Emerging trends in lifelong learning: New directions for ACS surgical education programs
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Looking forward

by David B. Hoyt, MD, FACS

The American College of Surgeons (ACS) released a new video in February called Driven by Highest Standards, Better Outcomes: American College of Surgeons. This video focuses on the inner drive that keeps surgeons going throughout years of training and long hours in the operating room and research lab—all to reach the ultimate goal of making a positive difference in the lives of others.

Too often, though, faced with myriad pressures both clinical and financial, we lose sight of all the great things surgeons have accomplished. The public often loses sight, too. This video, which has been posted on the College’s website and YouTube, reminds us all of how being driven has led to remarkable advances in surgical patient care and encourages surgeons to maintain that drive to keep setting higher standards and achieving better outcomes.

The great ones

It is this passion for excellence that fueled the curiosity and commitment to innovation and patient care of some of the College’s most prominent members and leaders. The video focuses largely on some of these key figures. These luminaries and their legendary contributions to surgery are as follows:

• Ernest Amory Codman, MD, FACS: First proposed the end-result concept, which called for maintaining complete patient medical records, tracking and documenting long-term outcomes, and reporting findings. He also established the College’s Bone Sarcoma Registry—the first repository for collecting and evaluating cancer data.

• Franklin H. Martin, MD, FACS: Established Surgery, Gynecology & Obstetrics, now known as the Journal of the American College of Surgeons, and the Clinical Congress of North America. He and several other prominent surgeons of his generation founded the ACS, and Dr. Martin was largely responsible for sustaining the organization throughout its formative years.
Each of you demonstrates this same drive to be the best and to make a difference in the lives of surgical patients every time you enter the operating room, spend countless hours in the research lab, or mentor a medical student or surgical trainee.

- **William J. Mayo, MD, FACS, and Charles H. Mayo, MD, FACS**: With their father, William W. Mayo, MD, the brothers founded the Mayo Clinic in Rochester, MN, promoting the multidisciplinary approach to patient care. Charles was a founding member of the ACS, and William was ACS President from 1916 to 1918, at which time the ACS established its hospital standards program.

- **Mary Edwards Walker, MD**: A Civil War surgeon and the only woman ever to have been awarded the Medal of Honor.

- **George Crile, Jr., MD, FACS**: A founder of the ACS, Dr. Crile established the Cleveland Clinic in Ohio and was an outspoken opponent of unnecessary operations. He contributed to the concept of field hospitals during World War I.

- **Merritte Weber Ireland, MD, FACS**: Served as U.S. Army Surgeon General from 1918 to 1931 and led efforts to develop more advanced military medical centers, including Walter Reed Army Hospital in Washington, DC.

- **Michael E. DeBakey, MD, FACS**: World-renowned American cardiac surgeon, innovator, scientist, medical educator, and international medical statesman, Dr. DeBakey is credited with playing a prominent role in all of cardiovascular surgery.

- **Harvey Williams Cushing, MD, FACS**: Considered by many to be the father of modern neurosurgery, he was the first person to describe the signs and symptoms associated with prolonged exposure to inappropriately high levels of cortisol, now known as Cushing’s syndrome.

- **Joseph E. Murray, MD, FACS**: Nobel Prize-winning surgeon who performed the first successful kidney transplant in both identical and fraternal twins and introduced drug immunosuppression in the clinical setting.

- **Charles R. Drew, MD, FACS**: Played an instrumental role developing blood banking and ensuring that blood was available for use during World War II. The first African-American surgeon to serve as an examiner on the American Board of Surgery.

- **Olga Jonasson, MD, FACS**: Developed a successful transplantation program at the University of Illinois-Chicago and headed the department of surgery at Ohio State University, Columbus, making her the first woman to chair an academic surgery department. Dr. Jonasson also was the first woman to serve as a director of the American Board of Surgery and to serve on an ACS executive committee.

- **Shukri F. Khuri, MD, FACS**: Best-known for his leadership in developing the National Surgical Quality Improvement Program (NSQIP) at the Department of Veterans Affairs—the precursor to the College’s quality improvement program (ACS NSQIP).

**The journey continues**

Each of you demonstrates this same drive to be the best and to make a difference in the lives of surgical patients every time you enter the operating room, spend countless hours in the research lab, or mentor a medical student or surgical trainee. Likewise, the College’s ongoing pursuit of highest standards, better outcomes, continues through our educational, quality improvement, and advocacy programs.

I encourage each of you to watch the video, which can be accessed at the College’s home page at www.facs.org or on YouTube at www.youtube.com. You might also consider posting the video on your practice’s website and encourage your patients and their families to view it so they have a better understanding of what it means to be a Fellow of the American College of Surgeons and of your commitment to excellence. We all can take great pride in what the College has represented for the last 100 years and in our efforts to improve surgical care in the future. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Emerging trends in lifelong learning:

New directions for ACS surgical education programs

by Tony Peregrin
Educational expectations for practicing surgeons will continue to evolve in the future as concerns regarding quality of patient care and health care reform propel the field into innovative directions. At its core, continuing medical education (CME) for surgeons is the acquisition of new knowledge and skills after completing residency or fellowship training in an ongoing effort to provide optimal patient care. Over the past two decades, exceptional advancements in surgical technologies have compelled physicians to pursue a kind of “technical retooling,” motivating them to become “knowledgeable in areas of science that did not even exist during their medical school or residency years.”

The CME opportunities of tomorrow will help surgeons become acquainted with new surgical techniques and devices and learn how to apply that technology in their day-to-day practice—a key component in providing consistent, high-quality care. In fact, the future of lifelong learning, according to education experts, will be shaped by content that is easily accessible and up to date and will include robust CME activities, telesurgery, and simulation-based training.

**Training across a lifetime**

Lifelong learning has been a top priority for surgeons since the turn of the 20th century, when, on July 3, 1900, Sir William Osler gave a speech titled The Importance of Post-Graduate Study—a presentation that is generally accepted as the birth of continuing medical education (CME). In fact, the American College of Surgeons (ACS), founded in 1913, was launched as a scientific and educational association with the goal of improving quality of care by setting high standards for surgical education. This goal was met in part through the launch of *Surgery, Gynecology & Obstetrics*, now the *Journal of the American College of Surgeons*, and with the organization’s annual Clinical Congress.

Today, surgeons continue to maintain, develop, and increase their knowledge and skills, while facing new challenges that Sir Osler and the College’s founders probably couldn’t have imagined more than 100 years ago.
“What we have now, in terms of surgical education, is oriented primarily toward the instructional aspects related to a new device or a new technique. But the current system is incomplete because it does not entirely address the change of practice. This component has a lot more to do with process, how we treat the patients, for example, or how we evaluate the results of therapeutic applications than with learning a new device or technique.”

—Dr. Pellegrini

In a presentation to the Society of American Gastrointestinal and Endoscopic Surgeons titled the Role of ACS in Advancing Surgical Education and Training, Ajit K. Sachdeva, MD, FACS, FRCS(C), Director of the ACS Division of Education, said the “underpinnings of the new and innovative direction of the division” include rapid advances in surgery and surgical education and training, new national imperatives and regulatory mandates, and unprecedented scientific discoveries. These are the basis of the new and innovative directions of the division, noted Dr. Sachdeva.

“There was a time when we finished residency training, we thought it was the end of our training, and that one just needed to refine certain skills across one’s lifetime,” explained Dr. Sachdeva. “But now, as rapid advances in science, emerging technologies, and new approaches to treating diseases continue to reshape surgical care, it is imperative that we focus on education and training across the entire span of the professional careers of individuals to help them continue to acquire new knowledge and skills and remain current with the latest advances.”

“Change is inevitable, and change is here to stay—and the pace of change will only increase in the future,” added ACS President-Elect Carlos A. Pellegrini, MD, FACS, FRCS(I)(Hon), The Henry N. Harkins Professor and Chair, department of surgery, University of Washington, Seattle. “Once that principle is accepted, we must then create a system that addresses that need,” said Dr. Pellegrini, who also called for a commitment to lifelong learning on the part of the individual surgeon. “The ‘system’ that I am talking about requires coordination of all the stakeholders: professional organizations like the College, hospitals, insurance carriers, and national institutes devoted to the improvement of care,” explained Dr. Pellegrini. “What we have now, in terms of surgical education, is oriented primarily toward the instructional aspects related to a new device or a new technique. But the current system is incomplete because it does not entirely address the change of practice. This component has a lot more to do with

ACS Program for Accreditation of Education Institutes

The Division of Education launched the innovative ACS Program for Accreditation of Education Institutes in 2005. A network of ACS-accredited Education Institutes (AEIs) has been created to offer state-of-the-art simulation-based surgical education and training at regional levels and to address the needs of surgeons throughout their careers. These accredited institutes provide practicing surgeons, surgery residents, medical students, members of the surgical team, and other health care professionals with the opportunity to participate in programs to acquire skills in new procedures and emerging technologies and to refresh their skills in infrequently performed procedures. As new simulations and simulators are developed and introduced into education and training programs, the need for wet laboratories, animals, and cadavers should progressively diminish.

The goals of the network of 76 ACS-accredited institutes are to promote excellence in surgical care, address the core competencies, enhance access to contemporary surgical education and training, and support surgeons’ efforts to meet the requirements for Maintenance of Certification (MOC) and other national mandates.

The efforts at the AEIs also include pre-course and post-course interventions. The pre-course interventions enable surgeons to acquire relevant knowledge before participating in on-site skills training, thus reducing the time physicians need to be away from their practices, and post-course interventions help in transfer of new knowledge and skills to practice. According to Dr. Sachdeva, these accredited education institutes are also heavily engaged in research and development to advance the field of simulation-based surgical education and training. “This network offers a range of surgical
Dr. Lewis noted that the MOC program “represents a major philosophical shift by the American Board of Medical Specialties, [and is] intended to provide a more continuous monitoring of physician performance rather than intermittent “snapshots.” This change is fully as important as the earlier shift from initial certification to the need for recertification every 10 years, according to Dr. Lewis.

One AEI network member, University of California-Davis Center for Virtual Care, uses patient simulation that is based on flight-simulation technology and features devices that are programmed to react like real patients, blink, speak, breathe, and have heartbeats and other anatomical features, allowing students to practice intravenous drug delivery, cardiopulmonary resuscitation, airway management, and other procedures.

“Accreditation by the American College of Surgeons serves as an acknowledgement of the high-quality and multidisciplinary nature of the training opportunities offered by the Center for Virtual Care,” said Aaron Bair, associate professor of emergency medicine and director of emergency medicine simulation for the center.

“We now have a system that ensures each one of our accredited institutes is offering education and training of the highest quality, and has the requisite tools, resources, and trained faculty to achieve the best outcomes,” noted Dr. Sachdeva.

“There can be no quality improvement or excellence in surgery without innovative education and training; that is absolutely key,” he said. “The path to supporting practice of state-of-the-art surgery and to providing the best possible patient care is through education and training.”

As for the future of the AEI consortium, Dr. Pellegrini said he wouldn’t be surprised if it became an essential part of a comprehensive system of continued professional development for surgeons. “I think eventually, in my opinion, the AEI will become an essential component of a larger system that addresses the overall needs related to remaining current in the midst of constant change,” said Dr. Pellegrini, outgoing Chair of the ACS Committee for the Accreditation Review of Education Institutes. “The College has created the consortium—which all AEI members are invited to participate in—to provide high-quality continuous learning not just of a new device or technology, but with a
focus on the process, which would include patient satisfaction, for example. The future of these institutions and of the consortium is bright as we develop a system that addresses the continuing education of practicing surgeons,” he said.

Changes in MOC

Another factor guiding renewed interest in lifelong learning and participation in CME activities is MOC. In 2003, the American Board of Medical Specialties (ABMS) and its 24 member boards “formally committed to evolve the recertification programs into maintenance of certification programs.”7 In 2005, the American Board of Surgery (ABS), a member of the ABMS, began MOC at the time of initial certification or recertification.7 The MOC program was developed by surgeons for surgeons to assess physician competencies on a continuous basis in four key areas: professional standing, lifelong learning and self-assessment, cognitive expertise, and evaluation of performance in practice.

In 2012, the ABS introduced changes to the MOC program with the goal of simplifying the requirements while offering basic guidelines as to appropriate CME for Part 2—lifelong learning and self-assessment. As of July 2012, ABS diplomates must complete 90 hours of Category I CME over a three-year MOC cycle. Of those 90 hours, 60 must comprise self-assessment. For the CME to count as self-assessment, a score of 75 percent or more must be attained on the self-assessment portion of the CME activity.8

According to Dr. Sachdeva, several programs of the ACS Division of Education include robust self-assessments. The Surgical Education and Self-Assessment Program (SESAP®), the ACS Comprehensive General Surgery Review Course, and Selected Readings in General Surgery (SRGS®) are examples of renowned ACS programs that include state-of-the-art self-assessment models. “In addition, when there is a need to demonstrate mastery of the content or skill, we expect learners to achieve 100 percent. Learners repeat the learning or training exercises until they achieve this benchmark,” explained Dr. Sachdeva. “The ACS Division of Education is ahead of the curve in providing practicing surgeons a broad spectrum of innovative education and training programs to support lifelong learning and address national mandates.”

MOC and the future of surgical education

The future of MOC and its success are tied to an issue that’s been a priority for Frank R. Lewis, MD, FACS, executive director of the ABS since the program’s inception—collecting accurate outcomes data. Dr. Lewis noted that the MOC program “represents a major philosophical shift by the American Board of Medical Specialties, [and is] intended to provide a more continuous monitoring of physician performance rather than intermittent ‘snapshots.’ This change is fully as important as the earlier shift from initial certification to the need for recertification every 10 years, according to Dr. Lewis.9

In the last five to six years, the Centers for Medicaid & Medicare Services has issued quality indicators that, according to Dr. Lewis, “principally address chronic medical conditions, but that have minimal relevance to surgical issues.” “Most of these fall into the category of ‘process’ measurements—when what is actually needed in surgery in order to define quality are outcome measurements,” explained Dr. Lewis.

SESAP: Advancing the boundaries of self-assessment

A nationally and internationally renowned learning and self-assessment program of the ACS, SESAP is available to practicing surgeons and surgery residents, and is recognized by the ABS as a resource that meets Part 2 of the MOC requirements, according to John A. Weigelt, MD, DVM, FACS, Medical Director of SESAP. It is also useful in preparing for the recertification or certification examinations.
“The content for each SESAP is new—we do not recycle anything,” added Dr. Weigelt. “Each cycle we start anew.”

SESAP 14 consists of 655 newly constructed multiple-choice questions with discussions and references to the current literature in 15 major areas of general surgery. The 14th edition includes a completely redesigned self-assessment model that is eligible for credits by providing the equivalent of a closed-book test on the material. “This unique self-assessment model makes SESAP a standard-setting learning and self-assessment tool,” said Dr. Sachdeva.

“SESAP 14 was a major shift in content compared to previous versions,” explained Dr. Weigelt. “Up to that time, it was a CME product that could be used by fellows in any way they saw fit to study it. SESAP 14 was a major shift because we designed it to be compliant with the rules for self-assessment.

“The content for each SESAP is new—we do not recycle anything,” added Dr. Weigelt. “Each cycle we start anew.”

Along with content development updates, the future of surgical education will continue to trend away from the traditional print format toward an increase in electronic and Web-based offerings.

“Based on a recent survey of our customers, we are seeing a slow move to the electronic format as the preferred format. Previously, it was a 50/50 split, compact disc (CD) versus print copy. For SESAP 12, users were still favoring print, even though we had the CD available for that version,” said Dr. Weigelt. There has been a “slow migration” toward the electronic format, said Dr. Weigelt. “SESAP 15 will continue to be available in all three formats: hardcopy, CD, and online. I think the trend will be a continued push to CD and Web formats for self-assessments,” he said.

“With the electronic format, you can feature more audio and video learning tools in SESAP. For instance, we have a few video clips now, but unfortunately, if you get the paper form those are obviously not available. One of the complaints about the book is that when we feature a computed tomography scan within the stem of a question, users have said they need to see more than one cut. In an electronic format we can upload more than one cut, but in the book we aren’t able to do that,” Dr. Weigelt said.

Beyond the electronic versus print conundrum, SESAP developers face other challenges when designing new SESAP content. “At times, one of the difficulties in developing SESAP has to do with new advances in treatment,” observed Dr. Weigelt. “For instance, there was one topic we considered including in SESAP 14, and we had multiple questions on this topic, but eventually it was decided that it was too soon to ask questions on it. We have the same topic in SESAP 15 and it has been determined that it is, in fact, the appropriate time to include it. I think it is simply good stewardship.”

Another new consideration for developing the next edition of SESAP is related to the organization of material and the overall user experience. “The other thing we have learned from this first go-around as we are getting ready to put ‘15’ together is that with SESAP 14 you had to go through all of the material to qualify for CME, and the feedback that we got was that it was much too onerous a task. For SESAP 15, we will break down some of the larger modules into smaller parts, which we hope will enhance the learning value,” explained Dr. Weigelt. “We are trying to divide the material into approximately one-hour learning blocks. We believe this will allow surgeons the ability to manage their time better and identify which modules and parts are most important to their medical knowledge needs.”

The system to earn CME credits will also be different for SESAP 15. “Individuals will be able to claim CME credits as they complete each module and then receive a final Certificate of Completion for the entire program. This will help them meet various regulatory requirements,” said Dr. Sachdeva.

The role of telemedicine
Barrett G. Haik, MD, FACS, a member of the ACS Board of Regents and Chair of the ACS Committee on Emerging Surgical Technology and Education (CESTE), embraces telemedicine as an integral part
“Surgical procedures will be totally different 20 years, even 10 years from now. The whole field will change,” asserted Dr. Haik. “In ophthalmology, career longevity depends on adaptability to rapidly evolving medical technology, [and] adopting new procedures and technologies once they are proven safe and effective.”

of lifelong learning today and in the future. Dr. Haik is Hamilton Professor of Ophthalmology and director of the Hamilton Eye Institute at the University of Tennessee Health Science Center in Memphis, which houses the Freeman Auditorium, a state-of-the-art facility that was one of the first eye centers in the nation to offer three-dimensional (3-D) video capability. According to Dr. Haik, there is evidence that 3-D surgical video enhances learning in some individuals, perhaps because it provides a more realistic view of tissue depth and tool manipulation as it will be seen through the binocular operating microscope.

“Surgical procedures will be totally different 20 years, even 10 years from now. The whole field will change,” asserted Dr. Haik. “In ophthalmology, career longevity depends on adaptability to rapidly evolving medical technology, [and] adopting new procedures and technologies once they are proven safe and effective.”

As 3-D video instruction and other types of “immersive” teaching technologies continue to evolve, they will emerge as a trend in future CME initiatives, noted Dr. Haik. “These are additive, however, and will never overshadow the importance of basic skills instruction lectures or the standard binocular surgical assistance experience,” Dr. Haik added.

“Because ocular tissue is generally transparent, it is possible to provide surgical mentoring over the Internet,” explained Dr. Haik. “Currently, we provide consults based on case reports and still images, but our goal is to enable international outreach centers to broadcast surgeries in real time so we can observe, discuss technique, and provide feedback.”

The Hamilton Eye Institute is a leader in ophthalmic telesurgery and has established collaborative relationships with centers in Guatemala, Honduras, and Panama. The institute also holds grants from the U.S. Department of Defense to develop new technology for remote assessment of patients in the field.

“There is no question that people learn and retain knowledge and skills better through multimedia and interactive education programs, as compared to the traditional teacher-centered models,” said Dr. Sachdeva. “Technology allows us to create interactive programs and provides flexibility through which we can tailor interventions to meet the specific needs of the individuals. It also allows us to readily deliver pretests and posttests. In addition, technology helps us to offer a range of programs and products that learners can mix and match based on their specific needs.”

Dr. Sachdeva said technology-based CME offerings must be placed within the context of a rigorous educational framework, one that involves basic tenets of good education—needs assessment, learning objectives, effective content delivery, assessment, and so on.

**Simulation-based education and training**

A wide spectrum of simulations is available for surgical instruction and for assessment of knowledge and skills. These include computer-based case simulations, standardized patients, part-task trainers, simulators, and virtual reality. Both low- and high-fidelity simulations are helpful in technical skills training and maintenance of skills for procedures not performed on a routine basis. “Simulation is being used across a variety of different programs of the Division of Education to address cognitive, technical, and non-technical skills and the division is recognized as a national and international leader in this field,” said Dr. Sachdeva.

“I think simulation is going to play an even greater role as we go forward,” asserted Dr. Sachdeva. “Simulation-based education and training are closely linked to future advances in CME and lifelong learning. Use of simulation allows learners to be trained in controlled environments without compromising patient safety or comfort and offers surgeons and surgical trainees the opportunity to be exposed to complex and life-threatening events in controlled settings. Added to that, simulation-based education allows individuals to ‘practice until they are perfect,’ which should posi-
Dr. Sachdeva cautioned against the use of simulation without a rigorous educational design. “Also, simulation does not replace experiences in real environments,” he said. “There is real value in face-to-face interactions. Simulation is an adjunct, but a very valuable adjunct. The bottom line is the curriculum has to drive simulations—not the other way around.”

Simulation training has been particularly successful in the areas of upper and lower gastrointestinal endoscopic procedures, according to Dr. Lewis, as well as for some endovascular procedures.

“Where simulation isn’t as successful is in the duplication of actual operations,” explained Dr. Lewis. “Virtual reality programs can’t duplicate tissue characteristics with any realism, and it is not as successful in the duplication of the characteristics of bleeding and [the mastery] of other skills that are necessary in managing the operative field.”

Simulated procedures that involve “geometric operations” or “mechanical exercises” where the learner is using a simulator to learn how to manipulate objects in a geometric space—such as teaching them how to tie and suture knots—tend to work quite well in getting someone initially trained, explained Dr. Lewis.

“Surgical simulation is a tremendous educational tool,” concurred Dr. Haik. “It provides a high degree of realism as well as a progressive, graduated experience with a personalized, postoperative assessment of efficiency and competence, preparing the learner for the next level of training. Ophthalmic microsurgery requires simultaneous, precise coordination of both hands and feet, and the simulator provides a safe and effective method for surgeons to develop this skill. The simulator cannot yet duplicate the tactile sensation of actually penetrating or manipulating tissue, however, so the simulator has not yet invalidated the importance of working with animal tissues in wet labs.”

Dr. Sachdeva cautioned against the use of simulation without a rigorous educational design. “Also, simulation does not replace experiences in real environments,” he said. “There is real value in face-to-face interactions. Simulation is an adjunct, but a very valuable adjunct. The bottom line is the curriculum has to drive simulations—not the other way around.”

The future is now

All surgeons face the ongoing challenge of maintaining their knowledge and skills, keeping up with changes in the pathophysiology of disease, becoming acquainted with new or improved surgical techniques, and improving day-to-day medical and surgical care practices. Keeping up with this information can be challenging, but there are some important concepts surgeons should consider to ensure they are engaging in lifelong learning activities that are cutting-edge yet practical.

Dr. Sachdeva recommends that surgeons continually assess their specific education and training needs through ongoing analyses of their practices and benchmarking to determine any gaps. He noted that professional organizations such as the ACS have a key role in providing individuals the tools to conduct such analyses and then offering appropriate education and training programs to address these needs.

“The large national meetings, such as the Clinical Congress, will continue to play an important role in the future, but they must continue to evolve,” added Dr. Sachdeva. “If you look at these meetings, they alone are not sufficient to change practices and address the continuum of lifelong learning. They need to be linked to post-activity follow-up and offer support for the transfer of new knowledge and skills to practice. Such a comprehensive approach is necessary to ensure the greatest impact.”

“One of the things I find disconcerting when I attend CME meetings is that the lowest in attendance are those who are out of training in their first 10 years,” observed Dr. Haik. “This could be because new surgeons have a certain confidence, and maybe giving up weekends, along with the financial pressure of being out of the office, is not something they choose to do unless they are really certain a course is going to be extremely valuable to them.”

Attracting young surgeons to educational activities involves offering content that is unbiased and relevant, particularly when it comes to technological
advancements, according to all of the surgical education experts interviewed for this article.

“CESTE and the College ensure that new technologies being developed are in the best interest of patients, which is key because there are so many industry-driven advancements that it would be incredibly difficult and time-consuming for an individual surgeon to assess everything. Objective analysis and filtering is needed,” explained Dr. Haik. “The College provides that. It is one of the few sources of unbiased, continuous information for the surgeon.”

Conclusion
The future of surgical education will involve innovations in telemedicine and immersive instruction, increased emphasis on simulation, and lifelong learning opportunities that are customized to the individual surgeon’s training and knowledge gaps. The learning needs of surgeons can vary greatly, but through state-of-the-art educational programming and training, the ultimate goals of lifelong learning—patient safety and quality of care—are obtainable.◆

REFERENCES
Physicians and other health care professionals have encountered a relatively new type of state legislation in the past few years that affects the way they prescribe painkillers. This legislation has emerged in response to the growing epidemic of misuse and overprescribing of painkillers and the rising costs associated with overdoses and pill mills.

Nationwide, more than 116 million Americans struggle with chronic pain each year.¹ In 2008, painkillers were linked to 14,800 overdose deaths—more than for heroin and cocaine combined—and more than 12 million people reported using prescription painkillers for unintended reasons in 2010.² The quantity of prescription painkillers sold to pharmacies, hospitals, and physicians’ offices was four times higher in 2010 than in 1999. In fact, the supply that year was large enough to medicate every American adult for one month with painkillers.³
Federal agencies have found that most prescription drugs enter the illegal market primarily through “doctor shoppers,” meaning people known to seek out and take advantage of physicians who inappropriately prescribe and pharmacists who improperly dispense medications.

This epidemic affects nearly every state in the U.S., which is why policymakers, medical associations, and government agencies, such as the medical boards, have joined the fight to combat this elusive issue on both the legislative and regulatory fronts. This article reviews the government programs in place presently, highlights examples of legislation enacted at the state level, and discusses alternative approaches to legislation.

Government efforts
Federal agencies have found that most prescription drugs enter the illegal market primarily through “doctor shoppers,” meaning people known to seek out and take advantage of physicians who inappropriately prescribe and pharmacists who improperly dispense medications.1

To prevent this practice, states have implemented prescription monitoring programs (PMPs). PMPs are state-run electronic databases designed to monitor and give a prescriber or pharmacist critical information regarding the patient’s controlled substance prescription history.2 PMPs are currently in place in 38 states, and policymakers in more than 12 states and the District of Columbia have enacted new legislation to authorize PMPs.1 PMPs must adhere to the following guidelines:

• Collect data on the physician who wrote the prescription and the pharmacies that dispensed the medication. Pharmacists are required by law to report the data; physicians are encouraged to do this but are not mandated to do so in most states.1

• Serve as a central repository for the data collected.

• Provide a protocol describing how authorities and agencies can access the data.

The medical community has concerns about the accessibility of PMPs, and several barriers are preventing PMPs from realizing their full potential and widespread implementation. First, the Centers for Disease Control and Prevention (CDC) recommends that PMPs link to electronic health record (EHR) systems so that the information is readily available. However, some states do not use EHR systems.1,3

Second, the federal government has not fully funded the 2005 National All Schedules Prescription Electronic Reporting Act, which must be reauthorized to support modernization of state-based PMPs.1 Although many states have passed legislation with reporting requirements for physicians to use PMPs, budget constraints will prevent the programs from being realized or implemented, and, as a result, funding will be pulled. Unfortunately, until PMPs are funded and in place in every state, doctor shoppers will still be able to evade detection and obtain prescriptions for painkillers.

Other state legislative efforts
Following are examples of other types of prescription painkiller legislation that has been considered or enacted at the state level and that have received national attention.

Florida has one of the highest numbers of pill mills—a problem that is causing significant strain on the state. In 2010, the state enacted H.B. 7095, which established standards of care for physicians who prescribe narcotic-grade pills. The law requires physicians to register with the Florida Department of Health and to write prescriptions on counterfeit-proof paper. Physicians who overprescribe face a minimum fine of $10,000 and suspension of their license for six months. The law also bans physicians from on-site dispensing of the more commonly abused drugs, such as oxycodone and hydrocodone.1

In 2011, Ohio passed H.B. 93 to address pill mills in the wake of record high incidences of accidental overdose deaths in 2007 and 2008. This law mandates licensure of pain management clinics, authorizes the state medical board to establish rules on when a physician should review the state prescription reporting database, severely restricts in-office dispensation of controlled substances, and establishes a Medicaid pharmacy lock-in program and prescription drug take-back program.1

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Pill mill legislation H.B. 1 took effect in Kentucky on July 20, 2012, and imposes requirements not just for physicians practicing pain medicine, but for all practitioners who prescribe controlled substances. The bill places significant limits on who may own a pain clinic and how a pain clinic is operated, such as requiring a licensed physician to be present at the facility at least 50 percent of the time that patients are being seen. Additionally, the legislation requires Kentucky’s licensing boards, including the Kentucky Board of Medical Licensure and the Kentucky Board of Nursing, to enact new regulations that impose standards for physicians, nurses, and other practitioners when a Schedule II or Schedule III controlled substance is prescribed. These regulations require the practitioner to keep accurate, readily accessible and complete medical records on each patient receiving Schedule II and III prescriptions. These records must include medical history and physical exam; diagnostic, therapeutic, and laboratory results; evaluations and consultations; treatment objectives; discussion of risks, benefits, and limitations of treatments; medications, including date, type, dosage, and quantity prescribed or dispensed; and periodic reviews of a patient’s file.

Under legislation that became effective in January 2012, health care professionals who dispense drugs in Oklahoma must report all scheduled narcotics that have been given to patient within five minutes of being dispensed. Oklahoma is the first state to enact real-time electronic prescription database requirements. S.B. 5516, which took effect in January 2012 in Washington State, specifies that rules affecting physicians and nonphysician prescribers offer specific instructions on how to evaluate and care for patients with chronic pain that is not due to cancer. It also requires written treatment plans, known as patient contracts, that may mandate periodic urine screenings.

Because of these stricter opioid laws, many physicians have decided to avoid prescribing the narcotics to circumvent regulatory and administrative burdens. Pill mill legislation imposes sweeping changes for pain clinics and prescribing practices, and, therefore, health care providers and their patients will face new challenges in treating and managing pain. While these bills often aid in preventing the pattern of drug abuse, physicians are often the primary agents for reducing a patient’s misuse of prescription drugs.

Alternatives
Many state medical associations have opposed the laws highlighted in this article because they use a one-size-fits-all formula, rather than allowing physicians to determine the best care for each patient. It is very difficult to write legislation that strikes a balance between averting misuse and maintaining patient access due to the fact that laws typically must be applied uniformly.

The Federation of State Medical Boards has published recommendations for model opioid prescription policies, which recognize the growing problem of misuse of prescription medications and provide model language that state boards may use to clarify their positions regarding the use of controlled substances to treat pain, alleviate physician uncertainty about such practices, and encourage better pain management. In summary, the model policy reflects significant progress made in the medical community’s understanding of pain management by:

- Acknowledging the inadequate management of pain and barriers to appropriate treatment
- Emphasizing the dual obligation of government to develop a system that prevents abuse, trafficking, and diversion of controlled substances while ensuring their availability for legitimate medical purposes
- Revising definitions of addiction, chronic pain, and physical dependence to reflect current consensus and expertise in the medical community
- Updating criteria for evaluating the appropriate management of pain
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CME requirements
An alternative to restricting and monitoring a physician’s prescription practices is for state medical boards to mandate that physicians attend continuing medical education (CME) courses on pain management and opioid prescriptions. A total of eight states now require that at least some physicians take CME courses related to pain medication prescribing practices: California, Florida, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and West Virginia. In other states, every physician, regardless of specialty, must complete a CME course on pain management and opioid prescriptions. Some physicians, however, oppose this sort of legislation, arguing that while these courses are appropriate for some specialties, they may be inappropriate for others.

Public health officials, state policymakers, and medical professionals are still learning how to best address the growing epidemic of misuse and abuse of prescription painkillers. There are many facets to the problem, and the concerns some health care professionals have expressed regarding the legislative and regulatory action taken thus far in many states must receive proper consideration. The laws are often too difficult, if not impossible, for some states to develop due to the cost of the technology needed for physicians to implement these requirements into daily practices. Furthermore, the policies are too uniform and general in how they are applied and often place the onus on the physician.

Misuse and the overprescribing of painkillers is an issue that will continue to play out in state legislatures. At the time this article was published, the state legislatures in Kentucky, Iowa, New Jersey, New York, and Pennsylvania were considering bills aimed at preventing prescription drug overdoses. The College will continue monitoring these bills and will provide updates on their status through The ACS Advocate and the Bulletin.

REFERENCES
Dr. Brendan C. Brady serves “invisible population” of migrant workers in upstate New York

by Jeannie Glickson
On a seemingly ordinary day in 2005, a migrant farmworker with a frostbitten hand sought the help of general surgeon Brendan C. Brady, MD, FACS, in Canandaigua, NY. Through an interpreter, the surgeon learned that the worker couldn’t afford to buy gloves to protect his hands and that his employer did not provide them. As the surgeon came face-to-face with the plight of farmworkers in his community, the day became extraordinary and from that point forward, Dr. Brady could not turn away. This experience launched a journey that Dr. Brady has traveled for the last seven years as he has focused on providing migrant workers in upstate New York with access to safe, quality surgical care.

Dr. Brady received the 2012 American College of Surgeons (ACS) Surgical Volunteerism Award for Domestic Outreach, sponsored by Pfizer, Inc., for his efforts to care for migrant workers in his community. The volunteerism award, inaugurated in 2003, recognizes “surgeons and surgical residents committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities.”

Dr. Brady is quick to note that he didn’t provide those services alone. He had lots of help. “The award was nice,” he said, “but the real awardees are the people who work at the clinic and, with a very low budget, make it their life’s work to serve an indigent population.”

Yet Dr. Brady is quick to note that he didn’t provide those services alone. He had lots of help. “The award was nice,” he said, “but the real awardees are the people who work at the clinic and, with a very low budget, make it their life’s work to serve an indigent population.”

Dr. Brady is not one to boast about his own accomplishments. But he ultimately agreed that publicizing his work with migrant workers might inspire other surgeons and health care professionals to commit to helping marginalized populations.

Early motivation
A practicing surgeon for 30 years with the Canandaigua Medical Group in New York State’s Finger Lakes region, which lies roughly between the cities of Syracuse and Buffalo, Dr. Brady has provided steady, quality care to patients, and it has all been “fun and interesting,” because the surgical field has always held that fascination for him.

His first inklings that he might want to become a physician occurred to him in the 1960s when, as a teenager on a New York City subway with his brother, he noticed an ail-
ing passenger who looked close to death. The sight of the man affected him profoundly, and he remembers regretting that he lacked the expertise to help him. “That was the first time I felt motivation to become a doctor,” he said.

A few years later, he enrolled at the State University of New York School of Medicine, Buffalo, graduating in 1975. He completed his surgical residency at Buffalo General Hospital.

“One of the blessings of my life was a Jesuit high school education and growing up in the 1960s,” Dr. Brady said. “It is fair to say the combination made for a heavy emphasis on social responsibility. As the 1960s evolved, and I was in college as a pre-med student, I vividly recall a conversation in chemistry lab with other ‘doctors-to-be’ about spending time in Africa once we were doctors. While others noted they would like to volunteer some time, I bragged that I planned on devoting my life there. Things turned out differently.”

“I had always intended to do some volunteer work, but things got in the way. Medical school was a huge amount of work, and residency even more so. By the time residency was done, we had three kids,” he said. “I had to establish a practice, and before you knew it, there were four college tuitions to pay. I found I was working even harder just to save enough to retire. That is when I knew I was in trouble.”

But Dr. Brady never lost sight of the primary reasons he became a surgeon. For many years, he worked with InterVol, a Rochester, NY-based, not-for-profit organization founded by a physician that provides medical supplies and equipment and connects volunteer physicians with hospitals and medical professionals. Through InterVol, Dr. Brady spent several of his summer vacations at the Rosebud Sioux Reservation in south central South Dakota, providing surgical relief to the indigent populations. Later in his career, he also spent time as a volunteer with Operation Giving Back partner CRUDEM (Center for the Rural Development of Milot) in Haiti. Dr. Brady volunteered in Haiti before and after the 2010 earthquake.

**Transient patient population**

His work on behalf of migrant workers marks the continued development of Dr. Brady’s social conscience. He took it upon himself to learn as much as he could about migrant workers, who mostly are in the U.S. for a limited time—four to five years, he said. Their goal is to earn money here, send the money home, and eventually return to their native country. Most migrant workers in upstate New York are from Mexico, although some are from other Latin American nations and Haiti and, in more recent years, from Poland and Germany.

According to Dr. Brady, there is a difference between a migrant worker and a seasonal farmworker. A migrant worker is someone who crosses state lines at least once every two years in search of agricultural employment, he said. A seasonal farm worker, on the other hand, is one who stays in the region. Migrant workers, Dr. Brady learned, “are an integral and neglected part of our communities.”

He contacted Finger Lakes Migrant Health (since renamed Finger Lakes Community Health), where he established a surgical clinic. He studied the farming industries of upstate New York, where the key crops are apples, grapes, and corn. A number of dairy farms also can be found in the area, and they generally employ seasonal workers. In gathering information about the migrant population in New York State, Dr. Brady learned that anywhere from 3 to 5 million migrant and seasonal workers are in the U.S., and the number is rising. Migrant workers in the U.S. earned an estimated $440 billion in 2011, and, according to the World Bank, this population transferred more than $350 billion in earnings to developing countries. “Migrant workers are my neighbors,” Dr. Brady said. “They are your neighbors. They are everyone’s neighbors.”

As he pursued his interest in the “invisible population” of migrant workers, Dr. Brady quickly realized the magnitude of their health care needs. Getting involved led him to an epiphany: “The farm worker population is physically and culturally hidden and lives in an almost parallel universe,” Dr. Brady said. “One of the largest on-farm camps in our area is two
miles away from an upscale rural restaurant. Those enjoying their meal at the restaurant have little appreciation that those harvesting the crops live just around the corner.”

Harvest of Shame
Dr. Brady’s brother-in-law suggested that he watch a 1960 television documentary, Harvest of Shame, narrated by legendary CBS news anchor Edward R. Murrow. This groundbreaking report, presented the day after Thanksgiving in 1960, brought the stark life of migrant workers and their families into America’s living rooms. “This broadcast is still a powerful messenger of the harsh conditions facing those who harvest our crops, and how poverty has affected their lives and health,” explained Dr. Brady. The TV documentary did have an impact. Two years after the expose aired, the U.S. Congress passed the Migrant Health Act, which led to the establishment of approximately 400 federally funded primary care health facilities for migrant workers.5

Despite these developments, migrant workers continue to live lives of diminished potential. Today, the average life expectancy of the migrant worker is 49 years, compared with 77.2 years for most Americans.6 The grueling nature of their work, combined with minimum wage or low piece-rate wages, frequent relocation, and substandard and crowded housing, make migrant workers susceptible to a number of communicable diseases. Toiling daily under a hot sun in fields sprayed with toxic pesticides, they become afflicted with dermatitis and lacerations and are exposed to a variety of carcinogens. Musculoskeletal issues also diminish their well-being. The combined effects of repetitive motion, bending, and twisting often lead to tendonitis, joint deterioration, and chronic back pain. In addition, the sun, dust, and wind that migrant workers confront each day often lead to blinding eye conditions.6,7

A number of general health problems pervade the migrant population.6 Among Mexican populations in the U.S., 1.2 million have been diagnosed with diabetes, and cardiovascular disease remains the leading cause of death among Latinos in the U.S. Ultimately, many migrant workers do not receive any type of medical care, and virtually none of them has employer-provided health insurance.8,9

The workers give more than they receive. Un/R/ocumented workers generate goods and services worth more than $120 billion a year in the U.S. Furthermore, documented and undocumented Mexican immigrants pay $25 to 30 billion in U.S. taxes each year.10,11 The U.S. food industry depends on the low-wage workers, as the jobs of planting and harvesting remain essential to providing a wide array of fruits, vegetables, meats, grains, and nuts to supermarkets and restaurants, Dr. Brady noted.

The surgeon offers his services
“‘There’s no way that I’ve done anything that many good-hearted doctors and nurses wouldn’t do,” Dr. Brady insists. He initially planned to provide surgical care gratis to the migrant population, but it was the cost of hospital care, not the physician’s fee, that proved prohibitive for the workers. Dr. Brady appealed to the chief executive officer and the board of the F. F. Thompson Health System, where he operates, and asked them to provide a sliding scale of fees to the workers in Canandaigua. The hospital eventually agreed to provide anesthesiology services at Medicaid
rates and to institute a roughly 90 percent reduction in other hospital costs to any Finger Lakes migrant worker. These actions, in effect, made the cost of surgical care both predictable and affordable.

Then came the support of the “amazing” Jessica Hoff, PA, who, according to Dr. Brady, has provided vital support to the migrant program for the past five years. Ms. Hoff, a clinic employee, has happily taken on the “crazy hours,” as she said, to meet the health needs of migrant workers.

“If it’s a day I work, the clinic owns me,” Ms. Hoff said. “That’s why it’s so hard for me to know what time I’m leaving on a daily basis. There is a personal toll, but all of medicine is like that. But because I love what I do, it’s not a sacrifice.” She calls this her “dream job.”

“We see a lot of injuries, fractured arms and hands,” Ms. Hoff said. “Typically, the workers don’t get a day off. They work from sunrise to sundown, six or seven days a week, so we have this very small window of opportunity to see them. And even though they receive Medicaid rates, it’s still an unbelievably high amount of money, so it’s always important to make a good decision about what the patient needs.

“Surgeons have such busy, stressful jobs that don’t give them a lot of time to volunteer,” Ms. Hoff added. “But by contributing a few hours of volunteer work, they can give people like me their expertise. I can describe a patient’s condition over the phone, and they can advise me if the patient should take a day off from work to see a surgeon.” By consulting with a surgeon, the clinic staff can help avoid unnecessary surgical appointments.

Dr. Brady met Ms. Hoff for the first time last spring when he began traveling to the migrant camps for visits. “I was so impressed with her skills and dedication to her job,” Dr. Brady said.

**Dr. Brady’s reputation grows**

By word of mouth and through Dr. Brady’s growing reputation among the workers, the migrant population began traveling from a radius of 75 to 100 miles to receive Dr. Brady’s care at the clinic. He and the staff quickly recognized the wide-ranging barriers that prevent migrant workers from seeking medical care, including a lack of English language skills, transportation, and time to obtain health care. “We see some of the craziest things,” said Mary Zelazny, chief executive officer (CEO) of Finger Lakes Community Health. “Many patients have not seen a doctor in 15 years. But that’s our gig, to provide access to care, and that’s what we keep working to do.”

**OPERATION GIVING BACK: A GLOBAL OUTREACH**

The mission of OGB is to facilitate surgical humanitarian outreach to underserved patients throughout the world. An integral part of that mission is to better understand unmet surgical needs in the U.S., the barriers that continue to exist in addressing them, and to seek solutions.

For more information on surgical volunteerism in the U.S., refer to the OGB website:

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Although the clinic provides interpreters and patient navigators, a lack of communication prevents many workers from seeking help. Transportation issues involving the time and means required to travel from the farm to the clinic add additional challenges to health care access. Time is an essential factor to migrant workers. Scheduling an appointment with a physician cuts into their workday and their already low wages.

Living with fear
Fear may be the migrant worker’s most formidable barrier to accessing care. Most migrant workers worry that they will lose their jobs suddenly without explanation. Although migrant workers are covered by workers’ compensation laws, Dr. Brady maintains that many do not report their injuries in trepidation that doing so may cost them their jobs.

In the meantime, the nation’s Immigration and Customs Enforcement officers have stepped up efforts to find undocumented workers, escalating the general distress among migrant workers, “even among those who are documented,” according to Dr. Brady. Some of the workers are fully documented U.S. citizens who have been detained, he said, and have been denied basic rights, such as being allowed to make a phone call.

Cash transactions
Because migrant workers pay for their medical services in cash, they need to know the precise cost of treatment. If that sounds like...
a simple, obvious step, Dr. Brady points out that it is anything but.

“It is one of the major barriers to health care for migrant workers,” he said. “We know of one hospital that would not even discuss discounting fees unless the patient could prove citizenship. If a hospital is willing to discuss discounts, the discounts are based on sliding scales that demand income history that is generally not pertinent to migrant workers or is hard to obtain. These discussions alone can mean more time off from work.” Furthermore, he said, “many hospital executives do not identify the migrant and seasonal workers as their patients.”

Not so for Dr. Brady, who considers the migrant workers not only his patients, but a source of professional joy and fulfillment as well. “The migrant population is very judicious, especially in the way they relate to physicians,” he said. “They appreciate your help, and they want to pay for the services they receive.”

The skillful Ms. Hoff managed to convince another local hospital to provide care to them on a sliding scale. She explained to the hospital the difficulty she was having finding care for migrant workers. Hospital personnel initially denied that there were any migrant workers in the service area, reflective of the “invisible population” of migrant workers. Ms. Hoff convinced the community hospital to recognize the farmworkers as members of the community, and thanks to her efforts, the workers now need only to bring their pay stubs to be eligible for the sliding scale rates.

“This is a really amazing example of how effective she is, and what a great voice she has been for the farmworker population,” Dr. Brady said.

Dr. Brady is grateful that the work has put him in contact with people he otherwise may not have met. “I love working with migrant workers. You can’t work with this population and not feel appreciated,” Dr. Brady said. “It’s like going to another country and caring for a different culture, right in your own backyard. You just want Americans to appreciate the work that migrant workers provide to produce butter and other products at the prices that we demand.” The clinic’s support of migrant workers, Dr. Brady said, “helps level the playing field.”

Like Dr. Brady, Ms. Hoff values the rewards of working with patients who are truly appreciative. “They are totally different from the general population,” she said. “Maybe it’s selfish of me, but I really like caring for people who are thankful for everything you give them.”

“Dr. Brady is a well-respected surgeon in our region,” noted CEO Ms. Zelazny, “and I can’t begin to tell you how much his work has boosted the health of migrant workers in our area.” Ms. Zelazny noted that with hernias being a common occurrence among the workers, she would frequently see workers with duct tape wrapped around their stomachs. Dr. Brady changed much of that, she said, and has helped to change workers’ perceptions about their own health. “I think as a provider, he appreciates the opportunity to save lives. He takes the time to explain things. I have literally seen doctors do things to patients and never explain anything about the procedure to them. The farm workers can tell that Dr. Brady cares about them and takes the time to make sure they understand what he’s doing,” she said.

“Dr. Brady is just a wonderful person,” Ms. Zelazny added, “and when he comes to see patients in our clinics, I think he really feels appreciated. We’re very low-key around here, and Dr. Brady fits right in. We manage to keep it fun.”

Like wartime medical care

Controversies in the U.S. over the work and presence of the migrant population are not a concern to the Finger Lakes Community Health staff. The job of providing quality care is what matters to the physicians, nurses, and administrative staff. “It’s like medical care in time of war,” said Dr. Brady. “It’s not a political statement. If you’re taking care of patients, you’re taking responsibil-
If you’re taking care of patients, you’re taking responsibility for their care, and you are not concerned with whether or not they are documented.”

At the end of 2012, when the 63-year-old Dr. Brady left private practice, he pointedly noted that he had no plans to retire from his volunteer work with the migrant workers.

Dr. Brady “gets it”

Once a month, Ms. Hoff said, Dr. Brady visits the clinic. “He is kind and wonderful with the patients. There’s a whole culture that the volunteer surgeon has to understand, and Dr. Brady gets it,” she said. “He really connects with the patients.”

To Dr. Brady, volunteering is simply an extension of a surgeon’s desire to change the world, one patient at a time. What surgeons must bring to the experience is a singular desire to help without any expectation of monetary award. Volunteer surgeons who bring their expertise to these situations must carry medical liability insurance. “No hospital would let you work at the facility without insurance,” Dr. Brady said.

Dr. Brady’s decision to continue as a volunteer is reassuring not just to the migrant populations in his community, but also to members of the clinic staff.

“Dr. Brady is the ideal volunteer. He knows what needs to be done, and he does it,” said Ms. Zelazny. “He is perfectly comfortable with other cultures, and he is motivated by an honest desire to improve life for these folks.”

“I wish we could have given him an award for his work,” she said. “I’m just so glad that he was honored by his peers. It gives us the chance to confirm what a very valuable resource he is.”

REFERENCES


The last patient we saw at a clinic in India encapsulated virtually the entire experience shared by a group of Fellows of the American College of Surgeons (ACS) who traveled to the developing nation in 2011. The team had just completed a day of staffing a free clinic in the rural Haryana province when the parents arrived with their infant daughter. They had to travel by foot, so they were understandably late, disheveled, and anxious. It was their hope that the American physician could cure what ailed their seven-month-old baby. At first glance she appeared typical, with kohl eye shadow and red lips from betel seed. However, when the infant cried, her nail beds turned distinctly blue. An exam with a stethoscope revealed the loud systolic murmur.

The team had traveled to India as delegates of People to People (P2P), an organization started under the direction of President Dwight D. Eisenhower, which promotes cultural exchange tourism. P2P sends hundreds of Americans on cultural exchange programs around the world every year. Originally a not-for-profit organization, P2P is now a for-profit company with 50 years of experience in the niche industry of tourism that combines the usual sightseeing with a more in-depth volunteer experience. P2P has sent thousands of high school students on exchange programs; more recently they have found success at arranging programs for professional adult travelers.

This delegation was known as the Surgical Leadership and Service Delegation—the first group that P2P had organized with members of the ACS. P2P had sent many other delegations to India in the past, including teachers, engineers, nurses, and other physician groups. The ACS delegation would learn about the health care system in India, meet some of our surgical counterparts in the region, and visit some of India’s sites.
Participation in the free clinic was our last professional activity of the trip.

**Building a delegation**

P2P first contacted Mark Savarise, MD, FACS, a co-author of this article, in the spring of 2011 during his tenure as Chair of the College’s Young Fellows Association, proposing that he serve as delegation leader. The process started with the development of some objectives for the trip, which were as follows:

- Develop an understanding of the impact of India’s culture on its current medical care system
- Learn about the economic forces that affect surgeons in India
- Gain exposure to the surgical conditions that are unique to India
- Attain an understanding of medical tourism from the perspective of the Indian surgeon

P2P sent invitations to potential surgeon participants throughout that summer. “I decided to go because I thought it would be an opportunity to learn about the health care systems that are available in developing countries,” said pediatric surgeon Joelle Pierre, MD, an Associate Fellow of the College in Valley Stream, NY. “I had never considered going to India before but felt that this was a unique opportunity, and I realized I could use the experience in other countries.” Typically, P2P delegations include between 15 and 30 participants. By August, our delegation included only eight members; however, P2P decided to proceed with the delegation as this was their first group of ACS members.

Adrienne Fueg, MD, FACS, a general surgeon from Saint Mary’s, PA, said she decided to participate in the mission because “It was right after the revolt in Egypt. I thought it would be interesting and safe to travel to a place I wouldn’t go to on my own. The ACS name was associated with it so I felt it was legitimate,” continued Dr. Fueg. “When I received the to-do list from P2P, I started having second thoughts.” The process for obtaining the visa, including surrendering her passport, as well as the vaccinations required for this type of mission were a challenging undertaking, according to Dr. Fueg. “I never gave any thought to all the diseases I would be exposed to. [But] I have no regrets. The experience was so eye-opening. It’s the first time I’ve seen how the other half—well, three-quarters—live.”

**The journey begins**

The 14-hour flight from the Newark Liberty International Airport, New Jersey, deposited the delegation at the Indira Gandhi International Airport in Delhi at 10:00 pm on a Sunday night. Sandeep Singh, an impossibly tall man in a crimson turban, met us at the airport and would be our guide for the week. Mr. Singh did more than take us to our various destinations. He kept us on schedule, guided us through the throngs of people, acted as interpreter, bargained with hawkers and vendors, steered us to the best dishes on menus, and made sure none of us got lost during the week. He did all of these tasks with patience and skill obtained through years of leading groups of Americans. His first responsibility was to shepherd the group and its luggage into our tour van and into the chaos of a Delhi traffic jam in the middle of the night.

The delegation’s itinerary was arranged by P2P, more precisely by the company’s contacts in New Delhi who were skilled at negotiating meetings with peers in and around the city.

The first morning started with a briefing during which several delegates learned that their experience would include hands-on care of patients, something even the delegation leader found out only days prior to departure. Balu Menon is responsible for arranging the professional interactions of P2P delegates in India. He had arranged for previous medical groups to tour the Deepalaya clinic and school in the Sohna village, but Mr. Menon had arranged a more ambitious plan for the surgeons on this trip. Because our mission was titled Surgical Leadership and Service, this group would spend one day of its cultural exchange in service to the community. “My major concern at this point was the fact we would be delivering primary care, something I had truly never had to do since medical school,” said John J. Como, MD, MPH, FACS, a co-author of this article.
Economic and cultural realities

The itinerary would also include tours of three hospitals in Delhi and an exchange with the physician staff at each facility. Our Indian counterparts had been given our list of objectives prior to our visit. Notably, interspersed with daily professional activities were visits to historic sites in the area.

The first hospital the delegation visited was the Fortis Flight Lt. Rajan Dhall Hospital. Nearly the entire surgery department participated in the meeting held that afternoon. The surgeons were very interested in speaking with the ACS delegation about the Indian medical system. Many of the physicians had completed some of their training in the U.S. or Europe and could readily explain the differences between the health care systems.

India has a two-tiered health care system; the Fortis hospitals are part of the private sector, providing care to the 14 percent of Indians who carry health insurance or pay for their care. They also provide 10 percent of their care free of charge.

Most Indians rely on the public health system, which is fully funded by the government. In the private system, costs are about one-tenth of those in the U.S. During the tour of the hospital, it was apparent that the medical facilities were similar to those at most American hospitals, so the cost savings were not completely at the expense of the level of care. The staff pointed out the factors that contribute to the large cost disparity:

- Physicians earn less than their counterparts in the U.S.
- Drugs and devices cost much less in India than in the U.S.
- There is less pressure to perform potentially unnecessary services in India.
- Indians routinely use cost-saving measures, such as the reuse of items.
- There is much less liability pressure in the Indian health care system.

A private room costs $68 per day, although most patients were on wards for a fraction of that cost.

The Indian physicians are aware of the effects that westernization will have on the system as their economy expands, including an increase in the cost of care and use to a point where workforce shortages will be severe.

A member of our delegation, Jagdish S. Gill, MD, FACS, a general surgeon in Sioux Falls, SD, has family ties to India; in fact, his mother still lives there. Dr. Gill coordinated his trip to include a visit with her and was surprised at how much he learned about India during the trip. “I was unfamiliar with People to People and first saw their notice in the Bulletin of the American College of Surgeons. I was intrigued to see the medical treatment applied to patients in the third world,” Dr. Gill said. “I learned a great deal about the business of medicine and the delivery system in India.”

The ACS delegation noted that the private hospitals seemed to lack facilities for obstetric or pediatric care and that the emergency departments were not much more than simple receiving areas for trauma patients. India, in fact, provides very little pediatric specialty care and very few obstetric services. Most deliveries are done at home, and infant mortality is significantly greater there than in the West. Economic and cultural realities simply do not permit large expenditures of resources for children from the areas with the greatest demonstrated needs.

The lack of trauma systems revealed another reality of India: its infrastructure cannot facilitate rapid response and transport of injured patients. In other words, there is no Golden Hour for Indian trauma patients.

Public health issues

The next day, the delegates’ orientation continued at the Maulana Azad Medical College, which is affiliated with the University of Delhi and is one of the public teaching hospitals in the city. The physicians had prepared presentations for the ACS delegation...
The Indian physicians are aware of the effects that westernization will have on the system as their economy expands, including an increase in the cost of care and use to a point where workforce shortages will be severe.

on the communicable and noncommunicable diseases common to India, and on the Indian public health sector. Because of the country’s longstanding economic disparities, India still endures many endemic infectious diseases. However, as India’s middle class develops, the nation now is facing epidemics of the noninfectious diseases of the Western world, including arterial disease, cancer, and skyrocketing rates of diabetes.

Two surgeons—Distinguished Professor R.C.M. Kaza, MB, BS, and Anil Agarwal, MB, BS, FACS—were especially helpful in explaining the situation for surgeons in India. In training, Indian surgeons have experience in laparoscopy, robotics, endovascular techniques, and complex oncology surgery; however, in practice, they have limited opportunities to perform these procedures outside of major training centers in large cities, adding to the shortage of surgeons in smaller cities and rural areas with limited resources.

In fact, the discrepancy in the surgical and other specialty care provided at large, urban, public hospitals and the services provided at rural public facilities is significant, clearly demonstrating how India’s caste system affects health care. Corollaries to this problem are high rates of infant mortality and even occasional instances of “honor killing” of young women.

The delegation’s final day of learning about modern Indian health care was also the most impressive. Medanta Medicity—a two-year old hospital that is in the process of expanding from 600 to 1,200 beds—is located in two spotless towers in the Delhi suburb of Gurgaon, the technology capital of India. The chief of surgery, Adarsh Choudhary, MB, BS, explained that he performs more than 100 Whipple procedures annually with a very low morbidity rate.

Sandep Malhotra, MB, BS, FACS, another surgeon at this facility, received training and was an attending surgeon in the U.S. He returned to India for the sake of family. Dr. Malhotra was very open in offering his insights into the practice of general surgery in modern India. He was able to highlight the contrasts between his life and ours. Although he earns less, Dr. Malhotra is able to employ a chauffeur and servants. He has a great deal of control over his practice in the private sector. However, he noted that the quality of nursing care is not as good as it is in the west and that Indian physicians receive less training in critical care.

In the trenches

The delegation traveled less than 20 miles from the Medanta Medicity to the Deepalaya clinic, the final locale during the cultural exchange visit, which is located near the rural village of Sohna—but it may as well have been 1,000 miles for the difference in the patients we met the next day. The Deepalaya school and hostel are funded and administered by the Deepalaya Foundation, an international resource group, which has also built a health clinic at this location. Our delegation was greeted by the school children who performed traditional songs for us in Hindi and Urdu. The team toured the hostel and met with a counselor, who discussed the difficult upbringing of some of the children in the facility, as well as some of the success stories of their graduates. The donation process was explained to the delegation, including how a British company donated 50 computers to the school. We also got a sense of the hardships of life in Sohna and what the school has done to accommodate the residents’ need to increase attendance at the school. For example, the school year is adjusted so that students can work on the farms in the planting and harvest season. Also, with multiple religions, the school has had to be very sensitive in this regard, but the facility successfully places Hindu, Islamic, and other students together into classes and dormitories.

The delegation was then transported to the village to meet the locals. Custom dictated that we were separated into male and female contingents. The men encountered a group of about 30 local males, at which time the delegates received their first glimpse of the medical problems in the community. An elderly gentleman, obviously of some local importance, had a dirty gauze bandage on a chronic wound on his leg. The stigmata of his peripheral vascular disease due to diabetes and chronic smoking were obvious and more easily appreciated by the locals than the explanation for the wound’s poor healing.
After four days, the College delegates had seen the spectrum of health care in India, from the private rooms and high-tech wizardry of Medanta and Fortis, to the strained but dedicated public hospital and medical school, to the underserved villages and the grateful, hopeless poor in Sohna.

The women joined a support group in one of the homes, where the village women described their programs and their business success. It was hard not to note the contrast of the dusty surroundings with the brightly colored saris and scarves of the crowd.

The next morning, there was a great deal of anticipation for the day of medical service to the Sohna village. None in our delegation of three general surgeons, a trauma surgeon, a hand surgeon, and a pediatric surgeon had much experience with medical missions, and it had been years since any of us had done any primary care. However, the large number of patients seeking help were uninterested in our specialty credentials but very eager to seek our help. Even our one guest traveler, the physical therapist wife of one of the surgeons, was going to participate.

When the delegation arrived at the hospital, a small number of patients had already gathered for registration. This number quickly grew as news of our presence permeated the community by loudspeaker and word of mouth. The clinic started at 9:30 am and continued until 2:00 pm. The time flew by quickly as we began to see the patients who were led to the facility one by one with the aid of an interpreter.

The delegates had learned previously that Indian patients are generally wary of Indian physicians, whom they perceive as primarily interested in making a profit by ordering tests, performing procedures, or ordering treatments. These patients, we were told, would be much more trusting of the motives of the ACS group of volunteer American physicians.

The patients presented with a host of ailments, including abdominal pain, back pain, kidney stones, neurologic deficits, cataracts, carpal tunnel syndrome, skin diseases, peripheral vascular disease, and diabetes. Some brought their records from local clinics (which seemed to be generally very accurate). We obtained histories with the help of our translators, performed physical exams, made diagnoses, prescribed from the limited pharmacy, and performed minor procedures.

The delegation had planned to break into teams of two for patient visits. In light of the patient volume, we soon decided to double our efforts. We pressed into service our P2P guides and administrators as interpreters. Our physical therapist was directed to evaluate and treat musculoskeletal problems, while a social worker—who had arrived at the school from Britain days before—worked to coordinate patient flow. The pharmacist and nurse who regularly staffed the clinic were kept constantly busy.

“Very quickly all of the general medicine and pediatrics I had purposefully pushed to the recesses of my mind resurfaced,” re-
In fact, the discrepancy in the surgical and other specialty care provided at large, urban, public hospitals and the services provided at rural public facilities is significant, clearly demonstrating how India’s caste system affects health care.

called Dr. Pierre. “Seeing that many patients in such a short amount of time without being encumbered by an EMR [electronic medical record] was exhilarating. At times, I felt overwhelmed by the inability to help those who were in need of additional specialized care, especially since talented specialists seemed just out of their reach.”

By 2:00 pm, the ACS delegates had provided care to more than 150 patients. It was amazing to see, despite language and cultural barriers, the appreciation of the patients as we each took time to listen and treat their individual problems. They showed a level of gratitude that we do not always experience in our day-to-day practices in the U.S. At the end of the clinic, the delegates were treated to lunch at the school, a cultural performance by the students, and a game of cricket.

Confronting limitations

It was at this point during the exchange that the delegation met the parents of the infant girl with Tetralogy of Fallot mentioned at the beginning of this article. The diagnosis had already been made at a small town clinic where a very good ultrasound had been performed, but the parents were hopeful that the American physicians would be able to do something to help her that, perhaps, the Indian physicians were unwilling or unable to provide. Having completed our introduction to health care in India, we knew at some level that the girl was not going to survive. Her only hope would be to make it to one of the very few cardiac surgeons in the city who could repair the defect. For her parents, pursuing this option was going to be an impossibility. For us, it brought home the realities of India—that the massive population, pervasive poverty, limited supply of surgical specialists, and deeply entrenched caste system continue in the 21st century and prevent some patients from getting care that would be provided in our country.

“I remember feeling how little we were able to do to actually help—for example, with the patient who needed an aortofemoral bypass,” recalled Dr. Como. “Some basic primary care, with access to specialists as needed, would have been invaluable for these patients. Instead, many will never get the help they need, and in fact, may die of their ailments. There is only so much anyone can do in one day,” said Dr. Como. Dr. Gill added, “There was a much greater need than we could accommodate. Since returning home, I have attempted to contact Indian physicians in the U.S. to organize some international efforts that go beyond where we have gone.” Specifically, Dr. Gill has contacted the American Association of Physicians from India and is working to organize volunteer rotations.

New understanding

After four days, the College delegates had seen the spectrum of health care in India, from the private rooms and high-tech wizardry of Medanta and Fortis, to the strained but dedicated public hospital and medical school, to the underserved villages and the grateful, hopeless poor in Sohna. Interspersed with these activities were visits to tourist attractions, including temples, mosques, and markets and a stop at Mahatma Gandhi’s modest memorial—not to mention the view of daily life of some of the 20 million residents of Delhi and the other millions in the countryside through the windows of our bus. At this point, only a visit to Agra and the grandeur of the Taj Mahal remained on our agenda. To call it a whirlwind exposure to this culture halfway around the globe would be an understatement.

Our group had a bit of informal debriefing at our farewell dinner and in the departure lounge at the airport. We all agreed that we could not call the week a vacation in any sense of the word. For some, it had been the most intense week since residency training, but all concurred that the experience had been worth it. Each of us would take home a slightly different meaning from the experience, including an understanding of India in a way that is not easily conveyed through words or even photographs—the juxtaposition and harmony of a blossoming economy and absolute poverty, of dirt and color, of despair and happiness that is everywhere. ♦
Centennial reprint:
1942: ACS plays critical role in war effort

To help commemorate the American College of Surgeons’ (ACS) Centennial, the Bulletin is reprinting articles centered on the issues and developments that have defined the character and integrity of the organization throughout its history. This month, the Bulletin is reprinting two items that represent the ACS’ involvement and commitment to service during World War II: first is introductory material from the “War Issue,” published in April 1942; second is the announcement, published in September 1942, that the 1942 Clinical Congress would be cancelled.

The War Issue contained information shared at 27 ACS War Sessions in March, April, and May. A summary of the sessions is included in the reprint that follows. According to the reprint, an estimated one out of five members of the medical profession throughout the U.S. attended one War Session that year. The College continued to present the War Sessions until the war ended in September 1945.

Likewise, the Clinical Congress was cancelled in 1942, 1943, and 1944. The College’s decision to cancel the meeting was motivated by a number of factors, including patriotism, the large number of surgeons serving in the military, and the need to keep the nation’s transportation system open for transferring military personnel and equipment.

The College and its Fellows continue to serve during wartime and strive to provide excellent care to returning troops as reflected in the ACS’ participation in the Joining Force campaign, which seeks to ensure that veterans and their families have access to housing, education, and appropriate medical care.
1942 WAR SESSIONS

THE DOCTOR AND THE HOSPITAL IN WAR

MALCOLM T. MACEACHERN, M.D., CHICAGO, ILLINOIS
Associate Director, American College of Surgeons

KEYED directly to the war needs, a program of twenty-seven War Sessions was conducted by the American College of Surgeons during the months of March, April, and May, with audiences whose intensity of interest was occasion for remark by many observers. It is estimated that one out of every five members of the medical profession throughout the United States attended one of these sessions, and that practically all of the remaining physicians were reached through medical journals and newspaper reports. At four meetings, half of the doctors in the participating state or states attended; at five meetings, one-third attended; and at six, one-fourth. The largest meeting was in Detroit, with about 1,300 physicians present. In two cities, the war session was the largest medical meeting ever held in the area.

These one-day sessions in which every state in the Union and the District of Columbia participated, superseded the originally planned schedule of three Sectional Meetings of three days each. After Pearl Harbor, the immediate urgency of disseminating the facts concerning enlistment of medical personnel in the armed forces, and of giving authoritative information on the treatment of war wounds, suggested to the officials of the College the desirability of changing the Sectional Meeting plans. Wider geographical scope was indicated, as well as a more concentrated purpose. Canada as well as the United States was considered in formulating the new program and co-operation with Canadian military and medical organizations is planned.

Submission of the program for the United States to the Surgeons General of the Army and the Navy, the Office of Civilian Defense, and the Procurement and Assignment Service, produced enthusiastic response, which events have shown was fully justified. The co-operation of these services has been constant and accounts in large part for the outstanding success of each meeting in the entire series.

The opportunity for personal contacts with medical officers in authoritative positions in the Army and the Navy and the other Government agencies was invaluable for those members of the medical profession who were seeking information as to their war duties—and they constitute almost the entire profession. Captain Frederick R. Hook, Chief of the Surgical Service, United States Naval Hospital, Washington, who represented the Navy at every one of the meetings, won the esteem of all who attended. The Army’s official representatives, Brigadier General Charles C. Hillman, Colonel Hugh J. Morgan, Colonel Fred W. Rankin, Lieutenant Colonel B. Noland Carter, and Lieutenant Colonel Roger G. Prentiss, Jr., likewise won admiration and support at the meetings which they respectively addressed, by their co-operative spirit and obvious ability as medical leaders.

The functioning of the Procurement and Assignment Service by means of which it is hoped to safeguard civilian medical services and also to preserve the tradition of never having to draft a medical man for medical military service, was explained at each meeting by Lieutenant Colonel Sam F. Seeley, executive officer of the Service, or his representative. In New Haven, Portland, and Albany, the subject was presented by Dr. Frank H. Lahey of Boston, chairman of the directing board of the Procurement and Assignment Service. Other members of the directing board who represented the Service at the War Sessions were Dr. James E. Paulin of Atlanta, and Dr. Harold S. Diehl of Minneapolis. The meetings served to publicize the pressing need for 16,000 doctors for the Army by December 31, and for 2,500 doctors for the Air Corps by July 1 and 600 per month after that. It is hoped that many additional enlistments were gained as a result of the War Sessions.

Civilian defense needs were emphasized in talks at each meeting by a medical officer of the Office of Civilian Defense. As one of these speakers pointed out, the key to successful organization of emergency medical services in wartime is for each community to organize its own medical resources and not rely...
## SCHEDULE OF 1942 WAR SESSIONS

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THE DOCTOR AND THE HOSPITAL IN WAR

on help from elsewhere, and to utilize all the resources available, organizing them for efficient operation under any and all circumstances.

The timely nature of the War Sessions won for them the complete co-operation of the state and local medical societies in each area. It was fully realized that not only the physician in military service or the one who is about to enter the service was concerned with the treatment of war wounds but that any physician in civilian practice might be called upon to treat war injuries under the program of Civilian Defense. The exceptionally co-operative attitude of hotel管理部门 should also be acknowledged. It was impossible to make definite luncheon reservations, for instance, because in most places many more than had bought tickets in advance appeared for the luncheon. Frequently the anticipated attendance was doubled; nevertheless, the hotels treated the situation in war emergency fashion and accommodated as many as they possibly could. Good service was given despite the universal shortage of personnel.

The War Sessions were divided into two sections, one for the medical profession and one for hospital representatives, with two separate and three joint meetings. A businesslike schedule, stripped of all nonessentials, was adhered to throughout. Registration detail was dispensed with. The dinners were informal. The headquarters staff in charge of arrangements was limited to two persons. Meetings started and ended sharply on time, and speakers were specific and terse in their remarks. Compressed into each one-day meeting, as a result, was a strikingly comprehensive coverage of the war situation as it affects the medical profession and hospitals.

SCIENTIFIC PROGRAM

On the succeeding pages will be found reproductions of typical talks at the War Sessions by General Hillman, Captain Hook, Colonel Seeley, and Dr. George Baehr, covering their respective services; also one paper each on the following subjects that were presented at each meeting with discussion of the panels by Captain Hook and Colonel Rankin:

Treatment of War Injuries to the Chest; Prevention and Treatment of Shock; Treatment of Wounds of Soft Parts; Fractures; Treatment of Burns; and Treatment of War Injuries to the Skull and Face.

A good epitome of the scientific talks at the Baltimore meeting, which was typical, is extracted from an article by Dr. Gilson C. Engel in the May issue of Philadelphia Medicine and immediately follows the presentation of the panel discussions.

The programs for the twenty-seven meetings were built on the same pattern. The scientific program for the first session on March 2 in Louisville is reproduced on the following page.

HOSPITAL CONFERENCES

The program for the hospital conference at the first session in Louisville is reproduced on page 97.

A typical opening discussion for the afternoon panel at each meeting on "Special Problems Incident to the War As Affecting Hospitals" is presented by including the address at the Nashville meeting by Very Reverend Monsignor John J. Healy of Little Rock, Director of Hospitals, Diocese of Little Rock. Following are a few other outstanding statements which were made on the various special subjects covered at the hospital conferences:

Meeting the Increasing Costs of Hospital Service. "We may have to increase our rates, but let us look into our books, examine our organization, and see if each one concerned is doing his or her part. Giving the best service possible, wasting nothing, and doing each task a little more efficiently each day, but asking no more in dollars than we must." (Sister Rose, Superintendent, St. Vincent's Hospital, Indianapolis.)

Maintaining Standards of Hospital Service During the War. "Two heads are better than one, and by telephone and letter, by local city or regional conferences, and by attending the conventions of our national groups, we can work out the best solutions of our common problems. Standards of hospital service can be maintained during the war if we remember to put first things first, to build high morale, to reward our loyal workers with pay sufficient for the increasing cost of living, and to serve the needs of our patients under a wartime economy which of necessity must cause us to trim our sails so that our ship, The Hospital, will weather the storm and be ready to go on with its service to mankind when peace again shall urge man to build and not to destroy." (Arthur H. Perkins, M.D., Superintendant, Riverside Hospital, Newport News, Virginia.)

"We must do a real selling job if we are to maintain standards and keep the interest and support of patients. . . . Proper public relations will be most essential for the hospital during the trying war period. . . . Collaboration of hospitals is essential if all are to have the benefit of trained medical specialists. In New England the radiology and pathology societies, anticipating the present difficulties, have worked out plans so that when one of their members goes to the armed services, his hospital is properly covered by some other members. . . . It is also possible for large hospitals to assist the smaller hospitals by sharing these specialized services." (Olive G. Fratt, Director, Salem Hospital, Salem, Massachusetts.)

Conservation of Personnel, Labor and Supplies. "The degree of conservation which we are able to effect depends upon how well we sell the idea to our personnel and upon their morale. Their morale will be highest when each individual is made to realize that he is needed, that his task is vitally important and challenges his full powers." (Edgar Galloway, M.D., Superintendant, Shreveport Charity Hospital, Shreveport, Louisiana.)

Maintaining Adequate Professional and Non-Professional Personnel. "It will be necessary and vital to prepare a loose organization of emergency workers—married and inactive ex-nurses, technicians, secretaries, defense course trainees and graduates . . . to replace young men with old men . . . to use women, more women, and all women possible . . . to constantly resurvey and shorten techniques . . . The keynote policy is to use women, add training, and trainees." (F. V. Altavater, Superintendent, Duke Hospital, Durham, North Carolina.)
AMERICAN COLLEGE OF SURGEONS

WAR SESSION

Program for the Medical Profession

Monday, March 2, 1942

BROWN HOTEL
LOUISVILLE, KENTUCKY

Program

Crystal Ballroom

9:00 a.m.
Panel Discussion: Treatment of War Injuries to the Skull and Face
Leaders: R. GLEN SPURLING, M.D., Louisville; Clinical Professor of Surgery, in Charge of Neurosurgery, University of Louisville School of Medicine; JAMES B. BROWN, M.D., St. Louis; Associate Professor of Clinical Surgery, Washington University School of Medicine.

9:45 a.m.
Panel Discussion: Treatment of War Injuries to the Chest
Leader: BRIAN B. BLADES, M.D., St. Louis; Instructor in Clinical Surgery, Washington University School of Medicine.

Crystal Ballroom

10:45 a.m.–12:15 p.m.
W. BARNETT OWEN, M.D., Louisville; Chairman, Kentucky State Executive Committee, American College of Surgeons, Presiding.

The Organization and Functions of the Medical Department of the United States Army
BRIGADIER GENERAL CHARLES C. HILLMAN, Washington; Chief of Professional Service Division, Office of the Surgeon General, United States Army.

The Organization and Functions of the Medical Department of the United States Navy
CAPTAIN FREDERICK R. HOOK, Washington; Chief, Surgical Service, United States Naval Hospital.

The Doctor and the Hospital in Civilian Defense
WILLIAM S. KELLER, M.D., Columbus; Regional Medical Officer, Fifth Civilian Defense Region, United States Office of Civilian Defense.

Roof Garden
12:30–2:00 p.m.
Luncheon for Physicians, Surgeons, and Hospital Representatives
ELMER L. HENDERSON, M.D., Louisville; Chairman, Fifth Corps Area Committee, Procurement and Assignment Service, Presiding.

The Procurement and Assignment Service
LIEUTENANT COLONEL SAM F. SEELEY, Executive Officer, Procurement and Assignment Service.

Crystal Ballroom

2:15 p.m.
Panel Discussion: Treatment of Wounds of Soft Parts
Leader: WILLIS D. GATCHE, M.D., Indianapolis; Professor of Surgery, Head, Department of Surgery, and Dean, Indiana University School of Medicine.

2:50 p.m.
Panel Discussion: Prevention and Treatment of Hemorrhage
Leader: M. JOSEPH HENRY, M.D., Louisville; Member of Staff, St. Joseph's Infirmary.

3:45 p.m.
Panel Discussion: Fractures
Leader: R. ARNOLD GRISWOLD, M.D., Louisville; Professor and Head, Department of Surgery, University of Louisville School of Medicine. Associates of Dr. Griswold.

Crystal Ballroom

6:00 p.m.
Dinner for Physicians, Surgeons, and Hospital Representatives
IRVIN ABBEY, M.D., Louisville; Chairman, Board of Regents, American College of Surgeons, Presiding.

Crystal Ballroom

7:30 p.m.
Activities of the American College of Surgeons and Their Relation to the Defense Program
IRVIN ABBEY, M.D., Louisville.

8:00 p.m.
Panel Discussion: Treatment of Burns
Leader: JOSEPH E. HAMILTON, M.D., Louisville; Assistant Professor of Surgery, University of Louisville School of Medicine.

9:00 p.m.
Panel Discussion: Prevention and Treatment of Shock
Leader: R. ARNOLD GRISWOLD, M.D., Louisville; Professor and Head, Department of Surgery, University of Louisville School of Medicine.

NOTE: BRIGADIER GENERAL HILLMAN and CAPTAIN HOOK will participate in each of the panel discussions to represent their respective services.

*This panel discussion was included only in the first meeting.
THE DOCTOR AND THE HOSPITAL IN WAR

WAR SESSION

Program for Hospital Conferences

Monday, March 2, 1942

BROWN HOTEL
LOUISVILLE, KENTUCKY

Program
9:00–10:30 a.m., South Room

M. Joseph Henry, M.D., Louisville; Chief of Emergency Medical Services, Louisville Civilian Defense Area, Presiding.

Forum: Civilian Defense as Related to Hospitals
Led by William S. Keller, M.D., Columbus; Regional Medical Officer, Fifth Civilian Defense Region, United States Office of Civilian Defense.

10:45 a.m.–12:15 p.m., Crystal Ballroom

Joint Meeting for Physicians, Surgeons, and Hospital Representatives

W. Barnett Owen, M.D., Louisville; Chairman, Kentucky State Executive Committee, American College of Surgeons, Presiding.

The Organization and Functions of the Medical Department of the United States Army
Brigadier General Charles C. Hillman, Washington; Chief of Professional Service Division, Office of the Surgeon General, United States Army.

The Organization and Functions of the Medical Department of the United States Navy
Captain Frederick R. Hook, Washington; Chief, Surgical Service, United States Naval Hospital.

The Doctor and the Hospital in Civilian Defense
William S. Keller, M.D., Columbus.

12:30–2:00 p.m., Roof Garden

Joint Luncheon for Physicians, Surgeons, and Hospital Representatives

Elmer L. Henderson, M.D., Louisville; Chairman, Fifth Corps Area Committee, Procurement and Assignment Service, Presiding.

The Procurement and Assignment Service in Relation to the Medical Profession and to Hospitals
Lieutenant Colonel Sam F. Seeley, Executive Officer, Procurement and Assignment Service.

2:15–5:00 p.m., South Room

Panel Discussion: Special Problems Incident to the War as Affecting Hospitals
Conducted by Arden E. Hardgrove, Louisville; Superintendent, John N. Norton Memorial Infirmary.

Opening Statement—Hospitals and the War
Albert G. Hahn, Evansville; Administrator, Protestant Deaconess Hospital.

Organization of the Hospital for Civilian Defense
William S. Keller, M.D., Columbus.

The Procurement and Assignment Service and the Hospital
Lieutenant Colonel Sam F. Seeley, Executive Officer, Procurement and Assignment Service.

Priorities, and the Problem of Obtaining Hospital Equipment, Furnishings, and Supplies Essential to Rendering Adequate Services to the Patient
H. L. Dobbs, Louisville; Superintendent, Kentucky Baptist Hospital.

Maintaining Adequate Professional and Non-professional Personnel During Enlistment in the Military Services and Industrial Expansion
Lake Johnson, R.N., Lexington; Superintendent, Good Samaritan Hospital.

Maintaining Standards of Hospital Service During the War
Nellie G. Brown, R.N., Muncie; Superintendent, Ball Memorial Hospital.

Meeting the Increasing Costs of Hospital Service
Sister Rose, R.N., Indianapolis; Superintendent, St. Vincent’s Hospital; President, Indiana Hospital Association.

Conservation During Wartime, as Applying to Hospital Personnel, Labor and Supplies of All Kinds
Sister M. Michaela, R.N., Louisville; Superintendent, St. Joseph Infirmary.

6:00–10:00 p.m., Crystal Ballroom

Dinner for Physicians, Surgeons and Hospital Representatives, followed by Meeting
Irvin Abell, M.D., Louisville; Chairman, Board of Regents, American College of Surgeons, Presiding.

Activities of the American College of Surgeons and Their Relation to the Defense Program
Irvin Abell, M.D., Louisville.

Panel Discussion: Treatment of Burns
Leader: Joseph E. Hamilton, M.D., Louisville; Assistant Professor of Surgery, University of Louisville School of Medicine.

Panel Discussion: Prevention and Treatment of Shock
Leader: R. Arnold Griswold, M.D., Louisville; Professor and Head, Department of Surgery, University of Louisville School of Medicine.
AMERICAN COLLEGE OF SURGEONS

Priorities and Hospitals. "If we have an ounce of patriotism left in us, we are not going to ask for more goods and supplies than we really need to do our essential job. . . . In general, if a hospital can prove that it really needs additional facilities, it will receive assistance in obtaining the necessary construction materials. . . . In general, we in the hospital field have been well treated. This places upon us an obligation to do everything within our power to reciprocate by being our own policemen." (ALDEN B. MILLS, Managing Editor, The Modern Hospital, Chicago; Secretary, Committee on Priorities Affecting Civilian Hospital and Medical Requirements.)

CO-OPERATION OF THE PRESS

A reaction which should not be overlooked in connection with the War Sessions is that of the public, as represented by the press. Public understanding of the problems that confront the medical profession and hospitals will be a great help in meeting them. Following are brief extracts from a few of the many news articles that appeared in newspapers throughout the country:

New York Times, New York. "By the end of this year the United States Army expects to have requisitioned 16,000 more physicians and 3,000 more dentists and the Navy to have more than doubled its present force of 3,000 regular and reserve medical officers, representatives of the two branches disclosed today at an all-day conference of a thousand physicians held in Newark by the American College of Surgeons for medical men in New Jersey and Delaware."

Jacksonville Journal, Jacksonville, Florida. "Because of a meeting in Jacksonville yesterday, your son, brother, sweetheart or nephew might have a better chance to come out of this war alive. The point was not made that bluntly. Doctors always have a way of minimizing their work in the public eye. But the fact was clear to any layman who read between the long words and complicated outlines. . . . Large numbers of the doctors attending, still in civilian clothes, were expected to don uniforms at any time. . . ."

The Constitution, Atlanta, Georgia. "It was all right for Junior to eat green apples and turn up with a stomach-ache a couple of years ago. . . . But now the nation is at war. . . . Physicians and surgeons have more to do than to come out to see about ailing Junior. . . . So, keeping him from eating the apples or having the stomach-ache or anything else, for that matter, is a patriotic duty that includes Mama and Papa and Sister, too. . . ."

Sioux City Journal, Sioux City, Iowa. "As doctors are taken into the service from communities all over the country, there will be more patients for every doctor who remains. It is up to the people to stay as well as common sense hygiene might make possible. Proper food, rest, sanitation and the like would go a long way to keep us fit."

The Columbus Dispatch, Columbus, Ohio. "World War II is finding the best of medical science in the heart of the combat zone to treat today's wounded soldiers in a manner undreamed of in the first World War. How this is being done was outlined at the all-day 'war session' of the American College of Surgeons."

The Denver Post, Denver, Colorado. "Surgery in wartime differs from peacetime practice, just as driving a tank in the jungle differs from driving a truck over a civilian highway. To bring the problems of war medicine directly to doctors, surgeons, medical students and hospital officials of Colorado and Wyoming, a 'War Session' of the American College of Surgeons was held here Tuesday, with high officials of the Army, Navy and the OCD as speakers."

Los Angeles Evening Herald and Express, Los Angeles, California. "The day of the battleship porthole, traditional in American naval lore since the days of John Paul Jones, is gone forever. Development of modern aerial warfare has removed the porthole from the sides of the Navy's big battlecruisers. Captain Frederick R. Hook today told a war session of the American College of Surgeons, adding, 'Bombs that miss ships but fall in the immediate vicinity explode with such violence that glass in the portholes is shattered with resulting casualties in the compartments. As a result, no portholes are being built in new ships, and those in the older ships are being blocked out.'"

The Deseret News, Salt Lake City, Utah. "Civilians will be faced with a rationing of doctors, hospital facilities and medical supplies and equipment for the 'duration,' leading speakers declared today at the war conference of medical and hospital personnel of Utah and Idaho, which presented a concentrated picture of the doctor in wartime, and explained the streamlined efforts of the Army and Navy and the medical profession to get the maximum protection to the armed forces, the civilian populace in case of attack, and the average citizen with a normal medical problem."

NATIONAL RESEARCH COUNCIL

The National Research Council has been adapted to war needs. The description which appears in this issue of the Division of Medical Sciences and the lists of members and committees of the Division is incorporated in this War Issue for purposes of ready reference. Also listed are the titles of Military Surgical Manuals which are being published by the National Academy of Science through the National Research Council and the Surgeons General of the United States Army and Navy.

BIBLIOGRAPHY

There is presented in this BULLETIN, a selected bibliography of articles and books related to war medicine and surgery. This is included in the War Issue to add to its usefulness for reference purposes.
PARTICIPANTS IN WAR SESSIONS OF THE AMERICAN COLLEGE OF SURGEONS

MARCH 2, 1942 TO MAY 28, 1942

PANEL DISCUSSIONS*

PREVENTION AND TREATMENT OF SHOCK
Louisville: R. ARNOLD GRISWOLD, M.D., Louisville.
Nashville: JAMES A. KIRTLER, JR., M.D., Nashville.
St. Louis: WARREN H. COLE, M.D., Chicago.
Chicago: DALLAS B. PREMISTER, M.D., Chicago.
Detroit: FREDERICK A. COLLER, M.D., Ann Arbor, and
GROVER C. PENBERTHY, M.D., Detroit.
Columbus: CARL H. LENHEART, M.D., Cleveland.
New Orleans: MICHAEL E. DEBAKEY, M.D., New Orleans.
Atlanta: LLOYD NOLAND, M.D., Fairfield, Ala.
Jacksonville: LLOYD NOLAND, M.D., Fairfield, Ala.
Durham: J. DERVL HART, M.D., Durham.
Baltimore: ALFRED BLAOCK, M.D., Baltimore.
Harrisburg: NORMAN E. FREEMAN, M.D., Philadelphia.
Newark: JOHN H. MULHOLLAND, M.D., New York.
New Haven: SAMUEL C. HARVEY, M.D., New Haven.
Portland, Me.: CHARLES C. LUND, M.D., Boston.
Albany: JOHN H. MULHOLLAND, M.D., New York.
Denver: FREDERICK R. HARPER, M.D., Denver, and
MICHAEL E. DEBAKEY, M.D., New Orleans.
Salt Lake City: KENNETH B. CASTLETON, M.D., Salt Lake City.
Portland, Ore.: THOMAS M. JOYCE, M.D., Portland, Ore.
San Francisco: EMILE HOLMAN, M.D., San Francisco.
Los Angeles: VERNE C. HUNT, M.D., Los Angeles.
Phoenix: CLARENCE J. BERNE, M.D., Los Angeles.
Dallas: ROBERT M. MOORE, M.D., Galveston.
Minneapolis: HABIB. PH. HALL, M.D., Minneapolis.
Madison: ERWIN R. SCHMIDT, M.D., Madison.
Omaha: CHARLES M. WILHELMJ, M.D., Omaha.
Oklahoma City, and CLIFFORD C. NESSELRODE, M.D.,
KANSAS CITY, KAN.

TREATMENT OF WOUNDS OF SOFT PARTS
Louisville: WILLIS D. GATCH, M.D., Indianapolis.
Nashville: BARNEY BROOKS, M.D., Nashville.
St. Louis: THOMAS G. CRR, M.D., Kansas City.
Chicago: RICHARD J. BENNETT, JR., M.D., Chicago.
Detroit: CHARLES G. JOHNSTON, M.D., Detroit.
Columbus: WILLIAM A. ALTENEUIER, M.D., Cincinnati.
New Orleans: URBAN MAES, M.D., New Orleans.
Atlanta: JAMES M. MASON, M.D., Birmingham.
Jacksonville: EDWIN A. HALL, M.D., Jacksonville.
Durham: CARRINGTON WILLIAMS, M.D., Richmond.
Baltimore: WARFIELD M. FIFOR, M.D., and PERRIN H. LONG, M.D., Baltimore.
Harrisburg: JOHN S. LOCKWOOD, M.D., Philadelphia.
Newark: JOHN J. MOONHEAD, M.D., New York.
New Haven: CLARENCE E. BIRD, M.D., Providence.
Portland, Me.: FRANK H. LAHEY, M.D., Boston.
Albany: WM. CRAWFORD WHITE, M.D., New York.
Denver: GEORGE B. PARCHARD, M.D., Denver.
Salt Lake City: MARTIN C. LINDEM, M.D., Salt Lake City, and MICHAEL E. DEBAKEY, M.D., New Orleans.
Portland, Ore.: HOMER D. DUDLEY, M.D., Seattle, and
NEIL OWENS, M.D., New Orleans.
San Francisco: H. GLENN BELL, M.D., San Francisco.
Los Angeles: MICHAEL E. DEBAKEY, M.D., New Orleans.
Phoenix: LAWRENCE CRAFFIN, M.D., Los Angeles.
Dallas: JOHN W. DUCKETT, M.D., Dallas.
Minneapolis: OWEN H. WANGENSTEEN, M.D., and
CLARENCE DENNIS, M.D., Minneapolis.
Madison: CARL W. EBERBACH, M.D., Milwaukee.
Omaha: THOMAS G. ORE, M.D., Kansas City, Mo.
Oklahoma City: THOMAS G. ORE, M.D., Kansas City, Mo, and L. HAYNES FOWLER, M.D., Minneapolis.

TREATMENT OF BURNS
Louisville: JOSEPH E. HAMILTON, M.D., Louisville.
Nashville: NEAL OWENS, M.D., New Orleans.
St. Louis: JAMES B. BROWN, M.D., St. Louis.
Chicago: SUMNER L. KOCH, M.D., Chicago.
Detroit: CONRAD R. LAM, M.D., Detroit.
Columbus: VINSTON SILER, M.D., Cincinnati.
New Orleans: NEAL OWENS, M.D., New Orleans.
Atlanta: JOHN D. MARTIN, M.D., Atlanta.
Jacksonville: EVERETT IDRIS EVANS, M.D., Richmond.
Durham: EVERETT IDRIS EVANS, M.D., Richmond.
Baltimore: HARRY C. HULL, M.D., Baltimore.
Harrisburg: JONATHAN E. RHODES, M.D., Philadelphia.

*At each of the War Sessions the representatives of the United States Navy and the United States Army participated in the panel discussions on behalf of their respective services.
FRACTURES
Louisville: R. Arnold Griswold, M.D., Louisville.
Nashville: J. Spencer Speed, M.D., Memphis.
St. Louis: J. Albert Key, M.D., St. Louis.
Chicago: Paul B. Magnuson, M.D., Chicago.
Detroit: Carl E. Badgley, M.D., Ann Arbor.
Columbus: J. Huber Wagner, M.D., Pittsburgh.
Atlanta: Thomas P. Goodwyn, M.D., Atlanta.
Durham: Lenox D. Baker, M.D., Durham.
Baltimore: George E. Bennett, M.D., Baltimore.
Harrisburg: William L. Estes, Jr., M.D., Bethlehem.
Newark: Robert H. Kennedy, M.D., New York.
New Haven: George W. Van Gorder, M.D., Boston.
Portland, Me.: Henry C. Marble, M.D., Boston.
Albany: Clay Ray Murray, M.D., New York.
Denver: Hamilton I. Barnard, M.D., Denver.
Salt Lake City: Paul S. Richards, M.D., Bingham Canyon.
Portland, Ore.: Leo S. Lucas, M.D., Portland, Ore.
San Francisco: LeRoy C. Abbott, M.D., San Francisco.
Los Angeles: John C. Wilson, M.D., Los Angeles.
Phoenix: Alfred E. Gallant, M.D., Los Angeles.
Dallas: William B. Careell, M.D., Dallas.
Minneapolis: Paul B. Magnuson, M.D., Chicago.
Madison: Herman S. Schum, M.D., Milwaukee.
Omaha: Robert D. Schrock, M.D., Omaha, and
Arthur Steinheil, M.D., Iowa City.
Oklahoma City: Earl D. McBride, M.D., Oklahoma City.
Portland, Ore.: Michael E. DeBakey, M.D., New
Orleans.
San Francisco: Leo E. Lofesser, M.D., San Francisco,
and Michael E. DeBakey, M.D., New Orleans.
Los Angeles: Frank S. Dolley, M.D., Los Angeles.
Phoenix: Victor S. Randolph, M.D., and
Michael E. DeBakey, M.D., New Orleans.
New Orleans: Thomas J. Kinnella, M.D., Minneapolis.
Madison: Joseph W. Gale, M.D., Madison.
Omaha: Herbert H. Davis, M.D., Omaha.
Oklahoma City: John R. Payne, M.D., Minneapolis.

TREATMENT OF WAR INJURIES TO THE SKULL
AND FACE
Louisville: R. Glen Spurling, M.D., Louisville, and
James B. Brown, M.D., St. Louis.
Nashville: Cobb Pilcher, M.D., and Beverly Douglas,
M.D., Nashville.
St. Louis: Ernest Sachs, M.D., and Louis T. Byars,
Jr., M.D., St. Louis.
Chicago: Frederick Christophl, M.D., Evanston.
Detroit: Max Minor Peet, M.D., Ann Arbor, and
Ferdie Smith, M.D., Grand Rapids.
Columbus: Alexander T. Bunts, M.D., and Paul G.
Mooke, M.D., Cleveland.
New Orleans: Dean H. Echols, M.D., New Orleans.
Atlanta: Edgar F. Fincher, M.D., Atlanta.
Jacksonville: James G. Lyerly, M.D., Jacksonville.
Durham: J. H. Meridith, M.D., Richmond.
Baltimore: Walter E. Dansy, M.D., and J. Stage
Davis, M.D., Baltimore.
Harrisburg: Francis C. Grant, M.D., and Robert H.
Ivy, M.D., Philadelphia.
Newark: Byron Stookey, M.D., New York.
New Haven: Wm. John German, M.D., New Haven.
Portland, Me.: Gilbert Hornb, M.D., Boston.
Albany: Joseph E. J. King, M.D., New York.
Denver: James R. Jaeger, M.D., and Thomas E. Car
mody, M.D., Denver.
Salt Lake City: Neal Owen, M.D., New Orleans.
Portland, Ore.: John Raff, M.D., and Charles E.
Gurney, M.D., Portland, Ore.
San Francisco: Howard C. Naffziger, M.D., San Francisco.
Los Angeles: Rupert B. Raney, M.D., and Emil
Tohen, M.D., Los Angeles.
Phoenix: Howard C. Naffziger, M.D., San Francisco.
Dallas: S. R. Snodgrass, M.D., and Truman G.
Blocker, Jr., M.D., Galveston.
Minneapolis: A. W. Adson, M.D., and J. B. Erek
M.D., Rochester, Minn.
Madison: Loyd Davis, M.D., Chicago.
Omaha: George S. Baker, M.D., Rochester, Minn., and
Charles W. McLaughlin, Jr., M.D., Omaha.
Oklahoma City: George S. Baker, M.D., Rochester.
Minn., and Louis T. Byars, Jr., M.D., St. Louis.
PARTICIPANTS IN WAR SESSIONS

THE ORGANIZATION AND FUNCTIONS OF THE MEDICAL DEPARTMENT OF THE UNITED STATES ARMY
Chicago, Detroit, and Columbus: LIEUTENANT COLONEL ROGER G. PRENTISS, JR., M.C., U.S.A., Washington, D. C.
New Haven, Portland (Maine), and Albany: COLONEL FRED W. RANKIN, M.C., U.S.A., Washington, D. C.
Phoenix, Dallas, Minneapolis, Madison, Omaha, and Oklahoma City: LIEUTENANT COLONEL B. NOLAND CARTER, M.C., U.S.A., Washington, D. C.

THE ORGANIZATION AND FUNCTIONS OF THE MEDICAL DEPARTMENT OF THE UNITED STATES NAVY
CAPTAIN FREDERICK R. HOOK, M.C., U.S.N., Washington, D. C., presented this subject at each of the War Sessions of the American College of Surgeons, March 2 to May 28, 1942, inclusive.

THE DOCTOR AND THE HOSPITAL IN CIVILIAN DEFENSE
Louisville and Columbus: WILLIAM S. KELLER, M.D., Columbus.
St. Louis, Chicago, Detroit, and Madison: JOHN S. COULTER, M.D., Chicago.
Atlanta, Jacksonville, and Durham: BURT A. DYAR, M.D., Omaha.
Baltimore and Harrisburg: W. ROSS CAMERON, M.D., Baltimore.
Newark and Albany: HENRY VAN ZILE HYDE, M.D., New York.
New Haven: DUDLEY A. REEKIE, M.D., Boston.
Portland (Maine): A. WILLIAM REGGIO, M.D., Boston.
Denver, Dallas, and Oklahoma City: W. B. RUSS, M.D., San Antonio.
Salt Lake City, Portland (Oregon), and San Francisco: L. A. SCHEETE, M.D., San Francisco.

Los Angeles and Phoenix: FORD WILLIAMS, M.D., San Francisco.
Minneapolis and Omaha: WALLACE HUNT, M.D., Omaha.

THE PROCUREMENT AND ASSIGNMENT SERVICE
Nashville, St. Louis, and Columbus: E. L. HENDERSON, M.D., Louisville.
Chicago and Detroit: CHARLES PHIFER, M.D., Chicago.
New Orleans and Durham: EDGAR GREENE, M.D., Atlanta.
Atlanta and Jacksonville: JAMES E. PAULLIN, M.D., Atlanta.
Harrisburg: ARTHUR M. SHIPLEY, M.D., Baltimore.
New Haven, Portland (Maine), and Albany: FRAK H. LANEY, M.D., Boston.
Denver: ROY W. FOUTS, M.D., Omaha.
Salt Lake City, Portland (Oregon), San Francisco, Los Angeles, Phoenix, Dallas, Minneapolis, Madison, Omaha, and Oklahoma City: HAROLD S. DIEHL, M.D., Minneapolis.

ACTIVITIES OF THE AMERICAN COLLEGE OF SURGEONS AND THEIR RELATION TO THE DEFENSE PROGRAM
Louisville, Nashville, and Chicago: IRVIN ARELL, M.D., Louisville.
St. Louis: EVARTS A. GRAHAM, M.D., St. Louis.
Detroit, Albany, and Madison: FREDERICK A. BESELY, M.D., Waukegan.
Columbus: GEORGE CRILE, M.D., Cleveland.
New Orleans: IDYS MIMS GAGE, M.D., New Orleans.
Atlanta: JAMES M. MASON, M.D., Birmingham.
Jacksonville: FREDERICK J. WAAS, M.D., Jacksonville.
Durham: FRANK K. BOLAND, M.D., Atlanta.
Baltimore: ARTHUR M. SHIPLEY, M.D., Baltimore.
Harrisburg: GEORGE P. MULLER, M.D., Philadelphia.
Newark: HENRY W. CAVE, M.D., New York.
New Haven: ARTHUR W. ALLEN, M.D., Boston.
Portland (Maine), Denver, Salt Lake City, Portland (Oregon), Phoenix, Dallas, Minneapolis, Omaha, and Oklahoma City: MALCOLM T. MACEACHERN, M.D., Chicago.
San Francisco: HOWARD C. NAFFZIGER, M.D., San Francisco.
Los Angeles: VERNE C. HUNT, M.D., Los Angeles.
1942 CLINICAL CONGRESS CANCELLED

The annual Clinical Congress of the American College of Surgeons, which was scheduled to be held in Cleveland November 17 to 20, 1942, was cancelled by the Board of Regents of the College at a meeting held in Chicago, Wednesday morning, October 14. Motivated primarily by patriotism, the Regents were influenced by the present conditions surrounding the general war program which have led to a greater burden on the members of the surgical profession in their local communities as a result of the large proportion of the profession which is serving with the armed forces. The Regents by this action took cognizance of the desire of the profession to do nothing which would interfere with the successful prosecution of the war program such as would be caused by temporary absence of its members from civilian duties during the period of the Congress, embarrassment of the transportation system, and interference with the work of the local profession in Cleveland in preparations and presentations incident to such a meeting.

At the annual meeting of the Board of Regents which will be held in December, fellowship in the College will be conferred in absentia on the class of initiates of 1942, as there will be no Convocation exercises. At the same time the list of hospitals, cancer clinics, medical services in industry, hospitals conducting programs of graduate training in surgery, and medical motion pictures, that meet the College standards, will be approved and later published.

All present Officers, Regents, Governors, and Standing Committees will continue in office.

NOTE: The International Society of Surgery (now confined to the Western Hemisphere) which was to have met in special session on November 20, at the close of the Cleveland Clinical Congress, under the presidency of Professor José Arce of Buenos Aires, has also cancelled its meeting.
Statement on optimal access

The American College of Surgeons Regental Committee on Optimal Access developed the following statement. The Board of Regents approved the statement at their February 8–9, 2013, meeting in Chicago, IL.

The American College of Surgeons recognizes the critical relationship between the health of a patient and access to care. This association is strongly documented with respect to conditions requiring surgical care specifically, including interventions for trauma, cancer, heart, and vascular disease, renal disease, and other correctable conditions that interfere with normal development, employment, and independent living.

Access to surgical care is affected by socioeconomic status, age, gender, level of education, race, ethnicity, health care availability, and geographic distance. While insurance status proves to be the most reliable surrogate for prediction of outcome differences, underuse, and delay of surgery, rural location and limited access to high volume hospitals are additional mechanisms that lead to inequities in surgical outcomes. Despite these factors, several studies have shown that where access to care is equal outcome disparities become indiscernible.¹

Optimal access is the key to quality of care. Efforts to increase surgical presence and availability are crucial to providing the right care, at the right time, in the right place. Optimal quality, the centerpiece of the mission of the American College of Surgeons, is not achievable without optimal access. ♦

Governors’ Socioeconomic Issues Committee

by Joseph J. Tepas III, MD, FACS

The Socioeconomic Issues Committee (SEIC) of the American College of Surgeons (ACS) Board of Governors (B/G) had another busy year. The SEIC has become the largest Governors’ committee, which reflects the broad expanse of socioeconomic factors that affect virtually every aspect of daily surgical practice. Interactions among members at the committee’s annual meeting at the Clinical Congress, and through multiple conference calls throughout the year, clearly reflect the numerous socioeconomic issues that affect the delivery of surgical care in the U.S. and throughout the world.

**Humanitarianism and volunteerism**

As has been recent practice, the SEIC again had the privilege of reviewing nominations for the ACS/Pfizer Surgical Volunteerism Awards and Surgical Humanitarian Award. The increasing number of candidates for these awards demonstrates the fact that many Fellows are committed to the principles of Operation Giving Back. Their donations of time, talent, and financial support enable programs that bring surgical care and training to patients and health care professionals throughout the world as well as underserved areas of the U.S. The accomplishments of those whom the SEIC selected were described in the September 2012 issue of the *Bulletin of the American College of Surgeons*; however, virtually all of the nominees deserve acclaim for their impressive records of selfless dedication to serving where help is needed most.

The inclusion of Robin T. Petroze, MD, a general surgical resident at the University of Virginia, Charlottesville, among the recipients of the 2012 awardees was particularly noteworthy. Dr. Petroze’s work in helping to develop a trauma system in Rwanda demonstrates how residents now have real opportunities to dedicate some of their training time to participation in

humanitarian programs and receive appropriate credit from the Accreditation Council on Graduate Medical Education.

**Changing practice paradigm**

On the domestic front, the SEIC produced a white paper described in last year’s report, which was published in the October 2012 issue of the Bulletin.† Titled Surgical Care and Career Opportunities in a Changing Practice Paradigm, the paper is designed to provide insights and information to the surgeon who is facing a change in practice paradigm, either voluntarily or as the result of the continued amalgamation of clinical care into large, integrated health care delivery systems. Recognizing that these changes in practice affect both the mature surgeon and the finishing trainee, the paper is intended to complement the guidelines regarding hospital employment recently published in the ACS booklet titled Surgeons As Institutional Employees: A Strategic Look at the Dimensions of Surgeons As Employees of Hospitals. Developed by the ACS Division of Advocacy and Health Policy, the brochure was disseminated with the February 2013 issue of the Bulletin.

Surgical Care and Career Opportunities in a Changing Practice Paradigm is currently under peer review for publication in the *Journal of the American*

Recognizing that these changes in practice affect both the mature surgeon and the finishing trainee, the paper is intended to complement the guidelines regarding hospital employment recently published in the ACS booklet titled *Surgeons As Institutional Employees: A Strategic Look at the Dimensions of Surgeons As Employees of Hospitals*.

*College of Surgeons* and includes a six-part discussion of critical socioeconomic factors that affect many of the processes described in *Surgeons As Institutional Employees*. The white paper begins with an overview of the characteristics of the changing health care environment, including the impact of health care reform legislation and emerging models of funding for clinical care. The next four sections are designed to assist the surgeon in assessing a prospective employer or partner. These portions of the document focus on identifying critical characteristics that ensure the type of practice or health care organization under consideration will offer professional and personal satisfaction and will allow the surgeon to remain an effective and meaningful advocate for the surgical patient and for optimal quality of care.

The final section of the document addresses the new “product” of surgical practice. In the evolving systems of shared risk and shared reward, surgeons and all acute care providers will find that productivity will be measured based on quality of care provided rather than simply volume of relative value units produced and reported. This new era will require that acute care professionals work with primary care providers to ensure that a population’s chronic diseases are effectively managed so that when acute events do occur, patients are optimally prepared to sustain the acute insult with least potential for deterioration of related or unrelated chronic comorbidities. The acute care provider—among whom the surgical specialist is often most prominent—must, in turn, earn the trust of the primary care practitioner by ensuring that patients requiring surgical intervention receive the highest quality of care.

The mandate is clear: now more than ever surgeons must advocate for optimal quality across the continuum of patient care, define quality in objective terms, and actively lead efforts to evaluate the provision of care to ensure that quality is both optimal and continuously improved. Recognizing that the new paradigm demands a surgical “product” that is as focused on quality assurance as it is on number of surgical interventions, the SEIC offers in this final section a first glimpse at the pathway to the future. Surgeons who remain disengaged from quality improvement efforts will become technical commodities in the professional services cost center of massive integrated health care delivery systems. Those who understand and embrace the full commitment to optimal surgical care will remain the patient’s most important advocate and will guide, if not lead, these emerging systems of care.

**Future directions**

The evolving redesign of the B/G will provide current and future Governors with even greater opportunities to focus their talents and time on College activities that will enhance focus and productivity. In so doing, the Governors will become even more effective in their role as the voice and agents of the Fellows.

In light of the many broad issues discussed previously and the ever-changing socioeconomic environment in which Fellows must practice effectively, the committee’s objectives will be redefined to reflect the broad nature of its focus and accomplishments over the past five years. The SEIC will become the Health Policy and Advocacy Workgroup, which resides under the Advocacy pillar of the redesigned B/G—same people, same mission, yet working with more efficiency to continue the same commitment to excellence for surgical care of all of our patients. ✦
As the Board of Governors is currently reorganizing its committee structure to align with the major pillars of the College, members of the Committee to Study the Fiscal Affairs of the College and the Executive Committee of the Board of Governors determined that this committee was essential to provide transparency to the Board of Governors and should continue to exist.

Maintaining transparency
As the Board of Governors is currently reorganizing its committee structure to align with the major pillars of the College, members of Committee to Study the Fiscal Affairs of the College and the Executive Committee of the Board of Governors determined that this committee was essential to provide transparency to the Board of Governors and should continue to exist.

Over the past year, the committee has met by conference call and in person to fulfill its responsibilities and to provide a transparent review of the College’s financial matters.

Financial stability
The committee reviewed the consolidated financial statements of the College for fiscal year APR 2013.
2012 and is pleased to report that the College remains fiscally sound. In addition, the committee has reviewed the 2012 resource allocation data as well as the discrete cost methodology adopted by the College. Review of these data indicates that resource allocation is consistent with the strategic goals and objectives of the College and is well aligned with the organization's mission.

The committee has also reviewed the allocation of dues to dues-supported programs. Once again, dues-supported program costs exceed dues revenue by a considerable amount. This disparity highlights the value of ACS membership given our current dues structure. ACS staff provided the 2013 budget projections as well as the 2014 preliminary budgets and forecast that the committee reviewed. Review of these data indicates the College’s Finance and Accounting staff are using strong budgeting practices.

The Investment Subcommittee of the Finance Committee of the Board of Governors met during the 2012 Clinical Congress and, at press time, was scheduled to meet again in March 2013. The investment performance report provided by Cambridge Associates indicates that the College is using a sound investment strategy that is consistent with the organization's goals.

The Board of Governors’ Committee to Study the Fiscal Affairs of the College serves an important role in assuring the members of the College and the Board of Regents that the ACS is in sound fiscal condition and has the appropriate resources to meet the strategic goals of the organization. ♦
Governors’ Committee on Chapter Relations

by John P. Rioux, MD, FACS

The Board of Governors’ Committee on Chapter Relations (GCCR) had a very busy year. Last year, the GCCR was structured into 10 geographic areas representing groups of state chapters. Following the annual meeting at the 2011 Clinical Congress, the committee functioned during 2012 principally through the use of conference calls. These calls included discussion of several individual subcommittee projects.

Meanwhile, the Board of Governors (B/G) has been undergoing a redesign under the direction of B/G Chair Lena Napolitano, MD, FACS. An ad hoc committee was appointed for this purpose at the close of the Governors’ meetings held during the 2012 Clinical Congress. Although still a work in progress, some aspects of that redesign will be discussed in this summary of the GCCR’s activities over the last year.

Increasing diversity
As an advocate and resource for all chapters of the American College of Surgeons (ACS), the GCCR has evolved into a diverse assembly of Governors representing U.S. Fellows and as an emerging voice for ACS Fellows throughout the world. The ACS now has 65 U.S. chapters, two Canadian chapters, and 37 international chapters. All chapters are increasingly emphasizing inclusion of women and minorities, as well as Fellows representing different surgical subspecialties, when selecting ACS Governors, Council Members, and Officers.

The International Governors are currently represented under the umbrella of the GCCR as the International Affairs Subcommittee; however, due to their recent growth and increased visibility, they will soon be organized into the Chapter Activities International Workgroup. Ray Price, MD, FACS, a general surgeon from Murray, UT, currently chairs the subcommittee and will lead the workgroup as well. Both the national and the international workgroups will be part of the Member Services pillar of the Governors’ new organizational structure under the leadership of Patricia L. Turner, MD, FACS, Director of the ACS Division of Member Services, working with Fabrizio Michelassi, MD, FACS, and will be composed almost exclusively of Governors. During last year’s committee meeting the GCCR voted unanimously to include a volunteer group of Chapter Executives as consultant members of the committee, reflecting the close partnership that exists between chapter leaders and their management teams.

Advocacy
The Advocacy and Coalitions Subcommittee, chaired by David McAneny, MD, FACS, associate professor of surgery, Boston University School of Medicine, continued its charge to provide

MEMBERS OF THE GOVERNORS’ COMMITTEE ON CHAPTER RELATIONS

RENAMED:
CHAPTER ACTIVITIES (DOMESTIC) WORKGROUP
John P. Rioux, MD, FACS, Chair
Samual Robert Todd, MD, FACS, Vice-Chair

John H. Armstrong, MD, FACS
Miguel Angel Cainzos, MD, FACS
Gregory Spicer Cherr, MD, FACS
David W. Dexter, MD, FACS
Stephen Edmund Ettinghausen, MD, FACS
Daniel S. Johnson, MD, FACS
Matthew B. Martin, MD, FACS
Eric Zenko Matayoshi, MD, FACS
David B. McAneny MD, FACS
Raymond R. Price, MD, FACS
Gary L. Timmerman, MD, FACS
Bruce J. Waring, MD, FACS

CHAPTER ACTIVITIES (INTERNATIONAL) WORKGROUP
Quyen D. Chu, MD, FACS
Jamal J. Hoballah, MD, FACS
Fabrizio Michelassi, MD, FACS

STAFF
ACS Division of Member Services:
Patricia L. Turner MD, FACS, Director
Mark Chou
Jamie Kazay
Donna Tieberg
synergy to national advocacy efforts through review of grants from state chapters participating in the ACS Chapter Advocacy Grant Program. The College provided $35,000 in Lobby Day funding grants, an average of $2,200 per grant, to state chapters for advocacy efforts. Participating chapters included Alabama, Northern California, Connecticut, Florida, Georgia, Illinois and Metro Chicago, Indiana, Kansas, Maine, Massachusetts, Michigan, North Carolina, Ohio, Oregon, Tennessee, and Virginia.

At press time, plans were under way to launch a grassroots advocacy program through which Fellows will regularly visit their U.S. legislators and congressional staff in their district offices. The Massachusetts Chapter of the ACS is working with the Division of Advocacy and Health Policy to begin pilot testing the plan. Details will be published in the Bulletin.

This subcommittee also assisted in reviewing and selecting recipients of the Arthur Ellenberger Award for Excellence in State Advocacy. This award is named for Art Ellenberger, the longtime, now-retired Executive Director of the New Jersey Chapter and expert in grassroots and advocacy. The award is presented to “recognize a career of outstanding leadership and distinguished service and commitment to protecting patients’ access to high-quality surgical care by their involvement with their state’s legislative regulatory process.” The Advocacy and Coalitions Subcommittee provided recommendations to the final selection committee. In 2012, John Maa, MD, FACS, a general surgeon in San Francisco, CA, received the Ellenberger Award in recognition of his work in state advocacy with the Northern California Chapter.

**Best practices**

Each year at Clinical Congress, ACS chapter leaders from Maine to Hawaii convene to discuss what works and what doesn’t when it comes to making their chapters successful. The event is a must-attend meeting for incoming officers of state chapters and those interested in chairing committees within the chapter. In years past, the meeting was called the Chapter Showcase, but it was recently renamed Best Practices to Keep Chapters Running Smoothly.

The 2012 Best Practices session focused on four specific aspects of chapter administration:

- Managing the chapter’s finances
- Encouraging residents’ involvement
- Providing self-assessment continuing medical education (CME) programming at chapter meetings
- Engaging in strategic planning

A brief synopsis is provided here, but the presentations in their entirety may be found on the ACS website at www.facs.org/about/chapters/showcase2012.html.

**Financial management.** Running a state chapter is much like running a small business. Some chapters are of a sufficient size that a professional management firm is paid to conduct the day-to-day business of the chapter, which may include the collection of dues, planning of executive committee and council meetings, and so on. Larger chapters with a diverse range of activities may have robust operating budgets and host large annual meetings, which may translate into a significant number of financial transactions. Keeping up with this complexity requires some basic accounting and financial management skills.

**Resident involvement.** Astute chapter leaders recognize the value of recruiting members into the College early, and surgical residency is an excellent place to start. Most chapters and the College itself provide significant financial relief for residents to attend annual chapter meetings. Popular resident sessions, such as Surgical Jeopardy and resident paper competitions, also serve to promote another source of scholarship support that surgeons in training may pursue.

**Self-assessment CME.** Most medical and surgical boards now require that a certain percentage of CME credits obtained to satisfy Maintenance of Certification requirements
Each year at Clinical Congress, ACS chapter leaders from Maine to Hawaii convene to discuss what works and what doesn’t when it comes to making their chapters successful.

involve self-assessment activities (SA CME). In other words, it is no longer sufficient to sign in to a lecture, listen, and return home. The activity must involve an assessment of the attendee’s comprehension of the material presented. Self-assessment may take place in the form of a written or electronic question-and-answer exercise that assesses the surgeon’s understanding of the material presented in the CME program—most commonly a short test following the presentation. Many chapters have incorporated SA CME into their annual meetings and there are a few details that must be attended to in this regard, such as guidelines regarding question format and the availability of online testing.

• Strategic planning. A formal planning process to identify the mission of any organization is central to its success. Many large corporations regularly involve several levels of the organization in the process of strategic planning. Since chapters vary widely depending on their geographic location, size, and make-up, the strategic planning process can be tailored to have maximal effect to achieve the goals of the chapter.

Each ACS chapter has a core mission and carries out activities that are specific to its mission. Some chapters are heavily involved in advocacy, retaining lobbyists for legislative efforts at the state level; others work through their state medical societies to achieve this goal. A number of chapters offer high-quality annual meetings that feature authoritative speakers on surgical, legislative, and other topics. The organization and planning of a state chapter meeting is a significant undertaking. Attendees at the 2012 Best Practices to Keep Chapters Running Smoothly session in Chicago, IL, suggested that the 2013 session include a presentation on the crucial factors leading to a successful annual meeting of a chapter. A session on planning annual meetings will be presented at 2:30 pm on Tuesday, October 8, at the 2013 Clinical Congress in Washington, DC, along with another session focusing on the Chapter Performance Checklist.

Promoting ACS goals and mission
A key component of a chapter’s success rests in part in its ability to mirror the activities of the College. For example, chapters that have councils composed of Fellows who are involved in the Commission on Cancer, the Committee on Trauma, and other key College programs, such as the ACS National Surgical Quality Improvement Program®, tend to have a depth and breadth of activity in these areas that spills over into the entire chapter membership. One way a chapter may assess how well it is doing in terms of fulfilling the goals and objectives of the College is through thoughtful completion of the Chapter Performance Checklist. Far from a report card on chapter activities, this field guide to success was developed more than a decade ago by what will soon become the Chapter Activities National Workgroup under the Board of Governors’ redesign. The checklist is useful in helping chapters to identify activities that will better serve its members while maintaining the focus of the overall mission of the College.

Time of transition
As the Board of Governors redesign progresses, the GCCR will transition into the Chapter Activities National Workgroup, renewed and re-invigorated to provide state chapters with the resources they need to be successful. The Chapter Activities International Workgroup will be given additional visibility, and we can undoubtedly expect our international surgical colleagues to offer great ideas and projects that will increase the College’s stature throughout the world. The chapter representation on the Health Policy and Advocacy Group will certainly strengthen the ties between national and state advocacy efforts. Governors interested in serving the College by improving their state chapters are encouraged to get involved in the endeavors of these evolving groups of extraordinary College leaders.

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PQRS reporting in 2013

The Centers for Medicare & Medicaid Services (CMS) has continued the Physician Quality Reporting System (PQRS) into 2013 as required under the Medicare Improvements for Patients and Providers Act of 2008. PQRS is the first CMS-crafted national program to link the reporting of quality data to physician payment. The Affordable Care Act authorized incentive payments for eligible professionals (EPs) who successfully participate in the program through 2014.

The incentive payment for the 2013 reporting year is 0.5 percent of the total allowed charges for Medicare Part B professional services covered under the physician fee schedule and furnished during the reporting period. For reporting year 2014, EPs may earn an incentive payment of 0.5 percent of their total estimated allowed charges for Medicare Part B physician fee schedule-covered professional services furnished during the respective reporting periods. If EPs are unsuccessful PQRS participants in 2013, they will be subject to a penalty in 2015. Table 1 on page 57 summarizes the payments during these years.

What are some of the differences between the requirements in the 2012 PQRS and the 2013 PQRS?

CMS released the Medicare physician fee schedule final rule for calendar year (CY) 2013 on November 1, 2012. In the final rule, CMS finalized several changes to the PQRS for 2013. Major program changes are highlighted in Table 2 on page 57.

It is important to note that the 2013 PQRS includes 259 quality measures (individual measures) and 22 measures that are part of a 2013 measures group. Whereas 2012 PQRS quality measures may be continued in the 2013 PQRS, measure specifications may have been updated for the new program year. Surgeons who are currently reporting in 2012 PQRS should review the 2013 PQRS Measure Specifications Manual for Claims and Registry Reporting of Individual Measures for updates and changes. Surgeons can also visit the American College of Surgeons (ACS) PQRS website for more information on the program: http://www.facs.org/ahp/pqri/.

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How do I use the measure specifications manual?

The 2013 PQRS Measure Specifications Manual for Claims and Registry Reporting of Individual Measures should be used to identify measures applicable for professional services that a practice routinely provides. The manual can be accessed at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html. Next, select those measures that make sense based upon prevalence and volume in the practice, as well as your individual or practice performance analysis and improvement priorities.
TABLE 1.
PQRS PAYMENT INCENTIVES AND PENALTIES

<table>
<thead>
<tr>
<th>REPORTING YEAR</th>
<th>INCENTIVE</th>
<th>PENALTY</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>0.50%</td>
<td>-</td>
</tr>
<tr>
<td>2014</td>
<td>0.50%</td>
<td>-</td>
</tr>
<tr>
<td>2015</td>
<td>-</td>
<td>1.50%</td>
</tr>
<tr>
<td>2016 and beyond</td>
<td>-</td>
<td>2.00%</td>
</tr>
</tbody>
</table>

TABLE 2.
2013 PQRS CHANGES

<table>
<thead>
<tr>
<th>2012 PQRS</th>
<th>2013 PQRS</th>
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</thead>
<tbody>
<tr>
<td>CMS sought to eliminate the distinction between group practice reporting option (GPRO) GPRO I and GPRO II for group practices. The two groups will instead be consolidated such that a group practice GPRO will consist of 25 or more eligible professionals.</td>
<td>CMS finalized its proposal to define a group practice as one having a single tax identification number (TIN), with two or more EPs as identified by their individual national provider identification number who have reassigned their Medicare billing rights to the TIN.</td>
</tr>
<tr>
<td>CMS required a minimum patient sample of 30 Medicare patients for reporting measure groups via registry and claims.</td>
<td>CMS required a minimum patient threshold of 20 patients for reporting measure groups via registry and claims. For reporting measure groups via registry only, 11 of the 20-patient threshold must be Medicare beneficiaries, and the rest can be non-Medicare.</td>
</tr>
<tr>
<td>CMS finalized the claims, registry, electronic health records (EHR), and GPRO methods to earn the 2012 PQRS incentive.</td>
<td>In addition to retaining the 2012 methods to earn the 2013 PQRS incentive payment, CMS also finalized two additional methods that will help EPs avoid the 2015 PQRS penalty. These two additional methods include the administrative claims reporting option and reporting on one measure or measures group.</td>
</tr>
</tbody>
</table>

TABLE 3.
2013 REPORTING OPTIONS TO AVOID 2015 PQRS PENALTY BUT NOT RECEIVE 2013 INCENTIVE

| Administrative claims reporting option | Under this option, CMS will analyze each EP’s or group practice’s Medicare claims to determine whether the EP or group has performed any of the clinical quality actions indicated in a specific set of measures. |
| Alternative reporting option | In this method, required data submission must be for at least one applicable patient using any of the available methods (claims, EHR, or registry). |

How do I report PQRS measures?

There are a number of ways that EPs can report in PQRS 2013 in order to receive an incentive payment and/or avoid the 2015 payment penalty. A matrix that lists all six options for reporting under PQRS 2013 is available at http://www.facs.org/ahp/pqri/2013/reporting-options-chart.pdf. Moreover, the 2013 physician fee schedule also finalized two methods by which EPs can simply avoid the 2015 PQRS penalty without receiving an incentive payment for PQRS 2013. The two methods are outlined in Table 3 on this page.

These two options are currently only available for 2013 and are intended for practices that may be overwhelmed with attempting to comply with other reporting programs. Successful PQRS compliance will still be required after 2013, and it is possible that CMS may finalize other reporting methods in future rulemaking.

The ACS has developed useful PQRS resources for surgeons, including the 2013 PQRS flow sheets for claims-based reporting. The flow sheets are categorized by procedure codes relating to various surgical procedures for the perioperative measures set. The perioperative measures set includes measures #20, #21, #22, and #23. This flow sheet provides...
CLAIMS 1500 EXAMPLE

Please note that this is a sample with outdated CPT codes.

the corresponding current procedural terminology II code that should be used on the Claims 1500 form as shown in the figure on this page. The flow sheets should be used as a reference only and should not be submitted to CMS. The flow sheets are available at www.facs.org/ahp/pqri/. Additional background information regarding the PQRS program can be found on the following websites: www.cms.hhs.gov/pqrs/ and www.facs.org/ahp/pqri/index.html. If you have questions regarding PQRS, contact Sana Gokak in the ACS Division of Advocacy and Health Policy at sgokak@facs.org.
If you follow health policy in this country, you will have noticed that a common topic of discussion is the looming general surgery workforce shortage. This imminent shortfall, particularly among broadly trained general surgeons, will particularly affect surgery in rural America.

In response to the impassioned and reasoned pleas for help with this critical issue from two leading rural surgeons—American College of Surgeons (ACS) Governor Tyler Hughes, MD, FACS, a general surgeon in McPherson, KS, and Phil Caropreso, MD, FACS, a general surgeon in Keokuk, IA—the College’s Board of Regents established an Advisory Council for Rural Surgery. This council is charged with studying the issue and advising the College on solutions to this impending crisis. Emphasizing the importance of this problem as well as the College’s commitment to helping to resolve it, A. Brent Eastman, MD, FACS, ACS President, included rural surgery as one of the four pillars of emphasis for the ACS in his Presidential address. In addition, the Bulletin of the American College of Surgeons has established this quarterly column to better highlight the challenges facing our colleagues in rural America.

As the Regental liaison to the Advisory Council for Rural Surgery, I have been asked to discuss my past experiences as a practicing rural surgeon and potential solutions to the challenges facing rural surgical care.

My time as a rural surgeon
As a medical student and as a resident, I had the privilege of observing two master rural surgeons in the small Georgia mill town of Thomaston. I quickly became enamored with the quantity and quality of their work, as well as their total dedication to the community. As I was completing a vascular fellowship and searching for a place to make a difference, it became apparent that I could make a contribution in this community and quickly accepted an offer to join their practice. An important contributing factor in that decision was that one of the sister communities that this practice served—Culloden, GA—was the boyhood home of the great Alfred Blalock, MD, FACS.

As a confirmed city boy who believed that urban sprawl...
Despite my magnificent training and a spectacularly successful first case—repair of a leaking aortic aneurysm—it rapidly became apparent that I was woefully unprepared for the breadth of clinical problems that a busy rural surgeon treats.

and carbon monoxide were aphrodisiacs, as well as an ardent Kennedy Democrat, it quickly became apparent that some cultural adjustments were in order if I was going to live harmoniously in my new home. I was surprised by the warm community welcoming, shocked by how well-versed people were with almost every detail of my unaccomplished life, and struggled constantly to answer the all-important question, “Where do you go to church?” As time went on, I adjusted and came to realize that their insatiable curiosity about my daily life was motivated more out of sport than malice, I kept my liberal ideology to my closest confidants, and went to church with everyone.

Despite my magnificent training and a spectacularly successful first case—repair of a leaking aortic aneurysm—it rapidly became apparent that I was woefully unprepared for the breadth of clinical problems that a busy rural surgeon treats. This deficiency became painfully obvious when I was first confronted with a full office. Not only was I scheduled to see patients with the standard, garden-variety problems, but also a large number of patients needing tionsillectomies, carpal tunnel releases, circumcisions, and rotational flaps for significant skin lesions. I was horrified and shocked at my newly discovered shortcomings, but through the guidance of my masterful partners and a strong motivation to learn, I slowly became a real rural surgeon.

One of the joys and satisfactions of practicing in a rural setting is that surgeons are instantly recognized as important and critical members of the community. With these accolades come an expectation of community involvement and leadership. I quickly found engaging with the community in this manner an unexpected reward of rural living, which markedly enhanced my sense of satisfaction and fulfillment. The opportunities for such involvement are legion and diverse and simply require an expressed interest and commitment to the role. I quickly became involved with many service organizations, the chamber of commerce, tutoring programs, and a child abuse prevention organization. I also served a term as a county commissioner.

Probably the most rewarding part of rural practice was the intimate relationships I developed with my patients and the community. I found tremendous satisfaction and sense of purpose in resecting a colon cancer in the wife of a running buddy, treating my children’s teacher’s breast cancer, removing the tonsils of the school superintendent’s children, repairing the ruptured aneurysm of my yardman’s mother, treating the carotid dissection of the director of the local chamber of commerce, and repairing the subclavian injury of a hometown U.S. Marine hero, to name but a few cases. Using my skills to care for neighbors in need was extremely humbling and fulfilling. It provided a level of satisfaction and reward that I have been unable to replicate in the urban environment, with its transient and varied demographics.

Challenges of rural surgery
Currently, 60 million Americans live in rural areas, which are defined as communities having a population of less than 50,000. Data from studies that the American College of Surgeons (ACS) Health Policy and Research Institute has conducted indicate that an estimated 925 U.S. counties have no surgeon, and of these regions, 57 had populations of more than 25,000.* Currently, only 7 percent of all U.S. surgeons practice in rural settings. These physicians tend to be mostly male with an average age of 58, and fully 50 percent plan to retire in the next 10 years. Most are in one- or two-person practices, are frequently employed, and all report significant difficulty in attracting future partners, according to the College’s surveys of rural surgeons.

Factors contributing to the challenges in recruitment include decades of deteriorating demographics and economic and cultural contraction. Rural communities tend to have a lower tax base, making investments in

required medical technologies difficult and often impossible. The population’s characteristic low per capita income and high number of indigents translate into low physician reimbursement, adding to the difficulty of attracting young surgeons with significant school debt.

Many rural surgeons complain of feeling professionally isolated, with insufficient call backup, limited and shallow medical and subspecialty consultative services, and a lack of tertiary care support. Increasing demands for Maintenance of Certification and continuing medical education (CME), as well as investment in electronic health records, are particularly burdensome for small, marginally capitalized practices. Recent generational shifts and the trend toward producing narrowly trained surgical specialties that afford predictable lifestyles further limit the recruitment pool.

Rural community limitations, the imminent retirement of a large portion of the surgical workforce, and a lack of qualified or interested replacement surgeons are converging to create an imminent crisis in rural surgery. This perfect storm, if you will, will have disastrous effects on community economics and the overall wellness and safety of rural Americans.

Potential solutions
Like all complex problems, the salvage, stabilization, and re-invigoration of rural surgery has no simple answer and will require a comprehensive understanding of all the important variables driving this crisis. Reason would suggest that this problem may be pragmatically broken down to issues of recruitment, training, and support.

Recruitment
It is critical that we enhance and expand efforts to expose aspiring young surgeons to rural health systems. It is widely known that two of the most important factors that influence a young surgeon’s interest in rural practice are being raised or having lived a part of one’s life in a rural community and exposure to rural surgery during training.

Local communities can effectively participate in this process by identifying promising young students, setting up surgical shadowing and mentoring programs, and providing health care scholarships. Medical school rural clerkships and resident rural rotations, as well as rural surgical faculty mentors, provide key exposure to this type of work. Also, databases listing rural communities with workforce needs should be developed and made available to interested residents.

Financial incentives are a key component of recruitment. With the staggering debt residents now face and the low remunerative potential of rural practice, it is going to be imperative to offer loan forgiveness to finishing residents. In addition, a supportive hospital administration offering competitive and stable employment contracts will be essential for both recruitment and retention of young surgeons.

Training
Unfortunately, many of the newly minted surgeons are ill-prepared to practice broad-based general surgery, especially in an environment with limited support from partners, subspecialists, technologies, and tertiary care. New paradigms are needed to produce broadly trained general surgeons with added competencies in endoscopy, urology, orthopaedics, gynecology, and plastic surgery. Additionally, this group will need to have a good general knowledge of internal medicine and be facile in the management of common medical problems. The famed John Arlie Mansberger, MD, FACS, used to call this type of surgeon “an internist that operates.” We need to recreate this type of surgeon for rural America.

The ideal training program would be based in a major medical center with a large and diverse patient population with active divisions representing the broad-based components of general surgery. The program should be resident-centric with few subspecialty fellowships and no minimally invasive fellowship programs. There should be a strong commitment...
Like all complex problems, the salvage, stabilization, and re-invigoration of rural surgery has no simple answer and will require a comprehensive understanding of all the important variables driving this crisis. Reason would suggest that this problem may be pragmatically broken down to issues of recruitment, training, and support.

to adequately train residents in endoscopy and to provide residents with opportunities to attain appropriate, needed skill sets in many of the other surgical disciplines as well. There should be extensive immersion at the junior resident level in the major medical disciplines.

For residents completing their training and feeling unprepared for the challenges of rural practice, the availability of a one-year fellowship dedicated to these principles would be extraordinarily helpful. With the near universality of fellowship training today, I think this would be acceptable to many trainees and should be a fellowship with distinction such as “Master in Surgery” or other appropriate accolade. Along these lines, the College is developing an ACS Transition to Practice Program in General Surgery, which will be pilot tested at five institutions beginning July 1: University of Louisville School of Medicine, KY; Gundersen Lutheran Medical Center, La Crosse, WI; University of Tennessee, Chattanooga; Ohio State University, Columbus; and Mercer University School of Medicine, Macon, GA. Eastern Virginia Medical School will launch a program in 2014.

Support
As stated previously, the challenges of rural surgery are protean, resources are limited, and economies are lean. For the heroes who choose rural surgery as their life’s mission, adequate support structures must be in place to make practice tenable and retention possible.

The local community must offer an unwavering commitment to adequately supporting a surgical service that is feasible given the available resources. Inherent to that commitment is the development and maintenance of a strong primary care system, an investment in technology and training, and available employment situations that offer a competitive salary and benefits package. Innovative approaches to the often onerous call schedules and limited time off should be developed and may include the expanded use of allied health personnel, locum tenens, and the creation of a registry of recently retired, credentialed surgeons willing to provide periodic respite coverage.

Feelings of professional isolation may be lessened with the development of strong relationships between the rural community and a local sister medical center. This relationship can provide access to relevant CME, new skills acquisition, consultative services, as well as a dependable conduit for timely patient transfer.

Finally, it is imperative that both the ACS and the American Board of Surgery continue to strive to understand the unique challenges of rural surgery and to provide the support needed for rural surgery to thrive.

Final perspective
One afternoon during my residency, I found myself in the presence of the great W. Dean Warren, MD, FACS, while he was holding court. During this monologue of high-minded musings, he posed a question that significantly influenced my future surgical career: “Who do you fellows think is the best surgeon in America today?” After a period of awkward silence, he said, “I will tell you who he is. I don’t know his name, but I know where he works. He or she lives in some rural town using all their resources with minimal support, inadequate pay, little time off, and devoid of professional recognition, dedicating their life to the care of their people. This selfless physician is the greatest surgeon in America.”

I’ve had the rare life’s privilege of working with two such surgeons—William M. Dallas, MD, FACS, and Michael W. Oxford, MD, FACS—doing just what Dr. Warren held in esteem. I can’t say I don’t miss it. We must do what is necessary to preserve this niche in surgery for all of America’s future great surgeons and the people who will need them.
Imagine the following scenario: a surgeon is finishing up a complicated case near the end of the day. He is exhausted and hungry. The scrub technician is fresh out of training and is nervous to be working with this particular surgeon. When asked for a hemostat, the technician passes a DeBakey forceps. The surgeon throws the instrument onto the Mayo stand and berates the scrub tech for not paying attention. The surgeon’s tirade is just loud enough to get the attention of the entire operating room (OR) staff, and care of the patient grinds to a halt.

Sound familiar? This fictitious example probably strikes a chord with most, if not all, of us who have worked or trained in the American medical system, regardless of discipline. Few professions in the 21st century tolerate such outbursts the way medicine does. If not all, of us who have worked or trained in the American medical system, regardless of discipline. Few professions in the 21st century tolerate such outbursts the way medicine does. Imagine what would happen to a board member at a Fortune 500 company who repeatedly exhibited similarly disruptive behavior. The employment of that executive within the company would probably be short-lived.

Counterproductive culture of intimidation
The prevalence of bad behavior in the health care profession is high. In a survey of more than 2,500 executives, nurses, and physicians, greater than 90 percent of respondents said they had witnessed disruptive behavior. Although the majority of health care professionals may not exhibit disruptive behavior, the aphorism “one bad apple ruins the whole barrel” rings true. In an era of quality controls and checklists, it would appear unacceptable that a nurse would choose not to alert a surgeon in the OR that a step has been missed or an error committed. However, that individual may feel it best to remain silent for fear of repercussion or reprimand.

In health care, the culture of intimidation is often perpetuated down the chain, as that same intimidated individual turns around and bullies a resident or medical student. Students and trainees are often the victims of disruptive behavior. It is astonishing to witness some of these unprofessional interactions between health care practitioners, especially when they are the same individuals providing care to our loved ones. The community of health care professionals must question why this bad behavior continues to be tolerated.

Although the medical and surgical professions have begun to address disruptive behavior over the past decade, the need for continued improvement at medical institutions throughout the country is tremendous. The American Medical Association (AMA), in its Code of Medical Ethics, states that “personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior.” Furthermore, in 2003, the American College of Surgeons’ (ACS) Board of Regents approved a Code of Professional Conduct, which calls upon Fellows to “respect the knowledge, dignity, and perspective of all other health care professionals.”

The AMA and the ACS adopted these principles with the realization that it is our responsibility as physicians to protect the safety of our patients and provide high-quality care. Eliminating the intimidation and disruptive behavior that will undermine the delivery of high-quality patient care is paramount. According to a survey conducted by the Institute for Safe Medication Practices, 49 percent of clinicians reported that after experiencing intimidation or mistreatment, they changed the way they asked questions regarding medication orders and sought order clarifications. Of the respondents who had concerns about medication orders, 40 percent said they would remain silent or have a colleague discuss the issue with the intimidating prescriber.

The financial impact of disruptive behavior has been described in a recent article. The effect is evident at multiple levels, ranging from adverse events to the increased risk of litigation. The
loss of human capital secondary to bullying can be significant; a recent survey showed that one-third of nurses left work after being subject to intimidation. Nurse attrition results in significant financial consequences, with direct costs of recruiting a new nurse ranging from $60,000 to $100,000. This figure does not account for the additional costs of orientation and training or the time needed for employees to adapt to a new work environment.

**Surgeons must lead**

Perhaps more than any other discipline, surgery requires a commitment to fostering a culture of patient safety. Typically, it is the surgeon who sets the tone for how things are going to run in an OR, during a trauma resuscitation, and during other patient encounters. As other members of the health care team look to surgeons to lead by example, our behavior can completely change the dynamic of patient care in either a positive or negative manner. It is clear that a functional team improves patient care, so now more than ever, our leadership is needed to address this prevalent problem.

Leadership in this arena must come from the top down with a zero-tolerance policy for disruptive behavior. Disruptive behavior violates our code of conduct as physicians, erodes worker morale, imperils patient safety, results in negative financial consequences, increases loss of human capital, and heightens the risk of liability litigation.

The hierarchy of medicine that has been the prevailing culture for centuries might have something to do with disruptive behavior. The time has come to flatten the hierarchy and work together as one body, for our goal is the same—to deliver safe and high-quality medical care. As surgeons, we must take the lead in driving this process.

A number of centers have taken the initiative to develop centers of professionalism to address these issues among clinicians. Although The Joint Commission initiated a professionalism standard in 2009 requiring a disruptive behavior policy to be in place as part of the accreditation protocol for hospitals, policies must be enforced and applied consistently across disciplines. Enriching the work environment to provide a safe, collegial, and positive atmosphere has multiple benefits—perhaps the most important of which is fostering an environment that will enhance the safety and quality of patient care.  

**REFERENCES**

The Joint Commission Center for Transforming Healthcare and the South Carolina Hospital Association (SCHA) have teamed up to launch the South Carolina Safe Care Commitment. The initiative, which is the first of its kind for the center, includes 20 hospitals from seven health care systems located in South Carolina that will seek new ways to strengthen processes, systems, and structures in order to provide consistently excellent, safe patient care.

The collaboration is part of the center’s efforts to facilitate the progress of health care institutions toward high reliability in health care. High reliability is defined as consistent performance at high levels of safety over long periods of time. In other words, highly reliable health care eliminates all preventable harm and provides the safest, highest-quality care to every patient, every time.

Chief executive officers and other executives from participating South Carolina hospitals will meet regularly and participate in webinars and coaching sessions to collaborate on processes to move health care toward the same highly reliable performance found in industries such as commercial aviation and nuclear power. Success will be measured through the results of safety culture survey assessments and evidence that improvement activities have produced significant reductions in patient harm. In addition, the participating South Carolina hospitals will use a Web-based electronic application that the center has created to identify critical practices leading to high reliability and to help hospitals assess their performance.

Beyond the hospitals initially participating in the project, the collaboration between the center and the SCHA is designed to improve safety and quality in health care facilities across the state. The lessons learned about identifying the underlying causes of specific breakdowns in care and creating targeted solutions at participating hospitals will be shared with other hospitals. The focus on offering targeted, tested solutions has been a hallmark of the center, which has, through its Targeted Solutions Tool, provided a step-by-step process to assist accredited health care organizations in measuring performance, identifying barriers to excellent performance, and implementing proven solutions that are customized to address specific barriers.

For more information about the Center for Transforming Healthcare, visit www.centerfortransforminghealthcare.org/.

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Circular saws and table/bench saws have been around for more than 200 years and predate the discovery of electricity. Early versions of these saws were powered by wind or foot-powered treadles, and many early sawmills were built on the banks of rivers to harness the power of moving water. They all had one thing in common that holds true of today’s table saws: a flat horizontal surface on which to push wood toward a spinning circular blade. Several modern-day advances have occurred in the overall design of the table saw, but the concept of an individual using his or her hands to push material (most often wood) toward a rapidly spinning blade with nothing more than a plastic covering over the top of the blade has not changed.

A spinning blade in close proximity to one’s extremities is a recipe for potential disaster and, unfortunately, the standard plastic blade guard has been ineffective in reducing table saw-related injury. Approximately 40,000 individuals in the U.S. seek emergency department treatment each year for table saw-related injuries. Of these patients 4,000, or an average of more than 10 every day of the week, require amputations.

Table saw injuries have a resultant cost of approximately $2 billion per year. However, improved safety devices and a few reengineered saws have been invented recently that have the ability to stop a saw blade spinning at 4,600 revolutions per minute (rpm) to zero rpm in as little as five milliseconds, which is seven times faster than an automobile airbag deploys. Unfortunately, there is a price associated with this safety. It would cost an estimated $100 per saw to place automatic safety technology on every such tool in the U.S. However, the savings in injury prevention per saw would be $753, not to mention the reduced number of amputations and emotional trauma associated with these devastating injuries.*

To examine the occurrence of table saw injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2012, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Specifically searched was external cause of injury code (E-code) 919.4 (injury caused by woodworking and forming machines [band saw, bench saw, circular saw, molding machine, overhead plane, powered saw, radial saw, and sander]). A total of 2,042 records were found; 1,742 records contained a hospital discharge status, including 1,713 patients discharged to home, 17 to acute care/rehab, and eight to skilled nursing facilities. Four died. Patients were 95.5 percent


The NTDB Annual Report 2012 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.
male, on average 48.8 years of age, had an average hospital length of stay of 2.5 days, an intensive care unit length of stay of 4.2 days, an average injury severity score of 4, and were on the ventilator for an average of 6.3 days. More than half of the incidents took place in the home, with another 20 percent occurring in industrial environments (see figure, this page). Of the 253 patients tested for alcohol, 16 percent were found to be positive.

The opposing thumb is an evolutionary marvel, distinguishing humans from all other non-primates. It allows us to perform highly dexterous tasks with our hands. Unfortunately, technology has not been able to replace amputated fingers, hands, or arms with the same success as some of the newer lower-extremity prostheses. So, $100 for a safety device is a small price to pay to prevent injury and keep your hands and fingers off the table.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. The NTDB Annual Report 2012 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.
To whom it may concern,

Dear sir or madam,

reporting health care data

We read with interest the article “Public reporting of health care data: A new frontier in quality improvement” in the June 2012 issue of the Bulletin (Bull Am Coll Surg. 2012;97[6]:6-11). We maintain that administrative data can be used to improve “processes of care and clinical and patient outcomes in efforts to optimize quality” and thought your readers might be interested in how the state of Victoria in Australia has used administrative discharge coding data for this purpose.

In Victoria, the funding of public hospitals is based on a system related to the complexity of cases. For example, a simple hernia has one code, while a recurrent hernia has a different code reflecting a higher payment. Postoperative heart attacks, DVTs [deep venous thrombosis], wound infections, and other complications all qualify for increased funding and are coded separately, so it is in a hospital’s interests to code an admission fully to ensure maximum funding.

In 2001, the state government established the Victorian Surgical Consultative Council (VSCC) to scrutinize adverse events after surgery. Most VSCC members (80 percent) are practicing surgeons. In 2005, the VSCC became aware of the huge amount of data stored on the government computer system, which makes it possible to analyze data and compare hospital with hospital. VSCC decided to use this information to identify problems in the overall health system and in individual hospitals. The VSCC created the Surgical Outcomes Information Initiative (SOII) to fulfill this responsibility.

The SOII looks at data on select elected operations to compare the performance of de-identified health services with the state average. Feedback is provided confidentially to any hospital with apparently outlying performance, inviting its examination of the circumstances and affording the opportunity for it to tackle any problems. VSCC also advises others of the risks and remedies. Following one such study, the hospital’s own investigation prompted action to improve surgeons’ practice and patient safety in their day-surgery operating suite.

In 2010 the SOII subcommittee looked at the following procedures and complications:

- Hemorrhage following dacryocystorhinostomy
- Removal of wrong intraocular lens and replacement
- Mortality following repair of subcapital fractured femur in 80+ year olds
- Mortality following bariatric surgery
- Orchidectomy following admission with torsion of the testis
- Mortality, wound infection, and transfer to a different hospital after colectomy

This data has enabled the VSCC to identify the state mortality rate for each procedure as well as the mortality rate...
Dear sir or madam,

for each of the health services that have undertaken these procedures. For example, we know the state mortality rate for elective laparoscopic cholecystectomy is 1 in 2,047 (0.05 percent), for elective inguinal hernia repair (initial and recurrent) is 1 in 22,892 (0.004 percent), and for laparoscopic hernia repair is 0 in 4,829.

Initially, a few surgeons and hospitals were somewhat skeptical about the process, but as they realized that the whole process was de-identified, confidential, and educative rather than punitive they accepted it and were keen to help. Around the world, undoubtedly, many systems would benefit from this type of data analysis in an effort to improve patient care.

Peter L. Field, MD, FRACS, chairman, Victorian Surgical Consultative Council
John P. Royle, OAM, FRACS, FACS, member, Victorian Surgical Consultative Council

Back to basics
The July and August 2012 issues of the Bulletin represented a one-two punch for this recently retired general surgeon, starting with an article on surgery in the 21st century, which described the transition from the “sustaining technology” of open surgery to the “disruptive technology” of minimally invasive and endoscopic procedures (Bull Am Coll Surg. 2012;97(7):6-11). The next two articles in that issue centered on the electronic health record (Bull Am Coll Surg. 2012;97(7):12-19) and the benefits of exposing surgical trainees to global surgery, respectively (Bull Am Coll Surg. 2012;97(7):20-26).

The author of the article on modern-day surgery notes that a surgeon trained in the 1970s might have been able to complete a career without adapting to new technology with the implication that anyone training thereafter would not have that luxury. Along with many of my contemporaries, I did seek training in laparoscopic techniques in the 1990s and did my share of lap cholecystectomies before retiring in 2010. Since then, I have been told more than once that I retired at the right time, given the sea change of private practice disappearing while hospital employment becomes the norm. Likewise, I was delighted to depart [at a time] when the written chart that I could carry to the bedside while making rounds was being replaced by a computer requiring me to log on every time I arrived at a nursing station.

In 2011, I spent a month in Africa’s Ivory Coast with Doctors Without Borders (DWB). I brought my stethoscope. The only lab tests available at L’Hôpital Général de Duekoué were for hemoglobin and malaria. The only X-ray machine was an old “wet-reading” unit. Medical records were scanty and virtually meaningless. Nonetheless, patients with perforated typhoid peritonitis, appendicitis, incarcerated and strangulated hernias, peripheral bullet wounds, long bone fractures, and emergency cesarean sections almost always did well. I kept wondering if newly trained surgical residents would be able to cope without CT [computed tomography] scans, surgical staplers, and laparoscopes. In a way, I felt that I was back in my 1970s residency, and it was thoroughly refreshing.

It was therefore gratifying to read the article about surgical training in limited resource countries. It was all the more impressive to learn that the American Board of Surgery will allow certain international electives to count toward board eligibility. If high-tech training trends in the U.S. continue, what other opportunity will there be for surgical residents to work in the open abdomen with needle and thread?

The capstone article was in the August issue and described a postgraduate fellowship in global surgery featuring general surgery procedures plus some plastics, gynecology, and orthopaedics as well as public health and surgical education (Bull Am Coll Surg. 2012;97(8):46-50). This sort of training holds promise and would be even better if mid-career surgeons could participate as well. More recent articles in the Bulletin have discussed rural surgery in the U.S. There are clear parallels here with humanitarian surgery. It will be interesting to see if crossover training programs develop.

Late last year, I went on another mission with DWB, this time to Haiti. I only wish that...
I had done this sort of thing at intervals during my 33 years of practice. I believe global surgery will help us get back to basics while improving the lot of global citizens and am impressed with the strides the American College of Surgeons has made in this area through Operation Giving Back.

Edward Walworth, MD, FACS, Lewiston, ME

End of life surgery
I wish to comment on the two essays dealing with end of life surgery that were published in the November 2012 Bulletin (Bull Am Coll Surg. 2012;91[11]:19-23). The articles did not clearly differentiate emergency from elective operations nor do many studies evaluate the experience of the operating surgeons, which I agree would be a formidable task. I presented a study of operations in more than 300 octogenarians at the papers session of the American College of Surgeons Clinical Congress more than 25 years ago. Clearly it’s almost impossible to predict the last year of life. All experienced surgeons can cite anecdotal material of survivals in the elderly, but withholding surgery (particularly elective procedures) can deprive patients of a chance at a reasonable survival.

We know there are differences in survival rates from major operations, such as pancreatectomy, related to hospital and surgeon experience. Factors such as choice of incision, judicious use of anesthesia, and fluids, and use of local anesthesia in some procedures (biliary emergencies, surgical decompression, incarcerated hernias, and so on) may play a significant role in results.

While certification in geriatric surgery may not be feasible, many referring physicians should be selective in their referrals. I am impressed daily by the number of persons older than age 75 in my local community who have undergone successful major operations.

We are loath to criticize the use of chemotherapy to achieve one or two months of increased survival (usually poor quality) and there is a readiness to criticize a 70 or 80 percent survival in acute emergency operation in the elderly. Obviously, distinguishing a hopeless operation is dependent upon experience, and I am not advocating this approach. I just wish to emphasize that operations in the elderly should not be approached negatively.

Bernard Gardner, MD, FACS, Venice, FL

Murphy memories
I am proud to have been a Fellow of the American College of Surgeons since 1970. I write to commend you on your reprinted article on the dedication and inauguration of the John D. Murphy Memorial (Bull Am Coll Surg. 2013;98[1]:37-44). The article is, in itself, an excellent reminder of a time when surgeons were respected for their craft and knowledge and not relegated to a pro bono computer technician/stenographer, as many of us are today.

In reading the article, I was reminded of the beauty and elegance of the Murphy Memorial and of the many times I have attended meetings in that facility. I particularly remember the many postgraduate courses on fractures and other trauma, which John J. Fahey, MD, FACS, originated.

It occurs to me that having the College sponsor lecture courses for the younger surgeons and perhaps residents and fellows from time to time in the Murphy Auditorium would give these younger people some sense of the vanishing grandeur of our profession. I can still recall many stellar surgeons who have presented excellent papers within that auditorium, and I recall, 40 years later, the majesty of the surroundings after having long ago forgotten the specifics of the lecture.

Boone Brackett, MD, FACS, Oak Park, IL

To whom it may concern,

Dear sir or madam,

I am pround to have been a Fellow of the American College of Surgeons since 1970. I write to commend you on your reprinted article on the dedication and inauguration of the John D. Murphy Memorial (Bull Am Coll Surg. 2013;98[1]:37-44). The article is, in itself, an excellent reminder of a time when surgeons were respected for their craft and knowledge and not relegated to a pro bono computer technician/stenographer, as many of us are today.

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Boone Brackett, MD, FACS, Oak Park, IL
With a commitment to maintaining the American College of Surgeons’ (ACS) vitality and excellence and with a vision of strengthening and securing the organization’s future, the ACS Foundation Board of Directors has launched the 1913 Legacy Campaign. This special, one-time fundraising initiative, in honor of the College’s Centennial, will ensure the College’s capacity to sustain and develop high-priority programs that will benefit surgeons and their patients. The campaign will invest in continuing education, support development of best practices and health policy, and advance the societal good through volunteerism.

Philanthropy is in the College’s DNA, with each founder having donated $1,000 in 1913—the equivalent of nearly $25,000 today. All members of the College will have the opportunity to continue this legacy of giving back. Fellows and friends who make a campaign gift of $1,913 will be members of the 1913 Legacy Circle; those who choose to donate at higher levels will receive special recognition and benefits. Fellows and friends who establish testamentary gifts (through a will) that benefit the College will be recognized not only as 1913 Legacy Circle donors, but also will receive membership in the Mayne Heritage Society, the Foundation’s planned giving recognition program.

The 1913 Legacy Campaign is a call to action to all Fellows and friends of the College who care about the future of the organization and the surgical profession. Donors will join the leaders of the College, who have made their own campaign gift, including David B. Hoyt, MD, FACS, Executive Director; Julie A. Freischlag, MD, FACS, Chair of the Board of Regents; A. Brent Eastman, MD, FACS, President; and Amilu Stewart, MD, FACS, Chair of the ACS Foundation.

Don’t miss your opportunity to be a part of this historic campaign. For more information, go to www.facs.org/acsfoundation or call the Foundation at 312-202-5338. ◆

Dr. Hoyt (right) presents his 1913 Legacy Campaign gift to Martin H. Wojcik, CFRE, Executive Director, ACS Foundation.
The American College of Surgeons (ACS) joined the Florida Hospital Association (FHA) and Florida Blue (Blue Cross and Blue Shield of Florida) on January 23 in Winter Park for the 12th Surgical Health Care Quality Forum. The event was part of an ACS-sponsored national tour that brings together hospitals, health plans, physicians, government, and other health care leaders to share best practices for improving patient care and achieving better outcomes.

Participants discussed the progress of the Florida Surgical Care Initiative (FSCI), a two-year pilot program. With 67 hospitals participating, this initiative is the largest statewide hospital collaborative that uses the ACS National Surgical Quality Improvement Program (ACS NSQIP®) to focus on improving outcomes in key areas of surgical care.

Florida Surgeon General and Secretary of Health John H. Armstrong, MD, FACS, who opened the program, offered insights into Florida’s health care system and noted new initiatives that will continue to track key performance measures. “Florida faces the same question as the rest of the country: How can we provide quality, affordable health care for all people in our state?” Dr. Armstrong told the gathering. “We are applying systems thinking in disease control, trauma, and cancer care, and applying established standards to an infrastructure that generates measurable, reliable outcomes and promotes efficiency. The Florida Surgical Care Initiative has taken this approach to the next level by demonstrating higher quality care and lowering cost simultaneously. We need this performance improvement mindset to expand across our state.”
“Florida faces the same question as the rest of the country: How can we provide quality, affordable health care for all people in our state?” Dr. Armstrong told the gathering. “We are applying systems thinking in disease control, trauma, and cancer care, applying established standards to an infrastructure that generates measurable, reliable outcomes and promotes efficiency.”

David B. Hoyt, MD, FACS, ACS Executive Director, announced that the College will continue to support FSCI for an additional three years, in partnership with the FHA and Florida Blue. “There are now several NSQIP state collaborative programs around the country, and we’ve found they are most successful with the mutual involvement and support of surgeons, hospitals, and health plans,” Dr. Hoyt said.

“The magnifying glass is on physicians and health care systems to make our care more safe, efficient, and cost-effective,” said Joseph J. Tepas III, MD, FACS, FAAP, forum co-host and professor of surgery and pediatrics, University of Florida College of Medicine, Jacksonville.

John P. Rioux, MD, FACS, forum co-host; general surgeon; member, ACS Board of Governors; and Secretary-Treasurer, ACS Florida Chapter, noted: “The progress of the Florida Surgical Care Initiative, particularly results showing participating hospitals’ savings in avoidable expenses, speaks volumes about the benefits of collaboration among health care providers.”

“Our hospitals are defined by the quality of the health care they provide to their patients,” said forum panelist Martha DeCastro, RN, vice-president for nursing, FHA. “FSCI has enabled participating hospitals to see tangible improvements in key areas such as postoperative complications, which means better outcomes for patients and hospitals to drive down costs.”

“Participation in quality improvement collaboratives like FSCI, and data measurement registries like ACS NSQIP, are becoming more and more critical for hospitals to consider as regulators and health plans move toward value-based care delivery models and formulate accountable care arrangements,” added Jonathan B. Gavras, MD, FCCP, senior vice-president and chief medical officer at Florida Blue.

“Veterans Affairs (VA) has long realized the value of using clinical, risk-adjusted data to measure the quality of our care and ensure we are focused on the most critical areas for improvement,” said Vincent A. DeGennaro, MD, FACS, president, Florida Medical Association; chief of staff and assistant chief, surgical services, Miami VA Healthcare System; and affiliated associate professor of surgery, University of Miami School of Medicine. “Since ACS NSQIP’s inception out of the VA nearly a decade ago, the program has yielded hospitals, surgeons, and patients tremendous benefits in terms of improving outcomes and lowering costs.”

Michael S. Nussbaum, MD, FACS, Methodist Medical Center professor and chair, department of surgery, University of Florida College of Medicine, Jacksonville, added: “Integrating quality improvement programs like ACS NSQIP into education and training is becoming a high priority nationally, as accrediting and governing bodies call for clinical effectiveness components in graduate medical education.”

Since launching its Inspiring Quality initiative in 2011, the ACS has brought together health care leaders across the nation in an effort to foster discussions about surgical quality programs that advance patient care and measurably improve outcomes.

To view the archived Florida forum video and follow additional updates, visit InspiringQuality.facs.org or the College’s YouTube channel at http://www.youtube.com/AmCollegeofSurgeons.
Connecticut Chapter hosts Scientific and Annual Meeting

The Connecticut Chapter of the American College of Surgeons (ACS) hosted its 45th Scientific and Annual Meeting on November 8, 2012, in Waterbury, CT. Power outages from Hurricane Sandy and a major snowstorm delayed the meeting, but attendees reported that it was a resounding success. The meeting featured more than 50 resident research presentations; a keynote address from U.S. Army Brig. Gen. W. Bryan Gamble, MD, FACS, deputy director, TRICARE Management Activity; debates on clinical treatment options for various surgical conditions; and sessions for residents on contract negotiations and choosing a fellowship.

The chapter presented its Distinguished Service Award to ACS Regent Lenworth Jacobs, MD, MPH, FACS, a general surgeon who practices at Hartford Hospital. The award recognizes Dr. Jacobs’ contributions to the Connecticut Chapter as well as his work to improve the quality of patient care worldwide. Dr. Jacobs served as Chapter President from 2000 to 2002, as Governor-at-Large from 2004 to 2006, and chaired the Regional State Committees from 1998 to 2004. Dr. Jacobs launched the annual Connecticut Trauma Conference, which is now in its 15th year. The conference draws more than 500 trauma care professionals from around the state. Dr. Jacobs currently serves on the ACS Central Judiciary Committee and the ACS International Relations Committee. In 1998, he developed the Advanced Trauma Operative Management (ATOM®) course, a method of increasing surgical competence and confidence in the operative management of penetrating chest and abdominal injuries. In 2008, the ACS Committee on Trauma assumed leadership of the course.

The chapter extended its Legislator of the Year Award to U.S. Sen. Michael Blumenthal (D-CT). Senator Blumenthal has always listened intently and responded to concerns of the Connecticut Chapter. During his tenure as Connecticut’s Attorney General, Senator Blumenthal helped secure a landmark settlement with the tobacco industry. In the U.S. Senate, he has worked for patients’ access to safe and affordable prescription drugs.

The meeting ended with the chapter’s first Surgical Skills Competition™, which is a test of clinical skills for residents from training programs across the state competing in teams of three. Now in its fifth year, this competition, made possible through a unique partnership with industry, continues to be an engaging way to enhance resident training. The recipient of the 2012 Surgical Skills Competition prize in 2012 was the team from Saint Mary’s Hospital in Waterbury, CT. Saint Mary’s first-year residents each received a pair of loupes, and the mid-level and senior residents were awarded complimentary financial planning sessions.

Massachusetts Chapter meets

The Massachusetts Chapter of the American College of Surgeons (ACS) held its 59th Annual Meeting on December 1, 2012, at the Westin Copley Place in Boston. A total of 138 surgical professionals attended the meeting, including 80 residents and medical students.

The meeting began with a Quiz the Experts session featuring the following topics and surgeons:

• Endocrine/Pancreas: general surgeon Richard B. Wait, MD, PhD, FACS, chair, department of surgery, Baystate Medical Center, Springfield; and general surgeon Gerard M. Doherty, MD, FACS, Utley Professor and chair of surgery, Boston University, and surgeon-in-chief, Boston Medical Center of Boston University.
• Colorectal Surgery: Rocco Ricciardi, MD, FACS, department of colon and rectal surgery, Lahey Clinic, Burlington, and Ronald Bleday, MD, FACS, section chief, colon and rectal surgery, Brigham and Women’s Hospital; and associate professor, Harvard University Medical School, Boston

• Open Abdominal: colorectal surgeon Timothy C. Counihan, MD, FACS, Berkshire Medical Center, Pittsfield, and general surgeon Lisa A. Patterson, MD, FACS, Baystate Medical Center, Springfield

The following individuals received Resident Research Awards:

• Oral presentation winners:
  – Basic science: Sulaiman R. Hamarneh, MD, Massachusetts General Hospital: Intestinal Alkaline Phosphatase Prevents Acute Alcohol-Induced Liver Injury
  – Clinical: Ryan P. Cauley, MD, Brigham and Women’s Hospital: Split Liver Transplantation in Adult Recipients: Is the Learning Curve Over?

• Poster winners:
  – Basic science: Tara E. Deelman, MD, Brigham and Women’s Hospital, Boston: Selective Vagal Deafferentation Leads to Improvement in Insulin Response and GLP-1 Secretion
  – Clinical: Ali Ardestani, MD, Brigham and Women’s Hospital: Changes in Insulin Dependence after Bariatric Surgery

A highlight of the meeting was a session titled So You Want to Say You’re Sorry: A Panel on Medical Malpractice, featuring guest speakers Alan C. Woodward, MD, FACEP, Emerson Hospital, Concord, MA; Michael B. Barkley, JD, attorney for Alder, Cohen LLP; and Jeff Catalano, JD, attorney for Todd & Weld LLP.

Other sessions and speakers at the Massachusetts annual meeting included:

• President of the ACS Massachusetts Chapter and colorectal surgeon Marc S. Rubin, MD, FACS, department of surgery, North Shore Medical Center, Salem, spoke on Massachusetts Surgeons Building a Statewide Surgical Quality Collaborative.

• A talk on the Politically Active Surgeon by colorectal surgeon Peter T. Masiakos, MD, FACS, Massachusetts General Hospital, and assistant professor, Harvard Medical School; and Steven A. Baddour, Esq., partner, McDermott Will and Emory, Boston.

• A presentation by general surgeon David McAneny, MD, FACS, of Boston Medical Center on the American College of Surgeons Grassroots Advocacy Pilot Program.

• A scientific session moderated by Jacqueline Wu, MD, Berkshire Medical Center, on Head Games: Chronic Traumatic Encephalopathy and the Long-Term Consequences of Repetitive Brain Trauma, presented by Robert A. Stern, PhD, Boston University School of Medicine.

• The luncheon speaker was John O’Shea, MD, MPA, FACS; Senior Health Policy Advisor, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC, who discussed Paying for Surgery in the U.S.

In addition, the chapter presented the second annual Resident Top Gun Competition, which challenged surgical residents from each of the 10 general surgery training programs throughout Massachusetts. The competition allowed these surgical residents to showcase their laparoscopic skills, with teams of three residents from each institution participating in a series of skills tests. These tests included intracorporeal knot tying, transferring objects from...
cases and improves diabetes in another 31 percent of cases. In the second talk, Dr. Mattar showed that all bariatric surgical procedures have a positive effect on diabetes with a relative advantage of gastric bypass over restrictive procedures.

Ahmed Ibrahim, MB, BCh, FACS, and Chair of the Egyptian Chapter’s Metabolic and Bariatric Surgery Committee, introduced a discussion of metabolic surgery. Abdelwahab Ezzat, MB, BCh, vice-president of Ain Shams University, and Sherif Omar, MD, FACS, President of the Egyptian Chapter of ACS, chaired the symposium. Alaa Ismail, MB, BCh, FACS, Governor of the Egyptian Chapter of ACS, introduced the speakers, and Mohey Elbanna, MB, BCh, FACS, Chapter Secretary/Treasurer, moderated the program.

Professors, staff members, residents, and interns of the department of surgery at Ain Shams University, attended the symposium. The concept of performing bariatric surgery as a treatment for metabolic surgery is new in Egypt. It was the first time this discussion has occurred at Ain Shams University, opening a new frontier for bariatric surgery and diabetic patient management at the institution.

Brooklyn-Long Island Chapter, Nassau Surgical Society host Clinic Day 2012

The Brooklyn-Long Island Chapter of the American College of Surgeons (ACS) and the Nassau Surgical Society hosted their combined Annual Clinic Day on December 5, 2012, in Uniondale, Long Island, NY. With 469 attendees, the meeting was the largest 2012 ACS chapter gathering in the U.S. The meeting featured an educational program highlighting 11 surgical specialties, including cardiothoracic, general/vascular, obstetrics/gynecology, ophthamology, orthopaedic, otolaryngology, plastic surgery, transplant surgery, trauma and emergency, and urology. The general sessions for all attendees featured renowned speakers from across the U.S. Luncheon speakers included Kathleen Heneghan, RN, PNP-C, MSN, Assistant Director, Patient Education, ACS Division of Education; and Karen Zupko, a coding and reimbursement expert and president of KarenZupko & Associates, Inc. The event also included an abstract poster presentation in which 56 posters were submitted by residents. The top 11 posters received special awards. Over the last 11 years, the joint efforts of the Nassau Surgical Society and the Brooklyn-Long Island Chapter have expanded and improved this annual event.

Egyptian Chapter presents metabolic surgery symposium

The Egyptian Chapter of the American College of Surgeons presented a symposium on February 6 titled Update on Metabolic Surgery. The primary speaker was Samer Mattar, MB, BCh, FACS, associate professor of surgery and medical director, Indiana University Health Bariatric and Medical Weight Loss, Indianapolis.

Dr. Mattar gave two talks—one on Sleeve Gastrectomy as a Metabolic Operation, and the other on comparing the Effects of Gastric Bypass, Sleeve Gastrectomy, and Gastric Band on Diabetes Mellitus. In his talk, Dr. Mattar offered data showing that sleeve gastrectomy cures 66 percent of diabetes one hand to another, and pattern cutting. All contestants were timed and graded. The winning team was from Baystate Medical Center and included Connie Rossini, MD; Matthew Kronick, MD; and Kaitlyn Wong, MD. The team received the Massachusetts Chapter ACS Cup, which they will keep for one year. For more information, go to www.mcacs.org.

Brooklyn-Long Island Chapter (BLIC). Left to right: John Gaffney, DO, FAAOS, president Nassau Surgical Society; Ms. Heneghan; Teresa Barzyz, BLIC Chapter Administrator; James C. Rucinski, MD, FACS, President, BLIC Chapter; Ms. Zupko; Michael Setzen, MD, FACS, program organizer, Nassau Surgical Society.
ACS in the news

Editor’s note: Print, broadcast, and online media around the world, including social media, frequently report on the work of the American College of Surgeons (ACS). Following are brief excerpts from news stories published from November 2012 to February 2013 that mention key ACS activities and initiatives, including research findings appearing in the Journal of the American College of Surgeons. To access the news items in their entirety, visit the online ACS Newsroom at http://www.facs.org/newsroom/acs-in-the-news.html.

Center for simulated medicine opens in Anne Arundel County
The Baltimore Sun
February 18, 2013
“The American College of Surgeons has granted professional accreditation to 83 simulation centers so far, most of them in the United States. Of those, all but a few are affiliated with major university hospitals.”

Prescribing a new kind of rehab for cancer survivors
The Informed Patient
Wall Street Journal
January 28, 2013
“Rehabilitation services are ‘an absolutely essential part of cancer care,’ says Dan McKellar, chairman of the Commission on Cancer. Last year the nonprofit standards-setting group, overseen by the American College of Surgeons, began requiring cancer programs to offer rehabilitation services to be eligible for accreditation.”

Surgical errors: In ORs, “never events” occur 80 times a week
American Medical News
January 28, 2013
“Given the common estimate that 50 million operations are done each year in the U.S., the calculation would translate to one surgical ‘never event’ in every 12,248 procedures. Although surgical never events are extremely rare, that does not lessen the gravity of these mistakes,’ said T. Forcht Dagi, MD, MPH, chair of the American College of Surgeons’ Committee on Perioperative Care. ‘Checklists and protocols

Patients urged to watch for trouble after colon surgery
MedLine Plus
February 13, 2013
“The experts also said there were two other symptoms—chest pain and shortness of breath—that require a trip to the nearest emergency department, according to the study in the February issue of the Journal of the American College of Surgeons. The study [on specific signs of complications in colorectal surgical patients] is the first step toward incorporating these warning signs into already established discharge instructions for bowel surgery patients, said study author Dr. Linda Li, of the Michael DeBakey Veterans Administration Medical Center and Baylor College of Medicine in Houston.”

Breast reconstruction using women’s own tissue appears safe: Study
Healthday
US News and World Report
February 22, 2013
“The risk varied by the type of flap procedure, however.

The rates of complications were about 7 percent, 13 percent and 19 percent for the three types of flap procedures examined in the study, according to the findings, which were published in the February issue of the Journal of the American College of Surgeons.”

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designed to prevent these errors must be followed,’ he said.”

The type of hospital affects racial disparities in pediatric care
“The study, published in [the] Journal of American College of Surgeons, found Hispanic children were 23 percent more likely than white children to experience appendix perforation at community hospitals. Asian children were 34 percent more likely than white children to experience appendix perforation, and Hispanic patients treated at children’s hospitals were 18 percent more likely than white patients to develop the complication.”

God’s Surgeons in Africa
The Atlantic December 28, 2012
“You hate to use the term bang for the buck,’ Thomas Crabtree, a reconstructive surgeon based in Hawaii, told me, ‘but, very often, there’s at least a chance for a very high level of efficiency when you’re doing this type of work.’ Crabtree went to Stanford Medical School and trained in plastic surgery at the Walter Reed Army Medical Center. He spent 20 years in the military, and now serves as a senior medical advisor to the Pacific Command. In 2007, Crabtree was given a military volunteer award from the American College of Surgeons for his humanitarian work.”

Among their peers: Peer review can prove tricky for rural surgeons
Modern Healthcare December 15, 2012
“In Kansas, the state medical society coordinates a service to assemble peer-review panels when it becomes difficult to do so because of ‘local considerations, small staff size or other considerations,’ according to the Kansas Medical Society website. One physician who has participated in that service is Dr. Tyler Hughes, chairman of the American College of Surgeons’ Advisory Council for Rural Surgery.”

Simple measures cut infections caught in hospitals
USA Today November 28, 2012
“A project at sevenbig hospitals reduced infections after colorectal surgeries by nearly one-third. It prevented an estimated 135 infections, saving almost $4 million, the Joint Commission hospital regulating group and the American College of Surgeons announced Wednesday. The two groups directed the 2 1/2-year project.”

ACS NSQIP improves quality, reduces costs at Hartford, CT, hospital

In an interview published recently in the Healthcare Financial Management Association’s Leadership e-Bulletin, Scott J. Ellner, DO, MPH, FACS, vice-chair of surgery and director of surgical quality, Saint Francis Hospital and Medical Center, Hartford, CT, stated that using data from the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) helped the hospital to reduce catheter-associated urinary tract infections by 62 percent and save $53,000 in medical costs.

Dr. Ellner highlighted the critical factors for a successful quality improvement program, including having reliable benchmark data and the ability to pinpoint variation, building key alliances, working with the finance department, incorporating patient feedback, and encouraging full staff participation in quality programs. Go to http://www.hfma.org/Content.aspx?id=15387 to view the article. ♦
American Cancer Society celebrates its centennial

Along with the American College of Surgeons, the American Cancer Society is observing its 100th anniversary in 2013. Throughout their shared 100-year history, the American College of Surgeons and the American Cancer Society (the two ACSs) have collaborated on many programs, including the establishment of what are now known as the Commission on Cancer and the American Joint Commission on Cancer. The American Cancer Society will officially recognize its centennial on May 22.

The progress that has been made in treating all forms of cancer is remarkable, and the American Cancer Society’s 100th anniversary is an opportunity to acknowledge the progress the two ACSs have made together this past century and to celebrate the millions of lives saved. The American Cancer Society reports that today, two out of three people diagnosed with cancer are surviving for at least five years. Since the early 1990s, the cancer death rate in the U.S. has declined by 20 percent.

To commemorate its 100th anniversary, the American Cancer Society has launched a campaign aimed at achieving the following goals, among others:

• Raise $100 million additional dollars to support cancer research and care
• Help position the American Cancer Society as the premier organization that will solve the cancer problem this century
• Increase public knowledge of the progress and accomplishments made

To help eliminate cancer, the American Cancer Society intends to continue to ensure lifesaving cancer research gets funded and is undertaking a historic research project called the Cancer Prevention Study-3 (CPS-3). The goal is to enroll at least 300,000 adults of various racial/ethnic backgrounds from across the U.S. in the study by the end of this year. The society will also continue to work to ensure that cancer patients have access to quality health care and that all Americans have access to a range of health care basics, from lifesaving screenings to clean air.

Details regarding the longstanding partnership between the two ACSs were published in an article by LaMar S. McGinnis, Jr., MD, FACS, titled “Common origins: The two ACSs—100 years of collaboration to improve the lives of cancer patients,” which appeared in the April 2012 Bulletin (Bull Am Coll Surg. 97[4]:6-15). For more information on the American Cancer Society, go to www.cancer.org.

ACS Bulletin launches user-friendly website

The Bulletin of the American College of Surgeons now is available at http://bulletin.facs.org. The online version of the Bulletin offers all of the content in the print version in a contemporary, user-friendly, electronic format that is easily read on mobile devices as well as on desktop computers. With its interesting and vivid graphics as well as links to “related posts” featuring similar content, the site is a convenient option for those who prefer electronic publications. Users also have the ability to share content across multiple social media platforms including Facebook, Twitter, and LinkedIn. As the website evolves, it will start featuring more Web-exclusive content.

The Bulletin website was developed by staff in the ACS Division of Integrated Communications, primarily Gena Hayward, Jim Losby, Amy Hastings, and Tony Peregrin. If you have any questions or comments about the website, please send an e-mail to bulletin@facs.org or contact Diane Schneidman, Editor-in-Chief, at dschneidman@facs.org.
• Office Coding and Profitable Practice Operations (THURSDAY)

• Mastering General Surgery Coding (FRIDAY)

NEW CASES for 2013!

Vein and thoracic surgical cases are featured this year – along with bariatric, breast, GI, skin cancer and trauma. Learn to apply modifiers correctly. Understand how to reduce delays and appeals.

Real case examples illustrate key documentation and coding principles – not vague theory. The workbook will serve as a useful, readable reference.

You’ll learn how to stay out of the auditor crosshairs for your evaluation and management coding.

Coding isn’t like riding a bicycle – once you’ve mastered cycling, you’ve got it down. Codes change, rules change, payers change – it’s a dynamic art.

These two workshops in combination will sharpen your ability to run your practice profitably and compliantly. Read signed reviews by workshop alums on our website.

* Earn CME credits!

OUR INSTRUCTORS

Mary LeGrand, RN, MA, CCS-P, CPC, consultant with more than three decades of nursing and administrative experience, including leadership positions on several national boards

Betsy Nicoletti, MS, CPC, author, speaker and consultant with over two decades engaged in coding education, billing, and accounts receivable management

99% of the 2012 attendees would recommend the American College of Surgeons and KarenZupko & Associates workshops to a colleague!!

“Excellent course. The speaker was exceptional!! She was able to simplify the complicated areas for me, a new surgeon in practice.”

David J. Dupree, MD, Dr. Chaagares and Dupree, Shrewsbury, NJ

“I think the course was well presented and formatted. There was a lot of good information that will be useful for everyone.”

Sandra Kenning, RN, Kearney Clinic, Kearney, NE

“As usual, excellent presentation. I will attend again.”

Mitzi Edge, Administrator, The Breast Center, PC, Marietta, GA

To register visit www.karenzupko.com or call 312-642-8310

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
Call for nominations for ACS Secretary and Treasurer positions

The 2013 Nominating Committee of the Board of Regents (NCBR) will select nominees for the positions of Secretary and Treasurer of the American College of Surgeons (ACS). The Board of Regents approved this new open nomination process at its October 2012 meeting.

The NCBR will use the following guidelines when considering potential candidates:

• Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.

• Nominees must have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

• Members of the NCBR recognize the importance of achieving representation of all who practice surgery.

• The College encourages consideration of women and other underrepresented minorities.

All nominations must include a letter of recommendation, a current curriculum vitae, and a personal statement from the candidate detailing ACS service and the name of one individual who can serve as a reference. Any attempt to contact members of the NCBR by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification. Applications submitted without the requested information will not be considered.

The deadline for submitting nominations is Monday, May 6, 2013. Submit nominations to secretaryandtreasurernominations@facs.org.

If you have questions, contact Barbara L. Dean, Director, Executive Services, and Senior Staff Liaison for the NCBR, at 312-202-5386.

Responsibilities of the Secretary and Treasurer

• The Secretary and Treasurer shall each serve an initial three-year term and may serve a maximum of two three-year terms.

• The Secretary shall oversee the minutes of the annual meetings of the members, give notices in accordance with the provisions of law and the Bylaws of the ACS, keep the records and corporate seal, and perform such other duties as may from time to time be assigned by the Board of Regents. The Secretary will attend the meetings of the Board of Regents and will work with designated staff members to ensure that the official minutes of meetings accurately reflect the discussion of the Board of Regents. The Secretary has the co-responsibility with the Executive Director to provide such oversight.

• The Treasurer shall oversee, in conjunction with the Chief Financial Officer, the funds of the College under the supervision of the Finance Committee and shall make such reports to the Finance Committee, the Executive Committee of the Board of Regents, and the Board of Regents as may be required. The Treasurer will attend the meetings of the Board of Regents and will have a reporting relationship to both the Finance Committee and the Executive Director. The College shall purchase a bond or insurance coverage ensuring the faithful performance of the duties of the office of Treasurer. In the absence or inability to act of the Treasurer, the duties of the Treasurer shall be performed by such person and in such manner as the Finance Committee may direct.
Register now for two 2013 surgery oral examination courses

Two Clinical Performance and Oral Examinations in Surgery courses will be offered in the coming months: first on May 10–15 at Amelia Island Plantations in Florida, and then on September 8–13 in Stowe, VT. The courses have been added to accommodate increased demand and maintain minimal class sizes.

Leaders of the Association of Program Directors in Surgery reviewed the outcomes of this course in 2011 and published the results in January 2012 in the Journal of Surgical Education. The report notes that, based on preliminary results, the success rate among those providing follow-up was 97 percent for surgeons who followed their remediation plan.

The course provides an opportunity for surgeons who have not passed the certifying examination or senior residents/fellows who anticipate difficulty with the certifying examination to receive individual feedback on their oral examination skills and knowledge base. The expanded course will begin with an evening reception on the first day and allow for more individual assessment. All participants will be videotaped in a mock certifying examination on the fifth day of the course and participate in a debriefing session on the final day. Each debriefing will include a behavioral analysis, content areas of weakness, a plan, and questions for review along with a video of the participant’s mock exam.

Go to http://www.oralboardreview.net/ for a full description of the course and to register online. Questions about the program should be sent to Pamela Rowland, PhD, at PRowland@med.unc.edu, or PhDSurgery@gmail.com, or by calling 919-843-3546. ♦
Submit applications now for ACS 2014 Traveling Fellowship to Japan

The International Relations Committee of the American College of Surgeons (ACS) announces the 2014 ACS Traveling Fellowship to Japan, which was created to encourage the international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America. The closing date for receipt of all completed applications is June 3, 2013.

Basic requirements
The scholarship is available to an ACS Fellow from most of the surgical specialties who meets the following requirements:

• Has a major interest and accomplishment in clinical and basic science related to surgery

• Holds a current full-time academic appointment in Canada or the U.S.

• Is younger than 45 years of age on the date the application is filed

• Is enthusiastic, personable, and possesses good communication skills

The Fellow will spend a minimum of two weeks in Japan and engage in the following activities:

• Attend and participate in the annual meeting of the Japan Surgical Society, which will be held in Kyoto, Japan, April 3–5, 2014

• Attend the Japan ACS Chapter meeting during the Japan Surgical Society meeting

• Visit at least two Japanese medical centers (in locations other than the annual meeting city) before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with local surgeons

The academic and geographic aspects of the itinerary would be finalized in consultation and mutual agreement between the Fellow and designated representatives of the Japan Surgical Society and the Japan ACS Chapter. The surgical centers to be visited would depend to some extent on the special interests and expertise of the Fellow and professional contacts that the Fellow has established previously with surgeons in Japan.

The Fellow’s spouse is welcome to accompany the successful applicant. There will be opportunities for social interaction, in addition to professional activities.

Financial support
The College will provide the sum of $7,500 (U.S.) to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society. The Fellow must meet all travel and living expenses. Senior representatives of the Japan Surgical Society and the Japan ACS Chapter will consult with the Fellow about the centers that the Fellow will visit in Japan, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow will make travel arrangements in North America: These arrangements will reduce the fares and travel packages for travel in Japan.

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

Applications for this traveling fellowship may be obtained via the College’s website, http://www.facs.org/memberservices/acsjapan.html, or by contacting the International Liaison at kearley@facs.org or International Liaison Section, ACS, 633 N. Saint Clair Street, Chicago, IL 60611-3211.

The successful applicant and an alternate will be selected and notified by November 1, 2013. •
# Calendar of events

*Dates and locations subject to change.

## APRIL 2013

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Event</th>
<th>Dates</th>
<th>Location</th>
<th>Contact</th>
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<tbody>
<tr>
<td>Chile Chapter</td>
<td>April 14–17</td>
<td>Hotel Sheraton Convention Center, Santiago, Chile</td>
<td>Contact: Ivan Alcoholad, MD, FACS, <a href="mailto:ialcoholado@alemana.cl">ialcoholado@alemana.cl</a>, <a href="http://www.principal.acschile.cl/">http://www.principal.acschile.cl/</a></td>
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<tr>
<td>New Jersey Chapter</td>
<td>Joint 2013 Dublin Educational Pilgrimage with the Royal College of Surgeons</td>
<td>April 21–28</td>
<td>Contact: Andrea Donelan, <a href="mailto:njsurgeons@aol.com">njsurgeons@aol.com</a>, <a href="http://www.nj-acs.org/">http://www.nj-acs.org/</a></td>
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<tr>
<td>Argentina Chapter</td>
<td>XXII International Course</td>
<td>April 26</td>
<td>Salta, Argentina</td>
<td>Contact: Rodolfo L. Faraco, MD, FACS, <a href="mailto:rfaraco52@gmail.com">rfaraco52@gmail.com</a></td>
</tr>
<tr>
<td>North Dakota and South Dakota Chapter</td>
<td>April 26–27</td>
<td>Ramkota Hotel, Bismarck, ND</td>
<td>Contact: Leann Benson, <a href="mailto:leann@ndmed.com">leann@ndmed.com</a></td>
<td></td>
</tr>
<tr>
<td>Indiana Chapter</td>
<td>April 26–27</td>
<td>ACS Headquarters, Chicago, IL</td>
<td>Contact: Carolyn Downing, <a href="mailto:cdowning@ismanet.org">cdowning@ismanet.org</a>, <a href="http://www.infacs.org/index.html">http://www.infacs.org/index.html</a></td>
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<tbody>
<tr>
<td>Ohio Chapter</td>
<td>May 3–4</td>
<td>Sheraton at Capital Square, Columbus</td>
<td>Contact: Jennifer Starkey, <a href="mailto:jennifer@executive-office.org">jennifer@executive-office.org</a>, <a href="http://associationdatabase.com/aws/ACS/pt/sp/OH_Home_Page">http://associationdatabase.com/aws/ACS/pt/sp/OH_Home_Page</a></td>
<td></td>
</tr>
<tr>
<td>Virginia Chapter</td>
<td>May 3–5</td>
<td>Hilton Virginia Beach, VA</td>
<td>Contact: Susan McConnell, <a href="mailto:smcconnell@ramdocs.org">smcconnell@ramdocs.org</a>, <a href="http://www.virginiaacs.org/">http://www.virginiaacs.org/</a></td>
<td></td>
</tr>
<tr>
<td>Australia and New Zealand Chapter</td>
<td>May 6–10</td>
<td>SKYCITY/Crowne Plaza Convention Centre, Auckland</td>
<td>Contact: Monique Whear, <a href="mailto:monique.whear@surgeons.org">monique.whear@surgeons.org</a></td>
<td></td>
</tr>
<tr>
<td>Vermont Chapter</td>
<td>May 9</td>
<td>The Quechee Club, Quechee, VT</td>
<td>Contact: Jeanne M. Kunkle, <a href="mailto:jeanne.kunkle@vtmednet.org">jeanne.kunkle@vtmednet.org</a></td>
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<tr>
<td>West Virginia Chapter</td>
<td>May 9–11</td>
<td>The Greenbrier Sulphur Springs, WV</td>
<td>Contact: Sharon Bartholomew, <a href="mailto:sbartholomew@hsc.wvu.edu">sbartholomew@hsc.wvu.edu</a></td>
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<tr>
<td>Michigan Chapter</td>
<td>May 17–18</td>
<td>Radisson Plaza Hotel &amp; Suites, Kalamazoo</td>
<td>Contact: Angie Kemppainen, <a href="mailto:akemppainen@msms.org">akemppainen@msms.org</a>, <a href="http://www.michiganacs.org/">http://www.michiganacs.org/</a></td>
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## FUTURE CLINICAL CONGRESSES

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Dates</th>
<th>Location</th>
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<tbody>
<tr>
<td>2013</td>
<td></td>
<td>October 6–10</td>
<td>Washington, DC</td>
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<td>2014</td>
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<td>October 26–30</td>
<td>San Francisco, CA</td>
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<td>2015</td>
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<td>October 4–8</td>
<td>Chicago, IL</td>
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