Public reporting of health care data:

A new frontier in quality improvement
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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.
The leadership and the staff of the American College of Surgeons (ACS) continue to gear up for our year-long celebration of the College's centennial, which will begin with the Opening Ceremony at the 2012 Clinical Congress. A wide variety of commemorative items will be available at the Congress to help mark this momentous occasion. A particularly noteworthy gift that will be available to all attendees is a book chronicling the history of this organization titled *A Century of Surgeons and Surgery: The American College of Surgeons—1913–2012*.

The authors—David L. Nahrwold, MD, FACS, retired chair of surgery at Northwestern University, Chicago, IL, and Peter J. Kernahan, MD, PhD, FACS, a surgeon and medical historian who has written a thesis on the College's formation—have devoted much of the last four years to the Herculean task of researching and writing this book. The result of their painstaking work is an engaging account of the College's achievements, occasional setbacks, and changes in direction. It vividly captures the complex personalities of the individuals who have led the College over the years, and I anticipate that ACS Fellows of all generations will find it a compelling read.

**The concept**

The original plans for the book were laid in 2006, when Thomas R. Russell, MD, FACS, then-Executive Director of the ACS, organized an exploratory meeting to discuss the possible development of a book celebrating the College's 100th anniversary in 2012–2013. George Sheldon, MD, FACS, chaired the panel. Other individuals who served on the committee included the late C. Rollins Hanlon, MD, FACS, then-Executive Consultant to the College; J. Patrick O’Leary, MD, FACS, then-First Vice-President of the College; and several executive staff members.

The committee reviewed histories that other medical organizations have published, as well as previously published books about the College, including: *The Joy of Living*, the autobiography of the College’s founder, Franklin H. Martin, MD, FACS, published in 1933; *Fellowship of Surgeons: A History of the American College of Surgeons*, written by Past-President Loyal Davis, MD, FACS, published in 1960; and *The American College of Surgeons at 75*, by George W. Stephenson, MD, FACS, who served the College in many executive positions for 48 years.
After reviewing these materials, the committee members agreed that the College should, in fact, publish a book chronicling the ACS’ first century and recruited Drs. Nahrwold and Kernahan to carry out this responsibility.

**Intense research**

Peter wrote the first four chapters of the narrative, which focus on the state of the surgical profession from 1880 to 1910, the necessity for the establishment of standards for surgical patient care, and Dr. Martin’s career. David and Peter collaborated on the development of the fifth chapter, which recounts “the end of the Martin Era.” David wrote the remaining 18 chapters, which, among other topics, cover the following:

- Creation of the American Board of Surgery
- The challenges that the College faced when we initiated the first African-American Fellow
- Activities during World War II
- Formation of The Joint Commission
- The College’s position on fee splitting and other unethical practices
- Medicare and the ongoing efforts to ensure that surgeons receive appropriate compensation

To compile much of the information in the book, David and Peter combed through the College’s archives, which contain the minutes, agendas, and supporting materials from the meetings of most ACS committees; records of educational programs; Dr. Martin’s papers; and a plethora of photographs. One particularly valuable resource was the collection of 26 three-ring binders that Dr. Martin’s secretary, Eleanor K. Grimm, assembled. After Dr. Martin’s death, Ms. Grimm served as the College’s chief executive officer, and throughout her tenure with the College, she used those binders to compile clippings and tear sheets from ACS publications, the minutes of meetings, and her own notes.

The minutes of the Board of Regents meetings were also very useful because they contain all of the supplemental information provided to the Regents before and at their meetings. Examples of these items include reports, background papers, correspondence, statistical and demographic information, and summaries of the issues presented to the Regents to assist in their development of College policies. David read every single one of those documents over the course of the last four years, and he and Peter cite them frequently throughout the book. Furthermore, because the Board minutes were transcribed verbatim until the 1950s, they provided the authors with unique insights into the distinct personalities and perspectives of the College’s early leaders.

**A must-read**

I want to commend David and Peter for the superb job they have done of taking all of this historical information and creating from it an engaging and insightful narrative. This book really became a labor of love for David, especially, and the College owes him an enormous debt of gratitude.

Be sure to save room in your suitcase for a copy of *A Century of Surgeons and Surgery*. You will definitely want to keep one of these volumes on your bookshelf and to refer back to it for many years to come.

David B. Hoyt, MD, FACS
Public reporting of health care data:

A new frontier in quality improvement

by
Ketan Sharma, MPH;
Ian Metzler;
Steven Chen, MD, FACS;
John E. Mayer, Jr., MD, FACS;
and
John Meara, MD, DMD, FACS
The American College of Surgeons (ACS) historically and continuously has sought to promote the highest standards of surgical care. Hence, the ACS recognizes the importance of objectively collecting, analyzing, and reporting data regarding processes of care and clinical and patient outcomes in efforts to optimize quality. The public and the government are now expressing a greater demand for this data. This article addresses the role of public reporting as a means of informational transparency that aims to maximize the quality of deliverable surgical care.

Properly done, public reporting offers several potential benefits. It could reduce information asymmetry between both patients and providers and providers and payors; promote competition in the health care marketplace; apply pressure to reduce costs and improve quality; empower patients to be more active participants in their own care; and foster a culture of accountability, transparency, and efficiency. However, to be successful, public reporting must use a framework that has credibility for both those being evaluated and for those using the data.

Most current health care data collection and reporting modalities suffer from inherent limitations. For example, the claims data that commercial payors and the Centers for Medicare & Medicaid Services (CMS) currently use are designed primarily for billing and payment purposes and are not specifically tailored for quality measurement. Therefore, these claims data are ineffective for tracking many relevant clinical processes and outcomes. The three main drawbacks of administrative claims data pertain to: (1) documentation; (2) coding; and (3) attribution. With regard to documentation, it is often unclear from claims data which physician served as the primary surgeon or anesthesiologist and which served as the assistant.

The second issue is that coding is carried out by hospitals’ medical records staff who are not directly involved in the care of patients and is limited by the information entered into patients’ medical records. The issue with attribution is that no standardized methodology is available to appropriately ascribe patient episodes of care among the several providers who participate in the care. Furthermore, the crucial ability to risk-adjust at the individual patient level to account for differences in prior medical health status and other factors affecting procedural risk remains limited, despite the many algorithms that attempt to compensate for these deficiencies.

Whereas feedback from outcomes data to physicians and hospitals can be a powerful tool in quality improvement, an over-reliance on claims data, for the reasons listed previously, is potentially problematic. Ideally, surgical care should be assessed with clinical data using outcomes measures specifically designed for surgical quality improvement that are clinically relevant and risk-adjusted. These data may then be combined with episode-based and long-term resource use data that assess cost.

Ultimately, national reimbursement policies (such as Medicare’s hospital conditions of participation or value-based purchasing) will be driven by quality performance measures. How these measures are developed and reported to various interested groups will be crucial to optimizing quality. The ACS believes a strategy that addresses the needs of all pertinent stakeholders (patients, physicians, hospitals, and payors) is critical to successfully reporting health care data, while avoiding unproductive and potentially harmful regulatory and payment policies. The ACS remains committed to providing leadership in innovative quality assurance and the development of data-driven standards through programs such as the College’s National Surgical Quality Improvement Program (ACS NSQIP®), a hospital-based registry used by more than 400 hospitals. Through the use of clinical data, ACS NSQIP has provided surgeons with vital patient information that has led to real cost savings through improved care.

Other efforts

Many physician, insurer, and governmental organizations have collaborated to establish guidelines for public reporting. Several are described in this article, but this list is by no means comprehensive.

AQA

The AQA alliance—originally known as the Ambulatory Care Quality Alliance—is a coalition started by the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), America’s Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ). It is now a multi-stakeholder collaborative composed of more than 100 organizations representing physicians, clinicians, consumers, and health insurance plans. The AQA alliance has focused on establishing a
consensus regarding a set of measures for assessing clinical performance that will be useful to payors, a multi-year strategy for rolling out measurements in the marketplace, a model for aggregating data, and a method for reporting useful data to providers, consumers, and purchasers. With regard to health care reform, the AQA aims to facilitate alignment between public and private efforts, promote best practices, address the gap between measurement and improvement, and provide guidance to the U.S. Department of Health and Human Services.4

The Commonwealth Fund
The Commonwealth Fund is a private foundation that was established in 1918 and supports independent research with the ultimate goal being to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society’s most vulnerable populations, including low-income people, the uninsured, minority Americans, young children, and elderly adults.5 Regarding public reporting, The Commonwealth Fund recognizes the powerful potential of quality improvement, but stipulates the following: information must be presented consistently and appropriately, multidisciplinary collaboration between numerous stakeholders is essential, research and concurrent evaluation should remain a prospective goal as well, and automated data collection is ideal.6

STS and ACCF
Public reporting of non-risk-adjusted coronary bypass mortality rates by Medicare was first undertaken in the 1980s, and this initiative provided the catalyst for the formation of the Society of Thoracic Surgeons’ (STS) Adult Cardiac Surgery Database. This database has grown and evolved since its initial formation into an audited database containing more than 4.5 million patient records with more than 1,000 adult cardiac surgical centers currently submitting data on each patient undergoing a cardiac surgical procedure. A “rating” system (one, two, or three stars)—based on risk-adjusted mortality rates and on a number of National Quality Forum (NQF)-approved process measures—has been developed. Each center participating in the database receives reports on its performance twice each year. Auditing is carried out upon data submission, and randomly by an external auditing entity (Iowa Foundation for Medical Care). In an agreement with Consumer Reports, over the last 24 months, database participants may voluntarily submit their STS rating for presentation in this publication.7-9 In addition, participating centers may also post their star ratings on the STS website (www.STS.org).

New York State and Pennsylvania began reporting coronary artery bypass graft (CABG) mortality rates for surgeons and hospitals in the early 1990s. New York developed its own risk-adjustment system for both coronary bypass procedures and for percutaneous coronary interventions, and Pennsylvania reports unadjusted (raw) mortality rates. The American College of Cardiology Foundation (ACCF) has developed its own clinical registries for various subspecialty areas, the most prominent being an interventional catheterization database. The ACCF 2008 health policy statement on principles for public reporting of physician performance data state the following: the driving force behind such measures should be quality improvement, performance measures should be scientifically valid, reporting programs should be developed in partnership with physicians, disparate reporting programs should be standardized and uniform as best possible, reporting should occur at the appropriate level of accountability, and all reporting programs should include a formal process evaluating the program’s effect on quality and cost, including an assessment of potential unintended consequences.10

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<th>Stakeholders’ data needs in the public reporting schematic</th>
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Stakeholder perspective

Given the dynamic interplay of the medical industry, public reporting necessarily involves a mix of various stakeholders. Successful reporting will require consideration of each party’s various needs (see table, page 8).

Patients

Because the driving force behind public reporting should be improvement of quality of deliverable care, the patient perspective remains essential. Information asymmetry between patients and providers has been a consistent barrier to increasing the role of patient choice in improving quality and decreasing costs. Public reporting constitutes a powerful intervention that can bridge this gap, but only if conducted appropriately. Therefore, patients should have access to information that meets the following criteria:

• Understandable. Measures on processes and outcomes must be reported to patients in a manner that the lay population can easily interpret. Information in performance reports must not be misleading or confusing; it should be clear and accurate, otherwise it can exacerbate the already-prominent information asymmetry. Using performance reports to make health care choices is a very difficult cognitive task. Patients have a difficult time differentially weighing factors reported about physicians, and although they often believe they are weighing various factors, they often are not.11

• Useful and relevant. Patients should be able to use public reporting data to make logical and informed decisions that guide their care-seeking behavior, including choice of physician(s) and/or hospital(s). Such measures should also offer reassurance that current care is safe, effective, affordable, and patient-centered as a form of positive reinforcement. Finally, comparative metrics that allow selection between providers and/or hospitals should be considered as well. The likelihood of differences, when identified as statistically important and/or clinically relevant, should be explained. Reports should provide guidance on making the information provided actionable for the patient.

• Easily accessible. Patients should be able to find and view information with a public search, and various methods of access should be built into the design of public reporting protocols. Information technology has already been used to bridge information asymmetry in other industries (such as used car sales) and offers a powerful tool in the area of public reporting as well.

Physicians

Physician participation is crucial to the success of public reporting initiatives. Therefore, the following provider perspectives must be considered:

• Physician-led. Due to the increasing complexity of specialized medicine, physicians delivering care within the specialty being reported should identify, maintain, and prospectively review quality metrics that evaluate processes and outcomes. These metrics should be created in an open fashion with provisions made for external comments into the rule-making process.

• Quality-oriented, not punitive. Public reporting initiatives should be implemented primarily as quality improvement efforts that aim to improve systems and prevent systems failures; they should not serve as punitive indictments that mark individual and organizational culpability. Individualized confidential reports for physicians to understand where their care or outcomes differ from their peers should be considered for all
Principles in public reporting

The following should serve as guiding principles for enacting accurate and effective public reporting:

**Data characteristics**
- Quality improvement should remain the driving force behind public reporting initiatives.
- Processes of care, and the clinical, patient, and outcome quality metrics, should be valid, timely, reliable, evidence-based, and appropriately risk-adjusted to account for medical, socio-cultural, and economic factors that affect patient care.
- Data safeguards must be implemented to protect the privacy of patients and physicians.

**Data collection**
- Expert physician involvement and oversight are required to create measures, analyses, outcomes, and public reports.
- Data should be collected in a manner verifiable by independent clinicians and/or trained data abstraction experts.
- Data collection facilities should have appropriate infrastructure, including staffing, specialists, and equipment.
- Data collection should, itself, be cost-effective and, ideally, electronic.

**Data analysis**
- Data analysis should be transparent, clearly defined, and independently reviewable by those being reported on, as well as statistically robust.
- Periodic external peer review is vital to verifying analytic methodology.
- Both processes and outcomes should be measured and benchmarked, with more emphasis placed on outcomes.

**Reporting**
- For outcomes that are dependent on multidisciplinary performance of teams of physicians and other ancillary health care professionals, reporting is most appropriate at the organizational, as opposed to the individual physician, level.
- Quality and resource use measures should be linked at both the physician and organizational levels to demonstrate overall value and effectiveness.
- All reports, both electronic and paper-based, should include disclaimers regarding the limitations of physician performance assessment and the uses of such information for consumer choice and overall quality improvement.
- All public reporting initiatives should include prospective and concurrent evaluations of their effect on cost, quality, and any unintended consequences.
- Reporting on patient experience should use validated, reliable, and standardized tools.
- Public reporting should include an appeals process for dispute resolution that is accessible by clinicians and consumers, with timely and responsive data adjudication and correction.

• *Protected.* Physicians should balance the issues of maintaining patient confidentiality against promoting transparency of public reporting measures themselves. Current federal law does not protect information submitted to patient safety systems from discovery in legal proceedings, which discourages their use and limits their potential for future corrective measures. To be
optimally effective, public reporting systems may require such protections, so that information provided by physicians remains privileged for judicial proceedings in civil matters or other disclosures.

- **Publicly accountable.** Because disputes between physicians or between physicians and other agents will arise, public reporting should include mechanisms for timely review and appeal of any results, with public resolution of such issues.

### Employers/purchasers

Publicly reported data are also valuable to employers as well as patients, as long as they meet the following criteria:

- **Aggregated.** Employers should have access to aggregated information that they can use to select coverage options and providers for their employees. Protections to avoid the release of specific outcomes of certain patients within the employer group must be included in reporting in order to protect the privacy of the patients in the database. This information should include costs and quality outcomes of possible providers and hospitals, as well as benchmarks of service and quality standards.

- **Easily obtainable.** This information should be presented in a manner that is understandable for purchasers and easily obtainable.

### Payors/insurance companies

Substantial information asymmetry also exists between patients and insurers, and between insurers and in-network providers. Public reporting may potentially bridge this gap as well by meeting the following criteria:

- **Available.** Insurers should be able to use available data to evaluate in-network providers on processes and outcomes.

- **Comparative.** Insurers should be able to evaluate their own performance on service and quality against competitors and other relevant norms.

- **Tailored.** Quality outcomes should be tailored to remain relevant to the insured population.

- **Effective.** It is worth noting in this context that the most powerful information will likely result from a merger of clinical registry outcome data with insurance company data upon use. These merged data will allow the assessment of the effectiveness of treatment strategies and fulfill a major need in the U.S. health care system for more rational use and control of resources.

### Hospitals

Publicly reported data will benefit hospitals as well by meeting the following criteria:

- **Comprehensive.** Information submitted to reporting systems should be comprehensively analyzed to identify interventions that minimize the risk of unintended negative consequences.

- **Confidential.** Confidentiality protections must be enacted for patients, health care professionals, and health care organizations to enable a culture of identifying and reducing errors.

- **Collaborative.** Reporting systems should facilitate sharing of patient information across health care organizations and foster confidential collaboration across different reporting systems.

### Government/policymakers

It is important to note that, at the current critical juncture in health care, public reporting can be used to guide future policymaking by meeting the following criteria:

- **Cumulative.** Policymakers should have access to current and accurate aggregate information on providers, hospitals, and health plans.

- **Granular.** Governing bodies should be allowed to monitor changes in the health care system, identify areas requiring closer examination, and promote a culture of self-reporting by monitoring groups.

- **Systems-based.** Policymakers and other regulatory bodies should stress the importance of avoiding direct punitive actions against individual providers or groups, and, instead, should favor systems-wide corrective actions tailored for quality improvement.
• **Efficient.** Policymakers should support the development of improved quality measures and promote coordination between groups to decrease duplication and other redundancies.

• **Innovative.** Policymakers should foster cooperation and reward innovation to incentivize public reporting and implementation of improvements.

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**Unresolved issues**

Despite the powerful benefits that public reporting offers and the increasing recognition of its utility, several issues remain unresolved, which should serve as guidelines for future inquiry.

First, an AQA alliance survey revealed that consumers want information on individual physicians, as well as larger groups and hospitals. While feasible, “concerns about sample size, attribution, and other technical issues challenge the ability to measure physicians at the individual level.”

Therefore, process and outcomes metrics may need to be further designed to specifically analyze individual physicians, and this information needs to be reported in a fair and accurate manner to patients. Efforts to ensure equity and accuracy are particularly important when considering various lower volume services where statistical “noise” may yield results that are not reflective of the quality of care. For complex in-hospital procedures that require interaction among multiple providers from different specialties, a focus on a single physician may not provide an accurate reflection of the overall quality of care provided by a team of caregivers.

Second, in any public reporting schema there are trade-offs between the transparency required for success and confidentiality required to protect physicians from litigation and from unfair and invalid characterizations of their clinical practices. If public reporting data may be used in litigation, physicians are far less likely to comply, which may undercut public reporting initiatives. Ultimately, patients themselves may be on the losing side of this situation due to the lack of potential quality improvement. Therefore, a solution must be enacted that balances appropriate confidentiality and protection required for compliance from providers with transparency needed to fairly and accurately assess publicly reported information.

Third, public reporting poses numerous issues concerning data management. Various agencies could manage and audit the entire public reporting process, including professional societies, certifying medical boards, regulatory bodies, and third-party payors. This option, which bypasses control of the process, will invariably affect the financial incentive structure.
required to make public reporting sustainable in the long-term. Furthermore, the relationship between professional public-reporting registries and both the CMS and private insurance companies will need to be defined.

**Conclusion**

Public reporting involves the objective collection, robust analysis, and transparent reporting of health care data to patients, providers, insurers, hospitals, and policymakers. Such measures constitute a new frontier in quality improvement that may promote competition in the health care marketplace, empower patients to be more active participants in the handling of their own care, and foster a greater culture of accountability, transparency, and efficiency. In the organization’s continual quest to provide the highest standards of surgical care, the ACS remains committed to propelling public reporting forward as a market-based initiative that will drive quality improvement.

**References**


**Dr. Meara** is plastic surgeon-in-chief at Children’s Hospital Boston, and associate professor of surgery and director of the Program in Global Surgery and Social Change, Harvard Medical School, Boston, MA. He is Chair of College’s Legislative Committee.

**Dr. Mayer** is a professor of surgery at Harvard Medical School, Boston, MA, and senior associate in cardiac surgery, Children’s Hospital Boston.
Editor’s note: As David Hoyt, MD, FACS, Executive Director of the American College of Surgeons (ACS), explained in his March 2012 “Looking forward” column, the College is participating in a national program known as Joining Forces. Through its participation, the ACS is partnering with a number of other health care organizations to help ensure that the veterans returning from the wars in Iraq and Afghanistan receive the compassionate care they need and deserve.

As part of this effort, the Bulletin will be running occasional profiles of ACS Fellows and other individuals who are actively involved in Joining Forces for purposes of helping other surgeons learn what they can do to help, and what initiatives they might consider implementing in their institutions. This article profiles John B. Holcomb, MD, FACS, director of the Center for Translational Injury Research; chief of the division of acute care surgery; vice-chair, department of surgery; and Jack H. Mayfield, MD, Chair in Surgery at the University of Texas Medical School, Texas Medical Center, Houston.

Joining Forces and the ACS:

Dr. Holcomb dedicates career to improving trauma care for soldiers and civilians

R
etired U.S. Army Col. John B. Holcomb, MD, FACS, developed a passion for ensuring that military service people receive the best possible care on and off the battlefield in 1993, during his deployment to the east coast of Somalia, Africa. He operated on many of the U.S. casualties of the Battle of Mogadishu, perhaps the most violent episode in that conflict. One of those soldiers bled to death in Dr. Holcomb’s hands—an experience that would profoundly affect his decision to center his career on trauma surgery and research.

“Somalia was a pretty short episode. It’s interesting. People say, ‘Well, it didn’t last very long,’ but while it lasted, it was just as violent as any episode in this war,” he observed. “People talk about low-intensity conflicts. That’s a real oxymoron. Any time you have a conflict, it’s high intensity.”

Joining Forces

Dr. Holcomb subsequently deployed overseas on multiple occasions before retiring three and one-half years ago after completing more than 23 years of military service. Six of those tours of duty were for purposes of providing care to the troops in Iraq. So, it is perhaps no great surprise that he has become a proponent of the College’s involvement in the Joining Forces program. “Throughout my career as
a trauma surgeon, I’ve had the opportunity to take care of many casualties, so I have sort of a personal interest in this,” he said.

Presently, Dr. Holcomb is particularly concerned about the long-term effects of the wars in the Middle East. The U.S. has been fighting in Iraq and Afghanistan for more than a decade, and nearly 2.3 million troops have been deployed. “That’s a large chunk of the population. How that number will change the United States is unclear at this point, but I think there’s no question that it will change the United States. Vietnam changed the United States; World War II changed the United States; the Korean War changed the United States at all levels; and this conflict will as well,” Dr. Holcomb noted.

The White House, the U.S. Department of Defense, Veterans Affairs, and all of the organizations participating in Joining Forces have designed the program “to anticipate, rather than to react to, those changes,” Dr. Holcomb said. More pointedly, Joining Forces is a far-reaching effort to ensure that returning troops and their families have access to education, jobs, housing, and health care.

**TMC activities**

The Texas Medical Center (TMC)—which includes the University of Texas (UT) School of Medicine and the Center for Translational Injury Research, where Dr. Holcomb practices, teaches, and studies trauma care—had been strategizing to implement programs that would support returning veterans before anyone at the institution had even heard of Joining Forces. “What’s interesting is that, along with James ‘Red’ Duke, Jr., MD, FACS, we had launched a local effort at the TMC to hire veterans, and that effort is expanding across the TMC and its 50 institutions,” Dr. Holcomb said. “Over the last couple of months, some of the institutions have hired more veterans than they would have, and then, at the same time, this [Joining Forces] effort came along, and we jumped at the opportunity to participate.”

UT’s health care-related activities are closely tied to a directive from the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM). “What the AAMC and the AACOM have asked the medical schools to do is to raise awareness—to make sure that veterans’ issues are identified and discussed within the curriculum of the medical schools,” he said. Some key issues that Joining Forces encourages health care providers to address include traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD). An estimated one in six veterans of the Iraq and Afghanistan conflicts is experiencing the life-altering effects of one or both of these conditions.

“We’ve met and discussed this with our curriculum committee, which I’m on. We’ve discussed the TBI and PTSD concepts already in our curriculum, but not in the context of veterans,” Dr. Holcomb said. He anticipates making changes in the medical school program specific to veterans’ issue starting with next year’s class. “One of the big things that we’re going to do locally is to develop a military trauma scenario for our problem-based learning portion of the second year schedule, which will allow us to go through all the phases of trauma, including anticipation, explosion, injury, TBI, physics, evacuation, infection, rehabilitation, all the way through to PTSD,” Dr. Holcomb, who serves on the ACS Committee on Trauma, said. The curriculum will also explore the psychosocial issues associated with these conditions, their effects on veterans’ families, including children, and so on. “It will be a significant portion of the education block,” he added.

Not all institutions need to follow this model to prepare medical students for the challenges they may face when providing care to veterans. “What I like about what the Joining Forces folks have done is that they’ve said, ‘We’re not going to tell you how to do it, but we think you should do something.’ So, each school will have different ways of raising awareness of veterans’ issues, which I think is a great way to
do this,” Dr. Holcomb said. “They’ve also created a website (http://www.whitehouse.gov/joiningforces) where we can share these different solutions to a common problem, so that everyone can adapt different solutions to their local institutions.”

The medical and surgical communities should be able to readily adapt to training people to deal with the effects of wartime trauma, Dr. Holcomb observed. “Certainly within the surgical community, there are a lot of veterans. Eight percent of our department of surgery is either on active duty or reservist or retired,” he noted.

Veteran surgeons at UT also try to educate surgeons who have not had military experience through their daily interactions, as well as in more formal settings. “We have grand rounds every week, and two to three grand rounds [at UT] every year are devoted to military issues. We also have the required disaster committees, which have a strong military presence,” Dr. Holcomb said.

Silver lining

Furthermore, the Center for Translational Injury Research’s efforts often focus on such issues as bleeding and resuscitation that are commonly seen on the battlefield, and their correlation to civilian patients. “A lot of the lessons learned in the military are spreading throughout the civilian trauma community,” Dr. Holcomb said. “A study we did in San Antonio showed that the PTSD rates between civilian and military burn victims were both very high. One of the things that’s under-acknowledged about civilian trauma patients is how high their PTSD rate is. One of the silver linings, I think, of the war [in Iraq and Afghanistan] will be not only a heightened awareness about veterans’ issues, which was very much lacking after the Vietnam War, but also a heightened awareness of the nonvisible injuries of civilian trauma patients.”

Furthermore, Dr. Holcomb said, “The [current] war has generated interest and funding for trauma studies. These studies are ongoing, and we anticipate great improvements in the care of trauma patients. And in the next war, which will inevitably come along at some point, we’ll have data-driven, rather than tradition-driven, treatment options and protocols.”

ACS activities

In addition to leading efforts to fulfill Joining Forces’ objectives at UT, Dr. Holcomb is playing an active role in the College’s activities in this arena. He will be participating in a panel discussion at the 2012 Clinical Congress, titled Joining Forces: How We Can Help Our Returning Vets (see sidebar for details). His portion of the program will compare and contrast military surgery with civilian practice.

Dr. Holcomb is impressed with the level of support members of the College and both the public and private sectors have shown for the Joining Forces initiative. “Everyone is really joining in to support this effort. It gives me goosebumps,” he said. “It is the right thing to do for veterans. Veterans have followed the orders from their Commander-in-Chief. They make every organization better, and we should do everything we can to help them.”

Mark your calendar: 2012 Clinical Congress session on Joining Forces

The American College of Surgeons will present Joining Forces: How We Can Help Our Returning Vets during the 2012 Clinical Congress in Chicago, IL. The session is designed to provide an overview of the Joining Forces program and to help surgeons become aware of the unique challenges facing the nation’s returning veterans and to offer insights into how to refer them to appropriate care. Following are the details that were available at press time regarding the session.

**Time:** 9:45–11:15 a.m.  
**Date:** Tuesday, October 2  
**Location:** McCormick Place, room TBD  
**Moderator:** A. Brent Eastman, MD, FACS, ACS President-Elect  
**Co-Moderator:** Michael F. Rotondo, MD, FACS, Chair, ACS Committee on Trauma

### Topics and speakers:

**Joining Forces:**
**The Structure and Goal of the Program**  
Capt. Bradley Cooper, U.S. Navy, executive director of Joining Forces

**The Scope and Impact of the Problem**  
Jonathan Woodson, MD, FACS, Boston Medical Center, MA

**Military Service versus Work in the Civilian Community**  
Dr. Holcomb

Ms. Schneidman is Editor-in-Chief of the Bulletin of the American College of Surgeons, Division of Integrated Communications, Chicago, IL.
The term “disruptive surgeon” conjures the image of an individual prone to angry outbursts, swearing, or throwing instruments. The American Medical Association’s Code of Medical Ethics defines disruptive behavior as “personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care.”¹ With this broad definition of disruptive behavior, physicians and nurses may be unaware that their behavior may fall into this category.
Raising the bar

In the past, surgeons were not expected to show empathy, and explanations were offered for bullying and other forms of overbearing behavior. Communication skills were not emphasized, and personality quirks were tolerated to retain talent. The surgeon was the *enfant terrible*. And so it was. The range of accepted behaviors we would now question without hesitation extend from the odd but innocuous—Nobel Laureate Alexis Carrel’s insistence on black surgical gowns, black drapes, and a black operating theater—to exhibitions of temper, objectionable humor, and demeaning forms of address.²

In an American College of Physician Executives’ survey, greater than 30 percent of more than 1,600 respondents reported that they observe disruptive behavior at least monthly.³ Despite the relatively frequent occurrence of disruptive behavior, only an estimated 3 to 4 percent of physicians are referred for remediation for unacceptable behavior.⁴ This discrepancy reflects the challenge of identifying more subtle forms of disruptive behavior.

There has been a great deal of emphasis recently on the repercussions of bullying, both in the workplace and in American society at-large.³ Workplace bullying may be categorized as sabotage (typically involving passive-aggressive behavior), verbal abuse, or conduct that is threatening, intimidating, or humiliating.³ These behaviors have been linked to loss of concentration, reduced team collaboration, failure to comply with system processes, and reduced information transfer. As a consequence there may be increased potential for patient harm such as wrong site surgery and medication errors.⁶ In a survey of more than 2,000 pharmacists, nurses, and other health care professionals conducted by the Institute for Safe Medication Practices, 88 percent of those surveyed had encountered condescending language or voice intonation, 87 percent encountered impatience, 79 percent dealt with reluctance or refusal to answer questions, 48 percent were subjected to strong verbal abuse, 43 percent experienced threatening body language, and 4 percent reported physical abuse. Almost half (49 percent) of all respondents indicated that their past experiences with intimidation had altered the way they handle order clarifications or questions about medication orders. Almost 50 percent of clinicians felt pressured by an intimidating prescriber to dispense medication despite unresolved safety concerns. Additionally, 40 percent of the respondents reported that at least once during the prior year, when they had concerns about a medication order, they assumed that it was correct or asked another professional to talk to the prescriber, rather than interact with the particularly intimidating prescriber.⁷

Professional standards

On July 9, 2008, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)—now known as The Joint Commission—announced that disruptive or inappropriate behaviors would be considered sentinel events. These behaviors included intimidation and disruptive acts that might foster errors, contribute to poor patient care, increase costs, and discourage teamwork. These actions encompassed verbal outbursts, threats, or passive-aggressive behavior, regardless of the underlying cause and whether they might be attributable to stress, personality, emotional pressures, or abuse of authority. Although The Joint Commission intended to put these rules in place on January 1, 2009, full implementation has been delayed because of the need to address a number of ambiguities and unintended consequences. For example, there was concern that strong advocacy for patient safety could be considered disruptive behavior. Also, the term “disruptive behavior” could be used in a setting in which patient behavior could unsettle the care environment. In a revised policy, set to go into effect July 12, 2012, the term disruptive behavior has been replaced with “behavior that undermines a culture of safety.”⁸

These guidelines require that health care organizations create a code of conduct that defines acceptable and unacceptable behavior and establishes a formal process for managing unacceptable behavior. Institutions are urged to educate all health care members about professional behavior, including telephone interactions and etiquette. All members of the team are to be held accountable for implementing desirable behaviors. Codes of conduct are to be enforced consistently and equitably.

The American College of Surgeons (ACS) has long-standing standards pertaining to professional behavior and relationships, which residents and fellows should read and discuss with their mentors/mentees at the beginning of and during training.
How does one know where to draw the line between reasonable reactions to stress and unacceptable behavior?

The scope of these standards can be determined by reviewing the following excerpts from section I, part A, numbers 4 to 6, and section III, part B, of the ACS Statements on Principles:

I. Qualifications of the Responsible Surgeon

A. Competencies

4. Interpersonal and Communication Skills that result in effective information exchange and effective interaction with patients, their families, and other health care professionals.

5. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

6. Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively utilize system resources to provide care that is of optimal value.

III. Interprofessional Relations

B. Discrimination or Harassment

The ethical practice of medicine establishes and ensures an environment in which patients, staff, colleagues, students, residents and all other individuals are treated with respect and tolerance. Discrimination, harassment, or creation of a hostile working environment…is inconsistent with the ideals and principles of the American College of Surgeons.

In the context of these standards, it becomes important to develop a surveillance system to detect and receive reports of unprofessional behavior, and to initiate training programs in which institutional leaders become conversant with organizational strategies to address intimidating and disruptive behavior. The importance and the gravity of disruptive behaviors must be emphasized, together with potential opportunities for improvement.

Identifying disruptive behavior

Disruptive behavior clearly includes angry outbursts, yelling, publicly degrading team members, cursing, and being physically abusive. Passive-aggressive behavior includes hostile e-mails, derogatory comments about the institution or individuals, inappropriate joking, and sexual harassment. Although less obvious, patterns of disengagement and/or withdrawal—such as avoiding meetings, failure to return calls, and delinquent chart notes—may also be disruptive. Frequently reported problem behaviors include degrading comments, refusal to follow established protocols, and failure to cooperate with other providers. All of these disruptive behaviors provoke stress, frustration, and loss of concentration, which impede transfer of vital information and can compromise patient safety and quality of care. Disruptive behavior also leads to nurse dissatisfaction and may lead to increased turnover.

Tension occurs on a daily basis both inside and outside of the operating room (OR). In a study on communication in the OR by Lingard and colleagues, pairs of trained observers tallied a diverse range of communication events including jokes, stories, commands, questions, social chat, rebukes, and silences. The researchers found that each surgical procedure included between one and four high-tension events. These high-tension events sometimes extended beyond the OR to the scrub sink, the next room, and the front desk.
In a follow-up study, Lingard and colleagues created short videos that portrayed high-tension events occurring within the OR. When these videos were shown to nurses, surgeons, and anesthesiologists, the observers largely agreed on the intensity of the conflict. However, the different disciplines had differing perceptions about which character in the video was responsible for creating the tension and to what extent each character played a role in resolving the tension. Surgeon observers more frequently attributed the tension to the actions of the nurses or anesthesiologist. The anesthesiologists and nurses, however, identified the surgeon as the source of tension. The complexities involved in dealing with unprofessional behavior are illustrated by the differences in these perceptions. How does one know where to draw the line between reasonable reactions to stress and unacceptable behavior?

The institution’s role

Developing a comprehensive approach to addressing disruptive behavior starts with the recognition that addressing the well-being of physicians and staff can help individuals ameliorate the effects of stress before it compromises their work performance. Behavior lapses are often related to stress. A second component is to establish a shared understanding of what constitutes disruptive behavior. Team members should be taught to identify and be accountable for addressing unprofessional behavior as it occurs. They also need clear processes for reporting disruptive behavior that eliminate fear of retribution against whistleblowers.

Institutions should have a transparent and consistent system for dealing with individuals who demonstrate poor behavior. The pervasiveness of disruptive behavior is related, at least in part, to the culture of an institution. Institutions that have a lenient policy on disruptive behavior may foster an environment that allows further disruptive behavior.

Physician dissatisfaction and distress pose significant costs to the individual and the institution. Increasing patient care demands along with decreasing institutional support and financial reimbursement can overwhelm even the most committed practitioner. Excessive stress may lead to physician burnout, which includes symptoms of emotional exhaustion, cynicism, and a sense of depersonalization in relationships with coworkers or patients. Other potential contributors to unprofessional behavior include substance abuse, unresolved feelings of guilt or shame after patient complications, family or personal problems, and persistent frustration due to poor clinical or administrative support systems. Workers who are burnout may experience a breakdown in their sense of community and believe they are treated unfairly.

Over the past decade, Vanderbilt University Medical Center, Nashville, TN, has developed a model for addressing unprofessional behavior. A fundamental component of this program is “actively valuing wellness, both as an individual and as a leader who supports others’ wellness.”

Complaints of disruptive behavior must be addressed promptly and fairly, regardless of the status of whose behavior is in question. In institutions without a formal program to deal with disruptive behavior, managing behavior issues may fall to a chairman or a division chief. It is important for someone in a leadership position to take the time to investigate an alleged complaint.

Redonda Miller, MD, vice-president for medical affairs at Johns Hopkins Hospital, Baltimore, MD, noted that there are always two sides to every story: “The accused physician may want to focus on who was right and who was wrong. The leader should help the individual understand that there are professional and unprofessional ways to respond, even if another individual was in error” (personal communication with Dr. Halverson, March 2012). One must not assume that all problems can be ascribed to one individual. The discussion should include the potential inciting events and system issues that may have precipitated the situation. It is important to invite the physician's view and, together, examine potential solutions. The leader should express appreciation for the physician's willingness to talk and to acknowledge his or her perspectives. Any discussion of this nature should aim to maintain trust and respect, minimize distractions, balance empathy and objectivity, and anticipate the range of responses that may ensue.

An isolated episode of non-egregious behavior should be addressed with an informal intervention (a “coffee cup conversation”). Most of the time, a single conversation is enough to prompt the individual to modify his or her behavior. Allegations of sexual boundary violations, physical violence, substance abuse, or other egregious behavior, on the other hand, should be reported to the appropriate
authorities for further investigation and action as appropriate.

In addition to specific reports of unprofessional behavior by members of the medical team, Vanderbilt catalogs unsolicited patient complaints as a mechanism for identifying problematic physicians. When asked about identifying more subtle forms of unprofessional behavior, Gerald Hickson, MD, associate dean for clinical affairs at Vanderbilt University Medical Center, stated, “We look for outliers. Over a one-to-two-year period, several physicians may have one or two patient complaints; 20 complaints regarding an individual indicates a problem” (personal communication with Dr. Halverson, February 2012). If a pattern in behavior is recognized, the next step is an “awareness intervention.” This involves having a peer share data with the physician. For example, Vanderbilt will assign a specially trained peer coach to the individual physician to explore the etiology of problems and to provide constructive feedback. This sharing of information may be followed by an action plan that includes peer coaching.

Georgetown University Medical Center in Washington, DC, has adopted a similar peer-support system. According to Stephen R.T. Evans, MD, FACS, vice-president of medical affairs, chief medical officer and professor of surgery at Georgetown, physicians often lack insight into how their words and actions affect others. “Having a colleague observe for a half-day of clinic can provide valuable insight and feedback,” noted Dr. Evans (personal communication with Dr. Halverson, February 2012).

Approximately 60 percent of physicians improve after the awareness intervention alone, whereas 20 percent will require additional intervention in order to improve. Some health care practitioners will choose to leave the institution. “This represents a loss for the institution because faculty recruitment requires a significant investment in time and money. Do the math,” explained Dr. Evans. Also problematic is the fact that the physician is likely to continue to display behavior problems at the new institution.

Role of the individual

Although nearly all clinicians have witnessed some form of disruptive behavior, many individuals are ill-equipped to deal with the issues. When encountering a high-tension situation, the first step is to stay calm, and ask what can be done to alleviate the friction. Inviting one of the individuals to step away from the situation may allow the emotional level to abate. Various strategies for addressing the problem may be employed depending on the circumstances. Common strategies include describing the situation or the unacceptable behavior and inviting suggestions from the involved individuals. Articulating the problem and possible solutions helps individuals reach a mutually acceptable resolution. The conversation should aim to determine what is right rather than who is right. Taking no action may imply tacit approval of the behavior. There are significant implications for novices who are exposed to this behavior, especially when it is not called out and corrected. The resultant behaviors can range from mimicry to withdrawal.

Surgeons often are challenged to change their own behavior. The first step toward change is to understand how one’s own behavior affects others. Changing behavior requires self-reflection. Feedback from a trusted colleague or 360-degree evaluations may provide a useful perspective. Some individuals may lack insight into how their behavior is perceived. In some instances, individuals justify their behavior based on their circumstances.
In *Leadership and Self-Deception*, the authors explain that when individuals behave in a way that they know to be unprofessional, their instinct is to justify the behavior. Typically, they do so by finding fault in others and seeing themselves as the victims. As people become more deeply entrenched in their own perspective, they come to expect unwanted behavior from others. When it does occur, it reinforces an individual’s justification of his or her own bad behavior.\(^1\)

One must inventory internal and external stressors to assess how they are affecting work performance. Professional counseling may be necessary to improve stress management techniques and restore emotional equilibrium or to address problems such as depression or substance dependence. Continuing medical education courses are available that specifically address disruptive physician behavior.

**The role of prevention**

Promoting professional behavior is just as important as promoting surgical skills and domain knowledge, but in many respects it is more difficult. Whereas residents and fellows expect to be trained in surgery and surgical technique, surgical judgment, and surgical lore, professional behavior traditionally has been viewed as an ability that is absorbed rather than studied.

The most efficient way to prevent potential problems is by carefully choosing and training staff, residents, and fellows. In the selection process, it is helpful not only to screen for surgical skill and expertise, but also to look at elements of character, such as kindness and empathy, as well as communication skills and positive experiences in team environments. Authoritarianism, intimidation, excessive narcissism, or insecurity should be avoided. It is important to select for, and insist on, good manners.

In the course of surgical training and career development, it is important to include inculcation in leadership, negotiation, conflict resolution, and crisis management skills. Essential elements of an educational program should include helping trainees to identify disruptive behaviors, appreciate their effects on patient safety, and understand and locate the institutional resources available to address these issues. Finally, the surgical curriculum should provide information on strategies for stress management and maintenance of emotional well-being.

Vanderbilt begins professional behavior education in the first year of medical school and includes educational programs through every year of medical school and residency. Scott Hultman, MD, recently reported the results of a survey of fourth-year medical students from the University of North Carolina, Chapel Hill. Respondents revealed that they considered professionalism the third most important competency after clinical skills and medical knowledge. They said that professional behavior could be “taught” and “learned.” Although survey participants claimed reading materials and lectures on the topic of professional behavior may be useful, the students reported that the most effective teaching tools are mentoring and modelling.\(^1\)

As we teach future surgeons, it is imperative that our behavior is consistent with our stated rules of conduct.

**Conclusion**

Medical institutions and surgical training programs are entitled to have legitimate expectations of manners and civility from students and staff at all levels. Patterns of behavior matter and constitute a reasonable criterion upon which to evaluate physicians. It

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**Additional resources**

- **Vanderbilt Comprehensive Assessment Program for Professionals, Nashville, TN**

- **Sierra Tucson Assessment and Diagnostic Program, Tucson, AZ**
  - [www.sierratucson.com](http://www.sierratucson.com)

- **Professional Renewal Center, Lawrence, KS**
  - [www.prckansas.org](http://www.prckansas.org)

- **Elmhurst Memorial Healthcare Professionals at Risk Treatment Services, Elmhurst, IL**
  - [www.emhc.org](http://www.emhc.org)

- **Colorado Personalized Education for Physicians, Aurora, CO**
  - [www.cpepdoc.org](http://www.cpepdoc.org)
is important that surgeons undertake a leadership position in improving the medical workplace.

References

5. Stelmaschuk S. Workplace Bullying and Emotional Exhaustion Among Registered Nurses and Non-Nursing, Unit-Based Staff. The Ohio State University College of Nursing; 2010. Available at: https://kb.osu.edu/dspace/bitstream/handle/1811/45566/Workplace_Bullying_and_Emotiona Exhaustion_among_Registered_Nurses_and_Non_nursing_Unit_based_Staff_final.pdf. Accessed April 10, 2012.

Dr. Halverson is assistant professor of surgery, Northwestern University Feinberg School of Medicine, and a colon and rectal surgeon at Northwestern Memorial Hospital, Chicago, IL. She is Vice-President of the Metropolitan Chicago Chapter of the American College of Surgeons (ACS) and serves on the ACS Committee on Perioperative Care.

Dr. Neumayer is professor of surgery, University of Utah, Salt Lake City; the Jon and Karen Huntsman Presidential Professor of Cancer Research, Huntsman Cancer Institute; and co-director, integrated breast program, Huntsman Cancer Hospital, Salt Lake City. She is a Regent of the College and a member of the ACS Finance Committee.

Dr. Dagi is distinguished scholar and professor, The School of Medicine, Dentistry and Biomedical Sciences, Queen’s University, Belfast, Northern Ireland; visiting professor, Harvard Medical School, Boston, MA; and Chair of the ACS Committee on Perioperative Care.
Team approach minimizes risks in separating conjoined twins:
An interview with Gary Hartman, MD, FACS

*by Robyn McMurray Hurtig*

Only about two dozen conjoined twins have been successfully separated in medical history, and Gary Hartman, MD, FACS, a pediatric surgeon at Lucile Packard Children’s Hospital, Stanford, CA, has successfully parted six of them in the last few decades. Most recently, on November 1, 2011, Dr. Hartman separated two-year-old twin girls, Angelica and Angelina Sabuco, in a nearly 10-hour procedure.*

The girls, born in the Philippines but living in San Jose, CA, with their parents and 10-year-old brother, were joined at the chest and abdomen, a condition called thoraco-omphalopagus. Because of how they were connected, the operation entailed separating their livers, diaphragms, breastbones, and chest and abdominal wall muscles.

The Sabucos began researching surgeons via the Internet while the girls were still in the Philippines. In their online research, the family came across Dr. Hartman’s work, and saw what they felt was a close parallel between their daughters and his most recent separation in 2007 of Yurelia and Fiorella Rocha-Arias from Costa Rica. They reached out to Dr. Hartman and began the dialogue.

“In this case, the parents absolutely wanted the twins separated. We could see changes in their muscular-skeletal systems already at the age of two; there was some ketosis in the spine as well as some defor-


Angelica and Angelina before surgery

Angelina and Angelica after surgery
mity in the anterior chest wall,” said Dr. Hartman, professor of surgery at Stanford University School of Medicine, and director of regional pediatric surgery services. Although separating the girls posed significant risks, keeping the girls connected would have put their health in greater jeopardy, especially in terms of muscular and skeletal deformities that would worsen over time.

**New technology lowers risks**

Separation procedures typically are considered impossible when twins share a major organ, such as the heart or liver. And, indeed, that’s what Dr. Hartman perceived as the primary peril of operating on Angelica and Angelina. Performing surgery on conjoined twins is especially risky because if one twin dies during surgery, the other will die within hours.†

“The technical area we were most concerned about was separating the liver because there were two fairly large vessels that went directly across the plate that we needed to divide. That procedure went very well and was essentially bloodless, which didn’t surprise us because that had been the case with the last two sets [of conjoined twins] we did in 2007,” Dr. Hartman said. “We used a lot of the same equipment that our liver surgeons and transplant surgeons used for the last twins’ liver surgery, so there are some pretty good tools available now that make that procedure pretty bloodless.”

The technology has changed dramatically since the first time Dr. Hartman operated on conjoined twins in 1980 during his fellowship at the University of Oklahoma in Oklahoma City. The new technology primarily affected how the liver procedure was performed. Dr. Hartman’s team used a hydro-jet dissection instrument on the last two sets of twins to help them cleanly separate the liver. They also used an argon laser, as well as one of their regular laparoscopic endostaplers, on this set of twins, according to Dr. Hartman, who specializes in pediatric thoracic, cancer, and minimally invasive procedures.

“The case went quite well, pretty much as planned with no big surprises. We had really great imaging—a 3D CT [computed tomography]—so we had no surprises from a technical or anatomical standpoint,” he added.

Along with the liver, another area of concern was separating the girls’ sternum, mostly because an infection could occur if too little skin was available to cover the wounds. As a preventative measure before the operation, surgeons used tissue expanders to stretch the skin in the chest area to ensure they would have adequate skin to cover both girls.

When the surgeons disconnected the girls’ sternum it left a big gap at the breastbone, which needed to be reconstructed. For this procedure, the team was able to use some of the same materials that the plastic surgeons use in their craniofacial work. Peter Lorenz, MD, and

his plastic surgery crew rebuilt the girls’ chests and abdominal walls by implanting a thick, custom-made resorbable plate in each girl’s chest where the sternum should be located. Then they grafted bone pieces that were removed during the separation onto the plates. The plates will take about a year and a half to dissolve, after which the grafted bone will have time to fuse, providing Angelica and Angelina with normal bones and stable chests. Reconstructing the girls’ chest walls also had the potential to create respiratory problems. But fortunately, none of these concerns were realized.

Whereas new technology contributes to a positive outcome from conjoined surgery, much of it, according to Dr. Hartman, depends on the anatomy and physiology of the patients, including whether they are physically separable and have an adequate complement of organs and limbs.

**Planning and preparation**

Perhaps surprisingly, Dr. Hartman said performing this operation wasn’t so different from performing other procedures, but the preparation and planning were especially challenging. He elaborated, saying, “The surgery itself at each of its steps is a fairly standard surgical procedure; it’s the fact that you have two patients and all the personnel and equipment to deal with that makes it complicated.”

When it comes to performing surgery on conjoined twins, Dr. Hartman says it requires a different mindset. “Working as a team is a long process, but I’ve gotten a good idea of how to get the team organized, and I feel good about that process now,” he said.

Preparing the team for this type of surgery takes at least a few months, but Dr. Hartman feels comfortable that he has learned how to get ready effectively, especially over the course of the last three sets of conjoined twins.

The team Dr. Hartman put together for the operation on Angelica and Angelina consisted of many of the same individuals who helped him successfully separate the conjoined twins from Costa Rica in 2007, which was the first time such a procedure had occurred at the Lucile Packard Children’s Hospital, and the last time Dr. Hartman performed surgery on conjoined twins. “We had multiple people at each step of the way, so we had a contingency plan if anything happened to any of the individuals on the team. A back-up person was always identified and available, so we had a lot of skill and depth on the team,” said Dr. Hartman.

“What we’ve been doing in the last three sets is to assemble a team from all the clinical specialties: anesthesia, pediatric surgery, plastic surgery, operating room (OR) staff, biomedical engineering, nursing staff, and clinical care units, so we have representatives from each area. Additionally, especially when we work with kids, we have the child-life specialists, and physical and occupational therapists,” explained Dr. Hartman. The operation last November required an extensive team of specialists, including 10 physicians, two anesthesia teams (each composed of six members), eight surgeons, and multiple scrub technicians and circulating nurses.

During the planning process, one representative from each of these disciplines participated in regular meetings, usually early in the morning every other week for a few months; as the operating date drew closer, they met every week.

“Even though we only had one person [from each specialty] at each of the planning meetings, that person would go back to their area and discuss the relevant issues, so the nurses and scrub techs from the ORs would talk with the rest of the members of the team and do their planning. So, the team itself was actually much bigger than the planning team,” Dr. Hartman explained.

“The expertise is what the subspecialists bring from their own specialties. The things we do during the case are not necessarily unique to conjoined twins surgery, although there are unique differences. But most of the techniques and procedures that the specialists bring are tools they use in other types of cases, so it’s not potently new each time,” said Dr. Hartman.

**Ethical issues**

In addition to the complex nature of separating conjoined twins, this operation frequently raises ethical concerns. For example, the twins from Costa Rica suffered from congenital heart disease. Dr. Hartman said that at the time of that surgery the intensive care unit (ICU) space was limited, and the severity of the heart disease could have led to a difficult surgical procedure. The physicians involved in the case worried what would happen if each twin needed intensive care and there was only one spot available in ICU.

“The concern in the 2007 case revolved around the allocation of valuable resources, not the value of doing the procedure or the feasibility of doing it. We had no ethical concerns with this current set. We thought we could separate them and they would
have a normal complement of organs and a normal outcome,” Dr. Hartman said.

In the several cases in which Dr. Hartman has been involved, ethical concerns were not raised because the risks associated with not operating far outweighed the risks of keeping the twins conjoined.

“The sets I’ve seen have had significant muscular-skeletal changes even in the first few months of life, which would only get worse as they aged,” said Dr. Hartman.

**Unique stressors**

Dr. Hartman’s last three operations on conjoined twins were all heavily publicized beforehand, adding to the pressures associated with tackling a complex case. Dr. Hartman’s technique for coping with the stress is the same no matter what kind of surgery he’s performing.

“I’m not on call the night before or the night of surgery. Our family tries to do the regular routine the night before; we don’t do anything special. Personally, I try to have a good night’s sleep and not vary my routine too much. I don’t consciously handle the stress any differently with the extra publicity, but try to keep my routine as normal as possible.”

On the day of the surgery, access was limited to the OR. Security at the entrance ensured anyone entering the OR was wearing a badge identifying individuals with clinical responsibilities in the case. However, because there was an educational component to the procedure, Dr. Hartman said, “We are a teaching institution, so we did have fellows [involved] in the case, but there were a lot more people interested, so we had a video feed to a couple of rooms that were secured from the media. The video feed enabled people from the hospital and medical school to wander in and out of those rooms as their schedule allowed to see relevant parts of the case.”

**Positive prognosis**

Angelina and Angelica have now been out of surgery for several months. Their wounds are all healed, and the girls are home and eating normally. Within two months of the operation, they relearned how to walk.

“Beforehand, they were walking sideways and they were balancing each other. After the surgery, they had no counterbalance in front of them and they had to learn how to walk forward. Now, they are running up and down the halls when they come to clinic. They quickly learned how to walk on their own. The advantage of being young is that they are very flexible and malleable and adapt quite well,” explained Dr. Hartman.

The girls still have abnormal configurations of the chest, but Dr. Hartman is hoping that will improve with time. The chests are protruding out more than normal because they were growing out toward one another when the girls were attached.

“That’s the main thing we are monitoring at this point because their physical abilities seem to be developing quite rapidly. We are thinking that we might need to do some external bracing, and if that doesn’t work, then there’s some potential for further surgery, but hopefully not,” added Dr. Hartman.

To help the girls cope psychologically with the separation, Dr. Hartman has involved Packard’s child-life specialists and psychologists.

“In the last two sets of conjoined twin surgery, there were some significant but temporary changes. In both cases, before separation, one of the twins was more dominant than the other. And postoperatively the dominant twin has been unhappy. In fact, one of them wouldn’t even look at me for the first few days because we think she lost her little punching bag. The more submissive twin of the last two sets has been quite happy postoperatively. And, now the mother reports they are back to their more usual personalities,” said Dr. Hartman.

It appears that Angelica and Angelina are not the last set of conjoined twins that Dr. Hartman will get to watch develop as individuals. “Just recently, I was contacted by parents in Laos who gave birth to a set of conjoined twins. Their case looks very similar to the case we just did,” said Dr. Hartman.

With at least one other conjoined twin surgery looming in the near future, it appears that Dr. Hartman will have many more opportunities to achieve his goal of helping children lead better lives. “After months of intense planning and collaboration with almost every department in the hospital, it is rewarding to return two individuals home to happy, healthy lives. We’re tired, and very gratified.”

Ms. McMurray Hurtig is a freelance writer based in Evanston, IL.
Leadership conference focuses on outcomes data and surgeon engagement

by Tony Peregrin

Members of the American College of Surgeons (ACS) from across the nation and across the surgical specialties converged on Washington, DC, March 25–March 26, for the 2012 Leadership Conference.

“Surgical leadership for quality and safety” was the theme of this year’s conference, which featured separate, concurrent sessions for young surgeons, residents, chapter leaders, and chapter executives (administrators and executive directors).

The meeting took place at the JW Marriott in the nation’s capital and drew a total of 184 attendees. Members of the College’s Young Fellows Association developed and moderated the Leadership Conference, which preceded the ACS’s inaugural Advocacy Summit (see page 32 for the Advocacy Summit wrap-up).

Taking action

ACS President Patricia J. Numann, MD, FACS, welcomed attendees to both the Leadership Conference and the Advocacy Summit in her opening remarks by highlighting the College’s unparalleled commitment to quality care. “The College is entering its 100th year, and all of the programs we have are incredible. The College has always been at the forefront of ensuring that we give good, quality care,” said Dr. Numann.

She urged attendees to “shape their own future” instead of “waiting for outside agencies to shape it for you. It takes courage not to sit in your office and question what is going on with health care, but to stand up and say what you believe,” said Dr. Numann, referring to the Advocacy Summit and visits scheduled on Capitol Hill the next day.

ACS NSQIP promotes teamwork

J. Michael Henderson, MB, CHB, FACS, chief quality officer of the Cleveland Clinic; and Barbara L. Bass, MD, FACS, John F. and Carolyn Bookout Distinguished Endowed Chair and Director, Methodist Institute for Technology, Innovation, and Education, Houston, TX, participated in a panel discussion on the ACS National Surgical Quality Improvement Program (ACS NSQIP®).

They addressed how ACS NSQIP outcomes data may be used to promote teamwork as a means toward delivering quality care.

According to Dr. Henderson, four main characteristics distinguish ACS NSQIP data from the information used in other quality improvement (QI) programs. ACS NSQIP data are:

- Clinical data (not administrative or claims data)
- Risk-adjusted
- Case-mix adjusted
- Patients are tracked patients from pre-operation through 30 days post-operation

“The 30-day patient follow-up is a unique feature for ACS NSQIP, and is a critical component of this program,” said Dr. Henderson.

As of March 2012, a total of 440 hospitals were enrolled in the ACS NSQIP program, which Dr. Henderson called “significant growth,” but said the numbers were still relatively small when compared with other medical registries.

He said QI programs at their core are about “preventing complications, saving lives, and reduc-
ing costs. Most hospitals improve over time and bring value. The literature shows that quality does improve with this program,” he said, citing an article published in the September 2009 issue of *Annals of Surgery* titled “Does surgical quality improve in the American College of Surgeons National Surgical Quality Improvement Program?: An evaluation of all participating hospitals.”

One of the primary costs involved in running QI programs is hiring a full-time nurse or coordinator to collect the data, Dr. Henderson said. “So, I suppose it all depends on where you are as a hospital. Are you constantly scrambling to get things done, or are you able to commit to this program? If you’re not going to use the data—it might not be worth it,” said Dr. Henderson, who also emphasized ACS NSQIP’s flexibility with participation options for virtually every hospital size and type, including:

- Classic
- Essential
- Small and rural
- Targeted
- Pediatric (The ACS NSQIP Pediatric program is the first and only nationally benchmarked, risk-adjusted, clinical outcomes-based program for pediatric surgery in the nation.)

**Measures option**

“Over the next decade, how hospitals are improving will be more important than what their overall absolute scores are,” added Dr. Henderson. “This [program] is a great opportunity because it provides good data. The College needs to be commended for its efforts, but remember, success depends on us and our involvement. There is no question in my mind that this is the right thing to do.”

“If surgeons view [ACS NSQIP] as their program—they will want to use it,” said Dr. Bass during her presentation. “We all need to be ‘crusaders’ of NSQIP, as Dr. Henderson said, and persuade our colleagues of the credibility of the program.” Dr. Bass underscored the importance of surgeon engagement as a key to successful QI programs by offering the following suggestions:

- Offer surgeons actionable data about their own practices
- Encourage crusaders/supporters of the initiative
- Obtain the support of information technology staff and the quality infrastructure (including the leverage power of surgeons)

At The Methodist Hospital System, Houston, the facility follows specific QI goals, such as being patient-centered, effective, safe, timely, efficient, and value-driven. “These goals are the same at any hospital,” said Dr. Bass. “Making [these goals] public can only enhance the reputation of your institution in what is a very competitive market.”

A key challenge to successfully implementing a QI program is actually “putting the data to work,” added Dr. Bass. “The big question is: How do you convert data to quality improvement processes—especially if you fall in the middle range? You’re not great, but you’re not terrible, either.” She suggested addressing lower-hanging fruit first, by:

- Identifying systemic problem areas
- Identifying high-risk groups
- Applying best practices to those cohorts

Examining provider- or site-specific reports is another way to use data to foster surgeon engagement with QI programs. According to Dr. Bass, these reports help in the following key areas:

- Inform and engage the surgeons in QI process (surgeons care about their work)
- Inform and engage surgeons in the new era of quality transparency (surgeon protection)
- Improve quality of care (lack of data can mean no action taken)
- Allow surgeons to compare their work with others’ (including local and national outcomes data)

“To prepare surgeons for 2017, we want surgeons to know their own results,” explained Dr. Bass. “This is important for the surgeon protection process. This is all going to be public in 2017, so we might as well be proactive and become aware of this now. ACS NSQIP is the only program that offers individual surgeons their data,” she said.

**Developing leaders**

The QI Leadership Skills panel—composed of John Handy, MD, FACS, Providence Health System, Portland, OR; Deborah J. Baker, DNP, CRNP, director of nursing, Johns Hopkins Hospital Department of Surgery, Baltimore, MD; and Thomas Genuit, MD, FACS, University of Maryland Medical Center, Baltimore, MD—stressed the importance of strong leadership and effective communication to promote quality and safety initiatives.

Dr. Handy addressed the challenges in developing a multidisciplinary approach to quality and safety at both an individual institution and throughout a hospital.
According to Dr. Handy, the benefits of multidisciplinary care include:

- Improved staging
- Shorter time to therapy
- Increased rates of surgery
- Increased quality of surgery
- Increased compliance with established guidelines
- Increased protocol accrual
- Improved care of non-cancer co-morbidities
- Improved overall and progression-free survival

“The word ‘quality’ is a hard word to get your head around,” noted Dr. Handy, who said he defines quality as “structure plus processes plus outcomes equal quality.”

Through his work with the Providence Thoracic Surgery Initiative, Dr. Handy has determined some essential traits of a surgical leader, including:

- Authoritative reputation (at the local, regional, and national level)
- Expertise (practice-based, lifelong learning)
- Ability to communicate vision to team, leadership, colleagues
- Willingness to let others shine

“Let others shine—if it’s just about you, it won’t work. It’s not just about surgeons; it’s about the team,” explained Dr. Handy, who also advised surgical leaders to meet frequently with their teams to ensure successful implementation of a multidisciplinary approach to QI.

Ms. Baker provided the perspective of “frontline staff” and patients in developing effective, quality-driven teamwork. “We take a triad approach to quality improvement,” explained Ms. Baker. “And like the shape of a triangle, each component is equally important.” Her guidelines for improving patient safety include:

- Leadership engagement
- Comprehensive Unit-Based Safety Programs (CUSP) Culture, which empowers staff to assume responsibility for safety in their environment
- Patient- and family-centered care, which allows for greater accountability for health maintenance by patients and families

“You have to develop leaders—they don’t just happen,” added Ms. Baker. “To do this, you have to ‘build your bench,’ and this goes for nurses and physicians.” According to Ms. Baker, building a bench includes the following steps:

- Identify and expand on an individual’s strengths, minimize weakness
- Encourage staff to speak up and reward this behavior
- Provide feedback
- Ensure interprofessional team training
- Promote multidisciplinary problem solving

In his presentation, Dr. Genuit highlighted the challenges of implementing quality improvement measures in a teaching hospital. “Creating effective means of communication and supporting a ‘universal language around outcomes and QI’ are paramount steps to launching a successful program at a teaching facility, according to Dr. Genuit, as are
generating interest and involvement from residents, students, and “mid-level providers,” not to mention both full-time and private faculty.

Residents in particular face many competing demands, such as acquiring medical knowledge and mastering technical skills, fulfilling scholarship requirements, and maintaining work-life balance. “Traditionally, residents are not involved in long-term, hospital-wide quality initiatives,” said Dr. Genuit. “But incentives almost always work, such as a QI award to a resident that might involve additional training at a national conference. This is something we are seriously considering.” In addition to incentives, Dr. Genuit offered other suggestions for generating resident and midlevel provider engagement in QI programs, including:

- Changing the scope of morbidity and mortality conferences
- Offering opportunities for involvement in hospital-wide committees
- Establishing a resident committee
- Including formalized QI/outcomes evaluation education

At Dr. Genuit’s facility, 15 residents currently are involved in 11 committees and have participated in more than eight ongoing QI projects.

“It is our hope that these efforts will lead to the development of a culture of quality improvement, anchored in the mission and vision of the departments and of the institution, based on a universally understood language of processes and outcomes. This is an ongoing and sustainable process,” said Dr. Genuit.

**Characteristics of a strong leader**

David R. Flum, MD, MPH, FACS, director of the University of Washington’s Surgical Outcomes Research Center, Seattle—a multidisciplinary research center that supports outcomes research to improve the quality of surgical care—presented the conference’s keynote address. Dr. Flum focused on the effective traits of leaders.

“Leaders aren’t born—they are molded,” said Dr. Flum. “And leaders are doers. Like Dr. Nunnemann said, it’s very easy to have opinions about doing things, but taking action is something else entirely. There is a special place for people who complain about the health care system but do nothing to change that system; it’s called the doctors’ lounge,” said Dr. Flum.

Dr. Flum revealed five characteristics of successful leaders, which he discovered after reading *The Corner Office: Indispensable and Unexpected Lessons from CEOs on How to Lead and Succeed*, which features interviews with top leaders from various fields and industries. Those traits include the following:

- **Passionate curiosity**
- **Battle-hardened confidence** (many were at one time seen as horrible public failures, but they learned to “fail-forward” and were able to learn from their mistakes and move on to new challenges)
- **Team smarts** (the ability to get people to work together)
- **Simple mind-set** (distill complex information and establish a common vision)
- **Fearlessness** (look for opportunity even when things are not broken)

Successful leaders take action, said Dr. Flum, and they recognize truths, specifically toxic variability. “I see this truth—surgery has an existential threat when it comes to variability,” said Dr. Flum. “How it tracks it, how it controls it, and how it handles those on either side of the variability charts.”

Before implementation of the Surgical Care and Outcomes Assessment Program (SCOAP)—a physician-led, voluntary collaborative that uses aviation as a model to track and develop surgical quality—Washington State had what Dr. Flum called a very disturbing variability rate. “Prior to SCOAP there was no system in place that was providing information to hospitals and clinicians to help them understand what their care looked like compared to other hospitals and whether the care they were providing was meeting best-practice standards,” said Dr. Flum.

In addition to recognizing truths, strong leaders “search for opportunity, as shifting risk compels us to address variability,” according to Dr. Flum. He also encouraged leaders to “operationalize optimism by creating communities to change behavior,” and to not hesitate to “drive the bus” as long as they did so “with class.”

**Legal pitfalls and financial skills**

During a session titled “How to Avoid Legal Pitfalls,” Paula Cozzi Goedert, Esq., Barnes & Thornburg, LLP, Chicago, IL, provided an overview of legal considerations specifically geared toward chapter leaders. Ms. Goedert, the College’s legal counsel, covered the basics regarding chapter leaders’ fiduciary responsibilities, the legal and tax
benefits of incorporation, concerns about intellectual property rights, and chapters’ insurance needs.

Jim Dowden, Executive Director of the Southern California Chapter in El Segundo, CA, and Samantha Katzbeck, CPA, ACS Controller, Chicago, IL, led a session titled Financial Skills for Chapter Leaders. This session addressed sources of non-dues revenues that can be used to support chapters’ education missions. In addition, chapters’ financial statements, auditing procedures, and long-term savings were covered during the session.

**Town hall meeting**

As in years past, this year’s Leadership Conference ended with a town hall meeting featuring the following ACS leaders: John H. Armstrong, MD, FACS, Chair, ACS Professional Association-SurgeonsPAC, Tampa, FL; David B. Hoyt, MD, FACS, ACS Executive Director, Chicago, IL; Dr. Numann; J. David Richardson, MD, FACS, Chair, Board of Regents, Louisville, KY; Christian Shalgian, Director, ACS Division of Advocacy and Health Policy, Washington, DC; and Andrew L. Warshaw, MD, FACS, ACS Treasurer and Chair, Health Policy and Advocacy Group, Boston, MA. Each of the panelists underscored the relevance of the theme of the conference, “surgical leadership for quality and safety,” and offered their support of the College’s ongoing advocacy and quality initiative efforts.

**Mr. Peregrin** is Senior Editor of the Bulletin of the American College of Surgeons, Division of Integrated Communications, Chicago, IL.

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**Advocacy in action**

**ACS hosts first annual Advocacy Summit**

*by Chantay Moye*

The American College of Surgeons (ACS) convened a successful first annual Advocacy Summit March 26–27 in Washington, DC. The conference took place on the heels of the Leadership Conference and the same day the U.S. Supreme Court began historic hearings on the Affordable Care Act (ACA).

Throughout the conference, surgeon leaders and staff from the ACS Division of Advocacy and Health Policy (DAHP), political pundits, and congressional representatives teamed up to inform, educate, and demonstrate to ACS members how to become major influencers on the issues that affect their practices and their patients. The underlying theme of the meeting bore a clear resemblance to the longstanding mission of the College—to engage in activities that will help to improve the quality of care for the surgical patient.

The DAHP is dedicated to ensuring that Congress hears the voice of the College. This conference and other activities carried out through the division are intended to ensure that elected representatives in the House and Senate know how the decisions they make affect the delivery of health care services.

**An engaged membership**

“An educated, motivated electorate is critical to keeping government from making missteps or errors in one of the most important sectors of our economy—health care,” said John Meara, MD, FACS, Chair of the ACS Legislative Committee. With this concept in mind, the first day of the summit was dedicated to arming attendees with as much information as possible to reach out to congressional leaders on issues such as payment, medical liability reform, quality improvement, trauma, the surgical workforce, and so on. Day two was “Lobby Day,” when surgeons and surgical residents met face-to-face with their respective members of Congress and/or their staff and laid out the College’s position on these issues.

More than 200 College members from 42 states attended the...
Advocacy Summit and participated in 223 Senate and House meetings. The College’s DAHP staff believes that these numbers are an indication that members of the College understand that their hands-on involvement in congressional outreach is critical to the future of health care.

During the Summit, attendees raised more than $35,000 for the ACSPA-SurgeonsPAC, the political action committee of the American College of Surgeons Professional Association.

“Surgeons must understand the issues and be actively involved in shaping the changes coming rapidly in health care delivery and payment. To this end, the interaction among ACS leaders, Fellows, surgical residents, members of Congress, business leaders, and a constitutional lawyer did well in preparing the participating surgeons to advocate effectively on Capitol Hill and in their home states,” said Andrew Warshaw, MD, FACS, Chair of the ACS Health Policy and Advocacy Group.

Food for thought; know the issues

Luncheon speaker Stuart Rothenberg, editor and publisher of The Rothenberg Political Report, a non-partisan political newsletter, provided an overview of the current state of presidential politics and political developments in an attempt to answer the question, “Is this country headed in the right direction?” Mr. Rothenberg delineated the recent triumphs and failures of Democrats and Republicans alike and what it will take for either party to be successful on Election Day in November. As we get closer to the presidential election, he said, “You’re going to see a much-divided nation.” He also advised surgeons and residents who were participating in Lobby Day on Capitol Hill to “make the case—and make it well” and “know the issues.”

Preparing for the Hill

The aim of the Summit was to help participants not only understand the issues, but how to effectively influence Congress. Christopher Kush, CEO of Soapbox Consulting, a firm dedicated to working with associations to prepare them for their advocacy day, conducted an informational continued on page 35.
# ACS Congressional “Asks”

## Medicare Physician Payment (House and Senate)
- Congress must permanently repeal the sustainable growth rate formula (SGR)
- Repeal must occur prior to physicians shifting to new payment models
- Use the Overseas Contingency Operation funds as an offset for permanent SGR repeal

## Surgical Workforce (House)
- Ask House members to introduce legislation similar to S. 1627, which helps address the physician workforce shortage issue by increasing the number of residency positions
- Include the $5 million appropriations request for the Pediatric Subspecialist Loan Repayment Program in its fiscal year (FY) 2012 budget

## Surgical Workforce (Senate)
- Enact S. 1627, which helps address the physician workforce shortage issue by increasing the number of residency positions
- Include the $5 million appropriations request for the Pediatric Subspecialist Loan Repayment Program in its FY 2012 budget
- Enact legislation that reauthorizes Children’s Hospital Graduate Medical Education Payment Program

## Medical Liability Reform (Senate)
- Co-sponsor S.1099, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, which restores balance to the medical liability system, stabilizes medical liability costs, and protects patients’ rights
- Introduce and enact legislation similar to H.R. 157, the Health Care Safety Net Enhancement Act, which provides emergency on-call specialists with Public Health Service Act liability protections for physicians providing Emergency Treatment and Active Labor Act (EMTALA)-mandated care
- Introduce and enact legislation similar to H.R. 3586, the Good Samaritan Health Professionals Act, which will ensure that health professionals who wish to provide voluntary care in response to a federally declared disaster are able to do so and not face uncertainty about potential liability

## Medical Liability Reform (House)
- If the member voted in favor of H.R. 5, thank them
- If member voted against H.R. 5, ask for their reason
- Co-sponsor H.R. 157, the Health Care Safety Net Enhancement Act, which provides emergency on-call specialists with Public Health Service Act liability protections for physicians providing EMTALA-mandated care
- Co-sponsor H.R. 3586, the Good Samaritan Health Professionals Act, which will ensure that health professionals who wish to provide voluntary care in response to a federally declared disaster are able to do so and not face potential liability claims

## Trauma and Emergency Care (House and Senate)
- In order to ensure access to life-saving trauma and emergency care, Congress must include funding for critical trauma and emergency medical services programs and activities as authorized in the Public Health Services Act in the FY 2013 Labor/Health and Human Services/Education Appropriations Act

## Drug Shortages (House and Senate)
- Urge Congress to address drug shortages now, before delays and disruptions in patient care become even more widespread
- While congressional action is not enough, Congress can take action now, while longer-term solutions are examined. For example:
  - Authorize the U.S. Food and Drug Administration (FDA) to develop an early warning system that requires manufacturers to notify the agency when they experience a production disruption or discontinue a product
  - Require manufacturers to develop contingency plans to line up alternate suppliers of raw materials
  - Require the FDA and the Drug Enforcement Administration to work collaboratively to provide flexibility in the development of production and raw material quotas to ensure that manufacturing capacity is not compromised
session analogous to a “grassroots 101.” Mr. Kush and his team of experts prepared individual meeting schedules for attendees and provided tips on how to quickly and candidly seek support from members of Congress. Participants also received a DAHP pocket card that listed the key issues or “Congressional Asks” (see page 34), along with tips on writing an effective letter to Congress and what to expect when visiting with congressional leaders. Mr. Kush noted that once a constituent walks into a congressional office, he or she has mere minutes to state the case. He went on to say that on Lobby Day, “You undoubtedly will not cast a magical spell, but your presence will make a difference—which is why it is essential that you know the issues.”

The ACS leadership believes that it is imperative that members know the issues, and even more critical that we continue to foster and build relationships with members of Congress long after the meeting, as the issues and relationships will continue to be at the forefront of the ACS advocacy efforts to secure the future of health care.

The informational session was followed by an open forum in which participants were able to ask ACS advocacy experts questions about what to expect on Lobby Day, as well as about overall health policy. Participants spared no topics during the forum. The questions ran the gamut, and created an interesting and telling political dynamic in the room. Surgeons asked questions on topics ranging from the sustainable growth rate (SGR), the Independent Payment Advisory Board (IPAB), and accountable care organizations (ACOs), to graduate medical education (GME), bundled physician payments, health care law, and more.

Participants generally agreed that they felt prepared for Lobby Day following the advocacy training, issues briefing, and open forum. “I wanted to come to the summit to learn more about the issues and to get involved, [and] especially help those outside of clinical medicine who don’t understand the issues. I believe that the sessions were invaluable and helped guide participants [on Lobby Day],” said Mary Grace Hajec, MD, from Richmond, VA. “You’re always afraid that you’re going to say something to sink the ship [on Lobby Day], but this session helps,” said Emily Penman, MD, FACS, a general surgeon in Newark, DE. Unlike Dr. Hajec, Dr. Penman has prior experience in the advocacy process. Although she said that she understands how things work on Capitol Hill, she also believes that the informational sessions are a necessary progression towards positive change.

John Meara, MD, FACS, Chair of the ACS Legislative Committee, agrees. He believes the summit is an excellent venue that provides Fellows an opportunity to present their advice and concerns directly to their elected official, saying this is exactly how a representative democracy should function.

The afternoon was spent learning more from political experts, congressional representatives, and other organizational leaders about the state of health care and how to forge collaborative efforts to advance pertinent health care issues. Many questions were asked about such concerns as how to advocate in this seemingly divided environment, and when a true dialog will actually begin.

The general consensus was that respective groups can no longer work in “silos,” and that one of the most important ways to be effective on Capitol Hill is to forge coalitions—especially beyond surgery. To meet this challenge, the ACS invited leaders from the Federation of American Hospitals, Boston Scientific, and...
National Partnership for Women and Families to begin identifying scalable or measurable goals as a coalition. Participants also had the opportunity to hear first-hand from congressional leaders regarding their impressions of what is happening on the ground right now with regard to issues.

Dinner with George F. Will

Headlining the summit dinner, George F. Will, a Pulitzer Prize-winning columnist, asked the attendees if they believe the nation is on the right track politically. Since 1974, Mr. Will has provided one of the most widely read columns for The Washington Post and for more than 35 years provided a bimonthly essay for Newsweek magazine. He also has served as creator and panelist for ABC television’s This Week, taught political philosophy at the university level, and served as a staff member to the U.S. Senate.

During his presentation, Mr. Will pondered the question of “what would he depress the audience with first,” followed by a quick game of presidential trivia. The light-hearted satire quickly gave way to serious political statistics pertaining to the current condition of the economy. Mr. Will noted that every 10 seconds America goes $0.5 million further into debt. He asserted that trillions of dollars in home equity were lost in recent years and by 2050 those considered very old will be more numerous than the combined population of New York City and Chicago, IL—making the elderly an influential population. Mr. Will went on to talk about the debt of Medicare, the drivers of health care cost, and how the growing divide of income inequality will become a bigger issue in America. At the close of his presentation, Mr. Will urged participants to begin thinking about how to make effectual change. He said to remember that all change begins and ends at the ballot box.

The College encourages surgeons to plan ahead to be a part of ACS advocacy efforts by following the issues described in this article. In the coming months, watch for updates on the date and location of the 2013 ACS Advocacy Summit.

Ms. Moye is Communications Manager, Division of Integrated Communications, Washington, DC.
The American College of Surgeons (ACS) and Centers for Disease Control and Prevention (CDC) have signed a strategic partnership agreement to work on shared goals of reporting, measuring, and preventing surgical site infections (SSIs) and other adverse outcomes among surgical patients. The agreement builds on the initial success of the ACS’ and CDC’s joint development of a coordinated SSI measure. The goal of sustaining quality health care lies at the core of the alliance, as the two organizations will combine their expertise and organizational resources to meet these demands.

The ACS National Surgical Quality Improvement Program (ACS NSQIP®) and the CDC’s National Center for Emerging and Zoonotic Infectious Diseases, Division of Health Care Quality Promotion (DHQP) will form a working group and jointly develop and maintain measures of SSIs and infectious and noninfectious complications that affect surgical patients. The work group will build upon the portfolio of SSI measures that the ACS and the CDC developed jointly in 2010 for abdominal hysterectomy and colon operations.

“We welcome this opportunity to expand our progress in improving surgical patient outcomes on a national level by collaborating with the CDC,” said David B. Hoyt, MD, FACS, ACS Executive Director. “Partnering with the CDC speaks to our shared commitment to surgical patient safety, preventing complications, and lowering costs.”

“This partnership will help close gaps that exist between direct patient care and public health,” added Daniel Pollock, MD, a medical epidemiologist and the Surveillance Branch Chief in CDC’s Division of Healthcare Quality Promotion. “Bringing clinicians, surveillance experts, and prevention leaders to the same table will help ensure we collect the right data in the right way so that patient safety can be maximized.”

Under the agreement, the ACS and the CDC will continue to develop quality of care measures, foster greater use of electronic health record systems for quality measurement purposes, exchange data, and conduct joint analyses and reports using data collected through ACS NSQIP and the CDC’s National Healthcare Safety Network.

“It’s clear that our national health system is seeking better...
ways to measure quality care. Better data makes it possible because it creates more opportunities to improve the care hospitals and providers offer their patients,” said Clifford Y. Ko, MD, FACS, Director of the ACS Division of Research and Optimal Patient Care, which administers ACS NSQIP. “The CDC has tremendous experience with their quality programs, and through the ACS, hospitals participating in ACS NSQIP have already shown significant improvement in patient mortality and morbidity and are preventing 250 complications per hospital, per year.”

The announcement of the ACS-CDC collaboration followed the National Quality Forum’s (NQF) endorsement of two outcomes-based measures from ACS NSQIP. The two measures, surgical site infection and urinary tract infection, were developed by the ACS with input from the Centers for Medicare & Medicaid Services (CMS) and CDC as possible national outcome measures that could be adopted by CMS as early as 2015. Five ACS NSQIP outcomes-based measures are now endorsed by NQF, including elderly surgery outcomes, colectomy outcomes, and lower-extremity vascular bypass outcomes.

Go to http://www.cdc.gov/nhsn/ for more information on the NHSN, and go to http://site.acsn-sqip.org/ to view the ACS NSQIP website.

Disciplinary actions taken

The American College of Surgeons (ACS) Board of Regents took the following disciplinary actions at its February 10, 2012, meeting:
• Roy E. Berkowitz, a retired general surgeon from Slidell, LA, had his full Fellowship privileges restored following a period of probation. His Fellowship was restored after it was determined that he met the conditions for reinstatement set by the Central Judiciary Committee.
• A neurosurgeon has had a non-public disciplinary action taken against his ACS Fellowship following charges that he had violated the Bylaws, Article VII, Sections 1(b) and (f), when disciplinary action was taken against him by his state medical board.
• Dwight M. Fitzgerald, a general surgeon from Conover, NC, had his ACS Fellowship placed on probation with conditions for reinstatement. That action followed a disciplinary action from the North Carolina Medical Board involving charges of disruptive behavior in the workplace.

Definition of terms

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

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

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

Suspension: A severe punitive action for a period of time, during which the Fellow or member, according to the membership status, (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the member’s name from the public listing and mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or member is returned to full privileges and obligations of Fellowship.

Expulsion: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
As part of its ongoing Inspiring Quality (IQ) program, the American College of Surgeons (ACS) hosted nearly 80 health care and aviation industry leaders at its fifth Surgical Health Care Quality Forum on Wednesday, April 11, at the Rainier Club in Seattle, WA. Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), Henry N. Harkins Professor and chair, department of surgery, University of Washington, and Past-Chair, ACS Board of Regents, moderated the event, which brought together a diverse group of leaders from Washington State’s aviation and health care industries to discuss quality improvement programs and best practices.

Among the topics panelists discussed were checklists, standardization, culture shifts, and transparency—all of which are tools that can make surgery safer and reduce health care costs. Congressman Jim McDermott (D-WA) provided opening remarks about the challenges of health care quality and cost and why the surgical community needs to be involved in health care discussions on Capitol Hill.

“One of the greatest challenges we face in Congress is [health care] costs,” said Representative McDermott. The congressman discussed the challenges of health care quality and cost, Washington State’s leadership in quality improvement, and why it is important for the surgical community to be involved in health care discussions on Capitol Hill.

“We thought it was very appropriate to unite the ACS Inspiring Quality initiative with aviation expertise and the successful quality programs we have implemented to date here in the state of Washington,” said Dr. Pellegrini. “This was a unique opportunity to invite and learn from two industries that represent everything we are trying to achieve with Inspiring Quality: safety, quality, and excellence.

The Seattle forum highlighted research and data from key quality programs such as the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) (http://site.acsnsqip.org/), the Surgical Care and Outcomes Assessment Program (SCOAP) (http://www.scoap.org), and SCOAP’s Comparative Effectiveness Research Translation Network (CERTAIN) (http://www.becertain.org). Forum participants also celebrated the launch of the Strong for Surgery initiative in Washington State, which will bring preoperative checklists to patients and further improve outcomes.

“Strong for Surgery takes the idea of checklists and moves them to where decisions are mostly being made, before the patient gets to the hospital,” said David Flum, MD, MPH, FACS, associate chair for research and surgery, and professor of surgery, health services and pharmacy at Washington University in St. Louis. “We thought it was very appropriate to unite the ACS Inspiring Quality initiative with aviation expertise and the successful quality programs we have implemented to date here in the state of Washington,” said Dr. Pellegrini. “This was a unique opportunity to invite and learn from two industries that represent everything we are trying to achieve with Inspiring Quality: safety, quality, and excellence.”

At the Seattle IQ Forum: Front row, left to right: Ellen T. Farrokhi, MD, FACS; Keith W. Leverkuhn; Dr. Pellegrini; and Thomas K. Varghese, Jr., MD, FACS. Back row: David B. Hoyt, MD, FACS, ACS Executive Director; Morris G. Johnson, MD, FACS; Dr. Flum; Richard P. Billingham, MD, FACS; and Bradley D. Tilden.
the University of Washington in Seattle. “There would never be an airplane [crew] that would start a checklist when it is already moving down the runway, and the same concept applies to surgery. The doctor’s office is the last opportunity to have those important discussions about whether the patient is ready for an operation.”

Visit http://www.kuow.org/conversation/index.php?id=26456 to listen to an interview with Dr. Flum on KUOW, a Seattle public radio station. The program, called The Conversation, focused on Washington State’s quality improvement efforts and the ACS Surgical Health Care Quality Forum in Seattle. Go to http://www.facs.org/ to obtain more information on the event, including the video archive of the Seattle forum. Visit http://inspiringquality.facs.org/national-tour/ to view the ACS Inspiring Quality website National Tour page.
ACS offers resources to help surgeons achieve meaningful use of EHR

In an ongoing effort to help the surgical community achieve meaningful use through participation in the federal Electronic Health Records (EHR) Incentive Program and to better understand program requirements, the American College of Surgeons (ACS) has numerous EHR resources available on the home page of its website—www.facs.org—and is engaged in a number of other related activities.

Members of the ACS and other health care providers and professionals have expressed a number of concerns regarding the Centers for Medicare & Medicaid Services’ (CMS) EHR Incentive Program, which offers financial rewards to health care professionals and hospitals that “meaningfully use” EHR technology. The incentive program was established through the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was included in the American Recovery and Reinvestment Act (ARRA) of 2009, to promote the adoption and meaningful use of health information technology (HIT).

Some of the specific concerns surgeons have raised center on the following: choosing the right EHR vendor, implementing EHR in the workplace, understanding meaningful use requirements, and qualifying for incentive payments under the EHR Incentive Program.

ACS EHR resources

Currently, the College has identified two paths to provide surgeons with the most up-to-date and pertinent information on EHRs: (1) an online EHR Resource Page on the College’s website; and (2) access to a members-only Web-based resource for EHR system selection/implementation.

To start, access the “Online EHR Resources for Surgeons” at www.facs.org. This resource offers free online EHR comparison resources. Read through the “Basic Starter Guide,” located along the left-hand column, to gain an introduction of some of the key issues related to meaningful use of a certified EHR.

In addition, a “resources page” provides tips on negotiating an EHR vendor contract, gives details on the rule-making process, and provides a listing of the Regional Extension Centers (RECs). RECs offer technical assistance and guidance to providers in the U.S. to help them become meaningful users. Or you can bookmark the dedicated EHR resource Web page for immediate access by using this URL: http://www.facs.org/SurgeonsEHR/index.html.

In addition, the College is in the process of developing a series of webinars that will highlight key components of EHR, including incentive criteria, quality measures, the Health Insurance Portability and Accountability Act, and EHR benefits and barrier. The College is working to ensure that participants have access to and fully understand the documentation necessary to make optimal decisions about engaging in health information processes designed to enhance the care and service to patients.

ACS partners with EHR firm

The ACS also is one of more than a dozen professional society partners of AmericanEHR Partners, a Web-based resource for EHR system selection/implementation developed by the American College of Physicians and Cientis Technologies. Free EHR information may be accessed via its website at www.americanEHR.com. The site provides the tools necessary to identify, implement, and effectively use EHRs and other health care technologies. For example, surgeons may use the site to compare certified EHR systems and find the system that best suits their specific needs, or use the EHR Readiness Assessment Tool designed to assess a number of critical areas and gauge the effort and commitment required to make EHR adoption easier and more successful. Surgeons may also find useful the biweekly EHR educational newsletter, podcasts, and active blogs that discuss the HIT industry and more.

AmericanEHR Partners does not endorse or indicate a preference for any EHR system. The goal is to provide unbiased
information on all participating EHR vendors.

**ACS EHR advocacy activities**

The College is also working with other organizations to advocate on health care professionals’ and other providers’ behalf. This spring, the College’s Division of Advocacy and Health Policy (DAHP) and the National Coalition of HealthCare Providers (NCHP) convened two meetings with other groups to discuss meaningful use requirements, workforce issues, and HIT vendor selection. The College and other health care groups are gathering information pertaining to their members’ HIT-related concerns and working together to relay these issues to members of Congress and officials at federal agencies, such as the Office of the National Coordinator for Health Information Technology and CMS. In addition, the College recently participated in a meeting titled the EHR Surgical Quality Data Capture: Evolving a Learning Healthcare System, with key researchers, clinicians, and EHR vendors. Future meetings are being planned.

Furthermore, the College is urging CMS to reevaluate the penalty timelines associated with the EHR incentive program. With the recent release of the CMS meaningful use Stage 2 proposed rule, DAHP staff has been actively involved in writing a comment letter to CMS urging the agency to make the new meaningful use requirements more flexible and applicable to specialists. The College’s DAHP will continue to advocate for these and other issues to help strengthen surgeons’ overall ability to provide quality care to patients.

Direct questions regarding the EHR Incentive Program to Sana Gokak at sgokak@facs.org. For questions about the College’s HIT advocacy-related work on Capitol Hill and with relevant federal agencies, contact Dana Halvorson at dhalvorson@facs.org.

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**Additional EHR resources**

**CMS’ EHR Information Center Helpline:** 888-734-6433

**CMS’ EHR incentive program:**
https://ehrincentives.cms.gov/hitech/login.action

**ONC’s site on attaining meaningful use:**
http://www.healthit.gov/providers-professionals/meaningful-use-stage-2

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**We need your e-mail address**

Not sure if we have your current address? Go to the “My Page” area of the ACS Members-only Web portal at www.efacs.org to see what’s currently in our database and to make necessary changes so the College can keep you informed.

If you have questions or problems, contact dues@facs.org. Include your Fellowship ID number in your note.

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**Important Note:**

The American College of Surgeons does NOT provide your e-mail address to outside entities. E-mail addresses are used only for College communications.
The National Ultrasound Faculty of the American College of Surgeons has developed “Ultrasound for Surgeons: The Basic Course, 2nd Edition” on CD for physicians and medical professionals in ultrasound imaging.

The 2nd Edition includes:

♦ Updated graphics using 3-D medical modeling developed by NASA researchers to teach ultrasound and rapidly demonstrate key ultrasound skills
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♦ Cue Cards to view and print to prompt learners on three commonly performed scans
♦ 4 AMA PRA Category 1 Credit™

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

To purchase, go to www.acs-resource.org or call 888-711-1138
Members in the news

**Björn Brücher, MD, PhD, FACS, FRCSEng** (see photo, this page), was awarded honorary membership in the Israel Society for Surgical Oncology during the association’s biennial conference in February. Professor Brücher specializes in tumor diseases of the gastrointestinal tract, the esophagus, and the stomach, as well as peritoneal carcinomatosis.

**Lewis Flint, MD, FACS** (see photo, this page), Editor-in-Chief of *Selected Readings in General Surgery*, published by the American College of Surgeon's (ACS) Division of Education, was elected president of the Southern Surgical Association at its 123rd annual meeting, which took place recently in Hot Springs, VA.

**George L. Hicks, MD, FACS**, cardiothoracic surgeon and chief of cardiac surgery at the University of Rochester Medical Center, Rochester, NY, received the Socrates Award from the Thoracic Surgery Residents Association during the Society of Thoracic Surgery's annual meeting. The award is given annually to an outstanding faculty member.
who demonstrates a remarkable interest in resident training.

Pamela A. Lipsett, MD, FACS (see photo, page 44), received the 2012 American Medical Women’s Association (AMWA) Women in Science Award at the AMWA’s 97th annual meeting, April 13–15, in Miami, FL. Dr. Lipsett is the Firor Chair of Surgery and professor of surgery at Johns Hopkins Hospital, Baltimore, MD; the immediate past-president of the Society of Critical Care Medicine; and the current president of the Surgical Infection Society.

John M. Morton, MD, MPH, FACS (see photo, page 44), was honored for excellence during the seventh annual National Physician of the Year Awards, sponsored by Castle Connolly Medical Ltd. Dr. Morton, section chief, minimally invasive surgery; and director, bariatric surgery and surgical quality at Stanford School of Medicine of the Stanford University Medical Center, CA, received the 2012 award at a ceremony in New York, NY, in March.

Leigh Neumayer, MD, FACS, and David Rogers, MD, FACS (see photos, page 44), each received the Distinguished Educator Award of the Association for Surgical Education (ASE) during the 2012 Surgical Education Week, March 20–24, in San Diego, CA. The award is the most prestigious honor that the ASE bestows on surgical education leaders.

Dr. Neumayer is a professor of surgery, University of Utah, Salt Lake City, and the Jon and Karen Huntsman Presidential Professor of Cancer Research, Huntsman Cancer Institute, also located in Salt Lake City. Dr. Neumayer currently serves on the Board of Regents and is a member of the ACS Finance Committee.

Dr. Rogers is associate professor, division of pediatric surgery, Southern Illinois University, Springfield. A recipient of numerous departmental and institutional teaching awards, Dr. Rogers is a past-president of the ASE. Also at the ASE meeting, Timothy Farrell, MD, FACS; Charles Friel, MD, FACS; and Travis Webb, MD, FACS, received the Philip J. Wolfson Outstanding Teacher Award.

Paul J. Pearson, MD, FACS, was named one of three endowed chairs at NorthShore University HealthSystem, located in four northern suburbs of Chicago, IL. Dr. Pearson, division chief of cardiovascular surgery, was invested as the Owen L. Coon Chair of Cardiothoracic Surgery. Before joining NorthShore, Dr. Pearson practiced thoracic surgery at the Mayo Clinic, Rochester, MN, as chief resident associate. Dr. Pearson has developed the Pearson Shunt for use in cardiac surgery, and the Pearson Laryngoscope for use in the pre-hospital setting.

Dr. Greene receives SAGES award for endoscopy education

Frederick L. Greene, MD, FACS, chair of surgery at Carolinas Medical Center, Charlotte, NC, and a member of the Commission on Cancer (CoC) since 2000, has received the Jeffrey L. Ponsky Master Educator in Endoscopy Award. (Dr. Greene is pictured above right, with Dr. Ponsky.) The award was presented to Dr. Greene during the Society of American Gastrointestinal and Endoscopic Surgeons’ recent annual meeting in San Diego, CA. Dr. Greene served as chair of both the CoC and the American Joint Committee on Cancer, and continues to work as a surveyor for the CoC accreditation program. He currently serves on the American College of Surgeons Patient Education Committee.
One CoC clinical scholar departs, and another steps in

This month, Richelle Williams, MD, will complete her two years as a Surgical Oncology Scholar-in-Residence with the American College of Surgeons (ACS) Commission on Cancer (CoC). Jennifer Paruch, MD, will fill that position starting in July.

Dr. Williams, who is finishing a highly successful term as a Surgical Oncology Scholar-in-Residence, came to the College after completing her third year of general surgery residency at the University of Chicago (IL) Pritzker School of Medicine, and will enter her fourth year of training this summer. An aspiring academic surgical oncologist, Dr. Williams has conducted several studies using information from the CoC’s National Cancer Data Base (NCDB), culminating in multiple peer-reviewed publications, book chapters, and editorials, as well as national and international presentations. She has gained recognition as a highly adept speaker and received first prize in the resident paper competition at the 2011 Annual Symposium of the Society of Surgical Oncology.

In addition, Dr. Williams has finished the necessary course work, with distinction, for a master of science degree in health studies and will defend for her thesis before completing her clinical scholarship. “The NCDB has benefited from her acquired analytic skills and familiarity with the database,” said David P. Winchester, MD, FACS, Medical Director, ACS Cancer Programs. “Her experience in using the NCDB will serve as a basis for future enhancements and improvements to the database, and will benefit future scholars-in-residence as well as external investigators.”

As the incoming Surgical Oncology Scholar-in-Residence, Dr. Paruch also intends to use her two years with the CoC to conduct cancer clinical research using NCDB data. Furthermore, Dr. Paruch plans to compare and/or merge data from the NCDB with that of other databases including Medicare, the Society of Thoracic Surgeons, and the United Network for Organ Sharing.

Dr. Paruch received her bachelor of arts from the University of Chicago and her medical degree from the University of Michigan Medical School in Ann Arbor. She will complete her third year as a categorical general surgery resident at the University of Chicago Pritzker School of Medicine as she embarks upon her clinical scholarship at the College.

“Dr. Paruch is regarded as a highly skilled surgical resident and brings with her a robust portfolio of basic and clinical research conducted at the University of Michigan Medical School, the Massachusetts General Hospital in Boston, and the University of Chicago Hospital,” said Dr. Winchester.

Educational grants from Genentech, Inc. are funding the Surgical Oncology Scholar-in-Residence awards.
CoC accepting applications for 2013 scholar-in-residence

The American College of Surgeons (ACS) Commission on Cancer (CoC) is accepting applications for the 2013 Surgical Oncology Scholar-in-Residence program. The two-year fellowship in surgical oncology outcomes and health services research will begin July 1, 2013, and is available to a surgical resident who has completed two or three years of clinical training in the U.S. or Canada. The clinical scholar will work within the Cancer Programs area of the ACS Division of Research and Optimal Patient Care to conduct research using the CoC's National Cancer Data Base (NCDB), which is designed to help improve the quality of care for cancer patients. The application deadline is August 15, 2012.

The primary objective of the Surgical Oncology Scholar-in-Residence program is to harness the power of the NCDB to devise studies that will enhance the quality of patient care delivered in the CoC’s 1,500-plus accredited cancer programs. The Scholar-in-Residence will have access to the NCDB analytic files, which contain a full complement of data items necessary to conduct a broad range of clinical studies.

In addition, the clinical scholar will be expected to support the growth and development of the NCDB Participant User Files by helping to foster communities of experts and establishing a core-user community that will serve as an effective reference point for future uses. It is anticipated that this work will result in several disease-specific presentations at major oncologic and surgical meetings in the U.S. and/or Canada, including those presented by the Society of Surgical Oncology and the American Surgical Association. These activities also should result in the publication of peer-reviewed articles in major oncologic and surgical journals.

A secondary objective of the Surgical Oncology Scholar-in-Residence program includes working with multidisciplinary panels on the development, validation, and assessment of quality measures in cancer care. The information gleaned through this process will be broadly disseminated among the CoC’s accredited cancer programs to benchmark performance and facilitate quality improvement initiatives at the local provider level. It is anticipated that the measures developed will build upon the current National Quality Forum-endorsed breast, colon, and rectal quality measures currently being assessed in CoC programs.

Details about the program can be found on the CoC website at http://www.facs.org/cancer/can-news.html.

Program questions and completed applications with supporting documentation should be directed to Connie Bura, Administrative Director of Cancer Programs at the ACS, at cbura@facs.org.

ACS cited in Modern Healthcare article on rural surgeon shortage

The dearth of interest in rural surgical practice has created surgical deserts and health risks in small communities throughout the U.S., reports Paul Barr, in a recent Modern Healthcare article, “Looking for an oasis.” The story cites the American College of Surgeons (ACS) report, Surgical Deserts in the U.S.: Places without Surgeons, which points out that Americans in more than 900 mostly rural counties have no access to a local surgeon.

The scarcity of rural surgeons has an impact on quality of care, according to Tyler Hughes, MD, FACS, who is quoted in the story. “When you have a low density of surgeons, morbidity and mortality go up,” says Dr. Hughes, who is a member of the ACS Board of Governors and practices in McPherson, KS, a community with a population of about 40,000. Philip Caropreso, MD, FACS, who serves the rural communities of Keokuk, IA, and Carthage, IL, notes in the article that he has “tried and failed to recruit qualified surgeons” to the area. Drs. Hughes and Caropreso will both serve on a newly formed ACS Rural Surgery Task Force that will explore the surgeon shortage in rural areas.

To view the entire Modern Healthcare article, go to http://www.modernhealthcare.com/article/20120324/MAGAZINE/303249968/looking-for-an-oasis#. 
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• Guest lectures by prominent leaders in surgery
• Panel sessions in theme- and discipline-based tracks
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• A selection of didactic postgraduate courses and hands-on skills courses
• Leading-edge, research-in-progress papers in all surgical specialties for presentation during the Surgical Forum and Papers Sessions
• Daily Town Hall meetings and “Meet the Experts Luncheons”
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Approximately 200 companies will display products or services that improve the quality of surgical patient care or enhance management practices within the surgical profession.

Join us for an educational opportunity you don’t want to miss and be a part of this historic event as we launch the ACS Centennial Celebration with a host of special events. Online registration will be open by early June.

Visit www.facs.org/clincon2012/ in the coming months for details about educational programs, registration, housing, and transportation.
Survey reveals most physicians unwilling to recommend health care as a profession

The Doctors Company, the official provider of medical liability insurance for the American College of Surgeons, recently announced the results of the largest physician survey conducted to date on the future of health care in the U.S. More than 5,000 physician members of The Doctors Company responded to the independent survey, which indicated that concerns surrounding a shortage of health care professionals may be exacerbated by current physician sentiment toward the profession.

Specifically, nine out of 10 respondents indicate an unwillingness to recommend health care as a profession. In addition, 43 percent of respondents indicate that they are contemplating retiring within the next five years as a result of transformative changes occurring within the U.S. health care system. A copy of the Future of Health Care Survey is available on The Doctors Company Knowledge Center at [http://www.thedoctors.com/KnowledgeCenter/index.htm](http://www.thedoctors.com/KnowledgeCenter/index.htm).

“The physician sentiments expressed in the Future of Health Care Survey are deeply concerning and disheartening,” said Donald J. Palmisano, MD, JD, FACS, a member of The Doctors Company board of governors. “For years, the medical profession has been predicting a shortage of health care professionals. Today, we are perilously close to a true crisis as newly insured Americans enter the health care system and our population continues to age. Unfortunately, we may be facing a shift from a ‘calling,’ which has been the hallmark for generations among physicians, that could threaten the next generation of health care professionals.”

Nearly 32 million newly insured individuals will enter America’s health care system by 2016,* increasing demands on America’s health care professionals.† An anticipated shortage of primary care physicians and nurses will necessarily increase the number of patients treated per physician, adversely affecting patient outcomes. A total of 65 percent of respondents believe the current legislative initiatives designed to reduce health care expenses are insufficient for addressing the underlying causes of costly defensive medicine.

Furthermore, the physicians surveyed expressed concern that the increase in patient volume will limit the attention to each patient, with 60 percent of respondents indicating that the pressures to increase patient volume will negatively affect the level of care they can provide. In all, 51 percent of respondents believe their ability to foster patient relationships will be adversely affected.

Due to these concerns, nine out of 10 physicians surveyed said they actively discourage friends and family from pursuing medical careers. Finally, 43 percent of respondents indicated that they are contemplating retiring in the next five years as a result of the immense change that the health care system is undergoing.

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Read this month’s Bulletin online at [www.facs.org/fellows_info/bulletin/bullet.html](http://www.facs.org/fellows_info/bulletin/bullet.html)
In a typical breast surgery practice, nearly one-fifth of new patients present with ductal carcinoma in situ (DCIS), usually detected on mammography as an incidental finding. Most of these women are otherwise healthy, take care of themselves, have had a mammogram as part of their routine health maintenance, and are now grappling with a “cancer” diagnosis. When explaining to patients that DCIS generally has a favorable outcome and that it rarely affects mortality, it always becomes apparent that medical and surgical professionals still have more questions than answers regarding this disease. Is DCIS cancer or not? What would happen if no treatment for DCIS were available—if patients had to wait until they developed invasive cancer before choosing to have surgery? And how do we have a conversation with patients so that we can reduce the anxiety that often motivates these women to choose a bilateral mastectomy for a noninvasive disease?

**Additional research**

DCIS is one of the earliest examples of a significant unintended consequence arising from population-based screening. Since mammography was introduced in the early 1980s, the incidence of DCIS has increased from a rarely encountered diagnosis to nearly 50,000 new cases in 2011. The cornerstone of treatment assumes that all occurrences of DCIS could become invasive if left untreated. Although clearly some high-grade, extensive DCIS could become invasive, it is difficult to predict how often and how soon this process is likely to happen in an individual patient.

Studies based on current incidence rates of DCIS and invasive cancer have shown that less than half of DCIS cases become invasive cancer. If these patients could be identified before recommending treatment, many women could be safely managed with observation, similar to patients with other known risk factors for breast cancer, such as atypical ductal hyperplasia (ADH) or a breast cancer mutation. A related biologic question is whether some occurrences of DCIS can revert from DCIS to ADH, and, if so, whether some low-risk DCIS cases may be safely managed with either systemic therapy or active surveillance alone. Preliminary research has shown that short-term, preoperative endocrine manipulation for DCIS reduces cell proliferation with reversion to ADH in some patients, but whether this strategy is sufficient for long-term management is a topic still undergoing active research. In the very near future, molecular markers may allow for more reliable identification of this low-risk group.

**CALGB 40903**

Cancer and Leukemia Group B (CALGB) 40903 is a recently activated Alliance study that will de-
termine which subsets of ER(+) DCIS might be most amenable to systemic treatment. It is a single-arm trial for postmenopausal women with hormone receptor positive ER(+) DCIS, who will be monitored during six months of preoperative endocrine therapy while being treated with an aromatase inhibitor (AI) (letrozole, 2.5 mg PO QD; see figure, page 50).

Response to neoadjuvant therapy will be assessed by imaging endpoints, with change in magnetic resonance imaging tumor volume as the primary endpoint of the study. However, an important goal is to look for pathologic changes in the DCIS, with molecular studies planned to identify biomarkers predictive of response to endocrine therapy.

A quality of life companion study has been embedded into the trial to assess frequency and severity of side effects associated with neoadjuvant hormonal treatment, as well as how these symptoms affect treatment adherence. Women most likely to benefit from participation in this study are those who, because of the extent of the disease, are borderline candidates for lumpectomy. If, as in neoadjuvant studies for invasive cancer, overall tumor size is reduced, some women with DCIS may be better lumpectomy candidates after AI treatment.

Although the trial is designed to include surgical excision at six months, the study will lay the groundwork for future trials of DCIS management that reserve surgical excision for only those patients at highest risk for invasive progression. Such trials are already under way for patients diagnosed with pancreatic intraductal papillary mucinous neoplasm and early prostate cancer.

The long-term clinical objective of these studies is to reduce the consequences of over-diagnosis by making locoregional treatment a targeted therapy for those patients who would benefit most. It is expected that such research will yield important insights into early cancer biology. Clinical trials in DCIS will answer which options, including nonsurgical ones, may be safely recommended to patients.

References:


Dr. Hwang is the principal investigator for CALGB 40903 and chief of breast surgery and professor of surgery at Duke University Medical Center in, Durham, NC.

Dr. Nelson is Fred C. Andersen Professor of Surgery and chair, division of surgery and research, Mayo Clinic College of Medicine, Rochester, MN, and Program Director of the Alliance/American College of Surgeons (ACS) Clinical Research Program.

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

- **Point/Counterpoint XXXI, Acute Care Surgery**, June 11–13, National Harbor, MD. For information, contact 757-446-8967.
A look at The Joint Commission

JCR to engage surgeons and physicians to reduce adverse hospital events

Surgeons and other medical professionals want to prevent patients from being harmed during their hospital stays and to ensure that they heal without complication after they are discharged; however, accomplishing this goal can be somewhat difficult. Within the surgical continuum of care, patients may experience surgical site infections, adverse drug events, postoperative venous thromboembolism, and other adverse events that can ultimately lead to readmission.

In the near future, up to 50 U.S. hospitals across the nation will have proven resources to help ensure patient safety and to avert post-discharge complications through their participation in the Joint Commission Resources (JCR) Hospital Engagement Network. The Centers for Medicare & Medicaid Services (CMS) selected JCR, the not-for-profit affiliate of The Joint Commission (TJC), to serve as one of its 26 Hospital Engagement Networks. These networks are part of the Partnership for Patients campaign, a nationwide public-private collaboration sponsored by the U.S. Department of Health and Human Services. Specifically, the Partnership for Patients campaign aims to reduce a set of hospital-acquired conditions by 40 percent and to reduce readmissions by 20 percent by the end of 2013. The involvement of each surgeon within his or her subspecialty will be critical to the success of the campaign.

Achieving these goals would mean approximately 1.8 million fewer injuries to patients in the hospital, saving more than 60,000 lives over three years, and would mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring rehospitalization. It would also help prevent the current trend of one in every 20 patients acquiring an infection while in the hospital and an average of one in seven Medicare beneficiaries being harmed in the course of his or her hospital care. In addition, nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, translating into approximately 2.6 million seniors and people with disabilities. CMS estimates that this initiative could save Medicare $50 billion over the next 10 years.

As a Hospital Engagement Network organization, JCR will help participating hospitals identify specific risk points in their care and operational processes that create broken systems leading to human error within the surgical continuum and other areas of care. JCR will develop content, conduct learning activities, and make best practices available to partner hospitals in 10 core areas of focus (see boxed item, this page). It is important to note that hospitals do not have to limit their work to the core set of adverse events outlined in the list.

For each hospital, individual JCR patient safety consultants will be assigned to provide coaching on a weekly basis specific to

For more information on the JCR Hospital Engagement Network:

CMS Hospital Engagement Network
http://www.jcrinc.com/CMS-Hospital-Engagement-Network/

Partnership for Patients: Better Care, Lower Costs
http://www.healthcare.gov/compare/partnership-for-patients/index.html

Healthcare Team Training
http://www.healthcareteamtraining.com/what-we-do/team-stepps/

10 core areas of focus

- Surgical site infections
- Preventable readmissions
- Adverse drug events
- Venous thromboembolism
- Catheter-associated urinary tract infections
- Central line-associated bloodstream infections
- Injuries from falls and immobility
- Obstetrical adverse events
- Pressure ulcers
- Ventilator-associated pneumonia
the performance improvement methods used for each selected event. JCR and the other 25 Hospital Engagement Networks will also work to address additional topics related to organizational structures. These organizational topics will involve each Hospital Engagement Network working closely with surgeons, medical staff, and leadership in the hospital to produce a stronger safety culture. The reduction of preventable hospital-acquired conditions and readmissions is dependent on hospital teamwork, communication, and a collaborative work environment. To ensure quality and to promote a culture of safety, health care organizations must address any behaviors that may threaten the performance of the health care team. Healthcare Team Training, LLC, one of JCR’s subcontractors, has provided licenses for each of the JCR Hospital Engagement Network hospitals to access all of the TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety) educational sessions, as well as 15-minute video vignettes addressing each of the 10 areas of focus. TeamSTEPPS is a teamwork improvement system based on more than 25 years of research and evidence on team performance developed by the U.S. Department of Defense and the Agency for Healthcare Research and Quality.

Once a participating hospital’s core areas of focus are identified, JCR, in consultation with the hospital, will select appropriate measures to track each hospital’s progress in quality improvement, and then implement evidence-based solutions focused on the prevention of future adverse events. JCR will provide education and technical support to participating hospitals so that they can provide safer patient care and achieve quality measurement goals. CMS will also closely monitor the activities of all 26 Hospital Engagement Networks to ensure that they are improving patient safety.

Under JCR’s leadership, several other organizations will support the activities of JCR’s Hospital Engagement Network project, including The Joint Commission’s Division of Healthcare Quality Evaluation; The Patient Safety Education Program housed at Northwestern University’s Feinberg School of Medicine; Healthcare Team Training, LLC; EnCompass LLC; and Social Interventions and Research, Inc.

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**Named Lecture schedule for 2012 Clinical Congress updated**

Don’t miss out on your favorite Named Lectures during the American College of Surgeons 2012 Clinical Congress, which will take place September 30 to October 4, at McCormick Place in Chicago, IL.

Review the list below for updated times of this popular series.

**Monday, October 1**
- Opening Ceremony (sponsored by the American Urological Association) and Martin Memorial Lecture, 8:30–9:30 am
- John H. Gibbon, Jr., Lecture, 9:45–10:45 am
- Charles G. Drake History of Surgery Lecture, 2:30–3:30 pm

**Tuesday, October 2**
- Herand Abcarian Lecture, 8:00–9:00 am
- Excelsior Surgical Society Edward D. Churchill Lecture, 9:45–10:45 am

**Wednesday, October 3**
- Scudder Oration on Trauma, 12:45–1:30 pm
- Olga M. Jonasson Lecture, 2:30–3:30 pm

**Tuesday, October 2**
- Distinguished Lecture of the International Society of Surgery, 8:00–9:00 am
- Ethics and Philosophy Lecture, 9:45–10:45 am
- Commission on Cancer Oncology Lecture, 12:45–1:45 pm
- I.S. Ravdin Lecture in Basic Sciences, 2:30–3:15 pm

Online registration for Clinical Congress will be available in June 2012.

Registration for the 2012 Clinical Congress is required to attend any of the Named Lectures listed above.

For more information, call 312-202-5336, or e-mail Kathryn Matousek at kmatousek@facs.org.

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**JUNE 2012 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS**
The following comments were received regarding recent articles published in the Bulletin.

Letters should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to dschneidman@facs.org, or via mail to Diane Schneidman, Editor-in-Chief, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

RAS essay contest

It was indeed a pleasure to read the [RAS] essays in the November 2011 issue of the Bulletin (Bull Am Coll Surg. 2011;96[11]:19-29). At a time when our profession will never be the same as it was when I was in practice, it is encouraging to see that there is a new generation of young surgeons who still have the heart to feel for people. My compliments to Dr. Santry and the ACS for doing this contest—it must have the heart to feel for people. My compliments to Dr. Santry and the ACS for doing this contest—it must have been tough to pick a winner.

Lawrence J. Genender, MD, FACS
Dallas, TX

The value of xenotransplantation

The excellent review of logistic and ethical aspects of organ donation from deceased donors published in the January 2012 issue of the Bulletin (Bull Am Coll Surg. 2012;97[1]:12-23) ended on an optimistic note with regard to resolving the critical shortage of organs for transplantation.1 However, despite immense efforts on the part of many organizations and individuals over the past 50 years, and the expenditure of millions of dollars in efforts to influence the public, there has been no significant improvement in this situation. The greater the success of organ transplantation, then the greater the number of patients referred for this form of therapy.

The article made no mention of what I believe is the most likely way we can resolve this intractable problem, namely the transplantation of organs from an animal species (xenotransplantation). With the increasing availability of genetically engineered pigs, progress in this field has been accelerating. Pig organ survival in nonhuman primates has increased from a few minutes in 1986 to six to eight months today (using organs from pigs with one or two genetic manipulations).2,3 Diabetes has been controlled in monkeys by pig islet transplantation for periods now extending to more than one year.4 Pig corneal transplantation in monkeys has been successful for periods approximating one year.5 Pigs are now becoming available with five or more genetic manipulations, and it is likely that progress will become much more rapid.

This expensive field of surgical research has received welcome, but limited, support from the National Institutes of Health. If some of the many millions of dollars spent on attempts to increase the number of deceased human organ donors had been directed towards xenotransplantation research, we would, today, be much closer to being able to provide unlimited organs and cells for patients with end-stage organ failure.

David K. C. Cooper MD, PhD, FRCS, FACS
Thomas E. Starzl Transplantation Institute, University of Pittsburgh, PA

References


Stump appendicitis: Another “never event”?

In 2010, Deputy Inspector General [for the U.S. Department of Health and Human Services] Stuart Wright sent a memorandum (OEI-06-09-00360) to Carolyn M. Clancy, MD, director of the Agency for Healthcare Research and Quality, alluding to, and recognizing, the inappropriateness of the term “never” in describing “adverse events.” Mr. Wright went on to define adverse events as “harm to a patient as a result of medical care or harm that occurs in a medical setting.”

In addition, while recognizing the “significant appeal” of the phrase never events, particularly to our legal comrades, Alan Lembirz, MD, differentiates between serious reportable events and hospital-acquired conditions, and suggests approaches to reduce risk and enhance patient safety.

Regardless of whether it is labeled a never event, a “reportable event,” or a “hospital-acquired condition,”
stump appendicitis is one condition that should rarely, if ever, occur. In the more than 1,000 cases I’ve probably done, the classic, open surgical approach to treatment for acute appendicitis—with complete, urgent removal of the inflamed organ before it ruptures—begins with exposing the organ itself by peeling away the frequently surrounding omentum. Then, the surgeon performs separate ligation of the mesoappendix vessels followed by ligation of the organ itself by peeling away the mucosa within the stump. To date, it is next to impossible to perform this maneuver with laparoscopy.

The appendix is then clamped and amputated 1–2 mm distal to the teniae coli. The cecum (at the confluence of the appendix and its contained bacteria are then destroyed by direct application of a phenol solution (not cautery) to the mucosa within the stump. When possible, inversion of this stump to a position within the cecum is followed by placing a nonabsorbable purse-string suture around the stump and is a prerequisite for avoiding development of an intra-peritoneal stump, or stump appendicitis. Furthermore, to date, it is impossible to perform this maneuver with laparoscopy.

Mature surgeons realize that 100 percent accuracy in the preoperative diagnosis of acute appendicitis, although an admirable goal, is rarely achievable in the real world. The percentage of histopathologically demonstrated inflammation in appendices removed for treatment of unruptured appendicitis is said to vary 70 to 90 percent. Experienced surgeons also realize the importance of urgent operation and the consequences of delay.

When reviewing the results of nonincidental appendectomies, iatrogenic delay in diagnosis and treatment should also be measured and stressed because delay results in sepsis, particularly when any delay or deferral of operation (such as waiting for special studies or X rays) may result in bursting of the inflamed organ and subsequent complications. Of course, the ideal and achievable percentage here is zero.

Edward O. Goodrich, MD, FACS
Ardmore, PA
When hearing the word “twister,” one may conjure up images of a game involving a spinner and a vinyl sheet adorned with colored circles that became popular after Johnny Carson and Eva Gabor played it on the Tonight Show in May 1966. Perhaps one sees actor Bill Paxton chasing his “movie wife” Helen Hunt in order to deliver divorce papers before getting caught in a series of intense storms in Oklahoma in the 1996 movie Twister. However, those individuals who have survived the wrath of one of Mother Nature’s most devastating weather phenomena may recall a much more terrifying image.

A twister, another name for a tornado, is a violently rotating column of air extending between and remaining in contact with a cloud and the surface of the earth. It may appear with an accompanying funnel cloud, and there are no predictable patterns of rain, hail, lightening, or wind. (When these climatic occurrences form over water they are know as water spouts.) Tornadoes may achieve wind speeds in excess of 200 miles per hour.

Tornadoes originally were measured according to the Fujita Scale, or F-scale, named after T. Theodore Fujita, MD, who introduced the measurement system in 1971 to relate the degree of damage to the intensity of the wind. A much more precise Enhanced Fujita (EF) Scale has replaced the original scale and goes from EF 0 (65–85 mile per hour winds) all the way up to EF 5 (more than 200 miles per hour).*

Tornadoes can occur anywhere in the world but most frequently happen in the U.S., especially east of the Rocky Mountains. Oklahoma City has the distinction of being the city that has experienced the most tornadoes (more than 100). On average, roughly 1,300 tornadoes occur yearly, accounting for approximately 60 deaths. However, in 2011, the deadliest year on record, a total of 1,691 tornadoes resulted in 550 deaths in 15 states. Several of these tornadoes reached EF 5 level winds.*

To examine the occurrence of tornado-related injuries in the National Trauma Data Bank® research dataset for 2010, admissions 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 908.1 (injuries due to natural and environmental factors: tornado, cyclone, twister). A total of 101 records were found. In all, 72 records contained a hospital discharge status, including 48 discharged to home, 12 to acute care/rehab, and nine sent...
to skilled nursing facilities; there were three fatalities. Of these patients, 53.5 percent were male, on average 44.1 years of age, had an average hospital length of stay of 5.2 days, an intensive care unit length of stay of 5.9 days, were on the ventilator for an average of 7.4 days, and had an average injury severity score of 12.3 (see figure, page 56).

The Storm Prediction Center of the National Oceanic and Atmospheric Administration may issue a tornado watch for areas expecting hail measuring one inch in diameter or greater along with damaging winds and the possibility of tornadoes. These watch areas typically cover 25,000 square miles, about half the size of Iowa. If you find yourself in one of these watch areas and are inside, it is recommended that you follow these steps: go to the lowest floor, preferably a basement; position yourself in a centrally located area of the room; avoid windows; seek protection from possible falling items; cover yourself with thick padding, such as a blanket or mattress, or put on a helmet; crouch down; and cover your head. If you find yourself outside, seek shelter in a sturdy building, if possible; otherwise, lie face down, flat, on low ground as far away as possible from trees and cars, and protect the back of your head with your arms. Remember, Twister may be a fun-filled game, but a tornado is a life-threatening climatic occurrence.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. The National Trauma Data Bank 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 is available on our website about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

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.
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.

Chapter anniversaries

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Virginia Chapter announces humanitarian award recipients

For the fourth year in a row, the Virginia Chapter has provided humanitarian travel scholarships to surgical residents in that state. The Humanitarian Scholarship Award, which provides $500 to each recipient, was created to assist residents who are interested in participating in programs that deliver surgical care in underdeveloped countries. The 2012 Humanitarian Award recipients, who all attend Eastern Virginia Medical School, include Kara Friend, MD,* who will travel to Ecuador, and Sal Talierecio, MD,* and Peter Volsky, MD,* who will both travel to Honduras (see photos, this page).

Earlier this year, the Virginia Chapter also announced its new Facebook page, which is available at: https://www.facebook.com/pages/Virginia-Chapter-American-College-of-Surgeons/302483696451982.

North Texas Chapter hosts annual competition for residents

The North Texas Chapter conducted its annual meeting February 17–18. The program included a competition for surgical residents. The winning presentations are as follows:

- Best Overall: Amanda Kirane, MD, University of Texas Southwestern Medical Center, Dallas; Axl North Texas Chapter: Resident Jeopardy winners from the University of Texas Southwestern Medical Center, left to right: Andrew Riggle, MD; Martyn Knowles, MD,* and Hans Tulp, MD.*

continued on page 60

Virginia Chapter: Humanitarian Scholarship Award winners (left to right): Dr. Friend, Dr. Talierecio, and Dr. Volksy.

North Texas Chapter: Resident Jeopardy winners from the University of Texas Southwestern Medical Center, left to right: Andrew Riggle, MD; Martyn Knowles, MD,* and Hans Tulp, MD.*
## 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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<th>Date</th>
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<td>June 12–13</td>
<td>Brooklyn-Long Island (AP)</td>
<td>Location: Garden City Hotel, Long Island, NY Contact: Teresa Barzyz, 516-741-3887 e-mail: <a href="mailto:Acsteresa@aol.com">Acsteresa@aol.com</a> ACS Representative(s): Patricia J. Numann, MD, FACS</td>
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<tr>
<td>June 14–16</td>
<td>Alabama (AP)</td>
<td>Location: Sandestin Beach and Golf Resort, Destin, FL Contact: Lisa Beard, 205-585-4000 e-mail: <a href="mailto:alcollegesurgeons@yahoo.com">alcollegesurgeons@yahoo.com</a></td>
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<tr>
<td>June 15–18</td>
<td>Oregon and Washington (AP)</td>
<td>Location: Sunriver Resort, Sunriver, OR Contact: Harvey Gail, 503-371-7457 e-mail: <a href="mailto:harvey@spiremanagement.com">harvey@spiremanagement.com</a> ACS Representative(s): A. Brent Eastman, MD, FACS</td>
</tr>
<tr>
<td>July 13–15</td>
<td>North Carolina and South Carolina (AP)</td>
<td>Location: Marriott Resort and Spa at Grand Dunes, Myrtle Beach, SC Contact: Jennifer Starkey, 877-859-4561 e-mail: <a href="mailto:jennifer@executive-office.org">jennifer@executive-office.org</a></td>
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<tr>
<td>August 5–7</td>
<td>Tennessee (AP)</td>
<td>Location: Chattanoogan Hotel, Chattanooga, TN Contact: Wanda Johnson, 615-242-7275 e-mail: <a href="mailto:wanda@tnacs.org">wanda@tnacs.org</a> ACS Representative(s): Carlos A. Pellegrini, MD, FACS, FRCSI(Hon)</td>
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<td>August 11</td>
<td>Hawaii</td>
<td>Location: The Queen's Medical Center Conference Center, Honolulu, HI Contact: Gary Belcher e-mail: <a href="mailto:gbelcher@hawaii.edu">gbelcher@hawaii.edu</a> ACS Representative(s): Patricia J. Numann, MD, FACS</td>
</tr>
<tr>
<td>August 25–26</td>
<td>Georgia Society of the American College of Surgeons (AP)</td>
<td>Location: Savannah Hyatt Regency, Savannah, GA Contact: Kathy D. Browning, 404-625-1520 e-mail: <a href="mailto:kdb@georgiaacs.org">kdb@georgiaacs.org</a></td>
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<td>September 8–9</td>
<td>Kansas (AP)</td>
<td>Location: Wichita Airport Hilton Inn, Wichita, KS Contact: Gary Caruthers, 785-235-2383 e-mail: <a href="mailto:gcaruthers@kmsonline.org">gcaruthers@kmsonline.org</a></td>
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<tr>
<td>September 22</td>
<td>Arkansas</td>
<td>Location: Jackson T. Stephens Spine and Neurosciences Institute, Little Rock, AR Contact: Linda Clayton, 501-686-5847 e-mail: <a href="mailto:lindac92@comcast.net">lindac92@comcast.net</a></td>
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<tr>
<td>November 2–4</td>
<td>Connecticut</td>
<td>Location: Farmington Marriott, Farmington, CT Contact: Christopher Tasik, 203-674-0747</td>
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Receptor Tyrosine Kinase Is Critical to Pancreatic Cancer Progression and Metastases
• **Best Oncology:** Veronica Jones, MD,* Baylor University Medical Center, Dallas; Breast Mastectomy: Is there Occult Cancer within the Nipple?
• **Best Trauma:** Christopher Mitchell, MD, Methodist Dallas Medical Center, Dallas; Can Acute Care Surgeons Place Peg Tubes Safely?
• **Best Poster/Mini Talk:** Katherine Ostapoff, MD, University of Texas Southwestern Medical Center, Dallas; PG545, A Heparanase Inhibitor, Inhibits Pancreatic Cancer Metastasis and Growth in Vitro and Invivo
• **Resident Jeopardy Competition:** University of Texas Southwestern Medical Center (see photo, page 58)

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

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**HPB Surgery Fellowship Match opens for 2012–2013**

The Americas Hepato-Pancreatic-Biliary Association (AHPBA) and the Fellowship Council (FC) announce the 2012–2013 Hepato-Pancreatic-Biliary (HPB) match. In contrast to the past two years, the FC will conduct the entire HPB match search in 2012 via its website. This match will include all HPB fellowships that meet the standards and accreditation processes established by the FC and the AHPBA. Successful completion of an FC-accredited HPB Fellowship will qualify the fellow for a training certificate in HPB surgery granted by the AHPBA education and training committee. This certificate is typically presented at the AHPBA annual meeting.

The Fellowship application process began on May 1. Other deadlines for the 2012-13 HPB match deadlines are as follows:
- Fellowship application closes: August 1, 2012
- Match rank order list deadline: October 8, 2012
- Fellow match date: October 17, 2012


The HPB match will run with the FC main match. All applicants will submit one rank list that will allow them to rank any Fellowship Council program (for example, HPB or MIS) in order of preference. Society of Surgical Oncology-accredited programs are not participating in this match process.

For additional information, e-mail the Fellowship Council Executive Director Yumi Hori at yumi@fellowshipcouncil.org or Rohan Jeyarajah, MD, at rjeyar@sadtx.com.

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