Cultural competence:

Why surgeons should care
FEATURES

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

Nearly 2.3 million military men and women have been deployed to Iraq or Afghanistan in the last 10 years. Because of the advances in military medicine and protective gear, as well as the type of weaponry often used in these conflicts, the total number of casualties has been relatively low. However, approximately 50,000 veterans are returning home with serious bodily injuries, and one in six suffers from traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD).

As the war drawdown continues and the pool of veterans grows, access to effective care for active and former military personnel will become increasingly crucial. Yet, with the exception of military and Veterans Affairs (VA) physicians, few clinicians are trained to meet the challenges associated with providing care for this population. The American College of Surgeons (ACS) is partnering with other health care organizations and the government to rectify this problem through its participation in a program known as "Joining Forces."

Identifying veterans’ needs

A common misconception is that most veterans receive their medical and surgical care through the VA. Consequently, some surgeons and physicians who practice outside of the VA system believe they rarely, if ever, will be expected to deal with veterans’ unique health care issues. However, the fact of the matter is that more than 50 percent of veterans who have returned to civilian life have the same type of insurance coverage as other American workers. They have employer-based coverage and therefore seek care from physicians and other health care providers that participate in their insurance plans. So, all health care professionals need to be familiar with the unique physical and psychiatric problems that afflict a significant number of veterans.

As noted previously, many of the veterans have experienced multiple bodily injuries, a condition that the VA calls “polytrauma.” TBI is frequently seen in polytrauma patients, along with other disabling conditions, such as amputation, auditory and visual impairments, spinal cord injury, and so on. Due to the severity and complexity of their injuries, these patients may require an extraordinary level of coordinated and integrated clinical and support services, including care that only a surgeon can provide.

Many veterans—both those who were physically injured and those who were not—also are battling PTSD and other mental illnesses. The VA has reported 167,000 cases of PTSD, 195,000 cases of depressive conditions and affective psychoses, and 103,000 cases of anxiety disorders. These conditions
put people at risk for suicide. Tragically, the suicide rate in the U.S. Army and Marine Corps has, for the first time on record, reached that of the civilian population, and the VA's Veterans Crisis Line (800-273-8255) has received approximately 500,000 calls from returning veterans who are considering taking their own lives.

It behooves surgeons to get the training necessary to identify and help these patients locate the help they need. As trusted providers of patient care, all surgeons and other clinicians need to be able to detect when a veteran is reaching a mental breaking point. The VA offers many resources to help health care professionals understand TBI and PTSD, learn how screen for these conditions, and decide when to refer patients to mental health professionals.

This information can be accessed at http://www.ptsd.va.gov/professional/index.asp and http://www.polytrauma.va.gov/understanding-tbi.

**Joining Forces**

I recently had the privilege of learning about the Joining Forces initiative, which First Lady Michelle Obama and Second Lady Jill Biden, EdD, are spearheading. Joining Forces is a broad program designed to bring the government and the private sector together to ensure that veterans have access to jobs, higher education, and health care. (More information regarding the Joining Forces program is available at http://www.whitehouse.gov/joiningforces.)

In an effort targeted at addressing the health care component, in January, the White House, the Department of Defense (DoD), and the VA convened a roundtable program for leaders of an impressive number of health care organizations (see list at left). This discussion centered on how the medical and surgical communities can work together and with the government to better meet the neurological and psychological needs of our nation's returning servicemen and women.

Since the roundtable, the ACS and other groups represented at the meeting have started taking steps to mobilize their members to improve care for veterans and active service members. For example, the American Academy of Family Physicians (AAFP), the American Academy of Neurology (AAN), and the American Academy of Physical Medicine & Rehabilitation (AAPMR) have joined forces to ensure that 130 of the nation's medical and osteopathic colleges provide future health care professionals with training in the treatment of TBI, PTSD, and so on.

**ACS involvement**

Through the Joining Forces initiative, the College is partnering with the AAMC, the ACOM, and other participating organizations to collectively improve the quality of care that vets receive. The College is undertaking a number of projects independently as well to help arm surgeons with the skills they need to provide appropriate, compassionate care to wounded warriors. First, the ACS Committee on Trauma website, http://www.facs.org/trauma/index.html, is being updated to provide information about the Joining Forces initiative and the VA and DoD resources that are available to clinicians. Additionally, the next edition of the
Advance Trauma Life Support® manual will contain information on PTSD.

Furthermore, the Division of Education is developing a session on Joining Forces for presentation on October 2, at this year’s Clinical Congress in Chicago, IL. Staff is working with several Fellows who have ties to the military to put together what should be a fascinating and inspiring panel discussion.

I encourage each of you to participate in these programs, so that you can make a difference in the lives of your veteran patients. Ask them about their experiences during deployment and assess their risk for problems.

Also, think about taking a continuing education course in working with patients with TBI and PTSD. The VA offers several Web-based training courses for clinicians, including “PTSD 101” and an independent study course on TBI. For more information, go to http://www.ptsd.va.gov/professional/ptsd101/ptsd-101.asp and http://www.publichealth.va.gov/docs/vhi/traumatic-brain-injury-vhi.pdf, respectively.

As the College and its Fellows seek to ensure that all patients receive high-quality care, we must not abandon the men and women who risked their lives and whose families made enormous sacrifices on our nation’s behalf. They truly deserve the best and most compassionate care we can provide.

Acknowledgement

The data in this column were supplied through personal communications with representatives of the VA and are drawn from the Joining Force website listed in the text.

David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
A recent issue of the Bulletin featured a primer for surgeons on accountable care organizations (ACOs). The authors of that article provided information based on the proposed rule implementing the Medicare Shared Savings Program (MSSP), which the Centers for Medicare & Medicaid Services (CMS) issued on April 7, 2011. They also relied on related documents issued by CMS and other federal agencies, including the Office of the Inspector General of the Department of Health and Human Services, the Department of Justice, the Federal Trade Commission, and the Internal Revenue Service.

This article picks up where that one left off and is based on information in the final rule published by CMS on November 2, 2011, and other related documents. It also considers a related Pioneer ACO initiative being conducted by the Center for Medicare and Medicaid Innovation (CMMI), a new CMS component. Finally, this article explores the potential implications of the various Medicare ACO programs for surgeons and their patients.

How does the final rule describe ACOs?

In the Medicare context, an ACO is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are assigned to it. It is especially important to understand that, while accountable, an ACO is not required to directly provide all the services its assigned Medicare beneficiaries need. In fact, unlike the Medicare Advantage Program enrollees, beneficiaries assigned to an ACO retain full freedom of choice with respect to where they receive their services. They are not locked in.

How does the final rule define an ACO professional, participant, and provider/supplier?

- **ACO professional**: An ACO provider/supplier who is a physician (for this purpose, the term refers only to doctors of medicine and osteopathy), physician assistant, nurse practitioner, or clinical nurse specialist (note that the term “supplier” in this instance includes physicians)
- **ACO participant**: An individual or group of ACO provider(s)/supplier(s) that is identified by a Medicare-enrolled tax identification number (TIN), that alone or together with one or more other ACO participants comprise(s) an ACO
- **ACO provider/supplier**: An individual or entity that bills for items or services it furnishes to Medicare fee-for-service beneficiaries under a Medicare billing number assigned to the TIN (typically a National Provider Identifier or NPI) or an ACO participant and is included on the list of ACO providers/suppliers

To shed further light on the interplay of these definitions, ACO professionals are capable of independently forming an ACO under the MSSP, perhaps in company with one or more hospitals. The broad definition of ACO participant clearly indicates that essentially any professional or provider who bills Medicare may participate in an ACO. For example, whereas podiatrists, optometrists, or physical therapists do not meet the definition of ACO professional, they could nonetheless become ACO participants. Finally, in comparing the terms ACO provider/supplier and ACO participant, the former could, for example, refer to an individual surgeon in a group practice, whereas the latter would refer to the entire group practice.

Does the final rule respond to the concerns that stakeholders expressed about the proposed rule?

Yes. The final rule has been better received and makes a large number of changes clearly intended to increase interest in the ACO concept. These changes include the following:

- Less burdensome governance and structural requirements, with ACOs allowed to add or subtract ACO participants throughout the course of their agreement with CMS
- Fewer performance measures
- A revised beneficiary assignment methodology (final assignment is still retrospective but CMS will now also make periodic, preliminary assignments
based on the latest available data

- ACOs may choose a shared savings-only model for the initial three years and not be forced to switch to a model involving shared losses in year three
- Greater financial rewards for ACOs (once savings achieve the minimum savings rate assigned to an ACO, 2 percent to 3.9 percent, first dollar savings can be shared, with the maximum shared savings rate ranging from 50 percent to 60 percent)
- A significantly revised methodology for calculating ACO expenditure benchmarks and expenditures for ACO-assigned beneficiaries (most notably, these calculations now exclude both direct and indirect medical education payments and disproportionate share payments made to hospitals, which should help produce a level playing field for teaching hospitals)

What quality measures are in the rule, and how will they be measured?

Table 1 on this page and the measure list (Table 2, page 9) show how ACO performance in the MSSP will initially be assessed, using 33 quality measures across four measure domains. Surgeons will notice that the initial measure list is quite weak on surgical care. Nonetheless, ACOs in the MSSP will have to achieve a minimum level of performance on these measures to qualify for shared savings. Producing shared savings alone will be insufficient. This requirement is obviously viewed as a beneficiary protection. In addition, the performance measure list is likely to evolve over time, based on stakeholder input. However, for year one of the MSSP, only data reporting is required for all measures; in subsequent years, performance above the 30th percentile or 30 percent level on measures will become increasingly important.

How will beneficiaries be assigned to ACOs?

Beneficiary assignment to ACOs under the MSSP is a two-step process. The first consideration is where a beneficiary has received the plurality of Medicare-allowed charges for primary care. Under the rule, primary care services include the CPT/HCPCS codes for office, nursing home, rest home, home, and wellness visits. Thus—if a beneficiary over the course of a calendar year received the plurality of his or her primary care services from primary care physicians participating in an ACO—that beneficiary would be (retrospectively) assigned to the ACO at the end of a performance period. However, if a beneficiary receives no services from a primary care physician (inside or outside of the ACO), then assignment would be based on where the beneficiary received most of his or her primary care services from physicians, including specialists, and certain nonphysician practitioners (such as nurse practitioners, physician assistants, and clinical nurse specialists).

This new, two-step assignment methodology could have important implications for specialists who provide primary care services (for example, office visits) because a beneficiary could theoretically be assigned to an ACO based on the services provided by specialists participating in that ACO. More specifically, CMS has stated that:

Each ACO participant TIN upon which beneficiary assignment is dependent [not just primary care physicians] must be exclusive to one...ACO for purposes of Medicare beneficiary assignment. ACO participant TINs upon which beneficiary assignment is not dependent are not required to be exclusive to one...ACO.3

While the full implications of this exclusivity policy are uncertain, and the matter is likely to require further clarification from CMS, it seems reasonably clear that at least some specialists might only be able to participate in a single Medicare ACO.

Table 1.

Four quality performance measurement domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Category</th>
<th>Number of measures (measure #s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient/caregiver</td>
<td>experience</td>
<td>7 (1–7)</td>
</tr>
<tr>
<td>2. Care coordination/</td>
<td>patient safety</td>
<td>6 (8–13)</td>
</tr>
<tr>
<td>3. Preventive health</td>
<td></td>
<td>8 (14–21)</td>
</tr>
<tr>
<td>4. At-risk population</td>
<td>Diabetes</td>
<td>6 (22–27)</td>
</tr>
<tr>
<td></td>
<td>Heart failure</td>
<td>1 (28)</td>
</tr>
<tr>
<td></td>
<td>Coronary artery disease</td>
<td>2 (29–30)</td>
</tr>
<tr>
<td></td>
<td>Hypertension</td>
<td>1 (31)</td>
</tr>
<tr>
<td></td>
<td>Ischemic vascular disease</td>
<td>2 (32–33)</td>
</tr>
</tbody>
</table>
What are the application deadlines for the 2012 MSSP?

There will be two start dates for interested organizations, April 1 and July 1; after that, a single annual start date is envisioned. Organizations interested in applying for the MSSP began by submitting a Notice of Intent (NOI) to apply. For those interested in an April 1 start date, the NOI was due by January 6. For those interested in the July start date, the NOIs were due by February 17. The application deadlines for the two start dates were or are January 20 and March 30, respectively. CMS’ target dates for announcing its decisions on applications are March 16 (for the April start date), and May 31 (for the July start date). Comparable deadlines for the 2013 MSSP have not yet been announced.

What is CMS doing to encourage participation in the MSSP?

To facilitate participation in the MSSP, CMS has created a mechanism for certain organizations to receive upfront funding to assist in ACO development and operations. This mechanism is formally known as the Advanced Payment Model. This mechanism will only be available to organizations applying to participate in the MSSP for 2012. In addition, advanced payments are only available to two types of organizations:

- ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue
- ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare

Table 2.
ACO performance measures under the MSSP

<table>
<thead>
<tr>
<th></th>
<th>Consumer Assessment of Health Providers and Systems (CAHPS): Getting timely care, appointments, and information</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>CAHPS: How well your doctors communicate</td>
</tr>
<tr>
<td>3</td>
<td>CAHPS: Patients’ ratings of doctor</td>
</tr>
<tr>
<td>4</td>
<td>CAHPS: Access to specialists</td>
</tr>
<tr>
<td>5</td>
<td>CAHPS: Health promotion and education</td>
</tr>
<tr>
<td>6</td>
<td>CAHPS: Shared decision making</td>
</tr>
<tr>
<td>7</td>
<td>CAHPS: Health status/functional status</td>
</tr>
<tr>
<td>8</td>
<td>Risk-standardized, all condition readmission</td>
</tr>
<tr>
<td>9</td>
<td>Ambulatory sensitive conditions admissions: COPD (Agency for Healthcare Research and Quality [AHRQ] Prevention Quality Indicator [PQI] #5)</td>
</tr>
<tr>
<td>10</td>
<td>Ambulatory sensitive conditions admissions: CHF (AHRQ PQI #8)</td>
</tr>
<tr>
<td>11</td>
<td>Percent of primary care physicians who successfully qualify for an electronic health record incentive program payment (Medicare or Medicaid)</td>
</tr>
<tr>
<td>12</td>
<td>Medication reconciliation: Reconciliation after discharge from an inpatient facility</td>
</tr>
<tr>
<td>13</td>
<td>Falls: Screening for fall risk</td>
</tr>
<tr>
<td>14</td>
<td>Influenza immunization</td>
</tr>
<tr>
<td>15</td>
<td>Pneumococcal vaccination</td>
</tr>
<tr>
<td>16</td>
<td>Adult weight screening and follow-up</td>
</tr>
<tr>
<td>17</td>
<td>Tobacco use assessment and tobacco cessation intervention</td>
</tr>
<tr>
<td>18</td>
<td>Depression screening</td>
</tr>
<tr>
<td>19</td>
<td>Colorectal cancer screening</td>
</tr>
<tr>
<td>20</td>
<td>Mammography screening</td>
</tr>
<tr>
<td>21</td>
<td>Proportion of adults 18+ who had their blood pressure measured within the preceding two years</td>
</tr>
<tr>
<td>22</td>
<td>Diabetes composite (all or nothing scoring): hemoglobin a1c control (&lt;8 percent)</td>
</tr>
<tr>
<td>23</td>
<td>Diabetes composite (all or nothing scoring): low-density lipoprotein (&lt;100)</td>
</tr>
<tr>
<td>24</td>
<td>Diabetes composite (all or nothing scoring): blood pressure &lt;140/90</td>
</tr>
<tr>
<td>25</td>
<td>Diabetes composite (all or nothing scoring): tobacco non use</td>
</tr>
<tr>
<td>26</td>
<td>Diabetes composite (all or nothing scoring): Aspirin use</td>
</tr>
<tr>
<td>27</td>
<td>Diabetes mellitus: Hemoglobin a1c poor control (&gt;9 percent)</td>
</tr>
<tr>
<td>28</td>
<td>Hypertension: Blood pressure control</td>
</tr>
<tr>
<td>29</td>
<td>Ischemic vascular disease (IVD): Complete lipid profile and LDL control &lt;100 mg/dl</td>
</tr>
<tr>
<td>30</td>
<td>IVD: Use of aspirin or another antithrombotic</td>
</tr>
<tr>
<td>31</td>
<td>Heart failure: Beta-blocker therapy for left ventricular systolic function</td>
</tr>
<tr>
<td>32</td>
<td>Coronary artery disease (CAD) composite (all or nothing scoring): Drug therapy for lowering LDL-cholesterol</td>
</tr>
<tr>
<td>33</td>
<td>CAD composite (all or nothing scoring): Angiotensin-converting enzyme inhibitor or angiotensin receptor blocker therapy for patients with CAD and diabetes and/or left ventricular systolic dysfunction</td>
</tr>
</tbody>
</table>
low-volume rural hospitals that have less than $80 million in total annual revenue

Under the Advanced Payment Model, eligible organizations approved by CMS would gain up-front access to capital but they would essentially be “borrowing against” expected future shared savings because of their participation in the MSSP.

What is the interest level among providers?

Despite all the changes in the MSSP final rule, the level of interest in the option remains uncertain, especially with respect to 2012 start dates. CMS estimates that 50 to 270 ACOs will be participating in the MSSP in the first four years (CY 2012–2015), serving 1 to 5 million Medicare beneficiaries. CMS “median” estimates include $470 million in net Medicare savings, $1.31 billion in shared savings payments to ACOs, nothing in shared losses, and $451 million in ACO start-up and continued investment costs.

What is going on with the Pioneer ACO initiative?

On December 19, 2011, CMS announced that 32 health care organizations had been selected to participate in the Pioneer ACO initiative.5 This initiative, directed by the CMMI, was designed expressly for organizations “with experience offering coordinated, patient-centered care, and operating in ACO-like environments.” Unlike the MSSP, the Pioneer ACO initiative will require participants to partner with non-Medicare payors as well as Medicare in shared savings-types of arrangements. It may also eventually involve partial capitation payments (not just normal fee-for-service payments). In addition, under the Pioneer ACO initiative, beneficiary assignment can be prospective rather than retrospective. The Pioneer ACO initiative resembles the MSSP in that participating ACOs may qualify to receive shared savings if they maintain quality at acceptable levels and reduce Medicare expenditures below specified levels. In turn, the ACOs will have the responsibility of allocating shared savings across their ACO participants.

The 32 organizations selected to participate in the Pioneer ACO are listed in Table 3, page 11, with organizations in the same state listed together.

More detailed information about each of the selected organizations, including affiliated hospitals, can be found on the CMMI website.6

How will Medicare ACO programs affect me?

First, it’s important to remember that the MSSP is not a demonstration or pilot project, but an entirely new way of doing business with the Medicare program. In addition, as should be evident from a review of selected Pioneer ACOs, this separate initiative, which is a demonstration project, covers a wide swath of the health care marketplace. Hence, some surgeons may be part of an organization participating in the Pioneer ACO program or know that their organization is planning to apply for the MSSP. Other readers may practice in communities that already have or will soon have Medicare ACOs. And, if there is a Medicare ACO in your community, it is possible for your practice to exist either inside or outside of the ACO.

Although Medicare beneficiaries assigned to an ACO will retain full freedom of choice, it would be foolhardy to assume that ACOs might not alter patient referral patterns in a community over time. In this regard, an ACO might preferentially “suggest” or “recommend” that beneficiaries obtain specialty care from specialists participating in the ACO (with these specialists sharing in any Medicare savings produced). On the other hand, an ACO might also favor referring patients to non-ACO participants if doing so is likely to result in high-quality, low-cost care. Also of note, an ACO would be under no obligation to share savings that might be produced by cost-efficient surgeons not participating in the ACO (the ACO would not necessarily be precluded from doing so, provided it was careful not to run afoul of federal or state anti-kickback or physician self-referral laws, as well as the Civil Monetary Penalty Law).

What about billing for services under the MSSP?

Medicare payments under the MSSP and billing for services furnished by all involved providers and suppliers would be unchanged. For example, surgeons would continue to bill for the services they provide to all Medicare beneficiaries, including those who will ultimately be assigned to an ACO, and they would continue to be paid individually on the usual fee-for-service basis. What would change is that at the end of a performance period, CMS would determine whether shareable savings have been produced by the ACO as a whole and, if so, pay the ACO a portion of these savings based on the ACO’s quality performance scores. The ACO
would, in turn, have to decide how to allocate the savings among its ACO participants.

**How will ACOs determine the allocation of any Medicare shared savings?**

CMS believes that it does not have the legal authority to dictate how shared savings are distributed and anticipates that ACO participants would negotiate and determine among themselves how to equitably distribute shared savings or use these savings to meet the goals of the MSSP program. Nonetheless, MSSP applicants must indicate how they plan to use potential shared savings to meet the goals of the MSSP, including the criteria that will be used to distribute shared savings among ACO participants. That said, there is very little specific information or consensus about appropriate methodologies for allocating shared savings. For example, to what extent should such allocations be based on individual physician performance in the areas of quality, efficiency, or other measures?

It is also worth emphasizing that under an ACO-like demonstration project, the Physician Group Practice (PGP) Demonstration program, the participating sites that received shared savings appear to have simply used the payments organization-wide (for example, to help acquire health information technology), rather than allocating them to individual physicians.

In any event, shared savings raise the potential that physicians who reduce Medicare expenditures (for example, by taking steps that help decrease hospital admissions or readmissions) could essentially end up receiving a portion of Medicare Part A payments that would otherwise have gone to a hospital, in addition to the Medicare Part B payment they received for their professional services.

**What are the chances that an ACO will be able to produce shareable savings?**

This is obviously a question that an organization interested in applying to become a Medicare ACO needs to ask and answer. Suffice it to say that, all other things being equal, it would be more challenging for an ACO in a historically low-cost area to receive shared savings because the expenditure benchmarks for each ACO are set locally, based on historic data. Thus, an organization that has historically adopted conservative care practices would likely find it more

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**Table 3. Pioneer ACO participating organizations (alphabetical by state)**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner Health Network, Phoenix, AZ, metropolitan area (Maricopa and Pinal Counties)</td>
<td>Arizona</td>
</tr>
<tr>
<td>Brown &amp; Toland Physicians, San Francisco Bay Area, CA</td>
<td>California</td>
</tr>
<tr>
<td>Healthcare Partners Medical Group, Los Angeles and Orange Counties, CA</td>
<td>California</td>
</tr>
<tr>
<td>Heritage California ACO, southern, central, and coastal California</td>
<td>California</td>
</tr>
<tr>
<td>Monarch Healthcare, Orange County, CA</td>
<td>California</td>
</tr>
<tr>
<td>Primecare Medical Network, southern California (San Bernardino and Riverside Counties)</td>
<td>California</td>
</tr>
<tr>
<td>Sharp Healthcare System, San Diego County, CA</td>
<td>California</td>
</tr>
<tr>
<td>Physician Health Partners, Denver, CO, metropolitan area</td>
<td>Colorado</td>
</tr>
<tr>
<td>JSA Medical Group, a Division of HealthCare Partners, Orlando, Tampa Bay, and surrounding south Florida</td>
<td>Florida</td>
</tr>
<tr>
<td>OSF Healthcare System, central Illinois</td>
<td>Illinois</td>
</tr>
<tr>
<td>Franciscan Alliance, Indianapolis and central Indiana</td>
<td>Indiana</td>
</tr>
<tr>
<td>TriHealth, Inc., northwest central Iowa</td>
<td>Iowa</td>
</tr>
<tr>
<td>Eastern Maine Healthcare System, central, eastern, and northern Maine</td>
<td>Maine</td>
</tr>
<tr>
<td>Atrius Health Services, eastern and central Massachusetts</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>Beth Israel Deaconess Physician Organization, eastern Massachusetts</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>Mount Auburn Cambridge Independent Practice Association (MACIPA), eastern Massachusetts</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>Partners Healthcare, eastern Massachusetts</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>Steward Healthcare System, eastern Massachusetts</td>
<td>Massachusetts</td>
</tr>
<tr>
<td>Genesys PHO, southeastern Michigan</td>
<td>Michigan</td>
</tr>
<tr>
<td>Michigan Pioneer ACO, southeastern Michigan</td>
<td>Michigan</td>
</tr>
<tr>
<td>University of Michigan, southeastern Michigan</td>
<td>Michigan</td>
</tr>
<tr>
<td>Allina Hospitals &amp; Clinics, Minnesota and western Wisconsin</td>
<td>Minnesota</td>
</tr>
<tr>
<td>Fairview Health Systems, Minneapolis, MN, metropolitan area</td>
<td>Minnesota</td>
</tr>
<tr>
<td>Park Nicollet Health Services, Minneapolis, MN, metropolitan area</td>
<td>Minnesota</td>
</tr>
<tr>
<td>Healthcare Partners of Nevada, Clark and Nye Counties, NV</td>
<td>Nevada</td>
</tr>
<tr>
<td>Dartmouth-Hitchcock ACO, New Hampshire and eastern Vermont</td>
<td>New Hampshire</td>
</tr>
<tr>
<td>Presbyterian Healthcare Services–Central New Mexico Pioneer Accountable Care Organization, central New Mexico</td>
<td>New Mexico</td>
</tr>
<tr>
<td>Bronx Accountable Healthcare Network (BAHN), New York City (the Bronx) and lower Westchester County, NY</td>
<td>New York</td>
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<tr>
<td>Renaissance Medical Management Company, southeastern Pennsylvania</td>
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<tr>
<td>North Texas Specialty Physicians, Tarrant, Johnson, and Parker Counties in north Texas</td>
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<tr>
<td>Seton Health Alliance, central Texas (11 county areas, including Austin)</td>
<td>Texas</td>
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<tr>
<td>Bellin-Thedacare Healthcare Partners, northeast Wisconsin</td>
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MARCH 2012 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
difficult to produce savings than an organization located in a high health care cost area. In addition, because ACO benchmarks will be re-based roughly every three years, savings achieved during one agreement period would be expected to yield lower expenditure benchmarks in the future, making it ever-more challenging to continue to qualify for shared savings.

How will Medicare beneficiaries react to the ACO concept?

The answer to this key question is largely unknown. CMS will develop a communications plan, including educational materials and other forms of outreach, to help educate beneficiaries about the MSSP. This exercise could be a delicate and challenging one, as most objective observers acknowledge that the ACO concept entails both potential benefits and potential risks for Medicare beneficiaries. ACOs also will be required to post signs in the facilities of participating ACO providers and suppliers and to make available standardized written information to Medicare fee-for-service beneficiaries whom they serve. Because beneficiary assignment to an ACO is retrospective, a beneficiary receiving care early in the year from a surgeon participating in an ACO—and being formally informed of such participation—might actually not get assigned to that ACO at the end of the year. In any event, any negative beneficiary reaction to the ACO concept, akin to the historic backlash against managed care, could have far-reaching implications for physicians and other ACO participants.

What other concerns do various stakeholders have?

Hospitals worry that some types of ACOs will seek to produce Medicare shared savings by substantially reducing hospital admissions and the use of other hospital-provided services. Health care technology producers worry that ACOs will end up denying beneficiaries prompt access to the latest technology in order to produce shared savings. Pharmaceutical companies worry that because Medicare Part D (prescription drug) costs do not count against ACOs, they will end up switching patients from pharmaceuticals covered under Medicare Part B, such as drugs administered intravenously in a physician’s office, to drugs covered under Medicare Part D, even if the latter might be less effective or otherwise carry more risk for patients. Employers and private insurers worry that ACOs participating in the Medicare program will attempt to produce Medicare shared savings by shifting costs to the private sector or that ACOs will use their market power to demand higher payments for privately insured patients.

Suffice it to say that the future of the MSSP—and of the ACO concept generally—is uncertain, but even the busiest of surgeons would be ill-advised to pretend that nothing has changed.

References

Cultural competence:

Why surgeons should care

by
Amal Khoury, MD;
April Mendoza, MD;
and
Anthony Charles, MD, MPH, FACS
The importance of cultural competence in medicine has gained recognition in academic forums and literature over the past five decades. These discussions were born of the realities that face health care today as a necessary response to the increasingly diverse U.S. population, coupled with emerging evidence of health care disparities and the initiatives that seek to eliminate them. Surgeons and the populations they serve are equally affected by these disparities. In this article, we discuss the history and evolution of cultural competence in health care; its implications for surgeons, residents, and surgical practice; and methods that may direct surgeons in their pursuit of the skills required to serve diverse patient groups.

The role of diversity and cultural competence in the practice of surgery will continue to grow as the ethnic composition of our patient population changes. As diversity is amplified in society, it is increasingly important for surgeons to be adept at interacting with patients from all backgrounds. The concept of cultural competency centers on the understanding of the specific cultural, linguistic, social, and economic nuances of a particular group of people and their community. In health care, cultural competency is the recognition of culturally influenced health beliefs and behaviors, disease prevalence and incidence, and disparities within a specific population of patients, along with the incorporation of cultural education programs, assessment of cross-cultural care, and improvement of access to care.1

Evolution of cultural competence
The genesis of cultural competency awareness can be related to the history of the U.S. and the diversity of its population. This population has evolved significantly over the past five decades, with two critical events that have accelerated the need for cultural competence. One event is the ongoing Civil Rights Movement that began in the 1950s, in which African Americans, women, homosexual and transgender persons, individuals with disabilities, and other minority groups have alerted the country to their distinct identities and long histories of oppression; the other component is the growing number of immigrant populations within the U.S.2

The 2010 U.S. Census shows that more than 40 percent of the population are members of a minority group. In the past 10 years, every minority group gained in population at higher rates than whites. Asian and Hispanic or Latino individuals surpassed all other ethnic groups in population growth, with 43 percent increases in each population. African Americans increased by a rate of 12 percent and Native Americans by 28.4 percent. Hispanic or Latino persons now account for the largest minority group in the U.S., at 16 percent of population.3

New immigrants to this country bring with them a spectrum of unique cultural, linguistic, religious, and political backgrounds. Melding these backgrounds with the history, experiences, and expectations of U.S.–born populations creates both challenges and opportunities for health care providers.1,2 Health care providers serving these populations may be met with difficulty initially in navigating the various beliefs that influence patient decision making; however, with each challenge comes an opportunity for providers to learn from their patients and sharpen their communication skills. With this increase in a diverse U.S. population, health care systems and providers need to respond to patients’ varied perspectives, values, and behaviors regarding health and well-being. Failure to understand and manage these social and cultural differences may have significant health consequences for minority groups in particular.1

The concept of cultural competence for health care providers has emerged, in part, to address the factors that may contribute to racial/ethnic disparities in health care.4 The ultimate goal is to deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, sexual orientation, or English proficiency.5

Barriers to culturally competent care
Barriers between patients, providers, and the U.S. health care system that may affect quality and contribute to racial/ethnic disparities in care include the following:

• Lack of diversity in health care leadership and workforce6,7
• Systems of care poorly designed to meet the needs of diverse patient populations8
• Poor communication between providers and patients of varying racial, ethnic, or socioeconomic backgrounds8,9

Cultural competence at the individual level
At the individual level, a physician may harbor prejudices including racism, sexism, homophobia, as well as various ethnic and religious biases, which may
cause a great deal of personal discomfort, particularly because discussion of these issues is often viewed as taboo. Such biases, ingrained in the physician’s subconscious, have an impact on the quality of health care provided.10

It is important to note that on the individual level, cultural competence requires more than practicing tolerance. It entails identifying and challenging one’s own cultural assumptions, values, and beliefs, in addition to the development of empathy—the ability to see the world through another’s eyes, or at the very least, the ability to recognize that patients from various ethnic backgrounds may view the world through a different cultural lens.3 The movement toward cultural competency involves diminishing ethnocentric attitudes and developing greater flexibility and non-judgmental perceptions.11

**Cultural competence at the institutional level**

At the institutional level, organizational factors, policies, and culture can also affect the quality of care provided. A total of five essential behaviors contribute to a system or institution’s ability to become more culturally competent:7,12

- Valuing diversity
- Having the capacity for cultural self-assessment
- Being conscious of the dynamics inherent when cultures interact
- Having institutionalized cultural knowledge
- Developing adaptations to service delivery reflecting an understanding of cultural diversity

These five behaviors should be manifested at every level of an organization.

**Cultural competence and surgeons**

The Institute of Medicine’s (IOM) report, titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, has promoted awareness of health care disparities around the world and has served as a catalyst for positive change.4 The IOM report found considerable evidence that racial and ethnic minorities in the U.S. receive lower quality of health services and have worse health status indicators than do Caucasian Americans. Furthermore, the report asserts that racial differences in health outcome exist even when insurance status, income, age, and severity of conditions are comparable. The report suggests that these disparities are caused, in part, by conscious and unconscious bias on the part of the caregiver.4 Like all health care practitioners, the shifting ethnic and cultural demographics of the U.S. population pose a challenge for surgeons, as they must navigate varying cultural traditions and values to evaluate and connect with patients in order to deliver effective care.

The rapid pace of surgical practice can present a formidable challenge in establishing trust and confidence between surgeon and patient. Active patient–provider participation is required preoperatively in order to optimize outcomes. Culture, education, and belief systems have a tremendous influence on all aspects of the surgical experience, from accepting surgery as a treatment option, to pain management and performance of postoperative care.

**Communication and informed consent**

In order for a patient to make a truly informed decision, the surgeon must go beyond offering a simple explanation of proposed diagnostic and treatment plans; they must attempt to elicit reasons for apprehension or refusal of treatment, as there may be underlying cultural beliefs, fears, or myths that present obstacles to care. It is crucial that communication barriers are acknowledged and appropriately managed during patient encounters. Moreover, informed consent requires that surgeons communicate effectively to patients the risks, benefits, and alternatives to surgery, and ensure that the patients are willing to participate in follow-up and appropriate postoperative care. Proper communication needs to be determined on a case-by-case basis, and the physician should rely
on cultural competence, sensitivity, and a clear set of informational and trust-building goals when dispensing this information to patients. Communication barriers—whether derived from cultural or social origins—can have a significantly negative impact on patient satisfaction, compliance, clinical outcomes, and even malpractice suits.11,12

Health disparities and outcomes
Disparities in the delivery of health care and clinical outcomes are widely recognized, with minority and low-income populations adversely affected.4 The Centers for Disease Control and Prevention’s Healthy People 2020 initiative acknowledges this inequality and identifies the reduction of health disparities as a primary objective.13 Beyond race, socioeconomic status has received considerable attention as another contributor to disparities in clinical outcomes.14,15 Evidence suggests institutional complicity is also a culprit, in that hospitals where minority patients receive treatment have significantly poorer outcomes overall due to lack of resources.16,17 Other research suggests that behavioral issues, including provider bias and patient attitudes, negatively influence patient-provider communication and are possible explanations for the outcomes seen in minority patients.4

Disparities in surgical care are most commonly seen in cancer and trauma care for the underinsured, the uninsured, and ethnic minorities.18-20 Race and insurance status have consistently been shown as predictors of mortality after trauma.14,21 In addition, racial differences have also been seen in ambulatory surgery outcomes.22 Despite controlling for health insurance, disparities continue to exist in surgical outcomes among patients with lower socioeconomic status.23,24 Ultimately, the surgical workforce needs to be trained to recognize and address the distinct social and cultural values of patients in order to eliminate disparities in surgical care.

Surgical volunteerism
A growing number of residents and surgeons are crossing international borders with the intention of reducing disparities between global wealth and poverty. However, American surgeons have been relative latecomers to international volunteerism.25 U.S. physicians recognize their obligation to be leaders in providing relief to the global burden of surgical disease. Increasingly, surgical residents have displayed interest in participating in global health and volunteerism. A national survey of Resident Members of the American College of Surgeons revealed that 92 percent were interested in an international elective, and 85 percent planned to volunteer in practice.26 Another survey showed that 57 percent of surgical programs that were not currently offering global surgery electives had program leaders who were interested in initiating them.4 The growing demand for international surgical volunteerism within surgical residencies underscores the importance of developing a methodical training curriculum focused on providing care to culturally and socially distinct populations.27 Developing tools and honing skills in cultural competency within our own diverse population allows surgeons to become more attuned to these differences, serving as preparation for an experience abroad. Volunteerism is one way surgeons can seek and develop strategies that may potentially reduce barriers to obtaining health care and decrease health disparities in the long-term in both urban and rural underserved regions within the U.S.

Surgical workforce
The American surgical workforce is lacking in representation by minorities and women. The realities of medical school enrollment portend the changing gender balance in the surgical workforce—but less so for ethnic minorities. This is attributable to pipeline limitations, as medical schools have had only minimal increases in minority enrollment.28,29 U.S. medical schools have responded to these deficiencies by incorporating courses that address communications skills and cultural competence training into their curriculum.30,31 In 2001, the Accreditation Council for Graduate Medical Education made cross-cultural education a requirement for both medical students and residents.32

Cultural competence training
There are several different approaches to cultural competence training, and various learning tools are, in fact, available for physicians, but none are tailored specifically to surgeons. Traditional approaches focus on cultural sensitivity, cultural adaptability, and cross-cultural skills.6 Cultural sensitivity focuses on health care provider attitudes as well as various qualities that are indicative of professionalism. This approach emphasizes the
fact that cultural competence is achieved when the pillars of professionalism are met: empathy, humility, respect, and sensitivity. Cultural adaptability emphasizes the importance of acquiring general knowledge of health attitudes and behaviors specific to a certain race or ethnic group. Providers who work with a particular patient population may benefit from this knowledge-based approach. Information regarding the customs, beliefs, history, sociopolitical, and economic factors that shape the community are crucial in this dynamic. And lastly, cross-cultural skills acquisition—in which patient-provider communication is strengthened by focusing on the social, cultural, and health issues of varying population groups while emphasizing professionalism—is vital. The health care provider allows the patient to communicate the cultural beliefs that influence their health beliefs, attitudes, and decision-making processes. Ideally, a curriculum that integrates these different approaches equips surgeons with the skills required to serve diverse populations.

There are numerous tools available for physicians and other health care providers through the U.S. Department of Health and Human Services’ Health Resources and Services Administration to elevate the U.S. Cultural competence is a necessary and critical hallmark of surgical professionalism both perceived and real as we continue to strive to provide quality care for our surgical patients.

References
19. Trivers RF, Shaw KM, Sabatino SA, Shapiro JA, Coates RJ.


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Dr. Mendoza is a NIH T32 trauma research fellow, department of surgery, University of North Carolina, Chapel Hill.

Dr. Charles is assistant professor of surgery, department of surgery, school of medicine, University of North Carolina, Chapel Hill. He is Chair of the ACS Committee on Diversity Issues.
M y son and I were recently involved in a motor vehicle crash. The car in which we were riding was a total loss. As a pediatric surgeon and an instructor in the American College of Surgeons (ACS) Advanced Trauma Life Support® program for more than 20 years, I was able to quickly assess that neither my son nor I had life-threatening injuries. However, mindful of the wisdom of not treating oneself or one’s family members, I had both of us evaluated by one of my surgical colleagues at the ACS-accredited trauma center where I work. Despite an underlying feeling we would both be fine, I have never felt more vulnerable and anxious. I am eternally grateful to my surgery and emergency medicine colleagues for their rapid, efficient, and thorough evaluation as well as for the compassionate care we received. Fortunately, there were no serious injuries.

Trauma surgeons and emergency medicine physicians throughout the U.S. stand at the ready on a daily basis, at all hours of the day and night and on holidays and weekends to assist patients in their time of need. My personal experience reminded me once again of the critical nature of having these services available and how the very availability of such services is threatened by the current liability environment.

At the 2011 Joint Surgical Advocacy Conference, surgeons from a broad range of specialties and subspecialties across the country were briefed on legislative initiatives and pending regulations that could potentially impact their practices and the care of their patients. I first became aware of H.R. 157, the Health Care Safety Net Enhancement Act of 2011, at this event. Introduced by Rep. Pete Sessions (R-TX), at press time, the bill had more than 32 cosponsors in the U.S. House of Representatives. In essence, the legislation would apply the Federal Tort Claims Act to cases involving services mandated under the Emergency Medical Treatment and Active Labor Act (EMTALA).

**EMTALA**

EMTALA is a federal statute passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under this legislation, hospitals and their emergency departments (EDs), as well as the physicians on call staffing those EDs, have three obligations. First, they must provide a medical screening examination to any individual who requests it in order to determine whether an emergency condition exists. This examination and any necessary treatment cannot be delayed due to the patient’s inability to pay, inadequate insurance coverage, or citizenship and legal status. Second, the emergency room or other inpatient units of hospitals are required to treat the patient until the condition has either been resolved or stabilized. Inpatient care provided must be at the same level (that is, to the fullest extent of the institution’s capabilities) for all patients regardless of their ability to pay. Third, if a hospital does not have the capability or appropriate specialists necessary to treat the patient’s condition, the institution may then transfer the patient to a facility with the necessary resources; in other words, transfer to another institution is needed STAT.
only allowed in order to facilitate the provision of a higher level of care.1,2

EMTALA applies to all hospitals that accept Medicare payment from the U.S. Department of Health and Human Services’ Centers for Medicare & Medicaid Services (CMS). In other words, virtually every U.S. hospital is subject to the mandates in EMTALA. Stiff penalties apply for violation of the law.

EMTALA was originally passed to stop the practice of “patient dumping,” whereby hospitals would transfer patients to other facilities if the patient was financially unable to pay or had insufficient insurance coverage for the care necessary to treat their condition. The cost of the emergency care mandated by EMTALA is not directly covered by the government. Consequently, EMTALA has been criticized by some health policy experts as an unfunded mandate, given that much of the emergency care provided in the U.S. is uncompensated. Hospitals and physicians may write off the expense or charges for the care provided as charity or bad debt for tax purposes. However, because of financial pressures, many hospitals have closed and/or consolidated, resulting in a decrease in ED capacity while at the same time the demand for emergency care has increased.2,3

Physician shortage

By the very nature of their profession, trauma surgeons and emergency medicine providers cannot select their cases. However, if they could, most of these providers would not want to do so. Surgeons and other health care professionals who choose a career in the provision of emergency care thrive on never knowing what is going to roll through the door next. Because trauma surgeons and emergency medicine physicians treat a broad spectrum of conditions and injuries, they rely heavily on other physicians with specific specialized areas of expertise to provide consultative services.

A 2006 study from the Institute of Medicine titled The Future of Emergency Care in the United States Health System addresses the shortage of physicians who are capable of staffing and provide consultative services in our nation’s EDs.4 For a number of reasons, it has become increasingly difficult to secure adequate numbers of physicians of various specialties to provide coverage for EDs. One of the critical causes of this problem is the additional liability risk of working in the ED or providing consultative services for ED patients. The care that trauma surgeons, emergency medicine physicians, and health care professionals working in this inherently challenging environment provide often requires that critical decisions be made based on limited information in a very short time frame. In addition, emergency care professionals usually do not have an established relationship with the patient. As a result, those providing care in the ED incur a significantly increased exposure to medical liability claims as compared with other professionals who have been able to build the trust of their patients.

Physicians and surgeons in the early stages of their careers will often actively participate in trauma call and ED call as part of their effort to build their practice. These younger physicians and surgeons are leaving states with the most severe liability issues. A study by the Pew Charitable Trusts of resident physicians training in general surgery and emergency medicine in the state of Pennsylvania found these residents named malpractice costs as the reason for leaving the state three times more often than any other factor.3 In addition, according to an American Hospital Association study, the medical liability crisis has led to difficulties with physician recruitment by hospitals, which has already resulted in less coverage for their EDs.7 In recent years, lack of adequate physician coverage has ultimately resulted in the closure of trauma centers in the states of Florida, Mississippi, Nevada, Pennsylvania, and West Virginia.4,8-10 Recognizing these concerns and the attendant cause and effect relationship, in 2005, the congressionally created EMTALA Technical Advisory Group recommended that HHS take action to amend the EMTALA statute in order to provide liability protection for both physicians and hospitals who were acting in accordance with the mandates of the law.11

Federal Tort Claims Act

The Federal Tort Claims Act of 1946 (FTCA) is the statute by which the U.S. government authorizes torts to be brought against itself.12 The law was originally passed after a B-25 bomber flown in thick fog crashed into the north side of the Empire State Building. The act gave American citizens the right to sue the federal government for the first time. Eight months after the crash, the federal government had offered compensation to the survivors and families of those killed. While some of these individuals accepted the offer, others filed a lawsuit which ultimately culminated in the passage of the legislation.13

In essence, the FTCA permits private parties to
file suit against the U.S. in federal court for torts committed by persons acting on behalf of the U.S. As such, it represents a limited waiver of sovereign immunity. The FTCA specifically exempts claims based upon the performance or failure to perform a discretionary function or duty. In the 56 years since its passage, the FTCA has been the legal mechanism by which persons injured as a result of acts of federal employees, committed within the scope of their employment, receive compensation. According to a 1988 amendment note, the purpose of the act is to protect federal employees from personal liability for common law torts committed within the scope of their employment, while providing persons injured by the common law torts of federal employees with remedy against the U.S.14

Successes by the states

On a federal level, little has changed in the area of tort reform over the past few decades. However, states like Texas that have enacted comprehensive tort reform have seen an influx of physicians. In addition, since Texas passed tort reform legislation in 2003, liability insurance rates have decreased and charitable care has increased.15,16 California passed its landmark Medical Injury Compensation Reform Act (MICRA) in 1975. Comparatively, in the 37 years since MICRA was enacted, California providers have seen their malpractice premiums rise by 283 percent versus the 925 percent increase seen by providers in the other 49 states. In addition, California has more physicians, surgeons, and subspecialists per capita than states with higher malpractice premiums. It would seem logical to attribute at least part of this to the effect of MICRA.17-19

Frustrations on the federal level

The reasons for maintenance of the status quo on the national level are multiple, complex, and, of course, political. Because of the usual partisan gridlock and the significant monetary contributions made by the trial attorney lobby, federal resolution of this issue has thus far been unattainable. Solutions are possible only if the following developments occur. First, the blame game between physicians, attorneys, and their respective political champions must stop and be replaced with a common-sense approach that focuses on the shared issues between these professionals who serve the public in varying capacities. Most people would agree it is an absolute necessity that trauma surgery and emergency medical services continue to be available for the American people in their hour of greatest need. Certainly, we would all want such services available for ourselves and our family in the unfortunate event the need should arise. Based on the data presented earlier in this article, we should also be able to agree that we need to be concerned about the health care system’s ability to retain adequate numbers of physicians willing to provide these services. A significant part of their reluctance to do so is borne out of the fact that such work puts them at increased risk of being involved in litigation.

Second, problems in our country go unresolved for far too long because those in positions of power who are sent forth to work on the solutions are often tempted to “swing for the fences.” The more global issue of federally enacted tort reform would best be addressed by playing “small ball”—at least at the outset. Though numerous other comprehensive bills have been introduced, it seems less likely they will ever be able to glean enough bipartisan support to become law. On the other hand, it is hard to see how any member of Congress could legitimately argue against providing the same protections afforded to federal employees to trauma surgeons, emergency medicine physicians, and their consulting specialist colleagues when they are acting under the mandates of a federal law.

The Health Care Safety Net Enhancement Act of 2011 addresses the growing crisis in access to
emergency care by deeming emergency and on-call physicians who provide EMTALA-related services as federal employees under the Public Health Safety Act for purposes of any civil action that may arise due to providing that EMTALA-related care.

I am reminded of the response that a wise man gave when asked, “How do you eat an elephant?” His response was, “One bite at a time.” H.R. 157 is a good first bite. It simply mandates federal protection to those surgeons and physicians who are providing not just the care that it is their passion to provide, but also the care that is federally mandated under EMTALA.

By protecting those who stand at the ready 24 hours a day, 365 days a year to care for patients when they are injured—exercising their remarkable skills to the best of their ability in a high-stress environment—we not only take a meaningful step toward the resolution of the global tort reform issue but, more importantly, take a significant step toward continuing to assure ourselves of the highest quality trauma and emergency care.

References


Dr. Bailey is a pediatric surgeon at Maricopa Medical Center, Phoenix, AZ, and a member of the ACSPA-SurgeonsPAC Board of Directors.
Mobile devices are gaining significant traction with American College of Surgeons (ACS) members, with a 191 percent increase in the use of iPads and a 24 percent increase in iPhone rate usage over a one-year period, according to a recent survey of the membership. Interestingly, though, for those surveyed, print and online journals are still the preferred choice to satisfy their professional needs, with 54 percent viewing professional journals online.

The survey revealed that while not all surgeons fully understand or approve of the role of social media, they are more interested in using it as a communications tool. Compared with a similar survey conducted in the fall of 2010, more respondents now show a willingness to embrace social media, provided their primary communication vehicles (ACS NewsScope, the Bulletin, Journal of the American College of Surgeons, and so on) remain intact.
The purpose of the survey was to gain insights into how the College can use social media platforms to engage with members, and to track changes from the survey in 2010. Participants were asked to list their usage habits on various communication channels, and they were encouraged to comment about their individual experiences—feedback which provided important insights into usage interests and patterns.

Based on this feedback, the ACS put additional effort into building a strong social media presence at last year’s 97th Annual Clinical Congress in San Francisco, CA, in order to develop member engagement with social media.

Key findings

Based on a strong initial response to the survey, social media awareness and interest appear to have increased since 2010 (see Figure 1, this page). By the end of the first day alone, the survey accumulated 950 responses, compared with a grand total of just 324 responses in 2010. The survey ran for two weeks and by October 4, 2011, a total of 2,070 responses had been collected. Slightly more than 81 percent of the respondents were male, 46.3 percent were between the ages of 46 and 64, and 94.8 percent were 30 or older.

Key findings from the study include the following:

- **Mobile device usage is on the rise.** As technology and wireless access increases, mobile device use to access the Internet, as well as social media in general, will continue to grow. More and more members are looking for mobile apps to access information.
- **Traditional news consumption stays balanced.** Respondents are receiving their news using a variety of media sources, with online news websites leading at 64 percent, followed closely by broadcast outlets (55 percent) and newspapers (54 percent). Almost a third of respondents (28.6 percent) said they receive news from their mobile device, and a majority (47 percent) of write-in answers included radio news programs such as National Public Radio as vehicles for staying informed on current events.
- **Professional information gathering holds steady.** Respondents showed that industry news is still largely gathered through print and online journals, with 54 percent viewing professional journals online. Professional meetings and industry conferences were top write-in choices for how surgeons stay informed on a professional level.
- **Blogs and online forum usage continues to lag.** According to the survey, members don’t typically spend a lot of time participating in online forums or blogs. For those who do participate in these areas, participation has decreased slightly from 2010 to 2011. A total of 29.9 percent said they participated in forums and blogs in 2011 compared with 34.9 percent in 2010.
- **Privacy remains a key concern.** Key factors hin-

![Figure 1. Key survey findings](image-url)

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**2011 statistical highlights:**

- 64% get their news online followed by broadcast outlets (55%) and newspapers (54%)
- 28.6% get news on their mobile device
- 54.2% receive medical news through online journals
- 47% of write-in responses noted meetings and medical conferences were how they stay informed
Awareness of ACS social media presence has increased. Although many respondents still were unaware that the ACS is communicating and sharing information via College-branded social media sites, such as Twitter, Facebook, YouTube, and Flickr, awareness has increased from 2010 to 2011 in each of the following areas, representing modest but steady gains:

—A total of 25 percent of the members surveyed were aware that the College has a presence on Facebook, up 22 percent from 2010.
—Awareness of the ACS Twitter profile was also up 22 percent compared with 2010.

In addition to posting news and updates on Facebook and Twitter, the College shares video on YouTube and photos on Flickr. Awareness of both of these channels has risen significantly over the previous year—for YouTube there was a 77 percent increase in awareness and for the College’s Flickr account there was a 104 percent increase, as shown in Figure 2, this page.

Social media at Clinical Congress

In response to feedback from the 2010 survey, the College integrated a more robust social media presence at last year’s Clinical Congress program to increase the organization’s presence online, share real-time updates from the conference with followers, and encourage participation among attendees. ACS developed social media signage throughout the conference to promote the College’s social media sites, and take-away bookmarks featuring the Col-

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lege’s online destinations were available at registra-
tion. Quick response (QR) codes were added to this
year’s bookmarks to direct smartphone users to the
Clinical Congress mobile application.

The ACS also hosted a Social Media Resource
Center where attendees could work one-on-one with
experts to answer questions about navigating various
social websites and connecting to the updates the
College provides via social media.

The ACS worked with six volunteer surgeons to
tweet about special topics at Congress. These ACS
Twitter correspondents included the following:
- David Tom Cooke, MD, FCCP, FACS
  (@UCD_ChestHealth)
- Philip Glick, MD, MBA, FACS
  (@glicklab)
- Niraj J. Gusani, MD, MS, FACS
  (@NirajGusani)
- Osama Hamed, MB, BS
  (@hamed_os)
- Raphael Malikian, MD
  (@NavyBlueScrubs)
- Oluwatosin O. Thompson
  (@tosinthompson)

Social media metrics comparing usage over the last
year can be found in Figure 3, page 25.

Clinical Congress-related tweets led to an increase
of 122 Twitter followers for the College. These
tweets also resulted in 1,234 @AmCollSurgeons
or “American College of Surgeons” mentions from
October 15 to October 31. In addition, the event
hashtag #ACSCC11 received more than 1,100 tweets
within the same time frame.

Looking ahead

Efforts to strengthen communications via social
media will be a priority for many organizations in
the coming years as social media becomes more in-
grained in the way people communicate. The ACS
will be one of them.

Currently, the ACS is working to determine best
practices for members to better understand and
effectively use new media. The College leadership
courages members to visit the websites shown in
Figure 4, this page, to find and share the latest news
and information from the ACS.

The authors of a recent article published in
the Bulletin emphasized the fact that social media
isn’t a passing fad, and offered practical ways that
surgeons can use social media to enhance their
communication and patient education. The au-
thors concluded the following: “This tool [social
media], when understood and used properly, can
give surgeons tremendous leverage over the avail-
ability and quality of online information, and it is a
major potential source of education for the surgical
community, and, perhaps more importantly, the
patient population.”*
Poland’s syndrome is an eponym for unilateral, congenital absence of the pectoralis major muscle that is often associated with an ipsilateral upper extremity deformity such as syndactyly. It is sometimes mentioned on rounds or in the operating room to test the younger participants’ knowledge of surgical anatomy and history. Few, however, may realize that although Alfred Poland, MD, was an accomplished surgeon, he may not have been the first to describe this anomaly.

Alfred Poland (1822–1872)

Dr. Poland was born in London, England, and as a medical student served as an apprentice in anatomy to Charles Aston Key, MD, at the prestigious Guy’s Hospital in London (see photo 1, this page). He became a demonstrator in anatomy, a fellow of the Royal College of Surgeons, and by 1861 was a designated surgeon at Guy’s Hospital.

From 1848 to 1861, Dr. Poland served as surgeon to the Royal Ophthalmic Hospital but relinquished this role due to a debilitating infection he contracted while on the ward. He continued at Guy’s Hospital and was considered a popular teacher, good surgeon, and expert orator. His dissertation titled “The Origin, Connection, and Distribution of the Nerves of the Human Eye and its Appendages” won a Triennial prize. His Jacksonian essay titled “Gunshot Wounds
and their Treatment” is still retained in the Royal College of Surgeons library. In 1853, Dr. Poland won the Fothergill gold medal for his essay titled Injuries and Wounds of the Abdomen.1

Plagued with poor health and a violent cough, he continued to see patients at Guy’s Hospital until four days before his relatively early death from consumption in 1872.

**Poland’s syndrome**

As an apprentice in 1841, Dr. Poland dissected a cadaver unlike any he had ever seen. The body was that of a 27-year-old convict named George Elt who was reported to have had difficulty drawing his left arm across his chest. Dr. Poland’s findings would offer an explanation for this condition, and inspire him to ask a friend, Mr. Tilston, to sketch the cadaver’s anatomy (see photo 2, page 27).

Dr. Poland’s brief report of this dissection was printed in *Guy’s Hospital Reports* under the title “Deficiency of the Pectoral Muscles.”2 References to this seminal report are often included in manuscripts regarding Poland’s syndrome. And though this paper generated the eponym, the history of the syndrome actually begins prior to Dr. Poland’s involvement. When he reported his “unusually satisfactory dissection,” as he described it in 1841, there was no syndrome or eponym, only isolated case reports that were largely unknown. Although other reports of similar deformities preceded Dr. Poland’s, these accounts described only the chest wall deficiency without concomitant hand abnormality.3-5 R. Froriep’s account of a woman with unilateral amastia and absence of the sternocostal portion of the pectoralis major muscle illustrates this type of article (see photo 3, page 27).5

**Discussion**

The value and celebrity accorded to Dr. Poland lies in his meticulous attention to detail, which serves as an example to surgeons and anatomists. Aside from his clear description of the anatomy, he was the first to associate the absence of the sternocostal head of the pectoralis major muscle with an ipsilateral upper extremity deficiency. This association is not as uncommon as it was initially thought to be.

Reviewing Dr. Poland’s description, Mr. Tilston’s illustration, and the appearance of Mr. Elt’s left hand (see photo 4, this page), it is obvious that Mr. Elt had the severe form of the chest wall anomaly as well as brachysyndactyly. This combination still applies to the clinical findings of patients with Poland syndrome and is exactly as the physician described it 171 years ago.6,7

For more than 100 years following Dr. Poland’s description, the condition existed without an eponym, although other authors seemed to recognize the unusual anatomy of Poland syndrome, which was always unilateral.8,9 Then, in 1962, Patrick Clarkson, MD, a plastic and hand surgeon at Guy’s Hospital, described three patients with breast hypoplasia and syndactyly.10 According to Dr. Clarkson’s son, the physician rediscovered Dr. Poland’s earlier article and gave the syndrome its eponym, Poland’s syndactyly, and published his article in the same journal as Dr. Poland’s original article.11 Five years later, Baudinne and colleagues first referred to Poland’s syndactyly as Poland’s syndrome—a trend that continues to this day.7,12 Sporadic reports have continued to focus on chest wall defects, hand
deformities, and other variations, and some have classified the problems according to the degree of deformity in order to guide surgical repairs.6,7,13-16

Interestingly, Mark Ravitch, MD, FACS, a pediatric surgeon, was critical of attributing the syndrome to Dr. Poland. And Frank McDowell, MD, a plastic surgeon, referring to the chest-hand association, commented that “Poland hadn't the foggiest notion” that the two deformities constituted a syndrome.18 Such critiques appear to be unfounded since Dr. Poland not only described the condition with amazing detail, but had a colleague illustrate the chest wall and had his subject's hand preserved for posterity (see photos 2 and 4).

Mr. Tilston's exclusion of the extremity in his illustration is odd, although Dr. Poland's role in this is unclear and it must have taken some effort to have Mr. Ett's left hand preserved as a specimen. As Dr. Poland's footnote stated, “The hand has been deposited in the museum of Guy's Hospital” —where it resides to this day (see photo 4).

On surgical rounds and in the operating room, eponyms can be entertaining and colorful. They are common in clinical practice and credit earlier and observant physicians for their identification of a disease, deformity, or association of findings. The syndrome ascribed to Dr. Poland, a gifted surgeon, relates to the accuracy and detail with which he recorded the deformity and his awareness of its uniqueness. His foresight in adding an illustration of the dissection and his preservation of the subject's hand has earned him the eponym, Poland's syndrome.

References

Dr. Seyfer is distinguished professor and course director in anatomy at the F. Edward Hebert School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, MD. He is also a former Governor of the College.

CPT Fox is a general surgery resident, department of surgery, Wright State University Boonshoft School of Medicine, Dayton, OH.
The American health care system is evolving at an increasingly rapid pace. The structure of health care delivery is moving toward larger and more integrated systems. The traditional pattern of independent practice for physicians is being supplanted by contracted arrangements among large groups of clinicians. The financing of medical care is undergoing changes due to federal legislation as well as pressures from payors to remain competitive. Financing systems are evolving toward “bundles” and disease-based reimbursement with the anticipation that patient outcomes will one day form the basis for payment. These trends all have implications for the supply of health care professionals as they choose to enter medicine and surgery.

The practice of otolaryngology and many other surgical specialties has changed significantly over the past three decades. For instance, vascular surgery barely existed in the early 1980s and is now an independent specialty. New procedures, unheard of even 20 years ago, are now performed by a variety of surgical specialists. The practice of head and neck oncologic surgery, skull base surgery, neuro-otology, head and neck endocrine surgery, and pediatric otolaryngology has developed over this time period, increasing the demand for otolaryngologists to perform procedures

Table 1.
Otolaryngologists, 1981–2009

<table>
<thead>
<tr>
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<td>Otolaryngologists</td>
<td>6,246</td>
<td>6,899</td>
<td>7,985</td>
<td>8,745</td>
<td>9,388</td>
<td>9,909</td>
<td>10,002</td>
<td>60%</td>
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Table 2.
Percent change in U.S. surgeons per 100,000 population, 2001–2009

<table>
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<tr>
<th></th>
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<td>Thoracic</td>
<td>1.71%</td>
<td>1.84%</td>
<td>1.83%</td>
<td>1.80%</td>
<td>1.79%</td>
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<td>1.54%</td>
<td>7.0%</td>
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<td>General</td>
<td>12.56</td>
<td>11.74</td>
<td>11.33</td>
<td>10.32</td>
<td>10.38</td>
<td>9.86</td>
<td>9.51</td>
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<td>5.86</td>
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<td>15.0</td>
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<td>1.66</td>
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<td>0.23</td>
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<td>8.7</td>
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<td>Plastic</td>
<td>1.33</td>
<td>1.60</td>
<td>1.80</td>
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<td>2.13</td>
<td>2.15</td>
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<td>12.8</td>
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<td>Colorectal</td>
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<td>0.38</td>
<td>0.41</td>
<td>0.45</td>
<td>0.46</td>
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<td>0.52</td>
<td>0.64</td>
<td>0.74</td>
<td>0.83</td>
<td>0.85</td>
<td>N/A*</td>
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</table>

*Data were not available for vascular surgeons in 1981.
that have been newly developed to treat cases that are referred to them by general surgeons. New technology, new procedures, and changes in surgical training pathways and certification have resulted in a redistribution of the division of labor within all the surgical specialties and an increasing proliferation of specialty surgeons of many types, including otolaryngologists.

This article is based on a fact sheet that was developed as part of a series of policy briefs produced by the American College of Surgeons Health Policy Research Institute (ACS HPRI) illustrating surgical workforce trends. The aim of these brief reports is to provide decision makers with descriptive data on the workforce that can be used to inform health policy.

This fact sheet focuses on trends in the otolaryngology workforce since 1981.

Key findings

Relative to population, the supply of otolaryngologists increased from 1981 until 2001, was stable between 2001 and 2006, and then began to decline between 2001 and 2006. Furthermore, between 2000 and 2009 the number of otolaryngology residents becoming certified by the American Board of Medical Specialties (ABMS) dropped 19.3 percent. As supply has contracted, distribution also has become problematic. Between 2004 and 2009, one in five (641) counties lost otolaryngologists relative to population. Of
these, 88 counties lost all their otolaryngologists. More than half (59.8 percent, n=1,858) of all U.S. counties had no otolaryngologists in either 2004 or 2009.

In addition, we found that otolaryngology is more male-dominated than most surgical specialties. Female otolaryngologists are disproportionately represented in hospital settings. In the last decade, the number of solo practice otolaryngologists in rural counties decreased significantly.

The number of otolaryngologists in active practice for all U.S. counties from 2004 to 2009. In 2009, otolaryngologists practiced in 37.4 percent (1,161) of U.S. counties, representing an increase of 20 counties from 2004. From 2004 to 2009, 20.6 percent of U.S. counties (641) lost otolaryngologists relative to population, and 88 counties (2.8 percent) lost all otolaryngologists (see Figure 1, page 31). During the same period, 13.3 percent of counties (412) gained otolaryngologists relative to population, and 108 counties (3.5 percent) that had no otolaryngologists

Training in otolaryngology

According to ACGME data, from 2001 to 2009, the number of otolaryngology residents increased by 23 percent. The number of otolaryngology training programs held steady at 103 during this period. However, otolaryngology residents receiving ABMS certifications declined by 19.3 percent from 2000 to 2009.

Geographic distribution of otolaryngologists

As supply has contracted, distribution has also become problematic. To examine geographic variation in the supply of otolaryngologists, we analyzed practitioner and population data...
in 2004 gained at least one otolaryngologist by 2009. Slightly more than 59.8 percent of counties (1,858) had no otolaryngologists in 2004 or 2009.

**Age and gender of the workforce**

With an average age of 51.4 years in 2009, otolaryngologists in active practice are slightly older than the average age for all surgical specialties (50.9 years). In 2009, 15.1 percent were older than 65 compared with 14.2 percent for all surgeons. This represents more than a 4 percentage point increase in otolaryngologists 65 and older since 1981, when the 65 and older age group comprised 10.8 percent of the workforce. This increase is roughly equal to the average rate of aging of the overall surgeon workforce.

Women have been entering the surgical workforce with increasing frequency since 1981, although at different rates in different specialties. Since 1981, the number of female otolaryngologists has grown from 111 to 1,158, an increase of nearly 10 percentage points (see Figure 2, page 32). Nonetheless, men continue to account for a large majority of otolaryngologists, representing 88.4 percent of the workforce versus 80 percent for all surgeon specialties combined.

Since 1981, the age gap between male and female otolaryngologists has remained steady, with males being an average of eight years older than their female counterparts. In 2009, female otolaryngologists were 44.4 years old on average and males were 52.0 years old. Among all active surgeons in 2009, males were slightly older at 52.5 years old. Female surgeons on average are approximately the same age as female otolaryngologists. As Figure 2 indicates, more female otolaryngologists have recently entered the otolaryngology workforce.

In 2009, otolaryngologists practicing in rural areas (average age 52.6) were 1.7 years older than those in urban areas, a trend that has reversed since 1981 (see Figure 3, page 32).

**Movement from solo to group practice**

Following trends for all practicing surgeons, otolaryngologists are increasingly likely to practice in a group (see Figure 4, this page). The proportion of the otolaryngologist workforce in group practice increased from 37.8 percent in 2001 to 53.4 percent in 2009. As the number employed in group practices increased, there has been a corresponding decline in the percentage of surgeons self-employed in solo practice. In 2001, slightly more than 30.1 percent of otolaryngologists were in solo practice compared with one in four (25.1 percent) in 2009. The percentage of surgeons employed by HMOs, nonhospital government, and other entities (defined in Figure 4 as “other setting”) also declined substantially between 2001 and 2009. In 2009, otolaryngologists in solo practice were on average 6.7 years older than otolaryngologists in group practice.

Not surprisingly, urban otolaryngologists have chosen to practice in groups proportionally more often than rural otolaryngologists. From 2001 to 2009, the number of urban otolaryngologists in group practice increased by 52.2 percent, while rural otolaryngologists increased by 34.1 percent. Also, the number of urban otolaryngologists in solo practice decreased by 15.3 percent. Also, the number of urban otolaryngologists in solo practice decreased by 15.3 percent, while rural otolaryngologists decreased by just 6 percent. The decrease in rural solo practice for surgeons in general was much larger (16 percent).

Most female otolaryngologists practice in a group setting (49.6 percent), and a slim majority of males choose group practice (53.9 percent). Although females make up just 11.6 percent of the otolaryngology workforce, they
represent 18 percent (in 2009) of the otolaryngologists practicing in a hospital, an increase from 11.7 percent in 2001. Overall, otolaryngology saw larger increases in hospital practice in both urban and rural areas than surgeons in other specialties.

**Implications**

Work by Kim and colleagues demonstrated an increasing concentration of neck dissections at high-volume centers from 2000 to 2006. Urban otolaryngologists more often chose group practice than their rural counterparts. If otolaryngologists continue to concentrate in fewer locations, new models of care, such as the “medical mission” used in developing countries, may improve access to otolaryngology care in rural U.S. areas where proportionately more Medicaid and uninsured patients reside.

Although the distribution of otolaryngologists may foreshadow geographic problems with access, research has shown that practitioners are taking on a greater workload. This trend may have effects on entry into the specialty as graduating medical students assess the relative burden of practice in rural versus urban communities.

Although the otolaryngology workforce increased by 20 percent per 100,000 during the period 1981–2009, the trend has recently reversed. Bhattacharyya’s predictions about an increasing workload due to the aging U.S. population suggest the need for close monitoring of the otolaryngology workforce. Otolaryngology currently relies less on international medical graduates (11.7 percent) than the surgeon population in general, and has trended away from international medical graduates since 1981. Hence, the U.S. graduate medical education system will likely play a larger role in the otolaryngology workforce than other surgical specialties.

**Data and methodology**

Surgeons were identified as surgeons and classified into surgical groups using a combination of American Medical Association (AMA) primary and secondary self-reported specialties and American Board of Medical Specialties (ABMS) certifications. This analysis only included active, nonresident, nonfederal surgeons. “Active surgeons” are under the age of 80 and report working in administration, direct patient care, medical research, medical teaching, or other nonpatient care activities, or who have an “unclassified” activity status. Active surgeons exclude those who are classified as retired, semi-retired, temporarily not in practice, or not active for other reasons. “Urban-Rural” was defined as a county’s Metropolitan Statistical Area status as defined by the Office of Management and Budget.

**References**


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

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**Dr. Weissler** is the Joseph P. Riddle Distinguished Professor of otolaryngology/head and neck surgery and neck surgery chief, division of head and neck oncology, UNC-Chapel Hill School of Medicine.

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

**Ms. Gaul** is a research associate at the Cecil G. Sheps Center for Health Service Research, UNC-Chapel Hill, and the ACS HPRI.
Advocacy for surgeons at the AMA House of Delegates

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

The American Medical Association's House of Delegates (AMA HOD) convened for its interim meeting November 12–15, 2011, in New Orleans, LA. Delegates from state medical societies and national specialty societies converged on the Big Easy under the cloud of persistent uncertainty about Medicare physician payment.

The American College of Surgeons was well-represented by a delegation of surgeons seasoned in the processes and politics of the HOD. Whether participating in reference committee hearings, meeting with various caucuses, or engaging in sidebar discussions with other delegates, members of the College’s delegation gave voice to surgical concerns. (See box, this page, for the complete ACS delegation.)

Two delegates completed their service on the delegation: Sanjay Parikh, MD, FACS, and Chad Rubin, MD, FACS. Both had advanced from the AMA Young Physician Section into the delegation and were highly effective in shaping AMA policy on behalf of surgeons. Other ACS Fellows who play prominent roles within the AMA are Peter Carmel, MD, FACS, a neurosurgeon from Newark, NJ, AMA president; Lee Morisy, MD, FACS, a general surgeon from Memphis, TN, chair of the Council on Science and Public Health; and Jay Gregory, MD, FACS, a general surgeon from Muskogee, OK, chair of the Organized Medical Staff Section.

Adopted policies

Following the pattern of similar interim meetings, debate was focused on advocacy issues. College clout was felt on many resolutions and reports relevant to surgery, including:

- Censorship of physician discussions on firearm risk: In response to the passage of legislation in Florida during 2011, the HOD took a strong stand against state government efforts to restrict physicians from being able to inquire and talk about firearm safety issues and risks with their patients. The AMA now opposes any law that would inhibit physician discussion about guns with patients and their families, and views such legislation as an intrusion into medical practice.
- Physician supervision of invasive procedures and the provision of fluoroscopy: This scope-of-practice issue gained traction when the Iowa Board of Nursing adopted regulations permitting advanced practice nurses to independently perform fluoroscopy. As a result of HOD action, the AMA will now uphold the position that interventional chronic pain management, including techniques employing radiation, is an aspect of the practice of medicine and should be performed only by a physician (MD/DO). The AMA will develop appropriate model state legislation to reflect this policy. In addition, the AMA will convene a task force to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training, and provision of other invasive procedures by non-physicians, including those employing radiologic imaging.
- ICD-10: Reflecting physicians’ considerable consternation regarding looming implementation of ICD-10 and the perceived unnecessary and significant burdens it is likely to present for medical practices, the HOD adopted a policy to vigorously oppose this new coding system. In addition, the AMA will work with other national and state medical and informatics asso-
ciations to assess an appropriate replacement for ICD-9.

- **Federal liability protection for EMTALA-mandated care:** Medical liability reform is a regularly discussed issue within the House of Medicine, and this meeting was no exception. Strong support was expressed for extending the Federal Tort Claims Act to all mandated Emergency Medical Treatment and Labor Act care provided by physicians.

- **Medical student, resident involvement in disaster response:** Based on a well-written report from the AMA Council on Medical Education, the HOD agreed that the organization should support medical student and resident education and involvement in disaster medicine and public health preparedness planning so that the U.S. will have an adequate, well-trained, and deployable response team. To view a copy of this report, visit [http://www.ama-assn.org/assets/meeting/2011i/i11-addendum-tab-k.pdf](http://www.ama-assn.org/assets/meeting/2011i/i11-addendum-tab-k.pdf) and click on Council on Medical Education Report 1 (accessed December 19, 2011).

**Surgical Caucus**

Surgeons and other specialists participated in the activities of the Surgical Caucus, which included election of officers and sponsorship of an education session. During the business meeting, the following were elected to the Executive Committee:

- Charles Drueck, MD, FACS, chair
- Michael Simon, MD, chair-elect
- Michael Deren, MD, FACS, secretary
- Dr. Morisy, treasurer
- Molly Katz, MD, member-at-large

The panel discussion, titled Pulling It All Together: Challenges Facing Academic Surgery, centered on identifying the complex challenges surgical graduate medical educators face and the management of surgical departments. Of considerable concern to panelists were the looming funding cuts to graduate medical education, and the potential consequences for surgery and other specialty programs. Panelists included Dr. Carmel; Robert Havlik, MD, FACS, interim chair, department of surgery at Indiana University, Bloomington; and Christian Shalgian, Director of the ACS Division of Advocacy and Health Policy, Washington, DC.

**Future surgical involvement**

The College's delegation has a strong impact on the AMA HOD activities that affect surgery. To continue and expand this presence, AMA members are encouraged to complete their ballots for specialty representation by choosing the ACS.

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

**Mr. Sutton** is Manager of State Affairs, Division of Advocacy and Health Policy, Chicago, IL.
ACS President Dr. Numann attends Clinical Congress of Philippine College of Surgeons

Patricia J. Numann, MD, FACS, President of the American College of Surgeons (ACS), and professor emeritus at the State University of New York, Syracuse, delivered a keynote address and participated in a number of sessions at the 67th Annual Clinical Congress of the Philippine College of Surgeons (PCS). The conference, which coincided with the PCS’ 75th anniversary, took place December 4–7, 2011, in Mandaluyong City, the Philippines.

In 1936, a group of 35 pioneering surgeons, led by Gregorio T. Singian, MD, developed bylaws for the Philippine College, which has worked ever since to raise the standards of surgical practice in the country. “They observed the anniversary by carrying a symbolic flame from chapter to chapter,” Dr. Numann said. “They are rightly proud of their accomplishments. Their enthusiasm is incredible. Even during the very last session, the room was full.”

Dr. Numann said the response she received during her visit was gratifying. “The surgeons expressed their appreciation not only for my visit, the first of a sitting ACS President, but also for all of the ACS materials that help them perform their jobs better,” she said. More than 300 surgeons in the Philippines are Fellows of the ACS.

“One of the top priorities for the Philippine College is the implementation of the College’s Advanced Trauma Life Support (ATLS®) program,” Dr. Numann added, noting that ATLS was among key points stressed during the address of new president Maximo Simbulan, Jr., MD, “They want to do something about the high mortality associated with trauma, and I am confident they will.”

The meeting’s comprehensive scientific program reflected the sophistication of care available in the Philippines as well as their need for improvement and dissemination of some programs. “They are working diligently on quality improvement programs, following the guidelines of the World Health Organization. They were very interested in strategies that have worked in the U.S.,” Dr. Numann said.

Dr. Numann also noted similarities between the U.S. and the Philippine training models. “They proudly told me that medical education and residency training in the Philippines follows the American model,” she said.

However, Dr. Numann found discussions regarding the need
for the patient to finance medical tests a bit unsettling. “They talked about waiting for the family of a patient to gather funds to pay for a CAT scan,” she said. “This is not the kind of discussion we have in the U.S. It shows the impact that poverty has on medical care and the challenge it presents to surgeons.”

An enthusiastic discussion followed Dr. Numann’s keynote address on “Gender Equity in Surgery.” As in the U.S., the Philippines has a number of women surgeons, mostly younger surgeons, and very few are in leadership positions. Josefina R. Almonte, MD, FPCS, who presided over the meeting, is the first woman to serve as president of the Philippine College of Surgeons. She began the Association of Women Surgeons of the Philippines a few years ago. Also at the conference were representatives from other Asian nations, including China, India, Malaysia, Myanmar, Pakistan, and Singapore.

Other Fellows who served on the international faculty at the event were Neal Handel, MD, FACS, associate clinical professor, division of plastic surgery, at the University of California, Los Angeles; and Jatin P. Shah, MD, FACS, chief, head and neck service and Elliot W. Strong Chair in Head and Neck Oncology, at Memorial Sloan-Kettering Center, in New York, NY. Dr. Shah has participated in several Philippine Clinical Congresses and has trained a number of fellows there.

During the Clinical Congress, surgeons relaxed with one another to discuss their interests outside the operating room, a diversion that Dr. Numann enjoyed. “On Fellowship Night, chapters entertained the crowd with skits. This was just a wonderful, spirited session. The winning chapter contained a group of older surgeons, all well over 70, who performed a soft shoe dance,” she said.

“My priority as ACS President is to visit the American chapters, but this trip made me realize how important it is to reach out to chapters, Fellows, and sister surgical organizations in other countries,” Dr. Numann noted. “This kind of outreach benefits us all.”

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“Your Lung Operation” provides patients with the knowledge needed to fully participate in their surgical care and help ensure optimal recovery.

**The program contains:**

- CMS measures and Joint Commission guidelines for safe operations.
- A 20-page booklet with an overview of the procedure, potential risks, perioperative preparation recommendations, cancer staging, discharge, and home care.
- A DVD with an overview of the lungs, lung cancer, and lung surgery options, preparation steps, and what to expect during hospitalization and recovery.
- Information sheets, including lung images, medication lists, exercise and pulmonary rehab activity guides, and smoking cessation resources.
- Additional resources and a patient evaluation form.

Visit [www.SurgicalPatientEducation.facs.org](http://www.SurgicalPatientEducation.facs.org) for all your surgical patient education needs.
The National Quality Forum (NQF) recently endorsed two outcomes-based measures from the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). The ACS developed the two measures for surgical site infection (SSI) and urinary tract infection (UTI) in partnership with the Centers for Medicare and Medicaid Services (CMS), and NQF’s endorsement marks the most recent step on the path toward national implementation of surgical quality measures.

“Increasingly, our national health system is looking for better ways to measure quality care. Better data creates more opportunities to improve the care hospitals provide patients. That’s why it will be important to measure quality using clinical, risk-adjusted, and nationally benchmarked outcomes-based measures,” said Clifford Y. Ko, MD, FACS, MS, MSHS, Director of the ACS Division of Research and Optimal Patient Care. “Endorsement of these measures brings us closer to implementing outcomes-based measures on a national level.”

In recent months, the ACS has worked with the Centers for Disease Control and Prevention (CDC) to harmonize their respective SSI measures. The ACS and CDC worked together to develop a joint measure for NQF’s endorsement, so that hospitals will be able to measure SSI through participation in either ACS NSQIP or the CDC National Healthcare Safety Network program.

The SSI and UTI measure endorsements are the fourth and fifth ACS NSQIP outcomes-based measures that the NQF has endorsed. Previously endorsed measures include elderly surgery outcomes, colectomy outcomes, and lower-extremity vascular bypass outcomes. The ACS developed all five measures in partnership with CMS based on an ongoing evaluation of scientific evidence. A directory of NQF-endorsed quality measures can be viewed at http://www.quality-forum.org/Measures_List.aspx.

In addition, as part of its move toward using clinical outcomes data to drive quality improvement in health care, CMS recently announced the ACS NSQIP Hospital Compare pilot using the three measures previously endorsed by the NQF. This pilot marks the first time hospitals across the country have the opportunity to report surgical outcomes to Hospital Compare, the CMS website that provides quality information to health care consumers. Data from the pilot will be publicly available on the CMS Hospital Compare website beginning in October 2012. The effort is part of a two-year CMS pilot program using the three measures.
Introducing the ACS Clinical Research Program of the Alliance

by Heidi Nelson, MD, FACS

In last month’s Bulletin, Monica M. Bertagnolli, MD, FACS, described how the American College of Surgeons Oncology Group (ACOSOG) recently merged with Cancer and Leukemia Group B (CALGB) and North Central Cancer Treatment Group (NCCTG) to form the Alliance for Clinical Trials in Oncology.* As Dr. Bertagnolli explained, the Alliance has five programs, including a new program known as the American College of Surgeons Clinical Research Program (ACS CRP). ACS CRP will work to reduce the impact of cancer by validating and disseminating strategies for its prevention and treatment.

The members of the ACS CRP intend to achieve their mission by increasing surgeon participation in the Alliance and by increasing meaningful interactions between the Alliance and the College’s Cancer Programs. The four committees of the ACS CRP have unique goals and activities.

- The Member Services Committee, led by Mitch Posner, MD, FACS, Chair, and Lee Wilke, MD, FACS, Vice-Chair, will engage a broad oncology community in cancer clinical trials. The committee will work with the Alliance Membership Committee to encourage ACOSOG members to join the Alliance as either members or affiliates. The committee will also work with leaders of the newly funded ACOSOG Community Clinical Oncology Program Research Base and the Commission on Cancer to recruit new surgeons and community oncologists to the Alliance. This committee will also assist in defining criteria for surgeon credentialing in trials where surgery plays a vital role, and they will conduct quality assurance and quality control activities for the Alliance. Surgeons from diverse specialties make up the Member Services Committee, thereby ensuring that surgical standards meet the broad needs of the group with respect to surgical standards.
- The Education Committee, with Henry Kuerer, MD, FACS, as Chair, and Judy Boughery, MB, BCH, FACS, as Vice-Chair, will work to reduce the time between trials reporting to practice implementation. Through a coordinated effort with both the ACS Division of Education and the Commission on Cancer’s Education Committee, this committee will implement a dissemination program that should increase awareness among clinicians of new trial findings. Programs will be developed for presentation at national meetings, such as the ACS Clinical Congress and specialty society meetings, as well as for written communication vehicles, such as the Bulletin and ACS NewsScope.

When trial results support the introduction of new technologies or techniques, the committee will work with the ACS Division of Education to make optimal use of existing infrastructures, such as the ACS Accredited Education Institutes. Coursework and text that will facilitate clinical trials participation by clinicians and allied health staff will be developed and offered to increase trial participation.

- The Cancer Care Standards Development Committee, led by James Fleshman, MD, FACS, Chair, and Leslie Kohman, MD, FACS, Vice-Chair, is charged with developing “best cancer practices” and standardizing cancer practices across the Alliance and the ACS Cancer Programs. The committee will start the process of standardization by collaborating with ACS.

Cancer Programs, including the Commission on Cancer Quality Measures Committee (CP3R). This activity will facilitate the integration of ACS standards and accreditation criteria into clinical trials and Alliance standards. One project under way is the coordination of existing ACS Cancer Program standards (including the American Joint Committee on Cancer Staging and the National Accreditation Program for Breast Centers accreditation standards); existing CALGB, NCCTG, and ACOSOG data elements; along with NCI Common Data Elements, into a single data set for the new Medidata Rave clinical trials database. This process will speed the transition of clinical trials results into practice through common language and common metrics.

The Cancer Care Standards Committee will also work closely with other ACS CRP committees to evaluate technical standards and surgical quality assurance and quality control standard operating procedures that have evolved in the context of Alliance cancer trials, with the goal of transferring these procedures into credentialing activities within ACS Cancer Programs.

- The Research Development Committee, led by Stephen Edge, MD, FACS, Chair, and Barbara Pockaj, MD, FACS, Vice-Chair, will create novel research studies on comparative effectiveness and emerging technologies. This committee will facilitate research conducted by the Alliance by providing data essential for optimal study design and accrual strategies. The primary resource for this effort will be the National Cancer Data Base (NCDB); however, these data will be supplemented as necessary with other existing data sources.

The Committee will use these sources to identify care patterns in both common and rare cancer types, which will assist in design of clinical trials and assist the Alliance in identifying institutions with case volumes that permit rapid study accrual. It is envisioned that the ACS CRP will develop unique research programs, including projects centered on comparative effectiveness research and emerging technology research. The NCDB can serve as a valuable and unique opportunity for the development of a comparative effectiveness research program and for monitoring implementation of new best practices based on clinical trial evidence from the Alliance.

The Alliance continues to gain momentum. At its inaugural meeting in Chicago, IL, in November, more than 950 attendees, representing 45 U.S. states, the District of Columbia, and two Canadian provinces, chose from more than 60 scientific sessions. Among the meeting’s most popular activities were a networking event and a poster session. The 2012 Spring Committee Meetings of the Alliance will be held March 15–17, 2012, at the Inter-Continental Chicago O’Hare in Rosemont, IL.

Take the ethical challenge on e-FACS.org

Weigh in on the latest “Ethical Challenge,” an innovative feature on e-FACS.org, the American College of Surgeons’ (ACS) members-only Web portal. This feature is intended to encourage discussion among visitors to the Ethical Issues in Surgery portal community. The latest challenge appears in the box at right.

Log in to the ACS Web portal and share your thoughts on this and other topics. Under the leadership of co-community editors Ira J. Kodner, MD, FACS, and Jason D. Keune, MD, this online forum engages Fellows on a regular basis in an online discussion of ethical issues facing practicing surgeons today. To access the Ethical Issues in Surgery community, http://efacs.org/ethicalissues.

**Ethical challenge**

At the indigent surgery clinic that you staff, a 63-year-old man with no insurance presents with complaints of a small umbilical hernia that is painful. On questioning, you learn that he has had several episodes of incarceration that have resolved without medical attention. At the initial visit to the clinic, the man noted a history of heroin use, so his urine was sent for a drug screen. The screen was positive for cocaine, so his case was canceled. He presented a second time several months later and again tested positive for cocaine. Today he presents a third time and again tests positive for cocaine. A drug rehabilitation program is not available to him, and he states that he is not able to quit using drugs. What do you do?
So, You Want to Be a Surgeon...

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

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

For further information, contact Elisabeth Davis, MA, Education Research Associate, Division of Education, at 312-202-5192, or via e-mail at edavis@facs.org.
March 31 is deadline to claim CME credit for 2011 Clinical Congress

American College of Surgeons (ACS) members who attended the 2011 Clinical Congress in San Francisco, CA, October 23–27, have until March 31, 2012, to claim their continuing medical education (CME) credits. After this date, the Division of Education's Program for the Verification of Surgical Knowledge and Skills will no longer accept CME claims for the 2011 Clinical Congress.

ACS members can go to http://efacs.org to claim CME credit online by accessing their “My CME” page; go to My CME under “Quick links,” and click on the orange button, “Claim 2011 Clinical Congress Credit” link. Forgot your username and password? The login default is your ACS membership number (username) and last name (password).

Postgraduate courses and Meet the Expert Luncheons will be posted directly to members’ transcripts in the coming weeks. Member participants will receive e-mail notification when the credits are posted to their record and will not need to file any additional claims for these courses.

For more information by e-mail, contact mycme@facs.org, or call toll-free 866-918-4799.

Trauma meetings calendar

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

- **Point/Counterpoint XXXI, Acute Care Surgery**, June 11–13, National Harbor, MD. For information, contact 757-446-8967
- **Advances in Trauma Conference**, December 7–8, Kansas City, MO
  Complete course information can be viewed online (as it becomes available) through the American College of Surgeons’ website at http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312-202-5342.

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.

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.
You’re reading articles every month in the *Journal of the American College of Surgeons*...

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Visit [http://jacscme.facs.org](http://jacscme.facs.org) for more information
College’s historical collection of rare books achieves new visibility

Few College Fellows have been aware of the Catalogue of the H. Winnett Orr Historical Collection and Other Rare Books in the Library of the American College of Surgeons, published by the American College of Surgeons (ACS) in 1960. The collection, currently housed in the special collections of the McGoogan Library of Medicine at the University of Nebraska Medical Center, Omaha, contains more than 2,000 volumes and archival materials, many extremely rare and dating from the 16th and 17th centuries.

Authors represented include such giants in the history of medicine as Andreas Vesalius, Avicenna, and Galen Claudius.

The collection also includes a significant amount of materials on orthopaedic surgery, military medicine, and the history of women physicians.

H. Winnett Orr, MD, FACS (1877-1956), one of the founders of the American College of Surgeons (ACS), specialized in orthopaedics and served in World War I, attaining the rank of lieutenant colonel. One of his early claims to fame was the highly controversial “Orr Treatment,” which referred to discharging patients from the hospital even though suppurating wounds were present. He was a prolific writer, but is best known to the College as the donor of his exquisite rare book collection on the history of medicine and surgery. He began haunting secondhand bookstores wherever he went during the war, and entered into lengthy correspondence with librarians and rare book dealers about his finds. His good friend and medical school classmate Mary McKibben-Harper, MD, an outstanding personality in her own right, collected books as well, particularly those exploring the history of women physicians. Dr. Orr encouraged her to contribute many volumes from her library to be joined with his donation to the ACS, as well as funding for the care and preservation of the collections. It is because of her generosity that the College has been able to ensure the long-term care for this magnificent collection.

Since 2009, Joint Commission Resources (JCR), an affiliate of The Joint Commission, has helped hospitals reassess their discharge processes and reduce the number of readmissions due to post-discharge adverse events with the help of Project RED (Re-Engineered Discharge). Of the 39.5 million hospital discharges per year, 19 percent of patients have a post-discharge adverse event and 20 percent of Medicare patients are readmitted within 30 days. Project RED provides new interventions and is a patient-centered, standardized approach to discharge planning and discharge education. It was initially developed through research at the Boston Medical Center, with funding from the Agency for Healthcare Research and Quality (AHRQ).

In September 2009, AHRQ awarded JCR a five-year knowledge transfer implementation contract, which has subsequently been extended through September 2012, to engage, train, and support hospitals in their participation and use of Project RED. Currently, more than 260 hospitals are using the Project RED program to assess their discharge performance, identify barriers, process breakdowns, implement the different components of RED in designated patient populations, collect new data, and use a performance improvement methodology to implement improved discharge performance. JCR’s research on the use of Project RED by hospitals has shown a decrease in required hospital use that resulted in a 30 percent overall reduction in readmissions from surgeries and other hospital care, and an average savings of $412 per patient. Project RED has also achieved recognition as a National Quality Forum Safe Practice.

Project RED’s success is generated through the elimination of barriers in patient care and education that can form during the discharge process. Many hospital readmissions are a result of a lack of clarity of discharge communications, unreconciled medications, pending testing and results, or the failure to take new prescriptions properly.

### Table 1. Project RED: 10 guiding principles

| 1. Explicit delineation of roles and responsibilities |
| 2. Discharge process initiation upon admission |
| 3. Patient education throughout hospitalization |
| 4. Timely, accurate information flow: |
| • From the primary care provider |
| • Among the hospital team |
| • Back to the primary care provider |
| 5. Complete patient discharge summary before discharge |
| 6. Comprehensive written discharge plan given to patient before discharge |
| 7. Discharge information that matches the patient’s language and literacy level |
| 8. Reinforcement of plan with patient after discharge |
| 9. Availability of case management staff outside of limited daytime hours |
| 10. Continuous quality improvement of discharge processes |

### Table 2. Critical components for patient discharge

<table>
<thead>
<tr>
<th>Critical component</th>
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<tbody>
<tr>
<td>Medication reconciliation</td>
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<tr>
<td>Reconcile discharge plan with national guidelines</td>
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<tr>
<td>Follow-up appointments</td>
</tr>
<tr>
<td>Outstanding tests</td>
</tr>
<tr>
<td>Post-discharge services</td>
</tr>
<tr>
<td>Written discharge plan</td>
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<tr>
<td>What to do if problem arises</td>
</tr>
<tr>
<td>Patient education</td>
</tr>
<tr>
<td>Assessment of patient understanding</td>
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<tr>
<td>Discharge summary sent to the primary care provider</td>
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<tr>
<td>Telephone reinforcement</td>
</tr>
</tbody>
</table>
The prescriptions many patients commonly fail to take properly and that may lead to a hospital re-admission are the antibiotics that were used to fight off a surgical site infection they were recovering from at the hospital.

The 10 guiding principles that Project RED uses to prevent these and other possible causes of readmission appear in Table 1 on page 46.

Project RED’s intervention is based on the 11 critical components for patient discharge (see Table 2, page 46).

While many of these may seem like familiar areas of focus, Project RED uses three unique factors to address these components in its intervention. The role of a discharge advocate to oversee the discharge program and coordinate the planning, the delivery of a written care plan developed specifically for the patient at discharge, and the post-discharge follow-up activities (such as follow-up appointments and a telephone call with the patient to assess any medical concerns) are the three key factors behind Project RED. For more information on Project RED, visit http://www.jcrinc.com/AHRQ-Project-Red/.

Disciplinary action taken

The following disciplinary action was taken by the Board of Regents at its October 22, 2011, meeting:

- A Fellow was admonished following charges that he violated Article VII, Section 1(f) of the Bylaws (unprofessional conduct) when he testified as an expert witness in a medical malpractice lawsuit. The basis for the charges of a Bylaws violation was a complaint that had been submitted to the College about this general surgeon, alleging that he was in violation of the suggested qualifications and guidelines for behavior set forth in Statement 8, Statement on the Physician Acting As an Expert Witness.

Definition of terms

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

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

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

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

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

Expulsion: The certificate of Fellowship and all other indicia of Membership previously issued by the College must be forthwith returned to the College. The member 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.
2013 Traveling Fellowship to Japan available

The International Relations Committee of the American College of Surgeons has announced the availability of the 2013 ACS Traveling Fellowship to Japan.

Purpose

The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America.

Basic requirements

The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

- Has a major interest and accomplishment in clinical and basic science related to surgery
- Holds a current, full-time academic appointment in Canada or the U.S.
- Is younger than 45 years of age on the date the application is filed
- Is enthusiastic, personable, and possesses good communication skills

Activities

The Traveling Fellow is required to spend a minimum of two weeks in Japan, engaging in the following activities:

- Attending and participating in the annual meeting of the Japan Surgical Society, which will be held in Fukuoka, Japan, April 11–13, 2013
- Attending the Japan ACS Chapter meeting during that congress
- Visiting at least two medical centers in Japan (located in cities other than the city where the annual meeting convenes) before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and designated representatives of the Japan Surgical Society and the ACS Japan Chapter. The surgical centers to be visited will be determined, to some extent, by the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Japan.

The spouse of the successful applicant is welcome to accompany him or her. There will be opportunities for social interaction in addition to professional activities.

Financial support

The College will provide the sum of $7,500 to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society.

The Traveling Fellow must meet all travel and living expenses. Senior Japan Surgical Society and representatives of the Japan Chapter will consult with the Fellow about the centers to be visited in Japan, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his or her own travel arrangements in North America so that reduced fares and travel packages for travel in Japan are available.

The American College of Surgeons International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested before the final selection.

Applications for this traveling fellowship may be obtained from the College’s website at http://www.facs.org/memberservices/acsjapan.html or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is June 1, 2012.

The successful applicant and an alternate will be selected and notified by November 1, 2012.
2013 Traveling Fellowship to Germany announced

The International Relations Committee of the American College of Surgeons (ACS) announces the availability of the Traveling Fellowship to Germany. The purpose of this fellowship is to encourage international exchange of surgical science, practice, and education, and to establish professional and academic collaborations and friendships. The ACS Traveling Fellow will visit Germany and, as part of the exchange program, a German Traveling Fellow will visit North America.

Basic requirements
The scholarship is available to a Fellow of the American College of Surgeons in most of the surgical specialties who meets the following requirements:

- A major interest, and accomplishment, in clinical and basic science related to surgery
- Holds a current full-time academic appointment in the U.S. or Canada
- Younger than 45 years of age on the date the application is filed
- Enthusiastic, personable, and possesses good communication skills
- Applicants possessing some German language skills are particularly encouraged

Activities
The Fellow is required to spend a minimum of two weeks in Germany and to engage in the following activities:

- Attend and participate in the annual meeting of the German Surgical Society in Munich, Germany, April 30–May 3, 2013
- Attend the German ACS Chapter meeting
- Visit at least two medical centers (other than the center in the annual meeting city) in Germany before or after the annual meeting of the German Surgical Society to lecture, and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the German Surgical Society and the German ACS Chapter. The surgical centers selected for a visit would depend, to some extent, on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Germany.

His or her spouse is welcome to accompany the chosen applicant. There will be many opportunities for social interaction, in addition to professional activities.

Financial support
The College will provide $6,000 to the chosen applicant, who will also be exempted from registration fees for the annual meeting of the German Surgical Society.

He or she must meet all travel and living expenses. Senior German Surgical Society and ACS German Chapter representatives will consult with the Fellow about the centers to be visited in Germany, the local arrangements for each center, and other advice and recommendations regarding travel schedules. The Fellow is urged to make his or her own travel arrangements in North America, due to the likely availability of reduced fares and travel packages for travel in Germany.

The ACS International Relations Committee will select the Fellow after reviewing and evaluating the final applications. A personal interview may be requested prior to the final selection.

Applications for this traveling fellowship may be obtained from the College’s website, http://www.facs.org/memberservices/acsgermany.html, or by writing to the International Liaison, American College of Surgeons, 633 N. Saint Clair Street, Chicago, IL 60611-3211.

The closing date for receipt of completed applications and all supporting documents is April 1, 2012. The successful applicant, and an alternate, will be selected and notified by July 31, 2012.
Banking activities date back to the second millennium BC, when the Code of Hammurabi (one of the earliest known formal laws) contained written standards of practice relating to financial transactions. Ancient Egypt also had banking arrangements that related to grain harvests and storage. Although these early transactions pertained to deposits of cattle, grain, and, later, precious metals, the concepts are somewhat similar to today’s banking system of financial deposits and withdrawals.

Modern-day banking practices can be traced back to the medieval Italian cities of Venice, Florence, and Genoa. The most famous medieval bank was the Medici bank of Giovanni Medici, which was founded in 1397. Medici’s business started out as a green-covered table in a marketplace before he moved it to a hall in his large palace. The Medici bank subsequently became the banker for the Pope of the Catholic church. Over the next several centuries, both the Dutch and the British refined the Italian banking techniques. Within five years of the Declaration of Independence, the first U.S. bank was chartered in Philadelphia.1

How does banking relate to trauma? The National Trauma Data Bank®, the largest aggregation of U.S. and Canadian trauma registry data ever assembled, acts like a bank. Data are submitted (deposited) by trauma centers and data requests (withdrawals), including data for the Annual Report, are performed.

Another bank that plays a prominent role in the care of the injured patient is the blood bank. Milestones for blood and transfusion therapy began in 1628 when
William Harvey, a British physician, discovered the circulation of blood. Shortly after that, the first blood transfusion was attempted. Richard Lower, an English physician, performed the first successful transfusion in 1655 when he kept a dog alive by direct transfusion from another dog. In 1667, occurrences of sheep-to-human transfusions were reported in France and England. In 1818, James Blundell, MD, a British obstetrician, performed the first successful transfusion of human blood for a case of postpartum hemorrhage.

At the start of the 20th century, Austrian physician Karl Landsteiner, MD, discovered the first three human blood groups. Then, 75 years ago this month, on March 15, 1937, Bernard Fantus, MD, director of therapeutics at Cook County Hospital in Chicago, IL (and the great and great-great uncle to the authors of this article), opened the first large-scale, U.S. hospital-based blood bank. His 1937 landmark article titled “The Therapy of the Cook County Hospital” described his oversight of collection, storage, and indications for transfusions. Dr. Fantus is also credited with coining the term “blood bank” and with being the first blood bank and transfusion service medical director. In only a matter of a few years, community and hospital blood banks sprang up across the U.S.

By 1950, there were 1,500 hospital blood banks, 46 community blood centers, and 31 American Red Cross regional blood centers in the U.S. The collection, banking, and transfusion of blood skyrocketed over the next several decades. Today, according to the Red Cross U.S. blood facts and statistics from 2006, someone needs blood every two seconds, 38,000 blood donations are needed every day, and 30 million blood components were transfused in 2006. There were 16 million blood donations in the U.S. that year. In order to examine the occurrence of blood use in the NTDB research dataset 2010, admissions records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure code 99.04 (transfusion of packed cells). A total of 39,154 records matched the procedure code. In all, 37,569 records contained a hospital discharge status, including 12,048 discharged to home, 9,821 to acute care/rehab, and 10,928 sent to skilled nursing facilities; 4,772 died.

These patients were 56 percent male, on average 54.8 years of age, had an average hospital length of stay of 14.2 days, an average intensive care unit length of stay of 10.2 days, were on the ventilator for an average of 9.8 days, and had an average injury severity score of 18.2. The increase in severity of this group as compared with past analyses is also represented in that their emergency department disposition included one-third going to the intensive care unit and more than 28 percent going directly to the operating room (see Figures 1 and 2, page 50).

Blood was a rare commodity in the early 1930s and experimental use of cadaver blood for transfusion was not going to meet the needs of a growing Cook County. How do you get people to donate their blood before it is actually needed? Dr. Fantus took a concept and coined a term that has held a prominent place in the medical vocabulary of the past nine decades. At a time when people did not have much money to put in a bank, they did have a precious resource that they were able to share with their loved ones. Family members and friends of hospitalized patients could preemptively deposit units of blood, and the patient could withdraw blood if the need arose.

The Cook County Hospital blood bank, like any bank, had accounts with ledger sheets that tracked credits (deposits) and debits (withdrawals). Millions of individuals worldwide, from every ethnicity, race, and social class, have benefited from the prompt availability of banked blood. Banking may have been around since 2,000 BC, but it is the last 75 years of banking that have saved countless lives across the globe.

Throughout the year, we will be highlighting data through brief reports that can be found monthly in the Bulletin. The NTDB Annual Report 2011 is available on the ACS website as a PDF file and 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.

References

1. A Brief History of Banking. Available at: http://people.brandeis.edu


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.

Mr. Richard Fantus is a second-year medical student at Baylor College of Medicine in Houston, TX.

Mr. Robert Fantus is a senior pre-med biology major at DePauw University, Greencastle, IN.