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On the cover: The College continues to represent and advocate for the surgical viewpoint. Pictured are the chambers of the U.S. House of Representatives and the U.S. Senate (photos courtesy of Architect of the Capitol). (See articles on pages 4 and 6.)
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
We will seek to preserve the ability of a surgeon to recommend the surgical treatment plan that best meets each patient’s needs as guided by best practices and evidence-based medicine.

Public apprehensions

Polls before the election suggested that health care was an important but secondary voting issue in the mid-term elections. Most Americans said that candidates’ position on the ACA would affect their voting decision. However, the issue of greatest concern to most Americans (55 to 62 percent) was the economy/unemployment.*

Whereas many Americans like certain aspects of the ACA—including measures to make insurance more affordable, expansion of the Medicare prescription drug benefit, and the requirement that insurers cover all applicants, even if they have preexisting conditions—in the minds of many voters, the ACA and the economy are related. More voters believed that the U.S. economy will worsen (38 percent) than thought it will improve (21 percent) because of the ACA. Furthermore, approximately two-thirds of the public said the law will increase the federal deficit (65 percent), which will lead to higher taxes in the next five years (67 percent).*

Just before the election, polls indicated the following:
• Only 18 percent of registered voters said that Congress should implement the ACA as written
• 31 percent thought Congress should make additional changes to increase the government’s role in the nation’s health care system
• 41 percent believed that Congress should repeal most of the major provisions in the law and replace them with a completely different set of provisions

Not surprisingly, more Democrats favor leaving the legislation as it stands or expanding it to allow greater government intervention, while Republicans favor scrapping the law and starting over fresh with a completely new bill.’

Congressional action

Total repeal of the ACA is highly unlikely. Republicans are still in the minority in the Senate, and if by some fluke repeal legislation did get through both chambers of Congress, President Barack Obama would veto it. Hence, Republicans have the following three options: (1) drop the health care issue after a symbolic vote, but try to repeal the law again after the next presidential election; (2) pursue piecemeal changes to the law’s most unpalatable provisions; or (3) defund the implementation, hold hearings to force the...
Obama Administration to defend its activities, and use the majority’s investigative power to highlight the law’s unpopular provisions.†

From the Republican perspective, doing nothing after failure to repeal the law is an unviable option. After all, many of them were elected because of their opposition to the ACA.†

Tweaking the ACA bit by bit is perhaps the most complicated solution and could have devastating effects on the health care system if handled incorrectly. Congress would need to find a way of removing the unpopular parts of the law without eliminating the provisions that will keep the system running. Furthermore, excising the provisions the public opposes would weaken Republicans’ arguments for completely repealing the legislation if a member of their party is elected President in 2012.†

In light of the dangers associated with pursuing the first two options, some health policy analysts anticipate that Republicans will choose to slow implementation of the law through hearings, investigations, and appropriations riders.†

The ACS response
All of this potential political warfare raises an important question for the leadership of the American College of Surgeons (ACS): How do we position our organization to move forward during all of this strife? First of all, the ACS is prepared for health care reform to continue to be a contentious issue on Capitol Hill, and our advocacy staff will respond appropriately.

More importantly, however, we fully intend to move forward with our quality improvement initiatives and to keep our core principles alive. Regardless of what our elected officials do, this organization must remain dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment. The College will act as a positive voice in the ongoing effort to develop a patient-centered, quality- and safety-driven, physician-led, efficiency-based health care system.

We will continue to promote patient access to appropriate, high-quality treatments and interventions. We will advocate for a system that rewards participation in proven, physician-led quality improvement programs that promote quality outcomes for patients. (Examples of such initiatives include the ACS National Surgical Quality Improvement Program, the National Cancer Data Base, the National Trauma Data Bank®, and the Trauma Quality Improvement Project.) We will seek to preserve the ability of a surgeon to recommend the surgical treatment plan that best meets each patient’s needs as guided by best practices and evidence-based medicine. We will support incentives for physicians who, separate from larger system-based payment models, choose to individually participate in proven quality improvement programs, including registries and clinical databases.

The political climate in the U.S. is changing with increasing rapidity. In an age of uncertainty, the ACS stands by its everlasting mission of ensuring that surgical patients receive the safest and best possible care.


If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
The 2011 Medicare physician fee schedule

by Vinita Ollapally, JD

The Centers for Medicare & Medicaid Services (CMS) released the Medicare physician fee schedule final rule for calendar year (CY) 2011 on November 2, 2010. This regulation implements certain proposals set forth in the Medicare physician fee schedule proposed rule issued early last summer. The final rule also responds to comments that the American College of Surgeons (ACS) and other stakeholders submitted in response to the proposed rule. This article answers key questions that surgeons may have about the 2011 Medicare fee schedule.

What is the 2011 conversion factor update?

On November 30, President Barack Obama signed into law the Physician Payment and Therapy Relief Act of 2010 (H.R. 5712), which halts the 23 percent reduction in Medicare physician reimbursement that was scheduled to take effect December 1, 2010. The legislation also preserves the current fee schedule conversion factor for CY 2010, $36.8729, through the end of 2010. As of press time, Medicare payments are scheduled to be reduced by approximately 25 percent on January 1, 2011; however, even if Congress does intervene regarding these possible sustainable growth rate (SGR) reductions, other updates present in the fee schedule (for example, updates to the Medicare economic index (MEI), the relative value unit (RVU) budget neutrality adjustment, and so on) will result in a CY 2011 conversion factor that is different from the CY 2010 conversion factor.

ACS Division of Advocacy and Health Policy staff will notify membership via NewsScope and e-mail blasts regarding developments with respect to the conversion factor. The ACS leadership and staff continue to strongly advocate for long-term measures that would stop future cuts, reform the Medicare payment system, and preserve Americans’ access to quality surgical care.

Many changes in the fee schedule are based on the work that the American Medical Association’s Relative Value Scale Update Committee (AMA RUC) does. For example, the proposed rule called for referring some multispecialty codes to the AMA RUC for review. What does the final rule call for with regard to this issue?

CMS has finalized its proposal to refer 33 of the codes on the multispecialty points of comparison (MPC) list to the AMA RUC for review in CY 2011. The MPC is a scale used by the AMA RUC to evaluate the reasonableness of a specialty society’s recommended RVU for a service. The MPC list contains reference codes of established comparison services that are used in the valuation of new codes. The current MPC list contains 316 codes that the AMA RUC may use to compare and contrast the relativity of codes under review to existing relative values.

The ACS agrees with CMS that it is important for the services on the MPC scale to remain valid. However, the ACS also remains confident, as stated in the August 24, 2010, comment letter on the proposed rule, that the codes on the MPC list are appropriately valued, well-established, and understood physician services.

What does the final rule say about codes with site-of-service anomalies?

In light of strong objections from the ACS and from other organized medicine groups, CMS has declined to finalize its proposal regarding codes with site-of-service anomalies. In previous years, CMS has requested that the AMA RUC review codes that, according to the Medicare database, have experienced a change in the typical site of service since the original valuation of the code. One example involves codes that were originally performed in the inpatient setting, but current claims data show that the typical case has shifted to the outpatient setting. Throughout 2009 and 2010, the AMA RUC reviewed and recommended...
to CMS revised work RVUs for 40 codes.

For CY 2011, CMS proposes that the AMA RUC reevaluate the 40 codes using a new approach that the agency describes as the “reverse building block methodology.” CMS received strong opposition to this proposed methodology and has chosen instead to accept the existing AMA RUC-recommended work RVUs on an interim basis for CY 2011. CMS also requests that the AMA RUC reconsider its previously recommended values and submit recommendations for CY 2012.

What does the rule say about codes for 23-hour stay services?

CMS has finalized its proposal regarding codes with “23-hour” stay services, namely codes that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. CMS views these procedures as primarily outpatient services and expresses concern that the value of evaluation and management visits for inpatients was inappropriately included in the valuation of codes that qualify as 23-hour stay outpatient services. CMS has finalized its proposed approach to valuing 23-hour stay services by allowing the intra-service portion of the subsequent hospital care visits furnished to outpatients in the hospital post-procedure to be allocated to the immediate post-service time of the procedure to account for the physician work in these cases. CMS does not refer any codes to the AMA RUC for review, but does encourage the AMA RUC to apply this methodology in the recommendations it provides for valuing 23-hour stay codes.

What does the final rule say about changes to the refinement panel process?

CMS has finalized its proposal regarding changes to the refinement panel process. CMS has historically convened refinement panels that typically meet in the summer before the promulgation of the final rule to finalize the RVUs for selected codes. The purpose of this meeting has been to assist the agency in reviewing the public comments on interim physician work RVUs for such codes. Under the final rule, CMS eliminates the use of the F-test—the statistical test used to evaluate the RVU ratings of individual panel members—because the test has become less reliable, according to the CMS. CMS maintains that the physicians on the refinement panel have tended to select a previously discussed value, rather than independently evaluate the work. CMS also asserts that the agency has the final authority to set the RVUs if policy concerns warrant modifications to the values derived from the refinement panel process.

Does the final rule expand the multiple procedure payment reduction (MPPR) policy for imaging?

Yes, the rule finalizes CMS’ proposal to expand the MPPR policy as it applies to imaging. Until now, the MPPR applied only to the technical component of procedures involving contiguous

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body areas within a family of codes—not across families. The MPPR also applied to those computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and ultrasound services that are provided in a single session to the same patient.

As suggested in the proposed rule, the CY 2011 fee schedule expands the MPPR policy in two ways—it applies the MPPR both to multiple imaging services furnished within the same family of codes or across codes, and it does not limit the policy to contiguous body areas. More specifically, the final rule applies a 50 percent imaging multiple procedure payment reduction to all CT, CTA, MRI, and MRA services, regardless of the family of codes, furnished to a patient in the same session, regardless of body area.

In comments on the proposed rule, the ACS expressed concern that an expansion of the MPPR may not make sense. The College noted that similar efficiencies in the areas of clinical labor, supplies, and equipment time may not exist for imaging services provided to noncontiguous areas or using different imaging modalities.

What does the final rule say about plans to rebase and revise the Medicare Economic Index (MEI)?

The rule finalizes CMS’ proposal to rebase and revise the MEI, the input price index used in determining annual updates to the physician fee schedule. “Rebasing” refers to moving the base year for the cost structure on an input price index, while “revising” describes other types of changes, such as changing data sources, cost categories, or price proxies used in the input price index.

CMS had proposed to make the necessary MEI rebasing adjustments without modifying the work RVUs because many groups that commented on the proposed rule stressed that work RVUs should remain stable. Instead, CMS proposed to increase the practice expense (PE) RVUs and malpractice RVUs, but to decrease the CY 2011 conversion factor in order to maintain budget neutrality. As a result, the final rule increases the PE RVUs by 18.1 percent and the malpractice RVUs by 35.8 percent, but decreases the conversion factor by 8.19 percent. CMS states that rebasing and revising the MEI for CY 2011 will allow the MEI to appropriately reflect more recent data. Surgeons who have contracts with private payors should be aware of the contract structure. If payment is tied to the conversion factor or to total RVUs, their payment rate will change based on the upcoming changes to both the conversion factor and total PE and malpractice RVUs.

Does the final rule affect payment for the efficient use of resources?

Yes. In the final rule, CMS states its intent to move forward with Phase II of the Resource Use Measurement and Reporting program, renamed the Physician Feedback Program (PFP). Through this program, CMS will provide feedback reports to physicians that measure resources used in furnishing care to Medicare beneficiaries. For Phase II of the PFP, the final rule states that CMS anticipated distributing reports to individual physicians and physician groups in the fall of 2010. At press time, the College was not aware of any ACS members who had received Phase II reports. The College will continue to monitor the development of the PFP and will alert ACS members if it appears that surgeons are receiving such reports. ACS comments to CMS, in response to the proposed rule, stressed, among other admonishments, the importance of risk attribution, physician involvement with the development of an algorithm to generate the reports, and a clear plan for evaluating the effect of the reports.

CMS is in the process of developing a Medicare-specific episode grouper by January 2, 2012, for use in preparing the reports. Until the episode grouping software is available, CMS plans to produce reports for Phase II that contain per capita cost information overall and for beneficiaries with five common chronic diseases (diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and prostate cancer). These reports will provide total Part A/B per capita cost information as well as service category breakdowns. For quality measures, CMS will use the claims-based measures developed by CMS in the Generating Medicare
Physician Quality Performance Measurement Results project.

In the future phases, CMS intends to explore the possibility of linking the Physician Feedback Program to the value-based payment modifier, an Affordable Care Act (ACA) requirement to apply a separate, budget-neutral payment modifier to the fee-for-service (FFS) physician fee schedule payment formula. The payment modifier will be phased in beginning January 1, 2015, through January 1, 2017, and will provide differential payment under the physician fee schedule to a physician or a group of physicians based upon the relative quality and cost of care of their Medicare beneficiaries. The ACS expressed concern with the proposed connection between the modifier and the Physician Feedback Program at this time. Until additional information is available, the ACS disagrees with CMS’ plans to use the Physician Resource Use program as a foundation for implementing the value-based payment modifier.

What does the final rule say about providing incentive payments for major surgical procedures performed in health professional shortage areas?

The rule finalizes CMS’ proposal to establish a five-year incentive payment for major surgical procedures furnished to Medicare beneficiaries in a health professional shortage area (HPSA) beginning January 1. The ACA defines a general surgeon as a physician who has designated a CMS specialty code of 02-General Surgery on the Medicare physician enrollment form. The ACA defines a major surgical procedure as one for which a 10- or 90-day global period is used under the physician fee schedule, which for CY 2011 includes approximately 4,300 procedures. For major surgical procedures furnished in a designated HPSA, but not included in the list of zip codes eligible for automatic payment, practitioners should submit claims with an “AQ” modifier in order to receive the incentive payment. CMS will make the 10 percent incentive payment to general surgeons on a quarterly basis, and the payment is in addition to payments that would otherwise be made for the major surgical procedures.

The list of zip codes eligible for automatic payment can be found at http://www.cms.gov/HPSAPSAPhysicianBonuses/01_Overview.asp by selecting the appropriate year under the download files. CMS creates a new automated HPSA bonus payment file and provides it to Medicare contractors in early December of each year.

How does the final rule address CMS’ proposal to implement disclosure requirements for imaging services?

The rule finalizes the proposal to implement a provision of the ACA that requires referring physicians who provide advanced imaging services such as MRI, CT, or positron emission tomogra-
phy (PET) scans to inform the patient in writing at the time of referral that he or she may obtain the services from other suppliers in the area. To meet this requirement, physicians must provide to the patient a list of five alternate suppliers within a 25-mile radius of the physician’s office. Physicians need not list the alternates’ distance from the physician’s office, and there is no need for physicians to obtain a patient’s signature on the disclosure. CMS also indicated that the agency will not expand the disclosure requirement and will only apply it to advanced imaging listed in the ACA (MRI, CT, and PET). Initially, CMS had proposed that the disclosure include 10 alternate supplies, but based on feedback from the ACS and other groups, CMS reduced the number to five.

What effect does the final rule have on the Physician Quality Reporting System (PQRS)?

CMS finalized several provisions related to the PQRS, formerly the Physician Quality Reporting Initiative (PQRI). The College supported CMS’ plan finalized in the regulation to continue the PQRS program in 2011 and provide an incentive payment equal to 1.0 percent of the estimated total allowed charges for all covered professional services furnished during the reporting period of 2011. CMS also finalized its proposal to retain the 2010 PQRI reporting mechanisms, including claims-based, registry-based, and electronic health records-based reporting.

The ACS also supported a proposal that, for registry-based reporting of measures groups in 2011, the minimum patient numbers or percentages must be met by Medicare Part B FFS patients exclusively, and may not include data on non-Medicare Part B FFS patients. In the past, non-Medicare Part B FFS patients have been included for the registry-based reporting of measures groups using the 30-patient reporting option. Due to the difficulty of analyzing data received from registries where patients other than Medicare Part B FFS patients are included, the ACS supported the proposal that allows CMS to compare claims data and registry submitted data. CMS finalized this proposal. In addition, CMS finalized the ACS-supported proposal to reduce the reporting threshold for eligible professionals (EPs) who report individual quality measures using the claims-based mechanism from 80 percent to 50 percent. Lowering this reporting threshold to 50 percent will ideally increase the likelihood for successful reporting in PQRS and increase the participation in 2011.

Regarding group reporting, CMS finalizes it proposal to continue for 2011 the group practice reporting option (GPRO). Under GPRO, EPs affiliated with a group practice are considered to satisfy reporting PQRS quality measures data if the group practice reports satisfactorily under GPRO. In 2010, GPRO I was available to group practices of 200 or more physicians, and in the final rule CMS finalized its proposal for GPRO II for group practices composed of from two to 199 EPs. CMS also finalized its proposal to provide an additional 0.5 percent PQRS incentive payment for years 2011 through 2014 for providing data on quality measures through a Maintenance of Certification program operated by a specialty body of the American Board of Medical Specialties.

With respect to feedback reports, CMS finalized its proposal to provide “timely” (on or about the time of issuance of the incentive payment) feedback reports to EPs with respect to whether they satisfactorily submitted data on quality measures. CMS proposed to provide interim feedback reports for EPs reporting 2011 measures groups through the claims-based reporting mechanism, but did not finalize this proposal due to the agency’s inability to complete the necessary programming and development work.

A proposal has also been finalized which states that registries may no longer use their own algorithms to calculate measure results, but rather must use a CMS-specified measure calculation algorithm. The ACS supported this proposal because registry data results have been inconsistent in the past and do not yield reliable information for EPs to analyze their performance results for practice improvement. Without reliable information, the data is not meaningful to report. CMS also finalized an informal appeals process, as required by the ACA, by which EPs may seek a review of a determination that he or she did not satisfactorily submit data for PQRS.
What does the law say about the electronic prescribing incentive program?

CMS finalizes several aspects of the electronic prescribing incentive program in the final rule. CMS is required to implement a payment adjustment beginning in 2012 for those EPs who are not successful electronic prescribers. For purposes of the electronic prescribing 2012 penalty, the rule finalizes CMS’ proposal to make a determination of whether an EP or a group practice is a successful electronic prescriber in 2012 based on the reporting period that began January 1 and ends June 30. All claims for services during this period will have to be processed by no later than July 31 for the claim to be included in CMS’ analysis. For purposes of the 2013 penalty, CMS finalized its proposal to make a determination of whether an EP or a group practice is a successful electronic prescriber in 2013 based on the reporting period that begins January 1, 2011, and ends December 31, 2011. CMS did state, however, that the agency might revisit this reporting period in the CY 2012 physician fee schedule, due to the fact that the 2012 and 2013 reporting periods overlap for the purposes of the penalty.

CMS also finalized its proposal to specify that the 2012 penalty would apply to an EP unless at least one of the following conditions is met:

- The EP is not a physician, nurse practitioner, or physician assistant as of June 30, 2011
- The EP does not have at least 100 cases containing an encounter code that falls within the denominator of the electronic prescribing measure for the dates of service between January 1, 2011, through June 30, 2011
- The EP is a successful electronic prescriber at least 10 times during the January 1, 2011, through June 30, 2011 period
- Less than 10 percent of the EP’s estimated total allowed charges for the January through June 2011 reporting period are comprised of services that appear in the denominator of the 2011 electronic prescribing measure

CMS also notes that EPs or groups must use claims-based reporting in order to avoid the 2012 electronic prescribing penalty.

The ACS supports the continuation of the Electronic Prescribing Incentive Program due to the potential advantages of electronic prescribing.

Eye outreach program: Making an international impact

by Barrett G. Haik, MD, FACS
Retinoblastoma is a malignant pediatric eye tumor with a high cure rate when the disease remains intraocular, and, in fact, its cure rate and sight preservation rate is higher than 90 percent in developed countries. This is partly due to early diagnosis and access to adequate treatment led by a team of ophthalmic surgeons and pediatric oncologists. Specifically, early diagnosis is crucial to improving survival and preserving vision in children with retinoblastoma. Parents and primary care providers must recognize leukocoria (white pupil), the most common initial sign of retinoblastoma, and promptly refer the child to an ophthalmologist trained to treat the tumor.

Although retinoblastoma is a rare cancer, accounting for roughly 3 percent of all pediatric malignancies, research into the causes and treatment of retinoblastoma is important for all cancer patients. Retinoblastoma was the first cancer in humans that was found to be a hereditary disease. The retinoblastoma protein RB1, which is found to be dysfunctional in many types of cancer, was also the first human tumor suppressor gene to be cloned. Most tumors in humans have some genetic abnormality in the RB pathway that contributes to deregulated cellular division. Additionally, the p53 pathway and p14 tumor suppressor gene are postulated to be significantly connected to retinoblastoma and numerous other tumors. The landmark hypothesis by Knudson predicted two genetic “hits” that are key to the development of retinoblastoma, laying the groundwork for understanding the difference between patients with a germinal mutation versus those with spontaneous disease.

Approximately 65 percent of retinoblastoma patients present with unilateral disease, while 35 percent have bilateral involvement. Enucleation is the usual treatment for those with unilateral disease, while few also receive adjuvant chemotherapy, radiation therapy, and orbital reconstructive surgery. However, management of bilateral patients is much more challenging because eye salvage and vision preservation must also be considered. Also, all bilateral and hereditary cases, and 15 percent of unilateral patients, carry a germinal mutation that increases the number of primary tumors distributed between the two eyes, and the number of subsequent primary malignancies. In addition, these cases carry an almost 50 percent chance of children being affected by retinoblastoma. Treatment for these cases includes chemotherapy and careful, intensive use of focal treatments. Such a regimen requires the cooperation of a highly specialized, multidisciplinary team.
Cure rates in developing countries

In developing countries, however, cure rates are estimated between 30 to 50 percent and loss of sight of the affected eye is about 90 percent. Additionally, global incidence of retinoblastoma can show a 40- to 60-fold variation in impoverished unilateral patients. Environmental factors such as parents’ occupations, age, conditions of fertilization, diet, and viral agents may all play a role in geographic, ethnic, and socioeconomic variations of incidence. Delays in diagnosis are one reason for this much lower rate of cure, resulting in advanced intraocular and extraocular disease. Based on American Joint Committee on Cancer classification, approximately 73 percent of patients in Central America present with extraocular disease, compared with fewer than 5 percent in the U.S. or Europe. Another reason for this lower cure rate is deficiency in treatment, due to a paucity of resources and technology for diagnosing, monitoring, and treating retinoblastoma.

Between 1998 and 2001 in Central America, 161 children were diagnosed with retinoblastoma. More than 50 percent of those were older than three years of age, and more than 20 percent were older than four years of age, which indicates a significant delay in diagnosis or in the referral to a pediatric cancer center. Sixty percent of patients had extraocular disease at the time of presentation (involvement of the orbit, brain, or with distant metastases to the bones or bone marrow). In the U.S., by comparison, fewer than 10 percent of patients have extraocular disease. Additionally, at many of our international partner sites, retinoblastoma is one of the most common solid tumors diagnosed in children, suggesting that retinoblastoma may be more common in developing countries with higher indigenous populations. The scientific literature supports the view that one form of retinoblastoma has a genetic link.

Since 2003, hundreds of professionals at the Hamilton Eye Institute (HEI) at the University of Tennessee Health Science Center (UTHSC) and St. Jude’s Children’s Research Hospital (SJCRH) in Memphi, TN—including ophthalmic surgeons, pediatric oncologists, radiation oncologists, epidemiologists, geneticists, anesthesiologists, technicians, researchers, photographers, program coordinators, writers, and other staff members—have been reaching out to underserved areas of the world in the fight against pediatric eye cancers. The St. Jude International Outreach Program (SJIOP) is always seeking innovative, new ways to continue its mission to improve the survival rates of children with catastrophic illness worldwide through the transfer and implementation of knowledge, technology, and organizational skills. This mission is accomplished by partnering with international health care sites to provide them with mentorship and consultation on clinical services, education, and research. This combination creates local and regional capacity for long-term, sustainable health systems.

UTHSC HEI and SJCRH have been working...
together with ORBIS International to develop centers of excellence in Guatemala, Honduras, Panama, Jordan, Morocco, El Salvador, Nicaragua, and Vietnam, where we have been able to aid physicians by providing the surgical technology and oncologic training they need to enhance their ability to diagnose and treat retinoblastoma and other ophthalmic diseases. Part of this technology includes telecommunication tools that enable physicians at those sites to engage in weekly consultations with ophthalmologists and oncologists at SJCRH and UTHSC to discuss diagnoses, treatments, and collaborative research.

Improved therapy has dramatically increased survival rates for children with cancer over the past three decades; but worldwide, fewer than 30 percent of children with cancer have access to modern treatment. International Outreach transfers the progress achieved in the treatment of childhood cancer in developed countries to those with limited resources.

History of the program

In 1998, the SJIOP was formally established, with El Salvador as the first partner site. Today, the program partners with 20 pediatric cancer treatment centers in 15 countries around the globe—Brazil, Chile, China, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Ireland, Jordan, Lebanon, Mexico, Morocco, the Philippines, and Venezuela. The SJIOP was created to develop partnerships with medical institutions and fundraising organizations in partner countries and recruit other agencies and organizations to support key programs and the education of local personnel. Regionally, advanced telecommunication technologies are used to link programs and professionals who learn from, and assist, each other. The cost efficiency of shared resources also promotes local and regional self-sufficiency, which in turn enhances local capacity to treat children with cancer.

In June 2003, Eugene Helveston, MD, visited the UTHSC department of ophthalmology and SJCRH to propose a childhood eye cancer project to be started in Guatemala. To link doctors in Central America with those at UTHSC and SJCRH, Dr. Helveston offered access to ORBIS Cyber-Sight®, an internet-based telecommunication program. Leaders at both organizations agreed to participate in the project, and Dr. Helveston presented the proposal at an ORBIS board meeting, where board chairman Al Ueltschi agreed to donate the money for a RetCam, which was purchased for the pilot project in Guatemala City.

In January 2004, after months of preparation, the SJIOP initiated its pilot program in Guatemala and Honduras, which was aimed at reducing the high rate of mortality and blindness caused by ophthalmic diseases. Later the same year, Panama became the third site in this program (see photo, page 13). Each center was supplied with advanced ophthalmic equipment including fundus cameras, diode lasers, and RetCams, ensuring the ability of experts at SJCRH and the UTHSC to provide more detailed input and advice on cases. Our primary reasons for selecting these...
countries were the: (1) large number of patients, (2) presence of an existing committed treatment team and effective local fundraising foundation, and (3) central location of these countries, which facilitates expansion to all of Central America. The UTHSC, SJCRH, and ORBIS partnered in this initiative by capitalizing on complementary expertise and experience to treat eye diseases in Central America. This collaboration established a comprehensive ophthalmology program with a strong telemedicine component. In addition to improving eye care in the region, this program builds health care infrastructure at program sites; serves as a template for the development of other medical treatment, education, and data management programs; and enhances international goodwill. The retinoblastoma project is one of the most successful ventures at SJIOP.

In November 2005, Matthew W. Wilson, MD, FACS, professor of ophthalmology and St. Jude Chair of Pediatric Oncology at the UTHSC, volunteered to travel to Guatemala and help establish a localized brachytherapy protocol there (see photo, page 14). Three brachytherapy plaques were made in Memphis and sent with Dr. Wilson, who met with the radiation oncology team, physicists, and ophthalmologist Margarita Barnoya, MD, in Guatemala for the transfer of skills in the handling and placement of plaques. The following month, Dr. Wilson did the same for our newly developing site at the King Hussein Cancer Center in Amman, Jordan. At this site, another center of excellence in the retinoblastoma outreach program was established as a result of consultations through ORBIS Cyber-Sight® and Horizon Live at Cure4Kids.org. The establishment of this center led to the introduction of state-of-the-art treatment modalities in Jordan, such as trans-pupillary thermotherapy, subconjunctival chemotherapy, and cryotherapy. Physicians in Amman were further aided in their consultations via Cyber-Sight and Horizon Live by the addition of a RetCam, which enabled them to send digital photographs electronically for review to mentors at UTHSC and SJCRH.10

A landmark event occurred in January 2006: the world’s first international ophthalmology telehealth symposium held aboard an aircraft. This symposium convened on the ORBIS flying eye hospital parked at the Federal Express global “SuperHub.” Physicians aboard the aircraft were connected with telehealth sites at the UTHSC, SJCRH, and our centers of excellence in Guatemala and Honduras (see photo, page 15). This important event received a great deal of media attention, demonstrating how effectively this outreach program has brought physicians in underserved nations together with each other and with physicians at UTHSC and SJCRH.

The author; Judith Wilimas, MD; George Vélez, DHAc, CFAAMA; and other international outreach representatives from the UTHSC, SJCRH, and American Lebanese Syrian Associated Charities (ALSAC) traveled in February 2007 for a site visit at the Hospital del Niño in Tegucigalpa, Honduras. At the facility, the outreach representatives met with pediatric hematologist Ligia Fu, MD, and local ophthalmologists Carlos

Thanks to the efforts of physicians like Dr. Ligia Fu and her team, posters such as this are helping educate people in Honduras about retinoblastoma.
Maldonado, MD; Lilia Lopez, MD; and Geraldina Amador, MD. The team from Memphis provided and installed a RetCam and other equipment at the site, and then the visiting physicians trained the local Honduras physicians—who were already experienced in the treatment of retinoblastoma using laser and cryotherapy—how to use the new equipment, as well as how to access the ORBIS and Cure4Kids websites for consults. Dr. Fu now participates in educational campaigns in Honduras to increase awareness of pediatric eye diseases, including retinoblastoma, and recognition of white pupil, its most common indicator (see photo, page 16).

In the past three years, UTHSC and SJCRH have extended this telemedicine outreach program (see Figure 1, this page) to Jordan and Vietnam, holding landmark video conferences with institutions in both countries (see photo, page 18). Santiago, Chile, may soon be added to this list, as discussions of developing a new center there have recently begun. A protocol has also been established so that tumor tissue from any of our international centers of excellence may be transported to Memphis via a special arrangement with Federal Express for analysis by consulting physicians at UTHSC and SJCRH.

**Telesurgical technology**

In November of 2009, with the acquisition of a new telehealth communications system, the UTHSC HEI achieved its goal of establishing international ophthalmology grand rounds. The recent installation of this new Sonic Foundry Mediasite system allows us to share webcast links with health professionals anywhere in the world, enabling them to attend events held in the Freeman Auditorium at the HEI, and to witness presentations by our faculty, residents, and visiting guest speakers live via the Internet. After these live events have transpired, they are stored in the media section of the HEI website (http://www.eye.uthsc.edu).

Since the installation of the Mediasite, the international audience for UTHSC’s weekly grand rounds quickly grew from only three viewers, in December 2009, to more than 50 by May 2010. This rapid growth in our weekly audience is due in part to Ibrahim Qaddoumi, MD, director of telemedicine at the SJOP. Dr. Qaddoumi, along with many other physicians who have viewed our webcasts, shared his excitement about these weekly events with many of his colleagues around the world, especially in the Middle East. In Jordan, the webcasts are accessed on a regular basis by ophthalmologists at the King Hussein Cancer Center, the largest and most prestigious

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**Figure 1**

International outreach telemedicine services
multidisciplinary medical institution in Jordan. At other institutions, such as the Ibn Al Haytham Hospital, the webcasts have become part of the regular educational activities for ophthalmology residency programs. Furthermore, the ability to attend these events provides an additional layer of involvement for physicians at all of our centers of excellence, through which they may enhance their proficiency in managing pediatric eye tumors and other ophthalmic diseases.

With the assistance of ORBIS International, ophthalmologists and oncologists have access to ORBIS Cyber-Sight® ([http://www.cybersight.org](http://www.cybersight.org)), a Web forum enabling physicians at outreach sites to connect via the Internet with our experts, led by Dr. Wilson, to share patient clinical data, retinal images, the current diagnosis, and proposed treatment. After a case file has been submitted by a partner, a mentor receives e-mail notification, reviews the case, and provides immediate advice. This e-consultation program further helps to strengthen communication among international partners and the mentors at UTHSC and SJCRH.

SJCRH provides another internet-based consult system. The [www.Cure4Kids.org](http://www.Cure4Kids.org) website allows health professionals to discuss difficult clinical cases with colleagues via a secure online system. Physicians at international partner sites can submit a clinical case for review by a faculty member at St. Jude or other authorized expert with experience in that disease. In response, the expert provides an opinion on the case via a secure, password-protected website that stores all messages regarding the case. E-mail is used in this system only to notify each party when a message is ready for review on the website. When a discussion is completed, the international physician can then close the discussion and archive the case online. The Cure4Kids site also provides retinoblastoma specialists, oncologists, and researchers at SJCRH and UTHSC a forum in which to hold live, bimonthly videoconference meetings with our established international centers of excellence to discuss retinoblastoma patients with advanced or complicated disease via St. Jude’s Horizon Live network.

Additionally, in 2008, Cure4Kids added the Onco-pedia to its website, creating a space for health care professionals treating patients with retinoblastoma and other cancers and catastrophic illnesses to interact with other
physicians around the world and submit cases for expert panel review. Furthermore, presentations from the 2007 symposium, Retinoblastoma: One World, One Vision,\textsuperscript{11} have been placed on the Cure4Kids website. When a site is recruited to our outreach program, the medical team at the partner site receives ongoing mentored training in advanced treatments and protocols. Methods range from traditional continuing medical education to more innovative uses of teleconferencing and Internet-mediated learning. As part of this training, SJIOP brings physicians from these partner sites to Memphis for retinoblastoma conferences, clinical rotations, and in-person skills transfer with the ophthalmology teams at both UTHSC and SJCRH so they can see how multidisciplinary retinoblastoma teams work together. Conference proceedings are also videotaped, edited, and then posted to an educational website where partner sites can view them as often as they wish.

During these visits, physicians from abroad benefit from an array of e-surgical learning and communication tools. They are invited to utilize the EYESI Ophthalmology Surgical Simulator, a virtual reality system that allows virtual training of cataract and vitreoretinal intraocular surgical procedures. The simulator records all surgical performance data and offers a detailed evaluation after each training session. International visiting physicians also observe surgeries at UTHSC and SJCRH, either in person or by a streaming video connection.

The surgery suites and laboratories at UTHSC HEI are fully furnished with hardware and connections enabling viewers to observe procedures from our classrooms, telehealth suite, or our state-of-the-art Freeman Auditorium. One recent addition, the Aperio system, permits archiving of histopathologic specimens as digital images and sharing them via the Internet, teleconferencing, or durable digital media. This, in combination with the AJCC Staging Manual,\textsuperscript{12} facilitates the teaching and classification of cancer staging. Additionally, through use of the RetCam, our international physician partners may remotely view evaluations under anesthesia (EUA) through a secure connection from any authorized computer in either real time or as post-case reviews. This connectivity has the added benefit of reducing the risk of contamination, since observers and consultants do not have to enter the sterile area to view the EUA. With approximately 18 to 24 EUAs per week, the ability to share these live images for consultations greatly improves the efficiency of the referral process.

This remote consultation process also enables

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\item Eugene Helveston, MD
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\item Carlos Rodriguez-Galindo, MD
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consulting surgeons at UTHSC and SJCRH to view EUAs taking place at our international centers of excellence that are equipped with RetCams. The inclusion of RetCam EUA as a component of our centers of excellence leads to improved outcomes not only in early diagnosis of retinoblastoma, but the same technology with its associated telesurgical communications has permitted improved care for children with retinopathy of prematurity, congenital ocular disease, and hematologic and infectious involvement of eye diseases.

Present and future impact

All of this technology and access to consultation with leading experts in childhood cancers and other eye disorders have had a far-reaching impact on the effort to prevent blindness. Numbers of patients successfully treated have increased (see Figure 2, page 18). Our center of excellence in Jordan deserves special mention. Before the program was established there, the mortality rate for retinoblastoma was 38 percent, and the enucleation rate for patients with bilateral disease was 92 percent. However, during the period of March 2003 to December 2005, when 37 patients were referred to the program, the only death was of a patient who arrived with metastatic disease after failing therapy elsewhere. Moreover, the ocular salvage rate for patients with bilateral disease was reduced to 58 percent.

The UTHSC will continue to support and further develop the retinoblastoma international outreach program in its partnership with the SJCRH international outreach program and ORBIS International. As our regional centers of excellence develop greater expertise, this will enable them to further develop their health care programs in their respective regions, creating a lifelong network of surgical colleagues that will improve patient care worldwide through the latest in telesurgical communications technology and advances in ophthalmic research.

References

Former NFL player uses team approach as a general surgery resident

by Tony Peregrin
Some might say an exceptional surgeon is like an exceptional athlete—and perhaps no one knows this better than Steven E. Brooks, MD, a resident member of the American College of Surgeons (ACS) who is a chief resident in general surgery at Texas Tech University Medical Center, Lubbock, TX, and a former professional football player for the San Francisco 49ers, New Orleans Saints, and Detroit Lions.

“In this bump and shuffle of men I experienced the unspoken chemistry that occurs between teammates,” says Dr. Brooks, referring to his time on the field. “And there is a tremendous parallel between teamwork in football and teamwork in the operating room (OR), where the stakes are obviously much higher—especially in trauma cases—when you are saving lives.”

In addition to being team-driven professions, surgery and professional athletics share other commonalities: both require lots of practice and dedication, both involve performing under extreme pressure, and both rely on strong coaching—an area Dr. Brooks is very familiar with as the recipient of the 2010 Resident Award for Exemplary Teaching, sponsored by the ACS Division of Education.

**Brains and brawn**

Dr. Brooks has been “putting the pads on” since he was eight years old, but becoming a physician has always been more important to him than becoming a professional football player. While a student-athlete at Occidental College, a small liberal arts college in Los Angeles, CA, he paid his way though school by working as a phlebotomist at a nearby hospital—and that’s when he realized he wanted to be a doctor. “That experience offered me an all-access pass into everything that goes on in a hospital. I knew I wanted to be a doctor as a result of the interactions I had with patients and physicians, and from those first experiences I had as part of a medical team.”

However, Dr. Brooks’s medical school matriculation was temporarily put on hold when he was invited to try out for the Los Angeles Rams.

“I tried out for the Rams before they moved to St. Louis. They invited me to work out with the team, and I did, and I thought that was it—it was a great honor, but I thought that was the extent of it. Then, I was invited back for four or five more workouts, and each time the stakes got a little higher, and the pressure was a little greater,” says Dr. Brooks, who was signed to the team as a free agent in 1994.

After five years of playing tight end/long snapper for various NFL teams, including the L.A./St. Louis Rams, the San Francisco 49ers, the New Orleans Saints, the Detroit Lions, and the Washington Redskins, Dr. Brooks was less interested in crossing the goal line and more interested in waiting in line to receive his medical school diploma.

As he was interviewed by various medical schools, administrators would remark on the fact that he hadn’t been in a classroom for six years. While some school administrators may have been skeptical about this former tight end’s future as a medi-
cal student, Dr. Brooks’s family and teammates weren’t surprised that his heart was set on the OR rather than the gridiron. “I didn’t go along with the typical stereotype of a football jock—I had always known in my heart that I would go to med school.”

In fact, Dr. Brooks’s parents have had a huge influence on his career path—particularly his mother, who has been a critical care nurse for most of her life. “A lot of people ask me what made me interested in medicine. As I mentioned earlier, my work as a phlebotomist had a big impact on my decision to enter medical school, but even before that, I remember my father taking me to visit my mom while she was working at an intensive care unit. We would bring her a sack-lunch, and I remember looking around in awe. With all of the lights and sounds and equipment, it was like being inside a spaceship! I remember stealing glances at people returning from open-heart surgery and the way she cared for all those people who were in really bad shape, and I think it was at that point that I knew I wanted to practice medicine,” says Dr. Brooks, who is completing his fifth year of training in general surgery, and is preparing for his next two years as a trauma surgery and surgical critical care fellow at Vanderbilt University, Nashville, TN.

Setting the stage

Buried a few pages deep in Dr. Brooks’s curriculum vitae, under the heading “Additional Professional Experience,” there is a section entitled “Screen Actors Guild.” During his tenure as a professional football player, Dr. Brooks primarily resided in Los Angeles, CA, and eventually he succumbed to the siren call of Hollywood.

“It wasn’t nearly as planned out as football or medicine,” reveals Dr. Brooks. “I had my sights on those two things and I was driven to accomplish them. But while I was living in LA, my main focus was to be physically prepared for the next season, so I had a lot of free time. I always felt comfortable speaking publicly, and I’d had the chance to speak on behalf of a lot of different groups such as DARE or the Make a Wish Foundation, and so I decided to give [acting] a try,” says Dr. Brooks, whose TV credits include Beverly Hills, 90210; Arliss (HBO); and national television spots for Wheaties, Nike, Sony, and others.

This acting experience, according to Dr. Brooks, hasn’t had an impact on his role as a physician the way his training as a professional athlete has—although he does admit that all three professions require the ability to interact well with others.

“Acting doesn’t play into the way I am as a doctor,” explains Dr. Brooks, “but as a teacher, it has helped hone my ability to get my point across and to motivate others. When you think about it, part of being an effective instructor is sometimes being an entertainer.”

Coaching on the field and in the OR

Dr. Brooks has played for many notable NFL coaches, including Wayne Sevier, George Siefert, Mike Shanahan, Jim Mora, and Bobby April, to name a few, and he’s taken what he’s learned from these mentors and used it as a foundation for his teaching “game plan” at Texas Tech University.
“I’ve learned that the best coaches and the best teachers study their teammates to determine their individual strengths and to figure how they learn best, and what truly motivates them. A good coach or leader will find a way to individualize what they are teaching. For example, some people need you to be hard on them and need you to push them, while others tend to push themselves and only require guidance. When a coach or a teacher has the ability to make individuals in a larger group each feel personally inspired, then you have a powerful teacher and leader,” explains Dr. Brooks.

Dr. Brooks says he was “completely blown away and surprised” when he learned he would be receiving the 2010 Resident Award for Exemplary Teaching at this year’s Clinical Congress in Washington, DC. John A. Griswold, MD, FACS, surgery chairman at Texas Tech University, was present at the ceremony. In a letter of recommendation, Dr. Griswold noted that Dr. Brooks is a “naturally gifted teacher” and “he looks forward to [Dr. Brooks] completing his fellowship and joining the faculty.”

As a surgery resident and a former NFL player, Dr. Brooks says he has been fortunate to encounter numerous outstanding teachers and leaders. “A coach once said to me, ‘Whether compliment or criticism, any attention is good attention! When coaches stop paying attention to you, that’s when you should worry.’ I learned as a competitor and student that receiving attention from a leader meant

Dr. Brooks playing tight end for the St. Louis Rams: arms out, about to finish the tackle and put a big hit on a Seattle Seahawks player (with the ball).

Playing for the San Francisco 49ers.
that person was making an investment in me and in my development as an athlete or a surgery resident.”

“I think that as a teacher or a leader of any kind, be it medicine or athletics or whatever, it’s important for people to let themselves have different sides to their personalities—and I learned that from my dad,” adds Dr. Brooks. “He taught me that toughness and kindness do not need to be mutually exclusive. My dad could be very intimidating just because of his large physical stature, but he was the kindest man, and he was able to relate to anyone he came into contact with. Little did I know that I would eventually become a large person like my father—and like him, I really enjoy being gentle with children, families, and with all of the patients,” says Dr. Brooks, who is 6’5″ and 265 pounds.

Dr. Griswold puts it another way: “[Steve] is always cheerful, [and] the most supportive, dedicated, respectful individual we have had in our program. For his size, he is gentle beyond belief.”

Teamwork

Of all the professional football teams Dr. Brooks has played with, the San Francisco 49ers really stand apart from the rest. “At that time they were such a winning organization, and I learned a lot. I was a tight end, and sometimes I was blocking or sometimes I was catching the ball; but whatever we did, everyone expected the utmost [in terms of] work ethic and maximum effort—and these expectations were set not by the coaches but by the players! If a receiver caught the ball, there was no jogging for a few extra yards followed by a stroll back to the huddle. After catching a pass, I was expected to turn up field and sprint 30 or 40 yards to the end zone, and then to hustle back to the huddle. ‘Practice the way that you’re gonna play,’ was the standard we set and enforced from within our group. I never saw that anywhere else, and I still carry those ideals with me today. The proverbial bar should be set high, set from within, and you have to prepare the same way you want to perform. A surgery residency is a huge team, and if there is a collective agreement of what is
expected, it makes everyone a better physician and teammate,” says Dr. Brooks.

Dr. Brooks also strives to foster an inclusive approach with his patients. “Sometimes people will say to me, ‘What’s so special about playing pro sports, all you did was slam into other people—what’s so special about that?’ Well, playing professional football allowed me to travel across the country, and even throughout Europe, where I was exposed to a variety of people from different cultures and religions. This taught me how to take care of patients from diverse backgrounds.”

Professional sports also taught Dr. Brooks how to convince his patients that they are all playing for the same team.

“I have been training in Texas, and you know that football is a huge, integral part of the culture here. On Friday nights, entire towns close down for the local high school game. As a surgeon who sees a lot of trauma, well, we see a lot of high school kids, kids who have been put back out on the field not long after they’ve had a concussion, and they often suffer the results neurologically,” explains Dr. Brooks.

“I have taken an interest in trying to be part of the medical system that educates families that we have to be cautious about what we do with young people playing sports,” adds Dr. Brooks. “I have a hard time wearing my past profession on my sleeve, but if I am talking to a family and I can be certain it will have more of an impression on them or get their attention regarding keeping their kids safe, then I mention it. I can say to them, ‘I have taken hits to the head. I know what that means as an athlete and I know what it means as a trauma and critical care surgeon.’”

Heart, soul, and sweat

Ask Dr. Brooks if getting drafted into the NFL was on par with getting accepted into medical school and he’ll tell you they were both lifelong dreams.

“Well, I wasn’t drafted, I was signed as a free agent. I was a blue collar guy from Occidental College in Los Angeles, so I wasn’t recruited from a big Division I school, which was fine with me. I remember I had girlfriends who would try and get me to go to the beach with them, but I was so driven that I’d have to tell them ‘no’ because I had to work out or run around the track, and later on, I had to tell them ‘no’ because I had to take time to study. Professional football and medical school were both about pouring my heart and soul and sweat into something for years and years—and finally having it pay off.”

Mr. Peregrin is Associate Editor of the Bulletin, Division of Integrated Communications, Chicago, IL.
Every year, in nearly every state, nonphysician practitioners lobby for expanded scope of practice. Typically, they seek to gain prescribing and independent practice rights. Some nonphysician health care providers have become increasingly aggressive in their efforts to expand their scope to include treatments, procedures, and privileges that exceed their level of education and training. When scope-of-practice expansions are inconsistent with practitioners’ education and training, or are not coupled with safeguards (such as practice protocol arrangements with a physician who provides oversight of the care provided), the safety and quality of health care delivered to patients is likely to be compromised.

In 2010, the American College of Surgeons (ACS) tracked 44 scope-of-practice bills in 22 states. One bill of particular interest to the College was S.B. 230, which was introduced in West Virginia, and sought to expand the scope of practice for optometrists. Through a number of grassroots efforts, the medical community was able to favorably amend S.B. 230 to ensure patients continue to receive the care they have come to expect from their physicians.

Provisions in S.B. 230
Early into the 2010 West Virginia legislative session, the American Optometric Association persuaded a legislator to introduce S.B. 230, after seeking passage of similar bills on several previous occasions. Like the bills that came before it, S.B. 230 sought to expand the scope of practice for optometrists through the following provisions:

- Grant optometrists the authority to use lasers to operate on patients with glaucoma
- Authorize optometrists to advertise as, and refer to themselves as, “optometric physicians”
- Authorize optometrists to perform injection procedures

Various medical organizations including the ACS, the American Medical Association (AMA), the American Academy of Ophthalmology (AAO), as well as members of the Scope of Practice Partnership (SOPP) (a coalition opposing nonphysician scope expansion efforts) were immediately concerned about the implications this bill could have on patients in West Virginia.

Grassroots campaign
Although the AAO and the West Virginia State Medical Association (WVSMA) spearheaded the grassroots effort in West Virginia, the College was soon called upon to offer its support. The AAO had the backing of their membership in the state but did not have the network of surgeons necessary to reach other specialists. The AAO stressed the importance of having the College on board with their legislative efforts. The College’s advocacy staff and leadership maintain that it is important

West Virginia offers model to stop ill-conceived scope-of-practice legislation
by Alexis Macias

that the broad spectrum of specialties collaborate to achieve passage or defeat of legislation.

Whereas an orthopaedic surgeon’s practice may not be affected directly by optometrists expanding their scope of practice, his or her patients will certainly be affected if they visit an optometrist who is unqualified to perform a procedure. It therefore is the responsibility of physicians to reach across specialty lines to protect patients.

Physicians must be the voice that legislators are hearing on Capitol Hill and in the statehouse with regard to the training and education that ophthalmologists and other physicians undergo to provide quality care. According to an e-mail written by AMA board member Rebecca J. Patchin, MD (October 2010) to the author of this article, physicians must “ensure that legislators understand the implications of inappropriate scope-of-
practice legislation. Physicians must discuss how their extensive years of education and training provide them with not only the clinical expertise, but also the judgment necessary to provide the most appropriate medical care at the right time in the right setting.”

In an effort to be that voice, a number of physicians across West Virginia wrote to, and called, their legislators to remind them that while optometrists are qualified in certain areas of care, they are unqualified to perform the various surgical procedures included in S.B. 230. In an effort to engage surgeons in West Virginia, the ACS issued a call to action through its Surgery State Legislative Action Center (SSLAC), a website (http://www.facs.org/sslac) dedicated to grassroots advocacy efforts. A number of surgeons responded by sending letters and making phone calls to their state representatives. The ACS also sent a letter of opposition to the West Virginia House Health and Human Service Committee.

Getting the message out

One way to get the message of education and training across to legislators is by participating in a lobby day or a “white coat rally.” These events allow physicians to gather in a large group and have a forceful and powerful presence at the state capitol. For example, the WVSMA invited physicians from across the state to stand in the gallery of the Senate on the day of the vote to show opposition to the bill. Examples like this are part of what leads to a successful defeat of inappropriate scope-of-practice legislation.

Once state legislators get the message about the differences in education and training between physicians and nonphysicians, this information must be disseminated to the patient community. Patients need to be aware of the potential problems that could occur if an optometrist is practicing outside of his or her training because they are at the greatest risk of being harmed by unqualified practitioners.

In 2008, Global Strategy Group, an organization hired by the SOPP to conduct a survey of patients regarding Truth in Advertising legislation, found that 54 percent of the respondents indicated that they believe an optometrist is a medical doctor, while 10 percent were unsure if an optometrist was a medical doctor. Once patients are educated on the risks they face by receiving treatment from an unqualified nonphysician health care practitioner, they can become advocates. There are various ways surgeons can educate their patients about the risks that scope-expanding legislation poses to them. Physicians can provide brochures or flyers on a particular issue. Letters to editors of local newspapers are another effective way to get patients engaged in the issues. In West Virginia, radio ads ran throughout the state during the legislative session that allowed physicians to educate the patient community on the risks they could face with passage of S.B. 230.

A successful outcome

After implementing several grassroots strategies, West Virginia ophthalmologists and the physician community were successful in lobbying for amendments aimed at protecting patients. Hence, when S.B. 230 was signed into law it stated that an optometrist licensed in the state may not do the following: perform surgery except as provided in the statute; use a therapeutic laser; use Schedule II controlled substances; treat systemic disease; or present to the public that he or she is a specialist in surgery of the eye or use the term “optometric physician.”

Nonphysician health care practitioners show no signs of slowing down their expansion efforts in the coming years. Participating and engaging in various grassroots efforts is one of the few ways surgeons are able to protect their patients from scope expansion legislation. The College urges its members to participate in one or more of the following grassroots initiatives: developing a strong relationship with a legislator, writing or calling a representative when a call to action has been placed, participating in a lobby day or white coat rally, reaching out to patients, and contributing to a state or federal political action committee.

For more information on scope-of-practice legislation contact Alexis Macias, Regional State Affairs Associate at 312-202-5446, amacias@facs.org.

Ms. Macias is Regional State Affairs Associate, Division of Advocacy and Health Policy, Chicago, IL.
Highlights of the 96 Annual Clinical Congress
At the 2010 Clinical Congress in Washington, DC, a wide selection of presentations covering subjects from education to practice to clinical considerations—in addition to poster presentations, papers sessions, and special-interest meetings—were offered. The meeting was attended by 14,249 participants, including 8,800 physicians; the remaining attendees included exhibitors, spouses, guests, and convention personnel.

Convocation

L. D. Britt, MD, MPH, FACS—a general and acute care surgeon from Norfolk, VA, and the Brickhouse Professor and chairman of the department of surgery, Eastern Virginia Medical School—was installed as the 91st President of the American College of Surgeons (ACS) during Convocation ceremonies that denoted the official opening of the Clinical Congress (see photo, this page). (See the December 2010 issue of the Bulletin for a summary of the Presidential Address.)

Other officers installed during the Convocation were Richard J. Finley, MD, FACS, FRCSC, as First Vice-President and Frederick L. Greene, MD, FACS, as Second Vice-President. Dr. Finley, a general thoracic surgeon, is professor and head of the division of thoracic surgery at the University of British Columbia. A Fellow of the ACS since 1983, Dr. Finley has been actively involved in the governance of the College. He served as Chair of the Board of Governors from 1993 to 1995 and as a member of the Board of Regents from 2000 to 2009. Dr. Finley was instrumental in the development and successful launch of the ACS members-only Web portal and the ACS Case Log System.

Dr. Greene, a general surgeon, is chairman, department of general surgery, Carolinas Medical Center, Charlotte, NC, and director of the surgical residency program at that institution. A Fellow since 1983, Dr. Greene served as Chair

Overleaf, clockwise from top: The Howard University Air Force ROTC Drill Team presenting colors at the Opening Ceremony; ACS Regent H. Randolph Bailey, MD, FACS, affixing the first-prize ribbon to the Best Scientific Exhibit; Congress attendees consulting the Program Book; and participants in a scientific session, training in flexible gastrointestinal endoscopy.

Outgoing ACS President Dr. McGinnis (right) passes the Presidential Medallion to Dr. Britt during the Convocation.

Martin Memorial/AUA Lecturer Dr. Atala (center) with Dr. Britt and Howard M. Snyder III, MD, FACS, who introduced the lecture.

Regina M. Benjamin, MD, Surgeon General of the U.S. Public Health Service (center), was a guest of Dr. and Mrs. Britt at the Presidential Dinner, where she spoke about her long association with Dr. Britt.
of the Commission on Cancer from 2004 to 2008. He was also a member of the Board of Governors from 1995 to 2001. Dr. Greene has represented the College on the American Joint Committee on Cancer (AJCC) and is editor of the sixth edition of the *AJCC Cancer Staging Manual*.

Honorary Fellowship was conferred on the following six prominent surgeons: Mehmet A. Haberal, MD, FACS, FICS(Hon); Bernard Launois, MD, FACS; Ralph John Nicholls, MA, MB, MChir (Cantab), FRCS(Hon Eng, Glas), EBSQ (Coloproctology), FRCP(Hon Lon), FASCORS(Hon); Tehemton E. Udwadia, MB, BS, FACS; Dario Birolini, MD, FACS; and William I. Wei, MB, BS, FACS, FRCS (Edin, Eng), FRACS(Hon).

**Named Lectures**

As was the case last year, the Martin Memorial Lecture and the American Urological Association Lecture were combined for presentation during the Opening Ceremony of the Clinical Congress. Anthony Atala, MD, FACS, delivered his lecture, *Regenerative Medicine: New Approaches to Health Care*, immediately following the Opening Ceremony on Monday morning (see photo, page 30). Also on Monday, The Society for Thoracic Surgeons and Veterans Affairs Cardiothoracic Surgical Databases: Their Role in Quality Improvement, Research, and Health Care Policy, was presented as the John H. Gibbon, Jr., Lecture by Frederick L. Grover, MD, FACS, and Denton A. Cooley, MD, FACS, sent a pre-recorded video presentation, titled *Surgery for Cardiovascular Anomalies in Infants: Personal Reflections*, as the Charles G. Drake History of Surgery Lecture. The Excelsior Surgical Society Edward D. Churchill Lecture convened Tuesday with Thomas R. Russell, MD, FACS, presenting *From Excelsior Society to the Present—What Will Be Expected of Us?* Other Named Lectures that convened Tuesday were the Scudder Oration on Trauma, during which David V. Feliciano, MD, FACS, presented *Vascular Trauma Revisited*; and the Olga M. Jonasson Lecture, Women in the Professions, presented by Nina Totenberg. Wednesday’s Named Lectures included the Ethics and Philosophy Lecture, *Is There a Role for Race in Science and Medicine?* presented by Clive O. Callender, MD, FACS; Gene Therapy
for Cancer, the Commission on Cancer Oncology Lecture presented by Steven A. Rosenberg, MD, PhD; and the I.S. Ravdin Lecture in Basic Sciences, where Ian Frazer, MB, ChB, MD, delivered Cancer Immunotherapy—Where Are We Heading? The Herand Abcarian Lecture, Radical Reform or Gentle Tweaking? The Cure to Challenges in Resident Education, was offered by Richard K. Reznick, MD, MEd, FACS, FRCSC; and Ethics and Errors in Surgery, the Distinguished Lecture of the International Society of Surgery, was presented by Alberto R. Ferreres, MD, PhD, JD, MPH, FACS.

Awards, honors, celebrations

Presiding President LaMar S. McGinnis, Jr., MD, FACS, presented the first Lifetime Achievement Award of the American College of Surgeons to C. Rollins Hanlon, MD, FACS, during Convocation ceremonies Sunday evening (see photo, page 31). “It is fitting that the Honors Committee of the College has selected an individual who has devoted a lifetime to his chosen art by not only providing skilled, ethical, and loving care to thousands of surgical patients in his long and illustrious career, but also by serving in many roles and sharing his vast knowledge with our beloved College since becoming a Fellow in 1953,” Dr. McGinnis said. “He exemplifies the highest professional and personal standards and has provided mentorship, guidance, and direction for many of us in this room tonight and countless others around the globe.” (See related story, page 53).

The 2010 ACS/Pfizer Inc Surgical Volunteerism and Surgical Humanitarian Award winners were honored at a general session on Monday, sponsored by the College’s Operation Giving Back program. Richard S. Bransford, MD, FACS, was presented with the humanitarianism award, and Samuel B. Broaddus, MD, FACS; COL...
National Safety Council Surgeons’ Award for Service to Safety awardee Dr. Knudson (center) with Dr. Britt and Michael F. Rotondo, MD, FACS, Chair, Committee on Trauma.

Jacobson Innovation Award winner Dr. Dimick (third from left) with (left to right) Dr. Hoyt, Dr. Britt, Dr. Jacobson, Mrs. Jacobson, and A. Brent Eastman, MD, FACS, Chair of the Board of Regents.

2010 Surgical Forum volume dedication recipient Dr. LoGerfo (right), with C. Keith Ozaki, MD, FACS, member of the Surgical Forum Committee.
Michael W. Cruz, MD, FACS; and T. Peter Kingham, MD, received the volunteerism awards (see photo, page 32).

Also Monday, Norman M. Kenyon, MD, FACS, and Mrs. Sue C. Kenyon were presented with the Fellows Leadership Society’s Distinguished Philanthropist Award in recognition of their personal contributions, along with Dr. Kenyon’s tireless work to raise philanthropic support on behalf of the College (see photo, page 32).

Justin B. Dimick, MD, MPH, FACS, an assistant professor with the department of surgery, University of Michigan, Ann Arbor, was presented with the Joan L. and Julius H. Jacobson II Promising Investigator Award (see photo, 33). Dr. Dimick’s initial research centered on evaluating benefits of selective referral policies. More recently, he has developed a new approach to measuring hospital outcomes by using a composite measure that optimally combines multiple quality indicators and filters out statistical noise. His research efforts are already being translated into policy. More importantly, his research will contribute to improvements in the quality of surgical care nationally.

The National Safety Council Surgeons Award for Service to Safety was conferred at the meeting. M. Margaret Knudson, MD, FACS, was presented with the award, which states, “For your visionary leadership in injury prevention and control, we commend your lifelong commitment to the care of injured patients. Your work has saved countless lives.” Presenting the award were Dr. Britt, who is president of the American Association for the Surgery of Trauma, and Michael F. Rotondo, MD, FACS, Chair, Committee on Trauma (see photo, page 33).

The 2010 Owen H. Wangensteen Surgical Forum volume was dedicated to Frank W. LoGerfo, MD, FACS (see photo, page 33). Residents honored with the Surgical Forum Excellence in Research Awards included Daniel S. Wu, MD; Ryan M. Gobble, MD; Janette N. Zara, MD; Victor W. Wong, MD; Matthew A. Nehs, MD; Elizabeth A. Ziemba, MD; Farzad Alemi, MD; Vanessa P. Ho, MD, MPH; Alexander Kutikov, MD; Haejin In, MD; Scott M. Damrauer, MD; Michael T. Longaker, MD, FACS (Chair, Surgical Forum Committee); and Michael J. Krzyzaniak, MD.

The 2010 Distinguished Service Award, the College’s highest honor, was presented to Amilu Stewart MD, FACS, for her service to the
Oweida Scholarship recipient Dr. Navarro (left), receiving his award from Stephen E. Olson, MD, FACS, Chair of the Rural Surgery Subcommittee of the Advisory Council for General Surgery.

ACS and to the profession of surgery as a gifted and dedicated community surgeon and an active volunteer and leader (see photo, page 31). Dr. Stewart currently serves on the admissions committee at the University of Colorado Health Sciences Center, Colorado Springs.

The Committee on Cancer Liaison recognized three Commission on Cancer State Chairs for outstanding performance and significant contributions to the Liaison Program in 2009. Honored were Lisa Bailey, MD, FACS, California State Chair, Summit Medical Center, Oakland, CA; Lisa A. Rutstein, MD, FACS, Main State Chair, Maine Medical Center, Portland, ME; and Terry Sarantou MD, FACS, North Carolina State Chair, Carolinas Healthcare System, Charlotte, NC.

Fernando A. Navarro, MD, FACS, a general surgeon from Norway, NE, received the 2010 Nazar N. Oweida Scholarship at the Rural Surgeons meeting (see photo, this page).

The eighth annual ACS Resident Award for Exemplary Teaching was presented to Steven E. Brooks, MD, a PGY-5 resident in general surgery at the Texas Tech University Health Sciences Center, Lubbock, TX (see a profile of Dr. Brooks on page 21). The award is sponsored by the Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives. Dr. Brooks was selected by an independent review panel of the Committee on Resident Education (see photo, page 36).

The International Guest Scholar program welcomed its 2010 guest scholars including the following: Anil Mandhani, MS, MCh, Lucknow, India; Jean-Claude R. Givel, MD, FACS, IRC member; Tezazu Teffera Tekle, MD, Hawassa, Ethiopia; Toru Ikegami, MD, Fukuoka, Japan; Jorge G. Curi Lehmann, MD, Montevideo, Uruguay; Eduardo E. Montalvo-Jave, MD, FACS, Mexico DF, Mexico; Akihiko Soyama, MD, PhD, Nagasaki, Japan; Thorsten Vowinkel, MD, PhD, Muenster, Germany; Michel Michaelides, BSc, MB, BS, MD, London, UK; Laurent Brunaud, MD; Simon Ng, MB, BS, FRCS(Ed), Hong Kong, China; and Ruben H. Hovhannisyan, MD, Yerevan, Armenia (see photo, page 36).

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JANUARY 2011 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
The International Guest Scholars for 2010, with members of the International Relations Committee (IRC). Front row, left to right: Dr. Mandhani, MS, MCh; Kate Early, International Relations Liaison; Jean-Claude R. Givel, MD, FACS, IRC member; Fabrizio Michelassi, MD, FACS, IRC Chair; and Dr. Tekle.

Back row: Dr. Ikegami, Dr. Lehmann, Dr. Montalvo-Jave, Dr. Soyama, Dr. Vowinkel, Dr. Michaelides, Dr. Brunaud, Dr. Ng, and Dr. Hovhannisyan.
Simplified Negative Pressure Wound Therapy in the Disaster Relief Setting was designated a Poster of Exceptional Merit and named Best Scientific Exhibit, and was authored by Gita N. Moody, MD; Danielle Zurovcik; Alexi Matousek, MD; Jesula Eustache, RN; and Robert Riviello, MD, MPH, of Brigham and Women’s Hospital in Boston, MA (see photo, this page).

Medical student Courtney A. Green, University of Minnesota, was awarded first place honors for her poster entitled Development and Implementation of a Simulation-based Critical Skills Course for PGY-1 Surgical Interns: Mid-term Analysis (see photo, this page). Ms. Green’s poster and oral presentation were selected from 40 posters featured at the Medical Student Program offered during the Clinical Congress, by the Division of Education through the Committee on Medical Student Education. The program spanned three days, with approximately 35 speakers and more than 300 medical students who submitted almost 120 abstracts for the poster session.

The ACS Committee on Video-based Education sponsored a session to highlight outstanding surgical videos previously presented at various international meetings, nominated by prominent international surgeons. At the conclusion of the session, coordinated by committee chair Tonia M. Young-Fadok, MD, FACS, members of the audience voted on the best video of the session. The 2010 winner was Augusto Tinoco, MD, for the video entitled Laparoscopic Roux-en-Y Hepaticojejunostomy for Treatment of Common Bile Duct Cyst. Dr. Young-Fadok, along with panelist Hermann P. Kessler, MD, PhD, FACS, presented Dr. Tinoco with an award and a year’s subscription to the ACS Online Video Library (see photo, page 38).
The Young Fellows Association (YFA) met during Clinical Congress. L.D. Britt, MD, FACS, ACS President, addressed the group. Pictured, front row, left to right (all MD, FACS): Danielle Katz; Peter Kim; Cecilia Boardman; Steve Chen; Laurel Soot; and Scott Coates.

Back row: Nancy Baxter; Keith Amos; Dinakar Golla; Adam Cohen; Rob Todd; Sanjay Parikh, YFA Vice-Chair; Dr. Britt; Mark Savarise, YFA Chair; Juan Paramo; Marcovalerio Melis; David Tom Cooke; and Nathaniel McQuay, Jr.

Best surgical video award winner Dr. Tinoco (center), with Dr. Young-Fadok and Dr. Kessler.

College governance
At the Annual Business Meeting of Members on Wednesday, where Dr. Britt presided, A. Brent Eastman, MD, FACS, presented the Report of the Chair of the Board of Regents; Michael J. Zinner, MD, FACS, presented the Report of the Chair of the Board of Governors; David B. Hoyt, MD, FACS, presented the Report of the Executive Director of the College; Henri R. Ford, MD, FACS, presented the Report of the Chair of the Nominating Committee of the Board of Governors, during which the elected Regents and Board of Governors Offices were announced; and Charles F. Rinker II, MD, FACS, presented the Report of the Chair.
of the Nominating Committee of the Fellows and announced the nomination and election of Governors and Officers. It was also at this meeting that Dr. Stewart received her Distinguished Service Award, Dr. Dimick was presented with the Promising Investigator Award, and Dr. Brooks was given the Resident Award for Exemplary Teaching.

**New Officers-Elect**
At the Annual Business Meeting of Members, new Officers-Elect were named. **Lazar J. Greenfield, MD, FACS**, was named President-Elect and will begin his tenure as the 92nd ACS President at the 2011 Clinical Congress in San Francisco, CA. Dr. Greenfield is a vascular surgeon from Ann Arbor, MI. **Patricia J. Numann, MD, FACS**—a general surgeon, and professor emeritus at the State University of New York, Syracuse, NY—was named First Vice-President-Elect. Named as Second Vice-President-Elect was **Robert R. Bahnson, MD, FACS**, a urologic surgeon, professor and chairman of the department of urology, and The Dave Longaberger Chair in Urology, The Ohio State University College of Medicine, Columbus.

**Board of Governors/Board of Regents**
The Board of Governors elected **Margaret M. Dunn, MD, FACS**, Dayton, OH; and **Michael J. Zinner, MD, FACS**, Boston, MA, to the ACS Board of Regents.

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Members of the Advanced Trauma Life Support® (ATLS) international community met to discuss pertinent issues related to the program. More than 100 representatives from nearly 40 countries attended the meeting. Currently more than half of all ATLS activity is conducted outside the U.S. and Canada.

Ms. Marilyn Lux (center) was recognized for her contributions to the Surgical Education and Self-Assessment Program™ (SESAP™) over the past 34 years. The Editorial Consultant for the just released SESAP 14, Ms. Lux was given a presentation in honor of her retirement by John A. Weigelt, MD, DVM, FACS, SESAP 14 Medical Director (left), and Dr. Sachdeva (right).
Dr. Dunn, a general surgeon, is professor of surgery and executive associate dean, Wright State University Boonshoft School of Medicine, Dayton, OH. She is also president and chief executive officer of Wright State Physicians. A Fellow of the College since 1986, Dr. Dunn has served on the Board of Governors (1997–2003), as Chair and Vice-Chair of the Nominating Committee of the Board of Governors (2001–2003), as President of the ACS Ohio Chapter (1999–2000), as a member of the ACS Committee on Diversity Issues (2002–2008), and as a member of the Board of Governors’ Committee to Study the Fiscal Affairs of the College (2002–2003).

Dr. Zinner, a general surgeon, is Moseley Professor of Surgery, Harvard Medical School; clinical director, Dana-Farber/BWH Cancer Center; and surgeon-in-chief, Brigham and Women’s Hospital, Boston, MA. A Fellow since 1983, Dr. Zinner has served as liaison to the Board of Governors’ Committee on Surgical Infections and Environmental Risks (2004–2008), as a member of the Surgical Research Committee (1988–1994), and as a member (2002–2008), Vice-Chair (2007–2008) and Chair (2008–2010) of the Executive Committee of the Board of Governors. He currently serves on the Public Profile and Communications Steering Committee.

Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), was elected Chair of the Board of Regents. Dr. Pellegrini is the Henry N. Harkins Professor and chair, department of surgery, at the University of Washington, Seattle, WA (see article, page 54).

Thomas V. Whalen, MD, FACS, was named Vice-Chair of the Board of Regents. Dr. Whalen is chair, department of surgery, Lehigh Valley Health Network, Allentown, PA.

Elected to additional three-year terms on the Board of Regents were Barrett G. Haik, MD, FACS, Memphis, TN; and Howard M. Snyder III, MD, FACS, Philadelphia, PA.

The Board of Governors elected Timothy C. Flynn, MD, FACS, Gainesville, FL, as Chair of its Executive Committee; Henri R. Ford, MD, FACS, Los Angeles, as Vice-Chair; and Lena M. Napolitano, MD, FACS, as Secretary. Also elected to the Board of Governors’ Executive Committee were William G. Cioffi, Jr., MD, FACS, Providence, RI; Lorrie A. Langdale, MD, FACS, Seattle, WA; Gary L. Timmerman, MD, FACS, Sioux Falls, SD; and Sherry M. Wren, MD, FACS, Palo Alto, CA.

Clinical Congress 2011: San Francisco, CA

It’s never too early to start planning for the 97th annual Clinical Congress, scheduled for October 23-77, 2011, in San Francisco, CA. Be sure to visit http://www.facs.org in the coming months for more details regarding the educational program, registration, housing and transportation.
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Norfolk, VA

Richard J. Finley
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Treasurer
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Patricia J. Numann
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Robert R. Bahnson
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Columbus, OH
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*New York, NY*

Margaret M. Dunn  
*General surgery*  
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*Dayton, OH*

Julie A. Freischlag  
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William Stewart Halsted Professor and surgeon-in-chief, The Johns Hopkins Hospital  
*Baltimore, MD*

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Calgary, AB

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Private practice
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Joseph I. and Barbara Ashkins Professor of Surgery, and professor of obstetrics and gynecology, Mayo Clinic
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Louisville, KY
Board of Regents/Board of Governors’ Executive Committee

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New York, NY

Howard M. Snyder III
Urology
Associate director of pediatric urology, The Children’s Hospital of Philadelphia; and professor of urology, University of Pennsylvania School of Medicine
Philadelphia, PA

Michael J. Zinner
General surgery
Moseley Professor of Surgery, Harvard Medical School; clinical director, Dana-Farber/BWH Cancer Center; and surgeon-in-chief, Brigham and Women’s Hospital
Boston, MA

Henri R. Ford
Vice-Chair, Board of Governors
Pediatric surgery
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Los Angeles, CA

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Pediatric surgery
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Otolaryngology
Joseph P. Riddle
Distinguished Professor of Otolaryngology, professor of otolaryngology–head and neck surgery, and professor and chief of head and neck oncology, University of North Carolina Neurosciences Hospital
Chapel Hill, NC

Timothy C. Flynn
Chair, Board of Governors
Vascular surgery
Senior associate dean, clinical affairs, University of Florida College of Medicine
Gainesville, FL

Lena M. Napolitano
Secretary, Board of Governors
General surgery
Division chief, acute care surgery; associate chair for critical care; and professor of surgery, University of Michigan Health Systems
Ann Arbor, MI

ACS Officers and Regents
New CPT codes and code changes for 2011

by Jenny Jackson, MPH

The coding manual for Current Procedural Terminology (CPT) 2011 comprises several new codes and code changes pertaining to general surgery and closely related specialties. This article summarizes these modifications. This information should be useful not only to surgeons, but also to the office staff who perform coding functions.


Debridement

The CPT section on Excision and Debridement has been revised to refer only to Debridement. All wound debridements are now reported by depth of tissue removed and by surface area of the wound. 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.

Codes 11040 and 11041, previously used to report debridement of partial or full thickness skin, have been deleted. To report debridement of skin (that is, dermis or epidermis), use the active wound care management codes 97597 and 97598.

Codes 11042, 11043, and 11044, previously used to report debridement of subcutaneous tissue, muscle, or bone, respectively, have been revised as well. These three codes are now used to report debridement of the first 20 sq cm or less of tissue, muscle, or bone. 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 which codes to report, keep in mind that the CPT code numbers are in non-sequential order. 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.

The active wound care management codes, 97597 and 97598, have also been revised to report the first 20 sq cm or less of total wound surface area (97597) and each additional 20 sq cm, or part thereof, of total wound surface area (97598).

Incision and drainage

CPT code 20000, previously used to report a superficial incision of a soft tissue abscess, has been deleted. For correct reporting of cutaneous/subcutaneous incision and drainage procedures, see code 10060, Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single, or code 10061, Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple. For subfascial incision and drainage procedures of a soft tissue abscess (for example, below the deep fascia), use 20005.

Sentinel lymph node mapping

Sentinel lymph node analysis has become the standard of care for initial regional lymph node assessment, replacing complete regional lymph node dissection for most patients. Codes exist for lymph node biopsy and complete regional dissection. Surgeons now have a code for accurate reporting of sentinel node mapping technique. New add-on CPT code 38900, Intraoperative identification (eg, mapping) of sentinel lymph node(s), includes injection of non-radioactive dye, when performed (List separately in addition to code for primary pro-

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.
procedure), is reported in conjunction with 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745. Use modifier 50 to report bilateral sentinel lymph node mapping. Injection of radioactive tracer for identification of sentinel node is reported separately as it is typically performed outside the operating room, prior to the primary procedure, and often by clinicians other than surgeons.

Biopsy of stomach
Code 43600, previously used to report gastric biopsy using a peroral hydraulically operated tube, has been deleted as an obsolete procedure that other endoscopy procedures have replaced.

Biliary tract
CPT has revised two codes to distinguish between open and percutaneous cholecystostomy. Code 47480 was revised to distinguish it as an open procedure to report cholecystostomy or cholecystotomy. Code 47490, percutaneous cholecystostomy, was revised to include imaging guidance, catheter placement, cholecystogram, and radiological supervision and interpretation as inherent components.

Intraoperative placement of fiducial markers
Two new add-on codes are available to report intraoperative placement of fiducial markers for radiation therapy guidance. 49412, Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intrabdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure, and 49327, Laparoscopy, surgical: with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure). These two add-on codes for open and laparoscopic placement complement the code for percutaneous placement of fiducial marker(s), 49411. Other codes for placement of fiducial marker(s) for radiation therapy guidance include 31626, 32553 (lung), and 55876 (prostate).

Intraperitoneal catheter
The family of codes related to insertion of an intraperitoneal catheter has been revised. The old terminology that referenced a rigid cannula and distinguished between temporary versus permanent is no longer common practice and caused confusion among coders. Code 49420, previously used to report insertion of a temporary intraperitoneal catheter for dialysis or drainage, has been deleted. Code 49421 has been revised to report the open insertion of tunneled intraperitoneal catheter for dialysis. For open or percutaneous peritoneal drainage, codes 49060, 49061, 49062, 49080, 49081 would be reported. For percutaneous placement of an intraperitoneal catheter (for several different diagnoses), a new code was created: 49418, Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous. Separately, the code to report laparoscopic placement of an intraperitoneal catheter was revised to incorporate the current terminology of tunneled catheter, instead of cannula: 49324, Laparoscopy, surgical; with insertion of tunneled intraperitoneal catheter.

Subsequent observation care
Subsequent observation care, per day, is now reported with a series of new codes (99224, 99225, 99226), resulting in the ability to report observation services that extend beyond the initial day of service. These codes are comparable to subsequent hospital care, but are reported for patients admitted for observation instead of inpatient services. All levels of subsequent observation care include reviewing the medical records, results of diagnostic studies, and changes in the patient’s status (for example, changes in history, physical condition, and response to management) since the last assessment by the physician.

Coding highlight—debridement
The integumentary system subsection of CPT 2011 comprises numerous new, revised, and deleted codes; indeed, even the guidelines for continued on page 50
<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>20000</td>
<td>Code deleted. Incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial (see 10060, 10061)</td>
</tr>
<tr>
<td>▲ 20005</td>
<td>Incision and drainage of soft tissue abscess, subfascial (eg, involves the soft tissue below the deep fascia)</td>
</tr>
<tr>
<td>● +38900</td>
<td>Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>43600</td>
<td>Code deleted. Biopsy of stomach; by capsule, tube, peroral (one or more specimens)</td>
</tr>
<tr>
<td>▲ 47480</td>
<td>Cholecystotomy or cholecystostomy, open, with exploration, drainage, or removal of calculus (separate procedure)</td>
</tr>
<tr>
<td>▲ 47490</td>
<td>Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation</td>
</tr>
<tr>
<td>CPT code</td>
<td>CPT descriptor</td>
</tr>
<tr>
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<td>----------------------------------------------------</td>
</tr>
<tr>
<td>▲ 49324</td>
<td>Laparoscopy, surgical; with insertion of tunneled intraperitoneal catheter</td>
</tr>
<tr>
<td>● +49327</td>
<td>Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+49412</td>
<td>Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>● 49418</td>
<td>Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous</td>
</tr>
<tr>
<td>▲ 49419</td>
<td>Insertion of tunneled intraperitoneal catheter, with subcutaneous port (eg, totally implantable)</td>
</tr>
<tr>
<td>49420</td>
<td>Code deleted. Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary (see 49060-49062, 49080-49081, 49418, 49421, as appropriate)</td>
</tr>
<tr>
<td>▲ 49421</td>
<td>Insertion of tunneled intraperitoneal catheter for dialysis, open</td>
</tr>
<tr>
<td>▲ 49422</td>
<td>Removal of tunneled intraperitoneal catheter</td>
</tr>
<tr>
<td>● 99224</td>
<td>Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: Problem-focused interval history; problem-focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
<tr>
<td>● 99225</td>
<td>Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem-focused interval history; an expanded problem-focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
<tr>
<td>● 99226</td>
<td>Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: A detailed interval history; a detailed examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
</tbody>
</table>

*new code; ▲ revised code; + add-on code*
their use have changed. The following example is intended to clarify the correct use of the new and revised debridement codes.

A young man who was rollerblading fell and suffered injuries to the palmar surface of both hands and the anterior aspect of his right leg. No bones were fractured. His right hand required minimal wound cleaning of a 4 cm x 4 cm area of erythematous epidermis. His left hand required debridement through the subcutaneous tissue of a 3 cm x 10 cm area. His right leg required debridement down to and including bone of a 5 cm x 10 cm area.

Reportable procedures for this example include the following:

- 97597, Debridement of skin, ie, epidermis and/or dermis, first 20 sq cm, right hand
- 11042-59-51, Debridement, subcutaneous tissue, first 20 sq cm, left hand
- +11045, Debridement, subcutaneous tissue, additional 20 sq cm, or part thereof, left hand
- 11044-59-51, Debridement, bone, first 20 sq cm, right leg
- +11047, Debridement, bone, each additional 20 sq cm, right leg
- +11047, Debridement, bone, each additional 20 sq cm, right leg

The procedure on his right hand involved debridement of epidermis. Revised codes 97597 and 97598 are used to report debridement of the first 20 sq cm of skin and each additional 20 sq cm of skin, respectively. Because only 16 sq cm of skin required debridement, only code 97597 would be reported.

The procedure on the left hand involved debridement of a 30 sq cm area of subcutaneous tissue. Code 11042 would be reported for the first 20 sq cm and add-on code 11045 would be reported for the remaining 10 sq cm of 30 sq cm total wound surface.

The procedure on his right leg included debridement of bone. Code 11044 would be reported for the first 20 sq cm, and add-on code 11047 would be reported twice for the second 20 sq cm and the remaining 10 sq cm of 50 sq cm total wound surface. Note that codes 11010–11012 would not be correct because there was no fracture in either hands or the leg.

The debridement on the right hand and right leg were separate wounds at separate operative sites and depths, so modifier 59 (distinct procedural service) should be appended to the primary procedures 11042 and 11044. Additionally, 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, please feel free to contact Jenny Jackson at jjackson@facs.org or 202-672-1506. If you have additional coding questions, contact the Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain Time, holidays excluded.

Ms. Jackson is Practice Affairs Associate, Division of Advocacy and Health Policy, Washington, DC.
Each year, injuries remain a leading cause of death for Americans of all ages, regardless of gender, race, or economic status. In fact, injuries accounted for more than 170,000 deaths in 2005. With so many people injured each year, the American College of Surgeons (ACS) and its Committee on Trauma (COT) are committed to supporting various legislative efforts to protect patients.

To help the ACS COT carry out its mission, the State Affairs staff of the ACS Division of Advocacy and Health Policy tracked approximately 210 injury prevention bills during the 2010 legislative session, focusing on injury prevention resulting from, among other measures, restrictions on distracted driving and requirements for motorcycle drivers and riders to wear helmets.

**Distracted driving**

Driver inattention is a leading factor in many crashes, and cell phone use while driving is one of the most common distractions. The National Highway Traffic Safety Administration estimates that in 2008 (the most recent year for which data is available), 5,870 people lost their lives, and another 515,000 were injured in crashes in which one form of distraction was noted on the police report. The Centers for Disease Control and Prevention has noted that the proportion of drivers reportedly distracted at the time of a fatal crash has increased from 8 percent in 2004 to 11 percent in 2008. Many states are introducing and enacting laws, such as banning texting or hand-held cell phones while driving, to help raise awareness about the dangers of distracted driving and to keep it from occurring.

Many state legislatures tackled the issue of distracted driving in 2010, with 31 states introducing distracted driving legislation; Iowa alone debated 14 related bills. The Iowa legislature ultimately succeeded in passing legislation, specifically H.F. 2456, pertaining to distracted driving. Other states—Connecticut, Delaware, Georgia, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Nebraska, Oklahoma, Vermont, Washington, Wisconsin, and Wyoming—passed similar laws in 2010. A jurisdiction-wide ban on driving while talking on hand-held cell phones is now in place in nine states—California, Connecticut, Delaware, Maryland, New Jersey, New York, Oregon, Utah, Washington—and the District of Columbia. The use of all cell phones while driving a school bus is prohibited in 19 states and the District of Columbia. The use of all cell phones by novice drivers is restricted in 28 states and the District of Columbia. Text messaging is banned for all drivers in 30 states and the District of Columbia.

The effectiveness of distracted driving legislation remains debatable. Some legislators wonder if roadways will see a significant decrease in the number of accidents resulting from distracted driving in states that have enacted distracted driving legislation. However, in September 2010 at the Distracted Driving Summit in Washington, DC, U.S. Transportation Secretary Ray LaHood had some encouraging news from the nation’s roads. Deaths related to distracted driving fell by...
6 percent in 2009, Mr. LaHood stated, and injuries associated with distracted driving declined by 4 percent.\(^5\)

**Helmets**

Motorcycle fatalities have steadily increased over the past decade. These deaths increased 7 percent, from 4,837 in 2006 to 5,154 in 2007. Per vehicle mile traveled in 2007, motorcyclists were about 37 times more likely than passenger car occupants to die in a motor vehicle traffic crash, and nine times more likely to be injured.\(^6\) These staggering statistics reinforce the College’s commitment to supporting motorcycle helmet legislation, particularly efforts to enact and sustain universal helmet laws for motorcycle riders. The ACS Statement in Support of Motorcycle Helmet Laws recognizes the importance of helmet legislation for a number of reasons, including the following:

- Helmeted motorcycle riders have up to an 85 percent reduced incidence of severe, serious, and critical brain injuries compared with unhelmeted riders
- Unhelmeted motorcyclists are more than three times more likely to suffer a brain injury when compared with helmeted motorcyclists
- The average inpatient care costs for motorcyclists who sustain a brain injury are more than twice the costs incurred by hospitalized riders without a brain injury\(^7\)

Currently, 20 states have a universal helmet law in place, which requires all motorcycle operators and passengers to wear a helmet; laws requiring only some motorcyclists to wear a helmet (usually riders or passengers under a certain age) are enforced in 27 states; and three states—Illinois, Iowa, and New Hampshire—have no helmet law in place. During the 2010 legislative session, 15 states introduced motorcycle helmet legislation, and six states introduced bills in an effort to strengthen their existing helmet laws. Illinois and New Hampshire both introduced legislation that would have enacted a universal helmet law, but the legislative sessions in both of those states adjourned with little movement on those bills.

The majority of the bills that were introduced in 2010 were legislative efforts to repeal the universal law to exempt riders older than 21 years from wearing a helmet. Michigan was the only state to introduce legislation (H.B. 4747) that would have fully repealed the helmet law. H.B. 4747 was passed by the House before stalling in the Senate. Michigan is likely to introduce similar legislation in 2011.

For additional information on injury prevention legislation, contact Alexis Macias, Regional State Affairs Associate, at amacias@facs.org.\(^3\)

### References


Ms. Macias is Regional State Affairs Associate, Division of Advocacy and Health Policy, Chicago, IL.
Presiding President LaMar S. McGinnis, Jr., MD, FACS, presented the first Lifetime Achievement Award of the American College of Surgeons (ACS) to C. Rollins Hanlon, MD, FACS, at the Convocation ceremony that preceded the 96th Clinical Congress in Washington, DC.

“It is fitting that the Honors Committee of the College has selected an individual who has devoted a lifetime to his chosen art by not only providing skilled, ethical, and loving care to thousands of surgical patients in his long and illustrious career, but also by serving in many roles and sharing his vast knowledge with our beloved College since becoming a Fellow in 1953,” Dr. McGinnis said.

“He exemplifies the highest professional and personal standards and has provided mentorship, guidance, and direction for many of us in this room tonight and countless others around the globe.”

After receiving his medical degree at Johns Hopkins University in 1938 and surgical residency education at Johns Hopkins; Cincinnati General Hospital; and University of California, San Francisco, Dr. Hanlon returned in 1946 from service in the U.S. Navy overseas to a surgical faculty position at Johns Hopkins.

From 1950 to 1969, he served as surgeon-in-chief and departmental chairman at St. Louis University before assuming the Directorship of the ACS from 1969 to 1986. He was a Regent of the ACS from 1967 to 1969 and President of the College from 1987 to October 1988. He has served as voluntary Executive Consultant to the College for the past 22 years.

Dr. Hanlon belongs to 30 medical and surgical societies and has been president of six, including the Society of University Surgeons, the Society for Vascular Surgery, and the American Surgical Association. He is an Honorary Fellow of the surgical colleges of Australia, New Zealand, Canada, England, Ireland, and South Africa.

He has chaired the American Board of Surgery, the Surgery Study Section of the National Institutes of Health, and the...
Coordinating Council on Medical Education. He founded and served as president of the Warren and Clara Cole Foundation and is a board member of several medical-related foundations, including the American College of Surgeons Foundation. He has a particular interest in facilitating the archival work of the College.

Dr. Hanlon is emeritus professor of surgery at Northwestern Feinberg School of Medicine and serves as a senior editor of the *Journal of the American College of Surgeons.*

Dr. Hanlon has been married to Margaret Hammond Hanlon, MD, a skilled pediatric specialist, for 61 years. They have eight children, eight grandchildren, and two great-grandchildren.

Carlos A. Pellegrini elected Chair of Board of Regents

Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), a general surgeon from Seattle, WA, was elected Chair of the American College of Surgeons (ACS) Board of Regents during the College’s annual Clinical Congress in Washington, DC. Dr. Pellegrini is the Henry N. Harkins Professor and chair, department of surgery, at the University of Washington (UW).

Dr. Pellegrini will work closely with ACS Executive Director David B. Hoyt, MD, FACS, in his leadership role as Chair of the Board of Regents, and in that capacity, he will chair the Regents’ Finance and Executive Committees. The College’s 22-member Board of Regents formulates policy and is ultimately responsible for managing the affairs of the College. The Board’s diversity and the variety of experiences and interests among its members enable the Regents to represent views related to myriad issues in contemporary surgery.

Dr. Pellegrini received a medical degree in 1971 from the University of Rosario Medical School in Argentina. After training in general surgery in Argentina, he completed a second residency at the University of Chicago. Today, he is a world leader in the field of minimally invasive gastrointestinal surgery. Dr. Pellegrini is a pioneer in the development of videoendoscopy for the surgical treatment of gastroesophageal reflux disease and esophageal motility disorders, particularly achalasia. At UW, he founded the Center for Videoendoscopic Surgery and the Center for Gastric and Esophageal Surgery. He also developed the UW Institute for Simulation and Interprofessional Studies and is currently the chair of its board.

A Fellow of the College since 1982, Dr. Pellegrini began serving on the Board of Regents in 2001 and served as Vice-Chair of the Board, 2009–2010. Dr. Pellegrini has also served on a number of College committees, often assuming a leadership role. He was Chair of the Central Judiciary Committee (2005–2009); Vice-Chair of the Board of Regents Finance Committee (2009–2010); Chair of the Medical Motion Pictures Committee (1993–1994); and Chair of the International Guest Scholars Subcommittee of the International Relations Committee (1988–1987). In addition, he served as President of the Northern California Chapter of the ACS (1990–1991).

Dr. Pellegrini’s service to the surgical profession hasn’t been limited to the work done on behalf of the College. He has also served as a director...
of the American Board of Surgery, president of the Society of Surgical Chairs, chair of the Digestive Disease Week Council, and president of the American Surgical Association. Currently, he is president-elect of the World Organization for Specialized Studies on Diseases of the Esophagus.

Dr. Pellegrini publishes regularly in the field of minimally invasive surgery for upper gastrointestinal diseases, esophageal cancer, and related areas, as well as in the field of training and new technologies for preparing surgeons in this area. His bibliography lists more than 300 articles, chapters, editorials, and books, as well as 11 surgical videos and movies.

Call for nominations for the ACS Board of Regents

The 2011 Nominating Committee of the Board of Governors has the task of selecting three nominees for pending vacancies on the Board of Regents, to be filled during the 2011 Clinical Congress in San Francisco, CA. The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents:

• Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
• Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
• Recognition of the importance of their representing all who practice surgery
• Also to be taken into consideration are geography, surgical specialty balance, and academic or community practice
• The College encourages consideration of women and other underrepresented minorities
• Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents

Priority consideration for two of the seats should be given to representatives of general surgery. The third seat is a Bylaws-designated Canadian seat, and therefore, only Canadian Fellows should be considered for this position.

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Monday, February 28, 2011.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Board of Governors, at psprecksel@facs.org.

For information purposes only, the current members of the Board of Regents who will be considered for re-election are as follows: Mark A. Malangoni, MD, FACS; and Valerie W. Rusch, MD, FACS.

Did you know... THAT YOU CAN NOW RECEIVE MORE of the latest information from Surgery News? The College has launched Surgery News UPDATE, a monthly e-newsletter created in partnership with Elsevier Global Medical News. As an offshoot of the official newspaper of the ACS, Surgery News UPDATE will help keep you on top of emerging surgical trends, results of breaking clinical trials, and important developments in the various fields of surgery. Professional medical journalists attend the meetings and review the literature in order to keep you current in your specialty. Visit http://www.facs.org/surgerynews/update/index.html to start receiving this essential, authoritative—and free—resource.
Membership in the American College of Surgeons?

HERE’S WHY IT’S IMPORTANT:

AS A BODY REPRESENTING ALL OF SURGERY, THE COLLEGE:
- Provides a cohesive voice addressing societal issues related to surgery.
- Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
- Is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients.
- Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

THERE IS STRENGTH IN NUMBERS.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to shape the College’s agenda for the future.

If you aren’t a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain that status and consider getting involved in the work of the College.

Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

HERE ARE SOME OF THE MANY BENEFITS BEING A MEMBER OF THE COLLEGE AFFORDS YOU:
- Access to the College’s free coding consultation hotline
- Subscription to ACS NewsScope, the College’s weekly electronic newsletter
- Subscription to the Bulletin of the American College of Surgeons
- Subscription to the Journal of the American College of Surgeons
- Access to Maintenance of Certification tools
- Access to all College-sponsored insurance, credit card, and other helpful programs
- Free posting of resume on ACS Career Opportunities

Information on becoming a member of the College and an application form are available online at www.facs.org/memberservices/documents.html or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800-293-9623, or via e-mail at chicks@facs.org.
The 2011 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College:

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College
- Recognition of the importance of their representing all who practice surgery
- Consideration of women and other underrepresented minorities

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Monday, February 28, 2011.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Fellows, at psprecksel@facs.org.

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Call for nominations for ACS Officers-Elect

The 2011 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College:

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice
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Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to memberservices@facs.org by Monday, February 28, 2011.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Fellows, at psprecksel@facs.org.

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January 2011 Bulletin of the American College of Surgeons

57
ATLS® inaugurates course in France

by John Kortbeek, MD, FACS; Pedro Pereira, MD, FACS; Eric Voiglio, MD, FACS; and Jasmine Alkhatib

Only a month after training in Switzerland, representatives of the Advanced Trauma Life Support® (ATLS) program in France held their ATLS inaugural course in Lyon, under the auspices of Société Française de Chirurgie d’Urgence, July 5–9, 2010. Dr. Voiglio (co-author of this article) provided outstanding leadership for the French team, with support from the ATLS Europe group.

The instructor candidates, who demonstrated enthusiasm throughout the courses, included Jean-Yves Maritano, MD; Frederic Rongieras, MD; Yoann Baudoin, MD; Vincent Dubuisson, MD; and Benoit Frattini, MD. As for international faculty, Dr. Kortbeek (Canada, ATLS International Course Director, and co-author of this article); Dr. Pereira, (Portugal, ATLS Europe Chair, and co-author of this article); Patrick Schoettker, MD, FACS (Switzerland, ATLS Instructor); and Domenic Scharplatz, MD, FACS (Switzerland, ATLS Instructor) participated in the student course. Pascale Lavieville (France), Frederic Lodier (France), Laura Bruna (Italy, ATLS Europe), and Ms. Alkhatib (U.S., ATLS International Coordinator, and co-author of this article) served as the course coordinators. Raphael Bonvin, MD (ATLS-Switzerland), led the Instructor course discussions as the educator.

Dr. Kortbeek (right) provides feedback to instructor candidates.

ATLS instructor course in France.
The course participants represent a variety of prehospital, emergency medicine, and surgical specialties. As a result, the dialogue during the courses provided interesting insight into some unique aspects of the French trauma system, including where ATLS could support current training and development. Furthermore, ATLS faculty members were able to appreciate the strong system of medical education and prehospital care in France.

Lyon, France’s second city in terms of size and popularity among tourists, was the center of Roman Gaul and served as a major cultural and communication hub. A United Nations Educational, Scientific and Cultural Organization World Heritage Site, today Lyon is well known as a center of French gastronomy. It is also famous for its two rivers, the Rhône and the Saône, and some consider Beaujolais wine to be Lyon’s third river. Additionally, Lyon has a tremendous history of contribution to the art and science of surgery and medicine. Famous citizens and graduates include:

- Léopold Ollier (1830–1900), who has been called the Father of Orthopaedic Surgery
- Léon Bérard (1870–1956), a neck surgery specialist, who was the first to perform major thoracoplasties
- Alexis Carrel (1873–1944), who was awarded the Nobel Prize in Physiology or Medicine

Lyon serves as the administrative center of ATLS in France, and additional course sites are to be planned; Bordeaux has shown early interest.

Dr. Voiglio and his team have set the stage for a strong beginning in France. The ATLS Committee, the Committee on Trauma of the ACS, and ATLS Europe welcome France to the ATLS family.

Dr. Kortbeek is the ATLS International Course Director, Calgary, AB.

Dr. Pereira is the ATLS Europe Chairman, Lisbon, Portugal.

Dr. Voiglio is the ATLS France Chairman, Lyon, France.

Jasmine Alkhatib is the ATLS International Coordinator, 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.

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

by John Kortbeek, MD, FACS; Claus Falck Larsen, MD, FACS; and Will Chapleau, EMT-P, RN, TNS

Nigeria, Africa’s most populous country, held initial Advanced Trauma Life Support® (ATLS) student and instructor courses July 10–14, 2010. The inaugural ATLS courses were held at the Garki Hospital in Abuja, the nation’s capital, which is a planned city constructed in the heart of the country. It was designated in the 1970s, with most of the construction occurring since 1980.

The Nigerian Orthopaedic Association and the Nigerian Emergency Response Service hosted the ATLS program. Nnamdi Nwauwa, MD, FACS, led the initiative, and Bob Yellowe, MD, FACS, served as the initial course director. The Nigerian faculty previously completed training in Fujairah, United Arab Emirates (UAE), with the support of the ATLS Middle East group in October 2009. The course in Nigeria had very strong representation from orthopaedic surgery.

The instructor candidates included Bob Yellowe, MD; Dr. Nwauwa; Philip Eymina, MD; Giwa Suleiman, MD; Odu-nubi Olurotimi, MD; and Nkele Chinyere, MD.

International faculty included Dr. Larsen (Denmark, co-author of this article); Dr. Kortbeek (Canada, co-author of this article), Saud Al Turki, MD, FACS (Saudi Arabia); Subash Gautam, MD, FACS.
(UAE); Andrew Baker, MD, FACS (South Africa); Ayoola Ali, MD (U.S.), Mr. Chapleau (U.S., co-author of this article), and Diane Chetty (UAE). The initial Educator Candidate was Chineze Nwauwa, MD.

Opening ceremonies were attended by a number of Nigerian dignitaries, such as Prof. Onyebuchi Chukwu, the honorable Nigerian Minister of Health.

With nearly 155 million inhabitants, Nigeria possesses one of the continent’s most rapidly growing economies. Injury rates are rising in Nigeria and lifetime risk of death due to injury now exceeds 10 percent. The introduction of ATLS is one of several initiatives under way to address this serious health issue.

The students attending the course represented districts from across the country and participated with much enthusiasm and energy. The course was enhanced by a fantastic social program that included traditional Nigerian dance and cuisine, as well as an enjoyable evening watching the World Cup. The ACS is pleased to welcome Nigeria to the ATLS family.

**Dr. Kortbeek** is the ATLS International Course Director, Calgary, AB.

**Dr. Larsen** is ATLS Region 15 Chairman, Copenhagen, Denmark.

**Mr. Chapleau** is ATLS Program Manager, Chicago, IL.
The National Ultrasound Faculty of the American College of Surgeons has developed “Ultrasound for Surgeons: The Basic Course, 2nd Edition” on CD-ROM for surgeons, surgical residents, and anyone interested in ultrasound imaging.

The 2nd Edition includes:

♦ Updated graphics using 3-D medical modeling developed by NASA researchers to teach ultrasound and rapidly demonstrate key ultrasound skills
♦ Targeted clinical applications are highlighted, including Head and Neck, Breast, Vascular, Abdominal, Thoracic, Critical Care/Trauma, Foreign Objects, and Fractures
♦ Cue Cards to view and print to prompt learners on three commonly performed scans
♦ Easier navigation and support of the CD-ROM
♦ Four CME credits available

The CD-ROM provides the learner with basic education and training in ultrasound imaging as a foundation for specific clinical applications.

To purchase the NEW edition, go to www.acs-resource.org or call 888-711-1138.
Chapters use strategic planning as a management tool

by Mary H. McGrath, MD, MPH, FACS

In addition to these one-day programs, sessions on conducting and performing strategic planning have been presented at the annual Leadership Conference for Chapter Leaders and at Chapter Showcase sessions, which are provided during the Clinical Congress. Also, there are a few chapters, such as Ohio and Virginia, that conduct strategic planning on a regular basis. Chapters interested in scheduling a planning session should contact the Division of Member Services at 888-857-7545.

To help the ACS chapter leaders prepare for the strategic planning session, background information is sent to the participants ahead of time. The surgeons and staff who are planning the meeting try to include any material that offers focus on the issues, and that discusses choices that the planning process should address.

In general, the background materials include membership and financial reports, administrative and governance documents, and historical patterns of growth and member involvement. Compiled from chapter and ACS databases, materials often include the following:

• Financial statements for the previous three to five years
• Membership counts for the previous three to five years, including statistics on specialty, practice location, age, dues-paying status, gender, and age
• Annual meeting information for the previous three to five years, including programs, dates, attendance figures, expenses, revenues, setting, vendor participation, and evaluations
• Minutes or summaries of previous board/council meetings

for the previous three to five years

• Bylaws with a description of officers and committee structure
• Newsletters, e-mail lists, or other communication vehicles

The program opens with an overview of strategic planning as a tool for identifying common goals, defining direction, and focusing on what’s important for success. The first part of the planning session is devoted to a thorough response to the following questions: Why does the chapter exist? What makes the chapter relevant? What does the chapter aspire to achieve? From this discussion flows development of a tailored mission statement that sets out the fundamental purpose of the chapter. (The mission statements from the chapters that have participated in these strategic planning sessions are listed in Table 2 on page 65.)

With a mission statement in place, a situation analysis of the chapter’s environment is done through a detailed SWOT analysis (strengths, weaknesses, opportunities, and threats). This creates a clearer picture of the chapter’s situation, including demographic changes, financial trends, marketing success, competition from other organizations, and other factors. This analysis, which can include several dozen data points, exposes issues for deeper discussion, and from this, the chapter participants must come to agreement on specific priorities. They then can move
into articulating goals and objectives, and crafting a strategic action plan that will serve as a blueprint for carrying the chapter forward.

While only eight chapters have participated in these planning sessions supported by the College, a few key issues and goals have emerged:

• Large or small, leaders in these chapters have expressed the need to be more active and involved with advocacy. Whether engaging with the state medical society, hiring a lobbyist, or concentrating on statewide trauma care and systems planning, advocacy has been identified as a service and benefit that chapters are uniquely qualified to provide.

• Electronic communications—including newsletters and websites—have consistently been identified as “must-haves” by the chapter leaders. These

Table 2

ACS mission statement: The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>The mission of the Alabama Chapter of the ACS is to be an effective voice for surgeons and to advance the highest standards of ethical patient care through education, mentorship, fellowship, and advocacy.</td>
</tr>
<tr>
<td>Iowa</td>
<td>The Iowa Chapter of the American College of Surgeons is dedicated to promoting the highest standards of surgical care through fellowship, education, and advocacy.</td>
</tr>
</tbody>
</table>
| Louisiana      | The mission of the Louisiana Chapter of the ACS is to:  
• Support the standards and directives of the ACS in Louisiana  
• Advance the art and science of surgery in Louisiana through continuing education of Louisiana surgeons  
• Further communication and camaraderie among Louisiana surgeons  
• Provide a forum for young surgeons  
• Provide a means through which Louisiana surgeons can cooperate with other professional, political, and civic organizations in promulgating good health among Louisiana citizens  
• Advocate for safe, effective surgical care for Louisiana citizens |
| Keystone (PA)  | The mission of the Keystone Chapter of the ACS is to provide a regional voice for surgeons in all specialties, be an advocate for its members and the patients they serve, provide educational opportunities for its members, and to encourage the highest standards of ethical surgical practice. |
| New York       | The New York Chapter of the ACS advocates for Fellows of the American College of Surgeons in New York State, assists the federal lobby efforts of the ACS, and provides continuing medical educational activities for its members. |
| South Texas    | The mission of the South Texas Chapter is to improve quality of care through enhancing surgical education, maintenance of competency, providing a forum for young surgeons and fostering communication with all fellows, and to support the goals of the American College of Surgeons. |
| Tennessee      | The mission of the Tennessee Chapter is to improve the health of the people of Tennessee and the Southeastern Region of the U.S. by promoting the ethical practice of the art and science of surgery. |
can focus on communication among surgeons, outreach to residents and students, and/or referral databases and websites for patients.

- Universally, chapter leaders have expressed the need to involve and engage more members in the activities and programs of the chapters. In some instances, chapters plan to expand their governing councils (or board of directors) to be more inclusive by adding young surgeons, academic surgeons, and community-based surgeons. Other chapters intend to improve their education offerings by delegating the planning and development activities to a larger number of members, including surgical residents.

Dr. McGrath is professor of surgery, division of plastic surgery, University of California, San Francisco. She is a former Regent and First Vice-President of the College.

Become a surgeon advocate at JSAC 2011

by Catharine Harris

Following one of the most exciting and unpredictable midterm elections last November, the 112th session of Congress features many new faces, and the American College of Surgeons (ACS) and other surgical societies are working to build relationships and educate new members of Congress regarding the issues that are important to surgeons and their patients.

In recent years, the ACS and a wide range of other surgical societies, with a combined membership exceeding 250,000, have been working together as a coalition to amplify surgery’s collective voice on Capitol Hill. One of the most successful collaborations has been the annual Joint Surgical Advocacy Conference (JSAC) in Washington, DC.

The Fourth Annual JSAC will take place March 27–29 at the JW Marriott Hotel, which is located near the U.S. Capitol and the White House. Registration will open in January. A link to the registration website will be e-mailed to all U.S. members of the College once it is activated.

**JSAC highlights**

Although many surgical societies, including the College, have professional lobbyists in Washington, there is no substitute for the power of hundreds of surgeons—as both constituents and experts in their fields—blanketing Capitol Hill to voice their views to their senators and representatives. By the end of the conference, surgeons will be armed with the political skills necessary to be effective advocates.

The conference begins with in-depth beginner or advanced advocacy training to prepare attendees for their Capitol Hill meetings. Based on recommendations received at the 2010 conference, JSAC 2011 will also feature a resident-specific advocacy workshop.

Participants in the 2010 JSAC indicated that they appreciated the opportunity to earn continuing medical education credits for attending the sessions on practice management and contract negotiations; CME credits will also be available this year.

Each year, the conference features speakers representing...

JSAC attendees also have the opportunity to meet with surgical society staff to get an overview of current legislation affecting surgeons, in-depth analysis of the sponsoring societies’ position on the issues, and tips for lobbying House and Senate offices. At press time, much of the legislation that will be affecting surgeons in March was still in flux; however, previous issues of focus have included replacing the flawed sustainable growth rate, addressing the surgical workforce crisis, developing meaningful medical liability reforms, and implementing health care reform.

On the final and most important day of JSAC, hundreds of surgeons join together on Capitol Hill to meet with their senators, representatives, or their health policy staff. These meetings provide surgeons with their chance to tell legislators their personal stories and illustrate how the decisions made by Congress affect the surgeons and surgical patients who live in their states and districts. The more surgeons who attend the JSAC lobby day, the harder it will be for Congress to ignore the surgical presence.

**Staying involved**

Although JSAC is an important occasion for surgeons to get involved politically, it is crucial to remember that advocacy is an ongoing process. The College recommends that surgeons who want to serve as advocates for the profession participate in the following additional activities:

- **Join the ACS Grassroots Network.** By visiting the website, [http://www.capitolconnect.com/acspa](http://www.capitolconnect.com/acspa), members of the College can follow the links to join the College’s Grassroots Network. Members of this group receive legislative updates, calls to action, and other pertinent advocacy information. Members of the Grassroots Network are called upon to meet with their legislators in their district offices, represent the College at various legislative and political functions, and personally deliver campaign contributions from surgery’s political action committee (PAC), the American College of Surgeons Professional Association (ACSPA)-Surgeons PAC. Grassroots Network members are encouraged to cultivate personal relationships with both senators and representative as a further means to advance the legislative goals of the College.
- **Build relationships with federal legislators.** Individual relationships with members of Congress and their staffs are critical to the success of

### 2010 JSAC participating societies

- American Academy of Facial Plastic and Reconstructive Surgery
- American Academy of Ophthalmology
- American Academy of Otolaryngology-Head and Neck Surgery
- American Association of Orthopaedic Surgeons
- American Association of Neurological Surgeons/Congress of Neurological Surgeons
- American Congress of Obstetricians and Gynecologists
- American College of Osteopathic Surgeons
- American College of Surgeons
- American Osteopathic Academy of Orthopaedics
- American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery
- American Society of Bariatric and Metabolic Surgery
- American Society of Anesthesiologists
- American Society of Breast Surgeons
- American Society of Cataract and Refractive Surgery
- American Society of Colon and Rectal Surgeons
- American Society of Plastic Surgeons
- American Urological Association
- Society of American Gastrointestinal and Endoscopic Surgeons
- Society of Gynecological Oncologists
- The Society of Thoracic Surgeons
- Society for Vascular Surgeons
surgery’s advocacy efforts on Capitol Hill. Here are some ways physicians can start to foster these relationships:

—Communicate with legislators’ offices on a regular basis, not just when a physician “needs something.”
—Set up in-district delivery of ACSPA-Surgeons PAC checks. This is a great way for physicians to get to know their members of Congress or to help foster existing relationships.
—Work with the ACS Division of Advocacy and Health Policy to set up a time for the physician’s member of Congress and/or his or her staff to tour the office and learn more about issues facing surgery.
—Host an in-district fundraiser for the greater physician community benefiting the physician’s member of Congress.

• Get involved in the ACSPA-Surgeons PAC. The ACSPA-Surgeons PAC elevates the College’s advocacy presence on Capitol Hill and allows College leadership and Washington staff to build critical relationships with lawmakers. The ACSPA-Surgeons PAC is bipartisan and contributes to the congressional campaigns of incumbents and candidates for federal office who are champions for surgery. For more information about ACSPA-Surgeons PAC, visit http://www.surgeonspac.org.

For additional information regarding the 2011 Joint Surgical Advocacy Conference, contact Catharine Harris at charris@facs.org or 202-672-1511.

Ms. Harris is Congressional Affairs Assistant, Division of Advocacy and Health Policy, Washington, DC.

International Surgical Week ISW 2011
August 28 – September 1, 2011, Yokohama, Japan

by the
International Society of Surgery ISS/SIC

“Exploring the Future of Surgery”

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

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

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

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The Joint Commission Cen-
center for Transforming Health-
care recently unveiled solutions
to critical patient safety chal-
lenges that surgeons and other
caregivers encounter every
day—breakdowns in commu-
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offs. An estimated 80 percent of
serious medical errors involve
miscommunication between
caregivers when responsibility
for patients is transferred or
handed off. Recognizing this
as a critical patient safety issue,
a group of 10 leading U.S. hos-
pitals and health care systems
team up with the Joint Com-
mission Center for Transform-
ing Healthcare to implement
new methods to find the causes
of, and put a stop to, these dan-
gerous and potentially deadly
breakdowns in patient care.

Health care organizations
have long struggled with the
process of passing necessary
and critical information about
a patient from one caregiver to
the next, or from one team of
caregivers to another. A hand-
off process involves “senders,”
the caregivers transmitting pa-
tient information and releasing
the care of the patient to the
next clinician, and “receivers,”
the caregivers who accept the
patient information and care
of the patient—for example,
surgeons and nurses involved
in the transfer of a patient from
surgery to the ICU.

A look at The Joint Commission

TJC tackles miscommunication
among caregivers

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surgery to the ICU.

The Hand-off Communications Project began in August
2009. During the measure
phase of the project, the par-
ticipating hospitals found that,
on average, more than 37 per-
cent of the time hand-offs were
defective and didn’t allow the
receiver to safely care for the
patient. Additionally, 21 per-
cent of the time senders were
dissatisfied with the quality of
the hand-off. Using solutions
targeted to the specific causes
of an inadequate hand-off, par-
ticipating organizations that
fully implemented the solu-
tions achieved an average 52
percent reduction in defective
hand-offs. Two of the partici-
pating hospitals examined the
transfer of patients from the
operating room to the inpatient
floor.

Although The Joint Com-
mission requires accredited
organizations to use a stan-
dardized approach to hand-off
communications, breakdowns
in communication have been
a leading contributing factor
in sentinel events, which are
unexpected occurrences involv-
ing death or serious physical or
psychological injury, or the risk
thereof. In addition to patient
harm, defective hand-offs can
lead to delays in treatment,
inappropriate treatment, and
increased length of stay in the
hospital.

Recognizing that there is no
quick fix for this problem, the
center and the participating
hospitals set out to solve the
problems through the appli-
cation of Robust Process Im-
provement™ (RPI) tools. RPI
is a fact-based, systematic, and
data-driven problem-solving
methodology that allows proj-
ect teams to discover specific
risk points and contributing
factors, and then develop and
implement solutions targeted
to those factors to increase
overall patient safety and
health care quality. Barriers to
effective hand-offs experienced
by receivers include incomplete
information, lack of opportu-
nity to discuss the hand-off,
and lack of a hand-off at all.
Senders identified too many
delays, receivers not returning
calls, or receiver unable to take
the report due to workload or
competing priorities, as rea-
sons for hand-off failures.

The targeted hand-off solu-
tions from the center, which
are described using the ac-
ronym SHARE, address the
specific causes of unsuccessful
hand-offs. SHARE refers to the
following:

• Standardize critical con-
ten. This step includes pro-
viding details of the patient’s
history to the receiver, empha-
sizing key information about
the patient when speaking with
the receiver, and synthesizing
patient information from sepa-
rate sources before passing it on to the receiver.

- **Hardwire within your system.** This step includes developing standardized forms, tools, and methods (such as checklists); identifying new and existing technologies to assist in making the hand-off successful; and stating expectations about how to conduct a successful hand-off.

- **Allow opportunity to ask questions.** This step includes using critical thinking skills when discussing a patient’s case, as well as sharing and receiving information as an interdisciplinary team (for example, a pit crew). Receivers should expect to receive all key information about the patient from the sender, receivers should scrutinize and question the data, and the receivers and senders should exchange contact information in the event there are any additional questions.

- **Reinforce quality and measurement.** This step includes demonstrating leadership commitment to successful hand-offs such as holding staff accountable, monitoring compliance with use of standardized forms, and using data to determine a systematic approach for improvement.

- **Educate and coach.** This step includes educating the organization’s teaching staff about what constitutes a successful hand-off, standardizing training on how to conduct a hand-off, providing real-time performance feedback to staff, and making successful hand-offs an organizational priority.

For more information on the hand-off communications project and the participants, and other projects related to the Center for Transforming Healthcare, visit [http://www.centerfortransforminghealthcare.org](http://www.centerfortransforminghealthcare.org).
The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at

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

Oral presentations

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

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

Poster presentations

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

Video presentations

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

Submission information

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

*Accepted authors are encouraged to submit full manuscripts to JACS.
Nominations sought for 2011 volunteerism and humanitarian awards

The American College of Surgeons, in association with Pfizer, Inc, is accepting nominations for the 2011 Surgical Volunteerism Award(s) and Surgical Humanitarian Award.

The ACS/Pfizer, Inc Surgical Volunteerism Award is given in recognition of those surgeons committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities. Surgeons of all specialties are eligible for each of these awards.

The awards for domestic, international, and military outreach are intended for ACS members in active surgical practice whose volunteerism activities go above and beyond the usual professional commitments, or retired Fellows who have been involved in volunteerism during their active practice and into retirement. Surgeons who have been involved in significant surgical volunteer activities during their postgraduate training are eligible for the resident award.

For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism in this case does not refer to pro bono or uncompensated care provided as a matter of necessity in most practices. Instead, volunteerism should be characterized by the prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gains.

The ACS/Pfizer, Inc Surgical Humanitarian Award is given in recognition of those surgeons whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for a surgeon who has dedicated a significant portion of his or her surgical career to full-time or near full-time humanitarian efforts rather than routine surgical practice. This effort may reflect a career dedicated to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received compensation for this work does not preclude a nominee from consideration, and, in fact, may be expected, based on the extent of the professional obligation.

Nominations will be evaluated by the Socioeconomic Issues Committee of the Board of Governors, with final approval of award winners by the Executive Committee of the Board of Governors.

Potential nominees should make note of the following:

- Self-nominations are permissible but require an outside letter of support
- Previous nominees are encouraged to be re-nominated but require an updated application
- Supplemental materials should be kept to a minimum and will not be returned

The nomination forms will be available for download from the “Announcements” section of the Operation Giving Back website during January and February at http://www.operationgivingback.org. Nomination forms can also be requested by mail, if preferred. Contact Kathleen M. Casey, MD, FACS, Director of Operation Giving Back Program, with such requests or any questions.

Completed nomination forms should be addressed to the attention of Selwyn Vickers, MD, FACS, Chair, Board of Governors’ Socioeconomic Issues Committee, and can be submitted electronically, or by mail c/o Dr. Kathleen Casey, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; 312-202-5458; fax 312-202-5021; kcasey@facs.org, or ogb@facs.org. All nominations must be received by Friday, February 25, 2011.
We reward loyalty. We applaud dedication. We believe doctors deserve more than a little gratitude. We do what no other insurer does. We proudly present the Tribute® Plan. We go way beyond dividends. We reward years spent practicing good medicine. We salute a great career. We give a standing ovation. We are your biggest fans. We are The Doctors Company.

You deserve more than a little gratitude for a career spent practicing good medicine. That’s why The Doctors Company created the Tribute Plan. This one-of-a-kind benefit provides our long-term members with a significant financial reward when they leave medicine. How significant? Think “new car.” Or maybe “vacation home.” Now that’s a fitting tribute. Our medical professional liability program has been sponsored by ACS since 2002. To learn more about our program for ACS members, including the Tribute Plan, call (800) 862-0375 or visit us at www.thedoctors.com/tribute.
Heller School Executive Leadership Program scholarships available

The American College of Surgeons (ACS) is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management (http://heller.brandeis.edu/academic/execed/index.html) at Brandeis University, in Waltham, MA. The 2011 course takes place June 1–7, and the $8,000 award is to be used toward the cost of tuition, travel, housing, and subsistence during the period of the course and the post-course follow-up period.

Two 2011 scholarships are reserved for general surgeons and are fully funded by the College. In addition, the College is very pleased that a large number of the surgical specialty societies have partnered with the ACS to co-sponsor a scholarship for a member in good standing of both the College and his or her surgical society. The participating societies supporting scholarships are the American Association of Neurological Surgeons, the American Association for the Surgery of Trauma, the American Pediatric Surgical Society, the American Society of Breast Surgeons, the American Society of Colon and Rectal Surgeons, the American Society of Plastic Surgeons, the American Surgical Association, the American Urogynecologic Society, the Eastern Association for the Surgery of Trauma Foundation, The Society of Thoracic Surgeons, and the Society for Vascular Surgery.

The American Urological Association (AUA) will also co-sponsor a health policy scholarship with the College, via the mechanism of the AUA’s Gallagher Scholars program (visit http://www.AUAnet.org/Gallagher).

General policies covering the granting of the scholarships are as follows:

• The award is open to surgeons who are general surgeons or members in good standing of one of the listed societies and of the ACS.
• The award is to be used to support the recipient during the period of the course and the following period of service. Indirect costs are not paid to the recipient or to the recipient’s institution.

• Applications for this scholarship consist of the following items:
  —The applicant’s current curriculum vitae
  —A one-page essay discussing why the applicant wishes to receive the scholarship

• Application for this award may be submitted even if comparable application to other organizations has been made. If the recipient accepts a similar scholarship from another agency or organization, the scholarship will be withdrawn. It is the responsibility of the recipient to notify the Schorships Section of the ACS, which administers this program, of competing awards.

• The scholarship must be used in the year for which it is designated. It cannot be postponed.
• The selected scholar is required to provide one year’s health policy-related assistance to the ACS and the co-sponsoring society, attending meetings, reviewing applications, and so forth, as requested by either organization.

• A brief report of the scholar’s experiences and activities is due at the conclusion of the course and again at the end of the scholarship period. A simple accounting is also required.

The closing date for receipt of applications is February 1, 2011. All applicants will be notified of the outcome of the selection process by March 31, 2011.

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

Please send applications for this scholarship to Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
College seeks nominations for Jacobson Promising Investigator Award

The American College of Surgeons is accepting nominations for the seventh Joan L. and Julius H. Jacobson II Promising Investigator Award, to be conferred in 2011. This award has been established to recognize outstanding surgeons engaged in research advancing the art and science of surgery, who have shown through their research early promise of significant contribution to the practice of surgery and the safety of surgical patients. The 2011 award, funded through a generous endowed fund established by the donors, is in the amount of $15,000. The College’s Surgical Research Committee administers the award.

Award criteria
- Candidate must be board-certified in a surgical specialty and must have completed surgical training in the last six years.
- Candidate must be a Fellow or an Associate Fellow of the American College of Surgeons.
- Candidate must hold a faculty appointment at a research-based academic medical center (military service position included).
- Candidate must have received peer-reviewed funding such as a K-series award from the National Institutes of Health (NIH), Veterans Administration, National Science Foundation, or U.S. Department of Defense merit review to support their research effort.
- Nomination documentation must include a letter of recommendation from the nominee’s department chair. Up to three additional letters of recommendation will be accepted.
- Only one application per surgical department will be accepted.
- Nomination documentation must include an NIH-formatted biosketch and copies of the candidate’s three most significant publications.
- Nominee must submit a one-page essay to the committee explaining why he or she should be considered for the award and discussing the importance of the research he or she has conducted/is conducting.

Special consideration will be given to surgeons who are at the “tipping point” of their research careers, with a track record indicative of early promise and potential (such as degree program in research or K-award). Surgeon-scientists who are well established (for example, funded by NIH R01 grants) are not eligible candidates.

Award criteria and nomination procedures are posted on the College website at http://www.facs.org/cqi/src/jacobsonpia.html.

Nomination procedures
To be considered for the award in 2011, submissions must be e-mailed or postmarked no later than March 11, 2011. After compiling the necessary award criteria documentation in an electronic format, you may submit it via e-mail to Mary T. Fitzgerald at mfitzgerald@facs.org. Nomination materials may also be submitted on a CD-ROM and mailed to Ms. Fitzgerald at the following address: American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

Applicants are encouraged to verify that all necessary documentation has been received before the March 11 deadline. For additional information, contact Ms. Fitzgerald by e-mail, or call 312-202-5319.
American College of Surgeons Professional Association (ACSPA)

As of September 14, 2010, the ACSPA-SurgeonsPAC raised $1,184,214 for the 2009/2010 election cycle. Of this amount, $565,980 was raised in 2010. Sixty percent of the U.S. Governors had contributed funds, and 81 percent of the U.S. Officers and Regents contributed as well. As of October 7, 2010, more than 70 percent of the U.S. Governors had made contributions.

American College of Surgeons (ACS)

Board of Governors

The Executive Committee of the Board of Governors held its five telephone conference calls scheduled for the year. In addition, two face-to-face meetings were held during the Clinical Congress in Washington, DC.

The Board of Governors annual survey communicates the concerns and recommendations of the Fellows regarding major issues related to surgery to the College’s leadership. The results of the survey were presented to the Board of Regents as it considers future College endeavors. The top five issues of concern to the Fellows of the College in 2010, as reported by the Governors, are as follows:

• Health care reform
• Physician reimbursement
• Professional liability/malpractice
• Graduate medical education
• Workforce issues

The Board of Governors and the Board of Regents held a joint session during the annual business meeting of the Governors. The session featured keynote speaker Brent C. James, MD, executive director of the Institute for Health Care Delivery Research and chief quality officer, Intermountain Health Care, Salt Lake City, UT. Dr. James’ presentation focused on surviving health care reform.

The Governors and Regents reviewed and discussed a draft document that was tentatively entitled Principles for Payment Reform, and offered comments and suggestions.
for revising the document. As the College did with its 2008 and 2009 health care reform statements, it will use its finalized 2010 Principles for Payment Reform document to form the basis of its interactions with Congress on health care policy. (The Governors and Regents also received an additional document entitled Glossary of New Health Care Terms.)

ACS scholarships
The Scholarships Committee and the International Relations Committee requested continued and additional funding for the ACS scholarships, fellowships, and career development awards. The Board of Regents approved approximately $1.9 million in funding. Full details regarding the scholarships, fellowships, and awards that are either fully or partially funded by the ACS are available at http://www.facs.org/memberservices/research.html.

ACS statement
The Board of Regents approved a revised Statement on Recommendations for Use of Real-time Ultrasound Guidance for Placement of Central Venous Catheters (ST-60). ST-60 was initially drafted by the ACS Committee on Perioperative Care (CPC) and then subsequently revised by the CPC. The revised statement will be published in a future ACS Bulletin and then posted on the website.

Advocacy
The College’s leadership received an update on advocacy activities, and was also informed that a number of College members had misunderstood the College’s position on health care reform. The issues that were misunderstood are clarified as follows:

• The ACS supported the original House Bill because of the following:
  1. Included full repeal of flawed Medicare physician payment system
  2. Did not include Independent Payment Advisory Board
• The ACS opposed the Senate bill because of the following:
  1. The bill did not address Medicare physician payment
  2. The bill did include Independent Payment Advisory Board

• Final negotiations: The ACS was “in the room” during these negotiations, and as a result, the following made it into the final bill:
  1. Coverage of 32 million Americans
  2. Bonus payments for rural general surgeons
  3. Trauma provisions reauthorizing the Trauma-EMS program, authorizing pilot projects on regionalized emergency care systems, stabilize and support existing trauma centers
  4. Pediatric loan repayment program including pediatric surgeons

• The ACS successfully urged that sections be taken out of the final bill, including the following:
  1. Tax on cosmetic surgery
  2. Medicare application fee requiring physicians to pay a fee to cover a background check for participation in Medicare
  3. Paying primary care physicians more by cutting surgeons and other non-primary care physicians
• The deal-breakers for the ACS, and why the College did not support the final bill, include the following:
  1. The final bill did not include Medicare physician payment fix
  2. The final bill included the Independent Payment Advisory Board (IPAB)
  3. The final bill did not include meaningful medical liability reform

Priority policy areas for the College include physician payment, quality, regionalization/workforce, and medical liability reform. Congress will likely spend significantly less money and provide fixes that last months, hopefully years, rather than permanently eliminating the sustainable growth rate (SGR).

The College needs to decide whether to continue to make the full repeal of the SGR its only priority when it comes to physician payment, or whether the College should advocate a period of stability (two to four years) while a longer-term strategy is developed.
The College needs to decide whether to invest the resources into developing a replacement strategy to the SGR, or if it is comfortable with reacting to what others bring forward.

Accountable care organizations and bundling are likely to be a part of any new system. Also, some in Washington will attempt to make balance billing and private contracting front and center in the coming year. In order to educate Fellows on all of these new physician payment options, the College will work to develop revised practice management sessions and an extensive webinar campaign to assist its Fellows.

The College will continue to show that improving quality will help to reduce health care costs. The health care reform law has some opportunities for ACS National Surgical Quality Improvement Program® (NSQIP®) that will be explored.

The College will continue to advocate for policies that help to address the surgeon workforce crisis that currently exists in this country. In addition, the College will work to develop clear policies on issues such as the role of physician extenders and the acute care surgeon. The College will work to expand the duration and scope of the rural general surgery bonus that was created in the health care reform law.

The College will continue to support traditional medical liability reform and caps on noneconomic damages. There is a greater likelihood for success at the state level, as seen in Texas, California, and other states. At the federal level, the College will explore options for helping to reduce surgeons’ liability costs.

ACS Health Policy Research Institute (ACS HPRI)

ACS HPRI research projects include the following:

• Access to surgical care: Describing the referral process for surgical care. HPRI proposes conducting case studies of multiple sites to understand how different teams of providers work together to shepherd patients from primary care to surgical care, how different organizational relationships affect the referral process, how patients’ characteristics affect the referral process, what system tools promote efficient and effective referrals from primary to surgical care, and how patients perceive the referral process in different settings.

• Regional variation in surgical care in the U.S. Building on the work of Dartmouth and the HPRI analysis of variation for orthopaedic surgical care, the HPRI will use state-level and Healthcare Cost and Utilization Project discharge data to continue to explore the factors associated with variation in surgical utilization and cost of care. The intention is to develop an internally funded project that makes use of extant data and to explore partnerships for external funding.

• Health reform legislation and effect on surgical outcomes. H.R. 3590 and 4872 will improve access to health care for millions of Americans over the next decade through Medicaid expansion, sliding-scale subsidies, and insurance reform. The HPRI will complete a policy review of the effects of the passage of the legislation, and develop a priority list of specific projects that should be developed.

• Further examination of surgical practice content and subspecialization trends. A 2009 Annals of Surgery article by ACS HPRI staff showed differences in the content of practice among rural and urban general surgeons in North Carolina. The HPRI proposes to extend previous research to examine multiple years of North Carolina utilization data for general surgeons and other specialties, examining patterns with respect to the narrowing or broadening of care.

• Surgical workforce analyses. The institute will continuously analyze trends of the surgical workforce and project the future supply by subspecialty, gender, race, and location, and in contrast to projections of other medical specialties.

• Innovative rural surgery staffing models. Rural communities across the U.S. have long struggled to maintain surgical services in local hospitals, and recent data show further
contraction of the rural surgical workforce. The HPRI’s goal is to produce information that may be useful to rural communities in addressing current or anticipated shortages in the surgical workforce.

The ACS HPRI has completed the first version of a surgical workforce projection model and is currently engaged in the development of a dissemination strategy for health workforce planning. The HPRI is poised to release its Surgery Atlas, a web-based interactive mapping resource illustrating the current surgical workforce. This atlas will provide a picture of the supply and geographic distribution of institutions and individuals providing surgical services, in an effort to help practitioners, policymakers, and patients anticipate current and future distribution, and identify places with limited access to surgical services. A unique feature of the Web product will be interactivity, which allows users to turn layers on and off, select from a dropdown menu to switch variables, and hover over counties to view the data behind the map. The atlas will be rolled out in phases: Version 1.0 was released September 17, 2010, for initial testing and feedback; Version 2.0 will be released in 2011; and a release date has not yet been determined for Version 3.0. The atlas will be posted on the ACS HPRI website at http://www.acshpri.org/atlas. It will be freely available and no registration will be required at this time.

ACS NSQIP

The High Risk Pilot Project took place July 2009–June 2010, with the aim of capturing 100 percent of targeted procedures that are associated with a higher likelihood of mortality/morbidity, and also collecting data regarding new variables and outcomes, such as hospital readmission within 30 days of surgery, in the ACS NSQIP Workstation’s custom fields. Nine hospitals participated in the pilot project.

NSQIP released a Return on Investment (ROI) calculator in 2009. The calculator allows participating sites to enter the number of complications that were averted in a particular time period to see how improved outcomes led to a reduction in costs for the hospital. Sites that are not yet participating in ACS NSQIP can use the ROI calculator to determine how much complications are costing their institutions, and how an investment in ACS NSQIP can result in dramatic cost savings for their hospitals.

ACS NSQIP collaboratives allow participating sites to compare outcomes and share best practices in a cooperative, noncompetitive environment, and provide for data sharing opportunities beyond the scope of the standard ACS NSQIP participation. ACS NSQIP is expanding the scope of collaboratives to increase the number of sites benefiting from the enhanced data sharing.

More than 700 individuals attended the 2010 ACS NSQIP National Conference in Chicago, IL, in July. Attendees enjoyed presentations from ACS leaders and ACS NSQIP participating sites on a variety of program updates and surgical quality improvement topics, including the ACS NSQIP’s role in health care reform. The 2011 ACS NSQIP National Conference will take place at the Westin Copley Place in Boston, MA, July 24–26.

Several surgical specialty groups are involved in the development of specialty-specific data variables and modules, further enhancing the ACS NSQIP. These specialty groups include the Society of Gynecologic Oncologists, the Society of Thoracic Surgeons, and the Society of Vascular Surgeons. NSQIP staff continues to work with members of a number of other specialties as the program moves forward with its development of additional targeted procedure modules, including urology, plastic surgery, neurosurgery, and colorectal surgery.

The High Fives Project is a partnership with The Joint Commission, the Agency for Healthcare Research and Quality, and the American Hospital Association, designed to confront the five most challenging patient safety problems, in five countries, over five
years. The initiative has expanded to approximately 15 countries.

There are 121 fully approved centers in the ACS Bariatric Surgery Centers Network. Additionally, there are nine provisionally approved centers in the network.

Arrangements were made for the fourth biennial Outcomes Research Course, November 11-13, 2010, at ACS headquarters, in Chicago, IL. For the first time, the Outcomes course offered breakout sessions on qualitative research and using Microsoft Access to create a clinical database, along with lectures covering funding, grantsmanship, and setting up an individual program.

Meeting rooms and a hotel block have been requested for the next Clinical Trials Methods Course, November 11-15, 2011, which will be held at ACS headquarters. Kamal Itani, MD, FACS, will chair the course.

The eleventh biennial Surgical Investigators Conference is scheduled for March 2012 near the National Institutes of Health in Bethesda, MD. Colleen Brophy, MD, FACS, is slated to chair the conference. The Surgical Research Committee will be considering several adjustments to the format, as well as suggestions from the Society of University Surgeons.

Trauma

Currently, there are 334 verified trauma centers in the U.S. In 2010, 164 site visits were scheduled. The final pass rate for hospitals seeking verification was 97 percent for 2008, and 96 percent for 2009.

There are now 65 hospitals participating in the Trauma Quality Improvement Program (TQIP). Another 25 centers are being recruited for participation in 2011. A new online data analysis tool is now in place. The first TQIP Annual Scientific Meeting will be held in November 2010 in conjunction with a training session.

The ACS Committee on Trauma (COT) offers the following educational courses:

- Advanced Trauma Life Support® (ATLS) Course
- Rural Trauma Team Development Course
- Disaster Management and Emergency Preparedness Course
- Advanced Surgical Skills for Exposure in Trauma Course
- Advanced Trauma Operative Management Course
- Optimal Trauma Center Organization and Management Course
- Trauma Outcomes and Performance Improvement Course

Edward E. Cornwell III, MD, FACS, of Washington, DC, will head the COT advocacy effort. He is working with the ACS staff in Washington to support national trauma legislation, as well as with staff in Chicago on issues including prevention, seatbelt, trauma systems, and many other types of trauma legislation.

Education

The College continues to make major strides in developing, launching, and evaluating innovative competency-based education and training programs/products to support delivery of surgical care of the highest quality. These offerings are based on systematic gap analyses and are aimed at addressing the learning needs of surgeons, surgery residents, and members of the surgical team.

The Accreditation Council for Graduate Medical Education (ACGME) unveiled the proposed Resident Duty Hour Requirements for public comment in late June 2010. The College reconvened the special task force that helped draft the original position statement of the College regarding resident duty hours that was sent to the ACGME in 2009. The task force included broad representation from across the surgical specialties. Several Officers and Regents of the College served on this task force.

Response from the College was drafted and sent to the ACGME during the window of time allotted for public comment. The College’s response focused on both short- and long-term implications of the proposed duty hour
requirements on patient care, as well as on resident education and training. The College applauded the ACGME for including greater flexibility in duty hours for residents in the final years of training. Support was expressed for no further reduction in the maximum of 80 hours, thus keeping the current duty hour requirements unchanged. The College’s response supported the proposed requirements related to maximum frequency for in hospital night duty, mandatory time off duty, moonlighting, duty hour exceptions, home call, alertness management, teamwork, clinical responsibilities, professionalism, personal responsibility, and patient safety.

On September 2, 2010, Public Citizen, along with the Committee of Interns and Residents and the American Medical Student Association, sent a 43-page petition to the Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor, expressing concerns about the proposed ACGME duty hour requirements, requesting intervention by OSHA, and recommending implementation of duty-hour limits for residents that were even more stringent than those proposed by the ACGME. Various professional organizations, including the College, began discussions related to this significant development. The Board of Directors of the ACGME considered various implications related to resident duty hours during its meeting, September 27–28, 2010.

The program of the 2010 Clinical Congress included significant enhancements and changes. The program included specialty-specific and thematic tracks, composed of blocks with the various types of sessions. The program included 11 Named Lectures and 117 panel presentations that addressed a broad range of important topics spanning the breadth of surgical practice. In addition, eight didactic postgraduate courses and 18 skills-oriented postgraduate courses were offered. This year, pre- and post-tests for the postgraduate courses were offered online. The program also included 30 Meet the Expert Luncheons and nine Town Hall Meetings. Credits earned through participation in the Clinical Congress will be transferred seamlessly to the “My CME” Web pages of the respective surgeons.

The Surgical Education and Self-Assessment Program™ (SESAP™) remains a premier self-assessment and cognitive skills education program for practicing surgeons and is used widely by surgery residents, as well. SESAP 13 offers surgeons the opportunity to earn a maximum of 60 Category 1 CME credits. The feedback from SESAP subscribers has been extremely positive.

SESAP 14 was released during the Clinical Congress and ushers in a new era of robust self-assessment and guided cognitive skills education in surgery. The new self-assessment and guided cognitive skills education model is founded on cutting-edge principles of contemporary surgical education and also meets the current stringent requirements of the American Board of Surgery (ABS). SESAP 14 will offer surgeons the opportunity to earn a maximum of 70 Category 1 CME credits.

The inaugural Comprehensive General Surgery Review Course was held in June 2010 in Chicago, IL. The course was designed to fulfill requirements for Part 2 of Maintenance of Certification (MOC) and to help surgeons in preparing for the Recertification Examination to fulfill Part 3 of MOC. The course provided a four-day intensive review of the essential content areas in general surgery. The response to this inaugural course was outstanding, and post-course evaluations from the participants were stellar. The course provided a maximum of 32 Category 1 CME credits, and five additional Category 1 CME credits are available through the online models offered after the course. Ultimately, a decision was made to offer this course twice in 2011.

Eight issues of Selected Readings in General Surgery (SRGS) were published in 2010. Recent issues have covered the topics of patient safety and business aspects of surgical practice, and a forthcoming issue will focus on clinical problems encountered by
general surgeons engaged in rural practice. The evidence-based content and new format of SRGS have been very well received by the subscribers. SRGS is recognized by the ABS as an educational program that may be used to fulfill the requirements for Part 2 of MOC. SRGS offers surgeons the opportunity to earn a maximum of 10 Category 1 CME credits per issue.

SRGS Connect will soon be available in the following three different formats:
- SRGS Connect–Resident is currently available to residency programs
- SRGS Connect–Practicing Surgeon will soon be available to any practicing surgeon and will no longer be limited to residents
- SRGS Connect–Premium will be available to practicing surgeons who prefer the convenience of receiving, with their subscriptions, full-text reprints of the most important articles from the overview

Both SRGS Connect–Practicing Surgeon and SRGS Connect–Premium may be used to earn up to 80 Category 1 CME credits per subscription year, or 10 Category 1 CME credits per issue.

Webcasts from the 2009 Clinical Congress included a total of 33 Plenary Sessions, which were made available online, along with 58 sessions from previous Clinical Congress meetings. The webcast package provided surgeons the opportunity to earn 164.5 Category 1 CME credits. A similar package of webcasts and audio recordings from the 2010 Clinical Congress includes 25 Plenary Sessions.

The Surgical Skills Patient Education Program remains a major priority of the College. This skills program is designed to help patients and their families acquire and demonstrate requisite skills to participate effectively in postoperative care. Each skills kit includes a variety of resources and tools to facilitate this process. This kit has been extremely well received in a variety of national forums. A major grant is supporting the distribution of 30,000 free kits to College members for use with their patients. Other activities of the program include the development and dissemination of patient education brochures. The demand for these brochures has recently increased. Also, the number of visits to the Patient Education public website (http://www.facs.org/patienteducation/) continues to grow.

The College provides Category 1 CME credits for educational programs across the entire College. The rigorous and evolving standards of the Accreditation Council for Continuing Medical Education must be met for continu- ing accreditation of the College as a provider of CME credits. In calendar year 2009, the College directly sponsored more than 31,000 hours of instruction, and provided CME Credits to more than 51,000 physicians. In addition, the CME Accreditation Program of the College offers other surgical organiza- tions the opportunity to provide Category 1 CME credits in collaboration with the College through the CME Joint Sponsorship Program.

Journal of the American College of Surgeons (JACS)
Elsevier Inc., the publisher of JACS, has redesigned the JACS website (http://www.journalacs.org/) to increase its functionality. The site has a new, much cleaner design, and is easier to navigate. The redesigned JACS CME website continues to be popular among Fellows and subscribers. From September 1, 2009, to September 1, 2010, 66,583 credits were earned, and 2,422 individual surgeons participated in the Journal’s CME program.

Operation Giving Back (OGB)
Since June 2010, there were 10,345 unique visitors who conducted more than 30,000 page views of the OGB website at http://www.operationgivingback.facs.org/. Forty-six new and updated volunteer opportunities had been posted to the site. The number of surgeons enrolled in the “My Giving Back” feature of the OGB site exceeded 1,525.

Haiti support activities continue to thrive. ACS Executive Director David B. Hoyt, MD, FACS, continues to convene meetings related to ongoing activities and discussions...
Regarding the current efforts to rebuild and strengthen Haiti’s medical and surgical infrastructure, including workforce and education-centered initiatives, as well as continuing volunteer support.

In appreciation for the continued financial support over the past seven years for the Surgical Humanitarian and Volunteerism Awards program, representatives from Pfizer, Inc participated in the presentation of the awards at the Board of Governors dinner during the Clinical Congress in Washington, DC.

Kathleen M. Casey, MD, FACS, OGB Director, continues to receive multiple requests for support and guidance from surgical residents interested in surgery and global health, health equity and surgery in the U.S., and research related to both. Dr. Casey continues to meet regularly with the ACS Foundation leadership regarding fundraising activities related to OGB, including ongoing exploration of grant possibilities.

**ACS Foundation**

The ACS Foundation is involved in a number of activities, including the following:

- Developing a diverse, customized print and electronic annual gifts campaign for the Fellowship. (There was a net of nearly $200,000 in the past fiscal year.)
- Implementing a major gifts (> $10,000) campaign with a national cross-section of Fellows and organizations focusing on the needs of the College. Three $100,000+ commitments are under discussion; one is completed. Further visits during Clinical Congress and around the country are planned.
- Ongoing fund-seeking initiatives to support College program infrastructure (the Archives Campaign directed by C. Rollins Hanlon, MD, FACS) and young surgeon career development (the Thomas R. Russell, MD, FACS, Scholarship promoted by the Foundation Board and assisted by the Foundation staff). Both efforts are well past the $100,000 threshold.
- A higher, more distinctive profile and promotion of the Mayne Heritage Society, our recognition circle for estate gifts and bequest commitments from the Fellowship, has been developed. Plan to move from 30-something to 100 members before the Centennial Year. Launched bi-monthly electronic and print outreach campaigns; three new commitments in the past six months totaling more than $100,000; other estate commitments under discussion.
- Growing collaborations among the Foundation and College leaders and divisions to seek corporation and foundation funding. Major commitments from the Stavros Niarchos Foundation (Fabrizio Michelassi, MD, FACS), Emerson Charitable Trust (William F. Sasser, MD, FACS), and Kriendler Charitable Trust (Edward R. Laws, MD, FACS); Brinson Foundation (Amilu Stewart, MD, FACS) funding discussion is in process; $1,600,000 in funding from organizations last year.

Future activities for the ACS Foundation include the following:

- More consistent, informative outreach to College chapters and their members; priority on Foundation Board members building philanthropy culture with the Fellowship.
- Greater visibility and accountability for gifts to the Foundation; more informative and timely Foundation website information (thanks to Kenneth Warren Sharp, MD, FACS, for his work).
- Development of Philanthropy at Work e-newsletter; more visible recognition of our donors and why giving matters; tax benefits of philanthropy to the College; highlights of Fellowship involvement in philanthropy.
- Annual reporting on use of donated funds to support College programs; accountability and impact reports to donors supporting specific programs.
- Focus on long-term philanthropic relationships and matching donor interests with the needs of the College.
- Greater involvement by College leaders in supporting the philanthropy charge; personal giving, opening doors, and meeting with potential donors. If College leaders affirm that philanthropy, then more Fellows will follow.
As of September 8, 2010, there were 1,022 active jobs listed on the website, with 376 posted résumés. This is a valuable service for all members of the College, and is free for Resident members.

Resident and Associate Society (RAS)

The RAS Communications and Membership Committees launched a RAS-ACS Fan Page on Facebook. The aim of this project includes the following:

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

The Issues Committee worked to highlight legislative priorities and advocacy efforts as well as make information easier to access for residents. This endeavor will keep issues most relevant to young surgeons and their practices in the forefront and prepare them for future challenges.

The Membership Committee is writing a plan for the 2010–2011 year that will include the following:

• Utilize tools from the Weber-Shandwick Recruitment Report
• Assign specific tasks and duties to program liaisons
• Incorporate a calendar guideline for presentations
• Measure recruitment/retention numbers at each program

Young Fellows Association (YFA)

The YFA hosted the 2010 Leadership Conference for Young Fellows and chapter leaders on July 24–25 in Washington, DC. Board of Regents Chair A. Brent Eastman, MD, FACS, presented the welcoming remarks and shared a few observations regarding U.S. health care policy. This year, 41 U.S. chapters participated in the Leadership Conference, which was attended by nearly 100 College members. The theme for this year’s Leadership Conference was Leadership from All Angles, and the presenters focused on various aspects of leadership skills, including time management, hiring staff and human resources management, communications, and volunteerism. The 2011 Leadership Conference will be held March 26–27.

The YFA conducted its second annual meeting on October 4, 2010. ACS President L.D. Britt, MD, FACS, presented the welcoming remarks.

YFA and RAS members plan to work with the ACS staff in DC to help with briefings for congressional staff members. The YFA workgroups—Advocacy, Communications, Education, and Member Services—continue to work on multiple projects.

New chapter

The Board of Regents approved the formation of the College’s 36th international chapter: the ACS Portugal Chapter. This brings the total number of ACS chapters to 103: 36 international, two Canadian, and 65 U.S.

Communications

The Board of Regents previously approved the development of a proposal for a brand/reputation-building campaign. The core attribute and focal point of the campaign will be to communicate the power, scope, and ongoing achievements of the ACS quality programs. The focus on quality is intrinsic to the College’s mission and agenda, and it is important that this message resonates with all of the College’s key stakeholders, and that it reflects the most positive and important contributions the College makes on behalf of its patients and Fellows. The campaign will target health care business audiences more than other audiences because they share the College’s interest in performance improvement. The communica-
tions vehicles that will be employed for this campaign will attract the attention of all of the audiences the College wishes to reach with its messages.

The College’s Division of Integrated Communications continued to maintain routine interaction with reporters representing both the lay and trade press. In addition, vigorous media relations activities were launched to bring newsworthy presentations to the Clinical Congress in an effort to gain the attention of reporters in Washington, DC, and throughout the country.

**ACS centennial event**

The ACS will celebrate its 100th anniversary in 2013. The process of incorporation for the College was begun in 1912, and the 2012 Clinical Congress will be in Chicago, IL, the headquarters city of the organization. The centennial celebration will start at the 2012 Clinical Congress and continue to highlight and celebrate the event through the 2013 Clinical Congress in Washington, DC.
NTDB® data points

Annual Report 2010: Seeing red

by Richard J. Fantus, MD, FACS; and Avery B. Nathens, MD, PhD, FACS

The 2010 Annual Report of the National Trauma Data Bank® (NTDB) is an updated analysis of the largest aggregation of U.S. 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. These facilities include 210 Level I trauma centers, 220 Level II trauma centers, and 198 Level III or IV trauma centers.

For the second year, there is an expanded section on facility information. This section includes information on hospital characteristics such as bed size and trauma level, as well as registry inclusion criteria for participating hospitals. A few of the inclusion criteria that are highlighted include minimum length of stay, hip fractures, and death on arrival. This information allows the reader to consider differences in case mix across hospitals while reading the report.

The mission of the American College of Surgeons (ACS) 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 medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

Each year there has been a graphic included in the report that outlines the percentage of hospitals submitting to the NTDB by state and U.S. territory. It has taken on different colors over the years, and this year you will be seeing the color red. This color signifies that a state or territory’s designated or verified trauma centers has a 67 percent or greater participation in the NTDB.

Many dedicated individuals on the ACS COT, as well as 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, our goals in the coming years include improving data quality, updating analytic methods, and enabling more useful interhospital comparisons. These efforts will be reflected in future NTDB reports to participating hospi-
Appendectomy • Cholecystectomy • Colonoscopy • Hernia

What are the common symptoms?

Appendicitis, can burst and release infection called peritonitis. An infected appendix, called appendicitis, can burst resulting in an abdominal infection, or bursting of the gallbladder.

Appendectomy is the surgical removal of the appendix. An appendectomy will remove the appendix is removed through an incision in the lower right abdomen.

Benefits and Risks

While it is a very safe procedure, there are possible complications including infection, or bursting of the gallbladder.

Diarrhea or constipation

Can occur for up to 10 days after surgery.

Polyps may be removed with medication, heat treatment, or off the bleeding site by injecting a sclerosing agent into the polyp.

Barium enema

Surveillance colonoscopy

Surveillance colonoscopy

Surgeons will discuss your health history, include blood work and urinalysis.

Gallbladder removal will relieve pain, treat possible polyps, and cancer, or diseases such as Crohn’s disease.

Surgeons will discuss your health history, include blood work, an abdominal ultrasound. Your provider to review your health history and an evaluation by your provider to review your health history and an evaluation by your provider.

Stone retrieval

Small intestine

Hernia is repaired with mesh or tissue bulges out through an opening in the abdomen.

Surgeons will discuss your health history, include blood work, an abdominal ultrasound. Your provider to review your health history and an evaluation by your provider.

Laparoscopic hernia repair—The surgeon makes small incisions in the abdomen. Hernia is repaired with mesh or tissue bulges out through an opening in the abdomen.

Laparoscopic cholecystectomy—The surgeon makes small incisions in the abdomen. Gallbladder is removed with instruments and your role in healing.

Information that will help you understand your operation and your role in healing.

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