

BULLETIN

AMERICAN COLLEGE OF SURGEONS
INSPIRING QUALITY: Highest Standards, Better Outcomes



July 2011
Volume 96, Number 7

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AMERICAN COLLEGE OF SURGEONS

INSPIRING QUALITY: Highest Standards, Better Outcomes



JULY 2011
Volume 96, Number 7

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September 30-
October 4

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October 6-10

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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.

Looking forward



A recent panel at the American Surgical Association, created by the organization's president, Kirby Bland, MD, FACS, got me thinking about comparative effectiveness research (CER). Herewith, a few thoughts as we look forward to the symposium's publication in the future. As our nation steadily moves toward a value-based health care system, surgeons and other providers will be expected to demonstrate that their services and products have proven benefits for patients and are cost-effective. Many leading health policymakers maintain that CER is a potentially useful method for determining the value of health care. Proponents of CER claim that these investigations will support the objectives of improving quality and reducing care costs by leading the nation's health care system toward the delivery of less wasteful, more scientifically verifiable, patient-centered care. Consequently, the Affordable Care Act (ACA) and other laws enacted in recent years call upon the medical community and government agencies to step up efforts to conduct CER.

What is CER?

The Institute of Medicine (IOM) defines CER as “the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels.”¹ CER also can involve cost analysis—perhaps the most controversial aspect of this research in that some individuals fear that it is the first step toward rationing of care. However, determining the monetary value of health care is a necessity in light of the fact that our current system is financially unsustainable, and most experts agree that cost analysis should occur as a secondary analysis only after the best care has been established.

We already have a model of effective CER—the randomized clinical trial (RCT). However, while RCTs do involve comparative research, they measure *efficacy* under ideal, well-controlled clinical conditions rather than effectiveness in a real-world clinical environment.² Indeed, systematic reviews of the RCTs routinely conclude that they provide too little

“The processes and goals of the CER are in line with our modern-day understanding of surgical professionalism, which is increasingly becoming focused on accountability.”

information that health care professionals can apply in their practices.

Under the CER model, researchers may conduct systematic reviews of the data drawn from existing clinical trials, observational clinical studies, and other research about the benefits and harms of each treatment option for different patient populations. Researchers also may conduct studies that generate new evidence of effectiveness or comparative effectiveness of a test, treatment, procedure, or other health care service. CER involves the development, expansion, and use of a variety of data sources and methods to conduct timely and meaningful research and disseminate the results that clinicians, patients, policymakers, and payors can readily use.³

The appeal of CER lies in the fact that it attempts

to answer clinical questions by using the best evidence to analyze real-world experiences. It truly focuses on effectiveness as defined as positive patient-centered outcomes. Carried out appropriately, CER has the potential to rapidly improve care, rather than forcing patients to suffer through the typical years-long delay from generating new information to applying new treatment options in clinical practice.

How it's done

The federal government has placed a great deal of trust in CER as an important means of ensuring that patients receive value-based care and has been working to build the infrastructure necessary to support this type of research as a means of stimulating the proliferation of value-based care.

The groundwork for CER actually was laid several years before the ACA was enacted, largely as a means of addressing issues raised in the IOM reports on patient safety and gaps in quality of care.^{4,5} For example, the AHRQ Effective Health Care Program was initiated in 2005 as required under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The American Recovery and Reinvestment Act of 2009 awarded additional funding to broaden CER, build an infrastructure to support expanded efforts, and to disseminate research findings.⁶

AHRQ CERs are conducted by an Evidence-based Practice Center using rigorous methods and protocols. Researchers review clinical research, clinical trials, and other studies to answer the key questions they've been asked to examine. Sometimes too few studies are available to conduct a thorough review. In these instances, two other Effective Health Care Program research networks conduct original studies to provide new evidence of outcomes and potential adverse effects or events that might be associated with a test, operation, or treatment plan. These networks are the Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Network and the Centers for Education and Research on Therapeutics (CERTS).³

The CER carried out through the AHRQ Effective Health Care Program generates, synthesizes, and translates evidence through the following process:

- Stakeholders submit suggestions for research studies.
- Accepted recommendations lead to either new research or a review of existing studies.

- A research abstract or a set of key questions is posted on the Internet.
- Upon completion of a research review, a draft report is produced and made available for public comment.
 - A final report that incorporates the public's comments is published online.
 - To make the key results of the study more meaningful to different users, separate guides are created for clinicians, patients, and policymakers.³

In addition to promoting the work at AHRQ, the ACA establishes a new Patient-Centered Outcome Research Institute, which is charged with setting priorities and coordinating with existing agencies that support patient-centered outcomes research. By law, it is prohibited from being construed as a mandate for practice guidelines, coverage decisions, or cost-cutting. Leaders of the AHRQ and the National Institutes of Health serve on the institute's Board and Methodology Committee.

The College's role

Looking forward, CER has the potential to have a significant effect on how surgeons practice and on the public's expectations of health care professionals and providers. Patients and payors alike are going to have access to considerable information about the effectiveness of various treatment options and will be seeking out clinicians who have proven track records in delivering value-based care.

As a leader in improving quality of care for surgical patients through scientific investigation, surgical education, accreditation, and standards-setting activities, the American College of Surgeons (ACS) has been working closely with AHRQ to study surgical care and develop appropriate protocols. We also have a Fellow, Robert Zwolak, MD, FACS, a vascular surgeon and associate professor of surgery at Dartmouth-Hitchcock Medical Center, Lebanon, NH, who has been appointed to their board.

In addition, our Clinical Scholars are using information from the National Cancer Data Base, the National Trauma Data Bank®, and the ACS National Surgical Quality Improvement Program to study patient outcomes and develop standards of care for various patient populations. Furthermore, the ACS is working to establish an Office of Evidence-Based Medicine to start the process of guideline development. We also have reaffirmed our support for the

activities carried out through American College of Surgeons Oncology Group (ACOSOG) and are working with the National Cancer Institute to develop new opportunities to demonstrate how ACOSOG's findings can be applied to clinical practice.

Of course, the ACS will continue to present educational programs to help surgeons stay abreast of new scientifically validated skills, information, and techniques and to offer opportunities to engage in practice-based learning.

The processes and goals of the CER are in line with our modern-day understanding of surgical professionalism, which is increasingly becoming focused on accountability. We, as Fellows of the ACS, are certainly up to this challenge and have a 100-year history of inspiring quality by developing higher standards and better outcomes.

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David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.



Using
SOCIAL MEDIA
to enhance
surgeon and patient education
and communication

by

Sani Z. Yamout, MD; Zack A. Glick;
D. Scott Lind, MD, FACS; Rebekah A. Z. Monson, JD;
and Philip L. Glick, MD, FACS

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Social media has taken the world by storm and terms like “facebooked” and “tweeted” have become part of our daily language. The popularity of these sites and their use for the spread and exchange of information, whether for personal or professional purposes, is on the rise. Surgeons’ and surgical organizations’ use of social media is also increasing, as reflected by the recent panel discussion at the 2010 Clinical Congress in Washington, DC, and other materials and articles published by American College of Surgeons (ACS) addressing this subject.¹⁻³ Despite this progress, many physicians still do not fully realize social media’s potential. Social media is a powerful tool that can be used effectively and efficiently for peer, patient, and family communication, as well as a vehicle for learning, as part of patient education, graduate medical education (GME), and continuing medical education (CME). Reasons for the delay in adoption of social media by surgeons include doubts about its utility, time constraints, and medicolegal risks. This article will address the Internet and social media sites, particularly Twitter, as a means for information access and exchange between surgeons, current trends of Internet use by surgeons and patients, and the subject of online security and medicolegal implications for surgeons using this technology.

Online social networking refers to the use of social media (websites that allow for the creation and exchange of user-generated content) for communication between people who usually share common interests.

Surgeons must constantly acquire up-to-date information to help provide the best care for their patients, and therefore they would greatly benefit from the ability to share and exchange knowledge, experience, and expertise through this time-efficient and cost-effective tool, often referred to as Web 2.0. However, practicing surgeons and surgical trainees with diverse levels of training and specialization can be overwhelmed by an abundance of information sources available through the Internet. Using social media, surgeons with similar interests and levels of training can exchange information that is relevant to them and their peers, and thus make the process of GME and CME a more streamlined and productive one. As an example, pediatric surgery fellows have access to a group of social media sites designed to be a tool for GME. This group of websites, named Pediatric Surgery Zone, includes a Twitter account (@PedSurgZn), Facebook page (<http://www.facebook.com/group.php?v=wall&viewas=851385296&gid=247787279780>), and a medical blog (<http://pedsurgzone.blogspot.com>), that discuss educational and other issues related to pediatric surgery.

Current status of social media use by surgeons

Most surgeons already use some form of social media for personal use. A survey conducted by the American College of Surgeons (ACS) in September 2010 to assess the patterns of use of social media by its members showed that a substantial percentage

Table 1. How often do you engage in the following social media sites?

Total surveyed: 315

	Daily (%)	Weekly (%)	Monthly (%)	Rarely (%)	Never (%)	Never heard of it (%)
Twitter*	5.6	3.0	1.3	10.5	79.0	0.7
Facebook†	23.4	13.1	3.2	15.1	44.9	0.3
YouTube	7.4	22.3	19.4	32.4	17.8	0.6
Flickr	0.0	3.0	2.6	14.9	65.9	13.6
LinkedIn	1.6	5.9	5.3	19.4	52.3	15.5
Sermo	1.4	5.8	2.4	8.5	41.2	40.8

Sources: http://www.surveymonkey.com/sr.aspx?sm=K1Fal2kH861MhqHLI5WbVcuC2xCZAOz6PgpLBiB6hWA_3d, <http://www.convinceandconvert.com/twitter/7-surprising-statistics-about-twitter-in-america/>, <http://www.socialmediatoday.com/roywells1/158020/416-us-population-has-facebook-account>.

engages in social media sites such as Facebook, Twitter, and LinkedIn (see Table, page 8). Interestingly, only about a third of surgeons reported reading or contributing to online health forums or blogs. Although there are no available statistics to reflect the number of surgeons who actually use social media on a professional level, one would assume that number must be smaller. There are many reasons why surgeons might be hesitant to incorporate online social media into their practice for educational or patient communication purposes. These reasons can be divided into three main categories: doubts about the benefits of social media sites, time constraints, and medicolegal concerns.

Looking beyond the “bad rap”

Because the majority of people use social media for seemingly trivial purposes, it is not surprising that many surgeons are skeptical about the use of social media for education and training. What many surgeons do not realize is that social media is a cost-effective and efficient means to share information and create and maintain professional relationships. Although the medical community in general, and the surgical community in particular, has lagged behind many professional organizations in utilizing these tools, social media sites are rapidly becoming an integral part of many medical organizations’ armamentarium.

In an effort to keep surgeons and their patients in touch through the power of the Internet, the ACS has a presence on Facebook (<http://www.facebook.com/group.php?gid=36660331571>), Twitter (@AmCollSurgeons), YouTube (<http://www.youtube.com/user/AmericanCollegeofSurgeons>), and Flickr (<http://www.flickr.com/photos/americancollegeofsurgeons>).

To test the advisability and usefulness of social media for surgeons, the ACS unveiled a rural surgeons pilot community at this year’s Rural Surgery Symposium, which was held May 5–8 in Chicago, IL. The secure online pilot community is accessible via *e-FACS.org* as well as via a mobile application for both iPhone and iPad (and coming soon to Android devices). Like existing Web portal communities, this pilot community can be used as a repository of valuable resources. However, the pilot community also uses social technology to break down traditional communication barriers, thereby providing rural sur-

Web 2.0 is a term used to describe the “second generation” of the Web, with applications that facilitate interactive information sharing and contribution by users, who can generate their own content and thus directly contribute to available information through blogs, social networking sites, and other social media tools.

geons who are participating in the pilot project with the opportunity to do three things that they have not been able to do before:

- Establish and maintain meaningful and professional connections among peers and share information with members of similar interests either openly or privately via secure social networking tool
- Create content, including updates, documents, images, tags, and videos, as well as comment on content created by themselves and others
- Receive notifications via handheld devices or computer when relevant content, posts, and so on, are added

This pilot community will be used to evaluate the effectiveness of a secure, interactive, online platform. The College believes this pilot may have the potential to transform the way rural surgeons presently communicate and collaborate. The pilot project will be evaluated, and if successful, these new capabilities may be extended to other communities on the ACS Web portal.

Twitter as a tool for GME and CME

One of the more rapidly expanding social media tools is Twitter, an online social networking site with more than 190 million users. Twitter allows users to communicate and exchange messages that are limited to 140 characters. Even with this character limitation, a vibrant Twitter community has emerged, with users who share their thoughts and opinions and exchange information relevant to their profession. Twitter is an example of how the powers of social media can be used for education purposes in the surgical community.

One of the main advantages of Twitter is that, within its 140 character-limited messages, users can include shortened URLs (Uniform Resource Locator: the online address of a source of information) that direct the user to other online resources such as journal websites, YouTube videos, and medical blogs. This ability to seamlessly direct users to online sources of information greatly augments Twitter's potential applications for education and exchange of information in the surgical community. Twitter, in addition to being used for direct communication between surgeons, can be used as a point source of exchange of information by a group of surgeons with common interests as they locate information on the Web. For example, by sifting through a sea of information, surgical residents who interact as a group on Twitter

can combine their efforts and collect and share information that is relevant to their level of training. Additionally, they can enrich this information with commentary and advice that reflects their personal experience, thus creating a dynamic and practical database. Additionally, faculty members can become involved by contributing to, commenting on, and providing a "peer review" of this information, thus adding to the value of this information exchange. When groups of surgeons with similar interests search the Web and share what's relevant to them, they effectively organize the Web content into a personal learning network. When used in this manner, Twitter can be a potent tool as part of a GME curriculum for resident education and for practicing surgeons as part of CME. It can also be used for advocacy, administration of surveys, patient education, and, more controversially, communication with patients.

The e-patient is "in" and here to stay

Understandably, surgeons have been hesitant to use social media to communicate with patients because of the time commitment and the medicolegal risks. For professionalism and confidentiality concerns, surgeons should avoid "friending" patients on Facebook or dispensing patient-specific medical advice on blogs. On the other hand, surgeons should contribute to the medical information available online to benefit patients seeking health-related information on the Web. Surgeons can also safely interact directly with established patients to address their specific concerns and questions through secure e-mail servers.⁴

"E-patient" is a term that refers to health consumers who use the Internet to obtain information about medical issues of interest to them. They use online tools, including social media sites, to discuss and learn more about specific medical topics. Pew Internet surveys have shown that 80 percent of Internet users have turned to the Web for health-related information at some point.⁵ Health consumers seek information for themselves, family members, or others in an attempt to obtain the latest medical information.

The Internet is replete with lay opinions and medical misinformation. Surgeons who use social media have a unique opportunity and non-legal responsibility to critically review and correct this misinformation. The importance of surgeons' contribution to patient education through the use of social media sites can be

better appreciated when one looks at the demographics of patients' use of the Web. Between 1995 and 2010, the percentage of American adults with access to the Internet grew from 10 percent to 75 percent. Broadband access—an important contributor to increased Internet use—is now available in two-thirds of American homes.⁶ In fact, President Barack Obama, in his State of the Union address in February 2011, discussed a plan to provide high-speed wireless services to at least 98 percent of all Americans in the next five years.⁷ Another contributing factor to the pattern of increased access to online information is the increased availability of smartphones and other mobile access devices. Six in 10 American adults go online wirelessly with a laptop or mobile device.⁶ Access is not the limiting point anymore; it's what people are doing with the access that matters. Mobile devices are changing people's behavior as Internet users, making patients more likely to share—and more likely to access—information on the go.

Surgeons' role in the online conversation

As patients rely more and more on medical information found on the Web, one must question who is providing this information. If only one-third of surgeons access—and a smaller fraction contribute to—online health forums, who is providing these patients with the information they seek and are armed with on arrival at the surgeon's office? As more patients go online for health information, the presence of surgeons online through blogs, Twitter, and other social media sites allows them to contribute expertise and science to a conversation that is frequently dominated by lay people and inaccurate information. This opportunity is where surgeons can play an important role. Surgeons can add data, science, and evidence to what is, in many instances, anecdotal information. Surgeons must have a clear and loud voice online.

In addition to obtaining information from health-related media sites, a substantial number of patients are giving each other information and advice. As patients exchange stories and share information online, surgeons who engage in social media can actively participate in these online patient conversations. The ability to monitor, or listen to, what patients are saying to each other provides an unprecedented opportunity to have insight into their viewpoints, concerns, and expectations.

Another reason surgeons should have an online presence is related to their online reputation, both individually and as a group. As more and more physician rating websites are created, surgeons' reputations are becoming progressively more dependent on feedback left on physician rating sites. Based on a recent Pew

The ACS has created a “find a member of ACS” service on the College website to help patients find ACS members:

<http://www.facs.org/>

[patienteducation/patient-resources/surgery/acsmember.html](http://www.facs.org/patienteducation/patient-resources/surgery/acsmember.html).

This service automatically notifies ACS members when they have been recommended to patients.

Internet survey, 44 percent of Internet users look online for information about their doctors and health care providers (N = 3,001).⁵ Another Pew survey showed that 24 percent of Internet users, looking for health information online, visit sites that provide online ranking or reviews of doctors and other health care providers (N = 2,253).⁸ As more patients turn to the Web when selecting their surgeon, surgeons need to know what is presented on those sites and have some input into that information. When a surgeon has an online presence through social media sites, he or she can take charge of their online reputation and the information available about them on the Web. By interacting and contributing to online health information, they can establish a positive image that can help counteract any negative or inaccurate information on physician rating sites.

Online presence can take the form of participation in health forums or blogs, or establishing personal or group websites that allow for patient interaction and commentary. When a patient searches for a specific surgeon and finds that he or she contributes accurate and useful information to health forums and has positive online feedback from patients and other surgeons, the effect of an aberrant negative report found on a rating site is less remarkable than if that same surgeon had no other online presence. A proactive online strategy by a surgeon may help restore his or her reputation after having been discredited by unfair or inaccurate physician grading sites.⁹

Surgeons, social media, and patient interaction

The use of social media for direct communication with patients for the purpose of dispensing patient-specific medical information and advice is strongly discouraged. The reasons are obvious and relate mainly to issues of confidentiality and professionalism. Alternatively, contact between physicians and pre-established patients via e-mail through a secure server is a safe and efficient communication option that can enhance and potentially replace some outpatient visits as well as improve patient care. In fact, communication with patients by e-mail, as part of the meaningful use of electronic health records, was one of the objectives of the American Recovery and Reinvestment Act (ARRA) of 2009, the economic stimulus package enacted by the U.S. Congress that year.¹⁰ The effectiveness of physician-patient communication via e-mail was illustrated in a recent study conducted through the Kaiser Health System. In this study, e-mail communication—when used as part of a comprehensive electronic record system—was associated with a significant improvement in the effectiveness of patient care.⁴

The issue of time constraints facing busy surgeons was a concern raised at a panel discussion on social media use by surgeons held at last year's Clinical Congress meeting in Washington, DC. How is a busy surgeon supposed to tweet and/or write blogs? The answer is simple. He or she doesn't have to actively tweet or post something online. Merely listening and gathering information from social media sites can be very educational. In fact, the majority of people who use social media fall in this category. As users become more involved, they may choose to start sharing information they find interesting or useful with others

in their network. At the other end of the spectrum are those users who actively create online content for others to use and share.

Operating safely on social networks

Security concerns and the medicolegal risks of Web-based information exchange, particularly when related to patient care, are real. To protect themselves, surgeons using social media sites must be familiar with basic online security settings. The safest online security setting creates a "read-only" format where users can access information posted by the person running the website, but they cannot change or comment on this information.

Clearly, social networking presents a number of legal risks and challenges for surgeons.¹¹ The legal consequences of publishing medical media—including photos and videos—on sites such as Facebook without patient consent are obvious, given the clear breach of confidentiality and privacy. The boundaries of right and wrong are less clear when it comes to issues such as protection of patient information, liability exposure, inadvertent establishment of physician-patient relationships, and potential reliance on misinformation.

A significant challenge for networking surgeons is compliance with federal and state laws governing the privacy of patient information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the HIPAA Privacy and Security Rules regulate when protected health information (PHI) may be used or disclosed by covered entities (such as physicians, hospitals, and others) and require safeguards to protect the information. The passage of the ARRA, including the Health Information Technology for Economic and Clinical Health Act, added new and more stringent requirements for protecting PHI, and enhanced penalties.¹²

In certain circumstances, PHI disclosure is permitted—if the information is used to advance the patient's treatment, if the information is related to the payment for the service, or if the patient consents to the specific disclosure. Additionally, information de-identified within the HIPAA safe harbor may be disclosed; however, the information must be truly de-identified. Surgeons should be extremely cautious in deciding what information to share on social networks. Determining how much information qualifies as "too much"

continued on page 14

twitter 101

Twitter is a website that allows for social networking through brief messages (140-character limit) called “tweets.” Although tweets, by default, are visible to the general public, these messages can be modified so only specific people can see them.

Users of Twitter can “follow” other users, and thus receive updates of their tweets. These “followers” can choose whom they follow, usually based on topics of interest (for example, “pediatric surgery” or “trauma”). As users follow more people, they may wish to organize their twitter feeds into separate subjects. Many third-party applications, such as TweetDeck, are available to help organize and make Twitter accounts more manageable and compatible with mobile devices.

Messages

In order to organize and control content, several prefixes have been established:

- Hashtag: The pound symbol (“#”) preceding a word or phrase helps group twitter posts by topic.
- Direct message: “DM” or “d” followed by a user name allows users to send private messages.
- The “at” symbol: “@” followed by a user name can be used to respond or mention a user. This message is public.

Content

In addition to standard messages, users can imbed links to online sites, pictures, and videos in their tweets. With the 140-character limit, the use of abbreviations

is very popular. Additionally, many applications have a built-in URL shortener that can abbreviate an embedded URL and conserve space.

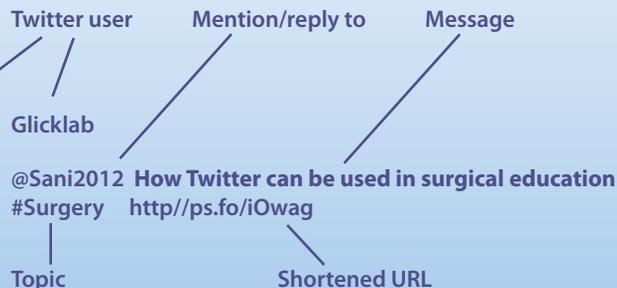
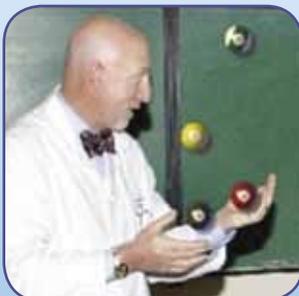
Registering/participation

Registering for Twitter can be accomplished on a computer running Windows or Macintosh by visiting <https://twitter.com/signup>. Once registered, users can participate in this online community. The simplest way to get one’s feet wet is to find individuals to follow who are posting messages about a subject of interest to the user. The Twitter website has a “Suggested Users” feature that allows the a new member to browse through better-known users, for a start. Twitter can also search a user’s e-mail contact list and find friends who are already on Twitter.

A Twitter user does not have to immediately dive in. Participation on Twitter can be a gradual process, with three basic levels of use. Some users simply “listen” and gather information, without actual participation. Others share information; they act as filters that sift through information and share what is relevant to them and their audience. On the “deep end of the pool,” as Susannah Fox put it (see reference 6 on page 15), are the users who create information on blogs and other network sites. As users become more familiar and comfortable with Twitter, they may wish to move from simply listening (80 percent of online users), to sharing and contributing.

Sample tweet

Glicklab sent a message (public) to Sani2012 regarding a website (<http://ps.fo/iOwag>) that discusses the use of Twitter in surgical education. Glicklab labeled the Tweet with #Surgery so other users interested in topics related to Surgery can easily locate his tweet. When Sani2012 sees this tweet, all he needs to do is “click” on the shortened URL and it will direct him to the website.



and what information makes the posted information identifiable can be problematic.

In addition to the myriad privacy concerns presented by social media, exchanges between surgeons and individuals via social media can give rise to other areas of liability exposure. Areas of potential liability include the following: when a social media interaction establishes a physician-patient relationship (and potential patient abandonment); unlicensed practice of medicine (if the physician is not licensed in the individual/patient's state); and medical malpractice. Dispensing, or appearing to dispense, medical advice via social media is a grey area and surgeons should exercise caution if they provide information through these channels.

Surgeons looking to increase their social media usage should consider taking the following steps to help safeguard their online interactions:

- *Social networking policies.* Surgeons should create



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social networking policies with guidelines and requirements for their practice's (including their employees') online interactions. While there is no "one-size fits all" policy, a well-designed policy can limit the risks while taking advantage of the benefits afforded by social media.

- *Disclaimers, consents, and notices.* Surgeons who post on social networking sites, blog, tweet, and so on, should be certain that their postings are not interpreted by readers as providing diagnosis or treatment, which could violate the prohibition against the unlicensed practice of medicine in a particular state or jurisdiction, and expose surgeons to medical malpractice, patient abandonment, and so on. All Web pages or social networking pages should contain appropriate, noticeable disclaimers informing visitors and readers that the sites are for information purposes only and do not provide medical advice, diagnosis, or treatment. Media sites such as Twitter and others present obvious problems with disclosures due to their limited character requirements.

- *Utilize networking safeguards.* Facebook, Twitter, and other social networking sites allow users to regulate the security features on their individual pages. Surgeons should carefully consider before accepting "friend requests" and other invitations to connect with users or groups. Additionally, surgeons should be wary of accepting invitations from patients or posting personal images and videos, and all providers should closely monitor, or disable altogether, the comment feature on their YouTube, Facebook, and Twitter sites. While it is beyond the scope of this discussion, there are ethical concerns with practices such as "friending" patients.

- *Use common sense.* The underlying issues of physician/patient boundaries are not new; however, the social networking medium recasts the issues. Be sure to keep in mind that what is posted, tweeted, blogged, and so forth, remains "out there" to be viewed either currently, or conceivably at any time in the future. Using common sense can help surgeons avoid, or at least limit, a whole host of risks. A physician should be sure to consider what he or she is doing and whom it could affect. And if there ever is a doubt, don't hit the "send" button!

Conclusion

Social media is not a fad or craze; it is a fundamental shift in the way we communicate. Social media is here to stay, whether we like it or not. It is a powerful

communication tool, allowing for time-efficient and cost-effective exchange and spread of information. This tool, when understood and used properly, can give surgeons tremendous leverage over the availability and quality of online information, and it is a major potential source of education for the surgical community, and, perhaps more importantly, the patient population. The infrastructure is there—surgeons just need to learn to use it. 

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Beyond volunteerism:

Augmenting surgical care in resource-limited settings



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Surgical care was recently characterized as “the neglected stepchild of public health.”¹ Critical shortages of health care workers throughout the developing world have led to “calls to action” and have reinforced the need for safer surgery.² Highlighting a vast gap in health care for developing world populations, it is estimated that of the 234 million operations performed annually throughout the world, only 8.1 million (3.5 percent) are undertaken in low-income countries.² With growing evidence indicating that surgery is a cost-effective intervention, now is the time to critically evaluate the role of outside surgical interventions in the developing world.³ Re-evaluating current methods is vital, as local voices from low- and middle-income countries (LMICs) are beginning to raise questions about the negative consequences of short surgical missions that lack a long-term coordinated goal.⁴

Historically, medical and surgical care in the least developed parts of the world has been provided by local shamans and healers. For example, in many countries in Sub-Saharan Africa, most fractures are handled by local bonesetters. As health systems struggle to provide care for local populations, outside entities have often augmented meager local resources. Non-governmental organizations (NGO), individual surgeons, and academic groups have contributed substantially to providing surgical care. These organizations encompass a wide array of secular, religious, relief, and developmental groups, whose central mission is typically to assist in the care of local populations. This article summarizes the traditional role of NGOs, and provides recommendations for capitalizing on the increased interest in working in LMICs by utilizing a new paradigm for building surgical capacity within the LMICs. Recent data pulled from the resident and attending level suggest that now is the time to consider new models for coordinating and improving surgical missions to LMICs (see table on page 18).⁵

The current paradigm

An estimated 6,000 short-term medical missions (STMMs) are undertaken every year from the U.S. to LMICs. The cost of these programs is an estimated USD \$250 million.⁵ The exact percentage of these STMMs that are surgical in nature is unknown, although there appears to be a substantial number of such missions, given the plethora of surgical organizations listed with Operation Giving Back and the

American College of Surgeons. There is a varying degree of size and commitment from these teams; some are organized on a yearly trip to one location; others are larger in scope, covering more locations with multiple yearly missions. Each of these missions has many unique qualities (some are faith-based while others are secular), as they bring varying combinations of supplies, equipment, and personnel to these LMICs.

Currently, there isn't a coordinating or credentialing body to certify that missions are conducted properly, or are even desired by the host country. While there is a need for surgical services in many locations, the current situation is one where missions are usually conducted on a site-specific basis. Some of the surgical specialty groups have large programs that treat local patients for a variety of complex procedures that cannot be performed locally, often due to lack of training or resources. A number of organizations also use local surgeons, or provide a training component as part of their mission; when the long-term impact, however, of most strategies is assessed, the results are often utilized internally, and not always published. In addition to NGO missions, several academic medical centers have organized programs that link their surgery department with departments in LMICs.⁶

Volunteerism to professionalism

In light of the growing interest in improving access to safe surgery and the isolated nature of many surgical missions, an improved paradigm is essential. There are numerous models that provide short-term successes; the problem, however, is identifying the model that provides a long-lasting impact to the health care delivery system. A new paradigm should include surgical mission standards, creation and recognition of the subspecialty in global surgery, pre-deployment and international humanitarian surgery courses, and coordination among NGOs, physicians, and academic groups involved in surgery in LMICs.

Develop surgical mission standards

In order to ensure a baseline level of quality between surgical efforts that are led by a disparate group of organizations, surgical mission standards should be universally accepted. Many organizations have organization-specific standards, but a universal set of surgical standards—as follows—should, in fact, be adopted:⁷

- *Volunteer certification.* The first step in establishing standards is ensuring that participants have certi-

fication or licensure in their home country. In order to verify competence, active certification in the surgeon's home country should be a prerequisite. While hospital-based privileges are maintained in the U.S. to govern who is allowed to perform specific procedures, this is not easily transferable to working in LMICs, as often surgeons are called upon to expand the scope of their normal practice. Training, prior to missions, in order to reinforce the basic principles of safe surgery when a surgeon is confronted with conditions that are beyond the scope of his or her normal practice, can help ensure a successful experience. Instead of solely relying on altruism and a desire to help the local populace, there should be a way of ensuring that physicians are adequately prepared to enter into these situations. Given the increasing availability of the Internet in even austere environments, utilizing Internet-based communication, especially with live video feeds, is possible and provides a link to colleagues at other institutions who may offer valuable consultations.

A way forward:

Paradigm to increase effectiveness of surgical missions to LMICs

1. Develop and agree to universal standards and best practices for all NGO, individual, and academic groups working in LMICs.
2. Institute the WHO's Safe Surgery Checklist in all facilities where organizations and individuals are working in LMICs.
3. Create a field of surgery in LMICs to develop and support leaders in the field of surgery and public health.
4. Develop a pre-deployment course in international humanitarian surgery:
 - Discuss expectations of surgery in LMICs
 - Provide training materials to address the wide array of surgical situations that can develop in LMICs
 - Establish an online interactive vehicle to assist with problems that are confronted while in the field
5. Coordinate between NGOs, individual volunteers, and academic centers to encourage sharing data and resources.

- **Supervision.** One aspect of establishing mission standards is identifying optimal surgical personnel and determining what levels of supervision are appropriate. At times, even fully trained and board-certified attending surgeons from developed countries benefit from local supervision, when first working in resource-poor environments. Supervision at the resident level is even more important and should be standardized as well. Optimally, resident/attending pairs could be utilized for missions to provide for appropriate training and mentorship on a mission. If this is not feasible, then resident supervision must be provided by an appropriate local surgeon. Given the severe manpower shortage in many LMICs, it is easy for a resident to find himself or herself in an unsupervised position, with unfortunate consequences that might harm both his or her patients and the resident's training. Although this problem is less prevalent than in the past, it is vital that supervision and recruitment standards continue to improve, and that these standards remain a central tenet of surgical missions.

- **Needs assessments.** A vital part of surgical mission standards is the needs assessment that should be utilized to ensure that visiting surgeons and external programs are addressing local priorities. Truly assessing need optimally is separated from the visiting surgeons' preconceived perceptions of local concerns. Matching appropriate resources from visiting groups to the true needs of the local population will provide a greater chance for sustainable growth in local surgical capacity. The World Health Organization's (WHO) Tool for Situational Analysis to Assess Emergency and Essential Surgical Care is one such assessment tool that can be utilized to develop a bilateral understanding of what surgical needs are present, and what the current surgical capacity is.⁸ In addition, the data from the needs assessment may assist with post-intervention analysis, and will help determine the effect of these surgical programs.

- **Surgical safety.** Surgical safety—for both patients and surgical staff—is an important aspect of surgical missions to LMICs. An example of a uniform standard of care that can be adopted by all groups working in LMICs is the WHO's Safe Surgery Checklist.⁹ Applying this checklist perioperatively in low-, middle-, and high-income countries was shown to decrease preventable complications and death due to surgery by 50 percent.⁹ Another valuable aspect

of surgical safety that can be included in surgical missions is universal precautions training for both the surgical volunteers and the surgical workforce in LMICs. Often a small investment in local supplies, such as aprons, goggles, and gloves, can help improve universal precautionary measures.¹⁰

Developing the next generation of leaders

Most surgical residencies have, as part of their mission, the goal to train the next generation of surgical leaders. As disparities in surgical care are growing wider between developing and developed countries, global surgical leaders are needed to help find ways to provide access to appropriate and sustainable surgical care to the 90 percent of the world's population who now lack it.³

Creating a subspecialty in international or global surgery could enhance the leadership and professionalism of surgical missions. Such a subspecialty could entail a mixture of general, emergency, and trauma surgery; rural, tropical, and war surgery; and other traditional non-general surgery specialties such as obstetrics, gynecology, urology, orthopaedics, otolaryngology, plastic, thoracic, and neurosurgery. Integrating public health training into surgery could help identify simple and cost-effective technology that could offer possible solutions to the obstacles related to providing surgery to larger populations in resource-poor areas.

As training for such a subspecialty is limited in the U.S. or Europe, programs providing such training would need to partner with sister institutions in locations where this type of surgery is routinely performed. Extended rotations of residents and fellows would begin to create a cadre of skilled professionals able to function at home, but also with the ability to assist with training in LMICs. The surgical residency rotations to LMICs, which are becoming more common, are a small step in the right direction; however, a larger commitment is needed if such a specialty is to be legitimized, recognized, and eventually accredited. Training curricula will need to be established, and best practices developed, for dealing with such conditions as sigmoid volvulus with ileosigmoid knotting, footling breech deliveries, suspected epidural hematomas with no computed tomography, screening patients when there are no laboratory resources, or developing and improving hospital systems to manage mass casualty situations.

Pre-deployment courses

Although conditions in hospitals around the world differ considerably, there are a number of similarities that should be highlighted to surgeons wishing to work in these settings. Health Volunteers Overseas has developed a pre-deployment course for orthopaedics that is taught once every two years.¹¹ The course provides insight and lessons learned to volunteers, including information that has actually dissuaded some surgeons from pursuing an overseas mission.

A training course in international humanitarian surgery should also be created to disseminate baseline knowledge and to provide reasonable expectations for the multitude of clinical situations that differ greatly in LMICs when compared with what surgeons deal with in developed countries. One possibility for this course would be to develop a CD-ROM and online version of the course, so that it could be utilized throughout the world, including when a surgeon is abroad. International certification is also a possibility, potentially through one of the international surgical societies, if the training can be developed to a high level, with a hands-on component with instructors.

Coordinating efforts

Coordination with similar organizations, especially in similar geographic areas, is vital to the development of more consistent surgical missions. While some NGOs have published data detailing their work, NGOs have traditionally used data primarily for internal evaluation. Academic surgical missions, on the other hand, frequently publish data describing their work, but the scale of their missions and resources are often much more limited than those of large NGOs.¹² Data, personnel, and methods for improved surgical interventions should be shared between both groups. Efforts have now begun—through groups like Operation Giving Back—to assist in coordinating efforts between NGOs and academic groups. In addition, global surgery fellowships are beginning to develop a cadre of surgeons more formally trained in research efforts in LMICs. Along with addressing the inherent needs of local populations and surgical providers, organizing the resources, abilities, and interests of surgeons and surgical trainees from high-income countries could help alleviate some supply, training, and manpower constraints.

Linking, or “twinning,” of medical schools and

residencies between developed and LMICs is another manner in which collaborative relationships can be formed to help improve surgical training and capacity. For example, Weill Cornell Medical College has forged a long-term relationship with the Ministry of Health of Tanzania to help improve the medical school at Bugando Medical Center in western Tanzania.¹³ The bilateral international exchange that develops from such relationships is vital to improving surgical care in the future.

When discussing a long-term collaborative process, we need to find ways to make the process reciprocal. Visiting surgeons from developed countries are much more likely to be allowed to operate in a developing world hospital if they have established a reciprocal relationship with that facility. This is partially due to the manpower needs of the resource-limited facilities; however, the credentials, abilities, and self-esteem of

the host surgeons must be considered when planning short- and long-term surgical missions in order to ensure collaborative efforts and prevent adversarial relationships. In addition, care must be used to prevent undermining the trust that the local community has in its own surgical workforce, because waiting for the “expat” surgeons to arrive may not always be feasible or produce the best medical treatment. The visitor’s role should be supportive, rather than substitutive or authoritative.

Conclusion

Low-income countries, with 35 percent of the global population, accounted for 3.5 percent of the annual surgical procedures performed worldwide in 2004.³ In an effort to address this unmet surgical need, a large number of volunteer surgical missions have delivered substantial care to countless people, providing much-needed services worldwide. Despite millions of dollars and the donated time of surgical team volunteers, sustainable surgical care continues to elude much of the world.

As interest in volunteerism has grown among surgeons, anesthetists, nurses, paramedical professionals, residents, and medical students, now is the time to capitalize on the successes of the many organizations providing surgical care and training in LMICs. Overcoming the obstacles to providing and sustaining surgical care in LMICs will require a new paradigm, one that is based not solely on volunteerism, but on professionalism, as well.

Myriad surgeons and anesthesiologists have participated in extremely successful efforts that have provided surgical care and education in the developing world. This very important work could potentially have even more of a long-term sustainable effect by improving the training offered to volunteers, developing surgical mission standards, and providing methods to collaborate between organizations. Global leaders in surgery must be trained through global surgical programs that address surgery not only for the individual, but also for the population in general. Until surgery is widely recognized as an integral component of primary health care, and surgeons are involved in the decision and resource allocation process, the underlying problem will persist. Coordinating the array of volunteer organizations and academic institutions working in LMICs and developing long-term relationships with the host countries could provide



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a mechanism to maximize limited resources. A more uniform approach to surgical missions may help harness the impressive energy and work that currently exists within the surgical community, resulting in improved surgical care around the world. 

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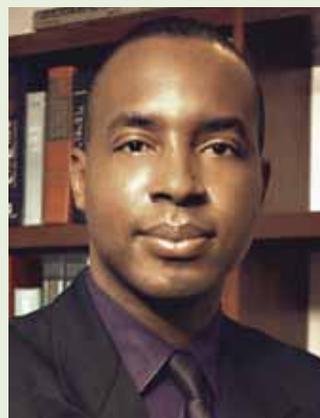
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THE STATE OF MEDICAL LIABILITY REFORM

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The nation's current medical liability system places patients in jeopardy of losing their access to vital health care services and forces surgeons and other physicians to practice “defensive medicine” by ordering additional tests to protect themselves from frivolous lawsuits. Additionally, medical liability insurance premiums have risen steadily, at times increasing an average of 15 percent a year. In some states, surgical specialists—particularly obstetrician/gynecologists, neurosurgeons, and orthopaedic surgeons—have witnessed even more dramatic increases, making premiums prohibitively expensive.

With affordable medical liability insurance becoming increasingly difficult to find, physicians are retiring early, limiting their practices, or moving to states with less costly premiums. At the same time, reimbursement from Medicare and other insurers is declining, providing no way to offset the continuing escalation in premium costs. This disturbing trend is leaving entire communities without access to critical health care services.

FEDERAL RESPONSE

Efforts to address this crisis have included a variety of public policy measures. Over the years, Congress has made several attempts to adopt health care liability reforms like those enacted in California under the

Medical Injury Compensation Reform Act (MICRA) of 1975. MICRA has demonstrated that medical liability costs can be stabilized while patients' rights are protected.

In 2009, the Agency for Health Research and Quality issued \$25 million in grants to support patient safety and medical liability reform demonstration and planning projects. Additionally, the Affordable Care Act (ACA) authorized \$50 million over five years in grants to states for the development, implementation, and evaluation of certain alternatives to current medical litigation.

Most recently, Rep. Phil Gingrey (R-GA) introduced H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act. Identical to legislation that was previously passed by the House of Representatives, the bill would address concerns regarding medical liability and areas unaddressed by the ACA.* The first section of the H.R. 5 sets a \$250,000 damage cap on noneconomic damages regardless of the number of parties involved in the lawsuit. Noneconomic damages are defined here as damages primarily from pain

*Chu VS. Medical malpractice liability reform: Fifty-state surveys of caps on noneconomic and punitive damages and of punitive damages burden of proof standard. Available at: <http://healthlegislation.blogspot.com/2011/03/medical-malpractice-liability-reform.html>. Accessed May 19, 2011.

and suffering. H.R. 5 would not enforce a damage cap on economic damages defined as monetary losses resulting from an injury like medical expenses, lost wages, and rehabilitation costs. H.R. 5 would limit punitive damages to the greater of \$250,000 or two times the amount of economic damages awarded. Punitive damages are often awarded when compensatory damages (economic and noneconomic) are deemed an inadequate remedy and are intended to deter similar conduct. An additional provision of H.R. 5 would set the statute of limitations for medical malpractice cases at three years after the manifestation of injury or one year after the discovery of the injury or when the injury should have reasonably been discovered. A third provision of H.R. 5 would place a limit on attorneys' contingency fees. Advocates of contingency fee limits argue that such costs cause juries to inflate verdicts and prompt lawyers to file frivolous lawsuits in the hope of settling. A fourth provision of H.R. 5 provides that in cases involving multiple defendants in which each party is responsible for damages, the damages would be in direct proportion to individual percentage of fault and would not make an individual liable for the share of any other person.

STATE SOLUTIONS

Several states across the country have successfully enacted medical liability tort reform legislation, but problems with affordability and availability of insurance persist in many regions and in multiple physician specialties. California's MICRA, passed in 1975, is the standard for a state's response to the medical liability crisis. Since MICRA was enacted, California physicians have seen a 283 percent increase in liability premiums compared with the astronomical 925 percent for physicians in the rest of the U.S. Not surprisingly, California has more physicians per capita, including surgeons and specialists, than states with higher malpractice premiums. The following information is a brief summary of alternative reforms that states are instituting to reduce the cost of malpractice insurance. (*Editor's note: The information featured in quotes in the following paragraphs are sourced directly from state codes, chapters, and law.*)

■ *Medical malpractice review panels*

Pre-trial medical malpractice review panels have been instituted in 21 states. The execution of this concept has varied from state to state, and the impact of these panels is still an area of intense investigation.

Of those 21 states, only 13 have mandatory processes and only four are admissible in court. One state that has successfully implemented medical malpractice review panels is Delaware, which has an established system designed to prevent meritless controversies from advancing to litigation. The panel advises the court as to whether the evidence supports the conclusion that the defendant failed to comply with the standard of care. A party may ask the court to review the opinion of the panel, and the court has the power to strike any portion of the panel's opinion that is based on an error of law or unsupported by substantial evidence. If the case proceeds to trial, the panel's negative opinion is admissible as evidence of negligence, but the opinion is not viewed as conclusive. Moreover, members of the review panel may not be required to testify in court.

In Indiana, all claims against qualified providers for more than \$15,000 must be heard by the medical review panel (unless each party executes a written waiver). The medical review panel consists of one lawyer and three health care providers. The health care providers on the panel have a duty to express an expert opinion as to whether the evidence supports the conclusion that the defendant acted or failed to act within the appropriate standards of care and whether they were factors in the resulting injury. The opinion issued by the panel is admissible as evidence in any subsequent action but is not conclusive.

In Maine, a mandatory pre-litigation screening panel has been established. Before a medical malpractice claim may be filed, a complaint must be filed with a pre-litigation screening panel. The screening panels serve a two-fold function of encouraging both the early resolution of claims and the withdrawal of unsubstantiated claims. However, the pre-trial screening process can be waived if all parties agree. Unless the panel's decision is unanimous, the findings of the panel and any disclosures made at the hearing are confidential and cannot be used in subsequent litigation.

In Massachusetts, a tribunal consisting of a judge, physician, and lawyer is formed to review a medical malpractice action and determine if the evidence merits a question of liability. The panel's findings, as well as the expert testimony given before the panel, are admissible at trial. If the panel finds against the claimant, the claimant must post a \$6,000 bond (this amount may be increased at the court's discretion) for the payment of the defendants' costs if the claimant is unsuccessful at trial as well.

In New Mexico, a mandatory medical malpractice review commission must look at the details of the case before the filing of a lawsuit; however, the commission's findings are neither binding nor admissible in any subsequent court proceedings.

■ *Punitive damages*

Some states have implemented statutes to limit punitive damages in hopes of deterring frivolous lawsuits and providing more stability for malpractice insurance. In Mississippi, punitive damages are limited to 4 percent of the defendant's net worth if that net worth is \$50 million or less. Mississippi requires that punitive damages are awarded in a separate proceeding with a standard of "actual malice, gross negligence which evidences a willful, wanton or reckless disregard for the safety of others, or committed actual fraud."

In North Carolina, punitive damages are limited to the greater of three times the amount of compensatory damages or \$250,000. North Carolina does not require a separate proceeding but requires that the standard be fraud, malice, or willful or wanton conduct. According to *Woods v Mendez*, "Willful and wanton negligence is action undertaken in conscious disregard of another's rights or with reckless indifference to consequences with the defendant aware, from his knowledge of existing circumstances and conditions, that his conduct probably would cause injury to another."^{*}

The state of Oklahoma limits punitive damages for reckless disregard at \$100,000 or actual damages awarded; whereas intentional acts by defendant and acts with malice are awarded the greatest of \$500,000, twice the actual damages awarded, or financial benefit derived by defendant. If the court finds beyond a reasonable doubt that the defendant engaged in conduct that was life-threatening, then there is no cap for punitive damages. Meanwhile, Virginia has implemented a mandatory cap for punitive damages that is not to exceed \$350,000. In order to receive punitive damages, the defendant's conduct must be shown to have been willful or wanton.

■ *Noneconomic damages*

Typically, in discussions regarding medical malpractice reform, the focus has been almost solely on capping noneconomic damages. Advocates for limits on noneconomic damages argue that a lack of caps

^{*}*Woods v Mendez*, 527 SE 2d 263 (2003).

guarantees unpredictability and inconsistency in awards to plaintiffs and forces insurers to counteract the effects of these potential losses by charging higher premiums. Those advocating against noneconomic damages caps argue that it could have disparate effects on different patient populations, including but not limited to elderly plaintiffs who may not be able to claim economic damages for lost wages. Therefore, noneconomic damages caps would leave the individuals with minimal compensation and a decreased incentive for lawyers to represent them.

Several states have successfully implemented caps on noneconomic damage awards. California's MICRA allows a cap at \$250,000 for noneconomic damages. MICRA, while not perfect, has stabilized medical malpractice insurance costs and preserved patient access to physicians, nurses, hospitals, and other health care providers. In New Mexico, noneconomic damages are capped at \$600,000. These damages are not to be awarded for future medical expenses in malpractice claims. Texas passed a law in 2003 that

Medical liability reform ideas

To alleviate the medical liability crisis and ensure patient access to surgical services, the College believes incorporating the following medical liability reform ideas is critical:

- Reasonable caps on noneconomic damages
- Alternatives to civil litigation, such as health courts and early disclosure, and compensation offers to encourage speedy resolution of claims
- Protections for physicians who follow established evidence-based practice guidelines
- Protections for physicians volunteering services in a disaster or local or national emergency situation
- Collateral source payment offsets that prevent duplicate payments for the same expense
- Fair share rule
- Periodic payment of future damage awards of more than \$50,000
- Limits on plaintiff attorney contingency fees
- Application of punitive damages only when there is clear and convincing evidence that the defendant intended to injure the claimant
- Payment of defendants' costs if claimant is unsuccessful at trial

limits noneconomic damage awards to \$250,000 per claimant per provider. If more than one health care institution is found liable, the cap against the providers rises to \$500,000. The results have shown a reduction in liability insurance rates, reported growth in the number of physicians licensed each year, and increased charity care.

Tennessee does not have a statute limiting noneconomic damages. However, in October 2008, the state implemented the Tort Liability and Reform Act. Under this law, a certification process requires written notice to medical providers issued 60 days before the medical malpractice lawsuit is filed. The law also requires early attorney certification that a qualified medical expert has concluded that there is good cause to pursue the claim against each defendant. The certificate of merit is of great value in preventing baseless cases. Failing to comply with the certification process could cause the case to be dismissed and the violating attorney to pay the opposing parties' attorney's fees and expenses. Since the law became effective, the number of claims filed is down at least 50 percent.

■ *Contingency fees*

To date, contingency fee caps and restrictions are used in four states. In Indiana, a lawyer's contingency fee may not be more than 15 percent of any award, including awards from the patient compensation fund. Both Tennessee and Utah have implemented a cap on contingency fees that is not to exceed one-third of the amount recovered, whereas California and Connecticut have implemented a sliding scale similar to that of H.R. 5.

CONCLUSION

For more than a decade, many Fellows of the College have seen their liability insurance premiums skyrocket, regardless of their personal litigation history. The crisis confronting the surgical profession continues to grow, limiting access to safe surgical care for the sickest and most vulnerable patients in society. Therefore, the College will continue to strongly advocate for meaningful medical liability reform on both the state and federal level.

The College's leadership is aware of the current challenges in passing federal and state medical liability reform legislation. However, College leadership believes that passing such legislation should remain a significant priority for both Congress and state leg-

islatures, and that there are a number of approaches worthwhile to pursue in order to achieve this goal. To alleviate the medical liability crisis and ensure patient access to surgical services, the College believes that incorporating certain medical liability reform ideas (see box, page 24) in future legislation is critical. 

Ms. Pollack is a law student at the Catholic University of America, and was an intern for the ACS Division of Advocacy and Health Policy, Washington, DC.

Dr. Selzer is a general surgeon, IU Health University Hospital, Indianapolis, IN.



Dr. Meara is plastic surgeon-in-chief, Children's Hospital Boston, and associate professor of surgery and director of the program in global surgery and social change, Harvard Medical School, Boston, MA. He is Chair of College's Legislative Committee.



97TH ANNUAL

AMERICAN
COLLEGE OF
SURGEONS

Clinical Congress

SAN FRANCISCO, CA

OCTOBER 23-27, 2011



American College of Surgeons
INSPIRING QUALITY:
Highest Standards, Better Outcomes

THE SURGEON AS A LEADER: ADDRESSING HEALTH CARE DISPARITIES





Dear Colleagues,

I want to invite you to attend the American College of Surgeons 97th Annual Clinical Congress, scheduled for October 23–27, 2011, at the Moscone Convention Center in beautiful San Francisco.

The Program Committee, chaired by Barbara L. Bass, MD, FACS, and the Division of Education, under the leadership of Ajit Sachdeva, MD, FACS, have put together an outstanding Scientific Program that takes into consideration the sea change in the practice of surgery as well as many other aspects that impact the daily lives of surgeons. This includes a wide array of timely and important topics that are essential to delivery of surgical care of the highest quality. Among those are broad-ranging Panel Sessions, which include experts from across the surgical specialties and nonsurgical disciplines and Named Lectures delivered by top leaders in their fields. The Didactic and Skills-Oriented Postgraduate Courses will focus on important domains and will help attendees advance their knowledge and acquire new skills. Experiential, hands-on learning will be used to achieve the objectives of these courses.

The Scientific Program for the Clinical Congress will also include a large number of high-quality Scientific Papers, strong Surgical Forum Sessions, timely Video-Based Education Presentations, and excellent posters. These sessions will be complemented by Meet-the-Expert Luncheons and Town Hall Meetings. Attendees will be able to obtain certificates of verification following their participation in Postgraduate Courses and additional certificates will be provided for participation in specific sessions, to address requirements for Maintenance of Certification, Maintenance of Licensure, privileging, and credentialing.

The Clinical Congress Program has been arranged in thematic tracks that address content of interest to all surgical specialties as well as specialty-based tracks that address the learning needs of various specialty groups. The stimulating educational content, which includes special opportunities to address regulatory requirements and interact with experts, and the ability to reconnect with professional colleagues make the 2011 Clinical Congress an essential meeting for all practicing surgeons, surgical residents, and members of surgical teams. On behalf of the American College of Surgeons, I look forward to welcoming you to San Francisco for the 97th Annual Clinical Congress, which will have as its theme *The Surgeon as a Leader: Addressing Health Care Disparities*.

We will look forward to seeing you at this year's meeting!

With best regards,

Carlos A. Pellegrini, MD, FACS
Chair, Board of Regents



ACS PROGRAM COMMITTEE

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Barbara L. Bass, MD, FACS, *Houston, TX*

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William D. Spotnitz, MD, MBA, FACS, *Charlottesville, VA*

Staff:

Ajit K. Sachdeva, MD, FACS, FRCSC, *Chicago, IL*

Julie A. Tribe, MEd, *Chicago, IL*

Katie M. Anthony, *Chicago, IL*

Meeting Overview



What's New in 2011?

The Surgeon as a Leader:
Addressing Health Care Disparities

- Sessions addressing quality and outcomes
- Special focus on education and training to improve quality and promote patient safety
- Current and timely health policy topics
- Sessions on supporting surgical practice in a changing health care environment

Cancellation of Sessions

The American College of Surgeons reserves the right to cancel any of the scientific sessions listed in this Program Planner. The information in this Program Planner is preliminary. Check the College's website at www.facs.org for updates.

Goal

The Clinical Congress is designed to provide individuals with a wide range of learning opportunities, activities, and experiences that will match their educational and professional development needs.

Objective

By the conclusion of the Clinical Congress, participants should gain and be able to apply the knowledge to improve their current practice, research, and care of surgical patients.

Accreditation

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AMA Credit Designation

The American College of Surgeons designates this live activity for a maximum of 50.5* *AMA PRA Category 1 Credits*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

²⁸ *A maximum of 33.5 *AMA PRA Category 1 Credits*[™] for nonticketed sessions only, including evening video sessions.

CME Certificates

On-site claiming of CME Certificates will be issued at the My CME Connection booth located in the ACS Programs Area at the Moscone Convention Center, October 23–27, 2011.

Physicians are responsible for claiming CME credit for the Clinical Congress. Claims for CME credit for this event will be accepted until March 31, 2012.

Scientific and Technical Exhibitions

The Scientific Exhibition is a forum of more than 300 exhibits presenting completed research, research in progress, and case reviews. Innovative surgical practices and teaching methods will also be presented. The Scientific Exhibits will be located in the North Hall of the Moscone Convention Center and the hours are Monday through Wednesday, 7:00 am–4:00 pm.

The Technical Exhibition comprises more than 200 companies displaying their products and services. The exhibition provides an excellent opportunity to explore the surgical marketplace by comparing products firsthand and planning purchases. The Technical Exhibits will be located in the South Hall of the Moscone Convention Center. Technical Exhibits hours are Monday through Wednesday, 9:00 am–4:30 pm.

Friends of Bill W

Friends of Bill W will meet Monday, October 24 through Wednesday, October 26, 7:00–8:30 pm at the Hilton San Francisco.

Clinical Congress News

The official annual meeting newspaper, *Clinical Congress News* will be distributed at the Hilton San Francisco each morning during the Clinical Congress.

Convocation

Sunday, October 23, 6:00–8:00 pm
Moscone Convention Center, West Building

Conferral of Fellowship and Response on behalf of New Fellows, Presentation of the 2011 Distinguished Service Award, Granting of Honorary Fellowships, Installation of Officers, and Presidential Address

All initiates of ACS must register for Clinical Congress if they wish to participate in Convocation. Confirmed ACS Initiates will be bestowed Fellowship in the College during the ceremony regardless of their attendance at the event and may begin using the FACS designation upon conclusion of the ceremony.

Family members of Initiates are not required to register for the Clinical Congress program to attend the Convocation Ceremony.

Opening Ceremony

Monday, October 24, 8:30–9:00 am
Moscone Convention Center, West Building

The Canadian and American national anthems are presented, along with a short video highlighting the new President's theme for the year. The President presides and introduces the College Officers and Regents, Honorary Fellows, Past-Presidents, the recipient of the Distinguished Philanthropist Award, Special Invited Guests from national and international health care organizations, the Resident Research Scholars, the Franklin Martin, C. James Carrico, and Louis C. Argenta Faculty Research Fellows, and the International Guest Scholars. The Martin Memorial Lecture, sponsored by the American Urological Association, follows immediately.

Annual Business Meeting of Members

Wednesday, October 26, 4:15–5:15 pm
Moscone Convention Center

- Reports from the Chair of the Board of Regents, the Chair of the Board of Governors, and the Executive Director
- Presentation of the Resident Award for Exemplary Teaching and the Joan L. and Julius H. Jacobson II Promising Investigator Award
- Reports of the Nominating Committee of the Board of Governors and the Nominating Committee of the Fellows, and introduction of the President-Elect

Clinical Congress Track Schedule



The scientific program, scheduled in discipline- and theme-based tracks, will focus specifically on the needs of various surgical specialties and learner groups.

Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
General Surgery (GEN)					
		Basic/Translational Research (BTR)			
		Cardiothoracic Surgery (CTS)			
		Colon and Rectal Surgery (CRS)			
Education (EDU)					
		Ethics (ETH)		Ethics (ETH)	
				Geriatric/Palliative Care (GER)	
Health Policy: Practice Management/Reimbursement/Liability Issues (HP)					
	International (INT)				
		Neurosurgery (NEU)			
		Obstetrics & Gynecology (OBG)			
			Orthopaedic Surgery (ORT)		
		Otolaryngology–Head & Neck Surgery (OTO)			
		Pediatric Surgery (PED)			
		Plastic & Maxillofacial Surgery (PLA)			
	Residents/Medical Students (RES/MED)				
	Surgical Humanitarian Outreach (HUM)				
	Surgical Oncology (ONC)				
	Trauma/Critical Care (TRA)				
	Urology (URO)				
	Vascular Surgery (VAS)				





Named Lectures

MONDAY, OCTOBER 24

NL01 8:30–9:30 am

Opening Ceremony/Martin Memorial Lecture Sponsored by the AUA: Too Big to Fail? Health Care Reform in the U.S. and Canada

PRESIDING OFFICER: Patricia J. Numann, MD, FACS, *Syracuse, NY*

LECTURER: C. David Naylor, MD, DPhil, *Toronto, ON*

Introduction of Honorary Fellows, recipient of the Distinguished Philanthropist Award, officers, Regents, Past-Presidents, and special invited guests.

SPONSORED BY THE AMERICAN UROLOGICAL ASSOCIATION AND ALTERNATELY NOMINATED BY THE ACS ADVISORY COUNCIL FOR UROLOGICAL SURGERY AND THE ACS HONORS COMMITTEE

NL02 9:45–10:45 am

John H. Gibbon, Jr., Lecture: The Problem of Physician Payment Reform: A Surgical Solution

PRESIDING OFFICER AND INTRODUCER: Frank W. Sellke, MD, FACS, *Boston, MA*

LECTURER: John E. Mayer, Jr., MD, FACS, *Boston, MA*

SPONSORED BY THE ADVISORY COUNCIL FOR CARDIOTHORACIC SURGERY

NL03 2:30–3:30 pm

Charles G. Drake History of Surgery Lecture: The Virtuoso Surgeon—Past, Present, and Future

PRESIDING OFFICER AND INTRODUCER: John L. D. Atkinson, MD, FACS, *Rochester, MN*

LECTURER: Edward R. Laws, MD, FACS, *Boston, MA*

SPONSORED BY THE ADVISORY COUNCIL FOR NEUROLOGICAL SURGERY

TUESDAY, OCTOBER 25

NL04 9:45–10:45 am

Excelsior Surgical Society/Edward D. Churchill Lecture: Changes in Combat Casualty Care in the Last 20 Years

PRESIDING OFFICER AND INTRODUCER: David V. Feliciano, MD, FACS, *Atlanta, GA*

LECTURER: Donald Trunkey, MD, FACS, *Portland, OR*

SPONSORED BY THE ADVISORY COUNCIL FOR GENERAL SURGERY

NL05 12:45–1:30 pm

Scudder Oration on Trauma: Thoracic Aortic Injuries—Crossing the Rubicon

PRESIDING OFFICER AND INTRODUCER: Michael F. Rotondo, MD, FACS, *Greenville, NC*

LECTURER: Demetrios Demetriades, MD, FACS, *Los Angeles, CA*

SPONSORED BY THE COMMITTEE ON TRAUMA

NL06 2:30–3:30 pm

Olga M. Jonasson Lecture: Effective Advocacy

PRESIDING OFFICER AND INTRODUCER: Hilary A. Sanfey, MB BCh, FACS, *Springfield, IL*

LECTURER: Patricia J. Numann, MD, FACS, *Syracuse, NY*

SPONSORED BY THE WOMEN IN SURGERY COMMITTEE

WEDNESDAY, OCTOBER 26

NL07 8:00–9:00 am

Distinguished Lecture of the International Society of Surgery: Surgical Training and Surgical Practice: Are We Getting the Formula Right?

PRESIDING OFFICER AND INTRODUCER: John R. Clarke, MD, FACS, *Philadelphia, PA*

LECTURER: Eilis McGovern, MD, PRCSI, DCH, *Dublin, Ireland*

SPONSORED BY THE U.S. CHAPTER OF THE INTERNATIONAL SOCIETY OF SURGERY

NL08 9:45–10:45 am

Ethics and Philosophy Lecture: Ethical Foundations of Health Care Reform—Implications for Policy and Law

PRESIDING OFFICER AND INTRODUCER: Richard B. Reiling, MD, FACS, *Charlotte, NC*

LECTURER: Robert M. Sade, MD, FACS, *Charleston, SC*

SPONSORED BY THE COMMITTEE ON ETHICS

NL09 12:45–1:45 pm

Commission on Cancer Oncology Lecture: Translational Cancer Research—Playing to Win in a Team Sport

PRESIDING OFFICER AND INTRODUCER: Stephen B. Edge, MD, FACS, *Buffalo, NY*

LECTURER: Monica M. Bertagnolli, MD, FACS, *Boston, MA*

SPONSORED BY THE COMMISSION ON CANCER

NL10 2:30–3:15 pm

I. S. Ravdin Lecture in the Basic Sciences: Cathbots: Ultrasound Guidance for Robotic Beating Heart Surgery

PRESIDING OFFICER AND INTRODUCER: T. Forcht Dagi, MD, MPH, FACS, *Boston, MA*

LECTURER: Robert D. Howe, PhD, *Cambridge, MA*

SPONSORED BY THE I. S. RAVDIN SURGICAL SOCIETY

NL11 2:30–3:30 pm

Herand Abcarian Lecture: Improving the Quality of Cancer Surgery in a Single Payer System: The Cancer Care Ontario Experience

PRESIDING OFFICER AND INTRODUCER: Patricia L. Roberts, MD, FACS, *Burlington, MA*

LECTURER: Robin S. McLeod, MD, FACS, FRCS, *Toronto, ON*

SPONSORED BY THE ADVISORY COUNCIL FOR COLON AND RECTAL SURGERY



Postgraduate Courses

POSTGRADUATE COURSES AND FEES

Only registered meeting attendees may purchase postgraduate course tickets. Seating capacities are limited, and ticket requests will be filled on a first-come, first-processed basis. All courses require a ticket for admission. Postgraduate course tickets may also be purchased on-site in San Francisco, subject to availability. No refunds for postgraduate courses will be accepted after October 19, 2011. However, tickets may be exchanged for another course prior to the start of the course and only if room is available.

Description of Fee Categories

Fellow	A surgeon who is a Fellow of the College
Non-Fellow	A practicing physician who is not currently a member of the College
RAS	Associate Fellows, Resident Members, Medical Student Members, and Affiliate Members of the College
Non-RAS	A physician in training or member of the surgical team who is currently in an accredited training program or working in a surgical-related setting, but has no affiliation with the College

ACS SYSTEM FOR VERIFICATION OF KNOWLEDGE AND SKILLS

The Board of Regents of the American College of Surgeons has approved a five-level model for verification and documentation of knowledge and skills by the Division of Education, following participation in the educational programs of the College. The model provides a framework for designing and implementing educational courses, based on principles of contemporary surgical education, and permits provision of appropriate documentation to the attendees.

The postgraduate didactic and skills-oriented courses offered at the Clinical Congress have been assigned verification levels I–III based on requirements of each level.

		Requirement(s):
Level I	Verification of attendance	Course ticket and course evaluation form
Level II	Verification of satisfactory completion of course objectives	Pre-/post-test and/or skills report card
Level III	Verification of knowledge and skills	Pre-/post-test AND skills report card
Level IV	Verification of preceptorial experience	Not available at Congress
Level V	Verification of satisfactory patient outcomes	Not available at Congress





Postgraduate Courses

REGISTER ONLINE FOR ANY OF THESE POSTGRADUATE SKILLS-ORIENTED OR DIDACTIC COURSES

Course Code	Course Title	Fellow	Non-Fellow	RAS	Non-RAS
SC01-A	Fundamentals of Laparoscopic Surgery (Lecture Only)	\$350	\$400	\$175	\$200
SC01-B	Fundamentals of Laparoscopic Surgery (Lecture + Hands-On Lab)	\$700	\$805	\$350	\$405
SC02	Surgical Education: Principles and Practice	\$360	\$415	\$180	\$210
SC03	Ultrasound Course for Residents	NA	NA	\$340	\$390
SC04-A	Flexible Endoscopy for General Surgeons (Lecture Only)	\$305	\$350	\$155	\$180
SC04-B	Flexible Endoscopy for General Surgeons (Lecture + Hands-On Lab)	\$940	\$1,080	\$470	\$540
SC05-A	Intraoperative Decisions in Laparoscopic Inguinal and Ventral Hernia Repair	\$305	\$350	\$155	\$180
SC05-B	Intraoperative Decisions in Laparoscopic Inguinal and Ventral Hernia Repair	\$940	\$1,080	\$470	\$540
SC06	Humanitarian Surgery: Surgical Skills Training for the International Volunteer Surgeon	\$650	\$750	\$325	\$375
SC07-A	Robotic Surgery: An Introductory Skills Course (Lecture Only)	\$250	\$290	\$125	\$145
SC07-B	Robotic Surgery: An Introductory Skills Course (Lecture + Hands-On Lab)	\$940	\$1,080	\$470	\$540
SC08	Surgeons as Effective Communicators: Sharpening Skills for Critical Moments	\$360	\$415	\$180	\$210
SC09	Advanced Colonoscopy Skills Course: Polypectomy and Beyond	\$655	\$755	\$330	\$380
SC10	FAST Ultrasound Skills Course	\$655	\$755	\$330	\$380
SC11-A	Reduced-Port Laparoscopic Surgery (Lecture Only)	\$420	\$485	\$210	\$240
SC11-B	Reduced-Port Laparoscopic Surgery (Lecture + Hands-On Lab)	\$1,500	\$1,725	\$750	\$865
SC12	Thyroid and Parathyroid Ultrasound	\$1,350	\$1,555	\$675	\$775
SC13-A	Laparoscopic Colectomy Skills Course (Lecture Only)	\$450	\$520	\$225	\$260
SC13-B	Laparoscopic Colectomy Skills Course (Lecture + Hands-On Lab)	\$1,500	\$1,725	\$750	\$865
SC14	Abdominal Ultrasound: Transabdominal, Intraoperative, Laparoscopic	\$1,300	\$1,495	\$650	\$750
PG15	Rocket to Reimbursement Success (Basic)	\$410	\$470	\$205	\$235
PG16	"Meaningful Use" of Electronic Health Records	\$350	\$405	\$175	\$200
PG17	Hepatobiliary-Pancreatic Disasters for the GI Surgeon	\$375	\$430	\$190	\$220
PG18	Big Bang Surgical Coding (Advanced)	\$425	\$490	\$215	\$250
PG19	Employing Allied Health Professionals in a Surgical Practice	\$305	\$350	\$155	\$180
PG20	Modern Evidence-Based Management of Thyroid Cancer	\$375	\$430	\$190	\$220
PG21	Update on Surgical Critical Care	\$375	\$430	\$190	\$220
PG22	General Surgery Review Course	\$815	\$940	\$410	\$470
PG23	Breast Cancer: Current Treatment Paradigms	\$375	\$430	\$190	\$220
PG24	Creation and Maintenance of High-Performance Teams in Surgery: An Educational and Operational Strategy	\$360	\$415	\$180	\$210
PG25	Bariatric and Metabolic Surgery	\$375	\$430	\$190	\$220
PG26	Review Course in the Essentials of Vascular Surgery for General and Vascular Surgeons	\$410	\$470	\$205	\$235
PG27	Trauma and Acute Care Surgery Update	\$375	\$430	\$190	\$220

Postgraduate Skills-Oriented Courses

SC01 Fundamentals of Laparoscopic Surgery (FLS)

TRACK: EDU, GEN

LECTURES ONLY: 4 credits, Verification Level I

Saturday, October 22 • 8:00 am–12:30 pm

LECTURES AND HANDS-ON LAB: 7 credits, Verification Level II

Saturday, October 22 • 8:00 am–5:00 pm

CHAIR: Nathaniel Soper, MD, FACS, *Chicago, IL*

CO-CHAIR: Daniel J. Scott, MD, FACS, *Dallas, TX*

All Session I and II participants will receive online access to the FLS didactic curriculum before the course and will be expected to review the materials. Approximately 10 FLS trainer boxes will be available for training and practice during the Hands-On Session. If participants choose to sit for the FLS exam, they must purchase a test voucher and make a testing appointment through the FLS Program in advance of the Clinical Congress at www.flsprogram.org.

SPONSORED BY THE COMMITTEE ON EMERGING SURGICAL TECHNOLOGY AND EDUCATION

LECTURES ONLY

FEE FELLOW \$350 NON-FELLOW..... \$400
RAS \$175 NON-RAS \$200

LECTURES AND HANDS-ON LAB

FEE FELLOW \$700 NON-FELLOW..... \$805
RAS \$350 NON-RAS \$405

SC02 Surgical Education: Principles and Practice

6 credits, Verification Level I

TRACK: EDU

Saturday, October 22 • 10:00 am–5:30 pm

CHAIR: Anne T. Mancino, MD, FACS, *Little Rock, AR*

CO-CHAIR: Guy F. Brisseau, MD, FACS, FRCS, FAAP, MEd, *Halifax, NS*

SPONSORED BY THE DIVISION OF EDUCATION

FEE FELLOW \$360 NON-FELLOW..... \$415
RAS \$180 NON-RAS \$210

SC03 Ultrasound Course for Residents

5 credits, Verification Level II

TRACK: RES/MED

Sunday, October 23 • 7:30 am–1:00 pm

CHAIR: Amy C. Sisley, MD, MPH, FACS, *Baltimore, MD*

CO-CHAIR: Sarah B. Murthi, MD, FACS, *Baltimore, MD*

Completion of a pre- and post-test is required for Verification Level II courses.

SPONSORED BY THE NATIONAL ULTRASOUND FACULTY

FEE RAS \$340 NON-RAS \$390

SC04 Flexible Endoscopy for General Surgeons

TRACK: GEN

LECTURES ONLY: 4 credits, Verification Level I

Sunday, October 23 • 8:00 am–12:30 pm

LECTURE AND HANDS-ON LAB: 8 credits, Verification Level III

Sunday, October 23 • 8:00 am–5:30 pm

CHAIR: Jeffrey M. Marks, MD, FACS, *Cleveland, OH*

CO-CHAIR: John D. Mellinger, MD, FACS, *Springfield, IL*

Completion of a pre- and post-test and a skills report card are required for Verification Level III courses.

SPONSORED BY THE COMMITTEE ON EMERGING SURGICAL TECHNOLOGY AND EDUCATION

LECTURES ONLY

FEE FELLOW \$305 NON-FELLOW..... \$350
RAS \$155 NON-RAS \$180

LECTURES AND HANDS-ON LAB

FEE FELLOW \$940 NON-FELLOW..... \$1,080
RAS \$470 NON-RAS \$540

SC05 Intraoperative Decisions in Laparoscopic Inguinal and Ventral Hernia Repair

TRACK: EDU, GEN

LECTURE ONLY: 3.5 credits, Verification Level I

Sunday, October 23 • 8:30 am–12:30 pm

LECTURE AND HANDS-ON LAB: 7.5 credits, Verification Level III

Sunday, October 23 • 8:30 am–5:30 pm

CHAIR: Carla M. Pugh, MD, PhD, FACS, *Chicago, IL*

CO-CHAIR: Gerald M. Fried, MD, FACS, *Montreal, QC*

Completion of a pre- and post-test is required for Verification Level III courses.

SPONSORED BY THE COMMITTEE ON EMERGING SURGICAL TECHNOLOGY AND EDUCATION

LECTURES ONLY

FEE FELLOW \$305 NON-FELLOW..... \$350
RAS \$155 NON-RAS \$180

LECTURES AND HANDS-ON LAB

FEE FELLOW \$940 NON-FELLOW..... \$1,080
RAS \$470 NON-RAS \$540

SC06 Humanitarian Surgery: Surgical Skills Training for the International Volunteer Surgeon

TRACK: HUM, INT

7 credits, Verification Level II

Sunday, October 23 • 8:30 am–5:00 pm

CHAIR: Sherry M. Wren, MD, FACS, *Palo Alto, CA*

CO-CHAIR: Kathleen M. Casey, MD, FACS, *Newport, RI*

This course will take place at an off-site location.

SPONSORED BY OPERATION GIVING BACK

FEE FELLOW \$650 NON-FELLOW..... \$750
RAS \$325 NON-RAS \$375



Scientific Program



SC07 Robotic Surgery: An Introductory Skills Course

TRACK: EDU, GEN

LECTURE ONLY: 2 credits, Verification Level I

Monday, October 24 • 10:00 am–12:15 pm

LECTURE AND HANDS-ON LAB: 6 credits, Verification Level II

Monday, October 24 • 10:00 am–5:30 pm

CHAIR: Ronney Abaza, MD, FACS, *Columbus, OH*

CO-CHAIR: Pier C. Giulianotti, MD, FACS, *Chicago, IL*

Participation in the hands-on portion of the course requires an application. Preference will be given to practicing physicians with access to robotic equipment at their institution. Accepted participants will be required to complete a 2-hour online curriculum prior to the course.

Completion of a pre- and post-test is required for Verification Level II courses.

SPONSORED BY THE COMMITTEE ON EMERGING SURGICAL TECHNOLOGY AND EDUCATION

LECTURES ONLY

FEE FELLOW \$250 NON-FELLOW..... \$290
RAS \$125 NON-RAS \$145

LECTURES AND HANDS-ON LAB

FEE FELLOW \$940 NON-FELLOW..... \$1,080
RAS \$470 NON-RAS \$540

SC08 Surgeons as Effective Communicators: Sharpening Skills for Critical Moments

6 credits, Verification Level I

TRACK: EDU, GEN

Monday, October 24 • 10:00 am–5:30 pm

CHAIR: Thomas R. Gadacz, MD, FACS, *St. Petersburg, FL*

CO-CHAIR: L. D. Britt, MD, MPH, FACS, FCCM, FRCS(Eng)(Hon), *Norfolk, VA*

SPONSORED BY THE DIVISION OF EDUCATION

FEE FELLOW \$360 NON-FELLOW..... \$415
RAS \$180 NON-RAS \$210

SC09 Advanced Colonoscopy Skills Course: Polypectomy and Beyond

TRACK: CRS, GEN

4 credits, Verification Level II

Monday, October 24 • 1:00–5:15 pm

CHAIR: Peter W. Marcello, MD, FACS, *Burlington, MA*

CO-CHAIR: Toyooki Sonoda, MD, FACS, *New York, NY*

Completion of a pre-and post-test is required for Verification Level II courses.

SPONSORED BY THE ADVISORY COUNCIL FOR COLON AND RECTAL SURGERY

FEE FELLOW \$655 NON-FELLOW..... \$755
RAS \$330 NON-RAS \$380

SC10 FAST Ultrasound Skills Course

TRACK: GEN, TRA

4 credits, Verification Level II

Monday, October 24 • 1:00–5:15 pm

CHAIR: Dan Adrian Galvan, MD, FACS, *Hershey, PA*

CO-CHAIR: Heidi L. Frankel, MD, FACS, *Hershey, PA*

PREREQUISITE:

Completed basic ultrasound course.

The following options meet the prerequisite:

1. Completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons.
2. Completion of the CD-ROM course, Ultrasound for Surgeons: The Basic Course. The CD-ROM is available for purchase online at www.facs.org in the ACS Publications and Services Catalog or by contacting ACS Customer Service at 312-202-5474.
3. Completion of a comparable course elsewhere. Please include either a CME Certification or a Certificate of Completion with your registration. Equivalent ultrasound courses are subject to approval by the National Ultrasound Faculty.

Completion of a pre-and post-test is required for Verification Level II courses.

SPONSORED BY THE NATIONAL ULTRASOUND FACULTY

FEE FELLOW \$655 NON-FELLOW..... \$755
RAS \$330 NON-RAS \$380

SC11 Reduced-Port Laparoscopic Surgery

TRACK: GEN

LECTURE ONLY: 4 credits, Verification Level I

Tuesday, October 25 • 7:30 am–12:00 noon

LECTURE AND HANDS-ON LAB: 7 credits, Verification Level II

Tuesday, October 25 • 7:30 am–4:30 pm

CHAIR: Deborah A. Nagle, MD, FACS, *Boston, MA*

CO-CHAIR: Paul G. Curcillo II, MD, FACS, *Philadelphia, PA*

Completion of a pre- and post-test is required for Verification Level II courses.

SPONSORED BY THE PROGRAM COMMITTEE

LECTURES ONLY

FEE FELLOW \$420 NON-FELLOW..... \$485
RAS \$210 NON-RAS \$240

LECTURES AND HANDS-ON LAB

FEE FELLOW \$1,500 NON-FELLOW..... \$1,725
RAS \$750 NON-RAS \$865





SC12 Thyroid and Parathyroid Ultrasound

TRACK: GEN, OTO

7 credits, Verification Level III

Tuesday, October 25 • 8:00 am–4:30 pm

CHAIR: Robert A. Sofferman, MD, FACS, Burlington, VT

CO-CHAIR: Lisa A. Orloff, MD, FACS, San Francisco, CA

PREREQUISITE: Registrants must have completed the CD-ROM course, Ultrasound for Surgeons: The Basic Course, 2nd Edition. The CD-ROM may be ordered online, by phone, or by a mail-order form. Please visit <http://www.facs.org/education/usCDROM.html> for details.

Completion of a pre- and post-test and a skills report card are required for Verification Level III courses.

SPONSORED BY THE NATIONAL ULTRASOUND FACULTY

FEE FELLOW \$1,350 NON-FELLOW..... \$1,555
RAS \$675 NON-RAS \$775

SC13 Laparoscopic Colectomy Skills Course

TRACK: CRS

Lecture Only: 4 credits, Verification Level I

Wednesday, October 26 • 8:00 am–12:30 pm

LECTURE AND HANDS-ON LAB: 7 credits, Verification Level II

Wednesday, October 26 • 8:00 am–4:00 pm

CHAIR: Sang W. Lee, MD, FACS, New York, NY

CO-CHAIR: Howard M. Ross, MD, FACS, Red Bank, NJ

Completion of a pre- and post-test is required for Verification Level II courses.

This course will take place at the SimSurg Education Center at California Pacific Medical Center.

SPONSORED BY THE ADVISORY COUNCIL FOR COLON AND RECTAL SURGERY AND THE COMMITTEE ON EMERGING SURGICAL TECHNOLOGY AND EDUCATION

LECTURES ONLY

FEE FELLOW \$450 NON-FELLOW..... \$520
RAS \$225 NON-RAS \$260

LECTURES AND HANDS-ON LAB

FEE FELLOW \$1,500 NON-FELLOW..... \$1,725
RAS \$750 NON-RAS \$865

SC14 Abdominal Ultrasound: Transabdominal, Intraoperative, Laparoscopic

TRACK: GEN

8 credits, Verification Level II

Wednesday, October 26 • 8:00 am–5:30 pm

CHAIR: Junji Machi, MD, PhD, FACS, Honolulu, HI

CO-CHAIR: Leo Villegas, MD, Durham, NC

PREREQUISITE: Completed basic ultrasound course.

The following options meet the prerequisite:

1. Completion of the previously offered ACS postgraduate course titled Ultrasound for Surgeons.
2. Completion of the CD-ROM course, Ultrasound for Surgeons: The Basic Course. The CD-ROM is available for purchase online at www.facs.org in the ACS Publications and Services Catalog or by contacting ACS Customer Service at 312-202-5474.
3. Completion of a comparable course elsewhere. Please include either a CME Certification or a Certificate of completion with your registration. Equivalent ultrasound courses are subject to approval by the National Ultrasound Faculty.

Completion of a pre- and post-test is required for Verification Level II courses.

SPONSORED BY THE NATIONAL ULTRASOUND FACULTY

FEE FELLOW \$1,300 NON-FELLOW..... \$1,495
RAS \$650 NON-RAS \$750





Postgraduate Didactic Courses

PG15 Rocket to Reimbursement Success (Basic)

6 credits, Verification Level I

TRACK: HP

Saturday, October 22 • 9:00 am–4:30 pm

CHAIR: Christopher K. Senkowski, MD, FACS, Savannah, GA

CO-CHAIR: Albert Bothe, Jr., MD, FACS, Danville, PA

SPONSORED BY THE GENERAL SURGERY CODING AND REIMBURSEMENT COMMITTEE

FEE FELLOW \$410 NON-FELLOW..... \$470
RAS \$205 NON-RAS \$235

PG16 “Meaningful Use” of Electronic Health Records

4 credits, Verification Level I

TRACK: HP

Sunday, October 23 • 8:00 am–12:15 pm

CHAIR: Pamela A. Howard, MD, MBA, FACS, Little Rock, AR

CO-CHAIR: Paresh C. Shah, MD, FACS, New York, NY

SPONSORED BY THE GENERAL SURGERY CODING AND REIMBURSEMENT COMMITTEE

FEE FELLOW \$350 NON-FELLOW..... \$405
RAS \$175 NON-RAS \$200

PG17 Hepatobiliary-Pancreatic Disasters for the GI Surgeon

6 credits, Verification Level I

TRACK: GEN

Sunday, October 23 • 9:00 am–4:30 pm

CHAIR: Michael G. Sarr, MD, FACS, Rochester, MN

CO-CHAIR: Jennifer F. Tseng, MD, FACS, Worcester, MA

SPONSORED BY THE PROGRAM COMMITTEE

FEE FELLOW \$375 NON-FELLOW..... \$430
RAS \$190 NON-RAS \$220

PG18 Big Bang Surgical Coding (Advanced)

6 credits, Verification Level I

TRACK: HP

Sunday, October 23 • 10:00 am–5:30 pm

CHAIR: Mark T. Savarise, MD, FACS, Sandpoint, ID

CO-CHAIR: Albert Bothe, Jr., MD, FACS, Danville, PA

SPONSORED BY THE GENERAL SURGERY CODING AND REIMBURSEMENT COMMITTEE

FEE FELLOW \$425 NON-FELLOW..... \$490
RAS \$215 NON-RAS \$250

PG19 Employing Allied Health Professionals in a Surgical Practice

4 credits, Verification Level I

TRACK: GEN, HP

Sunday, October 23 • 1:30–5:45 pm

CHAIR: Peter Jeffrey Fabri, MD, PhD, FACS, Tampa, FL

CO-CHAIR: Constantine V. Godellas, MD, FACS, Maywood, IL

SPONSORED BY THE COMMITTEE ON ALLIED HEALTH PROFESSIONALS

FEE FELLOW \$305 NON-FELLOW..... \$350
RAS \$155 NON-RAS \$180

PG20 Modern Evidence-Based Management of Thyroid Cancer

6 credits, Verification Level I

TRACK: GEN, ONC, OTO

Monday, October 24 • 9:45 am–5:15 pm

CHAIR: David J. Terris, MD, FACS, Augusta, GA

CO-CHAIR: Cord Sturgeon, MD, FACS, Chicago, IL

SPONSORED BY THE PROGRAM COMMITTEE

FEE FELLOW \$375 NON-FELLOW..... \$430
RAS \$190 NON-RAS \$220

PG21 Update on Surgical Critical Care

6 credits, Verification Level I

TRACK: GEN, TRA

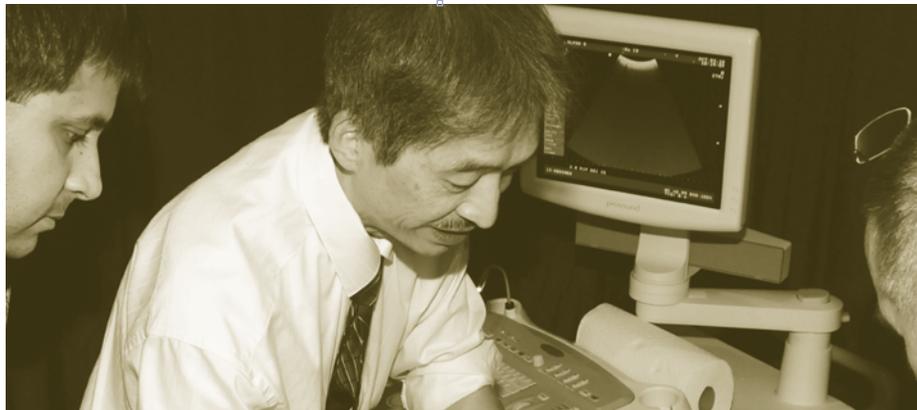
Monday, October 24 • 9:45 am–5:15 pm

CHAIR: Joseph Cuschieri, MD, FACS, Seattle, WA

CO-CHAIR: Lena M. Napolitano, MD, FACS, Ann Arbor, MI

SPONSORED BY THE PROGRAM COMMITTEE

FEE FELLOW \$375 NON-FELLOW..... \$430
RAS \$190 NON-RAS \$220





PG22 General Surgery Review Course

12 credits, Verification Level II

TRACK: GEN

Monday, October 24 • 10:00 am–5:30 pm

Tuesday, October 25 • 8:00 am–3:30 pm

CHAIR: John A. Weigelt, MD, DVM, FACS, Milwaukee, WI

VICE-CHAIR: Eugene F. Foley, MD, FACS, Madison, WI

VICE-CHAIR: Robert C. McIntyre, Jr., MD, FACS, Aurora, CO

SPONSORED BY THE DIVISION OF EDUCATION

FEE FELLOW \$815 NON-FELLOW..... \$940
RAS \$410 NON-RAS \$470

PG23 Breast Cancer: Current Treatment Paradigms

6 credits, Verification Level I

TRACK: GEN, ONC

Tuesday, October 25 • 9:00 am–4:30 pm

CHAIR: V. Suzanne Klimberg, MD, FACS, Little Rock, AR

CO-CHAIR: Kimberly J. Van Zee, MD, FACS, New York, NY

SPONSORED BY THE PROGRAM COMMITTEE AND THE ADVISORY COUNCIL FOR GENERAL SURGERY

FEE FELLOW \$375 NON-FELLOW..... \$430
RAS \$190 NON-RAS \$220

PG24 Creation and Maintenance of High-Performance Teams in Surgery: An Educational and Operational Strategy

6 credits, Verification Level I

TRACK: EDU, GEN

Tuesday, October 25 • 9:30 am–5:00 pm

CHAIR: Donald W. Moorman, MD, FACS, Pittsburgh, PA

CO-CHAIR: David L. Feldman, MD, MBA, CPE, FACS, Brooklyn, NY

SPONSORED BY THE COMMITTEE ON DEVELOPMENT OF HIGH PERFORMANCE TEAMWORK IN SURGERY

FEE FELLOW \$360 NON-FELLOW..... \$415
RAS \$180 NON-RAS \$210

PG25 Bariatric and Metabolic Surgery

6 credits, Verification Level I

TRACK: GEN

Tuesday, October 25 • 10:00 am–5:30 pm

CHAIR: Daniel B. Jones, MD, FACS, Boston, MA

CO-CHAIR: Giselle G. Hamad, MD, FACS, Pittsburgh, PA

SPONSORED BY THE PROGRAM COMMITTEE AND THE ADVISORY COUNCIL FOR GENERAL SURGERY

FEE FELLOW \$375 NON-FELLOW..... \$430
RAS \$190 NON-RAS \$220

PG26 Review Course in the Essentials of Vascular Surgery for General and Vascular Surgeons

6 credits, Verification Level II

TRACK: GEN, VAS

Wednesday, October 26 • 8:00 am–3:30 pm

CHAIR: Sean P. Lyden, MD, FACS, Broadview Heights, OH

CO-CHAIR: Vivian Gahtan, MD, FACS, Syracuse, NY

SPONSORED BY THE ADVISORY COUNCIL FOR VASCULAR SURGERY

FEE FELLOW \$410 NON-FELLOW..... \$470
RAS \$205 NON-RAS \$235

PG27 Trauma and Acute Care Surgery Update

6 credits, Verification Level I

TRACK: GEN, TRA

Wednesday, October 26 • 9:00 am–4:30 pm

CHAIR: Gregory J. Jurkovich, MD, FACS, Seattle, WA

CO-CHAIR: Karen J. Brasel, MD, MPH, FACS, Milwaukee, WI

SPONSORED BY THE PROGRAM COMMITTEE

FEE FELLOW \$375 NON-FELLOW..... \$430
RAS \$190 NON-RAS \$220





Meet-the-Expert Luncheons

Converse with experts on selected topics over an informal lunch. There will be no formal presentations or A/V provided during these luncheons. Case-based discussions will be encouraged. Cost for each luncheon is \$45. The luncheons will be from 1:15 to 2:15 pm on Monday and from 11:30 am to 12:30 pm on Tuesday and Wednesday.

Monday, October 24, 1:15–2:15 pm	
ME101	Minimally Invasive Hepatic Surgery by David A. Geller, MD, FACS, Pittsburgh, PA
ME102	Bariatric Surgery by Daniel B. Jones, MD, MS, FACS, Boston, MA
ME103	Hemorrhoids: New Treatments for an Old Problem by David E. Beck, MD, FACS, New Orleans, LA
ME104	Treatment of Thoracic Emergencies Seen by the General Surgeon on Call by Thomas K. Varghese, MBBS, FACS, Seattle, WA
ME105	Treatment of Anal Fissure by Herand Abcarian, MD, FACS, Chicago, IL
ME106	Thoracic Outlet Compression Syndrome by Julie A. Freischlag, MD, FACS, Baltimore, MD
ME107	Surgical Morbidity and Mortality by David M. Mahvi, MD, FACS, Chicago, IL
ME108	Esophageal Cancer by Jeffrey H. Peters, MD, FACS, Rochester, NY
ME109	Patient Education by H. Randolph Bailey, MD, FACS, Houston, TX
ME110	How to Close the Open Abdomen by Hugh M. Foy, MD, FACS, Seattle, WA
ME111	Complex Issues in Thyroid Cancer by Ashok R. Shaha, MD, FACS, New York, NY
ME112	Crohn's Disease by John H. Pemberton, MD, FACS, Rochester, MN
ME113	What Is the Role of Robot Thyroidectomy? by Nancy D. Perrier, MD, FACS, Houston, TX
ME114	Critical Care Management for the Traumatic Brain Injury Patient by Alex B. Valadka, MD, FACS, Austin, TX
ME115	21st Century Management of Iliofemoral Deep Vein Thrombosis by David L. Gillespie, MD, FACS, Rochester, NY
ME116	Advocacy for Surgeons: How I Do It by John H. Armstrong, MD, FACS, Tampa, FL
ME117	Challenges in Surgical Privileging by Barbara L. Bass, MD, FACS, Houston, TX
Tuesday, October 25, 11:30 am–12:30 pm	
ME201	Pancreatic Cancer by L. William Traverso, MD, FACS, Boise, ID
ME202	Difficult Diverticulitis by Jeffrey L. Cohen, MD, FACS, Hartford, CT
ME203	Hernia/Open Abdomen by Lena M. Napolitano, MD, FACS, FCCP, FCCM, Ann Arbor, MI
ME204	Treatment of Intraabdominal Infections: When to Operate? by Saman Arbabi, MD, FACS, Seattle, WA
ME205	Difficult Ostomies by Peter A. Cataldo, MD, FACS, Burlington, VT
ME206	The New Guidelines for Recurrent Nerve Monitoring for Thyroid and Parathyroid Operations by Gregory W. Randolph, MD, FACS, Boston, MA
ME207	Managing the Difficult Family by Craig S. Derkay, MD, FACS, Norfolk, VA

ME208	Abdominal Disasters by Michael G. Sarr, MD, FACS, Rochester, MN, and Jennifer Tseng, MD, FACS, Worcester, MA
ME209	Laparoscopic Colectomy: Moving Up the Learning Curve by Övunc Bardakcioglu, MD, FACS, St. Louis, MO
ME210	Robotic Laparoscopic Surgery by Myriam J. Curet, MD, FACS, Los Altos, CA
ME211	Surgery for Thyroid Cancer by Gerard M. Doherty, MD, FACS, Ann Arbor, MI
ME212	Breast Reconstruction by Laura J. Esserman, MD, FACS, San Francisco, CA
ME213	Current Recommendations for Blood Products in Trauma Resuscitation by Ernest E. Moore, MD, FACS, Denver, CO
ME214	Blunt and Penetrating Trauma of the Genitourinary Tract by Jack W. McAninch, MD, FACS, San Francisco, CA
ME215	Creating Arteriovenous Fistulas that Work by Thomas S. Huber, MD, FACS, Gainesville, FL
ME216	Liver Resection for Cancer by Yuman Fong, MD, FACS, New York, NY
ME217	Choosing the Correct Bariatric Procedure by Ninh T. Nguyen, MD, FACS, Orange, CA
Wednesday, October 26, 11:30 am–12:30 pm	
ME301	New Strategies for Managing Ductal Carcinoma In Situ (DCIS) by Lisa A. Newman, MD, MPH, FACS, Ann Arbor, MI
ME302	Complex Abdominal Trauma by David V. Feliciano, MD, FACS, Atlanta, GA
ME303	Anorectal Fistulae and Abscesses by Randolph M. Steinhagen, MD, FACS, New York, NY
ME304	Goiter Surgery: When and How by Christopher R. McHenry, MD, FACS, Cleveland, OH
ME305	New Concepts in Breast Cancer by Armando E. Giuliano, MD, FACS, Santa Monica, CA
ME306	Pilonidal Disease by Jan Rakinic, MD, FACS, Springfield, IL
ME307	Appendicitis: Antibiotics, Laparoscope, or Open Surgery? by Rodney J. Mason, MBBCh, PhD, FACS, Los Angeles, CA
ME308	Creating a High-Quality Surgical Video by Tonia M. Young-Fadok, MD, FACS, Phoenix, AZ, and Steven D. Schweitzberg, MD, FACS, Cambridge, MA
ME309	Gastroesophageal Reflux Disease (GERD) by W. Scott Melvin, MD, FACS, Columbus, OH
ME310	Severe Liver Injuries by Rao R. Ivatury, MD, FACS, Richmond, VA
ME311	How to Effectively Use Topical Hemostats, Sealants, and Adhesives by William D. Spotnitz, MD, MBA, FACS, Gainesville, FL
ME312	Current Resuscitation of the Critically Injured Patient by Ronald V. Maier, MD, FACS, Seattle, WA
ME313	Ulcerative Colitis by Stephen R. Gorfine, MD, FACS, New York, NY
ME314	How to Diagnose and Treat a Necrotizing Soft Tissue Infection by Eileen Metzger Bulger, MD, FACS, Seattle, WA

Special Interest Sessions

Please note, these are non-CME designated sessions, unless otherwise indicated.

SUNDAY, OCTOBER 23

Medical Student Program

Session I: 12:00 noon–6:00 pm

The Division of Education invites students from all four years of medical school to attend the Clinical Congress and to participate in a program designed specifically for medical students who may be interested in pursuing a career in surgery.

This program starts on Sunday afternoon and continues on Monday and Tuesday afternoons. Programming is varied from day to day, and students are welcome to attend all or selected portions of this three-day program.

Students must be enrolled in a U.S., Canadian, or international allopathic or osteopathic medical school in order to participate. For additional information, please contact Ms. Krashina Hudson at 312-202-5335 or khudson@facs.org.

Please register for this special program online at www.facs.org.

Resident and Associate Society Debate

Sunday, October 23, 1:00–4:00 pm

RAS DEBATE 2011: "WHAT IS THE FUTURE OF SURGERY: AUTONOMOUS PROFESSIONALS OR STUCK AS EMPLOYEES?"

The 2011 RAS Debate will discuss if the future of surgery will allow surgeons to retain independence in their day-to-day practice, or whether they will be contracted staff of large integrated health systems or health care delivery networks, subject to multiple levels of management. What are the advantages of our current practice models? What might be the advantages of an employed system? Will today's surgeons want to practice in the work environment of the future? Join us for a panel discussion followed by an audience question and answer/debate. For additional information, please contact Ms. Peg Haar at 312-202-5312 or phaar@facs.org.

MONDAY, OCTOBER 24

Interviewing, Selecting, and Preparing for Surgery Residency: A Special Program for Medical Students

9:45 am–12:00 noon

Join residency program administrators, program directors, and surgical residents as they present a program designed specifically for medical students. Topics will include mastering the interview process, preparing the NRMP rank list, exhibiting professionalism, succeeding in residency, and employing innovative strategies to find work/life balance. An "Ask the Experts" session will conclude the program.

SPONSORED BY THE AMERICAN COLLEGE OF SURGEONS, THE ASSOCIATION OF PROGRAM DIRECTORS IN SURGERY, AND THE ASSOCIATION OF RESIDENCY COORDINATORS IN SURGERY

Surgery Resident Program

ESSENTIAL SKILLS FOR SURGICAL PRACTICE: A PRIMER FOR RESIDENTS

10:00 am–4:00 pm

Surgery residents from all postgraduate year levels are invited by the Division of Education to participate in a special program designed to assist surgery residents with essential nonclinical issues they face during residency training and the transitional period to their posttraining career.

For additional information, please contact Ms. Cherylann Sherman at 312-202-5424 or csherman@facs.org.

Please register online at www.facs.org.

Medical Student Program

Session II: 1:00–6:00 pm

For a brief description of this program, please refer to the Sunday schedule. Note that programming is varied from day to day, and students are welcome to attend all or selected portions of this three-day program.

Cardiothoracic Surgery in the Future: Technology Overview for Residents and Medical Students

5:30–9:00 pm • Fee: \$25 (includes dinner)

LOCATION: Marriott Marquis

COURSE DIRECTORS: Daniel L. Miller, MD, FACS, Atlanta, GA; James T. Fann, MD, FACS, Stanford, CA

This course will introduce surgery residents and medical students to conventional and less invasive procedures that are available to cardiothoracic surgeons today and provide information about new technologies and the integrated cardiothoracic surgery training programs. The primary focus of the session will be hands-on experience with specific cardiothoracic surgical procedures. Participants will experience and have the opportunity to perform these procedures using surgical simulators. The program will be taught by surgeons who are leaders in conventional and less invasive cardiac and general thoracic surgery.

SPONSORED BY THE AMERICAN COLLEGE OF SURGEONS, THE SOCIETY OF THORACIC SURGEONS, AND THE AMERICAN ASSOCIATION FOR THORACIC SURGERY

Please refer to the registration section of the ACS website at www.facs.org.

TUESDAY, OCTOBER 25

Town Hall Meetings

7:00–7:45 am

TH01: "Surgical" Technologies that Will Revolutionize Surgery

SPONSORED BY COMMITTEE ON EMERGING SURGICAL TECHNOLOGY AND EDUCATION

TH02: Do Practicing Surgeons Also Need Duty Hour Rules?

SPONSORED BY ACS RESIDENT ASSOCIATE SOCIETY

TH03: What Is the Scope of General Surgery Practice?

SPONSORED BY THE ADVISORY COUNCIL FOR GENERAL SURGERY

TH04: Quality Improvement through the ACS NSQIP

SPONSORED BY DIVISION OF RESEARCH AND OPTIMAL PATIENT CARE

TH05: Grant Writing Update: From K's to R's to VA Grants

SPONSORED BY THE COMMITTEE FOR THE FORUM ON FUNDAMENTAL SURGICAL PROBLEMS



2011 Excellence in Research Awards Distribution/Surgical Forum Dedication

Quality, Outcomes, and Costs I

12:45–4:00 pm

The Committee for the Forum on Fundamental Surgical Problems will distribute awards for excellence in research in the following categories: alimentary tract, cardiothoracic surgery, critical care, biomarkers/genetic determinants of disease and outcomes, geriatric surgery, orthopaedic surgery, plastic/maxillofacial surgery, quality, outcomes and costs, surgical education, surgical oncology, targeted therapies, transplantations, progenitor cells and cell-based therapies, urology, and vascular surgery. In addition, the 62nd volume of the Owen H. Wangensteen Surgical Forum will be dedicated to Eric W. Fonkalsrud, MD, FACS, Los Angeles, CA. Introduction will be made by O. Joe Hines, MD, FACS, with remarks from Dr. Fonkalsrud immediately following. Surgical residents and their mentors are encouraged to attend the awards distribution/dedication following the session.

Medical Student Program

Session III: 1:00–6:00 pm

For a brief description of this program, please refer to the Sunday schedule on page 39. Note that programming is varied from day to day, and students are welcome to attend all or selected portions of this three-day program.

Posters of Exceptional Merit Presentation

11:30 am–12:30 pm

All attendees are invited to join in a lunchtime tour and discussion of the Posters of Exceptional Merit, facilitated by Barbara L. Bass, MD, FACS, Chair of the Program Committee. More than 300 posters will be on display at the Clinical Congress, but only a select few are designated Posters of Exceptional Merit. Come hear the authors of these distinguished works present their research and answer questions prior to the judges awarding one poster the title of Best Scientific Exhibit.

Chapter Showcase: How We Do It

2:30–4:00 pm

This year, the Chapter Showcase will focus on “How We Do It.” Chapter leaders will report on how their Chapters undertake and produce new services and membership benefits. For 2011, quality-improvement and resident-engagement programs will be presented.

Chapter leaders are encouraged to attend. In addition, leaders of surgical specialty societies are welcome to attend, too. This year’s Chapter Showcase includes:

ACS NSQIP: HOW WE DO IT

TENNESSEE CHAPTER—Joe Cofer, MD, FACS, will report on how the TN Chapter has successfully collaborated with two stakeholders to form the TN Surgical Quality Collaborative to implement the College’s National Surgical Quality Improvement Program (NSQIP) in 10 hospitals. Dr. Cofer also will share early results of the Collaborative.

FLORIDA CHAPTER—In May 2010, the College, the Florida Chapter, and the Florida Hospital Association announced a partnership to launch the Florida Surgical Care Initiative (FSCI), a statewide surgical quality improvement collaboration based on NSQIP. Joseph J. Tepas III, MD, FACS, will present a status report on the FSCI.

SKILLS COMPETITIONS FOR RESIDENTS: HOW WE DO IT

Orlando Kirton, MD, FACS, will report on the Connecticut Chapter’s development of a successful new education program to engage residents as part of the Chapter’s annual meeting and education program.

Eighth Annual Rural Surgeons Open Forum and Oweida Scholarship Presentation

4:15–5:45 pm

The session opens with the introduction of the 2011 Nizar N. Oweida Scholarship recipient, Afaq Z. Khan, MBBS, a rural general surgeon practicing in Hays, KS.

The Rural Surgery Subcommittee of the Advisory Council for General Surgery sponsors this open forum to enable direct communication between rural general surgeons and a panel comprised of four to six influential leaders of the American surgical profession. Representation from the Board of Regents, the Board of Governors, the Executive staff and its Divisions as well as from the American Board of Surgery will be present.

As the meaning of sustainable health care reform, and in particular, the crucial role of the rural general surgeon in this process, continues to evolve, these panelists look forward to hearing your experiences and recommendations.

If you believe that rural general surgeons have valuable input for the College’s leadership, then this forum is for you.

WEDNESDAY, OCTOBER 26

Town Hall Meetings

7:00–7:45 am

TH06: Beyond Local Peer Review

SPONSORED BY THE BOARD OF GOVERNORS’ COMMITTEE ON SURGICAL PRACTICES

TH07: When Are You Off the Learning Curve? Graduating Residents and Experienced Surgeons Doing New Things

SPONSORED BY THE YOUNG FELLOWS ASSOCIATION

TH08: Advancing Surgical Advocacy: Opportunities above the Grassroots and Grasstops

SPONSORED BY THE ADVISORY COUNCIL FOR OPHTHALMIC SURGERY

TH09: Quality Improvement through the ACS Bariatric Surgery Center Network Accreditation Program

SPONSORED BY DIVISION OF RESEARCH AND OPTIMAL PATIENT CARE

TH10: Applying the New Commission on Cancer Quality Metrics in Your Cancer Program

SPONSORED BY THE COMMISSION ON CANCER

THURSDAY, OCTOBER 27

Town Hall Meetings

7:00–7:45 am

TH11: Assessing the Core Competencies of the General Surgeon

SPONSORED BY THE BOARD OF GOVERNORS’ COMMITTEE ON SURGICAL PRACTICES

TH12: Women in Surgery: Are We Doing Our Part to Improve Diversity?

SPONSORED BY THE WOMEN IN SURGERY COMMITTEE

TH13: Advocacy Efforts of ACSPA-SurgeonsPAC

SPONSORED BY ACSPA-SURGEONSPAC

General Information



AIR TRANSPORTATION

ACS has arranged special meeting discounts on United Airlines. These special discounts are available by booking with United directly (independently or through a travel agent). Be sure to reference the ACS file number below to obtain the special fares.

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ACS FILE: 501CR

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Avis is designated as the official car rental company for the 2011 Clinical Congress. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

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CHILD POLICY

The ACS policy regarding children is as follows:

- Under 12 not permitted on Social Program tours
- Under 16 not permitted on exhibit floor or in scientific sessions
- 16 and over must have a badge to enter exhibit area or meeting rooms

This policy includes infants in strollers and arms.

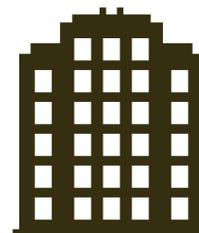


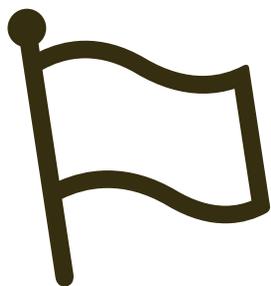
CAMP ACS

The American College of Surgeons is once again partnering with ACCENT on Children's Arrangements, Inc. to provide an exciting on-site children's camp in San Francisco. ACCENT has prepared a program of activities such as arts and crafts and active games, all designed to entertain your children while you are attending meetings and sessions. Camp ACS is available to children ages six months through 17 years. It will be located at Marriott San Francisco Marquis. For more information on Camp ACS, please visit our website at <http://www.facs.org/clincon2011/social/campacs.html>.

AFFILIATE GROUP FUNCTIONS

Groups planning a social function or business meeting to be held in conjunction with the Clinical Congress will need to make arrangements through ACS. For more information and to request function space, please contact Carrie Ryan, ACS Convention and Meetings, at cryan@facs.org.





INTERNATIONAL ATTENDEES

Travel Packages

In an effort to improve the level of services provided to our international attendees, ACS has appointed ESA Voyages of Paris as the official international travel provider. Working directly with corporate travel departments and your preferred travel agent, ESA will provide full-service travel packages for international guests. Packages include full-service air inclusive or ground-only travel packages to fit the needs of both individual travelers and groups. All of the packages include hotel stay, daily American breakfast, airport transfers in San Francisco, travel assistance during the meeting, and on-site registration material delivery coordination.

For additional information regarding international travel packages, please visit www.esavoyages.fr or contact:

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Visa Information

International Fellows, guest physicians, and meeting attendees: Please be aware that the process of obtaining a visa to attend meetings in the U.S. takes much longer than in the past. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting. For detailed information regarding the Visa Waiver Program (VWP), please visit the U.S. Homeland Security website at http://travel.state.gov/visa/temp/without/without_1990.html#.

You may request a letter from the College welcoming you to the Clinical Congress when you register online for the meeting. You may also contact the International Liaison Section via e-mail at postmaster@facs.org or by fax at 312-202-5021.

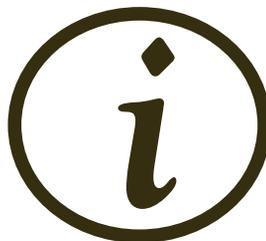


SHUTTLE BUS SERVICE

Complimentary shuttle bus service will be provided for all registrants at regular intervals between the Moscone Convention Center and most designated ACS Clinical Congress hotels. Schedules and routes will be available at the Convention Center and participating hotels.

LOST AND FOUND

Lost-and-found areas will be located in the ACS Convention Office at the Hilton San Francisco and in the Convention and Exhibit Office at Moscone Convention Center, North Hall. Persons looking for or finding lost items should contact one of these offices.



HELP AND INFORMATION CENTER

The Help and Information Center will be located at the Moscone Convention Center and will be available during registration hours.

Registration Information



Who should attend and what's included?

Registration is open to all physicians and individuals in the health care field and includes a name badge, program book, and entrance to the exhibits and all sessions* other than postgraduate courses and Meet-the-Expert Luncheons. To review the full registration policies and submit your 2011 Clinical Congress registration, please visit our website at <http://www.facs.org/clincon2011/registration/index.html>.

*The following sessions are included with your Clinical Congress registration and are not ticketed. Registering for these sessions does not guarantee seating within the course. Seating is provided on a first-come, first-served basis until the meeting room is full.

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- Panel Sessions
- Scientific Exhibits
- Scientific Paper
- Surgical Forum
- Town Hall Meetings
- Video-Based Sessions

REGISTRATION AND MEMBERSHIP QUESTIONS

Should you have any questions regarding Clinical Congress registration, please contact Registration Services. **Phone registrations are not accepted.**

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PHONE: 312-202-5244

FAX: 312-202-5003

Should you have any questions regarding your ACS membership prior to registering for the Clinical Congress, please contact Member Services at the appropriate number below.

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ASSOCIATE FELLOW, RESIDENT, MEDICAL STUDENT, AND AFFILIATE MEMBERS 800-293-4029

For information on becoming a member of the College and to download an application, please visit www.facs.org/memberservices/documents.html. You may also contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800-293-9623 or via e-mail at chicks@facs.org.

Registration Location and Hours

MOSCONE CONVENTION CENTER
NORTH HALL

Sunday, October 23	7:00 am–6:00 pm
Monday, October 24	6:30 am–5:00 pm
Tuesday, October 25	7:00 am–4:00 pm
Wednesday, October 26	7:00 am–4:00 pm
Thursday, October 27	7:00–10:00 am

Registration Fees and Credentials

CATEGORY	ON OR BEFORE 8/22	8/23–10/22	ON-SITE	
ACS Fellow (2011 dues paid)~	\$150	\$200	\$275	Commercial representatives may obtain the commercial registration form by e-mailing a request to registration@facs.org . ~Retired Fellows fall under the ACS Fellow registration category for the Clinical Congress. Applicable registration fees apply.
Initiate	No Fee	No Fee	No Fee	
Associate Fellow	\$150	\$200	\$275	*Nonmembers who pay the applicable registration fees will have their membership application fees waived if they apply for membership by December 31, 2011. The American College of Surgeons is pleased to offer discounted registration fees for residents and medical students. Please submit a letter verifying your educational status with the completed registration form to expedite processing. Residents should obtain a letter from their program director; students should contact their department chairs. †Resident and Medical Student Membership The College has membership opportunities for medical students and residents. Medical students must be attending a U.S., Canadian, or international allopathic or osteopathic medical school. There is a one-time fee of \$20, which covers all four years of medical school. Membership will expire upon graduation from medical school. Residents enrolled in a program accredited by the Accreditation Council for Graduate Medical Education or surgeons in surgical research or fellowship programs acceptable to the American College of Surgeons are eligible for Resident Membership. The application fee of \$20 is waived for first-year residents. Annual dues thereafter are also \$20. Nonmember medical students and residents who register for this meeting and meet the appropriate membership category requirements will be contacted to affirm their membership status.
Resident Member	No Fee	No Fee	\$30	
Medical Student Member	No Fee	No Fee	\$15	
Affiliate Member	\$45	\$95	\$170	
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Resident Nonmember (with verification letter)†	\$45	\$45	\$75	
Medical Student Nonmember (with verification letter)†	\$25	\$25	\$35	
Hospital Administrator (nonphysician)*	\$450	\$500	\$575	
Hospital Purchasing Agent*	\$350	\$400	\$475	
Medical Association Personnel*	\$350	\$400	\$475	
Nurse Nonmember*	\$350	\$400	\$475	
Surgical Assistant Nonmember*	\$350	\$400	\$475	
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PhD Nonmember*	\$470	\$520	\$595	
Commercial Press	\$550	\$600	\$675	

Printable registration forms are available at <http://www.facs.org/clincon2011/registration/index.html>.

Covering patients through insurance mandates

by Alexis Macias

Beginning in the 1960s, states began to require insurance companies to cover certain health benefits and treatments. Early on, mandates guaranteed that the insured would receive a certain level of care and benefits under a given policy. In the past few years, advocates for specific diseases and conditions have lobbied legislatures to improve access and treatment for people with specific diseases and medical conditions.

A number of insurance mandates cover a wide spectrum of medical problems that affect surgical patients, including repair of cleft lip/palate and other birth defects; various treatments for prostate, breast, and colorectal cancer; and bariatric surgery for obese patients.

Cancer mandates

States require insurers to cover a large number of cancer-related procedures and services. These mandates began as requirements for treatments but now include screening and prevention efforts to expand access to life-saving services. Early detection, treatment, and follow-up reduces the chance that cancer will spread, making it generally easier, and less costly, to treat.

Common cancer-related services that insurers must cover include screenings for cervical, prostate, and testicular cancers, as well as minimum mastectomy and hysterectomy hospital stays. A wide variation exists in the number of cancer-related mandates in a given state, from 18 in Rhode Island to two in Idaho and Utah.

The most broad-reaching insurance mandate regarding cancer-related illnesses is a federal law that requires insurance coverage for breast reconstruction after a mastectomy, which applies to every state and the District of Columbia. No other insurance mandate is federally regulated or enforced in all 50 states. The second most common cancer-related mandate is related

to mammography, with 49 states and the District of Columbia requiring coverage. Utah is the only state that does not require insurance companies to cover mammography.

Screening for colorectal cancer is another common insurance mandate being regulated at the state level. Colorectal cancer is the third leading cause of cancer-related deaths in the U.S. for both men and women.* In an effort to detect the disease in its early stages, 26 states and the District of Columbia have enacted legislation that requires insurance coverage for a full range of colorectal cancer screening tests. Minnesota, New York, Vermont, and Wyoming have screening laws in place that require insurers to cover some, but not all, tests. However, while not required by law, many insurers in these states have voluntarily agreed to cover a full range of tests. Supporters of mandated insurance coverage of colorectal screening tests argue that these policies are cost beneficial, because they encourage the identification of precancerous polyps or cancer at its earliest stages. In 2011, Florida was the only state to introduce a colorectal screening bill (S. 350). Unfortunately, the bill saw little movement during the legislative session.

A number of colorectal screening tests are covered under Medicare, and Medicaid coverage for colorectal cancer screening varies by state. The Affordable Care Act also mandates the coverage of colorectal screenings.

Bariatric surgery mandates

According to the American College of Surgeons' statement, Recommendations for Facilities Performing Bariatric Surgery, approximately 300,000 Americans die prematurely from obesity-related complications each year.† Obesity costs the U.S. approximately \$100 billion annually in direct health care expenses or in lost productivity.‡ Bariatric surgical procedures in current use have been reported to result in marked, lasting weight reduction in the majority of morbidly obese patients when assessed five years after operation. Bariatric surgery is saving lives and reducing health care costs.

A number of states have adopted insurance mandates

continued on page 57

*Colorectal cancer screening: What are states doing? National Conference of State Legislatures. Available at: <http://www.ncsl.org/Default.aspx?TabId=14328>. Accessed April 18, 2011.

†Recommendations for Facilities Performing Bariatric Surgery. American College of Surgeons. Available at: http://208.250.24.72/fellows_info/statements/st-34.html. Accessed April 19, 2011.

Developing an index of surgical underservice

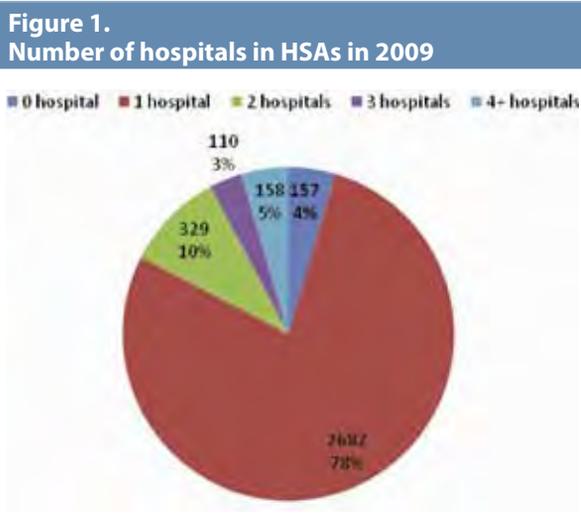
by Thomas C. Ricketts, PhD, MPH; Kristie Thompson; Simon Neuwahl; and Victoria McGee

A substantial number of Americans must travel to the next county or beyond to receive necessary or lifesaving surgical treatment. Concern for patients with limited access to surgical care and the effects of a shrinking supply of general surgeons are two policy issues that the Affordable Care Act (ACA) addresses with a new payment incentive for surgeons who practice in underserved areas. The ACA calls for the Centers for Medicare & Medicaid Services (CMS) to pay a 10 percent bonus to general surgeons who perform major surgery in health professional shortage areas (HPSAs) (Subtitle F, Section 5501). A problem with this new policy is that eligibility for the bonus payment is based on surgical procedures performed in primary care HPSAs. Primary care HPSAs were developed to identify places and populations without access to primary care physicians, not surgeons. In order to accurately determine surgeons' eligibility for the bonus payment and to identify systems and regions at risk for lower-quality care and access due to a shortage of surgery resources, HPSA designations should be reconsidered with surgical care access in mind. This article provides guidance for the development of a surgical HPSA designation from the American College of Surgeons (ACS) Health Policy Research Institute (HPRI).

Defining local surgical care markets

The geographic areas upon which this analysis is based are hospital service areas (HSAs), developed by the Dartmouth Atlas of Health Care Project.* HSAs were constructed in the early 1990s to identify local health care markets, and were centered on hospitals using ZIP code-based Medicare patient origin data from 1992 to 1993. Based on this historical Medicare claims data, 3,436 HSAs were defined by assigning ZIP codes to the hospital area where the majority of Medicare patients had been hospitalized. This methodology aggregated 42,000 ZIP codes into 3,436

*Dartmouth Medical School. Center for the Evaluative Clinical Sciences. 1998. *The Dartmouth Atlas of Health Care 1998*. Chicago: American Hospital Publishing, Inc. Available at: <http://www.dartmouthatlas.org/downloads/atlas/96Atlas.pdf>. Accessed May 3, 2011.



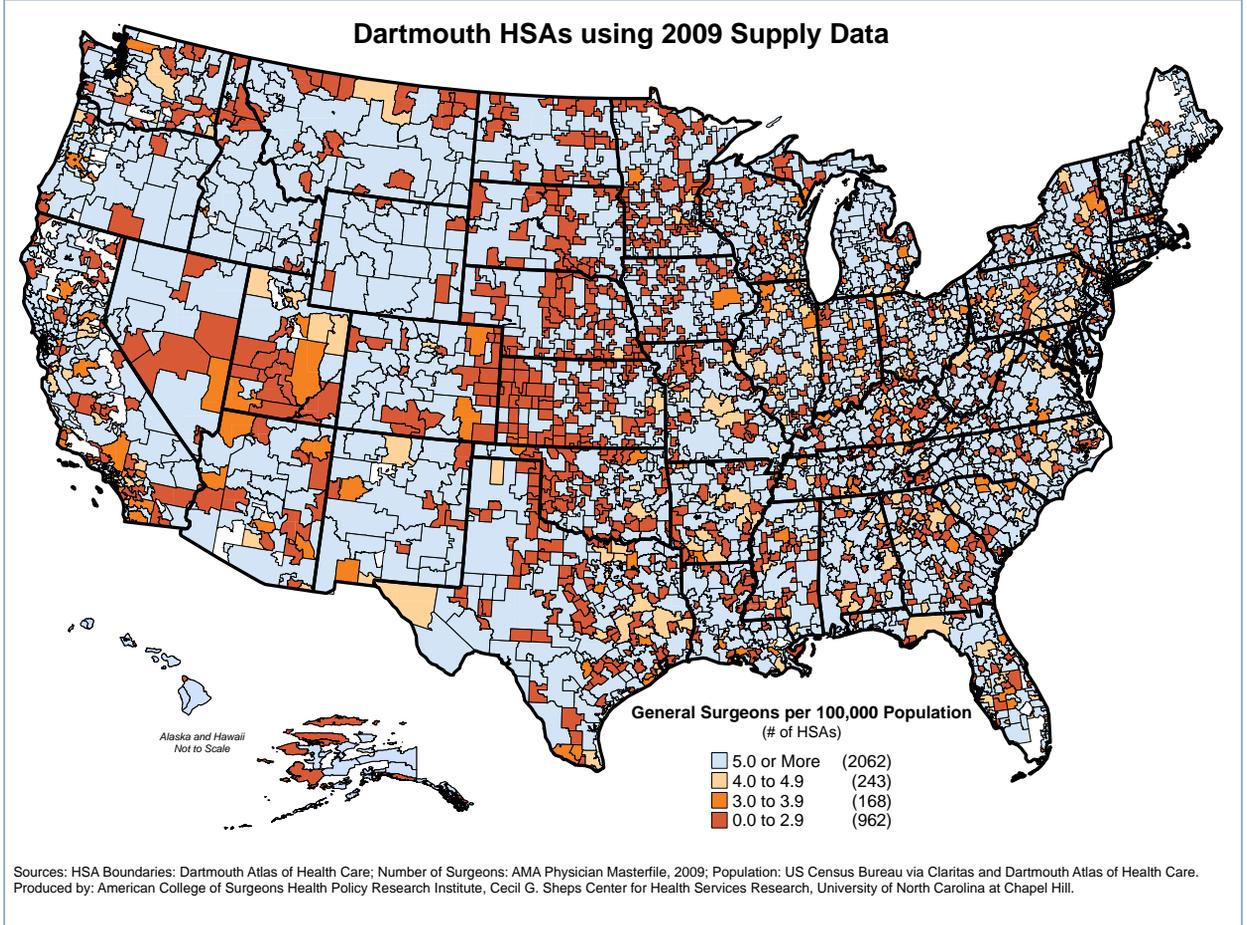
HSAs in 1993; of these, 2,830 had a single hospital, 332 had two, 106 had three, and 178 had four or more hospitals.*

Since HSAs were developed, health care utilization has changed due to the closure of hospitals and changes in service lines. However, HSA boundaries have not been updated except to accommodate changes in the division and redrawing of ZIP code boundaries by the U.S. Postal Service. As a result, 157 of the HSAs had no hospital in 2009 (see Figure 1, this page). Before creating a final surgical HPSA designation, it will be essential to update HSA boundaries using more recent patient origin data to account for changes in practices in addition to hospital closings and openings. In the absence of an updated set of boundaries, the distributions and thresholds described at this preliminary stage make use of the Dartmouth Atlas' original 3,436 HSAs.

Population is also a factor

In addition to hospitals, the distribution of surgeons is also tied to population, as maintenance of a surgical practice depends on a minimum patient volume and the economic activity necessary to support a hospital

Figure 2.
Potential surgical HPSAs



or surgical center. Within the original 3,436 HSAs, the average ratio of total surgeons to population in 2009 was 27.9 per 100,000, and for general surgeons, 7.2 per 100,000. A total of 608 areas had no surgeons of any specialty, and 828 had no general surgeons. A total of 4,558,732 people lived in the areas without surgeons, the largest area with a population of 53,233 and the smallest with a population of 649. These

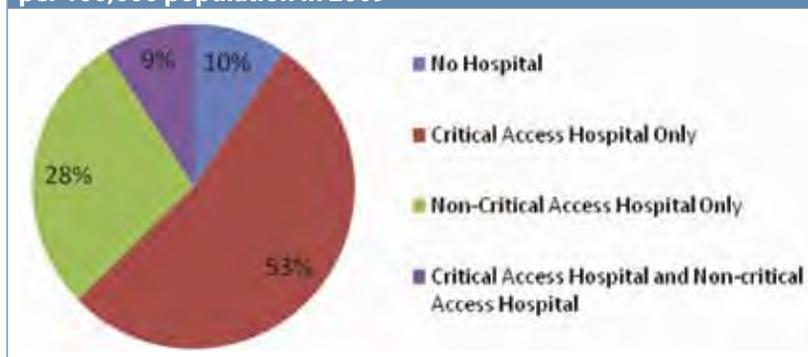
608 areas without surgeons would readily qualify as surgical HPSAs if the criteria included a requirement that the population be included in a “rational service area”[†] for inpatient care, and the standard was based on the existing HSA definition. However, not all of those areas have a hospital or can actually support a general surgeon.

Defining a critical shortage of surgeons

Although there is no formal consensus on the optimal number of surgeons necessary to treat a population, there are discussions and reports that contend that 6.0 general surgeons per 100,000 reflects a minimum number that can meet population

[†]The U.S. Department of Health and Human Services Health Resources and Services Administration requires primary care HPSAs to be based on rational service areas for primary care services. These may be an entire county or a subdivision of a county or cross county boundaries. In the case of the surgical HPSA, the rational service area would be defined by use patterns for surgical services.

Figure 3.
Hospitals in HSAs with fewer than three general surgeons per 100,000 population in 2009



apparent clustering in the largely rural areas of the states in the center of the nation, from North Dakota to Texas. The problem of low access to surgical services is indeed a national problem and one that requires national attention.

Implications

This definition of the surgical HPSA under development will not be intended solely for application of the bonus payment, but as a step toward identifying systems and regions that are at risk for lower-quality care and access due to a shortage of surgery resources,

needs.[‡] We suggest that a level of 3.0 general surgeons per 100,000 would constitute a “critical” shortage and propose to set that as a threshold. This ratio is based on the idea that an area capable of supporting a general surgeon should have 15,000 to 20,000 people—or a ratio of between 5.0 and 6.0 surgeons per 100,000 population. If an area with 30,000–40,000 people had only one surgeon, then adding another full-time surgeon would bring the area into the acceptable surgeon-to-population range. Our analysis shows that in 2009, 28 percent (962) of HSAs in the U.S. had fewer than 3.0 general surgeons per 100,000 population—constituting a critical shortage. These critical shortage areas included more than 21,412,439 persons and ranged in size from 649 to 437,029 people. There were 269 general surgeons indicating a primary practice location in these potential critical shortage areas in 2009. Given the current practice of surgery in smaller hospitals, there are likely to be additional part-time surgeons who operate in hospitals in those HSAs. A decision about their eligibility for the bonus will have to be made prior to establishing a surgical HPSA rule.

Proposed surgical HPSA based on existing HSAs boundaries

Figure 2 on page 46 is a map of HSAs with the potential surgical HPSAs identified with shading indicating severity of shortage. The potential surgical HPSAs are spread across the nation, with the only

such as hospitals. Many areas are struggling to support a small hospital. For example, more than half (592) of the HSAs with potential critical surgeon shortages have only critical access hospitals (CAHs) (see Figure 3, this page). For many of these hospitals, the presence of a surgeon is essential for their survival and their integration into effective systems of care. Likewise, if a community lacks the basic resources to support surgical procedures, incentives to attract surgeons are irrelevant.

In addition to highlighting areas that may not have the resources to support surgery, this analysis shows that the current HSA definitions are not adequate for the development of a surgical HPSA methodology. The ACS HPRI is redefining HSAs based on similar, but updated, data.

Data and methodology

The American Medical Association (AMA) Physician Masterfile data from 2009 representing all licensed physicians was analyzed along with 2009 U.S. Census Bureau population data and the Dartmouth HSA boundary file to calculate surgeon-to-population ratios in HSAs. Providers with a self-reported specialty of surgery and certification in surgery by the American Board of Medical Specialties were included in the analysis. Only providers who identified their practice type as “direct patient care,” were 69 years old or younger, and who reported a practice location within a U.S. county or county-equivalent (for example, Federal Information Processing Standard [FIPS]

continued on page 57

[‡]Physician community requirements in the 21st Century: The 2003 physicians to population ratios. A Report from Solucient, LLC (2004).

Northern California Chapter builds influence in state capital

by John Maa, MD, FACS; and John E. Garry, MD, FACS

With the support of a chapter advocacy grant from the American College of Surgeons (ACS), the Northern California Chapter of the ACS sponsored an inaugural Lobby in the Capitol Day on April 5. This event occurred in conjunction with the California Medical Association (CMA) Legislative Day. CMA President James Hinsdale, MD, FACS, a trauma surgeon from San Jose, CA, directed a program that included keynote addresses by both Gov. Jerry Brown and Lt. Gov. Gavin Newsom. The conference also featured a panel presentation by the two physicians in the California Legislature—pediatrician Richard Pan, MD, and general surgeon Linda Halderman, MD, FACS. More than 500 practicing physicians, residents, and medical students from across California attended the meeting.

Members of the leadership of the Northern California Chapter, including the ACS delegates to the CMA—Con Michas, MD, FACS, and Steven Chen, MD, FACS—were joined by Jon Sutton, Manager of State Affairs, ACS Division of Advocacy and Health Policy, as they participated in meetings with members of the California General Assembly. Specifically, they met with the following Assembly members: Fiona Ma from San Francisco (D); Jerry Hill from San Mateo (D); and Linda Halderman, MD, FACS, from



The California State Capitol building in Sacramento.

Fresno (R). The group also met with two state senators—Mark Leno from San Francisco (D) and Ed Hernandez, OD, from Los Angeles (D). The consistent message delivered during the meetings

San Francisco-Fresno in 2002, Dr. Halderman practiced in Fresno, serving underprivileged residents of rural areas in California, and she also assisted in medical relief in American Samoa after the

severe budgetary constraints in California. She is cognizant of the challenges facing the delivery system and of allied health practitioners' legislative efforts to expand their scope of practice, potentially to the detriment of the quality of surgical care patients receive. Dr. Halderman indicated that one of the greatest threats to the delivery of care is California's decision to reduce funding for Medicaid, especially when the ACA will likely expand the Medicaid population.

Dr. Halderman also noted that the legislative progress is easily hampered by inertia. She said that a key hurdle to addressing inadequate physician payment issues is the legislators' perception that, regardless of what cuts may be implemented in Medicaid, physicians will remain dedicated to their ethical and professional values and continue to provide care to their patients. The difficult work that surgeons perform on a daily basis makes them uniquely qualified to educate legislators and the public regarding novel, innovative solutions to the problems that stand in the way of patient access to quality care. Finally, Dr. Halderman encouraged any physician with the interest and passion to make a difference to consider running for elected office.

Optometrists' scope expands

In several states across the nation, optometrists have advocated for an expansion in scope of practice and have succeeded in having their proposals become laws. A primary intent of the chapter lobby day was to enlighten California's elected officials about the unintended consequences of an optometric scope of expansion bill, which the Califor-



Dr. Halderman (left) and Dr. Garry in Dr. Halderman's Sacramento office.

was that the ACS is committed to maintaining high-quality patient care as the U.S. expands access through the implementation of the Affordable Care Act (ACA), and to exploring new solutions to ensure an adequate and appropriately trained surgical workforce.

FACS in the legislature

A highlight of the day was an extended visit for the chapter delegation with newly elected Assemblywoman Halderman, the first Fellow of the ACS to be elected to the California legislature. After completing general surgery training at the University of California

earthquake and tsunami in 2009. The frontline challenges she faced as a surgeon and her passion for quality care, combined with her previous experience assisting the California State Senate Health Committee, fueled her desire to run for public office. She handily won both the primary and general election in November 2010.

Part of the lobby day schedule included meeting with Assemblywoman Halderman to glean her insights into the political process in Sacramento. Dr. Halderman passionately articulated the challenges to an individual's access to care, especially in light of the

nia legislature passed in 2008 (S.B. 1406) and former Gov. Arnold Schwarzenegger (R) signed. This law allows optometrists to treat glaucoma patients after receiving special certification. In 2009, it was determined that more than 100 veterans treated at the Department of Veterans Affairs (VA) Palo Alto Health Care System lost either partial or total eyesight as a result of glaucoma management solely by optometrists, without the mandatory involvement of ophthalmologists. Several of the resulting medical liability lawsuits have now been settled; however, in a case that remains open, the plaintiff alleges negligence in the failure of the VA ophthalmology department to conduct proper oversight of the optometry department concerning diagnosis and treatment of glaucoma and failure to follow an established VA policy.

The CMA and the California Academy of Eye Physicians and Surgeons spearheaded a subsequent challenge through a lawsuit filed in January to halt the implementation of the glaucoma certification process instituted under S.B. 1406. The tragic events at the Palo Alto VA highlight the inevitable consequences of the learning curve, as optometrists gained difficult real-world experience when they expanded their scope of practice into the less familiar area of complex glaucoma care. The medical community will likely witness similar events around the country in other disciplines, and in all different types of practice settings, as the ACA is implemented.

The central message delivered to the California elected officials was as follows: It is essential to maintain the focus and commitment on

quality of care for Americans, and to ensure that undesirable outcomes resulting from an expanded scope of practice are investigated in an honest, transparent, and intelligent manner to reduce the

care. To this end, the College recognizes that a partnership between physicians and allied health care providers is important to meet the needs of Americans. Concerns do persist that as a result of the cre-



Assemblywoman Halderman addresses the CMA audience, with Dr. Hinsdale in the background.

likelihood that the mistakes will be repeated. A key solution may be to further encourage ophthalmologists and optometrists (and other nonphysician providers) to train together in unified teams, to work collaboratively to deliver optimal patient care, and to conduct mutual peer review and oversight to continuously improve the quality of the care provided.

The VA's leadership should be applauded for undertaking proper and ethical action to compensate those veterans who were harmed. The ACS remains committed to ensuring that patients continue to receive appropriate, safe, and high-quality medical and surgical attention across the continuum of

denialing process used in the VA system, the inadequacy of supervision of optometrists may not be confined to this one facility. The fundamental tasks that remain for our nation are to ensure that internal VA policies and procedures have been corrected to prevent this tragedy from occurring again, and to address the loophole in the VA credentialing process that allows a health care provider to practice in one state with privileges and certification obtained in a different state. For additional information on this case, see "College advocates for ensuring quality eye care for America's veterans" in the September 2010 issue of the *Bulletin* (*Bull Am Coll Surg.* 95(9):8-10).

Lessons learned

The success of the Northern California ACS Chapter Lobby in the Capitol Day was the result of careful planning and the development and expression of a clear

state-specific legislative agendas and advocacy. Fellows of the College, such as Dr. Hinsdale, who currently serve as leaders of their state medical societies may prove to be a valuable resource for this kind of initiative.

sion in California, in February, Kentucky Gov. Steven L. Beshear (D) signed into law S.B. 110, which allows optometrists in that state to perform laser procedures and limited scalpel-based procedures. The optometrists are well-organized at the state level, understand the legislative process, are excellent fundraisers, and are effective in delivering the message that they are available to meet the anticipated expansion of patient needs to access primary care in the face of a critical shortage of physicians. In justifying the passage of S.B. 110, Gov. Beshear stated, "Access to quality health care is a critical issue for families across the Commonwealth."^{*}

Optometrists have been accomplished champions in both the state and federal government. In November 2010, at the national level, Rep. John Boozman (R-AZ), an optometrist, was elected to the U.S. Senate, and in California, optometrist and state Sen. Ed Hernandez (D) was recently appointed Chair of the Senate Health Committee. Our intent is to stimulate interest and action within the profession of surgery to match the advocacy and legislative achievements of our optometry colleagues.

Dr. Maa is assistant professor, department of surgery, University of California, San Francisco.

Dr. Garry is assistant clinical professor, department of surgery, University of California, San Francisco-Fresno.



Northern California Chapter ACS members at ACS Lobby Day/California Medical Association Legislative Day. Left to right: Dr. Maa; Dr. Hinsdale; Delegate Dr. Chen; and ACS Governors Dr. Garry and Dr. Michas.

message. This activity was useful in building relationships with elected officials and their staff. Other insights gained from this lobby day include the following:

- In state, such as California, which include several ACS chapters, greater collaboration across chapters should be fostered to increase the visibility and impact of the ACS in state government.
- At the state level, the formation of individual ACS political action committees should be strongly considered to assist with

- Continued support should be cultivated among physicians and surgeons who have been elected to state legislatures and Congress. Local chapters can prepare letters of support and endorsements for the bills introduced by physician legislators.

The College encourages other chapters to conduct lobby days. An ACS lobby day toolkit is available at <http://www.facs.org/ahp/lobbytoolkit.pdf>.

Conclusion

Perhaps the field of surgery can learn from the legislative accomplishments of the field of optometry. In addition to the significant strides in scope-of-practice expansion

^{*}Governor Steve Beshear's communication office. Press Release. February 24, 2011. Available at: <http://migration.kentucky.gov/newsroom/governor/20110224sb110.htm>. Accessed May 10, 2011.

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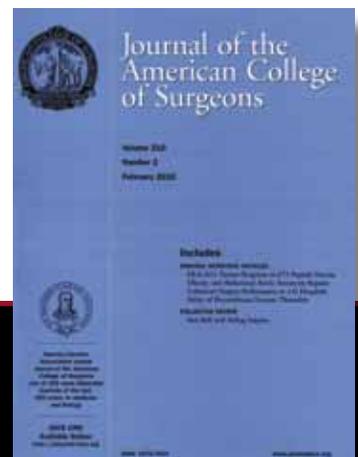
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Survey reveals ACS Fellows' views on industry relationships

by Amilu Stewart, MD, FACS

The Corporate and Foundation Relations Committee of the American College of Surgeons (ACS) Foundation, along with the support of David Hoyt, MD, FACS, Executive Director, recently conducted an electronic survey of 27,000 Fellows to determine the extent of their interaction with industry. The survey was specifically designed for brevity and was

limited to three questions. The participants were asked to list their surgical specialty; comments were also encouraged.

Of the 27,000 included in the survey, there were 2,582 respondents. The responses by specialty are shown in the table on this page.

The three questions posed to survey participants, and their responses, are as follows:

1. Have you developed a product in collaboration with medical industry that has been a benefit to patients?

- A. Yes 341 responses 13.26%
- B. No 2,230 responses 86.74

2. Have you developed a surgical procedure in collaboration with medical industry that has been a benefit to patients?

- A. Yes 247 responses 9.65%
- B. No 2,312 responses 90.35

3. Have you participated in a clinical trial in collaboration with medical industry that has been a benefit to patients?

- A. Yes 1,172 responses 45.66%
- B. No 1,395 responses 54.34

The survey also asked participants to comment on the general appropriateness and value of surgeon-industry collaborations. The responses were as follows:

- Positive 355 comments 71%
- Negative 84 comments 17
- No opinion 60 comments 12

According to the survey, the assumption can be made that, generally, the Fellows are in favor of surgeon-medical industry relations—specifically, that the advances made in surgery in the past century and ongoing in the current

Survey responses by specialty		
Specialty	Number of responses	Percent
General surgery	1,408	54.72%
Vascular surgery	182	7.07
Plastic and maxillofacial surgery	180	7.00
Cardiothoracic surgery	145	5.64
Otolaryngology-head and neck surgery	145	5.64
Colon and rectal surgery	111	4.31
Urology	107	4.16
Pediatric surgery	76	2.95
Orthopaedic surgery	61	2.37
Neurological surgery	57	2.22
Gynecology and obstetrics	56	2.18
Ophthalmic surgery	45	1.75
Responses by practice type		
Group	Number of responses	Percent
Group	891	34.94%
Medical school	616	24.16
Hospital-based	531	20.83
Solo practice	479	18.78
Group HMO	33	1.29

century could not have been made without this relationship. Many of the advancements that have been made—if the medical community had to rely on government funding—would likely be delayed by five to 10 years.

To summarize the feelings of the positive comments relative to this relationship, many of the Fellows find it offensive that Congress legislates regulations because they fear that physicians can be bought by the medical industry. The respondents believe that they have more integrity than “to be bought by a piece of pizza” from an industry representative when determining what is the best product for their patients. There is frustration on the part of the Fellows that members of Congress are supposed to be intelligent enough not to be influenced by lobbyists, yet the Fellows can seemingly be influenced by their interactions with industry.

Many of the Fellows rely on the interaction between the surgical community and medical industry, as this relationship provides information about new products and procedures that they would

not have exposure to otherwise. The responding Fellows believe that innovation will come from the private sector and not the government, and they believe that it is an affront to their intellect to be told that these relationships will unduly influence their judgment in treating patients.

Further comments centered around the perspective that surgeons should maintain adherence to truth and science, and maintain ethical relationships with industry. Generally it is perceived that clinical trials supported by industry are superior to those relationships with government, and that typically industry-supported trials include interactions with engineers and other technical personnel. The current relationship between industry and surgeons works best, respondents said, when it is done in an ethical manner and with full disclosure to the public and the patients.

Overall, respondents believe that companies are the innovators, surgeons provide care to patients, and the relationship between the surgeons and industry is in the best interests of all three parties.

Some of the negative comments made in response to this survey include the following:

- Royalties create too much conflict and should not be allowed.
- Contracts should be clearly defined so that money is paid for what is delivered.

In addition, there were comments regarding the College’s policies with regard to surgeon-industry interactions. Also, there were comments that full disclosure should be the norm, and ongoing ethical discussions should continue.

With the information from this survey, the Corporate and Foundation Relations Committee will continue to establish ethical relations with industry, and to provide full disclosure regarding the gifts and donations from industry received by the ACS Foundation for surgical scholarships, and for College projects that benefit patients and promote quality surgical education for the Fellows.

Dr. Stewart is Chair of the ACS Foundation’s Corporate and Foundation Relations Committee.

**Did
you**

know... THAT THE SOCIO-ECONOMIC FACT CENTER FOR SURGERY of the American College of Surgeons is now available on the College’s website? This online resource provides socioeconomic and statistical information relevant to the field of surgery, and other associated health care topics. The Fact Center presents a collection of data on a variety of socioeconomic issues of interest to physicians, health care professionals, medical and health reporters, and anyone who wants to stay informed about today’s rapidly changing health care environment. The information is compiled by the College’s Advocacy and Health Policy Division from a variety of nationally recognized sources, who are attributed accordingly throughout this online reference guide. For further information, go to <http://www.facs.org/se-factcenter/index.html> or contact Bob Jasak at bjasak@facs.org.

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Z6041: Neoadjuvant chemoradiation, local excision for T2N0 rectal cancer

by David M. Ota, MD, FACS; Heidi Nelson, MD, FACS; and Julio Garcia-Aguilar, MD, PhD, FACS

Patients with early rectal cancer are treated by total mesorectal excision (TME). TME, nonetheless, still has a mortality rate of 1 to 6 percent along with significant morbidity. Local excision (LE) is an alternative approach, but it has not gained acceptance because the technique can result in a higher local recurrence rate and ultimately reduce survival rate.* On the other hand, LE has the added benefit of alleviating the need for the patient to experience a colostomy or the distressing sequelae related to a low colorectal anastomosis.

The use of neoadjuvant chemoradiation in conjunction with TME has reduced recurrence. Several retrospective case series, and a small prospective study, suggest that neoadjuvant chemoradiation prior to local excision may lower the recurrence risk to a level comparable with that of total me-

sorectal excision. However, these studies are limited by sample size, variable staging criteria, imaging modalities, heterogeneous populations, and different chemoradiation regimes.

To address this need, the American College of Surgeons Oncology Group (ACOSOG) designed a single-arm, non-randomized, multicenter, phase II clinical trial using neoadjuvant chemoradiation followed by LE in patients with ultrasound-staged T2N0 rectal cancer (Z6041).† The study addressed the efficacy and safety of neoadjuvant chemoradiation and local excision. The study population included cancer patients having ultrasound-staged T2N0 rectal carcinoma and an Eastern Cooperative Oncology Group Performance Score greater than or equal to 2. Subjects were treated with capecitabine (825 mg/m², days 1-14 and 22-35) and oxaliplatin (50 mg/m², weeks 1,2,4, and 5) concurrent with radiation (54 Gy total) followed by LE. LE was performed four to eight weeks after completing neoadjuvant chemoradiation.

From 2006 through 2009, 90 subjects from 31 institutions were registered in the Z6041 study. There were 84 subjects who were evaluable, five of whom were ultimately rejected as ineligible. Of these 84 subjects, 77 completed the treatment.

The primary endpoint is the rate of disease-free survival three years after LE. Secondary endpoints include pathologic complete response rate of the primary tumor after neoadjuvant chemoradiation, sensitivity and specificity of surgeon clinical assessment of tumor response prior to surgery, resectability rate with R0 negative margins, procedure-specific morbidity and mortality following neoadjuvant chemoradiation and local excision, and a quality of life assessment.

During the study, subjects were evaluated for neoadjuvant chemoradiation-related toxicity. Because a higher toxicity rate was observed, a decision was made to reduce capecitabine to 725 mg/m² and radiation dosage to 50.4 Gy; oxaliplatin dosage was unmodified. A total of 62 subjects received the original dosage, and 28 received the revised dosage. Despite the reductions, toxicity continued to be high; there were no deaths on the study.

Toxicity and the pathology of the resected specimen were recently submitted to the *Annals of Surgical Oncology*‡ and included the following:

- The mean pretreatment tumor size of subjects was 2.9 cm.
- Eighty-one percent of the subjects completed chemotherapy.
- Eighty-eight percent of

*You YN, Baxter NN, Stewart A, Nelson H. Is the increasing rate of local excision for stage I rectal cancer in the United States justified? A nationwide cohort study from the National Cancer Database. *Ann Surg.* 2007;245(5):726-733.

†Ota D, Nelson H. "Never...was so much owed by so many to so few": An update on Z6041. *Bull Am Coll Surg.* 2007;92(8):44-45.

‡Garcia-Aguilar J, Shi Q, Thomas CR, Chan E, Cataldo P, Marcet J, Medich D, Pigazzi A, Oommen S, Posner MC. A phase II trial of neoadjuvant chemoradiation and local excision for T2N0 rectal cancer: Preliminary results of the ACOSOG Z6041 trial. Submitted to *Ann Surg Oncol.* In press.

the subjects completed radiation therapy.

- There was a 44 percent pathologic complete response rate.
- One subject had positive resection margins.
- Thirty-nine percent of the subjects developed neoadjuvant chemoradiation-related Grade ≥ 3 adverse events. The most common reported adverse event was rectal pain.

The study, conducted by Dr. Garcia-Aguilar (co-author of this article) and colleagues, demonstrated that this regimen of neoadjuvant chemoradiation and

local excision for T2N0 rectal cancer achieves a pathological complete response rate in almost half of the treated subjects with a negative margin rate of close to 100 percent. These results are one of the highest pathological complete response rates observed in a rectal cancer cooperative group trial. However, toxicity of the regimen was high, and perioperative complications following excision were common. The study indicates the regimen is a promising one; however, the treatment approach still requires further modification. Future studies should investigate

modifications in the regimen to enhance the therapeutic ratio, decrease toxicity, and to optimize complete response rate. Surgeons will work with their medical oncologists and radiation oncologists to achieve these ends. We want to thank all the site investigators and patients who participated in this trial.

Dr. Ota, of Durham, NC, and Dr. Nelson, of Rochester, MN, are ACOSOG Co-Chairs.

Dr. Garcia-Aguilar is professor of surgery and chair, department of surgery, City of Hope, Duarte, CA.

State STATs, from page 44

that require insurance companies to cover the costs associated with bariatric surgery. Arkansas, Georgia, Indiana, Maryland, New Hampshire, and Virginia all require insurers to provide for surgical treatment of morbid obesity, according to obesity and health-status mandates for private insurance obtained by the author through personal correspondence with the Obesity Action Coalition. Arkansas was the most recent state to require an insurance mandate for bariatric surgery. The mandate was signed into law during the 2011 legislative session.

Seventeen states have opted not to provide coverage of bariatric surgery, but instead require insurers to

provide financial incentives to participants for adhering to health promotion programs. During the 2011 legislative session, Mississippi was the only state to introduce a bill (H.B. 946) that would have required insurance coverage for certain obesity treatments, but it died in the House Insurance Committee.

For additional information on insurance mandate legislation, contact Alexis Macias, at amacias@facs.org. 

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

HPRI data tracks, from page 47

codes) were included in the analysis. Physicians were excluded from the analysis in a given year if they reported being in residency training, semi-retired, or if they reported their primary present employer was the U.S. government, locum tenens, medical school, or other non-patient care employment. 

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

Ms. Thompson is a research associate at the Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill, and project manager for the ACS HPRI.

Mr. Neuwabl is a graduate research assistant at the Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill.

Ms. McGee is a research assistant at the Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill.

Next stop, high reliability

Ten years after the Institute of Medicine report, *Crossing the Quality Chasm*, proposed a strategy for reinventing the health care system to better meet patient needs for safety and quality, health care continues to struggle with the issue of preventable harm.¹ Although examples of health care excellence exist—such as the delivery of beta blockers to heart attack patients 98 percent of the time at discharge, and the achievement of zero central line infections in many intensive care units—health care does not provide consistent, high-quality care to all people.¹⁻³ For example, an estimated 40 wrong site surgeries occur in U.S. health care organizations every week; fires that occur during surgery result in burned patients; and infection control failures continue to rise and are unacceptably high.⁴⁻⁶ Preventable harm affects millions of Americans each year and may actually be on the rise in hospitals due to the fact that hospitalized patients are sicker nowadays, and care is increasingly complex.

To move into a new realm where health care is safer, looking to the example of industries such as aviation provides tested and practical strategies to achieve high reliability outcomes. Defined as consistent excellence over long periods of time, high reliability offers a framework for health care to transform itself. Specifically, health care professionals must focus on the following three components:

- *Leadership.* Health care leadership must make it clear that high reliability is the priority right now, and will remain a priority as long as it takes to achieve desired results.

- *Implement a safety culture.* Health care organizations must create a culture of safety that emphasizes trust, reporting of unsafe conditions, and improvement.

- *Robust Process Improvement.*TM Organizations must use proven quality improvement methods—Lean, Six Sigma, and change management (known together as Robust Process Improvement)—to systematically improve processes and avoid common, crucial failures.

Health care organizations are at different stages in implementing the leadership, safety culture, and Robust Process Improvement components that lead to high reliability. It is, therefore, important to conduct a self-assessment of the current state of leadership, safety culture, and capacity to execute Robust Process Improvement. By performing an assessment, health care organizations can gain an overall understanding of where to focus their improvement efforts. The Joint Commission is now developing a self-assessment tool to allow health care organizations to analyze their adoption of the various practices that are thought to lead to improved operational efficiency, consistent excellence in patient care, and, therefore, high reliability. In addition, Joint

Commission standards (leadership, national patient safety goals, performance improvement) emphasize the need to create a culture of safety and to continuously improve performance. The Joint Commission Center for Transforming Healthcare is also working with health care organizations and using Robust Process Improvement tools to identify causes and create customized solutions to ensure quality and safety in regard to hand hygiene, hand-off communications, wrong site surgery, surgical site infections, preventing avoidable heart failure hospitalizations, and other areas.

For more information about high reliability, visit The Joint Commission at <http://www.jointcommission.org/> to read an April 2011 *Health Affairs* article about high reliability.

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Society of Gynecologic Oncologists changes its name

The Society of Gynecologic Oncologists (SGO) has changed its name to the Society of Gynecologic Oncology. The new name recognizes SGO's expanded membership, which now includes representatives from the entire cancer care team,

including medical and radiation oncologists, pathologists, researchers, gynecologic oncology nurses, palliative care specialists, and social workers. In addition to the name change, SGO modified its mission statement to acknowledge that its

members not only treat patients with gynecologic cancers, but also play a critical role in preventing gynecologic cancers worldwide.

For more information on SGO, go to its website at <http://www.sgo.org>.



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2011 ANZ, Japan, and German Exchange Travelers announced



Dr. Anderson



Dr. Yamada



Dr. Hoepfner

The International Relations Committee of the American College of Surgeons (ACS) has established exchange programs with the Royal Australasian College of Surgeons, the Japan Surgical Society, and the German Surgical Society, in collaboration with the associated College chapters.

For each exchange program, the College sends a North American surgeon to the annual surgical meeting of the participating country, including a tour of several sites tailored to each surgeon's specific research interests. In exchange, the College accepts a scholar-surgeon from each of the three corresponding programs to attend the College's annual Clinical Congress.

This year marks the first time the College will welcome an exchange traveler from Australia. The initial Australian visitor is

Peter John Anderson, MB, ChB, PhD, FRACS, FRCS(Eng), associate professor at the Australian Craniofacial Unit, Women's and Children's Hospital, North Adelaide (see photo, this page). Dr. Anderson's research centers on craniosynostosis—premature fusion of fibrous sutures of the skull in infants. Dr. Anderson's practice includes pediatric-acquired and congenital facial anomalies and maxillofacial trauma. His U.S. counterpart, Thomas A. Aloia, MD, FACS, of The Methodist Hospital, Houston, TX, attended the Annual Scientific Congress of the Royal Australasian College of Surgeons in Adelaide, in May.

Matthew M. Hanasono, MD, FACS, of MD Anderson Cancer Center, Houston, TX, was unable to attend the annual meeting of the Japan Surgical Society, which

was cancelled due to the recent earthquakes. He will attend next year, along with the 2012 Fellow. This October, in San Francisco, CA, the College will welcome the Japan Exchange Fellow, Suguru Yamada, MD, PhD, a gastroenterological surgeon at Nagoya University Graduate School of Medicine (see photo, this page). Dr. Yamada's research focuses on pancreatic cancer, and he has published an impressive bibliography of his translational research studies on the topic.

The German Surgical Society and the ACS Germany Chapter have developed a similar exchange program with the College. Gregory J. Landry, MD, FACS, of Oregon Health & Science University, Portland, and Ali Khoynzhad, MD, FACS, of Cedars-Sinai Medical Center, Los Angeles, CA, both

attended the German Surgical Society's annual meeting in Munich in May. Dr. Landry, the 2010 Fellow, had been prevented from attending last year due to the volcanic eruptions in Iceland. Their

German counterpart, Dr. Jens Hoepfner, MD, PhD, of Freiburg (see photo, page 60), will attend the Clinical Congress this year, and choose several surgical sites to visit with the guidance of his

mentors at home and in the U.S. Dr. Hoepfner is a gastrointestinal surgeon whose research interests include intestinal anastomosis and issues surrounding hepatopancreatobiliary transplantation.

ACS resident research scholarships are available

The American College of Surgeons is offering two-year resident research scholarships for July 1, 2012, through June 30, 2014. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty. American College of Surgeons' Resident Research Scholarships are supported by the generosity of Fellows, chapters, and friends of the College, to encourage residents to pursue careers in academic surgery.

General policies

The policies for granting of the American College of Surgeons Resident Research Scholarships are as follows:

- The applicant must be a Resident Member of the College who has completed two postdoctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarship is awarded (July 1, 2012), and shall not complete formal residency training before June 2014. Scholarships do not support research after completion of the chief residency year.
- The scholarship is awarded for two years, and acceptance of it requires commitment for the two-year period. The award is to support a research plan for the two years of the scholarship, July 2012 through June 2014. Priority will be given to the projects of residents involved in full-time laboratory investigation. Study outside the U.S. or Canada is permissible. Renewal of the scholarship for the second year is required and is contingent on the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Section of the College by May 1, 2013.
- Application for these scholarships may be submitted even if comparable application to other

organizations has been made. If the recipient is offered a scholarship, fellowship, or research award from another organization, it is the responsibility of the recipient to contact the College's Scholarships Administrator to request approval of the additional award. The Scholarships Committee reserves the right to review potentially overlapping awards and to adjust its award accordingly.

- The scholarship is \$30,000 per year; the total amount is to support the research of the recipient and is not to diminish or replace the usual or expected compensation or benefits of the recipient. Indirect costs are not paid to the recipient or to the recipient's institution.
- The scholar is expected to attend the Clinical Congress of the American College of Surgeons in 2014 to present a report on the research as part of the Surgical Forum, and to report and receive a certificate at the annual meeting of the Scholarships Committee.
- Approval of the application is required from the administration (dean or fiscal officer) of the institution. Supporting letters from the head of the department of surgery (or the surgical specialty) and from the mentor who will be supervising the applicant's research should be submitted. Only in exceptional circumstances will more than one scholarship be granted in a single year to applicants from the same institution.

The closing date for receipt of completed applications and all supporting documents is **September 1, 2011**.

Application forms may be obtained from the College's Web site at <http://www.facs.org/memberservices/research.html>. For additional information, contact Kate Early, Scholarships Administrator, at kearly@facs.org.

ACS Multimedia Atlas of Surgery

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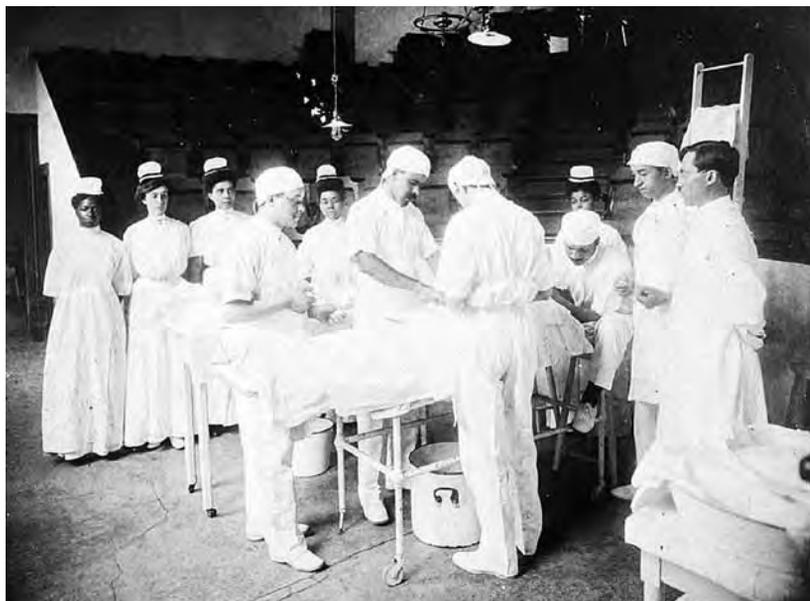
College hosts exhibit of contemporary African-American academic surgeons

The American College of Surgeons (ACS) is hosting a traveling exhibit from the National Library of Medicine's History of Medicine Division (HMD) extolling the contributions of African Americans to medicine. "Opening Doors: Contemporary African American Academic Surgeons" is one of several traveling exhibits created by the HMD that are part of the educational outreach mission of the National Library of Medicine to enhance public and scholarly awareness and appreciation of its collections. The exhibit—which is on display at the College from June 13 to July 27—has been hosted by various academic medical centers, associations, and libraries for periods lasting five to six weeks. The exhibit—which includes six roll-up panels and a 500- to 700-square foot structure—has been on the road for three years and features many Fellows of the College.

Each of four sections of the exhibit features one renowned surgeon. Of these four surgeons, three are Fellows of the College—Alexa I. Canady, MD, FACS; Claude Organ, MD, FACS; and LaSalle D. Leffall, Jr., MD, FACS (the latter two are Past-Presidents of the ACS). The other panels feature material on various topics and are titled "Pioneers" and "New Frontiers." The panels feature many Fellows of the College, and their notable accolades and accomplishments. This traveling exhibit is part of a much more comprehensive one on the NLM



The exhibit banner, featuring a photo of Sharon M. Henry, MD.



Freedmen's Hospital, Howard University, 1903.

website, which includes current ACS President L.D. Britt, MD, MPH, FACS, FCCM, FRCS(Eng) (Hon), and several other ACS Fellows, at <http://www.nlm.nih.gov/exhibition/aframsurgeons>.

For more information on the NLM History of Medicine Division's traveling exhibits program, see their website at <http://www.nlm.nih.gov/hmd/about/exhibition/travelingexhibitions.html>.

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ACS cosponsors K08/K23 NIH Supplement Awards

The American College of Surgeons has announced a program that will provide supplemental funding to individuals who receive a National Institutes of Health (NIH) Mentored Clinical Scientist Development Award (K08/K23).

This award is directed at surgeon-scientists working in the early stages of their research careers. The award requires cosponsorship with an approved surgical society of a three-, four-, or five-year period of supervised research experience that may integrate didactic studies

with laboratory or clinically based research.

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

The application deadline is **October 12, 2011**, with funding to begin July 1, 2012. Applications are made by submitting a copy of the NIH application to the College.

Awardees must be members in

good standing of both the College and the cosponsoring surgical society.

Participating surgical societies include the American Head and Neck Society, American Vascular Association, and Thoracic Surgery Foundation for Research and Education.

For further details, see the College's scholarships Web page, <http://www.facs.org/memberservices/research.html>, or contact Kate Early, ACS Scholarships Administrator, at kearly@facs.org.

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Disciplinary actions taken

The following disciplinary actions were taken by the Board of Regents at its February 11, 2011, meeting:

- Four thoracic surgeons were given nonpublic disciplinary actions following disciplinary action by the Oregon Medical Board. These Fellows were reprimanded by the state following charges of unprofessional conduct with regard to billing practices.

The following disciplinary action was taken by the Board of Regents at its October 2, 2010, meeting:

- A general surgeon was given a nonpublic disciplinary action for providing expert witness testimony that was found to have violated the *Bylaws*.

Definition of terms

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

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

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

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

Suspension: A severe punitive action for a period of time, during which the Fellow or member, according to the membership status, (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the member's

name from the *Yearbook* and from the mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor's registration fee when attending College programs; (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or member is returned to full privileges and obligations of fellowship.

Expulsion: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.

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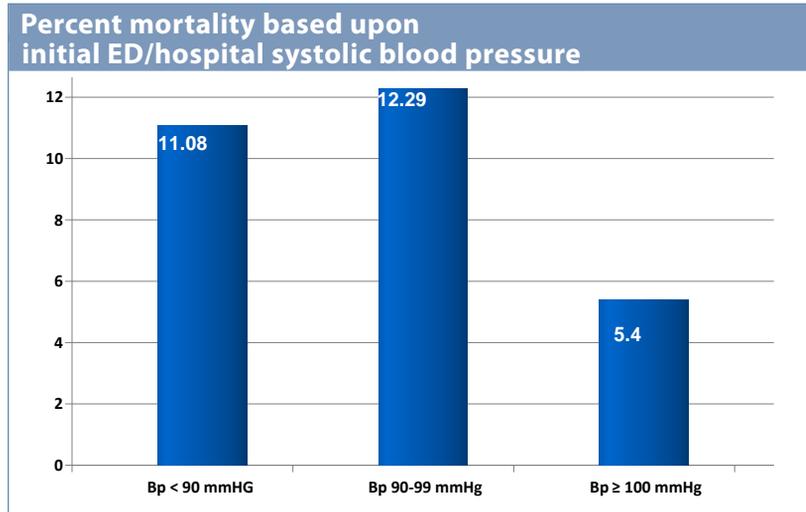
by Richard J. Fantus, MD, FACS

Editor's note: This month marks the 100th NTDB data points column written or co-written by Dr. Fantus.

The number “100” is significant in many fields. Enter 100 into a search engine and it will result in more than 32 million results. In math, 100 is the basis of percentages, the sum of the first nine prime numbers, as well as the sum of the cube of the first four integers. In science, 100 degrees is the boiling point of pure water at sea level on the Celsius scale and the atomic number of Fermium, an element that was discovered in the debris of the first hydrogen bomb explosion in 1952 and named after Enrico Fermi, one of the pioneers of nuclear physics. It is also interesting to note that the U.S. government has 100 senators, and that our currency is based on a decimal system in which there are 100 pennies in a dollar, and the “Benjamin”—the \$100 bill that features the image of Benjamin Franklin—is currently the largest U.S. bill in print.

All of the following include the number 100 in some shape or form: the number of years in a century, the number of tiles in a standard Scrabble set, the phone number for the police in several foreign countries, the number of yards in an American football field, the minimum distance in yards for a par three on a golf course, the record number of points scored by

*Fantus RJ. ACS releases 2002 NTDB™ annual report. *Bull Am Coll Surg.* 2003;88(4)62.



a single player in one NBA game—and this article marks the 100th consecutive month of the publication of NTDB data points.

It is hard to believe that it has been more than eight years since John Fildes, MD, FACS (at that time, Chair of the American College of Surgeons' National Trauma Data Bank® subcommittee), came up with the idea of writing a brief *USA Today*-type blurb on various aspects of the National Trauma Data Bank. Dr. Fildes' vision was to publicize the value of this important database by highlighting it through easily digestible factoids. The first article, published in April of 2003, highlighted the NTDB *Annual Report 2002*, and revealed information regarding the 400,000 records contained in the database since its inception in the early

1990s.* In the past eight years, participation by trauma centers has skyrocketed, and, currently, each year more than 600,000 records from a single admission year are added to the NTDB. The complete collection of all of the past NTDB *Bulletin* articles are available in pdf format on the ACS website at <http://www.facs.org/trauma/ntdb/datapoints.html>.

As reported in the NTDB data points column titled “Older but thinner” in the September 2010 issue of the *Bulletin* (*Bull Am Coll Surg.* 2010;95[10]:59-60) the segment of Americans who will be 65 years and older will increase by 36 percent, to 55 million by 2020. As this segment of the population increases, it only follows that the potential for the number of elderly patients included in the NTDB

will increase each year. If one looks at the percentage of records of those age 65 and older featured in the last three *Annual Reports*, from 2008 through 2010, these percentages were 19.08, 20.80, and 22.64. Elderly patients present unique challenges as trauma patients, as they often have coexisting comorbidities and decreased physiologic reserves.

The first recorded systolic blood pressure in the emergency department (ED)/hospital is one of the fields contained in the NTDB *Annual Report*. In order to examine the impact of initial ED/hospital systolic blood pressure on trauma patients age 65 and older contained in the NTDB research dataset 2009, admissions records were searched by the field for age greater than or equal to 65. These records were then divided into three groups (Group 1: <90 mmHg, Group 2: 90-99 mmHg, Group 3: ≥ 100 mmHg) based upon their initial

ED/hospital systolic blood pressure recorded. A total of 136,475 records had age greater than or equal to 65. In all, 126,252 records had discharge status recorded including 48,685 discharged to home, 20,298 to acute care/rehab, and 49,217 to nursing homes; 8,052 died. These patients were 59 percent female, on average 79.36 years of age, had an average length of stay of 6.24 days, and an average injury severity score of 10.46. The mortality for the three groups evaluated were 11.08 percent for Group 1, 12.29 percent for Group 2, and 5.4 percent for Group 3. (see figure, page 67).

There appears to be a greater than two-fold increase in percent mortality once the initial ED/hospital blood pressure is below that magic number of 100. One hundred is a number that exists in our daily lives. In fact, an individual's chance of survival may depend on it.

Throughout the year, we will be

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

Acknowledgment

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

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

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