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2012 Chicago, IL,
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2013 Washington, DC,
October 6–10

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On the cover: National Public Radio correspondent Nina Totenberg addresses the challenges women have had to overcome when pursuing careers in business, law, or medicine. (See article, page 12.)
Since its inception nearly 100 years ago, the American College of Surgeons (ACS) and its Fellows have pledged “to serve all with skill and fidelity.” Embedded firmly within those words is a commitment to constantly improve the quality of care we provide to our patients, and to assist the surgeons who deliver that care in continually enhancing their skill and expertise.

For Fellows of the College, a focus on quality is an integral part of daily practice. What is new, however, is the health care community’s emerging appreciation of the potentially positive impact that a fully integrated, continuous, quality improvement program can have on patient care and health care costs. Quality improvement fundamentals in our databases and our accreditation and verification programs are increasingly understood as being essential elements in surgical patient care, and these programs help create the infrastructure for a continuous learning environment.

The demand for these kinds of substantive outcomes-based concepts will only grow with the implementation of the Affordable Care Act. Even if there are changes to the legislation, leaders in government, business, and health care are still looking for innovative thinking on how we can collectively drive better quality and value in health care.

Now is the time for the ACS to more publicly assert its preeminence in quality improvement models and performance improvement measures.

Looking forward

“‘Inspiring Quality’ is at the heart and soul of what it means to be a Fellow.”

Certainly, the public policy, demographic, and economic forces are all aligned to create an environment that is suitable and ready for making great strides in health care quality in this country. As the major innovator and promoter of surgical quality programs, the College has an opportunity to lead.

To take advantage of the current climate, the ACS is launching a new campaign this month. The campaign, “Inspiring Quality: Highest Standards, Better Outcomes,” seeks to capture the intensity, passion, and dedication that we share in our pursuit of excellent patient care. Just as importantly, it will highlight how others in the health care community “inspire quality” as well. The ultimate campaign message is clear: ACS systems and programs measurably improve care and deliver better patient outcomes, and we are eager to work with all stakeholders to address quality improvement and value in health care. Quality is a shared interest and a shared mission. Working together, we can deliver inspired health care solutions.

About the campaign

The Inspiring Quality campaign provides the communications platform that will allow us to help shape and lead the quality agenda. It will highlight the College’s leadership in the development and implementation of quality improvement programs and models and will show why our programs are the “gold standard” in this arena.

Our goals will be to inspire and engage stakeholders across the health care continuum to join in the effort to improve quality using the most fundamental metric: Did the patient have the best outcome we could expect given his or her individual circumstances? We know when we focus on the patient, we deliver better care, our patients heal faster, and we learn more. The job of this campaign is to rally all stakeholders around
this simple, yet sometimes forgotten, principle.

We want health care stakeholders to value our expertise in quality improvement not because we are hungry for credit, but rather to assure them that while the road to quality is sometimes rocky, it can be traversed.

When stakeholders think about “new models of care” that work collaboratively across the continuum of care, we want them to think of the ACS trauma and cancer programs.

When the health care policymakers and payors think about new and better ways to measure, track, and improve outcomes, we want them to think of the ACS National Surgical Quality Improvement Program (ACS NSQIP®) and its positive impact on morbidity, mortality, and preventable costs.

When hospitals look to reduce preventable complications and hospital-acquired conditions, we want them to be aware of ACS NSQIP’s ability to address these problems now and in the future.

And, when industry researchers and government regulators look for new models of clinical trials that are transparent, ethical, and appropriate, we want them to know that the College has proven systems for measuring safety and efficacy, and for comparing the relative effectiveness of different treatments.

Because quality improvement is an ongoing process, the College’s programs will continue to evolve. Nonetheless, the ACS unquestionably is in the vanguard of quality improvement, and the good news is that momentum is building in the public and private sectors to find answers to the same challenges we have been exploring for decades.

The campaign’s quality story will be marketed tested to ensure resonance with key audiences, and to provide attitudinal benchmarks for evaluation. We have been working with a research firm in Washington, DC, to survey business and health care leaders nationwide, in organizations large and small, to discover what they currently know about quality goals and initiatives (including the College’s role) and how best to communicate about quality.

We have developed a series of clear, lay-friendly communications pieces that describe our work and models. They provide background on the studies and the science that underlie our quality programs. A white paper that boils down the complexities of our quality initiatives to a concise message platform will serve as the intellectual foundation for the campaign. It is the cornerstone for our messaging in all its forms, whether a brochure, speech, video, media interview, or presentation.

Much as the white paper serves as the intellectual foundation for the campaign, an “anthem video” will be its spiritual equivalent. Designed to touch an emotional chord within those of us who care for patients, it also carries a universal truth that we believe will resonate with all viewers.

While the campaign is designed to appeal to all audiences, we are very directly targeting a subset of health care stakeholders who share a professional and financial interest in seeing genuine and comprehensive quality improvement succeed. These audiences include the business community—health care business purchasers and coalitions, hospitals and health plans—as well as the quality community, including individuals who work in health plans, insurance companies, hospitals, and government agencies. Through one-on-one meetings, news stories, interviews, speeches, and other communications with key decision makers, we hope not only to inform, but to deliver a call to action that will open the door for future partnerships in the public and private sectors.

Ensuring success

The Inspiring Quality campaign structure depends on active engagement and participation by our Fellows. Because you are the quality champions in your own communities, I invite you to learn more about the campaign as we provide updates in future issues of the Bulletin and on our website, http://www.facs.org. As the campaign evolves, I hope you will find time to review these materials and pass them on to others in your community.

And, please share your thoughts on the campaign with me and the College’s staff. We are eager to hear from you because we believe that “Inspiring Quality” is at the heart and soul of what it means to be a Fellow.

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.
PQRS reporting in 2011
by Caitlin Burley

The Centers for Medicare & Medicaid Services (CMS) has continued the Physician Quality Reporting System (PQRS), formerly known as the Physician Quality Reporting Initiative (PQRI), into 2011 as required under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). PQRS is the first CMS-crafted national program to link the reporting of quality data to physician payment. The Affordable Care Act (ACA) authorized incentive payments for eligible professionals who successfully participate in the program through 2014. The incentive payment for the 2011 reporting year is 1 percent of the total allowed charges for Medicare Part B professional services covered under the physician fee schedule and furnished during the reporting period. For reporting years 2012 through 2014, eligible professionals can earn an incentive payment of 0.5 percent of their total estimated allowed charges for Medicare Part B physician fee schedule covered professional services furnished during the respective reporting periods. Beginning in 2015, eligible professionals who fail to satisfactorily report PQRS measures will be subject to a payment adjustment or penalty. Table 1 on this page summarizes the payments during these years.

What are some of the differences between the requirements in the 2010 PQRI and the 2011 PQRS?

CMS released the Medicare physician fee schedule final rule for calendar year (CY) 2011 on November 2, 2010. In the final rule, CMS finalized several changes to the Physician Quality Reporting System for 2011. Major program changes are summarized in Table 2 on page 7.

It is important to note that 2011 PQRS includes 200 quality measures (including both individual measures and measures that are part of a 2011 measures group). Whereas 2010 PQRI quality measures may be continued in the 2011 PQRS, measures specifications may have been updated for the new program year. Surgeons who aren’t currently reporting in 2010 PQRS should review the 2011 PQRS Measure Specifications Manual for updates and changes.

How do I use the measure specifications manual?

The first step for implementing PQRS in your office is to use the 2011 PQRS Measure Specifications Manual to identify measures applicable for professional services that your practice routinely provides. Next, select those measures that make sense based upon prevalence and volume in your practice, as well as your individual or practice performance analysis and improvement priorities. The 2011 PQRS Measure Specifications Manual can be found at http://www.cms.gov/PQRI/15_
Table 2. 2011 PQRS changes

<table>
<thead>
<tr>
<th>2010 PQRI</th>
<th>2011 PQRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registry-based reporting of measures groups in 2010 may include, but may not be exclusively, non-Medicare patients</td>
<td>For registry-based reporting of measures groups in 2011, the minimum patient numbers or percentages must be met by Medicare Part B fee-for-service patients exclusively and may not include data on non-Medicare Part B fee-for-service (FFS) patients</td>
</tr>
<tr>
<td>For claims-based reporting of individual quality measures in 2010, the reporting threshold is at least three measures (one–two if fewer than three apply) for 80% of applicable Medicare Part B FFS patients</td>
<td>For claims-based reporting of individual quality measures in 2011, the reporting threshold is at least three measures (one–two if fewer than three apply) for 50% of applicable Medicare Part B FFS patients</td>
</tr>
<tr>
<td>For claims-based reporting of measures groups in 2010, the reporting threshold is one measures group for at least 80% of applicable Medicare Part B FFS patients (15 patient minimum)</td>
<td>For claims-based reporting of measures groups in 2011, the reporting threshold is one measures group for at least 50% of applicable Medicare Part B FFS patients (15 patient minimum)</td>
</tr>
<tr>
<td>In 2010, “Group Practice Reporting Option (GPRO) I” was available to group practices of 200 or more physicians</td>
<td>In 2011, “(GPRO) I” and “GPRO II” are available to group practices. “GPRO I” will consist of 200 or more physicians, and “GPRO II” will consist of two to 199 eligible professionals</td>
</tr>
<tr>
<td>In 2010 PQRI, CMS makes public the names of eligible physicians (EPs) and group practices that satisfactorily submit quality data</td>
<td>In 2011 PQRS, CMS will make public the names of EPs and group practices that (1) submit data on the 2011 PQRS quality measures through one of the available reporting mechanisms, (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups, and (3) qualify to earn a PQRS incentive payment for covered professional services furnished during the applicable 2011 reporting period</td>
</tr>
</tbody>
</table>
What is the “frequency?”

The frequency refers to how often the measure should be reported. Measure #21 should be reported each time an applicable procedure is performed during the reporting period (full or half-year).

How do I report measure #21 via claims?

The measure specifications for measure #21 indicate that it is a claims and registry measure, meaning it can be reported using either the claims-based or the registry-based method. This article looks at the claims-based method only. The Current Procedural Terminology (CPT) codes and patient demographics identify the patients who are included in measure #21, otherwise known as the denominator. Beginning on page 59 of the 2011 PQRS Measure Specifications Manual, there is a listing of all surgical procedures and CPT codes that qualify patients as eligible to meet this measure’s inclusion requirements (see Table 3, this page and page 9). It is important to review the CPT codes associated with each measure reported. Also, please note that the included procedure codes may change from year to year, so review the 2011 measure specifications before beginning to report for this year.

Table 3.

<table>
<thead>
<tr>
<th>Surgical procedure</th>
<th>CPT code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integumentary</td>
<td>15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369</td>
</tr>
<tr>
<td>Spine</td>
<td>22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042</td>
</tr>
<tr>
<td>Hip reconstruction</td>
<td>27125, 27130, 27132, 27134, 27137, 27138</td>
</tr>
<tr>
<td>Trauma (fractures)</td>
<td>27235, 27236, 27244, 27245, 27269, 27759, 27766, 27769, 27792, 27814</td>
</tr>
<tr>
<td>Knee reconstruction</td>
<td>27440, 27441, 27442, 27443, 27445, 27446, 27447</td>
</tr>
<tr>
<td>Vascular</td>
<td>33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35151, 35601, 35606, 35612, 35615, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35635, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35658, 35661, 35665, 35666, 35671, 36830</td>
</tr>
<tr>
<td>Spleen and lymph nodes</td>
<td>38115</td>
</tr>
<tr>
<td>Esophagus</td>
<td>43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43345, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496</td>
</tr>
<tr>
<td>Stomach</td>
<td>43500, 43501, 43502, 43510, 43520, 43560, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43801, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870</td>
</tr>
<tr>
<td>Small intestine</td>
<td>44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136</td>
</tr>
</tbody>
</table>

the process for submitting a claim form?

CPT II codes, or quality data codes (QDCs), are used to report the clinical action required by the measure on the claims form. For measure #21, there are three choices: 4041F, 4041F with 1P, and 4041F with 8P. 4041F indicates documentation of order for cefazolin or cefuroxime for antimicrobial prophylaxis (written order, verbal order, or standing order/protocol); 4041F with 1P modifier indicates order for first or second generation cephalosporin not ordered for medical reasons; and 4041F with 8P modifier indicates order for first or second generation cephalosporin not ordered, reason not specified. Please note that both the CPT code and the appropriate CPT II code should be submitted on the same claim form.

Can you provide a step-by-step overview of the process for submitting a claim form?

CPT II codes can be reported on claim form CMS 1500 or via electronic form ASC X12N 837. Figure 1 on page 10 is an example of the CMS 1500 claim form.

Based on Figure 1, the steps for reporting via claims include the following:

• Step 1: Look in the measure specifications for measure #21 to see if this procedure, 44120, is listed in the table of surgical procedures for which there are indications for a first or second generation cephalosporin prophylactic antibiotic. If so, continue to step 2.

• Step 2: On the CMS 1500 claim form, the CPT procedure code 44120 is listed on line 1.
Figure 1. Procedure 44120: Enterectomy, resection of small intestine; single resection and anastomosis—Example claim form

Reporting PQRI Quality Data to CMS

Example Claim Form

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Procedure Code</th>
<th>CPT II Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>152 2</td>
<td>44120</td>
<td>9876543120</td>
</tr>
</tbody>
</table>

![Image of a sample health insurance claim form with highlighted parts: ICD-9 Code (152 2), Procedure Code (44120), and CPT II Codes (9876543120).]
• **Step 3:** On line 2, the CPT II code, 4041F with 1P is listed, which indicates the order for first or second generation cephalosporin not ordered for medical reasons. Note that the CPT II code may be one of three options, as discussed earlier in this article.

• **Step 4:** Lines 3 through 6 are CPT II codes that correspond to other PQRS measures (#20, #22, and #23). Measures #20, #22, and #23 are often reported by eligible professionals when measure #21 is reported because these four measures are perioperative care measures. CPT procedure code 44120 corresponds with these perioperative measures as well, so the CPT II codes are listed on the same claim form.

• **Step 5:** Be sure billing software and clearinghouse can correctly submit PQRS CPT II codes, or quality-data codes (QDCs).

• **Step 6:** Regularly review the remittance advice notice from the carrier to ensure the denial remark code N365 is listed for each QDC submitted. This indicates that claims have made it to the CMS national claims history file.

Surgical practices that follow these steps should be able to successfully report via claims in PQRS 2011 to receive incentive payments. There are various ways to report for PQRS, and this article has only covered the claims-based method for individual measures. Please refer to the correct measure specifications manual if you choose another method. Table 4 on this page is a matrix that lists all 11 options for reporting in PQRS 2011.

For more background information regarding the PQRS program, go to [http://www.cms.hhs.gov/pqri/](http://www.cms.hhs.gov/pqri/) and access the resources posted at [http://www.facs.org/ahp/pqri/index.html](http://www.facs.org/ahp/pqri/index.html). If you have any further questions regarding PQRS, please contact Caitlin Burley at cburley@facs.org.

**Table 4. PQRS 2011 Reporting options matrix**

<table>
<thead>
<tr>
<th></th>
<th>Claims-based methods</th>
<th>Registry-based methods</th>
<th>EHR-based methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-year period</strong></td>
<td>Individual measures 1. At least three PQRS measures (one–two if fewer than three apply), for 50% of applicable Medicare Part B FFS patients of each eligible professional</td>
<td>6. At least three PQRS measures for 80% of applicable Medicare Part B FFS patients of each eligible professional</td>
<td>11. At least three PQRS measures for 80% of applicable Medicare Part B FFS patients of each eligible professional</td>
</tr>
<tr>
<td></td>
<td>Measures groups 2. One measures group for at least 30 Medicare Part B FFS Patients</td>
<td>7. One measures group for at least 30 Medicare Part B FFS patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. One measures group for 50% of applicable Medicare Part B FFS patients of each eligible professional</td>
<td>8. One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional</td>
<td></td>
</tr>
<tr>
<td><strong>Half-year period</strong></td>
<td>Individual measures 4. At least 3 PQRS measures (one–two if fewer than 3 apply), for 50% of applicable Medicare Part B FFS patients of each eligible professional</td>
<td>9. At least three PQRS measures for 80% of applicable Medicare Part B FFS patients of each eligible professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Measures groups 5. One measures group for 50% of applicable Medicare Part B FFS patients of each eligible professional (at least eight patients during reporting period)</td>
<td>10. One measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (at least eight patients during the reporting period)</td>
<td></td>
</tr>
</tbody>
</table>

**Ms. Burley** is Quality Associate, Division of Advocacy and Health Policy, Washington, DC.
Olga M. Jonasson Lecture: Women in the professions

by Nina Totenberg
For the first 10 years of my career in journalism, I was usually the only woman, or one of two, everywhere I worked. Even at National Public Radio, known for its female stars, there was a sort of geographical ghetto. Cokie Roberts, Linda Wertheimer, and I sat in one corner of the newsroom together. The guys referred to that corner as “the fallopian jungle.” You would have to be deaf, dumb, and blind today to not know there has been a sexual revolution in the professions. In 1965, 7 percent of medical degrees were awarded to women. Now it’s 50 percent. The numbers in the field of law are close to identical. Women MBAs trail only slightly—female graduates are about 45 percent, with the number around 30 to 35 percent in the schools like Harvard University and University of Chicago that emphasize finance, according to an interview I had with Harvard economist Claudia Goldin, in September 2010.

History of women in the workforce

Lest we take these numbers too much for granted, I think it pays to look at a little history. Women didn’t win the right to vote in this country until 1920. And even then, women were hardly equal in American society. It wasn’t until 1964 that Congress banned sex discrimination in employment. But women still lacked property rights in many places, could get loans only with the approval of their husbands or fathers, and, as late as the 1970s, couples found that the wife’s income didn’t count when they were applying for loans.

Indeed, it wasn’t until 1974 that female members of Congress, led by Louisiana’s Lindy Boggs, won passage of a law that outlawed discrimination in lending and credit based on sex or marital status. When first proposed, the bill actually banned only discrimination based on race, religion, and ethnicity. Congresswoman Boggs, who served on the Banking Committee, added in longhand the words, “gender or marital status,” and in her inimitable way, said to the chairman, “Darlin,’ I know you didn’t mean to leave this out.”

If you look at the history of women in the workforce in the early twentieth century, the average woman worker was less educated than the population as a whole. The explosion in high school graduation rates in the early 1900s and the demand for more clerical workers meant that young women entered nicer, cleaner, shorter-hour, and more respectable jobs. Most left when they married, due in significant part to laws barring married women from working in many fields, even teaching. In World War II, of course, women were in every field of endeavor, though Harvard Law School’s dean bragged that things were not so bad that the school had to admit any women.

When the men came back from the war, though, the women went back home, or to jobs traditionally held by females. They didn’t return in large numbers until the 1970s, when the idea of female equality started to take root in the daughters of the WW II generation. I think those moms, having gotten a taste of equality, somehow passed it on to their daughters.

The changes for women in the last quarter to half century cannot be overstated, and I know of no better way to illustrate that than to talk about some of the icons in each of the professions. Obviously I can’t cover every occupation. But let me make some observations.

When I grew up, there was only one female reporter in broadcasting, Pauline Frederick, and later, Nancy Dickerson. Today, two of the three nightly news anchors are women.

In the tough-guy world of national security, 25 years ago, the White House Chief of Staff Donald Regan famously opined that women “were not going to understand throw-weights.” Today, the entire team that negotiated the START treaty with the Russians was female, from the top diplomats and Pentagon officials to the top scientists.1

Icons and role models

In business, where today women still lag way behind men, take a look at the May 24, 2010, Time magazine cover. There you will see three dark-suited women under the headline “The new sheriffs of Wall Street: The women charged with cleaning up the mess.”2

Elizabeth Warren, a native Oklahoman with...
a fierce competitive streak, was the state’s top debater at 16, married at 19, had her first child at 22, graduated from law school, and while teaching law in the early 1980s, decided to investigate a new bankruptcy law. She expected to learn about a system full of slimy and lazy debtors, but instead found that many bankruptcies resulted from job loss or illness; the problems were compounded by banks’ murky agreements that kept people in debt, sometimes with interest and fees costing more than the original loan amount.2

A couple of months after Lehman Brothers collapsed, Ms. Warren, by then at Harvard, was tapped by leading Democrats to be the congres sional overseer for the Troubled Asset Relief Program (TARP). Since then, in Time’s words, she has “wielded her clout like a cudgel,” first making monthly reports on the TARP in language everyone can understand, and then fighting off business opposition to the creation of a new agency devoted to protecting consumers from “tricky” financial products and practices.2 The consumer protection agency was her idea, but her advocacy made it likely she could not be confirmed to head the new agency. So instead, President Barack Obama named her to get the agency up and running, with a chair to be named, presumably in the next six months or so.

Sheriff number two is Sheila Bair. Appointed by President George W. Bush to head the Federal Deposit Insurance Corporation (FDIC), she began warning, in early 2007, about massive mortgage failures. Her warning fell largely on deaf ears, and banks balked when she urged them privately to renegotiate entire categories of loans. Of course, by the end of 2008, the banks were becoming insolvent and had to be taken over by the FDIC. Ms. Bair found herself often the target of criticism in public and in private. After she called the president of a top bank to warn him about regulator disagreement on the bank’s ratings, the bank’s primary regulator, John Reich, head of the office of thrift supervision, e-mailed one of his male colleagues, “I cannot believe the continuing audacity of this woman.”2

Ms. Bair was born in Independence, KS, the daughter of a surgeon and a nurse. She went to Washington to work for Republican Sen. Bob Dole, who eventually urged her to run for Congress. A pro-choice Republican, she lost by a narrow margin. In a speech at Harvard in 2010, she said that Dole told her she had lost because she was a woman and unmarried. That, she said, made her even more determined to take on new challenges.2

Sheriff number three is the head of the Securities and Exchange Commission (SEC), Mary Schapiro. When President Obama tapped her to chair the SEC, the agency was bereft and disgraced. It had missed the Bernie Madoff scandal, pig-headedly refused to take extra money from Congress for enforcement, and been embarrassed by disclosures that officials had used SEC computers to look at pornography. Her first year on the job was not without bumps, but she added enforcement staff, started an in-house think tank to assess system risk, and launched initiatives to reform trading practices that favored institutions over individual investors.

The daughter of a college librarian and an antiques dealer on Long Island, Ms. Schapiro went to Franklin & Marshall College, got a law degree, and started working at the Commodities Futures Trading Commission. In 1994, when she was nine months pregnant, she was chosen to take over the agency. Once in the job, she refused a request by Chicago traders to be exempted from federal regulation. The head of the board of trade struck back, declaring that he would not be “intimidated

"The stories these women tell are hauntingly familiar to women in other professions. Ms. Bair spoke about the experience of being at a meeting, making a suggestion, and being ignored. Then 15 minutes later, one of the men made the same suggestion, and everybody nodded their heads."
by some blond 5'2" girl." Ms. Schapiro responded by telling a reporter: "I'm 5'5"."

The stories these women tell are hauntingly familiar to women in other professions. Ms. Bair spoke about the experience of being at a meeting, making a suggestion, and being ignored. Then 15 minutes later, one of the men made the same suggestion, and everybody nodded their heads.

Women in law

Supreme Court Justice Ruth Bader Ginsburg made a similar observation to a reporter in 2009, when she was the only woman on the nation’s highest court. She noted in passing that she had thought those days gone when Justice Sandra Day O'Connor was on the court with her, but, she hinted, she had been wrong. The current Supreme Court opened its new term with three women on the bench for the first time—fully one-third of its membership.

Since I cover the law, it is perhaps easiest for me to speak about Justice O'Connor and Justice Ginsburg. But remember that in the 13 years that these two women served together, not a single year went by without some leading male lawyer at oral argument confusing the two, and calling one by the other’s name. And believe me, these ladies do not look anything alike. Indeed, so notable was this phenomenon that the National Association of Women Judges presented the two with tee-shirts. One said, "I'm Sandra, not Ruth." And the other, "I'm Ruth, not Sandra."

Before I tell you more about these two justices, though, I just want to quote from an 1875 Wisconsin State Supreme Court ruling denying Lavinia Goodell the right to practice law. Observing that the profession of law is not fit for female character, the court said, “The peculiar qualities of womanhood, its gentle graces, its sensibility, its tender susceptibility, its purity, its delicacy, its emotional impulses, its subordination of hard reason to sympathetic feeling, are surely not qualifications for forensic strife.” About the same time, the U.S. Supreme Court upheld the exclusion of women from practicing law in Illinois, with one justice writing, “The paramount destiny and mission of women are to fulfill the noble and benign offices of wife and mother. This is the law of the creator.”

I’m not sure that the lions of the bar had a much different view when Justice O’Connor graduated from college, as you will see.

Sandra Day O’Connor was raised on a cattle ranch owned by her parents at the Arizona/New Mexico border. At age 10 she was sent away to school, and at age 16, she enrolled at Stanford University, eventually graduating from Stanford Law School, third in her class. On the job market, she soon learned nobody seemed to want to hire a woman lawyer. A major law firm did offer her a job as a secretary if she could prove that she possessed good typing skills.

After every job door was closed in her face, a desperate Ms. O’Connor finally made an offer to the San Mateo County Attorney, an offer that she hoped he would not be able to refuse. She offered to work for him for nothing, and to share an office with his secretary. He agreed to take her on, and after a typically stellar start, Ms. O’Connor was soon was put on salary. When she and her husband John moved to Arizona, she continued practicing law, stopping only when a dearth of babysitters forced a five-year hiatus to raise her three sons. Soon, she was a figure to be reckoned with in Arizona’s political life. Elected to the state senate, she quickly rose in Republican ranks to become the majority leader, then was appointed a state trial judge and a state appellate court judge. By then, in 1981, and with the retirement of Justice Potter Stewart, President Ronald Reagan had a Supreme Court vacancy to fill. He had promised to appoint a woman if he had a chance, and even though many of his aids urged him to name some male luminary, Reagan was not a sentence parser. He wanted to make good on the promise.

The problem was that there were precious few women lawyers or judges in those days, and even fewer conservative ones. Then-judge O’Connor was probably the highest ranking who was the right age. And she is the first to say she was not among the best-qualified candidates, that her appointment was something of an affirmative act. Once on the court, her main concern, she later said, was whether she could do the job. “If I stumbled badly,” she said, “it would make life much more difficult for women.”

As it turned out, of course, Justice O’Connor’s appointment gave a huge boost to women in the law. As soon as she was appointed, she later observed, the number of women on the bench started...
skyrocketing. In 1981, the year she was appointed to the court, there were just 12 women in total on the 50 state supreme courts. Today there are 111, or just under a third. And in the federal courts in 1981, only 6 percent of the judges were women. Today the number is 28 percent and rising fast. As for Justice O’Connor herself, she became, as one commentator put it, “the most powerful woman in America.”

Because of her position at the center of a court that was so closely divided on so many major questions, she often cast the deciding vote in cases involving abortion, affirmative action, national security, campaign finance reform, separation of church and state, states’ rights, and, of course, in the case that decided the 2000 election, *Bush v. Gore*. Her retirement allowed President George W. Bush to appoint a male and far more conservative justice in her place, and that appointment tilted the court in a decidedly more conservative direction, something that has not entirely pleased her.

Justice O’Connor is the first to say that despite how much she loved her work and her colleagues, her life on the court became ineffably better when a second woman was appointed—Justice Ginsburg. It wasn’t that the two always agreed. They didn’t. But they had a special bond, and when the court voted to invalidate the men-only policy at the Virginia Military Institute shortly after Justice Ginsburg joined the court, the assignment of writing the opinion initially went to Justice O’Connor, who was by then quite senior. But Justice O’Connor said no, that the assignment should go to the very junior Justice Ginsburg.

It was indeed fitting that Justice Ginsburg would get the assignment, even though a justice so junior does not usually get such a juicy opinion to write. But Justice Ginsburg quite simply changed the way the world is for American women today. And she did it before she became a U.S. Supreme Court justice. For more than a decade, until her first judicial appointment in 1980, she led the fight in the courts for gender equality. When she began her legal crusade, women were treated, by law, differently from men. Thousands of state and federal laws restricted what women could do, barring them from jobs and even from jury service.

By the time she donned judicial robes, however, Ms. Ginsburg had worked a revolution. She was an unlikely pioneer, a diminutive and shy woman, whose soft voice and large glasses hid an intellect and attitude that, as one colleague put it, “tough as nails.”

It was a toughness born of experience. From the time she was 13, her mother was sick, and just days before she was to graduate from high school as valedictorian, her mother died. Then 17, Ms. Bader went on to Cornell on full scholarship, where she met Martin Ginsburg, known as “Marty.”

After her graduation, they were married; he was drafted, and they went to Ft. Sill, OK, where Mrs. Ginsburg, despite scoring high on the civil service exam, could only get a job as a typist. When she got pregnant, she lost her job.

After the service, they went to Harvard Law School, where she was at the top of her class, served on the law review, took care of their two-year-old, and eventually her husband, as well, when he was diagnosed with advanced testicular cancer. After graduation, she was recommended for a Supreme Court clerkship with Associate Justice Felix Frankfurter, but he wouldn’t even interview her because she was a woman.

Eventually, she landed at Rutgers School of Law, where she hid her next pregnancy to avoid being fired from a job a second time. She was hired at Rutgers in 1963, which just happens to be the year the Equal Pay Act became law. Nonetheless,
as she has pointed out, she was not paid the same wages as her male peers. The dean explained that the school had limited resources, and after all, her husband had a good job.4

Now, Justice Ginsburg may be soft-spoken, but she is not timid. Seven years later she was part of a class action lawsuit against Rutgers to enforce the equal pay law. Each member of the class received an enormous salary increase in settlement of the suit.4

A couple of years later, after she joined the faculty at Columbia University in New York, NY, she gave that administration fits, too. When the law school decided to save money by sending layoff notices to 25 maids and not a single janitor, Professor Ginsburg entered the fray and as a result, no maids were laid off. And if that wasn’t enough, she joined a class action that sued the university over disparate pensions for female and male faculty.4

The case that launched the young professor on her pioneering crusade for women’s rights involved an Oklahoma man named Charles Moritz, who, in the early 1970s, sought to claim a $600 dependent care deduction for the care of his 89-year-old mother. The Internal Revenue Code allowed women and divorced men to take such deductions, but not single men—and Moritz was single. He went to court, representing himself, and lost. Tax lawyer Marty Ginsburg spotted the case in one of his tax reports, and dropped it on his wife’s desk. She emerged from her office a short while later, with just three words: “Let’s take it.” As the appeal progressed, the U.S. government attached to its brief a printout from the Department of Defense computer listing every provision of the U.S. Code that treated men differently from women. In an era when such a list was otherwise impossible to come by, this was a mother-lode for Professor Ginsburg. It was, in effect, the roadmap she would use over the next decade to almost single-handedly convince the Supreme Court to do away with gender differentials in matters ranging from a woman’s right to be the executor of her son’s estate, to a female Air Force officer’s right to secure housing allowances and medical benefits for her husband, to securing survivor’s benefits for a widower whose female school-teacher wife died in childbirth, leaving a baby to be cared for.11

It is hard to remember today how profound the legal differences were for men and women not that long ago. Not only did women lose their jobs when they got married or had a baby, but they could be barred from occupations for life for the crime of childbirth. In one case, a woman was honorably discharged from the U.S. Army when she became pregnant, and years later, when she sought to re-enlist, she discovered that such discharges counted as “a moral and administrative disqualification for re-enlistment.”4

There is a certain amount of amnesia about this history today—a notion that some women have that they have picked themselves up by their bootstraps, forgetting that they might well not have had bootstraps without women like Justice Ginsburg, a woman made of such steel that in June 2010, the day after her beloved husband Marty died, she was on the bench at the Supreme Court, delivering a major opinion for the Court.

**Women in medicine**

Now, moving on to my medical icons, this is tricky, both because it is not my field and because there are so many wonderful women surgeons in America today who are mentoring the next generation. So, with one exception, I am going to talk about women who are dead.

Let me start with Elizabeth Blackwell, MD, the first fully accredited woman doctor in this country, who also opened the first medical school for women (see photo, page 18). Born in England, she immigrated to the U.S. with her family at age 11. The unverified story is that she decided to become a doctor after visiting a dying family friend who told her how much she had been humiliated by male doctors.12

Dr. Blackwell studied medicine privately for two years while teaching music in North and South Carolina. Then she applied to medical school. Sixteen medical schools turned her down before Geneva College, now Hobart and William Smith Colleges, accepted her. In 1847, when she arrived at Geneva College, the wives of the faculty and the women of the town thought her either wicked or insane. Apparently, when she got there, there were so many second thoughts that the administration put her admission to a vote of the student body and said the decision had to be unanimous. The students apparently thought it would be a lark to vote her in, and did.12

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After further study in Philadelphia, she was determined to become a surgeon, and she went to Paris hoping to study surgery there. Denied access to Parisian hospitals because of her gender, she enrolled instead at La Maternité, a highly regarded midwifery school. Inadvertently splashed with some pus from a child’s wound, her eye became infected and had to be removed, making it impossible for her to become a surgeon.12

She returned to the U.S. determined to practice in New York City. It was so hard, though, to find a space, that when a sympathizer agreed to rent her a room in a boardinghouse, all the other renters moved out. Dr. Blackwell finally rented a house, lived in the attic, and used the main rooms as consulting rooms.12

Less than two years later, she opened the one-room New York Dispensary for Poor Women and Children in a slum area. It took some time before poor women had the courage to come, but once they did, Dr. Blackwell was so busy she had to move to larger quarters. By 1856, Dr. Blackwell and her sister Emily, who had also become a doctor, opened the New York Infirmary for Indigent Women and Children. After the Emancipation Proclamation, when white workers rioted over fears they would lose their jobs to newly freed slaves, white infirmary patients demanded that the Blackwells discharge several black expectant mothers, but the doctors refused.12

In 1868, Dr. Blackwell founded the Women’s Medical College adjacent to the New York infirmary. She was a professor at the school, the first school devoted entirely to the medical education of women; it later became one of the first medical schools in America to require four years of study. Among the first graduates was Rebecca Cole, MD, the first black woman to become a doctor.12

Moving to more modern times, I thought I would focus first on the woman for whom this lecture is named. Olga Jonasson was the first female academic chair of surgery in America (see photo, this page). Indeed, in an interview with Patricia Nuemann, MD, FACS, in September, 2010, she called Dr. Jonasson the “matriarch of American surgery.”

Born in Peoria, IL, the daughter of a Lutheran minister and a nurse, Dr. Jonasson entered Northwestern University, Evanston, IL, at age 16, and went on to medical school at the University of Illinois, Chicago, where she was an honors student. When she told her chief, Warren Cole, MD, FACS, that she wanted to be a surgeon, he thought the idea was ridiculous, but eventually accepted her into the surgical residency program, where she again excelled. I have been unable to find out much about Dr. Jonasson’s early surgical life, but C. Rollins Hanlon, MD, FACS, American College of Surgeons (ACS) Executive Consultant, told me that one of the reasons she went into transplant surgery was that it was a new field, a place where a new kind of surgeon, a woman, might succeed; and succeed she did, achieving many surgical and...
research firsts. By 1977, she was the chair of the department of surgery at Cook County Hospital, Chicago, IL, the first woman to hold such a position at a major medical center.13

In researching Dr. Jonasson, I found out some wonderful things. She loved to drive her orange Saab down Michigan Avenue and when someone passed her on a motorcycle without a helmet, she would gun her motor, catch up with him at the next light, and hand him a donor card.

She was a deeply religious person, and generous. In an interview with Dr. Hanlon in September 2010, he stated that Dr. Jonasson donated huge sums to her church, raised more, and willed her home to the University of Illinois.

Dr. Jonasson was a tough but wonderful mentor to residents. When she died, they told fabulous stories. Charles Stolar, MD, wrote, “She represented all that was good in surgeons/scientists/humanists. She had as much passion for the vagaries of the porta hepatitis as she did for the biology of rejection, as she did for Tosca’s plight, as she did for the well-being of her students.... She represented the quintessential surgeon...smart, accurate, adept, clever, direct, compassionate, and honest. We all wanted to be like OJ and still do.”14

Geosel Anson, MD, FACS, recalled scrubbing with Dr. Jonasson as an intern when a fly landed on the chest of chief resident Patty Pisanelli, MD, FACS. According to Dr. Anson, “Without missing a beat, OJ hit the chief’s chest with an open hand. ‘New glove for me, new gown for Dr. Pisanelli,’ she said. I swear. She never even looked up.”14

Perhaps more than anything else, I have been impressed by how much Dr. Jonasson changed over the years. Kimberly Ephgrave, MD, FACS, recalls her residency interview in 1979. Dr. Jonasson, at 6’2″, towered over the 5’10″ Dr. Ephgrave. Dr. Jonasson told Dr. Ephgrave that her application was good, as she was AOA, and had good scores, but that being absolutely superior in all ways was required for women in surgery. And then, says Dr. Ephgrave, “She really scared me. She said that the one thing that was unacceptable was that I was recently married. If I wanted to succeed in surgery, she said, I would need to get a divorce. I walked out of there shaking, but my optimistic husband assured me, as we processed the interview over supper that night, that there was no logical reason that general surgeons couldn’t be female, married, and have children.”15 Dr. Ephgrave ranked the program second, but matched at her first choice, so she didn’t have to get a divorce; but she and other women surgeons lived to see Dr. Jonasson change her views markedly over the years.

Dr. Jonasson not only changed her views regarding marriage, but of childbearing as well. By 1991, Dr. Jonasson co-authored an article that appeared in the Journal of the American Medical Association entitled “A pregnant surgical resident—Oh my!” It concluded that “Careful family planning, good communication, flexibility from the program director and faculty, support from coworkers, and most important, support from the spouse of the resident are the ingredients of successful childbearing during residency training.”15

There were other changes, too, after her six years as chair of surgery at Ohio State University, Columbus, OH. She was brought in during the late 1980s with the specific charge of elevating women in surgery; she said later that she simply was not accepted there, or elsewhere, as an equal in the academy. She returned to the college as head of postgraduate medical education, and she prospered; but her female friends and colleagues say that by the 1990s, she was a different woman, unwilling to depend on the favors of men, and determined to push women in surgery.

Dr. Jonasson, along with Patricia Donahoe, MD, FACS; Kathryn D. Anderson, MD, FACS, FRCS; and others, formed a group that Dr. Anderson nicknamed the HENs—“Have Equality Now.” They, and later, others like Dr. Numann and Barbara Bass, MD, FACS, would go over lists of women surgeons, their articles, their achievements, and pick out the “WWs” (Worthy Women), who should be in the SUS and the ASS. And then they would call the chairs of these women’s departments and ask them to nominate the WW. If the chair was reticent, they would look for another sponsor, according to interviews with Olga Jonasson’s female colleagues in September 2010.

Lastly, I want to talk about a living woman surgeon, albeit a retired one, and it is fitting that since this is an ACS meeting, that the woman is Dr. Anderson, the only woman to serve as president of the organization (see photo, page 18).

Born in England, Dr. Anderson completed her first years of medical school there, then moved to Harvard Medical School. Because her husband
was at the National Institutes of Health (NIH), Dr. Anderson went to Georgetown University, Washington, DC, for her residency. In an interview with Dr. Anderson in September 2010, she said that in her first two years, she did just six cases, but in her third year the school “farmed” her out to Virginia Hospital Center, Arlington, VA, and to Sibley Memorial Hospital, Washington, DC, and as she puts it, “I had a ball.” What she wanted was to be a pediatric surgeon, so every year she would go see Judson Randolph, MD, FACS, the head of surgery at Children’s Hospital in Washington, and what follows is the story Dr. Randolph told me.

Each year, Dr. Anderson would go up to Dr. Randolph and say, “When I complete my residency, I want to be your fellow.” And each year, Dr. Randolph would smile and “say something noncommittal.” He even remembers telling a colleague, “She’s just too attractive to be worth a damn,” and so he chose a man, and Dr. Anderson got a job in general surgery at DC General Hospital. In June, though, the male candidate Dr. Randolph had selected called to say that he had to go into the Army, that he was in the Berry Plan, which Dr. Randolph had not known. So there it was—June, and he had no fellow for July. So he called Dr. Anderson, and asked her if she still wanted to be a pediatric surgeon. He recalls her response, in that “clipped British accent”: “Well, that door has been closed to me.” He then started what he calls his “crawl,” and according to an interview with Dr. Randolph in September 2010, young Dr. Anderson said, “I really ought to tell you to go to hell.” She knew then that she would say yes, but she told him she had to think about it over the weekend.

She was “absolutely wonderful,” says Dr. Randolph. “There was no better technician. She brightened everyone’s day. She was never sick. She took no guff. She was wonderful with the patients.” Dr. Randolph says quite simply that Dr. Anderson and his daughter “made him the man I am today, a man who believes women can do anything and everything.”

Dr. Anderson stayed at Children’s as an attending for 10 years, becoming vice-chairman of the department of surgery, and when Dr. Randolph retired, she became the acting chairman. But she was not selected to succeed him. She sued the hospital and eventually won a large settlement.

In the meantime, Dr. Anderson moved to the University of Southern California (USC), Los Angeles, CA, as surgeon-in-chief at Children’s Hospital and vice-president for surgery. With her lawsuit still going on in Washington, her boss at USC, a very religious man, took her to lunch one day. As she tells the story, he said to her, “Kathy, I have talked to God and He has told me you must drop your suit.” To which Dr. Anderson responded, “I have talked to God also, and She has told me it was the right thing to do.”

Examining the data

Each of the women I have talked about here is a shining example of courage, dedication, and refusal to give up. And each can teach us something about where we are in these professions and where we are going.

But data can tell us a lot, too. For help in this part of my talk, I turned to Harvard economist Claudia Goldin. Her research has a lot of good news for medicine, and even for surgery, and some warnings, too.

The big question for women in all professions today is how to balance family life and work. Ms. Goldin’s studies show that women in business have the roughest road. A study of University of Chicago MBAs shows men and women start out at parity in earnings, but by 10–16 years out, women earn about 55 percent of what men do. Now, some of that is explained by women working fewer hours, some by prior training received. But about a third is because of any time off, usually for childbearing. In other words, time off, any time off, usually ended up as a permanent penalty.

Women lawyers are the middle group, meaning that there is a disparity in pay but not nearly as much as for MBAs. And for women doctors, there is almost no differential because of gender. What’s more, women who take time off to have a child still can return to the workforce at full pay, and if they work part-time, they are paid commensurately, not penalized. This is especially true in surgery, where, forgive me, a lot of work is piecework. You get paid by procedure.

The bad news is that even though half of medical grads are now women, they are not choosing surgery as much as other disciplines. Currently, women make up 32 percent of surgical residents,
according to the latest data available. That number lags behind most other medical specialties, and Ms. Goldin’s work, as well as many other studies, shows that the reason women still steer clear of surgery is the fear that they will not be able to balance work and family life. It is a fear fed in part by the books medical students rely on in picking specialties. And it is a fear that is not entirely borne out by the evidence. One survey shows that while female medical students who did not choose surgery believed that surgery is incompatible with a rewarding family life, the women surgeons at the same institutions had a far more positive perception of their careers.

Indeed, the reasons cited by women surgeons for dissatisfaction were very different from the men’s. The women cited lack of credit, and lack of support, while men cited too much competition, lack of autonomy, and too much clinical pressure.

A recent qualitative study copyrighted by the ACS shows male and female surgeons equally satisfied and content with their chosen profession.

In balancing work and family life, it is also worth noting that surgeons do have a schedule; I don’t. Most lawyers don’t have schedules. Whatever you want to say about surgical hours, the fact is that if you are in private practice, you have partners, and a rotation, and if you work for a hospital, you know when you are on and when you are not. That kind of predictability is a very big thing in family life.

One of my friends, former U.S. Deputy Attorney General Jamie Gorelick, says she always considered it a blessing that her husband was chairman of medicine at Georgetown University. She could never tell when some terrorist was going to blow up a building, but she knew when she looked at her husband’s schedule what time periods she had to make sure were covered at home.

In surgery, there are some interesting phenomena of late. Certain subspecialties have had big growth rates for women. Colorectal surgery is a prime example. In 2007, just 15 percent of colorectal surgeons over 45 were women. But a third of those under 35 were women. Ms. Goldin theorizes that the steep increase in the number of women in this field is attributable to the enormous expansion of colonoscopies, and with that, the demand for surgeons involved in routine and scheduled procedures.

Veterinary medicine is an example of a profession that became more attractive to women as it changed, perhaps because the needs of women spurred that change. In 1970, women were fewer than 10 percent of the graduates in veterinary school. Today, they are close to 80 percent. At the same time, there has been a huge growth in regional veterinary hospitals. This development allows veterinarians to maintain regular hours and to refer sick patients to a central location. In short, according to Ms. Goldin, there has been a change in the culture of the veterinarian business to make hours more predictable.

Nobody likes change, but nothing stays the same. And in the modern world, many of the dilemmas that we face are the result of a static way of looking at things.

I am reminded of a dinner I attended with my late husband in the early 1980s, when the former dean of Harvard Law School opined to a group of male alumni that women in law firms were nuts if they thought they could be partners and take weeks or months off to have a baby, and similarly nuts if they thought they could work part-time for a year or two. As the dutiful wife, I had been silent up to that point. But I simply couldn’t stay mute. What, I wondered, did law firms do about young partners and associates who were in the military reserves when they had to go off for weeks of training or months if called up? A deadly silence followed. It was a parallel that none of these folks had ever contemplated.

I am equally reminded of my now-husband’s comments after he started a new surgical residency program at Inova Fairfax Hospital, Washington, DC. My husband, H. David Reines, MD, FACS, FCCM, who had been chairman at one of the partner’s hospitals in Massachusetts, decided that a new residency program should recruit women in particular to get the best and brightest. Yet one day my exasperated husband came home to proclaim, “If I have one more female resident crying in my office, I am going to kill myself.”

To which I responded, “David, when will you learn that when women get tired and frustrated, they often cry. And when men get tired and frustrated, they yell at people. Now, which is more destructive in the work place?”

Let me add that many of my husband’s female residents are nothing short of heroic. In the last two years, two of his chiefs have delivered babies.

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One was on the phone checking the schedule and barking orders as she was wheeled into the operating room. The other had almost no support, with her military doctor husband away, and yet, there was not one whimper of complaint.

That said, there is no denying that many women tend to be attracted to some fields of medicine where they can practice part-time. About 36 percent of female pediatricians are part-time practitioners. According to Ms. Goldin, only 8 percent of male pediatricians work part-time, which is double the number from six years earlier.

Even in those fields where the hours can be long and demanding, there are ways to change the culture for doctors, for both men and women, who want to work fewer hours because of family responsibilities, or to make family responsibilities easier to manage. To cite just one example, on-site or close-by child care.

If you want to look at one area where there is a real warning for surgery, it is research. If you look at NIH research grants, women and men in their 30s apply in just about equal numbers and have equal success with loan repayment postdoctoral research grants. The trend continues for most, but not all, of the K grants. But when it comes to the crème de la crème, R01 grants, applications from women collapse. Men outnumber women applicants two or three-to-one, even though the success rate for female and male applicants is the same. Timothy Ley, MD, at Washington University, who compiled these statistics, says the reasons range from continued institutional sexism—women still not being put on the best committees at their universities—to the hesitancy that many women have in running their own lab, to the sheer workload and its incompatibility with being the primary caretaker of young children. We must, he says, figure out how to adjust the culture or we will lose some of our best research minds. The interesting thing, observes Ginsburg, was that the calls diminished greatly in number thereafter because school officials were much more hesitant to take a man away from his job.

I am about at the end of my rant here. When I gave the draft of this speech to my husband and my sisters, both my husband and my youngest sister, who’s been appointed a federal judge, said I had to have a conclusion. To which I responded, “I don’t do conclusions. Doctors do conclusions, scientists do conclusions, judges do conclusions. But reporters, at least the best of them, in my view, don’t do conclusions. They leave that to their listeners.”

My editors, however, insisted. So, here goes.

Conclusion

I am from a generation of women who did not cry, at least not in front of any man at work. We always knew we had to be better, to prove that we deserved even a chance. Many women of my era made sacrifices that no man did—they didn’t have much of a social life and didn’t marry, or they didn’t have children, and many of them who did saw their careers suffer because of it. I don’t think any of this was good. It just was. If you wanted a career, you often paid a price that, frankly, sometimes tested your humanity, and often it was only the superwomen who succeeded.

Today, women are being educated in medicine, law, and many other professions, at the same rate as men, and as I’ve indicated, sometimes at higher rates. In many fields, women drop out in pretty high numbers, and they decide to do something else. The women I talked about in the business
world—Elizabeth Warren, Sheila Bair, and Mary Schapiro—were all trained as lawyers; but none, except arguably Ms. Schapiro, practices law. There is, however, a glut of lawyers in the U.S. There is no glut of doctors.

And when you train as a doctor, you usually stay a doctor. There is almost none of the opt-out phenomenon seen in other professions. But more women than men choose to work part-time, especially when their children are very young. The problem is that in the specialties that have attracted women in the past, like pediatrics, a significant number of part-timer also resist the all-consuming work ethic that often compromises family life.

Doctors spend years attaining their skills and academic and community medical centers spend billions training them, as does, I should note, the federal government. So, the challenge, it seems to me, for surgery and all of medicine is to figure out how to lure part-timers back to full-time work, and to figure out how to manage medical hours so that the man and womanpower shortage we all know is coming doesn’t kill us all.

References


The historic 2008 elections left many Americans feeling that hope and change were just over the horizon. Frustrated by the ongoing wars in the Middle East and the plunging U.S. economy, voters, through the election of President Barack Obama, an overwhelmingly Democratic House, and a filibuster-proof Senate, delivered a clear mandate to transform the way things were being done in our nation’s Capitol.
When Charlie Cook, editor of the *Cook Political Report*, gave the keynote address at the 2010 Joint Surgical Advocacy Conference, he iterated just where and how things began to take a turn. In a rapidly deteriorating economic climate, the White House chose instead to lead Congress on a march toward health care reform rather than focusing on the economy like a “laser beam,” as former President Bill Clinton had done. Through this controversial process, in addition to the Wall Street bailouts, cap and trade legislation, and the stimulus bill, the seemingly inexhaustible goodwill toward President Obama and his Democratic colleagues began to dissolve.

This shift in public opinion certainly had a deep impact on the recent midterm elections. According to exit polls, Independents, who voted for Democrats by an 18-point margin in 2006, voted for Republicans by an 18-point margin in 2010. The results were dramatic. “The Democratic Congressional Campaign Committee (DCCC) outspent its Republican rival by more than $23 million in the weeks leading up to Election Day, a massive disparity aimed at protecting dozens of vulnerable House incumbents who ultimately fell amid historic Democratic losses. The DCCC and the National Republican Campaign Committee (NRCC) spent more than $86 million combined in the five-week period from October 14 to November 22, according to updated filings reported with the Federal Election Commission...[T]he NRCC spent $31.3 million, compared with the DCCC’s $54.8 million in that five-week period.” Despite the unprecedented level of air cover provided by the DCCC, Republicans captured the House with a net gain of 63 seats.

The power gap in the Senate also narrowed considerably, leaving the Democrats with only a six-seat advantage. Unfortunately for Democrats, the task of maintaining their edge in the Senate will be even more daunting in 2012, when they must defend 23 seats while Republicans must protect only 10. Some Beltway Democrats are already acknowledging that Republican takeover of the Senate in 2012 is a very solid prospect.

Perhaps most significantly, the seismic shift toward Republicans was not limited to federal offices. The following legislative bodies flipped as a result of the elections (see article, page 29):

- Maine: governor, state Senate, state House
- Pennsylvania: House delegation, governor, state House
- Indiana: Senate delegation, House delegation, state House
- Michigan: House delegation, governor, state House
- Ohio: House delegation, governor, state House
- Wisconsin: House delegation, governor, state Senate, state House
- Virginia: House delegation

These party turnovers have tremendous implications coming out of a census year, with redistricting decisions that will shape elections for years to come on the agenda of every state government. By winning this ability to redistrict and redirect the Congressional seats in each state, Republicans can work to ensure that conditions will be favorable for their party for at least the next decade.


ACSPA-SurgeonsPAC’s role

During the 2009–2010 election cycle, surgery’s political action committee (PAC), the American College of Surgeons Professional Association (ACSPA)—SurgeonsPAC, contributed a total of $701,380 to 109 campaigns for the U.S. House and Senate. The ACSPA-SurgeonsPAC also contributed to candidate leadership PACs and national congressional committees. In keeping with the party ratios in Congress, 57 percent of the contributions were dispersed to Democrats, while 43 percent went to Republicans; 84 percent of the candidates supported by the ACSPA-SurgeonsPAC contributions were victorious.

In addition, this fall, the ACSPA-SurgeonsPAC launched two independent expenditures (IEs) expressly supporting the re-election of incumbent Sen. Patty Murray (D-WA) and the election of Rep. Mark Kirk (R-IL) to the Senate.

A senator since 1992, Senator Murray serves on the Health, Education, Labor, and Pensions (HELP) Committee and on the Senate Appropriations Subcommittee on Labor/Health and Human Services/Education, where she has been a valuable champion for trauma and emergency care. Trauma surgeons and Washingtonians Jerry Jurkovich, MD, FACS, and Eileen Bulger, MD, FACS, were featured in the radio ads for Senator Murray, which praised her for working diligently to ensure that Washington State maintained funding to ensure the financial viability of Harborview Trauma Center, Seattle, WA. Since the election, Senator Murray has accepted a key leadership role as chair of the Democratic Senatorial Campaign Committee.

Senator Kirk, who represented the 10th district of Illinois in the U.S. House of Representatives for a decade, is also a staunch supporter of the physician community. In the House, Senator Kirk was co-chair of Tuesday Group, a group of moderate House Republicans. In this capacity he wrote one of the few Republican alternative proposals to the Democratic health care plans, turning to the physician community—especially the ACS—for guidance. Senator Kirk, who was sworn in this past November, narrowly won his special election race against Illinois state treasurer Alexi Giannoulias (D-IL), 48 percent to 46 percent.

These IEs serve as concrete examples of the considerable impact ACSPA-SurgeonsPAC dollars can have on election results.

Physicians elected to Congress

The ACSPA-SurgeonsPAC backed five physicians who were elected to Congress in 2010. They are as follows:

- **Dan Benishek, MD, FACS (R-MI-01)**, is a general surgeon in the first district of Michigan. Support from the ACSPA-SurgeonsPAC helped Dr. Benishek to win a seat in the U.S. House of Representatives against State Sen. Gary McDowell (D-MI) by capturing 52 percent of the vote.
- **Larry Bucshon, MD (R-IN-08)**, is a thoracic surgeon in Newburgh, IN. The ACSPA-SurgeonsPAC helped Dr. Bucshon to win his election against state Sen. Trent VanHaaften (D-IN), with 58 percent of the vote.
- **Andrew Harris, MD (R-MD-01)**, is an anesthesiologist and state senator in Cockeysville, MD. Dr. Harris defeated incumbent Rep. Frank Kratovil (D-MD) by claiming 55 percent of the vote.
- **Nan Hayworth, MD (R-NY-19)**, is an ophthalmologist in Bedford, NY. Dr. Hayworth defeated incumbent Rep. John Hall (D-NY) by winning 53 percent of the vote.
- **Joe Heck, DO (R-NV-03)**, is an osteopathic physician and former state senator from Henderson, NV. Dr. Heck narrowly defeated incumbent Rep. Dina Titus (D-NV), with 48 percent of the vote.

112th U.S. Congress

Washington, DC, insiders and the American public alike are steeling themselves to see what the 112th Congress has in store. A long list of pressing issues remain as top priorities moving in to 2011. However, with the near-complete elimination of conservative Democrats in the House, and the all but endangered-species status of moderate Republicans, bipartisanship and compromise seem unlikely qualities of the next Congress. Most of the 84 freshman Republican members of Congress ran on platforms of extreme fiscal conservatism, with vows to reduce the spending, size, and scope of the federal government, along continued on page 28
Democratic-held seats lost in House (66)

<table>
<thead>
<tr>
<th>State</th>
<th>Current Representative</th>
<th>New Representative</th>
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</thead>
<tbody>
<tr>
<td>AL-02</td>
<td>Bobby Bright to Martha Roby</td>
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<tr>
<td>AZ-01</td>
<td>Ann Kirkpatrick to Paul Gosar</td>
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<td>AZ-05</td>
<td>Harry Mitchell to David Schweikert</td>
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<td>AR-01</td>
<td>OPEN (Berry) to Rick Crawford</td>
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<td>AR-02</td>
<td>OPEN (Snyder) to Tim Griffin</td>
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<td>CO-03</td>
<td>John Salazar to Scott Tipton</td>
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<td>CO-04</td>
<td>Betsy Markey to Cory Gardner</td>
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<td>FL-02</td>
<td>Allen Boyd to Steve Southerland</td>
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<td>FL-08</td>
<td>Alan Grayson to Dan Webster</td>
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<td>FL-22</td>
<td>Ron Klein to Allen West</td>
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<td>FL-24</td>
<td>Suzanne Kosmas to Sandy Adams</td>
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<td>GA-08</td>
<td>Jim Marshall to Austin Scott</td>
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<td>ID-01</td>
<td>Walt Minnick to Raul Labrador</td>
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<td>IL-08</td>
<td>Melissa Bean (D) to Joe Walsh</td>
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<td>IL-11</td>
<td>Debbie Halvorson to Adam Kinzinger</td>
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<td>IL-14</td>
<td>Bill Foster to Randy Hultgren</td>
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<td>IN-08</td>
<td>OPEN (Ellsworth) to Larry Bucshon, MD</td>
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<td>KS-03</td>
<td>OPEN (Moore) to Kevin Yoder</td>
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<td>LA-03</td>
<td>OPEN (Mulan) to Jeff Landry</td>
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<td>MD-01</td>
<td>Frank Kratovil to Andy Harris, MD</td>
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<td>MI-01</td>
<td>OPEN (Stupak) to Dan Benishek, MD, FACS</td>
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<td>MI-07</td>
<td>Mark Schauer to Tim Walberg</td>
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<td>MN-08</td>
<td>OPEN (Baird) to Jaime Herrera</td>
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<td>MO-01</td>
<td>OPEN (Teague) to Steve Pearce</td>
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<td>NY-13</td>
<td>Mike McMahon to Michael Grimm</td>
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<td>NY-19</td>
<td>John Hall to Nan Haywood, MD</td>
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<td>NY-20</td>
<td>Scott Murphy to Chris Gibson</td>
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<td>NY-22</td>
<td>Michael Arcuri to Richard Hanna</td>
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<td>NY-25</td>
<td>Dan Maffei to Ann Marie Buerkle</td>
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<td>NY-29</td>
<td>VACANT (Massa) to Tom Reed</td>
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<tr>
<td>NC-02</td>
<td>Bob Etheridge to Renee Ellmers</td>
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Republican-held seats lost in House (3)

<table>
<thead>
<tr>
<th>State</th>
<th>New Representative</th>
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<tbody>
<tr>
<td>DE-AL</td>
<td>OPEN (Castle) to John Carney</td>
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<tr>
<td>HI-01</td>
<td>Charles Djou to Colleen Hanabusa</td>
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<tr>
<td>LA-02</td>
<td>Joseph Cao to Cedric Richmond</td>
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Democratic-held seats lost in Senate (6)

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<th>State</th>
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<th>New Senator</th>
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<tbody>
<tr>
<td>AR</td>
<td>Blanche Lincoln to John Boozman</td>
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<tr>
<td>IL</td>
<td>OPEN (Burris) to Mark Kirk</td>
<td></td>
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<tr>
<td>IN</td>
<td>OPEN (Bayh) to Dan Coats</td>
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<tr>
<td>ND</td>
<td>OPEN (Dorgan) to John Hoeven</td>
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<tr>
<td>PA</td>
<td>OPEN (Specter) to Pat Toomey</td>
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<tr>
<td>WI</td>
<td>Russ Feingold to Ron Johnson</td>
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</table>

Republican-held seats lost in House (3)

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</table>

Names in italics represent ACSPA-SurgeonsPAC supported candidates.

New U.S. House lineup‡

<table>
<thead>
<tr>
<th>112th Congress</th>
<th>111th Congress</th>
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<tbody>
<tr>
<td>Democrats</td>
<td>193</td>
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<tr>
<td>Republicans</td>
<td>242</td>
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New U.S. Senate lineup

<table>
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<tr>
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<th>111th Congress</th>
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</thead>
<tbody>
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<td>Democrats</td>
<td>53</td>
</tr>
<tr>
<td>Republicans</td>
<td>47</td>
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</table>

with the ubiquitous (yet highly improbable) pledge to repeal the Accountable Care Act. These factors will have important implications for the legislative priorities of the surgical community. For example, while full repeal of the flawed sustainable growth rate Medicare physician payment formula has nearly unanimous congressional and administrative backing, by 2011 it will come with a price tag exceeding $300 billion.

2012 elections

The ACSSPAC is already gearing up for the 2012 election cycle, which is sure to prove as significant and influential as 2010 (if not more so, as it is a presidential election year). It has been, and will always be, the unyielding aim of ACSSPAC to influence the makeup of Congress and support candidates who are champions for the practice of surgery, surgeons, and surgical patients. College and ACSSPAC leaders and staff strive each election cycle to enhance the size, scope, and political profile of the PAC through a greater market share of Fellows, growing PAC receipts and disbursements, and the development of an increasingly sophisticated political program.

These recent midterm elections showcased the enormous power and potential of political engagement, and how a group of engaged and motivated citizens can cause a seismic shift in the balance of power. There are many ways surgeons can get involved and help elect members of Congress who understand the critical role that surgeons play in the U.S. health care system, including the following:

• Visit the ACSSPAC website at http://www.surgeonspac.org for more information on how to get involved with the PAC and for disbursement lists of candidates the PAC has supported.

• Volunteer for, and contribute to, a candidate’s campaign, and be sure to be included on his or her health care advisory board if applicable. (Many members of Congress and candidates set up boards or panels composed of physicians and others with medical expertise to help guide policy decisions.)

• Attend the 2011 Joint Surgical Advocacy Conference in Washington, DC, March 25–27.

(Visit http://www.facs.org/grassroots/index.html for more information and to register for the 2011 Joint Surgical Advocacy Conference.)

You can also work with ACSSPAC staff to do the following:

• Set up in-district delivery of ACSSPAC checks. This is a great way for physicians to get to know their member of Congress or candidate and/or to help cultivate the existing relationship.

• Schedule a time for the member of Congress or candidate to tour the physician’s office and learn more about issues facing surgery, and how Congress directly affects the physician’s practice and patients.

• Host an in-district fundraiser for fellow surgeons and the greater physician community, benefiting the candidate in the physician’s district.

Individual relationships with members of Congress and staff are critical to the success of surgery’s advocacy efforts on Capitol Hill. There is no better time to cultivate these vital contacts than when a member or candidate needs a surgeon’s help.

Ms. Morse is Manager of Political Affairs, American College of Surgeons Professional Association, Washington, DC.
The recent midterm elections resulted in some very interesting outcomes and political upsets, reflecting major trends across the country. Many state legislatures experienced a distinct shift in the majority party, with Republicans replacing Democrats as the dominant state party. The most prominent Republican increases occurred in the Western and Midwestern parts of the country. Additionally, Republicans experienced huge gains in the number of candidates elected to governorships and other state offices.

Governor races

Important Republican victories included ousting the incumbent governors of Iowa and Ohio and taking away open seats that had previously been held by Democrats in Michigan, New Mexico, Oklahoma, Pennsylvania, Tennessee, Wisconsin, and Wyoming. Republicans also successfully retained incumbent governor seats in Arizona, South Carolina, Florida, and Texas. Ohio and Florida, both key battleground states in any election, received plenty of attention for their highly competitive gubernatorial races. In Ohio, Democratic incumbent Ted Strickland lost to former Republican congressman John Kasich, and in Florida, Rick Scott beat Democratic candidate Alex Sink. These two races were seen as major indicators of how people would vote nationally; and indeed, similar to Ohio and Florida, voters throughout the U.S. opted for Republican candidates. However, whereas Republicans made major inroads in gubernatorial elections, they lost some very closely watched races in Connecticut, Rhode Island, Hawaii, California, Oregon, and Illinois to Democrats.

Several gubernatorial races were too close to call in the days following the election. Oregon, Connecticut, Illinois, and Minnesota all had races where the margin of victory was too narrow to have a conclusive result. Eventually, candidates conceded in each of these elections. In all of these races, it was Democratic candidates who were declared governor and Republican candidates who conceded. This is yet another example of the impressive momentum behind Republican candidates and the uphill battle Democratic candidates experienced in this past election.

This election season also ushered in unprecedented levels of campaign spending for statewide elections. More than $850 million was spent in races for governor and lieutenant governor. This high level of spending was partially a result of new participation from Tea Party candidates. These candidates exerted additional pressure and competition on GOP tickets, which caused greater spending during primary races.

State legislature results

Republican candidates also experienced a banner year and significantly increased the number of seats they occupy in state legislatures. Before the 2010 election, Democrats controlled both the House and the Senate chambers in 27 state legislatures; the GOP controlled 14 states, and eight states were divided between Democratic and Republican control. After the election, Democrats have control of 16 state legislatures, while Republicans dominate 25 statehouses. The decisive drop in the number of Democrats voted into state government positions was remarkable and speaks to the current national political climate. Although

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2010 State Election Outcomes

by Charlotte Grill

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it was anticipated that Republicans would make gains in this election, these results exemplify an obvious and profound departure from the party of the sitting President.

In this election, Republicans took control of the following: Alabama House and Senate, Colorado House, Indiana and Iowa House, Maine House and Senate, Michigan House, Minnesota House and Senate, Montana House, New Hampshire House and Senate, North Carolina House and Senate, Ohio House, Pennsylvania House, and the Wisconsin Assembly and Senate. Democrats did not gain a single chamber. In all, the Republicans picked up more than 500 seats nationally—the highest number of Republicans in state government since 1928.‡

What to expect

While winning the majority of statewide seats does not directly translate into greater political influence at the federal level, it does imply that Republicans will have the power to push back and resist key components of the Democratic agenda. It can be anticipated that Republicans will challenged aspects of implementing the federal stimulus package and health care reform. They also will likely address a variety of other issues, such as energy, immigration, and the redistricting of congressional maps for the 2012 presidential election.‡

Perhaps the greatest challenge facing all governors and state legislatures will be the growing problem of state deficits and unbalanced budgets. Many states are going to have to start making cuts, most likely to Medicaid and other health care programs, in order to reduce state spending, as revenues are at an all-time low. In addition, a dozen of the incoming governors have vowed not to raise taxes, which will make balancing their states budgets a very challenging task. It is not going to be an easy economic environment for any state official to tackle and solve these daunting problems.

Important ballot issues

Several states had notable ballot initiatives in this past election. Arizona, Colorado, and Oklahoma all had ballot initiatives that would address how the Affordable Care Act (ACA) is implemented at the state level. Arizona and Oklahoma voters both passed constitutional amendments opposing the individual mandate contained in the ACA. These state constitutional provisions most likely will be tied up in litigation between states and the federal government as the Administration begins to enforce and implement the ACA requirements.

A ballot referendum of interest to the trauma community was an initiative in Georgia to impose a $10 surcharge on motor vehicle registrations and allocate the funds to a statewide trauma system. Unfortunately, this referendum received too few votes to pass. The American College of Surgeons (ACS) was supportive of this referendum because it would have guaranteed and protected annual funding for critical trauma care. It is hoped that, while it did not get passed this year, the Georgia legislature will again put this referendum on the ballot or pass legislation that will ensure their trauma system is adequately financed.

Future state issues

It is important that surgeons and ACS chapters make note of these election results as they attempt to build relationships with state legislators and expand their scope of influence within state legislatures. Fellows need to work with legislators to help advance legislative priorities, such as medical liability reform and trauma system funding and development, and to ensure that state governments support patient access to quality surgical care.

Fellows and chapters that would like further information on the 2010 state election results or are looking to advance state advocacy initiatives should contact Charlotte Grill at cgrill@facs.org.

Ms. Grill is State Affairs Associate, Division of Advocacy and Health Policy, Chicago, IL.


On a Sunday afternoon in late October 2006, Mark and Katie Kearney of Plymouth, MA, dropped their eight-year-old son, Sean (see photo, this page), off at a friend’s home for a hockey playdate. Several hours later, Sean sustained a severe brain injury as a result of an all-terrain vehicle (ATV) accident. I cared for Sean in the intensive care unit until he died from his injuries five days later. On that day, the Kearneys asked me how this tragic incident could have happened to Sean. I did not realize the far-reaching implications that their question would have for redefining the laws regulating all ATV use in Massachusetts, and the impact on redefining my responsibilities as a pediatric surgeon.

A year after Sean’s death, Mrs. Kearney had learned about the positions that the medical community, including the American College of Surgeons (ACS), have taken on ATV use. She did not realize that physician groups generally maintain that ATVs are as dangerous to their operators as any vehicle we allow on the highway, and that these vehicles should be subject to at least as much regulation and control. Mr. and Mrs. Kearney realized that there were no laws in Massachusetts intended to protect children from the dangers of ATVs and that
if a new law was passed, it would be the first of its kind in the nation.

At that point, Mrs. Kearney called me to propose advocating for a new law designed to educate the public about the dangers that ATVs pose on children. Initially, she asked me to do some preliminary research regarding ATV-related pediatric injuries, and to enlist the medical community’s support for a new law in Massachusetts.

**Armed with data**

I requested injury data from the state’s Department of Public Health. The information that I received was astounding. For the year spanning 2004–2005 (the most recent complete data set), 935 pediatric ATV-related injuries were recorded in Massachusetts, accounting for about 30 percent of all reported ATV injuries in the state. The average age of the injured child was 13.3 years. Of these injuries, 309 required surgery and 206 required intensive care unit admissions. In 2004–2005, 35 severe ATV-related head injuries occurred in Massachusetts alone. Hospital charges for these 35 injuries were nearly $2.3 million. These expenditures account only for the acute cost of caring for the children with head injuries and do not include rehabilitation or long-term care costs for the most seriously injured, whose lifetime costs reach in excess of $4 million per patient (see Figure 1, this page).

Data from the Consumer Products Safety Commission mirrored the results that we saw in Massachusetts. Children across the U.S. accounted for nearly 30 percent of all ATV-related injuries, and this number has increased by 15 to 20 percent per year since 1998 (see Figure 2, page 33). In 2004 alone, 44,770 children under the age of 16 were treated in U.S. emergency rooms for ATV-related injuries. Children riding in ATVs often sustained very serious injuries, including

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**Figure 1. Number of non-fatal ATV-occupant injuries, MA residents, 2004–2005***

![Figure 1](image-url)
severe brain, spinal, abdominal, and complicated orthopaedic injuries. Costs associated with child ATV deaths had increased from $493 million in 1999 to $723 million in 2003.

Riding an ATV involved almost twice the risk of injury serious enough to require hospitalization than any other activity studied, even such high-risk sports as football and snowboarding. It was sobering to learn that since 1982, approximately 2,500 children have been killed in the U.S. as a result of ATV crashes, while in the same period close to 1,800 were killed by accidental gunshot wounds.

It was no longer enough for me to say that children should be careful when they ride ATVs and to continue treating those who were injured riding them. The data compelled me to become an advocate for changes in public policy regarding ATV use by children, which would include vehicle registration, adult supervision, training and education, and age restriction.

**Educating legislators**

For decades, the self-regulated ATV industry and its supporters claimed that adult supervision, helmets, and training classes were the only way to limit youth injuries on ATVs and that a new law would not change behavior. The industry’s self-policing methods had no substantive effect on reducing pediatric injuries.

Faced with strong industry opposition to new legislation, it was necessary to educate the legislators about the dangers that ATVs pose to children and to dispel the misinformation circulated by the ATV lobby. As a surgical intern, my mentors continually reminded me that my job was to get all the pertinent information about a patient to someone who could do something with the data. As an attending surgeon, I exact the same standard from my residents, and I applied the same approach to this political process. I provided data about injury prevention to the politicians and answered their questions about injury outcomes and cost containment. I used the medical literature to teach them the facts about the dangers that ATVs pose to their riders.

Unpalatable as it may have initially seemed to some, a law promoting child health and safety made sense. It was apparent that similar laws enacted before the ATV law, such as graduated licensing and mandatory seat belt use, led to reduction of injuries beyond that attributable to education and training. We suggested that laws limiting use of ATVs to children older than the age of consent to drive other motorized vehicles would also effectively reduce injuries and deaths. For example, in 2004, a law banning ATV use by children younger than 14 was enacted in Nova Scotia, Canada. According to Natalie L. Yanchar, MD, of the department of pediatric surgery, IWK Health Center, Dalhousie University, Halifax, NS, in the year that followed enactment, injuries and deaths for that age group decreased by 50 percent (personal communication, August 12, 2009). Only training and supervision were mandated for 14- to 16-year olds. Not surprisingly, injury rates for that group had not fallen.

Based on the experience in Nova Scotia, we suggested that the Massachusetts law could spare hundreds of families from the grief that the Kearneys experienced. By the summer of 2008, the Kearneys had met with several state legislators,
including Senate President Therese Murray (D) and Sen. Steven Baddour (D), the Chairman of the Joint Committee on Transportation, who redrafted the bill. Senator Baddour’s rewritten legislation was comprehensive, and comprised many public benefits, such as improving rider safety, protecting private property and public land, and safeguarding sensitive natural resources. This new version of the bill would invigorate the debate and propel the bill forward.

Building a coalition

The Kearneys were extremely effective advocates for a new ATV law. Over a period of four years, they met with almost every member of the state legislature and retold their story every time they knocked on another door. I was charged with generating the medical support for this bill, a task that proved to be an easy one. Several major medical and surgical societies had position statements in print, and their leadership, including that of the ACS, were quick to endorse this bill. Gerald Healy, MD, FACS, President of the ACS at the time, wrote the first letter urging Massachusetts legislators to support this bill and enlisted the help of Jon Sutton, Manager of State Affairs, ACS Division of Advocacy and Health Policy. Mr. Sutton provided access to the action alert system through which almost 1,400 Massachusetts surgeons and their affiliated medical professionals sent e-mails and letters to their legislators.

By the end of 2008, every major medical center in Massachusetts and state medical society—including the Massachusetts Chapter of the ACS, The American Academy of Pediatrics, the American Academy of Orthopaedic Surgeons, Safe Kids USA, the Brain Injury Association of Massachusetts, and the Massachusetts Association of Health Plans—endorsed this legislation. In a surprising move, the Audubon Society and seven other environmental groups, along with the League of Women Voters, placed this bill on their legislative agenda and publicly endorsed it as well. In the end, even the Trail-Riders Association (an off-road organization traditionally opposed to age restrictions) endorsed Senator Baddour’s ATV bill.

The coalition that we formed was powerfully driven by independent lobbyists, each working to the same end. By the summer of 2009, the ATV bill had vigor and bipartisan support in the state House, with 22 members in both branches of government and in both parties co-sponsoring the Baddour bill even before it was presented for its first committee hearing.

Success at last

On July 31, 2010, after nearly four years and two legislative sessions, a new ATV law was passed and signed by Gov. Deval L. Patrick (see photo, this page). An Act to Regulate the Use of Off-Highway and Recreation Vehicles, or “Sean’s Law,” as it would be known, provides stricter safeguards for the use of ATVs by prohibiting children under the age of 14 from operating these powerful machines.

In addition to Sean’s Law, Massachusetts state legislators enacted two other comprehensive and forward-looking pediatric injury prevention laws in the nation in 2010.
With the realization that inadequately treated concussions cause potential long-term cognitive and medical consequences, Massachusetts also passed An Act Relative to Safety Regulations for School Athletic Programs. Under this legislation, high school athletic programs are required to have staff trained in concussion awareness. Students who are suspected of having a concussion must receive written medical clearance before they can return to play. This law will help to protect student athletes as they are faced with the mounting pressures related to athletic performance.

Finally, a new safe driving law was enacted. This law bans text messaging for all Massachusetts drivers, prohibits junior drivers from using cell phones, and institutes new license renewal procedures for mature drivers. The increased risk of car crashes associated with texting and cell phone use has been well documented—among adults and teens alike. For teens, who are seemingly immersed in a world of texting and smart phones, this law sends a powerful message that driving demands their undivided attention.

**Importance of surgical advocacy**

Some critics have relegated the 2010 Massachusetts legislative session to the annals of political inaction, due to the failure of the legislature to pass substantive cost-containing legislation. However, the fact of the matter is that our political leaders enacted legislation that will not only save lives and prevent injuries, but that also will reduce the burdensome health care cost of preventable injuries.

As a society, citizens look to the law to guide us when it comes to issues of public health. We invest heavily in health care delivery systems and institutions to manage problems once they have occurred. Significantly fewer resources are dedicated to preventing these problems, despite the evidence that prevention is a far more cost-effective strategy.

During a physician’s surgical training, he or she becomes skilled at identifying injuries and putting patients back together even in the most serious circumstances. Physicians devote little time during their education to understanding the effectiveness of injury prevention, although this too would be time well spent.

Over the last four years, I was impressed by the Kearney family’s selfless efforts to eliminate the risk that cost them their child’s life, in order that no other family would have to experience the tragedy that they have endured. I have come to realize that physicians have a unique ability to work with legislators to enact meaningful injury prevention legislation. The physician’s role as healer and educator can be effectively extended into the political process. More importantly, physicians have an obligation to participate in institutional change if he or she has evidence to support that the cause is just.

**References**


**Dr. Masiakos** is a pediatric surgeon and chairman, pediatric surgical quality and safety Committee, Massachusetts General Hospital, Boston. He also chairs the ACS Massachusetts Chapter Committee on Legislative Advocacy.
Revised statement on recommendations for use of real-time ultrasound guidance for placement of central venous catheters

Revisions to this statement were developed by the ACS Committee on Perioperative Care and approved by the Board of Regents in October 2010.

More than 5 million central venous catheters (CVCs) are placed each year in the U.S., with an associated complications rate of more than 15 percent.\(^1,2\) Mechanical complications such as arterial puncture and pneumothorax are seen in up to 21 percent of patients with CVC complications, and up to 35 percent of insertion attempts are not successful.\(^3-6\)

Several prospective, randomized trials,\(^7-15\) as well as two meta-analyses,\(^16-17\) document that the use of ultrasound has been associated with a reduction in complication rate and an improved first-pass success when placing catheters in the internal jugular vein and the subclavian vein.

Real-time (rather than static) ultrasound guidance is the safest, most cost-effective, and successful method for CVC placement compared with the traditional percutaneous landmark-based approach for cannulation of the internal jugular vein. The use of ultrasound for central venous catheterization increases success rate while simultaneously decreasing procedural time and complication rate. Although not as robust as for the internal jugular site, evidence favors ultrasound for the subclavian and femoral vein site, as well. Standardization of education, training, and practice is also an important component of this technique.\(^18\)

In 2001, the Agency for Healthcare Research and Quality recommended the use of ultrasound guidance for the placement of CVCs as one of the top 11 evidence-based practices that health care providers can use to improve patient care and patient safety.\(^19\)

The Guidance on the Use of Ultrasound Locating Devices for Placing Central Venous Catheters from the National Institute for Clinical Excellence had the following major recommendations:\(^20,21\):

- Two-dimensional (2-D) imaging ultrasound guidance is recommended as the preferred method for insertion of CVCs into the internal jugular vein in adults and children in elective situations.
- The use of 2-D imaging ultrasound guidance should be considered in most clinical circumstances where CVC insertion is necessary either electively or in an emergency situation.
It is recommended that all those involved in placing CVCs using 2-D imaging ultrasound guidance should undertake appropriate training to achieve competence.

Audio-guided Doppler ultrasound guidance is not recommended for CVC insertion.

The American College of Surgeons (ACS) supports the use of real-time ultrasound guidance for the placement of central venous catheters. The ACS encourages health care systems to provide for the appropriate education, training, and resources required.

References


Additional resources

I n the 2011 Current Procedural Terminology (CPT) handbook, the subsection heading “Excision and Debridement” has been revised to refer only to “Debridement.” As a result, codes have been deleted, and new debridement codes have been added. Additionally, the active wound care management and debridement of open fracture codes have been revised to correspond with current clinical practice.

Debridement is a common procedure appearing throughout the CPT book. It is often used to remove foreign material or damaged, dead, or contaminated tissue from a surgical field, wound, or injury. The purpose of debridement is to help promote healthy healing of damaged skin, tissue, muscle, or bone.

**When to use a debridement code**

The debridement of small amounts of devitalized or granulation tissue during a surgical procedure is typically not billed separately. However, debridement is separately billable when it makes up a significant portion of the procedure.

The debridement codes listed in the table on page 39 do not include repairs, whether done at the same operative session or at a later date. It is appropriate to code separately for an intermediate, complex, or reconstructive repair if performed after a debridement. For example, for debridement of a 20 sq cm injury on the left leg including subcutaneous tissue closed with complex repair, code 13121, 13122, 13122, 13122, and 11042–51.

**Depth and surface area**

Starting this year, all wound debridements should be reported by depth of tissue removed and by surface area of the wound. Codes 11042, 11043, and 11044, which previously were used to report debridement of subcutaneous tissue, muscle, or bone, respectively, have been revised. These three codes are now used to report debridement of the first 20 sq cm or less of tissue, muscle, or bone. For example, the debridement of a 7.5 sq cm wound on the left hand that includes subcutaneous tissue is coded with 11042.

Three new add-on codes (11045, 11046, 11047) will be used to report each additional 20 sq cm, or part thereof, of subcutaneous tissue, muscle, or bone in conjunction with 11042, 11043, and 11044. When choosing codes to report, keep in mind that the CPT code numbers are out of sequence. The code pairs for the first 20 sq cm and each additional 20 sq cm are: 11042 with 11045, 11043 with 11046, and 11044 with 11047. For example, if the debridement listed above also requires removal of muscle and bone, code 11044.

If debridement of a single wound is required, the deepest level of tissue removed is used to report the service. However, if multiple wound debridements are performed, sum the surface area of those wounds at the same tissue depth, but do not combine sums from different depths.

For example, for the debridement of an 8 sq cm wound on the right hand, 20 sq cm wound on the left thigh, and a 10 sq cm wound on right leg that all include subcutaneous tissue and muscle, code as follows:

- 11043, Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue); first 20 sq cm
- 11046, Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue); each additional 20 sq cm

**Active wound care management**

Active wound care management codes describe the removal of devitalized and/or necrotic tissue and promote healing. Codes 11040 and 11041, previously used to report debridement of partial or full thickness skin, have been deleted. To report debridement of skin (dermis or epidermis), use the active wound care management codes 97597 and 97598. These codes also have been revised to report the first 20 sq cm or less of total wound surface area (97597) and each additional
<table>
<thead>
<tr>
<th>CPT code</th>
<th>CPT descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 11010</td>
<td>Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues</td>
</tr>
<tr>
<td>▲ 11011</td>
<td>Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle</td>
</tr>
<tr>
<td>▲ 11012</td>
<td>Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone</td>
</tr>
<tr>
<td>11040</td>
<td>Code deleted. Debridement; skin, partial thickness (See 97597, 97598)</td>
</tr>
<tr>
<td>11041</td>
<td>Code deleted. Debridement; skin, full thickness (See 97597, 97598)</td>
</tr>
<tr>
<td>▲ 11042</td>
<td>Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>●+ 11045</td>
<td>Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>▲ 11043</td>
<td>Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>●+ 11046</td>
<td>Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>▲ 11044</td>
<td>Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less</td>
</tr>
<tr>
<td>●+ 11047</td>
<td>Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>▲ 97597</td>
<td>Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less</td>
</tr>
<tr>
<td>+▲ 97598</td>
<td>Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>97602</td>
<td>Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session</td>
</tr>
<tr>
<td>97605</td>
<td>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</td>
</tr>
<tr>
<td>97606</td>
<td>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</td>
</tr>
</tbody>
</table>

- new code; ▲ revised code; + add-on code
20 sq cm, or part thereof, of total wound surface area (97598). References to anesthesia services also were removed because these services can be provided regardless of anesthesia. For example, for an injury to the left leg requiring minimal wound cleaning of a 15 sq cm area of erythematous epidermis, code 97597.

**Open fractures**

Debridement of an open fracture and/or dislocation is not accurately described with the 11042–11047 codes. Frequently, open fractures have considerable contamination with foreign bodies and devitalized tissue. Codes 11010, 11011, and 11012 were revised to describe debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (excisional debridement).

If the debridement of an open fracture includes only skin and subcutaneous tissue, use code 11010; debridement down to the muscle fascia and muscle, code 11011; and debridement that includes skin, muscle fascia, muscle, and bone, code 11012. Codes 11010–11012 can be used for debridements performed at the same time as the fracture reduction and fixation or for initial debridement and reduction at a later date.

For example, a motorcyclist is struck by a car and sustains an open tibial plateau fracture with significant foreign material contamination and devitalization of the skin, subcutaneous tissues, muscle fascia, muscle, and bone. The procedures on the right hand involved debridement of epidermis and muscle with reduction and fixation. Open treatment of the dislocation is reported with the appropriate fracture code, in this case 26665. Code 11011 is used to report debridement of an open fracture and/or dislocation of skin, subcutaneous tissue, muscle fascia, and muscle. The procedures on the left hand involved debridement of bone of a 6 sq cm area. The procedures on the left thigh also include debridement of bone. Because the procedures on the hand and thigh are debrided to the same depths, the surface area of the wounds are summed. Code 11044 would be reported for the first 20 sq cm and add-on code 11047 would be reported three times for the second 20 sq cm, third 20 sq cm, and the remaining 6 sq cm of the 60 sq cm total wound surface.

Some software edit packages may bundle these debridement codes together; therefore, it may also be appropriate to append modifier 51 (multiple procedure).

If you have any questions or comments on this article, contact Jenny Jackson at j.jackson@facs.org or 202-672-1506. If you have additional coding questions, contact the Coding Hotline at 800-227-7911 between 8:00 am and 5:00 pm CST, excluding holidays.

**Coding highlight**

A young woman presents with multiple wounds from a rollerblading accident. She suffered a grossly contaminated open fracture dislocation of the right thumb, and palmar surface injuries to the left hand and thigh. Her right hand required debridement through the subcutaneous tissue, muscle fascia, and muscle of a 3 cm x 3 cm area with reduction and internal fixation. Her left hand required debridement down to and including bone of a 3 cm x 2 cm area. Her left thigh required debridement down to and including bone of a 6 cm x 10 cm area.

In this instance, reportable procedures are as follows:

- 26665, *Open treatment of carpometacarpal fracture dislocation, thumb, internal fixation*
- 11011–51, *Debridement open fracture and/or an open dislocation; skin, subcutaneous tissue, muscle fascia, and muscle, right thumb*
- 11044–51, *Debridement, bone, first 20 sq cm, left hand and thigh*
- +11047, *Debridement, bone, each additional 20 sq cm, left hand and thigh*
- +11047, *Debridement, bone, each additional 20 sq cm, left hand and thigh*
- +11047, *Debridement, bone, each additional 20 sq cm, left hand and thigh*

The procedure on her right hand involved debridement of epidermis and muscle with reduction and fixation. Open treatment of the dislocation is reported with the appropriate fracture code, in this case 26665. Code 11011 is used to report debridement of an open fracture and/or dislocation of skin, subcutaneous tissue, muscle fascia, and muscle. The procedures on the left hand involved debridement of bone of a 6 sq cm area. The procedure on her left thigh also includes debridement of bone. Because the procedures on the hand and thigh are debrided to the same depths, the surface area of the wounds are summed. Code 11044 would be reported for the first 20 sq cm and add-on code 11047 would be reported three times for the second 20 sq cm, third 20 sq cm, and the remaining 6 sq cm of the 60 sq cm total wound surface.

Some software edit packages may bundle these debridement codes together; therefore, it may also be appropriate to append modifier 51 (multiple procedure).

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**Ms. Jackson** is Practice Affairs Associate, Division of Advocacy and Health Policy, Washington, DC.
Surgeons as advocates

by Charlotte Grill and Catharine Harris

Surgeons are an integral part of ensuring that optimal surgical practices and patient care are upheld and protected in public policy, and they can personally attest to the potential impact that policy decisions can have on their practice and their patients. Increasing the role of surgeons in policymaking is especially critical when so many rules are being written with regard to the implementation of health care reform. Furthermore, many issues continue to be debated at the legislative level, including medical liability reform, physician licensure, Medicare payment reform, trauma system funding and development, and injury prevention and control.

Getting involved at the state level

Many opportunities are available to surgeons who want to get involved in state and federal advocacy efforts. For instance, the American College of Surgeons’ (ACS) Division of Advocacy and Health Policy has collaborated with several Fellows to provide critical testimony on a variety of issues to various federal and state governmental committees. Examples of topics on which Fellows have testified include the following: the Affordable Care Act; the Uniform Emergency Volunteer Health Practitioners Act, which would allow registered physicians to practice in another state during a declared state of emergency; physician payment reform; medical liability reform; patient safety and quality; and scope-of-practice legislation. The surgeons’ expertise, personal experiences, and patient stories strengthened their testimony and highlighted how patients and providers are affected by legislation.

Surgeons who are interested in expanding their role and knowledge of state advocacy and legislation may be interested in joining the State Advocacy Representative (StAR) program. StARs are the “eyes and ears” of the College at the state level and are asked to contact the State Affairs team at the College when they become aware of state legislation of interest to surgeons. StARs are also one of the first points of contact if a surgeon is needed to testify to a legislative committee, send letters of support to his or her representatives, or be involved in a Lobby Day at a state capitol. Surgeons interested in participating in the StAR program should contact Alexis Macias at amacias@facs.org or Charlotte Grill at cgrill@facs.org to enroll in the program.

Another effective avenue to one’s increased involvement in advocacy is through a local ACS chapter. Chapter leadership and executive staff work closely with the College on advocacy initiatives and in representing members’ interests at their state capitol. Additionally, many chapters have committees that focus on legislation in their state and organize efforts to either support or repeal legislation.

Getting involved at the federal level

Surgeons also may get involved in advocacy at the federal level through a variety of means. With a newly elected Congress in place, it is vital that surgeons build and maintain personal relationships with their senators and representatives. Surgeons interested in doing so are encouraged to work with the Division of Advocacy and Health Policy’s Washington, DC, office to set up meetings in their districts or in the capital to discuss issues such as the flawed sustainable growth rate, medical liability reform, or the surgical workforce shortage crisis.

For in-district visits, some surgeons give their senators or representatives a tour of their surgical practice or hospitals, providing an excellent opportunity for surgeons to show federal legislators how their decisions affect their constituents at home. The ACS Washington Office can help to set up these meetings, and will work with congressional press offices to generate media attention. If you would like more information about how to set up this type of meeting, contact Catharine Harris at charris@facs.org.

Surgeons also join together at the Annual...
Joint Surgical Advocacy Conference (JSAC), which will take place March 27–29 this year. JSAC brings together hundreds of surgeons from across specialties to learn about effective federal advocacy strategies, and concludes with a lobby day on Capitol Hill. For more information or to register for JSAC, visit http://www.facs.org/ahp/jsac2011.html.

Another way to get involved in federal advocacy is to become a member of a political action committee (PAC). For example, U.S. Fellows are eligible to become members of the American College of Surgeons’ Professional Association (ACSPA)-SurgeonsPAC. The ACSPA-SurgeonsPAC is bipartisan and contributes to the campaigns of incumbents and candidates for federal offices who are in positions to be champions for surgical issues. One option for PAC members is to personally deliver PAC checks to candidates backed by the ACSPA-SurgeonsPAC. This is an opportunity for surgeons to further build their relationships with their federal legislators and to thank them for supporting issues that are important to surgeons and their patients. For more information about the ACSPA-SurgeonsPAC, go to http://www.surgeonspac.org or e-mail ACSPA-SurgeonsPAC staff at acspa@facs.org.

Examples of surgeon advocates

The College recognizes Fellows and chapter administrators who are dedicated state advocates with the Arthur Ellenberger Award. This award was created in 2003 to acknowledge excellence in state advocacy. Named for Arthur Ellenberger, the long-time and now-retired Executive Director of the New Jersey Chapter and expert in state grassroots advocacy, the Arthur Ellenberger Award for Excellence in State Advocacy is presented periodically to recognize a career of outstanding leadership and distinguished service and commitment to protecting patients’ access to high-quality surgical care.

Past recipients of this award include: Mr. Ellenberger; Robert Harvey, former Florida Chapter Administrator; Thomas Gadacz, MD, FACS, Florida; Andrew Warshaw, MD, FACS, Massachusetts; and William Doscher, MD, FACS, New York.

The 2010 recipient of this award is Peter T. Masiakos, MD, FACS, a pediatric surgeon and Chair of the Massachusetts Chapter’s Legislative Advocacy Committee. Dr. Masiakos worked relentlessly to get bill S. 2257, also known as Sean’s Law, passed in Massachusetts. (See article on page 31.) The bill, signed into law in July of 2010, regulates the use of off-highway recreation vehicles and bans all-terrain vehicle (ATV) use by children under the age of 14. The legislation and was named after an eight-year old boy who was fatally injured when the ATV he was riding flipped over onto him.

Fellows in state legislatures

Involvement in advocacy may include running for office, and many surgeons have done so over the years. The American Medical Association recently published the names of state legislators who are physicians or who have immediate family members who are physicians. Currently, 141 medical professionals or their family members serve in state legislative offices. Included in these ranks are the following three Fellows:

- **Ralph Kilzer, MD, FACS**, is an orthopaedic surgeon and a state senator (R-District 47) from Bismark, ND. He began his political career serving in the House of the North Dakota State Assembly from 1997 to 1999, and then was elected to the state senate in 1999. Dr. Kilzer is
also a clinical professor of surgery at the University of North Dakota School of Medicine.

- **Don Van Etten**, MD, FACS, is a retired general surgeon and a state representative (R-District 33) from Rapid City, SD. Dr. Van Etten has been a state representative since 2001.

- **Dan Foster**, MD, FACS, is a retired general and vascular surgeon and hospital administrator who now serves as a state senator (D-District 17) from Charleston, WV (see photo, page 42). Dr. Foster was a state representative from 2002 to 2004 and has been senator since 2004. Dr. Foster practiced general and vascular surgery in Charleston from 1979 to 2001.

Three Fellows of the ACS are current members of Congress. They are as follows:

- **Daniel Benishek**, MD, FACS (R-MI-01), is a general surgeon representing the first district of Michigan. With the support of the ACSFA-SurgeonsPAC, Dr. Benishek defeated state representative Gary McDowell (D-MI-01) by more than 25,000 votes.

- **Charles Boustany**, MD, FACS (R-LA-07), is a cardiovascular surgeon representing the seventh district of Louisiana (see photo, this page). A member of Congress since 2005, Dr. Boustany serves on the House Ways and Means Committee.

- **Thomas Price**, MD, FACS (R-GA-06), is an orthopaedic surgeon who has represented the sixth district of Georgia since 2005 (see photo, this page). He is currently the chairman of the Republican Study Committee, a member of the Education and Labor and Financial Services Committees, and has been a repeat speaker at the JSAC.

The College appreciates the work these surgeons have accomplished and the direct impact they have had on legislation and public policy at both the state and federal levels. They provide an important surgical perspective and insight through direct representation in government. In comparison to other professions, such as law and business, physicians and surgeons are not as well-represented in politics, so their voices are even more critical to the debate.

Surgeons are encouraged to participate in state and federal advocacy through a variety of activities, whether that be contacting a state representative, getting involved in advocacy initiatives, and even running for office. The Division of Advocacy and Health Policy is available to assist surgeons with these activities. Surgeons and ACS chapters seeking further information should contact Charlotte Grill at cgrill@facs.org or Catharine Harris at charris@facs.org.

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**Ms. Grill** is State Affairs Associate, Division of Advocacy and Health Policy, Chicago, IL.

**Ms. Harris** is Congressional Affairs Assistant, Division of Advocacy and Health Policy, Washington, DC.
Can Twitter campaigns increase awareness about health issues?

by Marcos E. Pozo Jatem; Kathleen Casey, MD, FACS; and Adam L. Kushner, MD, MPH, FACS

Twitter, the social and microblogging service, where communication is posted via messages composed of 140 characters or less—known as tweets—has seen a rapid growth among physicians.

Founded in 2006, by 2007 the website was recording approximately 400,000 tweets per quarter. By the end of 2009, usage had skyrocketed to 2 billion tweets per quarter. In 2010, it was reported that Twitter has approximately 175 million users worldwide, or about half a million users per day, who produce approximately 65 million daily tweets.¹

The Twitter experience is based on getting live feeds from authors one selects or decides to “follow” after signing up for the service. The author’s tweets appear as a continued updated strand of information. In addition to following the information feed, a user can contribute their own content via tweets and communicate with others either publically by mentioning them by using the “@” sign, or privately by writing a direct message. Users can also sign up to receive messages by mobile text messaging or instant messaging.

Another feature of Twitter is the “retweet” function, which is designated by the letters “RT.” Retweeting reproduces a tweet and shares it with all who are following your tweets, allowing a single post to be shared exponentially in a short amount of time. To follow all related conversation or debate on a topic, users refer to a keyword preceded by the symbol “#” in their posts, known as a hashtag.

Estimated data from Quantcast.com reports that Twitter users are mostly females (55 percent) and young adults, with a mean number of 31 years of age, and a range of 18–34 years old.² By comparison, other social network sites such as Facebook and MySpace target a much younger population.³

Global Surgery Week Twitter campaign: @GlobalSurgWeek

Surgeons are increasingly interested in working and assisting colleagues overseas, and this, in part, led to the development in 2004 of the American College of Surgeons’ Operation Giving Back (OGB). A primary function of OGB is to serve as a conduit of information, resources, and networks to provide surgical care to underserved regions of the world. This shared concern for improving surgical care in low-and middle-income countries is commonly referred to as “global surgery.” With the aim of helping the surgical, humanitarian, and Twitter communities to raise awareness on this topic, @pozomarcos in Bogota, Colombia; @LEVYandMarie in Geneva, Switzerland; @globalsurgeon in New York, NY; and @OpGivingBack in Newport, RI (including the authors of this article), developed a week-long Twitter campaign using the hashtag #globalsurgery, that was called “Global Surgery Week.”

The campaign was seeded by 10 peer-reviewed articles from the OGB reading list, and highlights of each article were condensed into 140 character tweets and included the #globalsurgery hashtag.⁴ The Twitter account was named @GlobalSurgWeek and had a total of 108 tweets that were scheduled to be posted every one to
two hours starting November 1, 2010, and continuing through November 6, 2010. Individual tweets mentioned organizations central to global surgery such as the World Health Organization (@WHO_news), American Red Cross (@ARC, @RedCross), CARE USA (@CARE), Doctors Without Borders (@MSF_uk, @MSF_Press), Operation Smile (@OperationSmile), the Bill and Melinda Gates Foundation (@GatesFoundation), and the American College of Surgeons (@AmCollSurgeons).

Coinciding with Global Surgery Week, a symposium on the Role of Surgery in Global Health took place November 5, 2010, in Boston, MA. During this time, scheduled tweets were augmented by meeting attendees and highlights from speakers. By the end, the account @GlobalSurgWeek had 85 followers, resulting in significant retweeting of the 108 original tweets, in addition to the insights and comments generated by these followers.

**Where do we go from here?**

The Global Surgery Week Twitter campaign is a practical example of how this social networking tool can increase awareness about a specific health topic. Other examples include emergency physicians who have used Twitter to share information regarding certain diseases and links to new clinical trials.5 There have also been reports about the use of Twitter to track new cases of H1N1. In essence, “disseminating scientific information is a driving mission for many Twitter users,” according to one industry expert.6

Global Surgery Week is one of the first Twitter campaigns launched to increase awareness about a surgical issue. The resulting tweets, retweets, and numbers of followers illustrate how surgical topics can be discussed among people from different parts of the world, in real time, to galvanize an issue or form a global initiative. The true impact of Twitter on the medical community remains to be seen, but its utility for both gathering and disseminating information has great potential in creating a vibrant, dynamic dialogue among a global community of surgeons.

**References**


**Didyou know...**

THAT THE AMERICAN COLLEGE OF SURGEONS ONCOLOGY GROUP (ACOSOG) is one of 10 cooperative groups funded by the National Cancer Institute (NCI) to develop and coordinate multi-institutional clinical trials? ACOSOG is the only cooperative group with studies focusing primarily on surgical objectives. ACOSOG currently has treatment protocols available in three major disease areas: breast cancer, gastrointestinal cancer, and thoracic cancer. ACOSOG is composed of the Operations and Membership Center located at the Duke Clinical Research Institute on the Duke University Medical Center campus, and the Statistics and Data Center located at the Mayo Clinic Cancer Center. ACOSOG’s membership is composed of investigators and research associates representing oncology treatment modalities and research-related concerns, including surgery, medical oncology, radiation oncology, diagnostic imaging, pathology, ethics, CRA/nursing, and patient advocacy. For further information visit https://www.acosog.org/
When Sani Z. Yamout, MD, mentions to colleagues that he is using Twitter, the response he typically receives is, “So, you send out messages like: ‘Coming out of the OR, did a sweet pull-through!’”

“But what many people do not realize is that Twitter has had a substantial change in direction and purpose,” explained Dr. Yamout, during a panel session at the 2010 Clinical Congress meeting in Washington, DC, entitled To Tweet or Become Extinct: Why Surgeons Need to Understand Social Networking. “Twitter’s initial purpose was as a tool that helped people keep up with their friends and their day-to-day activities—and this has caused many to brand Twitter as a gimmick that is just another way for teenagers to waste their time,” Dr. Yamout said. “Many of the Twitter users have moved from talking about what they are doing on a daily basis, to sharing thoughts, findings, and news that interests them and people who are following them. This is what we are interested in—using Twitter to help with surgeon education and patient care,” he continued.

The session—the first Clinical Congress session to feature a live Q&A via an on-screen Twitter feed—covered the basic user fundamentals of the social networking site; practical advice on using the social networking site for research, patient care, and educational opportunities; and information on legal Do’s and Don’ts.

Philip L. Glick, MD, FACS, served as moderator and opened the session by citing a recent American College of Surgeons (ACS) survey on how members use social media tools. According to Dr. Glick, 7 percent of the U.S. population is on Twitter, while 20 percent of ACS survey respondents (approximately 300 at the time of the panel session) are on Twitter. Forty-one percent of the U.S. population is on Facebook, compared with 64 percent of ACS survey respondents (see table, page 48). The more sobering results, according to Dr. Glick, are the number of ACS survey respondents who participate in online forums or read online health blogs—34.5 percent—which is a comparatively low number.

Dr. Glick urged session attendees to join social networking sites because of who is already on them (colleagues, trainees, patients, patients’ families, payors, state medical licensing boards), and due to the fact that these sites are time-efficient, low-cost, geographically borderless ways to share interesting cases with colleagues, obtain CME credit, market new programs, and prevent burnout and rejuvenate the mid-career “blues.”

According to Susannah Fox, a presenter with an academic background in anthropology, social networking sites such as Twitter have three basic users: those who gather information (users who “listen” or visit social media sites but do not participate in them); those who share information (users who act as a filter for their audience by gathering information and then sharing it with others); and those who create information or content. “This is the deep end of the pool,” said Ms. Fox, referring to users who create information on blogs and on networking sites such as Twitter, YouTube, and Facebook.

It is important to note that 80 percent of people who are
online are simply listening and not contributing, noted Ms. Fox, who emphasized that listening to or observing the content on these sites is an excellent way to acquire new information.

Dr. Yamout could be described as personifying all three types of social media users. “I spend a substantial amount of my time online looking up articles and other sources of information to help me care for my patients,” said Dr. Yarmout. “Whenever I find a paper, website, YouTube video, or blog that interests me, I send out a tweet with a link to that site. So, effectively, I’m sifting through the Internet and gathering and sharing information useful to me at my level of training and interest. Now, other people following me, including other pediatric surgery fellows, also have access to this information through Twitter. They can browse through the brief 140-character message, and decide if they are interested enough in the content to hit the URL link and get more information. Now, imagine 10, 20, or 30 other surgeons with similar interests doing the same, and exchanging the information they find.”

According to Dr. Yamout, there are at least three distinct ways that Twitter can be used in surgical education: announcements, helping residents prepare for exams, and locating CME sources. “The ACS meeting is a huge conference. One way to make the most efficient use of it would be for surgeons of similar interests to tweet out information regarding talks, posters, and exhibitions relevant to their field of interest to help direct each other to these events,” said Dr. Yamout, as he explained how Twitter can be used for announcements.

In terms of helping residents prepare for exams, Dr. Yamout described a system where, once a week, he could tweet out a board-type question, and then link to a discussion of the question on his blog. “This way, I benefit from researching the subject, and others following me benefit from reading and contributing to my post,” said Dr. Yamout, who added that Twitter can also be used as a tool to direct surgeons to sources of CME credits relevant to their field of interest.

The session concluded with a presentation by Rebekah A. Z. Monson, JD, who outlined legal do’s and don’ts, particularly information regarding patient privacy. “Privacy rules apply online, said Ms. Monson. “Never post or disclose identifying information about patients, but it's important to be aware of the legal implications of sharing information on social media sites.”
either on public networks or on physician-only forums, such as Sermo.” She also urged attendees to obtain patient consent and to use appropriate disclaimers and notices.

It is also a good idea to confirm that your social networking activities are compliant with your employer’s policies, hospital/medical staff codes and policies, professional society codes, and malpractice/insurance carrier policies, noted Ms. Monson.

“It is important to understand—and use—all the social networking sites’ safeguard settings, and carefully consider what personal information you wish to disclose. Assume that all posts and tweets are public and that they continue to exist forever,” said Ms. Monson.

“Someone once compared attempting to get information from the Web to trying to drink from a fire hydrant,” said Dr. Yamout, a comment that was greeted by appreciative laughter from the audience. “Twitter, in conjunction with other forms of social media such as blogs, can help communities of surgeons with similar interest and levels of training sift through this mass of online information, share what’s relevant, and enrich it with their own thoughts and experiences.”

Mr. Peregrin is Associate Editor of the Bulletin of the American College of Surgeons, Division of Integrated Communications, Chicago, IL.
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Sir Bernard Ribeiro, CBE, FRCSEng, FRCPEng, a past-president of the Royal College of Surgeons of England who received an Honorary Fellowship in 2008 from the American College of Surgeons (ACS), was recently appointed to the House of Lords in Great Britain as a Life Peer.

An accomplished international surgeon, Sir Bernard has contributed significantly to the surgical profession in the United Kingdom, working to modernize surgical training and introducing a new surgical curriculum. He led the international community in addressing the problems raised by the European Working Time Directive. In 2008, he joined ACS leadership in presenting testimony on work hours to the Institute of Medicine of the National Academy of Sciences panel on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety.

For more information, go to http://www.rcseng.ac.uk/news/mr-bernard-ribeiro-appointed-as-a-life-peer.

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

From members’ MyCME page, click on the “Send CME to ABS” option at the top of the page.

Submission is quick and easy:
→ Review your transcript for accuracy and authorize transfer of credits
→ Have your ABS 13-digit authorization number ready

Log into the member Web portal at www.eFACS.org to get started
**Fellows receive AMA Foundation awards**

Kathleen Casey, MD, FACS, founding director of the Operation Giving Back (OGB) program of the American College of Surgeons, is one of three Fellows who will receive the American Medical Association Foundation’s 2011 Excellence in Medicine Awards on February 8, during the AMA’s National Advocacy Conference at the Grand Hyatt Hotel in Washington, DC. Dr. Casey will receive a Dr. Nathan Davis International Award in Medicine for her groundbreaking work with OGB.

Before joining the College staff, Dr. Casey served for eight years as a general surgeon in the U.S. Navy, achieving the rank of Commander. The Navy awarded her the Humanitarian Service Medal for her contributions in Guatemala following the devastation of Hurricane Mitch in 1998.

Since its founding in 2004, OGB has placed surgeons from virtually every specialty into underserved areas worldwide. The program has supported more than 100 not-for-profit organizations serving surgical patients in need, and has enhanced U.S. responses globally to humanitarian crises.

Mildred Olivier, MD, FACS, of Hoffman Estates, IL, will also receive a Dr. Nathan Davis award, and Robert Bowers, MD, FACS, of Chattanooga, TN, will receive the AMA Foundation’s Jack McConnell, MD, Award for Excellence in Volunteerism.


To view the OGB website, go to [http://www.operationgivingback.facs.org](http://www.operationgivingback.facs.org).

**Dr. Malangoni hired as ABS associate executive director**

Mark A. Malangoni, MD, FACS, joined the American Board of Surgery (ABS) on February 1 in a newly created associate executive director position. Dr. Malangoni is a member of the American College of Surgeons (ACS) Board of Regents and the executive committee of the ACS Committee on Trauma. He is a former chair of the College’s Advisory Council for General Surgery and the Board of Governors, as well as Past-President of the Ohio Chapter of the College. Dr. Malangoni is also a past-president of the Central Surgical Association and the Surgical Infection Society.
Now, it’s even easier to stay abreast of the current literature and to look up answers to clinical questions with ease using this completely Web-based version of Selected Readings in General Surgery (SRGS). What’s more, the CME program is included in the price of a subscription and can be used to earn 80 AMA PRA Category 1 Credits™ per subscription year, or 10 AMA PRA Category 1 Credits™ per issue.

Here’s what you receive with an online subscription to SRGS Connect:

➨ A keyword searchable, authoritative literature review and analysis provides an up-to-date overview of a new general surgery topic. A new topic is posted online every four to six weeks. An e-mail alert lets you know when a new issue has been published.

➨ The literature review is available in both HTML and PDF formats.

➨ Recommended Reading: Up to 20 articles cited in the review are annotated by Editor-in-Chief Lewis Flint, MD, FACS. Each citation is linked to its abstract and full text, where available.

➨ What You Should Know: A collection of 10 expert commentaries by practicing surgeons on articles published within the previous six months (not related to the current issue topic). Each citation is linked to the article’s abstract and full text, where available.

➨ The Knowledgeable Surgeon: Bernard M. Jaffe, MD, FACS, professor of surgery, Tulane University School of Medicine, New Orleans, provides a lighthearted look at the issues swirling around health care.

➨ A CME program that is one of the best of its kind. Easy to use, the online test is linked to an online transcript where you can track your CME credits and download certificates. Participation in the SRGS CME program can be used to fulfill the American Board of Surgery’s Maintenance of Certification Part 2 requirements that focus on lifelong learning and self-assessment.

Two versions of this completely Web-based education program are available:

➨ SRGS Connect Premium includes the traditional full-text reprints that are the mainstay of Selected Readings in General Surgery.

➨ SRGS Connect Practicing Surgeon does not include full-text reprints and is available at a reduced price.

SRGS Connect is published by the American College of Surgeons, Division of Education. To learn more, visit http://www.facs.org/srgs/, e-mail srgsconnect@facs.org, or call 800-631-0033.
In November 2007, the American College of Surgeons Division of Education began publishing Selected Readings in General Surgery, which had been published for 30 years at the University of Texas Southwestern Medical Center in Dallas. This monthly publication provides readers with a topic overview, enhanced with informed opinion and critique, and full-text reprints of the most valuable content.

The American Board of Surgery lists SRGS as a CME resource for surgeons enrolled in its Maintenance of Certification (MOC) program. Successful completion of the SRGS continuing medical education (CME) program fulfills MOC Part II requirements that focus on continued learning and self-assessment.

Lewis Flint, MD, FACS, serves as Editor-in-Chief of SRGS. Dr. Flint is an adjunct professor of surgery at the Feinberg School of Medicine, Northwestern University, Chicago, IL. In the following interview, Dr. Flint explains the literature review process and brings readers up to date regarding the latest enhancements to this unique resource for surgeons.

What is the process through which articles are selected for each issue?

Dr. Flint: With the assistance of a well-known expert in the field to be covered, I select 150 to 200 pertinent articles for each issue. Great care is taken to ensure that we use experts who are currently practicing in the given area to evaluate the articles.

After each article is reviewed, an overview that places the content of these articles in the perspective of the best day-to-day clinical practice is composed. In addition to an overview, 12 to 18 full-text articles are reprinted in each issue. A self-assessment quiz that offers readers the opportunity to earn CME credit is also published in each issue.

Since becoming a publication of the College, how has SRGS changed and evolved?

SRGS has grown from a publication produced by a single institution into one that is...
international in scope. The publication cycle has been condensed to two-and-a-half years and it now emphasizes practical applications, advances in basic sciences, and viewpoints from specialists, including internal medicine and pediatrics.

In addition, recognizing that the field of general surgery has become diverse and many new fields of interest have emerged, SRGS has appointed an international Editorial Board of leading surgeons to provide editorial oversight (see sidebar, this page).

We accentuate and emphasize accessibility and relevance in making the literature more manageable for the practicing surgeon. SRGS is now published in print, online, and CD-ROM formats, and reviews the entire specialty of general surgery.

**What makes SRGS a unique resource for surgeons?**

We provide a different, non-textbook approach to learning. Our intent is to analyze relevant medical literature in such a way as to give the surgeon the knowledge necessary to practice state-of-the-art surgery. SRGS is unique because the overview and selected full-text articles provide the reader with the most valuable and pertinent content illuminated with informed opinion and critique. Unnecessary and extraneous information is eliminated.

**How has the online version of SRGS progressed?**

In April of last year, we introduced a new online feature

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**SRGS Editorial Board**

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- Christopher B. Weldon, MD, PhD, FACS, Boston Children’s Hospital and Harvard Medical School, Boston, MA
- Zhenggang Zhu, MD, FACS, Shanghai Jiao Tong University, Shanghai, China
of the publication called SRGS Connect. It is completely Web-based and includes additional content you cannot find anywhere else.

SRGS Connect offers the literature review in both HTML and PDF formats. A keyword searchable, authoritative literature review and analysis is available, providing an up-to-date overview. A new general surgery topic is posted online every four to six weeks. An e-mail alert lets you know when a new issue has been published.

Other features include Recommended Reading, a summary of up to 20 of the most pertinent articles cited in the review; What You Should Know, which provides a list of 10 recently published articles that are accompanied by expert editorial commentary by a leading surgeon; and The Knowledgeable Surgeon, which offers a lighthearted but pertinent look at the issues surrounding the current state of health care as seen by Bernard M. Jaffe, MD, FACS, professor of surgery at Tulane University School of Medicine, New Orleans, LA. SRGS Connect also offers a CME program that is exceptional. Easy to use, the online test is linked to a transcript where the user may track CME credits and download certificates. Participation in the CME program can be used to fulfill the American Board of Surgery’s MOC Part II requirements.

In developing SRGS Connect, we took into consideration feedback from program directors, who indicated they wanted a more affordable and useful way of giving residents access to the most current information, including operative techniques and approaches published by the most experienced clinicians in any given area.

This past year, SRGS has explored such diverse topics as ethics, patient safety, general oncology, palliative care, business aspects of surgical practice, and pediatric surgery. What are some of the topics you will be exploring in forthcoming editions of SRGS?

We are working on a special theme issue regarding rural surgery issues for the general surgeon. We hope to have that ready at some point this year. Topics slated for 2011 include biliary tract and pancreas; small bowel obstruction and small bowel disease; endocrine surgery; and appendix, colon, rectum, and anus. Topics to be covered in 2012 include spleen, liver disease, vascular (aneurysms, obstructive diseases, and trauma/venous disease), and renal disease.

Where do you see SRGS in three years?

We hope to be able to offer Selected Readings to surgeons practicing outside the U.S. Another initiative that we hope will begin in the 2011–2012 time period includes a subscription format for e-readers such as the Kindle and the iPad. Some of our readers have asked us for podcasts and/or weblog posts so that reader comments can be posted. We are investigating this avenue as well.

Mr. Regnier is Editor of the Bulletin of the American College of Surgeons, Division of Integrated Communications, Chicago, IL.

Trauma meetings calendar

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

• Medical Disaster Response, April 10, 2011, Las Vegas, NV
• Trauma, Critical Care, and Acute Care Surgery 2011, April 11–13, 2011, Las Vegas, NV.
• Point/Counterpoint, National Harbor, MD, June 13–15, 2011
• Advances in Trauma, Kansas City, MO, December 9–10, 2011

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

**JCI introduces international quality measures**

Surgical care measures are going global through Joint Commission International’s (JCI) International Library of Measures. Effective January 1, the fourth edition of JCI’s *International Standards for Hospitals* requires the use of the International Library of Measures for the selection of at least five of the 36 measures that are categorized into 10 measure sets related to one or more clinical areas, including the Surgical Care Improvement Project measures.

The library and the fourth edition standards represent initial steps in standardizing measures that will be collected by the nearly 400 organizations accredited by JCI. The 36 measures within the 10 measure sets in the library are specifically defined so that all organizations will be collecting the same information. This standardization of measures is the first step toward reliable and consistent benchmarking among JCI-accredited organizations.

In the future, the measures will be reported to JCI for the creation of a comparative database to enhance learning and benchmarking. Benchmarking is a course of action in which an organization measures its internal processes in order to be able to identify, understand, and adapt/adopt best quality practices. The objective of benchmarking is to evaluate the current position of an organization in relation to “best practice,” and to identify areas and means of performance improvement.

While the International Library of Measures and the *International Standards for Hospitals* will evolve over time, the concept of benchmarking performance with good data will remain the backbone of global quality improvement in the foreseeable future. The library will begin the process of helping JCI-accredited organizations to speak a common patient safety and quality improvement language.

The surgical care measures that are part of the International Library of Measures include the following:

- Prophylactic antibiotics received one hour prior to surgical incision for hip arthroplasty patients
- Prophylactic antibiotics received one hour prior to surgical incision for knee arthroplasty patients
- Surgical patients (hip arthroplasty) whose prophylactic antibiotics were discontinued within 24 hours after anesthesia end time
- Surgical patients (knee arthroplasty) whose prophylactic antibiotics were discontinued within 24 hours after anesthesia end time
- Surgical patients (hip/knee arthroplasty) with recommended venous thromboembolism (VTE) prophylaxis ordered anytime from hospital arrival to 24 hours after anesthesia end time
- Surgical patients who received appropriate VTE prophylaxis within 24 hours prior to anesthesia start time to 24 hours after anesthesia end time

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Not sure if we have your current address? Go to the “My Page” area of the ACS Members-only Web portal at www.efacs.org to see what’s currently in our database and to make necessary changes.

If you have questions or problems, contact dues@facs.org. Include your Fellowship ID number in your note.

IMPORTANT NOTE:
The American College of Surgeons does NOT provide your e-mail address to outside entities. E-mail addresses are used only for College communications.
2012 Traveling Fellowship to Germany announced

The International Relations Committee of the American College of Surgeons (ACS) announces the availability of the Traveling Fellowship to Germany. The purpose of this fellowship is to encourage international exchange of surgical science, practice, and education, and to establish professional and academic collaborations and friendships. The ACS Traveling Fellow will visit Germany and, as part of the exchange program, a German Traveling Fellow will visit North America.

Basic requirements
The scholarship is available to a Fellow of the American College of Surgeons in most of the surgical specialties who meets the following requirements:
• A major interest, and accomplishment, in clinical and basic science related to surgery
• Holds a current full-time academic appointment in the U.S. or Canada
• Younger than 45 years of age on the date the application is filed
• Enthusiastic, personable, and possesses good communication skills
• Applicants possessing some German language skills are particularly encouraged

Activities
The Fellow is required to spend a minimum of two weeks in Germany and to engage in the following activities:
• Attend and participate in the annual meeting of the German Surgical Society in Berlin, Germany, April 24–27, 2012
• Attend the German ACS Chapter meeting
• Visit at least two medical centers (other than the center in the annual meeting city) in Germany before or after the annual meeting of the German Surgical Society to lecture, and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the German Surgical Society and the German ACS Chapter. The surgical centers selected for a visit would depend, to some extent, on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Germany.

His or her spouse is welcome to accompany the chosen applicant. There will be many opportunities for social interaction, in addition to professional activities.

Financial support
The College will provide $6,000 to the chosen applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society.

He or she must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and other advice and recommendations regarding travel schedules. The Fellow is urged to make his or her own travel arrangements in North America, due to the likely availability of reduced fares and travel packages for travel in Germany.

The ACS International Relations Committee will select the Fellow after reviewing and evaluating the final applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained from the College’s Web site, http://www.facs.org/memberservices/acsgermany.html, or by writing to the International Liaison, American College of Surgeons, 633 N. Saint Clair Street, Chicago, IL 60611-3211.

The closing date for receipt of completed applications and all supporting documents is April 1, 2011. The successful applicant, and an alternate, will be selected and notified by July 31, 2011.
The following comments were received regarding recent articles published in the Bulletin.

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

The future of general surgery
Society will learn to value surgeons, because the following algorithm—although common in many developing countries—will be unacceptable in the U.S.:

Infection → Antibiotics → Resuscitation → No surgeon on call → DEATH

Hemorrhage → Pressure → Transfusion → Correct coagulopathy → No surgeon on call

The sad, actuarial fact is death is cheaper. No randomized trial for this outcome is ethical or necessary. Some facts, however, I have been unwilling to accept. As a young Fellow of the American College of Surgeons (ACS), I have chosen a contrarian viewpoint for my career: do what nobody else wants to do. Be a generalist, because you never know when a cancer is an infection, or when your work in the upper abdomen will take you into the neck through the chest or down into the pelvis clutching a proctoscope. Take trauma call, because gunshot wounds, knife stabbings, and motor vehicle accidents are the scourge of our utopian society; these problems are not going away. Take night call, because sick people get sicker when everybody else is sleeping.

So for the medical students and surgery residents contemplating their futures, the following is a comforting short list of problems which cannot be solved simply by our medical colleagues: appendicitis, cholecystitis, colitis, peritonitis, anitis, fasciitis, myositis, osteomyelitis, perforated viscus, obesity, cancer, traumatic bleeding, and hernias. As of yet, I have no answer for my patients and their families when I am asked, “Why did I get appendicitis?” This list is the past, present, and future of surgery, not gene therapy or expensive designer drugs.

Because people will be coming to an emergency room near you in droves, our future as emergency general surgeons is secure. Many of these patients will need surgical consultations, and a large number will need to be admitted for healing by an operation. Insurance policies that decrease elective operations for hernias will result in more emergent operations for strangulation. Lack of timely and appropriate access to primary care physicians will result in infections that will rage unchecked. Poorly controlled diabetes will fuel the flames of immunosuppression and poor wound healing. Necessary employment by the hospital to take care of these patients will become the norm.

I give a lecture to the medical students at Albert Einstein College of Medicine entitled Surgical Infections, and for the brave souls who attend, I try to leave them with two basic tenets: (1) infected fluid should be drained, and (2) dead tissue needs to be debrided. Often, the best place for these surgical procedures is in the emergency room at the bedside, but in the operating room by a surgeon. Almost every “-itis” can be managed with these principles. Antibiotics and observation in a patient with a healthy immune system work most of the time, but it is difficult to predict which appendicitis will perforate, which pancreatitis will become necrotic, and which colitis will become fulminant. Time and lack of vigilance are the enemies of patients saddled with the diagnoses of infection, injury, and cancer. Lest we forget the rise of multi-drug resistant bacteria and the global lack of access to appropriate surgical care—two public health problems at the top of the list. The future of a young general surgeon is bright indeed.

A recent turn of lectures at the ACS’ Clinical Congress annual meeting in October 2010, in Washington, DC, created some new insights into our “dying profession.” I actually left the meeting with a sense of optimism, because the future for what I do seems limitless. First, change is inevitable, but if you enjoy what you do as a surgeon, decreasing reimbursements cannot take away your true motivation.

I recommend Daniel Pink’s book entitled Drive: The Surprising Truth About What Motivates Us, which basically says that what motivates surgeons is not money, but a sense of autonomy, the ability to learn and create, and a profound need to do better for the world. If we don’t learn
about the humanity of surgery and teach these ideals to the medical students and residents, then the ACS will not succeed.  

Peter K. Kim, MD, FACS, 
Bronx, NY 
Chair, New York Chapter Young Fellows Association

Surgeons make things happen
I read the fine article regarding hospital boards by Michael S. McArthur MD, FACS, in the October 2010 issue of the Bulletin (Bull Am Coll Surg. 2010;95[10]:26-28). Every surgeon should not wait to be asked, but should actively seek to be on a hospital board. Why? Because surgeons know a great deal more about the running of a hospital than most board members. It is imperative that surgeons have input into their own future, and they are well-trained to do just that. Too often, surgeons voice their gripes in their facility’s lounge, but they never take it any further than that. Surgeons should learn the system, and get in there and fight. No one else is going to do it for them. The other board members tend to respect surgeons’ judgment, even if they don’t agree on a particular point. Surgeons are used to making things happen.

Donald G. Blain, MD, FACS 
St. Clair Shores, MI

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The 2010 Annual Report of the National Trauma Data Bank® (NTDB) is an updated analysis of the largest aggregation of U.S. and Canadian trauma registry data that has ever been assembled. In total, the NTDB now contains more than 4 million records. The 2010 Annual Report is based on 681,990 records, submitted by 682 facilities, from the single admission year of 2009. The 2010 Annual Pediatric Report is based on 139,476 2009 admission year records. The NTDB classifies pediatric patients in this report as patients that are younger than 20 years of age.

This report includes a section on regional analysis. Incidents and case fatality rates are displayed not only by census region but also by rurality utilizing urban influence codes. As previously reported in the Bulletin NTDB data points column, “How rural is it?” (Bull Am Coll of Surg. 2008;93[4]:47-48), urban influence codes are described as a mechanism for defining rural populations. The Economic Research Service of the U.S. Department of Agriculture developed a set of county-level urban influence categories, and in 2003 they used these codes to divide the 3,141 counties, county equivalents, and independent cities in the U.S. into 12 groups (http://www.ers.usda.gov/briefing/rurality/urbaninf/). These urban influence codes can then be grouped into urban, suburban, rural, and wilderness. The rurality of pediatric trauma is depicted in the figure on this page.

The mission of the American College of Surgeons Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center registry data. The purpose of this report is to inform the pediatric medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured pediatric patients in our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

Many dedicated individuals on the ACS COT, including the Pediatric Surgery Subspecialty group, along with dedicated individuals caring for pediat-
ric patients at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, the goals in the coming years include improving data quality, updating analytic methods, and enabling more useful inter-hospital comparisons. These efforts will be reflected in future NTDB reports for participating hospitals, as well as in the pediatric annual reports.

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Pediatric Report 2010 is available on the ACS website as a PDF file and a PowerPoint presentation at http://www.ntdb.org. In addition, information is available on our website regarding how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

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.

Dr. Nathens is Canada Research Chair in Systems of Trauma Care, division head of general surgery, and director of trauma of St. Michael’s Hospital, Toronto, ON. He is Chair, National Trauma Data Bank Subcommittee.
CALL FOR SUBMISSIONS

2011 Clinical Congress of the American College of Surgeons

Oral presentations

- *Surgical Forum*
  Program Coordinator: Kathryn L. Matousek, 312-202-5336, kmatousek@facs.org
  (12 $1,000 Excellence in Research Awards were given in 2010)

  *Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)*

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

Poster presentations

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

Video presentations

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

Submission information

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

*Accepted authors are encouraged to submit full manuscripts to JACS.*
by Rhonda Peebles, Division of Member Services

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

Chapter execs convene in Chicago

For the last four years, more than 15 chapter executives (see photo, this page) convened at American College of Surgeons (ACS) headquarters for updates on various College programs and activities. The winter learning education program, held December 5–7, 2010, featured presentations by ACS staff on the following topics and/or sections: ACS-accredited institutes; My CME Page (on the ACS Portal); NSQIP and other quality improvement programs; Case Log System; Commission on Cancer/State Chairs; CME program for chapters; federal and state legislative/regulatory updates; and ACS communications programs and strategies.

David B. Hoyt, MD, FACS, the College’s Executive Director, met with the Chapter executives. Also, the College’s legal counsel, Paula Cozzi Goedert, Esq., presented an update on legal issues that may affect chapters, and she was featured in a session entitled “Ask a Lawyer.”

Chapters receive grants for state-level advocacy activities

For the first time in the history of the ACS, the organization has awarded grants to 10 chapters to support their advocacy activities. Each chapter that was awarded a grant will be required to match (or exceed) the College’s contribution. The chapters that were awarded grants include Alabama, Connecticut, Florida, Georgia, Indiana, Massachusetts, New York, Northern California, Ohio, and Virginia.

The Subcommittee on Advocacy and Coalitions—a component of the Governors’ Committee on Chapter Activities—helped to review the grant applications. This grant program is managed by the Division of Advocacy and Health Policy-State Affairs (Jon Sutton, Manager; Charlotte Grill, State Affairs Associate; and Alexis Macias, Regional State Affairs Associate). For more information about the grant programs, contact Jon Sutton at jsutton@facs.org, or at 800-621-4111.

continued on page 68

Front row (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).

Back row: 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 S TX); Nonie Lowry (N TX); Angie Kemppainen (MI); Gary Caruthers (KS); and Beth Mahlo (IL).
## 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](http://www.facs.org/about/chapters/index.html).

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
<th>Location/information</th>
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<tbody>
<tr>
<td>March 4–5, 2011</td>
<td>Florida (CS)</td>
<td>Location: Hyatt Grand Cypress, Orlando, FL&lt;br&gt;Contact: Brad Feldman, MPA, CAE, IOM 877-310-7316, e-mail: <a href="mailto:brad@executive-office.org">brad@executive-office.org</a>&lt;br&gt;ACS Representative(s): Lazar J. Greenfield, MD, FACS</td>
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<tr>
<td>March 25–26, 2011</td>
<td>Metropolitan Washington DC (CS)</td>
<td>Location: JW Marriott, Washington, DC&lt;br&gt;Contact: Brad Feldman, MPA, CAE, IOM 877-835-5809, e-mail: <a href="mailto:brad@executive-office.org">brad@executive-office.org</a>&lt;br&gt;ACS Representative(s): L.D. Britt, MD, MPH, FACS</td>
</tr>
<tr>
<td>April 8–9, 2011</td>
<td>North Dakota &amp; South Dakota (CS)</td>
<td>Location: Fargo, ND&lt;br&gt;Contact: Leann Tschider 701-223-9475, e-mail: <a href="mailto:leann@ndmed.com">leann@ndmed.com</a></td>
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<tr>
<td>April 30, 2011</td>
<td>New York (CS)</td>
<td>Location: TBA, Contact: Amy Clinton 518-283-1601, e-mail: <a href="mailto:NYCoFACS@yahoo.com">NYCoFACS@yahoo.com</a>&lt;br&gt;ACS Representative(s): Lazar J. Greenfield, MD, FACS</td>
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<tr>
<td>May 5–7, 2011</td>
<td>Illinois &amp; Metropolitan Chicago</td>
<td>Location: Loyola Medical Center, Maywood, IL&lt;br&gt;Contact: Beth Mahlo 309-236-6122, e-mail: <a href="mailto:acsbeth@yahoo.com">acsbeth@yahoo.com</a>&lt;br&gt;ACS Representative(s): Richard J. Finley, MD, FACS</td>
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<tr>
<td>May 5–7, 2011</td>
<td>West Virginia (CS)</td>
<td>Location: The Greenbrier, White Sulphur Springs, WV&lt;br&gt;Contact: Sharon Bartholomew 304-293-1258, e-mail: <a href="mailto:sbartholomew@hsc.wvu.edu">sbartholomew@hsc.wvu.edu</a>&lt;br&gt;ACS Representative(s): David B. Hoyt, MD, FACS</td>
</tr>
<tr>
<td>May 6–7, 2011</td>
<td>Ohio (CS)</td>
<td>Location: Hyatt Regency Cincinnati, Cincinnati, OH&lt;br&gt;Contact: Brad Feldman, MPA, CAE, IOM 877-677-3227, e-mail: <a href="mailto:brad@executive-office.org">brad@executive-office.org</a>&lt;br&gt;ACS Representative(s): Patricia J. Numann, MD, FACS</td>
</tr>
<tr>
<td>May 13–15, 2011</td>
<td>Virginia (CS)</td>
<td>Location: Hilton Richmond Hotel &amp; Spa, Richmond, VA&lt;br&gt;Contact: Susan McConnell 804-643-6631, e-mail: <a href="mailto:smcconnell@ramdocs.org">smcconnell@ramdocs.org</a></td>
</tr>
<tr>
<td>May 14, 2011</td>
<td>Northern California (CS)</td>
<td>Location: Marines Memorial Hotel, San Francisco, CA&lt;br&gt;Contact: Annette Bronstein 650-992-1387, e-mail: <a href="mailto:abronst230@aol.com">abronst230@aol.com</a></td>
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<tr>
<td>May 19, 2011</td>
<td>Vermont (CS)</td>
<td>Location: Lake Mansfield Trout Club, Stowe, VT&lt;br&gt;Contact: Jeanne Jackson 802-847-9440, e-mail: <a href="mailto:jeanne.jackson@vtmednet.org">jeanne.jackson@vtmednet.org</a></td>
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<tr>
<td>May 19–20, 2011</td>
<td>Michigan</td>
<td>Location: Amway Grand Plaza Hotel, Grand Rapids, MI&lt;br&gt;Contact: Angie Kemppainen 517-336-7586, e-mail: <a href="mailto:akemppainen@msms.org">akemppainen@msms.org</a></td>
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Changes in chapter managers

After more than 20 years, Carol Russell, the Executive Director of the North Carolina Chapter, has retired. Ms. Russell began providing management services to the North Carolina Chapter while she was employed with the North Carolina Medical Society. Later, she left the society to begin managing North Carolina-based specialty societies from her home. The College wishes Ms. Russell a successful and happy retirement.

BLF Management, Ltd., an association management firm located in Columbus, OH, recently reported that it will be managing seven ACS chapters, including North Carolina. The other chapters to be managed by BLF Management, Ltd., will include Florida, Maine, Maryland, New Hampshire, Ohio, and Washington, DC.

2011 Leadership Conference

The 2011 Leadership Conference will be held March 26–27 at the JW Marriott in Washington, DC. The theme for this year’s Leadership Conference is “Leading with Impact,” and the meeting will focus on negotiation skills, management skills needed for difficult situations, and volunteer leadership opportunities with the College.

Chapters are encouraged to send their chapter officers, two to three young surgeons (age 45 or younger), and their chapter administrator or executive director to the conference. Immediately following the Leadership Conference, the Joint Surgical Advocacy Conference (JSAC) will convene, March 27–29, and will also be held at the JW Marriott. The tentative schedule of events includes:

- Saturday, March 26 (5:00–7:00 pm): Welcoming reception hosted by the Washington, DC Chapter
- Sunday, March 27 (all day): ACS Leadership Conference for Chapters and Young Surgeons and JSAC opening reception and individual society briefings
- Monday, March 28: Congressional speakers and Capitol Hill reception
- Tuesday, March 29: Capitol Hill meetings (scheduled by ACS staff)

The College’s DC Office will schedule Capitol Hill visits for all of the Chapters that participate. These visits will be conducted on Tuesday, late morning or early afternoon. To register, call the Chapter Hotline at 888-857-7545, or visit http://www.facs.org/about/chapters/index.html. To reserve a room at the JW Marriott, go to https://resweb.passkey.com/go/acs2011wasjw.

Chapter anniversaries

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<td>Louisiana</td>
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<td>South Florida</td>
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<td>Iowa</td>
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<td>Eastern Long-Island, NY</td>
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<td></td>
<td>Washington State</td>
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Donor recognition: ACS chapters step up

The ACS recognizes the chapters for their vital role in promoting quality care, education, and communication, and gratefully acknowledges their generosity. During the past year, a number of chapters have made donations to the ACS Foundation in support of the College’s mission and programs. ACS chapters that have made donations include the following: Arizona, Florida, Hawaii, Indiana, Japan, Kansas, Louisiana, Massachusetts, Metropolitan Philadelphia, Michigan, Nebraska, North Carolina, Ohio, South Carolina, South Dakota, South Florida, South Texas, Southwestern Pennsylvania, Tennessee, and Wisconsin Surgical Society—A Chapter of the American College of Surgeons.

Many chapters make unrestricted gifts, which support the current operations of the College; others support specific programs. Over the past 10 years, chapters have donated a total of $247,588.