Commission on Cancer sets new milestone with patient-centered standards
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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.
Several regional surgical collaborative programs... are providing us with insights into how to bring the goals of improved quality, expanded access, and reduced spending to fruition.

Tennessee collaborative

Joseph B. Cofer, MD, FACS, professor of surgery at the University of Tennessee Center for the Health Sciences-Chattanooga, joined forces with two other Tennessee surgeons—Dan Beauchamp, MD, FACS, and Leonard Hines, MD, FACS—to form the Tennessee Surgical Collaborative. In July 2006, Dr. Cofer presented a plan for forming the group to the executive committee of the Tennessee Chapter of the ACS. The council unanimously supported the plan and gave Dr. Cofer a mandate to begin discussions with BlueCross Blue Shield (BC/BS) of Tennessee regarding the formation of a collaborative.

These efforts culminated in a three-way collaboration between the chapter, BC/BS of Tennessee Health Foundation, and the Tennessee Hospital Association, which was able to provide the infrastructure for the program through its Tennessee Center for Patient Safety. BC/BS agreed to provide funding to the collaborative for three years. By November 2008, a total of 10 hospitals had signed on to participate in the initiative.

The Tennessee collaborative has yielded significant quality improvements and cost reductions at participating hospitals. Dr. Cofer said that the Tennessee Surgical Quality Collaborative has resulted in savings of more than $2 million due to complications avoided per 10,000 general and vascular surgical cases, comparing 2010 with 2009 data.

At press time, the leaders of the Tennessee Surgical Quality Collaborative were in the process of applying for another three-year grant from BC/BS, and several additional hospitals have expressed interest in joining the collaborative. In addition, Dr. Cofer and his colleagues have submitted a paper regarding the formation and work of the collective that was accepted for presentation at the next meeting of the Southern Surgical Association in December 2011. This paper will be submitted for publication in the Journal of the American College of Surgeons.

Washington’s SCOAP

In 2005, the Surgical Care and Outcomes Assessment Program (SCOAP) was established in Washington State in response to perceived variation in the safety, quality, cost, appropriateness, and effectiveness of surgical services. Although it does not use the ACS NSQIP® platform, SCOAP is a clinician-driven, per-
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*Number of hospitals that have expressed interest in the collaborative.
†Number of hospitals eligible to join the collaborative.

SCOAP is in place at 56 Washington State hospitals, accounting for almost all inpatient care institutions where operations are performed, reported Dr. Flum, who has been a SCOAP leader since its inception. Programs have developed in general surgery, pediatric surgery, and vascular medicine and are being deployed in oncologic, urologic, gynecologic, and spine surgery. All SCOAP programs are administered through the Foundation for Health Care Quality, a not-for-profit organization; the University of Washington, Seattle, serves as the academic center for research and development.

SCOAP includes data collection for more than 150 processes of care and risk-adjusted outcomes for more than 25 commonly performed, higher-risk procedures to develop benchmarking information for clinicians and hospitals. Member hospitals then use these reports to address underperformance, with clinicians participating in peer-led educational and interventional activities. SCOAP spans across clinical disciplines, bringing together all the clinicians who perform procedures or whose work touches upon surgery (including radiology, pathology, and interventional radiology). *

SCOAP has been useful in helping performance data-sharing, and benchmarking collaborative, according to information provided by David R. Flum, MD, FACS, professor of surgery at the University of Washington, Seattle.

ing Washington hospitals to reduce adverse outcomes and lengths of stay, which translates into less spending. A recent analysis using administrative records estimated the unadjusted total cost difference for three procedures at SCOAP versus non-SCOAP participating hospitals from 2006 to 2008 at nearly $30.2 million. In 2009, the number of SCOAP hospitals nearly doubled, leading to an estimated cost savings of more than $60 million by the end of that year.

The leaders of SCOAP are in the process of taking the program to another level centered on using the collaborative to conduct comparative effectiveness research (CER) to determine the effects of different health care strategies on patient care. Opportunities for SCOAP hospitals to participate in CER are being coordinated through the SCOAP Comparative Effectiveness Research Translation Network, which has received $11.7 million in funding from the Agency for Healthcare Research and Quality.

The Michigan model

The concept for a surgical collaborative in Michigan was developed after BC/BS of Michigan/Blue Care Network experienced early success with a quality program focused on percutaneous coronary interventions. The insurer decided to make regional collaborative improvement a major component of its statewide Value Partnership program, and in 2004, began working with hospitals and clinicians to implement similar programs in other areas. The largest of the state’s regional collaborative quality improvement programs is the Michigan Surgical Quality Collaborative, which examines general and vascular operations.

With funding from the Michigan Blues, the collaborative has used ACS NSQIP data to compare surgical outcomes in hospitals in Michigan with those institutions outside the state, according to Darrell “Skip” Campbell, MD, FACS, a founder of the program. The Michigan Surgical Quality Collaborative studies the 30-day risk-adjusted morbidity rates at participating hospitals to determine which institutions are high performers and which are low, with the goal of enabling all hospitals to learn from one another. Members of the collaborative participate in site visits to the institutions so that processes and policies associated with good results can be identified.*

The bottom line

Clifford Ko, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, which operates ACS NSQIP, recently noted that regional surgical collaborative programs continue to be “extremely meaningful for achieving shared learning, quality improvement, and discovery.” I wholeheartedly agree and would encourage all surgeons who truly believe that clinicians and providers need to play a leading role in health care reform and quality improvement to reach out to payors and other stakeholders in their region to establish a collaborative. As Dr. Cofer said, these programs demonstrate what surgeons, hospitals, and insurers working together in a collegial fashion can do to improve patient care.

David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Medicare-enrolled Part B organizations, providers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), or Part A home health agencies (HHAs) may file Medicare claims for ordered or referred services. In May 2006, Medicare began requiring providers and suppliers to report their national provider identifiers (NPIs) on their Medicare enrollment applications. Subsequently, in May 2008, Medicare began requiring providers and suppliers to use NPIs on electronic claims to identify themselves as the billing provider, and to identify other health care providers who ordered or referred the service.

Traditionally, physicians are enrolled in the Medicare program to furnish covered services to Medicare beneficiaries. However, as a result of the implementation of the Affordable Care Act, some physicians will need to enroll in the Medicare program for the sole purpose of referring or ordering services for Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) plans to reject claims from a provider or supplier when claim forms do not include the billing, ordering, or referring provider’s NPI. However, CMS has not turned on the automated edits, which would deny claims for services that were ordered or referred by a physician or other eligible professional for lack of an approved file in the Provider Enrollment, Chain, and Ownership system (PECOS). At this time, CMS has not identified a date of implementation for claims rejection based on lack of Medicare enrollment of the ordering or referring physician.

In advance of CMS’ implementation of this policy, this article includes information on the billing process, as well as the enrollment process for referring and ordering physicians.

What are the requirements for ordering and referring?

The three basic requirements for ordering and referring are as follows: (1) the physician or health care practitioner must be enrolled in Medicare or in opt-out status; (2) the NPI used for ordering or referring must be for an individual physician or health care practitioner, not an organizational NPI; and (3) the physician or health care practitioner must be of a specialist type that is eligible to order and refer.

Who may order and refer for Medicare Part B and DMEPOS beneficiary services?

Only Medicare-enrolled physicians and certain nonphysicians are eligible to order/refer for Part B and DMEPOS Medicare beneficiary services. These individuals include the following: doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, doctor of chiropractic medicine, physician assistant, certified clinical nurse specialist, nurse practitioner, clinical psychologist, certified nurse midwife, and clinical social worker. Organizational providers cannot order and refer.

Who may order and refer for Medicare Part A HHA beneficiary services?

Only Medicare-enrolled physicians of a certain specialty type are eligible to order or refer for Part A when a plan of treatment is needed and submitted from an HHA for beneficiary services. These individuals include doctor of medicine or osteopathy and doctor of podiatric medicine.

How do I enroll in Medicare as an ordering or referring physician?

All ordering or referring providers must be enrolled in Medicare via the PECOS. Providers who order or refer should verify their enrollment in PECOS. Receiving payments from Medicare does not necessarily mean you have an enrollment record in PECOS. The easiest way to check on enrollment status is by visiting https://pecos.CMS.hhs.gov and navigating to the “My Enrollments” page; if no record is displayed, the provider does not have an enrollment record in PECOS. (More detailed instructions on accessing

If a provider believes an enrollment application has been submitted, but an enrollment record does not exist in PECOS, check the list of pending applications available at [http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp](http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp). Scroll to the “Initial Physician Applications Pending Contractor Review” in the “Downloads” section of the page.

Providers with neither an enrollment record in PECOS nor an entry on the list of pending applications should make arrangements to submit their enrollment application. CMS created Internet-based PECOS as a faster, more efficient way to enroll. For instructions, review the Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners at [http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf](http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf).

**How do I obtain an NPI?**

Providers may apply for an NPI in one of three ways:

- **Apply through a Web-based application process.** Visit the National Plan and Provider Enumeration System (NPPES) at [https://nppes.cms.hhs.gov/NPPES/Welcome.do](https://nppes.cms.hhs.gov/NPPES/Welcome.do) on the CMS website. Complete, sign, and mail a paper application to the NPI Enumerator. For a copy of the application (Form CMS-10114), refer to [http://www.cms.gov/cms-forms/downloads/CMS10114.pdf](http://www.cms.gov/cms-forms/downloads/CMS10114.pdf) on the CMS website. A hard copy application may be requested through the NPI Enumerator by calling 1-800-465-3203 or TTY 1-800-692-2326.

- **Give permission to have an Electronic File Interchange Organization submit the application data on behalf of the health care provider (for example, through a bulk enumeration process), if requested.** For more information on this option, visit [http://www.cms.gov/NationalProvIdentStand/04_education.asp](http://www.cms.gov/NationalProvIdentStand/04_education.asp).


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**Ms. Jackson** is Practice Affairs Associate, Division of Advocacy and Health Policy, Washington, DC.
In 1986, the U.S. Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in an effort to prevent hospitals from refusing to treat patients who were either unable to pay for their care or were covered under the Medicaid or Medicare programs. The act was designed to prevent “patient dumping”—instances in which hospitals would refuse to take care of the uninsured patients and would, instead, transfer them to other facilities, often in unstable condition.

The ostensible reason that hospitals could deny patients access to their services was that there were no state laws that mandated that the hospitals had a duty to treat patients just because they presented to the hospital. And, of course, since no patient-doctor relationship had been established, the physician did not yet have a duty to provide care.

Because the non-paying patients were often a financial drain on the hospitals, it made financial sense to transfer these patients to the so-called charity hospitals, which were already receiving funds from the state and local governments to care for them.

Based on the perception—which may have been fueled by the charity hospitals—that critically ill
patients were being transferred before they had been stabilized, members of Congress decided to mandate care to prevent dumping of patients who were unstable due to an emergency medical condition.1

**Plaintiffs use EMTALA for strategic reasons**

Shortly after EMTALA was passed into law, plaintiffs’ attorneys started to claim EMTALA violations, along with some malpractice causes of action. Why even raise the issue of an EMTALA violation in a malpractice case? The answer is strategic. It provides leverage for the plaintiff to push for a settlement. Although the monetary damages of an EMTALA violation are relatively low ($50,000 per incident, none of which would go to the plaintiff), the possible loss of the hospital’s ability to participate in Medicare and Medicaid would, in many instances, be a lethal blow to the institution’s ability to stay in business. Under these circumstances, the hospital leadership may decide it is better to settle than take the risk of losing the ability to participate in Medicare and Medicaid.

EMTALA defines the hospital’s obligation to a patient who “comes to the emergency department” (ED) requesting an “examination or treatment for a medical condition.”1 For these patients—who include everyone who comes to the ED—EMTALA first requires that an appropriate medical screening examination be done to determine if they have an “emergency medical condition.”

If the screening examination determines that the patient does not have an emergency medical condition, then there is no further obligation, under EMTALA, placed on the hospital. However, common law negligence under the laws of the state still may be applicable, so the hospital and medical care providers still need to do what a reasonable health care provider would do under the same or similar circumstances, or they may be liable for medical negligence (malpractice).

If the medical screening exam finds that a patient has an emergency medical condition, then the second requirement of EMTALA kicks in. This second mandate requires the facility to institute the care needed to stabilize the condition as best as the hospital is able to within its capabilities.1 This stabilization requirement is the focus of this article.

**EMTALA may allow patient transfers**

EMTALA recognizes that a hospital may not have the capabilities to stabilize a certain condition and, when this occurs, a process is described during which an “unstable” patient may be transferred to a facility that does have the capability to stabilize the condition. This type of situation may occur in a community hospital that is not equipped to do certain procedures, such as open-heart operations. A patient with, for example, an aortic dissection may not be stabilized under the requirements of EMTALA without an operation. Under these circumstances, there is a mechanism in the law where transfer of an unstable patient is allowed.

**The stabilization requirement**

As is true with most legislation, the words used in the statute are open to interpretation even when the words themselves have been defined in the statute. Under EMTALA, “to stabilize” is defined as “…to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman having contractions], to deliver….”

At first glance, it seems that a patient will be stabilized under the requirement of the act if the condition is not likely to worsen after leaving the facility. But what if the patient is being admitted to the facility? Unfortunately, various courts have interpreted the words differently in an attempt to determine when the hospital’s duty to stabilize the patient has been met.

**Court opinions vary**

In 1990, the Sixth U.S. Circuit Court interpreted the stabilization requirement in *Thornton v. Southwest Detroit Hospital.*2 Ms. Thornton had suffered a stroke and had been in the hospital for 21 days. She was then discharged to a nursing home, where the condition worsened. Ms. Thornton brought suit, claiming that the hospital had discharged her in an unstable condition and, thus, had violated the requirements of EMTALA. The district court heard the case and ruled that the hospital had stabilized the patient but, even if she was unstable at discharge, the EMTALA stabilization requirement ended when she left the ED and had been admitted into the hospital.

On appeal, the appellate court agreed with the district court that the patient had been stabilized prior to discharge, but disagreed that EMTALA had ended when the patient was admitted. The appellate court interpreted the words “emergency room care” to mean “emergency care,” and thus, the hospital still had a
duty to stabilize the patient even if he or she had been moved out of the ED and was admitted to the hospital.

The sixth circuit did not want hospitals circumventing the stabilization requirement by admitting the patient to another unit and then discharging the patient shortly thereafter.

In 2002, the Ninth U.S. Circuit Court of Appeals came to a very different interpretation of the stabilization requirement. In *Bryant v. Adventist Health System*, the court of appeals held that the stabilization requirement was not intended to apply to patients who had been admitted to the hospital. As such, EMTALA requirements ended when the patient was admitted to the hospital.

In *Bryant v. Adventist Health System*, the patient had been treated for pneumonia and was then discharged. After a check of the chest radiograph revealed a lung abscess, the patient was called back in and placed in the intensive care unit (ICU). He was later transferred to another hospital, had an operation, was eventually released, and then died. The ninth circuit did not believe EMTALA to be a malpractice law for a failure to treat cause of action. The court felt that the malpractice cause of action was better addressed by state malpractice law.

In *Bryan v. Rectors and Visitors of the University of Virginia*, a different court stated that “[EMTALAs] core purpose is to get patients into the system that might otherwise go untreated and be left without a remedy because traditional medical malpractice law affords no claim for failure to treat.”

In *Bryan v. Rectors and Visitors of the University of Virginia*, the patient had been admitted for respiratory distress. She was treated for 12 days in the ICU; then a do-not-resuscitate order was placed against the family's wishes. The patient died eight days later from a myocardial infarction. The court held, and the appellate court agreed, that stabilizing treatment had been provided for 12 days. When the patient had the myocardial infarction eight days later, EMTALA did not apply, as that would mean the statute would require the hospital to provide treatment indefinitely, perhaps for years. The court's reading of EMTALA was that it applied only to the emergency treatment required to stabilize the patient while the physicians considered whether they needed to admit the patient or transfer the patient for further care.

In *Harry v. Marchant*, the Eleventh Circuit agreed with the Fourth and Ninth. In *Harry v. Marchant*, the patient presented with pneumonia, possible sepsis, and possible pulmonary embolus. She was admitted after being in the ED for more than seven hours, during which time she did not receive antibiotics or a lung scan. After she was admitted to the ICU, she arrested and died. The court held that the duty to stabilize an emergency medical condition applies whether a patient is to be transferred or admitted to the hospital providing emergency care. However, once admitted, state law kicks in and the requirements of EMTALA end.

The *Harry v. Marchant* court stated that the stabilization requirement “continues until the patient is stabilized for transfer, release, or admission.”

It appears that the Fourth and Eleventh Circuits are in agreement with the Ninth Circuit in this regard. All three of these courts have held that the EMTALA stabilization requirement duties end when the patient has been admitted to the hospital.

**The Executive Branch’s opinion**

Based on the *Harry v. Marchant* decision, the George W. Bush Administration decided to clarify when the stabilization requirement of EMTALA ends. According to a letter authored by the Centers for Medicare & Medicaid Services (CMS), the decision to admit the patient to the hospital will not be enough to end the stabilization requirement of the statute; the patient will have to be admitted “…with the expectation that the patient will remain in the hospital at least over-night.” Also, “…a hospital’s EMTALA obligation ends toward an individual when the individual has been admitted for inpatient hospital services whether or not the individual has been stabilized.” However, “[i]f it is determined that the hospital admitted the patient for the purpose of avoiding its EMTALA obligation, then the hospital is liable under EMTALA and may be subject to further enforcement action.”

There is some discomfort with the CMS interpretation of this requirement. As Sara Rosenbaum wrote in *The Nation*, “…the landmark 2002 case *Harry v. Marchant* (quickly codified as a system wide rule by the Bush administration in 2003) held that EMTALA obligations end at inpatient admission: hospitals can now admit—and then dump—unstable patients, unless caught in a ‘subterfuge,’ a virtually impossible act to prove.”

**Will the Supreme Court get involved?**

When various circuits interpret the law differently, and the Administration takes a position that is open to question, the Supreme Court may decide to look at
a similar case to clarify the murky legal situation. As Justice Robert Jackson stated in a concurring opinion in Brown V. Allen in 1953, “[W]e are not final because we are infallible, but we are infallible only because we are final.” In fact, it is difficult to guess on which side of the issue the Supreme Court will fall.

What if a physician says the patient is stable?

What about the patient who is deemed to be stable? Is it enough for the ED physician to certify in writing that the patient has been stabilized to a reasonable degree of medical certainty to end EMTALA liability as is required in the statute? The answer is—probably not.

In 2007, the U.S. District Court of the Northern District of Iowa held that the jury must determine if the physician weighed the medical risks and adequately deliberated when he or she made the decision that the patient was stable. In Heimlicher v. Steele and Dickson County Memorial Hospital, an ED physician had certified that Ms. Heimlicher was stable for transfer. She was transferred to another hospital where she was found to have a ruptured uterus. Ms. Heimicher survived the emergency operation; however, the baby was stillborn. The court denied the hospital’s motion for a summary judgment and sent the case back for a trial.

Is there a “futile” exception?

Is there a futile care exception to the stabilization requirement? The Fourth Circuit addressed this issue in the Baby K case. In this case, the parents of an anencephalic child kept bringing the baby to the ED for episodes of respiratory distress. The hospital, believing that it was futile to keep treating this child, sought judicial permission to withhold ventilator care the next time the child presented to the ED. The court rejected the hospital’s request, holding that there was no exception for futile care under the statute. The court felt that Congress was free to add this exception if they so desired.

What should hospitals do?

In conclusion, each hospital that is subject to the EMTALA statute should have their legal counsel study what the courts in their jurisdiction have concluded in regard to the stabilization requirement of the statute. The practice of admitting the patient to the hospital may not be enough to end the stabilization requirements of the statute, which could make the hospital subject to penalties that could be severe. Also, there is a risk that the written certification of a physician that the patient has been stabilized may be second-guessed in a court of law. Again, the hospital could be on the hook for a violation.

Lastly, stabilizing treatment should be started even if the physician recognizes that he may be providing futile care. Federal law trumps state law in this regard.

References

1. EMTALA statute. Examination and treatment for emergency medical conditions and women in labor, 42 USC §1395 dd.
4. Bryant v. Rectors and Visitors of the University of Virginia, 95 F.3d 349, 352 (4th Cir 1996).
5. Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002).

Dr. Weiman is chief of surgery, Memphis Veteran’s Affairs Medical Center, Memphis, TN, and chief of cardiothoracic surgery, University of Tennessee Health Science Center, Memphis.
When the new Commission on Cancer (CoC) Patient-Centered Standards take effect January 1, 2012, they will represent another milestone for this consortium of nearly 50 member organizations that sets standards and monitors cancer care, developing programs for prevention, research, and education. The CoC strives to enhance both the quality of care and cancer patients’ quality of life. For Stephen Edge, MD, FACS, and Chair of the CoC, the new standards are additional proof that the group is “stepping up to the plate,” he said, and providing vital guidance for delivering patient-centered care to cancer patients throughout the U.S.

Dr. Edge (pictured, this page), the Alfiero Family Charitable Foundation Endowed Chair in Breast Oncology and medical director of the Breast Center at Roswell Park Cancer Institute in Buffalo, NY, is convinced that the new standards will further elevate cancer care and improve patient outcomes. A graduate of Case Western Reserve University Medical School in Cleveland, OH, Dr. Edge completed his residency at University Hospitals of Cleveland, and served a fellowship at the National Cancer Institute in Bethesda, MD. Dr. Edge has established himself as a national leader in uniting the subspecialties of cancer care and in develop-
ing the concept of continuous quality improvement in cancer management.

A surgical oncologist for 25 years who began his career practicing at the University of Virginia Medical Center in Charlottesville, Dr. Edge has witnessed a “revolution” in oncology care—and he fully expects the advances to continue.

“We are light years ahead of where we were just two generations ago,” he said, “and there’s no reason to believe that we won’t be many more light years ahead in another couple of generations. It’s amazing. We have made that much progress in enhancing outcomes for cancer patients.”

Rigorous CoC Standards enhance quality of care

CoC Standards effectively standardize cancer care through a process that began more than 80 years ago. It was in 1930 that the American College of Surgeons (ACS) first established standards to evaluate a cancer clinic’s performance. By 1933, 140 clinics had gained accreditation, and that number has grown steadily. Nationwide, there are now more than 1,500 hospitals and cancer programs in the CoC-accredited network. These programs treat more than 75 percent of patients who are newly diagnosed with cancer each year.

To become CoC-accredited, a cancer program must demonstrate its commitment to providing quality care through compliance with more than 40 rigorous standards and a commitment to continuing education, data collection and measurement, feedback, and continuous quality improvement. Cancer treatments don’t happen overnight, and because of the complexity of the disease, most positive outcomes in cancer patients are a product of multidisciplinary efforts, according to Dr. Edge. Participating in accreditation programs, he added, does not guarantee high-quality care, but it does reflect a commitment to these goals.

Knowledge of cancer biology

“We understand cancer biology so much better today,” said Dr. Edge. “We can target treatment to abnormal patterns of cancer, and we can save patients who, 30 years ago, would have succumbed to the disease,” he said. “We have a number of tools at our disposal now to treat the cancer patient.”

But the stakes are high, and cancer continues to hit close to home. Currently, nearly 12 million Americans have a cancer diagnosis, with approximately 1.3 million new cases diagnosed each year.

“Current screening of patients, early diagnoses, improved local therapy, and systematic treatments have all led to a dramatic reduction in cancer mortality,” according to Dr. Edge. But he does not discount the reality that cancer treatment today may be inequitable. The quality of care still varies widely, and scientific and technological advances aside, many cancer patients in the U.S. do not receive the high quality of care that is possible.

Many cancer patients still receive insufficient care, the wrong kind of care, or unnecessary procedures. CoC standards help ensure quality, comprehensive care delivery for all cancer patients—which is why Dr. Edge became involved with the Commission on Cancer.

“I have always viewed my involvement with CoC as a way to have an impact on cancer care, community-wide,” Dr. Edge said.

He noted an example of care he recently provided to a breast cancer patient. Through the CoC program of quality monitoring—the Rapid Quality Reporting System (RQRS)—a woman with breast cancer who needed chemotherapy had canceled and missed key appointments, and her chemotherapy had not started. The RQRS system alerted Dr. Edge’s cancer registrars that the allotted time for beginning therapy was nearly overdue, and his group contacted the patient again to be sure she received the critical therapy. This quality measure was proposed by the CoC and approved by the National Quality Forum, and the RQRS system is being implemented nationwide to provide the assistance to all accredited programs.

IOM: Ensuring quality cancer care

The CoC has evolved with advances in scientific knowledge and treatment of cancer. The National Cancer Policy Board responded in 1999 to the American public’s concerns about cancer care by reviewing the effectiveness and quality of cancer services and delivery systems, as well as the barriers in the U.S. to cancer care. The independent, not-for-profit medical think tank, the Institute of Medicine (IOM), in turn, issued its influential report, *Ensuring Quality Cancer Care*, which summarized knowledge about quality cancer care and established a number of recommendations for improving cancer care.

The report played a key role in developing the new
CoC standards that focus on the needs of patients. The IOM report recommended bold changes in cancer care, including the requirement that cancer care facilities employ quality measures and benchmarks to monitor the quality of care. The CoC has embraced this recommendation by including Standards 4.4: Accountability Measures, and 4.5: Quality Improvement Standards, which require that cancer patients are treated according to nationally accepted accountability and quality improvement measures endorsed by the National Quality Forum and measured through the CoC’s National Cancer Data Base reporting tools.

The National Cancer Data Base, a joint program of the CoC and the American Cancer Society, is a nationwide oncology outcomes database for accredited cancer programs in the U.S. and Puerto Rico.

The IOM also recommended that every person diagnosed with cancer receive key elements of quality care, including treatment by experienced professionals, an agreed-upon care plan, and access to resources that will make the care plan possible. The IOM report also called for access to clinical trials, full disclosure of information about treatment options, coordination of services, and psychosocial support.  

The IOM report was issued 12 years ago, and yet, the CoC is the only program in the U.S. that provides the standards, data system, quality metrics, and multidisciplinary approaches that embrace the IOM recommendations.

“Through the CoC, providers come together and define for specialists how they should relate to one another for the benefit of the patient, and how they should practice and document their work,” Dr. Edge said. “And as they do that, they must ensure that they measure results so that they are always striving for continuous quality improvement.”

Health care systems to treat cancer

Hospitals and other cancer care centers must continually demonstrate compliance with CoC standards in order to maintain accreditation. The result, according to Dr. Edge, is that health care organizations have proper systems set up or available through referrals to treat cancer, including high-quality tumor boards, pathology labs, diagnostic labs, blood banks, 24-hour physician staffing, social services departments, respiratory therapy departments, and advanced diagnostic equipment. CoC standards, Dr. Edge noted, accommodate large hospitals as well as the small ones. “Standards can be applied appropriately to all types and sizes of hospitals,” Dr. Edge said. Today, he said, most organized cancer care provided in the U.S. is based on the CoC framework.

“Most cancer care in the U.S.,” Dr. Edge added, “is community-based. It takes place in community hospitals around the country. Where necessary, these hospitals may access and refer patients to the services of larger hospitals.”

The CoC reviews its standards and survey processes routinely and revises them every five to seven years to reflect current cancer care practices. The standards have generally focused on structure and some process, but as in other areas of health care, outcomes are emerging as a key measure of effectiveness.

Dr. Edge added that the Commission is proactive when it comes to changes in cancer care. The CoC responds when there are wide reports of difficulties meeting compliance with certain standards, or when issues regarding changes in cancer care have been identified.

CoC consortium

The CoC has worked for more than 10 years with its current roster of the ACS and 47 other member organizations (see sidebar, page 16). CoC members are medical specialty societies, government agencies, and patient advocacy and support groups. Each organization appoints one representative to serve on the CoC for a three-year term, with eligibility to serve a
second term. The CoC holds meetings of all member organizations twice annually. The CoC Member Organization Steering Committee develops and evaluates collaborations and communication among member organizations.

In recent years, the CoC has taken major steps to bring more patient-based groups to the table, in addition to its long-time partner, the American Cancer Society. These include LIVESTRONG (the Lance Armstrong Foundation), the National Coalition for Cancer Survivorship, and the Cancer Support Community. All of these groups work with the multitude of needs that face cancer patients and their families, and provide support through research, patient services, education, and empowerment. These organizations are full members of the CoC and each has a voice and a vote.

Dr. Edge emphasizes that developing and applying the CoC Standards requires the work of many individuals, including a number of volunteers. “First and foremost are the staff of the Accreditation Program at the Commission on Cancer, led by Asa Carter, Connie Bura, Andrew Stewart, and David P. Winchester, MD, FACS,” noted Dr. Edge, adding that key volunteers in the development of the new standards include Frederick Greene, MD, FACS, of Charlotte, NC, former Vice-Chair of the Standards Revision Committee; Diana Dickson-Wilmer, MD, FACS, of Wilmington, DE, who chaired the Standards Revision Committee; and Daniel McKellar, MD, FACS, of Greenville, OH, Chair of the CoC Accreditation Committee.

CoC’s new patient-centered standards

The patient-centered standards that will become effective at the start of 2012 address vital patient issues. Standard 2.3: Risk Assessment and Genetic Counseling, calls on the staff at cancer facilities to assess a patient’s personal and family medical history, which is performed on-site or by referral to a qualified genetics professional. This personal history should include medical information about the patient’s first, second, and third relatives, as well as gathering information about paternal and maternal family history and ethnicity.

“A family with a history of cancer can use the information from genetic testing and cancer screening,” Dr. Edge said. “Identifying patients at high risk has impor-

CoC member organizations

American Academy of Hospice and Palliative Medicine
American Academy of Pediatrics
American Association for Cancer Education
American Cancer Society, Inc.
American College of Obstetricians and Gynecologists
American College of Oncology Administrators
American College of Physicians
American College of Radiology
American College of Surgeons Oncology Group
American College of Surgeons Resident and Associate Society
American College of Surgeons Young Fellows Association
American Dietetic Association,
       Oncology Nutrition Dietetic Practice Group
American Head and Neck Society
American Hospital Association
American Joint Committee on Cancer
American Medical Association
American Pediatric Surgical Association
American Psychosocial Oncology Society
American Radium Society
American Society of Breast Surgeons
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society of Radiation Oncology
American Urological Association
Association of American Cancer Institutes
Association of Cancer Executives
Association of Community Cancer Centers
Association of Oncology Social Work
Cancer Support Community
Centers for Disease Control and Prevention
College of American Pathologists
Department of Defense
Department of Veterans Affairs
Veterans Health Administration
LIVESTRONG (Lance Armstrong Foundation)
National Cancer Institute
National Comprehensive Cancer Network
North American Association of Central Cancer Registries
Oncology Nursing Society
Society of Gynecologic Oncology
Society of Nuclear Medicine
Society of Surgical Oncology
Society of Thoracic Surgeons
tant consequences for early detection and outcome.”

The standard requires both pre-test and post-test counseling. In the pre-test, the cancer facility must obtain the patient’s psychosocial assessment, either on-site or by referral. A CoC-accredited facility also will be required to evaluate a patient’s risk for developing a specific type of cancer and whether a patient carries a heritable or germ line mutation of a cancer gene. The cancer facility must also follow through by educating the patient about the suspected hereditary cancer syndrome. If genetic testing is recommended, the facility must obtain the patient’s informed consent. In the post-test, the facility must disclose test results, the patient’s medical management options, and the impact of the test results to the patient.

Standard 2.4: Palliative Care Services, dictates the availability of care, either on-site or by referral, that focuses on the pain, symptoms, and stress of serious illness. Palliative care relieves, rather than cures, cancer symptoms and can help patients live more comfortably. Palliative services refer to patient- and family-centered care that optimizes the quality of life. Palliative care serves a range of functions, including team-based care planning that involves the patient and family, pain and non-pain symptom management, communication among patients and families, and continuity of care across a range of clinical settings and services.

Standard 3.1: Patient Navigation Process, focuses on the continuum of care services, requiring the cancer committee of a facility to conduct an annual assessment of barriers to care for patients with cancer. Patient navigation refers to individualized assistance offered to patients, their families, and caregivers to help overcome barriers to care, whether through the health care system or the environment. Through navigation, the cancer center facilitates timely access to high-quality medical and psychosocial care that begins before the final diagnosis and continues through all phases of the cancer experience.

Cancer is a complex disease that has a major impact on patients and families, and the consequences of the disease affect all areas of the patient’s life—psychologically, socially, financially, and behaviorally. Standard 3.2: Psychosocial Distress Screening, emphasizes the importance of screening patients for distress and psychosocial health needs as a critical first step in providing quality cancer care and requires systematic follow-up and re-evaluation. The psychosocial representative on the facility’s cancer committee—an oncology social worker, clinical psychologist, or another licensed mental health profession—must lead this effort and issue annual progress reports.

Every cancer patient should have a plan for survival, which is covered in Standard 3.3: Sponsorship Care Plan, requiring the cancer committee to develop a process for disseminating comprehensive care summary and follow-up plans for patients who are completing treatment.

A privilege to care for cancer patients

The new patient-centered standards may increase the demands of CoC accreditation, requiring new programs and, to some extent, more administrative work and recordkeeping from cancer facilities. Dr. Edge recognizes the added demands, but he stresses their importance in addressing the needs of cancer patients and their families. “At some point, it is a privilege to care for cancer patients, and providing comprehensive care is not optional,” he said.

“There’s no question that the new patient-centered standards set a high bar,” Dr. Edge said, “but it is a level that the CoC has found that most accredited programs not only can meet but do want to meet.”

References


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Palliative intervention in Ethiopia:

The challenges and rewards of medical missionary work
After my retirement in July 2008 from the University of Alabama, Birmingham, and after 30 years in an academic surgical career, I yearned to take part in a surgical mission effort abroad. I wanted to spend enough time at it to make the effort seem worthwhile, both for the mission and for myself. I was told that most foreign surgical mission opportunities were in Africa, a continent I had never before visited. Through Medical Teams International, Portland, OR, I was able to arrange a two-month mission trip in September/October 2008 to a Korean mission hospital in Addis Ababa, Ethiopia. I had wanted to participate in surgical resident training; however, such a program had not been developed at the Myungsung Christian Medical Center (MCMC) at that time. The MCMC was on the list to develop a proposal by which they might join and take up resident training with the Pan-African Association of Christian Surgeons (PAACS). Instead of participating in a surgical resident training program, I worked closely with two young salaried Ethiopian general surgeons at MCMC.

The purpose of this report is to convey the unusual surgical and postsurgical experience of one patient encounter during the two months I was working in Ethiopia. It gave the medical team an opportunity to provide a palliative intervention in an often formidable disease course, only to be upstaged by minimal access to good medical care, and then to inadvertently succeed. This experience also revealed a surprising link back to the U.S, which I will address in more detail later in this article. Ultimately, this experience made me realize that I need to return to Ethiopia for another mission and teaching experience (which, in fact, provided the opportunity for me to follow up with this patient).

A patient encounter
The patient was a 50-year-old man who, surprisingly, was alive two years after surgery for an advanced malignant disease. The patient was a geography instructor who lived approximately 150 miles from Addis. He had traveled to Nairobi, Kenya, two years earlier with stomach cancer and had undergone a partial gastrectomy for a condition that may be described as a poorly differentiated
carcinoma with signet ring cells, and several lymph nodes involved. He had received a cycled triple-drug regimen of chemotherapy after the surgery in Nairobi, which was probably the reason he was alive. The medical team had a copy of the pathology documentation that, along with the chemotherapy, would project a median 24-month survival probability.* At that time, he was obviously jaundiced and very thin, and he had abdominal pain and stomach obstructive symptoms. Nonetheless, he displayed a vibrant demeanor. The patient had a recent computerized tomography (CT) scan of the abdomen, which showed a distended gallbladder attached to a common bile duct that narrowed near its outlet to the intestine. Either a recurrent tumor or scar tissue had compressed it into a stricture. The patient’s request was to undo the jaundice, and the surgical team’s strategy was to divert the obstructed bile through the gallbladder into a limb of intestine sutured to it.

The unknown factor with this procedure had to do with the stage and potential spread of the cancer, which could have prevented our surgical access to the gallbladder or intestine. His positive disposition—along with several laboratory tests that revealed close to normal results—assuaged us into believing an operation could help him. We promised no cure.

During the operation, we discovered he clearly had a tissue mass located next to the distal bile duct that was also next to his earlier gastrectomy junction with the intestine (duodenum)—this mass explained his symptoms. It was thick scar tissue. Surprisingly, the surgical team saw no evidence of recurrent cancer; in particular, the gastric omentum and the liver were free of tumor. The surgeons diverted both the gallbladder and the edge of stomach to an intestinal limb (cholecystojejunostomy and gastrojejunostomy) and obtained a biopsy of the most suspicious tissue found in the upper abdomen. The operation went well.

The patient had a brother in Addis who was always with him; he had another brother who, to my surprise, was a doctor of veterinary medicine and lived in Huntsville, AL. My first e-mail communication with that brother four days later was to say that the patient was doing well, and that the biopsy showed several areas of inflammatory dysplasia consistent with old gastric tumor, surrounded by fibrous scar tissue, interpreted as “burned out tumor.” The patient went home on the fifth postoperative day.

**Limited access**

The patient became ill at home and returned to our hospital on the 13th day after the operation. He was suffering from occasional vomiting, showed increased jaundice than he had shown on departure, and was in renal failure with a serum creatinine of 12 (normal 0.7–1.2). The surgical team soon determined that its surgical bypasses were working properly and that renal failure was the predominant diagnosis. The patient was seen by internists in the hospital who tried to arrange hemodialysis. This procedure was not conducted at the MCMC, but rather at two other city hospitals. Unfortunately, one center was experiencing an equipment failure, and the other had no dialysis catheters. This failure to provide life-saving therapy is common in Addis; radiation therapy is limited in scope and is available only at two hospitals, one of which is a free government hospital where the waiting list is long. No critical care facilities exist in this city, and the MCMC possesses the only neonatal incubators in the city. (There are 22 hospitals in the city of Addis, which has a population of approximately 4 million.)

**Assistance from an unlikely source**

During the next two weeks, the patient rallied and was in and out of the hospital, receiving intravenous fluids on three occasions. His serum creatinine at 12 slowly dropped to 6, and concentration of potassium in the blood was never a problem. Our Ethiopian surgeon, Solomon Bekele, MD, requested favors of his medical colleagues to conduct the dialysis. The patient went on invitation twice to each of the other facilities where dialysis was done, only to be turned away each time due to unavailable equipment or supplies. Needless to say, both patient and family were anguished and scared. Finally, a nephrologist colleague suggested that the patient obtain the necessary dialysis catheters from the patient’s brother in the U.S., and dialysis could then be done. While the patient was hospitalized and hydrated at the MCMC, the dialysis equipment was requested and shipped.

Four weeks after surgery, I went with the nephrologist to see the patient, who was alert, a little hungry, and urinating a larger volume daily. The creatinine had dropped to 4. The nephrologist interpreted the

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Patient's clinical condition as pre-renal failure that was slowly resolving. If this was the case, the newly arrived dialysis catheters would not have been necessary. Fortunately, his kidneys were improving, and the patient continued to recover. He soon went to his brother's home in Addis with strict dietary and fluid instructions, supplemented with regular clinic visits.

After I left Addis and returned home to Birmingham six weeks after the operation, I received this e-mail from the patient's grateful brother in Huntsville:

Dear Dr. John:

I believe it was by God's providence that you happened to be in Ethiopia when TG came to Dr. Solomon's office for consultation. It is because of the successful surgery the two of you did that TG is not experiencing abdominal pain and jaundice anymore. The latest creatinine level is 1.2 and BUN is also drastically reduced. When I called and talked to brothers RD and TG this afternoon, they told me they had just arrived home in Shashamane. They said he had been eating well and he will return to Addis in about two weeks for a checkup. I will keep you posted about his health.

Sometime, I would like to meet and thank you in person, and also eat some injera (native Ethiopian teff product) with you and your family.

Pleased with the clinical response, and the e-mail letter from the brother, my wife and I were determined to return to Ethiopia the next year (2009). That mission was outside Addis Ababa, in two other facilities—Soddo Christian Hospital, located in southern Ethiopia, and Tenwek Hospital, located in Kenya. Both facilities are mission hospitals where PAACS training had been established.

Patient follow-up

A year later, in September 2010, I returned to Addis and to the MCMC hospital. I was surprised and delighted to find that the patient had lived through these years and had continued to be seen at the MCMC. No renal difficulties had occurred. However, in April 2009, he was treated at the MCMC for acute intestinal obstruction, and he underwent surgery in which a large mid-abdominal mass invaded and obstructed the mid-transverse colon; a diverting ileostomy was done. The surgeon presumed that it was tumor mass with stomach remnant also involved, but no biopsies were taken. The patient was discharged five days postoperatively, and early weight loss (48 kg) was recovered promptly to 56 kg by October 2009. No operations have occurred since, and he was seen last at the MCMC with no specific complaints in March 2010. Outside CT and barium studies had shown some narrowing but satisfactory patency of the gastrojejunostomy. The CT also showed a larger 4 x 7 cm mass on or of the pancreas. The patient returned home to Shashamane and began teaching again into the early summer.

The patient died at home on July 14, 2010. His brother from Alabama attended the funeral and believed that he ultimately succumbed to his cancer. This was four years after his initial treatment of gastric cancer in Kenya, and probably the source (recurrence) of the enlarging peripancreatic mass on CT scan in March of 2010.

Many patients in east Africa, and in Ethiopia in particular, have no opportunities for adjuvant treatment of a cancer. In fact, many arrive for their first medical encounter with advanced malignant disease for which palliative surgery is no longer feasible. Yet the considerate gift of time and knowledge by medical missionaries toward care and support of the populations in the African continent brings personal reward to the missionary and a chance at survival to members of those populations. When that missionary can go to a country with full intention and technical know-how to train those physicians who will be left behind, as I have done on each occasion, the reward is even more bountiful, and ultimately extends to many more of that population.  

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The American College of Surgeons (ACS) Board of Governors’ Committee on Physician Competency and Health was created fewer than 10 years ago as the result of the merger of two previous committees: the Committee on Physician Competency and Liability, and the Committee on Physician Health. Building on preceding efforts under the proficient guidance of Kenneth W. Sharp, MD, FACS; Gerald J. Bechamps, MD, FACS; and subsequently, John B. Hanks, MD, FACS, the committee has continued its active role in the College. The responsibilities of the committee include the “maintenance of physical and mental wellness in the Fellows as well as addressing issues related to surgical competency, emphasizing credentialing, and practice within expected community standards.”

Accompanying the many changes in surgical training and practice in recent decades has been the increasing recognition of the potentially detrimental effects of the stressors that affect surgeons. In a demanding, high-intensity profession, anecdotal and personal experience suggests some of the negative effects of these stressors, but until recently, specific assessment of surgeons in this regard has been limited. In 2008, using data from a survey primarily developed by Dr. Bechamps and with the sponsorship and support of the ACS, Fellows of the College were anonymously surveyed electronically; survey support and data analysis was contracted through the Mayo Clinic. With 7,905 respondents, this survey was, by far, the largest study conducted of medical professionals of any specialty. The areas evaluated included demographic characteristics, as well as practice and call situations. Other topics included measures of career satisfaction and quality of life, and evaluation of burnout and depression. Analysis of the data from this study has yielded a remarkable number of articles and presentations and has greatly extended our understanding of the current surgical environment.1-9
Among the Fellows completing the survey, a significant finding was a 40 percent rate of burnout. Burnout was initially described by Christina Maslach and colleagues in the 1970s as a syndrome occurring in persons involved in the helping professions, characterized by emotional exhaustion and depersonalization (or cynicism) in relationships with colleagues or patients, and accompanied by a sense of inadequacy or reduced personal accomplishment (also termed inefficacy). In the 2008 survey, burnout was measured using the Maslach Burnout Inventory, which has been extensively validated. According to this survey, surgeon burnout was associated with the following: specialty choice (with highest odds ratios in those reporting trauma, urology, otolaryngology, and vascular surgery as specialties); having children who were younger than age 21; number of hours worked per week; number of nights on call; and compensation based entirely on billings. Furthermore, data analysis demonstrated that nearly a third of respondents screened positive for depression. Recent analysis presented by Charles Balch, MD, FACS, also indicates important differences between academic and private practice surgeons regarding factors contributing to burnout and career satisfaction, but found that hours worked and number of nights on call were common to both.3

Interpersonal factors
As might be presumed, stressors beyond the work environment also contribute to the development of burnout and depression. These factors included a recent situation involving a work-home conflict—particularly if the resolution favored work—as well as the number of hours worked. Not surprisingly, surgeons partnered with other physicians had a higher rate of work-home conflict. The overall rate of burnout and depression was also higher in female than male surgeons, although contributing factors were similar for both women and men.

Most Fellows surveyed reported that they would choose medicine as a career again (70.5 percent), and nearly three-fourths of participating Fellows (74 percent) would choose surgery again, but only 50 percent would encourage their children to pursue medicine or surgery as a profession. Although increased age, operating room time per week, academic rank, and subspecialty choice were found to be factors independently linked to career satisfaction as a surgeon, the absence of burnout was the most important reported factor (with an odds ratio of 4.12).

In an effort to better understand these issues, and with the strong support and funding of the College, a second survey was commissioned, and Fellows were again surveyed in October of 2010. The methodology was similar to the previous survey, with anonymous electronic responses that were submitted by approximately 7,000 Fellows. The data are currently under analysis, but one of the issues studied was substance misuse and abuse. A relatively high prevalence of alcohol abuse was found, which also correlated with burnout and depression—as well as hours worked per week and nights on call. Further analysis and discussion of the 2010 survey data will be presented at a panel discussion (PS213), titled Light at the End of the...
Tunnel: Prognosis for Recovery of Surgeons with Potentially Impairing Conditions, at this month’s Clinical Congress in San Francisco, CA.

The findings of these surveys are significant and clearly reflect a considerable degree of distress in a number of the Fellows of the College. Implications for the individual and for the profession as a whole are substantial. Degree of burnout and depression have been closely linked to suicidal ideation, with rates significantly greater in surgeons than the general population, yet with few seeking help.

**Quality and medical error**

Recognition and discussion of the contribution of medical error to adverse patient outcomes has increased almost exponentially in recent years. In several studies, approximately half of the adverse inpatient events were related to surgery (although not necessarily specifically to surgeons). As the delivery of surgical care is analyzed, it becomes apparent that many of the issues are system- and environment-related; however, for the Fellows who reported concern about having made a major medical error in the previous three months (9 percent of respondents), 70 percent ascribed individual causes rather than systemic issues. The survey question on this topic was phrased “even if no harm came to the patient,” yet the responsibility was shown to be felt by the surgeon. In this survey, the presence of burnout and depression was strongly associated with the likelihood of reporting a major medical error. Due to the anonymous nature of the survey, it is impossible to attribute causality—whether burnout and depression were the cause or result of the reported error. The traits recognized and valued in the surgical personality include perfectionism, compulsiveness, and a profound sense of responsibility to patients. Surgeons strive to practice surgery with excellence, yet it may be these very traits, coupled with a demanding practice, that may hamper surgeons’ abilities and lead to destructive behaviors and lack of competence.

**Workforce implications**

Despite projections several decades ago of an anticipated excess of surgeons, current assessments provide a significantly different analysis. The U.S. is currently underserved from a general surgical standpoint, with the number of surgeons currently in practice lagging behind population increase. Of greater concern is the expectation that this gap will continue to widen due to the lack of increase in trainees accompanied by increased surgical specialization. General surgical caseloads already appear to be increasing compared with those reported a decade ago. Hospital call and surgical emergency coverage is already at a crisis point in some areas of the country. Maintaining the workforce thus becomes even more essential, and yet, a review of the data from the 2008 survey suggests that maintaining the workforce will continue to be a challenge. Approximately 25 percent of surgeons surveyed reported at least a moderate likelihood of leaving their current surgical practice in the next two years (other than for retirement), with a quarter to a half of these surgeons planning to leave surgical practice altogether. Burnout and depression are the strongest independent predictive factors identifying surgeons considering leaving practice. If the situation remains unchanged, a continued contraction of the surgical workforce will increasingly add to the workload and call requirements for practicing surgeons and will exacerbate the potential for burnout.

**Looking ahead**

The Governors’ Committee on Physician Competency and Health continues to be actively engaged in surgical workforce issues and is keenly interested in both elucidating the concerns and working to improve the situation. Competence is defined as “the ability to practice with reasonable skill and safety” and remains a fundamental concern.

With the input, expertise, and participation of its members, the committee continues to grapple with challenges associated with surgeon burnout and other workforce-related issues. Current efforts of the committee include the development of an updated resource document for surgeons dealing with potentially impairing issues—which likely will be available via the College website with links to additional resources. Furthermore, development of a more defined support structure may be a potentially important topic requiring additional participation and support from the College. Given the prevalence and importance of the identified issues, augmentation of the role of the College is not unrealistic. Just as the College sets standards and provides educational opportunities to meet clinical challenges, involvement in this aspect of surgical practice by providing support, resources,
and training to address the demands inherent in the profession would be a reasonable expansion. As the evidence accumulates, physicians are increasingly confronted with the toll this profession takes on his or her self, patients, colleagues, and, not least of all, families and communities. The most able and dedicated surgeon may be the most susceptible to burnout, yet a physician’s own abilities may limit him or her from seeking help, support, and balance in life. Maintaining the well-being of this profession is essential; maintaining the well-being of individual surgeons is critical.

Acknowledgment

In addition to those individuals mentioned in this article, as well as the members of the committee, I would like to acknowledge my appreciation to Michael (Mick) R. Oreskovich, MD, FACS, for his expertise and support to the committee, as well as to Tait Shanafelt, MD, and his colleagues at the Mayo Clinic, who have provided exceptional leadership in analyzing and sharing the results of the survey.

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The Advocacy advisor

States use Web-based strategies to promote grassroots advocacy

by Charlotte Grill

The most effective grassroots advocacy efforts grab legislators’ attention and provide them with indicators as to what public policy issues are important and are gaining traction in their districts. Quite often, getting a response from a legislator requires a large number of constituents to write, call, and e-mail their representatives with their opinions about a bill. While a legislator might read a dozen e-mails, hundreds of e-mails will force the legislator to take a position and issue a response.

The American College of Surgeons (ACS) encourages participation in state-level advocacy and provides resources to help Fellows participate in policymaking. The State Affairs staff (Jon Sutton, State Affairs Manager; Charlotte Grill, State Affairs Associate; and Alexis Macias, Regional State Affairs Associate) use effective, user-friendly, Web-based tools to send important messages and alerts to Fellows and to make the grassroots advocacy process as hassle-free as possible. This system encourages the maximum level of communication between surgeons and legislators, especially when important bills emerge.

Internet advocacy

When a state bill requires urgent attention, Action Alerts through e-mail serve as the primary method of communication the ACS uses to inform College members. These alerts provide an efficient and quick means to disseminate essential information about a bill, direct members to pre-written letters they can send to legislators, and provide talking points for use in contacting legislators. These e-mails are intended to be brief and may include a complete list of targeted legislators, their contact information, and relevant facts about the bill. Sometimes Action Alerts direct surgeons to contact members of certain legislative committees, a specific chamber of the legislature, or the governor’s office. Chapter leaders often ask that the College send these notifications as a means of ensuring that every ACS Fellow receives information, and is aware of how to contact legislators regarding bills.

A coalition composed of 14 national surgical specialty societies and the ACS manage the Surgery State Legislative Action Center (SSLAC), a website designed to help with grassroots advocacy efforts (http://www.facs.org/sslac). The SSLAC is an easy way to mobilize surgeons to contact their elected officials at both the federal and state levels, as well as members of the media. ACS State Affairs staff and their colleagues from other surgical specialty societies that are part of the coalition will post pre-written letters to legislators on the website, which surgeons can then use to contact their state representatives, particularly regarding high-priority bills.

Effectiveness

Busy surgeons commonly ask, “Does it really make a difference if I send a letter to my legislator? Does it influence public policy?” The answer is a definitive, “Yes—there is definitely value to grassroots advocacy letter-writing campaigns.” During 2011, there was a high volume of grassroots advocacy efforts, with 12 letters to legislators posted on SSLAC and 13 Action Alerts sent to ACS members. Many of the bills included in these efforts attained the optimal outcome due to the advocacy efforts of the surgeons who took the time to visit the SSLAC and send their letters. Here are some of the highlights from the 2011 session:

- In Washington State, H.B. 1847/S.B. 5816 would have taxed all cosmetic medical procedures. The state would have imposed additional taxes on breast reduction surgery, late-stage cosmetic surgery following reconstructive care to improve the appearance of accident victims, and surgery to remove excess flesh after gastric bypass surgery. The Stop Medical Taxes coalition, which includes the College, opposed this bill because physicians, not state governments, should determine which procedures are elective and which are medically necessary. This bill also had the potential of violating patient privacy by allowing state auditors to review patient information. A letter in opposition to the bill was posted on the SSLAC website, and circulated to interested parties in an ef-
fort to encourage Fellows to send the letter to their legislators. More than 120 advocacy messages were sent to legislators regarding this bill, and it did not pass the Washington legislature.

- The New York legislature considered legislation to expand the scope of practice for dentists (A. 2820/S. 3059). The bills would have authorized dentists to perform any procedure in the oral and maxillofacial area regardless of its relation to the oral cavity. This bill received a lot of attention from Fellows, and 154 letters to legislators were sent out via the SSLAC website. Despite this effort, the bill still had such strong support from senators that it passed in the Senate. However, the bill stalled in the House at the end of the session and was not enacted. (For additional information on this legislation, refer to the “Advocacy advisor” column in the August 2011 issue of the Bulletin.*)

- Oklahoma passed major tort reform legislation this year, which places a $350,000 cap on noneconomic damage awards (H.B. 2128). Passage of this law was a huge legislative success, and if the bill had not passed this session, it would have been another two years before it could be considered again. The College joined with the Oklahoma State Medical Association in support of this legislation and sent out an Action Alert on April 1, notifying all Oklahoma surgeons and urging them to contact their legislators. The timing of the alert was critical; the House and the Senate voted on the bill in the following days, with the governor ultimately signing it on April 5.

- Efforts are ongoing in Massachusetts to get a primary seat belt law passed (SB 1211/HB 2401). At this time, Massachusetts is one of only 19 states with a secondary seat belt law. Primary seat belt laws are known to be effective in preventing injuries and increasing the number of drivers and passengers who wear seat belts. This bill is currently with the Joint Committee on Public Safety and Homeland Security Committee, and letters from Massachusetts surgeons could make the difference in getting this bill pushed to the forefront of the committee agenda. The SSLAC letter for this is available at http://capwiz.com/sslac/issues/alert?alertid=47741501.

Get involved
There are plenty of opportunities for Fellows to play a greater role in advocacy and grassroots efforts, especially at the state level. It is important to stay current with e-mails from the College and to take action as requested. A surgeon’s participation in state level advocacy does, in fact, make a difference in legislation affecting surgical practice and surgical patients. A surgeon’s participation will help to ensure that state legislators know and consider surgeons’ views when they are determining their position on issues and especially when they vote on these bills.

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

Dr. McGrath to receive 2011 Distinguished Service Award

The Board of Regents of the American College of Surgeons (ACS) has named Mary H. McGrath, MD, MPH, FACS, of San Francisco, CA, as the recipient of the College’s 2011 Distinguished Service Award. Dr. McGrath will receive the award on October 23 during the Annual Clinical Congress in San Francisco. The Board is recognizing Dr. McGrath with the College’s highest honor for her “steadfast commitment to the initiatives and principles embodied by the American College of Surgeons,” her numerous contributions to the College through service, her work as a clinical and academic surgeon, and her dedication to improving the quality of surgical patient care.

Dr. McGrath currently serves as professor of surgery in the division of plastic and reconstructive surgery at the University of California, San Francisco. A graduate of the St. Louis University School of Medicine, St. Louis, MO (1970), she completed an internship in pathology (1970–1971) and a residency in general surgery (1971–1976) at the University of Colorado Medical Center, Denver. She moved to New Haven, CT, to train as a plastic surgery resident at the Yale University School of Medicine (1976–1978) and to undertake a fellowship in hand surgery at the University of Connecticut and Yale University (1978).

In acknowledging Dr. McGrath’s work as an academic surgeon, the Regents noted her “outstanding clinical and academic contributions to the field of plastic surgery especially in the areas of breast, hand, wound healing, new technologies, and workforce issues made during her appointments.”

Dr. McGrath’s career as an academic surgeon started at Yale in 1978 with a position as assistant professor of surgery in the school of medicine’s division of plastic and reconstructive surgery. In 1980, she became an assistant professor of surgery in the division of plastic and reconstructive surgery at the College of Physicians & Surgeons of Columbia University, New York, NY. She moved to the George Washington University Medical Center, Washington, DC, in 1984, where she was appointed chief of the division of plastic and reconstructive surgery, director of the residency training program, and served as associate professor of surgery and, later, professor of surgery. She has held her current position of professor of surgery, division of plastic and reconstructive surgery at the University of California, San Francisco, since 2003.


She has also served as a “valued member of numerous other committees across the broad spectrum of College activities at national and local levels,” including the Development Committee, Research and Optimal Patient Care Committee, Surgical Education...
and Self-Assessment Program (SESAP) Committee, Central Judiciary Committee, Committee on Continuing Education, Pre- and Postoperative Care Committee, and the National Surgical Quality Improvement Program Policy Committee.

At the local level, Dr. McGrath served as President of the ACS Metropolitan Washington Chapter and on the chapter’s Executive Committee, Program Committee, and as a representative to the College’s Young Surgeons Committee. Additionally, Dr. McGrath was Editor-in-Chief and a contributing author for the ACS publication Ethical Issues in Clinical Surgery, which the Board of Regents called a reflection of her “exemplary commitment to heightening awareness and increasing the expertise of practicing surgeons and residents in examining the ethical underpinnings of surgical practice.”

In addition to recognizing Dr. McGrath for her involvement with the College, she is being commended for her noteworthy contributions to the quality of surgical patient care across the nation through collaborative relationships with the U.S. government and national health care organizations. She has served as a panel chairman, voting panel member, nonvoting panel member, and consultant for the U.S. Food and Drug Administration and as a panel member and reviewer for the National Institutes of Health. Dr. McGrath currently serves on the board of commissioners of The Joint Commission. Furthermore, her commitment to surgical education has included serving as a director of the American Board of Plastic Surgery, and she currently is vice-chair of the Accreditation Council for Graduate Medical Education’s Plastic Surgery Residency Review Committee.

In acknowledgment of the dedicated, continued service to and on behalf of the College and the surgical community, and the positive leadership shown throughout her distinguished career, the Board of Regents is pleased to recognize Dr. McGrath’s outstanding contributions by awarding her the College’s highest honor, the 2011 Distinguished Service Award.

Faculty Research Fellowships for 2012–2014 now available

Through the contributions of Fellows, Chapters, and friends, the American College of Surgeons offers faculty research fellowships to surgeons entering academic careers in surgery or a surgical specialty. Applications are due November 1, 2011. The fellowship award of $40,000 annually is intended to assist a surgeon in the establishment of a new and independent research program. Applicants should have demonstrated their potential to work as independent investigators.

The two-year Franklin H. Martin, MD, FACS, Faculty Research Fellowship honors the College’s founder. The two-year C. James Carrico MD, FACS, Faculty Research Fellowship is dedicated to trauma and critical care research. The one-year Louis Argenta, MD, FACS, Faculty Research Fellowship is dedicated to wound care research.

Full requirements and application form may be viewed at http://www.facs.org/memberservices/acsfaculty.html. Questions may be directed to the Scholarships Administrator, at kearly@facs.org.
Fellows honored for volunteerism

by Kathleen Casey, MD, FACS

The Governors’ Committee on Socioeconomic Issues is pleased to announce the recipients of the 2011 American College of Surgeons (ACS)/Pfizer, Inc Surgical Humanitarian Award and Surgical Volunteerism Award. As in previous years, the committee received a large number of nominations of exceptional nominees, reflecting the substantial commitment of the Fellows of the College to the care of the underserved.

Louis L. Carter, Jr., MD, FACS, of Chattanooga, TN, has been selected to receive the 2011 ACS/Pfizer, Inc Surgical Humanitarian Award in recognition of a veritable lifetime of service to the underserved spanning nearly five decades, 20 countries, and 74 mission trips.

Dr. Carter grew up in Memphis, TN, where both his father and grandfather were physicians; his father was an ACS Fellow. From an early age, his parents introduced him to missionaries from around the world, and at age 16, he felt a strong sense that God was directing him to full-time missionary service.

After completing his undergraduate education at Wheaton (IL) College, Dr. Carter graduated Alpha Omega Alpha from the University of Tennessee College of Medicine in 1964. Prior to starting his internship and general surgery residency at Parkland Hospital and the University of Texas Southwestern Medical School in Dallas, TX, he and his bride, Anne, spent five months at a mission hospital in Tanzania. Midway through his

Dr. Carter with burn patient Vivian in Kijabe, Kenya, after multiple reconstructive procedures, and (inset) Vivian before surgery.

Dr. Tefera teaching residents at the emergency medicine training center at Addis Ababa University, and (inset) at St. Paul’s Hospital in Addis Ababa.
RESIDENCY, Dr. Carter served two years in the U.S. Air Force, including a one-year tour in Vietnam. With his wife and two children, he returned to Africa in 1974 as a board-certified general surgeon and worked at the Egbe Hospital in Nigeria for the next seven years as a full-time medical missionary. In the early 1980s, seeking additional skills to address the reconstructive surgery needs he encountered, Dr. Carter returned to the University of Tennessee in Memphis to complete a plastic surgery residency. He returned to missionary service in Nigeria from 1985 to 1987, as a double-boarded general and plastic surgeon at Evangel Hospital in the city of Jos.

In 1987, Dr. Carter joined the Plastic and Hand Surgery Groups (now Hayes Hand Center) in Chattanooga, TN, and was named assistant clinical professor of plastic and orthopaedic (hand) surgery at the University of Tennessee, Chattanooga. He went on to receive additional certification in surgery of the hand from the American Board of Surgery in 1989.

Frequent visits to remote mission hospitals in Africa and other underserved regions became a regular part of his practice through 1995. In 1996, Dr. Carter returned to full-time medical missionary service with Serving In Mission U.S.A., as the sole American full-time missionary plastic and hand surgeon.

On an average two-month visit to an underserved hospital, he and his wife focus on teaching local national and missionary doctors basic techniques in plastic and hand surgery. They refer to this work as “home schooling for national and missionary doctors” or “on-site subspecialty training in plastic and hand surgery.” Dr. and Mrs. Carter incorporate repeat visits to teach additional techniques and incrementally raise the skill levels of local providers, and to provide donations of needed books, equipment, and supplies. Dr. Carter has left a legacy of surgeons, nurses, and other medical professionals who are equipped with the knowledge and skills to care for hand injuries, burn contractures, cleft lips and palates, and so on.

Dr. Carter’s commitment to humanitarian outreach and excellence in teaching has been widely recognized. At the University of Tennessee, he was frequently recognized as “Teacher of the Year” in plastic surgery. He’s received the Distinguished Alumnus award from Wheaton College, and the Excellence in Humanitarian Service Award from the Plastic Surgery Educational Foundation, among others.

For a career dedicated to teaching surgical skills and empowering local physicians to provide quality surgical care for the underserved around the world, Dr. Carter will receive this year’s Surgical Humanitarian Award.

Girma Tefera, MD, FACS, of the University of Wisconsin School of Medicine and Public Health, Madison, WI, will be awarded the Surgical Volunteerism Award for international outreach in recognition of his significant contributions toward improving the delivery of surgical care in Ethiopia. A native of Ethiopia, Dr. Tefera has dedicated himself to building robust and strategic partnerships that strengthen the way in which health care is delivered in his homeland.

Dr. Tefera grew up in Chencha, a small town in the south of Ethiopia, as one of seven children. Despite his father’s passing when he was six years old, his mother was committed to all of her children receiving an education. Dr. Tefera left home at the age of 12 to enroll in high school, which was located 35 km from Chencha. Highly motivated to make a lasting contribution to his country, he later traveled to Italy to pursue his chosen field of medicine at the University of Pisa. Throughout his time in medical school, Dr. Tefera engaged in volunteer activities in the local community and at local hospitals to help those in need.

Following medical school, Dr. Tefera returned to Ethiopia to serve five years in the military as a physician. On completion of this service, he traveled to Dresden, Germany, for postgraduate training in general surgery. Originally, Dr. Tefera had intended to return to Ethiopia to practice surgery at the completion of his residency, but found the political climate difficult because of a regime change and his prior military service. Unable to find a suitable position in a neighboring African country or an opportunity to work with a European aid organization serving in Africa, he ultimately decided to immigrate to the U.S., even though this decision meant Dr. Tefera had to repeat his postgraduate training.

In the U.S., he was accepted into a surgery internship at District of Columbia General Hospital in Washington, DC, followed by general surgery residency at Howard University. Following this experience, Dr. Tefera pursued a vascular surgery fellowship at the University of Wisconsin, Madison. Throughout his training he was frequently recognized for clinical excellence and outstanding academic performance. Dr. Tefera
has continued to be a member of the University of Wisconsin faculty since he completed his training. He also participates in community outreach at several clinics in neighboring areas in Wisconsin.

For several years, Dr. T efera has returned to Ethiopia semi-annually, gradually increasing both the impact and scale of his work there. In the early years, he would volunteer his general and vascular surgical skills to help meet immediate patient needs resulting from a shortage of trained physicians in the area. Over time, as relationships were solidified, Dr. T efera recruited U.S. colleagues to join him in these efforts, organizing surgical teams to visit Addis Ababa University with a focus on educational and training support for their Ethiopian colleagues and providing supplies and equipment. These efforts evolved into a professional bilateral exchange, as fundraising was effective in supporting the travel of Ethiopian surgeons to Wisconsin for training in trauma management, surgical oncology, and laparoscopic surgery.

Over the past four years, Dr. T efera's efforts have continued to evolve as additional stakeholders and funding have been identified that will promote significant investment in the long-term health care needs of Ethiopia, including workforce expansion and an academic partnership between the University of Wisconsin and Addis Ababa University. His work has been broadly based to strategically build the necessary infrastructure and train a workforce appropriate to local needs. Dr. T efera's leadership has been recognized with support from the American International Health Alliance and the U.S. Department of Health and Human Services through a Medical Education Partnership Initiative grant. This partnership has led to the establishment of the first emergency medicine residency program in Ethiopia, providing the foundation for future generations of emergency medical professionals. He has begun the process of implementing collaborative efforts in intensive care, pediatrics, and medicine programs, as well as upgrades to the operating rooms and surgical services.

For his strategic vision, his ability to foster meaningful and effective partnerships, and his dedication to strengthening the future of medical care for Ethiopians, Dr. T efera will be recognized with this year's Surgical Volunteerism Award for international outreach.

The extraordinary contributions made by Dr. Carter and Dr. T efera will be formally recognized at the annual Board of Governors' dinner on Tuesday, October 25, during the Clinical Congress in San Francisco, CA. Congress attendees are invited to hear them speak about their inspiration and work at the panel session on volunteerism (PS109), Monday, October 24, 9:45–11:15 am, and to meet them and others dedicated to surgical volunteerism in all its many forms at a volunteer networking reception later that evening.

Details on these events will be available on the Operation Giving Back website at http://www.operationgivingback.facs.org.

**Update your member profile on streamlined Find a Surgeon site or at Clinical Congress**

The Find a Surgeon site on the website of the American College of Surgeons, which holds profiles of ACS members, has been redesigned and streamlined, providing members with faster and easier navigation. The website allows each member to identify his or her specialty areas and the disorders/procedures they treat regularly.

Visit [http://efacs.org/myprofile](http://efacs.org/myprofile) to update your profile information. Go to “Update my Profile” on the left side under Quick Links. Your Member ID is your membership number, and your last name is your password.

Visit [http://www.facs.org/patient/education/](http://www.facs.org/patient/education/) to view the Find a Surgeon site. Member profiles are searched an average of 100,000 times monthly, and the search engine appears first in “Find a Surgeon” searches on Google, Yahoo, and Bing.

Members can also update their profile information during the 2011 Clinical Congress, in San Francisco, CA, October 23–27, where a professional photographer will take member profile pictures and technical staff will be on hand to help members update their profiles. All members who update their profiles at the Clinical Congress will receive a free 1 GB thumb drive, to which their photo will be added.

**Dr. Casey** is Director of Operation Giving Back, Chicago, IL.
ACS and Maryland health care leaders highlight quality improvement program

The American College of Surgeons (ACS) continued its surgical health care quality national tour on August 30 with its second community forum sponsored by Johns Hopkins department of surgery and Johns Hopkins Armstrong Institute for Patient Safety and Quality at the Johns Hopkins Medical Campus in Baltimore, MD.

U.S. Sen. Ben Cardin (D-MD) served as keynote speaker at the event, which was attended by 80 Maryland health care leaders.

The community forum is part of the ACS Inspiring Quality initiative to raise awareness of proven models of quality improvement, coordinated care, and disease management that can help improve the quality and value of health care.

Hosted by Julie Freischlag, MD, FACS, The William Stewart Halsted Professor and Chair at Johns Hopkins University School of Medicine’s Department of Surgery and a member of the ACS Board of Regents, the forum featured panelists who are surgical and nursing leaders from The Johns Hopkins Hospital, Johns Hopkins University School of Medicine, Sinai Hospital of Baltimore, and the University of Maryland School of Medicine. These individuals came together to participate in a discussion on quality improvement programs that reduce complications, improve outcomes, and cut health care costs.

To encourage hospitals to collaborate and share best practices in quality improvement, the ACS will host a series of community forums across the nation with health care leaders representing academic medical centers and medical schools, hospitals, and not-for-profit health care associations. Other potential ACS Inspiring Quality locations will include California, Massachusetts, Minnesota, Pennsylvania, Texas, Virginia, and the state of Washington.
Patricia L. Turner, MD, FACS, named Director of ACS Division of Member Services

Patricia L. Turner, MD, FACS, from the division of general surgery, University of Maryland School of Medicine, Baltimore, has been named Director of the American College of Surgeons (ACS) Division of Member Services. Dr. Turner is succeeding Paul E. Collicott, MD, FACS, who retired in May. She will officially assume the position on December 1.

“We are delighted to have someone of Patricia’s caliber join us in this important role,” said David B. Hoyt, MD, FACS, ACS Executive Director. “Her professional accomplishments to date are impressive, as is her service to the College. She understands our members, she understands the College, and she is the ideal person to take the Division of Member Services to the next level.”

Dr. Turner received an undergraduate degree from the University of Pennsylvania, Philadelphia, and a medical degree from Bowman Gray School of Medicine, Winston-Salem, NC. She was an intern and resident at Howard University Hospital, Washington, DC; a senior staff fellow at the National Institutes of Health (NIH) National Heart, Lung, & Blood Institute, Laboratory of Kidney and Electrolyte Metabolism, Bethesda, MD; and a clinical fellow, minimally invasive and laparoscopic surgery, Mount Sinai Medical Center, Weill Cornell University of Medicine and Columbia University, New York, NY.

Dr. Turner is associate professor of surgery, University of Maryland School of Medicine. She is the ACS National Surgical Quality Improvement Program® Surgeon Champion and has served as medical director of the surgical acute care unit since 2004, and chairs the University of Maryland Medical Center Executive Infection Control Committee. Previously, she served as an instructor at Weill Cornell University School of Medicine.

Dr. Turner joined the College in 1996 and has held a number of volunteer positions, including membership on the Committee on Informatics, Patient Education Committee, Health Policy and Advocacy Group, and the ACS Task Force on Duty Hour Standards. In addition, she serves as an ACS Delegate to the American Medical Association and as Liaison to the College’s Young Fellows Association.

Dr. Turner was a member of the Surgery Residency Review Committee, and currently serves on the Accreditation Council for Graduate Medical Education Surgery Appeals Panel. She is an American Board of Surgery (ABS) qualifying examination consultant, and has served as an associate examiner for the ABS certifying examination.

“I am very excited about this wonderful opportunity to contribute to the American College of Surgeons and grow with the organization,” Dr. Turner said. “I count many mentors among the leadership of the College, and I have great respect for its Fellows and staff. I look forward to traveling to the chapters to meet with individual surgeons to seek their input as to how we can provide the most complete membership services possible.”

Dr. Turner is actively involved in a number of other medical professional societies, including the Association of Women Surgeons, the Society of American Gastrointestinal Endoscopic Surgeons, the National Medical Association, the Association for Academic Surgery, and the Association of Program Directors in Surgery. She is a member of the Southeastern Surgical Congress and the Society of Black Academic Surgeons, and serves on the executive committees of both organizations.

Dr. Turner is the recipient of numerous honors and awards, including the NIH Fellows Award for Research Excellence; the Association of Women Surgeons Outstanding Woman Resident Award; the Claude H. Organ, MD, FACS, Traveling Fellowship; and the State of Maryland’s Henry Welcome Award. She served on the editorial board of *Surgery News* from 2005 to 2009, and has been published in a number of peer-reviewed journals.
In 2009, the Bulletin published an interview with Timothy J. Eberlein, MD, FACS, Editor-in-Chief of the Journal of the American College of Surgeon (JACS). The article highlighted the fact that the Special Libraries Association (SLA) had just identified JACS as one of the past century’s 100 most influential journals in biology and medicine. During the interview, Dr. Eberlein said that one of his main goals for the coming years was to improve the journal’s impact factor. Based upon data released this summer, it is more than safe to say that Dr. Eberlein, the JACS’ staff, and the publication’s editorial board are succeeding in fulfilling that objective.

Impact factor

The term “impact factor” refers to the average number of citations per article published in a scientific or social science journal during the two preceding years. It is frequently used as an indicator of a journal’s relative prestige within a field. That is to say, journals with high impact factors are often considered to be more important and influential than those publications with lower numbers. Impact factors are calculated annually for those journals that are indexed in the Journal Citation Reports, pub-

lished by Thomson Reuters.

JACS’ impact factor has more than doubled in seven years (see Figure 1, page 35). In 2003 it had an impact factor of 2.071, but in 2010 its impact factor climbed to 4.241. In other words, papers published in JACS in 2001–2002 received approximately two citations on average, whereas in 2008–2009 papers were typically cited more than four times. Thus, in 2010, JACS ranked seventh among all surgical journals in comparison with the number of citations in other publications (see Figure 2, page 35). In 2009, JACS placed 11th, and in 2003, it was 25th.

Reasons for the rise

Under Dr. Eberlein’s leadership, the journal has undergone a series of changes that he maintains have led to the publication’s heightened prestige. First, he believes JACS is attracting a larger pool of authors who are doing groundbreaking work or who have otherwise garnered respect in the medical and surgical communities. JACS has attracted some of these authors through its collaboration with surgical societies.

“A number of years ago, we made an arrangement with the Southern Surgical Association (SSA) and began publishing all of the papers presented at its meeting. Of all the changes we have made, this one was probably the most significant,” he said, because of the rigorous standards for acceptance of papers for presentation at that conference. The arrangement with the SSA led the Journal to publish the best papers of the Western Surgical Society meeting. This has been a possible impetus for other authors of high-impact papers to submit their work to JACS.

In addition, “We got rid of any copy that was not peer-reviewed,” Dr. Eberlein said. Peer reviewers are more likely to be enthusiastic about submissions that provide innovative insights and information. This approach results in the publication of more high-impact articles.

To speed up the sometimes time-consuming peer review process, JACS was one of the first journals to move to an entirely electronic submission system. From submission until first decision, the Journal has averaged two to three weeks’ turnaround. Authors appreciate this expedited process, so that they can get their studies published in a timely manner. Dr. Eberlein credits the two Managing Editors of JACS, Anne Magrath and Anne Wolfe, and the publisher, Elsevier, with making these enhancements work.

Moreover, the Journal also has been able to publish leading-edge articles on quality improvement initiatives that have been developed through use of ACS programs, such as the ACS National Surgical Quality Improvement Program, Dr. Eberlein noted. These articles are of considerable relevance at a time when the nation’s health care system is being reformed.

JACS also has been getting greater exposure in the lay press, which means more opportunities for authors to share their findings with the public. Articles centered on studies published in the Journal have appeared in the Wall Street Journal, The New York Times, The Washington Post, Businessweek, and so on. “This kind of exposure is pretty unique for a surgical journal,” Dr. Eberlein said. He credits the Journal’s greater public visibility to the ACS Division of Integrated Communication’s relationship with Weber Shandwick, a communications management firm.

Moving ahead

As part of the ongoing evolution of the Journal, efforts presently are under way to develop an electronic version of JACS for smartphones, tablets, and so on, and to use social media to reach an even broader audience and group of potential authors, Dr. Eberlein added. “The goal when I took over the editorship was to make JACS the best surgical journal in the world, and that’s still the goal. We’re not there yet, but we’re getting closer,” Dr. Eberlein said.

Ms. Schneidman is Manager of Special Projects in the ACS Division of Integrated Communications, Chicago, IL.
Dr. Eason

James Eason, MD, FACS, has been appointed to serve on the Advisory Committee on Organ Transplantation (ACOT) in the Health Resources and Services Administration (HRSA) by Kathleen Sebelius, U.S. Secretary of Health and Human Services (HHS), for a term that began in June 2011 and ends in January 2015.

Dr. Eason is the program director of the Methodist University Hospital Transplant Institute (MUHTI), in partnership with the University of Tennessee Health Science Center (UTHSC). He is a professor at UTHSC and is a member of the University of Tennessee Medical Group.

“I am deeply honored to be asked to serve by Secretary Sebelius on this national advisory committee with admired colleagues,” said Dr. Eason. “This will allow me to help shape national policies and agendas concerning organ donation and transplantation to better serve patients all across the country.”

The HRSA provides staff and logistics support to the ACOT, which makes recommendations to the HHS Secretary on issues concerning organ donation and transplantation.

Congressman Steve Cohen (D-Memphis), said, “Dr. James Eason is one of the most renowned transplant specialists in the world. HHS Secretary Kathleen Sebelius made a great choice in selecting Dr. Eason, who is one of the most caring, capable doctors I’ve ever met. “Since moving to Memphis to direct the Methodist University Hospital Transplant Institute, Dr. Eason has proven to be a passionate patient advocate who has fought for fair access to organs for the most vulnerable of Memphians and West Tennesseans," continued Congressman Cohen.

As program director of the MUHTI since 2006, Dr. Eason has led the program to becoming a nationally recognized center of excellence for liver and kidney transplantations based on volume and outcomes. Due to Dr. Eason’s research, the program’s physicians have the most experience in the nation in steroid-free liver transplantation. The MUHTI is one of the top 12 transplant programs in the country and the seventh largest liver program in the nation. The transplant one-year graft survival rate is among the highest in the nation at 87.57 percent. In July, the program became the first in Tennessee to perform a paired kidney donation and transplant via a partnership with the National Kidney Registry.

Dr. Eason served as a clinical fellow in surgery at Harvard Medical School and as a clinical and research fellow in transplant surgery at Massachusetts General Hospital.
Surgeons at work in the AMA House of Delegates

by John H. Armstrong, MD, FACS; and Jon H. Sutton

The annual meeting of the American Medical Association (AMA) House of Delegates (HOD) convened June 18–22 in Chicago, IL. In keeping with the workload at a typical annual meeting, delegates considered more than 225 items of business through eight reference committee hearings and debate on the floor of the HOD.

New AMA EVP
The ACS delegation to the HOD witnessed a changing of the guard at the AMA with the executive vice-president (EVP) succession from Michael Maves, MD, FACS, to James Madara, MD, a pathologist and former dean of the University of Chicago School of Medicine, Chicago, IL. Peter Carmel, MD, FACS, a neurosurgeon from Newark, NJ, was inaugurated as AMA president.

Election results
Patricia Turner, MD, FACS, from Baltimore, MD, was elected to the Council on Medical Education for a seat that opened as a result of the election of Susan Bailey, MD, Ft. Worth, TX, to the position of vice-speaker of the HOD. Dr. Turner’s election is a tribute to her quality as a candidate, the aggressive short-term campaigning of the ACS delegation, and the standing of the ACS delegation in the HOD.

Candidates endorsed by the College also fared well in the elections, with Jim Hinsdale, MD, FACS, of San Jose, CA, winning a seat on the Council on Medical Service (and announcing his gratitude for the College endorsement on the floor of the House); Russell Kridel, MD, FACS (Houston, TX), winning re-election to the Council on Science and Public Health; Jeff Gold, MD, FACS (Toledo, OH), winning re-election to the Council on Medical Education; and Andy Gurman, MD, FACS (Altoona, PA), winning election by acclamation to speaker of the HOD. Monica Wehby, MD, a neurosurgeon from Portland, OR, was elected to the Board of Trustees. Jeremy Lazarus, MD, a psychiatrist from Denver, CO, and HOD Speaker at this meeting, was elected unanimously to the office of president-elect.

Working in surgery
ACS delegates remained very engaged in activities surrounding the HOD meeting. Richard Reiling, MD, FACS, continued his efforts, representing the College on the AMA Council on Medical Education. Dr. Turner completed her term as speaker of the Young Physicians Section Assembly. Chad Rubin, MD, FACS, served with distinction on Reference Committee A, which was the most arduous of the reference committee assignments at this meeting. Both Dr. Rubin and Dr. John H. Armstrong (a co-author of this article) continue to serve on the Executive Committee of the Surgical Caucus of the AMA. For this meeting, Tim Kresowik, MD, FACS, an alternate delegate from the Society of Vascular Surgeons, substituted as an ACS delegate to fill the College’s contingent—reflecting the inclusive nature of the delegation within the HOD.

In addition, Dr. Armstrong represented the College on an HOD panel that discussed alternative payment mechanisms. His presentation focused on shaping the future of health care delivery by defining and measuring quality. The ACS Inspiring Quality video presentation was exceptionally well received and applauded by many physicians in the audience. Dr. Armstrong was also appointed for the next three years to the HOD Compensation Committee of the Officers and Trustees.

Surgical Caucus
The Surgical Caucus of the AMA education session, titled Physicians Under Fire: Surgery and Medicine in a Combat Zone, was filled to capacity. The session featured an overview of combat casualty care and a Skype phone presentation by MAJ (P) Raj Ambay, MD, FACS, MC, U.S. Army Reserve, a plastic surgeon who was en route home following a tour in Iraq. Two other speakers filled out the panel: CAPT Darin Via, MD, an anesthesiologist from Virginia Beach, VA, executive officer of the Naval Medical Center Portsmouth, and former commanding officer
of the NATO Hospital in Kandahar; and MAJ Andrew Muck, MD, an emergency medicine physician from Texas (Lackland AFB), assistant professor of military and emergency medicine in the Uniformed Services University of the Health Sciences, and assistant program director for emergency medicine at the San Antonio Uniformed Service Health Education Consortium.

The Surgical Caucus meets at each of the two HOD meetings each year. In addition to sponsoring an education session, meeting attendees discuss the development of positions that would best represent surgeons and affiliated specialties participating in the caucus. The caucus is managed by the College, and supported through voluntary annual dues of $35 per year. The caucus’ Web page is located at http://www.facs.org/ahp/activity/caucus.html.

**Issue highlights**

The most significant issues addressed at the annual meeting, from a surgical perspective, centered on the following:

- **Council on Ethical and Judicial Affairs Report 1, Financial Relationships with Industry in Continuing Medical Education (CME).** This report was recommended for referral back to the council by the Reference Committee. The House, by a 230–247 vote, defeated referral, and the report was subsequently adopted. The report’s negative tone, which challenges the ethics of commercial support for CME, was the point of contention. The ACS agreed with comments from the Council of Medical Specialty Societies, which stated the view that while commercial support is ethical, commercial influence is not—and the Council on Ethical and Judicial Affairs acknowledged this before the HOD. It is important to note that the report’s recommendations, which are the only enduring portion of this document, provide an acceptable framework for ethical commercial support for CME. For more information, go to http://www.ama-assn.org/assets/meeting/2011ala11-ceja-opinions.pdf.

- **Council on Medical Service Report 9, Covering the Uninsured and Individual Responsibility.** The dominant issue at the HOD meeting was the AMA’s support for an individual mandate using tax credit policy; the AMA HOD reaffirmed this policy, 60 percent to 40 percent, through this report, which was amended to read:

  The AMA is committed to achieving the enactment of health system reforms that include health insurance coverage for all Americans, and insurance market reforms that expand choice of affordable coverage, and are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

Several delegations offered amendments to change AMA policy to make an individual mandate a state-by-state issue (rather than a national issue). These efforts were defeated.

- **Resolution 201, Government Interference in Firearm Counseling.** This resolution, from the American Academy of Pediatrics, was adopted in response to recent efforts by the Florida legislature to prevent physicians from discussing the presence and safety of firearms in the home. It emphasizes that the AMA will vigorously and actively defend the physician-patient-family relationship, and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients. This resolution includes support of litigation to block implementation of state and/or federal laws that restrict the privacy of the physician-patient-family relationships and/or that violate the First Amendment right of physicians in their practices.

- **Council on Medical Education Report 8, Residents and Fellows’ Bill of Rights.** This report was adopted at the meeting, and included the following mandates:
  1. Continue to advocate for
Members of the American College of Surgeons are invited to honor the perioperative professional on their surgical team during Perioperative Nurse Week. November 7–13 is a week set aside to recognize and honor perioperative nurses for their important role and commitment to safe patient care.

Surgeons can take advantage of the opportunity to honor perioperative colleagues by making a donation to the Association of periOperative Registered Nurses (AORN) Foundation in their colleague’s name. An acknowledgement note of the donor’s contribution will be sent to each colleague honored.

The philanthropic arm of AORN, the AORN Foundation advances surgical patient safety by supporting nurses through education and research. Honorary gifts can be made at http://www.aorn.org/aornfoundation/, or by calling 800-755-2676, ext. 230.

Dr. Armstrong is associate professor of surgery, University of South Florida (USF), and medical director, Center for Advanced Medical Learning and Simulation, USF Health, Tampa, FL. He is Chair of the ACS Delegation to the AMA House of Delegates.

Mr. Sutton is Manager of State Affairs, Division of Advocacy and Health Policy, Chicago, IL.

Perioperative Nurse Week honors commitment to patient care

Members of the American College of Surgeons are invited to honor the perioperative professional on their surgical team during Perioperative Nurse Week. November 7–13 is a week set aside to recognize and honor perioperative nurses for their important role and commitment to safe patient care.
In 2004, The Joint Commission launched a renewed version of its accreditation processes to improve and assist the health care industry in providing better, safer care in response to the evolving health care environment. As a result, physicians and health care providers have become more active participants in the accreditation and survey operations, have gained increased access to health care safety and quality resources, and have engaged in a stronger dialogue with surveyors throughout The Joint Commission survey experience.

The Joint Commission Board of Commissioners has made enhancing physician engagement in accreditation one of its top strategic priorities through successful collaboration with physicians and the American College of Surgeons. There are many ways that The Joint Commission engages physicians, such as through the review of standards, the on-site survey process, National Patient Safety Goals, health care summits, and selection of Sentinel Event Alert topics.

The Physician Engagement Advisory Group, established in 2005, is another important channel through which valuable input from surgeons and physicians is received. This group advises The Joint Commission on expanding physician participation in the accreditation process and broadening their engagement in all quality of care and patient safety initiatives. Members of the Physician Engagement Advisory Group include physician quality directors and educators, chief medical officers, private practice physicians, and other medical leaders from urban and rural areas.

Physicians also influence the standards development process by serving on expert panels, providing expert opinions, and participating in electronic and written field reviews for The Joint Commission. The latest tool physicians can use to provide input is WikiHealthCare—a collaborative approach to the development of accreditation and certification standards. This approach encourages a forum for discussion by all users interested in improving health care quality. The Joint Commission standards are created to address challenging quality and safety problems with the broad input from those on the “sharp end” of health care. Participation from medical staff on the front lines of health care ensures that standards are contemporary, practical, and expert-based.

Physician participation in the on-site survey is also important to The Joint Commission survey process. These data-driven, patient-centered surveys are unannounced and objective in an effort to effectively evaluate the quality of the care that patients receive at individual facilities. The Joint Commission also uses an “individual tracer” methodology as part of the on-site survey process. Surveyors trace a patient’s care experiences through the health care provider’s systems to observe firsthand how care and services are administered. This process means that surveyors spend a majority of their time talking directly to caregivers, including physicians, while observing patient care.

Over the course of the survey, and through the tracer methodology, The Joint Commission evaluates whether an organization’s written processes and procedures are being carried out thoroughly to benefit the quality of care and safety of its patients. This evaluation process means that surveyors and individual physicians interact in both formal and informal settings to discuss, and better understand, how medical care is being provided and how it might be improved. However, surveyors are not seeking to evaluate clinical decisions, only how an organization’s systems create the foundation for safe and effective treatment.

In the spirit of The Joint Commission vision statement, “all people always experience the safest, highest quality, best-value health care across all set-
tions,” a large amount of work is also being done to fix some of the major barriers impeding a significant reduction in the rate of serious adverse events. These barriers include the absence of a strong leadership commitment to improvement, limited capacity to execute Robust Process Improvement (RPI) methods, and the failure to adopt a safety culture. RPI and error reduction are essential to producing health care excellence on a consistent basis while moving away from a culture of blame.

Although capacity for such improvements in the delivery system is limited in some areas, The Joint Commission is leading the effort to facilitate more rapid, widespread development and adoption of proven solutions and training programs that address these patient safety challenges. Through its Center for Transforming Healthcare, The Joint Commission is making an investment in producing new knowledge and Targeted Solutions Tools to guide health care provider’s efforts to effectively address quality and patient safety problems such as hand hygiene compliance, hand-off communications, wrong site surgery, and surgical site infections.

For more information on The Joint Commission’s work to evaluate and inspire through accreditation, visit http://www.jointcommission.org/physicians_guide/.

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**American College of Surgeons Official Jewelry & Accessories**

- **Tie Tac/Lapel Pin**
  - #S1 Single Gold-Filled: $60
  - #S2 Solid 14K Gold: $375

- **Cuff Links**
  - #S3 Single Gold-Filled: $225
  - #S4 Solid 14K Gold: $975

- **Key (shown actual size of 3/4”)**
  - #S5 Single Gold-Filled: $85
  - #S6 Solid 14K Gold: $775

- **Miniature Key (NotShown)**
  - #S7 Single Gold-Filled: $60
  - #S8 Solid 14K Gold: $475

- **Charm (Not Shown)**
  - #S9 Single Gold-Filled: $75
  - #S10 Solid 14K Gold: $575

- **Miniature Charm**
  - #S11 Single Gold-Filled: $50
  - #S12 Solid 14K Gold: $375
  - #S13 Sterling Silver w/ 18” Sterling Silver Chain: $65

- **Ring**
  - #S14 14K Gold: $2350
  - #S14.1 Solid 10K Gold: $1750

- **Tie Bar**
  - #S15 Gold-Filled Emblem: $50

- **Necktie**
  - #S16A Dark Blue: $35
  - #S16B Light Blue: $35
  - #S17 Maroon: $35

- **Diploma Plaques**
  - #S18 Satin Gold Finish: $300
  - #S19 Satin Silver Finish: $300

- **Money Clip (Not Shown)**
  - #S20 Solid Walnut with Cross Gold-Filled Pen & Pencil/Gold-Filled emblem; name and year elected a Fellow engraved on gold polished plate: $275

- **Desk Set (Not Shown)**
  - #S27 Solid Walnut: $60

- **Wallace (Not Shown)**
  - #S28 Black cowhide: $75

- **Blazer Buttons (Not Shown)**
  - #S29 Gold Electroplated: $35

- **Diploma Plaques**
  - #S30 Hand embroidered: $35

- **Shipping/Handling/Insurance**
  - Domestic (48 contingent states): $15
  - Alaska, Hawaii, Puerto Rico: $30
  - Foreign: $40

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American College of Surgeons Professional Association (ACSPA)

As of May 19, 2011, the ACSPA-SurgeonsPAC (political action committee) has raised $260,619. A total of 23 percent of the U.S. Governors contributed, and 59 percent of the U.S. Officers and Regents contributed, as well. The ACSPA-SurgeonsPAC also contributed to 42 candidates, leadership PACs, and party committees. In addition, the ACSPA-SurgeonsPAC board has approved a new strategic plan for the 2011–2012 election cycle.

American College of Surgeons (ACS)

Board of Governors

The Executive Committee of the Board of Governors has engaged in several strategic conference calls, and the Board of Governors committee chairs participated in the calls as well. An overview of the committees’ activities, as well as suggestions to reorganize the committees, were discussed.

Council of Medical Specialty Societies (CMSS)

The Board of Regents approved a document entitled Code for Interactions with Companies, developed by the CMSS. The CMSS is a not-for-profit organization committed to education, professionalism, and quality of care. The CMSS board of directors charged a CMSS task force with developing and recommending a voluntary code of conduct for medical specialty societies to enhance professionalism and to disclose, manage, and resolve relationships with industry. The purpose of the code is to guide societies in the development of policies and procedures that safeguard the independence of their programs, policies, and advocacy positions.

Scope of Practice Partnership (SoPP)

The Regents approved renewal of ACS membership in the American Medical Association (AMA) SoPP. The SoPP was formed to focus the resources of organized medicine to oppose inappropriate legislative or regulatory expansion
of scope of practice by nonphysician health care professionals that may threaten the health and safety of patients.

**Stop Medical Taxes Coalition (SMTC)**

The Regents approved renewal of ACS membership in the SMTC. The SMTC is an advocacy group managed by the American Society of Plastic Surgeons (ASPS) to address primarily state-level efforts to impose cosmetic and other physician taxes. With state budget issues being a critical issue for most state legislatures in 2011, a cosmetic tax has been viewed as a potential revenue stream by a number of states. In light of current state legislative battles over imposition of cosmetic surgery taxes, the SMTC has ramped up its activity. The ASPS provides considerable staff time and internal support for the SMTC.

**Public profile**

Planning is ongoing for the stops on the Inspiring Quality tour. All activities and materials developed for this program are branded with the College’s name and seal, and carry the slogan and tagline: Inspiring Quality: Highest Standards, Better Outcomes. In addition to highlighting the College’s long tradition of developing and implementing programs focused on improving and safeguarding the quality of care provided to surgical patients, this effort is intended to engage leading health care stakeholders in a dialogue about clear, workable solutions to the challenge of improving patient outcomes while cutting the cost of care. The initiative is intended to demonstrate the relevance of the College’s quality programs to real outcomes improvement at a time when hospitals, health plans, policymakers, and other health care leaders are all searching for ways to implement the Affordable Care Act. Through the Inspiring Quality tour and other initiatives, the campaign provides useful information and delivers a call to action for opening doors to future partnerships in the public and private sectors (http://www.facs.org/quality/index.html). For more information on this initiative see Dr. Hoyt’s “Looking forward” column in the February 2011 issue of the Bulletin, as well as the cover story for the September 2011 issue and page 33 of this issue.

**Strategic Planning—Advisory Council for General Surgery**

The Board of Regents approved a proposal for a one-and-a-half to two-day strategic planning session to discuss how the ACS can best serve its general surgery community. The top three issues to be discussed at this session include the following:

- How can the ACS best serve its general surgery membership?
- How can the ACS attract all board-certified general surgeons in the U.S. to be members?
- Should the ACS work with and attempt to influence the American Board of Surgery, Residency Review Committee for Surgery, American Surgical Association, Association of Program Directors in Surgery, and others in developing solutions to the main problems facing the general surgery community in the U.S?

**Advocacy**

The Board of Regents approved recommendations that the ACS not participate in the Joint Surgical Advocacy Conference (JSAC) beginning in 2012 and that the ACS have its own Advocacy/Legislative Conference in 2012. In 2008, the ACS helped develop the JSAC. The intention was to merge all of the advocacy/legislative conferences that the surgical groups were hosting in Washington, DC, each year. The hope was to reduce costs and increase surgical strength on Capitol Hill. While many of the surgical groups chose to participate in this conference, several of the larger surgical groups continued to have their own conference while sending a very small number of representatives to the JSAC. The number of attendees began to drop in 2010.

**ACS Health Policy Research Institute (ACS HPRI)**

- 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 effects of potential policy scenarios. With this...
information, the ACS HPRI has provided a series of documents for distribution among members of Congress, the White House, the ACS, and other relevant stakeholders. Among these documents are seven fact sheets available in print and on the ACS HPRI portal page at http://efacs.org/portal/page/portal/ACS_Content. A total of 12 new fact sheets describing the surgical subspecialties are currently under development.

- **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. Efforts to provide access to surgeons have frequently involved nontraditional staffing arrangements for surgeon payment, staffing, and contractual employment obligations. One of these models involves the use of surgical hospitalists, who often provide emergency department call coverage to hospitals. Anecdotal evidence suggests that this model of employment is becoming more common as a strategy to recruit surgeons and maintain essential surgery call coverage. However, there is wide variation in the details of these arrangements and very little information regarding the impact of the surgical hospitalist model on the delivery and organization of surgical care in a hospital or community, or how such staffing models might succeed or fail in rural health care environments. Using a semi-structured case study approach, the ACS HPRI is examining this surgical hospitalist model in hospitals. The goal is to produce information that is useful to communities, especially rural communities, in addressing current or anticipated shortages in the surgical workforce.

- **Accountable care organizations (ACOs) and regionalization.** In March 2011, the Centers for Medicare & Medicaid Services proposed rules for the implementation of a shared savings program, and offered guidance on the design and operationalization of ACOs. The organization of trauma care in the U.S. has emerged as a result of strong surgical leadership, recognition of the importance of providing a continuum of care, and an emphasis on interprofessional collaboration. In May 2011, the ACS HPRI completed a white paper titled *Trauma Systems: A Model for Accountable Care Organizations.*

- **Educational program model for surgeon re-entry into the workforce.** It is becoming increasingly common for surgeons to leave clinical practice for some period during their career and then seek re-entry into the workforce. Currently, there is no standardized/certified program that ensures that surgeons who are attempting to re-enter practice can demonstrate surgical competence. There is also little structure provided to surgeons to help them overcome the barriers that make it difficult for them to attain required competencies. In addition to developing a model program that could be adopted by state medical boards, the ACS HPRI will draw on the unique data housed at the North Carolina Health Professions Data System to describe the demographic and practice characteristics of surgeons who leave and re-enter practice. These data will identify the age and points in the career trajectory that surgeons are most likely to leave or re-enter practice and will provide much-needed information about the length of these absences. This project is timely, as the AMA and multiple state medical boards are currently developing recommendations regarding physician re-entry to the workforce.

- **National Surgical Quality Improvement Program (NSQIP®)**

  - **Pilot programs.** A number of important additions and advances are currently being developed for ACS NSQIP. As these items are being developed, pilot studies are instituted to work out issues related to developing a new item. Three pilots that are currently ongoing include the pediatric pilot, the Florida Surgical Care Initiative pilot, and the rural hospital pilot.

  - **Global Surgical Quality Initiative Pilot.** Several international sites have expressed an interest in joining ACS NSQIP. Due to administrative challenges, international sites were previously not allowed to participate in the program unless they had English records, English-speaking staff, and the backing of a U.S.-based hospital. The ACS NSQIP is now in the process of developing a pilot program to see if the ACS NSQIP data can
be correctly gathered and used successfully within interested international sites. The ACS NSQIP is currently in the process of gathering information from international sites interested in joining the Global Surgical Quality Initiative pilot, and hopes to launch the initiative later this year.

- **Collaboratives.** Collaboratives allow participating sites to compare outcomes and share best practices in a cooperative, noncompetitive environment, and provide for data sharing opportunities beyond the scope of the standard ACS NSQIP participation. The British Columbia NSQIP (BC NSQIP) Collaborative is the first large international collaborative and is made up of hospitals belonging to Health Shared Services British Columbia. The BC NSQIP is funded by the British Columbia Patient Safety & Quality Council and could serve as a model for other Canadian and international groups. As 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.

- **ACS Bariatric Surgery Centers Network (BSCN).** ACS leadership, on behalf of the ACS BSCN, submitted a proposal to the U.S. Food and Drug Administration (FDA) for a contract for services to evaluate the safety and effectiveness of laparoscopic adjustable gastric banding (LAGB) and gastric bypass surgery. After review of the ACS plan and subsequent conversations, the FDA selected the ACS proposal for funding. The ACS provided the FDA with the study protocol for each analysis in the proposal. Final analysis of the data has since been completed and compiled into a final report. In summary, the findings concluded that, at a minimum, all bariatric surgical procedures included in the study have relatively low rates of serious adverse outcomes. Both before and after risk adjustment, LAGB procedures have a rate of adverse events significantly below that of other procedures. The final report was delivered to the FDA. The FDA responded that it would like to pursue additional analyses beyond the scope of the initial contract.

The 2011 ACS NSQIP National Conference took place at the Westin Copley Place in Boston, MA, July 24–26. For the first time this year, the conference highlighted a bariatric track for ACS BSCN participants in attendance, as well as NSQIP participants who were considering future accreditation through the BSCN.

**Trauma**

The Committee on Trauma (COT) and all of its subcommittees met during the annual meeting in March. An advocacy day was organized by the Washington Office, as well. Ongoing COT activities include the following:

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

Other initiatives include:

- Consultation/verification program for hospitals
- National Trauma Data Bank®
- Trauma Quality Improvement Program

**Education**

- **Special committee to support peak performance in surgery through strategies aimed at recognizing and mitigating the impact of fatigue.** Over the past several years, national concern regarding the negative consequences of sleep deprivation has resulted in new regulations and more stringent oversight. The new regulations for accreditation of residency programs include greater restrictions on resident duty hours, most notably in the first year of training. Concerns about the short- and long-term negative consequences of these restrictions on patient care and on the education and training of surgery residents are widespread. These restrictions have brought to light the need to compre-
hensively study this important issue as it relates to surgery, and to develop appropriate strategies to recognize and mitigate the impact of fatigue. The solutions will require thorough analyses of various factors as they relate to surgery, and will need to be based on principles of self-regulation and exemplary professionalism. During the last meeting of the Board of Regents, Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), presented the idea of appointing a special committee of experts that would be charged to address this complex issue and propose recommendations. During the next fiscal year, College leadership will work very closely with Dr. Pellegrini to support this important endeavor, which should be of great interest to the entire house of surgery.

- **Disclosure of errors.** The Greenwall Foundation recently supported a National Consensus Conference of experts from the U.S. and Canada to discuss pertinent issues relating to disclosure of errors of team members, and to design educational interventions to address the needs identified. This complex topic is an extension of the previous national efforts that have focused on disclosure of a physician’s errors within the context of promoting patient safety. The College has previously contributed to this important field. A DVD titled *Disclosing Surgical Errors: Vignettes for Discussion* was launched in 2005, and another DVD titled *Communicating with Patients about Surgical Errors and Adverse Outcomes* was made available in 2007. The latter program includes simulated scenarios, didactic content, and other resources, and offers the opportunity to earn 2.5 Category 1 continuing medical education (CME) credits. The involvement of the College in the Greenwall Foundation project is an extension of these efforts.

- **Clinical Congress, San Francisco, CA:** The 2011 Clinical Congress program is broad in scope and encompasses a wide range of important clinical and nonclinical topics in surgery and the related fields. These topics address new directions and advances in surgery, and also focus on national issues that continue to affect surgical practice. The program is composed of 21 tracks that include 11 named lectures, 106 panel presentations, 27 postgraduate didactic and skills-oriented courses, 109 scientific papers, 339 poster presentations, 377 presentations in the *Owen H. Wangensteen Surgical Forum* sessions, 23 video-based education sessions, and 48 Meet-the-Expert luncheons. In addition, 13 town hall meetings will be convened. A total of approximately 1,500 speakers and faculty will participate in the 2011 Clinical Congress program.

- **Surgical Education and Self-Assessment Program (SESAP™).** The new CME model for SESAP 14 has been well-received. The committees that are developing SESAP 15 have commenced their work on the new edition.

- **ACS Comprehensive General Surgery Review Course.** The course, launched in 2010, was very well-received. It includes a robust self-assessment model, with pre- and post-tests that participants are required to complete. The course offers the opportunity to earn 29 Category 1 CME credits, and an additional four credits are available for completing the optional online modules that are sent to participants following the course.

- **ACS Fundamentals of Surgery Curriculum (ACS FSC).** The course is a simulation-based interactive online program that focuses on cognitive skills and is primarily directed at addressing the educational needs of surgery residents in the early years of training. Plans are also under way to offer selected ACS FSC scenarios to practicing surgeons.

- **Webcasts:** Individuals renewing their College membership in 2011 were offered the opportunity to purchase five webcasts, at a discounted rate, from the webcast library of 45 sessions from previous Clinical Congress meetings. A total of 295 members took advantage of the offer.

- **Preventing Errors and Near Misses in Surgery: Strategies for Individuals and Teams.** This program is a newly released educational tool available on DVD that focuses on the most common types of human factor errors made by individuals and teams. These include errors resulting from judgment, from inattention to detail, and from failure to understand the problem. This program is designed to facilitate better comprehension of the most common types of human factor errors,
why they occur, and the contexts in which they occur. Realistic patient scenarios are used to depict situations that are experienced frequently in everyday surgical practice. This program offers the physician the opportunity to earn 3 Category 1 CME credits.

- **Case Studies in Ethics.** A newly released CD-ROM entitled *Case Studies in Ethics* highlights a number of complex ethical dilemmas in clinical surgery. The program focuses on difficult choices and responsibilities in surgery relative to fatigue, age, anger, and disclosure. Each case is debated by two surgeons who take opposing views, along with a panel of experts who discuss additional ethical, legal, and other considerations. Interactive questions are interspersed throughout the program to help provoke analytical thinking and critical decision making. The program offers the opportunity to earn four Category 1 CME credits.

- **Personal finance programs:** Educational programs on practice management and financial management for residents and young surgeons have been developed to meet the needs of these groups. The programs, which cover practical information and have been well-received by users, cover key topics and are designed to support practice-related activities. These programs are currently available on CD-ROM, and efforts are under way to convert the new editions of the programs to an online format.

- **Annual Rural Surgery Symposium.** This conference was coupled with the offering of a new skills course titled *Patient Safety and Quality in Rural Surgery: Advanced Skills Training for the Rural Surgeon.* This course was offered, for the first time, in May. Both the symposium and the skills course appeared to be well-received by attendees. The final evaluations are not yet available, but the verbal feedback was very positive.

- The College provides Category 1 CME credits for educational programs. The rigorous and evolving standards of the Accreditation Council for Continuing Medical Education must be met in order for the College to continue to provide CME credits. In 2010, the College provided more than 34,000 hours of instruction for more than 68,000 physicians. The CME accreditation program also offers other surgical organizations the opportunity to provide Category 1 CME credits in collaboration with the College through the CME Joint Sponsorship Program. This program has shown substantial growth during recent years, and includes many prestigious surgical organizations.

*Journal of the American College of Surgeons (JACS)*

From January 1 to April 30, a total of 27,999 *JACS* CME credits were earned by 1,764 subscribers, averaging almost 16 credits per subscriber (15.87).

The Southern Surgical Association papers were published in the April issue of *JACS.* Selected papers from the Western Surgical Association were published in the July *Journal.* *JACS* published 22 papers from the Western Surgical Association meeting.

*Operation Giving Back (OGB)*

- **Disaster response—multi-specialty expansion teams.** In June 2011, in conjunction with the Assistant Secretary of Preparedness and Response (ASPR) in the Office of Preparedness and Emergency Operations (OPEO) of the U.S. Department of Health and Human Services (HHS), the ACS co-sponsored a meeting of medical specialty societies involved in traumatic disaster response. OGB worked closely with Bruce Browner, MD, FACS, in the planning of this event.

Recent national and international events such as Hurricane Katrina in 2005, the 2010 Haitian earthquake, and the 2011 Japanese earthquake and tsunami crisis bring stark attention to the need for a formalized mechanism to augment existing response teams in a timely and systematic fashion. Effective preparedness includes the ability to identify proper specialists and provide a safe environment for both patients and responders.

For several years, the ACS has worked with the HHS, the ASPR, and the OPEO to increase the engagement of trauma-related professional associations in an effort to enhance medical disaster response to major natural, man-made, and terrorist events that result in massive trauma. Government and professional association partici-
pants worked together on these critical issues and the important work done during this effort has continued to inform ongoing collaboration.

- **Disaster response—2011 Japanese tsunami.** Beginning on Friday, March 11, the day of the 8.9 magnitude earthquake and subsequent devastating 50-foot tsunami that struck the northeastern coastal region of the Japanese island of Honshu, standard situational assessments, networking procedures, and preparedness efforts were undertaken by OGB and continued for several weeks. Frequent updates on the evolving situation and the potential for volunteer disaster responders were communicated via dedicated Web pages linked to the OGB home page. Due to the nature of the disaster, the internal resources, and level of preparedness of the Japanese government, ultimately no international surgical support was requested by the Japanese government.

- **Medical student and resident issues.** OGB continues to receive multiple requests each month for support and guidance from medical students and surgical residents interested in surgery and global health, issues of health equity and surgery in the U.S., and research related to both. Three research projects and related publications are currently under way.

- **OGB website operations.** Since the last report, 13,000 unique visitors conducted approximately 38,000 page views of the OGB website (http://www.operationgivingback.facs.org). The number of surgeons who have completed profiles in “My Giving Back” has increased to more than 1,700.

**American College of Surgeons Foundation**

The Foundation’s cumulative records show that more than 11,000 Fellows made at least one gift to the College. These records also reveal the following:

- 95 percent of the Foundation Board members are Fellows Leadership Society (FLS) members
- 71 percent of the ACS Officers and Regents are FLS members
- 7 percent of the Board of Governors are FLS members

**HealtheCareers (Job Bank)**

As of May 11, there were 480 active jobs listed on the site with 330 posted résumés. This is a valuable service for all members of the College (and is free for Resident Members).

**Resident and Associate Society (RAS)**

The RAS continues to execute new and innovative ideas. New projects include the following:

- Completed the first exchange program with the Royal College of Surgeons in Ireland.
- Distributed written responsibilities for program liaisons.
- Established new system of recruiting program liaisons to include one senior and one junior representative.
- Developed a resident needs assessment tool.
- Submitted a program director survey to improve recruitment.
- Created a reward program for highest membership percentages at individual programs.
- Evaluated 16 essays for the Caring for the Dying Patient competition sponsored by the Communications Subcommittee. Ten of the essays will be published in the November 2011 issue of the Bulletin.

The Issues Subcommittee received eight essays for their debate topic, “What is the future of surgery—autonomous professionals or stuck as employees?”

**Young Fellows Association (YFA)**

The YFA continues to meet regularly via conference calls. In addition, the YFA Governing Council held its annual meeting in March in conjunction with the 2011 Leadership Conference for Chapter Leaders and Young Fellows. Based on the participants’ evaluations, the 2011 Leadership Conference for Chapter Leaders and Young Fellows was successful this year. This was the third year that the Leadership Conference preceded the Joint Surgery Advocacy Conference.

- Under the guidance of Jennifer Rosen, MD, FACS, a mentoring demonstration project is being pursued by the YFA. Dr. Rosen also intends to conduct the project’s initial, face-to-face introductions during this year’s Clinical Congress.

- Two YFA members are evaluating opportunities for engaging young, international Fellows. Quyen Chu, MD, FACS, and S. Rob Todd, MD,
FACS, will conduct a questionnaire via Survey Monkey to ascertain these members’ interests and needs. The results of the survey will also be shared with the Chapter Activities Committee.

The YFA Governing Council is evaluating a strategic planning session that would be conducted during the Clinical Congress.

**ACS Advisory Councils for the Surgical Specialties**

- The Chairs elected Thomas Tracy, MD, FACS, Providence, RI (pediatric surgery), as the new Chair of the Chairs. Dr. Tracy’s term will begin at the conclusion of the 2011 Clinical Congress.
- All of the Advisory Councils continue to discuss the Jacobson Innovation Award, Sheen Award, and Honorary Fellowship, and nominations will be forwarded to the ACS Honors Committee for its consideration.
- The Advisory Councils continue to propose specialty-sponsored programming for the Clinical Congress. In addition to panel discussions and courses, several Advisory Councils have submitted recommendations for Town Hall Meetings and Meet-the-Expert luncheons.
- Many Advisory Councils develop their specialty-specific plenary sessions with a multispecialty focus, incorporating other surgical specialties into the session. In addition, some Advisory Councils are making recommendations for ACS representatives to residency review committees, surgical boards, and other surgical committees.

**International relations**

- The Executive Committee of the International Relations Committee actively pursued fundraising for the Murray F. Brennan International Scholarship. The Scholar Selection Subcommittee has worked to thoroughly revise and upgrade the online application form for the International Guest Scholarships program.
- The Executive Committee was encouraged by the supportive reaction members had in response to the committee’s plan to enhance international outreach through proposed expansion of the program of International Guest Scholarships/Travel Awards. The awards are open to academic and community surgeons and residents, with particular emphases on new technology, surgical education, and safety and quality.

**Integrated Communications**

- The College worked in conjunction with Weber Shandwick staff to launch the Inspiring Quality campaign on the ACS website in mid-April. Key promotional space is devoted to the campaign near the top of the home page, and a fully dedicated issues page can be accessed at http://www.facs.org/quality/index.html. The page and materials are updated on a continual basis in an effort to inform ACS members about the active and evolving role the College plays in focusing its activities on the quality of care provided to surgical patients.
- In April, a Web presence was developed and placed online for the Society of Surgical Chairs, an international organization comprising chairs of departments of surgery and surgical specialty departments of medical schools, academic medical centers, and teaching hospitals in the U.S. and Canada.
- The members-only Web portal e-FACS.org received nearly 200,000 page views during the first quarter of 2011. In addition, the portal had nearly 9,000 unique visitors.
- Among the most frequently visited pages on the ACS Web portal during the first quarter of 2011 were the home page, “My Page,” “My Cases,” “My Profile,” and “My CME.” Some of the most popular communities on the portal during the first quarter included Rural Surgeons, General Surgery, Ethical Issues in Surgery, and Residents and Associate Fellows.
- The Communities & Specialties area of the portal continues to provide quality content targeted to the main interests of members of the College. Highlights for this area include the following:
  - Ethical challenge: Should surgeons disclose lack of sleep?
  - Surgery News notes
  - Ability to score topics added to discussion forums
  - Discussion forum added to Surgical Patient Safety community
Of puppies and dinosaurs: Why the 80-hour work week is the best thing that ever happened in American surgery

As of mid-May, the College was working on a new pilot community for rural surgeons.

*Surgery News* continues to hold the number two position in overall readership and ad exposures. The standard 24-page issue size increased to 32 pages in April and again in May.

**ACS Archives**

*Exhibit and reception.* The College hosted a traveling exhibit from the National Library of Medicine History of Medicine Division, June 13–July 27. The exhibit, *Opening Doors: Contemporary African American Academic Surgeons*, prominently featured two of the College’s former presidents: LaSalle D. Leffall, Jr., MD, FACS; and Claude H. Organ, Jr., MD, FACS; as well as Alexa I. Canady, MD, FACS. About a dozen other Fellows are featured throughout the exhibit.

On Monday, July 18, an informal reception for the honorees, other invited guests, and the ACS staff took place in the lobby of the College headquarters building. ACS President L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSED(Hon), FWACS(Hon) was also featured in the exhibit and he spoke at the event.

*Digitization of Eleanor Grimm retirement scrapbooks.* The three retirement scrapbooks of Eleanor Grimm, which were donated by her family members in December 2008, have now been scanned and digitized and the original artifacts de-acidified. As close personal assistant to ACS founder Franklin H. Martin, MD, FACS, from 1913 until his death in 1935, Ms. Grimm’s responsibilities continually increased over the years. As secretary to the Board of Regents, editor of all College publications, international members’ liaison, manager of the medical motion pictures program, and much more until her retirement in 1951, her scrapbooks are full of correspondence with all of the founders of the College and College leaders throughout the years. These scrapbooks are a wealth of untapped material, which describe the early history of the College and the accomplishments of individual surgeons including Dr. Martin, Ms. Grimm herself, and others. After she retired, the Board of Regents asked Ms. Grimm to record her recollections of the history of the College, which resulted in a 26-volume recording and manuscript known as the Grimm History Notebooks.

Dr. Flynn is senior associate dean, clinical affairs, University of Florida College of Medicine, Gainesville, FL. He is Chair of the ACS Board of Governors.
According to the U.S. Department of Transportation’s (DOT) Federal Railroad Administration (FRA), a highway-railroad grade crossing is defined as “an at grade crossing (tracks and road at the same level) where a public highway, road, street, or private roadway, including associated sidewalks and pathways, crosses one or more railroad tracks at grade, and is identified by a U.S. DOT National Highway-Rail Grade Crossing Inventory Number, or is marked by crossbucks (X-shaped sign), stop signs, or other appropriate signage.” There are more than 250,000 public and private highway-rail crossings in the U.S. Each year approximately 300 to 400 deaths occur at these crossings, a statistic that has captured the attention of several U.S. transportation agencies (http://www.fra.dot.gov/rrs/pages/fp_86.shtml).

Because an at grade crossing is a location where more than one mode of transportation meets, jurisdiction over various aspects of the crossing fall under several entities in the public and private sector. Railroad companies own and maintain the tracks, and they usually own the property located on either side of the tracks. The railroad companies maintain the roadway surface between and around the tracks, as well as the traffic control devices. However, the road at the crossing is either under the jurisdiction of a public entity (municipality, county, or state agency) or, in the instance of a private crossing, the road is the responsibility of the private owner. The Federal Highway Administration (FHWA) provides standards and guidelines for design, safety assessment, and placement of appropriate traffic control devices. These devices can include pavement markings, crossbucks, gates, bells, and flashing lights, depending on the location. Research programs provided by the FRA address which control/safety devices may reduce risk at various crossings. Potential safety devices include visual and audio warnings, crossing geometry, motor vehicle and train-presence detection, flashing light and crossing gate technology, and intelligent transportation systems prototypes.

In order to examine the occurrence of highway-railway grade crossing motor vehicle versus train-related injuries in the National Trauma Data Bank® research dataset 2009, admissions records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) external cause of injury E codes. Records that contained either E code 810.0 (motor vehicle collision with train/injured driver) or E code 810.1 (motor vehicle collision with train/injured passenger) were identified. A total of 251 records contained one of these E codes, while 208 had a discharge status recorded, including 147 discharged to home, 23 to acute care/rehab, 15 to nursing homes; 23 died. These patients
ACS Members who are recertifying can now enjoy the ease of submitting their ACS CME credits directly to the American Board of Surgery (ABS). From members’ MyCME page, click on the “Send CME to ABS” option at the top of the page. Submission is quick and easy:

→ Review your transcript for accuracy and authorize transfer of credits
→ Have your ABS 13-digit authorization number ready

Log into the member Web portal at www.eFACS.org to get started

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

Transfer your ACS CME credit to the American Board of Surgery electronically!

Acknowledgment
Statistical support for this article has been provided by Chryystal Price, data analyst, NTDB, and Michael Horrell, NTDB intern.

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. He is Past-Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.

Now Available
from the American College of Surgeons

were 69 percent male, on average 42.8 years of age, had an average length of stay of 7.38 days, and an average injury severity score of 16.6. This subset of motor vehicle/train-related injuries represents a two-and-one-half times greater mortality rate than the overall group of motor vehicle-related injuries.

The traffic control devices highlighted in this column have been designed to warn the motor vehicle driver that there is an upcoming crossing that is shared with more than one mode of transportation—a mode of transportation that is heavier, and one that features more momentum and that is harder to maneuver or stop when compared with their vehicle. Ringing bells, flashing lights, and big black-and-white gates closing in front of a driver should command attention and signify that there is most likely an at grade crossing where a train will be approaching. In spite of all of these devices, there remains the human factor—the individual behind the wheel. In an attempt to beat the train, the driver may not be crossing over the tracks but crossing over the threshold of life.

Throughout the year, we will be highlighting these data through brief reports that will be found monthly in the Bulletin. The NTDB Annual Report 2010 is available on the American College of Surgeons’ 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.

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Chapter news

by Rhonda Peebles

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

Alabama Chapter hosts lobby day

The Alabama Chapter’s first “A Day at the Legislature” program took place May 3 in Montgomery (see photo, this page). The advocacy day was presented in collaboration with the American College of Surgeons (ACS) Office of State Affairs and the Medical Association of the State of Alabama (MASA). Leaders of the Alabama Chapter met with state legislators, representatives of the governor’s office, and R. Bob Mullins, Jr., MD, commissioner of the state’s Medicaid agency. In addition to funding for critical access hospitals, the Alabama Chapter leaders addressed the need for funding a trauma system for Alabama. (The chapter was awarded a state advocacy grant from the College in 2010.)

Senior Surgeons Committee hosted by Connecticut Chapter

As a result of its 2010 strategic planning session, the Connecticut Chapter hosted its first Senior Surgeons Committee meeting on June 8 at the well-known Mory’s Club in New Haven. The guest speaker was Horace Laffaye, MD, FACS, who discussed the history of polo, both internationally and in Connecticut. Also, the Senior Surgeons Committee discussed how the newly formed group might be of service to the chapter, as well as how it could serve the needs of senior surgeons in the state (see photo, this page).

Annual Meeting and Young Surgeons Dinner

The Brooklyn-Long Island Chapter (BLIC) conducted its Annual Meeting and Young Surgeons Dinner on June 14 at The Garden City Hotel, Long Island, NY. David B. Hoyt, MD, FACS, Executive Director, presented an update on College activities to members of the BLIC, the Manhattan Council (NY), the Eastern Long Island Chapter, and the Nassau Surgical Society. (See photo, page 56.)

Missouri Chapter holds three-day CME event

The Missouri Chapter conducted its 44th annual meeting at the Country Club Hotel and Spa in Lake Ozark, MO. Topics presented during the three-day event included trauma surgery, wound care, and continuing medical education (CME). In addition, various competitions for residents and medical students were presented. Winners included the following:

- Paper competitions. Best papers for medical students: Jennifer Yu, MD, Washington University, St. Louis, MO, Compromised Margins following Mastectomy for Stage I – II Breast Cancer; and Ioanna Mazotas, MD, Washington University, St. Louis, MO, Errors in Pediatric Burn Wound Size Estimates

continued on page 56
### 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.

<table>
<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
<th>Location/Information</th>
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| November 03, 2011 - November 05, 2011 | Connecticut                  | Location: Holiday Inn, Waterbury, CT  
Contact: Chris Tasik, 203-674-0747, e-mail: info@CTACS.org  
ACS Representative(s): L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon) |
| November 04, 2011 | Keystone (AP)                 | Location: Lehigh Valley Hospital, Allentown, PA  
Contact: Lauren Ramsey, 717-558-7850 Ext. 2691, e-mail: Iramsey@pamedsoc.org  
ACS Representative(s): Thomas V. Whalen, MD, FACS |
| November 04, 2011 - November 05, 2011 | Wisconsin Surgical Society—A Chapter of the ACS | Location: American Club, Kohler, WI  
Contact: Terry Estness, 414-453-9957, e-mail: wisurgical@att.net  
ACS Representative(s): Thomas V. Whalen, MD, FACS |
| November 05, 2011 - November 06, 2011 | Arizona (AP)                 | Location: Scottsdale Plaza Resort, Scottsdale, AZ  
Contact: Joni Bowers, 602-347-6904, e-mail: jonib@azmedassn.org  
ACS Representative(s): Thomas V. Whalen, MD, FACS |
| November 18, 2011 | Japan                         | Location: Tokyo, Japan  
Contact: Kyoichi Takaori, MD, FACS, 81-75-751-4323, e-mail: takaori@live.jp |
| December 03, 2011 | Massachusetts (AP)            | Location: Westin Copley Place, Boston, MA  
Contact: Elizabeth Chouinard, 978-927-8330, e-mail: echouinard@prri.com |
| December 03, 2011 | New Jersey (AP)               | Location: The Renaissance Hotel and Conference Center, Iselin, NJ  
Contact: Andrea Donelan, 973-539-4000, e-mail: njsurgeons@aol.com  
ACS Representative(s): David B. Hoyt, MD, FACS |
| January 20, 2012 - January 22, 2012 | Southern California (AP)     | Location: Four Seasons Biltmore, Santa Barbara, CA  
Contact: C. James Dowden, 310-364-0193, e-mail: jdwden@prodigy.net |
| January 20, 2012 - January 22, 2012 | Louisiana (AP)               | Location: Ritz Carlton, New Orleans, LA  
Contact: Janna Pecquet, 504-841-0145, e-mail: janna@laacs.org  
ACS Representative(s): J. David Richardson, MD, FACS |
| February 17, 2012 - February 18, 2012 | North Texas (AP)             | Location: City Place Conference Center, Dallas, TX  
Contact: Nonie Lowry, 913-402-7012, e-mail: nonie@p-etc.com |
within a Regional Trauma System: Potential Impact on Patient Outcome and Burn Center Resources.

- **Abstracts of distinction.** Residents: Carla Fisher, MD, Washington University, St. Louis, MO, Neo-adjuvant Chemotherapy Is Associated with Improved Survival Compared with Adjuvant Chemotherapy in Patients with Triple-Negative Breast Cancer Only after a Complete Pathological Response; Christopher Aldridge, MD,* St. Louis University, St. Louis, MO, Access to Minimally Invasive Surgery: Regional Variation and Geographic Differences of Laparoscopic Partial Colectomy in the United States; and Andrew Wheeler, MD,* University of Missouri-Columbia, Columbia, MO, Laparoscopic Roux-en-Y Gastric Bypass Results in Greater Weight Loss than Laparoscopic Sleeve Gastrectomy—But with Greater Numbers of Major Complications.

- **Best oral abstract.** Derek Wakeman, MD,* Washington University, St. Louis, MO, Deletion of P38Alpha MAPK within Enterocytes Promotes Colon Tumor Genesis.

New officers were elected for the Missouri Chapter, including Mark Wakefield, MD, FACS, President; Julie Magenthaler, MD, FACS, Vice-President; Stanley Augustin, MD, FACS, Secretary-Treasurer; and William Hawkins, MD, FACS, Immediate Past-President.

**Tennessee passes tort reform**

Tennessee is the latest state to enact a law setting limits on noneconomic damages in lawsuits, including medical liability cases. The new law, signed by Gov. Bill Haslam on June 16, imposes a cap of $75,000 on medical liability awards. In certain cases involving serious injury, the limit rises to $1 million. Members of the Tennessee Chapter showed their support for passage of the legislation by contacting their legislators via the ACS State Surgery Legislative Action Center. For more information about the new law, contact Wanda Johnson, Tennessee Chapter Executive Director, at 931-967-4700 or wanda@tnacs.org.

**Chapter anniversaries**

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*Denotes Resident membership in the College.

**Ms. Peebles** is in the Division of Member Services, Chicago, IL.