezhad will participate in the annual meeting of the German Surgical Society in Munich, Germany, May 3–6, 2011. He will attend and participate in the Germany Chapter meeting during that event. Dr. Khoynezhad will also travel to several surgical centers in Germany, with assistance from mentors provided by the German Surgical Society and the Germany Chapter.

Dr. Khoynezhad’s work centers on open and endovascular repair of abdominal and thoracic aortic aneurysm. He is in the process of developing a nano-engineered prosthetic valve, to reduce mortality and aid recovery following cardiovascular surgery.

The application deadline for the 2012 Traveling Fellowship to Germany is April 1, 2011. The requirements will be published in a future edition of the Bulletin and are posted on the College’s website, http://www.facs.org/memberservices/research.html.

Clinical Congress panel to address surgeon burnout

The American College of Surgeons (ACS) Board of Governors’ Committee on Physician Competency and Health will sponsor a panel session on Tuesday, October 5, 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 2008, 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 surgeons), the data gathered have generated a number of manuscripts.

Briefly, the survey included, among other questions, the Maslach Burnout Inventory, the Primary Care Evaluation of Mental Disorders), and the Medical Outcomes Study Short Form (SF-12) to identify burnout, symptoms of depression, and quality of life, respectively.

Most 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 ultimate goal of the committee is to establish a resource center or area of expertise, housed within the College, that can be easily and confidentially accessed, for surgeons dealing with issues of burnout, depression, or other stress factors for themselves or colleagues. These important matters impact not only their own personal lives and surgical effectiveness, but have ongoing and far-reaching effects in the surgical community as a whole, including surgical workforce issues.

All members of the College with an interest in this exceedingly valuable topic are invited to participate in this thought-provoking and constructive panel discussion.

Panel session 232 will be moderated by Dr. Bechamps and Dr. Oreskovich. Panelists and scheduled presentations are: Further Results From the 2008 American College of Surgeons Survey Regarding Stress and Burnout, by Dr. Shanafelt; How to Recognize Burnout in Oneself and in Others, by Krista Kaups, MD, FACS; A Surgeon’s Personal and Professional Interest in Burnout, by Charles Balch, MD, FACS; The Role of Perfectionism in Burnout, by Dr. Oreskovich; A Systems Approach for Dealing with Burnout, by John Hanks, MD, FACS; and A Surgeon’s Toolkit for Dealing with Burnout, by Dr. Bechamps.

**PROVIDE YOUR PATIENTS WITH LEADING-EDGE, HIGH-QUALITY BREAST CARE**

Seek accreditation from the National Accreditation Program for Breast Centers (NAPBC).

NAPBC accreditation is the best way for your center to offer patients every significant advantage in their battle against breast disease.

NAPBC-accredited centers:

- Demonstrate a commitment to high standards of clinical practice and quality improvement by utilizing nationally recognized, multidisciplinary quality performance measures.
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Join the nationally recognized network of breast centers dedicated to providing quality breast health care with the full scope of resources and services to support the continuum of care.

MAKE A COMMITMENT TO PROVIDE HIGH QUALITY BREAST CARE TO YOUR PATIENTS.

APPLY FOR NAPBC ACCREDITATION TODAY!

To learn about the accreditation process, visit: [www.accreditedbreastcenters.org](http://www.accreditedbreastcenters.org)
Through the collaborative efforts of the ACS Foundation with College leadership and program staff, increased grant support has been secured from the medical industry for the benefit of educational activities. The funding from these industry sources has supported such areas as surgical resident and faculty scholarships, the in-house scholars program, surgical humanitarian outreach, and many other programs. These relationships with medical industry have produced new arenas for cooperation between the surgical provider and the manufacturer and developer. In supporting efforts to cultivate these funding sources, the ACS Foundation Board has been persistent in keeping transparent records, so that government requirements are met.

Each year, through the leadership of the ACS Division of Education and the Corporate and Foundation Relations Committee, the ACS Foundation sponsors a Medical Industry Breakfast during Clinical Congress to explore challenges and opportunities around relationships with industry. During the 2009 Clinical Congress, the topic of the panel discussion during this breakfast meeting was medical industry funding of continuing medical education. The audience heard from representatives from academia, community surgical practice, and the medical device and pharma industries. Audience members included and were limited to Officers and Regents of the College, members of the ACS Foundation board, members of the ACS Ethics Committee and the Committee on Emerging Technology, surgical residency program directors, and representatives from medical industry.

The 2010 Medical Industry Breakfast will be held Tuesday, October 5, in the Walter E. Washington Convention Center in Washington, DC. A panel will continue the discussion on medical industry funding for CME. Facilitated by Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the Division of Education, panel members will include Thomas V. Whalen, MD, FACS, ACS Regent and ACS representative to the Council of Medical Specialty Societies; Terry Chang, MD, JD, director of legal and medical affairs, AdvaMed; and Joanne M. Conroy, MD, chief health care officer, Association of American Medical Colleges.

Dr. Stewart is Chair of the Corporate and Foundation Relations Committee of the ACS Foundation.
Outcomes research course scheduled for November

The American College of Surgeons’ (ACS) Surgical Research Committee is sponsoring the fourth Outcomes Research Course, November 11–13, at the ACS headquarters in Chicago, IL. Although the course is intended primarily for surgeon researchers, its flexible curriculum and interactive format are designed to meet the interests of investigators with varying skills and experiences. Novice participants will learn the key concepts of outcomes research, including how to work with, and interpret, data. Surgeons with previous experience in outcomes research will get direct feedback on their work and practical advice from leaders in the field.

The course emphasizes the core concepts of outcomes research and its practical applications to important questions facing surgeons and surgical practice. New this year are a lecture and skills lab on qualitative research; an optional breakout session on critiquing studies based on clinical registries; and lectures on funding, grantsmanship, and setting up a program. In addition, participants will be exposed to both scientific and functional aspects of the ongoing outcomes research of the faculty.

Participants are urged to make reservations for this popular course as soon as possible, because space is limited and the course is only offered every other year. Preference is given to members of the ACS. Visit http://www.facs.org/cqi/src/outcomesres.html for additional information about the course, a course schedule, course fees, a link for online registration, and an application form. Contact Mary Fitzgerald, Course Liaison, at 312-202-5319, or by e-mail at mfitzgerald@facs.org, for more information.

Future kits: Central Line • Feeding Tubes

The Ostomy Skills Kit supports patients with education and simulation materials to learn and practice the skills needed for optimal postoperative recovery.

Skills kit contains:
• Practice equipment (pouch, scissors, stoma model, measurement guide, surgical marker)
• DVD with skill demonstration
• Skills instruction booklet with images
• Self-assessment checklist
• References for additional support

Professional training guide contains:
• Directions for use
• Evaluation criteria
• Measurement guidelines for documenting quality improvement

For all of your surgical patient education needs, visit www.SurgicalPatientEducation.facs.org

This program is funded by a grant from Coloplast Corp.
American College of Surgeons | Division of Education

The 2010 ACS Clinical Congress offers many valuable educational sessions, but busy attendees can’t be in five places at one time. Webcast sessions allow you to attend the lectures you may otherwise have missed. These Webcasts contain audio synchronized to PowerPoint™ presentations and an opportunity to earn CME credits after successfully completing an online CME examination and evaluation.

2010 WEBCAST PACKAGE
• 2010 Webcast Package includes 25 sessions and access to the Webcast Library consisting of 45 selected sessions from past Clinical Congresses  **Over 120 CME Hours**

Pre-Congress Price: $299 ACS Member/$400 Non-Member
Price onsite at Clinical Congress only: $350 Member/$475 Non-Member

2010 COMPLETE BEST VALUE PACKAGE (Webcast & MP3 Audio Recordings)
• 2010 Webcast Package (see above)
• Complete set of MP3 Audio recordings of Named Lectures and Panel Sessions (Over 100 sessions)

Pre-Congress Price: $374 ACS Member/$500 Non-Member
Price onsite at Clinical Congress only: $450 ACS Member/$610 Non-Member

To REGISTER for the 96th ANNUAL CLINICAL CONGRESS TODAY, visit www.facs.org AND take advantage of THIS SPECIAL PRE-CONGRESS PRICING for these WEBCAST PACKAGES!

For more information, visit www.acs-resource.org or email elearning@facs.org
Preventing violence in health care facilities

A recent Sentinel Event Alert newsletter from The Joint Commission warns that health care facilities today are being confronted with steadily increasing rates of crime. The Joint Commission urges increased attention to the issue of violence in these settings, and urges health care facilities to control access in order to protect patients, staff, and visitors, noting that assault, rape, and homicide are consistently in the top 10 types of serious events reported to The Joint Commission. The newsletter reports that the number of violent incidents is significantly under-reported, and advises organizations to mandate the reporting of all real, or perceived, threats.

To prevent violence in health care facilities, The Joint Commission suggests that facilities follow a series of 13 specific steps, including the following:

- Evaluate the facility’s risk for violence by examining the campus, reviewing crime rates, and surveying employees about their perceptions of risk.
- Take extra security precautions in the emergency room, especially if the facility is in an area with a high crime rate or gang activity. Precautions might include uniformed security guards, scanning people entering the building for weapons, and inspecting bags.
- Conduct thorough background checks of prospective employees and staff.
- Report crime to law enforcement.

In addition to the specific recommendations contained in the Alert, The Joint Commission urges hospitals to comply with the requirements outlined in their accreditation standards to prevent violence. The standards require accredited health care facilities to have a security plan, as well as conduct risk assessments for violence, develop strategies to prevent violence, and create a response plan. The Joint Commission’s standards also clearly state that patients have a right to be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse.

The warning about violence in health care facilities is part of a series of Alerts issued by The Joint Commission. Much of the information and guidance provided in these Alerts is drawn from The Joint Commission’s sentinel event database, one of the nation’s most comprehensive voluntary reporting systems for serious adverse events in health care. The database includes detailed information about adverse events and their underlying causes. For previous issues of Sentinel Event Alert, visit www.jointcommission.org.

Trauma meetings calendar

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

- Advances in Trauma, December 10–11, 2010, Kansas City, MO
- Medical Disaster Response, April 10, 2011, Las Vegas, NV
- Trauma, Critical Care, and Acute Care Surgery 2011, April 11–13, 2011, Las Vegas, NV

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ website at http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312-202-5342.
more on a two-lane road. The super speeder legislation will also increase driver’s license reinstatement fees for drivers committing a second or third offense for violations that result in a suspended license and for other negligent behaviors. The super speeder legislation was viewed as a tremendous success for the trauma care system in Georgia, but Georgia’s trauma system didn’t stop there.

During the 2010 legislative session, the Georgia legislature passed S.R. 277, a resolution that proposed an amendment to the Georgia constitution that would impose an annual $10 trauma charge on certain passenger motor vehicle registrations in the state for the purpose of funding trauma care. Proceeds of the trauma charge would be deposited on a monthly basis into a trauma trust fund. The amendment will be included on the November ballot as a referendum.

Arkansas is another state that has worked hard to implement a trauma system with state funding. In 2009, the state legislature passed a bill (S.B. 315) that increased the excise tax on cigarettes and smokeless tobacco, and it is expected to generate $88 million a year. Some of the money being raised will pay for a trauma center in northwest Arkansas, and $25 million has been earmarked for a statewide trauma system. The package included $25 million for fiscal year 2010, and $28 million for 2011 for a proposed trauma system.

Passing trauma system legislation is difficult under any circumstance; it is especially difficult when the system requests funding. Although difficult, it is not impossible to pass trauma system legislation, as witnessed in Alaska, Georgia, and Arkansas. The American College of Surgeons encourages all states, chapters, and Fellows to continue to pursue funding to ensure the success of the trauma system.

Questions or comments about trauma funding or any other StateSTATs issue may be sent to Alexis Macias, Regional State Affairs Associate, at amacias@facs.org or 312-202-5446.
American College of Surgeons Professional Association (ACSPA)

As of May 14, 2010, the ACSPA-SurgeonsPAC (political action committee) raised $286,009. For the 2009/2010 cycle, and with seven months left in the cycle, the PAC has raised $905,000. ACSPA leaders’ contributions included the following:

- U.S. Regents and Officers: 52 percent made an average contribution of $727, for a total contribution of $10,900
- U.S. Governors: 23 percent made an average contribution of $475, for a total contribution of $23,770

The PAC has contributed to 27 candidates, leadership PACs, and party committees. The ACSPA-SurgeonsPAC has severely limited the amount and quantity of political disbursements in the last half of 2009 and the first half of 2010, because of the uncertainty of health care reform and the fluctuating nature of the sustainable growth rate (SGR). The PAC has been diligent in supporting only those who have been true champions of surgery. As the election season begins in full force, however, a more liberal but judicious disbursement of funds will commence for the remainder of the cycle.

The ACSPA-SurgeonsPAC again had a strong presence at the Joint Surgical Advocacy Conference in July. On Monday, July 26, the ACSPA-SurgeonsPAC, along with several other surgical PACs, hosted a raffle and a fund-raising reception at the John F. Kennedy Center for the Performing Arts.

For the Clinical Congress in Washington, DC, the PAC booth will be upgraded to a PAC “lounge.” Planned PAC activities during the Clinical Congress include hosting a simultaneous VIP PAC event during the regular PAC reception, hosting an event for residents and young Fellows, and hosting a Town Hall meeting.

American College of Surgeons (ACS)

Board of Governors
The Board of Regents received a report from the Board of Governors that outlined Board
initiatives, as well as the work of various Board of Governors’ committees.

This year’s Board of Regents’ and Board of Governors’ joint session will be a follow-up to the new health care reform law that was passed earlier this year. The College’s Division of Advocacy and Health Policy has divided the new 2,500-page law into three areas, and created an action plan. The College will need to start gathering political support around the changes it will propose.

ACS Statements

The Board of Regents approved a Statement on Disparities of Health Care. Drafted by the Committee on Diversity Issues, the Statement will be published in a future edition of the Bulletin and posted on the College’s website.

ACS Health Policy Research Institute (ACS HPRI)

The ACS HPRI is engaged in a variety of projects, including the following: analysis of surgery workforce trends, utilization trends for orthopaedic and pediatric services, costs associated with different treatment options for gallbladder disease, outcomes related to surgical access, the viability of rural surgery, and assessment of capacity for expansion of general surgery residency training. Additionally, the ACS HPRI is engaged in the development of an interactive atlas of the U.S. surgical workforce, and a model for projecting future surgical workforce supply.

Staff members of the ACS HPRI attended the Physician Workforce Conference in Washington, DC, to present and exhibit research. Five oral and three poster presentations were given at the conference. Two booklets (Surgery Atlas and Surgeon Workforce Chartbook) and five factsheets were distributed, along with a brochure inviting applicants for the ACS HPRI fellowships.

ACS National Surgical Quality Improvement Program (ACS NSQIP) Generation Two

Steps are being taken to advance ACS NSQIP to the next level of surgical quality evaluation and improvement. ACS NSQIP Gen Two will continue to be based on:
- Risk-adjusted and case mix-adjusted outcomes
- Clinical data
- 30-day follow-up
- Trained surgical clinical reviewers
- Audited data
- Best practices

Over the years, hospitals have provided valuable feedback on aspects of ACS NSQIP that could be improved. The following areas are where changes will occur, and are a reflection of input from a variety of sources:
- Information technology platform flexibility
- Case collection options
- Data variables—both content and number of variables collected
- Statistical methods (which are advancing in line with the advancing science)
- Data reports
- “Closing the loop” materials (for example, best practices, case studies)

During the previous year, ACS NSQIP replaced the in-person training program with a comprehensive online training program in order to make the initial training of the surgical clinical reviewer (SCR) more convenient and less costly for hospitals. ACS NSQIP has also developed a SCR Certification Program. In addition, ACS NSQIP removed the registered nurse licensure requirement, set minimum requirements for the SCR, and continues to work closely with individual hospitals to identify qualified candidates.

In 2009, ACS NSQIP updated its audit policy to reflect widely accepted audit policies employed by the Internal Revenue Service and other organizations. Additionally, data analytics will be used to monitor all ACS NSQIP sites on a continual basis to identify significant variations over time that may be indicative of a degradation of the data.

The ACS NSQIP national conference took place at the Hyatt Regency Chicago, July 25–27. Peter Pronovost, MD, of Johns Hopkins School of Medicine, the keynote speaker, spoke
on bloodstream infections; his presentation was titled Eliminating BSI: A National Model for Improving the Quality of Care. David B. Hoyt, MD, FACS, ACS Executive Director, spoke on ACS NSQIP’s role in health care reform, quality improvement programs, and the ACS.

International interest in ACS NSQIP continues to rise. Currently, there are two sites outside the U.S. and Canada: Sheikh Khalifa Medical City in Abu Dhabi, United Arab Emirates, and American University of Beirut Medical Center, Beirut, Lebanon. Ongoing discussions continue with hospitals in the Brazil, Columbia, Ethiopia, Germany, Ireland, Italy, Mexico, Nigeria, Saudi Arabia, and United Kingdom.

FDA/ACS Bariatric Surgery Center Network (BSCN)

On behalf of the ACS BSCN, College leadership submitted a proposal to the U.S. Food and Drug Administration’s (FDA) call for proposals for a contract for services to evaluate the safety and effectiveness of laparoscopic adjustable gastric banding and gastric bypass surgery. The study requires a comprehensive analysis of a detailed data registry focusing on these procedures performed at participating bariatric centers. After review of the ACS plan and subsequent conversations with the FDA, the FDA selected the ACS proposal for funding.

ACS development of surgical practice guidelines

The Executive Committee of the Board of Regents has reviewed an informational report on ACS development of surgical practice guidelines. The Executive Committee has considered the question of whether the ACS should be the accrediting agency for graduate medical education in surgery.

Education

Efforts to redesign the Clinical Congress program have continued. The program includes 117 panel presentation sessions that will address a spectrum of topics essential for the safe and effective practice of surgery. One-hundred-forty-two abstracts have been selected for papers presentation, and 328 for scientific posters. Three-hundred-forty-one abstracts were selected for the Forum sessions, and 109 submissions were selected for the video-based education sessions.

The Surgical Education and Self Assessment Program (SESAP) remains a premier self-assessment and education program for practicing surgeons, and is widely used by surgery residents, as well. SESAP offers the opportunity to earn a maximum of 60 Category 1 continuing medical education (CME) credits. SESAP 14 is scheduled for release at the 2010 Clinical Congress, in Washington, DC. The new edition is based on the 15 content categories of the American Board of Surgery (ABS) recertification exam. SESAP 14 is slated to be available in print, on CD-ROM, and as a Web-based product. The new version will be more rigorous and should fulfill the new requirements for Part 2 of Maintenance of Certification as defined by the ABS.

SRGS Connect is a Web-based version of Selected Readings in General Surgery. It offers access to past overviews with searchable content and an annotated list of references with links to PubMed abstracts. SRGS Connect was developed over two years and beta tested at six institutions. It was launched in April, and is currently available for use in residency education. It will be available to practicing surgeons later this year.

A total of 33 plenary sessions from the 2009 Clinical Congress were made available online, along with 58 sessions from previous Clinical Congress meetings. This webcast package offers the opportunity to earn 164.5 Category 1 CME credits. For more information on ACS education activities, visit the Education Web page at: http://www.facs.org/education/index.html.

Advocacy

On March 23, President Barack Obama signed the Patient Protection and Affordable
Care Act (H.R. 3590) into law. The ACS and 18 other surgical organizations expressed opposition to H.R. 3590 in a December 1, 2009, letter. Some of the reasons for opposing H.R. 3590 included the creation of an unaccountable Independent Payment Advisory Board (IPAB), whose Medicare policy recommendations can become law without congressional action; the absence of Medicare payment reform; and the lack of meaningful medical liability reform.

The ACS, along with 23 surgical organizations, sent a February 19 letter to President Obama to reiterate their commitment to support changes to the health care system and to ensure access to care. The letter stressed the importance of addressing several issues, including repealing Medicare’s SGR formula. The letter did express support for measures that promote well-designed and tested quality improvement initiatives, incorporate medical liability reform, address surgical workforce problems, and ensure appropriate Medicaid payment rates. The organizations also expressed opposition to proposals to inject controversial scope-of-practice provisions that could confuse patients about the significant variations in training, education, and expertise between qualified physicians and other health care providers.

In a May 11 letter to all senators and representatives, a coalition of 23 surgical organizations, including the ACS, wrote to express strong opposition to any measure that would freeze Medicare payments to physicians over the next five years. Instead, the letter supported increases in Medicare reimbursement to physicians.

The ACS and the surgical coalition collaborated to survey their memberships to determine what impact the scheduled 21.2 percent payment cut in Medicare payments would have, should it take effect. The ACS and other members of the surgical coalition have used the results to stress the importance of enacting Medicare payment reform that repeal the SGR and increases Medicare payments to account for rising practice and liability costs. The report was released to the public along with a press release, and is featured prominently on the Operation Patient Access website.

At the last meeting of the Board of Regents, a proposal signed by 27 chapters for a chapter advocacy grant program was approved for the 2010–2011 and 2011–2012 fiscal years. The Division of Advocacy and Health Policy staff is creating a Planning a Lobby Day primer, and are finalizing the grant application form. The program was officially rolled out to the chapters at the Chapter Leadership Conference in July, and all chapters will have the opportunity to apply for a grant.

ACS contracted KarenZupko and Associates to provide a series of coding workshops this year. As in previous years, there are two all-day sessions offered back-to-back. Attendance at these workshops has exceeded our target enrollment, and evaluations of the sessions have been positive. Physicians have received CME credits for each workshop completed, and Certified Professional Coders have received continuing education units through the American Academy of Professional Coders. The schedule for the remaining 2010 Coding Workshops includes the following: August 26 and 27, Nashville, TN; November 4 and 5, Chicago, IL.

Journal of the American College of Surgeons (JACS)

The redesigned JACS CME website (http://www.facs.org/jacs/index.html) continues to be popular among Fellows and subscribers. From January 1 through April 30, 21,572 credits were earned and 3,035 individual surgeons participated in the JACS’s CME program.

Submissions to JACS have increased. The number of original scientific articles submitted to JACS in 2010 increased 26 percent over the same time period in 2009.

ACS website and portal

Traffic to the College’s public website continues to grow. Recent projects include the development of an interactive online program
for the 2010 Clinical Congress and an online interactive sample scenario for the Fundamentals of Surgery Curriculum. An online ostomy skills training patient education project is currently being developed.

As of May 13, the members-only ACS Web portal was approaching 2.5 million total page views since its launch in 2006. Some of the latest features include:

- Surgeon distribution PowerPoint slides
- YouTube highlights for rural surgeons
- Surgical lifestyles page
- Social networking for surgeons page

**Healthcareers (Job Bank)**

As of May 14, there were 1,062 active jobs listed on the website, with 361 posted resumes. This is a valuable service for all members of the College, and is complimentary to the Resident Members.

**Resident and Associate Society (RAS)**

The Resident and Associate Society proposed the establishment of a RAS Fan Page on Facebook with the following specific aims:

- To extol the principles of the College and encourage early adoption of the standards of professionalism represented by the Fellowship
- To increase membership in the RAS
- To promote the activities of the RAS and its various committees through both advance notifications and real-time updates of RAS-sponsored events
- To facilitate traffic to the RAS Web portal communities and other portal communities that appeal to our membership base, but are currently unnoticed

**Young Fellows Association (YFA)**

The YFA has been focusing on the following activities:

- Annual Meeting of the YFA Governing Council: Saturday, July 24, Washington, DC
- Leadership Conference for Young Surgeons and Chapter Leaders: July 24–25, Washington, DC
- Participation in several Clinical Congress sessions
- Second annual YFA Meeting: October 4, Washington, DC

**ACS Advisory Councils for the Surgical Specialties**

As of May 12, several of the Advisory Councils had held interim meetings. Standard items for discussion and review included updates from the various divisions of the College.

The Advisory Councils continue to propose educational programming for the Clinical Congress, and formulate programming that would benefit the varied surgical attendance at the annual meeting. Several councils are developing sessions with a multispecialty focus. In addition, several councils have submitted recommendations for Town Hall Meetings and Meet the Expert luncheons.

**Operation Giving Back (OGB)**

There have been two main areas of focus and activity in regard to disaster response, including:

- Ongoing activities and discussions related to collaboration with the Departments of Homeland Security and Health and Human Services
- OGB Haiti response efforts began on the evening of the quake and include the consensus on a Memorandum of Understanding with regard to future ACS involvement in support of the U.S. Navy hospital ships’ response to disasters, and long-term planning for on-going support of Haiti with 18 OGB partner organizations. Support continues as ongoing surgical needs are communicated with those enrolled in the ACS Volunteer Registry.

The 2010 ACS/Pfizer, Inc Surgical Volunteerism and Surgical Humanitarian Award winners have been confirmed (see article on page 36). A strong field of nearly 40 candidates was considered. Official notice of the four winners will be released by the ACS Division of Integrated Communications.

OGB staff continues to meet regularly with ACS Foundation leadership with regard to fundraising activities related to OGB, including ongoing exploration of grant possibilities.
Pfizer, Inc has approved continued financial support for the OGB program and the volunteerism awards for the seventh consecutive year.

**Membership retention and recruitment**
A membership survey is being developed to assess College membership. It has been 10 years since a membership survey was conducted by the College. A planning committee has been formed to oversee this project. The survey instrument will be constructed and the results analyzed by an outside vendor. It is anticipated that this survey can be completed and analyzed prior to October.
Submission of manuscripts
Electronic submission is encouraged; send files via e-mail to sregnier@facs.org. Submissions will be acknowledged and sent to appropriate reviewers.

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

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

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

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

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

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

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


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

**Tables/illustrations**

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

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

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

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

**Galley proofs**

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

Before publication, revised proofs must be returned either as a Word document with any edits indicated using the tracked changes function or as a list of requested changes to the editors. Authors of feature articles will have the opportunity to see a PDF of the article in magazine format that reflects any changes made to the document during the galley stage. After viewing the PDF, authors may only request changes to text that is currently outdated or presents egregious errors; all other edits will be rejected at that time.

**Inquiries**

Inquiries regarding potential articles for consideration, deadlines, the submission of manuscripts, author proofs, or style should be directed to Stephen J. Regnier, Editor, *Bulletin of the American College of Surgeons*; or Linn Meyer, Director, Division of Integrated Communications, via e-mail at sregnier@facs.org or lmeyer@facs.org, or by mail at American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211; 312/202-5331; fax 312/202-5021.

NTDB® data points

Older and thinner

by Richard J. Fantus, MD, FACS

A trait of human nature is that the older one gets, the higher the age one uses to define “elderly.” However, according to the U.S. Department of Health & Human Services Administration on Aging report, A Profile of Older Americans: 2009, the “older population” classifies the elderly as those individuals ages 65 and above.* This segment of the population numbered 38.9 million in 2008, which represents a 4.5 million, or 13 percent, increase since 1998. This increase means that one in every eight (or 12.8 percent of the population) is an older American. Over the next decade, this group will increase 36 percent, to 55 million by 2020.

The good news is that once a person reaches age 65, they have an average life expectancy of another 18.6 years. The 85 and older population is projected to increase 57 percent, from 4.2 million in 2000 to 6.6 million in 2020. This may explain the increasing numbers of records of patients that are 75 and older reported in the last three NTDB Annual Reports. In the 2007 Annual Report, 75 and older represented 12.7 percent of the total number of records. That number increased to 13.04 percent in 2008, and 14.24 percent in the 2009 Annual Report.

Aging takes its toll on the body. Physiologic reserves are not what they were in the earlier decades of life. Along with deteriorating organ function, there is an increase in the number of exogenous pharmaceuticals that are consumed to combat this decline. Included in that drug arsenal are often blood-thinning agents such as warfarin, aspirin, or clopidoogrel. Since trauma patients usually have injuries that have a tendency to bleed, medications with anticoagulant properties are often the enemy of the trauma surgeon. Their use has almost become ubiquitous in this patient population. In fact, it is not uncommon to see some of these pharmaceuticals marketed to the public in television commercials.

In order to examine the occurrence of injuries in patients over 74 years old in the National Trauma Data Bank® research dataset 2008, admissions records were searched for age 75 and greater. A total of 83,879 records matched this age range; 76,596 records had discharge status records, including 22,936 discharged to home, 12,153 discharged to acute care/rehab, and 35,852 sent to nursing homes; 5,675 died. These patients were 64 percent female, on average 83.9 years of age, had an average length of stay of 6.4 days, and an average injury severity score

of 9.8. The major mechanisms of injury categories for these records are listed in the figure on page 59.

There are no guarantees in life, especially when it comes to your own longevity. Enjoy each day and make the most of it. Too often, we take time for granted, and do not do the things that we want to do or say the things that we want to say. However, it is comforting to know that if one makes it to 65, one has an average of another 18-plus years to do or say the things one really wants to. But remember that along with aging comes the inevitable bag of medications, including anticoagulants, and that we are not only older, but our blood is thinner.

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

Acknowledgment

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

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