LEADERSHIP SKILLS in the OR
FEATURES

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On the cover: In order to successfully lead a surgical team in the operating room environment, as well as to function well in professional life, surgeons need to develop an important nontechnical skill set of leadership principles (see article, page 8).
NEWS

Inspiring Quality health care forum in San Diego: Quality improvement programs increase health care value

General Surgery Coding workshops planned for remainder of 2012

Dr. Fogarty inducted as first NAI fellow

Trauma meetings calendar

Dr. Hughes named rural health care practitioner of the year

ACS Clinical Research Program: A paradigm shift in rectal cancer treatment: The PROSPECT trial

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Report on ACSPA/ACS activities, February 2012

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Third annual WIS international symposium approaches

Outstanding achievement award granted to 106 CoC facilities

2012 COT Residents Trauma Papers Competition winners announced

From the Archives: Do you recognize the people in this photo from the 1959 Clinical Congress?

IRC announces two new travel awards for 2013

International Guest Scholarships available for 2013

2012 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship available

ACS offers international scholarships for surgical education, training

Correction notice

NTDB® data points: Call a cab

Richard J. Fantus, MD, FACS

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

The opening of the 2012 Clinical Congress will herald the beginning of the American College of Surgeons’ (ACS) centennial celebration, and the observation of this important landmark will conclude at the close of the 2013 Clinical Congress. Over the course of the year between, the ACS will be offering an array of products, services, and activities to honor this organization’s rich history.

For example, we are publishing a hardbound book written by David L. Nahrwold, MD, FACS, and Peter J. Kernahan, MD, PhD, FACS, titled *A Century of Surgeons and Surgery: The American College of Surgeons*, which profiles some of the outstanding Fellows who have populated this Fellowship and highlights the more significant contributions the College has made to patient care. The authors worked closely with the ACS Archivist Susan Rishworth for several years to compile this fascinating and visually stunning collection of stories and images. Meanwhile, a free high-gloss tribute to the major achievements in the surgical specialties over the last 100 years will be given to all Clinical Congress attendees. Commemorative items, such as mugs, lapel pins, and so on, will be available for purchase. You will be reading and hearing a great deal more about the centennial activities in the surgical specialties over the last 100 years will be given to all Clinical Congress attendees. Commemorative items, such as mugs, lapel pins, and so on, will be available for purchase. You will be reading and hearing a great deal more about the centennial activities in the months to come, and the College’s leadership and staff are all looking forward to celebrating this important milestone.

As we reflect on the College’s 100th anniversary, I thought it would be interesting to also look back at what was going on in the world in 1912–1913.

As we reflect on the College’s 100th anniversary, I thought it would be interesting to also look back at what was going on in the world in 1912–1913.*  

I hope you find this summary enlightening and entertaining, and I look forward to joining all of you in our 100-year anniversary celebration.

### September 30 to December 31, 1912

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 8</td>
<td>First Balkan War begins as Montenegro declares war on Turkey</td>
</tr>
<tr>
<td>October 14</td>
<td>Former President Theodore Roosevelt (Prog/Bull Moose) shot in Milwaukee, WI, while campaigning to reclaim the White House</td>
</tr>
</tbody>
</table>

*The information in this column was derived from a number of online sources, including History Orb and Wikipedia.

### January 1 to March 31, 2013

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>Post office begins parcel post deliveries</td>
</tr>
<tr>
<td>January 11</td>
<td>First sedan car (Hudson) goes on display at the 13th Auto Show in New York, NY</td>
</tr>
<tr>
<td>January 26</td>
<td>Versatile athlete Jim Thorpe relinquishes his 1912 Olympic gold medals in track and field so he can go pro; on February 2, he signs with the New York Giants football team</td>
</tr>
</tbody>
</table>
### February
- **February 2**: New York City’s Grand Central Terminal opens
- **February 9–18**: The Mexican Revolution’s 10-Day Tragedy of Mexico City takes place, ending in 3,000 deaths and Gen. V. Huerta’s ascension to the presidency
- **February 19**: First prize inserted into a Cracker Jack box
- **March 4**: Woodrow Wilson inaugurated as 28th U.S. President
- **March 14**: John D. Rockefeller seeks to establish Rockefeller Foundation with $100 million endowment
- **March 15**: President Wilson holds first U.S. press conference
- **March 18**: King George I of Greece is assassinated
- **March 21–26**: Statewide flooding in Ohio kills more than 400 people

### April 1 to June 30, 1913

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 10</td>
<td>Washington Senators pitcher Walter Johnson begins string of 56 consecutive scoreless innings</td>
</tr>
<tr>
<td>April 21</td>
<td>German passenger ship <em>Imperator</em> runs aground</td>
</tr>
<tr>
<td>April 29</td>
<td>Gideon Sundback of Sweden patents the modern-day zipper</td>
</tr>
<tr>
<td>May 1</td>
<td><em>Ladies Home Journal</em> publishes “What can we do about cancer?”—an article believed to have revolutionized the public’s understanding of the disease</td>
</tr>
<tr>
<td>May 7</td>
<td>British House of Commons rejects woman’s right to vote</td>
</tr>
<tr>
<td>May 13</td>
<td>Igor Sikorsky flies his newly designed four-engine airplane</td>
</tr>
<tr>
<td>May 30</td>
<td>First Balkan War ends with signing of the Treaty of London</td>
</tr>
<tr>
<td>May 31</td>
<td>Ratification of the 17th Amendment to the U.S. Constitution requiring direct election of senators</td>
</tr>
<tr>
<td>June 2</td>
<td>Newly formed U.S. Department of Labor mediates first strike settlement in a case involving railroad clerks</td>
</tr>
<tr>
<td>June 16</td>
<td>South African Parliament passes law forbidding blacks from owning land</td>
</tr>
<tr>
<td>June 21</td>
<td>Georgia “Tiny” Broadwick is first woman to parachute from a plane</td>
</tr>
<tr>
<td>June 25–July 3</td>
<td>Union and Confederate veterans of the Civil War participate in the Great Reunion of 1913</td>
</tr>
<tr>
<td>June 29–30</td>
<td>Second Balkan War begins</td>
</tr>
</tbody>
</table>

### July 1 to October 6, 1913

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 10</td>
<td>Death Valley, CA, hits 134° Fahrenheit—the highest recorded temperature in the U.S.</td>
</tr>
<tr>
<td>July 3</td>
<td>Common tern banded in Maine, later found dead in 1919 in Africa, making it the first known bird to have crossed the Atlantic Ocean</td>
</tr>
<tr>
<td>July 19</td>
<td><em>Billboard</em> publishes its first list of “Last Week’s Best Sellers among Popular Songs,” with “Malinda’s Wedding Day” by Fletcher Henderson topping the charts</td>
</tr>
<tr>
<td>August 3</td>
<td>Wheatland Hop Riot takes place at the Durst Ranch in Wheatland, CA, which was embroiled in an agricultural workers’ strike</td>
</tr>
<tr>
<td>August 10</td>
<td>Treaty of Bucharest signed, signaling the end of the Second Balkan War</td>
</tr>
<tr>
<td>August 13</td>
<td>Harry Brearley produces the first piece of stainless steel in Sheffield, England</td>
</tr>
<tr>
<td>August 27</td>
<td>LT Peter Nestrov of the Imperial Russian Air Service performs the first recorded aerobatic maneuver—a single loop</td>
</tr>
<tr>
<td>September 9</td>
<td>Association for the Study of Negro Life &amp; History organizes in Chicago, IL; becomes formally established two years later</td>
</tr>
<tr>
<td>September 10</td>
<td>Lincoln Highway opens as first paved coast-to-coast highway</td>
</tr>
<tr>
<td>September 14</td>
<td>Larry Cheney of the Chicago Cubs pitches a record 14-hit shutout against the New York Giants</td>
</tr>
<tr>
<td>September 22</td>
<td>Dawson, NM, coal mine explosion kills 263</td>
</tr>
<tr>
<td>October 3</td>
<td>President Wilson signs the Revenue Act of 1913, which formally reinstates a federal income tax</td>
</tr>
</tbody>
</table>

![Signature]

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.
The Centers for Medicare & Medicaid Services (CMS) Electronic Prescribing, or eRx, Incentive Program was authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). CMS defines e-prescribing as “the ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point-of-care.” Eligible professionals (EPs) who successfully e-prescribe in 2012 can qualify for an incentive payment of 1.0 percent.

What are the incentives and penalties under the eRx program?

Table 1 on this page shows both the incentives and penalties for each year starting from 2012.

What do I need to do to qualify for the 2012 eRx bonus?

To qualify for the 2012 eRx payment incentive of 1.0 percent, EPs must report electronically 25 times from January 1 to December 31, 2012, for denominator eligible visits (see Table 2 on this page for the eligible denominator codes).

What steps should I take to avoid the 2013 penalties for nonparticipation?

To avoid the 2013 eRx payment penalty of 1.5 percent of the Medicare Part B physician fee schedule amount for covered professional services, EPs must meet the following criteria:

- Have already reported prescriptions electronically 25 times from January 1 to December 31, 2011, for denominator eligible visits.
- Report prescriptions electronically 10 times from January 1 to June 30, 2012, for any visit (which does not have to be associated with a denominator eligible code).
- Apply for a significant hardship exemption to avoid the 2013 eRx penalty. The required form is available on the quality reporting communication Part.

Table 1. Incentives and penalties under the eRx program

<table>
<thead>
<tr>
<th>Year</th>
<th>Incentive</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>2013</td>
<td>0.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>N/A</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Table 2. eRx measure denominator codes (eligible)

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 9202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

Table 3. Hardship exemptions available for 2013

| Inability to electronically prescribe due to state or federal law, or local law or regulation |
| The EP prescribes fewer than 100 prescriptions during a six-month payment adjustment reporting period |
| The EP practices in a rural area without sufficient high-speed Internet access (G8642) |
| The EP practices in an area without sufficient available pharmacies for electronic prescribing (G8643) |
support page, which can be found on the CMS website at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234. Refer to Table 3 on page 6 for the hardship exemptions available for 2013. In addition, visit the ACS eRx website at http://www.facs.org/ahp/erx-exemption.pdf for step-by-step instructions on how to apply for hardship exemptions.

- Be automatically exempt from the eRx Incentive Program. An EP will be automatically exempt from the 2013 eRx Incentive Program penalty if:
  — The EP is a successful electronic prescriber during the 2011 eRx 12-month reporting period of January 1 to December 31, 2011.
  — The EP is not a MD, Doctor of Osteopathic Medicine (DO), podiatrist, nurse practitioner, or physician assistant by June 30, 2012.
  — The EP does not have at least 100 Medicare Part B physician fee schedule cases containing an encounter code in the measure's denominator for dates of service from January 1 to December 30, 2012. Refer to Table 2 for eligible denominators codes.
- At least 10 percent or more of the EP’s Medicare Part B physician fee schedule charges are not from codes in the denominator of the measure for dates of service from January 1 to June 30, 2012 (refer to Table 2 for eligible denominator codes).
- The EP does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1 to June 30, 2012.

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

To avoid the 2014 eRx payment penalty of 2.0 percent of the Medicare Part B physician fee schedule amount for covered professional services:
- Report electronically 25 times for denominator eligible visits from January 1 to December 31, 2012. Refer to Table 2 for denominator eligible codes.
- Report electronically at least 10 times from January 1 to June 30, 2013, for any visit (does not have to be associated with a denominator eligible code).

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

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

Ms. Gokak is Quality Associate, Regulatory Affairs, Division of Advocacy and Health Policy, Washington, DC.
LEADERSHIP SKILLS in the OR

Part I:
Communication helps surgeons avoid pitfalls

by
Amy L. Halverson, MD, FACS;
Danielle Saunders Walsh, MD, FACS;
and Layton Rikkers, MD, FACS
The OR is a unique environment that, although often rewarding, can become exceedingly challenging for any surgeon. The successful completion of an operation depends on the execution of a series of steps—each of which may be dependent on equipment as well as on the coordinated efforts of the surgical team. It is the surgeon’s responsibility to lead the team. Although most surgeons recognize good leaders and appreciate the importance of leadership, knowing how to develop leadership skills may be less clear. Surgical atlases provide step-by-step guides to the technical aspects of performing an operation; however, nontechnical skills are not so easily broken down into components that can be practiced and mastered.

This article is intended to offer a reflection on leadership skills pertinent to the OR environment. Many of the suggestions here may appear to the reader to be based in the development of basic good manners and even-tempered behavior. While that deduction may be somewhat true, the stresses of the OR environment can override the best of manners and the kindliest of dispositions. The basic leadership skills presented here are intended to optimize the surgeon’s role by emphasizing the importance of the nontechnical performance aspects of operations.

**Principles of surgical leadership**

Basic principles of leadership transcend the OR and are important in all aspects of a surgeon’s professional life. The first step in building leadership skills is to recognize one’s own strengths and weaknesses. Leadership may be separated into two components: self-management and team management. Self-management begins with emotional intelligence. Emotional intelligence may be thought of as the ability to manage ourselves and our relationships. For some people, mastering one’s emotions and understanding how best to respond to others may come naturally. For others, it takes time and patience to become adept at these skills.

Psychologist Daniel Goleman, PhD, asserts that emotional intelligence consists of four domains:

- **Self-awareness**—the ability to read one’s own emotions and recognize their impact
- **Self-management**—the ability to control one’s emotions and impulses and adapt to changing circumstances
- **Social awareness**—the ability to sense, understand, and react to other people’s emotions
- **Social skills**—the ability to inspire others with a compelling vision and to help others develop by offering feedback and guidance

Communication is an essential social skill that requires both listening and sending clear messages, according to Dr. Goleman, and conflict resolution can also be defined as a social skill that includes reducing conflict and facilitating resolutions, as well as promoting cooperation among team members.

**Leadership styles**

In the book *Primal Leadership*, Dr. Goleman and colleagues describe six leadership styles: authoritative, coaching, affiliative, democratic, pacesetting, and commanding. Multiple leadership styles are necessary for success and should be used according to specific circumstances. The following is a list of leadership styles as described by Dr. Goleman and colleagues:

- An **authoritative** leader inspires people by focusing on long-term goals. By listening to others, the leader articulates goals for the group and builds support.
- **Coaching**, or mentoring, involves delegating responsibility to other individuals as appropriate to their role. An effective coaching leader helps individuals assess their own strengths and weaknesses and set their own performance goals. The coach guides others in finding additional information and resources.
- The **affiliative** leader creates a safe, supportive environment that addresses other’s emotional needs. This style builds team harmony, boosts morale, and engenders loyalty. The affiliative leader typically offers ample positive feedback.
- A **democratic** leader obtains input from others in the group. Encouraging input from others stimulates new ideas and increases participation. The democratic style encourages buy-in and builds trust and respect.
• The leader who uses the pacesetting style sets high performance standards and exemplifies them. Weak performers are expected to improve or be prepared to be replaced. This style is most effective with a team of highly talented and motivated individuals. The risk of the pacesetting style is that it can compromise morale.

• The commanding leader articulates the goals of the group and expects immediate compliance. While input from others may be encouraged, the leader maintains the ultimate authority. This leadership style is effective in a crisis situation.

Improving leadership skills starts with creating a mental image of the ideal leader one aspires to be. This involves reflecting on one’s core beliefs and priorities. The leader must ascertain how others perceive him or her. It requires self-reflection, listening skills, and the willingness to solicit and receive feedback. It may require resetting one’s self-perception. An aspiring leader must then compare the “ideal self” with the “real self” to recognize strengths and opportunities for improvement. The next steps involve setting goals to build on strengths and improve in areas where one needs to be more effective. Like the development of technical skills, the cultivation of leadership skills requires deliberate practice. Personal growth will be enhanced by fostering relationships that are trusting and supportive.

Team management

Another essential component of leadership is team management. Much of what we understand about how teams function stems from studies of teamwork and communication among cockpit crew members. Detailed reviews of several aviation catastrophes revealed a common element: the crew’s failure to communicate and coordinate actions effectively. In response, airlines adopted a curriculum that included fostering skills such as team-building, situational awareness, briefing strategies, and stress management. A key principle of this training is the need to flatten the hierarchy so that each individual feels empowered to speak up when a question arises.

Surgery and aviation are similar in their potential for high stress, time pressures, dependence on properly functioning equipment, and a historically rigid hierarchy. In a 2000 survey comparing attitudes and performance of cockpit crews and OR teams, expert observers rated surgery team performance inferior to that of cockpit crews. The perceptions of poor teamwork were shared among the nonsurgeon OR team members. In contrast, the surgeon’s perception of the teamwork and communication was disproportionately high. This finding is important because the study demonstrated that surgeons may not recognize when their communication skills are lacking. Additionally, when questioned about factors that contribute to team performance, 95 percent of pilots and only 55 percent of surgeons rejected hierarchies.

Failures in teamwork and communication have been correlated with increased surgical errors and flow disruptions. Institutions that have implemented a formal team-training curriculum for OR personnel have increased efficiency, reduced errors, and improved staff satisfaction. Using adaptations of the aviation industry’s crew resource management program, the Department of Veterans Affairs initiated a medical team training program aimed at minimizing risk and improving patient safety. Risk-adjusted surgical morbidity declined 15 percent at the 74 hospitals with the medical team training program, compared with a decline of 10 percent in the 34 control hospitals. Other institutions have observed similar improved clinical outcomes after introduction of a team training curriculum.
intraoperative crisis from a sentinel event that occurred on August 5, 1949, and went on to revolutionize the way firefighters are trained to handle disaster. The following is a description of that event.

A seemingly routine forest fire was spotted in Montana’s Helena National Forest at Mann Gulch, and 15 randomly selected members of the recently developed “smokejumpers” parachuted in for containment. Their assigned leader, Wag Dodge, was considered a good fireman, but was a “man of few words” and tended to quietly go about his business, assuming others would follow his stride.

On arrival, Mr. Dodge’s initial take was that the fire was routine, and he proceeded to eat dinner. The rest of the team took their cues from him and a relaxed atmosphere, including the taking of photographs, was established as they began digging trenches to control the fire.

Shortly thereafter, Mr. Dodge sensed the fire was changing and ordered the men to head downhill into the gulch toward the river, his intended escape route. Partway down the hill his tenor changed a second time. He suddenly ordered his men to drop their tools and run. To his inexperienced team, this was extraordinarily confusing, as he was ordering them to drop the very instruments they used to fight fire. They hesitated until they saw the fire rapidly rise above a hidden ridge, cutting them off from the escape route. By the time they started running back up hill (some with tools still in hand), the fire was moving at breakneck speed. Mr. Dodge then confused them again. He stopped running, took out a match, and started burning the ground around him. He yelled for the team to do the same and join him on the burned grass. Again, this made no sense to the crew. There was a raging fire gaining on them and he was lighting a second fire. Their leader had lost credibility, and none of the team followed his command.

Of the 14 crew, two survived by sliding into a rocky crevice, and 12 died, unable to outrun the flames. Mr. Dodge also survived. By setting the area of grass around him on fire, he eliminated the fuel source for the approaching forest fire—the first documented use of an “escape fire.” He laid down in the center of this burned grass, and the raging fire passed around him, leaving Dodge unharmed.

Airline pilots use a preflight checklist to facilitate communication. The purpose of the checklist is to convey information so that each pilot has a shared understanding of the situation and to ensure that no detail is overlooked. Implementation of a preoperative briefing using a checklist facilitates the sharing of information by empowering junior members to speak up and training senior members to listen. The use of a preoperative briefing has been shown to improve team performance in the OR. DeFontes and colleagues reported fewer errors, improved staff satisfaction, and decreased nurse turnover. Subsequent studies have reported improved culture and efficiency after implementation of a preoperative briefing. While these tools may initially seem artificial or contrived, they may be of great value when introduced intelligently and when supported consistently.

Leadership during crises

Firefighting is a long-standing, respected profession dedicated to managing crises and casualties on a daily basis, often at risk of great personal harm. Surgeons can learn much about the skills required for handling
decision making. Secondly, the true intraoperative crisis creates an environment requiring advanced technical, communication, and leadership skills. And finally, team dynamics play a fundamental role in the successful management of emergencies.

In retrospect, Mr. Dodge erroneously set a casual tone at the Mann Gulch fire, which was difficult to overcome once the situation changed. In addition, he communicated poorly, particularly considering that he had never worked with the team he was about to lead. He could not realistically have expected others to follow him in the confusion of the crisis, and yet he did. How often do surgeons find themselves in similar positions?

Contributing factors

A true OR crisis is unexpected, constitutes a threat to the patient, and necessitates critical steps be taken in a short time frame. Difference in expected pathology, problems with equipment or technology, and errors of communication can all conspire to create a surgical crisis. Rarely is a lack of intelligence or malfeasance on the part of the surgical professional the cause of the problem. Studies of critical decision making in medicine and other industries suggest other factors, often unknown, at play. For example, the “sunk cost effect” is the tendency to make decisions based on what has already been invested in an endeavor. We already scheduled the OR time, the patient and his caregiver already took the day off of work, or the instruments and implant have already been opened, but the patient is found to have a wet cough when seen in preoperative holding by anesthesia. Are we proceeding because it is the right thing to do for the patient or because of the time, money, and effort already invested in the case?

Surgeons may also fall victim to biases, such as the anchoring bias, which involves a failure to adjust to changes in the initial assessment. In instances involving the confirmation bias, surgeons filter the data available to support continuing the current management and exclude data that promotes a change. In cases of an availability bias, an individual’s most recent experience becomes the basis for decision making without recourse to a more comprehensive data review, which might include similar, if less recent, events. Of course, not all biases are bad. In fact, some biases may help health care professionals recover from unfamiliar critical situations. Nevertheless, it is important to become aware of prevailing biases, dysfunctional references, and confounding circumstances when complications and other problems are reviewed. Errors in leadership should be identified, characterized, and studied in order to encourage improved decision making in the future.

As educator Michael Roberto said, “We want to believe that the failure of others is due to lack of intelligence or skill because we want to convince ourselves that we would succeed at a similar endeavor despite the obvious risks, when, in fact, most of the mistakes are cognitive traps, independent of intellect or expertise.”

Effective communication is key

As leaders, surgeons need to set the tone in the OR. We need to strike a balance between being so serious that we all are on edge and so relaxed that focus is lost. Communication is critical and should occur preoperatively, intraoperatively, and postoperatively. An amazing amount of crisis prevention can be accomplished by discussing the preoperative plan with the team. For example, anesthesia can have the right lines, medications, and backup plans in place, and nurses can pull additional equipment for the just-in-case scenarios. Perhaps most importantly, residents and assistants can better understand how to help the surgeon in a way that averts trouble before it starts.

Communication during a crisis requires a unique skill set, and outcomes may be dependent on it. It is important for health care professionals to learn to escalate urgency without increasing emotion. Communication should be precise and focused, but not laconic. It may be useful to deploy communications tools, such as SBAR, which stands for discussion of the situation, background, assessment, and recommendation. It is often a good idea to soften language by saying “I need” or “we need,” instead of the more accusatory “you need.” Using polite speech—including saying “please” and “thank you”—is also helpful. One should avoid creating a hostile atmosphere. Never hurl accusations in the heat of the moment or insult others. Exaggeration, imprecation, and the use of inflammatory language serve no function. In contrasts, calls for help—including to nurses, anesthesiologists, technical support, and even to another experienced surgeon—for assistance, advice, and support, are always worth considering. Crises are often best managed with good help and good counsel.

Delegating in times of crisis also requires leadership skills. It is essential for the surgeon to assign
...It is important for the surgeon to hear the other perspective, acknowledge it, and understand the intent, even if the surgeon decides to ask all to ‘fly in formation.’

...It is important for the surgeon to hear the other perspective, acknowledge it, and understand the intent, even if the surgeon decides to ask all to ‘fly in formation.’

The American College of Surgeons’ closed claims study found 19.8 percent of sentinel events were due largely to communication errors. Likewise, The Joint Commission has identified communication failure as a common contributing factor to operative and postoperative sentinel events. The importance of constant, effective communication cannot be overemphasized, as details and data obvious to the surgeon may not be visible or obvious to other personnel.

Conclusion

The tragedy at Mann Gulch provided the impetus to revolutionize the way forest fires are fought and, more importantly, how firefighters are trained. Standards for decision making and communication were created, team training was initiated, and mortality rates in wildfires diminished markedly.

While team training for surgical teams remains in its early stages, it holds tremendous potential for improving outcomes. The details differ, but the principles remain the same. Individual surgeons have the opportunity and the responsibility to guide other team members to adopt practices that optimize team performance. Changes in how we assess critical decision making, how we communicate through crises, and how we prepare as surgical teams all hold potential for improving patient safety.

Fundamental leadership skills include listening, sharing information, and supporting an esprit de corps. Effective listening is an active process that requires focus and deep attention. One must remain attuned to body language and tone that may communicate unspoken meaning. Listening with respect includes not interrupting and maintaining eye contact.

It is the responsibility of a leader to gather, note, and articulate the goals of a group and provide information that allows all team members to have a shared understanding. An effective leader establishes an environment in which other team members are motivated, feel a responsibility to the entire team, and feel comfortable speaking up to share relevant information. Establishing trust and respect will promote optimal teamwork during the daily routine as well as during critical moments.

Good leaders praise in public and deal with misbehavior in private. They make the effort to learn the names of individuals with whom they are working. Finally, one of the most important responsibilities of the leader is to say, “Thank you.”

Acknowledgement

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Physician leadership and the future of surgical practice

by Stefan W. Leichtle, MD, and Charles W. Hartin, Jr., MD
The practice environment for current and future surgeons is changing dramatically. Among the most prominent changes is a shift from independent private practices to large, integrated health care organizations, in which surgeons practice as employees. Whereas some surgeons see new opportunities in this integrated model, others fear it will lead to a loss of autonomy and a weakening of the physician-patient relationship.

The topic, “What Is the Future of Surgery: Autonomous Professionals or Stuck as Employees?” was debated at the 2011 Clinical Congress of the American College of Surgeons’ Resident and Associate Society (RAS-ACS) Symposium in San Francisco, CA. With both sides represented, the audience was presented with important facts and strong opinions in support of physicians practicing as either independent providers or as hospital employees. Following is a summary of the opinions offered during the debate, as well as a further exploration of the topic.

2011 RAS debate

Philip R. Corvo, MD, FACS, assistant professor of surgery at Columbia University, New York, NY, and surgeon at Stamford (CT) Hospital, moderated the debate on the topic of autonomy or employment, which involved four invited discussants.

Demetrius Litwin, MD, the Harry M. Haidak Distinguished Professor and chairman of the department of surgery at the University of Massachusetts, Worcester, concluded that “employment works,” based on his personal experience. He emphasized that surgeons can have a significant influence in health care organizations and actively shape the future of health care provision in general if they are willing to accept leadership roles.

Supporting Dr. Litwin’s position was the RAS essay competition winner, Kerianne H. Quanstrum Holman, MD, from the University of Michigan, Ann Arbor. Dr. Quanstrum challenged the audience to actively participate in shaping the future of health care. “Whether we like it or not, we are likely to be employees of integrated health care systems in the future. But whether we are ‘stuck’ in this position, or operating as respected and collaborative members of the same, is up to us,” she concluded.

Robert C. Moesinger, MD, FACS, adjunct assistant professor in the department of surgery at the University of Utah, Salt Lake City, spoke in favor of surgeons as autonomous professionals. He reported his experience as an independent provider within an integrated health care system in Utah, and asserted that continuity of care and a closer physician-patient relationship are major benefits of the private practice model.

RAS essay competition winner Ronald D. Collier, MD, from the University of Toledo, OH, supported Dr. Moesinger’s position on the basis of his extensive personal experience in health care policy. He emphasized that “physicians must be more active in the health care system.” They need to “advocate for patients,” to “actively participate in the creation of health care law and policy,” and to “demonstrate the long-term benefits of improved treatment beyond the short-term costs.”

The lively debate was followed by questions from the audience, many from senior residents and fellows facing the difficult decision of whether to join a large health care organization as an employee, or to commence a career as a private practitioner. These practical questions underscored the importance and timeliness of the topic.

Throughout the discussion, it became apparent that despite their differing opinions about practice and reimbursement systems, all participants shared a common goal: to ensure that our nation’s health care system will continue to provide high-quality care to all patients. All speakers agreed on the magnitude and significance of the current changes in the health care system, and emphasized that physicians have to be more active and vocal in the health care reform debate. This includes the willingness to actively shape the future of health care provision through leadership.

A time of change

Health care is undergoing a “quiet revolution.”1 Large health care networks with physicians as employees increasingly replace small group or solo practices managed by independent providers. This trend has been fostered by current developments in health care policy, medical innovation, and changing attitudes toward resident training and physician lifestyle. Whereas medical specialties seem to be the most affected, this trend has not spared the surgical community, and surgeons—whose identity as autonomous entrepreneurs is anchored deeply in history—are divided as to whether to struggle against the feared loss of independence or to em-
brace the opportunities that employment at large institutions may afford.2,4

The majority of today’s graduates start their careers burdened by overwhelming debt from ever-rising medical school tuition. Nearly 80 percent of all general surgery residents pursue fellowships after their five-to-seven-year residency, thus spending even more time in training.5 After training has been completed, the prospect of starting or joining a modern private practice, which requires a substantial investment of time and money, can seem daunting and quickly become a life-long commitment with limited profitability. Conversely, a salaried position may offer relative financial security, require less commitment, and provide more flexibility with regard to changes in career or location, thus making it an attractive financial option for surgeons early in their career.

Political challenges

Additional concerns, particularly among newly trained surgeons, include the increasing quantity and complexity of administrative and legislative challenges physicians are facing today. Practicing as an independent provider not only requires accounting and entrepreneurial skills, but also means more direct exposure to the consequences of legal and political decision making.

Expensive medical liability insurance coverage and the cost of practicing defensive medicine, exacerbated by the government’s failure to address tort reform, illustrate the legal risks and costs that individual surgeons bear. Surgeons in solo or small group practices are often at a disadvantage because of their focus on clinical practice rather than political advocacy and lobbying. Insurance companies, device manufacturers, and pharmaceutical companies, on the other hand, are well-versed in the means necessary to pursue their political agendas.6 Physicians in large health care organizations may be offered some degree of protection from liability costs and political representation. It remains to be seen, however, if the increased influence of large health care institutions and accountable care organizations will be of benefit to the individual physician.7

The increased power of health care organizations or larger physician groups may also influence negotiations about payment and reimbursement. The movement toward bundled payments, which would provide a predetermined sum to providers based on a given diagnosis, is being driven by the desire to increase value—for example, improving care and lowering costs.8 Large health care organizations may be more effective than individual surgeons or small group practices when it comes to negotiating these types of payment systems with Medicare and other insurers. This increase in market power, however, might come at the price of higher fees and inhibition of competition. Reports from several parts of the country raise concerns that large, powerful health care organizations may not convey cost savings to patients and payors.9 Furthermore, questions regarding whether measures such as care coordination, integration, and capitation translate into significant cost reductions have been ongoing.10 As an example, the recent results of the Centers for Medicare & Medicaid Services’ (CMS) Physician Group Practice Demonstration project have been interpreted very positively by the CMS, but more critically by others.11

Value-driven care

Improved value and patient outcomes are also the rationale for several of the more recent developments in the health care sector, including best practice guidelines, the maintenance of outcomes databases, and initiatives to coordinate and bundle patient care, among others. These measures have received significant attention from insurance companies and the government. In fact, the 2010 Medicare Improvement
for Patients and Providers Act sets a mandatory time frame for physicians to comply with certain electronic medical record requirements or face penalties.\textsuperscript{12}

Indeed, participation in quality initiatives like the ACS National Surgical Quality Improvement Program (ACS NSQIP\textsuperscript{®}) can improve patient outcomes and has the potential to lower costs over time.\textsuperscript{13,14} Implementing many of these quality initiatives, however, is a costly endeavor and may be difficult or impossible for a solo or small group practice. Subsequently, these concepts are more likely to be implemented in large group practices and health care organizations than in small private practices.\textsuperscript{15}

For patients, the transition from a fee-for-service model to a system that provides physicians with a guaranteed income might ease concerns that they are receiving unnecessary services for the physician's financial gain, or that they are receiving inadequate treatment if they are under- or uninsured. Moreover, despite the recent changes in our health care system, lack of adequate insurance or any insurance at all may remain a significant problem for both patients and providers and will affect autonomous providers more than employed physicians in large health care organizations.\textsuperscript{16}

\textbf{Teaching and research}

Economic and administrative obligations influence the role of teaching and research among autonomous and employed physicians. The education of medical students and residents and the advancement of medical science through research are crucial to maintaining the high standard of medical care in this country. Both, however, require enormous investments of money and time. A physician-entrepreneur may therefore encounter substantial difficulty attempting to balance academic interests with personal productivity, while a physician-employee may negotiate contractual reimbursements or incentives for participation in these activities.

\textbf{A new generation of physicians}

Financial and administrative implications of various practice models aside, the expectations of today's physicians are generally quite different from those of previous generations. Although still dedicated to patient care and willing to spend long hours in the hospital, many younger physicians also demand a lifestyle that allows time for family, friends, and hobbies.\textsuperscript{17} Running a private practice often means being on call 24/7, and a recent analysis of a 2008 surgeons' survey demonstrated burnout and depression to be more significant problems among private practice surgeons than among surgeons in academic and large group settings.\textsuperscript{18} Furthermore, particularly among the growing number of women in surgery, salaried and part-time employment is popular, as it provides an opportunity to reconcile professional and private life.\textsuperscript{19}

When comparing employment models, concerns pertaining to the loss of productivity and quality in salaried positions must be addressed. When reimbursement is guaranteed, the average employee may receive the same amount of money as one who goes the extra mile. Therefore, some employers provide additional compensation based on performance in addition to a base salary, thus offering incentives for quality, productivity, and/or cost control. The most important guarantor of excellence in patient care, however, is a strong, positive employer-employee relationship. Large health care organizations and hospitals need to grant their employed physicians a high degree of autonomy and emphasize each individual physician's importance to the hospital's success. In a favorable environment, productivity in hospital-owned versus independent practice need not suffer.\textsuperscript{19}

\textbf{Physician leadership}

Salary-based employment models in large health care organizations may allow surgeons to focus on patient care, reconcile professional and private life, and provide flexibility for education and research. However, concerns about loss of autonomy, weakening of the physician-patient relationship, and decreased productivity are valid and real. Inefficient use of resources, excessive spending, and defensive medicine significantly contribute to the ever rising costs of the U.S. health care system, which is already among the most expensive in the world.\textsuperscript{20} Substantial changes are inevitable, and surgeons must assume a leadership role to ensure that excellence in patient care remains the center of our health care model. As Haile T. Debas, MD, FACS, 2002 president of the American Surgical Association, so aptly stated, if we fail to accept this role, “History will record that the medical profession was sidelined and watched helplessly as MBAs and business executives defined the fate of healthcare.”\textsuperscript{21}
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Dr. Leichtle is a general surgery resident at Saint Joseph Mercy Health System, Ann Arbor, MI. He is a member of the RAS Issues and Membership Committees.

Dr. Hartin is a pediatric surgery fellow, State University of New York/Women & Children’s Hospital of Buffalo, NY.
Earlier this year, Congress attempted to address the Medicare physician payment problems associated with the use of the sustainable growth rate (SGR) formula. The good news first: Congress averted another steep cut in payment by passing a 10-month short-term patch. The bad news: there is no stability in the Medicare physician payment system and each short-term patch makes it increasingly difficult to enact permanent repeal. The short-term patches increase the size of future cuts as well as the future cost of permanently repealing the SGR.

These confounding consequences prompted the American College of Surgeons (ACS) to lead organized medicine’s most recent physician charge to eliminate the SGR formula once and for all by suggesting that Congress use overseas contingency operations (OCO) funds to cover the cost of permanent repeal.

Enacted as part of the Balanced Budget Act of 1997, the SGR formula was intended to be used as a prospective measure for controlling the growth of Medicare payments for physician services. The idea behind the SGR formula was that it would set health care spending targets, which, if exceeded, would result in a proportionate cut in the following year’s physician payment rate. However, this macroeconomic approach was suited to account for the volume and complexity of physician services as well as the needs of each individual patient. While Congress has interceded to prevent the cuts, its cumulative budgetary method has resulted in scheduled payment cuts of 27 percent on January 1, 2013.

As a result, many Fellows are asking some tough questions, such as: Why hasn’t Congress adequately addressed the issue? Is the use of OCO funds a viable solution? What is the ACS doing on my behalf to advocate for permanent repeal? This article responds to these and other questions surgeons may have about the status of the SGR.
Dating back to 2002, Congress has passed 14 short-term “doc patches.” Why haven’t our elected officials passed legislation that would permanently repeal the SGR?

The answer is simple: Congress has yet to find the political will to solve the problem. Congress unanimously acknowledges that the problem must be fixed and that its failure to address the issue years ago has added to the complexity of implementing a permanent solution. The nearly $300 billion price tag is prohibitive in today’s economic reality and in a Congress that requires that the cost of permanent repeal be offset by cuts elsewhere in the federal health care budget.

The College has made its position clear that Congress must enact permanent repeal and remove one of the biggest threats to Medicare beneficiaries’ access to care. The ACS has made known its willingness to address the Medicare physician payment structure and to arrive at a solution that will enable physicians to continue to improve the care of the surgical patient in more efficient settings, while appropriately paying them for their services. As long as physicians and their patients are faced with the current unstable system and fundamentally flawed SGR formula, it is difficult to discuss improvements to the physician payment system.

What are the long-term effects of short-term patches?

It is no secret that short-term patches have lasting effects on health care with respect to dollars and cents. Members of Congress have stated that the SGR formula is broken and must be repealed. With each short-term patch that Congress enacts, the schedule of cuts gets steeper, and the cost of fixing the problem increases. In 2005, the SGR formula could have been repealed permanently for less than $50 billion. Today, the cost exceeds a staggering $300 billion.

Those organizations and individuals fighting for repeal have estimated that in the next five years, the combined cost of the short-term patches and accumulated SGR debt will reach $600 billion, more than half a trillion dollars of debt. Keep in mind that the recent 10-month SGR patch through the end of 2012 costs $18 billion over 10 years and does not pay down the principal balance, which is currently estimated at $271 billion, according to the Congressional Budget Office (CBO).

What is the ACS doing on my behalf to advocate for permanent repeal of the SGR?

The College’s advocacy staff continues to carry out its mission of working every day to achieve permanent repeal of the SGR. ACS advocacy staff members have met with hundreds of congressional offices, urging them to commit to the use of unused OCO funds to offset the cost of SGR repeal. In an historic effort, the elected leadership from the four largest physician specialty organizations joined together in January to deliver a strong, unified message calling on key members of Congress to permanently repeal the SGR formula using war drawdown savings. Participating with the College were the American College of Physicians, the American Academy of Family Physicians, and the American Osteopathic Association. ACS leadership representatives included Patricia Numann, MD, FACS, President; A. Brent Eastman, MD, FACS, President-Elect; and David Hoyt, MD, FACS, Executive Director. Together, the organizations represent more than half of the practicing physicians in the U.S. In addition, ACS members stormed the Hill during the ACS first annual Advocacy Summit in March. After intensive advocacy training, the surgeons met with congressional representatives and staff to discuss the need to permanently repeal the SGR.

What are OCO funds? How could OCO funds be used to offset the SGR?

OCO funds are known as discretionary funds for the wars in Afghanistan and Iraq and similar activities. Make no mistake, OCO funds are not used to support the troops; they are a completely separate budget item. Funding levels for the OCO are established each year in the U.S. Department of Defense appropriations bill.

Due to CBO scoring requirements, it is widely acknowledged that the current baseline forecasts much more spending for Iraq and Afghanistan under the OCO than is likely to occur, given the ongoing drawdown. At the same time, CBO scoring conventions require it to unrealistically assume that Medicare physician payments will be cut more than $300 billion over the next 10 years. Members of Congress routinely state that cuts of this magnitude would destroy Medicare and should be averted. Using the OCO baseline as an offset for the SGR baseline...
essentially amounts to “cleaning up the books,” by eliminating bad fiscal policies and allowing for a more accurate accounting of future government expenditures without increasing the deficit.  

Why didn’t Congress use the OCO funds?  

Despite the medical community’s hard work and the valiant efforts of some legislators—Republicans and Democrats alike—opposition from key leaders and representatives proved too big a hurdle to overcome. Accordingly, Congress did what it has always done—put off repeal and permanent reform until another day.

Who is most affected by the cuts?  

Surgeons and other physicians certainly are affected, and, to a greater extent, so are their patients. The way the SGR’s target-based formula is set up provides individual physicians with no incentives for controlling volume growth, yet punishes even those physicians who do not increase volume, unnecessarily. This top-down economic model, which is tied to the nation’s gross domestic product, is fundamentally flawed and negatively affects physicians in specialties that have fewer opportunities to increase volume.

How can Fellows assist in efforts to repeal the SGR?  

Research has consistently demonstrated that members of Congress are driven to make decisions on issues by visits from their constituents, and communications (phone calls and/or e-mails) from voters in their district or state. Throughout the year, the College will send e-mail alerts to the membership (who may enlist their patients when appropriate) requesting their help with its advocacy efforts, including the repeal of the SGR.

Unfortunately, the two most recent grassroots alerts generated a combined total of less than 1,000 “contacts” with Capitol Hill, an average of less than two contacts per member of Congress. The College needs your help to push Congress to find the political will to end this decade-old problem, and will do as much as possible to make members’ involvement as easy as possible in the least time-consuming manner. You can make a difference—not only for your practice, but for your patients’ ability to access high-quality surgical care.

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Mr. Hedstrom is Deputy Director of Congressional Affairs, ACS Division of Advocacy and Health Policy, Washington, DC.

Ms. Moye is Communications Manager, Division of Integrated Communications, Washington, DC.
Ever since he was a young boy, Mehmet C. Oz, MD, FACS, wanted to follow in his father's footsteps by becoming a surgeon. Today he's not only a cardiothoracic surgeon at New York Presbyterian Hospital in New York City but he's also the host of The Dr. Oz Show, a nationally syndicated health information program that won two Emmy Awards and attracts nearly 4 million viewers daily.1

“...My father—a thoracic surgeon who trained in Turkey—always asks me how long I plan to ‘fool around with this television stuff,’” admits Dr. Oz with a good-natured chuckle. In addition to filming six shows a week—where he’s apt to discuss anything from diet and exercise to the importance of regular check-ups—Dr. Oz also consults with patients most Thursdays, and he performs approximately 75 to 100 heart operations every year. That fast-paced schedule almost came to a grinding halt last year, however, when Dr. Oz’s physician discovered a suspicious-looking polyp during an on-camera colonoscopy. The polyp turned out to be pre-cancerous, and although most of these polyps do not eventually become malignant, Dr. Oz was well aware of the fact that colon cancer usually starts with this sort of growth. The experience transformed “Dr. Oz” into “Mr. Oz,” and it gave him a new perspective on both his role as a surgeon and the role of the patient.

During a recent interview, Dr. Oz discussed what he learned from his cancer scare and offered his perspective on a range of topics, including mentoring residents, work/life balance, and the importance of delivering quality care.

Doctor as patient
In an essay for Time magazine published last June titled “What I learned from my cancer scare,” Dr. Oz presents a candid, look at what, for him, was a life-changing experience:
Dr. Oz said he feels frustrated when his patients ignore his medical instructions, but at that point in time, he was certainly acting like one of those defiant patients. “I was the worst,” he admitted. “Most doctors are bad patients, but that’s no excuse. Again, you have to remember that you follow doctor’s orders, not only for yourself, but for the people you love,” said Dr. Oz, a father of four.

**Mentoring and the “eureka moment”**

Physicians are constantly learning—not only from their experience as patients (or caring for patients)—but also from the mentor/mentee relationship, which is a very important component of the academic surgeon’s work.

“Mentoring is essential to where I am now and the way I live my life,” said Dr. Oz, vice-chair and professor of surgery at Columbia University, New York, NY, and director of the Cardiovascular Institute and Complementary Medicine Program at New York Presbyterian Hospital. “I try to find residents who are smarter than me, so that they can grow to continue to be smarter than me. Hopefully, that relationship results in the resident doing things that I could never do.”

In fact—as Dr. Oz’s professional responsibilities continued to rise—he made the decision to hand over a portion of his patient referrals to Mathew Williams, MD, also a cardiac surgeon.

“Mat Williams was a Columbia University undergrad when I was chief resident. He would take call with me, shadowing me as I worked on gunshot wounds and head traumas, and from the beginning I knew that he was someone very special. I’ve been involved in much of his life, and he’s returned the favor. He is one of the key people who I operate with today,” said Dr. Oz.

Dr. Oz has strong feelings on the topic of resident duty-hour restrictions. As a surgical resident he conditioned himself to get by on only two or three hours of sleep each night, and, as a result, he continues to struggle with insomnia some 25 years later.

“The danger of work-hour restrictions is that they can inhibit learning,” said Dr. Oz. “The intent of these restrictions is to make sure people have the proper amount of time to reboot and reset. We are struggling at Presbyterian Hospital because the residents want to learn a particular procedure, but can’t because they have to leave due to these restrictions. Look, it was tough to be on call [as a resident] because you did not get a full night’s sleep for a week or two at a time,

I take pride in being a good doctor and a good family man, but the fact is, I had been a pretty bad patient. Living my life on television, dispensing medical advice every day leaves me with a solemn obligation and moral imperative to be honest and to own up to mistakes—and I made some. They might not have been big, but they were more than enough to threaten my health, my future and the well-being of my family.

“When I first became a physician, I thought people didn’t do what was right for their health because they didn’t believe what I told them, or because they thought they wouldn’t live forever anyway—so why bother,” Dr. Oz added. “But I realized it wasn’t any of those things. As for my own situation, I didn’t want to deal with what I would learn [from the colonoscopy]. I was so busy in my life and the whole thing kind of intimidated me. But then I finally realized that I wasn’t getting the colonoscopy for me, but for the people I loved. Until I realized that fact, it wasn’t compelling enough for me to get the procedure. And you know what? It changed the way I talk to patients when I recommend a procedure. I tell them, ‘It’s not always just about you.’”

According to Dr. Oz, “The universe had to drill through three distinct layers of [his] arrogance or denial as it modified his perspectives on cancer treatment:

First, I was cavalier going into my initial screening. I was healthy, and I knew the statistics, and I figured the risks didn’t apply to me. Second, I felt that decades of research and experience that led to the prep-and-testing guidelines as we know them also didn’t apply to me. And last, I felt that the follow-up was somehow a formality and the risk still didn’t apply to me. The transformation from Dr. Oz to a modest, wiser Mr. Oz did not become complete until I was staring directly at a pathology report.”

Dr. Oz shows an audience member the organ in the body that creates the most toxins, the intestines.
and yes, it probably did inhibit some learning. But I also learned a great deal from those cases that I did not want to miss.

“If we were better at teaching, it would be possible to mold these restrictions to accomplish the true goal, which is recharging the mind,” continued Dr. Oz. “Our mantra at Columbia is, ‘My job is to teach young surgeons to save lives—that’s my job.’ Sometimes residents have to sleep a lot, and sometimes they have to stay with me in order to keep someone alive.”

A question that surfaces repeatedly when health care professionals discuss the mentor/mentee relationship is, “How do you deal with an incompetent intern?” Dr. Oz says it’s not the incompetent interns one has to worry about. “It’s an intern who doesn’t know he is incompetent,” he explained. “People make mistakes, and this is true outside medicine as well, when we don’t know what we don’t know.

“Mentoring is about helping students see the path where you walked, so they don’t fall where you tripped,” continued Dr. Oz. “And giving them the freedom to walk off the path where they need to.”

Dr. Oz says the early years of medical school often feature a series of eureka moments where the student gleans insight into their existence in the most unexpected ways. For him it was the first time he saw the heart.

“I remember the first time I saw this powerful organ pop through the pericardium, and I was petrified,” recalled Dr. Oz. “You don’t want to touch it, because it could stop, but let me tell you, fear is not a good way of starting a relationship with an organ—and that’s true for any surgeon. You have to make peace with it, and understand it in a way that is much more poetic than a cut here and a snip there. My epiphany was moving from fear to realizing you could hold the heart in your hands and cajole it and help keep a patient alive.”

Dr. Oz says that moment helped him realize why the heart is so infused in religion and the arts, and that it continues to allure him—both as a vital organ and as a symbol.

**Work/home balance**

Dr. Oz films six episodes of the Emmy Award-winning *The Dr. Oz Show* a week and has authored seven *New York Times* best sellers, including *You: The Owner’s Manual*. He’s launched a charitable foundation, HealthCorps, a national peer-mentoring initiative empowering teens to make healthier choices. And, as previously mentioned, Dr. Oz operates most Thursdays. How, then, does this active surgeon—who’s been married to his wife, Lisa, for 26 years—manage to strike a healthy work/home balance?

“It’s not about time management as much as it is energy management,” Dr. Oz observed. “When surgeons are in the operating room and they are working on an interesting case, there’s good camaraderie there with the team, and that is energizing. It’s the tedious chores, the laborious paperwork that drags you down and wears someone out.”

Considering the fact that Dr. Oz has such a hectic schedule, he chooses cases that are low-risk and where there is a pretty defined postoperative course. “I don’t mind spending lots of hours in the operating room, but I can’t do cases too often that are overly complex with lots of postoperative care. I usually do straightforward valve cases and bypasses—cases that are nonreoperative. And I always operate with a partner. I want my partner to be in charge of the patient’s postoperative care, and I always arrange this with the family beforehand.”

One of the biggest misconceptions about the Ohio native is that he entered the media spotlight early in his career, when in reality he only made what he calls “a serious move into media” over the last eight years. “My career path was specifically designed with academic medicine in mind, and that’s always been the case,” explained Dr. Oz, who has received several patents, including one for a device that allows surgeons to use minimally invasive surgical techniques to repair a defective mitral valve, without opening the chest or stopping the heart. His research interests include heart replacement surgery, minimally invasive cardiac surgery, and complementary medicine and health care policy.

Being in front of the camera and a live audience involves a lot of prep work, according to Dr. Oz. “I study for my shows—I have to. It’s like having a board exam every single day, because I have to have a working knowledge of all the topics we cover,” said Dr. Oz.
Quality care for all

A key issue of concern to Dr. Oz and his team is the provision of high-quality care. “Quality care is a cultural thing. If you make it easier to do the right thing, then the right thing happens,” he said. “Quality control systems, and things such as checklists in the OR, are hugely valuable because they get people thinking differently about the process—and not just trying harder, but trying smarter. The most expensive thing in health care is bad health care. If we can avoid complications, we can save lives and save money.”

Being fiscally responsible is a top priority for Dr. Oz, who has a business background in addition to his medical credentials. After graduating from Harvard University in 1982, he obtained a joint MD and MBA in 1986 from the University of Pennsylvania School of Medicine and Wharton Business School, both located in Philadelphia.

Dr. Oz—who was an invited participant in the 2012 Economic World Forum in Davos, Switzerland, earlier this year—noted that economic growth on a global scale must include affordable and quality health care if it is to succeed.

Closer to home, Dr. Oz said health care legislation will not succeed unless we become a healthier country. “We’re not going to figure out how to address health care expenses in Washington, DC. We’re going to win the health care battle in our homes, and in our kitchens and living rooms, because that’s actually where we decide how healthy we’re going to be. If we’re sick as we are right now, we’re not going to be able to keep up, no matter what kind of legislation is passed,” he said.

One key health care finance issue that leaders in Washington will, in fact, have to deal with, according to Dr. Oz, is the topic of care for the uninsured. “It is essential that we have affordable health care coverage for all, and I think that most people at the College would agree with that,” observed Dr. Oz, who has first-hand experience in dealing with patients whose health care coverage is less than adequate.

“As a practitioner, I have been sued by insurance companies for saving the lives of patients. This is public record. In one case I was asked to take care of a man who was in need of a heart transplant. He had undergone an unsuccessful emergency bypass surgery elsewhere, and he was in need of a mechanical pump that would keep him alive while he waited for a donor heart. His policy covered the heart transplantation—not the mechanical pump. I was sued by the insurance company because without the pump, they would never have been saddled with the bill for the transplant!”

Conclusion

“One of the reasons I did this interview is because I care about what the [members of the] College think. I care a lot—and that’s one of the reasons why I have so many doctors on my show,” revealed Dr. Oz.

He described his TV persona as that of the “goopy parts of Marcus Welby,” a role he uses to help walk viewers through various health-related topics, mixing in personal anecdotes with science and research. “I want to make it easier for people to have a conversation with their own doctors, the Fellows of the College. We try to give people the confidence to ask their doctor about whatever is bothering them, and to know what questions to ask. We don’t always get it right, but when we do, we try to make the doctors’ jobs easier.”

Despite all of his professional accomplishments, Dr. Oz is most proud of his relationship with his family. “I’m proud of the fact that I’ve kept my wife of 26 years still loving me—which is a huge challenge, and I’m proud of raising four kids, who, at least to me, seem happy. I’m also really proud of the fact that I’ve matured as a listener. I think that’s a big call to action for so many surgeons, and everyone, really. We’re not taught to listen to patients, to staff, or to each other. But the art of listening, and spending time with patients so that we can address the real problem rather than quick-fixes, is ultimately cost-effective and just better medicine in the long run.”

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Mr. Peregrin is Senior Editor, Bulletin of the American College of Surgeons, Division of Integrated Communications, Chicago, IL.
The state legislatures started their sessions in early January and are now considering thousands of bills that could impact patients, physicians, nonphysician health care providers, and virtually the entire health care system. Generally speaking, the American College of Surgeons (ACS) State Affairs area of the Division of Advocacy and Health Policy monitors and tracks more than 1,000 pieces of state legislation per year, with a focus on four main issues:

- Medical liability reform, including caps on noneconomic damages, alternative dispute resolution, expert witness qualifications, standards of evidence, statute of limitations, and so on
- Quality/patient safety, which includes scope of practice and injury prevention issues
- Workforce/surgical practice, including the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) model and trauma system funding and development
- Physician payment, including provider taxes

Of these four areas, considerable attention and many advocacy efforts are being directed toward defeating legislation that expands nonsurgeon health care practitioners’ scope of practice. Working in collaboration with a larger coalition of state medical societies and national surgical specialty societies is essential to ensure that health care professionals performing surgical procedures have the proper education, licensing, and training to do so.

It has become an all-too-common occurrence in state legislatures for one group of licensed health care professionals to seek modifications in their licensing acts in an effort to expand their scope of practice. Additional practice privileges may be reasonable in some cases if the health care professionals have the education, training, and experi-
ence necessary to gain these privileges. However, more frequently, these practitioners do not have the necessary medical/surgical training and experience that surgeons receive during medical school, residency training, and specialty fellowships. Patient safety and quality care are of vital importance in the debate over whether legislators should broaden scope of practice, especially when that expansion includes performing surgery.

**Definition of surgery**

A statutory definition of surgery at the state level can help to limit nonphysicians’ attempts to expand their scope into the performance of surgery. To this end, the College collaborated with a number of surgical specialty societies to enhance an existing ACS statement on laser surgery to include a definition of surgery. As described in ST-11, Statement on Surgery Using Lasers, Pulsed Light, Radiofrequency Devices, or Other Techniques, the College’s definition of surgery is as follows:

Surgery is performed for the purpose of structurally altering the human body by incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transportation of live human tissue, which include lasers, ultrasound, ionizing, radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system is also considered to be surgery (this does not include administration by nursing personnel of some injections, such as subcutaneous, intramuscular, and intravenous when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical intervention are not eliminated by using a light knife or laser in place of a metal knife or scalpel. Patient safety and quality of care are paramount, and the College therefore believes that patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.

Following the College’s adoption of ST-11—which was revised in April 2007—a resolution was introduced in the American Medical Association (AMA) House of Delegates (HOD) calling on the AMA to adopt the definition of surgery as created by the College. After considerable and thoughtful discussion, the HOD adopted this definition as stated in ST-11, providing uniformity within the house of medicine and surgery.

To see the full statement, go to [http://www.facs.org/fellows_info/statements/st-11.html](http://www.facs.org/fellows_info/statements/st-11.html).

**Status of related legislation**

Proponents of legislation that establishes a definition of surgery have a lot of work to do on the state level because the majority of states do not have a regulatory definition of surgery in place. Of the 50 states, only 25 have defined surgery in laws or regulations. Ten of those states have definitions that include a form of the word “incision” (Alabama, Arkansas, Arizona, Florida, Indiana, Kansas, Louisiana, Maine, Ohio, Rhode Island). Nine states included “diagnosis” as a part of the definition of surgery, which closely mirrors the ACS statement (Arizona, Kansas, Maryland, Mississippi, Nevada, Ohio, Pennsylvania, West Virginia, Wisconsin). Three states specifically define surgery to start at the point of incision and end at the close of the incision or when all operative devices have been removed (Indiana, Maine, New Jersey). Other states specifically define types of surgeries, such as elective, cosmetic, minor, major, or ophthalmic surgery.

**AMA definitions to consider**

As noted earlier, the AMA adopted the College’s definition of surgery and specifically references ST-11 in their policy. Although this definition is broader in scope, it may not always be feasible to enact such a definition the first time related legislation is considered. In fact, some states start with a definition of cosmetic or reconstructive surgery to protect patients...
undergoing those specific types of surgical procedures from receiving care from other health care providers. The AMA HOD passed two policies regarding cosmetic and reconstructive surgery that would be important to consider and incorporate if this type of legislation is being pursued at the state level, and they are as follows:

- **Cosmetic Surgery (H-475.992).** This surgery is performed to reshape normal structures of the body in order to improve the patient’s appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. This statement can be viewed on the AMA website at https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-475.992.HTM.

- **Laser Surgery (H-475.988).** The AMA supports the position that revision, destruction, incision, or other structural alteration of human tissue using a laser is surgery. This statement can be viewed on the AMA website at https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-475.988.HTM.

### 2012 legislation

The ACS—along with the AMA Scope of Practice Partnership and other key state stakeholders—are currently tracking a number of bills that have been introduced during the 2012 session that address and define surgery in some capacity. These bills are as follows:

- **Pennsylvania bill, HB 838.** This legislation amends the bill known as the Optometric Practice and Licensure Act and defines optometry and ophthalmic surgery while clearly prohibiting optometrists from performing ophthalmic surgery. The AMA Scope of Practice Partnership is working with the Pennsylvania Medical Society in the efforts to get this bill passed. It passed through the House in June 2011, and at press time was awaiting a vote in the Senate Consumer Protection and Professional Licensure committee.

- **Utah bill, SB 40.** The Medical and Osteopathic Act defines cosmetic medical laser procedures to be the practice of medicine and osteopathy. It permits the delegation of certain cosmetic medical laser procedures by a physician; requires supervision by a physician if the cosmetic laser procedure is delegated; and prohibits the delegation of supervision when supervision is required. On March 2, 2012, this bill was approved by the Senate.

- **Virginia bill, HB 266.** This bill was introduced due to the efforts of the Medical Society of Virginia. The bill states that surgery is defined as the structural alteration of the human body by the incision or cutting into of tissue for the purpose of diagnostic or therapeutic treatment of conditions or disease process by any instrument causing localized alteration or transposition of live human tissue, but does not include procedures for the removal of superficial foreign bodies from the human body, punctures, injections, dry needling, acupuncture, or removal of dead tissue. The bill also states that no person shall perform surgery unless they are licensed by the board of medicine as a doctor of medicine, osteopathy, or podiatry, and so on. This bill was signed by the governor on February 28, 2012, and will take effect July 1, 2012.

### Future action

Legislation that defines surgery and its scope is a preventive and proactive means for state medical societies, ACS state chapters, and the AMA to ensure that patients are protected and treated with the highest level of care. The College encourages ACS chapters to participate in collaborative state advocacy initiatives to assist in the passage of definition of surgery legislation, specifically containing the ACS definition. For more information on the legislation discussed in this article contact Charlotte Grill at cgrill@facs.org.

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Ms. Grill is State Affairs Associate, Division of Advocacy and Health Policy, Chicago, IL.
The Fundamentals of Laparoscopic Surgery™ program (FLS) was developed to ensure that every surgeon practicing laparoscopic surgery has the minimum knowledge, judgment, and technical skills required to perform basic laparoscopic operations. FLS was designed to be independent of specialty area and procedure type. The goal of the curriculum is to provide a strong foundation for practice. Beginning with the 2009–2010 academic year, the American Board of Surgery (ABS) required that all general surgery residents successfully complete the FLS exam to be eligible to take the ABS Qualifying Exam in surgery.

The FLS program was modeled after Advanced Trauma Life Support® (ATLS®), with a didactic and hands-on component. One of the unique features of the FLS program is the robust evaluations for both the didactic and psychomotor skills, consistent with the standards for high-stakes examination.

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and the American College of Surgeons (ACS) recommend that all surgeons practicing laparoscopic surgery be certified through the FLS program. FLS is the only validated, objective measure of a surgeon’s fundamental knowledge and skills related to laparoscopic surgery. As such, SAGES and the ACS also recommend that institutions credentialing surgeons to perform laparoscopic surgery consider FLS certification a requirement of their credentialing process.
More than 100 California health care leaders attended the American College of Surgeons (ACS) fourth Surgical Health Care Quality Forum on March 2, at Scripps Memorial Hospital, in La Jolla, CA. Speakers at the event included community health care leaders representing Scripps Health; Naval Medical Center, San Diego; University of California, San Diego; and Kaiser Permanente. A. Brent Eastman, MD, FACS, chief medical officer and corporate senior vice president, Scripps Health, and ACS President-Elect, hosted the community forum and introduced keynote speaker David B. Hoyt, MD, FACS, ACS Executive Director. Dr. Hoyt told the gathering that improving quality of care translates into better outcomes, enhanced access, and lower costs.

“One of the things we hope these forums will do is bring together the community to focus in a more collaborative way on sharing American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) data and finding solutions to common problems to improve quality,” said Dr. Hoyt. San Diego County’s trauma system, developed more than 30 years ago, has since become a prototype for quality improvement collaboratives, Dr. Hoyt noted.

The ACS Surgical Health Care Quality Forum in San Diego is part of the College’s Inspiring Quality nationwide initiative to promote critical elements of quality improvement that measurably improve outcomes while reducing health care costs.

“We all recognize our country is facing a broken health care system where costs are skyrocketing out of control,” said Dr. Eastman. “The good news is the evidence-based and proven value proposition that says, by improving quality, we can decrease costs and decrease variation in care, really can make a difference in working toward a sustainable health care system.”

A model for outcomes-based quality improvement, ACS NSQIP collects clinical, risk-adjusted, 30-day outcomes data in a nationally benchmarked database. The Institute of Medicine of the National Academies has credited ACS NSQIP as “Best in the Nation,” and approximately 400 hospitals nationwide now use the quality improvement program. A 2009 Annals of Surgery study determined that hospitals participating in ACS NSQIP prevented 250–500 complications, resulting in an average of 13–26 lives saved per hospital, per year. With the average cost of medical complications equaling $11,000 per occurrence, the combined potential
savings of 4,500 hospitals could add up to $13 billion to $26 billion each year, amounting to an estimated total savings of $260 billion over a period of 10 years.

Several speakers contributed to the community forum dialogue:

- Chris Van Gorder, FACHE, president and chief executive officer, Scripps Health, and immediate past chair, American College of Healthcare Executives: “I’ve never before seen this level of collaboration in over 30 years in health care—the doctors and administrators, all of us working together—we’re going to improve the health care system, create more value for patients and society.”

- Mark A. Talamini, MD, FACS, professor and chair, department of surgery, University of California San Diego (UCSD): “We’ve invested a large amount in a state-of-the-art medical training center at UCSD. Surgery is changing every day, so having a new high-tech training center where surgeons can come, relearn procedures, and hone in their skills is a critical part of our surgical quality improvement initiatives.”

- CPT Mark A. Kobelja, MD, MC USN, deputy commander, Naval Medical Center San Diego: “The ACS recognizes that quality improvement is not just about the surgeons; it’s about everyone involved in the care of the patient in a surgical environment. ACS NSQIP is an important program because it’s outcomes-based and focuses on ‘how did the patient actually do?’”

- Ralph Dilley, MD, vice-chair, department of surgery, Scripps Clinic Medical Group, and surgeon-in-chief, Scripps Green Hospital: “We decided to look closely at just one postoperative problem in great detail and see what we could improve. We chose to monitor urinary tract infections over two years, and our rates fell from 1.7 percent to 0.6 percent—a remarkable reduction.”

- Mark Schumacher, MD, FACS, physician director of hospital surgical services, Kaiser Permanente: “We started looking at changing our culture using a safety attitudes questionnaire that correlates well with clinical outcomes and found we had opportunities for improvement.”

- David Chang, PhD, MPH, MBA, director of outcomes research, department of surgery, University of California San Diego School of Medicine: “When we talk about quality improvement, it’s about implementing systems, and I think it’s time to push that message out to the policy world.”

- James E. LaBelle, MD, corporate vice-president, quality, medical management, and physician co-management, Scripps Health: “Physician engagement is critical to improving quality, and systems that drive the measurement of outcomes rather than process are much more meaningful.”

To view the archived forum video and follow updates on upcoming tour locations, visit InspiringQuality.FACS.org or the College’s YouTube channel at http://www.youtube.com/AmCollegeofSurgeons.

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**General Surgery Coding workshops planned for remainder of 2012**

The American College of Surgeons (ACS) and Karen Zupko and Associates, Inc. are proud to present coding workshops designed to help general surgeons build the skills they need and to earn continuing medical education credits. The workshops focus on using new codes, applying modifiers, minimizing audit risk for evaluation and management codes, and closing revenue gaps.

The remaining 2012 dates and locations are as follows:

- May 3–4: New York, NY
- August 16–17: Nashville, TN
- October 25–26: Costa Mesa, CA
- November 15–16: Chicago, IL

For more information and to register, go to [http://www.karenzupko.com/workshops/americancollegeofsurgeons/index.html](http://www.karenzupko.com/workshops/americancollegeofsurgeons/index.html).
Dr. Fogarty inducted as first NAI fellow

Thomas J. Fogarty, MD, FACS, of Portola Valley, CA, became the first individual ever to be inducted into the National Academy of Inventors’ (NAI) newly established Fellow membership category. The induction ceremony took place in February at the NAI’s Inaugural Annual Conference at the University of South Florida, Tampa.

The NAI—which includes approximately 1,000 inventor members who invent and patent medical, scientific, artistic, and engineering breakthroughs—is a not-for-profit membership organization that honors, recognizes, and encourages academic inventors.

According to NAI president Paul R. Sanberg, PhD, DSc, election to NAI Fellow status is the highest professional distinction accorded to academic inventors who have demonstrated a prolific innovative spirit in creating or facilitating outstanding inventions with tangible impact on the quality of life and society’s welfare.

Dr. Fogarty received the 2001 Jacobson Innovation Award from the American College of Surgeons for his work in developing industry standard minimally invasive surgical instrumentation, especially for cardiovascular surgery. In 2000, Dr. Fogarty received the Lemelson-MIT Prize for Invention and Innovation. He has been inducted into the National Inventors Hall of Fame and the National Academy of Engineering.

Dr. Fogarty’s many inventions revolutionized heart surgery, including his development of the now widely used balloon catheter. Dr. Fogarty has served as founder and co-founder and board chairman or board member for more than 30 businesses and research companies. He holds 135 surgical patents and established the Fogarty Medical Foundation that donates to nonprofit health research.

Go to http://www.eurekalert.org/pub_releases/2012-02/uosf-na022312.php to view a press release from the NAI on Dr. Fogarty’s induction into the Academy’s Fellow membership category.

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 by contacting the Trauma Office at 312-202-5342.
Tyler G. Hughes, MD, FACS, a native of Dallas, TX, was named Rural Healthcare Practitioner of the Year on April 1 by the National Rural Healthcare Association (NRHA).

Dr. Hughes has maintained a broad general surgery practice for the past 16 years at McPherson Hospital in McPherson, KS, a town of 13,000 with a surrounding population of 30,000. A member of the Board of Governors of the American College of Surgeons (ACS), Dr. Hughes was president of the Kansas Chapter in 2007. He assists in the ongoing development of the ACS Case Log system, and is Co-Editor of the Rural Surgeons’ Community Section of the ACS Web portal. In addition, Dr. Hughes serves on the editorial boards of Surgery News, Selected Readings in General Surgery, and Evidence-Based Reviews in Surgery. He also has written a number of articles for the Bulletin. In addition, he independently developed a rural surgeons’ network and served as a Co-Director of the ACS Rural Surgery Skills Course.

The NRHA is a not-for-profit organization that works to improve the health and well-being of rural Americans and provides leadership on rural health issues. NRHA membership includes 20,000 diverse individuals and organizations who share an interest in rural health.

Dr. Hughes obtained his medical degree from the University of Texas Southwestern Medical School, Dallas, and worked as assistant program director under Ernest Poulos, MD, FACS, and as a teaching attending at St. Paul Medical Center in Dallas, where Dr. Hughes completed his general surgery residency. Since moving to McPherson, Dr. Hughes has worked primarily with medical students as a clinical faculty member at the Kansas University School of Medicine (Kansas City). In 2010, Dr. Hughes received the school’s first Outstanding Preceptor Award. For more information on the NRHA, go to http://www.rural-healthweb.org/.

“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 for all your surgical patient education needs.

This Surgical Patient Education Program is a collaborative by the American College of Surgeons with the Society of Thoracic Surgery, the American Association for Thoracic Surgery, the Association of PeriOperative Registered Nurses, and the Commission on Cancer.

THIS PROGRAM IS FUNDED IN PART BY A GRANT FROM ETHICON ENDO-SURGERY.
A paradigm shift in rectal cancer treatment: The PROSPECT trial

by Yi-Qian Nancy You, MD, MHSc, FACS, and Heidi Nelson, MD, FACS

The “Miles” procedure, or abdominal-perineal resection (APR), recently celebrated a 100-year anniversary, which should remind us that while some things change, others remain the same. Whereas the APR is still practiced, numerous additional options have evolved, including sphincter-preserving procedures to improve quality of life, and neoadjuvant and adjuvant radiation and chemotherapy to reduce rates of local, regional, and systemic relapse. Indeed, our current paradigm calls for neoadjuvant radiation and sensitizing chemotherapy followed by surgery and postoperative chemotherapy as the standard of care for Stage II and Stage III rectal cancer. This standard is now challenged by rising concerns about the long-term toxicities of current regimens and new standards are encouraged by improvements in surgery and radiographic imaging and chemotherapy options.

To safely challenge the existing paradigm, the Alliance for Clinical Trials in Oncology Cooperative Group is launching a new trial titled the “PROSPECT” trial. PROSPECT is the acronym for Preoperative Radiation Or Selective Preoperative Radiation and Evaluation before Chemotherapy and Total Mesorectal Excision (TME).

The PROSPECT trial, by offering preoperative radiation or selective preoperative radiation and evaluation before chemotherapy and TME, provides the opportunity of reducing the use of pelvic radiation in patients who might not benefit from this treatment. In this phase II/III multicenter trial, neoadjuvant FOLFOX (Oxaliplatin, Leucovorin, and 5-Fluorouracil) with selective use of chemoradiation (5-Fluorouracil and pelvic radiation), is being tested against the current standard of preoperative chemoradiation (5-Fluorouracil and pelvic radiation) for rectal cancer patients undergoing low anterior resection with TME (NCCTG-N1048; N1048; NCT01515787; see figure, this page).

The rationales for conducting the trial are as follows: (1) pelvic radiation is associated with significant morbidities; (2) neoadjuvant chemoradiation may overtreat some patients whose risk of local failure is low after TME alone; and (3) moving systemic chemotherapy more proximately in the treatment regimen may benefit some patients. The trial’s primary endpoints are R0 resection rate, time to local recurrence, and disease-free survival.

Adult patients (ages ≥18 years) with biopsy-proven rectal adenocarcinoma of the following characteristics are eligible:

- Clinical stage T2N1, T3N0, or T3N1 (stage II À, II À A, or II IB) as...
determined by operative surgeons’ exam, computed tomography scan, pelvic magnetic resonance imaging (MRI), or endorectal ultrasound
- Tumor located at 5 to 12 cm (inclusive) of the anal verge on endoscopy
- Candidate for sphincter preservation TME before any neoadjuvant therapy

Additional criteria include: Adequate performance status; satisfactory laboratory studies; at least 3 mm of circumferential tumor clearance to mesorectal fascia; no obstructive symptoms; no prior pelvic radiation, chemotherapy, or malignancy.

Surgeons and the American College of Surgeons (ACS) Clinical Research Program of the Alliance group are integral to the success of this clinical trial for several reasons:
- Surgeons represent a port of entry for enrolling patients. Surgeons are often the first referring physicians for patients with newly diagnosed rectal cancer, and are responsible for coordinating subsequent multidisciplinary oncologic care. Surgeons are thus well-positioned to introduce this trial to potentially eligible patients, and to shepherd enrolled patients through the trial.
- Surgeons play a key role in the evaluation and identification of potential patients. Operative surgeons’ assessment of clinical tumor stage, circumferential resection margin, endoscopic tumor location, and most importantly, candidacy for sphincter preservation, form the very basis for determining eligibility for this trial.
- Surgeons must maintain high-quality tumor resection by TME technique for trial results to be interpretable. The common backbone of this trial is high-quality TME. Because TME and pelvic radiation are the key local treatment modalities for rectal cancer, and because the feasibility of omitting radiation is being tested by the trial, the quality of TME must be carefully and uniformly maintained. Participating surgeons must be credentialed in TME surgery through a process described in the sidebar on this page.

In summary, the Alliance and its American College of Surgeons (ACS) Clinical Research Program are poised to conduct this new clinical trial, which has the potential to dramatically change the current paradigm of rectal cancer treatment. Surgeon participation is pivotally important to this trial, and you are invited to participate. The study co-chairs include Alessandro Fichera, MD, FACS, a colorectal surgeon from the University of Chicago (IL); Debra Schrag, MD, a medical oncologist from Dana-Farber Cancer Institute, Boston, MA; and Robert McWilliams, MD, a medical oncologist from Mayo Clinic, Rochester, MN. The National Cancer Institute Adult Central Institutional Review Board has fully approved the trial.

For additional information regarding the credentialing process, contact Dr. Fichera at afchera@bsd.uchicago.edu. Any additional information about this trial may be obtained by contacting Dr. Schrag at deb_schrag@dfci.harvard.edu.

Dr. You is assistant professor, department of surgical oncology, and affiliate faculty of the clinical cancer genetics programs, University of Texas MD Anderson Cancer Center, Houston. She is a member of the Education Committee of the Alliance/ACS Clinical Research Program.

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

### Three steps to prepare for activating this trial at your institution

1. **Become a credentialed enrolling surgeon.**

   To ensure high-quality TME in this trial, surgeons are asked to undergo a credentialing process. Credentialing material includes operative and pathology reports of 10 rectal cancer resections performed within the last three years, and photographs (showing anterior and posterior views) of three different TME specimens.

   Surgeons should e-mail this material to tme_cred4prospect@calgb.org as soon as possible. They will be notified by the credentialing committee within two weeks.

   Surgeons previously credentialled for the American College of Surgeons Oncology Group (ACOSOG) Z6051 or previously instructed in the Total Mesorectal Excision Surgical Skilled Optimization Program are exempt from this credentialing process.

2. **Assemble a local study team.**

   Surgeons should identify a medical oncologist with whom they can partner as co-principal investigators at the local institution. Due to the complexity of the trial, collaboration from medical and radiation oncology will be critical.

3. **Submit the study protocol to the local institutional review board for approval.**

   This step is a prerequisite for trial activation and patient accrual at the local institution.
Earlier this spring, Joint Commission Resources (JCR), an affiliate of The Joint Commission (TJC), and Janssen Pharmaceuticals, Inc. released five new educational modules, which provide health care organizations with a strategic approach to successfully implementing and evaluating antimicrobial stewardship programs (ASPs). The modules, which are available free of charge, use established performance improvement tools and methods, and focus on the following issues:

- The clinical importance and impact of ASPs
- The business rationale for ASPs
- Strategies to initiate ASPs
- Key strategies ASPs can use to positively affect antimicrobial use
- Measuring and reporting ASP metrics

Interest in improving ASPs makes sense for today’s health care organizations, because an ASP can help these facilities analyze their use of antimicrobial agents. This analysis is essential, considering the diminishing number of new antimicrobial agents and the expanding number of multidrug-resistant organisms (MDROs), which limit the usefulness of existing antimicrobial agents. With the growing demand to address MDROs and health care-associated infections (HAIs), many organizations are preparing to improve their own approach to evaluating antimicrobial use. These new ASP modules provide a helpful and informative direction for implementing such a program.

In addition to potential clinical benefits, when effective antimicrobial stewardship is combined with a comprehensive infection prevention and control program organizations can also benefit from what is usually viewed as a secondary goal of antimicrobial stewardship—reducing health care costs without adversely affecting the quality of care.

The second antimicrobial stewardship module points out that it is important for health care organizations to realize that effective ASPs can be financially self-supporting and improve patient care. Antimicrobials that are used inappropriately result in unnecessary exposure to medications, persistent or progressive infection, emergence of antimicrobial resistance, increased costs, prolonged hospitalizations, and increased patient mortality—all of which are important factors to consider when developing an ASP. The annual cost of these infections in the U.S. is estimated to be greater than $5 billion.

The major effects that a successful ASP may have on a health care organization include improved patient outcomes and reduced adverse events due to pathogens, such as MDROs and Clostridium difficile, which contribute to an increasing number of HAIs. Organizations with existing ASPs may choose to evaluate their programs against defined metrics to ensure that maximum value is being realized. ASP evaluation and improvement are especially important in surgical settings where the risk for HAIs often is elevated.

The Affordable Care Act (ACA) of 2010 makes an even stronger case for having an effective ASP. The ACA uses the Centers for Medicare & Medicaid Services’ hospital value-based purchasing program to change the existing culture in health care to focus on value rather than volume in determining payment incentives. Investing in technology, knowledgeable practitioners, and best practices, including antimicrobial stewardship, will become even more essential to better patient outcomes and resource use in health care.

Hospitals and other health care organizations should also consider the TJC’s requirements when evaluating their own ASP. For example, National Patient Safety Goal NPSG.07.03.01 requires health care organizations to implement evidence-based practices to prevent HAIs due to MDROs.

For more information about ASPs and how to implement them, access the ASP modules at http://www.abxstewardship.com, or visit JCR’s MDRO learning community at http://jcrinc.com/Learning-Community-Home.
American College of Surgeons Professional Association (ACSPA)

In 2011, the ACSPA’s political action committee (ACSPA-SurgeonsPAC) raised $665,692. Approximately 77 percent of U.S. Governors of the American College of Surgeons (ACS) contributed an average of $467. The SurgeonsPAC Board met for a strategic planning session in January in an effort to update and align 2012 strategic objectives with tactics.

On the 10-year anniversary of ACSPA-SurgeonsPAC, the SurgeonsPAC Board and management see 2012 as a crucial year for growth. As of September 2011, the SurgeonsPAC had contributed $306,500 to 95 candidates, leadership PACs, and party committees. For more information about the ACSPA-SurgeonsPAC, go to http://www.facs.org/acspa/index.html.

American College of Surgeons (ACS)

Committee on Optimal Access

The Board of Regents approved the formation of a new Committee on Optimal Access in October 2011. The basic goals of this committee are as follows:

- To determine the metrics and analyses required to accurately assess the magnitude of health care disparities in the various disciplines of surgery
- To develop specific strategies for addressing health care disparities in select surgical environments—particularly areas having a documented propensity for extreme inequalities in surgical care
- To orchestrate alliances and partnerships with specific regional entities and organizations known to have “best practices” for combating health care disparities in surgery
- To establish funding mechanisms (for example, the Robert Wood Johnson Foundation, National Institutes of Health, Centers for Disease Control and Prevention, and the Bill and Melinda Gates Foundation) for major strategic initiatives designed to address the health care disparities in the care of the surgical patient
Research and Optimal Patient Care

- A total of 453 sites are participating in the ACS National Surgical Quality Improvement Program (ACS NSQIP®), and more than 50 additional sites are in the process of enrolling. In addition, more than 200 sites, including many international hospitals, currently are in talks with ACS NSQIP representatives about joining the program.

Approximately 60 percent of ACS NSQIP participating hospitals are in a collaborative where either quality improvement ideas and/or ACS NSQIP data are shared. A total of 28 collaboratives are now operational, and approximately seven more groups are interested in starting regional, system-wide, or virtual collaboratives.

In order to provide proven, more robust quality information, the ACS has been working with the Centers for Medicare & Medicaid Services (CMS) to allow ACS NSQIP to publicly report outcomes on the U.S. Department of Health and Human Services’ Hospital Compare website voluntarily, beginning this summer. Participating hospitals will voluntarily report on any combination of three National Quality Forum-endorsed measures: elderly surgery outcomes, colectomy outcomes, and lower extremity bypass.

Johns Hopkins University and ACS NSQIP are partnering to develop, implement, and evaluate a program intended to improve surgical patient outcomes and prevent complications. Based on the successful Comprehensive Unit-Based Safety Program, this pilot program will launch with 100 ACS NSQIP hospitals—10 hospitals in 10 states. The program will focus on implementing evidence-based protocols, improving teamwork, and sustaining organizational change.

The 2012 ACS NSQIP National Conference will take place July 21–24 in Salt Lake City, UT, at The Grand America Hotel and will include multiple preconference sessions. Brent C. James, MD, MStat, from Intermountain Healthcare, will be the keynote speaker.

- The ACS Bariatric Surgery Centers Network (ACS BSCN) also is expanding. The ACS BSCN is composed of 141 fully approved and seven provisionally approved centers, and five initial applications were under review at the time of the meeting. The ACS BSCN responded to a request for comment on the CMS proposal for a national coverage determination to include the sleeve gastrectomy as a covered procedure for Medicare patients.

The American Society of Metabolic and Bariatric Surgery (ASMBS) announced the termination of its contractual relationship with its vendor. This action sped up the ongoing discussions regarding unification of the ACS and the ASMBS bariatric surgery accreditation programs to create a joint body administratively supported by the ACS, which became effective on April 1.

- The ACS has continued development of a Surgeon-Specific Registry (SSR) that will target the following three items currently being used to assess individual surgeons:
  - Maintenance of Certification (MOC) by the American Board of Surgery (and other specialty boards)
  - The Physician Quality Reporting System (PQRS) by CMS
  - The Ongoing Practice Performance Evaluation by The Joint Commission

  Decisions are being evaluated regarding configuration, pricing, auditing, and data entry screens. The SSR will likely be offered with options. One option will target MOC Part IV. The second option will be nearly identical to the Case Log. The SSR is also being designed to meet PQRS’ requirements.

- With regard to ACS Cancer Programs, the Commission on Cancer (CoC) concluded 2011 with the launch of two major initiatives. First was the release of new standards for cancer program accreditation. A patient-centered approach is the focus for the Cancer Program Standards 2012: Ensuring Patient-Centered Care. These new standards are required for implementation by all CoC-accredited cancer programs beginning in 2012. Second was the release of the Rapid Quality Reporting System, a tool to facilitate quality cancer care delivery. Enrollment is open to CoC-accredited facilities, and participation is voluntary. Since the program’s release, 15 percent of the CoC’s 1,500 accredited cancer programs have enrolled.
The CoC held an application process for a two-year fellowship in surgical oncology outcomes and health services research. The CoC has a two-year position, supported by Genentech, available beginning July 1, 2012. The fellow will work in the Cancer Programs Department to conduct clinical research and further the research agenda of the CoC’s National Cancer Data Base with the goal of improving the quality of care for cancer patients.

A communication was sent to all CoC-accredited cancer programs regarding implementation of the new standards for accreditation. In addition, a brief PowerPoint presentation was provided, which explains the new standards. The CoC Surveyor and Consultant Training Program convened. This program focused on educating the surveyor and consultant teams regarding the new standards scheduled for implementation by all CoC-accredited cancer programs in 2012.

The ACS and the American Cancer Society hosted a two-day meeting to explore future opportunities for collaboration to address the changing health care environment and advance each organization’s respective agendas. In addition, as a key collaborator with the CoC, the American Cancer Society is seeking to enhance its ability to support the 2012 Cancer Program Standards, and, to this end, has collaborated with the CoC on a document, Cancer Program Standards 2012: Ensuring Patient-Centered Care, a Guide for ACS Field Staff and CoC-Accredited Programs. The goal is to identify American Cancer Society resources that will support specific standards. The guide presents key highlights of the 2012 standard revisions and matches American Cancer Society resources.

The Trauma Programs continue to be quite active. Some of the activities in the area of trauma education include:

- Advanced Trauma Life Support Course*  
  —9th edition of the manual and e-course will be released in October 2012  
  —2011 Promulgation: Syria, Oman, Egypt, and Iran
  —Approved applications: Bangladesh, Belize, Bosnia, Croatia, Czech Republic, Georgia, Ghana, Honduras, Iraq, and Poland  
  —Partnering with Operation Giving Back to provide course materials to surgeons on humanitarian missions
- Rural Trauma Team Development Course  
  —New countries: American Samoa, Canada, and India  
  —New online course management system in testing phase
- Disaster Management and Emergency Preparedness Course  
  —2012 scheduled courses: 17  
  —New country: Brazil  
  —Online course management system and e-course is under development (projected release in spring 2012)
- Advanced Surgical Skills for Exposure in Trauma (ASSET) Course  
  —2012 scheduled courses: 17  
  —Special report published in Journal of Trauma (December 2011) on Potential Role of the ASSET Course in Canada
- Advanced Trauma Operative Management Course  
  —2012 scheduled courses: 41  
  —New countries: Italy and Paraguay
- Optimal Trauma Center Organization and Management Course (OPTIMAL)  
  —ACS now offers continuing medical education (CME) credits to physicians participating in OPTIMAL
- Trauma Outcomes and Performance Improvement Course (TOPIC)  
  —ACS now offers CME to physicians participating in TOPIC

In addition, the trauma center Verification, Review, and Consultation (VRC) program is enjoying vigorous activity and continued growth. During calendar year 2011, the VRC conducted 158 on-site verification or consultative reviews, including one foreign review in Landstuhl, Germany. There are currently 354 verified trauma centers in the U.S. The trauma center verification standards found in Resources for Optimal Care of the Injured Patient are being reviewed and revised with publication expected sometime in 2012 or early 2013. A policy and procedures manual that formalizes a performance improvement process for the program has been approved. Additionally,
other nations are expressing increased interest in the program. The VRC and the Trauma Systems Evaluation and Planning Committee are working collaboratively with other trauma programs to develop a comprehensive strategy to best meet the needs of foreign hospitals and systems, taking into account the wide variations in culture and resource availability found in different parts of the world.

The Rural Trauma Committee completed the development of criteria for Level IV trauma centers after an exhaustive review of the standards and requirements imposed by states across the nation. The Rural Trauma Team Development Course is enjoying remarkable success.

The Trauma Quality Improvement Program (TQIP®) held its annual conference in November 2011, in Chicago, IL. The TQIP all-patients report was delivered in November 2011 and the report on elderly patients in January 2012. Upcoming report subjects include trauma brain injury and shock.

The Committee on Trauma (COT) Facebook page had nearly 200 “likes,” and its fan base was continuing to grow rapidly. In addition, a COT Twitter page was soon to be activated.

Rural surgery

The Board of Regents heard a discussion led by Tyler G. Hughes, MD, FACS, and Philip R. Caropreso, MD, FACS, that focused on the unique needs of rural surgeons and the role that the ACS may play in supporting rural surgeons. The discussion provided insight into ACS options regarding rural surgery as it relates to access to high-quality surgical care for the more than 50 million Americans who live in rural locations.

Drs. Hughes and Caropreso pointed out the personal rewards and fulfilling aspects of rural practices. Dr. Caropreso highlighted current College activities relative to rural surgery/surgeons, such as the rural surgery open forums at the annual Clinical Congress, the co-sponsored meetings held at College headquarters, the Rural Surgery Community site in the Web portal, the rural surgery skills courses co-sponsored by the Nora Institute for Surgical Patient Safety, the rural

surgeons’ listserv that Dr. Caropreso maintains, and the dedication of the February edition of Selected Readings in General Surgery (SRGS) to rural surgery. That edition of SRGS centers on the rural surgery workforce, including the characteristics of rural surgery and rural practice, educating surgeons for rural practice, the challenges of recruitment and retention of rural surgeons, and the unique clinical problems encountered in rural surgical practice.

It was emphasized that the rural surgery workforce is shrinking, and that burnout is a factor in this predicament. The College was commended for its attention to rural surgery/surgeons, but was asked to do more. The need for an honest and open dialogue regarding the issues was highlighted, as was a growing “us and them” (FACS and ACS) outlook because the College insufficiently presents itself as an advocate for the rural surgeon.

The College was asked to appoint a rural surgery representative to its Board of Regents and dedicated staff for rural surgeons. It was also requested that the current activities of the College in the rural surgery arena be continued.

Appreciation was expressed to J. David Richardson, MD, FACS, for bringing this issue forward. Various College leaders implored the Board of Regents to support rural surgery/surgeons, due to the rural surgery crisis. The Regents approved the formation of a rural surgery task force and appointed Dr. Richardson to serve as its Chair.

Communications and public profile

Two overarching priorities for the ACS in 2012 are the development of a content strategy and the creation of a bona fide marketing function. The proliferation of news and other information, and the increase in the delivery tools available, have created a need to determine how best to communicate with the College membership. To help ensure that the ACS delivers the information its various members want in the manner they prefer, the ACS is embarking on an initiative to develop a content strategy that will provide the much-needed communications blueprint. This plan is likely to have significant implications for the ACS website, Web portal,
e-mail newsletters, and, to a lesser extent, its print publications.

The College needs a more formalized marketing function. The formalization of such an area in the College would provide the strategic marketing counsel and the technical expertise to ensure that it approaches marketing with the level of sophistication and effectiveness needed to raise awareness and demand for the breadth of its programs, products, and services.

The Bulletin and Surgery News have benefited from readership surveys conducted over the past six months. Both surveys provided improvement opportunities, and editorial and design changes to the Bulletin are being planned. The new Bulletin format will be presented at the 2012 Clinical Congress. In addition, work is being done to create a visually attractive and easy-to-navigate Bulletin microsite, accessible through www.facs.org. The College also is analyzing how the Bulletin may make better use of social media and is planning to develop a version of the magazine that can be accessed and read on tablets, smartphones, and other digital devices.

The College has a new Facebook page, as well as separate pages for various programs, such as the Resident and Associate Society. In addition, the College has a robust Twitter presence and a growing YouTube presence.

The Inspiring Quality campaign has provided an opportunity to strengthen the College’s brand(s). With the development of branding standards it now has a model that ensures that the brand is applied consistently and, as appropriate, co-branded with various programs, such as ACS NSQIP. In addition, the College is developing standards to govern the use of its sub-brands by outside entities.

With the recent hiring of a Communications Manager for the College’s Washington, DC, office, the organization is in a strong position to effectively communicate the array of advocacy and health policy initiatives that the organization carries out on behalf of its members. (Subsequently, Chantay P. Moye officially filled this position). Key to this effort will be the development and execution of a strategy that reflects the unique challenges of communicating about issues that may lack membership consensus or that do not produce bona fide “wins” for College members.

Manuscript submission to publication time was decreased for the Journal of the American College of Surgeons (JACS). While the number of submissions is increasing, JACS is cutting the time from submission to acceptance, and from submission to publication. In addition, most articles are going online as e-published articles, at least one month before appearing in the print version of JACS. Also, to enhance the educational value of the JACS CME program, beginning in April 2012, the College was to expand the program to four questions per article, requiring a score of at least 75 percent to obtain credit. The JACS CME website is being redesigned and will give a more streamlined, user-friendly experience. Users will be able to select articles based on specialty and subject, which will be more useful for meeting Maintenance of Certification requirements. In addition, JACS is working to create a JACS app due to roll out this spring, and to develop a Web-based “JACS Resource Center,” an educational tool that will highlight JACS content pertaining to selected topics.

The ACS public website has been enhanced to include a new feature on the home page that highlights ACS programs and activities in a rotating tabbed format. Work also has begun on redeveloping the ACS patient education section with a stronger emphasis on the ACS patient education materials and resources for surgical patients and their families.

As of December 31, 2011, the ACS member-only portal had received a total of 3,702,666 page views since its launch. The “Communities and Specialties” area of the portal continues to provide content targeted toward ACS members’ main interests, such as ethical challenges and rural surgery. The editorial board continues to evolve. In addition to an Editor in Chief, a social media manager, and 17 at-large editors, there are now 50 community editors and approximately 235 associate community editors involved in the portal’s editorial board.
The GE initiative

Members of the GE team (http://commsweb.facs.org/index.html) have spent the past six months gathering information about the College from its staff, members, and volunteer leaders. The GE team attended the 2011 Clinical Congress in San Francisco, CA, to speak with some of the College’s Regents, Governors, and various other leaders. The insights gleaned from these activities have been extremely helpful in rounding out GE’s assessment of the College’s operations and culture. In addition, various College leaders and executive staff have participated in retreats related to this project. Substantial time has been invested in talking about ways to improve the Board of Governors. A Governors’ task force may be formed and may hold a retreat in order to further explore ideas that have been presented in these talks.

Dr. Napolitano is professor of surgery, University of Michigan Medical School, Ann Arbor, and division chief, acute care surgery, University of Michigan Hospital. She is Chair of the ACS Board of Governors.
The Commission on Cancer (CoC) of the American College of Surgeons has granted the Outstanding Achievement Award (OAA) to 106 currently accredited and newly accredited cancer programs across the U.S.

Established in 2004, the CoC OAA recognizes cancer programs that strive for excellence in providing quality care to cancer patients. The award is granted to facilities that demonstrate a commendation level of compliance with seven standards representing six areas of cancer program activity: cancer committee leadership, cancer data management, clinical management, research, community outreach, and quality improvement. During an on-site evaluation, a physician surveyor determines the level of compliance with the seven standards. In addition, facilities must receive a compliance rating for the remaining 29 cancer program standards.

As a result of surveys performed in 2011, 106 programs, approximately 21 percent of those surveyed, received the OAA. A majority of recipients are community-based facilities; however, there were also teaching hospitals, National Cancer Institute-designated comprehensive cancer centers, Veterans Affairs hospitals, and network cancer programs that received the award.

Go to [http://www.facs.org/cancer/co/coc/outstandingachievement2011list.html](http://www.facs.org/cancer/co/coc/outstandingachievement2011list.html) to view the list of 2011 award recipients.

Third annual WIS international symposium approaches

Sharona Ross, MD, FACS, assistant professor of surgery, Tampa General Hospital, and founder of the University of Southern Florida Women in Surgery initiative, will chair the third annual Women in Surgery (WIS) international symposium from May 31 to June 2 at the Hyatt Regency Hotel in Baltimore, MD.

Julie A. Freischlag, MD, FACS, professor and chair, department of surgery, Johns Hopkins University School of Medicine, will serve as co-chair of the program. American College of Surgeons President, Patricia J. Numann MD, FACS, will deliver the keynote address.

The WIS symposium is the largest professional and academic event dedicated to supporting women surgeons and those pursuing surgical careers. Participants will discuss the issues that face women as they advance in a changing surgical field that is still predominantly male. The program will highlight the importance of advancing women in surgery by providing meaningful avenues for surgical professionals and students to interact, exchange ideas, and formulate effective strategies.

For more information and to register online for the symposium, go to [http://www.cme.hsc.usf.edu/wis/#8](http://www.cme.hsc.usf.edu/wis/#8).
The Committee on Trauma (COT) announced the winners of the 35th annual Residents Trauma Papers Competition at its annual meeting in Chicago, IL. Submissions for the competition, which is open to surgical residents and trauma fellows, describe original research in the area of trauma care and/or prevention in one of two categories: basic laboratory research, or clinical investigation. The Eastern and Western States COTs, Region 7 (Iowa, Kansas, Missouri, and Nebraska), the National Trauma Institute, and the American College of Surgeons all provide funding for the competition.

Submissions begin at the state or provincial level, and winners are then judged at regional competitions. Each region is then eligible to submit two abstracts to a panel of COT judges, who make the final selection for presentation at the Scientific Session of the COT meeting. This year, 13 presentations were given at the session (see boxed item), which was moderated by Raul Coimbra, MD, PhD, FACS, Vice-Chair of the COT, and Chair of the COT Regional Committees. Each of the 13 presenters received a prize of $500; the two first-place winners received an extra $1,000 award, and the second-place winners in each category received an additional $500 award.

The 2012 final winners are as follows:
- **First Place, Basic Laboratory Research:** Laura E. White, MD, Houston, TX (Region 6): Kidney-Lung Crosstalk in Trauma: Identifying Pulmonary Endothelial Cell Alterations during Ischemic Acute Kidney Injury.
- **First Place, Clinical Investigation:** Kristin M. Cook, MD, Newark, NJ (Region 2): The Association between Plasma G-CSF Level and Signs of Bone Marrow Failure following Severe Trauma.
- **Second Place, Basic Laboratory Research:** Alex G. Cuenca, MD, Gainesville, FL (Region 4): Of Mice and Men: Commonality of the Murine and Human Response to Burn Injury.
- **Second Place, Clinical Investigation:** Jennifer C. Roberts, MD, Milwaukee, WI (Region 5): The Treatment of Low-Risk Pulmonary Emboli in the Trauma Population.

### Resident Trauma Papers Competition presenters

<table>
<thead>
<tr>
<th>Presenter Name</th>
<th>Region</th>
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<tr>
<td>Danielle K. DePeralta, MD</td>
<td>Region 1</td>
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<td>Kristin M. Cook, MD</td>
<td>Region 2</td>
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<td>Joshua B. Brown, MD</td>
<td>Region 3</td>
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<td>Alex G. Cuenca, MD</td>
<td>Region 4</td>
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<td>Jennifer C. Roberts, MD</td>
<td>Region 5</td>
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<tr>
<td>Laura E. White, MD</td>
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<td>Jacob A. Quick, MD</td>
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<td>Jeffrey N. Harr, MD</td>
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<td>Todd W. Costantini, MD</td>
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<td>Gordon M. Riha, MD</td>
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<td>Andrew P. Smith, MD</td>
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<td>David Gomez Jaramillo, MD</td>
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<td>Juan C. Salamea, MD</td>
<td>Region 14</td>
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Left to right: Michael F. Rotondo, MD, FACS, ACS COT Chair; Dr. Cuenca; Dr. Roberts; Dr. White; Dr. Cook; and Dr. Coimbra.
The National Ultrasound Faculty of the American College of Surgeons has developed “Ultrasound for Surgeons: The Basic Course, 2nd Edition” on CD for physicians and medical professionals in ultrasound imaging.

The 2nd Edition includes:

- Updated graphics using 3-D medical modeling developed by NASA researchers to teach ultrasound and rapidly demonstrate key ultrasound skills
- Targeted clinical applications: Head and Neck, Breast, Vascular, Abdominal, Thoracic, Critical Care/Trauma, Foreign Objects, and Fractures
- Cue Cards to view and print to prompt learners on three commonly performed scans
- 4 AMA PRA Category 1 Credit™

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

To purchase, go to www.acs-resource.org or call 888-711-1138
The Clinical Congress of 1959 took place in Atlantic City, NJ, with President Newell W. Philpott, MD, FACS, and incoming President Owen Wangensteen, MD, FACS, presiding.

The program featured U.S. Secretary of State Dean Rusk, who at the time was president of the Rockefeller Foundation, New York, NY, and delivered the 14th Martin Memorial Lecture. A program of “Musical Memories,” with singers Kirsten Kenyon, Margo Moser, and Warren Traiter, entertained the gathering. C. Everett Koop, MD, FACS, who went on to become Surgeon General of the U.S. under President Ronald Reagan, chaired a postgraduate course on Surgery of the Chest.

The new technology of color telecasts was introduced, emanating from Bellevue Hospital in New York, NY, with a moderator transmitting questions from the convention hall audience to the panelists, who held forth from a special television studio in Atlantic City, NJ, thus effecting a three-way conversation.

But who were these young surgeons meeting with C. Rollins Hanlon, MD, FACS (second from right), and another distinguished surgeon? Help us identify them if you can! Contact Susan Rishworth, ACS Archivist, at 312-202-5270 or srishworth@facs.org.

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From the Archives

Do you recognize the people in this photo from the 1959 Clinical Congress?

The Clinical Congress of 1959 took place in Atlantic City, NJ, with President Newell W. Philpott, MD, FACS, and incoming President Owen Wangensteen, MD, FACS, presiding.

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1. In-depth, topic-oriented overviews provide you with the latest approaches to surgical practice, supported by the literature, so that you can respond constructively to patients who come armed with information from the Internet.

2. The “What You Should Know” tab of the SRGS Connect website alerts you to recent literature contributions and gives you perspectives from expert surgeons. These commentaries provide a quick analysis of the strengths and weaknesses of articles you might have missed.

3. “The Knowledgeable Surgeon” section offers a pleasurable read on important social issues (medicine, government, society).

4. SRGS is one of the most economical ways to earn 80 AMA PRA Category 1 Credits™ in surgery annually. The SRGS CME program counts as self-assessment credit for Maintenance of Certification (MOC).

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Get immediate access to high-quality content when you place an SRGS Connect order today.
IRC announces two new travel awards for 2013

The International Relations Committee (IRC) of the American College of Surgeons (ACS) is pleased to announce two new travel awards—the Community Surgeon Travel Awards—for surgeons who are ages 30 to 50. These awards, in the amount of $4,000 each, provide international surgeons with the opportunity to attend and participate fully in the educational activities of the annual Clinical Congress. They are proposed to specifically assist surgeons who work in community or regional hospitals or clinics in countries other than the U.S. and Canada, or who are from struggling academic departments of surgery in low- or middle-resource countries. For the year 2013, preference will be given to candidates from African nations.

A successful applicant will show evidence of commitment to high-quality surgery, to surgical teaching, and to improving access to surgical care in his or her community. Each awardee will receive gratis registration to the Annual Clinical Congress and to one available postgraduate course at the Congress. Assistance will be provided to obtain preferential affordable housing in a hotel in the Clinical Congress city. The 2013 Clinical Congress will take place in Washington, DC, October 6–10.

Following the Clinical Congress, the awardees will send a brief report of their experiences to the International Relations Committee, specifically focusing on the value of the visit to the awardee and the potential beneficial effect to patients in the countries of origin.

For the full requirements and the online application form, see the ACS Scholarship Web page, http://www.facs.org/memberservices/research.html. Supporting documents and questions should be directed to: Administrator, International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, USA; e-mail kearly@facs.org; or fax 312-202-5021.

Completed applications for the Community Surgeon Travel Awards for the year 2013 and all supporting documents must be received at the office of the International Liaison Section before July 1, 2012, in order for an applicant to receive consideration from the selection committee. All applicants will be notified of the selection committee’s decision in November 2012.
International Guest Scholarships available for 2013

The American College of Surgeons (ACS) is offering International Guest Scholarships in 2012 to outstanding young surgeons from countries other than the U.S. or Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $10,000 each, provide the International Guest Scholars with an opportunity to visit clinical, teaching, and research institutions in North America and to attend and participate fully in the educational opportunities and activities of the ACS Clinical Congress in Washington, DC, in 2013.

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

The scholarship requirements are as follows:

- Applicants must be medical school graduates.
- Applicants must be at least 35 years of age, but younger than 45, on the filing date of the completed application.
- Applicants must submit their applications from their intended permanent location. The College will accept applications for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
- Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of their respective home country.
- Applicants whose careers are in the developing stage are deemed more suitable for receipt of this scholarship than those who are serving in senior academic appointments.
- Applicants must submit a fully completed application form provided by the College on its website. The application and accompanying materials must be submitted in English. Submission of a curriculum vitae without a completed application is not acceptable.
- Applicants must provide a list of all of their publication credits and must submit three complete publications (reprints or manuscripts) of their choosing from that list.
- Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which the applicant holds academic appointment or a Fellow of the ACS residing in the applicant's country. The chair’s or the Fellow's letter must include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant.

- The International Guest Scholarships must be used in their designated year. Recipients cannot postpone the scholarship.
- Applicants who receive scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.
- An unsuccessful applicant may reapply only twice, and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

International Guest Scholarships provide successful applicants with the privilege of participating in the College’s annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses, plus admission to all lectures, demonstrations, and exhibits, which are an integral part of the Clinical Congress. Assistance will be provided in arranging visits (following the Clinical Congress) to various clinics and universities of the scholars’ choosing.

To qualify for consideration by the selection committee, applicants must fulfill all of the requirements. The application form for the ACS International Guest Scholarship is available online on the College’s website at http://www.facs.org/member-services/igs.html. Questions should be directed to: Kate Early, International Liaison, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211 USA; kearly@facs.org.

The ACS must receive all completed applications, including all the supporting documentation for the 2013 International Guest Scholarships, no later than July 1, 2012.

All applicants will be notified of the selection committee’s decision in November 2012. The College urges applicants to submit their completed application package as early as possible in order to provide sufficient time for processing.
The family and friends of the late Claude H. Organ, Jr., MD, FACS, in 2007 established an endowment through the American College of Surgeons (ACS) Foundation to provide funding for an annual fellowship to an outstanding young surgeon from the Society of Black Academic Surgeons, the Association of Women Surgeons, or the Surgical Section of the National Medical Association. The fellowship, in the amount of $5,000, enables a U.S. or Canadian Fellow or Associate Fellow under age 45 who is a member of one of the societies noted previously to attend an educational meeting or to make an extended visit to an institution of his or her choice, tailored to his or her research interests.

Past awardees have used their fellowships to develop their careers in creative ways. Patricia Turner, MD, FACS, who received the fellowship in 2008 and now serves as Director of the College’s Division of Member Services, performed collaborative research on patient history and surgical outcomes with the anesthesia outcome research group at the Cleveland Clinic. Bridget Fahy, MD, FACS, the 2009 awardee, joined the American Academy of Hospice and Palliative Medical Clinical Scholars. Melina Kibbe, MD, FACS, the 2010 recipient, participated in the Executive Leadership in Academic Management for Women program. Carla M. Pugh, MD, FACS, the 2011 recipient, attended the ACS Clinical and Translational Research and Education Meeting.

The full requirements for the Claude H. Organ, Jr., Traveling Fellowship are posted at http://www.facs.org/memberservices/research.html. The deadline for receipt of all application materials is July 1, 2012, and the College will inform applicants of the decision by September 1, 2012. Submit questions and applications to the attention of the ACS Scholarships Administrator at kearly@facs.org.

PROVIDE YOUR PATIENTS WITH LEADING-EDGE, HIGH-QUALITY BREAST CARE

Seek accreditation from the National Accreditation Program for Breast Centers (NAPBC). NAPBC accreditation is the best way for your center to offer patients every significant advantage in their battle against breast disease. NAPBC-accredited centers:

- Demonstrate a commitment to high standards of clinical practice and quality improvement by utilizing nationally recognized, multidisciplinary quality performance measures.
- Participate in data collection to monitor outcomes and improve the quality of care at local, state, and national levels.
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MAY 2012 BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS
2011 CLINICAL CONGRESS WEBCASTS

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More than 100 MP3s of Named Lectures and Panel Sessions
BONUS: Access to 42 webcast sessions from past Clinical Congresses
Price: $530 ACS Member
       $610 Nonmember

2011 Webcast Package
All 33 webcasts of 2011 Clinical Congress
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       $460 Nonmember

Webcasts will be available for viewing from December 15, 2011, until December 31, 2012.

www.acs-resource.org
ACS offers international scholarships for surgical education, training

The American College of Surgeons’ (ACS) Division of Education and the International Relations Committee are pleased to announce two international scholarships focused on surgical education and training. The two scholarships will offer faculty members from countries other than the U.S. and Canada the opportunity to participate in a variety of faculty development activities that will result in acquisition of new knowledge and skills in surgical education and training. This knowledge and these skills will be useful in improving surgical education and training in the scholar’s home institution and country.

The two scholars will participate in the annual ACS Clinical Congress, including the course Surgical Education: Principles and Practice, as well as other plenary sessions and courses that address surgical education and training across the continuum of professional development. This continuum may include the needs of practicing surgeons across their entire careers, as well as the needs of surgery residents, medical students, and other members of the surgical team.

Following the Clinical Congress, each scholar will visit two Level I ACS-accredited Education Institutes selected in advance based on the scholars’ interest areas in surgical education and training. At the conclusion of the Clinical Congress and his or her visits to the ACS-accredited Education Institutes, each scholar will send to the International Relations Committee and to the Division of Education a brief report outlining the outcomes that have been achieved as a result of the scholarship, specifically focusing on achievement of the objectives outlined in the application for scholarship. The scholarships will facilitate the scholars’ involvement in subsequent collaborative ventures in education and training under the aegis of the ACS Division of Education.

Each scholarship provides a stipend of $10,000, supporting travel and per diem in North America, and the cost of courses undertaken at the Clinical Congress and at the ACS-accredited institutes to be visited. Clinical Congress registration and fees for attendance at the Surgical Education: Principles and Practice course will be provided gratis, as well as assistance in obtaining affordable housing in the Clinical Congress city.

Applicants must provide documentation of prior experience in surgical education and training, such as involvement in the development and evaluation of education modules, use of novel teaching and assessment strategies, or curriculum design. In addition, applicants must submit a one-paragraph description of their education philosophies, a list of specific educational goals and objectives for their visits, and evidence of support of these goals and objectives from the leadership at their home institutions. These documents will be reviewed by the Division of Education as part of the selection process. At least five years of experience is required beyond completion of all training and fellowships. Scholarships must be used in the year awarded; they may not be postponed.

Full scholarship requirements may be reviewed at http://www.facs.org/memberservices/research.html. The application for the scholarship may be accessed at the bottom of the requirements page. Questions may be directed to the ACS International Liaison at kearly@facs.org.

All applications materials and related documents are due no later than May 31, 2012, for attendance at the 2012 Clinical Congress in Chicago, IL, September 30–October 4, and no later than July 2, 2012, for the 2013 Clinical Congress in Washington, DC, October 6–10.
So, You Want to Be a Surgeon...

Medical student guide to residency training

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

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.
In spite of all the education, public awareness campaigns, and outreach programs, drinking and driving continues to be a problem that our society faces each day. According to the U.S. Department of Transportation National Highway Traffic and Safety Administration’s Traffic Safety Facts, an alcohol-impaired driving fatality occurred every 48 minutes in 2009. That same year, 10,839 people were killed in alcohol-impaired driving crashes, with the 21- to 24-year-old age group comprising more than one-third of all fatalities. Alcohol-related fatalities accounted for 32 percent of the total of all motor vehicle traffic fatalities that year.\(^*\)

Alcohol-impaired drivers are defined as those drivers who have blood alcohol concentrations (BAC) of .08 grams per deciliter (g/dl) or greater and are the operators of any motor vehicle, including a motorcycle. In 2010, according to a Centers for Disease Control and Prevention press briefing, alcohol-impaired adults in the U.S. got behind the wheel 112 million times, which averages out to about 300,000 episodes of drinking and driving per day.\(^*\) Whereas all of the above statistics are lower than those for previous years, alcohol-impaired driving remains a significant public health concern.


“Drinking alcohol”—also called ethanol, ethyl alcohol, pure alcohol, or grain alcohol—is a flammable, volatile drug with intoxicant properties. The alcohol in beverages is created through the process of fermentation, in which yeast fungus feeds on a substrate (sugar/starch) found in select plants, such as grapes or barley. During this process, ethyl alcohol is excreted along with carbon dioxide. The different tastes, colors, flavors, and strengths come from the use of various vegetables or fruits, as well as other additives, the diluting substances, and the by-products used. This fermentation process is one of the earliest biotechnologies undertaken by humanity that spans across time from the ancients through the moonshine stills, prohibition, and up to the sophisticated microbreweries of today. The standard measure for an alcoholic beverage in the U.S. is any drink that contains six-tenths of an ounce (14.0 grams or 1.2 tablespoons) of pure alcohol. This amount is found in 12 ounces of a regular beer or wine cooler, 8 ounces of malt liquor, 5 ounces of wine, or 1.5 ounces of 80 proof distilled spirits or liquor (such as rum, gin, vodka, or whiskey).1

To examine the occurrence of alcohol-related injured drivers of motor vehicles in the National Trauma Data Bank® (NTDB) research dataset for 2010, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Specifically searched were external cause of injury E codes 810 (motor vehicle crash with train); 811 (motor vehicle crash with re-entrant motor vehicle); 812 (motor vehicle crash with another motor vehicle); 813 (motor vehicle crash with other vehicle); 814 (motor vehicle crash with pedestrian); 815 (motor vehicle crash with collision on highway); 816 (motor vehicle crash due to loss of control); and 819 (motor vehicle crash, unspecified nature). These records were searched by the E code post decimal value of .0 for driver of a car or .2 for driver of a motorcycle (motorcyclist).

A total of 128,047 records for drivers/motorcyclists were uncovered. In all, 103,816 records contained a hospital discharge status, including 79,598 patients discharged to home, 12,153 to acute care/rehab, and 8,687 sent to skilled nursing facilities; 3,378 died. These patients were 67.5 percent male, on average 41.5 years of age, had an average hospital length of stay of 6.0 days, an intensive care unit length of stay of 6.3 days, an average injury severity score of 12.2, and were on the ventilator for an average of 7.4 days.

A total of 73,942 drivers/motorcyclists were tested for alcohol, with 35 percent testing positive. Of the drivers/motorcyclists who died and were tested, 26 percent were legally impaired based upon their BAC (see Figures 1 and 2, page 55).

Web pages that boast BAC calculators are available and can help people determine whether it is safe to drive after drinking by analyzing weight, gender, number of drinks containing alcohol consumed, and the time over which they were consumed. However, many factors go into determining an individual’s specific blood alcohol level, including what and when the person may have eaten or if the individual is taking any medications. There are smartphone applications (apps) that have BAC calculators; one even uses the phone’s camera to assess eye movements for horizontal gaze nystagmus to determine BAC.

The best strategy is to be responsible and to know one’s personal limitations. When those limits have been exceeded, people should consider alternate modes of transportation or travel with designated drivers. In fact, instead of using that smartphone to calculate BAC, it’s probably best to use it to call a cab.

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

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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.