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ACS partners with Johns Hopkins to reduce SSIs and improve outcomes

Dr. Sheldon receives prestigious UNC award

ACS HPRI publishes update of U.S. Atlas of the Surgical Workforce

Dr. Britt receives honorary degree from Tuskegee University

Dr. Ford receives humanism in medicine award

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Report of the 2011 ACS Traveling Fellow to Germany

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Library of Congress number 45-49454. Published in the USA. Publications Agreement No. 1564382.

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.
Since its founding, the American College of Surgeons (ACS) has been committed to working with all surgical organizations to ensure that patients throughout the world have access to high-quality surgical care. Hence, the ACS leadership was honored to receive and accept an invitation to cosponsor the 36th Annual Scientific Meeting of the Royal College of Surgeons of Thailand (RCST), the theme of which was International Collaboration in Surgery.

Spearheading the effort to make this meeting a joint presentation of the RCST and the ACS possible was Lt. Gen. Nopadol Wora-Urai, MD, FACS, FRCST, President of the RCST, and the leadership of the Nora Institute of Surgical Patient Safety of the ACS. Paul F. Nora, MD, FACS, for whom the institute is named, was Dr. Wora-Urai’s mentor and chief of surgery during his residency training in the U.S.

The conference took place July 14–17 in the seaside city of Pattaya, Thailand. ACS leaders who participated in the meeting with me are as follows: L.D. Britt, MD, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), then-President of the ACS; A. Brent Eastman, MD, FACS, Past-Chair of the Board of Regents and ACS President-Elect; LaMar S. McGinnis, Jr., MD, FACS, Past-President; and Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), then-Chair of the Board of Regents.

A vibrant nation
In addition to leading sessions on surgical care, ACS Fellows who participated in the program had the opportunity to meet with Thailand’s royal family, to tour parts of this exotic country, and to interact with our surgical colleagues from Asia, Europe, North America, South Africa, and the United Kingdom.
This year’s meeting of the RCST was unique in that the Kingdom of Thailand has been engaged in a year-round celebration of His Majesty the King Bhumibol Adulyadej’s seventh cycle (84th) birthday. His daughter, Her Royal Highness Princess Maha Chakri Sirindhorn, presided over the congress’ opening ceremony. We were extremely honored to have an audience with the princess and to offer a pillar inscribed to her father as a gift of friendship. This pillar recognizes the king’s leadership as the first U.S.-born monarch of Thailand and his lifelong contributions to humanity through the advancement of surgical care for the people of Thailand and its neighboring countries.

Before the meeting and throughout our stay,
Drs. Britt, Eastman, McGinnis, Pellegrini, and I had the chance to explore Thailand’s tropical wonders. We flew into and spent some time in Bangkok with its plethora of shops, businesses, and restaurants. We then traveled to Pattaya, which is nestled in a bay on the east coast of the Gulf of Thailand and is a popular vacation destination due to its scenic ocean views and diverse cultural attractions.

Exciting educational program
Each member of the ACS leadership team spoke at several sessions during the meeting. Drs. Britt, Eastman, and I spoke on a variety of issues in trauma and critical care. Dr. Britt also participated in a plenary lecture on surgical training, focusing his comments largely on American Board of Surgery requirements, and delivered the ACS Presidential Address. Dr. Eastman spoke on the surgeon’s role during natural disasters. Dr. Pellegrini gave presentations on surgical education and training, patient...
safety, and quality of care issues. He also talked about minimally invasive techniques in general surgery and delivered the Nora Lecture. Dr. McGinnis shared his knowledge about cancer surgery.

Many other ACS Fellows also participated in the conference, including the following (all of whom are MD, FACS): Anthony J. Comerota, Ralph J. Damiano, Max Downham, Steven Hadley, Stanley D. Herrell, Russell Jennings, Christopher M. Loftus, Frederick A. Moore, Monica Morrow, Bart E. Muhs,
Oscar Ramirez, Norman Rich, Richard D. Schulick, Julia Terzis, Frank J. Veith, and Bruce G. Wolff.

The general sessions presented at this meeting were relevant to surgeons from every nation, focusing on such universal issues as surgical education and training, patient safety, research, ethics, and medico-legal concerns. In addition, the program comprised forums targeted at specific categories of surgeons in practice or training, including academic surgeons, young surgeons, surgical leaders, surgical residents, and medical students. Sessions centered on the surgical specialties provided opportunities for attendees to develop leading-edge skills, techniques, and knowledge that could be readily transferred to their practices and institutions. Along with panel discussions and hands-on training courses, the program featured awards for audiovisual presentations, paper competitions, and poster contests.

**Future opportunities for collaboration**

The people of Thailand and the RCST leadership couldn’t have been more welcoming or more hospitable. The ACS surgeons who participated in this meeting were gratified to make many personal and professional connections that will last a lifetime.

We were deeply honored to meet with the royal family, to visit this beautiful country, and to interact with the surgeons of Thailand. We believe this type of collaboration and sharing of our experiences and knowledge will be of great value to the profession as the ACS strives to improve the care of surgical patients not only in the U.S, but in every part of the world as well.

*David B. Hoyt, MD, FACS*

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
The Centers for Medicare & Medicaid Services (CMS) released the proposed Medicare physician fee schedule for calendar year (CY) 2012 on July 1, 2011, and the final Medicare physician fee schedule (MPFS) for CY 2012 on November 1, 2011. The MPFS lists payment rates for Medicare Part B services, which CMS updates annually. In addition to providing this listing, the proposed rule addresses other policies related to physician reimbursement as well.

The American College of Surgeons (ACS) submitted comments on this proposed rule to CMS on August 30, 2011. Most of the provisions finalized in the fee schedule will become effective January 1, 2012. This article discusses some of the key issues proposed in the CY 2012 fee schedule and describes the ACS’ comments on these issues.

What is the 2012 conversion factor update?

Under the final Medicare physician fee schedule for CY 2012, without a congressional change in the controversial sustainable growth rate (SGR) formula, payments to physicians will be reduced by 27.4 percent for services in CY 2012, which is less than the 29.5 percent reduction that CMS had originally estimated in the proposed rule. The current political climate in Washington, DC, differs from previous years, and a cut in reimbursement for physicians is a real possibility. The CY 2011 conversion factor, which is effective through December 2011, is $33.9764. Application of the SGR and the resultant 27.4 percent cut will yield a CY 2012 conversion factor of $24.6712. Even if Congress intervenes and blocks the SGR-related reduction to the conversion factor, other updates present in the fee schedule rule will result in a CY 2012 conversion factor that differs from the CY 2011 conversion factor.

On June 27, the ACS and 112 other national and state medical and surgical organizations sent a letter to President Barack Obama, the Vice-President, the Speaker of the House of Representatives, the Senate and House Majority and Minority Leaders, and other key members of Congress, requesting that a permanent fix to the SGR be included in legislation to reduce the deficit and raise the debt ceiling. On August 2, President Obama signed the Budget Control Act of 2011 (BCA), S. 365, which is designed to raise the debt ceiling and to reduce the deficit. None of the provisions in the BCA addressed the SGR, but the legislation did create a Joint Select Committee on Deficit Reduction, also known as the “supercommittee,” which is tasked with cutting $1.2 trillion to $1.5 trillion in federal spending over the next 10 years. It is possible that the Joint Select Committee’s recommendations will include reductions in physician and other payments under Medicare and other federal health programs. While the Joint Select Committee on Deficit Reduction is required to make a recommendation to Congress on a deficit reduction plan by November 23, it is unlikely that Congress will act on the recommendation before late December.

However, even if Congress were to agree on a measure to prevent the pending 27.4 percent cut in Medicare payments in January, physicians and other providers could still face some form of Medicare payment cuts next year. If the Joint Select Committee on Deficit Reduction fails to agree on a debt reduction proposal, or if the proposal fails to pass Congress, the BCA calls for automatic cuts across the federal government totaling $1.2 trillion over 10 years, including up to a 2 percent reduction in Medicare physician payments beginning in 2013. On September 1, the ACS sent letters to the 12 members of the Joint Select Committee on Deficit Reduction advocating for the elimination of the SGR and offering the College’s proven quality programs as models of how Congress can reduce costs, prevent complications, and improve quality.

Although the ACS continues to aggressively advocate for Congress to permanently fix the broken Medicare physician payment system in an appropriate manner, it is not a safe assumption that all cuts to physician reimbursement will be stopped before January 1, 2012.
Many changes in the fee schedule are based on the work of the American Medical Association Relative Value Scale Update Committee (AMA RUC). What did CMS propose regarding potentially misvalued services under the MPFS?

CMS developed two lists of potentially misvalued codes that it proposed to refer to the AMA RUC for review: a list of 70 high-expenditure codes and a list of 91 evaluation and management (E/M) codes.

CMS identified the 70 high-expenditure codes as potentially misvalued based on the fact that these codes have not been reviewed for at least six years and that they account for some of the more costly procedures that Medicare covers. Three of these codes are for operations that general surgeons perform: codes 47563, Laparoscopy, surgical; cholecystectomy with cholangiography; 47562, Laparoscopy, surgical; cholecystectomy; and 49505, Repair initial inguinal hernia, age 5 years or older; reducible. The ACS commented that code 47563 may have been mistakenly included in the list of high-expenditure codes for review because it was just reviewed in 2010. Regarding codes 47562 and 49505, the ACS noted that these were reviewed at the CMS’ request in 2005 as potentially misvalued codes. Subsequent to that review, CMS determined that the current work relative value units were correct. In summary, because all three codes have been reviewed multiple times over 20 years and have been identified as potentially misvalued, because they have recently been reviewed at the request of CMS, and because the work involved in performing these services has not changed in the past five years, the ACS requested that CMS remove these three codes from the list of codes to be referred to the AMA RUC for another review. CMS finalized the proposed high expenditure/high volume list without modification.

CMS proposed that the AMA RUC review the 91 E/M codes because most E/M services have not been reviewed since CY 2006. CMS further maintains that the AMA review is necessary because, since 2005, the focus of primary care has evolved from an episodic treatment-based orientation to a comprehensive patient-centered care management focus in an attempt to prevent and manage chronic disease. CMS believes this shift in focus warrants the re-examination of the values of E/M codes. In response, the ACS comment letter requested that CMS reconsider its proposal for review of all E/M codes because the ACS believes these E/M codes are valued appropriately for the work described. The ACS agrees that Medicare patients with chronic diseases would be well-served by having a health care professional assist with managing their care, but these services would be better described by new codes, and not the current E/M codes. The current E/M codes, as written, do not correspond to the work associated with patient-centered care management. Additionally, the ACS believes that the new codes should bundle services and include a global period, because just as a surgical patient requires global care, the medical patient with chronic diseases also requires global care. A successful example of payment for chronic disease management using a global period is the family of end-stage renal disease codes, which have a global period of 30 days. CMS agrees with these comments and is not finalizing the proposal to review the list of 91 E/M codes at this time.

What changes did CMS propose regarding the Physician Quality Reporting System (PQRS)?

The PQRS is a quality reporting program that provides incentive payments and payment adjustments to eligible professionals who satisfactorily report data on quality measures for covered services furnished during a specified reporting period. CMS proposes several updates and revisions to the PQRS program, one of which includes a clarification of the “more frequently” requirement related to the PQRS Maintenance of Certification (MOC) program incentive set forth in the 2011 fee schedule. Currently, an eligible professional must meet all the elements of an MOC program more frequently than is required in order to qualify for an additional 0.5 percent PQRS incentive payment. Under the CMS proposal, however, an eligible professional would only be required to meet at least one element of an MOC program “more frequently” than is required.

In its comments, the ACS supported this CMS proposal, which would allow eligible professionals more flexibility in meeting this standard. The proposal would also allow the medical specialty boards to determine what qualifies as “more frequent” participation for a specific program element for their physicians, which would afford greater deference to the specialty boards. Because different specialties have distinctive certification requirements, the ACS believes that each specialty board should be able to determine whether...
the “more frequently” requirement has been met for their physicians, and the ACS encouraged CMS to avoid making any uniform prescriptive requirements across specialty boards.

The ACS also agreed with CMS’ view that the “more frequently” requirement should not apply to the MOC provision that physicians should maintain a valid and unrestricted license because it is impossible for a physician to maintain a valid unrestricted license “more frequently.” Also, current MOC requirements for most specialty boards mandate secure examination every 10 years. Although some boards require examinations more frequently, it is still over the course of several years, and applying the “more frequently than is required” standard in the context of an annual payment update does not make sense when applied to the secure examination element. In the final rule, CMS decided to allow the medical specialty boards to determine what qualifies as “more frequent” participation for a specific program element for their physicians.

What changes did CMS propose regarding the Electronic Prescribing Incentive Program?

The Electronic Prescribing (eRx) Incentive Program provides a combination of incentive payments and payment adjustments through 2014 to eligible professionals who are successful electronic prescribers. CMS proposes several changes to the eRx Incentive Program. The ACS comment letter specifically addresses CMS proposals for new six-month reporting periods and new hardship exception categories.

To qualify for the eRx incentive for years 2012 and 2013, CMS proposed that the reporting period be for the entirety of those calendar years. For the 2013 and 2014 eRx payment adjustments (also referred to as penalties), CMS proposed two different reporting periods to maximize the opportunities for participants to avoid the adjustment. For purposes of determining the 2013 eRx payment adjustment, in addition to the 12-month reporting period between January 1 and December 31, 2011, CMS proposed an additional six-month reporting period between January 1 and June 30, 2012. For the 2014 eRx payment adjustment, in addition to the 12-month reporting period between January 1 and December 31, 2012, CMS proposed an additional six-month reporting option between January 1 and June 30, 2013. Hence, an eligible professional can avoid the payment adjustment if, on at least 10 occasions during the six-month payment adjustment reporting period, at least one prescription per Medicare Part B patient that was created during a visit with that patient was generated and transmitted electronically using a qualified e-prescribing system.

Unlike the reporting criteria for the incentive payments, under which the numerator must be reported in connection with a denominator-eligible visit, for purposes of the six-month reporting period for 2013 and 2014 payment adjustments, CMS proposed that an eligible professional would be able to report the measure’s numerator for any Medicare Part B physician fee schedule service provided during those six months, regardless of whether the code for the service appears in the denominator.

The ACS supported CMS’ proposal to include an additional six-month reporting period to avoid the payment adjustment for years 2013 and 2014. The ACS also backed CMS’ proposal to no longer require that the electronic prescription be associated with one of the denominator codes for the six-month reporting period and encouraged CMS to apply this policy to the 12-month reporting period as well.

CMS also proposed to retain the following significant hardship exemptions for the 2013 and 2014 payment adjustments: (1) inability to electronically prescribe due to local, state, or federal law or regulation; and (2) production of fewer than 100 prescriptions during a six-month payment adjustment reporting period. The ACS supported both of these hardship exemption categories.

CMS finalized the proposal to add a six-month reporting window to avoid the payment adjustment for years 2013 and 2014, under which electronic prescriptions do not have to be associated with one of the denominator codes.

What comments did the ACS make to CMS regarding the Physician Feedback Program and the implementation of the value-based payment modifier?

The purpose of the physician feedback program is to provide physicians with confidential reports that measure the resources involved in furnishing care to Medicare beneficiaries. CMS plans to examine alternative attribution methods that would allow more Medicare beneficiaries to be matched to physicians for purposes of assessing the quality of care furnished and the associated resources.

The ACS reiterated comments from previous years
that any attribution methodologies used for the physician feedback reports must be transparent. The ACS also recommended that the entire algorithm used to generate the reports be in the public domain, along with clear plans for evaluating the impact of the reports. The ACS also stressed the necessity of risk adjustment, including a patient’s socioeconomic status and comorbidities.

CMS also plans to work to identify quality measures appropriate to the practices of specialists who perform surgical procedures or interventions, especially high-volume and/or high-cost services. The PQRS and claims-based measures that CMS proposes to use for Phase III of the physician feedback reports are generally not measures used for measuring surgical care. The ACS comment letter listed the following five surgery-related outcomes-based quality measures that CMS might consider including in the physician feedback program:

- A risk-adjusted vascular surgery lower extremity bypass measure
- A risk- and procedure mix-adjusted surgical site infection measure
- A risk- and procedure mix-adjusted urinary tract infection measure
- A colon resection outcomes measure
- A risk- and procedure mix-adjusted elderly surgery measure, which evaluates the outcomes of all procedures performed in a facility for persons 65 years and older

The ACS National Surgical Quality Improvement Program (ACS NSQIP®) staff collaborated with CMS to develop these measures. The ACS supports measures such as these five and other ACS NSQIP outcomes measures because they have greater clinical validity and are proven measures for evaluation and improvement of surgery quality.

CMS also indicated that it is moving forward with the development of the Medicare-specific episode grouper. The ACS comment letter urged CMS to be more transparent regarding the development of the Medicare-specific episode grouper by sharing relevant information with stakeholders via open door forums, town hall meetings, and/or listening sessions, rather than only through notice and comment rulemaking. This episode grouper, once implemented, will affect quality measurement and reimbursement for all physicians, so it is important that stakeholders are kept abreast of its progress.

In the final rule, CMS expresses its appreciation for specialty societies’ interest in working to develop measures that are more relevant to the practice of specialists.

The value-based payment modifier is under development as the result of a provision in the Affordable Care Act, which requires that CMS establish a payment modifier that accounts for differential payment to physicians under the physician fee schedule to reflect “value.” CMS proposed a list of quality measures to be used in the implementation of the value-based payment modifier starting in 2015. Similar to the measures proposed for the physician feedback program, the measures proposed for use with the value-based payment modifier are not used for measuring surgical care. The ACS comment letter recommended that CMS consider the inclusion of the aforementioned surgery measures developed by the ACS NSQIP, and offered to work with CMS to develop a list of appropriate measures for use in the application of the value-based payment modifier to surgery.

CMS also anticipates using physician feedback reports in future years as the testing basis for developing and implementing the value-based payment modifier. The ACS comment letter expressed concern about the proposal to link the value-based payment modifier and the physician feedback program without additional analysis of these programs. The value-based payment modifier is still in its infancy, and it is unclear at this stage how it will be implemented, especially in light of the hurdles associated with attributing care to a single physician and the effects of delivering complex care involving teams of physicians. The physician feedback program itself has not been adequately tested, and relatively few physicians received feedback reports during phases I and II. Perhaps at some later date it would make sense to link the two programs together, but until more is known about each, the ACS has strong concerns about CMS’ proposal to use the physician feedback reports as a foundation for implementing the value-based payment modifier.

In the final rule, CMS indicates that it plans to reach out to stakeholders to develop specialty measures for the physician value-based modifier. CMS also acknowledges concerns expressed about the implementation of the value-based modifier and will take issues related to risk adjustment into consideration as CMS develops the value-based payment modifier.
What policy changes did CMS propose regarding bundling of payments for services provided to outpatients who later are admitted as inpatients?

CMS proposed that, starting January 1, 2012, when a physician furnishes services to a Medicare beneficiary in a hospital’s wholly owned or wholly operated physician practice and the beneficiary is subsequently admitted as an inpatient to the parent hospital within three days, the “three-day payment window” policy will apply. Consequently, all diagnostic services furnished in the three days before admission and any nondiagnostic services that are clinically related to the reason for the patient’s inpatient admission would be paid at the facility rate, or the physician would be paid only the professional component if the service has a technical component/professional component split.

The ACS comment letter agreed with CMS that it is reasonable to apply this policy to wholly owned physician practices, but expressed concern about the application of the policy to practices that are only wholly operated by a hospital. This policy assumes that physician practice losses can be transferred to the hospital. However, in some instances, a practice may be wholly operated but not wholly owned by a hospital and, therefore, financially separate and distinct from the hospital, so the hospital would not absorb the costs. Thus, application of this policy to these types of practices would be inappropriate.

In addition, the ACS comment letter requested that CMS identify the physician practices that would be affected by this provision and make this information available to those practices. Physician practices must have the opportunity to review and validate whether they are wholly owned or operated according to CMS data, prior to implementation of the payment adjustments.

The ACS comment letter also requested that CMS delay the implementation of this provision for one year, to begin on January 1, 2013. The College furthermore questioned whether hospitals have the necessary systems in place to identify whether a beneficiary was seen at a physician’s office prior to admission as an inpatient and to communicate that information to the physician practice. A reliable system is critical as physicians who do not receive information from the hospital that their services fall into the three-day payment window could inadvertently overbill for those services.

The ACS comment letter also indicated that a delay in implementation is necessary to afford CMS time to clarify the meaning of “clinically related” as it applies to this proposal. CMS states that an exact International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis code match for the outpatient encounter and the inpatient stay is no longer required, but the comment letter requests further guidance on how the term clinically related will now be interpreted. A longer delay might be necessary if CMS does not clearly define the term clinically related, which is central to this policy, in time for a January 1, 2013, implementation date.

CMS has finalized its proposal that when a physician furnishes services to a beneficiary in a hospital’s wholly owned or wholly operated physician practice and the beneficiary is admitted as an inpatient within three days, the payment window will apply to all diagnostic services furnished. The payment window also applies to any nondiagnostic services that are clinically related to the reason for the patient’s inpatient admission regardless of whether the reported inpatient and outpatient ICD-9-CM diagnosis codes are the same.

At press time, the final rule had not yet been published in the Federal Register. After November 28, the final rule will be accessible at http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR.
This has been a busy and exciting year for the American College of Surgeons (ACS), and our Board of Regents, Officers, Board of Governors, volunteers, and staff are to be commended for their roles in developing and launching several important new initiatives.

For example, all of these groups and individuals made significant contributions toward bringing the Inspiring Quality: Highest Standards, Better Outcomes campaign to fruition in the spring. The College's leadership believes that this program not only promotes the ACS' reputation for raising the standards of surgical practice, but will also be useful in shaping the value-based health care delivery of the future.

Internally, the College initiated the GE Healthcare Organizational Initiative, also known as the Culture-Driven Performance Improvement Project. Objectives of this program include the following: accelerate efforts to position Inspiring Quality as the organization's core value; foster a culture of continuous improvement; bind executive leadership and staff with a common language and connected purpose; and integrate proven business models and processes.

Advocacy and Health Policy

Health care reform and, specifically, health care costs were the major focus of discussion in Washington this past year. The College's leadership and the staff of the Division of Advocacy and Health Policy worked tirelessly to ensure that four key issues—quality, physician payment, medical liability reform, and workforce shortages—were appropriately addressed at both the legislative and regulatory levels.

To enhance these efforts, Don E. Detmer, MD, FACS, joined the College's staff this year to serve as Medical Director of the Division of Advocacy and Health Policy. We believe that Dr. Detmer's extensive knowledge of health policy issues will help us to more effectively advocate for the ACS Fellowship. In addition, Frank Opelka, MD, FACS, serves as Associate Medical Director of the Division, focusing on quality efforts.

As you know, the federal government has begun implementation of the Affordable Care Act (ACA). The College is working to ensure that these measures are implemented in ways that will best serve the interests of surgeons and our patients. The bonus payment for rural general surgeons, which was established under the ACA, is one example of a program that we believe is being implemented inappropriately. The ACS has met with staff of the Health Resources and Services Administration to discuss flaws in the program's implementation and continues to work with agency staff to fix these problems.

The College also has sought to communicate to legislators how ACS quality improvement programs may lead to reduced costs and better patient care. To this end, in May, several of us traveled to Washington, DC, as part of the Inspiring Quality campaign. Surgeon participants in this event included Dr. Detmer, Dr. Opelka, me, and the following:
We delivered our key messages to 17 congressional offices. We also held two events centered on the Inspiring Quality program, one at the ACS headquarters in Chicago, which Sen. Mark Kirk (R-IL) attended, and one at Johns Hopkins University in Baltimore, MD, which Sen. Ben Cardin (D-MD) attended.

Surgeons continue to express their concerns about the Medicare physician payment system. The College ensured that their views were heard on Capitol Hill through a number of actions, including the following:

- Testifying before the House Energy and Commerce Committee about the need to fix the payment formula, particularly the problems stemming from the use of the sustainable growth rate.
- Leading a group of 47 physician organizations in sending a letter to House Speaker John Boehner (R-OH) on April 6 expressing our concerns about comments made at a Ways and Means Health Subcommittee hearing in March on the Medicare Payment Advisory Commission’s Report to Congress: Medicare Payment Policy. Some Subcommittee members at that hearing questioned the value and appropriateness of input from the American Medical Association’s Relative Value Update Committee (AMA RUC).
- Developing alternative payment models, including bundling.

In other payment-related activities, the College’s representatives to the AMA RUC met with Centers for Medicare & Medicaid Services (CMS) officials in July to discuss the results of the fourth five-year review. This meeting was quite productive, and we anticipate it will lead to some important changes in the payment system.

ACS congressional affairs staff worked on many other projects and issues this year. For example, they arranged for representatives of the College to testify in May before the Health Information Technology Policy Committee’s Meaningful Use Workgroup about issues related to the use of electronic health records. Furthermore, the ACS helped to present the fourth Joint Surgical Advocacy Conference (JSAC) in Washington, DC. More than 250 surgeons attended the conference, which took place in March, and participated in important visits on Capitol Hill. This JSAC was the last one that will include the College’s participation. Beginning in 2012, the College will present an ACS Advocacy Summit, and details regarding that program are currently being disseminated.

The College’s regulatory affairs staff has been active this year as well. They have been in regular communication with CMS, and have developed extensive comments on proposed rules pertaining to the following:

- The Medicare physician fee schedule
- The outpatient prospective payment system
- The five-year review of the fee schedule
- E-prescribing (eRx)
- The Health Information Portability and Accountability Act
- Medicare claims data proposed rule

Most recently, the ACS regulatory affairs staff worked with CMS to resolve issues pertaining to implementation of an eRx payment penalty in 2012. The ACS persuaded CMS to include in the final rule additional hardship exemptions, which address many of the problems surgeons might experience in their efforts to comply with the rule.

It is important to note that the Division of Advocacy and Health Policy has encouraged surgeons to be more engaged in the political process and to develop stronger ties to their elected officials. As an example of how Fellows have responded, Sen. Mike Crapo (R-ID) visited an ambulatory surgery center in Idaho at the invitation of Mark Savarise, MD, FACS. Additionally, Sen. Orrin Hatch’s (R-UT) staff met with surgeons at the University of Utah, Salt Lake City, who are implementing quality programs led by the ACS.

Lastly, I’m pleased to report that the Regents have approved the formation of the Health Policy and Advocacy Council (HPAC) to lead the College’s grassroots advocacy efforts.

**Research and Optimal Patient Care**

As we continue to inspire quality, another very important area within the ACS is the Division of Research and Optimal Patient Care. The division is responsible for the ACS National Surgical Quality Improvement
ACS NSQIP
More than 400 hospitals participate in ACS NSQIP, and approximately 900 health care professionals participated in the program’s annual conference this year. ACS NSQIP continues to partner with other stakeholders in the quality movement, including The Joint Commission, the Institute for Healthcare Improvement, CMS, and the Centers for Disease Control and Prevention.

Significantly, ACS NSQIP has finalized a public reporting contract with CMS. Under this agreement, surgeons will be able to voluntarily use ACS NSQIP outcomes data to demonstrate their ability to provide value-based services. ACS NSQIP also has contracted with CMS to develop data standards and to examine registry data quality.

ACS NSQIP is also in the process of updating performance measures derived from the database for the National Quality Forum’s (NQF’s) use. Furthermore, we have completed our efforts with the Centers for Disease Control and Prevention to harmonize ACS NSQIP surgical site infection (SSI) performance measures, and have submitted the findings to NQF. We also have secured funding from the U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) to work with the Johns Hopkins Armstrong Institute for Patient Safety and Quality, Baltimore, MD, to study the effects of a surgical unit-based safety program on reducing SSI and other complications (see related story, page 53).

Other updates on ACS NSQIP are as follows:
• We are submitting a formal proposal to the Hartford Foundation to work with the Institute for Healthcare Improvement on geriatric surgery quality of care.
• A new 22-hospital ACS NSQIP collaborative has been established in British Columbia, Canada, with more institutions slated to join in the coming year.
• More than 100 peer-reviewed articles using ACS NSQIP data have been published since 2010.

Commission on Cancer
As always, the Commission on Cancer (CoC) had a full schedule this year, in which they surveyed a total of 484 cancer centers. Currently, the CoC accredits 1,507 cancer programs. A total of 90 centers surveyed in 2010 were accorded the CoC’s Outstanding Achievement Award.

On August 31, the CoC issued a press release announcing its new standards for accreditation. Cancer Program Standards 2012: Ensuring Patient-Centered Care is the culmination of more than two years of work by a group of dedicated individuals. These standards, scheduled for implementation in 2012, ensure that key elements of quality cancer care are provided to oncology patients treated in CoC-accredited facilities.

In addition, open enrollment in the CoC’s Rapid Quality Reporting System for accredited facilities began September 19. This online system allows for immediate data entry and performance tracking of compliance with breast and colon-rectal quality of care measures.

Other highlights for the CoC are as follows:
• Workgroups were formed to address the development of disease-specific quality of cancer care measures.
• The National Cancer Data Base Cancer Program Profile Reports, which include NQF-endorsed quality improvement measures, were expanded to include three additional breast measures.
• The CoC Clinical Scholar-in-Residence, Richelle Williams, MD, initiated more than a dozen research projects and received the Society of Surgical Oncology’s Resident Essay Award for best clinical research paper.
• Data collection began for the ProvenCare® Lung Cancer Collaborative.

Another cancer program, the National Accreditation Program for Breast Centers (NAPBC), recently underwent a change in leadership. Cary Kaufman, MD, FACS, a breast surgeon from Bellingham, WA, replaced David Winchester, MD, FACS, as Chair in October 2010. Currently, the NAPBC accredits 350 breast centers in 47 states, and an additional 167 centers are in the accreditation process and scheduled for survey next year.

The American Joint Committee on Cancer (AJCC) held a leadership retreat for the purposes of addressing the challenges and opportunities facing the AJCC as it prepares for a future in which molecular medicine will be the dominant theme in cancer care. The AJCC also hosted a Surveillance Summit in April, which brought together the clinical and surveillance communities to learn about the
evolution of staging data and how each community uses the data, and also began production on the *Cancer Staging Atlas, Second Edition*.

**Trauma**

Among its many activities, the Committee on Trauma (COT) is responsible for the Advanced Trauma Life Support® (ATLS®) program. In 2011, the ATLS expanded its outreach to include the Middle East, and presented programs in Syria, Oman, and Egypt. Other ATLS-related accomplishments are as follows:

- Finalized copy for the ninth edition of the course book, and is developing the e-learning project so that it is on target for release in 2012
- Enhanced the ATLS reporting program so that it accommodates the Rural Trauma Team Development Course® and Disaster Management and Early Preparedness (DMEP) course reports
- Presented 1,842 courses since last October, with 29,472 trained

Other COT educational programs also made advances this year, and they are as follows:

- More than 5,000 copies of the third edition of the *Trauma Evaluation and Management* manual have been purchased, and an e-version is currently in production.
- The DMEP e-course is nearly ready to start production, and more than 600 students have been trained in 29 live courses.
- The *Advanced Surgical Skills for Exposure in Trauma* DVD has been finalized, and 32 courses have been held in the U.S. and Canada since last October, with more than 300 students trained in these courses.
- The second edition of *Advanced Trauma Operative Management* (ATOM) course materials has been well-received, and 202 courses have been held in 10 countries since October 2010, with more than 800 students trained.
- The Rural Trauma Team Development Course (RTTDC) course has been presented 102 times since last October, with 2,040 students trained in the course.
- The COT sponsored 11 educational sessions at this year’s Clinical Congress, in October, in San Francisco, CA.

In terms of its quality improvement activities, the COT completed consultations for the Navajo Nation in October 2010 and in the following locations in 2011: Arkansas; Wisconsin; Nevada; and Washington, DC.

The COT also is involved in a systems benchmarking project. The goal of this effort is to develop trauma system metrics, and thus far, six states have been invited to participate in the pilot project.

In addition, the COT successfully completed the first year of an Emergency Medical Services for Children Targeted Issues Grant as a subcontractor to Wake Forest University, Winston-Salem, NC, to study the effects of a pediatric emergency care recognition program on the care of injured children. Presently, 14 sites have been recruited to participate in the program. Institutional review board applications have been completed or are in process at all sites, and a database has been developed and beta tested.

With regard to the trauma center verification programs, the COT verified the Landstuhl (Germany) Regional Medical Center as a Level I Trauma Center in June. Landstuhl is the first overseas trauma center the COT has certified and is the only U.S. Department of Defense military hospital that has ACS approval. In addition, the COT verified a total of 345 trauma centers and has 145 site visits on its schedule.

Presently, 113 trauma centers are participating in the COT’s Trauma Quality Improvement Program. This program has released reports on traumatic brain injury and shock, with web conferences during which results are presented and discussed.

And lastly, this past spring, the COT participated in A Day on the Hill, in Washington, DC, which was organized by the ACS Division of Advocacy and Health Policy staff.

**BSCN**

More than 130 facilities now participate in the BSCN. The first report from the program was presented at the 2011 annual meeting of the American Surgical Association. The report compares the safety and effectiveness of laparoscopic sleeve gastrectomy with gastric band procedures. This paper was very well-received. Presently, the BSCN is studying how standards, the appropriate infrastructure, verification, and outcomes data affect the quality of bariatric care.

**Education**

The ACS Division of Education has continued to make strides in developing, launching, and evaluating innovative education and training programs. In
particular this year, important changes that were established in 2010 continue to be incorporated into the Clinical Congress program, such as the development of specialty tracks.

In addition, the division developed an electronic version of the 2011 program book, which meeting participants could access via their smartphones, tablets, and e-readers. Sessions from the past few Clinical Congresses also are available via webcast.

Another education program, the Surgical Education and Self-Assessment Program™ (SESAP™), continues to set the standard for self-assessment and cognitive skills development among practicing surgeons. The evidence-based content of SESAP 14, which was released in October 2010, addresses the core competencies of knowledge and patient care, as well as other core competencies. The program is available in a variety of formats that are specially designed to address different learning needs. SESAP 14 offers the opportunity to earn a maximum of 70 Category 1 continuing medical education credits—10 more credits than in previous editions.

The Division of Education also was responsible for presenting the ACS Comprehensive General Surgery Review Course, which is designed to enhance cognitive knowledge in broad areas of general surgery and to support preparation for the General Surgery Recertification Exam. A combination of didactic and case-based formats was used to create an efficient review course and to enhance comprehension and retention of the material. The course was offered twice in 2011 to accommodate the significant demand, and a total of 368 attendees participated in the courses. The program seems to be accomplishing the established objective, as enrollees’ post-test scores were 32 percent higher than their pre-test scores.

To meet the needs of different learners and to improve access, online versions of Selected Readings in General Surgery (SRGS) have been introduced. These include SRGS Connect Resident, SRGS Connect Practicing Surgeon, and SRGS Connect Premium. SRGS has more than 2,500 subscribers.

The educational programs highlighted in this annual report up to this point are intended mostly for practicing surgeons; however, many ACS programs are targeted at surgical residents and medical students. For example, the ACS Fundamentals of Surgery Curriculum is an online program that focuses on cognitive skills and is primarily designed to address the educational needs of surgery residents in the early years of training. This program involves an interactive format, and learners receive specific, individualized feedback on their choice of answers. The 11 modules in this program include 94 case scenarios with content that is relevant to residents from all surgical specialties. More than 1,500 residents in 156 surgery programs currently are enrolled in this program.

I believe the programs and initiatives we have undertaken this past year will elevate this organization to new heights in terms of reputation, influence, and member and staff enthusiasm and engagement.”

The 10-station ACS Surgery Resident Objective Structured Clinical Examination (OSCE) focuses specifically on patient safety. The exam is funded through a major grant from the AHRQ. The ACS Surgery Resident OSCE has been incorporated in the education and formative assessment of entering surgery residents at several institutions, and a model for summative assessment of surgery residents is currently in development. The College also offers the surgical skills curricula for residents and medical students in collaboration with the Association of Program Directors in Surgery and the Association for Surgical Education.

The College’s educational programs also address
faculty development and support. Examples include: the Surgeons As Educators course titled Technical Skills Education in Surgery: A Web-based Resource; a comprehensive database containing more than 255,000 resources covering all aspects of medical modeling and simulation; and the Web-based Residency Assist Page for program directors.

With regard to verification, the ACS Program for Accreditation of Education Institutes continues to receive widespread national and international acclaim as the gold standard for accreditation of simulation centers. The total number of ACS-accredited educational centers is 62, including 58 Level I Institutes and four Level II Institutes. The international reach of the program continues to grow, and ACS-accredited education institutes have been established in Canada, U.K., Sweden, Greece, Israel, France, and China.

Integrated Communications

Linn Meyer, Director of the Division of Integrated Communications, retired earlier this year. Lynn Kahn filled the position in June, and is doing a superb job of guiding the staff through this transition. Under the leadership of both Ms. Meyer and Ms. Kahn, the division has continued to produce important communications materials for both our profession and our patients.

Perhaps most significantly, the division has made important contributions to our Inspiring Quality initiative and has played an integral role in communicating the College's message to the membership and the public. Examples of these contributions include coordinating efforts between all the divisions, publishing articles in the Bulletin explaining the purposes and direction of the program, and launching and maintaining an Inspiring Quality page on the ACS website.

In another quality-related effort, the Division of Integrated Communications has worked on behalf of the NAPBC to raise public awareness about the program and how it benefits women with breast disease. The division was responsible for developing and placing NAPBC banner ads on the websites of Women's Day and Good Housekeeping, and secured a guest spot for Dr. Winchester on a Chicago public affairs radio show to discuss the meaning and value of breast center accreditation.

Other important achievements that have occurred in the past year within the Division of Integrated Communications are as follows:

- The Journal of the American College of Surgeons ranked seventh out of 187 surgical journals in terms of impact factor, the highest ranking the journal has ever achieved
- The number of ACS Web portal page views increased to more than 250,000 in a single quarter, largely as the result of posting original clinical content submitted by the portal's community editors and associate community editors
- Initiated the process of redefining the College's global vision for online communications for both members and nonmembers
- Continued to work closely with Weber Shandwick, the Division of Research and Optimal Patient Care, and ACS NSQIP surgeon champions on the Florida Surgical Care Initiative
- Finalized the redesign of the public website to bring all programs of the College into conformance with its brand identity

Member Services

Paul “Skip” Collicott, MD, FACS, Director of the Division of Member Services, also retired earlier this year. His successor, Patricia L. Turner, MD, FACS, joins the staff this month. In the meantime, the division has continued to collaborate with other areas of the College on a number of initiatives, including the following:

- Presented the 2011 Leadership Conference for Governors, Chapter Officers, Young Surgeons, and Residents in conjunction with the Division of Advocacy and Health Policy
- Continued to work with the Division of Integrated Communications and Information Services to refine the ACS Web portal project for Member Services
- Worked with the Division of Integrated Communication to improve the College's visibility
- Collaborated with the Division of Integrated Communications and Information Services to automatically generate an “invitation to CC” for international registrants to obtain visas
- Worked with ACS accounting staff to complete the final phase of our dues increase
- Secured a Pfizer grant for Operation Giving Back with the assistance of the ACS Foundation
- Conducted Web-based surveys for the Young
Fellows Association, the Resident and Associate Society (RAS), and the ACS chapters with communications and information technology
• Continued refinement of RAS and career development scholarships, as well as of the Heller School curriculum at Brandies University, Waltham, MA
• Initiated the largest class of Fellows to date
• Increased the number of Central Judicary Committee reviews pertaining to irresponsible behavior of Fellows acting as expert witnesses
• Collaborated with the COT and Operation Giving Back to carry out ongoing Haiti relief/support
• Conducted and evaluated a general membership survey
• Initiated management of the Society of Surgical Chairs
• Began development of the second Governors’ survey on surgeon burnout
• Investigated the development of affiliate chapters in economically disadvantaged countries

Other activities

The ACS Foundation experienced a 20 percent increase in gifts in 2011. Major donations were received from both Fellows and organizations to support current and future programs in patient care quality and education opportunity. Elias Hanna, MD, FACS, and Pon Satitpunwaycha, MD, FACS, established named restricted funds to support international education programs. In addition, the International Relations Committee initiated the Murray F. Brennan, MD, FACS, International Scholarship. Through the combined efforts of ACS volunteers, leadership, and program staff, more than 100 funding requests were submitted to the Foundation. Moreover, 85 grants were received from corporations, private foundations, and not-for-profit organizations in fiscal year 2011. These grants supported activities throughout the College—from quality improvement initiatives to skills courses to surgical volunteerism. Notably, three Scholars-in-Residence were made possible through grant funding from the Emerson Charitable Trust, Genentech, and the John A. Hartford Foundation. For more information about Foundation activities, see the ACS Foundation Annual Report 2010–2011 on page 29 of this issue.

The Division of Convention and Meeting Services had another busy year, handling the arrangements for more than 1,100 internal meetings within the ACS headquarters in Chicago, IL; 82 external ACS and Association Management Services meetings; and, of course, the Clinical Congress, in San Francisco, CA.

The College sold the building that formerly housed the Washington, DC, office at 1640 Wisconsin Ave., NW, to the Commission of the African Union. Our new facility at 20 F Street, NW, has achieved greater than 50 percent occupancy, with other contracts in negotiation.

Finally, I want to acknowledge the excellent support we all receive from the people in Executive Services. These staff members fulfill my daily staffing needs, provide oversight for the meetings of the College’s leadership, manage the President’s Dinner and the Jacobson Innovation Award Dinner, and coordinate multiple functions at the Clinical Congress. They also provide support to the College’s representatives on The Joint Commission’s Board. This year, Executive Services is also coordinating efforts with other key staff and consultants as planning and execution begins for the 2012–2013 Centennial Event.

Conclusion

In all, the ACS had a good year. I believe the programs and initiatives we have undertaken this past year will elevate this organization to new heights in terms of reputation, influence, and member and staff enthusiasm and engagement. I thank you all for your support as we move forward.

Dr. Hoyt is Executive Director of the College.
A year of inspiring change
As I write this article, my year as Chair of the American College of Surgeons (ACS) Board of Regents is coming to a close. It has been a busy year, filled with activities and initiatives that are likely to redefine what this organization means to existing and prospective ACS members, legislators, policymakers, the public sector, the College staff, and most significantly, our patients.

Throughout the course of this year, the College’s leadership made a deliberate effort to ensure that, as we move forward, all of our activities are targeted at fulfilling the ACS mission, which is as follows: 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.

In keeping with this mission, and to help clarify this organization’s key responsibilities, all ACS programs now revolve around the goal of Inspiring Quality: Highest Standards, Better Outcomes. By focusing on this core ideal and by trumpeting this message on Capitol Hill, in communities throughout the nation, and around the world, the College is further strengthening and promoting its position as the leading champion for the provision of high-quality, cost-effective surgical care.

When surgeons and community leaders focus their attention on quality of care—examine all its facets, report on their own outcomes, and discuss strategies for improving surgical outcomes—the result is providing patients with a better quality of life. And enhanced quality of life for the patient is what matters most to us as surgical professionals.

Inspiring and heralding quality

The Inspiring Quality initiative has enabled the College to think more strategically about its efforts to ensure that patients will continue to have access to optimal surgical care. One goal of the Inspiring Quality program is to communicate to legislators how ACS quality improvement programs can lead to reduced costs and, therefore, greater access to meaningful care. To relay this message, several ACS leaders traveled to Washington, DC, this spring and visited 17 congressional offices. Surgeon participants who joined me at this event included the following: L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), then-President of the ACS; Don E. Detmer, MD, FACS, Medical Director of the ACS Division of Advocacy and Health Policy; David B. Hoyt, MD, FACS, ACS Executive Director; Frank Opelka, MD, FACS, Associate Medical Director, ACS Division of Advocacy and Health Policy; J. David Richardson, MD, FACS, then-Vice-Chair of the ACS Board of Regents; and Clifford Y. Ko, MD, FACS, Director, ACS Division of Research and Optimal Patient Care. In addition, the College’s advocacy and health policy staff have continued offering their insights into the benefits of ACS quality-improvement activities during their ongoing meetings with congressional advisors, members of Congress, and regulatory personnel.

As an adjunct to meetings on Capitol Hill, the College also launched a national Inspiring Quality tour, an initiative where Fellows of the ACS and their colleagues invite legislators to hear from the surgeons in their...
home states and districts regarding what the surgical community is doing to inspire quality of care. At press time, the ACS had convened two community-based events as part of this effort. The first meeting took place in July at the College’s headquarters in Chicago, IL, and featured chiefs of surgery from hospitals throughout the metropolitan area who explained how the College’s National Surgical Quality Improvement Program (ACS NSQIP®) has helped them improve surgical outcomes. In attendance at the Chicago event was Sen. Mark Kirk (R-IL).

The Johns Hopkins University School of Medicine department of surgery and the Johns Hopkins Armstrong Institute for Patient Safety and Quality, Baltimore, MD, cosponsored the second community event in August. Sen. Ben Cardin (D-MD) served as the keynote speaker at that program, which 80 Maryland health care leaders attended.

Plans are under way to present another six community forums, including one in Seattle, WA. A central focus of this program will be Washington State’s Surgical Care and Outcomes Assessment Program and its utility in reducing adverse outcomes and lengths of stay. Other potential ACS Inspiring Quality event locations include California, Massachusetts, Minnesota, Pennsylvania, Texas, and Virginia. The College welcomes requests from Fellows who would like to host an Inspiring Quality event in their community, focusing on quality of surgical care in any of its dimensions.

Both the medical and the mainstream media have given these events wide coverage, ensuring that patients, prospective Fellows, legislators, policymakers, and the College’s other constituencies are aware of what this organization is accomplishing with this initiative. Members of Congress and their health policy staffs are paying attention to these media messages and are asking for the ACS’ input, while policymakers, such as Carolyn Clancy, Director of the Agency for Healthcare Research and Quality (AHRQ), have been meeting with College representatives and have demonstrated an interest in collaborating with the ACS to explore best practices for improving quality of care.

**Supporting programs**

A quality-related program that is of particularly great interest to all stakeholders is the ACS National Surgical Quality Improvement Program (NSQIP®). More than 400 hospitals participate in this program, and approximately 900 health care professionals attended the program’s annual conference. ACS NSQIP continues to partner with other leading organizations and governments agencies that are focused on health care quality improvement. For example, ACS NSQIP is in the process of updating performance measures for the National Quality Forum’s (NQF’s) use. Furthermore, the College has completed its efforts with the Centers for Disease Control and Prevention to harmonize the ACS NSQIP surgical site infection (SSI) performance measures with the agency’s measures, and have submitted the findings to the NQF. Johns Hopkins also has secured funding from the AHRQ to work with the ACS and other organizations to study the effects of a surgical unit-based safety program on reducing SSI and other complications (see related article, page 53). In addition, more than 100 peer-reviewed articles using ACS NSQIP data have been published since 2010.

Meanwhile, the College’s educational programming continues to become more focused. For example, important changes were made in the Clinical Congress program beginning in 2010, which have resulted in the following: the creation of thematic and specialty-specific tracks; timely postgraduate courses with special certificates documenting specific verification levels; provision of certificates for patient safety, ethics, and trauma to meet regulatory requirements; new Meet The Expert luncheons and Town Hall meetings; and awards for excellence in scientific work. In addition, the Division of Education has created a whole series of programs focusing on Maintenance of Certification, which will help Fellows not only remain current and compliant with board requirements, but also to acquire new knowledge and techniques.

The ACS Program for Accreditation of Education Institutes continues to receive widespread national and international acclaim as the gold standard for accreditation of simulation centers. The total number of ACS-accredited educational centers is now 62, including 58 Level I Institutes and four Level II Institutes. The international reach of the program continues to grow, and ACS-accredited education institutes have been established in Canada, the U.K., Sweden, Greece, Israel, France, and China. A consortium of accredited institutes has been formed to benefit from the collective knowledge of these centers in an effort to define standards, validate new methods, and bring uniformity to surgical training.

Furthermore, the College’s stature as a leader in health care quality on the international stage has ad-
Dr. Pellegrini is The Henry N. Harkins Professor and chair, department of surgery, University of Washington in Seattle, and Past-Chair of the ACS Board of Regents.

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vanced in a number of ways, including through the ongoing outreach programs organized by the ACS Operation Giving Back program.

In addition, ACS Past-President Lamar S. McGinnis, Jr., MD, FACS; A. Brent Eastman, MD, FACS, Past-Chair of the Board of Regents; Dr. Hoyt; Dr. Britt; and I participated in the 36th annual Scientific Meeting of the Royal College of Surgeons of Thailand this summer, which gave us the opportunity to form new professional and personal friendships with surgeons from all around the world. (See Dr. Hoyt’s “Looking forward” column on page 4 for further details.) I also had the opportunity to participate in the annual meeting of the Argentina Chapter of the ACS.

Internal change

In the past year, two key members of the ACS executive staff have retired—Paul “Skip” Collicott, MD, FACS, Director of the Division of Member Services, and Linn Meyer, Director of the Division of Integrated Communication. Dr. Collicott and Ms. Meyer were among the most dedicated members of the College’s staff, and we are fortunate that they both have agreed to continue to serve as consultants to the organization during this transition.

Dr. Collicott’s successor, Patricia L. Turner, MD, FACS, is a highly accomplished general surgeon and active member of the ACS community. She has served on numerous College committees, and she understands our members’ needs and interests. Dr. Turner is ideally suited to take the Division of Member Services to the next level. Dr. Turner joined the College’s staff at the beginning of this month.

Ms. Meyer’s replacement as Director of Integrated Communications is Lynn Kahn, who began her service at the College in June. Prior to joining the ACS staff, Ms. Kahn served as vice-president of programs and interim co-executive vice-president for the American Society of Plastic Surgeons. She has more than 25 years of experience as an executive communications professional.

This year, the College added an important new position in the ACS Division of Advocacy and Health Policy. Dr. Detmer began serving as the first Medical Director of the division in March. Dr. Detmer has many years of experience in surgical education and practice, health policy leadership, and biomedical informatics, making him highly qualified to add the surgeon’s perspective to the many topics currently under discussion in Washington. Dr. Opelka—a Fellow with substantial previous involvement in the activities of our Washington Office—was named Associate Medical Director. In this role, Dr. Opelka focuses primarily on quality initiatives.

To best serve its mission, a healthy organization must, periodically, review and adjust its structure and functions. This year we initiated such an effort by launching the GE Healthcare Organizational Initiative, also known as the Culture-Driven Performance Improvement Project. The objectives of this program include the following: foster a culture of continuous improvement that can catalyze rapid and sustainable change; bind executive leadership and staff with a common language and connected purpose; and integrate proven business models and processes to strengthen the ACS’ mission and goal realization. The ACS leadership anticipates that this initiative will help to re-energize the staff, all of whom already work hard to serve the College’s membership and its patients. I would be remiss if I did not take this opportunity to publicly express my personal thanks to this dedicated and most efficient group of people, who are accomplishing so much under Dr. Hoyt’s extraordinary talent and vision.

Finally, I would like to take this opportunity to reflect on the death of a man who truly embodied all of the finest attributes of the ACS Fellowship and who inspired so many surgeons and staff alike to ensure that surgical patients receive high-quality care—C. Rollins “Rollo” Hanlon, MD, FACS. No one has ever been more passionate about this organization and its mission than Dr. Hanlon. His spirit and his remarkable legacy will continue to guide the College on its mission to safeguarding the surgical patient for centuries to come.
Presidential Address:

STEWARDSHIP
of our profession

by Patricia J. Numann, MD, FACS
Welcome to Fellowship in the American College of Surgeons (ACS). You have demonstrated your commitment to society by becoming a surgeon. Now, by becoming a Fellow of the ACS you have committed to an even higher goal of becoming a steward of our profession.

Stewardship is an old concept dating to the 15th century. The word is derived from the old English word, "steward"—stig meaning "hall" and weard meaning "keeper." Stewardship is defined as the responsible overseeing and protection of something considered worth caring for and preserving. Originally, the term was primarily applied to religion, but now it is applied to many areas, including the environment, financial affairs, and health care.

In 2000, the World Health Organization (WHO) report established stewardship as one of the four essential functions of the health care system—the other three being service provision, resource generation, and financing. In November 2001, WHO suggested that the core domains of good stewardship were as follows: generating intelligence; formalizing strategic policy direction; ensuring tools for implementation; building coalitions; ensuring a fit between policy objectives, organizational structure, and culture; and maintaining accountability.

Other organizations, such as the American Board of Internal Medicine and the Aspen Institute, have developed defined programs in health care stewardship. The Aspen Health Stewardship Coalition, founded in 2007, hopes to bring meaningful principles to the reform of the U.S. health care system. A Fellow of the College, Delos Cosgrove, MD, FACS, is a member of their advisory board. The ACS has always acted as a steward of the surgical profession. As Fellows, you will be stewards of the profession of surgery and of the ACS, and you will carefully and thoughtfully contribute to the direction and management of this organization, as have the Fellows before you.

Commitment to stewardship

When the ACS was established almost 100 years ago, the quality of surgical care was variable and the professional behavior of surgeons often questionable. The founders of the College sought to change those less than desirable practices and become the stewards of our profession. They developed basic standards for surgical practice and a code of behavior followed to this day. Since then, Fellows of the ACS have made enormous contributions to the practice of surgery, the understanding of surgical disease, and the systems that affect patient care. They have developed an educational program to support surgeons in training and in practice as they strive to maintain the most up-to-date knowledge and skills.

As new Fellows, you are the future of the American College of Surgeons and of the profession all over the world. Hence, you must continue the work of your predecessors by being good stewards of our profession—a profession you will be proud to have your daughters and sons pursue.

You may think, “How can I, as one individual, make a difference or guide our profession?” My response would be, “Who can better know our patients’ and our profession’s needs?” For the past 100 years Fellows just like you have made incredible contributions and guided our profession responsibly. The process is never-ending as society, science, and technology are continuously changing.

Stewards of trauma care

For example, Fellows of the ACS have revolutionized trauma care and created a system that assures all Americans quality care should they be injured. The Advanced Trauma Life Support® (ATLS)® Program began when a Fellow, and former Director of the ACS’ Division of Member Services, Paul E. “Skip” Collicott, MD, FACS, experienced the preventable death of a colleague injured in an accident. That event led through the work of many to the ATLS Program and the system of trauma centers that exists today. The “golden hour” during which intervention has a major impact on survival was identified through the work of ACS Fellow Donald D. Trunkey, MD, FACS. The

Advanced Trauma Operative Management Course, devised by the ACS Committee on Trauma under the leadership of Lenworth Jacobs, MD, FACS, assists surgeons in learning and maintaining the technical skills necessary for the care of trauma victims. The work of such Fellows as Bill Schwab, MD, FACS, on the National Transportation Safety Board, has contributed to highway safety. Correlation of speed and crashes has helped shape policy and improve car design. Research performed by many Fellows has improved outcomes for trauma patients. Unfortunately, there is still death and disability from injury, so there is still the opportunity for you to become involved in these existing programs or create others that will help assure that all people have fewer injuries and excellent outcomes when injured.

Stewards of cancer care

Another area where Fellows of the College have been leaders is in cancer care. The Commission on Cancer (CoC)*, founded in 1922, is a multidisciplinary group with a robust organizational structure. The group has many functions, and it welcomes participation from all who are interested. The CoC maintains a National Cancer Data Base for use in outcomes measurement, uses a classification system that allows appropriate comparison of outcomes, and conducts numerous courses to provide the best information to our members. It has developed accreditation programs to ensure patients receive excellent care. Your health care facility’s participation in the accreditation program for cancer centers shows your patients and your community your commitment to excellence.

For decades, the ACS has supported cancer research. The National Surgical Adjuvant Breast program, administered by Bernard Fisher, MD, FACS, conducted trials that led to dramatic changes in breast cancer care. The American College of Surgeons Oncology Group continues to sponsor trials for a number of malignancies. Surgeons may enroll their patients in these trials and participate as investigators. M. Judah Folkman, MD, FACS, through his research on angiogenesis factor, brought a new understanding to the spread of malignancy and facilitated the development of a drug that interfered with that process, thereby improving survival. Fellows of the College have been, and through you will be, good stewards of cancer care.

Opportunities for stewardship

These are but a few of the programs of the American College of Surgeons. The Division of Education, under the leadership of Ajit K. Sachdeva, MD, FACS, FRCSC, has created numerous programs to assist surgeons in keeping current both in knowledge and skills. The Surgical Education and Self-Assessment Program™, now nearly 50 years old, has many volunteers authoring the questions. You can be one of those volunteers.

The ACS Division of Advocacy and Health Policy similarly keeps us abreast of the latest developments in these areas and represents us to our elected officials and to other health care organizations. Only through this advocacy will our perspectives on issues be heard. The ACS Professional Association’s political action committee (ACSPA-SurgeonsPAC) involves many Fellows who guide this advocacy effort. Literally hundreds of volunteer Fellows help the College accomplish its work.

Fellows of the College have contributed to society in so many ways. ACS Fellow C. Everett Koop, MD, FACS, when serving as the U.S. Surgeon General, aggressively promoted smoking cessation. Fellows are actively involved in important public health issues, such as the obesity and violence epidemics. Surgeons can certainly affect those issues. The number of opportunities is endless.

Ensuring all people access to excellent surgical care is also part of our stewardship. Distribution and numbers of surgeons are becoming critical issues. Rural America already has a severe shortage of surgeons. The ACS Committee on Rural Surgery is working to support rural surgeons and is investigating ways to increase their numbers through loan forgiveness and practice support. Tyler G. Hughes, MD, FACS, a general surgeon from McPherson, KS, is developing a communication system for rural surgeons that will allow them in real-time to discuss issues of concern to them. We can all help support rural surgeons in our area by making consultation easier. We need to ensure that they can easily participate in educational programs and acquire new skills. Our training programs must prepare residents to enter rural practice. Currently, 80 percent of residents pursue fellowships. I am sure most of you did. Data suggest that you did so because you did not feel ready to enter practice. Mark T. Savarise, MD, FACS, from Sandypoint, ID, and the College’s Young Fellows Association are
working to develop a transition-to-practice program to make the transition smoother and hopefully to reduce the need for prolonging training. New Fellows are the very people who can offer insight into the ways this program should develop.

**Worldwide stewards**

Our mission of stewardship extends beyond our borders. Access to surgical care throughout the world is variable. Civil unrest and environmental catastrophes further challenge the limited resources in many areas. In 2001, the Board of Governors’ Committee on Socioeconomic Issues encouraged the College to more closely examine the extent of volunteer involvement and interest among ACS members. A task force chaired by two ACS Fellows, Andrew L. Warshaw, MD, FACS, and Robert V. Stephens, MD, FACS, found great breadth and depth of engagement and, in fact, many surgeons considered volunteering an integral component of their professional identity. As a result, Operation Giving Back (OGB), directed by Kathleen Casey, MD, FACS, was founded. OGB programs contribute to the educational endeavors in many areas and provide service in times of great need. Fellows have rushed to aid the victims of Katrina, of the hurricane that devastated Haiti, and of the tsunamis in both Banda Aceh and Japan. Other volunteers go to educate and introduce new technology in other parts of the world. Fellows act as ambassadors for our College through these programs. Respect for the culture and sustainability of the programs are stressed. Fellows are always needed for these programs. In times of crisis, it is gratifying to see how many respond to that call.

Immigrant surgeons have long provided a significant proportion of surgical care in America. Many of these surgeons have become leaders in the American College of Surgeons. The loss of these surgeons to their country of origin is profound in its impact. Our surgical training programs now support the workforce in many countries by training U.S. surgical residents outside the U.S. and having American faculty supervise and teach at those training sites. A total of 35 surgical programs have rotations in other countries that count as part of their residency requirement. Other examples of collaboration are the Hernia Project in Ghana, in which the ACS and the West African College of Surgeons offer skills labs to bring new technical skills to Ghanian surgeons; and the Minimally Invasive Training Program in Mongolia, under the direction of Raymond R. Price, MD, FACS, of Murray, UT, and the Health Sciences University of Mongolia, which is bringing laparoscopic cholecystectomy to that country.

Fellows have been responsible stewards of our profession globally through their involvement in programs such as these and, thereby, have increased the dissemination of knowledge, the understanding of cultural differences, and improved access to surgical care. In addition, each year Honorary Fellowships are awarded to surgeons who support the mission of access to quality surgical care throughout the world. There are many programs at the Clinical Congress that address these initiatives, providing many opportunities for Fellows to find out how to become involved.

**Stewards of quality**

Systematic improvement in the quality of surgical care has been the mantra of the ACS since its founding, and continues to be so. The National Surgical Quality Improvement Program (NSQIP®), initially developed in the Veterans Affairs health care system under the leadership of Shukri Khuri, MD, FACS, has become a program of the College. This
project demonstrated the Hawthorne Effect—that is, observation alone creates change. Just observing a number of variables in the patient’s course of treatment have resulted in dramatic improvements in outcomes in every hospital that has implemented the program. The College is working diligently to disseminate this program and see that it is in place in all hospitals. Opportunity exists for Fellows to implement this program in their hospitals. Monitoring outcomes will result in constantly increasing the quality of our care.

It behooves all of us to track our own outcomes data. This year, the College launched the Inspiring Quality: Highest Standards, Better Outcomes program with a basic goal of fostering a culture of continuous improvement that can catalyze continuous change leading to increased quality. This new initiative will need many Fellows’ involvement to come to fruition and further demonstrates the commitment of the Fellows to quality care. All of us want to go beyond competent to excellent.

**Stewards of the profession**

Part of the stewardship of our profession is our responsibility to one another. When we see our colleagues in need of help, whether it is with regard to acquiring new knowledge or skills or in dealing with personal or professional crises or disabilities, we should help them. Should we see colleagues who have cognitive or physical impairments that do not allow them to continue practice, we must encourage them to modify or change their practice or to step down. If individually we are unable to advise them or influence them, we must ask for assistance from our leaders. Stewardship of our profession does not allow us to look the other way.

We all became physicians not only because of our interest in science but also because of our commitment to humanity. Each of us is a steward of our profession by the example we set in our personal and professional behavior. In this time of health care reform we must be ever-more vigilant in protecting our patients and our profession. We must take on the responsibility of continuing to contribute to resolving the issues of the day and advancing our discipline. With the responsibility of the stewardship of our profession comes enormous opportunity to leave your mark on your community and our profession.

Begin now to identify areas where you wish to make that special contribution. Actively participate in College activities: join your local chapter, attend College meetings, and sign up for committees. You will enjoy the tremendous rewards of the Fellowship of terrific surgeons. I could never have imagined how my involvement with the College would enrich my life. I want you to be able to have that experience as well.

Again, welcome to Fellowship in the American College of Surgeons, and thank you for the privilege of serving as your President.

*Dr. Numann is the Lloyd S. Rogers Professor of Surgery Emeritus, Distinguished Teaching Professor Emeritus at the State University of New York (SUNY) Upstate Medical University, Syracuse, and the 92nd President of the American College of Surgeons.*
American College of Surgeons
Foundation

INVESTING IN QUALITY

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes

Quality Care  •  Education Programs  •  Professional Outreach
The ability of the American College of Surgeons (ACS) to achieve its goals for highest standards and better outcomes for surgical patients depends significantly on the vital support provided by Fellows and friends through the ACS Foundation.

Philanthropy has played a major role throughout the College’s history—from the endowment established by the Board of Regents in 1914, to the generous estate gift provided by Earl Mayne, MD, FACS, in 1944 for surgical education, to the gifts from Julius Jacobson, MD, FACS, in 1992 and 2004 to support innovation and promising investigators, and to the gift this year from Pon Satipunwaycha, MD, FACS, toward international guest scholarships. The impact of these gifts has been sustained, as earnings from these investments yield meaningful support for the current programs of the College.

Today, as the College continues to work toward an improved health care system for patients and providers, philanthropic support for these efforts is vitally important. The Inspiring Quality initiative is building awareness of the College’s proven models of care that improve outcomes, and investment in our quality programs will ensure the College’s enduring impact on national health care improvements.

On behalf of the American College of Surgeons, I would like to thank all of the donors reflected in this annual report for their generosity. Your contributions allow us to pursue excellence throughout our profession and achieve the highest quality of care for surgical patients. Thank you for your support.

David B. Hoyt, MD, FACS
Executive Director, American College of Surgeons
President, American College of Surgeons Foundation

The Case for Giving Back

Every individual listed in this annual report is giving back to the American College of Surgeons in some way.

All forms of giving make a difference; the gift of volunteer time is especially important because it benefits the College directly in many ways.

The ACS Foundation is all about giving. Our directors and committee members give of their time, their knowledge, and their financial assets.

C. Rollins Hanlon, MD, FACS, gave so much to the College in every way during his career. Dr. Hanlon and his wife, Dr. Margaret H. Hanlon, are not only among the largest donors to the College, they have made the largest number of individual recorded gifts: 88 separate donations, starting in 1981.

The College recently lost another great champion of giving back, with the passing of Josh Jurkiewicz, MD, FACS. Dr. Jurkiewicz was not only a good friend of Dr. Hanlon, but also a generous donor to the College, making current gifts and a planned gift through his estate.

As you read this annual report, please know that you have received it because you, too, give back to the College. We thank you and hope that the College will continue to benefit from your generosity.

Thomas R. Russell, MD, FACS
Chair, American College of Surgeons Foundation

Quality Care • Education Programs • Professional Outreach

INVESTING IN QUALITY
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San Francisco, CA

Vice-Chair
Richard B. Reiling, MD, FACS
Charlotte, NC

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David B. Hoyt, MD, FACS
Chicago, IL

Secretary
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Colorado Springs, CO

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ACS President
L. D. Britt, MD, FACS, FCCM,
FRCs (Eng) (Hon)
Norfolk, VA

Foundation Executive Director
Martin H. Wojcik, CFRE
Chicago, IL

Chief Financial Officer
Gay L. Vincent, CPA, MBA
Chicago, IL

STAFF

Executive Director
Martin H. Wojcik, CFRE

Director of Corporate and Foundation Relations
David Korajczyk

Annual Giving/Donor Relations Coordinator
Chris Joslin

Consultant
Fred W. Holzrichter, CFRE

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Robert E. Hermann, MD, FACS
Charles E. Lucas, MD, FACS
Richard B. Reiling, MD, FACS
Kenneth W. Sharp, MD, FACS

COMMITTEE ON CORPORATE AND FOUNDATION RELATIONS
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Charles M. Balch, MD, FACS
Christopher J. Daly, MD, FACS
Michael P. Flesher
Bruce Gingles
Mary H. McGrath, MD, MPH, FACS
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Jonathan M. Sackier, MD, FACS

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Christopher J. Daly, MD, FACS
Rhonda Peebles
Steven C. Stain, MD, FACS

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Roger S. Foster, Jr., MD, FACS
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Julius H. Jacobson II, MD, FACS
Norman M. Kenyon, MD, FACS
Anna M. Ledgerwood, MD, FACS
Richard B. Reiling, MD, FACS
Steven C. Stain, MD, FACS

MANAGEMENT COMMITTEE
Thomas R. Russell, MD, FACS (Chair)
David B. Hoyt, MD, FACS
Richard B. Reiling, MD, FACS
William F. Sasser, MD, FACS
Amilu Stewart, MD, FACS
Jon A. van Heerden, MBCHB, FACS, FRCS

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Recollections of C. Rollins Hanlon, MD, FACS

“We are not born perfect. Every day we develop in our personality and in our profession until we reach the highest point of our completed being, to the full round of our accomplishments and of our excellences. This is by the purity of our taste, the clearness of our thought, the maturity of our judgment, and the firmness of our will” …“The complete person—wise in speech, prudent in act—is admitted to the familiar intimacy of discreet people and is even sought out by them.”

From “A Person at His Peak,” The Art of Worldly Wisdom, by Balthasar Gracian

He was a poet, a philosopher, a professor, a gifted administrator, and, above all, a skilled physician. Working in close proximity to C. Rollins Hanlon, MD, FACS, provided the opportunity to observe this unique human being during the latter seasons of his full and extraordinary, productive life. I shall always be grateful for the gift of having known Dr. Hanlon in both a personal and a professional manner. He was a pioneering cardiovascular surgeon, a well-organized leader and director, and he was, indeed, “a person at his peak.”

Bright, articulate, witty, and wise, Dr. Hanlon possessed the rare ability to effectively and carefully read others and circumstances while successfully maintaining a rock-solid professional presence in the face of challenge and conflict. He was a peacemaker and a civil man.

A devoted husband, father, grandfather, and great-grandfather, Dr. Hanlon was deeply religious, arriving at the office each morning well before 7:30 am, having come directly from Mass. He always made time to meet with individual ACS staff members and provided thoughtful guidance and counsel as they shared their serious concerns and issues, both professional and personal. He was never too busy to closely and carefully listen, and to help.

Following his years as Executive Director of the College, Dr. Hanlon remained fully engaged in the work of the College, serving as Executive Consultant, an unpaid position he held until his death. He was always among the first to arrive and the last to leave. Even as his health issues mounted, Dr. Hanlon faithfully continued to serve the College and the Foundation. He was a precious, consistent presence.

Dr. Hanlon was a charter-member of the ACS Foundation Board of Directors. Working with the late Oliver H. Beahrs, MD, FACS, and with Thomas R. Russell, MD, FACS, Dr. Hanlon was instrumental in the establishment of the Foundation. He continued to serve on the Board, and he worked to raise funds supporting programs of the College, including one of his favorites, the archives. Even as Dr. Hanlon’s health was deteriorating, he made several trips to solicit funds from ACS Past-Presidents in support of the archives. His professionalism and his patience brought significant success to these efforts, and although the trips were usually grueling, single-day round trips, Dr. Hanlon never complained, despite the long lines, the inevitable TSA searches, and the long hours. He was a faithful associate.

Dr. Hanlon will be sorely missed, but his extraordinary influence and the far-reaching results of his labors will forever live on, reflected daily in the ongoing vital work of the College and the Foundation he loved and served so well. Rest in peace, my dear friend.

Fred W. Holzrichter, CFRE

(Mr. Holzrichter served 10 years as Chief Development Officer for the College, working in close proximity and collaboration with Dr. Hanlon.)
The ACS chapters exert an important local influence on the College’s programs, communication, and collegiality. Chapters provide for a close association of their members to improve the quality of surgical care, as well as a forum through which young surgeons can share their thoughts and experiences with more established surgeons. Through their chapters, Fellows support College activities in trauma and cancer and collaborate with other groups on community health care and the socioeconomic and legislative aspects of health care.

The ACS chapters have a long history of philanthropic support for the College and its programs. Importantly, many of those donations are unrestricted and can be directed to the areas of greatest opportunity and need. During the 2011 fiscal year, 24 U.S. chapters made donations totaling $30,675. ACS Foundation Board members participated in 15 chapter meetings, as well as the Southeastern and Southwestern Surgical Congress meetings, in that period of time. The ACS Foundation is grateful for the interactive and supportive relationships it has enjoyed with the ACS chapters over many years.

In recognition of the valuable role of chapters in the College and its programs, the ACS Foundation has established a new entity, the Chapters and Affiliates Committee, to expand our relationships with chapters and their leaders and members.

American College of Surgeons Chapter Executives, Row 1 (seated, left to right): Brad Feldman (FL, DC, MD, ME, NH, OH, and NC), Lisa Beard (AL), Kathy Browning (GA), Terry Marks (SD), Linda Clayton (AR), and Wanda Johnson (TN). Row 2 (standing, left to right): Alice Romano (Metro Chicago), Jennifer Starkey (FL, DC, MD, ME, NH, OH, and NC), Camille Spenner (UT), Brad Reynolds (FL, DC, MD, ME, NH, OH, and NC), Christopher Tasik (CT), Janna Pecquet (LA and TX), Nonie Lowry (NTX), Angie Kemppainen (MI), Gary Caruthers (KS), and Beth Mahlo (IL).

www.facs.org/acsfoundation/
**Scholars-in-Residence Advance Surgical Quality**

The American College of Surgeons Clinical Scholars-in-Residence Program fosters the professional development of rising stars in the surgical field while addressing issues critical to excellence in patient care. Two-year fellowships enable a select cadre of promising new doctors to pursue an advanced degree while conducting extensive research that will have an important impact in the field of surgery and for the many patients who ultimately benefit from these advances. For the 2011–2012 fiscal year, generous funding has been secured to support the work of three Clinical Scholars.

Grants from the John A. Hartford Foundation and the American Geriatrics Society’s Geriatrics-for-Specialists Initiative, secured through the efforts of the Division of Research and Optimal Patient Care, are underwriting the James C. Thompson Geriatrics Surgical Fellowship, which honors the late former President of the College. The Thompson Fellowship, awarded to Warren Chow, MD (University of California at Los Angeles), is focused on best practices for surgical care of geriatric patients.

Building on the success of the ACS-Emerson Scholar in Medical Ethics, Emerson Charitable Trust provided a new grant to establish the ACS-SLU Emerson Sustainability Scholar-in-Residence. The recipient of this fellowship will have an opportunity to earn a masters of sustainability degree from Saint Louis University while pursuing research that will inform and advance sustainability-related initiatives that can have a positive impact on future health care delivery.

Through renewed grant support from Genentech, the ACS Scholar-in-Residence in Surgical Oncology is working with the Commission on Cancer to devise studies that will impact the quality of cancer patient care delivery within the Commission’s more than 1,400 accredited cancer programs. The Surgical Oncology Scholar, Richelle Williams, MD (University of Chicago), is working toward the creation and validation of quality measures to provide an important tool for benchmarking performance across cancer programs and for generating quality improvement initiatives across a broad spectrum of provider settings.

The American College of Surgeons Foundation is most appreciative of these grants in support of the ACS Scholars-in-Residence Program, as they advance the College’s efforts toward the ultimate goal of improving the quality of surgical patient care.
The educational opportunities of the American College of Surgeons have long been the most attractive reason for international surgeons to become Fellows and attend meetings. Dr. Murray F. Brennan, an esteemed Fellow since 1977, has been a tireless advocate for educational opportunities to meritorious surgeons from countries outside the United States and Canada. He has been both a member and Chair of the College’s International Relations Committee (IRC). A distinguished service awardee of the College, Dr. Brennan is known as a thoughtful, caring mentor of young surgeons.

In recognition of Dr. Brennan’s leadership role and his advocacy of educational opportunities for our international colleagues, the American College of Surgeons has established the Murray Brennan, MD, FACS, International Scholarship. The Brennan Scholarship will permit meritorious international surgeons to come to North America for academic site visits, participate in the annual ACS Clinical Congress, and take advantage of the educational opportunities offered by the College.

Members of the IRC Executive Committee have made personal funding commitments for this purpose and, in partnership with the ACS Foundation, are recruiting others who know and respect Dr. Brennan to invest in this fund. Donors to this scholarship are acknowledged as “Friends of Murray Brennan” in College and Foundation publications. The Murray F. Brennan, MD, FACS, International Scholarship is a collaborative effort to recognize an esteemed colleague while ensuring international education opportunities for the future.

www.facs.org/acsfoundation/
Gift Income Report

JULY 1, 2010–JUNE 30, 2011

SOURCE

- Fellows and Friends: $1,221,249
- Corporations and Corporate Foundations: $611,050
- Private Foundations and Organizations: $431,057
- Chapters and Medical Societies: $359,025
- TOTAL: $2,622,381

DESIGNATION

- Education: $167,450
- Member Services: $1,775,376
- Unrestricted Support/Other: $620,205
- Research/Optimal Patient Care: $59,350
- TOTAL: $2,622,381

Quality Care • Education Programs • Professional Outreach

INVESTING IN QUALITY
The Mayne Heritage Society

Membership in the Mayne Heritage Society recognizes Fellows who have provided a bequest or other “planned” gift of any size to the College through their estate plan. For those Fellows who believe that the future of surgery and the future vitality of the American College of Surgeons are intertwined, an estate gift is an ideal form of investment.

M. J. Jurkiewicz, MD, FACS, the 70th President of the College (1989–1990) and Vice-Chair of the Board of Regents, was firm in this belief. Dr. Jurkiewicz passed away in May 2011, leaving a distinctive legacy of current donations to the College, as well as a generous bequest through his will. In recognition of their service, loyalty, and philanthropic spirit, Dr. Jurkiewicz and Mrs. Jurkiewicz were honored in 2006 with the ACS Foundation’s Distinguished Philanthropist Award.

Among other benefits, Mayne Heritage Society membership ensures that dues-exempt and retired Fellows continue to enjoy a visible relationship with the College. Mayne Heritage Society members are listed prominently in honor rolls in both the Foundation Annual Report and on its website, and are welcomed to the Fellows Leadership Luncheon and Hospitality Center during Clinical Congress. The leaders of the ACS Foundation encourage your consideration of a bequest to the College through your estate plan, a simple transaction with considerable impact on the future.

The Mayne Heritage Society

Dr. and Mrs. Neil C. Clements • Arizona
Dr. Benjamin L. Crue, Jr. • Colorado
Dr. and Mrs. Martin L. Dalton, Jr. • Georgia
Dr. and Mrs. Henry Gans • Florida
Dr. and Mrs. David E. Grambort • Arkansas
Dr. Peter S. Hedberg • Oklahoma
Dr. and Mrs. Robert W. Hobson • New Jersey
Dr. John C. Iacuzzo • New Jersey
Dr. and Mrs. Paul H. Jordan, Jr. • Texas
†Dr. M. J. Jurkiewicz • Georgia
The Estate of Harry E. Keig • Florida
Dr. and Mrs. Norman M. Kenyon • Florida
Dr. William W. Kridelbaugh • New Mexico
Dr. and Mrs. LaSalle D. Leffall, Jr. • District of Columbia
Dr. and Mrs. Joseph H. Lesser • California
Dr. and Mrs. Eric T. Lincke • Michigan
Dr. and Mrs. James V. Maloney, Jr. • California
Dr. and Mrs. Richard W. Martin • North Carolina
The Estate of Dr. Earl H. Mayne • New York
†Dr. Mary L. McKenzie • Florida

Dr. and Mrs. Paul H. Jordan, Jr. • Texas
†Dr. M. J. Jurkiewicz • Georgia
The Estate of Harry E. Keig • Florida
Dr. and Mrs. Norman M. Kenyon • Florida
Dr. William W. Kridelbaugh • New Mexico
Dr. and Mrs. LaSalle D. Leffall, Jr. • District of Columbia
Dr. and Mrs. Joseph H. Lesser • California
Dr. and Mrs. Eric T. Lincke • Michigan
Dr. and Mrs. James V. Maloney, Jr. • California
Dr. and Mrs. Richard W. Martin • North Carolina
The Estate of Dr. Earl H. Mayne • New York
†Dr. Mary L. McKenzie • Florida

†Deceased

www.facs.org/acsfoundation/
Distinguished Philanthropist Award

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

RECIPIENTS

Dr. and Mrs. Norman M. Kenyon (2010)
Dr. and Mrs. Richard B. Reiling (2009)
'Dr. Paul F. Nora (2008)
'Dr. and Mrs. Maurice J. Jurkiewicz (2006)
Dr. Robert W. Hobson II and Mrs. Joan P. Hobson (2005)
Drs. C. Rollins* and Margaret H. Hanlon (2004)
Dr. William W. Kridelbaugh (2003)
Dr. and Mrs. Robert E. Berry (2002)
Dr. Pon Satipunwaycha (2001)
Dr. and Mrs. Paul H. Jordan, Jr. (1999)
Dr. and Mrs. LaSalle D. Leffall, Jr. (1998)
Dr. and Mrs. Eric Lincke (1997)
Dr. and Mrs. Neil C. Clements (1996)
Dr. and Mrs. Scott W. Woods (1995)
The Abdol Islami Family and Foundation (1994)
Dr. Julius H. Jacobson II (1993)
'Dr. Oliver H. Beahrs (1992)
'Dr. John Conley (1990)
'Dr. Armand Hammer (1989)

*Deceased

Fellows Leadership Society

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

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

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

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

- **Second Century Circle**
  - CUMULATIVE gifts totaling $500,000–$1,000,000

- **Legacy Circle**
  - CUMULATIVE gifts totaling $100,000–$500,000

- **Founders Circle**
  - CUMULATIVE gifts totaling $75,000–$100,000

- **Presidents Circle**
  - CUMULATIVE gifts totaling $50,000–$75,000

- **Regents Circle**
  - CUMULATIVE gifts totaling $25,000–$50,000

- **Governors Circle**
  - CUMULATIVE gifts totaling $10,000–$25,000

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

We acknowledge all donor gifts received through June 30, 2011.
Dr. Hanna Opens His Heart to International Surgical Scholars

Elias S. Hanna, MD, FACS, a retired cardiac surgeon, spent most of his career using his talents to help underserved patients with heart conditions throughout the world. His recent commitment of $160,000 to the American College of Surgeons Foundation is earmarked to ensure that other international surgeons will have every opportunity to do the same.

Dr. Hanna has developed an international reputation not only as an outstanding heart surgeon, but as a true humanitarian. He is the founder and president of the Elias S. Hanna, MD, FACS, Cardiovascular Foundation, which assists countries that lack the resources necessary to perform open-heart surgery.

Last year, Dr. Hanna agreed to sponsor an international guest scholarship at the American College of Surgeons, a program overseen by the College’s International Relations Committee. The Elias S. Hanna, MD, FACS, International Scholarship will grant a meritorious young surgeon residing outside North America complimentary attendance at all Clinical Congress events. The Hanna Scholarship also will support scholarly visits to medical centers of the recipient’s choosing. Dr. Hanna said he decided to make this donation because he greatly values the opportunities that he had to teach surgical techniques to residents and surgeons in developing countries.

“If I can extend those same opportunities to other residents and surgeons through the American College of Surgeons, then I’m happy to do so,” Dr. Hanna said. “I’m connected to institutions in 28 countries, so I think, through this partnership, we will be able to do a lot of good throughout the world.”

Dr. Pon satitpunwaycha

Oon Satitpunwaycha, MD, FACS, is a community surgeon with an international perspective. Dr. Pon was born in Thailand and undertook both premedical and medical training there. To develop his surgical expertise, he then came to Northwestern University in Chicago, IL, where he trained for six years as an intern, resident, and instructor. After returning to Thailand and starting his academic career, Dr. Pon accepted a fellowship at the Texas Heart Institute. He decided to remain in the Houston, TX, area, where he established a successful practice.

Since 1996, Dr. Pon has been a loyal and generous benefactor to the American College of Surgeons, investing in the College’s priority programs. What is his motivation? “For the years that I have been a member, I have benefited tremendously from the College’s efforts; therefore, I believe it is my obligation to give financial support to ensure that future surgeons will have the same opportunities,” Dr. Pon said. He views gifts to the ACS as “an investment in the future of surgery.”

Recently, he made an extraordinary gift of $500,000 to establish the Pon Satitpunwaycha, MD, FACS, International Education Initiatives Fund to promote learning opportunities among international surgeons, especially those in the early stages of their careers. His reason is clear: “I am grateful for the opportunity this country has given me. At this point in my life, I feel obliged to give back. I hope this fund leads to a better understanding and friendship between countries.”

The ACS Foundation has recognized the generosity of spirit shown by Dr. Pon with its Distinguished Philanthropist Award. While he may be retired from full-time practice, Dr. Pon’s energetic advocacy for international education continues.
Why I Give Back

By Idatonye I. Afonya, MD, FACS

I think I’m “old school.” My father was an Anglican pastor in Nigeria, where I was born. He taught me that if someone or someplace gives to you, you should give back to that individual or institution. That’s the way I grew up.

I have been a Fellow of the American College of Surgeons since 1983 and started contributing to the College’s development fund program in 1988. Since then, I have made regular donations to support the ACS Foundation—sometimes several in one year. I became a Fellow and have been a regular donor because the College has always been at the forefront of providing surgeons with the tools and skills they need to take care of people.

I have benefitted from the College’s programs and activities in many ways, and I want to make sure that both young surgeons in this country and international medical graduates, like me, have the same opportunities. I don’t think someone’s financial limitations should prevent them from pursuing their dreams.

It is my belief that the people who came before us provide the roadmap. It’s up to us to follow the roadmap and hopefully leave our footprints on it so that others can get to places they want to go. That’s what giving to the College does. It leaves a footprint for others to follow.

Ways to Give

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

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

A variety of gifting vehicles is available to our benefactors:

GIVING ONLINE
Please visit www.facs.org/acsfoundation to donate with a credit card.

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

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

ESTATE GIFTS
Including the American College of Surgeons in your will or estate plan is an easy way to ensure the future vitality of programs and services that benefit the Fellowship. The official legal bequest language for the American College of Surgeons Foundation is:

“I, [name], of [city, state, ZIP], give, devise, and bequeath to the American College of Surgeons Foundation [written amount or percentage of the estate or description of property] for its unrestricted use and purpose.”

GIFTS OF ASSETS (LIFE INSURANCE, SECURITIES, REAL ESTATE)
Consult your financial advisor or the Foundation website to determine optimal benefit.

LIFE INCOME GIFTS
Planned gifts such as gift annuities and trusts can provide mutual benefits. Please visit the Foundation’s website for details.
The April 2011 issue of the journal Surgical Clinics of North America featured an article titled “Update on Surgical Palliative Care,” which offered a heartening picture of the progress that has been made in this field. The article also brought to mind some recollections of surgeons who early on made significant contributions to the palliative care of patients and the development of hospice.

My own interest in palliative care began in the late 1950s during my surgical residency at The Johns Hopkins Hospital under Alfred Blalock, MD, FACS, President of the American College of Surgeons (ACS) between 1954 and 1955. Dr. Blalock was, in a sense, an early contributor to palliation. The shunting procedure that he and Helen Tausig, MD, designed and which Dr. Blalock and Vivien Thomas, a surgical research technician, perfected, relieved the symptoms of “blue babies,” but did not correct the complex anatomical abnormalities of the tetralogy of Fallot. (In 1976, Mr. Thomas was awarded an honorary doctorate by The Johns Hopkins University).

In the 1950s, physicians were curing no more than 5 to 10 percent of patients with esophageal and lung cancer. I became concerned with what we were doing to the other 90 to 95 percent. While a visiting professor at Johns Hopkins University, Philip Allison, MD, of Leeds, England, described his use of the Souttar tube—an endoscopic device—to relieve obstructive symptoms in patients with unresectable esophageal tumors. With the encouragement and help of James Cantrell, MD, FACS, who at the time was a member of the university’s full-time staff, I began placing Souttar tubes and found them helpful in diminishing the distress of severe dysphagia. My interest in surgical techniques...
to ameliorate troublesome symptoms continued through the ensuing years.

**Early surgical pioneers in palliation**

In 1967, *Palliative Care of the Cancer Patient* by Robert Hickey, MD, FACS, chairman of the department of surgery at the University of Wisconsin Madison, was published. This was a fascinating, comprehensive work which, as the preface states, “place(d) within one volume a compilation of documented experience and data on the palliative care of the advanced cancer patient.” A total of 22 Fellows of the ACS contributed to the book.

A couple of examples from *Palliative Care of the Cancer Patient* offer a picture of the insight of these surgeons in the mid-1960s. In the chapter on palliation of metastatic bone disease, Crawford Campbell, MD, FACS, stressed the importance of tailoring treatment to the needs of the individual patient based on careful communication and consideration of the pros and cons of particular options. Dr. Campbell’s outline of those options of nonsurgical methods (radiation, chemotherapy, hormonal therapy) and surgical techniques (external and internal fixation, prosthesis, and so on) would be little different from those in a textbook written today.

In another chapter, Colin Thomas, MD, FACS, provided a systematic review of palliative care of the patient with advanced thyroid cancer. Dr. Thomas covered not only surgical measures such as tracheotomy for airway obstruction, but the other available weapons including external beam radiation, radioiodine, and the use of thyrotopin suppression for well differentiated tumors. In this chapter, as in many of the other sections of *Palliative Care of the Cancer Patient*, remarkable groundwork was set forth for the development of improved methods of palliation.

J. Englebert Dunphy, MD, FACS, President of the College between 1963 and 1964, was another notable contributor to *Palliative Care of the Cancer Patient*. Dr. Dunphy had a long-standing familiarity with the complexities of the broader, non-technical problems in dealing with the treatment of cancer at various stages. However, it was Dr. Dunphy’s discourse at the 1976 annual meeting of the Massachusetts Medical Society, titled On Caring for the Patient with Cancer, which put the focus on palliative care of the patient with incurable disease. He addressed the difficult challenges of communicating diagnosis, prognosis, and life expectancy with these patients. He emphasized the importance of skilled nursing care and relief of symptoms, and he addressed the controversial topic of hydration and nutrition in the dying patient. Over the remaining years of Dr. Dunphy’s life he continued to stress that “the secret of the care of the patient is in caring for the patient.”

**The Church Hospital experience**

It was during the mid-1970s that Paul Dawson, the chaplain at Baltimore’s Church Hospital in Maryland, learned of Dame Cicely Saunders’ pioneering development of a hospice program at St. Christopher’s in Sydenham, England, which had opened in 1967. Knowing of my interest in surgical palliation (I was chief of surgery at Church Hospital at the time), and aware that medical staff initiative would be essential to the establishment of such a program at our hospital, Mr. Dawson approached me about the possibility of launching a hospice program. I was intrigued by the initiative, and though I liked the concept, I thought that it was too ambitious for an institution of our size. At that time, the only hospice program in the U.S. was The Connecticut Hospice in Branford, CT. Mr. Dawson did not accept my answer. He invited Balfour Mount, MD, FRCS, who had begun the palliative care service at the Royal Victoria Hospital in Montreal, to give a lecture to the Church Hospital staff. Dr. Mount is a urologist, and as a fellow surgeon, he got my attention. He is also a persuasive speaker and by the time Dr. Mount’s presentation was over, I was convinced that the possibility of a hospice program at Church Hospital was worth pursuing. Dr. Mount has continued over the years to play a monumental role in refining and promoting hospice care.

The Church Hospital’s governing board decided to investigate the possibility of creating a hospital-based hospice program, and in January 1977, sent a team to St. Christopher’s. It was there that I first met Tom West, MD, a surgeon who supervised the daily hands-on care provided at St. Christopher’s. Dr. West had, I believe, been an associate of Dame Cicely Saunders at St. Thomas Hospital in London when both were in training there. He served as a medical missionary in Africa for a number of years before joining Dr. Saunders when she opened her hospice program. Once we had breached the American-English language barrier, it was from Dr. West that I learned the nitty-gritty of providing symptom relief
to the terminally ill. He explained and demonstrated the use of adequate doses of oral narcotics for pain control and the effective techniques for dealing with anorexia, nausea, dyspnea, constipation, insomnia, and a host of other symptoms.

Upon our return to Baltimore, it was agreed that we should start a hospice program at the Church Hospital. Our first patients were admitted to the program later that year. We followed Dr. West’s firm advice not to try to duplicate St. Christopher’s hospice program, but to adapt our service to local conditions and needs. The Church Hospital Hospice, which was only the second hospice on the east coast when it began, flourished and grew. At the time, I presented our experiences at the Southern Surgical Association meeting in December 1978—a meeting that was attended by Dr. Dunphy. Though I do not recall Dr. Dunphy discussing the paper at the time of the presentation, I do remember him offering me encouraging comments during our one-on-one interaction.

Reactions of surgeons

The reactions of other surgeons present at the meeting were varied. One said, “That doesn’t sound very surgical to me.” On my way to the podium, the secretary of the association, who was responsible for projecting the name of the speaker and the title of his paper, stopped me to ask me how to spell the word “hospice.” However, Sheldon Horsley, MD, FACS, who has made valuable contributions to the treatment of breast cancer, emphasized the need for attention to palliative care for that disease in his formal discussion at the meeting. Overall, I sensed that there was appreciation and support among those present for surgical involvement in a field that had been too long neglected.

C. Rollins Hanlon, MD, FACS—President of the ACS from 1987 to 1988 and the organization’s former Director—was a reliable supporter of surgical participation in palliative care. From the time Dr. Hanlon first learned of the Church Hospital hospice program, he kept in touch with our progress and his comments reflected a genuine concern with this aspect of surgical care. Some of his Ethics Committee initiatives no doubt paved the way for subsequent College involvement in palliative care.

It is reassuring to know that surgeons in general and the American College of Surgeons in particular continue their commitment to the welfare of our patients through attention to the importance of palliative care. There is an ongoing need for innovation and improvements in this field. The College’s Surgical Palliative Care Task Force serves as a means of encouraging and facilitating such development.

References


Dr. Zimmerman is a retired associate professor of surgery, Johns Hopkins University, Baltimore, MD, and a retired chief of surgery, Church Hospital, Baltimore.
Surgical coding across the spectrum

by Linda Barney, MD, FACS; Daniel Nagle, MD, FACS; Sean Roddy, MD, FACS; Mark Savarise, MD, FACS; Christopher Senkowski, MD, FACS; Eric Whitacre, MD, FACS; and Jenny Jackson, MPH

This month’s column addresses—and reinforces—important concepts in coding for different types of surgical procedures using a series of fictional cases that cover the following areas: trauma, breast, vascular, gastrointestinal, and hand surgery.*

Trauma surgery

Case: A 30-year-old male involved in a motor vehicle collision arrives at the hospital in shock. He is taken to the operating room (OR), his spleen is removed, and a single segment of small bowel is resected. Damage control techniques leave the bowel disconnected. A temporary closure is applied. The following day, one of the surgeon’s partners takes the patient back to the OR and removes additional bowel with a small bowel re-anastomosis and closes the abdomen. Reportable codes include the following:

Day 1:
38100, Splenectomy; total
44120–52, Enterectomy, resection of small intestine; single resection and anastomosis
99223–57, Initial hospital care

Day 2:
44120–58, Enterectomy, resection of small intestine; single resection and anastomosis

The initial evaluation of this critically ill patient warrants reporting a high-level initial inpatient evaluation and management (E/M) code. For example, this may be reported with code 99223. The decision for surgery is noted by appending modifier 57 to the E/M code.

The initial operation on Day 1 is reported with the two separate resection codes, 38100 and 44120. Because the enterectomy did not include an anastomosis, the reduced services modifier 52 should be appended to code 44120.

The return visit to the OR by the surgical partner should be reported with the same enterectomy code that was reported on Day 1, because there is no specific code for closure of the abdomen. Abdominal closure is included in the enterectomy code. Appending modifier 58 to the enterectomy code indicates that the procedure during the postoperative period was planned or anticipated (staged) and more extensive than the original procedure. In this case, your partner is considered an extension of you. Code 49002 cannot be billed when other procedures, such as 44120 in the previous example, are performed. If the procedure on Day 2 is simply to “relook” and close the abdomen, the appropriate code to report is 49002, Reopening of recent laparotomy.

If the patient receives critical care services unrelated to the operation (for example, to deal with shock or respiratory failure as a result of the injury), this is reported by totaling the time spent on each calendar day and reporting codes 99291, Critical care, evaluation and management, first 30-74 minutes, and add-on code 99292, each additional 30 minutes, as appropriate. If all the surgeons are in the same group practice (that is, the surgeons share the same tax identification number), it is important to coordinate the critical care versus the admit codes among the partners who are billing. If negative pressure wound therapy is indicated, code 97605, Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters, or code 97606, Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters, would be reported based on the size of the wound.

Breast surgery

Case: A 58-year-old female undergoes a right breast lumpectomy and sentinel lymph node biopsy for a 1.2 cm moderately differentiated ER/PR positive node

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.
negative infiltrating ductal carcinoma. A multi-gene assay showed the patient would benefit from adjuvant chemotherapy, so she undergoes insertion of a venous access port two weeks following lumpectomy. This falls within the 90-day global billing period following lumpectomy. Reportable codes include the following:

36561–58, Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 or older
77001, Fluoroscopic guidance for central venous access device placement, replacement
or
76937, Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites

Insertion of a subcutaneous venous access port is reported with code 36561 and modifier 58 is appended because this is staged or related procedure performed by the same physician within the postoperative global period. A diagnosis of breast cancer (International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9] code 174.0-174.9) is reported. If imaging guidance is required for port placement, this may be reported with code 77001 for fluoroscopic guidance or 76937 for ultrasound guidance. Note that use of ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is used. Either the surgeon or the radiologist may report the guidance code.

Case: A 78-year-old female undergoes a left simple mastectomy and sentinel lymph node biopsy for extensive ductal carcinoma in situ of the left breast. The evening of the surgery, the patient develops swelling, pain, and ecchymosis over the left chest wall with copious bloody drainage in the closed suction drain. Examination shows a post-mastectomy hematoma and the patient undergoes surgical evacuation of the hematoma in the operating room that night. Reportable codes:

35820–78, Exploration for postoperative hemorrhage, thrombosis or infection; chest

Evacuation of a hematoma of the chest is reported with code 35820 and modifier 78 is appended because this occurred during the global period of the mastectomy and was an unexpected return to the operating room.

**Vascular surgery**

Case: A 68-year-old male nursing home resident who has never been seen in the surgeon’s office has a profound ischemic rest pain in the right lower extremity. Angiography demonstrates severe infrapopliteal trifurcation occlusive disease with reconstitution of the anterior tibial artery. He has preoperative vein mapping, which demonstrates adequate caliber saphenous vein. The surgeon decides to perform a distal bypass with reverse saphenous vein. Reportable codes include the following:

Day 1:
9920X, Office or other outpatient visit for the evaluation and management of a new patient

Day 2:
36246, Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family
75625, Aortography, abdominal, by serialangiography, radiological supervision and interpretation
75710, Angiography, extremity, unilateral, radiological supervision and interpretation

One week later:
9921X, Office or other outpatient visit for the evaluation and management of an established patient
93971, Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

Next day:
35566, Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels

Due to the fact that this patient has never been seen before in your office, the office visit is reported with a code for office visit of a new patient (99201-99205), selected based on the level of service documented.

The next day the surgeon reports code 36246 for the left femoral puncture with non-selective aortic catheterization followed by selective catheterization of the right common iliac, and then the right external iliac artery constituting a second order catheterization below the diaphragm. Report code 75625 for the aortogram, and code 75710 for unilateral leg angiogram.

One week later, the patient returns to the office for a follow-up visit to discuss the results of his angiogram. This is reported with a code for office visit of an established patient (99211-99215), selected based on...
the level of service documented. At this visit the surgeon decides that he will require surgery and that vein mapping will be necessary. Vein mapping, performed that same day, is reported using the extremity vascular ultrasound codes which are typically divided into “unilateral or limited” or “complete and bilateral.” Vein mapping does not typically involve evaluation of the deep system and, therefore, is classified as “limited.” A unilateral or bilateral vein ultrasound that does not interrogate the deep system is also classified as “limited” and reported with code 93971. The next day, the surgeon performs a distal bypass with reverse saphenous vein, reported with code 35566.

Gastrointestinal surgery

Case: A 45-year-old patient is taken to the OR for a laparoscopic cholecystectomy; at the time of the procedure, the surgeon discovers an umbilical hernia. The surgeon extends the surgical excision in order to repair the umbilical hernia. The reportable code is:

47562, Laparoscopy, surgical; cholecystectomy

Only the laparoscopic cholecystectomy is reported. When a laparoscopic cholecystectomy is performed, by convention, the approach is always through the umbilical area. If there is a defect (for example, umbilical hernia), then it is repaired as part of the closure. There is no additional coding for the repair of the umbilical hernia.

Hand surgery

Case: A patient with contracture of the right ring and small finger, metacarpophalangeal joints due to Dupuytren’s disease, undergoes percutaneous needle aponeurotomy to release two cords. The reportable code is:

26040, Fasciotomy, palmar (eg, Dupuytren’s contracture); percutaneous

Although two cords were released during this procedure, the Centers for Medicare & Medicaid Services has interpreted this code as applying to the release of one or more palmar cord.

Decision for surgery

Modifier 57 is appended to an E/M service to indicate the “decision for surgery.” Whether the day before surgery or the day of surgery, the E/M service CPT code must have modifier 57 appended so that the service is not disallowed as part of the surgical package. Modifier 57 is usually used with major procedures (for example, those with a 90-day global period).

Case: A diabetic patient presents in the emergency department with acute cholecystitis. Options are discussed with the patient and the patient’s primary care physician admits the patient for aggressive blood glucose control. You plan to perform a laparoscopic cholecystectomy. Proposed surgery is performed the following day. Reportable codes include the following:

Medicare patient:

9922X–57, Initial hospital care
47562, Laparoscopy, surgical; cholecystectomy

The initial E/M service is reported with an initial hospital inpatient code (99221-99223), selected based on the level of service documented. Modifier 57 is appended to the E/M code, indicating that the E/M encounter is the decision for surgery. Medicare does not recognize consult codes. It directs that all physicians use the initial inpatient or observation codes (depending on the admission status of the patient); the primary admitting physician appends the E/M codes with the modifier AI. The laparoscopic cholecystectomy is reported with code 47562; no modifier is appended. If a cholangiography is indicated, report code 47563, Laparoscopy, surgical; cholecystectomy with cholangiography.

Non-Medicare patient:

9925X–57, Inpatient consultation for a new or established patient
47562, Laparoscopy, surgical; cholecystectomy

The initial E/M service is reported with a consultation code (99251-99255), selected based on the level of service documented. Modifier 57 is appended to the E/M code, indicating that the E/M encounter is the decision for surgery. The laparoscopic cholecystectomy is reported with code 47562. No modifier is appended. If a cholangiography is indicated, report code 47563, Laparoscopy, surgical; cholecystectomy with cholangiography.

E/M on day of surgery

Modifier 25 is appended only to E/M codes, indicating that a “significant, separately identifiable” E/M service is provided on the same day as a “minor”
procedure (for example, those with a 0-day or 10-day global period) per Medicare guidelines.

Case: A patient notes a lump in her right breast the day of her laparoscopic cholecystectomy. The surgeon evaluates the 2 cm periareolar right breast mass and determines that a biopsy is necessary. Reportable codes include the following:

9923X–25, Subsequent hospital care
19100, Biopsy of breast; percutaneous, needle core, not using imaging guidance

The E/M service for the evaluation of the right breast is unrelated to the cholecystectomy and is reported with a subsequent hospital E/M code (99231-99233), selected based on the level of service documented. Modifier 25 is appended indicating a significant, separately identifiable service. In this case, the ICD-9 code will be different (lump or mass in breast, 611.72). The breast biopsy procedure, reported with code 19100, does not take modifier 25.

Procedures in the postoperative global periods

Case: A 53-year-old woman has undergone a unilateral mastectomy. Ten days later, the surgical site remains open and unhealed. She returns to the office and a wound vac is placed.

For Medicare claims, the global surgical package includes treatment of all complications related to the surgery, unless there is a return to the operating room or procedure room (as defined by CMS). Thus, if the surgical site of a mastectomy patient becomes infected, requiring placement of a wound vac in the office, this procedure is not separately reportable, unless performed in a CMS-approved procedure room.

Some payors may use Medicare rules in this situation, but many do not. Thus, if a wound vac is placed in the office, for a non-Medicare patient, the reportable procedure is as follows:

97605–78, Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

Diagnosis coding

Is a lesion of uncertain diagnosis reported with ICD-9 code 238.2, skin neoplasm of uncertain behavior?

If a surgeon is unsure of a diagnosis, the ICD-9 code should not be selected until after the pathology report is complete. ICD-9 code 238.2 is a definitive diagnosis. A diagnosis of uncertain behavior may include lesions such as dysplastic nevi and congenital giant pigmented nevi. ICD-9 code 238.2 should not be used if the diagnosis is not yet known.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain Time, excluding holidays.

Editor’s note

Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.

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Medical malpractice reform in North Carolina

by Matt B. Martin, MD, FACS; Catharine Harris; and Charlotte Grill

The July Bulletin featured an excellent summary of medical liability reform.* “The state of medical liability reform,” written by Don Selzer, MD, FACS; John Meara, MD, FACS; and Jennifer Pollack, was particularly meaningful to those of us in North Carolina who witnessed the political tempest that ultimately led to the passage of historic malpractice reform legislation in the “Old North State.”

Previous reform efforts

Policymakers in North Carolina had not passed any medical liability reform legislation since 1995, when the state enacted a pre-litigation expert review requirement and set standards for experts in medical malpractice cases. However, medical malpractice reform has been on the minds of Tar Heel physicians since the 1970s, when a malpractice carrier crisis resulted in the formation of physician-owned Medical Mutual of North Carolina, which has remained the dominant provider of physician liability insurance ever since. From 2004 to 2007, Medical Mutual of North Carolina helped organize Protect Health Care Now, an organization founded solely to motivate physicians to lobby the North Carolina General Assembly for medical malpractice reform. However, the Democratic-controlled House and Senate always stymied any substantive reform efforts. Cynicism abounded among physicians who felt ignored for their attempts to see even incremental tort reform, year after year.

The turning point came in the midterm elections of November 2010, when Republicans gained a majority in both the North Carolina House and Senate for the first time since 1870. At a January North Carolina political action committee (PAC) fundraiser, the new Senate majority leader, Phil Berger (R) boldly promised passage of a meaningful medical malpractice reform bill. Skeptics raised their eyebrows at Sen. Berger’s audacity, but he and the Republican leadership in the House delivered what was ultimately a sweeping reform bill.

S.B. 33

S.B. 33/H.B. 542 applies to health care professionals, hospitals, nursing homes, and other providers. It establishes trial bifurcation, whereby the jury first determines if the defendant was negligent. If so, the case proceeds to the second part of the trial, at which time the defendant’s liability is established. This process addresses the classic jury conundrum of confusing bad outcomes with medical negligence. Before this reform, plaintiff attorneys could elicit sympathetic responses from jurors by introducing evidence of the severity of harm, even before the court had decided if the physician had breached the standard of care. This measure will also save time in court and litigation costs for those trials ending in a determination of no negligence for the defendant.

S.B. 33 also ensures that a defendant can afford to appeal large jury awards that exceed coverage limits by requiring the court to set appeal bonds based on the consideration of relevant factors, such as the amount of the judgment, the policy limits of the insured, and the aggregate net worth of the health provider. Up to that point, the law required a bond in the full amount of the judgment to be set, and it was impossible for some defendants to meet this requirement because there would be no assets to back up such a bond.

This legislation is also pediatrician-friendly in that it requires complaints filed on behalf of minors to be closed in a timely fashion, which reduces the physician tail coverage from 20 years to 10. It also may reduce inappropriate lawsuits by requiring the pre-litigation reviewing expert to go over all of the reasonably available medical records. Furthermore, this legislation strengthens expert witness requirements on administrative and nonclinical issues by requiring experts to have substantive knowledge about the applicable standard in hospitals or facilities of the same type as the defendant’s facilities.

S.B. 33 broadens the scope of statutory protections applicable to malpractice cases by adding adult care homes to the definition of “health care provider.” The bill also provides that “medical malpractice” includes civil actions that allege a breach of administrative or corporate duties by hospitals, nursing homes, or adult care homes (such as credentialing, monitoring, and supervision of staff) if the claims arise out of the same facts or circumstances as a claim against a health care professional. This bill raises the burden of proof required to prove negligence in emergency medical conditions to “clear and convincing evidence,” rather than “the preponderance of the evidence.”

Finally, S.B. 33 caps noneconomic damages (pain, suffering, emotional distress, loss of consortium, inconvenience, and other non-pecuniary compensatory damages) at $500,000 per plaintiff.

**Veto overturned**

Both the House and the Senate ratified S.B. 33 on June 13. At that point, it was sent to Gov. Beverly Perdue (D). As was later reported by the *Raleigh News and Observer*, lawyers donated $151,209 to Governor Perdue’s campaign coffers in June, when it became clear that the medical malpractice bill was likely to pass the General Assembly. Governor Perdue vetoed S.B. 33 on June 24. After a brief recess, the Senate and House reconvened in late July and voted to override the governor’s veto on July 25. S.B. 33 became law on October 1.

Medical malpractice reform became possible only because of the seismic shift in leadership in the General Assembly. In years past, the House Speaker could let such legislation die in committee.

The North Carolina Medical Society’s (NCMS) political advocacy section did an outstanding job of representing physicians and promoting this legislation as good for the citizens of North Carolina and fair for patients who may have suffered from negligent care. Wisely, the emphasis was not on the cost of malpractice insurance, and tort reform did not become a liability insurance issue. The NCMS leadership reached out to physicians throughout the state and, along with partners in hospital and business communities, provided grassroots support to overturn the governor’s veto.

**Grassroots advocacy works**

Physicians are learning that they must engage in the legislative process, and as the passage of medical malpractice legislation in North Carolina demonstrated, grassroots advocacy works. Legislators ultimately are accountable to their constituents, which is why surgeons’ advocacy efforts are crucial to the future of the profession. Surgeons are not just experts in their field, but they also have the personal stories and local connections that help legislators see the connection between federal and state policies and the effects on surgeons and surgical patients. To that end, the American College of Surgeons (ACS) offers Fellows a variety of ways to get involved in grassroots advocacy initiatives at both the state and federal levels. They are as follows:

- **Respond to Grassroots Action Alerts.** When pertinent federal legislation warrants it, the College sends Fellows an e-mail that outlines how to contact their senators and representatives and provides talking points. In some cases, all it takes is the click of a button to send a prewritten e-mail or a quick phone call to legislators’ health policy staff. Despite the potential power of this method of advocacy, less than 10 percent of ACS Fellows respond to calls...
to action. Fellows also may visit the ACS Federal Legislative Action Center at http://www.capitolconnect.com/acspa/ to get updated on timely legislation being considered on Capitol Hill.

• **Use the Surgery State Legislation Action Center.** In addition to the Federal Legislative Action Center, the college offers the Surgery State Legislation Action Center (SSLAC), which is an online coalition of 14 surgical specialties. The SSLAC is an easy means to facilitate and mobilize surgeons to become involved in grassroots advocacy efforts at both the state and federal level. This website is open to both Fellows and non-Fellows at http://www.facs.org/sslac. The SSLAC allows surgeons to find their elected state officials and obtain relevant information on upcoming elections and candidates. In addition, important Action Alerts are posted through the SSLAC website, and surgeons are directed to the site to easily send prewritten letters on a variety of bills and issues to their legislators and to newspaper editors.

• **Read the College’s newsletters.** College-wide notifications of important advocacy efforts are posted monthly in *Newscope* and special e-mails that are sent out to all Fellows. Be sure to read these updates, as they often include calls to action on important legislation. State Affairs staff posted monthly updates on S.B. 33 from June through August 2011 and directed Fellows to the NCMS website to ensure that all North Carolina surgeons had the most up-to-date information on the bill and were able to contact the governor, senators, and representatives at critical times in the passing of this bill.

• **Attend the ACS Advocacy Summit.** The First Annual Advocacy Summit will take place March 26–27, 2012, at the JW Marriott in Washington, DC. The summit will feature advocacy training sessions and in-depth issue briefings. The event will culminate in hundreds of surgeons blanketing Capitol Hill to meet with their members of Congress and advocate for health policy issues, including liability reform. For more information or to register for the ACS Advocacy Summit, visit http://www.facs.org/ahp/summit/index.html.

• **Get involved with PACs.** PACs contribute to members of Congress who are typically supportive of the group they represent. The American College of Surgeons Professional Association’s PAC, known as the ACSPA-SurgeonsPAC, for example, contributes to members of Congress—both Republicans and Democrats—who have been supportive of issues that affect surgical practice, such as liability reform. For more information about the ACSPA-SurgeonsPAC, visit www.surgeonspac.org.

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Dr. Eastman is next President-Elect of the College

A. Brent Eastman, MD, FACS, a general, vascular, and trauma surgeon from San Diego, CA, was named President-Elect of the American College of Surgeons (ACS) during the Annual Business Meeting of Members that took place October 26, during Clinical Congress, in San Francisco, CA.

Dr. Eastman has been a Fellow since 1976 and has been active in the governance of the College, particularly as the Chair of the Board of Regents (2009–2010). Dr. Eastman is corporate senior vice-president, chief medical officer of Scripps Health, and the N. Paul Whittier Chair of Trauma at Scripps Memorial Hospital, La Jolla, CA. He is also a clinical professor of surgery-trauma at the University of California, San Diego.

A graduate of the University of Wyoming and the University of California, San Francisco (UCSF), School of Medicine (1966), Dr. Eastman was student body president at both institutions. At UCSF, he completed his surgical internship and residency and served as chief surgical resident. In addition, Dr. Eastman spent one year as surgical registrar at Norfolk and Norwich Hospital, Norwich, England.

Dr. Eastman began serving on the College’s Board of Regents in 2001. In addition to serving as a Regent, Dr. Eastman has been an active member of many College committees, particularly the ACS Committee on Trauma (COT). He helped create and was the first Chair of the COT Trauma System Consultation Committee, and is an instructor for the internationally renowned Advanced Trauma Life Support® course. In addition to chairing the COT (1990–1994), Dr. Eastman chaired the College’s Scholarship Committee (2005–2008), the Central Judiciary Committee (2007–2009), and the Finance Committee of the Board of Regents (2009–2010).

He is an active member of many leading surgical organizations, including the American Surgical Association, the American Association for the Surgery of Trauma (AAST), the International Society of Cardiovascular Surgery, the Society of Clinical Vascular Surgery, the Pacific Coast Surgical Association, and the Naffziger (UCSF) Surgical Society, of which he is President-Elect. In addition, Dr. Eastman served as chair of the Centers for Disease Control and Prevention (CDC) Research Agenda Steering Committee and is a member of the Board of Scientific Counselors for the CDC’s National Center for Injury Prevention.

Throughout his distinguished career, Dr. Eastman has authored or co-authored multiple publications and articles related to trauma. He served on the Institute of Medicine committee that in 2006 published the landmark report, *The Future of Emergency Care in the United States Health System*.

Dr. Eastman has been instrumental in the development of trauma systems worldwide. He is one of the co-founders of the San Diego Count Trauma System and has lectured and helped put trauma systems into place in the U.S., England, Argentina, Canada, Mexico, Australia, Brazil, South Africa, India, Pakistan, and other countries. He participated in the ACS/AAST Distinguished Visiting Surgeon in Combat Casualty Program at the U.S. military hospital, the Landstuhl Regional Medical Center, Landstuhl, Germany, in July 2007. He subsequently was granted the distinction of Honorary Member of the U.S. Army Medical Regiment, by order of the U.S. Surgeon General.

Dr. Eastman’s wife, Sarita, a graduate of UCSF Medical School, is a pediatrician and author. Their three children are Roan and Ian, who live with their families in Jackson Hole, WY, and Alexandra, who lives in Manhattan and is an associate producer of special events at the Metropolitan Opera. The Vice-Presidents-Elect were
also elected during the Annual Business Meeting of Members. R. Phillip Burns, MD, FACS, of Chattanooga, TN, is First Vice-President-Elect, and John M. Daly, MD, FACS, of Philadelphia, PA, is Second Vice-President-Elect.

Dr. Burns, a general surgeon, is chairman and professor of surgery, department of surgery, University of Tennessee College of Medicine, Chattanooga. A Fellow of the College since 1976, Dr. Burns served as President of the Tennessee Chapter (1998–1999) and as a member (2004–2006) and Chair (2006–2009) of the Board of Governors’ Committee on Surgical Practices.

Dr. Daly, a general surgeon, is dean emeritus, Temple University School of Medicine, Philadelphia, PA. A Fellow since 1983, Dr. Daly served as a senior member of the Commission on Cancer (1989–1999), Chair of the Governors' Committee on Physician Competency and Health (1999–2001), and Chair of the Nominating Committee of the Fellows (1998–1999).

ACS Members who are recertifying can now enjoy the ease of submitting their ACS CME credits directly to the American Board of Surgery (ABS).

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A M E R I C A N  C O L L E G E  O F  S U R G E O N S  •  D I V I S I O N  O F  E D U C A T I O N
The American College of Surgeons (ACS) and other organizations have partnered with the Johns Hopkins Armstrong Institute for Patient Safety and Quality in Baltimore, MD, to conduct a multistate study aimed at developing interventions to reduce surgical site infections (SSIs) and other complications from colorectal procedures. The U.S. Department of Health and Human Services’ Agency for Healthcare Research and Quality (AHRQ) awarded a $10 million grant to Hopkins to carry out the research in response to the AHRQ Task Order: Development and Demonstration of a Surgical Unit-Based Safety Program.

The College’s National Surgical Quality Improvement Project (ACS NSQIP)—the first nationally validated program to measure outcomes and improve the quality of surgical care—is providing surgical leadership, staff, and database resources for the project. Anesthesiologist and critical care specialist Peter J. Pronovost, MD, director of the Armstrong Institute, is the project’s principal investigator, and Clifford Y. Ko, MD, FACS, a colorectal surgeon and Director of the ACS Division of Research and Optimal Patient Care, serves as the ACS subproject principal investigator.

The robust ACS NSQIP database is an integral resource for this study. Furthermore, ACS NSQIP staff will make substantial contributions to the project as it begins to take hold in the months ahead. It will progressively advance in 10 states, all of which have significant ACS NSQIP participation at a minimum of 10 hospitals. Throughout the project, ACS NSQIP staff will advise the Hopkins team on the best methods of collecting rigorous and reliable data in hospital settings, and will provide ongoing perspective and technical expertise on developing effective interventions to improve patient outcomes.

Participating hospital teams will receive monthly reports using real-time NSQIP data. As the project progresses, ACS NSQIP will issue a report to each participating hospital every six months. These reports will provide each institution with its risk-adjusted outcomes benchmarked against all 100 hospitals during the initial project year, as well as all ACS NSQIP-participating hospitals in the U.S.

“Hospitals participating in ACS NSQIP appear to be preventing between 250 and 500 complications per hospital, per year,” Dr. Ko said. “ACS NSQIP is an ideal program to partner with the Hopkins team’s proven methods for implementing a quality improvement and safety program. Working together, we think we can certainly raise the bar in that regard for all participating hospitals.”

The project is modeled on the earlier success of Dr. Pronovost’s Comprehensive Unit-based Safety Program (CUSP)—an airplane cockpit-style, five-step checklist activated in tandem with a point-of-care cultural change that dramatically reduced central line-associated bloodstream infections in intensive-care units throughout the state of Michigan. CUSP is believed to have saved thousands of lives and millions of health care dollars and is now in place throughout the U.S. and many nations around the world.

“This work will build on our knowledge of how to prevent central-line infections and apply it to the task of preventing surgical-site infections, pneumonia, deep-vein thrombosis, and other common surgical complications,” Dr. Pronovost said. “We should be able to repeat that success in other areas.”

The first phase of study began September 1, and will run until August 31, 2012, with three, one-year options attached to it, making the projected end date of the award August 31, 2015. In subsequent option years, the goal is to expand the study to all states, the District of Columbia, and Puerto Rico.
Dr. Sheldon receives prestigious UNC award

George F. Sheldon, MD, FACS—Director of the American College of Surgeons (ACS) Health Policy Research Institute, Editor-in-Chief of the ACS Web portal, and a Past-President of the College—received the University of North Carolina’s (UNC) 2011 Thomas Jefferson Award on September 16. Dr. Sheldon is the Zack D. Owens Distinguished Professor of Surgery, professor of surgery and social medicine, and former chair of the surgery department of the UNC at Chapel Hill School of Medicine.

The Robert Earl McConnell Foundation created the annual Thomas Jefferson Award in 1961 to recognize a UNC faculty member who—through personal influence and performance of duty in teaching, writing, and scholarship—exemplifies the ideals and objectives of former U.S. President Thomas Jefferson.

UNC faculty members nominate candidates for the honor, which includes a monetary prize. A faculty committee chooses the recipient. UNC chancellor Holden Thorp presented the award to Dr. Sheldon.

Dr. Sheldon has served as president of the American Surgical Association and the American Association for the Surgery of Trauma. He also served as president of the Uniformed Services University of the Health Sciences (USUHS) and is now a member of the external advisory board of the USUHS department of surgery. Dr. Sheldon is the first surgeon who wasn’t also a dean to chair the Association of American Medical Colleges since 1879. He also served as chair of the American Board of Surgery.

ACS HPRI publishes update of U.S. Atlas of the Surgical Workforce

The American College of Surgeons Health Policy Research Institute (ACS HPRI) in September published an updated version of the interactive, Web-based U.S. Atlas of the Surgical Workforce. Using maps and charts, the Atlas conveys the supply and geographic distribution of institutions and individuals that provide surgical services. The Atlas enables practitioners, policymakers, and patients to view the current and future distribution of surgeons in the U.S., identifying geographical regions with limited surgical services.

The Atlas provides a view of the distribution of total surgeons, general surgeons, surgical subspecialists, total physicians, and primary care physicians in each state. On the Web-based tool, users are able to click on a state to obtain county-level information and are able to hover over a state or county on the map to view the data value.

Demographic and health access indicators are also available for each state and county, and users may select from different variables and color schemes, and filter the display based on metropolitan status.

Future versions of the Atlas will offer enhanced functionality, additional geographic units, and hospital point locations. For more information or to provide feedback, e-mail acs-hpri@facs.org.
Dr. Britt receives honorary degree from Tuskegee University

L.D. Britt, MD, MPH, FACS, FCCM, FRCS Eng (Hon), FRCS Ed (Hon), FWACS (Hon), received an honorary degree from Tuskegee (AL) University in September during the 12th Annual Biomedical Research Symposium. Dr. Britt is the Immediate Past-President of the American College of Surgeons and serves as the Henry Ford and Brickhouse Professor and chairman, department of surgery, Eastern Virginia Medical School, Norfolk. Tuskegee University president Gilbert L. Rochon presented Dr. Britt with a doctor of Humane Letters degree at the symposium.

After expressing his gratitude for receiving the honor, Dr. Britt said he felt a special connection to Tuskegee University because he graduated from Booker T. Washington High School in Suffolk, VA.

Hosted by Tuskegee’s College of Veterinary Medicine, Nursing and Allied Health, the symposium highlighted health issues that disproportionately affect human health. This year’s theme was Passion and Compassion in Eliminating Health Disparities. Symposium sessions covered topics such as HIV/AIDS research, new advances and old disparities in cancer treatment, strategies to decrease obesity, and stress management. Dr. Britt, one of the keynote speakers for the symposium, said one of the greatest health risks in the 21st century is health care disparities. He outlined the challenges facing American medical care, including population growth, diminished resources, increased unemployment, limited use of information technology, underserved communities, workforce shortages, and a large number of aging Americans. He said access and quality are the two most important variables in whether a patient will receive adequate medical care, and income is the key to controlling those variables.

Dr. Britt said American health care cannot continue on its present path and remain sustainable. He suggested several countermeasures, such as reduction of wasteful health care spending, passage of medical liability reform legislation, promotion of proven health care, and wider use of information technology. Despite the disparities and shortcomings of the current health care system, Dr. Britt said he is optimistic, and he believes change is on the way.
Dr. Ford receives humanism in medicine award

Henri R. Ford, MD, MHA, FACS, of the Keck School of Medicine of the University of Southern California, Los Angeles, received the Arnold P. Gold Foundation Humanism in Medicine Award from the Association of American Medical Colleges (AAMC). The AAMC honored nine individuals, including Dr. Ford, and one teaching hospital for their outstanding contributions to academic medicine at an awards ceremony on November 5, during the association’s annual meeting in Denver, CO. Dr. Ford presently serves on the American College of Surgeons (ACS) Committee for the Forum on Fundamental Surgical Problems and as the Surgical Forum Representative on the Advisory Council for Pediatric Surgery. He is the Immediate Past-Vice-Chair of the Executive Committee of the ACS Board of Governors and has been an active member of the ACS Committee on Trauma.

Dr. Ford has pursued what he calls “the quest for significance” across medical education, research, and patient care. Vice-president and chief of surgery of Children’s Hospital in Los Angeles and vice-dean of medical education, professor, and vice-chair for clinical affairs in the department of surgery at the Keck School, Dr. Ford is known internationally for his work in pediatric surgery. Dr. Ford previously served as professor, chief of the division of pediatric surgery, and surgeon-in-chief of Children’s Hospital of Pittsburgh (PA) and the University of Pittsburgh School of Medicine.

International women in surgery symposium set for spring 2012

The Third Annual International Women in Surgery Career Symposium will take place May 31 through June 2, 2012, and will be hosted by Johns Hopkins University in Baltimore, MD. American College of Surgeons President Patricia J. Numann, MD, FACS, Lloyd S. Rogers Professor of Surgery Emeritus at the State University of New York Upstate Medical University in Syracuse, will deliver the keynote address.

The symposium will promote personal and professional growth in women surgeons and provide interactions with surgical leaders and pioneers who have advanced the roles of women in surgery. Sharon B. Ross, MD, will serve as chair for the symposium, and Julie A. Freischlag, MD, FACS, will be the co-chair.
SGO releases national agenda for women’s cancer research

The Society of Gynecologic Oncology (SGO) has released a comprehensive, collaborative research report, titled *Pathways to Progress in Women’s Cancer*, to encourage national policymakers to make women’s health initiatives a funding priority. The report, released in September to coincide with the observation of Gynecologic Cancer Awareness Month, was developed by health care professionals representing the entire spectrum of women’s cancer care specialists. These specialists assess the landscape of gynecologic cancer research, in addition to recommending specific “requests for action” for all gynecologic cancer disease sites.

Monique Spillman, MD, the SGO’s government relations committee chair, explained, “This report [is] a crucial stepping stone in creating specific national research programs that can leverage existing resources and use new resources wisely, all leading toward research discoveries that will help women.” The report indicates the growing need for increased collaboration and funding for bench and translational research, clinical trials, training, and survivorship for each of the key cancers of the gynecologic tract, particularly ovarian, endometrial, and cervical cancers. “Pathways to Progress will not only help us educate national policymakers as to progress made and future needs in women’s cancer research. It will also help us to protect and continue support for the Department of Defense Ovarian Cancer Research Program,” Dr. Spillman said.

The ultimate goal in creating the report is to advance the women’s gynecologic cancer research agenda for the next 10 years, even in the current climate of funding constraints. The Pathways to Progress report is not the SGO’s first foray into setting a charge for progress in women’s cancer research. In 1997, the organization—then known as the Society of Gynecologic Oncologists—along with the National Cancer Institute (NCI) and the Office of Women’s Health, organized a conference titled New Directions in Ovarian Cancer Research, which set a national ovarian cancer research agenda from 1998 through 2003. At that time, the consensus among health care professionals was, according the report, that “progress in ovarian cancer research would be facilitated and hastened by an investment in research infrastructure, such as tissue banking, ovarian cancer-specific grant opportunities, and resources for uncovering the genetic underpinnings of ovarian cancer.”

The Ovarian Cancer Research Report, the collaborative report produced as a result of the 1997 conference, was considered an authoritative research strategy and was influential in the development of several key ovarian cancer research programs, including the NCI Specialized Programs of Research Excellence program and the Department of Defense Ovarian Cancer Research Program. The landmark conference also contributed to an increase in dedicated funding for clinical trials, research training grants, and public education and awareness programming. Additionally, the information in the 1997 report greatly affected the ovarian cancer research community, resulting in new treatment modalities, biomarker detections tests, and current ongoing clinical trials.

In 2010, members of the women’s cancer community decided it was time to re-examine the scope of ovarian cancer research needs and determine the necessity of focusing on the predominant requirements that will have a major impact on all gynecologic malignancies. Thus, the SGO leadership organized a research summit that brought together gynecologic oncologists, medical oncologists, radiation oncologists, basic science researchers, epidemiologists, and educators to evaluate the current state of gynecologic cancer research and propose strategic objectives for the next 10 years.

The spectrum of gynecologic malignancies examined in the new Pathways report includes ovarian, cervical, endometrial, vulvar, and vaginal cancers. The Centers for Disease Control and Prevention has estimated that in 2007, a total

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The American College of Surgeons (ACS) is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management (http://heller.brandeis.edu/academic/execed/index.html) at Brandeis University, in Waltham, MA.

The 2012 course takes place May 20–26. The award is in the amount of $8,000 to be used toward the cost of tuition, travel, housing, and subsistence during the period of the course and the post-course follow-up period.

The College is funding two 2012 scholarships reserved for general surgeons. The College is very pleased that a large number of the surgical specialty societies have agreed to co-sponsor a scholarship for a member in good standing of both the College and the respective surgical society to attend this intensive program (see box for list of participating societies that are supporting scholarships).

The closing date for receipt of all application materials is February 1, 2012. All applicants will be notified of the outcome of the selection process by March 31, 2012.

Questions may be directed to the ACS Scholarships Administrator at kearly@facs.org or 312-202-5281. Requirements and application instructions for the scholarships are available at http://www.facs.org/memberservices/research.html.

Send applications for this scholarship in PDF format to kearly@facs.org or to Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL, 60611-3211.

Participating societies
- American Association of Neurological Surgeons
- American Academy of Otolaryngology-Head & Neck Surgery
- American Association for the Surgery of Trauma
- American College of Surgeons
- American Pediatric Surgical Society
- American Society of Breast Surgeons
- American Society of Colon and Rectal Surgeons
- American Society of Plastic Surgeons
- American Surgical Association
- American Urological Society
- Eastern Association for the Surgery of Trauma Foundation
- Society for Surgery of the Alimentary Tract
- The Society of Thoracic Surgeons
- Society for Vascular Surgery

of 80,976 women were diagnosed with a gynecologic malignancy, and 27,739 died of their disease. The SGO believes that the information in the report will guide gynecologic cancer research for at least the next 10 years and that the report will be a functional tool for helping the SGO and other organizations and advocacy groups set research and funding priorities for the future. “The underlying implications of this report are far-reaching and pertinent for a host of audiences in the cancer care community,” said John P. Curtin, MD, SGO president. “We strongly believe in advocating for our patients and their families so that one day we can realize our vision of eradicating gynecologic cancers for women around the world,” he added.

The report may be viewed online, in its entirety, at http://www.sgo.org/Government_Relations/Pathways_to_Progress_Research_Report/.

Heller School Executive Leadership Program scholarships available

The American College of Surgeons (ACS) is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management (http://heller.brandeis.edu/academic/execed/index.html) at Brandeis University, in Waltham, MA.

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- Eastern Association for the Surgery of Trauma Foundation
- Society for Surgery of the Alimentary Tract
- The Society of Thoracic Surgeons
- Society for Vascular Surgery

Read this month’s Bulletin online at www.facs.org/fellows_info/bulletin/bullet.html
Our National Surgical Quality Improvement Program prevented 250-500 complications per year, per hospital. Improving care – and reducing costs. You can do both.

The ACS National Surgical Quality Improvement Program – a national effort to improve surgical care and cut costs run by the American College of Surgeons – is helping to prevent thousands of surgical complications each year, according to a study of 118 hospitals.

The hospitals experienced a reduction of 250-500 complications per hospital, per year. If these methods were used in every hospital in the nation, we could reduce health care costs by $13 to $25 billion every year, or $130 to $250 billion over the next decade – and help literally millions of patients avoid preventable complications.

So let’s stop focusing on the issues that divide us, and work together to make sure Congress rewards providers who deliver better care at lower costs by using measures like these.

Learn more about the ACS NSQIP® program at acnsqip.org
My participation in the German Traveling Fellowship was something of an odyssey, one that began in 2010. After being named the 2010 American College of Surgeons (ACS) Traveling Fellow, I prepared an extensive itinerary that included traveling to the German Surgical Society meeting in Berlin, followed by visits to multiple sites throughout Germany. Two days before my scheduled departure, the Eyjafjallajökull volcano erupted in Iceland, and all air travel in and out of Europe was disrupted. My 2010 trip was cancelled, and the waiting began, as I made preparations to attend the 2011 meeting in Munich—along with Ali Khoynezhad, MD, PhD, FACS, from Cedars-Sinai Hospital in Los Angeles, CA, the 2011 Traveling Fellow (see Dr. Khoynezhad’s report, page 63).

As a German major in college at the University of Wisconsin, Madison, I developed an interest in German language and culture. The traveling fellowship offered me an opportunity to revisit these interests, as well as to practice my German language skills, something I have had little opportunity to do otherwise. Although the fellowship does not require German language skills, and most Germans are very facile with English, I found the experience of communicating with my hosts in their native language exhilarating, especially because it allows a more in-depth understanding of the people and their culture.

**German Surgical Society meeting**

The 128th annual meeting of the German Surgical Society (Deutsche Gesellschaft für Chirurgie) took place in Munich at the International Convention Center. The meeting was divided into concurrent sessions by specialty. Plenary sessions included addresses by the president of the Society, Prof. Axel Haverich, MD, from the University of Hannover, as well as an address by Philipp Rösler, MD, the German minister of health, who, since the meeting, was named the Economic Minister and Vice-Chancellor of Germany.

I thoroughly enjoyed the scientific program. The vascular surgery portion was divided into sessions on thoracic and aortic aneurysm repairs, carotid interventions, arterial infections and substitutes, vascular medicine, and a last-minute session that covered a variety of topics. During the aortic session I presented my research on open repair of juxtarenal-abdominal aortic aneurysms, which was the first of many talks I gave in German during the fellowship.

One particularly interesting session discussed attracting medical students to vascular surgery and promoting academic achievement in vascular surgery. In this regard, the German vascular surgeons face many of the challenges that we face in the U.S. Particularly impressive was the emphasis on young surgeons at the meeting. Many sessions were geared toward their interests, and there were ample opportunities for surgical simulations.

The social program was truly the highlight of the meeting for me. Many of the attributes of German culture originate from Bavaria, and Munich encompasses many of these characteristics and preserves them in an authentic way. The opening night program included music by many young, talented musicians from Munich, in addition to Bavarian food and, of course, beer. The society also has a strong relationship with Ghana, and the opening reception was highlighted by a performance of Ghanaian musicians. On another evening, we were guests of the German Visceral Surgery Society at the Augustiner Keller, an old, beloved beer hall, where we were treated to traditional Bavarian food, drink, and music.

The **Festabend** of the society took place in the ballroom of the Bayerischer Hof Hotel, a venerable Munich institution. A band composed of surgeons from the University of Hannover provided the musical entertainment. In between all of these social activities, we had time to visit many of Munich’s landmarks, such as the Rathaus, Viktualienmarkt, English Gardens, and the Theresienwiese—which is the site of Oktoberfest. But during my time there, it was the site of the largest flea market I have ever seen.
Visiting academic institutions

Following the German Surgical Society meeting, I visited several centers of academic excellence in vascular surgery. I found the German rail system to be an excellent and economical method of travel, which also affords a continuous view of the German countryside.

The German academic centers have a hierarchy similar to, but more rigid than, what we are accustomed to in the U.S. Each department has a chief, or “chefarzt.” Under the chief are several “oberärzte,” which would be the equivalent of assistant or associate professors. In contrast to the U.S. academic system, generally only the chefarzt reaches the title of professor. The “assistenzärzte” function similarly to residents, but also are responsible for much of the noninvasive vascular imaging, as most centers do not have dedicated vascular technologists to perform these exams.

In Germany, vascular surgery exists as a separate specialty with a five-year training program. General surgery is not a prerequisite to entering this specialty, and is not a part of vascular training. This is similar to the 0 and 5 vascular training programs that are becoming more prevalent in the U.S.

The traveling portion of the fellowship added depth and richness to the overall experience. While the meeting in Munich provided concentrated interaction with a number of surgeons, the traveling portion allowed for more in-depth personal interaction with individual surgeons in their home environments. These interactions also allowed me to really see the nuts and bolts of how the German medical system in general, and vascular surgery specifically, function. I had prepared several talks in German about various aspects of my research, and I had the opportunity to hold many presentations during my visits to the individual academic institutions.

Münster

My first stop was in the city of Münster, where I visited Prof. Giovanni Torsello, MD. Dr. Torsello and colleagues have become leaders in the Germany medical community for their use of branched and fenestrated endografts to treat juxta- and suprarenal-abdominal aortic aneurysms, and in the development of hybrid operating room/endovascular suites. While in Münster, I observed many technologies and techniques not currently available in the U.S., including the branched and fenestrated endografts. I found this technology extremely impressive and am certain that it will be a huge benefit for many patients in this country after it receives U.S. Food and Drug Administration approval. For now, I found it quite rewarding to get a glimpse of the future.

While in Münster, Professor Torsello, who is originally from Italy, hosted a group of Italian vascular surgeons for an aortic workshop, in which I was also able to participate. Although I am very confident in my German language abilities, I speak no Italian, so English was the most effective method of communication in that situation.

Münster is also the home of Prof. Norbert Senninger, MD, chairman of the department of surgery and chief of transplantation at the University Hospital Münster, as well as the primary contact for the Traveling Fellowship. Profs. Torsello and Senninger were outstanding hosts and the trip to Münster was the perfect way to begin the academic visits.

Frankfurt

My second stop was Frankfurt, where I was the guest of Prof. Thomas Schmitz-Rixen, MD, at Johann Wolfgang Goethe University. I gave several lectures to the vascular surgery group at this institution and participated in several operations there as well. The vascular surgery department has a strong relationship with the Max Planck Institute in Bad Nauheim. Their current research focus is calcium-dependent signaling in arteriogenesis and angiogenesis, and the facilities at the Max Planck Institute are world-class. Bad Nauheim is a beautiful, old resort town about 30 miles north of Frankfurt, and is also famous as the place where Elvis Presley lived for two years while serving in the U.S. Army.

Heidelberg

My third stop was in the lovely city of Heidelberg, where I was the guest of Prof. Dittmar Boeckler, MD. The University of Heidelberg is the oldest medical school in Germany, and Dr. Boeckler is clearly one of the young rising stars in German vascular surgery. Under Dr. Boeckler, the university’s vascular surgery section recently received the title of “ordinarius,” which elevates it to departmental level. Only a handful of vascular surgery divisions in Germany have reached this level of distinction.
The group in Heidelberg strikes a strong balance of both open and endovascular surgery. This facility also has a hybrid angio/operating room suite that allows for the performance of complex endovascular procedures, similar to those performed at the facility in Münster.

The highlight of my trip to Heidelberg was a dinner hosted by Dr. Boeckler at his house in Schwetzingen, a city just outside of Heidelberg that served as the summer residence of the Kurfürsten Carl Theodor in the 18th century. During my visit, Dr. Boeckler took me on a bike ride around the castle grounds, and he also proved that he is not only an outstanding surgeon, but also an amazing chef and oenologist.

**Ulm**

The fourth stop was in the historic city of Ulm, famous for having the world’s tallest church steeple, as well as being the birthplace of Albert Einstein. While in Ulm, I was the guest of Bernd Mühling, MD, and Karl-Heinz Orend, MD. While not a particularly large city, the surgery department at the University of Ulm is one of the oldest and most respected in Germany. They have an extremely busy open and endovascular clinical practice, and I was able, once again, to participate in several operations.

Ulm lies near the origin of the Danube River, which flows eastward through Vienna and Budapest before entering the Black Sea. While eventually becoming a large river, the Danube is surprisingly small in Ulm but it is still the focal point for business and recreation in the city.

**Hamburg**

My final stop was Hamburg. I visited the center for vascular diseases at the University of Hamburg, which is under the leadership of Prof. Eike Sebastian Debus, MD. Dr. Debus began his education studying the piano, which remains a passion of his today. He performs and records regularly with the Quartetto Vasculare, which is composed of the heads of the faculty within the University Heart Center in Hamburg. Dr. Debus’ musical accomplishments are surpassed only by his surgical accomplishments, and he is currently the president of the German Vascular Surgery Society. I observed several operations performed by Dr. Debus, including the open repair of a juxtarenal aortic aneurysm in a young male with Loey-Dietz syndrome. Tilo Kölbel, MD, is the head of endovascular interventions at the University Heart Center in Hamburg, and I was able to observe him while he operated on many cases involving fenestrated aortic grafts.

As I reached the end of my stay in Hamburg, I was once again affected by volcanic activity in Iceland. This time, Grímsvötn erupted two days before my scheduled departure. Only northern Germany was affected by the volcanic eruption, but in fact, Hamburg was one of the airports that was temporarily shut down because of this event. On the morning of my departure, however, the airspace reopened and I was able to return to the U.S. without delay. However, as much as I was disappointed one year ago when my trip was delayed by an untimely geographic event, I was almost as disappointed that a second geographic event did not extend my time in Germany.

**Index event**

While it may sound cliché, the opportunity to serve as a German Traveling Fellow for 2011 truly was a once-in-a-lifetime experience. Throughout life we experience index events to measure the time before and after. My month traveling through Germany was such an event for me, and I owe the ACS and the German Society of Surgery my sincerest gratitude for this opportunity. I encourage all surgeons with an interest in such an experience to apply for, and support, the ACS fellowships for foreign travel. A focused and concentrated period of travel and interaction with surgical colleagues from another country has led to the formation of many professional associations and friendships that will clearly be longstanding. The value of such relationships can never be overestimated.

I would like to thank all of my hosts who made me feel more than welcome during my travels. I particularly would like to thank Professor Senninger, whose boundless enthusiasm and support of the Traveling Fellowship made this trip possible. And I would like to thank the College for establishing and supporting this fellowship, which has had, and will continue to have, a profound impact on all surgeons who have the honor and privilege of participating in it.

**Dr. Landry** is an associate professor of surgery, division of vascular surgery, Oregon Health & Science University, Portland, OR.
A deep feeling of anticipation and excitement rushed through my arteries as I fell exhausted in my seat on the United Airlines flight to Hamburg. It had been a busy call weekend, and my vascular colleagues and I had performed three hybrid arch and thoracoabdominal aortic operations on two antecedent days. My wife, Ziba Jalali, MD, who brought me to Los Angeles International airport, was unable to accompany me due to professional obligations. We enjoyed our courtship in Cologne during our first year of medical school. Many of my fond memories from Germany were intertwined with her presence, and I knew I would miss her throughout the American College of Surgeons (ACS) Traveling Fellowship to Germany.

After a refreshing rest on the plane, and upon my arrival to Fuhlsbüttel airport in Hamburg, I became aware of the significance and impact the next few days would have on my professional career. Besides attending the German Surgical Society meeting, I was planning to visit two prominent centers for both aortic and transcatheter heart valve operations, and to learn new procedures and ideas to incorporate into my clinical practice and academic life. This Traveling Fellowship, sponsored by the ACS International Relations Committee, is an extraordinary opportunity to interact with surgeons with similar clinical and research interests. In fact, my first aim was to meet and connect with German surgeons with similar academic aspirations, and I envisioned a professional relationship that would last for the years to follow.

German surgeons have quick access to state-of-the-art surgical products, such as valves and stent grafts. Regulatory constraints in the U.S. make Germany an exciting destination for surgeons, as it allows them to become familiar with the type of operations that will be introduced in the U.S. in the future. Therefore, my second goal was to get acquainted with the newer transcatheter devices that are already in clinical use in Germany, and to be involved with the pre-approval clinical trials of these devices in the U.S.

Furthermore, I aimed to fortify my German language skills, meet some old friends, and savor German delicacies. I had left Germany after my cardiac surgical training in Berlin 13 years ago. I had been back for three visits, but none of these trips was of any substantial length. I missed the German culture and lifestyle, and I couldn’t wait to taste the Curry Wurst mit Pommes along with the Kölschas as soon as I drove off from the airport on the Autobahn toward Hannover.

**Hannover University Medical Center**

Hannover, the capital of Lower Saxony, is a mid-sized German city located in the center of northern Germany. Besides being known for annual commercial
exhibitions, Hannover is also known for its prominent medical school and medical center. The cardiothoracic surgery division of the Hannover University Medical Center has a long tradition of excellence in aortic surgery and transplantation. The previous division chief, Prof. Hans G. Borst, MD, PhD—now an emeritus professor—trained two generations of cardiovascular and aortic surgeons in Germany and surrounding European countries, and was the co-founder of the European Society of Cardiothoracic Surgery. Professor Borst was the first surgeon to describe the elephant trunk technique in the early 1980s. This operation is a two-stage surgical remedy for total aortic replacement (from the ascending aorta to the abdominal aorta). The group in Hannover was also first to perform the frozen elephant trunk operation. This is a single-step hybrid operation combining open repair of the ascending and transverse aorta and endovascular stent graft coverage of the descending thoracic aorta, thereby reducing the morbidity and mortality of the second-stage traditional elephant trunk operation. I did not anticipate having the opportunity to witness such an operation in my short stay in Germany. Even in a busy aortic center such as Hannover University Medical Center, no more than a handful of these operations are done per year. Fortunately, my assumption was proven wrong.

On the first day at the medical center, I met with Prof. Christian Hagl, MD, PhD, the vice-chief of the division of cardiothoracic surgery. He introduced me to Malakh Shrestha, MD, PhD, associate professor of cardiothoracic surgery and director of valvular and coronary surgery. We attended the morning report meeting, where all new admissions, critical intensive care unit (ICU) patients, and operative cases were presented and discussed. We rounded through the cardiothoracic ICU, and subsequently put on scrubs for the operating room. I watched a valve-preserving aortic root replacement (David operation) through mini-sternotomy and a few other valve and coronary operations. We subsequently discussed the established basic and translational research projects.

On the second day, we started with the morning report meeting, then did ICU rounds, and then we went to the operating room for a frozen elephant trunk operation for type-A aortic dissection. This challenging procedure was performed on a heart-lung machine using moderate hypothermic circulatory arrest and antegrade cerebral perfu-
tion at the University Hospital Münster. As the General Secretary of the German Chapter of the ACS, Professor Senninger and I had been in contact via e-mail before my visit, and he helped me organize the Traveling Fellowship agenda. As a result of our conversation that night, as well as our interactions over the next few days, I began to appreciate Professor Senninger as an accomplished, generous, and witty master surgeon with an extraordinary organizational talent.

The next morning, I headed toward the convention center where the German Surgical Society annual meeting took place. Having just arrived, I met a thoracic surgery colleague from my residency in Berlin. I was excited to chat with Jens Rueckert, MD, PhD, associate professor of surgery, division of thoracic surgery at Charité University Medical Center in Berlin. Dr. Rueckert remained at our alma mater and has become a successful robotic and minimally invasive (non-cardiac) thoracic surgeon at Charite-Virchow complex. With 3,000 beds, this institution remains the largest hospital in Europe. His twin brother, Ralph Rueckert, MD, PhD, associate professor of surgery, division of vascular surgery, has become an expert in endovascular therapies. It was gratifying to see what my fellow residents have accomplished in their fields of interest after 13 years.

On Wednesday morning, I gave my presentation at the vascular session of the German Surgical Society meeting titled Hybridoperationen des Aortenbogens und der Thoracoabdominaellen...
Aortenchirurgie—Techniken und Ergebnisse. It was more than a pleasure to address the audience in an impromptu manner and in their native language.

The evening was spent in the Augustiner Keller, a must-see iconic beer garden and brewery established in 1812. The beer garden serves terrific traditional Bavarian cuisine, along with a liter mug of Augustiner Edelstoff straight from the barrel, accompanied by Bavarian music kappelle outfitted in lederhosen and dirndl—the traditional Bavarian attire. It was an unforgettable event. I was accompanied by Gregory J. Landry, MD, FACS, associate professor of vascular surgery at Oregon Health and Science University in Portland. Dr. Landry was the 2010 ACS Germany Traveling Fellow awardee, who had to postpone his visit to Germany due to “natural forces”—an Icelandic volcano that cancelled international air travel at the time of the 2010 meeting. Dr. Landry has written about his experiences in a report published on page 60 of this issue of the Bulletin.

**German Heart Centre (Munich)**

At the German Heart Centre Munich, I was greeted by Christian Schreiber, MD, PhD, associate professor of cardiac surgery and deputy director of the Heart Centre, who accompanied me to the morning report. At that point, we went to the operating room to observe complex valve/coronary and congenital heart operations. The two scheduled transcatheter heart valve procedures were, unfortunately, postponed due to a hybrid room imaging malfunction. Instead, I was able to attend an aortic clinic. Ulf Herold, MD, director of aortic surgery, and I discussed various algorithms and approaches to follow-up and screening of patients with various aortic pathologies.

The evening was the official night event of the German Surgical Society at the Bayrischer Hof. The next morning, I attended the morning report followed by a frozen elephant trunk operation by Dr. Herold using hypothermic circulatory arrest and antegrade cerebral perfusion. The hybrid graft used to replace the ascending/transverse arch, as well as the proximal descending thoracic aorta, is not yet available in the U.S.

Subsequently, I had an extended meeting with Rüdiger Lange, MD, PhD, surgical director of the German Heart Centre. We exchanged ideas about growing a transcatheter valve program, and clinical, translational, and basic science research topics pursued at the Centre.

**Epilogue**

I flew back the next morning to the U.S., reflecting on this unique experience that I was just beginning to digest and put into perspective. The primary mission of the ACS Germany Traveling fellowship is to establish and strengthen new bonds among surgeon clinicians and academicians between the two countries. The importance of nurturing international academic relationships cannot be underestimated, and remains the critical mission of the ACS International Relations Committee. To this end, Germany plays a very important role. The German Surgical training provided the foundation of William S. Halsted’s legacy, which spearheaded modern surgical training and promoted surgical excellence among U.S.
Returning to Germany after so many years was a profound experience. This Traveling Fellowship provided me with the opportunity to revisit my personal—as well as surgical—roots. I came to appreciate the influence of German culture on my personal growth and to understand the deep connection between Germany and the U.S.

I will make sure to keep in contact and collaborate with many of the surgeons that I met during my stay in Germany—many of whom I am fortunate enough to call friends. In fact, I already had the opportunity to collaborate with my German colleagues on various scientific and academic endeavors in June. First, I was able to recruit Dr. Shrestha to participate as a faculty member in the aortic and endovascular postgraduate training program at this year’s International Society of Minimal-Invasive Cardiothoracic Surgery meeting in Washington, DC. In addition, Dr. Schreiber and I participated as faculty members at the Cardiovascular Symposium in Beijing, China. We also shared our experiences about proctoring and mentoring Chinese surgeons in novel cardiovascular operations and therapeutics.

I am grateful to the ACS and the German Surgical Society for the privilege of participating in this most wonderful endeavor.

Dr. Khoynezhad is a cardiovascular surgeon, director of thoracic aortic surgery, and an associate professor of surgery at Cedars-Sinai Medical Center, Los Angeles, CA.
On September 14, The Joint Commission (TJC) released its 2011 annual report on quality and safety, titled Improving America’s Hospitals. For the first time, this report lists hospitals and critical access hospitals that qualify as top performers in using evidence-based care processes that are closely linked to positive patient outcomes. The 405 institutions identified as attaining and sustaining excellence in accountability measure performance for 2010 represent approximately 14 percent of the total TJC-accredited hospitals and critical access hospitals that reported core measure performance data for that year. TJC’s list of top performers singles out hospitals in 45 states based on their performance related to 22 accountability measures for heart attack, heart failure, pneumonia, surgery, and children’s asthma.

To be identified as top performers, hospitals had to meet certain conditions. First, they must have had a performance of 95 percent or above on a single, composite score that includes all the accountability measures for which they report data to TJC, including measures that had fewer than 30 eligible cases or patients. Second, hospitals must have also met or exceeded 95 percent performance on every accountability measure for which they report data to TJC. This excludes any measures that may have had fewer than 30 eligible cases or patients. TJC expects the percentage of hospitals and critical access hospitals achieving these thresholds to increase as it reports on the Top Performers on Key Quality Measures Program in the fall of each successive year.

The 2011 annual report also presents continual improvement on accountability measures over a nine-year period based on scientific evidence of hospital performance and how it relates to common medical conditions and procedures. The surgical care composite result measure has improved to 96.4 percent in 2010 from 82.1 percent in 2005 (14.3 percentage points). The individual measures and the corresponding scores that comprise the surgical care composite result are as follows:

- Antibiotics within one hour before the first surgical cut, up 15.6 percent from 86.6 percent in 2006 to 97.4 percent in 2010
- Appropriate prophylactic antibiotics, up 2.9 percent from 94.9 percent in 2007 to 97.8 percent in 2010
- Stopping antibiotics within 24-hours glucose, up 22.2 percent from 79.1 percent in 2006 to 95.7 percent in 2010
- Cardiac patients with 6:00 am postoperative blood glucose, up 4.2 percent from 89.9 percent in 2008 to 94.1 percent in 2010
- Patients with appropriate hair removal, up 2.3 percent from 97.4 percent in 2008 to 99.7 percent in 2010
- Beta-blocker patients who received beta-blocker perioperatively, up 2.4 percent from 92.0 percent in 2008 to 94.4 percent in 2010
- Prescribing venous thromboembolism (VTE) medicine/treatment, up 8.0 percent from 87.2 percent in 2007 to 95.2 percent in 2010
- Receiving VTE medicine/treatment, up 83.2 percent from 93.7 percent in 2007 to 93.7 percent in 2010
- Urinary catheter removed, which started in 2010 and ended at 91.3 percent

The Joint Commission 2011 annual report, which includes the list of top performing hospitals and the results of the other measure sets, is available online at http://www.jointcommission.org/annualreport.aspx.
Oral presentations

- **Surgical Forum**
  Program Coordinator: Kathryn L. Matousek, 312-202-5336, kmatousek@facs.org
  (15 Excellence in Research Awards were given in 2011)
  Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)

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

Poster presentations

- **Scientific Exhibits (Posters)**
  Program Coordinator: Carla Manosalvas, 312-202-5385, cmanosalvas@facs.org

Video presentations

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

Submission information

- Abstracts are to be submitted online only.
- Submission period begins after November 1, 2011.
- Deadline: 5:00 pm (CST), March 1, 2012.
- Late submissions are not permitted.
- Abstract specifications and requirements for each individual program will be posted on the ACS website at www.facs.org/education/. Review the information carefully prior to submission.
- Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.*
You’ll shoot your eye out!

by Richard J. Fantus, MD, FACS

In 1882, Plymouth Iron Windmill Company of Plymouth, MI, started out—as the company’s name implies—as a manufacturer of windmills. Due to a changing market and a struggling business during that decade, the company began to look for new ways to attract business. In 1886, a local inventor named Clarence Hamilton introduced a device made of wire and metal with a rudimentary shape resembling a gun that could shoot a lead ball using compressed air. The president of the Plymouth Iron Windmill Company tried out the device, which was essentially a BB gun, and proclaimed, “Boy, that’s a daisy.” The name daisy caught on and the air gun went into production as an item that was included as a gift when farmers purchased a windmill from the company. The gun was so popular, in fact, that the company changed its name to Daisy Manufacturing, halted the manufacturing of windmills, and began making the BB gun.

In 1938, the company produced the legendary Red Ryder BB gun modeled after the western Winchester rifle, which instantly became a popular American toy. In 1983, the Red Ryder BB gun was featured prominently in the movie A Christmas Story, in which the main character asks repeatedly for one as his Christmas gift. Each time he asks, he is met with the warning, “You’ll shoot your eye out.” (For more information, visit http://www.daisy.com/history.html.)

Originally, the BB gun used lead balls from shotgun shells as its ammunition. The BB-sized shot is derived from the size of the lead shot, which was larger than size B and smaller than size BBB. The current size of a BB is .175 inches in diameter.

In the late 1970s airsoft guns were created and marketed in Japan as a result of the ban on civilian ownership of firearms in that country. Airsoft guns fire a 6mm (.24 inch) plastic pellet that weighs approximately .20 grams and travels between 300 and 570 feet per second. Airsoft guns are “imitation” firearms created to closely resemble genuine firearms. In the U.S., federal law requires that all toy guns (including airsoft guns) have an orange tip on them to distinguish them from real firearms. However, over time, this orange coloring may wear off and there is no regulation in place mandating that the colored tip be replaced.

In the 1970s, the Nelson Paint Company produced the first paintball marker as a way for the U.S. Forest Service to mark trees from a distance. A few years of
sluggish paintball marker sales ensued until Charles Nelson moved to the Daisy Manufacturing Company—the same company that manufactures the BB gun. In 1976, a stock trader named Hayes Noel and a writer named Charles Gaines were talking about Gaines’ recent safari in Africa. The two men wanted to recreate the rush of the hunt, and they came up with the idea to hunt each other. Not until a year-and-a-half later, when George Butler, a friend of theirs, showed them a paintball marker in an agricultural catalog did Noel and Gaines come up with the idea. The two each purchased the device, and the Noel-Gaines duel became the first paintball duel. On June 27, 1981 Gaines, Noel, and 10 other men participated in the first paintball game. The rest is history.

The current paintball marker fires a 68 caliber round colored polyethylene glycol-filled biodegradable gelatin capsule at approximately 300 feet per second. They break upon impact and leave a colored paint mark (http://nicolpawn.ca/paintball-blog.php/2011/05/27/history-of-paintball-markers).

More than 3.2 million air guns are purchased each year in the U.S., and more than 10 million Americans participate in paintball-related activities annually. This activity results in more than 20,000 individuals seeking medical care for BB- and paintball-related injuries each year. The majority of these injuries are not life-threatening, but some can be fatal, and others can leave an individual with permanent impairment. The muzzle velocities outlined in this article are sufficient to cause permanent blindness, hearing loss, or cosmetic deformities depending on the area hit by the projectile. Recreational weapons are packaged with warnings recommending proper supervision, as well as the use of proper safety precautions and safety devices such as eye protection (http://www.hcup-us.ahrq.gov/reports/stat-briefs/sb119.jsp).

In order to examine the occurrence of air and paintball gun injuries in the National Trauma Data Bank* research dataset 2009, admissions records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) external cause of injury E codes. Records that contained one of the following E codes: 922.4/992.5 (injury caused by firearm and air gun missile, such as BB gun, Pellet gun, paintball gun), 985.6/985.7 (injury by firearms, air gun/paintball gun), or 968.6 (assault by air gun missile), were included in the analysis.

A total of 519 records were found, while 358 had an emergency discharge disposition that included some form of treatment. The records indicate that 148 were admitted to a floor bed, 113 went to the operating room, 51 ended up in the intensive care unit, 37 were transferred to another hospital, 17 were observed, and 9 were admitted to telemetry. These patients were 83.4 percent male, on average 18.2 years of age, had an average length of stay of 2.2 days, and an average injury severity score of 4.3. Of note, more than 30 percent of these patients went directly to the operating room from the emergency department, and 16.76 percent had an intent of assault.

While these devices may be plastic or metal toys, using them improperly may lead to serious consequences. If these items are on someone’s holiday wish list, make sure that caution is exercised when using these items, and encourage users to carefully read all the safety instructions and to follow the manufacturer’s recommendations. After all, without proper use, “You’ll shoot your eye out.”

Throughout the year, we will be highlighting data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2010 is available on the American College of Surgeon’s website as a PDF file and as 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

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

Dr. Fantus is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago, IL. He is Past-Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.
98% of attendees this year say they would recommend the workshops to a colleague and 97% would attend a future ACS/KZA workshop! Come see why, can you afford not to?

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Hope Day, Business Office Manager, Utah County Surgical Associates, Provo, Utah

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Carolyn Messere, MD, Integrative Surgery PA, Miami Beach, Florida

“I attend this course annually and I always learn something new to bring back to my office and physicians.”
Mary Ann Cross, General Manager, California Bariatric & General Surgery Associates, Arcadia, California

Mary Legrand, RN, MA, CCS-P, CPC, consultant with more than three decades of nursing and administrative experience, including leadership positions on several National Boards

Betsy Nicoletti, MS, CPC, author, speaker and consultant with over two decades engaged in coding education, billing and accounts receivable management
Chapter news

by Rhonda Peebles

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

Ecuador Chapter celebrates accomplishments

The Ecuador Chapter observed its 17th anniversary this past June. Enrique Guzmán Cotallatt, MD, FACS, President of the Ecuador Chapter and Chair of Ecuador’s Committee on Trauma, presided over the event, while César Gastón Cabezas Tamayo, MD, FACS, ACS Governor, gave a presentation titled The Past, the Present, and the Future of the ACS Ecuador Chapter. The chapter also recognized several members during the anniversary event for their leadership-related contributions to the chapter and for their humanitarian efforts: Angel Amén Palma, MD, FACS; Difilo Vargas Pazzos MD, FACS; and Edgar Rodas Andrade, MD, FACS (see photo, this page).

New Jersey Chapter announces 2012 pilgrimage to Portugal

In September 2010, the New Jersey Chapter announced plans for its next pilgrimage to Portugal, April 15–22. The chapter, in partnership with the Portugal Chapter (which was formed in 2010), will present a joint Academic Day. The pilgrimage also includes eight days of touring Portugal. All College members are invited to attend this educational event, which is being planned by the New Jersey Chapter Vice-President, Michael A. Goldfarb, MD, FACS.

For more information contact Andrea Donelan, Executive Director, at 973-539-4000, or visit the chapter’s website at http://www.nj-acs.org.

Tennessee Chapter reaches out to increase number of hospitals in TSQC

In his “Looking forward” column in the October issue of the Bulletin, ACS Executive Director David B. Hoyt, MD, FACS, highlighted the Tennessee Surgical Quality Collaborative (TSQC). The TSQC is a joint endeavor sponsored by the Tennessee Chapter, the Tennessee Hospital Association, and the Tennessee Blue Cross-Blue Shield Foundation. In response to a request issued by the TSQC last fall for new hospital participants, 11 hospitals joined the collaborative. continued on page 75
Chapter meetings

For a complete listing of the ACS chapter education programs and meetings, visit the ACS website at http://www.facs.org/about/chapters/index.html.

(AP) following the chapter name indicates that the ACS is providing AMA PRA Category 1 Credit™ for this activity.

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<th>Chapter</th>
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<td>January 20–22, 2012</td>
<td>Louisiana (AP)</td>
<td>Location: Ritz Carlton, New Orleans, LA Contact: Janna Pecquet, 504-841-0145,</td>
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<td></td>
<td></td>
<td>e-mail: <a href="mailto:janna@laacs.org">janna@laacs.org</a> ACS representative(s): J. David Richardson, MD, FACS</td>
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<td>January 20–22, 2012</td>
<td>Southern California (AP)</td>
<td>Location: Four Seasons Biltmore, Santa Barbara, CA Contact: C. James Dowden, 310-364-0193,</td>
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<td>e-mail: j <a href="mailto:Dowden@prodigy.net">Dowden@prodigy.net</a> ACS representative(s): L. D. Britt, MD, MPH, FACS</td>
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<td>February 17–18, 2012</td>
<td>North Texas (AP)</td>
<td>Location: City Place Conference Center, Dallas, TX Contact: Nonie Lowry, 913-402-7012,</td>
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<td>February 24–25, 2012</td>
<td>Puerto Rico</td>
<td>Location: La Concha Resort San Juan, PR Contact: Axia Velez-Silva, e-mail: <a href="mailto:genteinc@gmail.com">genteinc@gmail.com</a></td>
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<td>March 23–24, 2012</td>
<td>Metropolitan Washington DC (AP)</td>
<td>Location: JW Marriott, Washington, DC Contact: Jennifer Starkey, 877-835-5809,</td>
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<td>April 13–14, 2012</td>
<td>North Dakota and South Dakota (AP)</td>
<td>Location: Watertown Event Center, Watertown, SD Contact: Terry Marks, 605-336-1965,</td>
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<td>April 26–29, 2012</td>
<td>Virginia (AP)</td>
<td>Location: Inova Fairfax Hospital, Fall Church, VA Contact: Susan McConnell, 804-643-6631,</td>
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<td>April 27–29, 2012</td>
<td>Chile</td>
<td>Location: Santiago, Chile Contact: Celia Aldana M., 562-235-8934, e-mail: <a href="mailto:caldana@acschile.cl">caldana@acschile.cl</a></td>
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<td>ACS representative(s): Carlos A. Pellegrini, MD, FACS</td>
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<td>June 8–10, 2012</td>
<td>Missouri (AP)</td>
<td>Location: Country Club Hotel and Spa, Lake Ozark, MO Contact: Denise Boland, 513-882-2276,</td>
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<td>June 8–10, 2012</td>
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<td>Location: Mount Washington Resort, Bretton Woods, NH Contact: Jennifer Starkey, 877-249-9321,</td>
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At this point, additional funding from the Tennessee Blue Cross-Blue Shield Foundation through 2014 has been requested.

At this time, the collaborative grants provide each participating hospital with $60,000 annually, or approximately 50 percent of the total cost of participating in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®). The grant also provides $5,000 per year for each hospital’s surgeon champion, who serves as the hospital program director. Hospitals that participate in the TSQC are responsible for partially funding the surgical clinical reviewer, as well as paying the annual ACS NSQIP fee.

For more information about the TSQC, contact Wanda Johnson, Executive Director, at 931-967-4700, or via e-mail at wanda@tnacs.org.

North Texas Chapter tackles strategic planning

The North Texas Chapter held a strategic planning session in Dallas, September 23–24, with 16 chapter leaders participating in the meeting. The session was convened by Mark Watson, MD, FACS, the chapter President, and John T. Preskitt, MD, FACS, served as the session’s facilitator; Nonie Lowry, Executive Director, organized, planned, and recorded the event. The new mission and vision statements for the North Texas Chapter are as follows:

Mission statement: Advocating for quality care of surgical patients and safeguarding standards of care in an optimal and ethical practice environment. Provide a forum for educational needs and foster the recruitment of future surgeons by creating a collegial atmosphere for the exchange of information among all surgical specialties.

Vision statement: The chapter is dedicated to the following principles:
• Promotion of membership to reflect changing demographics
• Provision of advocacy for patients and surgeons
• Education of surgeons
• Promotion of ACS quality care initiatives

CoC state chairs to facilitate paper competitions

The Committee on Cancer (CoC) Liaison has announced the 2012 CoC Physician-in-Training Cancer Research Paper Competition. All CoC state chairs are asked to facilitate a cancer paper competition within their chapters, and to submit one abstract for judging at the national level.

Abstracts by residents and fellows-in-training on topics specific to oncology and related to the CoC mission will be considered in the national competition. Leading abstracts that have been previously presented at a state, regional, or national meeting within 24 months will be considered for judging. Original research is encouraged. A preselected panel of judges from the CoC Liaison will review the abstracts and select first-, second-, and third-place winners. Award announcements will be made no later than August 1, 2012.

For more information or assistance with this competition, contact Carolyn Jones at cjones@facs.org, or visit http://www.facs.org/cancer/coo/statechresource.html.

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