The critical state of graduate medical education funding
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Author bios

**DR. BLAGG**  (a) is a PGy-4 plastic and reconstructive surgery resident, University of Utah, Salt Lake City.

**DR. DEMMY**  (b) is clinical chair, department of thoracic surgery, Roswell Park Cancer institute, Buffalo, and professor of oncology, School of Medicine and Biomedical Sciences, State University of New York at Buffalo.

**DR. FANTUS**  (c) 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.

**DR. FIELDS**  (d) is professor and vice-chair, department of surgery; program director, general surgery residency program; and chief, division of trauma and surgical critical care and acute care surgery, University of Nevada School of Medicine, Las Vegas.

**MR. GANJAWALLA**  (e) is a research associate with the department of plastic and oral surgery, Children’s Hospital, Boston.

**DR. GARRY**  (f) is assistant clinical professor, department of surgery, University of California, San Francisco-Fresno, CA.

**MS. GRILL**  (g) is State Affairs Associate, American College of Surgeons (ACS) Division of Advocacy and Health Policy, Chicago, IL.

**DR. IBANGA**  (h) is the founder and director of Pro-Health international.

**DR. KAUPS**  (i) is health sciences clinical professor of surgery and program director, surgical critical care fellowship, University of California, San Francisco, Fresno, and surgical intensive care unit director, Community Regional Medical Center, Fresno, CA. She is Chair of the Governors’ Committee on Physician Competency and Health.

**DR. KIM**  (j) is the co-associate program director, surgical residency program, St. Luke’s-Roosevelt, Columbia University College of Physicians and Surgeons, New York, NY. In 2010 she founded the Surgical Mission Fund to help support resident missions overseas.

**DR. MAA**  (k) is assistant professor, department of surgery, University of California, San Francisco.

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Author bios continued

**Ms. Macias** (l) is State Affairs Associates, ACS Division of Advocacy and Health Policy, Chicago, IL.

**Dr. Matsen** (m) is a PGY-7 and chief resident in general surgery, University of Utah, Salt Lake City.

**Dr. Mattox** is the Distinguished Service Professor in the Michael E. DeBakey Department of Surgery at Baylor College of Medicine, Houston, TX.

**Dr. Meara** (n) is plastic surgeon-in-chief, Children’s Hospital Boston, and associate professor of surgery and director of the program in global surgery and social change, Harvard Medical School, Boston, MA. He is Chair of the College’s Legislative Committee.

**Dr. Metzler** (o) is a student at Harvard Medical School studying health systems improvement and health care policy at Children’s Hospital Boston.

**Dr. Nelson** (p) is the Fred C. Andersen Professor of Surgery and Chair, division of surgery research, Mayo Clinic, Rochester, MN, and Program Director of the Alliance/ACS Clinical Research Program.

**Ms. Ollapally** (q) is Senior Regulatory Associate, ACS Division of Advocacy and Health Policy, Washington, DC.

**Dr. Pellegrini** (r) is The Henry N. Harkins Professor and Chair, department of surgery, University of Washington, Seattle. He is ACS President-Elect and Past-Chair, Board of Regents.

**Dr. Podratz** (s) is the Joseph I. and Barbara Askins Professor of Surgery, Emeritus, and professor of obstetrics and gynecology, the Mayo Clinic, Rochester, MN.

**Dr. Schwartz** (t) is professor of surgery and pediatrics, Drexel University College of Medicine and Temple University, and surgeon-in-chief, St. Christopher’s Hospital for Children, Philadelphia, PA.

**Dr. Warshaw** (u) is W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School, and senior consultant, international and regional clinical relations, Massachusetts General Hospital and Partners HealthCare, Boston, MA.

**Dr. Wedderburn** (v) is director of trauma and critical care at St. Luke’s-Roosevelt and co-associate program director of the residency program.
On Christmas Day 2008, John Pryor, MD, FACS, was killed by mortar shrapnel while serving as a combat surgeon in Mosul, Iraq. A dedicated trauma and military surgeon, Dr. Pryor devoted much of his career after the September 11, 2001, attacks on the U.S. to serving his country.

Many stories have been written about Dr. Pryor since his death, including an article in the May 2009 Bulletin. But perhaps no one is better able to tell his story than Dr. Pryor himself, and his brother Richard J. Pryor, MD, a retired emergency physician, has enabled him to do just that in a new book titled Alright, Let’s Call It a Draw: The Life of John Pryor. To write this unique book, Dr. Richard Pryor compiled his brother’s journal entries, his own memories, correspondence, and interviews to allow John Pryor to tell his own life’s story.

I have read the book and found it to be an honest, vivid, and heart-breaking story—particularly those sections that take place in the combat zone. For this month’s column, however, I would like to share this space with Kenneth Mattox, MD, FACS, who knew Dr. Pryor and who has written a wonderful review of this book. Dr. Mattox masterfully weaves into his review comments on trauma surgery as a career and how it affects our loved ones.

I hope that Dr. Mattox’s commentary will encourage all members of the American College of Surgeons—from medical students to retired surgeons—to read Alright, Let’s Call It a Draw and to think about the enormous sacrifices military physicians and nurses, as well as their families, make for our country.

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For this month’s column...
I would like to share this space with Kenneth Mattox, MD, FACS, who knew Dr. Pryor and who has written a wonderful review of this book.
Alright, Let’s Call It a Draw: The Life of John Pryor,
by John and Richard Pryor

by Kenneth Mattox, MD, FACS

I write this as a review of a book that touched me in many ways, but also as an editorial on the evolution of surgical education and practice and the impact this career choice can have on family and friends. Indeed, this review serves as a call for all health care professionals to analyze how your career choices affect the other people in your lives.

Although graphic and, at times, painful reading, this is a book you will want to read—a book about humanism in medicine, professionalism, dedication, and the drive of trauma surgeons.

Unique account

“My name is John Pryor. I’m a surgeon. I’ll be 43 next month, An D i Ju ST Go T KiLLEd.” So begins Alright, Let’s Call It a Draw: The Life of John Pryor. It is beyond rare that anyone gets to write his or her biography and philosophy after death, but John Pryor has done so with the very able assistance of his brother, whose extensive research, writing skills, and recounting of personal anecdotes from Dr. Pryor’s comprehensive diaries and e-mails bring this touching biography home. The end result is an extremely compelling and absorbing page-turner about the human spirit and the struggles that confront all individuals, families, and even societies. Even though the outcome is known from the beginning, each life decision creates intrigue and anticipation.

This one-of-a-kind book, with its unique writing style and story, is a must-read for students contemplating a health care career, trainees who are frustrated with their career choice, and those anticipating a career in trauma or emergency surgery, military medicine, and acute care surgery.

First and foremost, this book is a detailed dissection of the genome of the trauma surgeon committed to the pursuit of excellence and attention to detail in all he does, but most especially, medicine. Every medical and surgical specialty carries with it certain characteristics that make it best-suited for one personality or another, and most health care professionals in other specialties criticize the self-imposed discipline and demanding lifestyle of the trauma surgeon. This trauma surgeon trait is not located on the “y” or “x” chromosome. Surgeons with mindsets like Dr. Pryor’s will read this book in one sitting.

Second, this book is about motivation, drive, vision, and leadership. It demonstrates that individuals can reach their goals if they are focused, deliberate, persistent, and hardworking. What is also clearly revealed is that accomplishing these objectives often comes at a high price, both for the individual and for those who are passengers in the lives of the super-driven trauma surgeon. Nonetheless, the prevalent feeling is that a career birthed out of sacrifice and dedication can be fulfilling and gratifying.

A tragic loss for all

The final chapter on “The Grief Club” alone is worth the price of the book. Although the reader knows and is often reminded of the inevitable end, even with Richard Pryor warning the reader not to read the last chapter unless you have a need to read, the reader is compelled to press on. As I read this chapter, I personally felt the pain of the family and friends of surgeons who sometimes put their passion for their craft before other people and aspects of their lives, only to realize, too late, the effect.

Finally, this book reminds us of our own mortality. John Pryor had a premonition and an acceptance of his death and even prepared for it with many instructions and documents. He told his family that he was not coming back from Iraq. We knew from the beginning of the book how it would end. That end came on Christmas Day, while his wife waited for a call from him that never came. No insights or warnings can really prepare loved ones for such a loss. The tears, the frustration, the anger, and the questions are inevitable. As John reminds us throughout his book, though death is all around us, and we attempt to make preparations, the sudden and painful loss of a husband, father, brother, and friend leaves a vacuum that no amount of planning can fill.

Our lifelong and repeated encounters with death, our personal and societal attempts to deal with death, pain, and injury, our identification with the drive and work of John Pryor, and his courage in going to the heart of danger to treat trauma patients will draw all readers into this intriguing and insightful book on the life of a (trauma) surgeon.
The critical state of graduate medical education funding

by Ian Metzler; Karan Ganjawalla; Krista L. Kaups, MD, MSc, FACS; and John G. Meara, MD, FACS
Medicare provides insurance coverage to elderly and disabled Americans and it also supports graduate medical education (GME). In 2009, Medicare paid $9.5 billion to teaching hospitals for resident training—$3 billion to cover direct costs of approximately 100,000 residency positions and $6.5 billion for the indirect costs of patient care associated with resident training.¹

Given the current budget constraints and economic recession, federal financial support for GME is under greater scrutiny, and in the past five years, legislators have sought to reduce GME funding.² Last year, the Joint Select Committee on Deficit Reduction proposed GME budget cuts of 50 percent in early versions of the Budget Control Act of 2011. Although these drastic cuts were omitted from the final bill, the automatic funding reductions scheduled to occur will result in across-the-board cuts. Medicare, biomedical research, and other health care expenditures, including GME, are expected to see a 2 percent cut due to the sequestration.³ Deficit reduction is still a high-priority political goal, and the potential for further cuts to GME remains a concern.

Compounding the tension about GME funding is the growing shortage of physicians, particularly in primary care and general surgery. The American Association of Medical Colleges (AAMC) projects a physician shortage of 62,900 physicians in the U.S. by 2015 due to the increased medical care needs of an aging population and a growing number of people who will be insured under the Affordable Care Act of 2010 (ACA).⁴ Without an increase in the number of training positions and funding for GME, many medical graduates will be unable to complete the training required to practice independently and therefore will not be in a position to meet the expanding health care demands of the U.S. population.⁵

HIGHLIGHTS

- The funding system for graduate medical education (GME) in the U.S. has reached a critical state.
- The recession and deficit have compelled federal and state governments to begin withdrawing longstanding support for residents and teaching hospitals while, simultaneously, predictions about the health care workforce suggest that more physicians will need to be trained than the current system allows.
- The government and advisory agencies have offered multiple suggestions on how to tackle this issue, but no attainable solutions have been determined.
- This article offers recommendations for moving toward a rational, multi-stakeholder solution to the GME funding crisis.

Current funding streams

Before Medicare, hospitals funded GME. During Medicare’s implementation, legislators believed that society at-large would eventually find other means to bear the costs of GME.¹ Despite attempts to establish long-term alternative sources of support for more than a decade, no policy has significantly addressed Medicare funding for GME, and Medicare remains the primary formal
Compounding the tension about GME funding is the growing shortage of physicians, particularly in primary care and general surgery.

financier of these programs, contributing 72 percent of all tax-financed support. Other federal payors include Medicaid (11 percent), the U.S. Department of Veterans Affairs (10 percent), the U.S. Department of Defense (3 percent), and the Bureau of Health Professions (3 percent). State and local governments also finance GME programs, but specific amounts vary widely.

Teaching institutions may fund GME activities and infrastructure through various informal sources as well. Tracking GME financiers is difficult because educational infrastructure is often paid through the teaching hospital’s general revenues or grants for research, not funds specifically designated for education. It is through this general revenue stream that private insurers provide unofficial, indirect support of GME through individually negotiated payments to teaching hospitals.

• Medicare

The federal government, primarily through Medicare, subsidizes training programs through direct and indirect payment methods. In 2009, Medicare allocated approximately $3 billion in direct graduate medical education (DGME) payments and $6.5 billion in indirect medical education (IME) payments, averaging out to more than $100,000 per resident per year. Both DGME and IME payments are hospital-specific, based on the institution’s share of Medicare patients and the resident-to-bed ratio as a measure of teaching intensity. See Table 1, page 12, for a summary of DGME and IME funding streams.

Under Medicare, GME has been viewed as a “public good” deserving billions of dollars from state and federal public funds. However, some analysts claim that Medicare distributes this funding with insufficient accountability for the proportion and quality of medical specialists produced. Relatively little information is available about what it truly costs participating hospitals to train residents or where the funds are specifically directed in their organization. Without accountability, teaching hospitals have been primarily focused on their individual workforce needs and more profitable specialties. Structured as it is, the current system of funding does not incentivize programs to train physicians for broader public interests or evaluate meaningful outcomes of their graduates.
The number of GME-funded positions has been stable since 1997, when it was capped by the Balanced Budget Act (BBA). The cap was included because organizations at the time predicted an oversupply of physicians, so they wanted to limit spending and align the number of GME positions to the number of u.S. medical graduates. Further funding modifications were made in 1999, 2000, and 2003 to reduce the iME payment to its current factor (see Table 1).

### Medicaid

Although there are no federal requirements that Medicaid programs contribute to GME, it remains the second largest funder of these programs. Most Medicaid programs have appropriated funding for GME with direct and indirect payments structured similarly to Medicare. Medicaid explicitly paid an estimated $3.78 billion for GME programs in 2009.

With no requirement for states to provide for GME, recent economic instability and budget constraints have led to a significant reduction in the number of states making Medicaid payments to GME programs. In 2005, a total of 47 states provided GME support of $3.18 billion through Medicaid, representing 6.6 percent of the program’s inpatient hospital expenditures. By 2011, Arizona, Massachusetts, Montana, Rhode island, Vermont, and Wyoming stopped making payments to GME. Nine additional states—Michigan, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, Oklahoma, Oregon, and Pennsylvania—have considered ending Medicaid payments to GME. Many others, including Florida and Washington, have decreased funding in the last few years. Based on a 50-state survey, the AAMC expects these cuts in GME funding to continue as states face ongoing fiscal pressures.

### Private insurers

Private insurers support GME through higher payments negotiated with teaching hospitals; however, the actual amount is difficult to calculate, as the proportion of these payments that is attributed to education is not specifically identified. Due to numerous private contracts and the respective bargaining power of providers and private insurers, these contributions are highly variable. Private insurers are expected to cover the proportion of GME for their own patients; however, no policy has mandated funding from the private sector. The financing from private insurers has no connection with the amount of work residents do for insurers’ beneficiaries because residents do not charge for services. A study at one teaching hospital estimated that the amount of services residents provide to privately insured patients would have yielded $232,726 of revenue annually.

### Predicted shortages

in the past decade, 62 reports have identified physician shortages in underserved areas and in many specialties. The AAMC estimates that the overall deficit of physicians will reach 62,900 by 2015, of which 29,800 will be in primary care. The predicted shortage will result from the GME system’s inability to train enough residents to keep up with the rate of retiring physicians or meet the growing demand for health care access. It is important to keep in mind that not only is the U.S. population continuing to expand, but the ACA now guarantees insurance for every American, and some experts doubt that the current system can cope with the influx of newly insured patients.

Shortfalls in the workforce have nothing to do with waning interest in meeting the nation’s growing health care needs. The number of U.S. medical school graduates has continued to rise due to increas-

**TABLE 1. EXPLANATION OF MEDICARE’S DIRECT AND INDIRECT FUNDING STREAMS FOR GME⁸**

<table>
<thead>
<tr>
<th>DIRECT GME</th>
<th>INDIRECT GME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient</td>
<td>Residents and residency programs</td>
</tr>
<tr>
<td>Description</td>
<td>Covers resident stipends and fringe benefits</td>
</tr>
<tr>
<td></td>
<td>Pays salaries of supervising faculty</td>
</tr>
<tr>
<td></td>
<td>Subsidizes educational overhead costs</td>
</tr>
<tr>
<td>Calculation</td>
<td>A hospital-specific per resident payment applied to Medicare’s share of inpatient days</td>
</tr>
<tr>
<td>Amount</td>
<td>$3 billion in 2009</td>
</tr>
</tbody>
</table>
Several independent governmental and non-governmental organizations that have issued recommendations about how the federal government, through Congress, should restructure Medicare’s contribution to GME to lower costs and encourage rational strategies in training the physician workforce.

in the recent debate over health care reform, Democrats, with the support of many medical organizations, proposed to lift the cap and increase the number of Medicare-funded GME positions by 15 percent. However, the American Academy of Family Physicians opposed the amendment because they believed that any additional GME spots should be used to train primary care physicians. As a result, Congress decided not to increase Medicare support but instead redistribute about 900 unused spots to programs reserved for primary care. The decision to retain the cap was based, in part, on the fact that teaching hospitals had been able to create about 8,000 new training positions since the limit was imposed. However, the growth of residency spots has been slow—approximately 0.9 percent per year over the past decade—and most of these positions were subspecialty training fellowships rather than in primary care. In the current deficit-focused political environment, the $15 billion price tag for the 15,000 proposed positions contributed significantly to the political opposition to lifting the cap. Experts believe that maintaining current GME support from Medicare and seeking alternative funding sources are likely the best outcome GME could achieve at this time.

Recommendations for reform

Several independent governmental and nongovernmental organizations have issued recommendations about how the federal government, through Congress, should restructure Medicare’s contribution to GME.
Because many of the funding streams that support GME flow into the general revenues of teaching hospitals, it’s difficult to know what amounts are used for education.

ments when hospital budgets already are stretched thin and demands for quality of care are on the rise. The AAMC determined that the MedPAC reductions in iME would have resulted in a loss of 72,600 jobs and $653 million in state and local revenues, costing the U.S. economy a total of $10.9 billion.16 Congress did not pursue the reduction in iME payments.

The bipartisan national Commission on Fiscal Responsibility and Reform (n CFRR), created in 2010, issued a report that called for bringing Medicare’s GME payments in line with the costs of medical education by limiting hospitals’ DGME payments to 120 percent of the national average salary paid to residents in 2010. In the report, the commission also concurred with MedPAC that the iME payments should be reduced to 2.2 percent. The proposal fell short of the 14 votes needed for formal endorsement and House and Senate consideration.17 According to MedPAC, the n CFRR proposal would have cut federal expenditures in GME by $6 billion by 2015 and $60 billion by 2020.18

in March 2011, the U.S. Congressional Budget Office (CBO) analyzed a proposal that consolidated all GME funding streams into one direct payment to teaching hospitals and reduced the indirect portion of funding by more than half.19 The CBO projected that this move would save $69 billion over 10 years. However, the CBO also noted that this proposal would result in the following: lower compensation for residents, iME payments growing more slowly than inflation, fewer education-directed activities, and less care for the uninsured. States would also lose discretion over the portion of GME that previously came from Medicaid.19 Ultimately, Congress did not pursue this proposal, to the relief of many in the health care community.

The institute of Medicine (Io M) played an important role in GME policy debates with its influential 2001 report, Crossing the Quality Chasm, which provided a vision for GME by addressing workforce, compensation schemes, quality, safety, and responsiveness of the health care system.20

in December 2011, seven senators requested that the Io M study the governance and financing of GME to address the significant concern of health care.21 The letter notes the inadequacy of medical training to meet the nation’s medical needs, and the need for high-quality, low-cost health care. It calls explicit attention to the following issues: accreditation, reimbursement, workforce supply, geographic distribution of physicians, care of the underserved, access, and maintenance of an appropriately skilled workforce. The Macy Foundation recently awarded the Io M $750,000 to research these problems.22

Unsuccessful proposals for GME reform

Two bills were proposed in 2001 that attempted to solicit more consistent and equitable contributions to GME programs from private payors. The All-Payer Graduate Medical Education Act was introduced by Rep. Ben Cardin (D-MD) and would have established a trust fund for private payors to contribute 1 percent assessment of private insurance premiums.23 These contributions, estimated to total approximately $4 billion, would then be used to make DGME and iME payments. Medicare would continue its DGME payments; however, the iME payment add-on ratio would be determined by the proportion of Medicare revenues to total revenues instead of the proportion of Medicare inpatient days. The inclusion of private payor GME payments would have reduced Medicare’s iME payment factor from 5.5 to 4.8 percent. A similar bill, the Medical Education Trust Fund Act, was introduced by Sens. Jack Reed (D-RI) and Hillary Clinton (D-NY). Their proposal had all private payors contribute a 1.5 percent assessment on premiums to a trust fund. Medical schools and teaching hospitals would apply for these funds through the Secretary of HHS.23 Health insurers strongly opposed both of these bills, which ultimately failed in Congress.

The original ACA legislation called for an additional $230 million in funding to support GME training of primary care physicians at community health centers. However, on May 25, 2010, the House voted 234 to 185 to eliminate this additional funding despite numerous reports projecting an increased demand for more health care providers.24 Ultimately, the ACA succeeded in establishing the Primary Care Residency Expansion Program, which provides $80,000 for resident positions designated for primary care, even if the number of total positions exceeds the training program’s GME cap.1 The ACA also increased funding for the national Health Service Corps to $1.15 bil-
lion and allowed residency programs to count outpatient training experiences toward GME payments. In response to growing national debt and political disagreement about whether to extend the U.S. debt ceiling, the Budget Control Act of 2011 established a Joint Select “Super” Committee on Deficit Reduction, which was intended to devise a bipartisan solution to balance the federal budget. Cuts to Medicare GME funding were in early versions of the Budget Control Act, but were ultimately dropped. Due to the inability of the Joint Select Committee to reach a consensus on budget cuts by November 23, 2011, an automatic sequestration will, by default, result in a $1.2 trillion cut in federal discretionary spending over 10 years. Medicare, research, medical education, and other health care expenditures, including GME, are expected to see a 2 percent cut as a result of the sequestration. However, with previously proposed GME budget cuts of 50 percent receiving serious consideration from federal legislators, the potential for further cuts to GME remains a real concern.

In an effort to reduce federal expenditures, the Obama Administration’s 2012 budget proposal eliminated annual funding of $317 million, which had been earmarked to support pediatric GME training. The justification for this proposal centered on the view that dedicated children’s hospitals should not receive Medicare funding because children do not qualify for Medicare coverage. However, with previously approved GME budget cuts of 50 percent receiving serious consideration from federal legislators, the potential for further cuts to GME remains a real concern. In the 2013 budget proposal, the Obama Administration again pushed to remove support for pediatric GME training, this time proposing to cut $88 million. Furthermore, the 2013

**TABLE 2. CONCEPTUAL FRAMEWORK FOR CREATING AND EVALUATING GME FUNDING ALTERNATIVES**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>Those that bear the cost of the activities should receive benefits that are proportional to their contributions Funding should be distributed to meet current and future needs of the entire population</td>
</tr>
<tr>
<td>Adequacy</td>
<td>An adequate system must provide funding to support the training needs of a high-quality physician workforce Stable funding should be available to allow teaching programs to invest in high-quality training programs</td>
</tr>
<tr>
<td>Efficiency</td>
<td>An efficient system must encourage effective educational programs at an economical price Funding must adequately subsidize educational activities so that teaching institutions remain fiscally solvent</td>
</tr>
<tr>
<td>Accountability</td>
<td>An accountable system must directly demonstrate the efficacy of resource allocation to achieve desired goals Funding recipients should be held accountable for producing a workforce to meet the needs of the public with respect to the supply, specialty mix, and geographic distribution</td>
</tr>
<tr>
<td>Administrative feasibility</td>
<td>A feasible system must ensure that its administrative burdens and costs do not outweigh its associated benefits</td>
</tr>
</tbody>
</table>

*Adapted from RAND Working Paper: Alternative Ways to Finance Graduate Medical Education.*
budget proposal called for cuts to Medicare’s iME payments at all hospitals, advocating a reduction of $9.7 billion over 10 years and encouraging more HHS oversight.

A way forward for GME reform
The iME component of GME funding is based on the assumption that the education process creates inefficiencies at teaching hospitals—inefficiencies that make them less competitive in the marketplace relative to other hospitals. However, the research does not support this assumption, and the extent to which uncompensated educational activities outweigh the work residents do for hospitals is unclear. MedPAC estimated that only 45 percent of the iME payments can be analytically justified. Medicare and Medicaid should fund studies to estimate the degree to which the iME payments are required and whether they vary by institution and specialty. It is essential that teaching hospitals be fairly compensated for the public good of training future physicians.

Under the current GME system, Medicare and Medicaid’s contributions are transparent because funding is provided using a formulaic approach based on public data. However, it is unclear how recipient programs use these funds because the internal system for distributing DGME and iME funding varies by institution. Because many of the funding streams that support GME flow into the general revenues of teaching hospitals, it’s difficult to ascertain what amounts are used for education. No mechanisms exist to hold residency programs accountable for their GME spending, so Medicare and Medicaid have no way to influence how the funding is used. Tracking performance measures and outcomes for each program, such as the number of graduates who enter undersupplied specialties and practice in rural settings, is a good first step toward ensuring the maximum public benefit.

However, to encourage priority programs, Medicare and Medicaid must take a second step and divorce GME funding mechanisms from patient payments. Under the current system, GME payments to teaching hospitals depend solely on the number of residents and the percentage of patients with Medicare or Medicaid. Hospitals are rewarded for the quantity

REFERENCES

continued on next page
To encourage accountability and create incentives to align the current training system with public demands, all stakeholders invested in GME must be actively involved in its financing.

of residents and publically funded patients, not for the quality of their educators or their graduates’ ability to meet future workforce needs. Training programs must be held accountable for their performance and GME funding needs to be specifically designated for training purposes.

in light of recent legislative proposals to cut GME funding and the reductions proposed by the Obama Administration, the GME system cannot continue to rely solely on federal funding; alternatives must be considered. To encourage accountability and create incentives to align the current training system with public demands, all stakeholders invested in GME must be actively involved in its financing (see figure, page 15). Every stakeholder has a different perspective and agenda, but all are invested in having a functioning health care system staffed by well-trained physicians and should support GME in some form.

An effective conceptual framework must drive the creation and evaluation of GME funding alternatives. In 2006, HHS commissioned the Research and Development (RAn D) Corporation to investigate the current GME system and establish one such framework. The mechanism RAn D developed uses five critical measures: equity, adequacy, efficiency, accountability, and administrative feasibility (see Table 2, page 15). Overall, the RAn D analysis revealed that Medicare’s most appropriate way forward was to continue iME support of teaching hospitals to compensate for higher patient care costs, but to shift responsibility for DGME payments to a separate federal organization dedicated to funding residency activities so that payment would not be tied to service use. RAn D team members also stated that funding residency programs directly would foster accountability and provide a method for federal funders to align their payments with public health priorities.

Conclusion
The role of Medicare and Medicaid in GME has been a longstanding source of debate. The BBA caps, a significant reduction in state support, and recent legislative cuts to GME have made the state of GME funding more precarious than ever. Further reductions may severely impair the ability of the GME system to continue to train future physicians. Training more physicians to

REFERENCES (CONTINUED)

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serve an increasing elderly population and the millions that will be newly insured by 2014 will require more support from all stakeholders, including federal and state governments. The rapid expansion of medical school capacity to meet health care demands, without proportionally increasing GME spots, adds further pressure to an already strained physician workforce and would disregard educational investments U.S. medical school graduates have made.

With further cuts looming and the mission of increasing training spots to meet current and future demands, GME faces a very real crisis. These competing agendas should serve as a signal to the medical community that the current GME funding policy is unsustainable. Previous proposals have attempted to address this problem by distributing the burden of GME financing to private stakeholders through the all-payer trust fund. However, reducing federal contributions without adequately assessing the costs of training and ability of other stakeholders to contribute has been unsuccessful. The use of a conceptual framework will allow for a structured analysis as various solutions for GME reform are proposed. With a clear understanding of costs, effective allocation of resources may create a more efficient GME system. With the input and consideration of various groups, relationships between payors and beneficiaries can help guide the creation of a fair, equitable system. To ensure the sustainability of U.S. health care, the GME system must continue to produce a high-quality physician workforce trained to address the growing needs of the public in a way that does not overburden any stakeholder.

REFERENCES (CONTINuED)

In light of the fact that Americans are living longer than ever, today’s surgeons are operating on a great many patients well into their 80s and older, many of whom are frail or in their last few months, weeks, or even days of life. The discussion regarding the risks and benefits of surgical interventions in end-of-life situations can be emotionally charged and ethically complex. A key issue that needs to be addressed in modern surgical training and practice is when and whether it is appropriate to operate on patients who are at the end of life.

To help start a discussion regarding these concerns, the Resident and Associate Society of the American College of Surgeons (RAS-ACS) selected Surgery At the End of Life: For Love or Money? as the topic for the issues Committee Essay Competition. Surgical residents from the broad spectrum of specialties submitted essays on the topic. The following two essays were runners-up in the competition. The two winning essays were presented at the RAS Symposium at this year’s Clinical Congress, and will be published in an upcoming Bulletin.
An argument against heroic intervention

by Cindy Brown Matsen, MD

To operate, or not to operate—that is the question. Data show that in 2008, among Medicare beneficiaries in the final year of life, nearly one in three underwent a surgical procedure. n early one in five had surgery in the last month of life, and nearly one in 10 had surgery in the last week of life.¹

Why do we operate on these patients? Does the availability of hospital beds influence the surgeon’s decision to operate more frequently? Perhaps, but the reasons surgeons operate are more complicated than these data would suggest. Interventions at the end of life are often deemed heroic, but this valor comes at great financial cost to society. The factors influencing the decision to operate near the end of life include economics, ethics, culture, and politics. of these, i argue that culture plays the greatest role. We do what we do because of who we believe we are and because of what we value. Although we may be, at times, misguided, it is the established cultural frameworks of both the patient and the surgeon that provide the context for decision making.

The surgical culture is defined by decisive action, hard work, technical acumen, passionate advocacy for patients, and the gratification of direct physical attention to pathologic processes. in light of these tenets of the surgical mindset, is it any wonder that we often provide surgical intervention near the end of life? We act because we value our ability to provide the highest level of care to those who are dying of disease and who are often elderly.

Critics have attacked our culture of action, alleging that surgeons are people who “live to cut.” As professionals, though, we strive to operate only on those patients whom we think we can truly help. We are sometimes wrong, and it is our failure to accurately prognosticate that exposes our actions to criticism. if we could truly foresee who will die in the next week, month, three months, or year, we would likely not operate on patients we know undeniably carry a poor prognosis. of our appreciation for the influence of age on prognosis is evidenced by the fact that surgical interventions near the end of life are less common in patients older than the age of 80.² yet, understanding these risks and how they are influenced by our cultural values, we may still operate with futility. in addition, our society’s expectations influence patient and family wishes, and they may also push us to operate in difficult situations.

Death is inevitable—an absolute truth. Surgeons like to operate. We want to help people. our training provides us with unique tools to intervene upon reversible, life-threatening pathology. Who do we think we are as surgeons, and what do patients expect of us? Are physicians or patients capable of fundamental cultural change?

American culture is complex. Whereas there are definite geographic, ethnic, and generational variations, we are united in our respect for autonomy, individualism, and risk taking.³,⁴ Thus, it is not surprising that most patients do not accept death without putting up a good fight. of ten our patients view surgery as a weapon in an epic war against disease and death. Virtually every obituary contains some version of the line “…lost their battle with….” indeed, death will always be the victor.

The fear of death is natural. The fight for life is admirable. Therefore, the push for intervention near the end of life is not driven by an administrative desire for monetary gain, but by a larger cultural view that denies mortality, refuses to accept inaction, and is affected by a professional culture that values action in the face of potential (even if vanishingly so) reversibility. We are asked to “do something” even if it may be an exercise in futility. in this way, our desire to help is transformed to serve the cultural needs of our patients, their families, and our profession.

If we are ever to succeed in decreasing the number and cost of interventions near the end of life, a major shift in our surgical culture and American culture as a whole is necessary. our knowledge of factors affecting morbidity and mortality should provide us with tools to effectively influence the decision making of our patients. Discussions that better incorporate important factors, such as preservation of quality of life, would better address the needs of the patient and guide discussions with families about the geriatric surgical population.⁵ Numerous studies support the notion that people do not wish to die in the hospital, yet many patients meet this fate. Families are often not satisfied with the care we provide at the end of life, reflecting a discon-
nect between what we think families want and what their loved ones truly desire.⁹ We can treat many illnesses in the elderly, but as the body prepares to succumb to its ultimate fate, we must be honest, compassionate, and experienced in recognition and acceptance. Goal-oriented care should take priority, and we must lay down our tools. We must accept the inevitability of death and find the nobility in facing mortality with resignation, dignity, and without intervention. We must learn to accept and even value inaction. Our statistics will not convince hesitant families, but can provide a basis for meaningful discussion and a path to acceptance of fate without absolute knowledge. It is only through fundamental cultural change that we can address the unsustainability of our current system, which too often provides unnecessary and insufficient care for the elderly population.

Our role is to serve as sages, not seers. We may think we intervene out of love, but sometimes love is blind. ◆
At weekly morbidity and mortality conferences, there always seems to be at least one discussion of a case involving an elderly patient who died after a heroic intervention. The resident involved is typically asked, “Doctor, what discussion of risk did you have with this patient and family?” The conversation that follows rolls forward like a song stuck on repeat.

Recent articles in the mainstream press indicate a growing public awareness that end-of-life procedures are overused.1,2 As surgeons, we know that the decision to perform surgery at the end of life is difficult, and there is no shortage of manuscripts delving into this complex topic. The very focus of debate at this year’s Resident and Associate Society Symposium challenged us to choose a side with regard to Surgery at the End of Life: For Love or Money? I suggest that framing this discussion so that one opposes love or money hides the complexity of the issue and draws out unintended emotionality inherent within these words. From my perspective, end-of-life operations, specifically in the elderly, are overused and do little to lengthen or improve quality of life and often cause more harm than good.

Use of surgery at end of life
Kwok and colleagues found that nearly one-third of aging Americans undergo a surgical intervention during the last year of life, and the majority of these procedures occur within the last month.3 Those who underwent surgical procedures in the year prior to death had more hospital admissions, almost twice as many days in intensive care units, and spent nearly 50 percent more days in the hospital than those who did not have surgery in the year before death.

The same study found that use of surgery near the end of life varies greatly by U.S. region. Moreover, the regions where more operations were performed at the end of life had higher death rates than the regions with fewer procedures at the end of life.4 Another study found that 50 percent of patients ages 80 or older who underwent emergent colectomy died within six months of the procedure.5

Patient expectations
Atul Gawande, MD, MPH, FACS, recently noted that technology can sustain bodies beyond coherence.6 Complicating the matter is that end-of-life wishes, when expressed, are variable. A study in the Journal of the American Medical Association confirmed such variability, but did find that saying goodbye, maintaining dignity, and having good pain control were consistently among the top-rated desires for people foreseeing their imminent death. Notably absent from the list is a desire for an incoherent existence in an intensive care unit after surgery.1

I recall a case involving an octogenarian who was struggling on a ventilator after surgery. When finally given pencil and paper, she demanded the tube be removed so she could have a Diet Coke. Her wishes were granted, and she died on the car ride home, her final wish in hand. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments found that many patients die prolonged, painful deaths while receiving unwanted, invasive care.6 This study confirms that end-of-life procedures may cause undue harm and lead to unwarranted costs.

Images of death on television further complicate this issue by depicting miraculous surgical saves. This skewed view may also contribute to excessive interventions at the end of life. Perhaps this is part of the reason surgeons are often faced with making last-minute decisions for patients and families suddenly blindsided by impending death. But physicians also appear too optimistic. A Harvard study revealed that 63 percent of physicians overestimate survival time of their terminally ill patients by a factor of 5.3 Dr. Gawande recently presented a possible explanation for this optimism when he recognized the personal difficulties physicians face in coming to terms with patients’ prognoses.2

A quest to be better
As surgeons, we need more data to help guide the decision to operate near the end of life. One such data-gathering mechanism is The American College of Surgeons National Surgical Quality Improvement Program (ACS nSQIP®). nSQIP originated in the Department of Veterans Affairs (VA) and was created in response...
to concerns about high postoperative complications and deaths at VA hospitals. n SQIP collected prospective data from 1991–2001 and used outcomes tracking to reduce 30-day death rates and complications by 27 percent and 45 percent, respectively. The average hospital length-of-stay decreased by 50 percent. These measures decreased patient suffering, deaths, and costs. Subsequently, the ACS took responsibility for bringing the program into private sector hospitals. If all u.S. hospitals participated in ACS n SQIP, such collected data could be used to decrease surgical overuse at the end of life. While surgeons aim to evaluate their outcomes with methods such as morbidity and mortality conferences, these conversations are flawed with the 20/20 retrospective vision that hindsight provides. We must embrace outcomes data analysis not as punitive but as a way to improve the appropriate use of surgery at the end of life.

Although we need prospective data, we must also remember that the patient is an individual, not just a statistic plucked from a study. In addressing the individual, we must be mindful not only of our decisions to operate, but also our decisions in managing complications when they arise. And we must subdue our egos when confronted with a problem out of our realm of expertise so that we may call on colleagues for advice.

It starts with a conversation

We must be willing to engage in conversations in which we responsibly address end-of-life realities without destroying all hope. A recent article in The New York Times noted that more than half of people polled would tell their physicians to stop treatment if they were in pain with no expectation of improvement. By identifying our patients’ wishes, we can help them get what they want before death’s surprise, be it a family conversation or a Diet Coke. Holding these wishes can provide hope in the face of death.

The patient’s withering grasp begs of us to do something. But perhaps “something” is to allow the patient the dignity to breathe out his or her last words rather than be silenced by the knife. By engaging in honest, early discussions, advocating for patient wishes, combined with better research, we can control the reins of surgery so that it is not an overused tool, but a perfected craft that provides enhanced life with more love and less money.

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In 2010, the American College of Surgeons (ACS) started a new program to increase the number of chapters that host lobby day programs at their state capitols. The Board of Regents approved a proposal that the Board of Governors and more than 27 chapters endorsed, which would provide $50,000 in grants over a two-year period for state chapters to organize lobby days during the 2011 and 2012 legislative sessions, with renewal in 2013 and 2014. Chapters were eligible to receive up to $5,000, but would be required to match that grant with one dollar for every two dollars received.

The level of interest from state chapters regarding the grant program was high and demonstrated a pent-up demand to increase their state-level advocacy efforts. For the first year of the program, 10 state chapters were awarded grants for the 2011 legislative session, including Alabama, Connecticut, Florida, Georgia, Indiana, Massachusetts, New York, Northern California, Ohio, and Virginia. In 2012, the second year of the program, the level of participation grew to include 16 states and 17 ACS chapters. The chapters that were awarded grants for the 2012 lobby day program were Alabama, Northern California, Connecticut, Florida, Georgia, Illinois (both the Metropolitan Chicago Chapter and Illinois Chapter), Indiana, Kansas, Maine, Massachusetts, Michigan, North Carolina, Ohio, Oregon, Tennessee, and Virginia. At press time, all of the chapters had completed their Day at the State Capitol programs except for Maine, Michigan, and North Carolina.

Following is a summary of the Day at the State Capitol programs held in 2012, including the various approaches for hosting lobby day events, and highlights of some of the important legislation and bills that were discussed with state legislators.

**Alabama Chapter lobby day (March 8)**
The Alabama Chapter held their lobby day with a core group of leaders from the chapter. Collective meetings with state senators and representatives were held and a number of important and complex issues facing the state were discussed. The surgeons offered their expertise and perspectives on the severe budget crisis and impending cuts to state programs, concerns over
workforce shortage and counties without immediate access to surgeons, trauma funding and trauma system development, scope-of-practice expansion, and insufficient funding for public, not-for-profit safety net hospitals. Mark Jackson, the director of legislative affairs and a registered lobbyist with the Medical Association of the State of Alabama, participated and helped organize these meetings with legislators. In addition, ACS State Affairs staff presented an overview of state policy and state legislative affairs at the College.

**California Chapter lobby day (April 17)**
The northern California Chapter held its lobby day in conjunction with the California Medical Association’s (CMA) Legislative Day. The CMA arranged some insightful briefings and invited excellent speakers to help the chapter leadership prepare for their legislative visits. While meeting with legislative leaders, discussion centered on a prostate exam bill (A.B. 1621) intended to address a flaw in the existing statute. Under the law, a physician and surgeon examining a patient’s prostate gland during a physical examination were required to provide the patient with specified information if certain conditions were present. A.B. 1621 provided an exemption to this requirement in a trauma/emergency care setting.

The bill was introduced by Assemblywoman Linda Halderman, MD, FACS, and sponsored by the northern California Chapter. Lobbying efforts for this bill extended beyond the lobby day and turned out to be very successful, as the bill passed and was signed into law by the governor on July 10. (For additional information on the northern California Chapter Day at the State Capitol, refer to the report by John Garry, MD, FACS, and John Maa, MD, FACS, on page 28.)

**Connecticut Chapter lobby day (March 13-14)**
The Connecticut Chapter held their event along with the Connecticut State Medical Society’s Doctor’s Day. This was a two-part event with a dinner sponsored by the chapter on March 13, which included a briefing on advocacy. The following day’s event featured many knowledgeable speakers, including strategic and influential members of the legislature, and Gov. Dannell Malloy. The 20 attending Fellows took the opportunity to discuss with legislators their opposition to the proposed changes to the certificate of merit law in Senate Bill 243. This bill would have revised and removed enacted provisions concerning certificates of merit in medical malpractice actions. This bill did die in the Senate upon adjournment of session.

**Florida Chapter lobby day (January 30)**
Representatives from the Florida Chapter and the Florida Committee on Trauma headed to Tallahassee January 30 to host their second Day at the State Capitol. The event kicked off with a cocktail reception that provided the opportunity for several ACS members and a number of legislators to have meaningful interactions. The following day, meeting attendees were briefed by the chapter’s lobbyist and then addressed by the former Florida Surgeon General, Frank Farmer, MD. The legislative appointments focused on a number of issues, including a high school student athlete concussion bill that was passed during the legislative session and the restructuring of the Department of Public Health and the Trauma Division.

**Georgia Chapter lobby day (February 2)**
The Georgia Chapter lobby day event included a breakfast orientation and briefing session that provided important information about planned meetings with legislative leaders. Issues discussed included working to reinstate funding for state employee health insurance coverage for bariatric surgery, as well as a discussion of the state’s need for the uniform Emergency Volunteer Health Practitioners Act. As a result, a senator and representative offered to introduce this legislation in the 2013 session. Surgeons also “worked the line,” which means they pulled representatives out of the chamber during general session in order to briefly meet with them. The attendees were given recognition by the chair of the House Health Committee on the floor of the House and then treated to a private meeting with Gov. Nathan Deal (R).
The level of interest from state chapters regarding the grant program was high and demonstrated a pent-up demand to increase their state-level advocacy efforts.

Metro Chicago and Illinois Chapter lobby day (April 25)
A small group of surgeons from the Illinois Chapter and Metro Chicago Chapter held a collaborative effort in their first lobby day program this spring. Following a breakfast briefing on budget issues and effective advocacy strategies, the group met with a number of representatives and senators. Although no specific bills were identified for lobbying, attendees recognized the importance of traveling to Springfield to meet with their representatives and continuing to build a rapport with them and create a strong working relationship.

Indiana Chapter lobby day (February 23)
The Indiana Chapter hosted its second Day at the State Capitol event after the conclusion of the chapter’s winter meeting. More than 25 surgeons gathered to listen to a number of presentations, including updates on the Affordable Care Act as well as a presentation titled How Surgeons Can Influence State Officials.

The keynote address was given by Indiana Rep. Cindy Noel (R), who was invited to participate after connecting with a constituent and ACS member at last year’s Day at the State Capitol. Meetings with legislators focused specifically on the proposed statewide smoking ban bill (H.B. 1149). The chapter’s lobbying efforts paid off when the smoking ban was signed into law during the 2012 legislative session.

Kansas Chapter lobby day (January 18)
The first lobby day program for the Kansas Chapter featured an informative program and agenda. The day started with a breakout session and included a presentation on state affairs resources, grassroots strategy, and legislative priorities from ACS State Affairs staff.

After an in-depth discussion, chapter members joined their primary care colleagues as part of the Kansas Academy of Family Physicians’ lobby day. The physicians were formally acknowledged during a House committee hearing on Medicaid reforms. A reception with legislators and staff concluded the event and allowed for additional conversations with state representatives and senators.

LOBBY DAY TAKE-AWAYS
The highly successful and diverse lobby day programs outlined in this article have increased the profile and reach of advocacy efforts by surgeons with their state legislatures. The following guidelines are key concepts to keep in mind when implementing a successful lobby day program:

• States are often seen as incubators for new ideas, and ACS chapters have proven that to be true with a variety of successful lobby day models and events. One size does not fit all.

• Building strong relationships with legislators takes time, and those chapters with a history of sponsoring lobby days and interacting with legislators are finding success in their advocacy efforts. Saying “hello” today over a cocktail at a reception can go a long way toward gaining sponsorship of a bill by a legislator.

• Effective lobby days do not have to cost huge sums of money. Most of the lobby days described in this article likely cost $3,000-$5,000 overall—well within the budgets of most chapters.

• Planning is already under way for the 2013 state legislative sessions, and many chapters have applied for lobby day grants for next year. Given the prevalence of health care issues and reforms at the state level, this will be a critical year for surgeons to be involved with advocacy efforts in their states.
Massachusetts Chapter lobby day (June 27)
The first lobby day organized by this chapter resulted in a large turnout, with 61 chapter members attending. The agenda offered a wide variety of programs, including poster presentations, a simulation session that fulfilled continuing medical education credits, and a session on the ACS National Surgical Quality Improvement Program® and surgeons’ roles in improving health care quality while also reducing costs. The chapter created and presented the John Collin Warren Award to Senate President Therese Murray, acknowledging all of her work and collaboration with Massachusetts Fellows’ efforts in getting injury prevention legislation passed in the state. In addition to numerous visits with legislators, there was an impromptu visit from former Gov. Michael Dukakis (D), who was able to spend some time discussing national health care reform with attendees.

Ohio Chapter lobby day (March 13)
The Ohio Chapter and the Ohio Committee on Trauma hosted their second Day at the State Capitol in 2012. This year, the chapter’s program tested a new format, including dinner with key state legislators. A total of 20 chapter members and six legislators, including members of the House Health and Human Services Committee, discussed a number of legislative issues during the dinner, including breast reconstruction requirements, surgical technology practice, and reform in the state’s trauma system.

Oregon Chapter lobby day (February 12)
The Oregon legislature had a shortened budget schedule as they do every other session, and considering that legislators were looking only at budgetary issues, the focus of the lobby day centered on the state health care transformation legislation. This legislation would enact the Affordable Care Act mandates at the state level, establishing a state health insurance exchange program as well as medical liability reform. There was a dinner with speakers hosted by the chapter, including a lobbyist from the Oregon Medical Association, state Rep. Tim Freeman (R), and state Sen. Elizabeth Steiner (D). On February 13, the group covered grassroots advocacy and advocacy skills with State Affairs staff before the surgeons broke out to meet with their legislators. More than 20 legislative visits were held that day.

Tennessee Chapter lobby day (March 7)
The Tennessee Chapter held its first lobby day on March 7, 2012, during the Tennessee Medical Association’s Physicians involved at the Tennessee’s Capitol Hill day. Five chapter members/officers were in attendance, who focused their conversations with legislators on the surgical quality improvement work being done through the Tennese Surgical Quality Collaborative. Other important topics covered during the event included trauma funding, cancer care, rural access to general surgeons, scope of practice, and Medicaid funding. The surgeons in attendance also were able to attend a committee hearing addressing the new and emerging problem of the misuse of bath salts and other illicit drugs.

Virginia Chapter lobby day (February 15)
Earlier this year, surgeons gathered in Richmond to participate in the Virginia Chapter’s White Coats on Call event sponsored by the Medical Society of Virginia. Six surgeons attended the event and met with a dozen legislators during their time at the Capitol. When meeting with legislators, attendees stressed the importance of passing a number of important health care initiatives, including a definition of surgery bill (H.B. 266), legislation addressing nurse practitioner collaborations (H.B. 346), and support of the governor’s budget protecting Medicaid reimbursement rates for physicians. Both the definition of surgery bill and the nurse practitioner collaborations bills were signed into law and demonstrate the success of this program and the effectiveness and importance of surgeons’ lobbying efforts.
Progress report:
Northern California Chapter’s legislative activities

by John Garry, MD, FACS, and John Maa, MD, FACS

The northern California Chapter sponsored its second Day at the State Capitol on April 17 with the support of an American College of Surgeons (ACS) chapter advocacy grant program. The event was held in conjunction with the California Medical Association (CMA) Legislative Day. This article highlights both the successes and the lessons learned from these unified advocacy efforts, and emphasizes key goals for the future.

Goals of the collaboration
Two factors played a significant role in efforts to engage surgeons in the state legislative process. The primary intent was to educate the California legislature about the growing factors that have led to emergency department (ED) overcrowding and its negative impact on the quality of care delivered in these facilities. The second goal was to increase visibility of the ACS in Sacramento, and strengthen existing relationships with state elected officials. In large part, the aim of this collaborative approach to advocacy is to enable California chapters to become more effective in their efforts to positively affect the future of surgery.

FACS in the legislature
Members of the northern California Chapter Council met on two occasions with members of the San Diego and Southern California Chapters to unify efforts across all three California chapters—which represent nearly 10 percent of the ACS Fellowship worldwide. The opportunity to speak with a unified voice helped to strengthen surgery’s message for the members of the California legislature.

In 2012, California Chapter members focused their legislative efforts on A.B. 1621 (see Figure 1, page 29), authored by Assembly Member Linda Halderman, MD, FACS (R), which addresses a flaw relating to prostate exams in the Grant H. Kenyon Prostate Cancer Detection Act. Under the act, a surgeon or other physician who performs a prostate exam on a patient with certain risk factors must present the patient with information about prostate cancer. However, no exemption was provided for situations where giving this information is either impossible or impractical,
Participation in the lobby day grant program over the past few years has given the northern California Chapter valuable insight into grassroots advocacy at the state level.

such as when treating a trauma patient who is initially assessed for a prostate injury in one ED but then transferred to a higher-level facility for further care. A.B. 1621 provided a common-sense exemption to the act, thereby enabling trauma surgeons and ED physicians to focus on strengthening the local delivery of emergency care.

Assembly Member Halderman introduced the bill on February 8, 2012. With the assistance of Jon Sutton, Manager of State Affairs, ACS Division of Advocacy and Health Policy, a letter of support for the bill was formally approved by the northern California Chapter Council and submitted to the State Assembly.

After hearing oral testimony from the chapter Secretary-Treasurer on March 27, the Assembly Committee on Business and Professions unanimously passed A.B. 1621. As a result of this testimony, the ACS northern California Chapter was included as a key sponsor of the bill. Subsequently, A.B. 1621 unanimously passed through the full Assembly floor with bipartisan support, and in April, the bill was sent to the State Senate for consideration. During the legislative day, chapter members and the co-authors of this article met with Assembly Member Richard Pan, MD, FACS (D), Sen. Mark Leno (D), Assembly Member Halderman, and Sen. Ed Hernandez, D (D), Chair of the Senate Health Committee, to advocate for passage of A.B. 1621 through the state Senate (see Figure 2, this page).

A.B. 1621 was unanimously approved by the State Senate Business and Professions Committee on June 11. On June 25, it was debated on the Senate floor and passed by a unanimous vote. On July 10, Gov. Jerry Brown (D) signed the bill, which became California law after it was filed with Secretary of State Debra Bowen (D). This accomplishment demonstrates the positive impact state-level advocacy may have on surgeons, and was featured in the inaugural issue of the ACS advocacy e-newsletter, The ACS Advocate, in July (see Figure 3, page 30).

Alternate solutions to ED overcrowding

During Legislative Day, chapter members encouraged the California Legislature to commission a study to evaluate the magnitude of ED overcrowding and board-
ing in California, and to identify solutions to promote safe and timely patient care delivery that are balanced with the operational needs in hospitals. Other potential solutions discussed that would strengthen emergency care at the event included:

• Creating alternate venues for the delivery of non-emergent care, such as an outpatient facility that is open after work hours and weekends
• Ensuring adequate surge capacity for mass casualties and disaster preparedness through available operating rooms and supplies
• Conducting a statewide study to evaluate boarding and overcrowding, similar to one that had been performed in the Sacramento region
• Reprioritizing health resources and hospital beds for patients with emergent or urgent conditions

Lessons learned
Participation in the lobby day grant program over the past few years has given the Northern California Chapter valuable insight into grassroots advocacy at the state level. Lessons we have learned as a result of this experience include the following:

• Persistent efforts to increase chapter visibility are rewarded over time. For the Northern California Chapter, this means it has now become a recognized entity in Sacramento resulting in the arrangement of a series of meetings with state elected officials, and being called upon by Senate committee staff to comment on A.B. 1621. The testimony of surgeons before legislative committees can be instrumental to catalyze change.
• By participating in grassroots advocacy on specific legislation—such as the successful passage of A.B. 1621—ACS chapters can learn more about the legislative process, and empower their members to be agents for proactive change.

Future goals
The long-term goal of the chapter is to inspire surgical residents and medical students to strengthen their advocacy and public policy skills, which can be a valuable addition to the clinical and professional skills necessary to become an expert surgeon. In addition, the chapter is committed to preparing a specific bill benefitting both patients and members of the ACS—one that chapter members could advocate for during their meetings at the capital on lobby day.

As policymakers continue to debate health care reform, the surgical profession has an opportunity to move the health reform debate forward both at a regional level and across the country. The chapter extends a special thanks to the visionary leadership at the College in sponsoring the chapter advocacy grant program. (It should be noted that James Hinsdale, MD, FACS, immediate past-president of the CMA, was a co-applicant in this year’s grant application, and traveled to Chicago to attend the State Leadership Advocacy Conference in April to represent the chapter.)

Finally, chapter members applaud the efforts of the ACS Division of Advocacy and Health Policy and the ACS leadership nationally for engaging in meaningful discussions on health care reform with White House and Department of Health and Human Services officials. ♦
Short-term surgical missions make a difference:

A life-changing case in Ibi, Nigeria

by Grace J. Kim, MD, FACS; Raymond V. Wedderburn, MD, FACS; and Iko Ibanga, MD
HIGHLIGHTS

- The need for basic surgical care in resource-poor countries remains significant.

- Partnering with an established host organization is key to an effective mission.

- Short-term missions—often disparaged because of its limitations—can have an impact on both patients and physicians.

During our first mission to rural Nigeria, we set up a medical and surgical clinic in a small town called Ibi. Our host organization, Pro-Health International, had hand-picked this location—an old, derelict government hospital about eight hours east of Abuja. Our team was composed of volunteer Nigerian and American physicians, surgeons, technicians, nurses, and other support staff. On the first day at the site, we resurrected the run-down shell into a busy, working hospital. There was no running water, but our hosts did bring a diesel generator that provided sporadic electricity.

Even though news of our presence spread primarily by word of mouth, hundreds of patients flocked to this makeshift hospital each of the five days we were there. Patients came from far and wide, usually on foot, to receive medical or surgical care for the first and only time in their lives. Most patients had infections or chronic illnesses for which we could give them only a small allotment of medication.

The tools available to the medical clinicians included anything they could bring by hand and that could run on batteries if power was required—limiting their instrumentation to stethoscopes, otoscopes, and ophthalmoscopes. The team had no radiology capability, but we did have the means to do basic laboratory work, including hematocrit, HIV testing, and urinalysis.

Operating in a challenging environment

A smaller cohort of the patients (both adult and pediatric) presented with surgical problems to which we could tend. The team primarily performed hernia repairs (inguinal, umbilical, and ventral), orchiopectomies, hydrocelectomies, and excision of soft tissue masses. Additional procedures included a mastectomy for a presumed phyllodes tumor in a young woman. The pathology we encountered was usually an extreme version of what is typically seen in the U.S.

Our operating room (OR) consisted of one small room with six operating tables cozily aligned in a mobile army surgical hospital, or MASH, style. Between the three attending general surgeons and a cadre of surgical residents, our team performed about 25 cases a day. We operated primarily using local anesthesia. We worked with three anesthetists who administered intravenous sedation in the form of ketamine, diazepam, and pentazocine for the big-
ger cases. Unfortunately, we did not have the capability to intubate, nor did we have supplemental oxygen or standard monitoring devices, which limited the scope of procedures we could undertake in Ibi.

We did have basic surgical instruments and functioning electrocautery, and suction that worked when the generator was working; we sterilized instruments by soaking them in Cidex. Our lighting was provided by battery-powered headlights. Patients would spend a few hours in a team-built recovery room before walking home. The patients’ families were the primary caretakers in the recovery room, but a few Nigerian nurses were available to supervise the postoperative care.

Though it was a humble and simple setup, the OR ran with amazing efficiency and miraculous energy. We were inspired to make the best of the Spartan conditions and assist the endless line of patients camped outside the door.

Pro-Health has years of experience organizing medical missions and they were an outstanding host. The Ibi trip was an example of a well-developed and time-tested model successfully applied for more than 20 years.

Although operating was certainly challenging in this environment, rarely did it feel as though the lack of resources was significantly compromising the outcome. We were doing the standard operations that we would do in the U.S., albeit under severely substandard conditions. The level of teamwork, grace, and camaraderie was unparalleled. Our patients were universally grateful, whether or not they received surgical care or not. They seemed to recognize the sacrifice we were making to try to help them. I will always remember one case in particular from this experience.

Team effort saves a life
A family brought a 22-year-old woman into the clinic. She presented with a syncopal episode and an altered mental status. The patient was also complaining of diarrhea and vaginal discharge. Upon further questioning from the medical staff, she indicated that she had been having abdominal pain for three to four weeks. She was too weak and altered to give any additional history.

On exam, the patient had a weakened radial pulse and heart rate of 120 and she was lethargic and diaphoretic. Her conjunctiva appeared markedly pale, and her abdomen was diffusely tender and distended.

An intravenous line was placed, and a finger stick was checked, revealing a glucose level of 36. An ampule of D50 was given with an improvement in her mental status. Her abdomen was still diffusely tender with worsening distention. At this point, a peritoneal tap was performed, which demonstrated gross, unclotting blood. A serum hematocrit returned at 14 percent. Blood donations were sought from her family as well as from other patients waiting in line to be seen.

The patient was quickly carried to our OR. As the team prepped and draped for emergent laparotomy, our anesthetists administered ketamine, diazepam, pentazocine, atropine, and promethazine. A urinary catheter was placed. An anesthetist monitored the patient’s ventilation by placing a hand over the mouth and through the use of a battery-powered pulse oximeter. Another anesthetist placed an additional intravenous line and started a saline bolus.

Upon exploration, the patient was found to have an approximately 2 liter hemoperitoneum. The clot was evacuated, and the abdomen was packed. The bleeding
Although operating was certainly challenging in this environment, rarely did it feel as though the lack of resources was significantly compromising the outcome.

was emanating from the pelvis, where it became clear that the patient was hemorrhaging from a ruptured ectopic pregnancy. A left salpingo-oophorectomy was performed. The abdomen was irrigated and closed after we confirmed that there was no further bleeding.

She was then carried to our recovery room and given two bags of uncross-matched, fresh whole blood that we were able to procure from other patients waiting in line. The team gave one of the nurses in the recovery room careful instructions for intensive care unit (ICu)-like care: BP q 30 minutes, strict i/o, and bolus with isotonic crystalloid if u o less than 20 cc/hr. We were required to return to our quarters that night, but we did go back later for a postoperative check. The nurses in our make-shift ICu were following our directions faithfully, and the patient appeared to be stable.

**Short-term missions make a difference**

The following morning, she looked remarkably better. The patient’s mental status was markedly improved, and her blood pressure and heart rate started to normalize. Her pain was well-controlled. Her conjunctiva were still pale, however, so we administered an additional bag of whole blood.

The following postoperative day the patient looked even better. Her blood pressure was now 120, and her heart rate 80. She was started on clears and began to ambulate freely.

On postoperative day three, she gave me a hug. It was our last day at this site, and time for us to go home. We will always remember her grateful eyes as our own filled with tears.

I do not think that she realizes how close to death she was, or just how extraordinary the effort of the Pro-Health team was that helped to save her life. We are grateful that she is now well. We happened to be in ibi when she became sick, she had a pathology that was within the reaches of what we could treat with our setup that day, and she lived. She may not understand all these details, but her story certainly energized each member of our team and helped us understand in small part why we had come to ibi. And the experience changed us all.

Short-term surgical missions clearly are not the long-term solution for sustainable health care in the developing world; however, this type of work is too often
SuRGIcAL VOLUnTEERISM

The team from St. Luke’s-Roosevelt Hospital. In scrubs, from left to right: Dr. Myers, Dr. Boone, Dr. Kim, Luka Gagi (nurse anesthetist), and Dr. Wedderburn.

The patient was still anemic, as demonstrated by her pale conjunctiva.

disparaged because of its limitations. Some members of the surgical community will point to these shortcomings as a reason for surgeons to abstain from missions. For this team, it became clear after that first trip to nigeriania that although our efforts might be just a small contribution in the grand scheme of things, our efforts can make a profound difference one life at a time. 

Acknowledgement

The authors would like to acknowledge the four general surgical residents from St. Luke’s-Roosevelt who each contributed to this patient’s care and provided many of these pictures: Deva Boone, MD; Gary Schwartz, MD; Daniel Kirchoff, MD; and Elizabeth Myers, MD.
On February 10, 1923, the S.S. Vandyck set sail from New York Harbor for a cruise to Central and South America. Aboard the vessel were several leaders of the American College of Surgeons (ACS), including College Founder Franklin H. Martin, MD, FACS. This voyage represented the culmination of the College’s early efforts to reach out to the international community and expand its influence beyond North America’s borders.

The entire September 1923 issue of the Bulletin recounts this experience, including the laying of the cornerstone of the Gorgas Memorial Institute of Tropical and Preventive Medicine in Panama, participation in the scientific meetings and convocations in South America, and the presentation of educational programs on board the ship. A few surgeons also describe the social activities and other pastimes in which the surgeons engaged during their travels.

Reprinted here, as part of the Bulletin’s Centennial series, are the “Foreword” and “Supplementary Foreword” to the issue by Dr. Martin and Edward I. Salisbury, MD, FACS, respectively. Dr. Martin summarizes events leading up to the cruise in addition to the events that took place during the surgeons’ visit with their East Coast Latin American colleagues. Dr. Salisbury recounts the experience of surgeons who traveled the West Coast.

Cruise participants received a commemorative photo album, from which selections are reprinted on the next page.
Selections from the Latin American Cruise commemorative photo album

The laying of the cornerstone of the Gorgas Memorial, Panama.

Gorgas Ceremony, Panama.

On deck at Colon, Panama.

Reception committee of surgeons, Montevideo, Uruguay.

Upon arrival at Buenos Aires.

Convocation at Buenos Aires.

On-deck sports—potato races.

The "Neptune Ceremony" on deck.
THE CRUISE OF THE S.S. VANDYCK

A VISIT TO THE SURGEONS OF LATIN AMERICA
THE CRUISE OF THE S.S. VANDYCK

A VISIT TO THE SURGEONS OF LATIN AMERICA

I. THE FOREWORD

BY FRANKLIN H. MARTIN, M.D., F.A.C.S., CHICAGO

I. INTRODUCTION

The sailing on the S.S. Vandyck from New York on February 10 of two hundred and seventy-five citizens of Canada and the United States, including Fellows of the American College of Surgeons and members of their families, for a cruise to Central and South American countries, was not merely the carrying out of a plan for a winter pleasure trip, but it was the culmination of a well-thought-out program to obtain a closer affiliation between the surgeons of North and South America, and to strengthen the foundations of a strong continental union through Fellowship in the American College of Surgeons.

The first step of this program was accomplished in the winter of 1920, when Dr. William J. Mayo and the writer visited the surgeons of Panama, Peru, Chile, Argentina, and Uruguay, and was pursued in the winter of 1921, at which time Dr. Thomas J. Watkins and the writer revisited these countries, adding to the itinerary Rio de Janeiro and São Paulo in Brazil.

In the meantime we had been generously received, and strong friendships had been created. More than one hundred of the leading surgeons of Latin American countries had become Fellows of the American College of Surgeons, and a large number of these southern surgeons had reciprocated by visiting us in the United States and Canada.

The story of our previous visits and the friendships we had been creating had deeply interested not only the members of the medical profession of our countries, but as well the men of broad vision in our State Department whose principal object it is to maintain a sympathetic friendship between the Governments.

2. THE START

And so, on the tenth of February, at twelve o'clock noon, we had gathered on the snow-covered deck of the S.S. Vandyck, our chartered ship, and amid snow-balling, still and motion picture taking, rejoicing and good-byes, we departed from our friends who stood on the dock. We slowly made our way as we reviewed the panorama of the shore line of a great city of the world, gave a farewell salute to the Goddess of Liberty, said adieu to zero weather and snow-storms, and sailed on to summer seas and tropical charm.

3. OUR CARGO

Fellows of the American College of Surgeons and members of their families and friends, bringing the number up to two hundred and seventy-five, comprised the bulk of the cargo. In addition we carried ballast of through freight and food and water supply. The College had representatives from thirty-five states of the United States and five provinces of Canada. Of these, eleven were Founders of the College, nine Governors, one Regent, and Dr. John George MacDougall, vice-president, and acting president for the period of the cruise.

4. THE SHIP

The S.S. Vandyck, with a displacement of 21,000 tons, the largest, newest, and most luxurious of the Lampert and Holt Line steamers, with her competent and genial Captain, John Byrne, whose character possesses the best the name implies, to guide her maritime destinies, furnished us a palatial floating hotel which, stripped of second-class and third-class passengers, afforded not only most satisfactory living quarters, but an abundance of deck space for exercise and desirable seclusion.

The aft lounge, ordinarily used for second-cabin passengers, was converted into a commodious meeting place for medical and popular gatherings. With its stereopticon lantern accommodations, it was available day or night, and furnished a delightful place for discussions of all kinds. The aft smoking-room, too, was an exclusive resort for card games and social confab. The main lounge,
A VISIT TO THE SURGEONS OF LATIN AMERICA

music-room, and smoking-room contained the usual luxurious accommodations for the more conventionally inclined. An out-of-door swimming tank of generous capacity on the aft deck was an everlasting source of refreshment and exercise for young and old. The cabin service and the dining-room service were well organized, and offered the very best that a well-regulated ship sailing under the British flag could furnish.

5. OUR MISSION

Among the many objects of our mission, which was abundantly fulfilled in actual accomplishments as we pursued our journey, were recreation in a tropical atmosphere far removed from the winter climate; social intercourse with our Latin American neighbors; an observation of their methods of practicing medicine and surgery; visits to their institutions of learning, especially their medical schools; a study of their hospitals and their method of organization; intimate contact with the members of the surgical profession working in their accustomed environment; and enjoyment of the hospitality of their cities, their governments, their clubs, and their places of amusement.

6. HIGH SPOTS OF OUR EXPERIENCE

The lover of the sea could conceive of no greater degree of pleasure than the ocean voyage from a New York port in February, south to Havana and Panama, east to Colombia, Venezuela, and Trinidad, past the mouth of the Amazon, across the Equator, east around the great bend, diagonally west again to Rio de Janeiro, south to Santos, Montevideo, and Buenos Aires, and then, after much sightseeing and many happy experiences, returning with a few stops to the starting point. It is a succession of balmy seas, undisturbed by storms, and an experience of restfulness that cannot, I am sure, be excelled.

7. HAVANA

At Havana our committee was met by a group from shore, immediately upon lowering our gangplank, consisting of a reception committee from our own Embassy, an official representative of the Government, and the Fellows of the College in Cuba. First was our genial and strenuous Major General Enoch H. Crowder, who within the hour had received almost simultaneously notices from the State Department and the War Department of Washington announcing, first, his appointment as Ambassador to Cuba (a newly created position), and, second, his retirement as Major General of the United States Army. Next our sympathetic Dr. José E. Casuso, and Dr. José A. Presno y Bastioni, both Honorary Fellows of the College, with their confrères, and the representatives of the president of the Republic, Señor Dr. Alféredo Zayas. Following the formal greetings and the necessary photographing by an enterprising group of journalists, our party was informed that the President was to receive us at four o’clock in the afternoon, and the other details of our day’s program were arranged.

At the Sevile Hotel, where practically all members of our party lunched, Ambassador Crowder and his staff were our personal guests. In the midst of the luncheon I announced the new honors that had come to our great friend, General Crowder, and the enthusiastic applause he received brought him forward to make his first speech as United States Ambassador to Cuba. Following his talk, the luncheon was almost forgotten because of an impromptu reception line that was immediately formed by our people who wished to shake the hand of the man who had so successfully organized the Selective Service Draft for the Great War. It was a great event for us, and obviously pleased the new Ambassador.

At four o’clock Ambassador Crowder appeared and led the procession that proceeded two by two on foot from the hotel to the President’s palace, two blocks distant. Our long line of people, headed by the man who has become a great friend to Cuba, attracted the attention of the many pedestrians on the streets. On arrival at the palace, we were received by the President and his Señora, who were assisted by the officials of our party and Ambassador Crowder.

Several interesting drives about Havana were provided for the sightseers, and a number of private luncheons and dinners entertained special friends.

8. PANAMA

It is always an inspiration to any traveler, and much more to a citizen of the United States, to approach Panama and slowly to make the landing at Colon. There is the fascinating beauty of the shore line, with its projections, its islands, and its bays, with its wealth of billowy green foliage, out of which peep red-roofed structures made by man and stalwart palms,—and to all of this is added the romance of history, the early landing of Columbus, the surprise of the enterprising Balboa, the sport of pirates, the early adventures of the Spaniards, the struggle against pestilence and disease, the enterprise of de Lesseps, and the final triumph of sanitation and engineering in overcoming the ruthlessness of the tropics and bringing forth a princely paradise.
FOREWORD

Our friends of old were at the dock to meet us, to greet us, and to guide us. Our party proceeded across the Isthmus to Balboa and Panama by relays of railroad and ship to inspect the Canal. At Panama a program had been planned which had for its principal feature the laying of the cornerstone of the Gorgas Memorial Institute of Tropical and Preventive Medicine. As the acting president of the Gorgas Memorial Institute, I had been requested by marconigram the day before to respond to the address to be delivered on this occasion by President Belisario Porras. On the beautiful site presented to the Gorgas Memorial Institute by the Republic of Panama an open pavilion had been erected to accommodate the speakers, the Government officials, and the distinguished guests. An audience of many hundreds had assembled, and on our arrival we proceeded to the pavilion through a narrow lane that was kept open by soldiers. A large band enlivened the scene with its music. An address was made by President Porras, whose delivery was that of a trained, impassioned orator, and he was received with great enthusiasm. He was followed by Dr. Augusto S. Boyd, who delivered an address of welcome to the English-speaking strangers, and a short response by myself. President Porras then, assisted by the other members of his committee and the writer, secured with trowel and mortar an appropriate tablet on the site of the future home of the Gorgas Memorial Institute. It was an inspiring occasion. At our right as we spoke was an heroic plaster bust of General Gorgas, and its life-like features, with the genial smile playing about its face, encouraged us who loved him to believe that he was there in spirit to lend approbation to our action.

The site selected for carrying on the work of Gorgas is located on a point of land which projects into the Bay of Panama, and commands a view of the heights of Balboa, Ancon Hospital, and the far-away hills and mountains bordering the Canal; it lies in close proximity to the new Santo Tomas Hospital which is partially finished, all occupying a generous tract of land on the old exposition grounds.

In the evening President Porras gave a formal reception at the Executive Mansion to which all members of our party were invited, as well as the society of Panama and the Canal Zone. It was a brilliant affair, combining cordiality, the highest type and an oriental display of hospitality that is seldom seen in these days of somber lights.

During the reception, an Honorary Fellowship in the College was conferred on Dr. Augusto S. Boyd, a distinguished surgeon of Panama, by the officers of the American College of Surgeons.

The President is not only a beloved executive and a man of strong personality and culture, but he has within him the power to impart enthusiasm to his associates and the quality the Spaniards express as "simpatico." It may be said, without danger of refutation, that he succeeded in making a friend of every member of the American College of Surgeons who visited Panama; and as to their wives, they are still inquiring when we shall go back to beautiful Panama and to their friend, President Porras.

9. COLOMBIA

Cartagena, Colombia, was our next stopping place, and that most ancient of all cities of the western hemisphere, with its protecting wall still in good repair, gave us a glimpse of the civilization of this most northerly Republic of South America. A drive about the city, a visit to the Governor, Señor Doctor Roman, a survey of their large municipal hospital, luncheon in the out-of-doors pavilion of the Club La Popa, and a tea dance at their seashore club, Miramar, created an atmosphere that was enjoyable, interesting, and never to be forgotten. Colombia has four Fellows of the American College of Surgeons, three of whom live in the interior, at the capital, Bogotá. Special envos from there, and officials of the medical societies of Colombia, called on us and presented the compliments of the medical men of the Republic. Dr. Rafael Calvo, C., of Cartagena, our host of the day, and one of the distinguished surgeons of the country, welcomed us with true hospitality. In the evening we conveyed him to our ship, and in the presence of members of his family, the Governor and other guests, Dr. MacDougall conferred upon him an Honorary Fellowship in the College.

10. VENEZUELA

We called at La Guaira, the port of entry to Caracas, Venezuela, on a beautiful morning, February 23. The snug little hamlet with its small exposed harbor lay before us, and a succession of imposing shore mountains of the Sierra Nevada coast range, covered with green, rose from the beach line and were the foot-hills of a bewildering bulwark of mountain terraces which terminated far above in snow-capped peaks. Laboriously and slowly we made a landing in the ship’s boats, aided by a small coast tender loaned to us in our emergency. On two trains we proceeded to Caracas, which is nestled on a plateau twenty miles away by rail, and six miles distant from the coast.
as the crow flies. Among the mountains above the sea we rose and meandered around the peaks, on ledges of barren rock, through tunnels, over treestles, and enjoyed a succession of scenes of one of the famous mountain rides of the world.

On arriving at the capital, we were whisked to the official residence of the President of Venezuela, General Juan Vincente Gómez, where our party was received by him and his entire cabinet, including the wives of the President and his officials. The reception room was on one side of a beautiful patio and was an imposing hall of about seventyfive by fifty feet, with a high ceiling. The carved walls were decorated with portraits of ex-presidents and generals of the Republic, nearly all of them in military dress. The President, a strong man with a military bearing, and several of his cabinet officers were in khaki uniforms. Military guards were all about the palace; and with the uniforms, the bright colors of the decorations and the ladies’ dresses, the entire scene was of unusual impressiveness. The President is an animated individual, and entered into the spirit of hospitality. He was ever ready to accommodate the ubiquitous photographers and posed for many pictures.

After the reception our party divided and the men and women lunched at separate hotels. Later the surgeons visited the hospitals, inspected the well-equipped laboratory of tropical medicine and other governmental institutions, and in all too short a time we glided down the scenic railroad to our ship in the blue waters of the bay three thousand feet below.

A committee of the Fellows of the College, headed by Dr. Luis Razetti, remained with us during the day and until we waved them adieu at twilight on the little landing in La Guayra.

11. TRINIDAD

We drew a surprise from Captain Byrne on Sunday, February 25, when he gave us a look-in at the beautiful city of Port of Spain on the island of Trinidad. As this was not on our itinerary, we were on our own, and succeeded in spending an interesting day in long country drives into the interior, examining some of the curious places, and enjoying the hospitality of the institutions and hotel. Trinidad, not unlike many of the islands of this archipelago, would make an ideal dwelling place for one who enjoys the charm of the equable climate of the tropics and an old civilization.

12. BRAZIL

Regrettfully, because of loss of time, we skirted the great breast of Brazil, by the mouth of the greatest river, and down by its old cities of Bahia and Pernambuco, which we could not visit at that time, and kept our appointment in the most beautiful city of the world. We cast anchor at Rio de Janeiro on the morning of March 7 and were met by representatives of the Government, Ambassador Edwin V. Morgan, members of the medical profession and of the Brazilian Exposition. They presented to us a program that they had arranged which included an audience with the President that very afternoon, a reception by the Minister of Justice at the Gloria Hotel that evening, a visit the next morning to the Oswaldo Cruz Institute of Tropical Medicine, and finally a reception at the medical school in the afternoon. In accordance with this program, President Arturo da Silva Bernardes, assisted by his officials and Ambassador Morgan, received all of our people at the Executive Mansion, and made us happy by consenting to photographs and a motion picture scene with us that will enable us to preserve a valuable record of the reception.

That evening a brilliant ball was given at the new Gloria Hotel, where in resplendent informalities we were greeted by Senhor Doctor João Luiz Alves, the Minister of Justice, in a formal speech, to which I replied: Both of these talks were interpreted by a representative of the Government, Senhor Felix Pacheco, Chancellor, for those not understanding either Portuguese or English.

We danced away the evening in this beautiful ball-room, from the windows of which we could observe Sugar Loaf and the many undulations of the bay, outlined by beads of electric lights, in the center of which was enblazoned in splendor the Exposition.

Guided by that most splendid of all hosts, Carlos Chagas himself, the distinguished director of the Oswaldo Cruz Institute, a large group of our Fellows wended their way early the next day to the Institute, where we feasted on the scientific display and on the very delightful repast that he had to furnish us.

That afternoon, although a number of our party had been drawn away by the physical attractions of Rio de Janeiro, we visited the medical school. This was one of the most attractive receptions that was accorded to us. The members of the faculty were in academic dress, resplendent in color and dignity, and made us regret that we had not come in our Fellowship gowns. In the great patio of the quadrangle that represents the buildings of the college, was a large military band which regaled us with inspiring music while we visited the marvelous institution that has been so completely planned by Dr. Aloysio de Castro. Then in a brilliant convocation hall, in the pres-
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ence of the students, distinguished guests, and our own people, Dr. de Castro greeted us by an address in English, to which our acting president, Dr. MacDougall, responded. Refreshments were served, and after surveying the building and classrooms, we departed, filled with admiration for their most comprehensive place of learning.

That evening the Academy of Medicine of Rio de Janeiro entertained the Fellows of the College and their wives and friends at the Exposition, and in the Palace of Festivals at 9:30 o’clock we held a formal medical meeting, attended by the members of the College in their Fellowship robes. It was a brilliant gathering. Professor Dr. Miguel Couto, president of the Academy of Medicine, presided. Dr. John Osborn Polak and Dr. F. N. G. Starr of our party, and Fellows Dr. José de Mendonça and Dr. Fernando Vaz of Rio de Janeiro, read short scientific papers. President Couto conferred upon Dr. MacDougall, our acting president, and on me as director general, Honorary Fellowships in the Academy of Medicine of Rio de Janeiro, which included the presentation of handsome medals. The American College of Surgeons conferred on Dr. Olympio da Fonseca an Honorary Fellowship.

During these two days of brilliant entertainment, many of our ladies and Fellows stole away and enjoyed the wonderful sights and interesting places of Rio de Janeiro. On Friday and Saturday of the week some of us took occasion to seek out their clinics, their hospitals, and other things of interest to the medical mind. On Friday a number of us visited Petropolis, and enjoyed a survey of this summer capital, a visit to some of our friends of old, and the acquaintance of new friends of value.

This sketch is not a book—the only thing that could even attempt to describe Rio de Janeiro. Therefore, we must remain satisfied to mention that the beauty of Rio de Janeiro was everywhere about us as we pursued our rapid pace. And here, busy showing us the high spots, were our old friends, the Fellows of the College, and always at our side, strenuous as ever, was Dr. Oscar Clark.

13. SANTOS AND SÃO PAULO

On Saturday, March 10, our party divided, about fifty traveling by railroad across country to São Paulo, the great coffee state of Brazil, and the others continuing on our ship to the port of Santos, the coffee outlet for São Paulo and the surrounding country, where we again joined our forces. Sightseeing was our principal object on this part of our trip. At São Paulo, however, our hosts of other years, members of the College and local officials, urged upon those taking the inland trip and those who would make the two-hour railroad ride from Santos in response to a hasty invitation, to partake of an elaborate and beautiful banquet which was given at the famous Automobile Club in São Paulo.

The following morning a number of our Fellows attended clinics at various hospitals, and here they were able to judge of the excellent scientific work of the surgeons of São Paulo. An invitation to attend a reception by the governor, extended through our gracious host, Dr. J. Alves de Lima, had to be regretfully declined because of the inability of all of our people to get together.

14. ARGENTINA

The three days of delightful rest on our comfortable ship, after our interesting entertainment of a week in Brazil, were very welcome, and that brought us on the morning of March 16 to the port of Buenos Aires, where we were to spend five days in sightseeing and entertainment—social and professional enjoyment. Dr. Marcelino Herrera Vegas, Dr. José Arce, Dr. Frank Pasman, Dr. Ricardo Pasman, Dr. Robert Halahan, other Fellows of the College, our Consul, a representative of Mr. John Riddle, our Ambassador, and officials of the Argentine Government were early on board to welcome us. An elaborate schedule of clinics was handed to us, one that filled our surgeons with joy. Sightseeing rides and excursions had been prepared by our official guides, Thos. Cook & Son, and with these there had been interspersed official entertainment which did not conflict. The high points were a reception by Ambassador Riddle, a reception by the president of the Republic, Señor Dr. Marcelo T. de Alvear, a reception at the headquarters of the medical society, a visit to the medical school and the Department of Sanitation, and finally our Convocation at the medical school. An Honorary Fellowship was conferred upon Dr. Marcelino Herrera Vegas, and Dr. Arce, rector of the University, Dr. MacDougall, and the writer made addresses, followed by two scientific papers by Dr. James T. Case and Dr. Hugh Young. This function was held in a beautiful academic hall, and was a very brilliant affair. The one hundred odd Fellows of the College from North America wore their Fellowship gowns and occupied the center of the hall surrounding the raised platform on which were gathered the members of the Faculty of Medicine of Buenos Aires; the ladies and members of the local profession occupied places immediately back of the Fellows of the College, and a large number of medical students were massed in the aisles, the window and door spaces, and in a solid group in
A VISIT TO THE SURGEONS OF LATIN AMERICA

the rear of the dais, forming an effective and interesting background.

There were many private entertainments which kept everybody busy, one of the most enjoyable being a luncheon given by Dr. Herrera Vegas to a large group of our ladies at the Plaza Hotel. Following this there was an excursion of Fellows and ladies to Las Hermanas, his large estancia.

On Wednesday morning, March 21, fifty of the members of our original excursion departed from us to return by the West Coast. The account of this portion of our cruise will be detailed by Dr. Salisbury, who accompanied the party.

15. URUGUAY

The prow of our ship was now turned home-ward, although the next morning, on March 22, we docked at Montevideo for a three days’ so-journ. Again we were greeted by the distin-guished citizens of the metropolis of a South American Republic. The members of the Col-lege, the Dean of the Medical Faculty, representatives of the Government, of our own United States, Minister Philip and our Consul, were there to meet us. After the greeting and the in-evitable camera practice that is always con-spicuous in the Latin American countries, we drove to the medical school and the university.

For three days we were the recipients of a con-tinuous round of delightful entertainment, and were given an opportunity of visiting all places of interest to members of the profession of medicine. The high points were visits to the innumerable clinics and hospitals and their medical school, a recep-tion by the president of the Republic, Si-ñor Dr. José Serrato, a reception and tea by our Minister, Hoffman Philip, and a formal evening medical meeting, attended by our Fellows in their College gowns and presided over by a Uruguayan Fellow of the College, Dr. Alfredo Navarro, president of the Society of Surgery of Montevideo, at which four of our Fellows—Dr. James F. Barnhill, Dr. A. J. Crowell, Dr. R. D. Kennedy, and Dr. James T. Case—presented formal scientific papers. Be-sides, small groups of the Fellows and their ladies interested in a variety of subjects were entertained by our hospitable hosts at luncheons and dinners.

Montevideo, since our first presentation of the ideals of the American College of Surgeons three years before, has been keenly interested in the College. In this smaller of the South American countries, affiliated with the College are seventeen of their leading surgeons, and the Commit-tee on Credentials at this time unanimously re-commended for Fellowship fourteen additional candidates. Two of the Fellows of the College from Montevideo, Dr. Horacio García Lagos and Dr. Enrique Pouey, were in Europe at the time of our visit; and Dr. Juan Pou Orfila and Dr. Julio Baudé, accompanied by members of their families, returned on our ship, each to spend eight months making a study tour of our clinics. They are already conversant with our language, and we hope and trust that they will return from this visit with their love for our country enhanced, and that they will come to us many times.

16. RIO DE JANEIRO AGAIN

Rio de Janeiro, as we crept into her beautiful bay in the early morning of March 28, was again revealed to us in all of her glory. The mists and clouds had disappeared, and the shore line, the mountains, and the terraced city lay invitingly before us. A schedule of clinics greeted the in-satiable surgeons, and the shops and places of beauty beckoned to the shoppers and sightseers. All of our friends were there to welcome us, and before us were two days for thorough enjoyment of this beautiful city of the world. On the second day, with the hosts impressing upon us their genuineness of friendship, our ship once more sailed forth, and we were truly on our way to our own homes in North America.

17. BARBADOS

Five days out we received a marconigram from our American Consul, Mr. John J. C. Wilson, and the medical profession of Barbados, inviting our cruise party to a reception at the Savannah Club on the afternoon of Saturday, April 7. On arriving at this interesting little British possession we were greeted on all sides by a pleasing hospitality, and the formal reception that was planned for us in advance was heartily enjoyed by us all. The shopping and sightseeing vied with our social activities, and we said good-bye with a genuine regret that we were on the last leg of a wonderful voyage. We had before us one more week of our ocean home that we had learned to love, with its congenial family, and then we began to think of home as on the evening of Friday, the thirteenth, we espied the lights from the “great white way” and we were anchored at quarantine within the “three mile limit.”

18. HOME AGAIN

For the third time we had made the voyage. For the third time we had been fascinated by a wonderful people of Latin America. As on previous visits we vowed that we had become neigh-bors, and that we would repeat our visit again and again.
FOREWORD

II. SUPPLEMENTARY FOREWORD

BY EDWARD I. SALISBURY, M.D., DENVER, COLORADO

1. DEPARTURE OF WEST-COASTERS

At eight-thirty o’clock on the morning of March 21 the shrill whistle of the “Internacional” echoed through Retiro Station of the Buenos Aires and Pacific Railroad. It shrilled a warning that fifty West-Coasters were leaving the cruise party of the S.S. Vandyck to enjoy thrills not to be had by the remaining cruisers who enviously followed the little group that morning to the station. There was a near panic among the West-Coasters as we scrambled for our cars lest we be left behind to retrace our steps on the S.S. Vandyck and miss a trans-continental tour and a cruise upon the South Seas.

The trip to Buenos Aires had been a glorious one—replete with joys and pleasures, filled with every luxury, and with pleasant associations of old friends and new. We were reluctant to say good-bye and have only memories for our tomorrows; but yet the call of the unexplored beckoned to us, and as we ran for the moving train we carried with us in our hearts a sorrow for those who were to be left behind and to be deprived of a most wonderful trip.

For some time I stood upon the platform as the “Internacional” rolled out of the train-shed, waving adieu to friends of the Vandyck. They stood there watching us depart, looking wistfully, longingly, wishing they had joined our party. And being a sympathetic creature I was moved and cast my eyes elsewhere that I might not view their dejection.

2. THE PAMPAS

Having recovered from the ordeal aforementioned, I took stock of the train, which was of the continental type. Our party was allotted two compartment cars and one diner.

Dr. Walter S. Stewart shared “Cámara No. 4” with me, and after arranging our baggage and lighting our cigars, we settled comfortably into the cushions to take note of the terrain en route. We were now hurrying through the environs of Buenos Aires, with healthy signs of business and industry in the factories. The little houses or casitas of the outlying districts flew by;—we caught a glimpse of the Río de la Plata in the distance, and soon were out upon the broad expanse of the Argentine pampas. As far as eye could see, like a restless ocean, stretched the waving green of the pampas grass, with here and there the hoary whiteness of its bloom appearing as white-caps in the surf. The far-scattered ranch-houses, with their ever-present windmills, dotted the horizon, and loomed like ships upon the deep. The illusion was constant, and one continually felt that he was riding along some coast-line, gazing seaward.

We came upon the great cattle-raising section and saw immense herds of fine cattle that were destined for the great markets of Buenos Aires, of Europe, and often the United States. Frequently we saw flocks of ostriches feeding in their awkward fashion in these great pastures. It was all so interesting, and as we drank in the uncustomed view the porter informed us individually that almuerzo or luncheon was being served in the diner ahead. We entered and received a service of numerous courses, typical of the great hotels of South America. Leisurely we ate and viewed the passing scenes, the monotony of the pampas broken by lagoons and ponds alive with wild duck and geese; and occasionally large flocks of flamingos were seen standing knee-deep in the morass, like flaming sentries.

After a hearty luncheon, slowly consumed, came a welcome siesta, from which we were summoned to tea and cakes, or Quilmes Crystal and biscuits. A surprise awaited us without, for we were now entering the great agricultural belt. It was autumn, and a series of gasoline tractors were pulling great gang-plows, preparing for the sowing of the winter wheat. A few months earlier golden grain would have greeted us, and we might venture to suggest that oxen were used for plowing.

With like scenes, interspersed with pastures and grazing cattle, and now and then a gaucho or cowboy in full regalia riding out to his herds, we passed the hours until sunset and darkness came. Another meal was served, and afterward the diner became a social hall while the berths were being made up, in which we soon sought refuge as we were to arrive in Mendoza early the next morning to change to the Trans-Andean train.

3. THE ANDES

At six o’clock we were aroused and had just time enough to shave and have a cup of coffee before we arrived in Mendoza. In the early dawn, far to the westward, we could see the brown foothills of the Andes, and as the sun cleared the air,
A VISIT TO THE SURGEONS OF LATIN AMERICA

the distant snow-caps became visible, with the volcanoes Tupungato and Aconcagua towering majestically over all. Spread out around us were the vast vineyards of Mendoza, the great wine-producing section of the Argentine.

At Mendoza we changed to our special narrow-gauge train for the trip across to the Andes to Chile. Up to this time we had traveled six hundred miles as straight as the crow flies, and had reached an altitude of nearly 2,500 feet. Breakfast was served aboard immediately, and we began our climb to the foothills. The track follows the course of the Mendoza River, whose waters supply the great irrigation system used in the vineyards.

We soon found ourselves traveling over a great moraine, the remnant of glaciers of ages past. All vegetation, except a few scrub bushes and cacti, disappeared, and our laboring engine told us that our climb of the Andes had begun. In a few hours we were conquering the bleak mountain barriers, and we lunched while our train struggled up a rack (cog) road at an elevation of seven thousand feet. On every side giant mountains rose to stupendous heights—desolate but majestic, eager in their solitude to echo the noise of the engine that alone disturbs the quiet. For centuries only the hallow of the muleteer, wending his way over Cumbre Pass, broke the stillness that reigned supreme; but a decade or two ago the ring of iron and steel, and the hissing of steam resounded through mountain and vale, proclaiming man’s triumph over a wilderness.

Occasionally we caught glimpses of snowcapped peaks, and fifty miles up the Tupungato Valley we saw the extinct volcano of the same name with its majestic peak raised some 22,000 feet heavenward. We passed Los Penitentes (The Penitents), a mass of volcanic pinnacled rock carved by nature and time to resemble a procession of cowled monks marching toward cathedral-like spires.

The air was chill as we left the train at Puente del Inca to view the great natural bridge of the Andes which spans the Cuevas River. The hotel near the sulphur springs is the starting point for excursionists to the monument of Chilean-Argentinian peace, “Christ of the Andes.” The statue is not visible from the railroad which passes at a level of some 2,500 feet below.

Toward evening we entered the two-mile tunnel through the International and Continental Divide two miles above sea level, or, to be exact, 10,400 feet, and emerged on the Chilean side. Here we met the headwaters of the Aconcagua and Juncal rivers that flow Pacificward to irrigate the vineyards of Chile. The route is now through the Chilean Andes, but darkness overtook us and we had to forego the pleasure of seeing the Salto (Soldier’s Leap). As our train was late, we dined aboard instead of in Los Andes. At this stop we changed to the broad-gauge Chilean State Railway, and were whisked off to the capital, Santiago. We reached our hotel and deserved rest at 2:00 A.M., after forty hours of travel.

4. SANTIAGO, CHILE

At Los Andes we were met by Dr. Edwyn P. Reed, of Valparaiso, the Secretary of our Committee on Credentials. He accompanied us to Santiago and informed us of the program they had prepared for us. The following morning we were received in the Hospital of the College of Surgeons. The next morning we were received in the Medical Faculty of the University, and recently elected president of the University, for Honorary Fellowship in the American College of Surgeons. This honor of the College was conferred by Dr. Truman W. Brophy, our acting president for the West Coast meetings.

Dr. Amunategui was greatly moved by the honor, and accepted enthusiastically the Toga Collegii, expressing his gratitude and declaring himself an humble disciple among the ranks to hold sacred the ideals of the American College of Surgeons.

The remainder of the morning was consumed by sightseeing and visits to the institutions and hospitals in company with the Chilean Fellows and members of the profession, prominent among them Dr. Lucas Sierra, Dr. Luis Vargas, Dr. Caupolican Pardo Correa, Dr. Francisco Navarro Valenzuela, and others. At noon we enjoyed their hospitality at the Union Club, and in the afternoon we were received by the United States Ambassador, Honorable William Miller Collier, at the Embassy, a beautiful edifice and one of the few owned by the United States, of which we should be justly proud.

At four o’clock we were received in the Government Palace by the president of the Republic, Dr. Arturo Alessandri, who has just written the new health code for the country.

Santiago was in gala attire for the opening of the Fifth Pan-American Congress, recently in session. It is a city beautifully located upon many hills and in little vales, with attractive buildings and wonderful parks. I regret that our
FOREWORD

The next day was spent at Mollendo, Peru, where cargo was taken aboard. The most striking thing of the ports are the myriads of guano birds that circle about in flight, almost in dense cloud formation.

7. LIMA, PERU

On Monday, April 2, we arrived in Callao, Peru, the port for the capital, Lima. Dr. Juvenal Denegri, Dr. Miguel Aljovin, Dr. Ricardo Palma, and Dr. Alejandro Bussalleu welcomed us at the port and accompanied us to Lima. We had but a few short hours to stay in that wonderful city; but we were able to see most of the interesting sights and visit the hospitals, University, and Medical School.

The Surgical Society of Peru, Dr. Miguel Aljovin, the president, presiding, entertained us at luncheon in the National Club, at which the wives of a number of local surgeons were present. Dr. Aljovin welcomed us in the name of the Surgical Society, eulogizing the surgeons of North America, their contributions to science, and the admirable organization of northern universities. Dr. Francisco Graña translated the address, and Dr. Truman W. Brophy responded, following which Dr. William F. Grinstead toasted the surgeons of Peru as representing the culture of the South. At a meeting of the Credentials Committee, four new candidates were presented, and Dr. Guillermo Gañáñeta asked us to carry back the message that the Fellows of Lima were working to bring their hospitals up to the Minimum Standard.

One could spend several weeks in Lima, the City of Kings, visiting the Spanish-Colonial buildings and viewing their carved interiors. They are examples of the fine work of the artisans of those times, as are the paintings and tilings. The tiles were creations of both the old world and the new, but today the art is lost and cannot be duplicated even in Spain.

The new museum of San Marcos University, named for its founder, Señor Javier Prado, is carrying on studies and investigations destined to enlighten us on the history of the Incas and Tiahuanacos, and the aboriginal tribes, the Chimús and Nascas, of which many monoliths remain.

We bade a hasty farewell to our friends of Lima and departed from their shores at sunset.

8. HOMEWARD BOUND

Our course was now set for the Panama Canal, and we arrived at the Balboa docks on the morning of April seventh. The party was divided, one group passing through the Great Gateway on the
A VISIT TO THE SURGEONS OF LATIN AMERICA

9. DISEMBARKATION

The good ship Essequibo reached New York on Sunday afternoon, April 15, its mettle having been tested by thirty hours of severe storm just at the end of our voyage. We were still feeling sorry for our friends who had returned on the S.S. Van- dyck; but we found that our sympathies were wasted, for those who met us on the dock reported a glorious return voyage, and they had been losing sleep fearing that we were unhappy on a strange ship!

The memory of the friends we made, their kindnesses, the associations, and the good fellowship will outlast time.

There is in each life some time or spot,
Some hour or moment of night or day,
That never grows dim and is never forgot,
Like an unfaded leaf in a dead bouquet;
Some rare season, however brief,
That stands forever and aye the same;
A sweet, bright picture in bas-relief,
Hanging before us in Memory's frame.

steamer, and the other spending a few hours in Panama and going to Colon by rail.

Since our visit in February much interest has been aroused locally in the Gorgas Memorial Institute of Tropical and Preventive Medicine. The Chamber of Commerce and Rotary Club have nominated a committee to represent Panama in raising an endowment for this institution. A similar plan is to be carried out in every country, state and province where the name of William Crawford Gorgas, soldier and sanitarian, is revered.

We left Colon on the night of April 7, New York-bound via Havana. The time aboard ship was profitably spent in interesting medical meetings, reviews of the cruise, and exchange of impressions of the countries visited. Deck golf was the most popular sport. The “races” and a “bull fight” afforded great amusement.

A birthday dinner was tendered to Dr. Truman W. Brophy, the admirable chieftain of the West Coast party, whom we had learned to revere and love during our happy days of association.
Health care fraud is a persistent and costly problem both for commercial and government payors. The Centers for Medicare & Medicaid Services (CMS) estimates that a significant amount of fee-for-service payments are misspent on improper payments every year. To address health care fraud, Congress and CMS have developed a variety of approaches over the past several years to audit Medicare and Medicaid claims. The tables in this article summarize the major types of Medicare and Medicaid audits that could affect physicians. Entities responsible for these audits include:

- Medicare Recovery Audit Contractors (RACs)
- Medicaid RACs
- Medicaid integrity Contractors (MiCs)
- Zone Program integrity Contractors (ZPICs)
- State Medicaid Fraud Control units (MFCUs)
- Comprehensive Error Rate Testing (CERT)
- Payment Error Rate Measurement (PERM)

This article is intended to present a high-level summary of these seven common audits. For more detailed information on a specific audit, please click on the links at the end of this article. In addition to the audits outlined in this article, surgeons and other providers could be subject to audits conducted by the U.S. Department of Health and Human Services office of the inspector General (oIG), prepayment reviews or other audits by their Medicare Administrative Contractor (MAC), or the RAC Prepayment Review Demonstration Program; however, this article focuses on the seven major audits described earlier in this article.

What is the scope of the various types of audits? Who will be conducting the audits, and what are the look-back periods (the period of time in which an auditor can review claims that have been submitted for payment) for each audit? See Table 1, page 50.

What are the audit/recoupment processes, penalties, and appeals processes for each audit? See Table 2, page 51.

Where can I find more information on each of the audits discussed?
- MiCs: http://www.cms.gov/MedicaidIntegrityProgram/
- MFCUs: https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp

To address health care fraud, Congress and CMS have developed a variety of approaches over the past several years to audit Medicare and Medicaid claims.
TABLE 1.

<table>
<thead>
<tr>
<th>Name</th>
<th>Scope</th>
<th>Auditor</th>
<th>Look-back period</th>
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<tbody>
<tr>
<td>Medicare RACs</td>
<td>Medicare RACs identify Medicare fee-for-service overpayments and</td>
<td>The four Medicare RACs, each</td>
<td>Medicare RACs perform audit and recovery activities on a postpayment basis and</td>
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<tr>
<td>Focus:</td>
<td>underpayments and collect overpayments as well as return overpayments.</td>
<td>responsible for a U.S. region,</td>
<td>may review a claim up to three years after the date the claim was filed.</td>
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<td></td>
<td>Medicare RACs operate nationwide and only review issues approved for</td>
<td>are private companies that</td>
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<td></td>
<td>review by CMS.</td>
<td>have contracted with CMS.</td>
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<tr>
<td>Medicaid RACs</td>
<td>Medicaid RACs identify all providers’ overpayments and</td>
<td>Each state contracts with a</td>
<td>Medicaid RACs perform audit and recovery activities on a postpayment basis and</td>
</tr>
<tr>
<td>Focus:</td>
<td>overpayments of Medicaid claims and recoup the overpayments.</td>
<td>private company that operates</td>
<td>may review a claim more than three years after the date the claim was filed,</td>
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<td></td>
<td>Medicaid RACs operate nationwide on a state-by-state basis. States</td>
<td>as a Medicaid RAC to perform</td>
<td>unless the Medicaid RAC has approval from the state.</td>
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<td>have discretion to determine what areas of their Medicaid programs</td>
<td>audits of Medicaid claims.</td>
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<td>to target and are not required to publicly announce audit target areas.</td>
<td>Individual states determine</td>
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<td>MICs</td>
<td>MICs review all Medicaid providers to identify high-risk areas,</td>
<td>MICs are companies contracted</td>
<td>MICs perform audit and recovery activities on a postpayment basis and may review a</td>
</tr>
<tr>
<td>Focus:</td>
<td>overpayments, and areas for provider education to reduce Medicaid</td>
<td>by CMS, which has divided the</td>
<td>claim more than three years after the date the claim was filed,</td>
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<td>fraud and abuse.</td>
<td>U.S. into five MIC jurisdictions,</td>
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<td></td>
<td>Medicare RACs operate nationwide and only review issues approved for</td>
<td>each encompassing two CMS</td>
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<td></td>
<td>review by CMS.</td>
<td>regions.</td>
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<tr>
<td>ZPICs</td>
<td>ZPICs investigate potential Medicare fraud, waste, and abuse and</td>
<td>ZPICs are companies contracted</td>
<td>ZPICs have no specified look-back period.</td>
</tr>
<tr>
<td>Focus:</td>
<td>refer these cases to their associated MAC for recoupment or to</td>
<td>by CMS, which has divided the</td>
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<td>other federal and state agencies for other penalties. The goal of</td>
<td>U.S. into seven ZPIC jurisdictions,</td>
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<td>ZPICs is to identify fraud, not to conduct random audits.</td>
<td>each aligned with one to two</td>
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<td>MFCs</td>
<td>MFCs, which are annually certified by the OIG, investigate and</td>
<td>MFCs are companies contracted</td>
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<tr>
<td>Focus:</td>
<td>prosecute (or refer for prosecution) criminal and civil Medicaid</td>
<td>by CMS, which has divided the</td>
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<tr>
<td></td>
<td>fraud cases.</td>
<td>U.S. into five MFCs jurisdictions,</td>
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<td>CERT</td>
<td>The CERT program identifies the rate of improper payments in the</td>
<td>CMS runs the CERT program</td>
<td>The CERT program reviews Medicare claims on a postpayment basis. The reviewed</td>
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<td>Focus:</td>
<td>Medicare program and publishes an annual report describing national</td>
<td>using two private contractors.</td>
<td>claims are limited to the current fiscal year (October 1 to September 30).</td>
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<td>paid claims and provider compliance error rates. CERT program</td>
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<td>findings are not considered a measure of fraud because CERT</td>
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<td>randomly samples claims, rather than examining billing patterns that</td>
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<td></td>
<td>indicate potential fraud.</td>
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<tr>
<td>PERM</td>
<td>The PERM program identifies the rate of improper payments in Medicaid</td>
<td>CMS runs the PERM program</td>
<td>The PERM program reviews Medicare claims on a postpayment basis limited to the</td>
</tr>
<tr>
<td>Focus:</td>
<td>and the Children’s Health Insurance Program. Individual state error</td>
<td>using two private contractors.</td>
<td>current fiscal year (the complete measurement cycle is 22 to 28 months).</td>
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<td>rates are measured and are then combined to extrapolate a national</td>
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<td>error rate. The PERM program findings are not considered a measure</td>
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<td>of fraud because PERM randomly samples claims, rather than examining</td>
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<td>billing patterns that indicate potential fraud.</td>
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### TABLE 2.

<table>
<thead>
<tr>
<th>Name</th>
<th>Audit/recoupment process</th>
<th>Penalties</th>
<th>Appeals process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare RACs</td>
<td>Medicare RACs use proprietary software programs to conduct two types of audits: automated, for which a decision can be made without requesting a medical record, and complex, for which the Medicare RAC will contact the provider to request medical records to make a decision about the payment. Limits exist on the number of documents RACs can request from providers.</td>
<td>There is no penalty if a provider agrees with a Medicare RAC's determination of an overpayment and pays the money back to CMS. If a provider misses a deadline in the appeals process, CMS could automatically recoup the alleged overpayment amount plus interest, which will start to accrue on the 31st day after the provider receives the initial demand letter from the Medicare RAC.</td>
<td>The Medicare RAC appeals process mirrors the five-level Medicare claims appeals process by which fee-for-service providers appeal reimbursement decisions.</td>
</tr>
<tr>
<td>Medicaid RACs</td>
<td>States have discretion in how they will coordinate with Medicaid RACs to conduct audits and recoup overpayments. States are required to set limits on the number and frequency of medical records to be reviewed by Medicaid RACs.</td>
<td>There is no penalty if a provider agrees with a Medicaid RAC's determination of an overpayment and pays back the money. If a Medicaid RAC identifies potential fraud, the case could be referred to the state MFCu.</td>
<td>States have the flexibility to decide the structure of the appeals process for providers to appeal any adverse determination made by the Medicaid RAC.</td>
</tr>
<tr>
<td>MICs</td>
<td>Using a data-driven approach to focus on aberrant billing practices, MICs analyze Medicaid claims and audit providers. Identified overpayments are referred to the states for collection. MICs are not bound by a number of claims records they can request in each audit.</td>
<td>Penalties, if any, are determined by the states.</td>
<td>The states individually adjudicate provider appeals.</td>
</tr>
<tr>
<td>ZPICs</td>
<td>A ZPIC audit may be initiated through data analysis or directly by fraud complaints. ZPICs' review of claims may be either pre- or postpayment. ZPICs may make unlimited document requests, in addition to conducting interviews and on-site visits. ZPICs refer identified overpayments to their associated MAC for recoupment or to other state or federal agencies for other penalties.</td>
<td>In addition to recouping overpayments, ZPICs can also refer a finding of fraud to law enforcement for criminal, civil monetary penalty, or other administrative sanction, involving the OIG or to the U.S. Attorney. ZPICs can also recommend that their MAC implement prepayment or auto-denial edits if deemed necessary.</td>
<td>A provider has the right to appeal ZPIC overpayment determinations through the five-level Medicare appeals process by which fee-for-service providers appeal reimbursement decisions.</td>
</tr>
<tr>
<td>MFCu</td>
<td>MFCus are not restricted to a specific investigational or audit process.</td>
<td>In addition to recouping overpayments or referring the matter to an appropriate state agency for collection, MFCus can also refer a finding of fraud to the appropriate investigation or prosecution authority. If there is a pending investigation of Medicaid fraud, MFCus may refer providers to the state Medicaid agency for payment suspension.</td>
<td>The appeal rights of providers investigated by MFCus depend on the entity to which the MFCu refers the case for overpayment, investigation, or prosecution.</td>
</tr>
<tr>
<td>CERT</td>
<td>CERT randomly selects a statistical sample of claims submitted to MACs and requests medical records from the providers who submitted the claims in the sample. The claims and the associated medical records are reviewed for compliance with Medicare coverage, coding, and billing rules. In instances of noncompliance, errors are assigned to the claims.</td>
<td>Claims selected for CERT review are subject to overpayment recoupment, potential postpayment denials, payment adjustments, or other administrative or legal actions depending on the result of the review. If a provider fails to submit a requested record to the CERT program, the claim counts as an improper payment and may be recouped from the provider.</td>
<td>A provider has the right to appeal CERT determinations through the five-level Medicare appeals process, which is the same as the appeals process for RAC determinations, described above.</td>
</tr>
<tr>
<td>PERM</td>
<td>PERM is conducted over a three-year period, focusing on 17 states per year. The PERM's contractors draw random samples of claims from each state and request medical records associated with those claims from the providers who submitted the claims. The medical records are reviewed to validate compliance with Medicaid coverage, coding, and billing rules. The claims that are determined to have been paid incorrectly are scored as errors and payments are adjusted.</td>
<td>If a provider fails to submit a requested record to PERM, the claim counts as an improper payment and may be recouped from the provider.</td>
<td>Providers have the right to appeal PERM determinations.</td>
</tr>
</tbody>
</table>
Malignant pleural effusion (MPE) remains a significant health care problem affecting approximately 150,000 U.S. patients each year. Despite being relatively common, MPE investigations have been encumbered by disease and treatment diversity, as well as difficulties proposing research to terminally ill patients with compromised quality of life.

Traditionally, patients are managed by inpatient applications of sclerosants like talc by video-assisted thoracic surgery or chest tube to accelerate pleurodesis. Gaining popularity are the small pleural catheters (usually tunneled) that are placed in the outpatient setting and that can control symptoms by protracted drainage. Recently, the results of an Alliance/Cancer and Leukemia Group B (CALGB) trial were published to help address which of these options might be better.

Patients who received a tunneled catheter were more likely to be alive with maintenance of effusion control at 30 days. Also, effusion control correlated well with improved quality of life scores. While randomization and consistency of the data supported the conclusions, the fact that the final analysis was of a much smaller sample size and a simpler endpoint than planned was a major limitation. Larger trials have shown that tunneled catheters are not inferior to talc pleurodesis.

**Lessons for future study**

By reviewing the challenges impeding this trial, important lessons for the future study of MPE are evident. First, patient preference for one of the treatments was a considerable barrier to enrollment. This limitation should have been obvious given that one treatment required several days of inpatient care, whereas the other could be done on an outpatient basis but lasted longer and required considerable self-care or caregiver involvement. Potential volunteers preferred inpatient or outpatient therapies in about equal proportion (this preference ratio is discussed in more detail later in this article). Furthermore, practitioner biases aligned with those patient preferences, or dominant approaches in certain regions may have existed.

The second important lesson gleaned from this study revealed that investigator review of the patient history and chest imaging often failed to exclude poor candidates for this pleurodesis research based on high 30-day mortality or trapped lungs. The complex organ system failures occurring in end-stage cancer may require a multiple parameter algorithm to reduce the chance of unexpected mortality. For the problem of detecting trapped lungs, the use of pleural manometry during thoracentesis...
This research also underscores the need for something other than traditional randomized trials to compare treatments with different levels of patient acceptance.

**Conclusion**

Our research shows that tunneled pleural catheters are reliable methods to control MPE and may be optimal if full lung expansion is uncertain. This experience also suggested that a phased data gathering approach to better launch complex surgical trials and the selective use of alternative trial designs would enhance such future endeavors.

**REFERENCES**

Surgical care measures show significant progress

New data collected by Joint Commission-accredited hospitals show significant progress in compliance with evidence-based care processes linked to improved outcomes for surgical patients. The Joint Commission’s 2012 annual report, Improving America’s Hospitals, shows that the 2011 surgical care result is 97.6 percent, up from 82.1 percent in 2005. This change represents an improvement of 15.5 percentage points.

Known as “accountability measures,” the surgical composite includes:

- Antibiotics within one hour before the first surgical cut
- Appropriate prophylactic antibiotics
- Stopping antibiotics within 24 hours
- Cardiac patients with 9:00 am postoperative blood glucose
- Patients with appropriate hair removal
- Beta-blocker patients who received beta-blocker perioperatively
- Prescribing venous thromboembolism (VTE) medicine/treatment
- Receiving VTE medicine/treatment
- Urinary catheter removed

These evidence-based measures are important in the prevention of common postsurgery issues such as surgical site infections and postoperative sepsis, as well as cardiovascular and thromboembolic complications.

Surgical care measure results

In the table on page 55, the overall measure and rates are indicated in color; the stratified measures (by specific surgical procedures) are indicated in regular type. The first three overall measures listed—antibiotics within one hour before the first surgical cut, appropriate prophylactic antibiotics, and stopping antibiotics within 24 hours—include rates on seven specific surgical procedures, as well as the overall measure rate.

Beginning in 2012, all Joint Commission-accredited hospitals are required to meet a performance improvement
A LOOK AT THE JOINT COMMISSION

<table>
<thead>
<tr>
<th>Performance measure</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Improvement since inception (percentage points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical care composite</td>
<td>88.9%</td>
<td>93.5%</td>
<td>95.8%</td>
<td>96.4%</td>
<td>97.6%</td>
<td>15.5%</td>
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<td>Antibiotics within one hour before the first surgical cut</td>
<td>89.5%</td>
<td>93.5%</td>
<td>96.2%</td>
<td>97.4%</td>
<td>98.2%</td>
<td>16.4%</td>
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<tr>
<td>CABG surgery</td>
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<td>94.0%</td>
<td>96.8%</td>
<td>97.8%</td>
<td>98.4%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Cardiac surgery (other than CABG)</td>
<td>89.0%</td>
<td>93.7%</td>
<td>96.6%</td>
<td>97.6%</td>
<td>98.4%</td>
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<td>82.4%</td>
<td>87.6%</td>
<td>91.8%</td>
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<tr>
<td>Hip joint replacement surgery</td>
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<td>93.4%</td>
<td>96.3%</td>
<td>97.5%</td>
<td>98.2%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Hysterectomy surgery</td>
<td>89.8%</td>
<td>93.7%</td>
<td>96.4%</td>
<td>97.5%</td>
<td>98.3%</td>
<td>15.9%</td>
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<tr>
<td>Knee joint replacement surgery</td>
<td>92.5%</td>
<td>95.3%</td>
<td>97.2%</td>
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<tr>
<td>Vascular surgery</td>
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<td>94.6%</td>
<td>96.0%</td>
<td>96.9%</td>
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<tr>
<td>Appropriate prophylactic antibiotics</td>
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<td>97.7%</td>
<td>97.8%</td>
<td>98.5%</td>
<td>3.5%</td>
</tr>
<tr>
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<td>99.5%</td>
<td>99.6%</td>
<td>99.7%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Cardiac surgery (other than CABG)</td>
<td>96.2%</td>
<td>99.1%</td>
<td>99.7%</td>
<td>99.8%</td>
<td>99.8%</td>
<td>3.6%</td>
</tr>
<tr>
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<td>75.7%</td>
<td>84.3%</td>
<td>87.8%</td>
<td>91.4%</td>
<td>93.2%</td>
<td>17.5%</td>
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<tr>
<td>Hip joint replacement surgery</td>
<td>98.0%</td>
<td>98.7%</td>
<td>99.2%</td>
<td>99.5%</td>
<td>99.6%</td>
<td>1.6%</td>
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<tr>
<td>Hysterectomy surgery</td>
<td>93.7%</td>
<td>96.1%</td>
<td>96.3%</td>
<td>94.5%</td>
<td>96.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Knee joint replacement surgery</td>
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<td>98.8%</td>
<td>99.3%</td>
<td>99.5%</td>
<td>99.7%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>95.3%</td>
<td>96.6%</td>
<td>97.8%</td>
<td>98.2%</td>
<td>98.6%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Stopping antibiotics within 24 hours</td>
<td>85.6%</td>
<td>90.5%</td>
<td>93.5%</td>
<td>95.7%</td>
<td>97.0%</td>
<td>23.5%</td>
</tr>
<tr>
<td>CABG surgery</td>
<td>89.7%</td>
<td>93.6%</td>
<td>95.5%</td>
<td>97.1%</td>
<td>97.9%</td>
<td>28.2%</td>
</tr>
<tr>
<td>Cardiac surgery (other than CABG)</td>
<td>89.7%</td>
<td>92.6%</td>
<td>94.8%</td>
<td>96.5%</td>
<td>97.6%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Colon surgery</td>
<td>74.8%</td>
<td>80.4%</td>
<td>84.9%</td>
<td>90.8%</td>
<td>93.6%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Hip joint replacement surgery</td>
<td>84.0%</td>
<td>89.8%</td>
<td>93.6%</td>
<td>95.9%</td>
<td>97.2%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Hysterectomy surgery</td>
<td>90.2%</td>
<td>92.8%</td>
<td>94.8%</td>
<td>96.3%</td>
<td>97.2%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Knee joint replacement surgery</td>
<td>85.4%</td>
<td>91.3%</td>
<td>94.7%</td>
<td>96.7%</td>
<td>97.7%</td>
<td>28.2%</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>77.0%</td>
<td>83.0%</td>
<td>88.2%</td>
<td>91.9%</td>
<td>93.8%</td>
<td>28.8%</td>
</tr>
<tr>
<td>Cardiac patients with 9:00 am postoperative blood glucose</td>
<td>N/A</td>
<td>89.9%</td>
<td>92.7%</td>
<td>94.1%</td>
<td>95.3%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Patients with appropriate hair removal</td>
<td>N/A</td>
<td>97.4%</td>
<td>99.2%</td>
<td>99.7%</td>
<td>99.8%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Beta-blocker patients who received beta-blocker perioperatively</td>
<td>N/A</td>
<td>92.0%</td>
<td>91.5%</td>
<td>94.4%</td>
<td>96.4%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Prescribing VTE medicine/treatment</td>
<td>87.2%</td>
<td>92.1%</td>
<td>93.7%</td>
<td>95.2%</td>
<td>97.8%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Receiving VTE medicine/treatment</td>
<td>83.2%</td>
<td>89.6%</td>
<td>91.9%</td>
<td>93.7%</td>
<td>96.9%</td>
<td>13.7%</td>
</tr>
<tr>
<td>urinary catheter removed</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>91.3%</td>
<td>94.1%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

standard that establishes an 85 percent composite compliance target on all of the hospital’s selected accountability measures. In addition to surgical care, the accountability measures include heart attack, heart failure, pneumonia, and children’s asthma care core measure sets. Most hospitals choose the surgical core measure set as one of their reported core measure sets.


Nov 2012 BULLETIN American College of Surgeons
Gunned down

Last month’s Bulletin column titled “Assaulted” reported an increasing trend toward violence across the nation. What do the following cities have in common this year: Dover, DE; Chardon, OH; Aurora, CO; Oak Tree, WI; College Station, TX; Chicago, IL; New York, NY; Seattle, WA; Newcross, GA; Philadelphia, PA; Tempe, AZ; Oakland, CA; and Miami, FL? They are all sites of multiple-victim shootings that involved at least three or more people injured or killed.

As of the middle of August, 25 individual occurrences of multiple-victim shootings were reported throughout the U.S. this year, averaging out to one incident every 8.6 days. These shootings accounted for 185 wounded and 83 dead. Of the 25 incidents, eight were gang-related and 18 took place in public places. Many of the shootings involved a gunman with no relationship to the victims and several took place in broad daylight. Several occurred in cities with very strict gun control; others occurred in locations that allow concealed weapons. No specific type of weapon was common to each of these incidents.

To examine the occurrence of firearm-related assaults in the National Trauma Data Bank® (n TDB) 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 codes 965.0 (assault with handgun), 965.1 (assault with shotgun), 965.2 (assault with hunting rifle), 965.3 (assault with military firearm), and 965.4 (assault with unspecified firearm). A total of 23,937 records were uncovered; 18,410 records contained a hospital discharge status, including 15,496 patients discharged to home, 1,132 to acute care/rehab, and 488 sent to skilled nursing facilities; 1,294 died (see Figure 1, page 57).

These patients were 89.9 percent male, on average 28.2 years of age, had an average hospital length of stay of 6.7 days, an intensive care unit length of stay of 6.1 days, an average injury severity score of 11.9, and were on the ventilator for an average of 5.5 days. Of the 13,345 that were tested for alcohol, 5,424 (41 percent) were found to be positive. The line graph in Figure 2, page 57, demonstrates the peak age ranges for firearm assault victims.

Multiple-victim shootings in the U.S. are turning into a weekly occurrence that may happen in a public place, take place at any time of the day, and are often unrelated to gang activity. The solutions to this problem are neither easy nor quickly apparent. Everyone needs to work together to solve this multifactorial issue.

Fortunately, there are trauma centers and trauma systems throughout the country that have mitigated the impact and body count of these occurrences. These trauma centers often function at...
Each of us needs to play a part in fighting interpersonal violence as well as preserving trauma care as we know it. a financial loss, and there is little federal or state support for their lifesaving activities. Each of us needs to play a part in fighting interpersonal violence as well as preserving trauma care as we know it. no one wants to go to his or her house of worship or go to see a movie and be concerned about being gunned down or not having access to a trauma center. (For more information visit http://www.facs.org/ahp/index.html.)

To access the American College of Surgeons position statement on firearm violence, visit the Committee on Trauma’s Subcommittee on Injury Prevention’s website at http://www.facs.org/fellows_info/statements/st-12.html.

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

Acknowledgement
Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, NTDB.
A. Brent Eastman, MD, FACS, installed as 93rd ACS President

A. Brent Eastman, MD, FACS, a general, vascular, and trauma surgeon from San Diego, CA, was installed as the 93rd President of the American College of Surgeons (ACS) during Convocation ceremonies at the 2012 Clinical Congress. Dr. Eastman is corporate senior vice-president and chief medical officer of Scripps Health, the n. Paul Whittier Endowed Chair of Trauma at Scripps Memorial Hospital, La Jolla, and a clinical professor of surgery-trauma at the university of California, San Diego.

A Fellow of the ACS since 1976, Dr. Eastman has been deeply involved in the governance of the College, particularly as the Chair of the Board of Regents (2009–2010). Dr. Eastman began serving on the College’s Board of Regents in 2001. As a Regent, Dr. Eastman assumed the role of Chair of the Central Judiciary (2007–2009), the Scholarship (2005–2008), and the Finance Committees (2008–2009), as well as a member of the Board of Regents Honors Committee (2011–2012). He also served on the ACS Member Services Liaison Committee (2001–2002), Comprehensive Communications Committee (2010–2011), and Patient Education Committee (2009–2011).

A dedicated trauma surgeon, Dr. Eastman was a particularly active member of the ACS Committee on Trauma (CoT). He was CoT Chair from 1990 to 1994 and helped to create and was the first Chair of the CoT Trauma System Consultation Committee (1999–2003). Furthermore, he has served as an instructor for the internationally acclaimed Advanced Trauma Life Support® course since 1982.

Dr. Eastman delivered the renowned Scudderration on Trauma during the 2009 Annual ACS Clinical Congress. The title of his lecture was “Wherever the Dart Lands: Toward the ideal Trauma System.”

As Chair of the Board of Regents, Dr. Eastman played a key role in the College’s efforts to provide care to the victims of the devastating earthquake that struck Haiti on January 12, 2010. With Scripps Health CEO Chris Van Gorder, he made two trips to the country in the first few weeks after the earthquake hit, leading operating teams and securing appropriate resources.

In addition, Dr. Eastman was a co-founder of the San Diego County Trauma System, which has become a model for the nation. He has been instrumental in the development of trauma systems worldwide, most recently for the subcontinent of India. In July 2007, Dr. Eastman participated in the ACS/American Association for the Surgery of Trauma Distinguished Visiting Surgeon in Combat Casualty Program at the Landstuhl (Germany) Regional Medical Center, a U.S. military-receiving hospital for wounded warriors from Iraq and Afghanistan. Later, he was granted and assigned the distinctions of Honorary Member of the U.S. Army Medical Department Regiment.
by order of the u. S. Surgeon General and Honorary order of Military Medical Merit by the order of the President.

over the course of his distinguished career, Dr. Eastman has authored or coauthored numerous trauma-related articles and publications. He was a member of the Institute of Medicine Committee that in 2006 published the landmark report, The Future of Emergency Care in the United States Health System.

Dr. Eastman is a graduate of the University of Wyoming, Laramie, and received his medical degree from u CSF (1966). Dr. Eastman was student body president at both institutions. At u CSF, he also completed a surgical internship and residency and served as chief surgical resident. He then spent one year as a surgical registrar at n orfolk and n orwich Hospital in n orwich, England.

His wife, Sarita, is also a graduate of u CSF Medical School and an acclaimed developmental-behavioral pediatrician and author. They have three children. Roan, a teacher and river guide, and ian, a specialist in renewable energy systems and mountaineer, both live with their families in Jackson Hole, WY. Their daughter Alexandra lives in n ew york, n y, and is an associate producer at the Metropolitan o pera.

Two Vice-Presidents also took office during the Convocation: R. Phillip Burns, MD, FACS, of Chattanooga, Tn, as First Vice-President and John M. Daly, MD, FACS, of Philadelphia, PA, as Second Vice-President.

Dr. Burns, a general surgeon, is professor of surgery and chairman of the department of surgery at the University of Tennessee College of Medicine in Chattanooga. A Fellow of the College since 1976, Dr. Burns currently serves as an Ex-officio Member of the Advisory Council for Rural Surgery. He has served as President of the Tennessee Chapter of the ACS (1998–1999) and as a member of the Board of Governors (2003–2009). During this time, he was a member (2004–2006) and Chair (2006–2009) of the Board of Governors’ Committee on Surgical Practices.

Dr. Daly, also a general surgeon, is dean emeritus of Temple University School of Medicine, Philadelphia, PA, and former chair of surgery at Weill-Cornell College of Medicine in n ew york, n y. A Fellow since 1983, Dr. Daly has served as senior member and then as Chair of the Commission on Cancer (1989–1999), Chair of the Governors’ Committee on Physician Competency and Health (1999–2001), and Chair of the nominating Committee of Fellows (1998–1999).
The second Lifetime Achievement Award of the American College of Surgeons (ACS) was presented to George F. Sheldon, MD, FACS, during the Convocation ceremonies at the 2012 Clinical Congress. Dr. Sheldon is the Zack D. Owens Distinguished Professor of Surgery at the University of North Carolina (UNC) at Chapel Hill School of Medicine and a Past-President of the ACS.

This award is only the second one ever presented for a lifetime contribution to the art of medicine, surgery, and service to the College. The late C. Rollins Hanlon, MD, FACS, received the first Lifetime Achievement Award in 2010 at the 96th Clinical Congress in Washington, DC.

Born in Salina, KS, to a physician father, Dr. Sheldon became involved in medicine at an early age. Due to a severe shortage of medical personnel in rural Kansas during World War II, he started helping his father in the operating room in the local hospital and worked there throughout his high school years.

**Education**
Attending the University of Kansas (KU), Lawrence, he exhibited an uncommon aptitude for leadership, service, and scholarship. For three of his undergraduate years, he held the faculty rank of assistant instructor in the department of Western civilization and taught classic literature. He also was elected student body president. While attending the KU Medical School, from which he graduated in 1961, he co-authored the book, *The Doctor, 1861–1961: A Pictorial History of Kansas Medicine*, during the state’s centennial year. Upon graduation, he was awarded the L.L. Marcell Award for the highest academic standing in medicine.

After completing an internship at KU and military service in the U.S. Public Health Service Commissioned Corps, the medical branch of the U.S. Coast Guard, Dr. Sheldon completed a one-year fellowship in medicine at the Mayo Clinic, Rochester, Mn, followed by surgical residency at the University of California-San Francisco (UCSF), where he completed a five-year residency in four years. In his third year, he received the Helmut Fresca Award for best resident.

His training continued with a postdoctoral fellowship from the National Heart Institute as well as a research fellowship in surgical biology at the Peter Bent Brigham Hospital of the Harvard Medical School, Boston, MA. Dr. Sheldon then joined the faculty of the UCSF and was promoted to professor in 1980.

**Contributions to trauma, surgical education**
Dr. Sheldon participated in the founding of one of the nation’s first trauma centers and became the chief of trauma service at San Francisco General Hospital, which trained not only UCSF residents, but also U.S. Army, navy, and Air Force surgeons before deployment to Vietnam. He also served as director of the physiological research facility and was among the first physicians on the West Coast to feed patients by intravenous hyperalimentation.

In 1984, Dr. Sheldon was named chair of surgery at the University of North Carolina (UNC) at Chapel Hill, and in that role, he structured the rapid expansion of department services and extensive recruitment of young surgeons. In 2001, Dr. Sheldon stepped down from that position, but was made a professor of social medicine and surgery and continued to teach a popular history of medicine course and conduct health policy research. The UNC named two distinguished lectureships in his name, and the Surgical Interest Group at UNC—for medical students interested in surgical practice—is named in his honor.
Continuing his scholarship and interest in history, he published the biography *Hugh Williamson: Physician, Patriot, and Founding Father* in 2010 and is working on a book on the life of Philip Syng Physick, long considered the father of American surgery. (Dr. Sheldon gave the opening Lecture at the 1978 Clinical Congress, titled Philip Syng Physick: The Father of American Surgery.)

In 2011 Dr. Sheldon received the Thomas Jefferson Award, the highest award given by U n C for exemplifying the following seven qualities: ecumenicity of spirit, intellectual distinction, professional superiority, interdisciplinary involvement in the humanities, scholarly productivity, service to the university, and service to the community on a Jeffersonian vision for higher education.

**Active ACS Fellow**

Dr. Sheldon was initiated into ACS Fellowship in 1973 and represented the Society of University Surgeons on the ACS Board of Governors (B/G). He went on to serve as Secretary and on the Executive Committee of the B/G. In 1984, Dr. Sheldon became an ACS Regent and Chairman of the Communications Committee and the first Editorial Advisor of the *Bulletin of the American College of Surgeons*. During his years as a Regent, he served on more than 10 ACS committees or task force groups.

In 1985, at the urging of o Iga Jonasson, MD, FACS, Dr. Sheldon, along with Dr. Hanlon, o liver H. Beahrs, MD, FACS, and David C. Sabiston, MD, FACS, worked with Sen. David Durenberger (R-Mn ) to protect graduate medical education (GME) funding. His testimony before Congress was shown on C-SPAN and was instrumental in ensuring continued GME funding for a five-year general surgery residency.

Dr. Sheldon served on the ACS Committee on Trauma, and in 1992 he gave the Scudder o ration on Trauma titled Trauma Manpower. During his term as ACS President (1998–1999), the Residents and Associates Society was founded. In 2004, Dr. Sheldon became the founding Editor-in-Chief of the ACS Web portal, now with 42 communities, nearly 300 editors and associate editors, and more than 4 million page views.

In 2008, he became the founding Director of the ACS Health Policy Research Institute (HPRi) with Thomas Ricketts, PhD, MPH, as Managing Director, and enlisted the part-time support of 160 researchers at the u n C Cecil G. Sheps Center for Health Service Research.

Their work has resulted in more than 70 publications. In 2009, Dr. Sheldon presented the Excelsior Surgical Society Edward D. Churchill Lecture titled Surgical Workforce in the Era of Health Reform.

**Other surgical organizations**

Among his extensive honors, Dr. Sheldon is one of the few surgeons to serve as president of several major surgical organizations, including the ACS, the American Surgical Association, the American Association for the Surgery of Trauma, the Society of Surgical Chairmen, the uniformed Services university of the Health Sciences, and the university Surgical Service Visiting Board. He also has served as chairman of the American Board of Surgery, and in 2003, Dr. Sheldon became the first surgeon since Samuel Gross in 1879 to chair the Association of American Medical Colleges (AAMC). He was named an AAMC Distinguished Service Member. He is a member of the institute of Medicine of the national Academies and was a charter member of the Council on Graduate Medical Education. Dr. Sheldon holds Honorary Fellowship in the Royal Colleges of Surgeons of
Continuing his scholarship and interest in history, he published the biography *Hugh Williamson: Physician, Patriot, and Founding Father* in 2010 and is working on a book on the life of Philip Syng Physick, long considered the father of American surgery.

Dr. Sheldon has authored more than 400 articles and book chapters on surgical biology, intravenous hyperalimentation, trauma, health policy, workforce, and historical issues. He has co-authored eight books and serves on multiple editorial boards. His regional, national, and international pre-eminence in academic surgery and social medicine distinguishes him even among the elite handful of prodigious educators at the summit of the surgical profession.

Dr. Sheldon has been supported by a wonderful family. He met his wife of 55 years, Ruth Guy Sheldon, in college and they married while he was in medical school. They have three daughters and two grandchildren.

The American Joint Committee on Cancer (AJCC) welcomes applications for the position of editor-in-chief of the 8th edition of the *AJCC Cancer Staging Manual*, planned for publication in 2015. This publication represents the latest iteration of the tumor, node, and metastasis (TNM) system.

The editor, who will be chosen in January 2013, will be expected to coordinate all activities leading to publication. A minimum three-year term will begin in March 2013 and will involve working with AJCC staff, the publisher, and all volunteer physicians, cancer registrars, and others who participate in the site-specific expert panels.

The position will be financially compensated by the AJCC. Candidates must be physicians and should submit their letter of interest to Karen Pollitt, AJCC Manager, kpollitt@facs.org, by December 1, 2012.
Honorary Fellowship in the American College of Surgeons (ACS) was awarded to five prominent surgeons from Japan, the Philippines, Mexico, England, and Belgium during the September 30 Convocation ceremonies that preceded the official opening of the Annual Clinical Congress in Chicago, Ill. The granting of Honorary Fellowship is one of the highlights of the Clinical Congress. This year’s recipients are as follows:

Seiki Matsuno, MD, FACS, of Sendai, Japan, is vice-dean of the medical faculty at Tohoku University and director of Tohoku Koseinenkin Hospital. He has been a central influence in the development of national registries and Japanese and international consensus and evidence-based guidelines for management of necrotizing pancreatitis, chronic pancreatitis, pancreatic adenocarcinoma, and cystic tumors of the pancreas. His work in the creation of standards resulted in the 2004 Sendai Guidelines, which have since been validated and are used worldwide.

Enrique T. Ona, MD, FACS, of Manila, the Philippines, is a transplant surgeon and the current Secretary of Health for the Republic of the Philippines. With a career-long focus on transplantation surgery and the effect of organ failure on public health, he was the founding transplant surgeon of the national Kidney and Transplant Institute, Quezon City. He served as the institute’s executive director for 11 years before his appointment as Secretary of Health in the Philippines.

Hector Orozco, MD, FACS, Mexico City, Mexico, is a general surgeon who has devoted his retirement years to caring for the medically underserved as a volunteer surgeon in his community. He spent 40 years at the Instituto de la Nutrición, Mexico City, reaching the positions of professor and chairman of the department of surgery. In that capacity, he worked with the University of Alabama, Birmingham, to create a mandatory rotation through that university for each of the institute’s senior residents.

Lewis Spitz, MB, BCh, PhD, FRCS, FRCS(Ed), of London, England, the Emeritus Professor of Pediatric Surgery and chairman of the department of surgery at Great Ormond Street Hospital, is one of his country’s most accomplished pediatric surgeons. He is recognized as the leading expert on the management of congenital abnormalities of the esophagus, esophageal replacement techniques, pancreatic and liver tumors, and the separation of conjoined twins.

Ignace B. Vergote, MD, PhD, of Leuven, Belgium, chairs the department of obstetrics and gynecology at Katholieke Universiteit, Leuven, and is director of the Cancer Institute at University Hospitals. His career as an academic surgeon has been characterized by extensive clinical and translational investigation with a special focus on endometrial and ovarian cancers. His pioneering use of neoadjuvant chemotherapy followed by interval cytoreductive surgery for treatment of advanced ovarian cancer was exemplary. He founded the European Network of Gynaecological Oncology Trials Group, which coordinates and promotes clinical trials in 17 European nations on patients with gynecologic cancer. He created an advanced surgical training fellowship for gynecologic and breast cancers in his university’s surgery department and enabled development of a system for certifying gynecologic oncology training centers throughout Europe.
Madam President, it is my privilege and honor to present to you Prof. Seiki Matsuno of Sendai, Japan, for Honorary Fellowship in the American College of Surgeons.

Professor Matsuno was born in Kofu, and most of his premedical and medical school education took place at Tohoku University in Sendai. After completing his surgical training there, he joined the university’s faculty in 1973, rising to professor in 1988. During that period he spent a year studying pancreatic diseases with Charles Frey, MD, FACS, at the University of California-Davis. Upon his return to Japan, Professor Matsuno introduced the “Frey procedure” for treatment of chronic pancreatitis, and built a continuing professional relationship and friendship with Dr. Frey that has endured for four decades.

In 2004, Professor Matsuno became vice-dean of the medical faculty at Tohoku, and in 2005, he was appointed director of Tohoku Koseinenkin Hospital. Since completing his doctoral thesis on pancreatic exocrine function in 1973, Professor Matsuno has focused with laser-like intensity on pancreatic physiology, pathophysiology, and diseases and their treatment. He has authored or co-authored more than 360 original articles in English, and many more in Japanese—most as first or senior author. Along with a focus in ischemia-reperfusion injury of the liver, his research on the pancreas comprises studies of basic and translational science, pancreatic function, pancreatic microcirculation, molecular biology, and immunotherapy and gene therapy of cancer. His clinical studies on acute pancreatitis included innovative treatment with regional arterial infusion of antibiotics and protease inhibitors to prevent pancreatic necrosis and infection. Notably, he has been a central force in developing national registries and nationwide and international consensus- and evidence-based guidelines for management of necrotizing pancreatitis, chronic pancreatitis, pancreatic adenocarcinoma, and cystic tumors of the pancreas. Evidence-based consensus on cystic tumors of the pancreas resulted in the 2004 Sendai Guidelines, which have since been validated and used worldwide.

Professor Matsuno has trained more than 200 surgical fellows, and developed a school of pancreatic surgery, now conducted by many of his trainees and by his successor at Tohoku, Prof. Masao Taneka. The mantra of that school of pancreatic surgery is “one for all, all for one.”

Professor Matsuno has been an ACS Fellow since 1989 and is a member of the Society of Surgery of the Alimentary Tract, the American Gastroenterological Association, and the American Pancreatic Club, among others. He has been elected president of the Japan Society of Gastroenterology, the Japan Pancreas Society, the Japan Surgical Society (which is the equivalent of the ACS), and the international Association of Pancreatology. He is an honorary member of the American Surgical Association and the German Surgical Society. He is acknowledged to be the leading pancreatic surgeon in Japan.

Professor Matsuno and his wife, Ryoko, have three children. He is an avid mountain climber who has topped Mount Fuji, the highest mountain in Japan, and served as president of the Japanese Society for Mountain Medicine. In a moment of Japanese philosophy, perhaps underlying his teaching, he asks, “Why does the water in the pool on top of Mt. Zao never go away?” His answer: “you must go there yourself to find the truth.”

Like many Japanese people, Professor Matsuno is also an avid soccer player and fan. He notes that the victory of Japan’s women’s soccer team has been a crucial element in the nation’s spiritual recovery after the devastation of his city, Sendai, by the tsunami in 2011.

An acclaimed and beloved surgeon, investigator, mentor, and mountain climber, Seiki Matsuno believes that the leader should always walk behind the weakest.

Madam President, members of the Board of Regents, diplomates, and guests, I present Prof. Seiki Matsuno, pancreatic surgeon, innovator, teacher, and advocate, for Honorary Fellowship in the American College of Surgeons.
Madam President, it is my distinct privilege and honor to present to you Prof. Enrique T. o na of Manila for Honorary Fellowship in the American College of Surgeons (ACS). Professor o na is the current Secretary of Health for the Republic of the Philippines.

Professor o na was exposed to health care and the medical field at an early age. His family made their home in Pagadian City in Zamboanga, one of the southernmost provinces in the Philippines known for its natural beauty and multicultural population. His father was a physician who served as the first provincial health officer of Zamboanga while his mother was a nurse dedicated to the nutrition, growth, and development of infants and children. Professor o na recalls that as a child, “our house… was in front of the church and every day I would see dead people being brought there, and the coffins were so small. So as early as then, I already knew that many of those dying were kids, for lack of care and lack of education in care.”

Professor o na received his doctor of medicine degree from the university of the Philippines in 1962. He completed his internship at Buffalo General Hospital, N Y, and surgical residency at Long Island College Hospital. He then pursued a fellowship in surgery at the Lahey Clinic in Boston, MA. Next he completed a research fellowship in experimental surgery in New York under the mentorship of the late John Madden, MD, FACS. Professor o na went on to become the Colombo Scholar in organ Transplantation at Cambridge University in England under the mentorship of Sir Roy Yorke Calne, MD, FACS. The focus of his professional life has been on transplantation surgery and the impact of organ failure on public health.

Professor o na is recognized as a master surgeon, a dedicated teacher, and an innovative researcher. For more than 30 years, he has been a professor of surgery at the University of the Philippines and has served as chair for sections of surgical education, general surgery, thoracic surgery, and cardiovascular surgery. Ultimately, he created the division of organ transplantation in 1986. He provided leadership at all levels in the department of surgery and was named the Enrique Garcia Professor of Surgery. He has delivered many invited and honorary lectureships, which are too numerous to list here. Professor o na has been the editor of several peer-review journals, the editor of the Philippine Textbook of Surgery, and the author of 64 peer-review publications detailing his research in transplantation. He received the Outstanding Health Research Award from the Philippine Council for Health Research and Development in 2010.

Professor o na is the founding transplant surgeon of the national Kidney and Transplant Institute in the Philippines and served as its executive director for 11 years before being appointed the Secretary of Health. He has also served as the president of the Transplantation Society of the Philippines since 1989. For more than a quarter century, his vision, leadership, and hard work have resulted in immeasurable improvements in the care of patients who require transplant surgery. As a result, he received the Presidential Award of Recognition for Organ Transplantation in 2000 and the Distinguished Service Award from the Philippine Medical Association in 2004.

Professor o na served as the president of the Philippines College of Surgeons and as the chair of the Philippines Board of Surgery. He has been an ACS Fellow since 1973 and functioned as the Governor of the ACS Philippines Chapter. On June 29, 2010, President Benigno Aquino III appointed him as Secretary of Health for the Republic of the Philippines. Madam President, it is with great pride that I present Prof. Enrique T. o na—a surgeon whose work is now to care for the health of a nation—for Honorary Fellowship in the American College of Surgeons.
Madam President, it is my privilege and distinct honor to present Prof. Hector Orozco, who was born in the city of Sahuayo, in the state of Michoacan in western Mexico. Sahuayo is a relatively small community close to Guadalajara. Dr. Orozco completed his schooling in this community and attended the Universidad Autonoma de Guadalajara where he obtained his medical degree.

He intended to return to the community of his birth and to serve the needs of its people as an internist and a family physician, and thus, he returned to the area to undergo his initial postgraduate studies. Given the limited resources in that area and to better prepare himself, he sought further training in the famous Instituto Nacional de la Nutricion in Mexico City, where he did a residency training in internal medicine.

It was while working at this prestigious institution that Dr. Orozco was first exposed to surgery, and he realized that his vocation actually would be best fulfilled as a surgeon. Thus, he undertook a second residency, this time training in surgery. After completing his program, he decided that before he returned to Sahuayo he should prepare himself with the best that the surgical field could offer, and so he sought and obtained additional surgical training in the U.S., moving to Pennsylvania for the next few years of his life.

As he settled in Pennsylvania, he returned briefly to Mexico to marry Silvia, with whom he has shared his life since 1967. They would have three sons, forming a family that Hector to this date credits with being the “wind beneath my wings.”

His training in the U.S. focused on hepatobiliary surgery and portal hypertension, and as he obtained his credentials in that area, it became clear that the small-town practice that he had dreamed about would be ill-suited to the skills he now had. Therefore, he returned to Mexico City to the Instituto Nacional de la Nutricion, where he would spend the next 40 years of his life working in every capacity, including reaching that of professor and chairman of the department of surgery in 1989.

During his nearly 20 years as chair he was responsible for the training of a large number of residents whom he wanted to prepare to meet the health care needs of Mexico in a way deeply embedded in the Mexican culture but taking advantage of the kind of training Dr. Orozco knew firsthand was only possible in America. To that end, working with Joaquin Aldrete, MD, FACS, at the University of Alabama, Birmingham, Dr. Orozco created a mandatory rotation through that institution for every senior resident in his program, a tradition that continues today.

In the academic realm, Dr. Orozco has been a prolific writer who has authored more than 70 chapters and more than 150 papers in peer-reviewed publications. For his efforts in the teaching of residents, in the pursuit of new knowledge and in the care of his patients, he was awarded the title of “Best Worker” by the Instituto Nacional de la Nutricion.

Using his medical background, he has worked closely with medical professional organizations in his country, achieving positions of leadership in them, such as president of the Mexican Association of Gastroenterology as well as the Mexican Association of Hepatology. In the world of surgery he has achieved similar notoriety, receiving Honorary Fellowship in the Mexican Association of General Surgery.

His work has also been recognized by the American Surgical Association, which made Dr. Orozco an Honorary Member in 1999.

After 40 years in the Instituto Nacional de la Nutricion, Dr. Orozco retired in 2007. A man who believes in the principle that in life one should “learn, earn, and return,” he finally was able to fulfill his lifetime dream and return to his native community of Sahuayo, to
practice medicine. Because he had officially retired and felt strongly that he had been given so much in his life, he decided to practice in a different fashion: to attend only to the poor and vulnerable and to charge no money for his services—not to the patient, not to the hospital, and not to the insurance carriers. Thus, for the last five years he has simply returned compassion, care, and work to his community in the area where it was most needed.

An avid reader of history, particularly biographies, a nature lover who enjoys long hikes through the woods and the mountains of his native land, a true teacher, a gentle person who is in the process of repaying what his good luck has brought him, he is the ultimate example of a true surgeon.

Madam President, it is my honor to present Dr. Hector o rozco, from Sahuayo, Mexico, for Honorary Fellowship in the American College of Surgeons.

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Nov 2012 BULLETIN American College of Surgeons
Madam President, it is my distinct honor to present to you Prof. Lewis Spitz of London, England, for Honorary Fellowship in the American College of Surgeons. Professor Spitz is among the foremost and accomplished pediatric surgeons of his generation and in the world today. A native of South Africa, Professor Spitz obtained his early education and attended medical school in Pretoria. His surgical and pediatric surgical training took place in Johannesburg, Liverpool (Alder Hey Children’s Hospital), and in London (The Hospital for Sick Children; Great o’ rmond Street).

Professor Spitz currently is the Emeritus nuffield Professor of Paediatric Surgery, Honorary Consultant Paediatric Surgeon at Great o’ rmond Street Hospital. He assumed the position of the nuffield Professor and chairman of the department of surgery at Great o’ rmond Street in 1979. The Great o’ rmond Street Hospital is known worldwide for the care it has provided to children for 160 years. Professor Spitz took charge of this pediatric department, which had seen better times, and built it up to become one of the foremost and most respected pediatric surgery departments in the world. In addition, he introduced to Great o’ rmond Street the value of anti-reflux surgery and gastrostomy placement for feeding problems in severely disabled children, which dramatically improved their quality of life and is now routinely performed worldwide. However, his accomplishments have not been limited to Great o’ rmond Street. He has also made major contributions to the education and training of pediatric surgeons worldwide and has trained several generations of pediatric surgeons in the United Kingdom.

As further demonstration of his accomplishments, Professor Spitz has been awarded two honorary MD degrees and numerous medals, including the 2012 Ladd Medal, the highest honor bestowed by the Surgical Section of the American Academy of Pediatrics. He has also been invited to give numerous named lectures and invited visiting professorships. Professor Spitz has served in many leadership capacities, including as an invited member of the Council of the Royal College of Surgeons of England. He has an extensive bibliography with more than 400 publications and has edited or co-edited 10 books.

Professor Spitz achieved further international recognition as a leading expert in the management of congenital abnormalities of the oesophagus, oesophageal replacement techniques, and pancreatic and liver tumors. He fostered a policy of evidence-based surgery, which led to many research projects on necrotizing enterocolitis, Hirschsprung’s disease, and the psychological impact of neonatal surgery on infants.

However, it is most important to point out that Professor Spitz is the world’s foremost authority on the management of conjoined twins. An article in the London Times from a 2004 BBC program, titled Last Challenge for Twins Surgeon, stated: “They were conjoined twins, fused together from the breastbone to the navel and sharing major organs like the liver. They had journeyed many thousands of miles to Great o’ rmond Street Hospital to see if their children could be separated, allowing them to lead individual, independent lives. However, for Professor Lewis Spitz, one of Britain’s foremost pediatric surgeons, it was to be his 24th and last separation before he retired.” Ladies and gentlemen, i can report to you that both children survived, and the operation was a stunning success.

Having had the privilege of knowing Professor Spitz for nearly three decades. For all of his accomplishments, he is a humble and gracious individual and a great friend. It was my honor last year, as the president of the American Pediatric Surgical Association, to invite him to give the coveted Journal of Pediatric Surgery Lecture at the association’s annual meeting.

Madam President, it is with great pleasure and personal pride that I present Prof. Lewis Spitz, the Emeritus nuffield Professor of Paediatric Surgery and Honorary Consultant Paediatric Surgeon, Great o’ rmond Street Hospital, for Honorary Fellowship in the American College of Surgeons.
Madam President, it is my distinct privilege to present to you Prof. Ignace Vergote of Leuven, Belgium, for Honorary Fellowship in the American College of Surgeons. Professor Vergote is currently the chair of the Department of Obstetrics and Gynecology at Catholic University Leuven, and director of the Cancer Institute at University Hospitals, Leuven.

Ignace Vergote was born in Ghent, an attractive medieval canal city in Flanders, Belgium, and, as the youngest of four children who entered medicine, obtained his medical degree from the University of Ghent. In addition to graduating with honors from the school, it was there that he met his wife Laure, a dermatologist, and together they have raised four children, two of whom have selected careers in medicine. He developed an early interest in cancers unique to women and following his residency in obstetrics and gynecology at the University of Antwerp, Belgium, he pursued specialty training in gynecologic oncology with Professors Per Kolstad and Claes Trope at the Norwegian Radium Hospital in Oslo. It was there that Professor Vergote defended his thesis and was granted a PhD from the University of Oslo.

Professor Vergote returned as Belgium’s first trained gynecologic oncologist to head the division of gynecologic oncology at the University Hospitals Leuven. His academic career has been characterized by extensive clinical and translational investigation with a special focus on ovarian and endometrial cancers. Ever embracing new techniques and technology, Professor Vergote has innovatively exploited their clinical utility. Exemplary was his pioneering use of neoadjuvant chemotherapy followed by interval cytoreductive surgery for treating advanced ovarian cancer. Whereas his initial efforts were met with substantial criticism within the surgical community, he engaged his skeptics and supporters alike to participate in a randomized surgical trial that demonstrated the efficacy of this approach.

Professor Vergote has also maintained an abiding interest in exploring the pathogenesis of gynecologic cancers. His laboratory curiosity has evolved from early studies of DNA ploidy status to contemporary clinical applications of molecular profiling. However, recognizing that accrual proficiency and standardization in conducting clinical trials would require collegial collaborations across borders, Professor Vergote founded the European Network of Gynaecological Oncological Trials Group. This network now includes 17 nations participating in academic surgical, radiotherapy, and targeted drug trials and emphasizes the incorporation of translational components. In addition, Professor Vergote has played a major role in the initiation and maturation of the specialty of gynecologic oncology in Belgium and in Europe. He initially formalized an advanced surgical training fellowship for breast and gynecologic cancers in his department and subsequently, while president of the European Society of Gynaecological Oncology, facilitated a system for certifying gynecologic oncology training centers throughout Europe.

As a member of numerous editorial boards, editor of several journals, author of more than 550 peer-reviewed publications, and president of several national and international specialty organizations, Professor Vergote has been the recipient of the Norwegian Kolstad, the Netherlands CoBRA, and the Austrian Wertheim prizes, all for excellence in gynecologic oncology.

Madam President, it is with great pride that I present Prof. Ignace Vergote, a surgeon dedicated to enhancing our knowledge and treatment of cancers unique to women, for Honorary Fellowship in the American College of Surgeons.
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The American College of Surgeons (ACS) hosted more than 80 health care leaders at the ACS Surgical Health Care Quality Forum in Houston, TX, on September 10 to discuss how programs focused on surgical quality and education reduce patient complications and readmissions, resulting in lower costs and greater value. The forum was part of the ACS inspiring Quality (iQ) initiative, which seeks to drive a national discussion on critical elements required for successful quality improvement programs.

Area leaders representing institutions of the Houston-based Texas Medical Center highlighted the influence of rigorous medical skills training and proven surgical quality programs on the overall state of health care in Texas and across the nation. Participants cited the quality improvement programs at the Methodist Institute for Technology, Innovation, and Education (MiTiE™), Houston, and the ACS national Surgical Quality Improvement Program (ACS n SQIP®) as proven models of success.

“`As surgeons get deeper into practice, our outcomes are only as good as we are—and continue to be—as new procedures and technologies are introduced that can make a considerable difference for patients,” said forum co-host Barbara L. Bass, MD, FACS, John F. and Carolyn Bookout Distinguished Endowed Chair of Surgery, The Methodist Hospital, Houston; executive director of MiTiE; professor of surgery, Weill Cornell Medical College, Houston; and former ACS Regent. “MiTiE is a unique program designed to help surgeons ‘re-tool’ their skills to stay on top of and safely deploy innovative technologies that will allow us to deliver better care,” Dr. Bass added.

U.S. Rep. Sheila Jackson Lee (D-Tx) delivered the keynote address, in which she encouraged members of the Houston surgical and health care communities to continue working with lawmakers to pursue important health policies.

“I commend the American College of Surgeons as well as the Texas Medical Center for their leadership and proactively taking steps to improve quality for patients throughout Texas,” said Representative Jackson Lee. “It is crucial that we are partners together and that policymakers have more give and take with physicians in order to understand how best to improve.”

“It’s critical that the clinical teams on the frontlines of patient care are engaged in the important dialogue around improving quality,” added forum co-host H. Randolph Bailey, MD, FACS, chief of the division of colon and rectal surgery, The Methodist Hospital; professor of surgery, Weill Cornell Medical College, University of Texas Health Science Center, Houston; and ACS Regent. “We know what works, and what doesn’t work. If we aren’t part of the discussion and sharing knowledge with our colleagues and policy leaders in Washington, then we can’t be part of the solution.”

“Health care organizations need to do everything within their power to become safe, effective, and high-reliability operations,” said panelist M. Michael Shabot, MD, FACS, FCCM, FACMi, system chief medical officer, Memorial Hermann Healthcare System, in Houston. “Memorial Hermann is working to achieve this goal with close attention to performance metrics and by using all the College’s programs and accreditations, including the ACS n SQIP, bariatric and trauma data registries and bariatric, trauma center, and Commission on Cancer certifications. The ACS Surgeon Specific Registry is also useful for individual surgeons to monitor personal performance. Using ACS n SQIP to compare their results with hospitals nationwide, participating hospitals..."
are able to identify areas where they may be underperforming and develop clinical performance improvement initiatives, as well as foster and improve internal education.

“There is a real science behind creating a quality improvement team. One critical element is working closely with all of the providers and sharing quality assessment feedback regularly,” said panelist Thomas A. Aloia, MD, FACS, assistant professor of surgical oncology, program director, American Hepato-Pancreato-Biliary Association (AHPBA) Hepato-Pancreato-Biliary Surgery Fellowship, University of Texas MD Anderson Cancer Center, Houston. “Because quality improvement programs are used to safeguard patient care, it is crucial that quality improvement data is peer-reviewed and physician-driven,” said panelist Kenneth L. Mattox, MD, FACS, distinguished service professor, Michael E. DeBakey Department of Surgery, Baylor College of Medicine, and chief of staff/chief of surgery, Ben Taub General Hospital, Houston. “Physicians, surgeons, and nurses need to be the major overriding voice in their institution when quality improvement protocol is being established.”

“When done correctly, outcomes or comparative effectiveness research using population-based data such as ACS n SQiP can play a critical role in the quality improvement process at the local, regional, and national level,” said panelist Taylor S. Riall, MD, PhD, FACS, John Sealy Distinguished Chair in Clinical Research; director, Center for Comparative Effectiveness and Cancer Outcomes; and associate professor, department of surgery, University of Texas Medical Branch, Galveston. Just as ACS n SQiP is helping to improve care for the general patient population, the ACS n SQiP Pediatric program is helping to support quality improvement in children’s hospitals.

“ACS n SQiP Pediatric is important because it provides risk-adjusted outcomes data that children’s hospitals can use for comparison—something that often is difficult to do because of the infrequent nature of health problems among pediatric patients,” said panelist Kevin P. Lally, MD, MS, FACS, A.G. McNeece Chair in Pediatric Surgery, Richard Andrassy Distinguished Professor, professor and chairman, department of pediatric surgery, University of Texas Health Science Center. “As with the adult ACS n SQiP, if there are national reporting standards that are based on ACS n SQiP, hospitals will use it.”

An important theme emerged at the program: Physicians must take the lead in patient education and in promoting quality improvement programs. “Our country is seeing a changing paradigm from ‘sickness care’ to ‘health care,’ and in order to expedite this transition, we need to equip people with the tools and education necessary to keep themselves healthy so we can focus resources on conditions that are largely unpreventable,” said panelist Richard E. Wainerdi, PE, PhD, president and chief executive officer, Texas Medical Center, Houston. “I see great opportunity for surgeons to become engaged leaders in their local communities and help drive this type of quality improvement as well.”

The next ACS Surgical Health Care Forum will take place in New York, NY, on Friday, November 16. To view the forum video and follow updates on upcoming forums, visit InspiringQuality.FACS.org or the College’s YouTube channel at http://www.youtube.com/AmCollegeofSurgeons. For more information on the iQ initiative, go to http://inspiringquality.facs.org/.
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This program has been funded in part by a grant from Coloplast Corp.
ACS and AGS collaborate on landmark guidelines for geriatric surgical patient care

The American College of Surgeons (ACS) and the American Geriatrics Society (AGS) have collaborated on the development of new comprehensive guidelines for the preoperative care of the nation’s elderly patients. The joint guidelines—published in the October issue of the Journal of the American College of Surgeons—apply to every patient who is age 65 and older as defined by Medicare regulations. The guidelines are the culmination of two years of research and analysis by a multidisciplinary expert panel representing the ACS and the AGS as well as a range of medical specialties.

“The major objective of these guidelines is to help surgeons and the entire perioperative care team improve the quality of surgical care for elderly patients,” said Clifford Y. Ko, MD, FACS, Director of the ACS National Surgical Quality Improvement Program (ACS nSQIP®) and the ACS Division of Research and Optimal Patient Care, professor of surgery at the University of California, Los Angeles (uCLA), and director of uCLA’s Center for Surgical Outcomes and Quality.

One of the driving forces behind the guidelines is America’s expanding geriatric population, Dr. Ko explained. The U.S. Census Bureau projects the percentage of men and women ages 65 and older will more than double between 2010 and 2050 and will increase by 20 percent of the total population by 2030. In 2006, elderly patients underwent 35 percent of inpatient surgical procedures and 32 percent of outpatient procedures, according to study authors.

“For elderly patients undergoing surgical procedures, we want to ensure we are optimizing each patient’s medical condition,” Dr. Ko said. “This population is growing in numbers and we want to emphasize the depth and breadth of care required for them. These evidence-based guidelines will enhance surgical practice by setting higher standards and performance measures for surgeons and the entire perioperative care team,” he said. This is the first time the ACS has worked with the AGS to develop guidelines for geriatric patients, according to Dr. Ko.

These guidelines have been developed in response to a performance measure that the ACS has developed with the Centers for Medicare & Medicaid Services (CMS), according to Dr. Ko. ACS nSQIP has worked with CMS to develop “the elderly surgery measure,” a hospital-based measure that assesses the outcome of elderly patients undergoing surgical procedures and evaluates quality of care in Medicare patients. The ACS and CMS launched a pilot program in October that gives hospitals the opportunity to publicly and voluntarily report the outcome results.

The guidelines recommend and specify 13 key issues of preoperative care for the elderly:

- Cognitive impairment and dementia
- Decision-making capacity
- Postoperative delirium
- Alcohol and substance abuse
- Cardiac evaluation
- Pulmonary evaluation
- Functional status, mobility, and fall risk
- Frailty
- Nutritional status
- Medication management
- Patient counseling
- Preoperative testing
- Patient-family and social support system

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“There is no single magic bullet for rendering this level of surgical care,” Dr. Ko said. “Each of the 13 issues covered by the guidelines is very important, comprehensive, and difficult to prioritize.”

preoperative care for the elderly (see sidebar, page 74).

“There is no single magic bullet for rendering this level of surgical care,” Dr. Ko said. “Each of the 13 issues covered by the guidelines is very important, comprehensive, and difficult to prioritize. For example, surgeons and perioperative team members may do perfectly well when analyzing a patient’s cognitive functioning, but not so well on the polypharmacy issue. So then suddenly, polypharmacy becomes the number-one issue for the surgical team to address during the preoperative care phase,” he explained.

Furthermore, the expert panel identified complex problems specific to the elderly, including use of multiple medications, functional status, frailty, risk of malnutrition, cognitive impairment, and comorbidities. “When surgeons evaluate elderly patients before they undergo operations, they want to know how many and what specific medications their patients are taking. This step will enable them to identify potential medication issues before operations and before the surgeons start adding pain medication to the patient’s medication list,” Dr. Ko explained.

As the guidelines state, “[C]onsider minimizing the patient’s risk for adverse drug reactions by identifying what should be discontinued before surgery or should be avoided and dose reducing or substituting potentially inappropriate medications.”

Additionally, the number and severity of underlying medical problems call for special strategies by the entire surgical team, according to Dr. Ko.

“Patients who are 90 years old tend to have more comorbidities than those who are 65 years,” he said. “There may be something wrong with the heart, the lungs, the kidneys, the liver. Surgeons have to plan and deal with these comorbidities simultaneously while the patient is undergoing a surgical procedure.”

The guidelines state that evaluating patients for developing heart disease and heart attack is critical in order to identify patients at higher risk. All patients should be evaluated for perioperative cardiac risk.

“Caring for the elderly generally requires a team approach,” said Dr. Ko. “The surgeon knows how to perform surgery, and the cardiologist knows how to take care of the heart. It’s best for everyone to work together to take care of the patient. We want everyone on the same page of providing good quality care.”

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Nov 2012 BULLETIN American College of Surgeons
### Calendar of events*

**NOVEMBER 2012**

#### Keystone Chapter November 9
Pennsylvania Medical Society Headquarters, Harrisburg, PA  
Contact: Lauren Ramsey, lramsey@pamedsoc.org

#### Arizona Chapter November 9–11
Hilton Tucson El Conquistador Golf & Tennis Resort, Tucson, AZ  
Contact: Joni Bowers, jonib@azmedassn.org

#### Delaware Chapter November 17
John H. Ammon Medical Education Center, Newark, DE  
Contact: Kristi Walters, defacs@ymail.com

**DECEMBER 2012**

#### Massachusetts Chapter December 1
TBD, Boston, MA  
Contact: Jennifer Gecawicz, jgecawicz@prri.com

#### 61st Annual Clinical Symposium/Annual Meeting of the New Jersey Chapter of the ACS December 1, 2012
The Renaissance Woodbridge Hotel and Conference Center, Iselin, NJ  
Contact: Andrea Donelan, 973/539-4000, njsurgeons@aol.com

**JANuARy 2013**

#### Louisiana Chapter January 11–13
Hyatt Regency New Orleans, New Orleans, LA  
Contact: Janna Pecquet, janna@laacs.org

**FEBRuARy 2013**

#### Puerto Rico Chapter February 21–23
TBD, San Juan, PR  
Contact: Aixa Velez-Silva, genteinc@gmail.com

#### South Texas Chapter February 21–February 23
Houston Marriott at the Texas Medical Center, TX  
Contact: Janna Pecquet, janna@laacs.org

**MARCH 2013**

#### Medical Disaster Response March 18
Caesars Palace, Las Vegas, NV  
Contact: Mary Allen, redstart@aol.com

#### Trauma, Critical Care, and Acute Care Surgery March 19–21
Caesars Palace, Las Vegas, NV  
Contact: Mary Allen, redstart@aol.com

**APRIL 2013**

#### 113th Annual Congress of the Japan Surgical Society April 11–April 13
Fukuoka International Congress Center, Japan  
Contact: Katsuhiko Yanaga, MD, PhD, FACS, kyanaga@jikei.ac.j

**MAY 2013**

#### Ohio Chapter Meeting May 2 –May 4
Sheraton at Capital Square, Columbus  
Contact: Jennifer Starkey, jennifer@executive-office.org

#### Virginia Chapter Meeting May 3–May 5
Hilton Virginia Beach, VA  
Contact: Susan McConnell, smconnell@ramdocs.org

**FuTuRE CLINICAL CONGRESSES**

#### 2013
October 6–10  
Washington, DC

#### 2014
October 26–30  
San Francisco, CA

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*Dates and locations subject to change.