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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

Last month’s column centered on the retirement of a key member of the American College of Surgeons’ Executive Staff—Linn Meyer, Director of the Division of Integrated Communications. This month, I again focus on the retirement of an individual who has contributed to this organization’s success in many ways and in multiple roles—Paul “Skip” Collicott, MD, FACS.

Surgical career

Dr. Collicott earned his bachelor’s of science and medical degrees at the University of Nebraska in Lincoln and Omaha, respectively. He completed a one-year rotating internship at Lincoln General Hospital. His subsequent training was interrupted by two years of service as a general medical officer in the U.S. Air Force during the Vietnam War. It was because of this experience that Skip decided to become a trauma surgeon. He completed his surgical training at the University of Washington, Seattle.

He built a robust peripheral vascular and trauma surgery practice in Lincoln and was on staff at five Nebraska hospitals. Skip also served as a surgical consultant for the Veterans Affairs Hospital, the University of Nebraska Student Health Center, and Lincoln Regional Center. He worked his way up the academic hierarchy at the University of Nebraska Medical College in Omaha and served as a trauma consultant at that institution.

ATLS®

Skip will probably be best remembered as the founding father of the Advanced Trauma Life Support® (ATLS) program, which is the internationally recognized educational program on the initial evaluation and management of trauma patients. Dr. Collicott introduced the ATLS concept to members of the Committee on Trauma (COT) at their 1979 annual meeting in Houston, TX, after presenting a pilot course to a group of family physicians in Auburn, NE, in 1978. That initial course was a response to a tragic plane crash involving James K. Styner, MD, FACS, an orthopaedic surgeon. Dr. Styner’s wife was killed and his children severely injured in the accident. The family had no access to appropriate medical care in the rural area of southeast Nebraska where the plane went down.

The members of the COT enthusiastically embraced the proposal, and in January 1980, the first ACS-sponsored ATLS course was presented in Lincoln, NE. Later that year, regional ATLS courses were presented in eight more cities. The following year, ATLS made its way into Canada, and in 1986, the course was introduced to the international community at the Royal College of Surgeons in London, England. Skip proudly served as a national and international course director for many years.

The ACS and other organizations have honored Dr. Collicott for his important contributions to the trauma and surgical communities. The ACS COT accorded him its Trauma Achievement Award in 1982, its Service Award in 1987, and the ATLS Meritorious Service Award in 1988. In 1992, the ACS, the American Association for the Surgery of Trauma, and the National Safety Council presented him with the Surgeon’s Award for Service to Safety, and the American Trauma Society honored him with the presentation of the William A. Stone Lectureship.

ACS leadership

In addition to serving on the COT for 10 years, Dr. Collicott served on the ACS Board of Governors from 1992 to 1994, the ACS Board of Regents from 1993 to 2002, and the Executive Committee of the Board of Regents from 1999 to 2001. In addition, he served on the Nominating Committee from 1997 to 1998, the Member Services Liaison Committee from
1993 to 1995, and the Central Judiciary Committee from 1995 to 1998. For his contributions to ATLS and to the ACS as whole, Skip was presented in 2008 with the College's Distinguished Service Award—the highest of all ACS honors.

For the last 10 years, Dr. Collicott has served as the Director of the ACS Division of Member Services. In this capacity, Skip has led substantial improvements in the College's efforts to expand its membership. Under his watch, ACS membership climbed by 22 percent, from 64,000 to 78,000, and the number of residents joining the College nearly doubled. The College opened up membership to other health care professionals who are involved in the delivery of surgical services, including surgical nurses, anesthesiologists, and so on.

He also oversaw the addition of a medical student category of ACS membership, the development of the ACS Resident and Associate Society (RAS), and the transformation of the Committee on Young Surgeons into the Young Fellows Association (YFA).

Skip reached out to other divisions of the College to collaborate on various projects. For example, the Division of Member Services worked with the Division of Integrated Communications and Weber Shandwick to develop a marketing strategy and to produce a recruitment and retention DVD. Member Services and Integrated Communications also worked together to develop more chapter websites, and electronic newsletters for the RAS and YFA. He worked with the ACS Foundation and the Finance area to ensure the continued success of Operation Giving Back and to consolidate the College's scholarship programs.

Other accomplishments that Skip led include substantially increasing the number of Central Judiciary Committee reviews by instituting standards for the behavior of a Fellow acting as an expert witness, initiating a general membership survey, and fostering a Board of Governors study on surgeon burnout.

Retirement

At press time, the College's leadership was interviewing candidates to fill Skip's post, which he intended to vacate May 31. However, I am pleased to report that he, like Linn, has agreed to serve as a consultant to his successor.

Skip looks forward to retirement and spending more time with his wife, Irvene Hughes Collicott, RN, who is also an ACS retiree. Skip and Irvene will divide most of their time between their Lincoln, NE, townhouse and their log cabin nestled in the middle of the Shoshone National Forest in northwest Wyoming. He intends to enjoy the wonders of nature by fly fishing, hiking, and teaching his grandchildren to appreciate wildlife and the great outdoors.

The College owes a great debt of gratitude to Paul Collicott for his many contributions to the work of this organization. His warmth, his commitment to patient care, and his level-headed approach to resolving issues will be sorely missed.

David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@fac.org.
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the Centers for Medicare & Medicaid Services (CMS) to develop an incentive program for electronic prescribing, or e-prescribing. E-prescribing is defined as “the ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point-of-care.”* Originally a quality measure in the 2008 Physician Quality Reporting Initiative (PQRI), CMS removed the e-prescribing measure and implemented a separate pay-for-reporting incentive program in 2009, with the goal of advancing quality through safer, more coordinated prescription writing. The creation of this pay-for-reporting program allows eligible professionals to potentially be able to qualify for two incentive payments in 2011—one for e-prescribing and one for PQRI, which is now called the Physician Quality Reporting System (PQRS). Eligible professionals who successfully e-prescribe in 2011 qualify for an incentive payment of 1.0 percent; however, Table 1 on this page shows the incentives and penalties for each year after 2011.

What are the benefits of e-prescribing?

E-prescribing is designed to positively affect four stakeholder groups: patients, payors, providers, and pharmacies. An e-prescribing system should help reduce patients’ out-of-pocket costs, improve their safety, and make filling prescriptions more convenient, because they will no longer need to carry a paper script, and pharmacies will have the prescription in the system immediately. E-prescribing should benefit payors because safer outcomes with reduced adverse medication errors and increased formulary compliance will reduce costs. Providers are expected to gain time from e-prescribing, as the system should reduce administration issues, illegible scripts, and incorrect dosage, as well as expedite drug selection. Lastly, e-prescribing should assist pharmacies by in-

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## Table 1.
Annual e-prescribing incentives and penalties

<table>
<thead>
<tr>
<th>Year</th>
<th>Incentive</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1.0%</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>1.0</td>
<td>1.0%</td>
</tr>
<tr>
<td>2013</td>
<td>0.5</td>
<td>1.5</td>
</tr>
<tr>
<td>2014 and beyond</td>
<td>0</td>
<td>2.0</td>
</tr>
</tbody>
</table>

## Abbreviations and acronyms used in this article

- ASC X12N 837: electronic claim form
- CMS: Centers for Medicare & Medicaid Services
- CMS 1500: standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers
- EHR: electronic health record
- e-prescribing: electronic prescribing
- GPRO: Group Practice Reporting Option
- HCPCS: Healthcare Common Procedure Coding System
- MIPPA: Medicare Improvements for Patients and Providers Act of 2008
- MFS: Medicare Part B Physician Fee Schedule
- PQRS: Physician Quality Reporting System
- QDCs: quality data codes
Increasing coordination and clarification with providers, while decreasing dispensing errors and costs.

Who is eligible to participate in this program?

Eligible professionals are those for whom office visits, eye exams, psychotherapy, or other services listed in the CMS E-Prescribing Measure Specifications represent at least 10 percent of their Medicare charges: physicians, physical and occupational therapists, qualified speech-language pathologists, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals, and qualified audiologists.

Electronic prescribing should only be reported for office visits that are separately listed on Medicare claims and separately payable by Medicare. Office visits provided as part of a global surgical package do not count toward calculations of penalties for not adopting e-prescribing. Only separately payable office services count toward the 10 percent of Medicare payments that determine a physician’s eligibility for the incentive payment, and toward the 25 office services for which e-prescribing must be reported in order to qualify for the incentive payment. (For more information, refer to the section of this article titled “What are the denominator codes?”)

Eligible professionals must have adopted a qualified e-prescribing system in order to report the e-prescribing measure. There are two types of systems: one for e-prescribing only (stand-alone), and the other is the electronic health record (EHR) with the e-prescribing functionality. Regardless of the type of system selected, in order to be considered “qualified” it must meet the following criteria:

• Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers, if available.
• Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts.
• Provide information related to lower cost, therapeutically appropriate alternatives (if any are available). (The availability of an e-prescribing system to receive tiered formulary information, if available, would meet this requirement for 2011).

• Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan, if available.

I think I’m an eligible professional; now what?

To further determine eligibility for the incentive payment, the health care professional will need to consider the following questions:

• Do I have an e-prescribing system/program and am I routinely using it?
• Is my system capable of performing the functions of a qualified system as described previously in this article?
• Do I expect my Medicare Part B physician fee schedule (PFS) charges for the codes in the denominator of the measure (see Table 2, page 8) to comprise at least 10 percent of my total Medicare Part B PFS allowed charges for 2010?

Surgeons who answer “yes” to all of these questions qualify for the incentive payment. Surgeons who answer “yes” to the first two questions, but “no” to the third question, may not qualify for the incentive payment. However, it is important to be sure that your Medicare Part B PFS charges for the codes in the denominator of the measure do not make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2011. If you answered “no” to either the first or second question, you are not eligible for the incentive payment.

How do I begin to participate for the 2011 incentive payment?

There is no registration required to participate in the e-prescribing program. Simply begin reporting the e-prescribing measure at any time in 2011. The surgeon can report e-prescribing data using claims-based reporting, registry-based reporting, or EHR-based reporting. For claims-based reporting, report the e-prescribing G-code (G8553) throughout 2011. For registry-based reporting, report 2011 e-prescribing data using a CMS-qualified registry during the first quarter of 2012. For EHR-based reporting, report 2011 e-prescribing data using a CMS-qualified EHR product during the first quarter of 2012.

It is important to note that only registries and EHR
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>

Source: CPT Manual data compiled by Division of Advocacy and Health Policy staff.
vendors that have been vetted by CMS for the 2011 PQRS/e-prescribing incentive program are qualified to report electronic prescribing information to CMS. These registries and EHR vendors are posted on the CMS website at https://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp#TopOfPage. Please note that these systems have not been checked for electronic prescribing functionality as defined in the specifications of the measure.

It is also important to note that eligibility and qualification for the 2011 incentive payment does not preclude the application of the e-prescribing penalty in subsequent years.

What is the reporting period for the 2011 incentive payment?

The e-prescribing incentive program reporting period is a full calendar year, January 1 to December 31, 2011.

How can I e-prescribe successfully to receive the incentive amount?

For the 2011 reporting period, an eligible professional must report the e-prescribing numerator G-code, which describes at least one prescription created...
during the encounter that was generated and transmitted electronically using a qualified e-prescribing system. To qualify for the incentive payment, the e-prescribing G-code, G8553, must be reported at least 25 times for Medicare office visits, as well as the other listed services for the calendar year for applicable Current Procedural Terminology (CPT) codes included in the CMS e-prescribing measure specifications. The specifications list the denominator codes, which are CPT or Healthcare Common Procedure Coding System (HCPCS) G-codes that represent eligible cases on which surgeons may e-prescribe.

What are the denominator codes?

The denominator codes for the e-prescribing measure are as follows:

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

The American College of Surgeons (ACS) encourages surgeons to e-prescribe. The College realizes, given that narcotics cannot be e-prescribed and many of the denominator codes do not routinely apply to surgeons, the opportunity to participate or avoid the penalty might seem limited. Based on the review of data on evaluation and management (E/M) allowed charges as a percent of total allowed charges, it appears that most surgical specialties meet or exceed the required 10 percent of denominator codes as a percentage of Medicare charges. Nevertheless, individual practices may vary significantly from national data. In addition, the data review shows that cardiac and thoracic surgery practices might fall below the 10 percent threshold of denominator codes as a percentage of Medicare charges. For those specialties and providers whose E/M charges are 10 percent or more of their total allowed Medicare charges, it is important to note that if you do not correctly report E/M charges, CMS will begin to apply a 1 percent penalty across a surgeon's total allowed charges.

When and where do I report the numerator and denominator codes?

If you bill one of the CPT or HCPCS G-codes (denominator codes) on the claim form that is submitted for the Medicare patient visit, and at least one prescription was created during the patient encounter and transmitted electronically using a qualified e-prescribing system, report G8553 (numerator code) on the same claim form. An example of reporting the e-prescribing measure on the Form CMS-1500 (Health Insurance Claim Form) is shown in the figure on page 9.

What is the 2012 penalty for unsuccessful e-prescribing?

As required under Section 132 of MIPPA, CMS is required to implement a payment adjustment, or penalty, for those eligible professionals who are not successful e-prescribers. While the payment adjustment will not take effect until 2012, the penalty is based upon the January 1 through June 30, 2011, reporting period.

How do I avoid the 2012 penalty?

To avoid the 2012 e-prescribing penalty, report on a minimum of 10 unique visits via claims from January 1 through June 30. Each visit must be accompanied by the e-prescribing G-code attesting that during the patient visit at least one prescription was written electronically. Electronically generated refills do not count and faxes do not qualify as an electronic prescription. New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit, and do not count toward the minimum unique electronic prescribing events. However, unlike qualifying for the e-prescribing incentive, reporting physicians must report the 10 visits via claims and not via the registry-based or EHR-based reporting methods.

Are there any other exemptions for the 2012 penalty?

To be an eligible professional to participate in the e-prescribing incentive program, 10 percent of a sur-

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1All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.
The College will continue its efforts on all fronts and provide updates on changes to the e-prescribing program as they become available.

For more information, go to http://www.cms.gov/ERxIncentive/. If you have any further questions regarding e-prescribing, contact Bob Jasak at bjasak@facs.org.

Ms. Burley is Quality Associate, Division of Advocacy and Health Policy, Washington, DC.

What are the significant hardship exemptions?

CMS is allowing for two significant hardship exemptions:

- G8642—eligible professionals, including physicians, who practice in a rural area without sufficient high-speed Internet access are exempt from penalties.
- G8643—eligible professionals, including physicians, who practice in an area without sufficient available pharmacies for electronic prescribing are exempt from penalties.

Eligible physicians must report the designated G-code at least once between January 1 and June 30 to avoid a penalty.

If I successfully participate in the EHR incentive program, am I exempt from the e-prescribing penalty?

No. The penalty applies regardless of whether an eligible professional is planning to participate in the EHR incentive program. However, if the physician chooses to participate in the Medicare EHR incentive program and qualify for the bonus, he or she is not eligible to receive an incentive payment under the e-prescribing incentive program simultaneously in the same program year. If a physician chooses to participate in the Medicaid EHR incentive program, he or she can participate in the Medicare e-prescribing incentive program simultaneously.

The ACS has been working diligently to address the implementation problems with both the incentive and penalty portions of the e-prescribing program.
TELEMEDICINE CONSULTATION for emergency trauma:

The 130 million square foot trauma room

by Rafael J. Grossmann Zamora, MD, FACS; Barbara Sorondo, MD; Robert Holmberg, MD, MPH; and Pret Bjorn, RN
n rural areas, connecting patients with health care specialists in a timely manner remains a pressing concern. This is the case particularly for rural trauma patients, due to a shortage of trauma care providers in rural and sparsely populated areas.\textsuperscript{1-3} This shortage specifically applies to Maine, where there are only three American College of Surgeons (ACS)-verified trauma centers covering an area of more than 35,387 square miles. Moreover, inclement weather, geographical impediments, and a relative lack of emergency medical service transportation services can make it difficult to transfer patients to trauma centers.\textsuperscript{2,3} Thus, telehealth technology provides an opportunity to efficiently improve quality of care in rural areas. In this article, which is based on a scientific exhibit winning entry from the 2009 Clinical Congress in Chicago, IL, the authors describe their experience implementing and evaluating a teletrauma network in rural Maine.

Having an experienced trauma specialist assist with care is a benefit for rural emergency physicians that can potentially improve patient outcomes and reduce the cost of care.\textsuperscript{4} Typically, when a rural trauma event occurs, and immediate transfer to a trauma-certified hospital is not feasible, local hospital providers consult with trauma specialists via telephone.\textsuperscript{5-7} These conversations, however, suffer predictable limitations. First, they encourage a linear process—prior to the phone consultation, the local provider may be immersed in minutes or hours of single-handed direct care. Furthermore, this treatment interval must in turn be summarized and processed for the trauma center colleague—a crucial conversation wholly reliant on the memory and mental organization of the rural provider. Perhaps most importantly, the consultation is neither contemporaneous nor usefully interactive, and is thus insensitive to inefficiency and error.

**Telemedicine for rural trauma health care**

Recent advances in technology and e-health have ushered in a new era—one in which the bridging of the rural health care disparities gap is becoming a distinct possibility. Telemedicine is one technological advance that is transforming the way rural health care is delivered. Emerging technologies in telemedicine offer increasingly affordable, high-definition multimedia systems that allow practitioners to share the patient care environment in real time. They permit clinicians to be “virtually” in the same room, across the geographical divide. For eastern and northern Maine, a largely rural area served by only one ACS-verified Level II trauma center—Eastern Maine Medical Center (EMMC), Bangor, ME—more than 200 miles away from some patients and local hospitals, telemedicine is intuitively an essential tool.

The use of such technology in trauma, emergency medicine, and acute care is relatively recent.\textsuperscript{8,9} Logically, telemedicine and telepresence should be beneficial for rural areas. As Latifi and colleagues argue, emergency room staff in rural areas “often have
Savings have been found to accrue through more efficient use of transportation services (for example, air transport), reduction of unnecessary transfers, and reduction in length of stay.\textsuperscript{8,17,18} Most of the studies demonstrating a reduction in length of stay have examined institutions before and after implementation of telemedicine.

Teletrauma in eastern and northern Maine

The EMMC is a key participant in the northern New England telemedicine system, which was initiated in 1996, long before most hospitals had adopted telemedicine technologies. Little systematic evaluation took place, however, until early 2006, when the EMMC began an extensive project to expand its telemedicine network. This project involved two major departments: trauma surgery and pediatric intensive care. The following discussion will concentrate on the authors’ teletrauma experience over the last four years, comparing telemedicine consultations to our limited experience with major traumas, which may lead to management errors and departures from the standard of care.\textsuperscript{8} This lack of experience contributes to the poorer outcomes observed in trauma cases taking place in rural as compared with urban areas.\textsuperscript{3,10}

Several studies on the use of telemedicine consultation have indicated a positive impact on the quality of care.\textsuperscript{2,11,12} In certain cases, patients were able to stay in their local community rather than being transported to a larger institution.

An early evaluation of telemedicine for emergency care found that it resulted in lifesaving care in two cases, and the researchers found that referring providers overwhelmingly felt that telemedicine improved patient care.\textsuperscript{13} Other studies have found that telemedicine may improve outcomes for patients with injury resulting from burns.\textsuperscript{14,15} In addition, telemedicine consultation in rural trauma cases can result in significant cost savings to patients and to health care systems.\textsuperscript{8,9,16-18} These cost savings have been found to accrue through more efficient use of transportation services (for example, air transport), reduction of unnecessary transfers, and reduction in length of stay.\textsuperscript{8,17,18} Most of the studies demonstrating a reduction in length of stay have examined institutions before and after implementation of telemedicine.
facility with traditional telephone consultations.

At the beginning of the study, we anticipated that access to trauma specialists through telemedicine would facilitate interventions for stabilizing patients, maximizing early care, and ultimately improving patient outcomes across the health care region. We thought that the teletrauma program would reduce the ratio of unnecessary transfers to the regional Level II trauma center, improve patient outcomes, and reduce medical errors, thus improving overall rural trauma care.

The EMMC provides trauma consultations to the 11 community and critical access hospitals (CAHs) that participated, including Blue Hill Memorial Hospital, Charles A. Dean Memorial Hospital, Houlton Regional Hospital, Inland Medical Center, Mayo Regional Hospital, Millinocket Regional Hospital, Mount Desert Island Hospital, Penobscot Bay Medical Center, Redington-Fairview General Hospital, Sebasticook Valley Hospital, and The Aroostook Medical Center. Figure 1, page 14, shows the teletrauma network, with the EMMC serving as the “hub hospital,” and outlying facilities representing the “spokes.” The geographic region covers more than 126,000 square miles and includes half of Maine’s 15 CAHs. This has inspired the conceptualization of what could be thought of as the “130 million square foot trauma room.” Telemedicine enables our specialists to work with providers at remote hospitals in real time, as if we are all in the same room.

What did we look for?

We utilized a non-equivalent, parallel, control group design to assess the impact of telemedicine trauma consultations as compared with trauma cases using telephone consultation in regard to patient outcomes, clinical process, and physician satisfaction. Telemedicine consultations were conducted using Tandberg camera systems, such as the mobile unit shown in the photo on this page, which features a 20-inch wide-screen LCD monitor with high-definition camera and audio transmission. This system enables “continuous presence” multipoint conference bridging between sites, linking them in real time. The attending and consulting physicians can see and speak with each other, and the consulting physician is also able to see the patient. In all instances, the decision of whether or not to transfer a patient is made locally—for example, by the attending physician at the remote site—based on information and advice provided by the consultant who actually “sees” the patient.

What have we found so far?

Our experience with teletrauma has been overwhelmingly positive, both for providers and patients. The data suggest that patient outcomes are improved when telemedicine is used (when appropriate) as compared with traditional telephone consultations. We also asked referring and consulting providers about their experience using telemedicine, through a survey administered within 48 hours of each telemedicine consultation (see Figure 2, page 16).

We have gathered data on more than 700 transfer consultations between the EMMC’s trauma team and our network hospitals since mid-year 2007. Consultations conducted by telemedicine account for 15 percent of these. Of the 105 telemedicine consultations, 55 (52 percent) resulted in transfer of the patient to the EMMC. A total of 192 surveys have been collected for each of the 105 telemedicine consultations recorded to date, representing a 91 percent response rate when at least one of the two providers completed a survey.

Patients transferred to the EMMC as a result of telemedicine consultation were more likely to be slightly younger (36 years of age, compared with 45) and more often male (84 percent compared with 66 percent) than were patients transferred to the EMMC after a telephone consultation. The EMMC code green (trauma team) response was also more likely to be activated (22 percent versus 5 percent) when telemedicine was used. While the majority of trauma cases we have consulted on involved motor vehicle crashes or falls, other mechanisms of injury included assault, watercraft inju- [continued on page 17]
### Figure 2. Telemedicine provider survey

**TELEMEDICINE: Transfer consultation survey**

**Adult Trauma? PICU?**

Please rate your response only to those statements that apply (circle one).

<table>
<thead>
<tr>
<th>Referring physician:</th>
<th>Consulting physician:</th>
<th>Date/time of consult</th>
</tr>
</thead>
</table>

**1.** It was my intention to transfer the patient prior to consultation. **YES** **NO**

**2.** The telemedicine process influenced patient disposition / transfer. **YES** **NO**

**3.** The telemedicine connection process was uncomplicated and efficient.

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**4.** The technical quality of the telemedicine connection (audio/visual) was optimal.

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**5.** The telemedicine process changed patient care management.

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**6.** The telemedicine process positively affected potential patient outcome.

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**7.** The telemedicine process better facilitated communication and decision making between clinicians.

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**8.** Telemedicine better facilitated communication and reassurance with family members (if appropriate).

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**9.** My overall satisfaction with this telemedicine consult was high.

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**10.** I will use telemedicine again in the future.

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**11.** A FOLLOW-UP consultation was done after the patient was transferred. **YES** **NO**

**12.** This FOLLOW-UP consultation served as an informative and effective training tool (if applicable).

| Strongly agree | Comments: 5 | 4 | 3 | 2 | 1 | Strongly disagree |

**PHYSICIAN’S SIGNATURE: _________________________________**
ries, fire, explosion, and self-inflicted wounds. Use of the telemedicine system forces the early inclusion of a trauma surgeon in pre-transfer decision making—thus, patients transferred by telemedicine consult are likely to receive more appropriate and higher-quality care.

Telemedicine has had a substantial impact on clinical process outcomes. For example, one of the outcomes we are tracking is the mode of transportation when a patient is transferred to the EMMC from a remote community. Our trauma coordinators review all patients transferred from other facilities and determine whether or not a transfer was necessary. In cases where the quality of patient management or transfer might be improved, a coordinator then determines whether or not telemedicine might have reasonably prevented any such shortcomings. We have found that more telephone consultations were deemed as a potentially “unnecessary transfer” compared with telemedicine. We also found that more telephone consultations resulted in an “inappropriate mode of transfer” compared with telemedicine consultations. The majority of these cases involved air transportation (at a much higher expense), when ground transportation would have sufficed. Thus far, we have not identified a single case in which an inappropriate mode of transport was associated with a telemedicine case. We believe that the more telemedicine is used, the better we will be able to statistically demonstrate that this technology results in fewer transportation errors.

Notably, we have found that the incidence of medical errors is lower when using telemedicine than for telephone consultations. That is, according to the judgment of our trauma coordinators, inappropriate clinical management was more likely to be associated with telephone consultation cases than telemedicine cases.

Finally, while the mortality rate was higher for those transferred after a telemedicine consultation, the Injury Severity Score (ISS) was also higher. The median ISS of those greater than 15 was higher for the telemedicine group (25.0 compared with 18.0). While more data is required for firm conclusions, the data thus far suggest that telemedicine can offer direct benefits for patient care.

Clinical cases

When seeking to illustrate the benefits of telemedicine, numbers may not tell the entire story. We have noted several cases in which telemedicine (subjectively) resulted in more efficient and potentially life-saving care. To convey this, we present three case studies that demonstrate how telemedicine can offer benefits to both referring and consulting medical providers. Thus, this report provides a unique combination of quantitative and qualitative data to evaluate our experience with telemedicine.

- A middle-aged patient presented in the evening to a rural emergency room with partial thickness burns to the face and both hands. An initial assessment determined that a transfer to the Level II trauma center was warranted; however, a teletrauma consult with an EMMC specialist resulted in the woman being treated safely and effectively within her local hospital. The patient fully recovered from the burns without complications. Teletrauma was credited as eliminating an unnecessary 150-mile round-trip transport to the EMMC. The referral physician stated, “Our patient is impressed with both hospitals.” The consulting physician stated, “Teletrauma is great for assessing burn patients.”

- In a rural town, a motor vehicle crash occurred, involving five individuals. Before transferring the five patients to the EMMC, a teletrauma consult was initiated with the EMMC trauma specialists. Additionally, the technicians, nurses, and physicians who took part in the initial work-up of the patients were able to stay involved in the entire process of care—from transport to treatment at the EMMC via reverse telemedicine (referring hospital providers were able to observe the treatment process after arrival at the trauma center). This event served as an important team-building and educational exercise for the referring rural health care providers.

- The third case involved a female who had been burned during the evening. Providers at the rural community hospital contacted the EMMC for advice and assistance in transferring the patient to a Boston, MA, burn center. However, a trauma physician was able to assess the injury and determine not only that a burn center was not indicated, but indeed, that the patient could be safely treated at the CAH, with no threat of morbidity or complication.

What do providers say about telemedicine?

According to the surveys we disseminated after each telemedicine consultation, providers (referring and consulting) are supportive of—and wish to continue to use—telemedicine. For example, we found that referring and consulting providers in general felt that the technology was easy to use, and improved com-
many services in which telemedicine can prove useful in reducing costs and increasing access to care. It is now, we believe, safe to say that telemedicine has a strong future in emergency and trauma care. This is the case especially in rural areas where there is a shortage of specialists. It simply makes sense to use this technology in a way that links specialists to providers in remote hospitals. After all, having a "30 million square foot trauma room" means that patients in rural, remote locations no longer have to travel long distances to meet with specialists, and providers in trauma centers do not have to "fly blind" with respect to advice we give to rural referring physicians.

To be sure, challenges remain. Credentialing across facilities can be a difficult task, and ensuring compliance with ever-changing regulations regarding patient confidentiality will likely remain a barrier to full adoption of telemedicine services for many locations. Regulatory conditions vary across localities, thus inhibiting full adoption of telemedicine across the nation, and according to the authors of a recent academic paper, the existence of inconsistent regulations is unconstitutional.20 Their point is that in order to make the best possible use of telemedicine, an infrastructure needs to be in place on the local, state, and federal levels. Another challenge has been the area of documentation and billing/reimbursement. We have a standardized process for dictation, coding, and charging payors in Maine for patients who receive telemedicine consultation and are not transferred. We have not, to date, researched the reimbursement aspect of the project. In addition, we have done a few trials of “tele-follow-up visits,” in which patients who reside long distances from the EMMC have been subsequently seen via telemedicine to evaluate their clinical progress. In our experience, telemedicine has had numerous benefits both to patients and providers. Now, patients have expanded access to specialists in a timely manner. In addition, preliminary analyses have shown that telemedicine could incur significant cost savings by averting unnecessary transfers to the EMMC. We are continuing our work with telemedicine in several areas (including TelePICU, TeleHomecare, Tele-ED Psychiatry, TeleNICU Stabilization, TeleStroke, TeleEndocrinology, and TelePsychiatry). We are also pursuing additional funding to expand our network in terms of geography and services. We hope that the national and world-wide trend toward increased use of telemedicine continues well into the future.

Conclusion
Fifteen years ago, when telemedicine first made an appearance in the health care field, providers were reasonably skeptical. To see patients through a video screen seemed interesting, but somehow less clinical than seeing them face-to-face. Also, providers wondered whether this technology would be feasible to use on a regular basis.19 Research has now shown that telemedicine is accepted by providers and that there are communication between each other and providers and families. Providers also stated that they would be very willing to use telemedicine cameras in the future. Importantly, the majority of survey respondents felt that the use of telemedicine improved the clinical care of the patients involved. Several cases have been identified as having been impacted by telemedicine in a potentially lifesaving way.

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Acknowledgments

The authors acknowledge the significant contributions of the following: Erik Steele, DO; David Burke, MD, FACS; Joannmarie Pellegrini, MD, FACS; David Rydell, DO; Amy Fenwick, MD, FACS; Rony Ramia, MD; Joseph Karem; Michael Rocque; Wanda Pacifici; and Karen Clements, RN. We also gratefully acknowledge the staff at the EMMC’s Emergency Department and staff at all remote sites in the teletrauma network.

References


Dr. Holmberg is a pediatrician and director of clinical outreach, Eastern Maine Medical Center, Bangor.

Mr. Bjorn is a registered nurse and trauma program manager, Eastern Maine Medical Center, Bangor. He is chair of the Maine Emergency Medical Services Trauma Advisory Committee.
A recent publication by Michael Nurok, MD, PhD, and colleagues in the New England Journal of Medicine has caused a stir in the surgical community and beyond. The article, entitled “Sleep deprivation, elective surgical procedures, and informed consent,” appeared in the December 30, 2010, issue. The article asserts that surgeons who are sleep deprived after a night of operating should be morally obligated to formally disclose their level of sleep debt to their elective patients who are scheduled for surgery the next day. It is recommended that this be done in the form of a standard informed consent procedure. Furthermore, the authors call for institutional changes that will prevent surgeons from scheduling elective procedures on their post-call days. The authors include data published in a 2009 issue of the Journal of the American Medical Association showing an “83% increase in the risk of complications (e.g., massive hemorrhage, organ injury, or wound failure) in patients who undergo elective daytime surgical procedures performed by attending surgeons who had less than a 6-hour opportunity for sleep between procedures during a previous on-call night.”

A response from the American College of Surgeons (ACS) leadership was printed as a letter to the editor in the same issue. Carlos A. Pellegrini, MD, FACS, Chair, ACS Board of Regents; L.D. Britt, MD, MPH, FACS, ACS President; and David B. Hoyt, MD, FACS, ACS Executive Director, agreed with the need for the problem of surgeon sleep deprivation to be addressed fully. They disagreed, however, with the proposed solution. First, they argued, surgeons who meet the professional and ethical standards of the ACS should be able to address such a problem individually, as a matter of delivering safe surgical care, and would likely view such a requirement as “oppressive and insidious.” Next, they assert that a simple disclosure rule will not address the root of the problem, and surgeons should be trained in evaluating their own level of sleep deprivation as a component of providing excellent patient care.

Two of us (Drs. Kodner and Keune, co-authors of this article), as the Co-Community Editors of the Ethical Issues in Surgery community on the e-FACS.org website, found this topic an apropos one for posting as an “ethical challenge”:

An experienced surgeon has three elective procedures scheduled for Wednesday morning. As it happens, on the night before, he performed emergency operations that kept him awake until 4 am. Although tired, he is confident that he can complete the three elective cases with the safety and efficiency that he is known for—after all, he was trained to be safe and effective, even when fatigued. Is he morally obligated to disclose his level of sleep deprivation to these elective patients? Should this disclosure be made as part of the informed consent process? Should his institution establish rules that prevent elective cases from being performed by surgeons who may be sleep deprived?

The challenge was posted to the eFACS.org community in early January, and the site has received a variety of responses. Tyler G. Hughes, MD, FACS, of McPherson, KS, noted that “A patient is not a competent judge of whether to proceed with surgery under these circumstances.” Dr. Hughes compared the sleep-deprived surgeon with a sleep-deprived pilot, noting that if the crew is not fit, “[the pilot] does not ask the passengers if it is alright to proceed, he does not fly.” Allan L. Liefer, MD, FACS, of
Chester, IL, writes, “More rules is not the answer, good judgment is the answer. Good judgment is the mark of a safe surgeon.” Alan Manning, MD, FACS, of Hammond, LA, wrote, “…no one [individual] or institution can make enough policies to replace our own personal professional responsibility.”

In partial agreement with Dr. Nurok and colleagues, Todd C. Campbell, MD, FACS, of Coatesville, PA, wrote, “The surgeon is professionally but not morally obligated to disclose sleep deprivation. Thus, this should be part of the informed consent process. All institutions should have rules and regulations in place governing the performance of all procedures and protecting the safety of public.” Similarly, Ramsey M. Dallal, MD, FACS, of Philadelphia, PA, noted, “If the data clearly documents that operative complications are increased if the surgeon has not slept, then we owe it to our patients to inform them.”

The authors have a further concern about Dr. Nurok’s recommendation. It is possible that patients, for whom an elective operation may be a major life event, might not be able to incorporate information about a surgeon’s level of sleep into their decision-making process. As Dr. Pellegrini and colleagues noted, “Many other factors—including marital difficulties, an ill child, financial worries, and so on—negatively affect performance. Are we going to demand full disclosure of these problems as well?” Just imagine trying to incorporate one of these mitigating factors into an informed consent procedure.

In partial agreement with Dr. Nurok’s view, though, it is a concern that an individual surgeon will not have good insight into his or her own level of sleep deprivation. To be sure, fatigue can alter one’s normally sound judgment. Such alteration of judgment can obscure the ability of a surgeon to both police himself, and to obtain reasonable informed consent. Moreover, physicians have many competing interests such as self-image, peer pressure, and financial pressure that can be difficult to weigh in a state of fatigue. For these reasons, the authors have serious reservations that self-regulation will be effective. Oversight should be at the institutional level, where the chance that a sleep-deprived surgeon might operate on an elective patient is more likely to be minimized. If such institutional oversight is not pursued at the level of a surgeon’s own department, then it is nearly inevitable that regulation will be imposed upon physicians from outside the surgical community.

To read all of the postings from the eFACS.org community, and to add your own view, visit http://efacs.org/ethicalissues.

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Dr. Healy is professor of otology and laryngology, Harvard Medical School, Boston, MA. He is a Past-President of the American College of Surgeons.
Elias S. Hanna, MD, FACS, a retired cardiac surgeon, spent most of his career using his talents to help underserved patients with heart conditions throughout the world. His recent commitment of $160,000 to the American College of Surgeons (ACS) Foundation is earmarked to ensure that other international surgeons will have every opportunity to do the same.

Dr. Hanna emigrated to the U.S. from his native Syria at age 17 to study at the University of Texas, Austin. He received his medical degree in 1963 from Tulane University, New Orleans, LA, and currently serves on the board of that institution. He went on to complete his residency at Baylor University School of Medicine, Houston, TX, where he trained under Michael DeBakey, MD, FACS, and Denton Cooley, MD, FACS.

Since then, Dr. Hanna has developed a reputation not only as an outstanding heart surgeon, but as a true humanitarian.

Service in Vietnam

In 1969, he was drafted by the U.S. Army to perform surgery in Saigon, Vietnam. “I was the only active heart surgeon in the program, which meant that I was able to get a great deal of experience,” Dr. Hanna said.

During “slow times” at the U.S. Army Third Field Hospital, Dr. Hanna created an important program that would have lasting positive effects on the lives of the Vietnamese people. “I would bring in Vietnamese kids with congenital heart disease and help them if I could. The hospital allowed me to use its facilities, and medical supply companies in the U.S. sent me a lot of free equipment,” he said. In the course of his one-year tour of duty in Vietnam, Dr. Hanna operated on 89 Vietnamese children. Dr. Hanna received South Vietnam's highest honor from the government’s Ministry of Health for performing the first successful heart operation on a Vietnamese citizen.

The operations that Dr. Hanna performed in Vietnam also afforded him the opportunity to train, without charge, physicians in open-heart surgical techniques. “The most important thing, I think, is that I showed the Vietnamese surgeons some simple cases that could be treated with their own [resources],” he said.

According to Dr. Hanna, though, the highlight of his service in Vietnam was when he successfully removed an enemy bullet from the heart of a 20-year-old American soldier. “Although fragments of bullets had been removed from soldiers in the past, the operation I performed that day was unprecedented in the Vietnam War,” Dr. Hanna said. “The very next day, articles with pictures of me, the soldier, and the bullet I removed were published in newspapers all over the world. I became a celebrity in the medical community.”

“Fastest hands in the West”

The operation on the soldier was just one of Dr. Hanna's accomplishments to make the headlines. After a stint at Fitzsimons Army Medical Center in Aurora, CO, as an assistant heart surgeon and becoming familiar with aorta coronary bypass surgery, Dr. Hanna was named chief of thoracic surgery at St. Mary's Hospital in San Francisco, CA, where he started a new open-heart surgery program.

It was there, in 1972, that he performed a triple bypass operation on a patient who was a Jehovah's Witness. Due to his religious beliefs, the man refused a blood transfusion. Not to be deterred from saving
this patient’s life, Dr. Hanna put together an 11-member operating team and successfully performed the procedure in approximately 75 minutes with no blood transfusion. This feat earned him a reputation for having the “fastest hands in the West.”

After receiving international acclaim for both the operation on the soldier in Vietnam and the triple bypass, “Countries all over the world asked me to teach their surgeons various cardiac procedures, concentrating mostly on bypass surgery,” Dr. Hanna said. In the course of his career, he took 48 medical trips to 28 countries, including China, Syria, India, Sri Lanka, Egypt, Iraq, Tunisia, Morocco, Saudi Arabia, Lebanon, Taiwan, and the Philippines. “In each country, I was the first cardiac surgeon to ever perform bypass surgery,” he noted.

By the time Dr. Hanna retired from operating, he had performed more than 24,000 open-heart operations, completing several each operating day at five cardiac surgery programs in northern California.

Winemaker

A farmer’s son, Dr. Hanna now devotes much of his time to the winery he established in Sonoma County, CA. “Becoming a vintner has been a natural evolution of my heritage,” he said.

Of course, one doesn’t go from operating to making fine wine without a little training. After reading up on the subject extensively, he took his family on a trip to the legendary chateaux of France. “I talked to winemakers whose families had been making wine for generations,” he said. He also observed their winemaking techniques and “the craft and artistry that went into every bottle of wine.”

In 1985, he hired a professional winemaker and a consultant to help him establish the Hanna Winery, which has vineyards in the Russian River and the Alexander Valley regions of Northern California. “In my vineyards, I find balance, genuine peace, and a wonderful sense of completion,” Dr. Hanna said. His daughter, Christine, presently runs the winery.

Philanthropist

Retirement from practice has done nothing to slow Dr. Hanna’s efforts to ensure that patients in every nation have access to quality cardiothoracic care. He continues to serve as the founder and president of the Elias S. Hanna, MD, Cardiovascular Foundation, a charitable organization that assists countries that lack the resources necessary to perform open-heart surgery.

Dr. Hanna’s foundation recently gave $1.25 million to the Tulane University School of Medicine to establish the Elias S. Hanna, MD, Foundation Chair in Cardiovascular Surgery, and to enhance the activities of an outstanding faculty member in the department of surgery. Thomas Yeh, Jr., MD, FACS, director of the Tulane Pediatric Heart Center, was installed as the chair in 2009.

Last year, Dr. Hanna agreed to contribute $160,000 to the ACS Foundation to sponsor an International Guest Scholarship. Dr. Hanna said he decided to make this donation because he greatly values the opportunities that he had to teach surgical techniques to residents and surgeons in developing countries.

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

Ms. Schneidman is Manager of Special Projects, Division of Integrated Communications, Chicago, IL.
Extremes of age:
Surprising similarities of pediatric and geriatric surgery
In 1951, when J. Alex Haller, Jr., MD, FACS, a coauthor of this article, expressed an interest in pediatric surgery, his chief surgeon, Alfred Blalock, MD, responded, “I am not sure there is a future for a specialty of children’s surgery.” Pediatric surgeons were embraced first by the American Academy of Pediatrics, not the American College of Surgeons (ACS). At that time, board certification was an unmentioned dream.

Sixty years later, thousands of surgeons have proven Dr. Blalock wrong, as there are now more than 30 highly competitive training programs available, and the American Board of Surgery (ABS) offers the imprimatur of certification.

In similar regard, would any resident today tell his chief that he or she is planning to be a geriatric surgeon? In fact, that is happening, and the state of geriatric surgery as a discipline today is interestingly similar to that of pediatric surgery a half-century ago.

Why geriatric surgery?

The aging of the population will be the greatest force affecting health care—and affecting society as a whole—in our lifetime. Already, the elder group is experiencing near-exponential growth, with the most explosive growth occurring in the older than 80 years subset. In addition, the conditions that require surgery (atherosclerosis, cancer, arthritis, prostatism, cataract, and others) increase in incidence with advancing age.

Most surgeons operate on the elderly and believe that they are providing excellent care—but there is room for improvement. These operations, unfortunately, are often accompanied by increased length of stay, increased cost, and increased complications. A number of centers have shown, however, that with a deeper knowledge of geriatric physiology and compulsive attention to detail, results need not differ at all from those of the general population. Geriatric surgery is certainly a worthy area of study and of promulgating what we learn.

History of organized pediatric surgery

Pioneers interested in children’s surgery in 1948 organized the Surgical Section of the American Academy of Pediatrics (see Figure 1, page 26). Unlike the ACS, which initially feared the fragmentation of general surgery, the pediatricians welcomed these sympathetic surgeons. One unfortunate result, however, was the perception that pediatric surgeons were the technical arm of pediatrics and not true surgeons themselves—an opinion that persisted for more than 20 years.

Two events changed this impression and brought pediatric surgery into the camp with other types of surgery. In 1966, William Clatworthy, MD, of Columbus Children’s Hospital, Columbus, OH, led a voluntary oversight committee of the Surgical Section of the American Academy of Pediatrics—a committee charged with establishing strict training criteria that included board certification in general surgery and two additional years in pediatric surgery. The second event took place in 1970, when a new generation of pediatric surgery leaders formed an independent organization, the American Pediatric Surgical Association.
Now in a stronger position, pediatric surgeons carried a petition to the Residency Review Committee and to the ABS, and in 1972, pediatric surgery was recognized with a Certificate of Special Competence in Pediatric Surgery. The ACS created an Advisory Council on Pediatric Surgery in 1969 (still in existence today) which strengthened the position of pediatric surgery within the surgical world. After a prolonged gestation, pediatric surgeons had been reborn as “real” surgeons.

**History of organized geriatric surgery**

When Mark R. Katlic, MD, FACS, a coauthor of this article, published the book *Geriatric Surgery* in 1990, no organized group of geriatric surgeons existed, and the list of chapter authors was composed of a large subset of those willing to consider the appellation.5 Many of these chapter authors went on to produce their own texts and to remain active in this nascent area of knowledge.6-8 In 1992, however, a visionary geriatrician—the late Dennis Jahnigen, MD, Goodstein Professor of Geriatric Medicine and director of the Center on Aging, University of Colorado Health Sciences Center, Denver, CO—recognized that geriatric medicine alone could not improve care of the elderly. In 1994, he championed the Geriatrics for Specialists Initiative (GSI) of the American Geriatrics Society (see Figure 1, this page).

The GSI was composed of representatives from 10 surgical and related specialties for an organization originally known as the Interdisciplinary Leadership Group. Later the organization was titled the Section of Surgical and Related Specialties, and now it is referred to as the Section for Enhancing Geriatrics Understanding and Education (SEGUE). There are plans to transfer increased responsibility from the American Geriatrics Society to the 10 surgical and related specialty societies that appoint representatives to this SEGUE council. The College has had a Task Force on Geriatric Surgery since 2004, and in 2010, the task force selected its first two-year surgical fellow to study geriatric surgical principles out of its Chicago, IL, headquarters. At least one general geriatric surgery clinical fellowship already exists, at the Medical University of South Carolina, Charleston.

A discussion of certification would be premature; however, the ABS has recognized the importance of geriatric surgical principles in its examinations, and recently has solicited a curriculum section for the Surgical Council on Resident Education website.

**Other similarities**

Both pediatrics and geriatrics deal with the extremes of age (see Figure 2, page 27). Organ system physiology may differ from the typical adult. Children are not just “little adults,” nor are the very elderly simply “old adults.” Both premature infants and octogenarians, for

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**Figure 1. History of specialty organizations**

<table>
<thead>
<tr>
<th>Pediatric surgery</th>
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<tbody>
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<td>• 1948 Surgical Section of the American Academy of Pediatrics</td>
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<td>• 1969 Advisory Council on Pediatric Surgery (American College of Surgeons)</td>
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<td>• 1970 American Pediatric Surgical Association</td>
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<td>• 1972 Certificate of Special Competence in Pediatric Surgery (American Board of Surgery)</td>
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<th>Geriatric surgery</th>
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<td>• 1994 Geriatrics for Specialists Initiative (American Geriatrics Society)</td>
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<tr>
<td>• 1998 Section for Surgery and Related Specialties, now Section for Enhancing Geriatrics Understanding and Education, SEGUE (American Geriatrics Society)</td>
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<tr>
<td>• 2004 Task Force on Geriatric Surgery (American College of Surgeons)</td>
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*Dr. Katlic is director of thoracic surgery, Geisinger Health System, Wilkes-Barre, PA.*
example, are at risk for hypothermia; the former have not yet developed stable temperature control and the latter manifest an attenuated vasoconstriction response and less metabolic heat production through loss of lean muscle mass. Diminished immune defenses in each group may compromise response to bacterial infection. The signs and symptoms of surgical disease may be subtle or different from those in the general population. For example, a pseudo-stability after trauma may exist both in preschool children and the elderly. The young child might lose half its blood volume before there is any drop in blood pressure, preventing hypotension via vasoconstriction and increased heart rate. The elderly, with decreased response to catecholamines, and often taking beta-blocking medication, will not show tachycardia proportional to the degree of stress.

Exceptional attention to detail in and out of the operating room is crucial for both extremes of age. Ageism—prejudice based on chronologic age—is an ugly reality of each specialty. Both age groups, coincidentally spanning two decades each, need advocates; surgeons can and do embrace this role.

Initially each specialty was considered a “hobby” for general surgeons. Now both pediatric surgeons and geriatric surgeons can reasonably be considered, in the words of Judson Randolph, MD, “general surgeons and something more, and something more.”

References

Health care integration is an often overlooked outcome of the health care reform process. For a physician, health care integration means (to paraphrase the U.S. White House) becoming employed by a hospital or joining a large group. Many view this as a development in the distant future associated with the planned implementation of accountable care organizations. Exactly how accountable care organizations will function is still not known. However, they will likely finance health care on a pay-per-event basis, where the insurance company assumes the risk of event occurrence and the health care delivery system assumes the risk of event treatment outcomes.

Driving factors

Health care integration is being driven by two factors. The first is related to the Medicare sustainable growth rate (SGR) physician payment formula, which, if not changed, will cut the physician’s gross pay by almost 30 percent by the first of next year. It is estimated that it will cost $330 billion to correct this payment schedule over the course of 10 years—a daunting sum for a nation in an economic downturn. To make matters even worse, the Office of the Actuary of the Centers for Medicare & Medicaid has released a financial analysis on the effect of health care reform which is in line with the earlier Congressional Budget Office’s report. Medicare is widening its deficit, and by 2019, health care costs in the U.S. will comprise 20 percent of the nation’s gross national product.

The second factor driving health care integration is related to hospi-
of hospital governance. Similar to the banking industry, auditing and quality assurance functions should operate like a separate corporation in the hospital, with staff being employed by, and reporting directly to, the hospital’s board and not to the CEO. Hospital boards should be trained in issues of patient advocacy by independent training agencies and community board members should not have a conflict of interest with the facility.

• Physicians need to be permitted the freedom to counsel their patients, patients’ families, and medical decision makers regarding health care quality and where the patient can receive the best value of health care, regardless of the facility that is recommended to the patient or the facility that currently employs the physician. Gag clauses and any form of retaliation against the physician regarding discussions of facility quality need to be strictly prohibited, provided that Health Insurance Portability and Accountability Act regulations are followed.

• Most importantly, physicians need to develop an independent voice. Integration not only affects hospital governance but also medical trade organizations. Being a patient advocate means more than telling the patient to stop smoking and lose weight. It means more than making sure health care is well funded so the doctor’s medical bills are paid. It means ensuring the patient is able receive the highest value health care in both cost and quality. To this end, transparency and public reporting are very important to health care integration. Public reporting of infections is currently supported by the Centers for Disease Control, the Association for Professionals in Infection Control, the Infectious Disease Society of America, the Society for Healthcare Epidemiology of America, the Council of State and Territorial Epidemiologists, and the Trust for America’s Differences in the increase in procedural versus facility CPT code reimbursement

<table>
<thead>
<tr>
<th>Year</th>
<th>CPT code</th>
<th>Surgery center</th>
<th>Hospital outpatient department</th>
<th>Surgeon</th>
</tr>
</thead>
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<tr>
<td>2008</td>
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<td>$1,418</td>
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<td>2010</td>
<td>42821</td>
<td>$920</td>
<td>$1,679</td>
<td>$299</td>
</tr>
</tbody>
</table>

†All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.
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Health. In addition, at least 27 states now mandate public reporting of health care-acquired infections. Placing a guarantee on services is something that is common in other industries and is expected by the public. This guarantee includes support of non-payment of hospital-acquired conditions—a policy which was universally applied to surgeons when global surgical fees were introduced in the mid 1980s. Global surgical fees have been viewed as good policy for the surgeon and the patient. Certainly, it is also good policy for facilities. The concern of inhibiting health care for the sickest patients is not valid due to the fact that it is the doctor, not the facility, who determines which patients are admitted. Under the current diagnosis-related groups system, facilities that treat the sickest patients who are at the greatest risk of developing hospital-acquired conditions will often still receive the maximum payment because of the presence of other coexistent, co-morbidity factors. The Geisinger Health System adopted this payment policy in February of 2006 for coronary artery bypass graft and currently with other ProvenCare procedures covered by its Geisinger Health Plan Insurance. Soon, this payment policy may become standard in accountable care organizations, which may receive one fee for all services related to an event.

Conclusion
Physicians have their work cut out for them to regain the leadership position in our health care delivery system. Physicians are at risk of belonging to a trade, as opposed to a profession, and therefore, they need to develop an independent voice, apart from the facility administration, a voice that truly advocates for patients.

References:

Dr. Kavanagh is a non-practicing otolaryngologist in Somerset, KY, and founder of Health Watch USA, a 501(c)3 organization whose mission is to promote health care transparency and value-purchasing.
Running for political office

by Charlotte Grill

Running for, and holding, political office is still one of the most powerful ways to contribute to our society and to influence legislative issues and decisions. Surgeons serving in public offices are greatly needed and can make the critical difference in ensuring that legislation reflects the needs of the profession, patients, and the health care system. Although being a candidate for elective office can be emotionally and physically draining and time-consuming, it affords those who are elected the opportunity to direct systemic changes in government and opens doors to future political opportunities. This article summarizes the steps for launching a campaign for office, and is intended to make the process less daunting.

Before moving forward, though, an honest personal assessment is in order. Candidates should think about their involvement in a local political party and the connections they have within the existing political establishment. They also should consider whether they can sacrifice time away from their practices and families for a campaign that will take energy, commitment, and resources, and whether their families are equally committed. They should determine whether they truly enjoy community involvement and have personalities that can handle the level of socializing and “politicking” needed to become successful elected officials.

Steps to getting a campaign started

- **Step one:** If all factors indicate that someone is in a position to launch a political campaign, the potential candidate should research different offices and positions in government. The candidate should explore elected positions at municipal, county, state, and federal levels to get an idea of the various time commitments, requirements for running, and responsibilities to find the best fit for his or her lifestyle and goals. Upon settling on a seat to pursue, the candidate should get details on filing deadlines, as well as residency and other requirements. For first-time campaigns, it probably is best to start at the local or state level because those contests are usually less expensive, have smaller campaign territories, and offer credible political experience for individuals who decide to pursue higher offices at a later date.

  - **Step two:** File with the appropriate agency. Most offices require, at minimum, that candidates are registered voters in the district of the office being sought. Additional requirements may include a certain number of signatures on petitions, a level of money, a minimum age, or other experience qualifications.

  If running for a state seat, the candidate should contact the secretary of state office to file; for a federal seat he or she should contact the Federal Election Commission (FEC). The FEC requires that candidates register within 15 days of raising $5,000, although most nominees register before they reach that total because the registration process usually takes longer than 15 days.* All federal elections require candidates to be registered to comply with federal fundraising regulations. At this stage in a campaign, it is necessary for the candidate to create a political fundraising name because it needs to appear on all fundraising and political materials.

  - **Step three:** Determine political party affiliation. By this point in the process, or long before, candidates already know the political party with which they identify and will declare. Although declaring party affiliation seems like a fairly obvious point, in many state and local races, independents are more likely to run, and party affiliation is less important than it is at the federal level. It also is a good idea to declare a party affiliation because political party offices have access to data on donors, volunteers, and experienced campaign personnel, and may be in the process of recruiting candidates.

  - **Step four:** Recruit staff and volunteers. All campaigns require, at the very minimum, a treasurer and a campaign manager. Treasurers are essential in terms of balancing campaign budgets, keeping records up to date on donors, and filing the proper fundraising reports. Campaign managers handle scheduling events, writing speeches, recruiting volunteers, and reaching out to donors. When running for higher education

state and federal offices, campaign staff tends to be much larger.

- **Step five:** Focus on fundraising efforts. It takes a lot of time and energy to call and reach out to people who can support candidates with financial contributions. Special events, such as teas, pig roasts, and party-affiliated dinners, can also “bring home the bacon” for a campaign fund.

- **Step six:** Create the campaign website. The Internet has become the hub for campaigns to access and reach the public. Websites are no longer just a forum for relaying a candidate’s message and talking about the issues; most campaigns post videos of speeches and links for contributors. Websites are an easy format for creating a strong campaign message and relaying biographical information and personal anecdotes. Moreover, they are particularly effective in reaching younger voters, who are more comfortable using technology on a daily basis.

- **Step seven:** The candidate should file papers to get his or her name on the ballot. Candidates are given instructions on this process when they register to enter a race, and these guidelines should be followed carefully; one small misstep may prevent a candidate from getting on the ballot.

- **Step eight:** Poll of voters in the district. The purpose of conducting polls is to find out how many voters in the district recognize the candidate’s name, are willing to vote for that individual, and what the top priorities are for voters in the district. Many companies and websites carry out these polls. Results from polls will show the candidate’s viability, if the campaign’s message and issues resonate with the public, and the public’s perception of the candidate. Polls will also help campaigns set strategy and develop a concise and clear message.

- **Step nine:** Communicate with the voters. Deliver a coherent, understandable, and accessible message that summarizes the candidate’s beliefs and objectives if elected. Several approaches are effective in disseminating a campaign message—from grassroots efforts, to using Web-based initiatives, to working with local media outlets. All of these approaches will get the word out about the candidate’s qualifications, expertise, and political agenda.

- **Step 10:** Interact with the public as much as possible. Canvas the district by handing out yard signs, bumper stickers, and other campaign materials. Attend public events and be as visible as possible.

Being in the public eye will help the candidate garner new supporters and volunteers, and will provide opportunities for him or her to meet with the press and get the candidate’s name out.

**Conclusion**

Campaigns are a very different experience for most surgeons who don’t interface with politicians or campaigns regularly. Running for office, however, is a manageable undertaking for anyone with the interest and passion to be involved in the public service sector. Organization and a good support staff can make all the difference in running a smooth and successful campaign. Starting in smaller races also is a great entry to getting involved without biting off more than is manageable for a first-time candidate. Although starting a campaign may be a stressful or unknown endeavor, the reward is getting into office and having a direct impact on the legislative process.

**Ms. Grill** is State Affairs Associate, Division of Advocacy and Health Policy, Chicago, IL.
Approximately 297 surgeons and surgical staff representing the American College of Surgeons (ACS) and 17 surgical specialty societies participated in the fourth annual Joint Surgical Advocacy Conference March 27–29 at the JW Marriott Hotel in Washington, DC. Highlights of this year’s conference include the following:

• A continuing medical education session on accountable care organizations (ACOs)
• An overview of legislative issues important to surgery and the surgical patient
• Comments from three new physician members of the U.S. Congress
• Advocacy training

**ACOs**

Four panelists addressed the development of ACOs and other new health care delivery and payment models, as well as how these emerging systems will affect surgical practice.

Sandra S. Marks, assistant director, division of federal affairs, American Medical Association (AMA) Washington Office, gave a brief overview of how medical and surgical organizations are addressing the innovative methods of providing health care services. She noted that the AMA House of Delegates has adopted a set of principles on ACOs, and that the AMA and the ACS are working together to form a physician payment reform leadership group. This group will be responsible for developing bundled payment, pay for performance, ACO, and other “shared savings group” plans for pilot testing. “Ultimately, all specialty societies will be invited to participate in this group to learn about what works and what doesn’t,” and to explore other collaborative initiatives, Ms. Marks said.

Harold D. Miller, executive director of the Center for Healthcare Quality and Payment Reform, Washington, DC, addressed the development of ACOs more specifically. Mr. Miller defined an ACO as “a group of providers who are responsible for the overall

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*College news*

**JSAC focuses on imminent health policy changes**

*by Diane S. Schneidman*

[JSAC participants gather in Freedom Plaza before departing for Capitol Hill to meet with their federal legislators.](Image)
cost and quality of care delivered to patients.”

Some patients fear that because one objective of ACOs is to control costs, they will ration care, said Mr. Miller, who also is president and chief executive officer of the Network for Regional Healthcare Improvement, Pittsburgh, PA. However, ACOs are designed to reduce costs through the provision of more coordinated, safer, better quality care without rationing, he explained.

“It’s really physicians who need to take the lead” in the development of ACOs, he continued, because they have first-hand knowledge about how to deliver more cost-effective and higher-quality care. Also, physicians and other providers will feel the biggest effects of the new payment systems that will be implemented through the ACOs.

Two proposed reimbursement models are episodic payment and comprehensive care payment. Under the episodic payment approach, patients would be provided with a “warranty” on their care. In other words, if a patient experiences a complication after an operation, the ACO will provide the necessary additional care at no charge to the patient or payor. The comprehensive care concept calls for making “global” payments for treating a patient’s health condition. Payment would be adjusted for the complexity of care and bonuses would be provided based on outcomes, Mr. Miller explained.

Mr. Miller noted that the Affordable Care Act (ACA) does not refer specifically to ACOs and instead calls for the establishment of “shared savings programs.” The ACA allows Medicare to project spending for these programs. No upfront money would be paid to providers, so “it doesn’t change fee-for-service at all,” he added. The law also “makes doctors liable for any spending increases and forces hospitals to hire and/or acquire physicians.”

Anthony T. Petrick, MD, FACS, director of minimally invasive and bariatric surgery at Geisinger Medical Center, Danville, PA, talked about how the accountable care model has been implemented at that institution.

Dr. Petrick said Geisinger’s ProvenCare system has been successful due to “motivated physicians and enthusiastic leadership.” It was developed through a collaboration of physicians and the institution and focused on the coordination of resources. “Everybody’s got to be all in on this,” he explained.

ProvenCare uses the episodic payment approach that Mr. Miller described. For bariatric surgery, Geisinger physicians and administrators developed 35 benchmarks, which are actionable and measurable. Since then, the bariatric surgery department has increased the value of care and fundamentally altered the payment system, Dr. Petrick said.

According to Alan Speir, MD, a cardiac surgeon and founding partner of Cardiac, Vascular, and Thoracic Surgery Associates in Falls Church, VA, “Alternative [health care delivery and payment] methodologies are now a reality. Not only are they here now, but they have been here for years.”

The strategic building blocks of value-based health care systems are as follows: collaboration, analysis of reliable information from trusted databases, performance measurement, cost estimation, promulgation of guidelines or “dashboards,” processes for controlling care, and the provision of incentives for high performance, Dr. Speir said.

Surgeons are uniquely positioned to lead the movement toward value-based care because they already measure outcomes. “We need surgeons to stand up and be accountable,” he added. The movement toward value-based care will require time. “It’s not a marathon so much as a death march,” Dr. Speir quipped.

**Key issues**

Lobbyists from three of the organizations that cosponsored the JSAC—the ACS, the American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS), and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS)—briefed the meeting attendees on key legislative issues in surgery.

Kristen Hedstrom, MPH, Assistant Director, Legislative Affairs, ACS Division of Advocacy and Health Policy, Washington, DC, spoke about payment and quality issues. With regard to Medicare payment, she noted that the flawed sustainable growth rate (SGR) formula used to calculate reimbursement for physicians will force a 29.5 percent cut in payment starting January 1, 2012. Given the enormity of these potential reductions, “Our focus is not on fixing the SGR. The bottom line is that we have to get rid of the SGR,” said Ms. Hedstrom. The SGR should be replaced with a new system that includes a stable mechanism for updating Medicare reimbursement,
preserves the patient-physician relationship, and ensures that patients have access to the physicians of their choice.

With respect to quality improvement initiatives, the surgical community agrees with the concept of improving the value of health care, Ms. Hedstrom said. In order to reach this goal, a system must be in place to reward physicians who take steps to improve the quality and cost-effectiveness of care. Surgical associations also recommend that the government take the following steps:

• Provide incentives and support for the development of specialty and/or condition-specific, outcomes-centered clinical data registries
• Fully fund the Patient-Centered Outcomes Research Institute, which is established in the ACA to conduct comparative effectiveness research
• Continue voluntary participation in the Physician Quality Reporting System (formerly known as the Physician Quality Reporting Initiative)
• Delay electronic prescribing and electronic health record penalties
• Postpone public reporting until risk-adjusted clinical outcomes data are available

Another key issue for the surgical community is liability reform, noted Katie Orrico, JD, director of the AANS/CNS Washington Office. Legislative reforms that surgical associations support to make compensating patients for medical injuries more efficient and equitable are as follows:

• Caps on noneconomic damages
• Application of the Federal Tort Claims Act to cases involving Emergency Medical Treatment and Active Labor Act-mandated services
• Liability protection for physicians who follow evidence-based practice guidelines
• Protections for physicians who volunteer their services in disaster or emergency situations
• Exploration of alternatives to tort reforms

Ms. Orrico also said that surgical associations support the Provider Shield Act, H.R. 816, which would clarify that nothing in the ACA creates a new cause of action, such as the establishment of health care provider standards of care in medical liability cases.

Joy Trimmer, JD, director of the government affairs at the AAO-HNS, Washington, DC,
addressed the concerns that physicians’ groups have about the ACA’s establishment of the Independent Payment Advisory Board (IPAB).

The most significant problems with the IPAB are as follows:

- The 15 members will be appointed solely by the president without approval from the Senate and House majority and minority leaders
- Fewer than half of the IPAB members can be health care providers, and none may be in active practice or otherwise employed
- The IPAB will be required to recommend cuts based on unrealistic spending targets starting in 2014
- Because hospitals, hospices, and other health care institutions are exempt from IPAB cuts until 2020, payment reductions will disproportionately fall on health care professionals

Without a permanent solution to the SGR, physicians essentially are subject to “double jeopardy” with cuts stemming from both the SGR and the IPAB’s recommendations.

According to Ms. Trimmer, there is “broad-based bipartisan opposition” in Congress to the IPAB.

In addition, Ms. Trimmer encouraged JSAC participants to ask their legislators to support H.R. 451, the Healthcare Truth and Transparency Act of 2011. This bill is designed to improve transparency in the marketing materials of all health care providers and requires that all health care professionals appropriately identify the field and specialty in which they are licensed.

**Physicians in Congress**

Three newly elected physician members of Congress spoke at the JSAC—Rep. Larry Bucshon, MD (R-IN), a cardiothoracic surgeon; Rep. Dan Benishek, MD, FACS (R-MI), a general surgeon; and Rep. Andrew Harris, MD (R-MD), an anesthesiologist (see photos, page 37).

Representative Bucshon said he

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**Trauma surgeons discuss issues on Capitol Hill**

*by Catharine Harris*

Three weeks prior to the Joint Surgical Advocacy Conference (JSAC), 25 members of the American College of Surgeons Committee on Trauma (COT) traveled to Washington, DC, from all regions of the U.S. to discuss trauma-specific issues with their senators and representatives. The COT’s Advocacy Day took place March 9 at the ACS Washington Office.

The program began with a legislative and political update from Division of Advocacy and Health Policy staff and advocacy training with Chris Huckleberry, legislative director for Rep. Kurt Schrader (D-OR), and Josh Martin, chief of staff to Rep. Mac Thornberry (R-TX). Attendees also heard from keynote speaker Rep. Joe Heck, DO (R-NV), an osteopathic physician elected to Congress last November.

Speakers from Capitol Hill addressed the “dos and don’ts” of lobbying—including keeping their requests brief, using personal stories to illustrate published data, and talking to challenging staffers. Mr. Huckleberry, Mr. Martin, and Representative Heck also emphasized the importance of ongoing advocacy, made possible through building personal relationships with legislators. Surgeon advocates can form these relationships by inviting their legislators to tour their practices or hospitals, hosting in-district fundraisers, and frequently visiting legislators’ DC and district offices.

Following these sessions, COT members met with 53 senators and representatives or their health policy staff to request that Congress include $224 million in trauma funding in the fiscal year 2012 Labor/Health and Human Services/Education Appropriations Act, as authorized by the Affordable Care Act. They also advocated for the Health Care Safety Net Enhancement Act of 2011 (H.R. 157), which would provide liability protections for physicians providing care in compliance with the Emergency Medical Treatment and Active Labor Act. Another topic of discussion was Medicare physician payment reform.

COT Advocacy Day participants also reached an important milestone by achieving 100 percent participation in, and raising more than $10,000 for, the American College of Surgeons Professional Association—SurgeonsPAC (political action committee).

Ms. Harris is Legislative Assistant, Division of Advocacy and Health Policy, Washington DC.
ran for Congress because “I really felt like we needed more physicians in office,” especially in light of the passage of the ACA. “As time goes by, I think we’re going to see the ACA having fundamentally detrimental effects on surgical care.” Consequently, he sponsored the bill calling for repeal of the ACA. He said he believes the ACA mandate that all Americans have health insurance coverage is unconstitutional and “should be expedited to the [U.S.] Supreme Court.” In addition, Representative Bucshon said he opposes the ACA for the provisions it is lacking, including repeal of the SGR and tort reforms. (For more information on Representative Bucshon, see the May 2011 issue of the Bulletin. *)

Representative Benishek also believes the ACA should be repealed. “There has been no better example of the ‘disconnect’ between the people [of this nation] and Washington than the passage of the ACA,” he said. “The IPAB is just a disaster,” he added.

The motivating factor for Representative Benishek’s bid for Congress dates back to 2009 and the enactment of the American Recovery and Reinvestment Act, also known as the stimulus bill. He said that law represented a negative turning point in the direction of the nation.

Representative Harris’s political career began in 1998 when he ran for and won a seat in the Maryland State Senate. He encouraged surgeons who are interested in effecting health policy changes to run for Congress. At the very least, he recommended that JSAC participants use their Capitol Hill visits wisely. “It takes effective advocacy to get your issues before the legislature,” Representative Harris said.

**Advocacy training**

The JSAC comprised two sessions designed to help surgeons hone the advocacy skills of which Representative Harris spoke. Judy Schneider, a specialist on Congress at the Congressional Research Service, Library of Congress, Washington, DC, led the session on advocacy for residents and first-time JSAC attendees. Other speakers for this program were as follows: John H. Armstrong, MD, FACS, Chair, American College of Surgeons Professional Association (ACSPA)-SurgeonsPAC Board of Directors; Sara Morse, Manager of Political Affairs, ACS Division of Advocacy and Health Policy; Megan Marcinko, program manager, Congress and political affairs, AAO-HNS; and Adrienne Roberts, senior manager, legislative affairs, AANS/CNS.

An advanced advocacy training workshop for all attendees included opportunities for role-playing with a former member of Congress and a discussion of grassroots advocacy. But first, Patricia A. Clark, a communications consultant for a number of medical and surgical organizations, offered tips on persuading legislators to take...
action on issues of concern to surgery. Ms. Clark recommended that surgeons communicate their message as concisely as possible, using sound bites. They can leave more detailed, written information behind at the meeting or send it subsequent to the discussion.

Meeting participants then had the opportunity to practice for their Capitol Hill visits with Steve Buyer, a former Republican U.S. representative from Indiana. While in Congress from 1993 to 2011, Mr. Buyer served on the House Energy and Commerce Committee, including the Subcommittee on Health.

Next, Jane C.K. Fitch, MD, professor and chair, department of anesthesiology, University of Oklahoma Health Science Center, Oklahoma City, and chair of the American Society of Anesthesiologists Committee on Government Affairs, provided helpful hints on successful grassroots advocacy. She encouraged physicians to speak in layperson’s language during indistrict meetings and to cultivate a relationship with their members of Congress. She noted that one way for surgeons to build a relationship with legislators is to offer site visits of their institutions to congressional staff.

Dr. Fitch also noted, “There are four things candidates want and need” from physician constituents, including the following:

- They want money. Host a fundraiser.
- They want their supporters’ time. They need volunteers to stuff envelopes and canvas neighborhoods.
- They want surgeons’ knowledge about health care issues. “Physicians have a unique skill set, unique knowledge, and we need to share that with our legislators,” Dr. Fitch noted.
- They want support. Vote and assist with campaigns.

Echoing Dr. Harris’s sentiments, Dr. Fitch said that physicians who want to play an active role in advocating on behalf of the medical community also should write to their newspapers and, perhaps, run for office. “Short of that, we have to take responsibility to educate legislators about the issues of importance to us,” she added.

**PAC receptions**

JSAC participants also were invited to attend a fundraising reception for the ACSPA-Surgeons-PAC. More than $27,000 was raised during that event. High-level donors—individuals contributing $1,000 or more—were invited to a private reception with Rep. Pete Sessions (R-TX). The congressman serves on the powerful House Rules Committee and chairs the National Republican Congressional Committee.

**Capitol Hill visits**

On the final day of the JSAC, meeting participants had the opportunity to put their freshly cultivated advocacy skills to the test. Most of the attendees met with their legislators on Capitol Hill to discuss their concerns about implementation of the ACA, Medicare payment reform, medical liability, the surgical workforce shortage, and other issues that affect surgical patient care.

Ms. Schneidman is Manager, Special Projects, Division of Integrated Communications, Chicago, IL.
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“Leading with impact” was the theme of this year’s American College of Surgeons (ACS) Leadership Conference for Young Surgeons and Chapter Leaders, which took place March 26 and 27 at the JW Marriott in Washington, DC. Members of the College’s Young Fellows Association developed and moderated the program.

**Defining leadership**

Offering the opening remarks for the meeting was L.D. Britt, MD, MPH, FACS, President of the College. Dr. Britt encouraged the young surgeons and chapter officers to speak out and influence change in their institutions and in the public policy sector. Quoting one of this nation’s historically most important leaders, Rev. Martin Luther King, Jr., Dr. Britt said, “Our lives begin to end the day we become silent about the things that matter.”

He noted that most of the great leaders in history assumed their positions of power in times of upheaval, yet they managed to leave their countries in better condition. He cited Queen Elizabeth I as the exemplar of leadership because of the profound changes she led in England, which left the nation more stable and respected than it was when she was crowned.

The best leaders of organizations also leave a lasting impression. “When a leader departs and the organization continues to prosper, then that leader succeeded,” Dr. Britt said.

**Leading during crisis**

Kenneth L. Mattox, MD, FACS, professor of surgery at Baylor University School of Medicine, Houston, TX, found himself leading a medical response team after Hurricane Katrina. Dr. Mattox and his colleagues developed a strategy for transporting more than 27,000 evacuees from New Orleans, LA, to Houston, developing an incident command and medical team, as well as policies about whom among the incoming would be admitted as patients.

According to Dr. Mattox, the six phases of leadership during crisis are:

- **Vision:** Clearly defining what needs to be achieved.
- **Situational awareness:** Keeping abreast of the current state of affairs.
- **Decision making:** Making timely and effective decisions.
- **Communication:** Ensuring that all team members are informed and aligned.
- **Adaptability:** Being able to adjust strategies as circumstances change.
- **Accountability:** Taking ownership and responsibility for the outcome.

**Did you know...?**

THAT THE COLLEGE HAS ENDORSED Partnership for Patients: Better Care, Lower Costs—a new public-private partnership aimed at helping to improve the quality, safety, and affordability of health care for all Americans?

On April 12, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and Centers for Medicare & Medicaid Services (CMS) Administrator Donald Berwick, MD, announced a new national partnership to stop millions of preventable injuries and complications in the next three years. The American College of Surgeons and other major stakeholders endorsed the effort and pledged to join with CMS in the initiative to improve patient care.

Using $1 billion in new funding provided by the Affordable Care Act, HHS will work with a variety of public and private partners to accomplish the following two core goals:

- Keep hospital patients from getting injured or sicker, so that by the end of 2013, preventable hospital-acquired conditions will decrease by 40 percent
- Help patients heal without complications, so that by the end of 2013, preventable complications during a transition from one care setting to another and all readmissions will be reduced by 20 percent

disaster response are as follows: (1) assess the problem; (2) make a plan; (3) implement the plan; (4) anticipate surprises; (5) finish the plan; and (6) review results. Surgeons are particularly qualified to lead in times of crisis because they are problem solvers and possess a “unique genome,” which makes them believe they are the only ones who can resolve the situation. Surgeons also are familiar with making decisions based on the existing data and decisively dealing with diversions, Dr. Mattox said. He encouraged surgeons to “go to the heart of danger, and there you will find safety.”

Dr. Mattox added, “You will face a time soon when you’re in charge of making things happen.” When that time comes, “it is absolutely amazing what a small, dedicated group of people can do to change the course of the world.”

**Negotiating with feeling**

People often view negotiation as a rational process in which two or more people are trying to reach a compromise on competing and varying objectives. However, negotiation is not a strictly logical process. It has an emotional element as well, according to Jamil Mahuad, PhD, president of Ecuador from 1998 to 2000, and an academic fellow at the Center for Public Leadership, Kennedy School of Government, Harvard University, Cambridge, MA.

Before entering into a negotiation, Dr. Mahuad recommended that people complete a self-inventory to determine their emotional triggers and how they will react to hot-button issues. Once a dialogue gets under way, “Read the other person’s emotions. Make the other person feel appreciated,” he said. Also, remember that “the problem is not the other person. It’s the situation.” Try to find common ground.

Dr. Mahuad explained how he applied these principles in his negotiations with Peru’s president at the time, Alberto Fujimori, a man whom most Ecuadorians viewed as the enemy due to the many years of armed conflicts between the two nations. Dr. Mahuad’s goal was to win back territory that Ecuador had lost to Peru over the course of nearly a half century.

To find common ground, the two presidents went on a rafting trip on the Amazon River to discuss how the surrounding land could be divided more equitably. In October of 1998, Dr. Mahuad and Mr. Fujimori signed the Binational Plan for the Development of the Border Area, with former U.S. President Bill Clinton serving as a mediator. Under the agreement, the two countries declared a reciprocal free navigation zone on the Amazon River in the region and ceded certain disputed territories to one another.

**Failing to follow**

According to Stephen R.T. Evans, MD, FACS, vice-president of medical affairs and chief medical officer at Georgetown University Medical Center, Washington, DC, the trend in health policy has been toward less physician control of patient care. As the government implements the Accountable Care Act, this drift will gain speed. Many surgeons balk at following policymakers’ lead with regard to these sorts of changes for the following reasons:

- Lack of trust. “For many mid-level physicians and surgeons in this country, their trajectory in terms of how they view their career is not going up. It is, in fact, going down,” Dr. Evans said. This situation has led some surgeons to view government payors, hospital administrators, insurance companies, and so on, skeptically.
- Surgeons are data-driven decision makers, but they believe the data that are used for physician profiling misrepresent the realities of practice. However, there are measurement instruments on which surgeons can rely. The College’s National Surgical Quality Improvement Program (ACS NSQIP®) is “by far and away the best database going” for analyzing surgical outcomes, Dr. Evans said.
- Surgeons and other physicians “live in a world of technical challenges” rather than adaptive challenges. They are uncomfortable dealing with cultural changes.
- Surgeons greatly value their independence. They typically have preferred to avoid working in teams.
- Physician leaders are not visible. “Surgeons want other surgeons leading them,” Dr. Evans said.
- Lack of urgency. “Surgeons operate only in crisis mode,” Dr. Evans observed. To get surgeons involved in an endeavor, leaders need to create a sense of urgency and make it time-sensitive.
- Time constraints create a barrier to participation.
- Intellectual elitism. “Surgeons are highly trained to practice medicine,” but not necessarily to resolve conflict by working with people of different backgrounds.
**Impaired physicians**

Like Dr. Evans, Michael R. Oreskovich, MD, FACS, clinical professor of psychology at the University of Washington, Seattle, noted that surgeons like to be in control. Consequently, “there has never been a surgeon born who wished to be an impaired surgeon,” he said.

“Physician impairment is defined as the inability to practice with reasonable skill and safety,” Dr. Oreskovich said. Causes of impairment include neurodegenerative disease, substance abuse, mental health issues, stress, and burnout. Indicators of potential impairment among physicians include isolation, conflicts with colleagues, disorganization, inaccessibility, frequent absences, and rounding at odd hours.

Physicians with substance abuse problems also may have a chaotic lifestyle and poorly explained accidents and injuries. Dr. Oreskovich suggested that physicians and other health professionals who believe a coworker has an alcohol or drug problem conduct an intervention, which he described as “a life-saving event.”

Meanwhile, surgeons suffering from burnout may show signs of depersonalization (such as no longer connecting with their patients), emotional exhaustion, low personal accomplishment, and cynicism. Surveys conducted by the ACS Board of Governors’ Committee on Physician Competency and Health indicate that 40 percent of Fellows meet the criteria of suffering from burnout, Dr. Oreskovich said. In addition, 30 percent screen for depression and one in six demonstrate signs of suicidal ideation. To help reduce these problems, “we need to promote a culture of medicine that values work-life balance,” he said.

“The things that make surgeons impaired are also the things that make us more likely to be impaired,” added Krista Kaups, MD, FACS, health sciences clinical professor of surgery at the University of California, San Francisco. Such characteristics include compulsiveness and perfectionism, she said as a lead into an interactive discussion of impairment.

**Departmental leadership**

J. Patrick O’Leary, MD, FACS, executive associate dean for clinical affairs at Florida International University College of Medicine, Miami, discussed the activities and qualities of successful surgery department chairs. Dr. O’Leary, who for many years chaired the department of surgery at Louisiana State University School of Medicine, New Orleans, cautioned surgeons who are being considered for chairmanships to make certain they understand the expectations of deans and other institutional leaders.

“Start off understanding and enforcing the status quo. Then be creative,” he said. “Pick the area that needs the most attention and do it first.” Understand the mission, identify goals, gather the right people, communicate responsibilities, and measure outcomes.

Dr. O’Leary listed his 10 personal keys to success as follows:

- Know yourself. Conduct an honest inventory of your strengths and weaknesses, likes and dislikes, and so on.
- Have a destination. Know where you want to end up and know which road you need to take to get there. Dream.
- Deal with perceived transgressions. “Forgive, forget, and file” when someone does something that you find upsetting. “Don’t let someone else control your happiness,” he said.
- Be approachable. Listen attentively, be flexible, and be visible.
- Be accountable.
- Expand your limits. Take some risks.
- Behave ethically. Exude integrity.
- “Exercise good judgment, but avoid being judgmental.”
- Be good at your job.
- Be nice.

**Leadership in the ACS**

Two surgeons who currently serve on several ACS standing committees—Hilary Sanfey, MD, FACS, and Patricia Turner, MD, FACS—presented a session titled Moving up the College Leadership Ladder.

Dr. Sanfey, professor of surgery and vice-chair of education at Southern Illinois University School of Medicine, Carbondale, said attaining leadership positions requires preparation. She encouraged young surgeons to do their homework and to attend the College’s leadership training programs.

Young surgeons can get leadership experience through their College membership by joining their local chapter, participating in the medical student program, and inquiring about openings on other ACS committees. Once involved, stay involved, Dr. Sanfey said. Accept criticism, follow through on activities, and promote yourself.
She also recommended finding a mentor. Surgeons who enter into leadership positions need to manage their time wisely. Leaders need to delegate, schedule “closed door” time, develop a strategy for dealing with e-mail, and “say ‘no’ to requests that aren’t going to help your career,” Dr. Sanfey said. They also need to achieve balance between their professional and their personal lives.

Patricia Turner, MD, FACS, an assistant professor of medicine at the University of Maryland Medical Center, Baltimore, acknowledged that getting involved in professional organizations can seem burdensome to residents and young surgeons who already are pressed for time and money. However, the benefits of membership in these associations outweigh the drawbacks. Active participation in professional organizations provides surgeons with networking and educational opportunities. Professional associations advocate for their members at the federal and state levels, provide practice management tools, and offer scholarships and grants for scientific inquiry, she noted.

Dr. Turner also offered several pieces of advice to young surgeons who are looking to take on leadership positions in their professional groups or their institutions, including the following: (1) be timely; (2) pay attention to detail; (3) accept new responsibilities when they are presented; and (4) “view every opportunity as a stepping stone.”

**Networking**

The program included separate networking luncheons for young surgeons and chapter leaders. During the gathering for young surgeons, Scott Coates, MD, FACS, a member of the ACS Young Fellows Association, provided an “insider’s guide” to the work and functions of that group. At the luncheon for chapter leaders, Jon Sutton, Manager of State Affairs, ACS Division of Advocacy and Health Policy, presented an update on state legislation.

**Town hall meeting**

As in years past, this year’s Leadership Conference ended with a town hall meeting with the following ACS leaders: Dr. Britt; Carlos A. Pellegrini, MD, FACS, Chair, ACS Board of Regents; John H. Armstrong, MD, FACS, Chair, American College of Surgeons Professional Association Political Action Committee (ACSPA-SurgeonsPAC) Board of Directors; David B. Hoyt, MD, FACS, ACS Executive Director; and Christian Shalgian, Director, ACS Division of Advocacy and Health Policy.

Dr. Pellegrini emphasized the importance of the College’s mission of providing optimal care to patients. He also encouraged young surgeons to get involved in the College and to seek out positions on committees that focus on matters that are of special relevance to them personally and professionally.

Dr. Britt emphasized the benefits of ACS membership and asked the chapter leaders and young surgeons to find out what factors may deter surgeons in their communities from joining the organization. Dr. Hoyt said that the College’s ongoing efforts in advocacy and quality improvement will help it to draw more members and interest from the public. “I think we’re on the threshold of moving forward with our College” through our ongoing commitment to quality and to our patients, Dr. Hoyt said. The College is starting to roll out its new Inspiring Quality program, and “what we’re seeing is that people really are starting to listen to us,” he noted.

Mr. Shalgian agreed with Dr. Hoyt and stated that the message of the Inspiring Quality program—that reducing health care costs is not about reducing payment, but rather about improving quality—is resonating in Washington. In addition, Dr. Armstrong encouraged participation in the ACSPA-SurgeonsPAC. This group advocates for surgeons in two ways: (1) by making bipartisan, pro-surgery campaign contributions to candidates for Congress; and (2) by providing education that elevates surgical practice.

Ms. Schneidman is Manager, Special Projects, Division of Integrated Communications, Chicago, IL.
Health Volunteers Overseas (HVO) is pleased to announce that Fredric V. Price, MD, FACS, a gynecologic oncologist, is a recipient of the sixth annual Golden Apple Award. As part of its World Health Day observances, HVO created this award to recognize the extraordinary educational contributions of volunteers to international program sites. Each volunteer honored with this award has demonstrated a strong commitment to HVO’s educational mission by working on curriculum development, teacher training, didactic or clinical training, or the enhancement of educational resources.

As vice-chair and then chairman of the International Network of the Society of Gynecologic Oncologists, Dr. Price led efforts to provide gynecologic oncology to women in developing countries, and established a program to send U.S. gynecologic oncologists to Honduras, where such specialized care was unavailable. He established a partnership with HVO to help maintain the Honduran program, and began recruiting oncologists throughout the U.S. to serve as visiting specialists in Honduras. Training Honduran residents and physicians through lectures, surgery, hospital teaching rounds, and interdisciplinary tumor conferences raises the standard of care available to women in Honduras. Dr. Price’s dedication to helping cancer patients in Honduras, and in future HVO sites, makes him a role model for physicians committed to improving health care in developing countries.

A graduate of Yale University, New Haven, CT, and University of Louisville School of Medicine, Louisville, KY, Dr. Price did his residency at Magee-Womens Hospital of the University of Pittsburgh Medical Center, and completed his clinical fellowship at Yale. Dr. Price is in private practice in Pittsburgh, PA.

“I am very pleased that the contributions made by Dr. Fredric Price towards improving gynecologic oncology services are being recognized with this award,” said Nancy Kelly, executive director of HVO. “By highlighting the accomplishments of volunteers like Dr. Price, we hope to raise awareness of global health issues and encourage others to work towards better health care around the world.”

Since 1950, World Health Day (April 7) has been celebrated annually by the World Health Organization and the international community. This year’s theme was “Antimicrobial resistance: No action today, no cure tomorrow,” which promotes the safeguarding of medicines for future generations. For more information on World Health Day 2011, visit http://www.who.int/world-health-day/2011/en/index.html.

A private, not-for-profit organization, HVO was founded in 1986 to improve global health through education. HVO designs and implements clinical education programs in child health, primary care, trauma and rehabilitation, essential surgical care, oral health, blood disorders and cancers, infectious disease, nursing education, and wound care. For more information, go to http://www.hvousa.org.
The ACS CoC recognizes 90 facilities with national award

The Commission on Cancer (CoC) of the American College of Surgeons (ACS) has granted its Outstanding Achievement Award (OAA) to a select group of 90 currently accredited and newly accredited cancer programs across the U.S. as a result of surveys performed during 2010. The list of cancer facilities that received the award can be found online at http://www.facs.org/cancer/coe/outstandingachievement2010list.html.

Established in 2004, the CoC OAA is designed to recognize cancer programs that strive for excellence in providing quality care to cancer patients. The award is granted to facilities that demonstrate a commendation level of compliance with seven standards that represent six areas of cancer program activity: cancer committee leadership, cancer data management, clinical management, research, community outreach, and quality improvement.

The level of compliance with the seven standards is determined during an on-site evaluation by a physician surveyor. In addition, facilities must receive a compliance rating for the remaining 29 cancer program standards. The 90 programs that received the OAA, following surveyor visits in 2010, represent approximately 17 percent of programs surveyed during this period. A majority of recipients are community-based facilities; however, teaching hospitals, National Cancer Institute-designated comprehensive cancer centers, pediatric, and network cancer programs also received the award.

Established in 1922 by the ACS, the CoC is a consortium of professional organizations dedicated to improving the survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care. Its membership includes Fellows of the College and representatives of 47 national organizations that reflect the full spectrum of cancer care.

The CoC’s core functions include setting standards for quality, multidisciplinary cancer patient care; surveying facilities to evaluate compliance with the 36 CoC standards; collecting standardized, high-quality data from accredited facilities; and using the data to develop effective educational interventions to improve cancer care outcomes at the national, state, and local levels.

There are currently more than 1,500 CoC-accredited cancer programs representing 25 percent of all hospitals in the U.S. and Puerto Rico. These CoC-accredited facilities diagnose and/or treat 71 percent of all newly diagnosed cancer patients each year. Receiving care at a CoC-accredited cancer program ensures that a patient will have access to the full quality spectrum of comprehensive cancer care close to home.

In addition, cancer patients’ data are reported by each CoC-accredited cancer program to the CoC’s National Cancer Data Base, a joint program with the American Cancer Society. These data account for approximately two-thirds of all newly diagnosed cancer cases in the U.S. each year, and are used regularly to monitor the quality of patient care delivered in CoC-accredited cancer programs and to improve cancer care outcomes at both the national and local level.

The CoC provides the public with information on the resources, services, and cancer treatment experience for each CoC-accredited cancer program. This information is shared with the public on the Cancer Programs page of the American College of Surgeons website at http://www.facs.org/cancer/index.html and through the American Cancer Society National Cancer Information Center at 800-ACS-2345.

For more information about the Commission on Cancer, visit www.facs.org/cancer/index.html.
Five American College of Surgeons Resident Research Scholarships for 2011 were awarded by the Board of Regents in February. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2011. These scholarships are sponsored by the Scholarship Endowment Fund of the College.

The recipients for these scholarships are as follows:

- **John R. Klune, MD**, resident in surgery, University of Pittsburgh Medical Center, Pittsburgh, PA.
  
  *Research project:* Targeting IRF1 as a potential therapeutic target in liver ischemia/reperfusion injury.

- **Greta V. Bernier, MD**, resident in surgery, University of Washington, Seattle, WA.
  
  *Research project:* Discovery of new genes for inherited predisposition to breast cancer by exome sequencing in high-risk families.

- **Erik G. Pearson, MD**, resident in surgery, University of Utah Health Sciences Center, Salt Lake City. (Research to be performed at Children’s Hospital of Philadelphia, PA.)
  
  *Research project:* Understanding the risk of graft versus host disease after in utero hematopoietic stem cell transplantation.

- **Serena Tan, MD**, resident in surgery, Stanford Hospital and Clinics, Stanford, CA.
  
  *Research project:* A novel injury
model of acute respiratory distress syndrome.

- Jocelyn Burke, MD, resident in surgery, University of Wisconsin, Madison.

Research project: Targeting notch in medullary thyroid cancer.

The requirements for these research-oriented scholarships offered by the College for 2012 will be published in a later issue of the Bulletin. This information will also appear on the College’s scholarships Web page, at http://www.facs.org/memberservices/research.html.

NCDB Research Fellow recognized by the Society of Surgical Oncology

Richelle Williams, MD, a third-year surgical resident from the University of Chicago, IL, recently received the Resident Essay Award for the best clinical research presentation from the Society of Surgical Oncology (SSO). The award was presented to Dr. Williams at the SSO’s 64th annual meeting in San Antonio, TX. Dr. Williams is in her first of two years as a Research Fellow with the Commission on Cancer’s National Cancer Data Base (NCDB), which is housed at the headquarters of the American College of Surgeons (ACS). Mitchell C. Posner, MD, FACS, program director and vice-chairman of surgery at the University of Chicago Medical Center, said of the award, “This is an extraordinary achievement and prior winners read as a virtual Who’s Who in academic surgical oncology. Congratulations to Richelle and her co-authors.”

The award was given in recognition of Dr. Williams’ work examining temporal trends in the utilization of needle versus excisional biopsy as the initial diagnostic procedure for breast lesions. The literature on current biopsy utilization rates is sparse, and Dr. Williams’ study sought to evaluate trends in utilization patterns and the factors driving these trends in a large (n=373,837) contemporary (2003–2008) cohort of patients with breast cancer.

Consensus guidelines recommend needle biopsy (fine needle aspiration or core) as the initial diagnostic procedure of choice for breast lesions. Needle biopsy is almost as accurate as, and offers several advantages over, surgical biopsy (for example, decreased cost and fewer complications). As a result, there are initiatives under way to make needle biopsy for diagnosis of breast cancer prior to surgery a quality indicator in breast cancer care.

Dr. Williams’ analysis revealed a steady increase in utilization of needle biopsy over time (73.8 percent in 2003 to 86.7 percent in 2008), with a concomitant decline in excisional biopsies. The three most important predictors of excisional biopsy use were disease stage, hospital location, and hospital case volume. Rates of needle biopsy utilization in high-volume centers suggested that a goal rate of 85 to 90 percent should be reasonable whenever needle biopsy rate is implemented as a quality improvement measure. The full paper reporting these results has been submitted for publication in the Annals of Surgical Oncology.

Dr. Williams
The interactive Multimedia Atlas of Surgery volumes present a step-by-step guide to both open and laparoscopic procedures. Each chapter is authored by a leading surgeon in the field, and includes:

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American College of Surgeons
INSPIRING QUALITY:
Highest Standards, Better Outcomes
The gender gap among U.S. medical graduates (USMG) in the traditionally male-dominated specialty of general surgery is shrinking, according to study results published in the March issue of the *Journal of the American College of Surgeons*. These findings align with the overall trend of increasingly equal gender enrollment of medical students.

The study found a 22 percent relative increase in the percentage of women among USMG applicants to general surgery programs between application years 2000 (n = 506; 27 percent) and 2005 (n = 754; 33 percent). Additionally, there was a 25 percent relative increase in the percentage of women among USMG who began general surgery training between academic years 2000–2001 (n = 282; 32 percent) and 2005–2006 (n = 384; 40 percent).

The study authors analyzed three related populations: (1) all USMG from academic years 1999–2000 through 2004–2005; (2) USMG applicants for positions at Accreditation Council for Graduate Medical Education (ACGME)-accredited general surgery residency programs for applicant years 2000 through 2005; and (3) USMG entering positions at ACGME-accredited general surgery training programs between academic years 2000–2001 to 2005–2006.

During the six-year study period, the percentage of women entering training increased not only in general surgery, but also in the surgical specialties of obstetrics and gynecology, ophthalmology, orthopaedic, otolaryngology, urology, and plastic surgery. At the end of the study period, general surgery had the second highest percentage of women among USMG entering surgery training (40 percent), behind obstetrics and gynecology (82 percent).

“...the presence of on-site childcare...”

From *Surgery News*: Guidelines to prevent catheter infections

Officials at the Centers for Disease Control and Prevention have released updated guidelines for the prevention of catheter-related bloodstream infections, report staff of *Surgery News*, the official newspaper of the American College of Surgeons.

Last updated in 2002, the guidelines are aimed at health care providers who insert intravascular catheters and those who are responsible for surveillance and control of infections in the hospital, in outpatient settings, and in home health care settings.

The release of the guidelines comes at a critical time. Starting this year, hospitals must track and report on central line-associated bloodstream infections in their intensive care units or risk losing 2 percent of their Medicare payments, according to Russell N. Olmsted, MPH, president of the Association for Professionals in Infection Control and Epidemiology. Furthermore, the Department of Health and Human Services has set a national goal of reducing central line-associated bloodstream infections by 50 percent by 2013.

To learn more about the updated guidelines, go to [http://www.facs.org/surgerynews](http://www.facs.org/surgerynews).
International Guest Scholarships available for 2012

The American College of Surgeons is offering International Guest Scholarships in 2012 to competent young surgeons from countries other than the U.S. or Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $8,000 each, provide the International Guest Scholars with an opportunity to visit clinical, teaching, and research institutions in North America and to attend and participate fully in the educational opportunities and activities of the ACS Clinical Congress in Chicago, IL, in 2012.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS (Hon), former Director of the College. More recently, gifts from Fellows and their families and associates have expanded the roster of International Guest Scholarships. The ACS Foundation website features additional information about these benefactors and the awards they support.

The scholarship requirements are as follows:

• Applicants must be medical school graduates.
• Applicants must be at least 35 years of age, but younger than 45, on the date that the completed application is filed.
• Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).

• Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of their respective home country.

• Applicants whose careers are in the developing stage are deemed more suitable for receipt of this scholarship than those who are serving in senior academic appointments.

• Applicants must submit a fully completed application form provided by the College on its website. The application and accompanying materials must be submitted in English. Submission of a curriculum vitae without a completed application is not acceptable.

• Applicants must provide a list of all of their publication credits and must submit three complete publications (reprints or manuscripts) of their choosing from that list.

• Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment or a Fellow of the ACS residing in their country. The chair’s or the Fellow’s letter must include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant.

• The International Guest Scholarships must be used in the year for which it is designated. The scholarship cannot be postponed.

• Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.

• An unsuccessful applicant may reapply only twice, and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

International Guest Scholarships provide successful applicants with the privilege of participating in the College’s annual Clinical Congress in October, with public recognition of their presence. They will receive

Trauma meetings calendar

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

• **Point/ Counterpoint,** June 13–15, 2011, National Harbor, MD.
• **Advances in Trauma,** December 9–10, 2011, Kansas City, MO.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ website at [http://www.facs.org/trauma/cme/traumtgs.html](http://www.facs.org/trauma/cme/traumtgs.html), or contact the Trauma Office at 312-202-5342.
The concept of a culture of safety is based on the idea that a health care organization cannot truly improve patient safety if it waits for adverse events to occur before taking action to address unsafe system issues. Waiting until an unwanted patient outcome occurs typically results in a reaction in which a caregiver is blamed for an event. That caregiver is then ordered to receive training or counseling, or is fired.

Although this type of approach is often seen in events such as wrong site surgery, safety experts believe that this approach is least effective in producing successful, long-term results. Instead, creating an environment or culture in which safety is the focus is recognized as the most effective way to achieve positive change.

"Culture" refers to the attitudes, values, and behaviors shared by a group of people, in which leaders influence the group. Surgeons are leaders in the operating room and beyond, which gives them an indispensable role in creating a culture of safety in a health care organization. Surgeons and other organizational leaders must frequently communicate the importance of safety and encourage everyone in the organization to focus on safety improvement as an ongoing concern. Safety is not a one-time-only effort. It is important for surgeons and other organizational leaders to acknowledge that adverse events can occur because of a human error, but that "to err is human." Therefore, reporting of adverse events is encouraged, not punished. It is important to avoid intimidating behavior that can result in staff not speaking up when they see something that could undermine team effectiveness and compromise the safety of patients.

In addition, a culture of safety includes the following components:

- Routine reporting and open discussion of adverse events
- Analysis of all such events
- Feedback to those who report such events to demonstrate the value of reporting
- Communication with patients about their care outcomes, including outcomes that were not anticipated
- Support for staff involved in adverse events
- Teamwork among caregivers
- Engagement of patients as active members of the care team
- Risk assessment before adverse events occur and adverse event prevention

Organizations should also actively search for information in the professional literature about how to do things safely. In addition, sharing information about safety efforts with others at conferences, through published articles, and through informal communication help to create an environment that supports safety.

For more information about patient safety, visit The Joint Commission at [link].
So, You Want to Be a Surgeon...

Medical student guide to residency training

The online resource, *So, You Want to Be a Surgeon... A Medical Student Guide to Finding and Matching with the Best Possible Surgery Residency*, is now available on the American College of Surgeons Web site at:

http://www.facs.org/residencysearch

This online, contemporary version of the popular “Little Red Book” has proved to be an invaluable resource for medical students seeking opportunities in graduate medical education. The revised online version of this helpful reference includes a searchable database containing a complete list of accredited surgical specialty residency programs, as well as a section devoted to assisting students in choosing a residency program that is their best match.

For further information, contact Elisabeth Davis, MA, Education Research Associate, Division of Education, at 312-202-5192, or via e-mail at edavis@facs.org.
Report on ACSPA/ACS activities
February 2011
by Timothy C. Flynn MD, FACS

American College of Surgeons Professional Association (ACSPA)

The ACSPA-SurgeonsPAC (political action committee) raised $1,345,374 for the 2009/2010 election cycle. Of this amount, approximately $735,805 was raised in 2010. A total of 78 percent of the U.S. Governors contributed, and 100 percent of the U.S. Officers and Regents contributed as well.

Plans for the ACSPA-SurgeonsPAC for 2011 include a two-day strategic planning meeting with the specific aim of assessing where the ACSPA-SurgeonsPAC stands, and determining new goals and the most effective means of achieving them. The ACS-SurgeonsPAC remains committed to increasing its overall market share of Fellows and Resident members.

The approval process is under way for the addition of a named lecture sponsored by the ACSPA-SurgeonsPAC during the 2011 Clinical Congress program. The lecture would capture multiple dimensions of advocacy in the public and private sectors, and would merit continuing medical education credit.

American College of Surgeons (ACS)

Board of Governors

The Board of Governors presented suggestions to the Board of Regents regarding College initiatives. The recommendations/suggestions came from the Governors during their October meetings, and included the following, among others:

- The College should remain extremely active in issues related to new reimbursement paradigms, such as hyper-bundling
- Public outcomes and cost-effectiveness reporting should be based on systems that have been thoroughly tested, vetted, and validated regarding metrics and systems that will be used to assess clinical skills
- Regarding graduating surgical residents who seem unprepared for practice, Governors would urge the College to develop a questionnaire for distribution to the Fellowship to begin to understand the problem, and perhaps, begin to develop solutions
- The ACS should assign resources to develop and test alternative payment models that will ultimately replace the sustainable growth rate (SGR)
• The ACS should investigate and develop action plans to deal with issues that impact the surgeon’s relationship to integrated health care systems
• Consider adopting dues increases gradually and in small increments more frequently, going forward

Public profile and communications
Work has progressed on the College’s brand/reputation-building campaign. The slogan/ tagline for the campaign—Inspiring Quality: Highest Standards, Better Outcomes—was selected. The core attribute and focal point of the campaign will be to communicate the power, scope, and ongoing achievements of the ACS quality programs. The focus on quality is intrinsic to the College’s mission and agenda, and reflects the most positive and important contributions the College makes on behalf of surgical patients.

Global Health Service Corps (GHSC)
The Board of Regents endorsed a proposal to create a U.S. GHSC (the equivalent of a Marshall Plan for health) that would train and fund local providers and U.S. health care professionals to work, teach, learn, and enhance the health care workforce and infrastructure in low-income countries. It would be designed and implemented as a federal international health service program to support skilled health professionals who work in developing countries through loan forgiveness and scholarships. The proposal would be based on the following:
• Loan forgiveness and scholarships for health professionals who commit to a minimum of one year of service
• Emphasis on long-term partnership and sustainability
• Provision of direct medical care in parallel to education and training of local providers and investment in infrastructure and human resource capacity
• Commitment to service to the vulnerable and poor
• Support of established academic, non-governmental and governmental programs

This grassroots effort would occur concurrently with the 50th anniversary of the U.S. Peace Corps, with a new form of investment in development, public diplomacy, and the global community.

Operation Giving Back (OGB)
Kathleen M. Casey, MD, FACS, Director, ACS Operation Giving Back, received the American Medical Association (AMA) Nathan Davis International Award in Medicine during the AMA’s National Advocacy Conference in February in Washington, DC.

The Resident and Associate Society of the American College of Surgeons (RAS-ACS) is soliciting input on resident involvement in global surgery work. This input will be shared with the OGB for planning and programming purposes in support of resident opportunities in this realm.

Other OGB news as of January 19 included:
• A total of 48 new and updated opportunities posted on the OGB website
• Number of surgeons enrolled in My Giving Back increased to more than 1,625
• A 30 percent increase in page views of the OGB website
• More than 48,000 site visits from 174 countries

American College of Surgeons Foundation
The Foundation had a relatively good year in 2010. Its primary mission is voluntary philanthropy from Fellows and friends to support the College’s goals, especially quality patient care. The Foundation’s goals for 2011 include the following:
• Increasing unrestricted gifts to the College
• Beginning to use social media
• Soliciting more invitations to present at chapter meetings

The Foundation’s industry breakfast this year will feature John F. Stossel. Mr. Stossel will speak on the very delicate balance of corporate support of CME.

Education
• A letter from the College articulating specific solutions to concerns about delivery of safe care by PGY-1 surgery residents, especially during long periods of duty, was sent by the College to the Accreditation Council for Graduate Medical Education (ACGME). The letter focused on the following specific solutions:
• Establishment and enforcement of stringent supervision standards
• Improved education and training of PGY-1 residents prior to, and subsequent to, starting residency training using standardized and structured experiences based on pre-determined standards.

This letter from the College was very well-received by the ACGME and in a variety of national forums. During the annual meeting of the Association of American Medical Colleges (AAMC) in November 2010, a meeting was convened by the leadership of the AAMC with surgical leaders and educators to discuss better preparation of medical students for surgery residency training. The AAMC remains very interested in collaborating in the design and implementation of new educational interventions to better prepare fourth-year medical students to enter residency education in surgery. The aforementioned letter and the educational programs of the Division of Education were the central focus of discussions in all the forums mentioned in this section.

Based on a strategic agenda, the Council of Medical Specialty Societies (CMSS) endorsed simulation-based education and training as a key new strategic imperative for the CMSS. The aim of the CMSS is to coordinate efforts to advance simulation-based education and training across all surgical and medical specialties, pursue new models for telemedicine and telementoring, cross-fertilize ideas, and define opportunities to share expensive resources across specialty societies.

The 2010 Clinical Congress program included 11 named lectures, 117 panel presentation sessions, 24 didactic and skills-oriented postgraduate courses, 334 Surgical Forum presentations, 128 scientific paper presentations, 242 scientific exhibits (including 74 from outside the U.S. and Canada), and 204 video-based education presentations.

The Surgical Education and Self-Assessment Program (SESAP) remains the premier self-assessment and cognitive skills education program for practicing surgeons. It is also used widely by surgery residents. The American Board of Surgery (ABS) recognizes SESAP as an educational program that may be used to fulfill the requirements for Part 2 of Maintenance of Certification (MOC).

SESAP 14 was released during the 2010 Clinical Congress in Chicago, IL, and is available in a variety of formats that are especially designed to address different learning needs. The evidence-based content of SESAP 14 addresses principally the core competencies of medical knowledge and patient care, and also focuses on the other core competencies, as defined by the American Board of Medical Specialties and the ACGME. The 15 content categories correspond with the content categories defined by the ABS for the recertification examination in surgery. SESAP 14 offers the opportunity to earn a maximum of 70 Category 1 continuing medical education (CME) credits, 10 credits more than previous editions of SESAP.

The ACS Comprehensive General Surgery Review Course is specifically designed to help practicing surgeons fulfill requirements for Part 2 of MOC, and also to prepare for the recertification examination in surgery, in order to fulfill Part 3 of MOC. The course includes a robust educational design, with online pre- and post-tests.

Two Comprehensive General Surgery Review Courses were approved for 2011. These will be held May 19–22 and June 23–26, in Chicago, IL.

Selected Readings in General Surgery (SRGS) is a preeminent, evidence-based educational program in surgery designed to meet the learning needs of practicing surgeons and surgery residents. The SRGS is recognized by the ABS as an educational program that may be used to fulfill the requirements for Part 2 of MOC. A forthcoming issue will focus on clinical problems encountered by general surgeons engaged in rural practice. The SRGS offers the opportunity to earn a maximum of 10 Category 1 CME credits per issue (80 Category 1 CME credits per year).

The SRGS Connect is an online publication that is based on SRGS, and is available in three different formats:

• SRGS Connect–Resident is currently available to residency programs
• SRGS Connect–Practicing Surgeon is available to individual practicing surgeons
• SRGS Connect–Premium is available to individual practicing surgeons who prefer the convenience of receiving with their subscriptions full-text reprints of the most important articles from the overview

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

- A number of sessions from the 2010 Clinical Congress program were selected for webcasting in an effort to offer convenient access to these important sessions. A total of 25 sessions from the 2010 Clinical Congress were bundled with 45 sessions from previous Clinical Congress meetings to produce a complete webcast package that offers the opportunity to earn 121 Category 1 CME credits.

Journal of the American College of Surgeons (JACS)

The JACS Category 1 CME program continues to be popular among Fellows and subscribers. In 2010, 71,982 credits were earned, and 2,593 individual surgeons participated in the Journal’s CME program.

ACS Health Policy Research Institute (ACS HPRI)

A hotline for workforce data or policy advice, the ACS HPRI is committed to providing reliable and useful data to support policymaking for health care in the U.S. Queries about data, provision of existing literature, and reports, slides, and maps are available to individual Fellows by request. In addition, the ACS HPRI has generated slide presentations that are available on the portal for use by the Fellows.

Compiling and analyzing the AMA and the AAMC data, the ACS HPRI has developed a longitudinal database that provides surgical specialist workforce trends, demographic characteristics, geographic distribution, and training background. These data can, and have been, used to develop a forecasting model that compares the effect of potential policy scenarios. With this information, we have provided a series of documents for distribution among members of Congress, the White House, and other relevant stakeholders. Among these documents are six fact sheets available in print and on the ACS HPRI website. The most recent fact sheet, Independent Practice Becoming Increasingly Rare Among Surgeons, provides some foreshadowing to what we might expect to see in the future as Accountable Care Organizations (ACOs) become more clearly defined and organized. Another more comprehensive report developed from this data is The Surgical Workforce in the United States. Published in 2010, this report provides a picture of the surgical workforce in practice as well as in training in the U.S. Each of the ACS HPRI reports has been made available on the ACS Web portal (e-facs.org), and the ACS HPRI website. The fact sheets have been adapted and published in the ACS Bulletin.

Thomas C. Ricketts, PhD, MPH, Managing Director of the ACS HPRI, was appointed to the National Health Care Workforce Commission in October 2010. Dr. Ricketts was one of 15 experts appointed to the new commission. The commission was established under the Affordable Care Act (ACA). It is an independent body that advises Congress and the White House on health workforce policy. It will also serve as a national resource for states and localities to evaluate education and training activities, identify and recommend ways to address barriers to improved coordination, and encourage innovations that address population needs, changing technology, and other environmental factors.

The ACS HPRI is currently engaged in multiple workforce-related projects with three tasks forming the core of this work, as follows.

- Atlas of Surgical Workforce. Version 1 of the online Atlas was released at the ACS Clinical Congress in October 2010. The Atlas provides a picture of the supply and geographic distribution of physicians and institutions providing surgical services in an effort to help practitioners, policymakers, and patients anticipate current and future distribution and identify places with limited access to surgical services.

- Longitudinal Database of Physicians. The Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC, and the HPRI have developed a longitudinal database of physicians in the U.S. This file links annual files of physicians and allows analysts to track the changes physicians make in their practice location, activity status, and, to a lesser extent, residency or fellowship training. These data have been used to determine the migration patterns of physicians and surgeons over time by age, gender, specialty, and training status.

- Surgical Workforce Projection Model. The model is a user-friendly prediction model of the
supply of surgeons in the U.S. It will allow users to forecast future supplies of surgeons by head count, and full-time equivalent by age, gender, race, geographic location, and specialty. The model is primarily intended to be a tool for policy analysis.

The HPRI research includes, but is not limited to, the following:

- **Innovative models of surgical staffing.** Rural communities across the U.S. have long struggled to maintain surgical services in local hospitals, and recent data show further contraction of the rural surgical workforce. Using a semi-structured case-study approach, the HPRI is examining surgical staffing models of rural hospitals. The goal is to produce information that is useful to communities, especially rural ones, in addressing current or anticipated shortages in the surgical workforce.

- Developing projects for the HPRI include the following:
  - **ACOs and regionalization.** The final rules that will guide the development of Medicare-ACOs are under development in the Centers for Medicare & Medicaid Services (CMS). There is guidance as to the ACO’s eventual design provided by prior demonstrations that suggest these entities will be hospital-centered, will make use of bundled pricing, will aggregate multiple physician groups, and will increase the trend toward organizational affiliation for surgeons. On the surgical side, less attention has been paid to the coordinating and integrating work on surgical services including burn care, wound care, pediatric surgery, oncology, thoracic, and transplant surgery that can be used as guidance for how to organize coordinated systems integrating primary care and post acute care to reduce costs and improve quality.
  - **Surgical service areas and underservice.** Health Profession Shortage Areas (HPSA) were defined and are administered by the U.S. Health Resources and Services Administration (HRSA) based on primary care resources. Primary care HPSAs do not adequately define all health professional shortage areas. To address this problem for surgeons, the HPRI has developed a proposal for a HPSA designation for areas that have critical shortages of general surgeons.
  - **Subspecialization trends and training.** This project builds on work that investigated the progressive specialization (voluntary narrowing of scope of practice over time) of general surgeons in response to the increased numbers of trainees pursuing fellowship training in surgical subspecialties. While this occurs in all specialty areas of surgery, it is especially problematic in general surgery.
  - **Rural surgery.** The Sheps Center has a long involvement in rural health, and due to the fact that it houses an Office of Rural Health, it is an obvious topic for in-depth analysis of critical access hospitals and surgical services. A total of 58 million Americans live in what is classified by the U.S. Census Bureau as rural America. Drafting criteria for health policy shortages of surgeons is in progress. In addition, analysis continues to examine and clarify differences between rural and urban surgical practice locations.

### ACS National Surgical Quality Improvement Program (ACS NSQIP)

On January 1, 2011, the ACS NSQIP launched several important changes to advance the program. The ACS NSQIP Generation Two has updated the program to address the variety of hospital types that have variable needs, have variable resources, perform variable case mixes, and so forth. The following areas are where changes are occurring and are a reflection of input from a variety of sources:

- Information technology platform flexibility
- Case collection options
- Data variables—both content and number of variables collected
- Statistical methods advancing in line with the advancing science
- More meaningful data reports
- “Closing the loop” materials (for example, best practices, case studies)

The ACS NSQIP has already developed a number of evidence-based best practices guidelines. Several new guidelines have been created and have been posted on the ACS NSQIP secure website. The best practices guidelines summarize key evidence-based recommendations from professional societies’ guidelines approved by an expert panel. Hospitals or individual practitioners are using these concise guidelines as a framework to prioritize and direct efforts for addressing postsurgical complications.

- **Collaboratives.** Collaboratives allow participat-
ing sites to compare outcomes and share best practices in a cooperative, noncompetitive environment, and provide for data sharing opportunities beyond the scope of the standard ACS NSQIP participation. The Florida Surgical Care Initiative is in the final stages of development and will soon be the largest ACS NSQIP collaborative, with nearly 100 sites.

- National conference: More than 700 individuals attended the ACS NSQIP National Conference in 2010. Peter Pronovost, MD, of Johns Hopkins School of Medicine, Baltimore, MD, served as the keynote speaker and delivered a presentation on bloodstream infections. Attendees also enjoyed presentations from ACS leaders and the ACS NSQIP participating sites on a variety of program updates and surgical quality improvement topics, including the ACS NSQIP’s role in health care reform. The 2011 ACS NSQIP national conference will take place at the Westin Copley Place in Boston, MA, July 24–26. The ACS NSQIP is currently in the process of finalizing the agenda for the upcoming conference.

As the ACS NSQIP becomes increasingly multispecialty, the ACS continues to collaborate with specialty experts from a number of different specialties and surgical societies. The addition of specialty-specific data variables and modules will continue to enhance the ACS NSQIP targeted procedure dataset and the overall program.

Building on a successful partnership, the CMS approached the College to develop additional outcome measures. The CMS recognizes the strong understanding and acceptance by providers of the ACS NSQIP data collection and statistical methodology. The ACS NSQIP data were used to develop risk-adjusted hierarchical models for four clinical, outcome-based, performance measures. These measures were submitted to the National Quality Forum (NQF) for evaluation and endorsement, and two measures have passed through the NQF committees; they are now out for public comment. The remaining two measures have started the NQF process, and, thus far, have been favorably discussed.

In 2011, the CMS is planning to release another request for applications to become a CMS-recognized vendor. The ACS expects to submit an application. If the ACS were able to be a CMS-recognized vendor, implementation on a large scale would be more possible.

International interest in the ACS NSQIP continues to rise. The ACS NSQIP currently has two sites outside of the U.S. and Canada. Because of the high interest of several international sites in joining the ACS NSQIP, the possibility of an international pilot is being evaluated. The ACS NSQIP is currently in the process of gathering information from international sites interested in joining the Global Surgical Quality Initiative pilot.

Advocacy
- The ACS responded to the CMS’ request for information regarding the ACOs and the implementation of the Medicare Shared Savings Program. The ACS provided feedback on various issues, including policies and standards to ensure that groups of solo or small practice providers have the opportunity to participate in the ACOs—specifically, the importance for the CMS to address legal concerns that might arise for the ACS members, and to implement effective risk adjustment methodologies. The comments also addressed the need for prospective attribution of beneficiaries to the ACOs, assessment of beneficiary and caregiver experience of care using the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey, the use of patient-centeredness criteria for assessment of the ACOs, and what quality metrics an ACO should meet. The comment letter emphasized that a new delivery system must focus on promoting quality care, improving patient access, and, ultimately, providing cost-efficient care.

- The ACS met with staff members of Senate Finance Committee Chair Max Baucus (D-MT) to discuss the implementation of provisions included in the ACA (P.L. 111-148) to provide 10 percent bonus payments under Medicare for general surgeons care for patients in HPSAs. The ACS staff discussed how to best ensure that the bonus payments are being delivered to those general surgeons who are caring for patients in underserved areas where there are demonstrated shortages of general surgeons. Based on the meeting, the ACS staff is working with Finance Committee staff to secure a meeting with the HRSA to discuss the possibility of creating
a HPSA for general surgery. At present, the CMS is implementing the bonus payment by providing bonuses to general surgeons for major procedures performed in already existing primary care and mental health HPSAs. This definition fails to take into account the unique requirements of surgery, and, therefore, the provision is poorly targeted. General surgeons operating in urban and suburban hospitals that provide care to underserved areas and populations could be excluded from receiving bonus payments. The College's Division of Health Policy and Advocacy staff continues efforts initiated early last year to improve the incentive payment through creation of surgery-specific HPSAs.

The College was joined by several surgical organizations in sending a letter to the Occupational Safety and Health Administration regarding the petition filed by Public Citizen addressing regulation of resident duty hours. The College strongly believes that the federal government should not regulate medical resident and fellow training education, including duty hours, outside of the currently existing ACGME structure. Resident hours are one of many factors that impact quality and safety of patient care and the well-being of residents. Severe restrictions on resident duty hours without supporting evidence of corresponding benefits will result in a host of unintended negative consequences.

The College, along with a variety of other constituencies, provided significant input following the ACGME's most recent 18-month evaluation of resident duty work hours. The comprehensive analysis addressed the full spectrum of issues with (1) a thorough review of the current scientific literature; (2) testimonies from key representatives from medical and surgical specialties, residents, medical students, and the public; and (3) expert opinion from leading authorities on sleep research, physiology, and fatigue management. The new duty hour requirements include increased safeguards to address the well-being and safety of residents. Over the past years, the ACGME has continued to rigorously monitor resident duty hours through the respective residency review committees that include individuals with the requisite expertise from the various specialties. Punitive actions have been taken against institutions that were found to be consistently out of compliance, and the ACGME continues to strengthen and enhance its enforcement procedures.

Regarding the Independent Payment Advisory Board, the ACS was among a select group of stakeholders and patient advocacy groups, including representatives from the disability and senior citizen communities, to participate in a roundtable discussion hosted by the Aspen Institute. The Aspen Institute is a widely respected nonpartisan organization and think tank that hosts a wide variety of policy forums, seminars, conferences, and events on numerous public policy issues. Among these programs is the Aspen Health Stewardship Project, which is a bipartisan effort that seeks to inform the policymaking process and to refocus the national dialogue on health reform legislation.

The College was among a select group of physician organizations who met with policy leaders at the Blue Cross/Blue Shield Association offices in Washington, DC, to discuss priorities and concerns with the implementation of health insurance exchanges, which were created by the ACA and will begin operation in 2014. Even though the exchanges will not be operational until 2014, state legislatures are beginning to consider how to draft legislation to implement exchanges at that time.

The ACS co-hosted a briefing for House and Senate staff in conjunction with the AAMC and the National Association of Children's Hospitals. The briefing, entitled Addressing the Physician Shortage Post Health Care Reform, was attended by more than 60 individuals from approximately 45 House and Senate offices, as well as several congressional committees and other health organizations. The briefing featured presentations from Atul Grover, MD, PhD; Patricia Hicks, MD; and Thomas Rick- etts, PhD, MPH. The briefing was organized to help raise awareness on Capitol Hill about physician shortages in areas other than primary care (especially in surgical fields and pediatric subspecialties), and how these shortages might be affected by the recently enacted health reform law.

Regarding trauma funding, the College, along with representatives of the Trauma Coalition, met with Mary Wakefield, administrator of HRSA, and her staff to discuss funding of the trauma provisions.
as authorized in the ACA. The College, represented by staff and Edward E. Cornwell III, MD, FACS, emphasized the tremendous opportunity to lower costs and improve outcomes by including funding for the trauma and emergency programs. Dr. Cornwell also highlighted the unique workforce shortages confronting trauma and emergency medical services, and the need to address those issues at all caregiver levels. The groups asked that funding be included in the President’s budget, or by utilizing discretionary dollars.

A similar meeting took place January 27 with Nicole Lurie, MD, Assistant Secretary for Preparedness and Response at the U.S. Department of Health and Human Services. At the meeting, the group also emphasized the need to utilize the trauma and emergency programs for disaster preparedness.

The College is simultaneously working with House and Senate appropriators to secure funding for these programs. It is very early in the appropriations process, and it promises to be an extremely challenging appropriations cycle. The College, however, is working hard to secure funding for these vital programs.

- CMS finalized various other proposed changes to the 2011 Physician Quality Reporting System (PQRS). The ACS supported a proposal that—for registry-based reporting of measures groups in 2011—the minimum patient numbers or percentages must be met by Medicare Part B fee-for-service patients exclusively, and may not include data on non-Medicare Part B fee-for-service patients. CMS finalized this proposal. In addition, CMS finalized the ACS-supported proposal to reduce the reporting threshold for eligible professionals who report individual quality measures using the claims-based mechanism from 80 percent to 50 percent. Lowering this reporting threshold to 50 percent will ideally increase the likelihood for successful reporting in the PQRS and increase participation in 2011. (For more information, refer to the series of “What surgeons should know about…” columns on PQRS reporting published in the Bulletin earlier this year.)

- The ACS continues to educate members and their staff about the e-prescribing incentive program through our website, meetings, and publications. The ACS signed on to two letters to CMS stating concerns with the e-prescribing payment adjustment for 2012. Highlighted in these letters were issues related to the reporting period ending June 30, 2011, and the exceptions. The letters urged CMS to extend the reporting period and add more exception categories, such as those physicians who attest to meaningful use in 2011 or 2012. The ACS continues to represent surgery at all meetings regarding the future of e-prescribing, and possible changes to the program. (For more information on the e-prescribing incentive program, see the “What surgeons should know about” column on page 6 of this issue of the Bulletin.)

- On the political side, state elections strongly reflected the Republican wave that struck at the federal level. From a medical liability reform perspective, these elections may result in a couple of additional states considering comprehensive reforms.

- The ACS continues to provide a series of coding workshops. Physicians receive CME credits for each workshop completed and certified professional coders receive continuing education units through the American Academy of Professional Coders. The 2011 coding workshop schedule includes the following: April 28–29, Chicago, IL, and August 18–19, Nashville, TN.

- Several commissions have announced various appointments. Robert M. Zwolak, MD, FACS, a member of the ACS General Surgery Coding and Reimbursement Committee, was appointed to the Patient Centered Outcomes Research Institute.

- The ACS prepared two comment letters related to the ACOs. The first letter addressed legal issues related to the implementation of the ACOs, specifically with respect to the antitrust, anti-kickback, physician self-referral, and civil monetary penalty laws. The ACS expressed concern that a general waiver will not adequately protect providers of care within the context of an ACO; rather, CMS must create explicit protection from these laws. The second ACO comment letter was a joint specialty society comment letter prepared in response to a CMS request for information regarding the ACOs. The ACS provided feedback on various issues, including policies and standards to ensure that groups of solo or small practice providers have the opportunity to
participate in the ACOs, the need for prospective attribution of beneficiaries to the ACOs, assessment of beneficiary and caregiver experience of care, the use of patient-centeredness criteria for assessment of the ACOs, and quality metrics that an ACO should meet.

- The ACS continues to call on Congress to take action to stop cuts to Medicare reimbursement mandated by the SGR and to replace Medicare’s broken payment system with reforms that will preserve Americans’ access to quality surgical care.
- The ACS prepared a joint specialty society comment letter regarding the ACA’s provisions for screening to prevent fraud, waste, and abuse in Medicare, Medicaid, and the Children’s Health Insurance Program. The comment letter agreed with CMS that the screening mechanisms applied should be based on provider type, and that physicians belong in the “limited risk” category. The letter did express concern that the application of screening provisions to physicians who also enroll as durable medical equipment, prosthetics, orthotics, and supplies suppliers would result in physicians being categorized as “high risk.” The ACS also supported the CMS position that would prevent physicians from being required to pay an application fee for carrying out the screenings and other program integrity efforts carried out under these sections of the law.

**Resident and Associate Society (RAS)**

The RAS had a very productive 2010 meeting. New projects for 2011 include the following:

- Exchange program with the Royal College of Surgeons in Ireland
- Revitalization of liaisons to residency programs
- Evaluation of the ACS resident membership data to evaluate retention trends
- Resident needs assessment
- Program director survey to better understand recruitment and retention opportunities
- Increased advocacy outreach through the ACS State Affairs staff and ACS chapters
- Annual scholarship competition for the ACS-sponsored courses (five to be granted)
- Increased contact with international surgical trainee organizations

**Young Fellows Association (YFA)**

During the YFA’s 2010 annual meeting, members discussed mentoring activities. Based on the discussions, it was agreed that the YFA Governing Council members would seek to establish mentoring relationships with well-established members of the College, including Officers, Regents, Governors, and so forth. Also, the YFA Governing Council will seek to identify the YFA members of the College who are interested in establishing mentor relationships with residents.

**ACS Advisory Councils for the Surgical Specialties**

All Advisory Councils routinely discuss the Jacobson Innovation Award, Sheen Award, and Honorary Fellowship. The nominations are forwarded to the ACS Honors Committee for its consideration.

The Advisory Councils continue to propose specialty-sponsored programming for the Clinical Congress. Following the recommendation of the ACS Program Committee, several sessions are co-sponsored by two specialty Advisory Councils or by a specialty Advisory Council and an ACS committee.

**HealtheCareers (Job Bank)**

As of January 20, there were 568 active jobs listed on the website, with 359 posted resumes. This is a valuable service for all members of the College (and is free for Resident Members).
NTDB® data points

The working wounded

by Richard J. Fantus, MD, FACS; and John Fildes, MD, FACS

According to the U.S. Census Bureau, the number of uninsured Americans rose to 50.7 million in 2009. That figure is equivalent to approximately one in six U.S. residents. Meanwhile, the percentage of Americans with private insurance was at its lowest since 1987—the first year that the U.S. government began keeping this statistic. The reason for this staggering increase in the uninsured population is multi-factorial. There was a segment of workers who lost their employee benefits when the recession eliminated their job, but there were also a significant number of companies that dropped employee health benefits. Additionally, there were families that went without coverage to cut household costs, since the average cost to insure a family of four is estimated at $14,000 per year. Workers between the ages of 18 and 64 were the biggest losers, as public programs such as the Children’s Health Insurance Program, Medicare, and Medicaid protected only the very young and the elderly portion of the population (http://www.usatoday.com/news/nation/2010-09-17-uninsured17_ST_N.htm).

In order to examine the occurrence of those workers in the overall group of individuals paying out of pocket for their health care in the National Trauma Data Bank® research dataset 2009, admissions records were searched by primary method of payment. There were 103,483 records that had primary payor source as self-pay. 79,088 records had discharge status recorded, including 70,340 discharged to home, 3,717 to acute care/rehab, 2,143 to nursing homes; 2,888 died. These patients were 78 percent male, on average 34.2 years of age, had an average length of stay of 4.5 days, and an average injury severity score of 9.55.

When looking at the distribution of records by payor source, it is interesting to note that the self-pay peak occurs in an age bracket that would not only include working Americans without employee coverage, but also college-age individuals who in 2009 were not able to be covered under their parents’ insurance policies. It will be interesting to see over the ensuing years how this peak or line may change as health care coverage according to the Affordable Care Act is finally implemented. (These data are depicted in the figure on this page.)

There is partisan rhetoric on both sides of the health care crisis in an effort to fix this national public health crisis. To date, there are a few improvements, and there is much that has yet to be finalized or realized. Unfortunately, the bottom line is that, at present, more individuals in the productive years of their lives—often from working families—will re-
main without coverage or be significantly under-covered as health insurance remains unobtainable, unavailable, or unaffordable for the “working wounded.”

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 website as a PDF file and a PowerPoint presentation at http://www.ntdb.org. In addition, information is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB at mneal@facs.org.

Acknowledgment

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.

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

For more information and pricing, please visit the JIM HENRY website: www.jimhenryinc.com.
Who will help you help them?

Patients and their families frequently look to surgeons for guidance and advice—especially when dealing with life-limiting illness.

Now a new curriculum from the American College of Surgeons and the Cunniff-Dixon Foundation offers surgeons-in-training and practicing surgeons guidance for the management of problems encountered in palliative care, including advice on personal awareness, self-care, and the surgeon-patient relationship.

*Surgical Palliative Care: A Resident’s Guide* can help surgeons learn what their judgment and skill in the art of surgery can provide for their patients’ comfort, function, and longevity.

To review the content of the manual and discover how it can help you deal with the challenges of life-limiting illness, visit:


Single copies of the manual are available at no cost by contacting dmazmanian@facs.org or by calling 312-202-5311. Multiple copies are also available—you only pay postage costs.
To report your chapter’s news, contact Rhonda Peebles toll-free at 888-857-7545, or via e-mail at rpeebles@facs.org.

**Peru Chapter co-hosts VII Congress**

The Peru Chapter co-hosted the VII Congress February 17–19, which was held in conjunction with the XII International Congress of General Surgeons Peruvian Society. More than 700 surgeons and surgical academicians attended the education program, which was held at the Lima Sheraton Hotel and Convention Center. Frederick L. Greene, MD, FACS, the College’s Second Vice-President, presented four cancer-related lectures: (1) Anatomical and Molecular Staging of Cancer: 2011 and Beyond; (2) Laparoscopic Management of Abdominal Malignancy; (3) Management of Carcinoid Tumors of the Large Bowel; and (4) Staging of Colorectal Cancer. In addition, Dr. Greene presented an update on College activities to the Peru Chapter members (see photo, right).

**North Texas Chapter meets in Dallas**

The North Texas Chapter held its 2011 annual meeting February 18–19 at the City Place Conference Center in Dallas. In addition to numerous presentations by residents, the meeting featured three notable lectures: The Robert S. Sparkman Memorial Lecture, the Harry M. Spence Memorial Lecture, and the Ethics Lecture.

Presentations by residents were a major component of the meeting (see photo, this page), and included the following:

- **Best Paper—Trauma:** Child Abuse: A Significant Etiology of Mortality in Pediatric Trauma Patients. Jordan Estroff, MD, Children’s Medical Center, Dallas

- **Best Paper—Oncology:** Long-Term Outcome Analysis In Patients With Breast Cancer and a Positive Axillary Micro Metastases Who Did Not Undergo Axillary Dissection. Elise Roe, MD, Baylor University Medical Center, Dallas

- **Best Overall Paper:** Who Will Cover the Cost of Undocumented Immigrant Trauma Care? Christopher Mitchell, MD, Dallas Methodist Medical Center

*Denotes Resident Membership in the College.

Peru Chapter, left to right: David Ortega, MD, FACS, Governor; Dr. Greene; and Danilo Bambaren Gastelumendi, MD, FACS, President.

North Texas Chapter: left to right: Michael Truitt, MD, FACS, Co-Program Chair; Dr. Roe; Dr. Wishnew; and Chris Bell, MD, FACS, Co-Program Chair.

- **Best Paper—Mini Talks:** Pericaval Mass: A Time to Reflect On Vena Cava Aneurysms. Jenna Wishnew, MD,* Texas Tech University, Lubbock.
  Also, this year, the winner of the Resident Jeopardy Competition was Baylor University, Dallas.
Advocacy days for chapters

In 2010, a grant program to assist chapters with advocacy efforts was created. The grants for 2011 averaged approximately $2,500 per chapter and were intended to help support Lobby Day events and education programs for chapter leaders and state legislators. A total of 10 chapters were selected to receive these initial grants: Alabama, Northern California (with involvement of Southern California and San Diego Chapters), Connecticut, Florida, Georgia, Indiana, Massachusetts, New York, Ohio, and Virginia.

The following are Lobby Day summaries from three of the selected chapters: continued on page 68
### Chapter meetings

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

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

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<th>Date</th>
<th>Chapter</th>
<th>Location/Information</th>
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<tr>
<td>July 15, 2011 -</td>
<td>North Carolina and South Carolina (AP)</td>
<td>Location: Grove Park Inn, Asheville, NC Contact: Brad Feldman, MPA, CAE, IOM, 877-859-4561</td>
</tr>
<tr>
<td>July 17, 2011</td>
<td></td>
<td>e-mail: <a href="mailto:brad@executive-office.org">brad@executive-office.org</a></td>
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<td>ACS Representative(s): Julie A. Freischlag, MD, FACS</td>
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<tr>
<td>July 29, 2011 -</td>
<td>Tennessee (AP)</td>
<td>Location: Memphis, TN Contact: Wanda Johnson, 931-967-4700</td>
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<td>July 31, 2011</td>
<td></td>
<td>e-mail: <a href="mailto:wanda@tnacs.org">wanda@tnacs.org</a></td>
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<td></td>
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<td>ACS Representative(s): David B. Hoyt, MD, FACS</td>
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<tr>
<td>August 27, 2011 -</td>
<td>Georgia Society of the American College of</td>
<td>Location: Atlanta, GA Contact: Kathy Browning, 404-625-1520</td>
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<tr>
<td>August 28, 2011</td>
<td>Surgeons (AP)</td>
<td>e-mail: <a href="mailto:kdb@georgiaacs.org">kdb@georgiaacs.org</a></td>
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<tr>
<td>August 27, 2011</td>
<td>New Hampshire (AP)</td>
<td>Location: Omni Mt. Washington Hotel, Breton Woods, NH Contact: Brad Feldman, MPA,</td>
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<td>CAE, IOM, 877-867-8712 e-mail: <a href="mailto:nh@nhfacs.org">nh@nhfacs.org</a></td>
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<td>ACS Representative(s): Thomas V. Whalen, MD, FACS</td>
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<td>September 10, 2011</td>
<td>Kansas (AP)</td>
<td>Location: Doubletree Hotel, Overland Park, KS Contact: Gary Caruthers, 785-235-2383</td>
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<tr>
<td>September 11, 2011</td>
<td></td>
<td>e-mail: <a href="mailto:gcaruthers@kmsonline.org">gcaruthers@kmsonline.org</a></td>
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<td>ACS Representative(s): Mark A. Malangoni, MD, FACS</td>
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<td>September 17, 2011</td>
<td>Maryland (AP)</td>
<td>Location: Baltimore Intercontinental Hotel, Baltimore, MD Contact: Brad Feldman, MPA,</td>
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<td></td>
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<td>CAE, IOM, 877-904-1915 e-mail: <a href="mailto:maryland@marylandfacs.org">maryland@marylandfacs.org</a></td>
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<td>ACS Representative(s): Charles D. Mabry, MD, FACS</td>
</tr>
<tr>
<td>October 14, 2011</td>
<td>Kentucky (AP)</td>
<td>Location: Boone Faculty Center, Lexington, KY Contact: Linda Silvestri, 859-323-6346</td>
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<td>e-mail: <a href="mailto:Isilv2@uky.edu">Isilv2@uky.edu</a></td>
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<td>November 03, 2011</td>
<td>Connecticut</td>
<td>Location: Holiday Inn, Waterbury, CT Contact: Chris Tasik, 203-674-0747</td>
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<tr>
<td>November 05, 2011</td>
<td></td>
<td>e-mail: <a href="mailto:info@CTACS.org">info@CTACS.org</a></td>
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<td>ACS Representative(s): L.D. Britt, MD, MPH, FACS</td>
</tr>
<tr>
<td>November 04, 2011</td>
<td>Wisconsin Surgical Society–A Chapter of the</td>
<td>Location: American Club, Kohler, WI Contact: Terry Estness, 414-453-9957</td>
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<tr>
<td>November 05, 2011</td>
<td>ACS</td>
<td>e-mail: <a href="mailto:wisurgical@att.net">wisurgical@att.net</a></td>
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<td>ACS Representative(s): David B. Hoyt, MD, FACS</td>
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<tr>
<td>November 18, 2011</td>
<td>Japan</td>
<td>Location: Tokyo, Japan Contact: Kyoichi Takaori, MD, FACS, 81-75-751-4323</td>
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<td></td>
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<td>e-mail: <a href="mailto:takaori@live.jp">takaori@live.jp</a></td>
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• The Florida Chapter held its Lobby Day on February 8, and topics discussed with legislators included the following: Maintaining the Office of Trauma within the state Department of Health, granting sovereign immunity for emergency services and Medicaid, and raising the minimum personal liability insurance coverage (see photo, page 66).

• The Virginia Chapter held its Lobby Day on February 9, and topics discussed with legislators included the following: Protecting physician Medicaid payments from further cuts, supporting the agreement between the Medical Society of Virginia and the Virginia Trial Lawyers to maintain the medical malpractice cap for at least the next 20 years, and protecting services provided through Medicaid and the Family Access to Medical Insurance Security—the state’s health insurance program for children (see photo, page 66).

• The Georgia Society of the ACS held its Lobby Day on March 2. In addition to meeting with several key state legislators, the Georgia Society–ACS members also examined and studied the day-to-day workings of the state capitol (see photo, page 66).

Chapter anniversaries

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<th>Month</th>
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<tr>
<td>May</td>
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Ms. Peebles is in the Division of Member Services, Chicago, IL.