LEADERSHIP
in a changing surgical environment
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
Looking forward

In the past decade, Congress has approved 14 pieces of legislation that have postponed reductions in Medicare physician payment, which would have been incurred due to the government’s continued use of the flawed sustainable growth rate (SGR) formula to calculate fees. Congress’ most recent action of this type occurred earlier this year, when legislators averted another steep cut in payment by passing a 10-month short-term patch.

Although these patches have offered some short-term relief to surgical practices and ensured ongoing access to care for Medicare beneficiaries, they provide no long-term stability and add to both the size of future payment reductions and the costs of permanently repealing the SGR. Indeed, the cumulative effect of Congress’ failure to repeal the SGR is a 27 percent cut in Medicare payment that is scheduled to take effect on January 1, 2013.

The American College of Surgeons (ACS), the surgical specialty societies, other medical associations, patient groups, and most members of Congress agree that this course of action must end. Disagreements arise, however, when the discussion turns to the development of a replacement for the SGR and how to fund its repeal. The ACS has developed a proposal called the value-based update (VBU), which we believe is a viable alternative to the SGR.

**Need for repeal**

The SGR was enacted as part of the Balanced Budget Act of 1997 and was intended to be used as a prospective measure for controlling the growth of Medicare payments for physician services. The premise behind the SGR formula was that it would set health care spending targets, which, if exceeded, would result in a proportionate cut in the physician payment the following year. However, this approach was ill-suited to account for both the volume and the complexity of physician services, let alone the unique needs of individual patients.

The College and other surgical and medical associations have maintained that a better way to reduce health care spending is through improved patient outcomes. Over the last year, the College’s Inspiring Quality campaign has successfully illustrated how quality improvement programs, such as the ACS National Surgical Quality Improvement Program (ACS NSQIP®), can improve patient outcomes and reduce costs. The VBU proposal is premised on the belief that higher quality care, better patient outcomes, and, therefore, reduced health care spending are achievable goals and that quality improvement programs can be incorporated into a more financially sustainable and patient-centered payment system.

**Five principles**

The VBU is based on the following five principles that the College and its allies believe must apply to any viable alternative to the SGR:

- Complement the current quality-related payment incentive programs, such as the Physician Quality Report System, the Electronic Prescribing Incentive Program, and the Electronic Health Record Incentive Program, while making necessary adjustments to those programs to facilitate participation by specialists.
• Provide a model that would have been immune to the outcome of the Supreme Court’s decision on the constitutionality of the Affordable Care Act

• Incorporate mechanisms that lead to improved quality of care and reduced waste

• Account for the varying ability of different segments of the health care system to improve care and reduce spending

• Create incentives for the provision of primary care services that appropriately and adequately address the needs of an increasingly complex patient population

At press time, the College and the surgical societies had developed a four-step plan for repealing the SGR and replacing it with the VBU. This proposal had not yet been finalized, but plans were in motion to roll out the VBU to Fellows over the course of the summer.

Time for change

Without question, a Medicare physician payment system that relies on the use of the SGR is unsustainable. It is time for Congress to muster the political will to repeal the SGR and replace it with a truly sustainable, patient-centric reimbursement mechanism.

The College’s leadership and the Division of Advocacy and Health Policy have worked very hard to develop what we believe is a viable and meaningful alternative to the SGR—a plan that makes the provision of high-quality, patient-focused care the key factor in determining how surgeons and other physicians are paid. We have introduced the concepts of the VBU and are continuing to schedule additional meetings to make improvements in the model with surgical specialty societies, other physician groups, and health care leaders and think tanks in Washington, DC.

We are also working with members of Congress to test the political waters for the establishment of the VBU Medicare physician payment system. As we further develop the plan, we are planning to hold an all-Fellow webinar to walk through the proposal and solicit input and answer questions from the College’s membership. As always, I look forward to hearing your feedback on this proposal. In the meantime, rest assured that the American College of Surgeons is working hard to repeal and replace the broken Medicare SGR formula with a model that is good for our patients, is appropriate for surgical practices, and inspires quality throughout the entire health care system.

David B. Hoyt, MD, FACS
Participating in the Medicare eRx Incentive Program

by Sana Gokak, MPH

The deadline to file for a hardship exemption from the 2013 Electronic Prescribing (eRx) Incentive Program has passed, and by now surgeons should be thinking about the requirements for the next few years. The Centers for Medicare & Medicaid Services’ (CMS) eRx Incentive Program was authorized by the Medicare Improvements for Patients and Providers Act of 2008. CMS defines e-prescribing as “the ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point-of-care.”* Eligible professionals (EPs) who successfully e-prescribe in 2012 can qualify for an incentive payment of 1 percent. The program is currently set to expire in 2015. This article addresses questions surgeons may have regarding remaining incentives and penalties for 2012–2014. (See Table 1 on this page for an overview of the eRx incentives and penalties remaining for 2012–2014.)

What are the incentives and penalties under the eRx program?

Table 2 on page 7 shows both the incentives and penalties for each year starting from 2012.

Do I still have time to qualify for the 2012 eRx bonus?

Yes, EPs can still qualify for the 2012 eRx payment incentive of 1 percent. To qualify, EPs must report electronically 25 times from January 1 to December 31, 2012, for denominator eligible visits (see Table 3 on page 7 for the eligible denominator codes). Denominator eligible codes are composed of evaluation and management codes.

Is it too late now to avoid the 2013 eRx penalty for nonparticipation?

Yes, it is too late for health care professionals to avoid the 2013 eRx payment penalty of 1.5 percent of the Medicare Part B physician fee schedule.

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Table 1. Overview of the eRx incentives and penalties for 2012 through 2014

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<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>Receive incentive</td>
<td>Report 25 denominator eligible prescriptions from January 1 to December 31, 2012, to receive incentive payment of 1.0% on Medicare Part B payment</td>
<td>Report 25 denominator eligible prescriptions from January 1, to December 31, 2013, to receive incentive payment of 0.5% on Medicare Part B payment</td>
<td>No incentive payment in place after 2013</td>
</tr>
<tr>
<td>Avoid penalty</td>
<td>Deadline to avoid the 2012 payment penalty has passed</td>
<td>Deadline to avoid the 2013 payment penalty has passed</td>
<td>1. Report electronically 25 times for denominator eligible visits from January 1 to December 31, 2012, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Report on any 10 electronic prescriptions from January 1 to June 30, 2013, or</td>
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<td></td>
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<td></td>
<td>3. Apply for a significant hardship exemption by June 30, 2013, or</td>
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<td></td>
<td></td>
<td></td>
<td>4. Be automatically exempt</td>
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</table>
amount for covered professional services if they did not do one of the following:

- Report prescriptions electronically 25 times from January 1 to December 31, 2011, for denominator eligible visits.
- Report prescriptions electronically 10 times from January 1 to June 30, 2012, for any visit (which does not have to be associated with a denominator eligible code but was submitted in conjunction with a billable, covered procedure not associated with a global period).
- Apply for a significant hardship exemption to avoid the 2013 eRx penalty on the CMS website by June 30, 2012, and receive CMS approval (it may take close to 30 days after application for the exemption for CMS to notify EPs regarding approval). See Table 4, page 8, for a list of the 2013 and 2014 significant hardship exemptions.

- Qualify for an automatic exemption from the eRx Incentive Program. EPs will be automatically exempt from the 2013 eRx Incentive Program penalty if they meet any one of the following criteria:
  - The EP was a successful electronic prescriber during the 2011 eRx 12-month reporting period of January 1 to December 31, 2011
  - The EP is not a MD, doctor of osteopathic medicine (DO), podiatrist, nurse practitioner, or physician assistant by June 30, 2012
  - The EP does not have at least 100 Medicare Part B physician fee schedule cases containing denominator eligible codes (listed in Table 3) for dates of service from January 1 to June 30, 2012
  - At least 10 percent or more of the EP’s Medicare Part B physician fee schedule charges are not from denominator eligible codes (listed in Table 3) for dates of service from January 1 to June 30, 2012
  - The EP does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1 and June 30, 2012

**What should I do to avoid the 2014 eRx payment penalty?**

To avoid the 2014 eRx payment penalty of 2 percent of the Medicare Part B physician fee schedule amount for covered professional services, health care professionals must do one of the following:

- Report electronically 25 times for denominator eligible visits from January 1 to December 31, 2012.
- Report electronically at least 10 times from January 1 to June 30, 2013, for any visit (does not have to be associated with a denominator eligible code but must be submitted in conjunction with a billable, covered procedure not associated with a global period).
- Apply for a significant hardship exemption by June 30, 2013, once the portal opens in early 2013. See Table 4, page 8, for a list of the 2014 significant hardship exemptions.
Be automatically exempt from the eRx Incentive Program. EPs will be automatically exempt from the 2014 eRx Incentive Program penalty if they meet any one of the following:

—The EP is a successful electronic prescriber during the 2012 eRx 12-month reporting period of January 1 to December 31, 2012

—The EP is not a MD, DO, podiatrist, nurse practitioner, or physician assistant by June 30, 2013

—The EP does not have at least 100 Medicare Part B physician fee schedule cases containing denominator eligible codes (listed in Table 3) for dates of service from January 1 to June 30, 2013

—At least 10 percent or more of the EP’s Medicare Part B physician fee schedule charges are not from denominator eligible codes (listed in Table 3) for dates of service from January 1 to June 30, 2013

—The EP does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1 to June 30, 2013

For more information on the eRx Incentive Program, continue to check the American College of Surgeons website at http://www.facs.org/ahp/erx.html or the CMS eRx website at https://www.cms.gov/ERxIncentive/. For more information on payment penalties, visit the following CMS Web page: http://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp.

If you have any questions, contact Sana Gokak, ACS Division of Advocacy and Health Policy, at 202-337-2701 or sgokak@facs.org. You may also contact the CMS eRx help desk at 866-288-8912.
From the Chair of the RAS-ACS:

LEADERSHIP SKILLS continue to serve past RAS-ACS Chairs in their current roles

by Heena P. Santry, MD
Surgeons lead in many different ways. Surgeons lead in the operating room (OR), heading a team of practitioners caring for a single patient who has put his or her well-being in their hands. Surgeons lead on rounds, heading a clinical team responsible for the day-to-day progress of a patient’s surgical care. Surgeons lead by educating their colleagues, fellows, residents, medical students, and affiliated practitioners about the clinical and technical aspects of the art and science of surgery. Surgeons lead by conducting research with widespread implications for surgical diseases and quality of care in surgery. Surgeons lead by serving in key roles for their institutional, loco-regional, and national organizations and committees. Surgeons lead by being the voice for the house of surgery to state and federal legislators. And notably, surgeons lead by mentoring the future generation of surgical leaders. The Resident and Associate Society of the American College of Surgeons (RAS-ACS) is the home of that future generation of surgical leaders.

As a junior surgical resident, I was aware of the ACS and knew that the faculty at my residency who were my leaders on rounds, in the OR, and in the research laboratories proudly acknowledged their Fellowship in the College, along with their other professional credentials. The latter represented years of hard work and ambition toward a degree, and the former represented the dedication to quality patient care, technical innovation, and continuous professional development in the field of surgery—a process that starts when one becomes a surgical intern and lasts throughout one’s surgical career. However, I was unaware of how to embrace that process and how to become a surgical leader until I became active in the RAS.

Mentorship and future leaders

I was fortunate early in my career to have a mentor who introduced me to several key leaders within the College, including Thomas R. Russell, MD, FACS, former Executive Director; Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the Division of Education; and R. Scott Jones, MD, FACS, former President and the first Director of the Division of Research and Optimal Patient Care. Through the professional relationships that I developed with these leaders, I was able to provide the perspective of young surgeons on a number of important surgical issues ranging from the quality of bariatric surgery to the growing trend of surgical health services research.

At a later point in my career, Danielle Katz, MD, FACS, encouraged me to become actively involved in one of the four standing committees of the RAS, which quickly led to roles on the RAS Communications Committee, the College’s Women in Surgery Committee, the RAS Web portal, the Advisory Council on General Surgery, and now the RAS Executive Board. These experiences have provided me with opportunities for professional development, networking, and leadership training far beyond the resources available in any of my training programs. I firmly believe that these experiences in the RAS have improved my ability to lead as a clinician, an educator, a researcher, and as a member of society who is interested in improving access to quality surgical care. The greatest and most challenging of these experiences has been serving as Chair of the RAS this year.

Past Chairs’ experiences

Rather than focus on my own experiences as RAS Chair, however, I have taken this opportunity to explore how those who have preceded me as leaders of this organization over the last decade were shaped as leaders as a result of their early engagement in the College through the RAS. The nine previous Chairs of the RAS from 2002 to 2011 were contacted via e-mail and asked to describe how their experiences as RAS Chairs have shaped them as professionals. Responses were analyzed using standard qualitative methods with NVivo software.

All nine past RAS Chairs responded to the query. Qualitative analysis of their responses revealed seven consistent themes, which are italicized in the following text. Their comments, some of which are highlighted below, and their current roles richly describe the many ways in which surgeons also serve as leaders.

Respondents found that they gained both specific leadership skills (5/9) as well as insight into the workings of complex organizations (7/9) and the issues facing the surgical profession (3/9) as a result of their experiences as RAS Chair. Dr. Katz noted, “Understanding an organization, its position in a greater context, and having some element of ‘institutional memory’ are critical for providing successful leadership.” Joshua M.V. Mammen, MD, FACS, responded that he “gain[ed] a perspective into the complex decisions that have to be made in leadership positions…[and learned to] anticipate barriers to change and to
The last decade of RAS Chairs

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<tr>
<th>Chair</th>
<th>Name</th>
<th>Current responsibilities*</th>
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<tbody>
<tr>
<td>2002–2003</td>
<td>Willie Underwood III, MD, MPH</td>
<td>Dr. Underwood is associate professor of surgical oncology, department of urology, Roswell Park Cancer Institute, Buffalo, NY. His career consists of delivering clinical care in urologic oncology, performing health service research, and contributing to health policy. His research focuses on understanding health system-related and societal factors that affect health outcomes and examines racial and socioeconomic differences in cancer knowledge, early detection, treatment, and survival. Dr. Underwood has also evaluated the impact of health policy changes in residency training on health care quality. His research reflects a commitment to improving the health and health care of Americans in general, and of the poor and disenfranchised more specifically.</td>
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<tr>
<td>2003–2004</td>
<td>Jeffrey Upperman, MD, FACS</td>
<td>Dr. Upperman is currently associate professor of surgery at the University of Southern California, Los Angeles, and the director of trauma at Children's Hospital Los Angeles.</td>
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<td>2004–2005</td>
<td>Danielle A. Katz, MD, FACS</td>
<td>Dr. Katz is associate professor of orthopaedic surgery at the State University of New York Upstate Medical University, Syracuse. She specializes in pediatric orthopaedic surgery and is the assistant program director for the residency program in orthopaedic surgery. She serves on a number of committees within her institution, including the clinical quality improvement committee and the institutional review board. Dr. Katz is currently the Secretary of the New York Chapter and a member of the Governing Council of the Young Fellows Association.</td>
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<tr>
<td>2005–2006</td>
<td>Michael Sutherland, MD, FACS</td>
<td>Dr. Sutherland is assistant professor of surgery at the University of Arkansas for Medical Sciences and is in private practice in Pine Bluff, AR. He is a general, trauma, and vascular surgeon with an interest in surgical critical care. He is the chair of the Arkansas Trauma Education and Research Foundation and is actively involved in the development of the statewide Arkansas Trauma System. He currently serves on the General Surgery Coding and Reimbursement Committee of the College and is on the Society for Vascular Surgery Health Policy Committee. He participates at the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) and is a member of the ACS-PAC Board of Directors.</td>
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<tr>
<td>2006–2007</td>
<td>Gregory S. Cherr, MD, RVT, FACS</td>
<td>Dr. Cherr is chief of vascular surgery, Buffalo General Hospital, NY, as well as associate professor of surgery with tenure and research associate professor of social and preventive medicine at the University at Buffalo, NY. He also serves as director, medical student programs, in the department of surgery.</td>
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*As described by the past Chairs with minor editing for tense and style.

maneuver through obstacles that may be present.” Jeffrey Upperman, MD, FACS, said, “RAS prepared me for working in a large organization with competing demands and learning to work within an organizational framework to reach important goals and objectives.” According to Michael Sutherland, MD, FACS, he learned that leaders succeed, in part, by delegating to “hard workers who will bring their
The last decade of RAS Chairs (continued)

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<tr>
<th>Chair</th>
<th>Name</th>
<th>Current responsibilities*</th>
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<tbody>
<tr>
<td>2007–2008</td>
<td>Ted James, MD, FACS</td>
<td>Dr. James is a surgical oncologist and associate professor of surgery at the University of Vermont College of Medicine where he serves as clerkship director for surgery. He is active in quality and outcomes research in cancer care delivery as well as translational research in oncology.</td>
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<tr>
<td>2008–2009</td>
<td>Jacob Moalem, MD, FACS</td>
<td>Dr. Moalem is assistant professor of endocrine surgery and of endocrinology at the University of Rochester, NY. He currently serves as Chair of the Young Physicians’ Surgical Caucus at the AMA, and is also on the Executive Board of the ACS Young Fellows Association and the Board of Directors of the ACSPA-SurgeonsPAC. He is a delegate for the ACS at the AMA. He runs a practice in endocrine surgery and he conducts ongoing research in endocrine surgery and surgical education.</td>
</tr>
<tr>
<td>2009–2010</td>
<td>Joshua Broghammer, MD, FACS</td>
<td>Dr. Broghammer is assistant professor of urology at the University of Kansas Medical Center, Kansas City, where he focuses on trauma and male genitourinary reconstruction. He is passionate about resident education and studies the management of renal injuries, post-prostatectomy complications, and the treatment of urethral stricture disease. He is also a member of the ACS Legislative Committee.</td>
</tr>
<tr>
<td>2010–2011</td>
<td>Joshua M. V. Mammen, MD, FACS</td>
<td>Dr. Mammen is an assistant professor of surgery and molecular and integrative physiology at the University of Kansas, Kansas City. He also serves as the associate program director of the surgery residency program. He is a surgical oncologist with a focus on melanoma, sarcoma, breast cancer, colorectal cancer, and peritoneal surface malignancies. His basic science laboratory focuses on the use of natural compound derivatives in the treatment of melanoma.</td>
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<tr>
<td>2011–2012</td>
<td>Heena P. Santry, MD, MS</td>
<td>Dr. Santry is assistant professor of surgery and quantitative health sciences at the University of Massachusetts Medical School. She is an acute care surgeon and health services researcher whose work focuses on quality and outcomes for unexpected surgical emergencies. In addition to her work in the RAS-ACS, she is active in the College’s Women in Surgery Committee.</td>
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*As described by the past Chairs with minor editing for tense and style.

energy and expertise to a project or a committee.” Dr. Katz echoed this sentiment, stating, “Personally, during that year as Chair I learned that I could hold a position of leadership, but also that, as a leader, I needed to rely on those around me. Surrounding oneself with talent seems to me to be a remarkably helpful aspect of being an effective leader.” Among the difficult and complicated issues facing the College and the profession of surgery that respondents were able to understand better and even address during their tenure were changes in surgical education, health care initiatives, economics, and advocacy, as well as credentialing, and family leave policies.

Beyond skills and issues, however, the ability to represent and network with one’s peers in surgical training (2/9 and 8/9 respectively) was a common theme among respondents. Willie Underwood III, MD, MPH, was one of the early chairs of the RAS when it was evolving from its prior iteration as the Candidates and Associates Society. He noted, “We were excited—we wanted to make a difference, to have our voices heard. At the time, surgical training was
under attack, and there was no venue for the surgical residents to express their opinions in an organized forum.” Dr. Mammen stated, “I had the privilege to communicate the opinions of my colleagues to the leadership of the American College of Surgeons.”

Networking with peers was, however, a more powerful theme. For Joshua Broghammer, MD, FACS, this was “the most important aspect” of his experience as RAS Chair. He commented that he made numerous contacts “from around the country with various backgrounds and specialties, which creates an incredible network of resources which I can call on from time to time and will continue to do so in the future.” Gregory S. Cherr, MD, RVT, FACS, cited a “network of friends and colleagues who provide me with support and advice in my professional and personal life” as an important component of the Chair experience.

The ability to find role-models and mentors (8/9) among leaders of the College was also a resounding theme among respondents, and yielded the richest commentary. “The inherent mentorship that is built into the three-year progression from Secretary to Vice-Chair to Chair was crucial to my development,” Dr. Moalem said. “By the point that I became Chair, I had numerous mentors and friends among ex-officio Chairs of RAS, and among the Regents and Governors of the College.”

“I also had the opportunity to see the leaders of the College at work in the Board of Regents and some of the ACS committees and tried to understand what qualities made these well-established leaders as successful as they were,” noted Dr. Katz. Echoing these observations, Dr. Mammon responded, “I was able to meet many of the thought leaders in surgery and thereby gain a perspective into the complex decisions that have to be made in leadership positions.”

Some respondents cited specific benefits of mentorship. For example, Dr. Broghammer noted, “Through my interactions with senior urologists on the Board of Regents I have developed relationships that have helped promote me within my subspecialty organization, the American Urological Association.” Dr. Cherr was able to meet “many outstanding medical educators who helped me to understand that it is possible to have a successful academic career in surgical education.” Finally, Dr. Sutherland directly credits his exposure “to the leaders of the College” as the reason for his current position and stated, “Dr. [Charles] Mabry [MD, FACS], my partner and a former Regent of the College, recruited me to Arkansas during my time as the Chair of RAS.”

Not surprisingly, respondents found that their experiences as RAS Chair served as a foundation for their future successes (4/9). Many of these successes are listed in the table on pages 11–12. Dr. Upperman summed it up well: “I also learned an incredible amount from the ACS leadership on how surgeons are relevant to health in America.”

**What’s ahead**

As the current Chair of the RAS, it is my privilege to introduce this special issue of the Bulletin and to reflect on what it means to be a leader as learned through participation in the RAS. The following four articles, written by RAS members, will delve into the many manifestations of surgical leadership. Readers will learn about the historical underpinnings of surgical leadership, the cardinal traits of effective leaders in surgery, and the ways in which every member of the College can take the opportunity to lead both within the organization and in myriad other arenas that shape the delivery of surgical care. I hope this informative and engaging issue will inspire you to encourage and promote the young surgeons around you to embrace a path to leadership within our profession.
Most surgeons seek to directly assist our patients through the course of their illnesses, paying little attention to the political environment or health care policy. After all, arguably, among all specialties in medicine, surgery can demonstrate the clearest relationship between clinical action and patient outcomes. However, over the last decade, it has become increasingly apparent that the independent patient-surgeon relationship is slowly vanishing.

Surgeons as political advocates

When we’re sitting with our patients in the clinic, rounding by the bedside, or operating in the middle of the night, worries regarding insurance coverage, Medicare reimbursement, and litigation may find their way into the physician’s conscious and/or subconscious thoughts. The fact of the matter is that the provision of health care services has grown in the last century from a two-person contract to a complex relationship that involves multiple stakeholders. It was only a matter of time until health care policy started to be shaped mostly by non-clinicians.

The rising health care costs and the variability of patient outcomes across different providers has led to the development of multiple performance indicators, as an attempt to improve quality of care while decreasing costs. The Centers for Medicare & Medicaid Services and private insurers immediately adopted many of these indicators for pay-for-performance purposes, despite multiple clinical studies suggesting that some of these measures were unreliable. The surgical profession’s failure to make itself heard in this specific instance and in many similar situations is due in part to our unfamiliarity with how policy is shaped and with the political process. In other words, our traditional focus on academia rather than advocacy has not served surgery well in recent years.

Over the last few years, the American College of Surgeons (ACS) has increasingly recognized and improved upon its ability to advocate on behalf of all surgeons in the U.S. The ACS established the American College of Surgeons Professional Association (ACSPA), which, because of its tax status, was able to form a political action committee (PAC), the ACSPA-Surgeons PAC, with the goal of relaying the perspective of surgeons to members of Congress. In the current era of health care reform, it is becoming more and more essential that we make every effort to be influential players in health care policymaking; otherwise, politicians and bureaucrats with little or no understanding of patient care will decide for us.

What is political advocacy?

Advocacy is part of the political process, and is defined as the actions of an individual or a group engaged in an effort to influence public policy through political, social, and economic systems and institutions. Advocacy covers a broad range of activities, including public speaking, media campaigns, research, and lobbying. In fact, lobbying is a key...
part of modern politics. It is defined as the act of approaching legislators directly on an issue in attempt to influence his or her decisions. Anyone can lobby, including individuals, groups, constituents, private-sector interests, corporations, government officials, and, of course, advocacy groups.

Quite often the act of lobbying has negative connotations associated with it, as some individuals may interpret this process as involving people with significant socioeconomic standing who use their power, money, and influence to corrupt the law and for personal gain. However, lobbying can be a tool that is used to protect others’ interests against corruption, ensuring that minority interests are fairly defended. In general terms, the value of lobbying and advocacy comes down to who is best able to convince their legislators to see things and act upon them from their point of view. One key access point that lobbyists have to legislators is through campaign contributions.

In 2010, the Center for Responsive Politics estimated that candidates in the 2010 midterm congressional election spent approximately $3.7 billion. To finance their campaigns, the candidates relied on assistance from a variety of sources, including individuals, interest groups, corporations, and unions. For federal elections, the primary source of campaign funds is individuals, followed by PACs.

PACs are organized for the purpose of raising and spending money to elect candidates who are likely to uphold the beliefs or interests of their members. PACs raise money from their eligible membership, and then make contributions to political campaigns. These groups also encourage members to become more politically active by providing relevant educational materials, organizing meetings, and facilitating congressional visits between legislators and PAC members.

Political money in our system is divided into two categories, “hard dollars” and “soft dollars.” Hard dollars are contributed by an individual and given directly to a candidate, political party, or PAC. These dollars are reported to the U.S. Federal Election Commission, which regulates campaign finance and enforces strict rules on who can contribute to candidates and to what extent. Contributions are capped at $5,000 per PAC per year.

Soft dollars are contributions from either corporate accounts or dollars spent by unions and are used for administrative and educational purposes. Recently, due to the U.S. Supreme Court’s decision in Citizens United v. Federal Election Commission, soft dollars have been allowed to be used for election-related independent expenditures. Regardless of the type of contribution one makes, be it in hard or soft dollars, it is important and vital for everyone to be an active member in their respective PACs, and contributing is a good way to start.

Getting involved

So, suffice it to say, advocacy is important for the future of your career. The next step in becoming a surgeon advocate is figuring out how to participate in these efforts despite a busy and demanding schedule. In reality, meaningful advocacy work can take place fairly quickly in the form of a phone call, a letter, or an e-mail—and we all have time to make one more phone call or send one more e-mail.

The first step in getting involved is to understand the issues. Although this is another task that may seem daunting or time-consuming, many resources are available to help surgeons get up to speed on relevant issues. Many different websites, blogs, and listservs are available to physicians seeking to stay current on legislative activities. Advocacy experts suggest the best way to become a more influential advocate is to focus your attention on topics about which you are most passionate, and then seek out information regarding legislation on that specific topic. Registries of active legislation organized by topic exist on the U.S. Senate and House of Representatives’ websites (http://www.senate.gov/pagelayout/legislative/b_three_sections_with teasers/active_leg_page.htm and http://thomas.loc.gov/home/LegislativeData.php?n=BSS, respectively). Alternatively, to narrow a search to health care-related topics, the ACS Division of Advocacy and Health

How to find and contact Congress members

**Listservs/blogs/websites**
- http://www.politicom.com/politicopulse/
- http://cookpolitical.com/
- http://drudgereport.com/

**Contact elected officials**
- http://www.usa.gov/Contact/Elected.shtml
- http://www.senate.gov/
- http://www.house.gov/
- https://www.votizen.com/
Policy has a very detailed website that summarizes state and federal legislation on which the ACS has issued statements.6

The five-minute phone call

Five minutes may not seem like enough time to make a substantial impact, but every phone call or e-mail represents one more of that representative’s constituents. It is not always possible to speak directly to a representative, which is fine as long as you are talking to someone from the representative’s staff. The staff members collect these opinions, tally the counts, and summarize the findings to the legislator. And there is power in numbers, which means it is important to encourage colleagues to participate in grassroots efforts as well. Website references in the box on page 15 provide guidelines for locating and contacting representatives by phone, letter, e-mail, or even via social networking tools, such as Twitter.

With regard to key topics, such as sustainable growth rate (SGR) repeal or health care reform, specialty groups, including the ACS, draft talking points to which users may refer during phone calls or when writing letters and e-mails to policymakers. However, these talking points are only examples or templates of items that may be covered during these exchanges. The important thing to remember is to speak up about what is important to you, including topics outside the realm of health care. The key purpose of these communications is to build a relationship with a representative. The more times you call, the more you move from “just another caller” to “a concerned and engaged constituent,” which will only strengthen your ability to discuss pertinent issues with your representatives, and influence their perspectives on issues that are important to you and your profession.

Advocacy days

Many state and professional medical societies host advocacy days at the local or national level, such as the College’s Advocacy Summit (http://www.facs.org/ahp/summit). These organized events usually start with a morning overview of the issues and talking points, followed by meetings with lawmakers. Visits with elected officials or their staff members can occur at any time throughout the year.

Select federal and state issues relevant to surgeons

| SGR | Each legislative cycle, the SGR, which is a flawed formula used to calculate Medicare reimbursement, is perpetuated by the U.S. Congress, creating billions to trillions of dollars in potential debt that ultimately may result in sharp Medicare payment cuts to physicians, particularly surgeons. |
| Tort reform | Medical liability insurance rates continue to rise and make provision of care in certain locales unattractive or financially impossible. Tort reform offers the promise of limiting liability and may help preserve the viability of surgical practices. |
| Workforce issues | Recent threats have included proposed cuts in graduate medical education funding, which would limit the number of residency slots and worsen the surgical workforce shortage. |
| Trauma systems funding | The trauma system provides care to millions of Americans each year, and additionally provides provisional support in the event of mass casualty scenarios. Funding continues the support of the maintenance and improvement of this critical national safety program. |
| Scope of practice | Each year, nonphysicians push for titles and privileges previously restricted to physicians and surgeons. This threatens both practice viability as well as public trust in the health care system as non-qualified individuals are permitted to prescribe medications or perform procedures without adequate training. |
| Biomedical research | Research is the foundation of discoveries that change the way we practice. As budget cuts threaten research funding, the surgical perspective on critical biomedical issues and the importance of funding research efforts is vital. |
Another way to get involved is to join a PAC. The strength and ability of a PAC to communicate messages to legislators comes from members’ donations and participation. There is an old quote, “You either are at the table or on the menu,” and supporting PACs ensures that they stay relevant and important and continue to be key components in successful political lobbying and advocacy.

The price of apathy
Fortunately, a nation governed by democratic rule affords its citizens the opportunity to engage in political activities to whatever extent they wish. However, U.S. physicians and surgeons have often been reluctant or relatively unwilling to participate in the political process. Physicians, on the whole, voted in federal elections at lower rates than the general population, and traditionally have had limited involvement in political activities.7,8 The reasons for this apparent apathy are many and are as individual as each physician’s personal beliefs and professional practices. Nonetheless, the simple truth is that a collective lack of participation by physicians and surgeons will ultimately place decision-making power into the hands of others whose understanding of the day-to-day practice of medicine is limited, and whose comprehension of the health care delivery system lacks appropriate perspective. As a consequence, policies may emerge that are often insensitive to the needs of physicians or patients.

The cost of indifference has the potential to be very high for surgeons. With the passage of the Affordable Care Act (ACA) in 2010, we have been launched into one of the most pivotal times in the history of U.S. medicine.9,10 The ACA will have far-reaching implications on nationwide health care delivery and finance and will affect the practice of surgery and the lives of surgeons in ways that are likely not entirely known at this stage of planning and implementation. Continuing to evaluate the feasibility and impact of the ACA as it transitions from paper to practice will require a concerted effort and strong leadership from the surgical community. Aside from the monumental shifts resulting from the ACA, several issues relevant to surgeons are currently being addressed in Washington, DC, and in state capitals nationwide, and those merit attention as well (see table, page 16).

Apathy toward these issues may or may not ultimately lead to unwanted consequences for surgeons and their patients. To use a pertinent example, consider the issue of the SGR. The SGR was developed and implemented to allow for increases in Medicare physician reimbursement based on the volume and intensity of services delivered, but was also designed to limit increases in the Medicare budget by implementing fee reductions for services that exceed spending targets.11 Unfortunately, flaws in the SGR have led to discrepancies between budgeted funds and payments, and with each passing fiscal year, the cuts in physician reimbursement are added to those of the previous year. This policy has not yet led to a significant decrease in physician reimbursement because Congress has consistently provided temporizing “fixes” to maintain reimbursement rates. These temporary patches have had a cumulative effect, and physicians now face a potential Medicare payment cut of nearly 30 percent in 2013. The consequences of this situation are potentially devastating to surgeons, as cuts of this magnitude threaten the ability of practices with large

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proportions of Medicare patients to remain financially viable. It further has the potential to lead to declining surgeon participation in the Medicare program, leaving a significant segment of society without access to appropriate care. The impact may be more far-reaching than this, though, because many private insurance companies base their reimbursement rates on what Medicare pays, leading to a second hit to surgeons, regardless of Medicare participation. This would be a doomsday situation for the U.S. surgical community.

Surgeon involvement in advocacy offers no guarantee that scenarios such as the one previously described can be avoided. However, without large-scale participation by the surgical community, the opportunity to help shape reasonable solutions to these types of challenges will be lost.

Conclusion

The world of health care is changing rapidly. Surgeons can no longer sit in their offices or focus solely on work in the operating room when it comes to taking care of and watching out for their patients. The political world has continued to merge with the health care world, and it is the surgeons’ responsibility to ensure that their patients have access to the best care possible. Being politically aware and politically active has now become a core part of being a practicing surgeon. The more surgeons are involved, the better things will be for our patients and for the world of health care. We are already leaders in the operating room and in the hospital; now we need to take the next step and lead outside the hospital walls as well. Our patients do not deserve anything less than that.

References


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Advanced degrees for surgeons and their impact on leadership

by Feibi Zheng, MD, MBA; Nicolas J. Mouawad, MD, MPH, MBA, MRCS; Nina E. Glass, MD; and Osama Hamed, MD

Good leaders are made not born. If you have the desire and willpower, you can become an effective leader. Good leaders develop through a never ending process of self-study, education, training, and experience.1

—A.G. Jago

Leadership is defined as “the process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task.”2 In 1935, physicians were in charge of 35 percent of the hospitals in the U.S.3 In contrast, in 2009, physicians headed fewer than 4 percent (235) of nearly 6,500 hospitals.4 Inadequate leadership education and preparation in the curricula of most U.S. medical schools and residency programs has contributed to this shift. Success in academic medicine requires scientific and clinical aptitude. However, a hallmark of accomplishment that receives little attention in medical school curricula is aptitude for leadership and organizational skill. In particular, physicians must learn and apply advanced skills in recruitment, retention, communication, conflict resolution, and strategic planning.

In the past, physicians acquired most of these skills through passive observation of peers and mentors, who were sometimes inconsistent in their behavior as role models. With more specialized leadership skills required, pursuit of a second degree might facilitate preparation for leadership positions. Medical schools have taken note of this new interest among students and physicians, which is reflected in the increasing number of dual-degree programs (MD/MBA, MD/PhD, and MD/MPH) available throughout the U.S.

In surgery, a growing number of surgeons in leadership positions have dual degrees. This article explores the motivations behind pursuing dual degrees, as well as the impact they may have on preparation for leadership roles. What is the unique perspective of the traditional physician-scientist, MD/PhD, in helping to guide academic surgery? How does new emphasis and interest in international surgery benefit from more surgeons with MD/MPH dual degrees? How does an improved business perspective achieved through an MD/MBA help inform surgeons who interact as much with hospital administrators and investors as they do with patients? This article addresses these and other pertinent questions for surgeons in this evolving profession.

Physicians pursuing an MBA

The increasing complexity of health care delivery and declining reimbursement have prompted physicians and physicians-in-training to evaluate whether excellent clinical education alone is enough to sustain a successful career. Some senior physicians are taking management and business courses, while others are taking on more extensive training to obtain an MBA. Physicians-in-training are following suit. The number of MD/MBA programs has increased dramatically over the past 30 years, and there are now more than 65 such programs in the U.S.5
“When you get an MBA, you learn a new language,” said Robert Udelsman, MD, MBA, William H. Carmalt Professor and chairman of surgery, Yale University, New Haven, CT. “It’s been helpful to me in understanding how funds get channeled through departments and hospitals and how different institutions work. Before getting the MBA, my only financial knowledge came from buying a house, paying a mortgage, managing a section, and funding grants.” (Personal communication with Dr. Zheng, February 3, 2012.)

The MBA curriculum generally consists of a foundation of core classes divided along the traditional business verticals of strategy, operations, finance, marketing, leadership, and human resource management. Elective courses delve into industry or country/region-specific topics—such as health care operations, provider strategy, and medical device commercialization—and develop both analytical and soft skills, such as model and simulation building and negotiation, respectively.

A 2007 survey of MD/MBA degree holders indicates that the most pertinent skills these individuals had acquired were those related to “evaluating systems, operations, and implementing improvements,” learning how to be an effective leader, comprehending financial principles, working within a team, and negotiating effectively. Though there is high variability, most surgical training programs do not provide formal training on negotiation, health care process improvement, or financial principles.

“We shouldn’t think of academic surgery only as teaching, basic science research and clinical work anymore,” noted Lynt Johnson, MD, MBA, FACS, Robert J. Coffey Professor and chairman of surgery, Georgetown University, Washington DC. “Leadership comes in many flavors. In the next 10 to 20 years, I think there [will be] tremendous opportunities, in both departmental leadership and hospital leadership, for surgeons with a background in business.” (Personal communication with Dr. Zheng, March 20, 2012.)

The decision to pursue an MBA is dependent on individual career aspirations. Those who embark on joint-degree programs often look to broaden their careers outside of clinical work. MD/MBAs are often recruited into management positions at bio-pharma and medical device firms, as strategy consultants for management consulting firms, and as associates for investment banks, sometimes without completing a residency. Physicians with entrepreneurial inclinations also find that an MBA may be helpful in building the professional networks necessary to launch a new device or commercialize a new technology. Senior physicians with increasing administrative responsibilities often pursue an MBA to communicate more clearly and negotiate more effectively with other hospital administrators and executives.

Two traditional paths currently exist for MD/MBAs. College graduates may apply to one of the 65 MD/MBA joint degree programs currently available, and senior physicians may decide to take evening and/or weekend classes in pursuit of an executive MBA. Though less common, a third pathway exists for residents wishing to pursue an MBA during their “research years,” if their chair and program director see value in formalized leadership and business training. Lastly, new leadership tracks such as those at Duke University, Durham NC, and the Methodist Hospital in Houston, TX, now enable MD/MBA graduates to leverage their MBA skills in administrative rotations while in surgical residency.

Pursuing an MBA requires a significant investment of time and money. A traditional full-time MBA program takes 22 months to complete, and tuition for a top program is approximately $80,000 per year. MD/MBA joint programs condense the dual-training pathway into five years (usually saving one year of tuition). An executive MBA is geared toward physicians with some management experience (usually more than 10 years of work experience) and costs considerably more, averaging approximately $150,000 for a 22-month part-time program. In the 2007 survey of MD/MBA degree holders mentioned earlier in this article, 81 percent of the 87 survey responders believed that their business degree had been “very useful or essential in the advancement of their careers.” The cost of the degree can be significantly subsidized through scholarships and grants or sponsorship arrangements with employers (hospitals or departments).

Determining whether an MBA is worth pursuing depends on an individual’s goals. What is clear is that knowledge of business practices and how to navigate the complex health care environment is essential for a successful surgical career today. To that end, the surgical societies have created several resources and opportunities for surgeons and surgeons-in-training to develop these skills. For residents, the Surgical Council on Resident Education portal offers a series of online lectures on systems-based practices, which covers basic principles of negotiation, cost accounting, and so on. For residents looking to sharpen their
leadership skills, the American College of Surgeons (ACS) Division of Education, in partnership with the Resident and Associate Society (RAS) of the ACS, has created an annual Resident as Teachers and Leaders course that helps residents master critical nonclinical skills related to leading a team and teaching. These tools provide an introduction into the business of medicine and formalized leadership instruction, and they may also help physicians determine whether an additional degree in management is appropriate.

**Global surgery and the MPH degree**

The MPH degree has become one of the most popular supplementary advanced degrees for physicians to obtain. Although traditional medical education for physicians has focused on identifying and treating illnesses on behalf of an individual patient, public health education is directed at populations, and includes the assessment of risk factors, the development of health education programs, and implementation of appropriate strategies with the goal of not only increasing overall health, but also of reducing infirmity and preventing disease. As such, it would seem a viable transition for health care professionals with medical training to expand individual-based methodologies to population-based programs—to effectively transition from empowering patients to empowering communities.

The MPH degree is a freestanding professional credential that may lead to a career in a variety of areas, including health education and promotion, health policy and management, epidemiology, biostatistics, environmental health, and toxicology, as well as international medicine. In fact, the current political milieu has propelled the topic of health care and health policy into the foreground, essentially compelling the interest in and necessity for national strategies for public health. A dedicated MPH curriculum can motivate and equip surgeons to tackle the salient contemporary considerations of disease prevention, health care provisions, and administrative cost curtailment.

As with other advanced degrees for physicians, acquisition of an MPH can be achieved in two ways: integrating the curriculum along with medical education, culminating in combined MD/MPH programs, or pursuing a supplementary degree at a separate time. The choice of a particular pathway is dependent on personal career goals and motivation, associated current responsibilities, and the institutional availability of programs. Most MD/MPH programs take five years to complete. However, some institutions allow enrollees to take all the required coursework within the four years of medical training. Alternatively, physicians may complete the stand-alone MPH program over a single year full-time or, for certain programs, over a longer period part-time.

Opinions vary as to the optimal course for pursuing an MPH. Proponents of combining the programs in medical school claim that physicians gain a greater perception of the complementary disciplines of medicine and public health and that they appreciate the seamless integration of the fields. On the other hand, however, some academicians maintain that the MPH should be obtained on its own so that it is not abbreviated in any way to accommodate the work involved in earning a medical degree or fulfilling residency responsibilities. In fact, the rigors of surgical clinical training may disallow a combined approach, but some physicians may consider pursuing it separately during research years.

Increasingly, programs are offering the MPH program to medically trained personnel. Driving this shift is greater awareness of global health concerns as well as the formalization of public health curricula. In some institutions, more than 20 percent of medical students enter an MPH program at some point between entering medical school and leaving for residency.

The addition of international experience to assimilate population-based strategies into practice has also proved valuable. Individuals with an MPH can expect to effectively and efficiently participate in the provision and administration of preventative health services, either domestically or abroad, as well as involved in health care policy, continuous quality improvement efforts, the delivery of culturally competent care, and international collaboration.

Many health leaders have obtained their MPH. In fact, every director of the U.S. Centers for Disease Control and Prevention since 1956 has had a dual MD/MPH degree, except for one who had an MD/PhD. These directors’ contributions to national and global health are indisputable.

Within the surgical leadership, the adoption of dual degrees is somewhat different. Of the 303 surgeons appointed to either the ACS Board of Regents or Board of Governors, 18 have combined MD/PhDs, 11 have MD/MBAs, and 25 have other advanced dual degrees (for example, MD/MSc, MD/JD, and even MD/MA); the MD/MPH contingent only accounts for four individuals.
Colleagues with MPH degrees emphasize that their coursework prepared them to conduct needs assessments and involve priority populations and stakeholders in specific planning processes, design strategies, and interventions. It also helped them to design instruments to collect data, manage fiscal and human resources, and implement action plans and obtain acceptance and support for programs.

These skills have enabled residents to set up make-shift surgical clinics in underserved nations, determine where and how to set up latrines and provide sanitary conditions, and even how to find and preserve necessary fresh water. In addition to formal coursework, relief missions to Haiti, India, Honduras, and Kenya have demonstrated the importance of understanding how to allocate and optimize scarce resources. The increasing burden of global disease and the economics of health care policy is a contemporary international concern. Whether the MD/MPH is worthwhile and cost-effective depends on the individual's career goals. What is clear, however, is that surgeons are steadfast in their aim to inspire and achieve quality as well as embrace the opportunity to equip themselves with the necessary skills to face future challenges. With the MPH advanced degree, a surgeon can transform into the veritable global physician.

**The physician-scientist track**

The MD/PhD is the most traditionally pursued dual degree among physicians. Graduates of these programs are typically innovative, comprehensively trained physician-scientists prepared to play a key role in the translation of scientific findings to clinical practice and vice-versa. MD/PhD programs typically attract students with a strong aptitude for the basic sciences and a passion for understanding how things work. More recently, physicians are pursuing less conventional degrees in fields ranging from anthropology to zoology. Currently, the Association of American Medical Colleges recognizes more than 100 MD/PhD programs available nationwide.

Most MD/PhD programs include two years devoted to the basic science courses of the traditional MD curriculum, and to one major graduate course, followed by three to four years of graduate study, including the pursuit of a doctoral thesis in the chosen field, supplemented with an ongoing clinical tutorial during those years. The final 13 to 14 months of clinical rotations are, again, part of the medical school course. It is expected that students will complete both degrees in seven or eight years with some variability inherent in pursuing research. The discipline of study may comprise a wide variety of biomedical sciences, such as biochemistry, cell biology, immunology, microbiology, neuroscience, and so on. If a physician's passion for scientific research becomes evident during residency, this interest can be translated into a PhD degree, which typically takes three years to complete, during or after residency, in addition to the clinical years of residency.

Most MD/PhD graduates follow career paths consistent with their training as physician-scientists and enter academic medicine with a focus on running research laboratories. Devoting time to a research career is essential for physician-scientists to succeed in obtaining the necessary funding for their research endeavors.

"The PhD degree was very helpful and gave me a strong background that allowed me to address scientific..."
issues critically,” said Kevin Staveley-O’Carroll, MD, PhD, program director and head of the liver, pancreas, and foregut tumor program at Penn State Hershey Cancer Institute, and holder of an R01 grant, “It is becoming very competitive to obtain R01 funding and having the PhD degree definitely set me apart and gave me an edge in obtaining the appropriate funding for my research.” (Personal communication with Dr. Hamed, February 10, 2012.)

Many surgeons with MD/PhD degrees maintain busy and productive research labs, and at the same time have active clinical practices. The MD/PhD degree is the most common dual degree among the department of surgery chairs of the top 50 medical schools named by U.S. News & World Report, and the most common dual degree in the 303 surgeons appointed to either the ACS Board of Regents or Board of Governors.13 These data suggest that despite the added time required to succeed in research, these surgeons succeed in managing their time to also incorporate administrative work and leadership positions in national surgical societies.

Conclusion

Research in organizational behavior and business administration indicates that people making the transition from individual contributors to leaders find that the experience of leading differs significantly from what was anticipated and is substantially more challenging.13 Surgeons interested in leadership positions have multiple options for development. “Good leaders develop through a never-ending process of self-study, education, training, and experience.” Obtaining a dual degree is one way to accelerate and focus these processes.

References

Over the past 25 years the proportion of women entering medical school has increased dramatically, such that nearly half of today’s graduating medical students are women. However, the number of women entering the surgical specialties remains relatively small. The reason for this discrepancy is multifactorial and has been attributed to unconscious bias, a lack of female role models, and perceptions regarding inability to achieve work-life balance. Although women have made great strides in medicine and more recently in surgery, a “glass ceiling” still exists for women surgeons when it comes to leadership roles at the departmental, institutional, and national level. Indeed, in the U.S., only 12 percent of department chairs in all specialties of medicine are women.

Several notable women surgeons have, despite many barriers, achieved the highest levels of leadership in surgery. In this article, three remarkable women—Olga Jonasson, MD, FACS; Kathryn Anderson, MD, FACS; and Patricia Numann, MD, FACS—will be highlighted for their achievements in surgical leadership (see photos, page 25).

This article goes on to examine current initiatives in surgical training aimed at increasing the leadership potential of the next generation of women surgeons. In addition, the complexity of the glass ceiling, as it relates to women surgeons who are seeking promotions and leadership roles, will be explored. Finally, initiatives aimed at promoting the advancement of women into the upper echelons of surgical leadership will be discussed.

### Prominent women leaders in surgery

- **Dr. Jonasson** has long been hailed as a pioneer for women surgeons around the world. Born in 1934 in Illinois, Dr. Jonasson attended medical school and completed her surgical residency at the University of Illinois, Chicago, after being inspired by her mother’s nursing career. She then went on to complete research fellowships in immunochemistry at the Walter Reed Army Medical Center, Washington, DC, transplantation immunobiology at Massachusetts General Hospital, Boston, and cardiovascular and thoracic surgery at the University of Illinois.

  From 1967 to 1987, Dr. Jonasson was a surgical faculty member at the University of Illinois Hospital. As the first woman transplant surgeon, she developed one of Illinois’ first transplantation programs, and she performed the state’s inaugural kidney transplant. Dr. Jonasson also was a leader in histocompatibility testing. In 1987, Dr. Jonasson left Illinois for Ohio State University, Columbus, where she became the first woman in the U.S. to head an academic surgery department at a coeducational school of medicine.

  Dr. Jonasson received many awards and accolades over her illustrious career. She was the first female initiate of many surgical societies,
including the Association for Academic Surgery, the American Surgical Association, and the Society of University Surgeons. She was the first woman to serve as director of the American Board of Surgery and the first woman appointed to an ACS executive committee. Dr. Jonasson held both editorial and reviewer roles at many prestigious surgical journals, including the *Annals of Surgery*, *Journal of the American College of Surgeons*, *Journal of the American Medical Association*, and the *New England Journal of Medicine*.

Dr. Jonasson passed away after a brief illness in August 2006 at the age of 72. She will always be remembered for her contributions to clinical medicine, and she will be celebrated as an innovative and inspiring teacher. Her mentorship efforts helped to advance and develop the careers of many young surgeons, both male and female.

Likewise, Dr. Anderson paved the way for women leaders in surgery by becoming both the first woman Officer of the ACS in 1992 and subsequently advancing through the ranks to be elected as the first woman President of the ACS in 2005. Born in England in 1939, she moved to the U.S. in 1962 after marrying her husband, an American. After earning her medical degree at Harvard University, Boston, MA, Dr. Anderson completed her residency in general surgery at Georgetown University Hospital, Washington, DC.

Throughout her training, Dr. Anderson encountered significant discrimination because of her gender. After being denied a surgical internship at her own medical school, she pursued a nonsurgical internship at Boston Children's Hospital. In her general surgery residency, Dr. Anderson was assigned only seven cases in her first two years. Fortunately, she was able to advance her surgical training in community hospitals, where she assisted in more than 700 cases in the subsequent year. Even though she was an accomplished resident, she struggled to find a position in a pediatric surgery fellowship. She was offered a position only after the selected fellow was called away for military duty.

Despite the obstacles she faced early in her career, Dr. Anderson has gone on to have a distinguished career as a pediatric surgeon, practicing at Children's National Medical Center in Washington, DC, and Children's Hospital in Los Angeles, CA. She has held prominent positions in many pediatric and surgical societies, as well as on numerous medical and surgical journal editorial boards.

Mentorship is a principle that Dr. Anderson believes in strongly, after being mentored by Dorothy Heard, MD, at the University of Cambridge, and W. Hardy Hendren III, MD, FACS, at Boston Children's Hospital. She has continued to embrace the principles of mentorship in surgery during her professional career. Throughout her career she has helped many medical students, residents, and attending surgeons navigate their career paths.
Currently serving as the 92nd President of the ACS, Dr. Numann has been inspiring women surgeons for the past 40 years. After completing medical school and general surgery residency at the State University of New York (SUNY) Upstate Medical University in Syracuse, she decided to stay loyal to her alma mater by completing the rest of her professional career at the center where she trained.9

As an attending surgeon at SUNY, Dr. Numann held many leadership positions, including associate dean of the college of medicine, associate dean of the college of medicine clinical affairs, professor of surgery, medical director of the University Hospital, and the Lloyd S. Rogers Professor of Surgery. After retiring from clinical practice in 2007, SUNY awarded her emeritus status and in 2009 created the Patricia J. Numann, MD, Chair of Surgery, the first endowed chair for a woman surgeon in the U.S.9

Since becoming a Fellow of the College in 1974, Dr. Numann has worked tirelessly on numerous ACS committees and boards. She has also received countless awards over the years at local, national, and international levels. She is renowned for her approachable spirit and inspires all who have the honor of meeting her.

Dr. Numann is perhaps most recognized for her singular role in establishing the Association of Women Surgeons (AWS). In an effort to meet other women surgeons at the annual ACS Clinical Congress she organized a breakfast for women surgeons at the meeting in 1981.9 Growing interest in this annual event led to the establishment of the AWS, the mission of which is to “inspire, encourage, and enable women surgeons to realize their professional and personal goals.” The AWS has expanded tremendously since that first breakfast meeting, and now has a membership of more than 1,600 members in more than 15 countries.10

Training the next generation

It is well known that presently the majority of medical students, both in the U.S. and abroad, are female. Women have become an increasingly greater proportion of American medical school graduates throughout the last 50 years, with a growth from 6.9 percent in 1966 to 48.3 percent in 2010.1 Even higher numbers have been reported in other areas of the world, with 62.1 percent of medical graduates in Switzerland identifying as women.11

While a rapid progression in the proportion of total female medical school graduates has been observed, this trend has not extended into surgical residency. Although the number of women in general surgery training has increased markedly from 21.2 percent in 1999 to 35.2 percent in 2009, the number of women residents has failed to achieve parity with their male counterparts. Women’s representation is and has been even more discrepant in other specialties including orthopaedic surgery and neurosurgery.1 In addition, enrollment in general surgery residencies has declined overall, which some individuals in the field attribute to the progressive increase in female medical school matriculates—who may be reluctant to pursue this rigorous career path.12 As we face a projected shortage of general surgeons over the next decade, it is worrisome that some of the brightest and most talented medical school graduates are not entering surgical training programs.

Many studies have looked at various factors that may influence a female student’s thoughts regarding whether to pursue a career in the surgical specialties. Considerations such as lifestyle implications of career choice, the surgical culture, the lack of female mentors in academic surgery, and equity issues have been shown to play roles in female students’ career choices. In one recent study of more than 1,300 students, 24 percent of male and only 15 percent of female medical students expressed interest in a surgical career.13 Women, in particular, have indicated their reluctance to pursue a surgical career due to lifestyle implications, and were more prone than men to be dissuaded from a surgical career due to a decision to have children.12

However, women students who had strong female role models or faculty members in general were more likely to pursue a career in surgery.12 These findings highlight the importance of female surgeons in academic practice and surgical leadership roles. Not surprisingly, gender discrimination encountered during surgical clerkship had a negative influence on whether to choose a surgical career. In another study, male academic surgeons were more likely than their female colleagues to state that surgery was “not a good choice for women.”12 Unconscious bias regarding traditional roles for males and females likely played a role in this finding. In
the same study, women actually found increased career satisfaction in positions with predictable work schedules and that offer opportunities to achieve work-life balance.

Research suggests that attitudes are changing and that female medical students are, indeed, interested in surgical careers. The proportion of females entering surgical residency is growing, albeit at a slower rate than what has been observed in medical schools. It is clear that increasing the number of women surgeons available to act as mentors and role models will serve to increase female medical students’ enthusiasm for careers in surgery. In addition, a dynamic residency program with a less traditional surgical culture and more emphasis on collegiality, diversity, and flexibility is necessary to attract more female students.\textsuperscript{14}

\textbf{The leaky pipeline}

It continues to be uncommon to find women in leadership positions across all specialties at most medical schools. In fact, the demographic has been so significantly skewed historically that various organizations have taken corrective actions. For example, in 1998 the Association of American Medical College’s (AAMC) Increasing Women’s Leadership Committee formalized a data collection process to quantify the advancement of women in academic medicine. Information was collected on a variety of data points that confirmed the lack of women in leadership positions at many medical schools. This information was used to make recommendations for the professional improvements for women in medicine.

In 2003, the Women in Medicine Coordinating Committee was established to develop new strategies for advancing women in academic medicine, and in 2009, this group was approved by the AAMC board of directors as an AAMC professional development group, now called the Group on Women in Medicine and Science. Of note, AAMC board recognition, which is a critical component for the advancement of women in academia, was formalized just three years ago.

Within the field of surgery, the paucity of women in positions of seniority is sobering, with women holding only four chairs in surgery departments in the U.S., while the number of female full professors in surgery rose to a meager 8 percent in 2010.\textsuperscript{1} It is also interesting to note that there has yet to be a women president or recorder of the American Surgical Association.

Although the number of women surgeons in positions of power continues to be low, the rise in the number of women choosing a career in surgery is encouraging. To build upon this trend, efforts must be made to retain women in surgery and to accurately identify challenges unique to women. Programs aimed at building leadership skills and identifying and supporting prospects for promotion will improve women’s representation in positions of seniority.

In order for positive change to occur, it is important to acknowledge that even in 2012 gender disparities for women in surgery exist. The glass ceiling metaphor implies that women and men have equal access to entry- and mid-level positions but not more senior positions. In reality, this metaphor is not entirely accurate. A more appropriate analogy is the “leaky pipeline,” which reflects the fact that the percentages of women found at the end of the pipeline do not match the percentages of women found at the input. In 2009, across the board in medicine, 17 percent of full professors were women, even though women constituted 24 percent of medical school students in 1975.\textsuperscript{15} Furthermore, it has been well-established that the proportion of women who have advanced to senior ranks continually has been lower than that of their male counterparts.\textsuperscript{16,17} This finding suggests that the scarcity of women in leadership positions is not the result of insufficient numbers; rather, it represents attrition of women along that pipeline. This loss of proportional representation at advancing stages of a woman’s career holds true in all fields of medicine—and is not limited to surgery.\textsuperscript{16,17}

The challenges women surgeons face are complex and difficult to measure and, as a consequence, problematic to resolve. Women in surgery face salary discrimination, slower promotion rates, conflicting cues regarding when to start a family, greater home-life conflict and depression, less research support, and restricted access to positions that lead to promotions and other forms of recognition.

What is behind this discrimination and the unconscious bias against women? Well-intentioned chairs and program directors may not consider a woman for positions due to concern about overburdening women faculty and residents. Although more women residents and fellows are having chil-
children, starting a family is still perceived negatively by both faculty and residents alike. Study after study in sociology, psychology, and business has pointed to the widely shared conscious and unconscious associations regarding the traits of women, men, and leaders. People tend to associate the traits of a good leader with the traits of men rather than with the personality traits of women. More research is needed to further define the challenges unique to women surgeons, so that a greater understanding of the impact of proposed interventions will achieve the goal of retaining and promoting this rich talent pool.

Advancing into leadership roles

In addition to teaching residents about surgery and patient care, chief residents, fellows, and established surgeons alike should seek out opportunities to develop their leadership skills and pursue positions that will lead to advancement and further job recognition. Over the past decade, various surgical societies have developed a number of programs to promote mentorship, develop leadership skills, and facilitate the advancement of women surgeons through the various stages of an academic career. The AWS has made this agenda a priority from its inception, and to this end, AWS offers networking breakfasts at the annual meeting, mentorship programs, and a variety of grants and awards targeted specifically toward the female surgeon.

The AWS leadership has also made a concerted effort to promote women surgeons through the leadership ranks of every major surgical society—such that many now have an AWS delegate or chair, including the ACS Board of Governors. In the past few years, the ACS Women in Surgery Committee has implemented an early-career mentorship program, which pairs prominent women surgeons with rising junior faculty in an effort to help these physicians navigate the somewhat challenging road to promotion and advancement in academic surgery. This program, and others like it, have brought together female surgical trainees and practicing surgeons alike from around the country to discuss many of the issues addressed in this article.

Conclusion

While women have achieved parity with men in terms of medical school enrollment over the past decade, the gender gap in surgical specialty training programs has only recently started to slowly close. The increased proportion of women entering surgical training programs may be attributed to a number of factors, including a steady rise in the number of female surgeon mentors and role models, along with the cultural changes in surgical training programs with respect to duty hours and work-life balance. In order for the advancement of women surgeons to continue, additional resources should be developed to ensure that more women rise through the ranks in their departments, institutions, and surgical societies, as exemplified by the notable women surgeons highlighted in this article. More programs than ever before are available to help women surgeons locate suitable mentors and build leadership skills among female surgical trainees and faculty alike.
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Over the last decade, a transformation has occurred in surgery. With rapid technological advances, changes in reimbursement, and modifications to resident training programs, strong leadership is needed to ensure future success.

Changes in health care

The future of the U.S. health care system is powered by the vision of those leaders who thoroughly understand its past and have explored the dominant factors that have played an important role in the transformation of medicine throughout the twenty-first century.

While twentieth century medicine revolved around the treatment of disease, today’s focus is largely on preventive care. The emerging application of the sciences, such as genomics, proteomics, medical technologies, and informatics, has facilitated our understanding of the molecular and cellular events leading to disease. This new understanding should improve physicians’ ability to detect patients at risk and to potentially implement necessary preventive strategies.1 With the advancement of treatment options, medicine has shifted from the management of acute disease to the management of chronic illnesses.2,3 One out of every two adults—almost 133 million Americans—suffers from at least one chronic illness, and in 2020 this number is expected to grow to 157 million.4 A growing body of evidence shows that the rising rates of chronic disease are placing an unsustainable burden on the national economy, with health care spending expected to reach $4.2 trillion in 2016.5 The steady increase and growing ethnic diversity of the U.S. population, as well as the 78 million baby boomers becoming Medicare-eligible over the next 18 years, are creating an ever more compelling need to transition from an acute to a chronic care model.6-9

As scientific knowledge accumulates, we realize that the etiology of disease is multifactorial. The interplay occurs between genes, infectious agents, environment, nutrition, behavior, and society. To solve the mystery of complex medical conditions, multi- and interdisciplinary research teams consisting of physicians, biologists, scientists, engineers, financial analysts, and other professionals are essential.10 A major barrier has been the lack of a common language among these multidisciplinary groups, the development of which would facilitate an effective and constructive dialogue. Surgeon leaders with the capability to effectively build and maintain multidisciplinary teams can set specific goals, find solutions, and translate such collaboration into effective health care delivery.11

One major difference between the practice of medicine today and that of the twentieth century is that patients have greater and easier access to medical information and tend to evaluate health care providers in various ways.12 The rise of social media, such as blogs and online social networks, has further fueled interest in the new “science of sentiment analysis,” a means of determining the attitude of an individual with respect to a specific topic or source.13 Access to care is considered a social right, and the patient plays an indirect, though crucial, role in any future renova-
tions of medicine. Surgeons must safeguard patients’ ability to access appropriate care.

Physicians, hospitals, and university researchers may not generally be viewed as political entities, but when it comes to topics such as the highly debated Affordable Care Act, all three parties have certain advantages over government leaders. A 2009 poll of 1,009 national adults ages 18 and older found that nearly three-quarters (73 percent) of Americans trust physicians to take the lead in reforming the U.S. health care system.14 Whereas with great trust comes great responsibility, surgeons, residents, and researchers cannot further neglect our unsustainable health care system. To ensure that surgeons are able to influence the health policy development process, future medical education should incorporate formal training that allows for the development of competent physician leaders.

**Advances in surgical training**

Surgical training has undergone rapid changes in recent years. Beginning in 2003, the Accreditation Council for Graduate Medical Education (ACGME) mandated that residency training programs restrict duty hours and, thus, the 80-hour workweek was implemented. More recently, interns’ duty hours were further limited to a maximum of 16 consecutive hours. The goal of these work-hour restrictions is to improve patient safety by reducing resident fatigue. Since the implementation of these new restrictions, concerns have arisen regarding resident education and competency, especially in the setting of technological advancements in the treatment of surgical disease.

Traditional surgical resident education has occurred according to the model formalized by William S. Halsted, MD, FACS. The “see one, do one, teach one” paradigm guided surgical educators, and helped aspiring surgeons develop their technical skills. Although this model was successful in creating a highly skilled surgical workforce, it relied on a high volume of operative cases with progressive levels of responsibility that took years to amass. In the eyes of many experienced surgical educators, work-hour restrictions can essentially deprive the resident of such educational opportunities. This concern has been validated in a review of the ACGME Resident Statistic Summary that reported a decrease in total operative case volume and senior-level cases, with the number of junior-level cases remaining the same.15 Furthermore, in a survey of surgical trainees, a large subset of senior residents considered work-hour restrictions to be an educational barrier and expressed a desire to work longer hours.16

Training surgeons outside of the traditional Halsted model is not a novel concept. Since the early 1990s, with the advent of endovascular surgical techniques and continued progress in minimally invasive surgery, surgeons have spent time outside of the operating room (OR) and in simulation labs learning new and innovative techniques. The acceptance of surgical skills education outside of the OR has been widely accepted, and this is no more apparent than in the ACGME’s Residency Review Committee’s (RRC) requirements for surgical training programs, which recommend access to simulation centers. In fact, the Fundamentals of Laparoscopic Surgery is a Web-based educational module endorsed by the American College of Surgeons (ACS) and required for applicants to the American Board of Surgery (ABS).

As technology advances among the surgical subspecialties, components of specialty training may be excluded from the current curriculum of general surgery residency. Over the past two decades, the number of open, major vascular operations performed has significantly decreased and been replaced with minimally invasive techniques, such as endovascular aneurysm repair.17 As a consequence, fewer open vascular cases are trickling down from the fellow to the resident level, which ultimately takes away from the experience in basic surgical principles, such as gaining proximal and distal vascular control. Simulation and skills training (using cadaveric, animal, inanimate, or computer models) are ways to teach surgical residents not only the lifesaving skill of vascular control, but also to introduce vascular access and basic endovascular techniques.

The surgery training paradigm has certainly been altered to accommodate work-hour restrictions while still providing residents with the proper amount of exposure to surgical patients both in the clinic, emergency department, ward, intensive care unit, and OR. With the tendency toward specialization throughout all of medicine, a transition is already taking place, with integrated surgical training programs or early specialization programs. This movement has allowed for rapid progression via a shorter course of basic/early general surgery training with a more dedicated period of development in the desired specialty training program.

Academic surgical units play a fundamental role in the future of surgery and require effective leaders.
to maximize their impact. At the same time as the demand for surgical procedures is growing, financial resources are becoming more limited. The current changes make it imperative that modern surgical leaders acquire not only surgical skills, but also the ability to develop critical thinking, problem solving, and team-building skills. Leadership development must be incorporated early on into the resident curriculum, which will facilitate the creation of leaders who understand these changes and are effective surgical educators.

**Leadership qualities**

Various definitions of leadership exist, most of which emphasize the importance of influence. For example, John C. Maxwell, who has written extensively on the topic, has stated, “Leadership is influence—nothing more, nothing less.”

Traditionally, leadership was judged largely on the basis of individual achievements. However, Wiley Souba, MD, FACS, and colleagues have asserted that great leaders have integrated their strengths in three fundamental areas: What they know, what they do, and who they are. This includes performance measures, such as knowledge, expertise, competence, action, results, accomplishments, and personal qualities and attributes.

In an interview with 10 female surgical leaders, 60 percent said the greatest challenges for leaders are obtaining buy-in, building consensus, and leading people through change. Other challenges identified during the interview include the following: maintaining clinical skills, creating positive cultures, keeping communication open, avoiding burnout, recognizing and implementing ideas, dealing with difficult personalities, being a role model, managing funds, and making tough decisions.

Traditionally, the emphasis in surgical leadership was almost solely on technical and clinical expertise with minimal consideration given to management skills. A total of 258 leadership behaviors were observed over the course of 63 hours in a recent study. Surgeons most frequently showed the following behaviors: guiding and supporting (33 percent), communicating and coordinating (20 percent), and task management (15 percent). Most of these behaviors were directed to the room rather than at a specific team member. Surgeons demonstrated leadership qualities significantly more often during highly complex cases.

The importance of mentorship in the development of a surgical leader has been widely acknowledged. In a discussion of mentorship in the twenty-first century, Eva Singletary, MD, FACS, said a good mentor should listen, facilitate and provide networking experiences, share knowledge of the system, offer assistance as needed, teach by example, motivate, promote independence and balance, and rejoice in the success of their mentees. Even the traditional method of mentoring, in which the mentor served as technical expert, political strategist, role model, coach, and confidant, has given way to the mosaic model of mentoring, in which residents have multiple mentors, one for each sphere of their life and work, including clinical practice, research, personal life, communication, management skills, and so on.

The ACS was founded with the primary goal of improving the quality of care for the surgical patient by setting high standards for surgical education and practice. As an organization that has fostered and developed surgical leadership over the past century, its impact on surgery in America and around the globe has been tremendous. One of our young leaders, Patricia L. Turner, MD, FACS, Director of the ACS Division of Member Services, exemplifies the type of leader who has cultivated mentors on multiple levels in order to excel at both the professional and personal level (see photo, this page).

Born and raised in Washington, DC, Dr. Turner said she “always wanted to be a surgeon, even as a young girl,” a sentiment not every physician may relate to. So, where does her passion and drive come from? Who was mentoring her at such a young age? As Dr. Turner’s career developed, many individuals provided guidance and contributed to her success. She cites L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), immediate Past-President of the ACS, as the individual who has had the greatest effect on her career.

Dr. Turner
Interestingly, she never attended Eastern Virginia Medical School, Norfolk, where Dr. Britt is the Edward Brickhouse Professor and Chair of surgery. She did not train there as a resident, and she has not directly worked for Dr. Britt. Their relationship actually began at a meeting for medical students, where she showed that same interest and zeal that many of us have seen in her. Over time, their relationship developed, and Dr. Turner was able to use his wisdom, experience, and guidance to make the necessary decisions to eventually become the surgical leader she is today.

Having the right mentors is only part of the leadership equation. Without the commitment, dedication, and a strong work ethic, Dr. Turner would not be where she is today. In fact, as a junior faculty member at the University of Maryland, Baltimore, Dr. Turner admitted that her academic productivity could have been better. In conversations with Dr. Britt, she began to provide him with various reasons why she had been less successful in her initial few years. Dr. Britt’s advice to her: “You can complain about your situation, but if you want to get promoted, the coin of the realm is delivering results.” Dr. Turner stated that this was probably the best single piece of advice she has been given with respect to her professional career.

Dr. Turner is as dedicated to her family as she is to the ACS. Her husband and two young daughters, Morgan Elizabeth (age 6), and Jessica Carmen (age 12), plan to join her in Chicago this year. Balancing our personal and professional lives is vital to long-term success.

Dr. Turner provides an excellent example of why it is important to find the right mentorship opportunities. Mentors will not do the work for their mentees, but they will provide them guidance in their chosen field. This relationship has been viewed with much gratitude among the mentees, who desire to “carry on the torch” of mentorship in their lives. As Ruth Whitman once said, “In every art, beginners must start with models of those who have practiced the same art before them.”

Theories of leadership

There are a wide range of theories regarding the development of skilled leaders. The “great man theory” postulated by Thomas Carlyle says that leaders are born and not made, and great leaders emerge when they are needed. The “trait theory” describes how traits of leadership are inherited, with successful leaders being endowed with the right combination of qualities. In contrast, the “behavioral theory” is grounded in the notion that leaders can be groomed through proper teaching and observation.

Various types of leadership styles are often exhibited by leaders. Autocratic leaders exert high levels of power over their team members. Under this leadership style, there is a clear division between the leader and the followers. Few opportunities are available for making suggestions, even if applying these recommendations would be in the team’s or the organization’s best interest. The autocratic style of leadership often breeds resentment, which leads to high levels of absenteeism and staff turnover.

On the opposite end of the spectrum are transactional leaders, who tend to adapt to and thrive in challenging environments. They promote networking and encourage problem-solving and innovation. This form of leadership depends on some form of exchange—for example, productivity in return for rewards.

Similar to the transactional leadership style, transformational leaders focus on collaboration and working toward and promoting an ideal. Leaders work toward a common goal with followers and invest in their development.

The current emphasis in surgical leadership has shifted from the traditional autocratic and transactional styles to a more transformational model. Thomas Lee, MD, recently published an article addressing the traditional approaches to leadership in medicine. According to Dr. Lee, physicians see themselves as heroic lone healers, and working in teams can be challenging. However, under the transformational model, building effective teams is a key part of being a successful leader. In contrast to traditional leaders who try to maximize revenue under existing revenue systems, new generation leaders focus on measures, such as outcomes and performance improvement processes. Development of health care systems that are patient-centered is now considered a touchstone toward improving quality of care.

Traditionally, hospital departments were organized around the physician. The culture of health care organizations has been moving away from these silos to the development of units where a variety of specialty physicians care for a particular patient population (such as heart patients) under one roof—called “collocation.” Due to the fact that the practice
of medicine is highly evidence-based, performance measures or outcome assessment plays a key role in referrals and potentially physician reimbursement. The surgeon-leader must be well-versed in these developments and possess not only basic leadership qualities, but also sound financial management skills and the ability to collaborate with multidisciplinary team members.

The contrast between clinical care and organizational leadership has been described as a difference in cultures. Medical culture is largely characterized by autonomous decision making, a reactive approach to problem solving, and a focus on individuals within the context of their biological, psychosocial, and sociological environments. The administrative focus is typically proactive, systems-oriented, and collective, and it is in sharp contrast to physicians’ focus on helping individual patients one at a time.

Leadership development

The transformational change necessary for physicians to develop business and leadership skills can be supported and encouraged in a leadership development program that includes a specific curriculum design, program monitoring, and opportunities to apply new skills in practice. Peter Büchler and colleagues demonstrated how implementation of business management concepts changes workflow management and surgical training, and they emphasize the importance of introducing a business skills curriculum into medical education and postgraduate surgical career development. Leadership courses in surgery also assist in the development of these skills, and examples of these courses include the College’s Residents as Teachers and Leaders course and the Surgeons as Leaders course, as well as the career development programs that the Association of Women Surgeons sponsors.

Conclusion

With rapid changes occurring in the nation’s health care system, the need for strong surgeon leaders has never been greater. The essential qualities and requirements for such leadership have changed. Although excellent clinical knowledge, technical skills, and strength of character are still the hallmarks of surgical leadership, current leaders also require administrative and management skills. Incorporation of early formal leadership training during both medical school and the residency period is necessary to produce capable leaders who can guide surgery through these changing times.

Disclaimers

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the U.S. Department of the Navy, U.S. Department of Defense, or the U.S. government.

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total of 18 percent of Medicare beneficiaries undergo a major operation in the last four weeks before their death. The discussion regarding risks and benefits of operative interventions in an end-of-life situation can be emotionally charged and ethically complex. Perception, expectations, and care plans often differ among patients and families, surgeons, and other physicians involved in a patient’s care. In a time of health care reform, outcomes tracking, and cost awareness, this becomes an even larger challenge.

A recent survey of patients found “hope” to be among the most important aspects of care. According to the survey, “Patients are uncomfortable with uncertainty about diagnoses and prognoses and often request tests to help alleviate those anxieties.” Guilt may play an important role in decision making if all care options are not pursued. However, considering that as much as 30 percent of health care costs are associated with unnecessary tests, procedures, and treatments, how do surgeons make decisions regarding end-of-life surgery and care? What factors are important to discuss with patients and families faced with difficult surgical decisions? And how do the costs and outcomes of end-of-life surgery affect the health care system?
Surgeon’s stake in the game

Autonomy is one foundation upon which all the health care decision making is built. With respect to patients, autonomy refers to their rights to make decisions related to the care of their bodies. The physician’s respective autonomy—their freedom to provide the best care to their patients based upon their best judgment—is often overlooked or simply ignored. In a viewpoint written by Ezekiel J. Emanuel, MD, PhD, and Steven D. Pearson, MD, MSc, and published in the Journal of the American Medical Association, the author appropriately defined physician autonomy as “the freedom to determine both the conditions of practice and the care delivered with the principal goal that care decisions are aimed at promoting the patient’s well-being.”

In fact, some health care professionals are concerned that the impending changes resulting from health care reform may restrict or enhance surgeons’ autonomy. It is surgeons’ commitment to a high standard, a drive for intellectual excellence, and the role of stewards of society that place them in a unique position to use evidence-based clinical judgment to balance and effectively address a patient’s desire for optimal health care.

Optimization of health care resources has gained increased popularity in recent years and is the founding principal of accountable care organizations (ACOs), the end goal of which is to reduce wasteful spending. Economists define waste as any expense from which profitable gains are not recuperated, such as the performance of unnecessary interventions. It has been estimated that a human life has a value of at least $3 million and that medical care that results in one year of good quality life should cost less than $100,000. If the costs of care delivered outweigh the medical and quality of life benefits, then it is wasteful from an economic perspective. Along those same lines, a surgeon could potentially define waste as performing an operation from which the patient will never recover to a reasonable and meaningful quality of life.

How might optimization of health care resources translate into patient care? For example, should a patient who presents with critical limb ischemia undergo primary amputation rather than a “costly” endovascular intervention? In this case, a primary amputation might appear to be economically sound, but a closer look provides cause for reconsideration. After accounting for the cost of hiring home health aides, modifying an amputee’s home, and providing long-term care, the cost-effectiveness of a cheaper medical intervention is less clear. In fact, after taking into account the economic impact on the patient’s family, time off from work, decreased work productivity, and so on, amputation becomes an even more unattractive option. In fact, the contrary argument holds more truth—interventions, which are more aggressive in salvaging critical limb ischemia, have been shown to be associated with lower complication rates and costs.

Surgeons, at some point, are patients, too. If surgeons evaluate themselves, what type and level of care would they prefer, particularly at the end of life? Many health care professionals and surgeons opt out of medical care in this situation. This decision may be surprising to the public, but not to most physicians. Many surgeons can recall a conversation regarding a critically ill, elderly patient lying on a proverbial mattress grave in the surgical intensive care unit (ICU) during which a physician or colleague has stated, “Don’t let that happen to me.” Retired physician Ken Murray, MD, captured this reality in an essay titled “How Doctors Die,” which describes the story of an orthopaedic surgeon who chooses not to undergo any treatment for a newly diagnosed pancreatic cancer but rather to spend his final months with friends and family. After receiving his diagnosis, he never stepped back inside a hospital.

This story sheds light on how physicians react to the life and death situations to which they are exposed more than any other profession. The futility of cardiopulmonary resuscitation (less than 85 percent survival rate even if witnessed cardiac arrest in a hospital), emergency department thoracotomies, and various other heroic measures are best appreciated by the physician community, who experience it every day. After all, medicine is just a form of palliation, and every human being has a 100 percent mortality rate; surgeons have frequent firsthand experience with this truism. However, the complexity of health care and its delivery makes this simple understanding become quickly complex.

Surgeons are not alone when faced with decisions regarding surgery at the end of life. Patients and their families are also caught in the midst of these decisions. For them it is often a foreign and confusing experience, as they are forced to make life-altering decisions about themselves or a loved one under extreme stress. This situation is made even more extreme in the U.S., which has a culture that is focused on rescue care.
Family perspective

What do families mean when they ask physicians to “do everything” they possibly can to save a loved one? Do they expect major operations to be performed with little chance of success? Do they envision the harsh realities of tracheostomies, feeding tubes, central lines, dialysis catheters, and epinephrine infusions as part of a last-ditch effort to treat the patient? Some may, but several studies among families of critically and terminally ill patients suggest otherwise. These studies show that what patient families truly want includes: a trusting relationship between physician, patient, and family; emotional support and mutual respect; avoidance of treatments lacking real benefit; relief of discomfort and pain; and good communication between all involved parties. Are there explanations for the difference between these needs and the real-life situation that is frequently encountered in ICUs throughout the country?

In his essay “Letting go,” Atul Gawande, MD, FACS, concluded that modern medicine, with its ability to maintain organ function in critically and terminally ill patients for weeks and months, has fundamentally changed the meaning of death. The process of dying has become a concept that can be hard to understand and no longer follows traditional knowledge and customs. Terminally ill patients and their families have to make treatment decisions regarding a disease process they may not understand, procedures they may be unable to pronounce, and survival statistics that may be disputed even among medical experts. Quite often, families must decipher terms and phrases, such as “full code,” “do not resuscitate,” “do not intubate,” “chest compressions,” and “vasopressors only.” They are expected to make decisions about tube feeds and other end-of-life procedures, and the reality is that all they want is what is “best” for the person they love.

Even physicians—guided by years of medical training and personal experience—are often wrong when estimating the prognosis of critical patients. Christakis and colleagues found that a mere 20 percent of physicians were correct in their prognosis for terminally ill patients, with physicians commonly overestimating survival by 530 percent. The closer physicians were to their patients, the more optimistic and incorrect they were in their prognosis. How, then, can families and relatives be expected to make rational and correct estimations in these situations?

Families tend to rely less on medical facts and more on their feelings and subjective impressions of a patient’s current state. Even when faced with dismal numbers about a patient’s prognosis, relatives tend to overestimate the chances for recovery, and frequently focus on individual reports about cases, in which prognosis and actual survival differed substantially. Depending on religion and spirituality, a significant number of people retain hope for a miracle that may alter their loved one’s clinical course.

Distrust and disbelief are common initial reactions when families are faced with a poor prognosis, and patients tend to believe that physicians offering a futility prognosis simply find the case beyond their scope of knowledge. This lack of trust may be exacerbated by today’s health care environment, where life-long physician-patient relationships and the presence of a single, trusted family physician are rare. More often, families face multiple, rotating ICU physicians who may give divergent explanations and opinions about a patient’s prognosis.

The consequences of treatments rendered in end-of-life care go beyond individual physicians, patients, and families. Health care resources are increasingly scarce, and interventions with little or no benefit impose a financial strain on an already heavily burdened health care system and, eventually, on our entire society.
Outcomes and cost

Surgery is a costly treatment option. When employed in dire situations with little hope for longer-term success, such as in end-of-life care, it often results in prolonged critical care, additional invasive interventions, and extensive rehabilitation. In younger patients, “heroic interventions” may be justified given the potential gain in remaining years of life, but are they justified for patients in their eighth, ninth, or tenth decade of life?

The remarkable advances of medicine in the last century have substantially increased life expectancy. This increase has produced new and challenging medical and surgical situations. At the same time, the population is aging, and there are fewer young people to contribute to the increasing cost of care for the elderly.

Nearly a third of Medicare beneficiaries undergo a major surgical procedure in the last year of life, and 18 percent undergo an operation in the last month of life. The provision of this level of care places a huge burden on the health care system and the national economy. Furthermore, these cases often require large resource use, which adds to the expense while offering potentially little benefit in terms of quality of life gained. An important factor to consider in these situations is the patient’s quality of life prior to surgical intervention. Although the term “elderly” typically applies to people 65 years or older, there can be a very big difference between a 65-year-old and an 85-year-old patient in terms of quality of life. Outcomes are going to vary based upon this age difference as evidenced in a study of colorectal cancer surgery in elderly patients. The patients classified as “oldest old,” age 85 or greater, had worse outcomes (specifically, 10-day mortality and length of stay) than elderly (age 65–85) and non-elderly patients, less than 65 years. (These results were for patients undergoing both elective and emergent surgery.)

Like all other patients, the elderly undergo operations in elective, urgent, and emergent situations. Each setting poses different clinical challenges for the surgeon, patient, and family. In emergent and life-threatening situations, the patient may be unable to participate in the decision-making process, and the family or surrogate decision maker may be unprepared to make life-or-death decisions on the patient’s behalf. A “do everything” mentality and plan often emerges in these situations, and subsequently 20 percent of Americans die in an ICU.

Are there identifiable factors that the surgeon can use to predict whether the patient with an emergent surgical problem is likely to survive the procedure and, equally important, to determine the postoperative hospital care and possibly the long-term rehabilitation associated with survival? Lissauer and colleagues found a surprising answer to this question: severity of illness was not linked to care decisions made by family members in a surgical ICU. The patients that were either the sickest or the most likely to survive did not necessarily have corresponding decisions made by family members. These findings suggest that physicians and families have different criteria regarding care decisions at the end of life. Physicians assess clinical factors to determine likelihood of survival, while family members rely on other criteria not necessarily linked to the clinical condition of the patient. These factors are important, because nearly one-third of patients admitted to a surgical ICU will face an end-of-life decision.

To better gauge the risks and benefits of surgery at the end of life, more data are necessary regarding patterns of care, cost of care, outcomes related to patient factors, and expectations of patients and their families. In the meantime, an honest and realistic conversation about the appropriateness of costly care to patients near to the end of life is crucial, and will, in turn, encourage additional data on this topic.

The armamentarium of modern medicine has provided physicians with the ability to treat even the most severe diseases and conditions. However, it has also created difficult ethical situations in which there is a discrepancy between what could be done and what should be done for patients with critical surgical conditions. Physicians, patients, and families may have differing perceptions of disease severity, prognosis, and plan of care. These situations represent a tremendously stressful and frustrating experience for patients, families, and health care providers. Decisions about end-of-life care touch the core values of medical care. Physicians involved in the care of severely ill patients need to find a balance between the principles of autonomy, requiring a physician to follow patients’ and families’ wishes, and beneficence, requiring a physician to explain why a treatment is unlikely to benefit a patient.

Advance care planning, an open dialogue about the goals of care, and early introduction of palliative care are key issues in the discussion about surgery at the end of life.
References


On April 4, James Cole, DO, FACS, boarded a commercial plane in Chicago, IL, for the 36-hour journey to the Far Western Desert, Morocco, an expanse of the Sahara in the southeastern part of the country. As a U.S. Navy Commander and the senior member of a mobile forward resuscitative surgical suite (FRSS) attached to 4th Medical Battalion, 4th Marine Logistics Group, Dr. Cole and his 15-person surgical team were called upon to provide support to a bilateral live-fire training exercise between the U.S. Marine Corps and the Royal Armed Forces of Morocco.

Over the last two decades, the 47-year-old father of four has been deployed to 10 countries as a military physician, often living in conditions that are spartan and, at times, hostile. Dr. Cole, who was recently promoted to the rank of Navy Captain, says his abiding interests in trauma care stretch far beyond the hospital walls he inhabits as a civilian surgeon. “I love trauma surgery, and I like the military, so that is sort of the perfect mix for me, being a trauma surgeon in a very austere environment,” he said. “It’s like pushing the trauma operative experience to a new level.”

Top: Members of Dr. Cole’s FRSS on sand dunes in Morocco. Left: Dr. Cole in the OR.

By Paula Rasich
The trouble with trauma

In his memoir, *Trauma: My Life as an Emergency Surgeon* (published in 2011), Dr. Cole tells the story about a particular U.S. civilian trauma so horrific that the patient did not survive.* In one passage, the author describes how he and his trauma team desperately tried to save the life of a young woman who had been gunned down by her estranged husband with a semi-automatic machine gun.

He writes, “Unfortunately, adversity is the very nature of trauma. Members of a trauma team get what’s handed to them. In our situation, it was a young woman who tried her best to avoid trouble, but trouble sought her out. And now she was dead.”

This, he said, was the first time he was faced with a patient who had so many injuries that he didn’t know where to get started. “I had plenty of experience dealing with people shot by someone, but that was the first time I was trying to treat someone shot 30 times by an automatic weapon,” he said.

In his book, Dr. Cole talks about this and so many other memories that he couldn’t shake off. He recalls his residency at William Beaumont Army Medical Center, El Paso, TX, averaging 120-hour work weeks honing his surgical skills to perfection, and one rotation so grueling he felt for certain the relentless stress of being put on endless call would lead to his own demise.

Looking back, he feels fortunate for his training in the military, especially under the direction of Col. Stephen Hetz, MD, FACS. “He was just a great leader, an awesome surgeon, and a great human being,” he said. “He was also a field surgeon, so he specifically prepared us for war, and I’m grateful for that.”

Even with that preparation, however, there were difficult, trying moments over the years. Seeing children die, operating for lengthy sessions, and breaking the news of lost loved ones to devastated family members were some of the pressures that had often left Dr. Cole physically and emotionally drained.

In the 15 years since he became a surgeon, some of the memories that have haunted the surgeon the most were the trauma injuries afflicted on children—the attempted murders of innocents. One such memory that didn’t fade with time was that of a little boy who was delivered to his trauma table with a screwdriver lodged into his chest, dying before his eyes.

Spurred on by family and friends to share his stories, he began writing about these and other events. “I wrote about experiences that had weighed on me over the years, especially from when I was in training and when I was in Iraq and Afghanistan,” he said. “I wrote about things that I had thought about over and over and over for a long time. I was sad for some of these patients who were so traumatized.”

For Dr. Cole, completing the book proved to be cathartic. After transcribing the details of every disturbing memory that continued to live on in his mind, he was finally able to release these powerful emotions and find peace. “It was as if my mind would not allow me to let go of the memories, but writing this stuff down cleansed a lot of my thoughts,” he said. “It was strangely therapeutic.”

Another benefit was that he gained new insight into his ever-evolving role as a physician. “Many trauma patients are substance abusers, mentally ill, or criminals. Many of my patients’ family members don’t even want them to return home. At times, I feel like a social worker,” he said. “But I realized that I had been given a great gift over the years, and this

has allowed me to spend extra time without losing my patient to offer solutions, support, and alternatives to my patients’ difficult social lifestyle problems.”

**Labor of love**

Another reason the self-described “working stiff” put pen to paper was to provide a real-world view of the day-to-day life of surgeons and other health care professionals. “Not only did I want to just tell the story, but I also really wanted to set the record straight, or at least let people know what we have to go through to get our board certification in surgery and the responsibilities of the job we have chosen,” he said. “I think, unfortunately, a lot of people have the wrong impression of what being a doctor is all about based on TV shows that make it look a lot more fun and relaxing than it is.”

In truth, learning every aspect of Dr. Cole’s surgical trade during residency often meant subsisting on a diet of sugar-laden snacks and caffeine-rich beverages, living in a sleep-deprived, semi-comatose state and being separated from his loved ones for long periods. “What we need more of in health care—and I’m talking doctors, nurses, technicians, providers of every variety—are people who really want to care for patients and have the intestinal fortitude and commitment to drive on,” he said. “We need people who are willing to put their hands in blood and are willing to handle the stress of people dying. I want the right people to get into health care, and hopefully this book might inspire a few people to do that.”

**In the trenches together**

On the military front, Dr. Cole was active as a U.S. Navy officer from 1991 to 2000. Then, in July of 2004, he got his orders to ship out to southern Afghanistan, his first deployment since rejoining the U.S. Navy Reserve following the terrorist attack on the World Trade Center on September 11, 2001. For Dr. Cole, a sense of duty brought him back into the military fold after a nearly three-year hiatus. “I felt a sense of obligation and even guilt for not being in the service when our country was at war, knowing that I had friends who were already deployed, and young soldiers and Marines and sailors that were in this combat zone getting injured. I thought, ‘this is my duty, I’m a surgeon, I’m supposed to be there taking care of these people,’” he said.

At the Bagram Air Base in Afghanistan, he was assigned to the U.S. Special Operations Command medical team. An expert rifleman, paratrooper, and Navy diver, he had been attached to this elite group several years prior to this assignment. For the next five months, Dr. Cole wore two hats: first, as the task force surgeon, supervising all health care matters related to the Special Operations Task Force, and second, as a member of a forward surgical team providing support to Special Operations commandos.

At the base, commandos were deployed every night to capture or kill Taliban and Al Qaeda fighters. Flying numerous missions, Dr. Cole was required to accompany the commandos armed as any other combat soldier, wearing body armor and weapons weighing 60 pounds. With just a few hours notice, the medical team would pack their gear, board a heavily armed helicopter, and lift off into the black of night. Departing from the safety of camp, they would then touch down a distance from a battle scene and wait to receive gravely injured soldiers. During one mission, Dr. Cole sensed a danger so palpable that he readied himself for ambush by encroaching adversaries.

“My typical day was a typical night. We always did all of our briefings, missions, and travels at night,” he said. “Every two to three days we would go out to the hinterland and support some sort of combat mission, and come back and decompress, then sleep during the day, and start the cycle all over again.”
surge—the worst of the fighting in Iraq. But in April of 2007, the civilian surgeon dropped what he was doing, and readied himself for the next mission.

At the outset, he was assigned to the surgical hospital aboard Camp Taqaddum, which was one of several surgical facilities established close to the combat zones. Many of the military personnel suffered injuries from improvised explosive devices; therefore, the surgical team often operated on multiple body parts simultaneously.

“In civilian trauma we do have some very devastating blunt traumas, but typically the penetrating traumas are pretty straightforward to deal with: one or a couple of holes from a fairly low-energy weapon, whereas

At various makeshift surgical sites throughout the southern region of the country, Dr. Cole operated on injured U.S. servicemen and United Nations personnel, as well as captured prisoners, performing chest surgery, abdominal surgery, and extremity surgery. “Land mines were an especially precarious enemy of the soldiers I treated, and were the primary reason why I performed so many completion amputations,” he said. He performed approximately 10 amputations in the combat zone.

Despite the challenges of living in this desiccated wilderness, Dr. Cole says he took great satisfaction from knowing that he and his colleagues were able to have a hand in saving the lives of soldiers on the battlefield. “It’s really heartbreaking when I see these young kids,” he said. “I feel good that we are able to do something for them, but a lot of the time I never know their definitive outcome because they get sent to another echelon of care, and eventually back to the United States.”

Desert hot spots

Dr. Cole didn’t know what to expect when he got another set of military orders to deploy with the U.S. Marines of the Second Marine Expeditionary Force to Al Anbar Province, Iraq, in support of the military

In the military environment you have these blast injuries where a casualty is peppered with 30, 40, or 50 rounds from an explosive device of a massive charge that just blows them up,” he said. “It’s pretty overwhelming to deal with sometimes—one person blown almost apart with numerous holes.”

Dr. Cole was also put in charge of a mobile FRSS. His handpicked medical team used equipment they brought with them to follow Marines as they moved through the Iraqi desert. The suite—including two 15x18-foot tents, a portable oxygen generator, portable ventilators, cardiac monitors, two electrical generators, and other medical equipment—could be set up or broken down within one hour.

“When you are in the field, you literally have to do everything yourself, from setting up the tents to opening all of the containers. There’s a lot of minutia that needs to be directed,” he said. “If all your equipment is not set and the generator is not working right, you can’t do your job.”

The mobile surgical unit lived out of tiny individual tents, sleeping on the ground, with their rifles and other weapons always close by. As time wore on, and mostly no way to bathe, they stayed coated with dirt and sand. The highest temperatures of 120 degrees did not offset the freezing temperatures they shivered through at night.
Altogether, Dr. Cole spent nearly one year in Iraq. “It’s tough to be away from home, away from my family for long periods of time,” the husband of 25 years said. “The military Medical Corps is getting smaller, and people are voluntarily separating because they are getting tired of the repeated deployments; so there are fewer of us left and, as a result, we are getting sent on these overseas support operations more often.”

By the time his assignment was up, Dr. Cole was glad to return home to suburban Chicago, IL. “The transition home was strange. I had this heightened sense of awareness for a while, hyper-perceptive to various sounds, wondering what that noise is outside,” he said. “It took me a while to get used to the flowers and the trees, and so forth. It was like going to Disney World.”

When it comes to making a smooth transition, Dr. Cole offers this advice to other servicemen returning home: avoid big welcome home receptions for awhile and take a few weeks off from your regular job. Give yourself time to adjust to the sights and sounds of your surroundings. And, to families and friends: try to avoid overwhelming your loved one with lots of questions about the war zone. “I know that I regressed socially for a while, but time and gradual reintroduction to everything brought me around,” he said. Dr. Cole credits these feats and more to his wife, “an amazing woman who supported me through it all.”

**Surgeon without borders**

Stateside, Dr. Cole is the assistant director of trauma services at Advocate Good Samaritan Hospital in Downers Grove, IL, where he treats victims of accidents, shootings, stabbings, and other trauma. Throughout his career, he has operated on a few thousand patients, as both a civilian and military surgeon.

Not surprisingly, he believes that his deep experience with combat medicine and other sufferings over the years taught him to think differently. “I think a lot of times we can just be frustrated by our trauma patient population. But being in Iraq and being one of them, a homeless person essentially, made me feel more compassion for them. When you go without for a long period of time—I’m talking food, shelter, warmth, and protection—it brings you down to a lower level,” he said. “I’ve learned that all people pretty much want to live another day. And they want to be treated compassionately.”

**The response is golden**

Years have passed since his first major trauma casualty. On that day, a four-year-old boy, who was critically wounded by a shot in the head, arrived at the hospital just after midnight. “I was a very junior surgeon, and of course I thought there was no way that anybody could survive this. And as a matter of fact, I was told that this is a non-survivable injury, a trans-cranial gunshot wound,” he said. But the child did survive, and a year later the bashful boy walked into the intensive care unit alongside his mother to thank the trauma team, and throw a foam baseball Dr. Cole’s way.

Trauma teams see sad endings. And miracles. “I take care of devastatingly injured patients, but it's a lot more than a surgeon and a surgeon's team that does save these patients’ lives and cures them,” he said. “I have seen patients get better when I thought it was not possible from the perspective of medicine and science.”

A man of faith, Dr. Cole has maintained a steady dialogue with God. “I tell my patients’ families in a very, very horrible situation that I think the likely outcome is going to be ‘X,’ but I never say always, and I never say never, because every once in a while the unexplainable happens,” he said. “So, I say, don’t ever lose hope, and don’t ever lose faith.”

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Ms. Rasich is a freelance writer based in Bethlehem, PA.
A

ccess to surgical care is a necessary public health provision and, in many people’s opinion, a basic human right. While access to medical care in resource-poor countries has increased with the global health movement, surgical care has largely been neglected. This article discusses the authors’ experiences in developing a global surgery fellowship and delivering surgical care in rural Haiti.

Establishing clinics

Haiti is the poorest country with the worst health and human development statistics in the Western Hemisphere. In the book Mountains Beyond Mountains, Tracy Kidder documented the work in Haiti by Paul Farmer, MD, and his colleagues at Partners Pictured above: Surgeons from around the globe and at all levels work together and have an exchange in surgical education. Haitian attending surgeon Dr. Marie May Louisfils (center) repairs the cleft lip of a young boy while surgery residents from Canada and Haiti, a Cuban nurse anesthetist, and an American global surgery fellow learn and assist. (Haiti map courtesy of the United Nations.)
in Health (PIH), Boston, MA, and its sister organization Zanmi Lasante (ZL), which operates in Haiti. In 1985, PIH/ZL mobilized around basic health needs in the Central Plateau of Haiti. ZL opened a free medical care clinic called Clinique Bon Sauveur, and in 1986 physicians at the facility documented the first known case of AIDS in Haiti’s Central Plateau. ZL focused its efforts on HIV prevention and education during the early years of the epidemic, and they offered free health care services to patients in need. Over time, the Clinique evolved into a sociomedical complex offering comprehensive inpatient and outpatient health care. More than 250,000 patient visits occur each year in Cange, which is linked to a network of 12 hospitals and clinics in rural Haiti.

Expanding surgical care

With growing recognition that these clinics provide high-level medical care, patients with a wide range of surgical diagnoses also travel to these facilities. Some of the conditions patients have are beyond the scope of practice and training for most local surgeons. For example Sara,* a 63-year-old woman from a remote farming village in Haiti, woke early each morning in the darkness of her small hut. In her usual routine, she stood, leaned over a kerosene lamp, and struck a match. Tragically, the lamp had accidentally been filled the day before with gasoline instead of kerosene. It exploded, and Sara suffered severe burns to her face, arms, and upper body. She was a several-hour walk from the nearest medical clinic and was suffering from life-threatening burns. Had it not been for the care delivered by nurses in a clinic in rural Haiti, Sara likely would have died.

For weeks, Sara teetered on the brink of dying. Despite renal failure, respiratory distress, and extreme pain, she was slowly and literally nursed back to life. The deep burns left massive wounds with raw flesh extending across her upper body. Such was Sara’s existence for the next 18 months. She desperately needed specialized surgical care, but unfortunately, these services were unavailable, a theme that is common in poor and rural areas around the world. Unable to care for herself or her family, meaningful life seemed uncertain. In 2009, following rumors of plastic surgeons working in rural Haiti as part of a global surgery fellowship, Sara traveled to Cange, a village in central Haiti, for the surgical care she so desperately needed (see photo, this page).

Existing models of medical care have demonstrated that hospitals in poor countries can work in tandem with academic medical centers and visiting physicians to expand access to care. PIH/ZL recognized the growing number of patients requiring surgical care, such as Sara, and in 1996, built an operating room (OR) at the Clinique. Since then, PIH/ZL has built additional ORs (see photo, page 48), and surgeons from around the world have donated time, skills, and equipment while working closely with Haitian surgeons to develop a surgical care system.

*Sara has been changed to protect confidentiality.
Inspired by colleagues in internal medicine, an increasing number of surgeons have recognized the need for global surgical care and are taking action. The American College of Surgeons’ Operation Giving Back program is one example of global surgery advocacy and provides a gateway for surgeons interested in this area.8 The Alliance for Surgery and Anesthesia Presence Today is developing a collaborative of surgeons, anesthesiologists, and public health specialists who are advocating for surgery to be a key component of efforts to improve global surgery outreach.9

The World Health Organization has partnered with the Ministries of Health, local and international organizations, and academic medical centers to form the Global Initiative for Emergency and Essential Surgical Care (GIEESC).10 The GIEESC is working to reduce death and disability from vehicular crashes, trauma, burns, falls, pregnancy-related complications, domestic violence, disasters, and other surgical conditions in more than 34 low- and middle-income countries. Medical students, residents, and fellows are also eager to experience and address global surgery needs as part of their education. When surveyed, a majority of U.S. anesthesia, general surgery, and orthopaedic surgery residents express an interest in having a global surgery humanitarian experience during their training.11-17 Many residents are willing to have such an experience even if it is part of vacation time. Despite interest, few programs offer a structured global surgery opportunity for residents.

Global surgery fellowship
In 2008, surgeons affiliated with Harvard University teaching hospitals and PIH/ZL founded a global surgery fellowship for surgeons who have completed their training and are interested in dedicating 12 to 24 months as a surgeon in a developing country. The clinical experience is coupled with a curriculum in public health and surgical education.18 The purpose of the fellowship is to train surgeons to be leaders in promoting surgical care, education, and research pertinent to global surgery in resource-poor regions around the world.

Global surgery fellows work closely with local surgeons and, together, have an exchange in surgical education while learning, teaching, and performing operations ranging from oncologic, pediatric, plastic, burn, obstetric, ophthalmologic, orthopaedic, urologic, and general surgery (see photo, this page). In a given week, these fellows have performed a spectrum of surgical procedures in a variety of surgical subspecialties.
of operations, including release of burn scar contraction, skin cancer resection, pediatric lymphatic malformation resection, facial neurofibromatosis excision, keloid excision, cleft lip repair, palatoplasty, breast reduction, inguinal herniorrhaphy, closure of myelomeningocele, and hydrocelectomy.

Over the course of one year, fellows have performed up to 65 operations for cleft lip and palate. Fellows also expand their operative skill set by helping with such procedures as cesarean section, splenectomy, cholecystectomy, appendectomy, colostomy, exploratory laparotomy, repair of imperforate anus, urogenital repair, hysterectomy, mastectomy, hand and extremity repair, amputation, and fracture fixation.

In the traditional model of an academic medical center, fellows not only provide surgical care, but can add to nascent research areas, such as exploring the use of implementation science in surgical delivery; enhancing educational curricula for local surgery residents, medical students, and other health care providers; strengthening public health systems; and building an infrastructure for preventative and trauma care. In the last two years, the fellowship has expanded to include clinical and research opportunities with PIH in Rwanda.

As for Sara, with this model of surgical partnership as exhibited by PIH/ZL, members of the collaborative worked with Haitian surgeons to provide the surgical care she desperately needed. Using skin grafts, the physicians treated her open wounds and scars and restored movement to her neck. For the first time in almost two years, Sara is now free of dressings, wound care, and excruciating pain. She can independently care for herself and, hopefully, now has a long and bright future as a member of her family and community. Additionally, through this experience, our Haitian colleagues have learned more about caring for patients with burns and those in need of plastic surgery.

Sara is just one patient who has suffered from the burden of untreated surgical disease and the need for essential surgical care in Haiti and other resource-poor countries around the globe. Through our partnership between PIH/ZL, the global surgery fellowship provides young surgeons with an opportunity to become involved in the global health movement, and it serves as a model for collaboration between hospitals in resource-poor countries and academic medical centers.

Acknowledgment

Mesi anpil (thank you very much) to our patients and colleagues in Haiti.

Dr. Sullivan is a plastic and reconstructive surgeon for Partners in Health, Boston, MA, assistant professor of surgery and pediatrics, Warren Alpert Medical School of Brown University, and member of the Global Health Initiative at Brown University, Providence, RI. He is a surgeon with the department of plastic and reconstructive surgery, Rhode Island Hospital and Hasbro Children’s Hospital, Providence, RI.

Dr. Hughes is a general surgery resident, University of Connecticut, and a Paul Farmer global surgery research fellow, Children’s Hospital, Boston, MA.

Dr. Raymonville is director of women’s health, Zanmi Lasante and Partners in Health, Cange, Haiti.
References


**Dr. Rogers** is chief, division of trauma, burn, and surgical critical care, department of surgery, Brigham and Women’s Hospital, BWH center for surgery and public health, Boston, MA.

**Dr. Steer** is surgical director, Partners in Health, and professor of surgery, Tufts University School of Medicine, and professor of surgery emeritus, Harvard Medical School. Boston, MA.

**Dr. Meara** is plastic surgeon-in-chief at Boston Children’s Hospital, and director, program in global surgery and social change, Harvard Medical School. He is Chair of the ACS Legislative Committee.
Dr. W. Hardy Hendren III receives 2012 Jacobson Innovation Award

W. Hardy Hendren III, MD, FACS, FRCS(Ire, Eng, Glas[Hon]), a pediatric surgeon from Boston, MA, received the 2012 Jacobson Innovation Award of the American College of Surgeons (ACS) at a dinner in his honor on June 8 in Chicago, IL. An ACS Fellow since 1963, Dr. Hendren was honored with this prestigious international surgical award in recognition of his pioneering work in developing urinary undiversion surgical techniques. Several of Dr. Hendren’s colleagues and patients testified movingly at the dinner to his innovative and life-altering contributions to surgery.

His work revolutionized the practice of pediatric surgery in reconstruction of the urinary and genital tract in patients with severe urogenital abnormalities. Dr. Hendren is the Distinguished Robert E. Gross Professor of Surgery at Harvard Medical School, Boston; emeritus chief of surgery at Children’s Hospital, Boston; and an honorary surgeon at Massachusetts General Hospital, Boston.

The Jacobson Innovation Award honors living surgeons who have been innovators of a new development or technique in any field of surgery and is made possible through a gift from Julius H. Jacobson II, MD, FACS, and his wife Joan. Dr. Jacobson is a general vascular surgeon known for his pioneering work in the development of microsurgery.

In the 1950s and 1960s, children with severe urogenital abnormalities were treated using multiple diversionary procedures, such as nephrostomy, ureterostomy, cystostomy, and ileal loop operations. However, as a practicing surgeon, Dr. Hendren recognized that infant abnormalities (such as esophageal atresia, bowel atresia, and cardiac abnormalities) could be repaired during infancy. He began to surgically fix, rather than divert, dilated ureters and kidneys. He devised a repair for megaureters, and a repair of complex cloacal anomalies, as well as a series of operations to reconstruct children...
with disorders of sexual differentiation. The next step was to repair problems in children who had undergone diversion procedures, an operation that went by the word “undiversion.”

Dr. Hendren has also enhanced the quality of patients’ lives by ending the use of collection bags for diversionary procedures. Through undiversion operations, Dr. Hendren and his team removed the collection bags from more than 200 children and young adults.

His surgical approach has since been refined to a level of sophistication such that children born with urogenital abnormalities show almost no physical abnormalities and are able to function without multiple stomas.

A highly active Fellow of the College, Dr. Hendren served as Second Vice-President (1997–1998), a member of the Advisory Councils for Surgical Specialties (1981–1986), an ACS Governor (1980–1986), and a Past-President of the Massachusetts Chapter of the ACS.

Dr. Hendren credits Eleanor, his wife of 65 years, with the

### Jacobson Innovation Award recipients

<table>
<thead>
<tr>
<th>Year</th>
<th>Name</th>
<th>Institution</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>Professor Francois Dubois, MD, FACS</td>
<td>Paris, France</td>
<td>Laparoscopic cholecystectomy</td>
</tr>
<tr>
<td>1995</td>
<td>Thomas Starzl, MD, FACS</td>
<td>Pittsburgh, PA</td>
<td>Liver transplantation</td>
</tr>
<tr>
<td>1996</td>
<td>Joel D. Cooper, MD, FACS</td>
<td>St. Louis, MO</td>
<td>Lung transplantation and lung volume reduction surgery</td>
</tr>
<tr>
<td>1998</td>
<td>Juan Carlos Parodi, MD</td>
<td>Buenos Aires, Argentina</td>
<td>Treatment of arterial aneurysms, occlusive disease, and vascular injuries by using endovascular stent grafts</td>
</tr>
<tr>
<td>1999</td>
<td>John F. Burke, MD, FACS</td>
<td>Boston, MA</td>
<td>Development and implementation of a number of innovative techniques in burn care, including the codevelopment of an artificial skin (Integra™)</td>
</tr>
<tr>
<td>2000</td>
<td>Paul L. Tessier, MD, FACS(Hon)</td>
<td>Boulogne, France</td>
<td>Development and establishment of the surgical specialty of craniofacial surgery</td>
</tr>
<tr>
<td>2001</td>
<td>Thomas J. Fogarty, MD, FACS</td>
<td>Portola Valley, CA</td>
<td>Design and development of industry standard minimally invasive surgical instrumentation, especially for cardiovascular surgery</td>
</tr>
<tr>
<td>2002</td>
<td>Michael R. Harrison, MD, FACS</td>
<td>San Francisco, CA</td>
<td>Creator of the specialty of fetal surgery and developing techniques of fetoscopy for minimally invasive fetal technology</td>
</tr>
<tr>
<td>2003</td>
<td>Robert H. Bartlett, MD, FACS</td>
<td>Ann Arbor, MI</td>
<td>Pioneer in the development and establishment of the first extracorporeal membrane oxygenation (ECMO) program</td>
</tr>
<tr>
<td>2004</td>
<td>Harry J. Buncke, MD, FACS</td>
<td>San Francisco, CA</td>
<td>Pioneer in the field of microsurgery and replantation</td>
</tr>
<tr>
<td>2005</td>
<td>Stanley J. Dudrick, MD, FACS</td>
<td>Waterbury, CT</td>
<td>Innovator of specialized nutrition support and a pioneer in the field of clinical nutrition</td>
</tr>
<tr>
<td>2006</td>
<td>Judah Folkman, MD, FACS</td>
<td>Boston, MA</td>
<td>Pioneer in the field of angiogenesis</td>
</tr>
<tr>
<td>2007</td>
<td>William S. Pierce, MD, FACS</td>
<td>Hershey, PA</td>
<td>Pioneer in the conception and development of the total artificial mechanical heart</td>
</tr>
<tr>
<td>2008</td>
<td>Donald L. Morton, MD, FACS</td>
<td>Santa Monica, CA</td>
<td>Pioneer in research efforts toward the development and clinical application of sentinel lymph node biopsy</td>
</tr>
<tr>
<td>2009</td>
<td>Bernard Fisher, MD, FACS</td>
<td>Pittsburgh, PA</td>
<td>Development and implementation of a new course for the treatment of breast cancer by proposing that it is a systemic disease that metastasizes unpredictably and would best be treated with lumpectomy combined with adjuvant chemotherapy</td>
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<tr>
<td>2010</td>
<td>Lazar J. Greenfield, MD, FACS</td>
<td>Ann Arbor, MI</td>
<td>Development of the Greenfield filter, a vena cava filter implanted under fluoroscopic guidance to prevent pulmonary embolism in susceptible surgical patients</td>
</tr>
<tr>
<td>2011</td>
<td>George Berci, MD, FACS, FRCS(Ed)(Hon)</td>
<td>Los Angeles, CA</td>
<td>Pioneering contributor to the art and science of endoscopy and laparoscopy, resulting in the high level of technology used to perform many endoscopic and laparoscopic surgical procedures</td>
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</table>
raising of their five children: Sandra, a teacher and nurse (deceased); Douglas, an orthopaedic surgeon; William, a cardiac surgeon; Robert, a urologist (all three are Fellows of the American College of Surgeons); and David, an attorney. Dr. Hendren and Eleanor have 11 grandchildren.

Administered by the Board of Regents Honors Committee of the American College of Surgeons, 18 prestigious surgeons, including Dr. Hendren, have received the Jacobson Innovation Award, established in 1994.

To view a press release about this year’s Jacobson Award, go to http://www.facs.org/news/2012/jacobson0612.html.

New leadership at the helm of ACSPA-SurgeonsPAC

by Chantay Moye

Robert R. Bahnson, MD, FACS, First Vice-President of the American College of Surgeons, has been named the new Chair of the Board of Directors of the ACSPA-SurgeonsPAC (the American College of Surgeons Professional Association’s political action committee). Dr. Bahnson succeeds John H. Armstrong, MD, FACS, who resigned from the post to assume the role of Surgeon General and Secretary of Health for the State of Florida in May.

Dr. Bahnson is chief of staff at The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute in Columbus, OH. He also is the Dave Longaberger Chair in Urology and professor and chairman of the department of urology at The Ohio State University.

The mission of the ACSPA-SurgeonsPAC is to advocate for surgeons and surgical patients through bipartisan financial support for pro-surgery candidates and political education that elevates surgical practice. “A well-funded PAC sends a clear message of our involvement,” said Dr. Bahnson. “It provides the political clout necessary to positively influence the composition of Congress. A strong PAC helps elect champions who will join the campaign for the best possible policy outcomes.”

One of Dr. Bahnson’s immediate goals is to increase Fellows’ knowledge of both the ACSPA-SurgeonsPAC and political processes. “Although awareness and participation have grown significantly in the past 10 years, only 4 percent of ACS Fellows invest in SurgeonsPAC,” he stated. “I hope to educate all surgeons about the critical importance of advocacy. When you understand how the system works, and you recognize the ramifications of not being involved, it is obvious we must be at the table to influence the delivery of health care.”

Another area of focus for Dr. Bahnson as Chair is to encourage all College members to enhance their advocacy efforts and get to know their senators and representatives. Personally delivering a campaign contribution, hosting a local fundraiser, leading members of Congress on a facility tour to demonstrate how surgeons save lives, participating in the ACS Advocacy Summit, and meeting with legislators on Capitol Hill are some of the ways Dr. Bahnson recommends that Fellows become engaged. “I was surprised to find out how simple it is to develop these relationships, and how much our College’s Washington Office facilitates these efforts,” he said. Dr. Bahnson speaks from personal experience, having hosted local physician fundraisers for Sen. Sherrod Brown (D-OH) and Rep. Pat Tiberi (R-OH) during this election cycle.

This year and beyond is a pivotal time for the future of health care. “It is a fact that health policy changes will dramatically alter the
health care delivery system in the United States,” said Dr. Bahnson, but “we must be poised for action, participate in the process, and protect our patients and our practices. As leaders and surgeons, we must become fully engaged stakeholders in the legislative and political process to secure a viable future for the practice of surgery.”

Dr. Bahnson is considered to be highly qualified to meet the challenges ahead. “His reputation for dedication and his understanding of the legislative and political processes precedes him. I look forward to working with Dr. Bahnson and seeing his knowledge and leadership skills at work,” said Christian Shalgian, Director of the ACS Division of Advocacy and Health Policy.

A graduate of Carleton College, Dr. Bahnson received his medical degree in 1979 from Tufts University in Boston, MA. He completed his residency at Northwestern University in Chicago, IL. He previously held faculty positions at Washington University in St. Louis, MO, and at the University of Pittsburgh, PA. Prior to being elected First Vice-President, he served in several key leadership positions in the College. He was a member of the Board of Governors from 2004 to 2009, chaired the Urologic Advisory Council from 2007 to 2011, and the Advisory Council Chairs from 2009 to 2011, and was Vice-Chair of the Program Committee from 2009 to 2010. He is presently a Consultant to the Program Committee.

Ms. Moye is Communications Manager, ACS Division of Integrated Communications, Washington, DC.

Dr. Armstrong named Florida Surgeon General, Secretary of Health

John H. Armstrong, MD, FACS, a member of the American College of Surgeons (ACS) Board of Governors and past Chair of the American College of Surgeons Professional Association’s political action committee (ACSPA-SurgeonsPAC) assumed the role of Florida Surgeon General and Secretary of the Florida Department of Health on May 23. Florida Gov. Rick Scott (R) appointed Dr. Armstrong to the position.

A trauma surgeon, Dr. Armstrong is chief medical officer of the University of South Florida (USF) Health Center for Advanced Medical Learning and Simulation and associate professor of surgery at the USF Morsani College of Medicine in Tampa. He chairs the ACS Delegation of the American Medical Association’s House of Delegates, is a member of the ACS Health Policy and Advocacy Group, and is a consultant to the ACS Committee on Trauma Ad Hoc Committee on Disaster Management. He served as the Army (State) COT Chair from 2003 to 2006 and is a member of the Residency Review Committee for Surgery.

Dr. Armstrong served in the U.S. Army Medical Corps for 17 years, concluding his service at the rank of Colonel. His final assignment was director of the U.S. Army Trauma Training Center in Miami, FL. He led the development and implementation of a two-week award-winning team training program in trauma care for military medical units deploying to Iraq and Afghanistan.

Dr. Armstrong earned a medical degree from the University of Virginia School of Medicine, Charlottesville. He completed his surgical residency at Tripler Army Medical Center in Hawaii, his fellowship in trauma/surgical critical care at the University of Miami/Jackson Memorial Medical Center in Florida, and completed the master educators of medical education program at the University of Florida, Gainesville. He is a graduate of the U.S. Army Command and General Staff College and remains on faculty in the Norman M. Rich Department of Surgery at the Uniformed Services University of the Health Sciences, Bethesda, MD.
NQF endorses SQA’s Patient-Focused Care Survey

The National Quality Forum (NQF) issued its endorsement of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey on June 1. The American College of Surgeons (ACS) led the effort to develop the survey, working in partnership with other members of the Surgical Quality Alliance (SQA) and the Agency for Healthcare Research and Quality’s (AHRQ) CAHPS Consortium.

The survey will assess surgical patients’ experiences before, during, and after surgical procedures to adequately identify opportunities to improve quality of care, surgical outcomes, public reporting, and patient satisfaction. It will capture patients’ thoughts on several factors that affect the patient care experience, including how well their surgeons prepared them for their operations, communicated, and explained the recovery process. Responses will help surgeons deliver more patient-centric care by identifying areas for practice improvement. The CAHPS Surgical Care Survey is the only NQF-endorsed measure designed to assess surgical quality from the patient’s perspective.

“Paramount to ACS is assessing surgical care based on what is important to the patient,” said Frank Opelka, MD, FACS, Associate Medical Director, ACS Division of Advocacy and Health Policy. “This surgical care survey is unique. It is the only NQF-endorsed measure designed to assess surgical quality from the patient’s perspective. Its development shows the College’s strong commitment to actively partner with organizations focused on improving the patient experience and to developing high levels of quality improvement guidance.”

Critical gaps in the assessment of surgical care from the patient perspective initiated the development of the CAHPS Surgical Care Survey. Preceding its development, proponents opined that critical surgical areas, such as consent, shared decision making, anesthesia care, postoperative instructions, and access were absent among previous evidence-based, validated surveys in the public domain.

The development of the survey followed AHRQ’s standardized and evidence-based methods that are used in the creation of all CAHPS surveys. The NQF endorses quality measures through scientific and evidence-based review and a multi-stakeholder consensus development process with the aim of improving quality of care. Measures that are endorsed must meet NQF’s criteria, which include a rigorous review of the measure’s ability to make significant gains in health care quality, scientific acceptability, usability, feasibility, and reliability.

The surgical care survey is one of nine new quality measures on surgical care performed in hospitals and in outpatient facilities that recently received NQF endorsement. The set of measures are part of NQF’s Surgery Endorsement Maintenance, Phase 2 Addendum report.


Trauma meetings calendar

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

- **Advances in Trauma Conference**, December 7–8, Kansas City, MO.
- **Trauma, Critical Care and Acute Care Surgery**, March 17–20, 2013, Las Vegas, NV

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons website at http://www.facs.org/trauma/cme/traumtgs.html, or by contacting the Trauma Office at 312-202-5342.
Three volumes of retirement scrapbooks compiled by Eleanor K. Grimm, long recognized as the pivotal recorder of the first 50 years of the American College of Surgeons (ACS), have been scanned and are available for viewing in PDF format on the ACS Archives webpage.

Hired by Franklin H. Martin, MD, FACS, when the College was founded in 1913, Ms. Grimm quickly became his trusted assistant. She was influential during Dr. Martin’s efforts to guide the organization through its formative years, and even more so after his death in 1935, when she served as the secretary to the Board of Regents and, in effect, chief administrative officer, until she retired in 1951.

The volumes contain Ms. Grimm’s correspondence with many ACS leaders of the first 50 years, such as Charles and William Mayo, George Crile, Albert Ochsner, Allan Kanavel, Ernest Codman, Alfred Blalock, Owen Wangensteen, Frederick Besley, John Bowman, and Malcolm McEachern.

To view the Eleanor K. Grimm Resources and the scrapbook volumes, go to:
www.facs.org/archives/ekgrimm.html
Florida initiative uses ACS NSQIP® processes to measure and improve care

At its 2012 annual meeting on May 18 in Sarasota, the Florida Chapter of the American College of Surgeons released preliminary data from the Florida Surgical Care Initiative (FSCI), a collaboration of the Florida Hospital Association, Blue Cross Blue Shield of Florida, and the American College of Surgeons (ACS). Applying the ACS National Surgical Quality Improvement Program (ACS NSQIP) processes, data from 26,824 operations reported by the first 50 of 65 participating hospitals were compared with a national sample of 313,529 procedures. Analysis of Florida participating hospitals’ rates of postoperative occurrences categorized by such critical issues as wound and bladder infections, pneumonia, blood use, and postoperative organ system failure demonstrated a level of performance equal to that reported by all hospitals participating in the program nationwide.

J.J. Tepas III, MD, FACS, state FSCI surgical coordinator, welcomed these findings as the starting point for continuous quality improvement in Florida. “The hospitals are performing comparably to the ACS NSQIP hospitals and, importantly, have identified areas where they are doing well and where there are opportunities for improvement. Ideally, every Florida hospital will join this program so that we can begin to work as a single entity to guarantee all surgical patients the best quality humanly possible,” Dr. Tepas said. “Better quality means less cost and much better value for everyone.”

Frank Evans, BSN, JD, surgical clinical nurse reviewer, South Miami Hospital, added that his institution depends on the ACS NSQIP to manage quality and save millions of dollars through the development of strategies aimed at avoiding complications. “Before beginning to address our surgical problems, we had to first identify what they were. ACS NSQIP was the tool we were able to use to immediately allow us to identify those problems,” said Mr. Evans.

John P. Rioux, MD, FACS, a member of the ACS Board of Governors in surgical practice at three community hospitals in Port Charlotte, noted the importance of assessing surgical outcomes in smaller community hospitals so that all Floridians can receive state-of-the-art care, regardless of their proximity to an academic medical center. The College recently revised ACS NSQIP to expand its availability to smaller hospitals.

Dr. Tepas emphasized that all participating hospitals are continuing to improve their outcomes. High performers get even better, and those that want to improve find ways to achieve that goal through this program. Because the data reported back to hospitals are risk-adjusted, hospitals can assess their performance using real-time clinical information rather than pooled administrative or claims data.

The Florida initiative will bring another dimension to the process of quality improvement. Now that an appropriate baseline of state performance for comparison with the leading national hospitals has been established, specific regions within the state can aggregate de-identified data to determine areas where superior performance may be used to develop best practices. “We have only just begun, but we have begun well, and are clearly on a path that will enable us to guarantee all Floridians the highest quality of surgical care every time and all the time,” Dr. Tepas said.

Read this month’s Bulletin online at www.facs.org/fellows_info/bulletin/bullet.html
The American College of Surgeons (ACS) presented the State Leadership Advocacy Conference in April at the College’s headquarters in Chicago, IL. A total of 20 chapter leaders attended, including Governors, administrators, and Executive Directors from eight chapters: Arizona, California, Connecticut, Georgia, Indiana, Massachusetts, New York, and Ohio. Attendees had the opportunity to network, learn how to structure their chapter to maximize advocacy efforts, explore innovative ways to motivate chapter members, identify best practices for communicating with legislators, and consider programs on building effective legislative messages and coalitions.

The conference was part of the College’s ongoing effort to enhance and support chapter advocacy in the states. In a 2010 ACS member survey, 65 percent of the Fellows surveyed reported that state-level advocacy is an “essential” and “very important” benefit of ACS membership. Ninety-two percent of those surveyed “strongly agree” or “agree” that advocacy should be a priority for the ACS.*

**Program highlights**

Throughout the day-and-a-half conference, various topics were covered by a wide array of speakers. The presenters, including College staff members, chapter Executive Directors, surgeon advocacy leaders, and staff from the American Medical Association offered a variety of content perspectives.

Attendees were introduced to numerous state advocacy programs that ACS chapters could readily implement. Kathy Browning, Executive Director of the Georgia Society of the American College of Surgeons, and Jennifer Starkey, president of Key Management Solutions in Columbus, OH, discussed advocacy programs that could be instituted at the state level. Ms. Browning highlighted the importance of having a structured advocacy agenda. She suggested that chapter leaders raise member awareness by highlighting advocacy when prioritizing chapter needs. She also recommended that chapters publish an advocacy newsletter to establish regular communication with chapter members, create a state politi-
cal action committee, effectively use social media, and create and participate in legislative “calls to action.” Ms. Browning reminded attendees of the importance of advocacy with a quote she attributed to Plato: “Those who are too smart to engage in politics are punished by being governed by those who are dumber.”

Ms. Starkey’s presentation focused on the importance of organizing and hosting a state lobby day. She provided tips for a successful lobby day, including working with the state medical society to collaborate on an agenda, creating a program that is structured to benefit chapter members and members of the state legislature, and creating materials that enhance the message for both lobby day attendees and legislators. Ms. Starkey also suggested engaging chapter members through programs outside of a formal lobby day, such as Doctor of the Day meetings, telephone marathons, and White Coat Rallies.

John Schwarz, MD, FACS, an otolaryngologist from Battle Creek, MI, provided illuminating insights into the political process drawing on his own political career serving as the mayor of Battle Creek, a Michigan state senator, president pro tempore of the Michigan Senate, and a U.S. representative. Dr. Schwarz regaled attendees with stories from his days serving in Congress and highlighted the importance of becoming involved even while continuing to practice surgery.

Peter Masiakos, MD, FACS, Legislative Chair, Massachusetts Chapter of the ACS, showed attendees how he implemented a successful advocacy campaign by describing his multi-year campaign to pass all-terrain vehicle (ATV) age restriction legislation in his state. During his presentation, Dr. Masiakos highlighted several key facets of a successful advocacy campaign:

- Think outside of the box when developing resources and coalitions
- Don’t reinvent the wheel
- Use research and data already available
- Don’t give up

Dr. Masiakos’ inspiring presentation and tireless efforts have encouraged representatives from Washington, West Virginia, and Virginia, as well as several ACS chapter leaders, to become interested in passing ATV laws in their respective states.

A surgeon’s perspective

As the President-Elect for the Tennessee Chapter, Dr. Guillamondegui, a co-author of this article, attended the recent State Leadership Advocacy conference to gain some understanding of the process involved in engaging members of Congress in a dialog regarding the laws that affect their surgical patients. He also sought to develop a plan to encourage the state membership to become active participants at the local level.

Every year, the Tennessee legislature introduces legislation that would repeal the state’s motorcycle helmet law. The advocacy conference allowed Dr. Guillamondegui the opportunity to gain perspective on how to actively participate and successfully oppose the repeal legislation by using the guidelines established by Drs. Masiakos and Schwarz. By leveraging the relationship built while attending the conference with David McAneny, MD, FACS, ACS Governor from Massachusetts, surgeons in Tennessee now have an opportunity to develop a program that connects active members of the chapter with less active members at a local level to ensure physicians have a voice with representatives in their home districts.

Although the State Leadership Advocacy Conference was focused on a defined group of chapter leaders, the advocacy development information covered during the conference is universal in application. All surgeons can benefit from a basic knowledge of advocacy and by supporting their respective chapter advocacy activities.

For more information on the topics discussed in this article, including copies of handouts or presentations, contact Alexis Macias, Regional State Affairs Associate, at amacias@facs.org or 312-202-5446.

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

Dr. Guillamondegui is associate professor, surgery and neurological surgery, and trauma medical director, division of trauma and surgical critical care, Vanderbilt University Medical Center, Nashville, TN.
Erin P. Fraher, PhD, MPP, and Thomas C. Ricketts III, PhD, MPH, of the American College of Surgeons (ACS) Health Policy Research Institute (HPRI), were guests of Sir Bernard F. Ribeiro, KtCBE, FACS(Hon), FRCSIEng, FRCPEng, May 22–23 at the United Kingdom’s House of Lords. Several doctoral students from the University of North Carolina (UNC), Chapel Hill, accompanied Drs. Fraher and Ricketts on the trip, where they witnessed firsthand the art of legislative compromise.

Lord Ribeiro was appointed in 2010 to the House of Lords as a Life Peer. During a distinguished career, Lord Ribeiro has contributed significantly to the surgical profession in the U.K., where he has worked to modernize surgical training and introduced a new surgical curriculum. He served as president of the Royal College of Surgeons of England from 2005 to 2008.

In 2008, he joined the ACS leadership in presenting testimony on resident work hours and work schedules to the Institute of Medicine of the National Academy of Sciences panel on resident hours and work schedules. “He helped panel members understand the ramifications of restricting resident hours,” said Dr. Ricketts.

The HPRI, established in 2008 at the UNC under the direction of ACS Past-President George F. Sheldon, MD, FACS, conducts research on surgical issues, including the geographic distribution of general surgeons in the U.S. Dr. Sheldon presented Dr. Ribeiro for Honorary Fellowship in the ACS in 2008.

At the time of the visit, “The British Parliament had just gone through a very long process of reforming the English health and social care systems (the Health and Social Care Act 2012, which passed on March 27). It was a serious overhaul of the National Health Service (NHS) and a very difficult one,” explained Dr. Ricketts. “The actual bill was longer than the Affordable Care Act, and observers described the changes as the English health system’s most extensive reorganization. Lord Ribeiro was really one of the key people who negotiated the process and compromise that was finally reached.” The newly created public body that will manage the health service, the NHS Commissioning Board, will officially begin its work on April 1, 2013.*

The new plan restructuring health service in England, giving groups of general practitioners (GPs—the equivalent of family physicians in the U.S.) and other health care professionals 60 percent control of the health service’s annual budget. “Basically, what it does is give family doctors the purse strings to

care for patients,” explained Dr. Fraher. “Clinicians will make the decisions on whether, for example, a patient needs a hip replacement.”

“The legislation also introduces competition into the health services,” Dr. Fraher continued. As in the U.S., the goal is to reduce administrative costs and the rising costs of caring for an aging population, she said.

“Even though our systems are different, it was striking to me how similar the challenges are,” said Dr. Fraher. One of England’s major health care issues, she said, centers on the evolving standards of quality health care and how quality can be measured and reported. “These are the same concerns that the ACS addresses today.

“The English parliament is looking to their professional groups for input in a process that has engaged clinicians in helping to transform the NHS,” she added.

The U.S. visitors also met with Baroness Judith Jolly, co-chair of the Liberal Democrat Party Committee on Health and Social Care in England, who was instrumental in passing England’s health service bill, and Earl Howe, Parliamentary Under Secretary of State at the Department of Health.

“The whole experience was very useful in helping us understand health reform in the U.S.,” said Dr. Ricketts. “Lord Ribeiro said he wants to continue to share information and communicate regularly with us. He asked that we keep him informed about what we’re working on here.”

Surgical quality forum focuses on how QI can help curb health care costs

The American College of Surgeons (ACS) hosted a Surgical Health Care Quality Forum in Boston, MA, on June 4, with health care policy and clinical experts discussing how quality surgical care leads to better patient and financial outcomes. The ACS Surgical Health Care Quality Forum Boston is part of the College’s Inspiring Quality initiative, which is designed to promote critical elements required in successful quality improvement programs that can measurably improve outcomes and reduce health care costs.

“If we can get to a place where improving quality reduces preventable complications, we will have found part of the solution to the vexing problem of controlling costs in an equitable, humane, and efficient way,” said keynote speaker Stuart Altman, PhD, economist and health policy expert, Brandeis University, Waltham, MA. “In the past we didn’t include physicians and surgeons in discussions on how to fix the American health care system because we thought they were part of the problem—a big mistake. We need them as part of the solution because they are American health care. Everyone needs to play, and physicians

Forum participants, left to right: Drs. Slavin, Gawande, Warshaw, Altman, Zinner, Finlayson, and Hutter.
and surgeons are really on the right track, focusing on quality improvement as one viable means to address the cost issue.”

According to ACS Regent and forum cohost Michael J. Zinner, MD, FACS, “If physicians, surgeons, and hospitals are engaged in the important dialogue around improving surgical quality programs that advance patient outcomes, we will be in a better position to deliver better value, because we believe that appropriate care delivered the first time lowers cost.” Dr. Zinner is Moseley Professor of Surgery, Harvard Medical School; clinical director of the Dana Farber/Brigham and Women’s Cancer Center; and surgeon-in-chief, Brigham and Women’s Hospital (BWH).

Surgical care takes up half of the annual commercial health care expenditures nationwide.* The ACS views improving quality as instrumental to adding value to health care systems because it reduces costs and improves care.

“Surgical quality matters everywhere in the country, but we’ve taken special pride here in Boston because this is where Ernest A. Codman, MD, FACS, the founder of the quality movement, made his stand on quality improvement as a critical component of the profession,” said ACS Treasurer and event cohost Andrew L. Warshaw, MD, FACS, W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School; surgeon-in-chief, emeritus, Massachusetts General Hospital (MGH); Chair, American College of Surgeons Health Policy and Advocacy Group.

“In surgery, we know what needs to be done to improve results and reduce costs,” added panelist Atul Gawande, MD, MPH, FACS, a surgeon at BWH, professor at Harvard Medical School and Harvard School of Public Health, lead advisor on surgery to World Health Organization Patient Safety, and prolific author. “The problem is doing it. But we are starting to see answers.”

“Truly focusing on quality improvement requires good data—data that surgeons trust—and we have that with ACS NSQIP® [American College of Surgeons National Surgical Quality Improvement Program],” said panelist Matthew Hutter, MD, MPH, FACS, director of the Codman Center for Clinical Effectiveness in Surgery at MGH, and assistant professor in surgery at Harvard Medical School. Known as a model for outcomes-based quality improvement, the ACS NSQIP collects clinical, risk-adjusted, 30-day outcomes data in a nationally benchmarked database. The program has been credited as “Best in the Nation” for surgical quality by the Institute of Medicine, and is currently used in approximately 400 hospitals across the U.S.

“When economic realities dictate that we can’t spend more, and our population demands that we do a better job of maintaining their health, the only solution is to increase the value of what we do,” said panelist Samuel Finlayson, MD, MPH, FACS, Kessler Director, Center for Surgery and Public Health at BWH. “To ensure that surgery is appropriately used, our current systems of care delivery have relied on hurdles and blocks in the form of insurance preapprovals, paperwork, and extra clinic visits. We need to redesign surgical care in a way that reflects a ‘make it easy to do the right thing’ approach. We need to develop ways to deliver better information, streamline and coordinate care flow, and structure surgical decision-making so that providing the most efficient, most appropriate surgical care is actually the easiest thing for a surgeon to do.”

“We’ve found at MGH that there are three key institutional fundamentals for continuous quality improvement to thrive: leadership, infrastructure, and incentives,” added panelist Peter Slavin, MD, president, MGH. “The institution can drive quality by implementing programs and protocols, but it’s up to the collaboration among all team members—from hospital administrators to clinicians—and their willingness to strive for culture change and progress that makes quality improvement ‘real.’”

As health care professionals, surgeons are aware of the gap between the care patients in resource-restricted countries receive and the ideal standard of care. The reasons for such disparities include a lack of qualified personnel, scarce financial resources, and the enormous burden of disease. To help providers deliver safe care to their patients—regardless of available resources—the new SafeCare Foundation is offering surgeons and other health care professionals a comprehensive system that can be used to improve outcomes.

The SafeCare Foundation is a cooperative comprising Joint Commission International (JCI), the South African-based Council for Health Service Accreditation of Southern Africa (COHSASA), and the PharmAccess Foundation of the Netherlands (PharmAccess). The foundation provides a step-by-step framework based on internationally recognized standards for improving health care delivery. Through automation of data entry, verification analysis, and computerized Web-based reporting, SafeCare will offer large-scale quality improvement programs and certification options.

The SafeCare program is focused on rural clinics and district hospitals where health care professionals may perform minor surgical procedures. Other types of operations are primarily performed in regional and national tertiary hospitals. Referrals to these surgical settings will be more timely, with better assessment information and communication to the receiving surgeons and coordination of care when the patient returns to the clinic.

To date, the SafeCare program has been successfully initiated in more than 107 clinics in six countries—Ghana, Kenya, Lesotho, Nigeria, South Africa, and Tanzania. The facilities participating in SafeCare have committed to improving the quality of their services as part of their participation in various insurance and medical credit programs. The first 10 of these facilities recently obtained Certificates of Improvement, which were awarded based on reaching predefined levels of standard compliance.

Certificates range from level 1 to 5, which allows for demonstrating incremental achievement in compliance with the SafeCare Foundation standards. Health care facilities are rewarded with a certificate every time they reach the next predefined SafeCare step. If executed completely (SafeCare Level 5), the facility will qualify for formal accreditation trajectories, for example, through COHSASA or JCI. What makes this program unique is the fact that the SafeCare route is centered on relative improvement and does not demotivate African facilities by imposing unreachable international absolute quality norms. Instead, SafeCare offers a step-wise approach, first confronting facilities with incremental challenges with respect to quality and patient safety, and eventually rewarding and encouraging these facilities with recognition through its certification system.

The impact of the SafeCare Foundation’s interventions will be monitored through data analysis, and operational research and findings will be published in peer-reviewed journals. The SafeCare Foundation will also publish information on the tools, goals, and results of the program and will make information and standards publicly available through its website. In addition, a SafeCare Knowledge Institute will be established to provide health intelligence data on health care quality improvement in Africa, provide benchmarks, perform gap analyses, and study the associations between quality improvement certification and medical output and outcome. These vital analyses can be used to inform donors and governments about the status of health care in specific regions or countries.

For more information about SafeCare, go to www.jointcommissioninternational.org/Other-Alliances.
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What’s new in renal cell carcinoma

by Maxwell V. Meng, MD, FACS, and Heidi Nelson, MD, FACS

Over the past decade, significant changes have occurred in the presentation, understanding, and treatment of renal cell carcinoma. Increased imaging has led to the incidental identification of most renal masses, with a concomitant migration of tumors to a lower stage at the time of diagnosis. This, in turn, has led to the opportunity to change the surgical management of renal cancers so that many tumors can now be managed in a minimally invasive fashion with either laparoscopic or robotic-assisted surgery. Potentially of greatest importance is the elucidation of the biological basis of sporadic as well as hereditary forms of renal carcinomas.

Most renal tumors arise from loss of function of the von Hippel-Lindau (VHL) gene and resultant activation of the hypoxic response, including upregulation of hypoxia-inducible factor leading to vascular endothelial growth factor induction and ultimately angiogenesis. In addition to the VHL syndrome, other hereditary forms include hereditary papillary renal carcinoma (MET gene), Birt-Hogg-Dubé (FLCN gene), and hereditary leiomyomatosis-renin cell cancer (fumarate hydratase gene).

The most revolutionary change in the management of renal cell carcinoma may be the approach and options for advanced disease. Surgical resection of localized renal cell carcinoma can be curative for lower-stage disease and remains the standard initial intervention. However, patients with advanced or metastatic disease are rarely cured through surgical procedures alone, and systemic treatments often benefit these patients. Historically, traditional chemotherapy has had poor response rates and systemic options have been focused on immunotherapy with cytokines, such as interleukin-2 and interferon alfa. Hence, new targeted agents that are routinely used for metastatic disease and being tested in the neoadjuvant and adjuvant settings have created some excitement among urologists and medical oncologists.

Improvements in the understanding of the molecular pathophysiology of renal cell carcinoma have led to the development of several novel targeted agents, with seven approved by the Food and Drug Administration (FDA) and currently available for patients with metastatic disease. These agents include the tyrosine kinase inhibitors sorafenib (approved in 2005), sunitinib (2006), pazopanib (2011), and axitinib (2012); mTOR inhibitors temsirolimus (2007) and everolimus (2009); and VEGF-inhibiting monoclonal antibody bevacizumab (2009). The role of these therapies in either the neoadjuvant or adjuvant setting remains unclear and is an active area of investigation.

The Adjuvant Sorafenib or Sunitinib in Unfavorable Renal Cell Carcinoma (ASSURE; ECOG 2805) trial completed accruing patients in September 2010. The trial, activated April 24, 2006, has enrolled 1,865 patients randomized to one year of sunitinib, sorafenib, or placebo therapy after surgical excision of the primary tumor. The current standard of care, even for patients with high-risk pathologic features, is surveillance after surgical procedures when no evidence of residual disease can be found. Thus, the study is designed to determine whether adjuvant targeted therapy improves cancer-specific survival.

Eligible patients included those having: (1) intermediate risk of relapse (≈33 percent) with pT1G3-4, pT2, or pT3aG1-2 tumor; (2) high risk of relapse (50 percent to 60 percent) with pT3aG3-4, +adrenal involvement, pT3b-c, pT4; or (3) very high risk of relapse (≥66 percent) with N+ disease. Results are expected to be available in the next few years, and the study was designed to demonstrate a 25 percent reduction in the hazard rate of disease-free survival events. The trial also included correlative science to examine items such as microvessel density and associated markers of angiogenesis; pharmacokinetics and effect of cytochrome p3A4/5, B-raf, and VEGF polymorphisms on outcome; and DNA hypermethylation of P16 and VHL.

A recently endorsed trial is the EVEolimus for Renal Cancer Ensuing Surgical Therapy (EVEREST) study (SWOG 0931). Similar in design to ASSURE, EVEREST examines the benefit of adjuvant...
systemic therapy after surgical procedures in patients with intermediate high-risk (pT1b G3-4; pT2 G1-4; pT3a G1-2) or very high-risk disease (pT3a G3-4; +adrenal involvement; pT3b-c; pT4; N+). Although sorafenib, sunitinib, and everolimus are all used clinically, sorafenib and sunitinib are tyrosine kinase inhibitors, whereas everolimus is an mTOR inhibitor. An estimated 1,218 patients will be randomized to either everolimus or placebo, stratified by pathologic stage, histologic subtype, and performance status. It will be interesting to see which agent(s) proves to be beneficial in the adjuvant setting, whether there are significant differences in side effect profile, and which population benefits the most.

Similar ongoing adjuvant trials include the Pfizer-sponsored S-TRAC trial (n=720) comparing sunitinib with placebo and the Medical Research Council SORCE trial (n=1,656) comparing sorafenib with placebo. Other agents are also being tested in the adjuvant setting, including pazopanib (PROTECT), as well as those that exploit the purported immunogenicity of renal cell carcinoma.

An accrued phase III trial has tested the antibody girentuximab, which binds specifically to carbonic anhydrase IX (G250 antigen) that is expressed on the cell surface of clear renal cell carcinomas. Future trials may extend the potential role of cell-based immunotherapy, such as RNA-loaded autologous dendritic cells, from patients with metastatic disease to the adjuvant setting.

**Dr. Meng** is associate professor of urology, department of urology, University of California, San Francisco, and director of the fellowship in urologic oncology.

**Dr. Nelson** is Fred C. Andersen Professor of Surgery and chair, division of surgery research, Mayo Clinic College of Medicine, Rochester, MN, and Program Director of the Alliance/American College of Surgeons Clinical Research Program.
The ACS National Surgical Quality Improvement Program – a national effort to improve surgical care and cut costs run by the American College of Surgeons – is helping to prevent thousands of surgical complications each year, according to a study of 118 hospitals.

The hospitals experienced a reduction of 250-500 complications per hospital, per year. If these methods were used in every hospital in the nation, we could reduce health care costs by $13 to $25 billion every year, or $130 to $250 billion over the next decade – and help literally millions of patients avoid preventable complications.

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November 1 closing date for Faculty Research Fellowship applications

Thanks to the generosity of Fellows, Chapters, and friends of the College, the American College of Surgeons (ACS) is offering two-year faculty research fellowships, running from 2013 to 2015, to surgeons entering academic careers in general surgery or a surgical specialty. The fellowships offer assistance to surgeons seeking to establish new and independent research programs.

Applicants should have demonstrated their potential to work as independent investigators. The fellowship award is $40,000 per year for each of two years, to support the research. The closing date for receipt of completed applications and all supporting documents is November 1, 2012, for the following fellowship awards:

- The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the ACS, which honors the founder of the American College of Surgeons
- The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care
- The Louis Argenta, MD, FACS, Faculty Research Fellowship for the Study of Wound Care

In addition, two unnamed Faculty Research Fellowships will be offered during this cycle.

General policies covering the granting of the ACS Faculty Research Fellowships include:

- The fellowship is open to Fellows or Associate Fellows of the College who have: (1) completed the chief residency year or accredited fellowship training within the preceding three years; and (2) received a full-time faculty appointment in a department of surgery or a surgical specialty at a medical school accredited by the Liaison Committee on Medical Education in the U.S. or by the Committee for Accreditation of Canadian Medical Schools in Canada. Applicants who directly enter academic surgery following residency or fellowship will receive priority.
- Recipients may use the award to support their research or academic enrichment in any fashion that they deem maximally supportive of their investigations. The fellowship grant supports the recipients’ research and does not diminish or replace the usual, expected compensation or benefits. Neither the recipients nor their institutions will receive reimbursement for indirect costs.
- Fellowship applications may be submitted even if comparable applications have been submitted to organizations, such as the National Institutes of Health (NIH) or industry sources. A recipient who is offered a scholarship, fellowship, or research career development award from such an agency or organization must contact the College’s Scholarships Administrator to request approval of the additional award. The Scholarship Committee reserves the right to review potentially overlapping awards and adjust its award accordingly.
- The College encourages applicants to leverage the fellowship funds with time and monies provided by their department of surgery. Formal statements of matching funds and time from applicants’ departments will promote favorable review by the College.
- Applicants must submit supporting letters from the head of the department of surgery (or the surgical specialty) and from mentors supervising their research. This approval entails a commitment to continue the academic position and facilities for research. Only in exceptional circumstances will more than one fellowship be granted in a single year to applicants from the same institution.
- Applicants must submit a research plan and budget for the two-year period of fellowship, even though renewed approval by the Scholarships Committee of the College is required for the second year.
- Fellows must spend a minimum of 50 percent of their time in the research proposed in the application. This percentage may run concurrently with the time requirements of NIH or other accepted funding.
- Martin and Carrico Fellows are expected to attend the College’s 2015 Clinical Congress to present a report to the Surgical Forum and to receive a certificate at the annual meeting of the Scholarships Committee.
- The Dr. Louis Argenta Faculty Research Fellowship, supported by Kinetic Concepts, Inc., is a one-year award in the amount of $40,000 to help a surgeon...
establish an independent research program on wound care. All of the same requirements apply as for the Martin and Carrico Fellows, except that the time period is one year. The Argenta Fellow will attend and report at the 2014 Clinical Congress.

Application forms may be obtained via the College’s website, www.facs.org, or upon request from the Scholarship Administrator, Kate Early, at kearly@facs.org.

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**Apply by September 4 for ACS Resident Research Scholarships**

The American College of Surgeons (ACS) is offering two-year Resident Research Scholarships for July 1, 2013, through June 30, 2015. Eligibility for these scholarships is limited to the research projects of residents in surgery or a surgical specialty. ACS Resident Research Scholarships are made possible through the generosity of Fellows, chapters, and friends of the College, and are intended to encourage residents to pursue careers in academic surgery. The closing date for receipt of completed applications and all supporting documents is September 4, 2012.

**General policies**

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

- Applicants must be Resident Members of the College who have completed two postdoctoral years in an accredited surgical training program in the U.S. or Canada at the time the scholarships are awarded (July 1, 2013), and shall not complete formal residency training before June 2014. Scholarships do not support research after completion of the chief residency year.

- Scholarships are awarded for two years, and acceptance requires commitment for the full two-year period. Awards must be used to support research plans for the two years of the scholarships, July 2013 through June 2015. Residents involved in full-time laboratory investigations will receive priority. Study outside the U.S. or Canada is permissible. Renewal for the second year is required and is contingent on the acceptance of a progress report and research study protocol for the second year, as submitted to the Scholarships Section of the College by May 1, 2014.

- Residents may apply for these scholarships even if they have made a comparable application to other organizations. If a recipient receives a scholarship, fellowship, or research award from another organization, the recipient must contact the College’s Scholarships Administrator to request approval of the additional award. The Scholarships Committee reserves the right to review potentially overlapping awards and to adjust its award accordingly.

- Each scholarship is $30,000 per year; the total amount is to support the research of recipients and is not to diminish or replace their usual or expected compensation or benefits. Indirect costs are not paid to recipients or to their institutions.

- Scholars are expected to attend the 2015 ACS Clinical Congress to present reports on the research during the Surgical Forum, and to report and receive certificates at the annual meeting of the Scholarships Committee.

- The administration (dean or fiscal officer) of the residents’ institutions must approve all applications. Applicants should submit supporting letters from the head of their department of surgery (or the surgical specialty) and from mentors who will supervise the applicants’ research. Only in exceptional circumstances will more than one scholarship be granted in a single year to applicants from the same institution.

- Application forms may be obtained from the College’s website at [http://www.facs.org/memberservices/lasresident.html](http://www.facs.org/memberservices/lasresident.html). For additional information, contact Kate Early, Scholarships Administrator, at kearly@facs.org.
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**UPCOMING DATES**

NASHVILLE, TN .................. August 16-17
COSTA MESA, CA ................. October 25-26
CHICAGO, IL ........................ November 15-16

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2012 Health Policy Scholars announced

Sixteen surgeons received scholarships to attend the May 2012 Leadership Program in Health Policy and Management, held at Brandeis University, Waltham, MA. Each scholarship includes participation in the weeklong intensive course, followed by a year’s service in a health policy-related capacity to the College and the surgical specialty society co-sponsoring the awardee.

American College of Surgeons (ACS) Health Policy Scholar for General Surgery: Michael D. Adolph, MD, FACS, Ohio State University, Columbus

ACS Health Policy Scholar for General Surgery: Janice N. Cormier, MD, MPH, FACS, MD Anderson Cancer Center, Houston, TX

ACS/American Academy of Otolaryngology-Head and Neck Surgery Health Policy Scholar: Michael J. Brenner, MD, FACS, Southern Illinois University School of Medicine, Springfield

ACS/American Association of Neurological Surgeons Health Policy Scholar: Anthony L. Asher, MD, FACS, Carolina Surgery and Spine Associates, Charlotte, NC

ACS/American Association for the Surgery of Trauma Health Policy Scholar: Erik S. Barquist, MD, FACS, Jackson South Community Hospital, Miami, FL

ACS/American Pediatric Surgery Association Health Policy Scholar: Peter W. Dillon, MD, FACS, Penn State Hershey Medical Center, Hershey

ACS/American Surgical Association Health Policy Scholar: Thomas F. Tracy, Jr., MD, FACS,
MS, Alpert Medical School, Brown University, Providence, RI
ACS/American Society of Breast Surgeons Health Policy Scholar: Michael Alvarado, MD, FACS, University of California, San Francisco
ACS/American Society of Colon and Rectal Surgeons Health Policy Scholar: Neil H. Hyman, MD, FACS, University of Vermont College of Medicine, Burlington
ACS/American Society of Plastic Surgeons Health Policy Scholar: Robert Havlik, MD, FACS, Indiana University School of Medicine, Indianapolis
ACS/American Urogynecologic Society Health Policy Scholar: Blair Washington, MD, MHA, University of Washington School of Medicine, Seattle
ACS/Eastern Association for the Surgery of Trauma Health Policy Scholar: John J. Como, MD, MPH, FACS, Case Western Reserve University School of Medicine, Cleveland, OH
ACS/New England Society of Surgery Health Policy Scholar: Joel Lafleur, MD, FACS, Penobscot Bay Medical Center–MaineHealth, Rockport
ACS/Society for Surgery of the Alimentary Tract Health Policy Scholar: Christos A. Galanopoulos, MD, FACS, Renown Regional Medical Center, Reno, NV
ACS/Society of Thoracic Surgeons Health Policy Scholar: Michael J. Davidson, MD, FACS, Brigham and Women’s Hospital, Boston, MA
ACS/Society for Vascular Surgery Health Policy Scholar: Margaret C. Tracci, MD, JD, University of Virginia, Charlottesville
The two words “surf’s up” may evoke various images or sounds, such as the 17th recorded album by the Beach Boys released in 1971 or perhaps the Academy Award-nominated best animated film of 2008 starring Cody Banks, an up and coming penguin surfer. For those individuals who inhabit or visit the coastal waters of the U.S., however, the phrase implies conditions are good for taking to the water on a surfboard.

Surfing is Hawaii’s gift to the world of sport. This activity dates backs several centuries and predates Captain Cook’s arrival into Kealakekua Bay, where he and his crew observed men standing on top of boards speeding toward the shoreline. People on five continents and numerous islands scattered throughout the world’s oceans now surf.*

Surfing is a demanding and complex sport. Scientific research into surfing waves and breaks dates back to the early 1970s. There are several different types of surfing, including longboarding, shortboarding, bodyboarding, and bodysurfing. Modern-day boards typically are made of fiberglass and range in size from six to 11 feet depending on the style of surfing for which they are used. A body board or “boogie board” is three feet long and made out of foam. Most of the scientific research has surrounded shortboarding, which involves the more aggressive riding style and faster, more powerful waves.† Waves such as these generate tremendous force that the surfer must harness to ride.

To examine the occurrence of surfing injuries in the National Trauma Data Bank® (NTDB) research dataset for 2010, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Specifically searched was external cause of injury E code 910.2 (while engaged in other sport or recreational activity without diving equipment).

A total of 85 records that include surfboard injuries were uncovered, of which 72 records contained a hospital discharge status, including 54 patients discharged to home, 10 to acute care/rehab, and three sent to skilled nursing facilities; five died. (See figure, this page.)

Patients with surfing injuries were 82.4 percent male, on average 29.2 years of age, had an average hospital length of stay of 5.3 days, an intensive care unit...
length of stay of 4.8 days, an average injury severity score of 11.9, and were on the ventilator for an average of 5.8 days.

Cruising on the ocean and riding its rhythmic waves can have a sedating effect until one approaches the shoreline where the waves start to break as they unleash a tremendous amount of power. Depending on your skill level, being armed with only a seven-foot piece of fiberglass strapped to your leg can result in significant injury. If trying this sport for the first time, respect the power of the wave, take lessons, and start out small. After all, the surf’s up, but you may not be as the wave breaks.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. The NTDB Annual Report 2011 is available on the ACS website as a PDF file and as a PowerPoint presentation at www.ntdb.org. In addition, information regarding how to obtain NTDB data for more detailed study is available on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgement

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

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

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

Dr. Fantus is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago. He is Past-Chair of the ad hoc Trauma Registry Advisory Committee of the Committee on Trauma.
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Note: 2012 Webcasts will be available for viewing from December 15, 2012; access expires December 31, 2013.

www.facs.org/clincon2012/registration
**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.

**Peru Chapter cohosts Congress**

The General Surgeons Peruvian Society and the Peru Chapter of the American College of Surgeons (ACS) cohosted the VIII Congress, which took place in March in Lima. More than 680 surgeons attended the scientific education event, which featured 14 trauma surgeons from Latin America, Spain, and the U.S.

A. Brent Eastman, MD, FACS, the College’s President-Elect, presented three lectures, as well as an update on ACS activities and programs (see photo, this page).

**Japan Chapter meets in Chiba City**

The Japan Chapter of the ACS conducted an education program this April in conjunction with the Japan Surgical Society. Patricia J. Numann, MD, FACS, the College’s President, met with Japan Chapter members, the Japan Association of Women Surgeons, and presented the lecture, “Inspiring and Assuring Quality.” Elections for the Japan Chapter also were held (see photo, this page).

**Metropolitan Chicago Chapter hosts Surgical Jeopardy, supports career fair**

On May 4, the Metropolitan Chicago Chapter of the ACS hosted its annual meeting, which included a Jeopardy contest for surgical residents. Later that month, the chapter supported a health-occupations career day at Malcolm X College in Chicago, IL. Elizabeth A. Blair, MD, FACS, and Charles Drueck III, MD, FACS, both chapter council members, met with many high school students during the event and shared a video of laparoscopic surgery with the students (see photos, this page).

**South Dakota Chapter observes 60th anniversary**

The South Dakota Chapter of the ACS conducted its 60th annual meeting this April, in Watertown. The event, which nearly 70 members from North and South Dakota Chapters attended, included guest speakers Robert Bahnson, MD, FACS, the College’s

*Denotes Associate Fellow, Medical Student, or Resident membership in the College.*

continued on page 79
### 2012 chapter meetings

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

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

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<td>August 25–26</td>
<td>Georgia Society of the American College of Surgeons (AP)</td>
<td>Location: Savannah Hyatt Regency Savannah, GA&lt;br&gt;Contact: Kathy D. Browning, 404-625-1520&lt;br&gt;e-mail: <a href="mailto:kdb@georgiaacs.org">kdb@georgiaacs.org</a>&lt;br&gt;ACS Representative(s): Patricia J. Numann, MD, FACS</td>
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<tr>
<td>September 6–9</td>
<td>Egypt</td>
<td>Location: To be determined, Cairo&lt;br&gt;Contact: Alaa Ismail, MD, FACS, 1 +(+2 )1222142526&lt;br&gt;e-mail: <a href="mailto:ahismail2002@yahoo.com">ahismail2002@yahoo.com</a>&lt;br&gt;ACS Representative(s): Patricia J. Numann, MD, FACS</td>
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<tr>
<td>September 7–8</td>
<td>New Mexico (AP)</td>
<td>Location: Albuquerque Marriott, Albuquerque, NM&lt;br&gt;Contact: Gloria Chavez, 505-796-3435&lt;br&gt;e-mail: <a href="mailto:specialties@nmms.org">specialties@nmms.org</a>&lt;br&gt;ACS Representative(s): Robert R. Bahnson, MD, FACS</td>
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<tr>
<td>September 8–9</td>
<td>Kansas (AP)</td>
<td>Location: Wichita Hilton Inn, Wichita, KS&lt;br&gt;Contact: Gary Caruthers&lt;br&gt;e-mail: <a href="mailto:gcaruthers@ksmedonline.org">gcaruthers@ksmedonline.org</a>&lt;br&gt;ACS Representative(s): Clifford Ko, MD, FACS</td>
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<tr>
<td>September 22</td>
<td>Arkansas (AP)</td>
<td>Location: Jackson T. Stephens Spine and Neurosciences Institute, Little Rock, AR&lt;br&gt;Contact: Linda Clayton, 501-686-5847&lt;br&gt;e-mail: <a href="mailto:lindac92@comcast.net">lindac92@comcast.net</a></td>
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<tr>
<td>October 18–19</td>
<td>Iowa</td>
<td>Location: University of Iowa Hospital and Clinics Iowa City, IA&lt;br&gt;Contact: Sue Hyler, 515-984-6043&lt;br&gt;e-mail: <a href="mailto:hylerse@q.com">hylerse@q.com</a></td>
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<td>November 2–3</td>
<td>Wisconsin Surgical Society–a Chapter of the ACS (AP)</td>
<td>Location: The American Club , WI&lt;br&gt;Contact: Terry Estness, 414-617-0880&lt;br&gt;e-mail: <a href="mailto:wisurgical@att.net">wisurgical@att.net</a></td>
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<tr>
<td>November 2</td>
<td>Connecticut</td>
<td>Location: Farmington Marriott, Farmington, CT&lt;br&gt;Contact: Christopher Taksik, 203-674-0747&lt;br&gt;e-mail: <a href="mailto:info@ctacs.org">info@ctacs.org</a></td>
</tr>
<tr>
<td>November 2</td>
<td>Kentucky (AP)</td>
<td>Location: University of Louisville College of Medicine, Department of Surgery, Louisville, KY&lt;br&gt;Contact: Linda Silvestri, 859-323-6346 x224&lt;br&gt;e-mail: <a href="mailto:Isilv2@uky.edu">Isilv2@uky.edu</a></td>
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<tr>
<td>November 10–11</td>
<td>Arizona (AP)</td>
<td>Location: Hilton Tucson El Conquistador Golf &amp; Tennis Resort, Tucson, AZ&lt;br&gt;Contact: Joni Bowers, 602-347-6904&lt;br&gt;e-mail: <a href="mailto:jonib@azmedassn.org">jonib@azmedassn.org</a>&lt;br&gt;ACS Representative(s): Patricia J. Numann, MD, FACS</td>
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First Vice-President (see article about Dr. Bahnson on page 53), and Timothy D. Sielaff, MD, FACS, a member of the ACS Board of Governors. A total of 17 Past-Presidents of the South Dakota Chapter participated in the 60th anniversary celebrations (see photo, this page). Peter A. Andreone, MD, FACS, a cardiothoracic surgeon in Sioux Falls, was instrumental in contacting these South Dakota Chapter leaders.

**Chapter anniversaries**

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<thead>
<tr>
<th>Month</th>
<th>Chapter</th>
<th>Anniversary</th>
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<tbody>
<tr>
<td>July</td>
<td>Southwest Missouri</td>
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<tr>
<td></td>
<td>New Jersey</td>
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<tr>
<td></td>
<td>Keystone (PA)</td>
<td>60</td>
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<tr>
<td></td>
<td>West Virginia</td>
<td>62</td>
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<tr>
<td>August</td>
<td>Georgia</td>
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<td></td>
<td>Hawaii</td>
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<td>Illinois</td>
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<td></td>
<td>Brooklyn–Long Island, NY</td>
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<tr>
<td></td>
<td>Northwest Pennsylvania</td>
<td>62</td>
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<tr>
<td></td>
<td>Rhode Island</td>
<td>59</td>
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</table>

*Denotes Associate Fellow, Medical Student, or Resident membership in the College.

South Florida Chapter residents compete for prizes

The South Florida Chapter’s 23rd Annual Fellow, Resident, and Medical Student Surgical Research Forum Paper Competition took place this April at the University of Miami. The event featured cash prizes, which were distributed among the following individuals (see photo, page 80):

**Surgical Research:** First prize: Antonio Maya, MD, Cleveland Clinic Florida. Second prize: Robert Van Haren, MD, University of Miami. Third prize: Mohammed Elmessiry, MD, Cleveland Clinic Florida.

**Clinical Surgery:** First prize: Tarik Husain, MD, University of Miami. Second Prize: Marylise Boutros, MD, Cleveland Clinic Florida. Third prizes: Chad Thorson, MD, University of Miami; Josefina Farra, MD,* University of Miami; Dawn Wietfeldt, MD,* Cleveland Clinic Florida; Katrina Goukasova, MSIII, University of Miami; Pejman Radkani, MD,* Mt. Sinai Medical Center, Miami Beach, FL; Maria Albuja-Cruz, MD,* University of Miami; and Cesar Reategui, MD,* Cleveland Clinic Florida.

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West Virginia Chapter honors
**Dr. Copeland and Dr. Codman**

During the May 10–12 annual meeting, the West Virginia Chapter members honored the late Charles L. Copeland, MD, FACS, by awarding him honorary membership in the West Virginia Chapter. Dr. Copeland, who hailed from Pittsburgh, was a regular supporter and presenter at the West Virginia Chapter. Also, the chapter members initiated an effort to provide a grave marker for Ernest H. Codman, MD, FACS (1869–1940). So far, nearly $1,000 has been collected. In addition, new officers were elected (see photo, this page).

**New Chapter Managers**

Recently, two chapters have hired new managers. The Oklahoma Chapter will be managed by Jennifer Starkey, president, Key Management Solutions, Inc., based in Columbus, OH.

The Minnesota Chapter will be managed by Nonie Lowry, president and director, LP etc., Inc., based in Leawood, KS.