Training the next generation of humanitarian surgeons
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A real challenge is brewing in surgical education, and the American College of Surgeons (ACS) is taking action to ensure that surgical patients will continue to receive high-quality care from competent and confident surgeons. More specifically, under the leadership of J. David Richardson, Immediate Past-Chair of the Board of Regents, the College has developed a Committee on the ACS Transition to Practice Fellowship in General Surgery. This committee is charged with developing fellowships for young surgeons who are leaving residency and entering into the practice of general surgery. The fellowships are intended to help fill perceived gaps in training today.

“A crying need”

Dr. Richardson, other members of the Committee on the ACS Transition to Practice Fellowship in General Surgery, and the ACS leadership believe that the College needs to establish this program for several reasons. As Dr. Richardson noted, “80 percent of all surgical trainees go on to pursue advanced fellowships in the surgical specialties.” Consequently, the profession could be “rightly accused of training too many surgeons in specialties for which there is a lesser need and not training enough people in general surgery for which there is a crying need,” he added. Young surgeons themselves offer perhaps the most telling rationale for establishing the fellowship program: at least one-quarter of all fifth-year general surgery residents say they feel inadequately prepared to enter practice.

The members of the Committee on the ACS Transition to Practice Fellowship in General Surgery and other ACS leaders maintain that current fifth-year residents often lack confidence in their capabilities and may be ill-prepared to enter practice due to a lack of general surgery mentorship and limited exposure to open surgical procedures. They attribute this deterioration to a number of factors, including reduced work hours, fewer hands-on experiences, and
reduced volume of cases, especially emergency cases. Of particular concern is the lack of continuity of care and supervision.

As committee member Don K. Nakayama, MD, FACS, Milford B. Hatcher Professor and chair, department of surgery, and general surgery residency program director, Mercer University School of Medicine, Macon GA, said, “The transition from being a chief resident on June 30 to a surgeon in independent practice on July 1 is a daunting step. They haven’t done an operation without an attending across the table. Far worse, the gaps in the current training paradigm have left graduating residents uneasy and insecure about a general surgical practice, much less one where they’re more isolated, such as in a smaller or a rural community.”

The College steps in
As an organization that is dedicated to ensuring the delivery of safe, effective, high-quality surgical care, and given the College’s considerable experience in accreditation and surgical education, the ACS is uniquely positioned to work with surgical training centers to establish and oversee general surgery fellowships. The committee, operating under the aegis of the ACS Division of Education, has developed a model for the fellowship, which will be distinct from other fellowships. “This will really fill a very important educational gap,” said Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the Division of Education.

These fellowships will offer considerable flexibility and allow the fellows to pursue opportunities tailored to their individual practice interests. Fellows will work with strong mentors, who will encourage their gradual autonomy. The committee members agreed that several basic experiences should be included in the curriculum, including endoscopic procedures, critical care, common general surgery operations, obstetrics-gynecology, and practice management.

Although the fellowships will not be subject to approval from the Accreditation Council on Graduate Medical Education, they will need to be approved by the graduate medical education committee at each institution. They will be designed in collaboration with the general surgery residency program director to ensure that this advanced training paradigm achieves its goals without interfering with the training of general surgery residents.

Roll out begins
The College is pilot testing the fellowship program at several sites in regions currently underserved by general surgery trainees. The rationale for launching the fellowships in these locations is to help address the shortage of general surgeons. At press time, the following institutions had committed to begin pilot testing the ACS Transition to Practice Fellowship in General Surgery on July 1, 2013:

- Gundersen Lutheran Health System, La Crosse, WI
- Mercer University School of Medicine/Medical Center of Central Georgia, Macon
- Ohio State University (OSU) Wexner Medical Center, Columbus
- University of Louisville School of Medicine, KY
- University of Tennessee College of Medicine, Chattanooga

The leaders of these programs have developed excellent plans for introducing the fellowships at their institutions. According to Thomas H. Cogbill, MD, FACS, general surgery residency program director emeritus, department of general surgery, Gundersen Lutheran Medical Center, that institution’s fellowship will provide experience in emergency general surgery, outpatient care, practice management, surgical subspecialty (obstetrics/gynecology, otolaryngology, urology, orthopaedics) skills, and outcomes tracking. “For fellows interested in rural general surgery preparation, Gundersen Lutheran Health System includes four sites at which regional surgeons would provide mentorship and experience in the practice of general surgery in communities with populations between 5,000 and 10,000,” Dr. Cogbill added.
According to Dr. Nakayama, the Mercer general surgery fellow will be a junior partner in an established three-surgeon practice in Cordele, GA, population 23,439. He or she will operate with an attending for a month or two, and by the end of the year, they’ll be practicing independently and relying on senior partners only for weekly case reviews. They will also attain practice management skills. “The fellow will set up a practice, visiting referring doctors, communicating about referrals, and being a member of a broader medical community,” he added. Opportunities will be available to pursue added experiences in high-demand specialties, such as otorhinolaryngology, urology, orthopaedics, and obstetrics and gynecology.

Likewise, the general surgery fellowship program in Chattanooga will focus “on the specific needs and career objectives identified by each prospective fellow in preparation for a fulfilling and sustainable career,” said R. Phillip Burns, MD, FACS, chairman and professor of surgery, department of surgery, at the University of Tennessee College of Medicine. “It will provide an expanded opportunity to gain autonomous experience in a protected environment in both clinical decision making and operative case completion,” added Dr. Burns, First Vice-President of the ACS.
The College is pilot testing the fellowship program at several sites in regions currently underserved by general surgery trainees.

The OSU fellow will complete two six-month rotations at two hospitals that are part of Wexner Medical Center: University Hospital and University Hospital East. University Hospital serves as a Level 1 trauma center and houses a burn center. University Hospital East is a community hospital staffed by OSU physicians and offers a full range of hospital services, according to E. Christopher Ellison, MD, FACS, Robert M. Zollinger Professor of Surgery, chairman of the department of surgery, and general surgery program director at OSU. “The key elements of the fellowship include autonomy, mentoring, greater responsibility, flexibility, and outcomes measurement,” Dr. Ellison said.

In addition, Eastern Virginia Medical School, Norfolk, will launch a program in 2014. According to L. D. Britt, MD, MPH, FACS, FCCM, FRCSEng (Hon), FRCS(Ed)(Hon), FWACS(Hon), FRCSI(Hon), FCS(SA)(Hon), the Eastern Virginia program will be built on rotations with faculty in busy general surgery practices in the Norfolk area. During committee meetings, Dr. Britt said, “The purpose of these programs is to emphasize transition to practice, and rotations need to focus on this important feature.”

As of press time, several other institutions had expressed interest in establishing the fellowships.

Building on tradition
The ACS was founded a century ago largely to ensure that surgeons were properly trained to provide safe, competent, high-quality, effective surgical care. As the profession and surgical education have evolved over the last 100 years, the means of fulfilling that objective have changed and fluctuated.

The College’s leadership believes that the present training paradigm and the increased interest in the pursuit of subspecialty training have left many young surgeons lacking the confidence to provide high-quality general surgery care. Given the organization’s long-standing involvement in education, the College is singularly qualified to assist in the establishment of a general surgery fellowship that will fill the gaps in training and perhaps inspire young people to pursue careers in general surgery in currently underserved areas.

I would strongly encourage all surgical educators to consider introducing this fellowship in their institutions. Our goal is to make this program more widely available in 2014. To learn more about each of the fellowship programs that are being pilot tested, contact the surgeons listed in the sidebar on page 9. ✤
Training the next generation of humanitarian surgeons
A win for all:

Faculty-student partnerships in surgical humanitarianism

by Ira L. Leeds; Jahnavi Srinivasan, MD, FACS; John G. Pattaras, MD, FACS; and Viraj A. Master, MD, PhD, FACS

HIGHLIGHTS

• The authors demonstrate the value of including medical students on surgical missions to low-income countries.

• The inclusion of medical students in international surgical relief efforts is a “win” for patients, the students, the attending surgeons, and the overall understanding of the value of providing surgical care in countries with limited resources.

• Responses to common criticisms of involving medical students in surgical missions are provided.

Overleaf: Dr. Master flushes a patient’s bladder irrigation piping during night rounds.

This page: From left: Dr. Srinivasan and Dr. Master perform an ultrasound evaluation of an abdominal mass while teaching medical students Lee Hugar and Pete Creighton the diagnostic technique. 2010’s surgical team brought a portable ultrasound machine for enhanced diagnostic imaging capabilities. (Photos courtesy of Nick Vittone.)
Medical humanitarianism is an increasingly stable fixture in the international relief community. Although previously termed the “neglected stepchild of global health,” surgery’s unique ability to provide definitive results has allowed surgical humanitarianism to become an increasingly important player within health care-related humanitarian endeavors. There is a long history of incorporating an educational component into both long-term and short-term surgical missions. Although, in recent years, there has been a groundswell in the promulgation of international training opportunities for residents, medical students are rarely included in these surgical missions.

For the last five years, Emory Medishare, a faculty-student collaboration at Emory University in Atlanta, GA, has facilitated a series of short-term surgical missions to rural Haiti’s Hôpital St. Thérèse in Hinche with the specific combined aims of providing appropriate surgical care to a population in desperate need and offering a credit-worthy educational experience (as part of medical students’ surgical clerkship rotation) for a team composed predominantly of medical students. However, some experienced surgeon-humanitarians have questioned the value of so heavily incorporating medical student participation and leadership into Emory Medishare’s surgical efforts.

It is important to note that this program does not simply provide medical students with the opportunity to obtain international experience. Instead, it is a surgical mission that authentically integrates medical education into its greater humanitarian objectives. In the strictest sense, these trips demand far more of medical students than just “showing up.” Such a program is a radical departure from the typical role of medical students in international health.

The design of a curriculum for inclusion of medical students in relief efforts, the clinical safety of patients, and the educational outcomes have all been described in other publications. The purpose of this article is to briefly synthesize the findings of prior work in the field, identify the major benefits of such medical student-dominated efforts, and reconcile the many criticisms and limitations of such projects.

“4-win” opportunity
The primary objectives of Emory Medishare have always been to provide the highest quality of care possible to the rural Haitian patient population it serves while also challenging participating medical students to gain new skills and knowledge from this unique educational opportunity. Two less-expected benefits to come out of this work have been the substantial effects such trips have had on supervising faculty and the benefits accruing to the field of surgical humanitarianism. These four wins—the benefits to patients, the benefits to medical student, the benefits to faculty, and the contributions to the field—are what have made this mission model so effective.

A win for patients
The burden of surgical disease among the world’s poorest nations has recently gained appropriate attention in the medical literature. The rising visibility of this global issue has led to the emergence of professional organizations, such as the Alliance for Surgery and Anesthesia Presence Today (ASAP Today), that serve to focus more U.S.-based resources on addressing the need for additional personnel and equipment.

Emory Medishare’s work in Haiti also demonstrates the need for more surgical care in low- and middle-income countries. The team’s completion of 19 open simple prostatectomies is an example of the group’s ability to provide care for untreated disease, as this procedure is the only available long-term therapy for patients with severe benign prostatic hypertrophy. In the industrialized world such a disease could be managed easily with medication and transurethral procedures for the most severe cases; however, these options are unavailable to Haitian patients due to the lack of consistent access to effective pharmaceuticals or available endoscopic technology.

With careful case selection and appropriate long-term local partnerships, these missions have been a very effective means of addressing surgical needs in under-resourced areas.
allowed otherwise healthy Haitian men to walk about unencumbered by a catheter for the first time in years. These cases have also reinforced claims that surgical care in low-income countries can be a cost-effective intervention.\textsuperscript{9,12} The demand for such a procedure has not receded, and Emory Medishare has had to turn away individuals who arrive at the surgical hospital too late to fit them into the mission’s operating schedule.

As a previously published case series has demonstrated, the benefit of surgical missions is not limited to one particular procedure or pathology.\textsuperscript{9} Over the last four years, surgical needs in Haiti have varied from an imminent septic wound to a slow-growing abdominal tumor of unknown etiology. The Emory Medishare program in Hinche has provided surgical care to patients from as far away as Port-au-Prince because even the capital did not have a urologist available to perform orchiopexy for a young boy with bilateral cryptorchidism. With careful case selection (for example, technically complex but low-risk recovery) and appropriate long-term local partnerships, these missions have been an effective means of addressing surgical needs in resource-poor areas.

A win for students
Faculty provide appropriate clinical supervision and perform each surgical procedure, but the medical students manage the host of nonoperative duties that must also be completed. Non-narcotic pharmaceutical and surgical supply procurement is done largely without faculty support other than to confirm procurement lists and verify that the correct item is administered at point-of-care. Postoperative care protocols are first written by medical students who have participated in previous trips, and then they are edited and approved by faculty members. Likewise, medical students work with experts at their home institutions to design systems for monitoring and evaluating the success of each surgical mission with respect to patient care and student learning.

Outside of clinical care, medical students function exclusively as the mission’s logisticians and manage their own international and in-country transport, housing, and non-governmental organization (NGO) partnerships. It should be noted that these trips are not an international experience loosely connected to the medical students’ curriculum, but rather are considered to be a formal part of medical students’ third-year surgical clerkship.

These efforts have been hugely rewarding for medical students, and previously published work on the program’s impact on students demonstrates the unique teaching points such trips provide while satisfactorily maintaining the same educational standards of a required surgical clerkship.\textsuperscript{10,13} Students have routinely reported that the empowering roles they hold as non-clinical trip leaders and the intensely fulfilling mentoring relationships formed in the months preceding the trip are unseen elsewhere in the traditional medical student curriculum. These trips also mark one of the few times in their medical school clinical training where students meet patients at first presentation and diagnosis, follow them to the operating room (OR), coordinate all facets of postoperative care, and then provide for discharge. Consistent with today’s trends in health care systems training, students are encouraged to consider the optimal care pathway given the patient’s limited external resources and the lack of access to further diagnostic testing.
These trips also mark one of the few times in their medical school clinical training where students meet patients at first presentation and diagnosis, follow them to the OR, coordinate all facets of postoperative care, and then provide for discharge.

**A win for attending surgeons**

One of the most surprising benefits of this program has been the degree to which attending surgeons find personal development from the experience. With unnerving consistency, each year produces a few clinical cases that push the attending faculty to balance their surgical scope of expertise with the utter lack of resources or support if unexpected problems arise. For this reason, the leaders of Emory Medishare have spent a considerable amount of time identifying experienced faculty members with both breadth and depth of surgical training necessary to ensure the best “human armamentarium.” This strategy has given the team the capability of performing highly technical, low-technology procedures, such as urethral reconstruction and complex tumor resections, in appropriate patients.

The participating faculty have noted that opportunity to perform these types of procedures in settings that do not otherwise lend themselves to surgical care is immensely rewarding and is part of what motivates them to make the sacrifices of time and personal resources that are a consequence of participating in these missions.

**A win for the field**

The Emory Medishare surgical program has had an impact on the field of humanitarian surgery that has not yet been fully realized. First, the broad array of research interests among participants has led to a number of scholarly presentations and publications stemming from the program. The depth of commitment from students and faculty over the past several years has resulted in contributions to the surgical literature that mimic traditional research activities built up over an academic career. These scholarly activities have engaged student participants in global health in a manner far exceeding one or two weeks of international field work. Prior par-
Participants have helped craft Emory University’s policies on extramural clinical experiences, have gone on to residency positions with formal global health components, and have met with thought leaders in the greater global surgery community at national meetings.

Criticisms and limitations
The most frequently cited concern regarding Emory Medishare’s surgical program is the minor role of local partners. In practice, logistical and administrative needs in Haiti are filled by the project’s lead local partner, Project Medishare for Haiti. Clinical responsibilities during the trips are conducted almost exclusively by visiting team members before arranging outpatient follow-up and formally transferring care of the few remaining inpatients to the local surgical practice. Both internal and external critics have noted the opportunity for educating local Haitian surgical trainees and for collaborative international research. Furthermore, this cooperative division is not aligned with accepted best practices in humanitarian surgery, nor does it adhere to the program’s long-term objectives.

Previous efforts to address this partnership deficit have been mixed. First, health care workforce shortages in Haiti combined with repeated national emergencies, including the 2010 earthquake and multiple cholera outbreaks, have limited the availability of local personnel. Second, the Emory team has had difficulty creating local training opportunities without detracting from one of the four benefits previously noted, namely the benefits to patients, the benefits to medical students, the benefits to faculty, and contributions to the field. Historically, the team has experimented with inviting local surgeons and nursing staff to participate in the OR, but these experiences have either severely curtailed clinical productivity or limited the involvement of medical student members of the team. Given the substantial investment of personal and institutional resources and the formalized curricular role of the trip, both of these trade-offs are inconsistent with the present program structure but will likely undergo additional refinement over time.

Our experiences do not rule out an obligation to involve local partners. Each year of the program, various methods were employed for balancing inclusion of local partners while maximizing short-term objectives. Evening rounds were instituted on later trips with invitations to local clinical staff to participate as appropriate. Similarly, 360-degree roundtable discussions were formally implemented at various points of each trip to ensure all voices of compliment and concern were heard. Further discussions with Emory’s administration have resulted in an extension of the trip to include a dedicated postoperative week, which has improved both short-term clinical follow-up and the process of transferring recovering inpatients to local partners. Through these efforts, Emory Medishare continues to review the relationships with local partners and maintains an ongoing dialog for revision.

Many of these criticisms center on the two-sided nature of humanitarian medicine rather than the unique medical student-driven approach adopted by Emory Medishare. One could argue that humanitarian efforts are intrinsically flawed by their disruptive effects on existing health systems and their role as palliative rather than curative therapy for an underlying social problem. A potential solution, then, is not to further inhibit medical student participation, as some have suggested, but to encourage it with the hopes of exposing future humanitarian physicians to the immensely difficult issues encountered in the field and encourage them to dedicate their careers to improve upon the existing paradigm.

Conclusion
The results of the Emory Medishare surgical program highlight the fact that surgical humanitarianism can be conducted safely and effectively with robust medical student involvement. We recognize such missions raise a host of ethical issues. Contrary to what others have
argued, we suggest that the involvement of medical students diminishes these issues.\textsuperscript{7, 14-15} With medical education formally integrated into such trips, surgical humanitarianism contributes to the education and training of future generations of physicians. The intersection of medical education and international medical humanitarianism is primed for medical students to take on a more serious role. Whereas traditional medical education will never be replaced by overseas training experiences, student involvement in surgical humanitarianism represents a unique enrichment opportunity that is currently underutilized.

More information on Emory Medishare’s platform of programs can be found at www.emorymedishare.org.

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REFERENCES

Pursuing a career in humanitarian and rural surgery: When is the best time to start?

by Crystal M. Cunningham, MD

At a meeting of the World Health Organization (WHO) Global Initiative for Emergency and Essential Surgical Care in November 2011, many medical students and surgical residents expressed interest in finding a way to prepare for a surgical career by combining work in resource-limited locations in the U.S. and service to developing countries.1

Because more and more trainees in surgery are showing an interest in providing surgical care in resource-limited settings and because the number of rural surgeons in America continues to decline, it is important to inform future surgeons regarding how they can establish a career in volunteer and rural surgery.2,3 Several surgical residency programs, such as the Duke Global Surgery residency program, Durham, University of North Carolina-Chapel Hill School of Public Health, have well-established global health programs; but what can residents do if they have chosen a community setting for residency or did not realize until later into residency that this was a path they wanted to pursue?

This article offers some suggestions on how surgical residents—especially those training at community-based teaching hospitals—can forge a career path in rural and humanitarian surgery.

Take control of your education
Finding mentors to foster a career in global surgery can be challenging, so residents should take control of their education and do some self-instruction. For example, during postgraduate training, residents should center their grand rounds assignments on global and rural surgical health care issues. This strategy will provide opportunities to research the current literature, learn the language of global health, become familiar with

RESOURCES

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Operating in low- and middle-income countries (LMIC) and even in rural America can call for a whole different set of skills and mastery of some techniques that may be unfamiliar to many general surgery residents.

the names of surgeons who write about global surgery, and increase other surgeons’ and residents’ awareness of the topic.

Residents may also choose to pursue a master’s degree in global health policy or public health either online or during research years, if their program permits. Earning a degree in these areas will provide a foundation so that the surgical epidemiology of humanitarian care will seem less foreign. Pursing these programs will also allow residents to develop their skills in research design and implementation as this is the focus of several public health programs and is a necessary skill for capacity-building in developing countries. These programs help increase understanding about the policy environment associated with issues of global health, and provide education regarding common tropical ailments encountered in these environments as well as fundamentals of epidemiology.

Participate in Global Surgery Week
Residents may increase their own and others’ awareness of global surgery by hosting a Global Surgery Week at their institution. Global Surgery Week activities may include distributing flyers with facts on global health care, placing key articles in physician lounges and auditoriums, and giving and coordinating presentations on the issue. Information to help host such activities can be found through organizations such as the WHO Global Initiative on Emergency and Essential Surgical Care and through an organization called Surgeons Overseas.

Sign up to receive tweets during this week from Adam Kushner, MD, MPH, FACS, a recognized leader in global surgery through his work with Surgeons Overseas and his lectures at Columbia University in New York, NY. Indeed, residents should take full advantage of social networking by following authors who have written articles on global surgery on Twitter and Facebook. Residents may have many questions not only regarding which skills are necessary for this kind of work, but also questions on topics ranging from financial commitments, security, and how residents can maintain their own health while overseas. Many professionals in this field are more than willing to correspond by e-mail or telephone with other surgeons and residents who are interested in global health care.

Go beyond general surgery
Operating in low- and middle-income countries (LMIC) and even in rural America can call for a whole different set of skills and mastery of some techniques that may be unfamiliar to many general surgery residents. At a community hospital residency program, learning these skills can be a pretty straightforward experience, especially if the facility doesn’t feature any competing residencies or fellowships. However, it can be challenging to arrange an international elective during residency due to the requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME) as well as by various training programs. The requirements of the ACGME for an international elective involve the completion of a stringent application. Additionally, the number of electives allowed by the ACGME during surgical residency are limited, which can make it challenging for a resident to obtain both an international rotation and subspecialty rotations.

Although residents may affiliate with other programs that offer rotations in international surgery, another option is to perform an elective in a subspecialty that is useful in delivering care to patients in LMICs and in rural America. One of the most important subspecialties is obstetrics and gynecology, as humanitarian surgeons commonly need to perform cesarean sections (c-sections). Orthopaedic and urological procedures are also commonly performed.

Endoscopic skills are a must for practice in rural America. Many residencies are affiliated with rural rotations, so it would be feasible to do an elective with one of these rotations or, with program director approval, at one of the Indian Health Service sites.

It is important to maintain an open dialogue with attending surgeons, informing them of your plans—and, while you’re at it, start to think like an LMIC surgeon. For example, when assisting with a procedure, ask the operating surgeon questions such as, “What if this technology or instrumentation were not available? What would you do then?” These are especially important questions because health care facilities in LMICs typically have limited or no imaging, interventional radiology, and operating equipment.

To summarize, residents interested in surgical volunteerism and humanitarian relief need to learn the “big five”:
When assisting with a procedure, ask the operating surgeon questions such as, “What if this technology or instrumentation were not available? What would you do then?”

ONE HUMANITARIAN SURGEON’S CAREER PATH
Following is a timeline of how the author pursued a career in global and rural surgery, starting in her second year of residency (PGY-II).

PGY-II
Began reading The World Journal of Surgery, focusing on topics that are particularly relevant in global surgery such as burden of disease, tropical surgical ailments, and capacity building.

PGY-III
Led grand rounds on damage control for the rural surgeon.
Embarked on research project on HIV-positive patients requiring surgical consultations to become familiar with infectious disease.

PGY-IV
Led grand rounds on Telesurgery As a Resource for General Surgeons in Rural Areas.
Investigated various humanitarian organizations and either became a resident member or applied for an assignment with such organizations as Doctors Without Borders, Mission Doctors Association, Surgeons Overseas, and the International Medical Corps.
Took an online course on not-for-profit fundraising and another on management of not-for-profit organizations offered through a local college. Each course was approximately one month long.

PGY-V
Led grand rounds on Tropical Medicine: A Compendium for the Surgery of Poverty and Neglect.
Joined the Alliance for Surgical and Anesthesia Presence Today listserv and offered services in the form of literature reviews, fundraising, and research collaboration to global health working groups.
Began French studies through both online courses and a private tutor from a local college.
Chose first assignments (St. Martin de Porres Catholic Mission Hospital Njinikom, Cameroon, for three months and a locum tenens position for one month with Indian Health Service prior to departure).
Commenced work on certificates in global health and management with Unite for Sight’s Global Health University. (The author has received a certificate in global health practice and is currently working on a global health management certification).
Initiated online studies for the master of science degree in global health policy with the London School of Hygiene and Tropical Medicine.

How to support yourself
Finding flexibility for humanitarian work and financial stability can be a real challenge. Working with the underserved in America through locum tenens companies can make this happen. When offered positions, residents should take a quick look at the easily searchable U.S. Department of Health and Human Services database available at http://muafind.hrsa.gov/ to see if the position is located in a designated rural and/or underserved area.

To finance missions, think of creative fundraising sources. There are many books, online courses, and generous people that can help residents find funding for humanitarian efforts.

Learn a foreign language
Learning a foreign language may be crucial for placement with various organizations that cover the expense of a humanitarian assignment, and familiarity with foreign languages is a necessity for surgeons who choose global health care as a career path. A career can shift in the form of directorships or WHO collaborations, and fluency in a foreign language may be what makes or breaks an opportunity.

Choosing a language depends on each resident’s area of interest. Spanish
Although it is not necessary to have a precise plan, residents should keep their eyes open for opportunities and seize them as they become available.

would be obvious for Latin America and South America, but French is the language of many humanitarian programs in Africa.

Look for opportunities
Although it is not necessary to have a precise plan, residents should keep their eyes open for opportunities and seize them as they become available. Trying to establish a career in any area of medicine takes innovation and ingenuity. To be successful, physicians need the courage to step out of the typical boundaries and make their own paths. As increasing numbers of general surgery residents pursue fellowships, it can be nerve-wracking to transition from residency into practice. Residents should have faith in those who trained them; no respectable program director will turn a physician loose who isn't ready to provide high-quality patient care.

Future needs
A career in humanitarian surgery, at present, is ill-defined, and many interested surgical residents are without guidance in this pursuit. Future surgeons should be aware of the opportunities available to pursue humanitarian surgery and public health leadership. In an ever-changing political and funding climate, the stability of this career path is definitely unpredictable. Our upcoming generations of surgeons need the training and the financial resources necessary to make this a successful career option and to ensure that humanitarian efforts in surgery can continue.

REFERENCES
In just two years, Twitter use among members of the College has increased dramatically. At the time of the 2010 Clinical Congress in Washington, DC, the American College of Surgeons (ACS) Twitter account, @AmCollSurgeons, had 907 followers, and a modest number of attendees tweeted about their experience or engaged with the College via Twitter. In fact, only 231 tweets included the conference hashtag #ACSCC10. In contrast, at the 2012 Clinical Congress in Chicago, IL, the ACS Twitter account featured 6,800 followers who engaged with the College, with more than 1,881 tweets including the conference hashtag #ACSCC12, representing an 800 percent increase in use from 2010. Through the conference hashtag, Twitter users around the globe were able to follow session presentations, announcements, and contribute to the Clinical Congress without traveling and on their own schedule.

Social media introduced at 2010 Clinical Congress

In 2010, Philip Glick, MD, FACS (@glicklab), moderated a general session titled To Tweet or Become Extinct: Why Surgeons Need to Understand Social Networking. More than 500 surgeons attended the panel discussion, during which speakers encouraged ACS members to embrace social media as a useful tool for networking, continuing education, and professional development. Twitter, in particular, was extolled for its time efficiency, low cost, and lack of geographical boundaries.

Among the 500 surgeons, residents, and other session attendees was Benedict C. Nwomeh, MB, BS, FACS (@bnwomeh), who, like many surgeons, had never used Twitter prior to that session. At one point during the presentation, Dr. Glick asked everyone to visit Twitter on their mobile devices. Impressed by the panel and inspired by the possibilities and potential impact of Twitter, Dr. Nwomeh reached for his phone and logged in. In an e-mail to Dr. Logghe (co-author of this article) in December 2012, Dr. Nwomeh recalled the moment, “Right there, I sent my first. It was that easy. I became Tweetborn, at the ACS Congress!”

As a follow-up to the session, the July 2011 issue of the Bulletin of the American College of Surgeons featured an article titled Using Social Media to Enhance Surgeon and Patient Education and Communication. The article expanded on the information presented at the 2010 Clinical Congress panel discussion and provided further details on how surgeons can responsibly engage in social media for professional and education purposes.* According to that article, a survey by the Pew Internet and American Life Project reported that nearly 60 percent of Americans conduct online searches for health care information, suggesting an opportunity for surgeons to use these online tools to educate and empower their patients through a better understanding of their illnesses and treatment options.

A growing force

Since its inception in 2006, Twitter has experienced rapid growth worldwide. In February of 2010, Twitter users sent 50 million tweets per day, and by March 21, 2012, six years after Twitter was launched, the social networking platform reported users sending 340 million tweets daily. The increased use of Twitter among ACS members mirrors this trend.

The 2012 Clinical Congress marked the first time that the ACS created a designated information booth where members could learn more about social media and how it can be used professionally to stay up-to-date on the latest news and events in the field of surgery. A second, new addition to the College’s social media presence at the meeting was the designation of four ACS Twitter correspondents who were recruited to tweet about their experiences at the Clinical Congress and to encourage retweets and engagement. This year correspondents, in addition to Dr. Nwomeh and Dr. Glick, included Niraj J. Gusani, MD, FACS (@NirajGusani) assistant professor of surgery and public health sciences at Penn State, and Dr. Logghe (@HeatherLoggheMD) general surgery residency candidate and coauthor of this article (see photo, this page).

To further encourage surgeon participation, bookmarks were placed in Congress registration packages to remind attendees of the College's official hashtags—#ACSCC12 for the conference and #ACS100 for tweets related to the College’s history and Centennial celebration. In addition, the Clinical Congress smartphone app included a link that allowed users to follow what the ACS was tweeting during the event. Conference presenters and attendees tweeted announcements of upcoming presentations and room locations, as well as personal observations regarding upcoming sessions. Many attendees tweeted live quotes and comments during presentations, particularly about controversial and stimulating topics such as rural surgery, acute care surgery, bioinformatics, and energy use.

In addition to the designated ACS conference hashtag, the use of individual session numbers as hashtags enabled Twitter users to follow the tweets related to specific sessions in which they were interested. Many presenters found Twitter to be a useful means for providing background and supplemental information as well as for expanding the audience for their presentations. For example, some presenters used Twitter to share references and resources related to the content of their conference presentations. Others shared their presentations by posting their slides on SlideShare and tweeting the link.

During the 2012 Eisenberg Legacy Lecture, which took place at the University of California San Francisco, Carolyn M. Clancy, MD, director of the Agency for Healthcare Research and Quality, noted that Twitter can be an effective tool for communicating across multiple audiences, for training purposes, and to improve quality of care. Twitter is a useful strategy, according to Dr. Clancy’s comments during the meeting, to “globalize the evidence” and “localize the decisions” in health care.
Second Clinical Congress social media session

The 2012 Clinical Congress also marked the second ACS panel session on surgeons and social media networking, which was again highly attended, with an audience of nearly 300. Expanding on the previous session in 2010, the 2012 panel session, titled Why Surgeons Need to Understand Social Networking, explored individual surgeon motivations for engaging in social networking, the meaningful use of social media by surgeons, social media’s role in medical education, and legal implications. Dr. Nwomeh prepared a series of tweets with quotes from the presenters’ slides, which were then live-tweeted during the presentations.

During the session, several surgeons were trained in how to tweet and, in fact, many of them sent their first tweets with the ACS hashtag during the session. Panelist Sani Yamout, MD, encouraged surgeons to use Twitter to establish their own “personal learning network” with surgeons who share both similar interests and a goal of organizing educational Web content. Specifically, he suggested that Twitter is useful for surgical education announcements, board preparation, and gathering and sharing resources. Indeed, Dr. Nwomeh has found that “Twitter makes it really easy to learn and share new ideas.” In the question/answer session, participants expressed interest in earning continuing medical education (CME) credits for their future participation and lifelong learning activities involving Twitter. Current programs do not offer CME credit through Twitter, although the College is exploring possible opportunities in this area.

What’s next for the ACS and Twitter?

A future vision for Twitter and the College was articulated by ACS social media manager Jerry Schwartz (co-author of this article): “Having established a social media presence, our next step is to become a more social organization so that staff members will think of social media as a powerful platform to promote the accomplishments and outreach efforts of the College.”

The rapid growth of Twitter use in 2012 signals the recognition by surgeons of the potential of the platform to improve the delivery of high quality care and to strengthen communication with colleagues. The College anticipates even greater use and greater use of Twitter at the next Clinical Congress in Washington, DC, this year.

Medicolegal issues and concerns

Henry Fader, Esq. (@PhillyFader) addressed medicolegal concerns of surgeons using social media. He emphasized that expectations of professional behavior are essentially the same on Twitter as they are in any public setting and thus, common sense, good judgment, and caution are prudent. Since the ramifications of unprofessional commentary are magnified by the public nature and electronic record of social media, he advised surgeons to assume that all tweets are public and will continue to exist forever.

Patient identifying information should never be posted on public forums such as Twitter, according to Mr. Fader and other session panelists, to ensure Health Insurance Portability and Accountability Act (HIPAA) compliance. Indeed, most physicians report using Twitter for educational and general public health purposes, not for individual patient-physician communications. To promote patient care coordination, HIPAA-compliant social networks are also available for physician-physician consultation and sharing of identifiable patient data. An issue that remains to be resolved is disclosure of conflict of interest in social media postings, which is particularly challenging on Twitter, given the imposed brevity and character limit.
2012 elections: $6 billion status quo

As the nation sat around the breakfast table the morning after Election Day in 2010, many were shocked at the robust Republican wave of victory. A mere two years after Democrats were given a clear mandate in the 2008 elections—overwhelming control of the U.S. House of Representatives, a filibuster-proof majority in the Senate, and President Obama in the White House—even the most seasoned Beltway insiders underestimated just how frustrated Americans had grown. In the opinion of some voters, President Obama and the Democratic supermajority in Congress had neglected the ailing economy and instead forged ahead with a contentious health care reform package, Wall Street bailouts, and cap and trade legislation, all of which led to a dramatic shift in public opinion and a good night for Republicans. Despite Democrats outspending Republicans, often by large margins, the Grand Old Party (GOP) captured the House with a net gain of 63 seats and narrowed the power gap in the Senate, leaving the Democrats with only a six-seat advantage.

At that time, Republicans were brimming with confidence heading toward 2012 and the presidential election year. It was almost a foregone conclusion the GOP would take control of the Senate, with Democrats

HIGHLIGHTS
• Provides an overview of the 2012 national elections
• Explores the meaning and impact of the elections and their likely effect on surgery
• Explains the role of the ACSPA—SurgeonsPAC
• Offers suggestions on how surgeons can get involved in the political process and be a voice for surgery and the surgical patient
defending 23 seats, many of which were particularly vulnerable, compared with Republicans’ 10. Furthermore, with the Republican sweep of state offices in 2010, the redistricting process was often conducted in a manner that would greatly strengthen Republican prospects in a majority of districts nationwide.

Early in the election cycle, other factors, such as what many Americans perceived as slow job growth and a persistently sluggish economy, indicated Republican gains would once again prove substantial. Furthermore, the U.S. Supreme Court ruling in Citizens United v. Federal Election Commission reversed two major restrictions on campaign spending—the first on corporate spending to explicitly support or oppose political candidates and the other on direct campaign spending by corporations and unions. Popular belief held that the reversal of these two spending bans would further bolster Republican chances. Though ultimately incorrect, these changes to campaign finance law unquestionably served to facilitate unprecedented levels of election spending.

Campaign spending on the rise

The official numbers for total dollars spent were unavailable at press time, but estimates just before the election from the Center for Responsive Politics, a leading research group concerning money in politics, put the final spending at more than $6 billion. It was projected that the President and challenger Mitt Romney spent approximately $2.6 billion, the House races totaled nearly $1.1 billion, and the Senate candidates spent around $743 million. Meanwhile, due to the Citizens United Supreme Court ruling, spending by outside groups tipped the scales with total spending by traditional political action committees (PACs) through independent expenditures and super-PACs spending reaching $1 billion.

As Election Day drew near and the voters, particularly in battleground states, endured seemingly endless political ads, contentious debates, and candidates whose own words ultimately ensured their electoral demise, the high expectations for the GOP failed to materialize. When the dust settled and all the votes were counted—in some instances, recounted—the dynamics in Washington, DC, remained unchanged. President Obama was reelected, Republicans maintained control of the House, and the Democrats retained their status as majority party in the Senate.

David Wasserman, the House editor for The Cook Political Report known for his encyclopedic knowledge and shrewd analysis of congressional races, asserted that “the last three election cycles have been ‘wave elections’ where one party has seen tremendous gains on election night.” However, he came to view 2012 as more of a whirlpool, stating, “There’s a lot of churning around and a lot of change that’s not going to work exclusively in one’s side’s favor.”

Democrats held the Senate with a 55–45 edge, thanks in large part to polarizing Republican primaries that eliminated more moderate or “mainstream” candidates, putting forth nominees who faced insurmountable difficulties in connecting with general election voters. Sen. John Cornyn (R-TX), Chairman of the National Republican Senatorial Committee, “suggested several of the losing GOP Senate candidates beat themselves, either through controversial comments or poorly run campaigns, rather than being outmaneuvered by Democratic opponents.” In the House, Democrats’ performance was better than initially forecast, though falling short of Minority Leader Nancy Pelosi’s (D-CA) prediction that the Democrats would gain the 25 seats needed to take back the House with a net gain of eight seats, bringing the balance of power to 234 Republicans to 201 Democrats.

Washington insiders and average Americans were left to ponder what $6 billion got them. Reid Wilson, editor-in-chief for the National Journal Hotline, described it as a “Democratic president hindered by a painfully slow economic recovery, a dysfunctional Senate controlled by a Democratic majority that cannot advance his agenda, and a Republican House determined to reverse course, all three institutions plotting against each other, unable and—more importantly—unwilling to forge a consensus.” Despite the historic levels of spending and the initial favorable condition for Republicans, significant change was simply not in the cards.
The stage is already being set for the 2014 mid-term elections, and if history continues to repeat itself, the Republican Party may have some advantages, despite an intra-party identity crisis.

The stage is already being set for the 2014 mid-term elections, and if history continues to repeat itself, the Republican Party may have some advantages, despite an intra-party identity crisis. According to Mr. Wasser- man, “A president’s party typically loses a large number of seats in the midterm cycle of the president’s second term; the most obvious recent example is the 2006 Democratic wave, when House Democrats gained 30 seats and the majority”—a phenomenon known as the six-year itch.6 Conditions in the Senate lean in favor of the Republicans once again, with seven fewer seats to defend (13 to Democrats’ 20), especially if they are able to seize better control of candidate recruitment. Furthermore, in 12 of the 13 states Republicans will be defending, Mitt Romney won all but Maine—in contrast to seats the Democrats must retain, seven of which are in states Governor Romney won. Those factors, combined with potential retirements and resignations, once again present Democrats with a significant challenge to maintain Leader Harry Reid’s control of the Senate.6

The very real concern exists that with a similar partisan breakdown in the House, Senate, and Executive, the potential for the status-quo gridlock in Washington remains disturbingly high. With surgeons now facing nearly 30 percent cuts due to the flawed sustainable growth rate formula used to calculated physician payment, an additional 2 percent in cuts due to sequestration, potential cuts to graduate medical education, continued long-term inaction on any meaningful medical liability reform, and so on—continued inaction by policymakers serves as a very real threat to the access and quality of care for surgical patients, and a true impairment to the practice of surgery.

ACSPA-SurgeonsPAC’s role

The ACSPA-SurgeonsPAC (the American College of Surgeons Professional Association’s political action committee) supported 93 candidates for the House of Representatives (79 total) and Senate (14 total) in the 2012 congressional elections, with an overall success rate of 92 percent. The disbursement ratio for individual candidate PAC contributions was 60 percent to Republicans and 40 percent to Democrats. Inclusive of party committees and other leadership PACs, the ACSPA-SurgeonsPAC disbursed $745,500—58 percent went to Republicans, 42 percent to Democrats. (A complete list of contributions can be found at www.surgeonspac.org, which is accessible to Members and Fellows of the College.)

As in years past, the shifting control of Congress helps to determine the overall disbursement strategy and party breakdown reflected in ACSPA-SurgeonsPAC spending. Due to the inert nature of the 112th Congress, to be careful stewards of PAC dollars, the 2012 elections saw a sharp decline (27 percent since the 2010 election cycle) in total ACSPA-SurgeonsPAC spending. However, the PAC was able to support several promising newly elected members of Congress, and was also able to help in many close races where incumbent champions for surgery on Capitol Hill were in danger of losing their seats.

It is critical that the ACSPA-SurgeonsPAC remain empowered to affect the course of future elections and work to elect the best possible advocates for surgery and the surgical patient. Additionally, individual surgeons must become advocates and build the relationships necessary to spur action in Congress. There are many ways surgeons can get involved and help to elect members of Congress who understand the critical role that surgeons play in the U.S. health care system, including the following:

- Visit the ACSPA-SurgeonsPAC website at www.surgeonspac.org for more information on how to get involved with the ACSPA-SurgeonsPAC and for disbursement lists of candidates the PAC has supported. The ACSPA-SurgeonsPAC is surgery’s most potent tool in shaping the make-up of Congress and exerting the profession of surgery’s political clout. The ACSPA-SurgeonsPAC provides the access and relationships critical to ensuring that surgeons’ unique expertise and perspectives are considered when health policy decisions are made in Washington.
- Many members of Congress and candidates set up health care advisory boards composed of physicians and other
experts to help guide policy decisions. Volunteer to serve on one of these panels or, more generally, on a candidate’s campaign.

- Attend the 2013 Leadership Conference and Advocacy Summit in Washington, DC, April 13–16, to learn about issues that affect surgeons, engage decision makers, and directly advocate for your patients and practice. (Learn more and register by visiting http://www.facs.org/ahp/summit/index.html.)

Surgeons may also work with the College’s Washington Office staff to:

- Set up in-district delivery of ACSPA-SurgeonsPAC checks (a great way for physicians to get to know their member of Congress or candidate and/or to help cultivate the existing relationship).

- Schedule a time for the member of Congress or candidate to tour the physician’s office and learn more about issues facing surgery and how Congress directly affects the physician’s practice and patients.

- Host an in-district fundraiser for fellow surgeons and the greater physician community, benefiting the candidate in the physician’s district.

Individual relationships with members of Congress and their staff are critical to the success of surgery’s advocacy efforts on Capitol Hill. There is no better time to cultivate these vital contacts than when a member or candidate needs your help. To learn more, or to get involved, contact ACSPA-SurgeonsPAC staff at 202-672-1512 or acspa@facs.org.

REFERENCES
This archival document demonstrates the College’s enduring commitment to ensuring that trauma patients received prompt, high-quality care.

To help commemorate the American College of Surgeons’ (ACS) Centennial, the Bulletin of the American College of Surgeons is reprinting articles centered on the issues and developments that have defined the character and integrity of the organization throughout its 100-year history. This month, the Bulletin is reprinting the foreword and general information from “The Principles and Outline of Fracture Treatment,” published in the March 1931 issue. The Fracture Committee of the ACS, which subsequently evolved into the Committee on Trauma (COT), developed and wrote these standards under the leadership of then Committee Chairman Charles L. Scudder, MD, FACS.

This reprint describes the pathology of fractures and the process of repair after fracture. It outlines the general principles of treatment, including first aid, examination, diagnosis, and treatment. The rest of the issue (not reprinted here due to space constraints) presented information on fractures of special bones, traction and countertraction, aphorisms, and the use of X rays.

This document demonstrates the College’s commitment to ensuring that trauma patients received prompt, high-quality care from both general practitioners, who typically provided emergency care, and experienced surgeons, who treated more complex and difficult injuries. The College’s dedication to training all health care professionals in the appropriate methods of caring for the injured patient lives on today in the Advanced Trauma Life Support® program and the other activities carried out through the COT.

Centennial reprint:
Committee on the Treatment of Fractures offers principles on caring for patients
THE PRINCIPLES AND OUTLINE OF FRACTURE TREATMENT

BY THE FRACTURE COMMITTEE OF THE AMERICAN COLLEGE OF SURGEONS

FOREWORD

The Fracture Committee of the American College of Surgeons presents this publication to the medical profession trusting that it may be helpful in the treatment of fractures. The fracture lesion and the process of repair following a fracture are described.

The principles underlying the treatment of fractures are stated and a generally acceptable form of treatment for certain fractures is outlined.

No attempt has been made to describe operative procedures, the technique of skeletal traction or of local anesthesia in the treatment of fractures. Such descriptions may be found in appropriate publications.

The Committee recognizes that the emergency initial treatment of a fracture is often carried out by the general practitioner. The functional usefulness of the part injured is of primary importance. Delay in the treatment of a fracture may be followed by serious consequences. The treatment of difficult fractures requires the care of experienced surgeons.

PATHOLOGY OF THE FRACTURE LESION

The local lesion in fracture cases is of paramount importance in establishing the general principles of treatment. When bone is broken there is coincident tearing of bone and soft parts—endosteum and periosteum—with vascular and lymphatic ruptures and thromboses. There may be laceration and contusion of muscle, fascia and skin. There is death of bone, as well as of injured soft parts. The tissues are infiltrated by blood, lymph, and inflammatory exudate as well as transudate because of mechanical circulatory interference.

This infiltration of the tissues causes the swelling and pain of the part, and is increased by handling of the extremity and movement of the fragments of bone. It is of significance that the blood, lymph and inflammatory exudate rapidly clot, and that the two latter are even richer than blood in fibrinogen. Within forty-eight hours this extensive fibrin shows active organization by cell growth, and is replaced by organizing tissue.

The tissue of the soft parts and the bone that have been killed by the trauma are autolyzed by ferments furnished by the death of the cells, and tissue fluids in the region of the fracture are permeated by a calcium compound derived from autolyzed bone. There are some who hold that the source of calcium is the blood stream. This process is slow and occupies several days. The swelling and infiltration reach their maximum in eight to twelve hours, and then circulatory disturbance from pressure and thrombosis adds an actual edema to the picture. The clotting of blood and exudate leaves a residue of their fluid contents which gradually diffuse toward the surface. This residue is important because the more fluid, whether exudate or transudate, present at the site of fracture the less efficient is the organization of the fibrin. In addition to this common picture there may be associated injuries of contiguous muscles, nerves, vessels, joints, tendons and tendon sheaths, which must be considered as part of the lesion.

PROCESS OF NORMAL BONE REPAIR AFTER FRACTURE

The actual mechanism whereby calcium is deposited in the tissues to form bone is unknown, as is the chemical form in which that calcium exists. But the rest of the process is sufficiently
AMERICAN COLLEGE OF SURGEONS

Healing by granulation tissue takes place in all fractures except where mechanical obstruction exists between the fragments. The slow deposition of calcium in the tissue produces so-called delayed union, whereas its absence produces so-called non-union. Delayed and non-union are more apt to occur in certain bones and certain portions of those bones even when all other factors are equal. Certain sites of fracture in some bones are therefore characterized by a prolonged "healing time" as the usual and expected result. Therefore, in addition to the other factors cited, the time needed for sufficient ossification of the healing process to allow function depends on what the function of the part calls for in the way of solidity.

GENERAL PRINCIPLES OF TREATMENT

First Aid—When a bone is broken the adjacent soft parts are usually injured as well. Often the displacement of fragments and additional injury to the soft parts are caused by the subsequent handling of the injured part or increased by it. Therefore first aid treatment should include:

(a) Application of some form of protection before the patient is moved. "Splint 'em where they lie."
(b) Avoidance of all unnecessary manipulations.
(c) Transportation with extreme care and gentleness. In fractures of the upper extremity the hinged splint (Thomas-Murray) (Fig. 1) is an adequate and comfortable splint for protection and transportation. In fractures of the lower extremity the Thomas splint (see Figs. 2, 3) may be used for protection and transportation. Slight traction (Fig. 4) may be used in transportation.

(d) Prevention and treatment of shock.

Examination—After the patient has been transported to the place where suitable treatment can be instituted, as complete and thorough an examination as possible should be made without causing additional injury.

(a) Begin with painless procedures, such as:
1. Inspection, which will reveal swelling, ecchymosis and deformity.
2. Palpation, which will reveal a local point of tenderness by both direct and indirect methods. A false point of motion should be searched for with extreme gentleness. Irregularity of bony contour should be noted. Crepitus which is caused by the broken ends rubbing against each other,
PRINCIPLES AND OUTLINE OF FRACTURE TREATMENT

Fig. 1. Thomas-Murray hinged splint, for upper extremity fractures. Note slings to arm, traction on forearm, elbow extended. Whole upper extremity at side of body. Injured arm ready for transportation, guarded and protected.

1. Since the reactions of the injured tissues to the trauma begin very soon after the injury and since these reactions interfere with the ease and perfection of reduction, and so greatly influence the process of repair and the end result, reduction of any displacement should be made as soon after the injury as possible, without waiting for the roentgen-ray examination if it is not immediately available.

2. Reduction should be made as gently as possible.

3. Reduction should be as complete as the case requires. Restoration of the normal axis and overcoming shortening and rotation may be quite satisfactory in the shaft of a long bone. In fractures into joints the articular surfaces should be restored as nearly as possible to normal.

4. Fluoroscopic control of reduction is sometimes very useful.

5. Reduction should be checked by roentgen-ray examination as soon as practicable.

6. Reduction should be carried out under an anaesthetic with but few exceptions.

7. Further attempts at reduction should be made as soon as the need is recognized.

8. The method of reduction is important and may be by:
   (a) Manipulation
   (b) Traction by
      (1) Gravity.
      (2) Manual pull.
      (3) Block and pulley.
      (4) Weight attached to limb.
   (c) Open operation.

Usually the reduction of displaced fragments will require a combination of traction and manipulation. The purpose should be first to disengage the fragments and then gently to restore them
to their normal relationship. In order to carry out such procedures with as little additional injury as possible, each case should be handled according to its actual deformity which has been determined by examination rather than according to any routine procedure. The roentgen films should be in sight while reduction is being effected.

(b) Maintenance of reduction, or immobilization, is necessary. If there is no displacement of the fragments of bone or if displacement has been overcome, correct position of the fragments must be maintained. The method to be employed should be selected according to the peculiar needs of each case and the proper appliances should be assembled before reduction is attempted. Such immobilization serves to hold the fragments in place until union has occurred and provides the rest that is so essential to any injured tissue.

1. Reduction can be maintained by:
   (a) Position—as by flexion of the elbow for certain fractures near that joint;
   (b) Splints and other external appliances;
   (c) Traction and suspension;
   (d) Internal appliances such as plates, screws, bands, etc.

   The inherent value of any apparatus is of less importance than the skill with which it is used. The surgeon should prevent localized pressure, especially over bony prominences and avoid constricting bandages. It should be remembered that most bandages will shrink and that the injured extremity will swell. The correctness of the position of the fragments should be confirmed by roentgen-ray examination after the apparatus is applied and after the patient has recovered from anesthesia and muscle tone has returned. Plaster-of-Paris must be kept dry until ready for use, or it will crumble and the plaster splints will break or soften. To immobilize a broken bone the contiguous joints must be immobilized. For a description of apparatus for traction and suspension, see page 28.

2. In the selection and employment of the method of immobilization to be used and in reaching a decision as to its duration, the physician should bear in mind the factors which influence repair and be guided by them. These factors are:
   (a) The condition of the circulation of the affected part. It may be interfered with by the original or subsequent injury, by the position of the adjacent joints (as by too great flexion), by constriction of bandages, by gravity when the extremity is allowed to be dependent, by pressure from displaced fragments of bone or by internal pressure caused by excessive hemorrhage;
   (b) The age of the patient. Repair is much more rapid in infancy than in later years. The compensatory changes which tend to obliterate angular deformity are great in infants and less in adults;
PRINCIPLES AND OUTLINE OF FRACTURE TREATMENT

(c) The character and extent of the injury to the bone;
(d) The amount of permanent displacement of fragments;
(e) The amount of stripping of the periosteum from the bone;
(f) The character of the bone. Repair in cancellous bone is far more rapid than in cortical bone;
(g) The degree of immobilization;
(h) The coexistence of infection which interferes with bone formation;
(i) The general condition of the patient;
(j) The presence of a foreign body which interferes with formation of bone in immediate points of contact of it with the bone.

(c) Treatment of the soft parts.

Much of the treatment required to protect the injured bone may be injurious to the soft parts. Too active treatment of the soft parts may disturb the position of bone fragments. Therefore careful judgment is required in order to accomplish the greatest good with the least harm. Prolonged inactivity after injury may result in atrophy of muscles, limitation of movements of joint and tendon, impairment of circulation and hence delay in bone repair.

The most important method of regaining function is by active movements. At first it will often be necessary to guide and assist such movements. Massage, heat and electricity may be of help if carefully and gently employed, while if roughly applied they may be harmful. Of the different forms of massage one must differentiate between gentle stroking without deep pressure, stroking with deep pressure, and kneading. Nothing but the first form should be permitted in the affected region until union has well started. These various aids should be applied as soon as the danger of additional injury or of displacement of fragments has passed. They may cause slight discomfort but should never cause pain. The pain of more active measures indicates harmful stretching or tearing of soft parts, often with hemorrhage, which will require additional repair. In the early stages of repair massage and movements should be carried out only by the physician; otherwise they are better omitted until union is well established.

(d) Operative treatment is indicated when a satisfactory reduction cannot be obtained and maintained by nonoperative methods, provided there is no contra-indication, and when the expected result of the open method
is sufficiently better than that of the closed to justify the additional risk.

Furthermore, it is generally recognized and accepted that it is impossible to obtain satisfactory restitution except by operative methods in certain types of fractures. The operative method is recommended to those surgeons who have had special training and experience, who have the necessary skill and judgment, and who have the hospital facilities and surgical armamentarium with which to do this work properly. In the case of those who do not have such facilities, operation is not advised.

(e) Treatment of compound fractures. In all compound fractures the use of tetanus antitoxin should be seriously considered.

In the case of compound fractures with small wounds in which it is evident that the wound of the soft parts is made by the protrusion of bone from within outward through the skin they must be regarded as potentially infected. These wounds should have a thorough preparation of the skin by washing with benzoin, shaving in a direction away from the wound, drying with ether and the application of tincture of iodin to the skin, followed by the application of sterile dressings. If it is not possible to carry out the foregoing cleansing treatment, the wound may be covered by a sterile gauze pad and the patient be transported to a hospital.

When a roentgen-ray examination is to be made before reduction, all the steps enumerated above, except reduction, are to be completed before the roentgen-ray is taken.

In the case of extensive compound fractures with a large wound:
1. A tourniquet should be applied only when it is obvious that some large vessel has been lacerated.
2. The wound should be carefully protected from contamination by a sterile gauze pad while the skin is being cleansed, fol-

lowing the foregoing routine. If this procedure can be undertaken without too much pain and shock to the patient, it should be carried out before he is sent to the roentgen-ray department; if this is not possible, tincture of iodin should be applied only to the edges of the wound, and a large sterile dressing applied before roentgen-ray examination. The procedure may be completed when the patient is anaesthetized.

3. The operative procedure consists of:
(a) Excision of, at least, 0.5 cm. of skin from the edges of the wound;
(b) Excision en bloc of traumatized and infected tissues;
(c) Thorough exposure of the wound by generous incisions;
(d) Excision of dead and dying fat, fascia and muscle with sharp instruments until fresh bleeding occurs;
(e) Removal of small fragments of bone that are unattached to periosteum and of soiled bone surfaces by a rongeur;
(f) Careful evacuation of a hematoma which is dissecting between muscle planes;
(g) Frequent changes of gloves and instruments to insure against carrying infection into the deep parts of the wound;
(h) Irrigation of the wound with salt solution to wash out particles of dirt, if necessary;

4. The final dressing of the wound varies according to indication. It may consist of:
(a) Incomplete closure after lavage with an antiseptic solution;
(b) Incomplete closure, as above, but with dependent drainage; or
(c) Application of Carrel tubes for the immediate use of 0.5 per cent solution of sodium hypochlorite.
Every Gift Makes an Impact

As Executive Director of the American College of Surgeons, one of my more enjoyable duties has been personally signing thank-you letters to donors. Each gift is meaningful to me, as it is an acknowledgment—especially from our Fellows—that they believe in what the College is doing and want to fuel its sustainability and growth. I can tell you that philanthropy truly has a significant impact, and with your help, the College is moving forward to fulfill its mission. Philanthropy lets us sustain meritorious programs and take timely advantage of opportunities for creative investment. Every gift allows the College to do more, like:

- Providing a margin of excellence to current College programs
- Increasing promotion of optimal quality-of-care strategies
- Improving educational opportunities for all surgeons, particularly those in training
- Bringing more life-saving systems of care to geographical areas with limited resources
- Supporting the image and future of the surgical profession

In the coming year, the College will celebrate its Centennial anniversary, and the individuals listed in this report are helping ensure that the College’s success, highlighted in these pages, will continue for another 100 years and beyond. I know that each gift is a thoughtful consideration, as there are many important charitable causes. Please know that donations to the College are sincerely appreciated and will be used strategically for top College priorities. On behalf of the American College of Surgeons, thank you for your commitment to the College and your profession, and for your philanthropic support that makes a real difference in our ability to better serve our patients.

David B. Hoyt, MD, FACS
Executive Director, American College of Surgeons
President, American College of Surgeons Foundation

Stewarding Your Investment

Stewardship of the surgical profession, especially as the medical community faces historic changes, has been one focus of the American College of Surgeons this year. An integral part of stewardship is the engagement of the Fellowship in the philanthropic initiatives of the College. Increasingly, the ACS Foundation plays an important role in providing a margin of excellence to College programs that support you and your patients.

The ACS Foundation acts as the steward of charitable contributions for the College. It is the Foundation’s charge to communicate philanthropic needs and opportunities and then uphold the donor intent. Demonstrating tremendous generosity during challenging times, our Fellows and other friends have increased giving to College programs and initiatives this fiscal year. From successful fundraising initiatives for scholarly purposes, like the Murray F. Brennan, MD, FACS, International Scholarship Fund, to major bequests, like the one received from the estate of Frederick W. Plugge IV, MD, FACS, to the hundreds of individual gifts faithfully made each year, philanthropy has a demonstrable impact.

For example, Dr. Plugge’s bequest as part of the College’s investments will sustain his passion for education and research for the next generation of surgeons. Through his forward-thinking gift, he joined other Fellows who have made the College a part of their estate plans, following the example of Earl H. Mayne, MD, FACS, among the first to bequeath a gift to the College. Dr. Mayne’s original gift, made in 1944, has grown to a $4 million endowment and will continue to be used to support the scholarly aspirations of young surgeons—a perfect example of how even one gift, stewarded with care, can touch many lives for years to come.

Each donor represented in this annual report is helping to change lives for the better. As the College enters its next 100 years, I am confident that the work of the College, through the support of the Fellowship, will continue to inspire the next Dr. Mayne, Dr. Plugge, and hundreds of faithful supporters. You, an ACS Foundation donor, are uniquely appreciated and are a part of the great philanthropic tradition of the College. Together, we will make an unforgettable impact for the College’s second century. Thank you for your commitment and generosity.

Thomas R. Russell, MD, FACS
Chair, American College of Surgeons Foundation
The American College of Surgeons Foundation is recognized as a tax-exempt, not-for-profit organization. Contributions to the American College of Surgeons Foundation are tax-deductible to the extent allowed by law.

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Made Possible by You

After arriving at the Foundation’s office, each contribution is processed and goes to work, enabling the College to provide a “margin of excellence” to you and your patients. Foundation donors choose to give to a variety of areas: the Sustaining Fund, Cancer Programs, Operation Giving Back, and many more.

Whichever fund you selected, you and other donors are helping the College achieve its mission of improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment—for today and for future generations of surgeons. Here are just a few of the funds and what you are making possible as a donor.

International Guest Scholarships

For more than 10 years, philanthropy has annually supported the awarding of 10 International Guest Scholarships (IGSs). The common purpose of these scholarships is to encourage international exchange of information concerning surgical practice and research and to establish professional and academic collaborations and friendships.

- “This scholarship enabled me to see a range of surgical procedures, meet people, and develop links that are likely to prove useful in the development of my career and also those of my residents/students who may make use of these linkages when they wish to travel abroad. I picked up a number of surgical tips that may help improve outcomes in my patients and provided ideas for potential future research, one of which has already been initiated.”
  Rajeev Kumar, MD • New Delhi, India

- “I strongly believe that knowledge and experience gained during this program will serve for better and safer patient management by all participants in their daily practice.”
  Rauf Shabbazon, MD, MRCS Ed, FEBS (Transplantation) • Baku, Azerbaijan

- “After going through the program I’ve realized that the experience had been better than I hoped, and it has definitely marked a turning point in my future as a surgeon.”
  Pablo Santiago Frioni, MD • Montevideo, Uruguay

ACS Archives

The generous support of Fellows to the ACS Archives allows for more of the College’s rich archival resources to be made available online. For example, three volumes of the “retirement scrapbooks” of Eleanor K. Grimm, long recognized by the College as pivotal in capturing and recording the history of the first 50 years of the ACS, are scanned and available for viewing on the ACS Archives Web page, www.facs.org/archives.

Hired by Franklin Martin, MD, FACS, in 1913, the year of the College’s founding, Ms. Grimm quickly became his right-hand person and trusted assistant from the earliest years of the College’s development. Her influence was felt throughout Dr. Martin’s reign but possibly even more so after his death in 1935, when she served as the secretary to the Board of Regents and, in effect, chief administrative officer until her retirement in 1951. Friendly with all the founders and other leaders of the ACS during its first 50 years, Ms. Grimm’s correspondence with many of them, including the Mayo brothers, George Crile, Albert Ochsner, Allan Kanavel, Ernest Codman, Alfred Blalock, Owen Wangensteen, Frederick Besley, John Bowman, Malcolm McEachern, and many others, is arranged in her books alphabetically by correspondent. This correspondence will yield information about these leaders in surgery in the first half of the 20th century that has not been available before, as well as new insights on the history of the ACS and about Ms. Grimm herself.

Support of the ACS Archives will bring even more ACS history to light during this year of the Centennial and is a fitting legacy to C. Rollins Hanlon, MD, FACS, who championed the ACS Archives during the last 10 years of his life.
Sustaining Fund

The majority of the funds raised through the year-end appeal were directed to the Sustaining Fund, which supports the areas of greatest need within the College. This fund boosts the financial strength of the ACS and enables the College to sustain valuable programs and respond to new opportunities or priority initiatives like the Inspiring Quality campaign.

Thanks to the Sustaining Fund, the College is also able to continue the value proposition provided to the ACS Fellowship by:

- Conducting research to provide cutting-edge best practices in patient care
- Developing innovative education and training programs to support practicing surgeons
- Fostering the next generation of promising surgeons through scholarships and fellowships
- Giving surgeons from across the U.S. and around the globe opportunities for networking
- Promoting the image of the surgical profession, today and tomorrow

Trauma Education

The College’s Committee on Trauma (COT) has three critical pillars of success: quality, education, and advocacy. Since its beginning, the COT has assumed a prominent role in professional activities at the College and has launched several programs, including the National Trauma Data Bank® (NTDB®) and the Advanced Trauma Life Support® (ATLS®) courses, which have changed the landscape of trauma care in the U.S. and throughout the world. For example, since 1978 the COT has taught the ATLS course to more than 1 million doctors in 63 countries. ATLS has taught a common language and a common approach, and thereby has become the foundation of care for injured patients worldwide. Last year alone more than 40,000 students were trained. The Trauma Program recently expanded its outreach to include the Middle East, presenting programs in Syria, Oman, and Egypt. Plans to conduct the inaugural course in Egypt were put on hold due to the “Arab Spring” uprising, and unplanned expense arose from this delay. Thanks to the Trauma International Education Fund established through the ACS Foundation for the support of internationally based ATLS training, the Egyptian program received grant funding and the inaugural course was successfully completed in September 2011. Many generous Fellows and organizations contributed a combined $335,000 to support trauma international education, and the funds will allow medical professionals around the globe to receive ATLS training proven to increase the number of lives saved and reduce the effects of life-altering injuries.
As the largest international organization of surgeons, the American College of Surgeons is dedicated to improving the care of the surgical patient. The Division of Education Surgical Patient Education Program provides a range of programs to improve the quality of surgical care. In partnership with other medical associations, the ACS Surgical Patient Education Program aspires to change the way surgical patients are educated, improve patient health literacy and participation, and maximize patient safety. The comprehensive program supports surgeons and the surgical community with current evidence to guide patients in their decisions and provides the knowledge and skills necessary for their continued postoperative care upon discharge. Early results from patient education programs include:

- Increased patient confidence
- Decreased anxiety
- Less time spent teaching
- Reduced unplanned, postsurgical physician visits
- Decreased use of additional services

Recognizing the need to implement a more efficient and cost-effective system, all of the program resources are free to ACS members and the public on the ACS website, www.facs.org/patienteducation/, thanks to the generous educational grants provided by Coloplast Corp., Ethicon Endo-Surgery, Inc., and Ethicon, Inc.

The American College of Surgeons Foundation is most appreciative of these grants in support of the Division of Education Patient Education Program, which is improving the lives of surgical patients and supporting our members with quality and effective patient education materials.
Better Post-Op Outcomes: Ostomy Home Skills Kits Program

Multi-year grants from Coloplast Corp. have been instrumental in the distribution and evaluation of 30,000 ostomy home skills kits, which help prepare patients and their families to manage complex care following hospital discharge. Each kit includes a DVD, booklet, practice supplies, additional resources, and an evaluation.

Program highlights

• The DVD was the recipient of the National Media Award, Internet Education, from the American Society of Colon and Rectal Surgeons (based on evaluation by Northwestern University’s Medill School of Journalism). This award commends recipients for excellence in communicating a better understanding of colon and rectal disease.

• A study found that patients using the ostomy home skills kit needed significantly less help, had greater confidence, and were half as likely to visit the emergency room in the two weeks following their discharge.

Informed Surgical Prep: Hernia Brochure and E-Learning Program

Ethicon, Inc. provided funding for the hernia brochure and e-learning program, including the cost of printing, distribution, and continued evaluation of the brochure series for inguinal/femoral, umbilical, and ventral hernias. The brochure content includes an overview of the surgical procedure, treatment options with images, potential problems, and discharge instructions.

Program highlight

• The format for the program resources is accessible for all levels of learners and has been evaluated as comprehensive, easy to read, and capable of empowering patients with the confidence to participate, ask questions, and understand all aspects of their operation.

Education for Better Recovery: Cancer Series

Generously funded by an educational grant from Ethicon Endo-Surgery, Inc., this program carefully coaches patients into becoming fully informed and active participants in their care and recovery. The first installment in this series, “Your Lung Operation,” was developed for patients requiring a lung resection/biopsy operation. The program includes a booklet, DVD, patient activity guides, lung images, a survivorship plan, and an evaluation for both patients and professionals.

Program highlight

• The DVD content for “Your Lung Operation” includes descriptions of video-assisted thoracic surgery and open procedures, a section on “Preparing for Your Operation,” and ideas for patient participation to prevent high-risk complications such as pneumonia and deep vein thrombosis.
This year saw the successful completion of two named scholarship fund campaigns. Both will be used to support the scholarly aspirations of young surgeons.

**Murray F. Brennan, MD, FACS, International Guest Scholarship Fund**

The Murray F. Brennan, MD, FACS, International Guest Scholar will recognize the scholarship’s namesake for his enduring collegiality and the value he placed on investing in quality patient care wherever surgeons practice. The ACS International Guest Scholarships Program recognizes international surgeons based on their academic potential. Numerous alumni of the IGS program now hold leadership positions in their departments or divisions.

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Thomas R. Russell, MD, FACS, Scholarship Fund

Russell Scholars, honoring Dr. Tom Russell’s advocacy for increased scholarly opportunities at the College, will be outstanding young surgeons who desire to pursue professional development and/or promising research initiatives.

FRIENDS OF TOM RUSSELL

Dr. Herand Abcarian—Illinois
Dr. Roxie M. Albrecht—Oklahoma
Dr. Maria Allo—California
American Society for Metabolic and Bariatric Surgery
American Society for Surgery of the Hand
American Society of Colon and Rectal Surgeons
Anonymous—Illinois
Mr. Leslie J. Armour—New Jersey
Dr. Nancy L. Ascher—California
Dr. Yoshio Aso—Japan
Dr. John L. D. Atkinson—Minnesota
Robert R. and Janet Bahnsen—Ohio
Dr. and Mrs. H. Randolph Bailey—Texas
Dr. and Mrs. Charles M. Balch—Texas
Dr. Donna J. Barbot—Pennsylvania
Dr. Linda M. Barney—California
Dr. Barbara L. Bass—Texas
Dr. Gerald J. Bechamps—Virginia
Dr. George Berci—California
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Dr. Karen R. Borman—Pennsylvania
Dr. and Mrs. D.L. and Charlene Britt—Virginia
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Dr. Philip R. Caropreso—Iowa
Dr. and Mrs. James G. Chandler—Colorado
Dr. Yanek S. Y. Chiu—California
Dr. Orlo H. Clark—California
Dr. John R. Clarke and Miriam Soloman—Pennsylvania
Dr. Amalia L. Cochran—Utah
Dr. and Mrs. Paul E. Collicott—Wyoming
Dr. and Mrs. J. Craig Collins—California
Cook Group Inc.—Indiana
Dr. Denton A. Cooley—Texas
Dr. Bard and Pamela Cosman—California
Dr. Alice and Edward Dachowski—Ohio
Dr. Carlo A. Dall’Olmo—Michigan
Dr. and Mrs. Christopher J. Daly—Pennsylvania
Dr. Jesse T. Davidson III—Virginia
Dr. Merrill T. Dayton—New York
Dr. Clark and Karen Deveney—Oregon
Dr. Ernest L. Dunn—Texas
Dr. A. Brent and Sarita Eastman—California
Dr. and Mrs. Timothy J. Eberlein—Missouri
Dr. and Mrs. Norman C. Estes—Illinois
Dr. Mary E. Fallat—Kentucky
Mr. Brad Feldman—Ohio
Dr. David W. Feliciano and Grace S. Rozycki—Georgia
Dr. and Mrs. Richard J. Finley—British Columbia
Dr. Roger S. Foster, Jr., and Baiba J. Grube—Connecticut
Dr. Julie A. Freischlag—Maryland
Dr. Daniel J. Frey—Louisiana
Dr. and Mrs. Donald E. Fry—Illinois
Drs. Nancy L. Gantt and Raymond J. Boniface—Ohio
Dr. Donald J. Gaskard—California
Dr. Stanley M. Goldberg—Minnesota
Dr. and Mrs. Frederick Leslie Greene—North Carolina
Dr. and Mrs. Douglas P. Grey—California
Dr. John B. Hanks—Virginia
Dr. Elias S. Hanna—California
Drs. Alden H. and Laurel S. Harken—California
Drs. Lynn H. and Lura A. Harrison, Jr.—Florida
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Dr. and Mrs. Kevin R. Hiler—California
Dr. and Mrs. James W. Holcroft—California
Dr. Verne L. Hoshal, Jr.—Michigan
Drs. David B. and Beth Hoyt—Illinois
Dr. Tyler G. Hughes—Kansas
Dr. and Mrs. Scott A. Hundahl—California
Dr. John and Mrs. Mary Lacuzzo—New Jersey
Dr. Roberto Iwaki—Peru
Dr. Oscar J. Jackson—California
Dr. David G. Jacobs—North Carolina
Dr. and Mrs. Gordon W. Jacobs—North Carolina
Dr. and Mrs. Julias H. Jacobson II—New York
Japan ACS Chapter—Japan
Dr. Daniel S. Johnson—Illinois
Dr. and Mrs. R. Scott Jones—Virginia
Dr. and Mrs. Norman M. Kenyon—Florida
Dr. and Mrs. Ira J. Kondor—Missouri
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Dr. and Mrs. Rene Lafreniere—Alberta
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LaMar and Mrs. Julia McGinnis—Georgia
Dr. Mary H. McGrath—California
Dr. and Mrs. Patrick S. McGreavy—South Dakota
Dr. Andrea P. Metkus—California
Anthony and Marian Meyer—North Carolina
Dr. Fabrizio Michelassi—New York
Midwest Surgical Association
Drs. Ernest E. and Sarah V. Moore, Jr.—Colorado
Dr. Akimasa Nakao—Japan
National Medical Association—Maryland
Dr. Juan J. Nogueras—Florida
Dr. Patricia J. Numann—New York
Dr. and Mrs. J. Patrick O’Leary—Florida
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Dr. Roger R. Perry—Virginia
Dr. and Mrs. John T. Preskitt—Texas
Dr. and Mrs. Richard B. Reiling—North Carolina
Dr. and Mrs. Layton F. Rikkers—Wisconsin
Dr. James F. Ross—Manitoba
Dr. Chad A. Rubin—South Carolina
Dr. Eduardo N. Saad—Argentina
Dr. Hilary A. Sanfey—Illinois
Dr. Michael G. Sarr—Minnesota
Dr. and Mrs. William F. Sasser—Missouri
Dr. Pon Satitpunwaycha—Texas
Dr. Marshall Z. Schwartz—Pennsylvania
Dr. Kenneth W. Sharp and Mrs. Jane E. Sharp—Tennessee
Dr. and Mrs. George F. Sheldon—North Carolina
Dr. and Mrs. Wihbi A. Shu’Ayb—Lebanon
Dr. Howard M. Snyder III—Pennsylvania
Dr. and Mrs. Nathaniel J. Soper—Illinois
South Texas ACS Chapter
Southwestern Pennsylvania ACS Chapter
Dr. Steven C. Stain—New York
Dr. Amil Stuart—Colorado
Dr. Ronald M. Stewart—Texas
Dr. and Mrs. Robert P. Sticca—North Dakota
Beth H. Sutton, MD—Texas
Tennessee ACS Chapter
Dr. Richard C. Thrily—Washington
Dr. and Mrs. Gary L. Timmerman—South Dakota
Dr. Robert F. Tranbaugh—New York
Dr. Jon A. van Heerden—South Carolina
Dr. and Mrs. Andrew L. Warshaw—Massachusetts
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Dr. and Mrs. Thomas V. Whalen—Pennsylvania
Dr. and Mrs. Lorin D. Whittaker, Jr.—Illinois
Mr. Martin H. Wojcik—Illinois
Prof. and Mrs. John Wong—China
Dr. and Mrs. Michael J. Zinner—Massachusetts
Dr. and Mrs. Robert M. Zvolak—New Hampshire
The Mayne Heritage Society

Membership in the Mayne Heritage Society, named in honor of the College’s first planned gift donor, Earl Mayne, MD, FACS, recognizes Fellows who have provided a bequest or other planned gift of any size to the College through their estate plan. For those Fellows who believe that the future of surgery and the continued vitality of the American College of Surgeons are intertwined, an estate gift is an ideal form of investment.

In honor of the College’s Centennial celebration, the Foundation Board of Directors put forth the “100 by 100” campaign, an initiative to encourage participation in the Foundation’s Mayne Heritage Society. The goal of this initiative is to gain 100 members by the 100th anniversary of the College in 2013. To date, there are 55 individuals or couples who have made a planned gift to the College or have indicated that they intend to name the College as a bequest recipient.

Over the last year, the following generous donors were made members of the Mayne Heritage Society and will receive permanent recognition in Foundation publications:

†Dr. Wilfred Guerra
Dr. Yeu-Tsu Margaret Lee
Dr. and Mrs. Richard A. Lynn
†Dr. and Mrs. Hector Marin
Dr. LaMar S. and Julia E. McGinnis
Antonio and Vivian Robles
Dr. William Charles Sternfeld

† Deceased
Frederick W. Plugge IV, MD, FACS

**Planned Gift Continues Legacy of Service to Others**

The estate of Frederick W. Plugge IV, MD, FACS, bequeathed a six-figure contribution to the American College of Surgeons for funding of its research and scholarship and fellowship programs. This significant contribution will establish an endowed fund that will carry out Dr. Plugge’s wish to support young surgeons in their education and research endeavors.

Dr. Plugge, inducted as a Fellow in 1965, spent most of his professional career as an Air Force medical officer, rising to the rank of Brigadier General. A highlight of his career was overseeing the medical recovery of the 52 Americans involved in the Iran hostage crisis of 1979 after their release from 444 days of captivity.

A well-respected surgeon and Fellow, Dr. Plugge served as a member of the Board of Governors from 1990 to 1993 and actively supported the College and the Foundation for many years. By designating the College as a beneficiary in his estate plans, Dr. Plugge was a member of the Foundation’s Mayne Heritage Society. Through careful estate planning, Dr. Plugge ensured that he would be financially secure during his lifetime while providing for the College’s work in the future.
Distinguished Philanthropist Award

The American College of Surgeons Foundation proudly acknowledges the philanthropy of individuals who have distinguished themselves through their extraordinary investment in the mission of the American College of Surgeons. We are pleased to honor them with the Distinguished Philanthropist Award.

Recipients

Dr. Murray F. Brennan (2012)
Dr. and Mrs. Norman M. Kenyon (2010)
Dr. and Mrs. Richard B. Reiling (2009)
Dr. Paul F. Nora (2008)
†Dr. and Mrs. Maurice J. Jurkiewicz (2006)
Dr. Robert W. Hobson II and Mrs. Joan P. Hobson (2005)
Drs. C. Rollins* and Margaret H. Hanlon (2004)
Dr. William W. Kridelbaugh (2003)
Dr. and Mrs. Robert E. Berry (2002)
Dr. Pon Satitpunwaycha (2001)
Dr. and Mrs. Paul H. Jordan, Jr. (1999)
Dr. and Mrs. LaSalle D. Leffall, Jr. (1998)
Dr. and Mrs. Eric Lincke (1997)
Dr. and Mrs. Neil C. Clements (1996)
Dr.* and Mrs. Scott W. Woods (1995)
The Abdol Islami Family and Foundation (1994)
Dr. Julius H. Jacobson II (1993)
†Dr. Oliver H. Behrs (1992)
†Dr. John Conley (1990)
†Dr. Armand Hammer (1989)
† Deceased

Fellows Leadership Society

Philanthropy has been a tradition of the American College of Surgeons since its inception. In 1914, the leadership of the College initiated a campaign to secure gifts from members to establish an endowment fund. That spirit of giving continues today with gifts of all sizes from thousands of donors who support the numerous programs of the College through the ACS Foundation.

The Fellows Leadership Society recognizes Fellows and friends who have invested most loyally in the American College of Surgeons. Through their leadership in giving, members of the Fellows Leadership Society exemplify the philanthropic spirit of the College’s founders.

Recognition is provided based on cumulative giving history. Annual renewable membership is accorded to individuals whose contribution during a given fiscal year totals $1,000 or more. Categories of membership include:

Pinnacle Circle
CUMULATIVE gifts totaling $1,000,000 or more

Second Century Circle
CUMULATIVE gifts totaling $500,000 or more

Legacy Circle
CUMULATIVE gifts totaling $100,000–$500,000

Founders Circle
CUMULATIVE gifts totaling $75,000–$100,000

Presidents Circle
CUMULATIVE gifts totaling $50,000–$75,000

Regents Circle
CUMULATIVE gifts totaling $25,000–$50,000

Governors Circle
CUMULATIVE gifts totaling $10,000–$25,000

Donors Circle
ANNUAL gift of $1,000 or more

We acknowledge all donor gifts received through June 30, 2012.
Welcome to Steven C. Stain, MD, FACS

The Foundation is pleased to welcome Dr. Steven C. Stain as the newest member of its Board of Directors. Dr. Stain, chair of the department of surgery at Albany Medical College in New York, first became active with the Foundation as a volunteer for the Chapters and Affiliates Committee. He was also a member of the Steering Committee to endow the Traveling Fellowship named in honor of the late Claude H. Organ, Jr., MD, FACS.

A Fellow of the College since 1994, Dr. Stain had his first interaction with the ACS at the Southern California Chapter meeting, where he, as a resident, presented a paper on hepatic trauma. “The Southern California Chapter was and still is a vibrant chapter that was a great entrée into the College,” said Dr. Stain. “The January chapter meeting, and presenting papers and meeting the speakers and leaders in our profession from various institutions, was the highlight of the year for the residency programs in Southern California.”

A loyal donor to the Foundation for many years, Dr. Stain is a member of the Regents Circle in the Fellows Leadership Society because, as he explained, “the ACS does so much for us as surgeons.”

Investing in the Future of the American College of Surgeons: Dr. and Mrs. Andrew L. Warshaw

The American College of Surgeons and the ACS Foundation have long benefited from the generosity of Andrew Warshaw, MD, FACS, and his wife, Brenda. Loyal donors for more than 20 years, Dr. and Mrs. Warshaw have also made the decision to include the College in their estate planning, providing for the future of the College, and are now members of the Foundation’s Mayne Heritage Society.

In their own words, the Warshaws describe why supporting the ACS is important to them:

The ACS has been a backbone of my life as a surgeon and provided so many opportunities for me to grow professionally and personally. It has been a source of continued learning, providing a forum to get and give new ideas. With the Governors, we launched Operation Giving Back, now a highly successful domestic and international volunteerism program, and the American College of Surgeons Professional Association-SurgeonsPAC, a key element in the College’s advocacy efforts that are so crucial in the rush of health care change. My current role as Chair of the Health Policy and Advocacy Group is to help advise and coordinate those efforts. As Treasurer, I have appreciated the fiscal acumen and responsibility of the College and had a close-up view of the extraordinary energy, intelligence, and innovation of our leaders.

All of this adds up to the fact that the American College of Surgeons has enlarged my life and the circle of friends with whom my wife, Brenda, and I have grown close. While my education and surgical practice have been rooted in Boston (I am a “Preparation H,” Harvard College, medical school, training, and faculty; Brenda, a surgical nurse, is a Boston native), we now have ACS buddies all over the country and beyond. The ACS has given so much to us; it is our turn to give back what we can to support its programs through the Mayne Heritage Society.

Will Rogers said, “Even if you are on the right track, you will get run over if you just stand there.” The ACS is moving ahead by championing surgeons, the profession of surgery, and quality in surgical care. We all need to fuel that engine.
Clinician, technician, administrator, educator, researcher, and philanthropist are words that describe Dr. Kenneth L. Mattox equally. Over his impressive career as a general and thoracic surgeon, Dr. Mattox has given back to mankind in many different ways. One example has been his remarkable advocacy for the College’s Committee on Trauma. Through personal giving and campaigning for support from the Trauma and Critical Care Foundation for more than 20 years, Dr. Mattox has provided the College with significant resources and is recognized as one of the ACS Foundation’s major donors. He is a member of the American College of Surgeons Foundation Legacy Circle of the Fellows Leadership Society, the donor recognition program of the Foundation.

Known internationally for his innovative approach to patient care and surgical advances, Dr. Mattox found a particular passion for trauma care. Dr. Mattox believes that because accidental injuries are the leading cause of death for individuals under the age of 45, trauma care is of tremendous importance, and working in this field gives him the opportunity to make a greater impact. Dr. Mattox found that he was able to fuel his passion for advancing the field of trauma through volunteer opportunities with the American College of Surgeons, finding its Committee on Trauma’s dedication to research-based best practices particularly innovative and inspiring.

Remarking on his reasoning for support of the College’s Trauma Programs, Dr. Mattox said, “Philanthropy has been an essential element to civilization for hundreds of years, a driving force for needed societal change. Individuals like surgeons and educators have a genetic disposition for giving back, and I am proud to continue this tradition through my own philanthropic support of the Committee on Trauma’s important work of saving lives.”

A member of the ACS since 1975, he has served the College in many capacities, including President of the South Texas Chapter, member of the Board of Governors, and senior member of the Committee on Trauma. Dr. Mattox is Distinguished Service Professor of the Michael E. DeBakey Department of Surgery at Baylor College of Medicine and chief of staff/chief of surgery at the Ben Taub General Hospital in Houston, TX. He helped develop the internationally renowned Ben Taub General Hospital emergency center and its equally respected trauma center. He has been a visiting professor or consultant to more than 800 medical schools, hospitals, and health care systems throughout the world.

The ACS Foundation strongly values and appreciates the philanthropic support demonstrated by Dr. Mattox, the Trauma and Critical Care Foundation, and the many faculty who annually support the Foundation’s conferences, thereby making it possible for the Committee on Trauma to fund initiatives like the Resident Trauma Paper Competition and international trauma programs.
Why I Give Back: Danny R. Robinette, MD, FACS

Dr. Danny R. Robinette, medical director of the Surgery Center of Fairbanks, superbly represents his profession and his small community of Fairbanks, AK, through his active support of both the American College of Surgeons and the ACS Foundation. A Fellow since 1992, Dr. Robinette has served the College as the Alaskan representative to the Board of Governors and as the Committee on Cancer’s State Chair for Alaska.

Referring to his life of blessings and fulfillment in both his professional career and family as motive, Dr. Robinette gives back in many different ways, one of which is financial support of the Foundation. He counts serving his patients as a privilege and sees the College as an embodiment of professional goals and ethics. Philanthropic support of the College is a natural extension.

“I see many things the Foundation is doing to improve education and training of young surgeons. The College also provides quality surgical care to underserved areas,” Dr. Robinette said. “These are all vital roles that may be left unfilled or underserved without the Foundation and the College.”

Dr. Robinette also greatly appreciates the many personal benefits he has received from the Fellowship, especially the help in developing his professional knowledge and ethics and providing high-quality care for his patients. It is easy to see why his favorite College program is the ACS National Surgical Quality Improvement Program. “It is very exciting to see a program that approaches quality using risk-adjusted patient outcomes rather than rate of compliance with a protocol as an end point,” he said.

As a generous member of the Fellows Leadership Society Governors Circle, Dr. Robinette and his wife, Paula, also are helping to ensure the College’s support of keeping surgeons current in new techniques and care models, particularly those surgeons living in small communities with limited resources. For example, through skills developed by the ACS, the small community of surgeons in Fairbanks, AK, has developed a cancer program that was recently accredited with commendation in all eight areas.

Additionally, Dr. Robinette is grateful to the Fellowship for introducing him to a number of contacts and peers throughout the country and, in fact, the world. This network of professionals assists and advises in difficult problem areas, both in clinical and leadership skills development.

“I can think of few other organizations that deserve our strong support as members of the profession of surgery,” Dr. Robinette said. “Giving to this organization will be a heritage you can be proud of. A gift to the ACS Foundation is a gift to future surgical patients and their surgeons—what could be better?”
Ways to Give

The American College of Surgeons Foundation is a tax-exempt, not-for-profit organization whose sole mission is to promote voluntary philanthropy to support the College’s priorities. Contributions are deductible to the extent allowed by law.

Gifts may be directed to general support of the College’s programs in quality patient care, education and research, and outreach activities. Donors may also direct their gifts toward a specific program area as outlined on the Foundation’s website: www.facs.org/acsfoundation

A variety of gifting vehicles is available to our benefactors:

**GIVING ONLINE**
- Please visit www.facs.org/acsfoundation to donate with a credit card.

**GIFTS OF CASH**
- You can donate through the mail by check or money order, payable to:
  American College of Surgeons Foundation
  633 N. Saint Clair St.
  Chicago, IL 60611-3211

**GIFTS OF APPRECIATED STOCK**
Contact your broker and provide required instruction authorizing the transfer of stock to the American College of Surgeons. Inform the ACS Foundation (312-202-5376, mwojcik@facs.org) of your intent to contribute stock, providing your full name; the name, address, and telephone number of your broker; the name of the stock(s) to be transferred; the number of shares; and the anticipated date of transfer.

**American College of Surgeons Northern Trust**
ACCOUNT: NT2058157
DTC: 226
CONTACT: Sue Ingraffia
PHONE: 312-557-2912
E-MAIL: sr37@ntrs.com
ACS FOUNDATION TAX ID: 30-0305504
ACS FOUNDATION: 312-202-5338

**ESTATE GIFTS**
Including the American College of Surgeons in your will or estate plan is an easy way to ensure the future vitality of programs and services that benefit the Fellowship. The official legal bequest language for the American College of Surgeons Foundation is:

“I, [name], of [city, state, ZIP], give, devise, and bequeath to the American College of Surgeons Foundation [written amount or percentage of the estate or description of property] for its unrestricted use and purpose.”

**LIFE INCOME GIFTS**
Planned gifts such as gift annuities and trusts can provide mutual benefits. Please visit the Foundation’s website for details.
The Physician Compare website

by Sana Gokak, MPH

As required under the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) established the Physician Compare website in January 2011. This site currently features information on Medicare physicians and other eligible professionals (EPs) who participate in the Physician Quality Reporting System (PQRS).

In the 2013 Medicare Physician fee schedule (MPFS) final rule, CMS lays out a framework for expanding the website by collecting information on physician quality, efficiency, patient experience of care, and how such information will be made available on Physician Compare. This column details how CMS’ plan may impact surgeons. For additional information on the Physician Compare website, visit the Medicare website at http://www.medicare.gov/find-a-doctor/provider-search.aspx?AspxAutoDetectCookieSupport=1.

What type of information is CMS currently posting on the Physician Compare website?

CMS lists basic provider information as well as information on whether a provider has successfully participated in the PQRS program and/or Electronic Prescribing (eRx) Incentive Program. CMS collects basic provider information through the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), making it imperative that the information a provider has on file in the PECOS system is up to date and accurate.

Using Physician Compare, EPs may obtain definitive information about physicians and other health care professionals by selecting a location and specialty. The results provide information on specialty, practice locations, group practice and hospital affiliations, Medicare assignment status, education, languages spoken, gender, and so on.

The ACA also mandates that CMS use the most recent incentive program information to indicate whether a professional has satisfactorily participated in the PQRS program and/or is a successful electronic prescriber under the eRx Incentive Program.

What type of information is CMS planning to post on the Physician Compare website in the future?

CMS is planning to include updated administrative information on an EP’s page as well as information regarding physician performance. CMS plans to enhance the administrative data by adding information on whether a physician or other health care professional is accepting new Medicare patients, board certification information, improved foreign language, and hospital affiliation data. CMS also intends to include the names of EPs who are successfully participating in the PQRS, the PQRS Maintenance of Certification bonus program, and the eRx Incentive Program.

When feasible, CMS will post the names of EPs who are successfully participating in the Electronic Health Record (EHR) Incentive Program. As noted in the 2013 MPFS final rule, CMS will display an indicator on the profile Web page of an EP to acknowledge satisfactory participation in the incentive programs.

Under the ACA, CMS is required to implement a plan no later than January 1, 2013, and make publicly available on the Physician Compare website information on physician performance that provides comparable quality and patient experience measures. The 2013 fee schedule finalized CMS’ plan to use data from the existing PQRS program as a first step toward making physician measure performance information public on Physician Compare. CMS has finalized the decision to make public on Physician Compare, beginning later in 2013 or early 2014, the performance rates on the quality measures that group practices submit under the 2012 PQRS group practice reporting option Web-interface and the Medicare Shared Savings Program, as well as patient experience of care data. Moreover, CMS will only post quality measure information on groups of 100 or more EPs and must meet a sample size of 20 patients who prove to be statistically valid and reliable.
To ensure that the data are statistically valid, CMS will not report on a measure if a measure meeting the minimum threshold is invalid or unreliable for any reason. Additionally, CMS plans to post on the Physician Compare website in 2014 several composite measures that reflect group performance across related measures. CMS also intends to work with specialty societies in the future to include specialty society data that are already collected for other purposes and go through appropriate testing. Lastly, CMS plans to post information on individual-level data beginning in 2015 but will address the details of doing so in future rulemaking.

How will Physician Compare impact me?
Although CMS will start posting physician performance and patient experience of care data in 2014, they will begin by only posting information on groups of 100 or more EPs. Before posting the patient experience of care data, CMS will provide group practices and accountable care organizations with a 30-day period to preview their quality data and how it will appear on the Physician Compare website. Eventually, CMS will include individual-level data on Physician Compare, and specific details on how this information will be presented will be decided in future rulemaking. EPs are encouraged to regularly check their profiles to ensure the accuracy of the information being provided.

Should there be any errors, providers are encouraged to log into their PECOS account, which is available at https://pecos.cms.hhs.gov/pecos/login.do. For more information on PECOS accounts, visit http://www.medicare.gov/find-a-doctor/staticpages/provider-resources/overview.aspx. By providing consumers with quality-of-care information, CMS’ goal is to help consumers make informed decisions about their health care and also encourage clinicians to improve the quality of care that they provide to their patients.
Coding for hospital admission, consultations, and emergency department visits

by Mark Savarise, MD, FACS

Coding for surgical services can be complicated because it involves numerous rules, guidelines, and exceptions that frequently change. An area of exceptional difficulty is the correct use of codes for evaluation and management (E/M) of patients who require hospitalization. Coding for E/M services has become even more complex due to the Centers for Medicare & Medicaid Services’ recent decision to reject the use of consultation codes and institute observation codes. This column provides sample cases that explain how to appropriately code for E/M services for a typical general surgery patient.*

E/M
A 60-year-old male with multiple co-morbidities presents with severe upper abdominal pain and has ultrasound evidence of cholecystitis. The correct E/M code to report in this case depends on several factors:

• The severity of illness and appropriate documentation of elements of the history and physical to determine the level of service
• The hospital admission status of the patient, such as inpatient, observation, emergency, or outpatient

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The disposition of the patient after the evaluation

Whether the patient is covered by Medicare

Health care professionals examine such factors to determine the appropriate code to use for services provided and how the codes compare for reimbursement. The relative value units (RVUs) of these codes are included here in the scenarios for comparison. RVUs are multiplied by the annual conversion factor to determine reimbursement for a service.

Office consultation
The simplest case involves a patient the surgeon sees in the office and then schedules for surgery through the outpatient surgery department. Consultations for Medicare patients are reported with new patient (99201–99205) or established patient (99212–99215) Current Procedural Terminology (CPT) codes. For non-Medicare patients (unless otherwise instructed by a payor), office or other outpatient consultations are reported with codes 99241–99245. Consultation codes are only appropriate if the patient is referred by another provider for consultation; otherwise, new or established patient codes are used. (See Table 1, page 55, for the 2013 total office/outpatient new, established, and consultation nonfacility RVUs.)

Emergency department (ED) consultation: Patient is admitted
In this example, a patient presents to the ED, general surgery is consulted, and the surgeon determines that the patient requires admission to the hospital through the general surgery service. For Medicare patients, if the patient is admitted to the hospital by the general surgeon, he or she should bill an initial hospital care code (99221–99223) and not an ED visit code. Medicare requires that the admitting physician append modifier AI to the initial hospital visit code (9922X-AI). If the patient is admitted for observation, codes 99218–99220 are reported. For patients receiving hospital outpatient observation services who are then admitted to the hospital as inpatients and who are discharged on the same date, the physician should report CPT codes 99234–99236.

For patients with insurance that follows non-Medicare CPT rules, the instructions are even more obscure. If a patient is admitted after an ED consultation and is not seen on the unit (in the intensive care unit, for example) on the date of admission, only report the outpatient consultation codes (99241–99245). If the surgeon sees the patient on the hospital unit on the date of admission, report all E/M services related to the admission with the initial inpatient admission.
service code (99221–99223) or initial observation care code (99221–99223). Do not report both an outpatient consultation and inpatient admission (or observation care) for services on the same day related to the same inpatient stay. (See Table 2, this page, for the 2013 total initial observation, hospital, same day observation and discharge, and outpatient consultation facility and nonfacility RVUs.)

**ED consultation: Patient is not admitted**
A patient presents to the ED; general surgery is consulted, but the patient is not admitted to the hospital. If the patient is a Medicare beneficiary, the general surgeon should bill the level of ED code (99281–99285).

Non-Medicare patients are considered outpatients until they are admitted to the hospital, and therefore the outpatient consultation codes are reported (99241–99245). If the surgeon does not come to the hospital to see the patient but only advises the ED physician by telephone, then the surgeon may not bill at all for this service. (See Table 3, page 56, for the 2013 total initial hospital and outpatient consultation facility and nonfacility RVUs.)

Multiple billings of initial hospital visit codes could occur in a single day. However, only one initial visit per specialty can be paid per stay. Follow-up visits in the facility setting may continue to be billed as subsequent hospital care visits (99231–99233). The coding depends on the admission status of the patient when seen and whether the patient is classified as Medicare or non-Medicare.

For Medicare patients, inpatient consultations are reported with the initial hospital visit codes (99221–99223). Do not append modifier AI, which is only used by the admitting physician. If the surgeon is consulted on case involving a Medicare patient who is in observation status, the surgeon should report new patient (99201–99205) or established patient (99211–99215).

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**TABLE 1.**
2013 TOTAL OFFICE/OUTPATIENT NEW, ESTABLISHED, AND CONSULTATION NONFACILITY RVUS

<table>
<thead>
<tr>
<th>CPT</th>
<th>Office/outpatient visit new</th>
<th>CPT</th>
<th>Office/outpatient visit established</th>
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<tr>
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<td>99213</td>
<td>2.13</td>
<td>99243</td>
<td>3.52</td>
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<td>99205</td>
<td>5.99</td>
<td>99215</td>
<td>4.20</td>
<td>99245</td>
<td>6.36</td>
</tr>
</tbody>
</table>

**TABLE 2.**
2013 TOTAL INITIAL OBSERVATION, HOSPITAL, SAME DAY OBSERVATION AND DISCHARGE, AND OUTPATIENT CONSULTATION FACILITY AND NONFACILITY RVUS

<table>
<thead>
<tr>
<th>CPT</th>
<th>Initial observation care</th>
<th>CPT</th>
<th>Initial hospital care</th>
<th>CPT</th>
<th>Observe/discharge same date</th>
<th>CPT</th>
<th>Outpatient consultation</th>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99245</td>
<td>6.36</td>
</tr>
</tbody>
</table>
office/outpatient codes. For non-Medicare patients, if the consultation is done after the patient is admitted to the hospital, consultation services may be reported with the inpatient consultation codes (99251–99255). Consultation services in observation status are reported with the outpatient consultation codes (99241–99245). (See Table 4, this page, for the 2013 total initial hospital, inpatient and outpatient consultation facility and nonfacility RVUs.)

An important factor for correct coding is to report the service based on the location/status at the time of admission and if the payor is Medicare or follows Medicare rules related to consultation services. In addition, it is important that the surgeon be aware of and/or communicate three things to staff members to accurately report services:

- Is the service a consultation service?
- Where is the service provided?
- What is the disposition of the patient (such as, admitted to observation status; admitted as inpatient to the general surgeon’s service or to another physician’s service)?

Once this information is determined, the burden of selecting the correct category of CPT E/M codes is minimized.

In summary, there are many ways surgeons are not reimbursed for services. There is very little advantage to “gaming the system” based on the admission status of the patient at the time of the evaluation. Incorrect coding may result in no payment at all.

For additional coding and practice management resources and guidance, visit www.facs.org/ahp/pubs/tips/index.html.

**Editor’s note**

Accurate coding is the responsibility of the provider. This summary is only intended as a resource to assist in the billing process.

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### Table 3.
**2013 Total Initial Hospital and Outpatient Consultation Facility and Nonfacility RVUs**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Initial hospital care</th>
<th>CPT</th>
<th>ED visit</th>
<th>CPT</th>
<th>Outpatient consultation</th>
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<td>1.76</td>
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<tr>
<td></td>
<td></td>
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<td>3.36</td>
<td>99244</td>
<td>5.20</td>
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<tr>
<td></td>
<td></td>
<td>99285</td>
<td>4.93</td>
<td>99245</td>
<td>6.36</td>
</tr>
</tbody>
</table>

### Table 4.
**2013 Total Initial Hospital, Inpatient and Outpatient Consultation Facility and Nonfacility RVUs**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Initial hospital care</th>
<th>CPT</th>
<th>Inpatient consultation</th>
<th>CPT</th>
<th>Outpatient consultation</th>
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</table>
ACS and The Joint Commission partner on project to decrease risk of colorectal SSIs

A collaborative project of the American College of Surgeons (ACS) and the Joint Commission Center for Transforming Healthcare aimed at reducing colorectal surgical site infections (SSIs) saved seven participating health care institutions more than $3.7 million. A total of 135 SSIs were averted through the two-and-a-half year project. These and other results of the project were presented at a press conference late last year at The Joint Commission’s headquarters in Oakbrook Terrace, IL.

The collaboration used SSI outcomes data from the ACS National Surgical Quality Improvement Program (ACS NSQIP®) to guide the improvement effort. ACS NSQIP uses detailed medical information on the severity of illness and comorbidity to produce data on risk-adjusted outcomes for surgical procedures. SSI is one of the most prevalent negative outcomes reported by ACS NSQIP hospitals.

32 percent overall reduction
The participating hospitals were able to reduce superficial incisional SSIs, which affect skin and underlying tissue, by 45 percent and all types of colorectal SSIs by 32 percent. The average length of stay for hospital patients with any type of colorectal SSI decreased from an average of 15 days to 13 days. In comparison, patients with no SSIs had an average length of stay of eight days.

The seven health care organizations that volunteered to address colorectal SSIs as a critical patient safety problem include:

- Cedars-Sinai Medical Center, Los Angeles, CA
- Cleveland Clinic, Cleveland, OH
- Mayo Clinic–Rochester Methodist Hospital, Rochester, MN
- North Shore–Long Island Jewish Health System, Great Neck, NY
- Northwestern Memorial Hospital, Chicago, IL
- OSF Saint Francis Medical Center, Peoria, IL
- Stanford Hospital & Clinics, Palo Alto, CA

Colorectal procedures were selected as the focus of the project because SSIs are disproportionately higher among patients following these operations. Colorectal operations are commonly performed across different types of hospitals, may result in complications, present significant opportunities for improvement, and have high variability in performance across hospitals. The project addressed preadmission, preoperative, intraoperative, postoperative, and postdischarge follow-up processes for all surgical patients undergoing emergency and elective colorectal surgery, with the exception of trauma and transplant patients and patients under the age of 18.

Project participants studied the potential factors that contribute to all three types of colorectal SSIs: superficial incisional, deep incisional, and organ space SSIs, which affect organs and the space surrounding them.

Robust Process Improvement
The project addressed the problem of colorectal SSIs using Robust Process Improvement (RPI) methods. RPI is a fact-based, systematic, and data-driven problem-solving methodology that incorporates Lean Six Sigma and change management concepts. Using RPI, project participants measure the magnitude of the problem, pinpoint contributing causes, develop specific solutions that are targeted to each cause, and thoroughly test the solutions in real-life situations. The hospitals in the SSI project identified 34 unique correlating variables that increased the risk of colorectal SSIs, including patient characteristics; surgical procedure; antibiotic administration; preoperative, intraoperative, and postoperative processes; and measurement challenges.

Examples of some of the targeted solutions to reduce superficial incisional, colorectal SSIs include standardizing the preoperative instruction to patients and caregivers for applying the preoperative skin cleaning product and establishing specific criteria for the correct management of specific types of wounds, which promotes healing and helps decrease the risk of
Colorectal procedures were selected as the focus of the project because SSIs are disproportionately higher among patients following these operations.

“ACS NSQIP uses rigorous data to produce risk-adjusted outcomes. By collaborating with the Joint Commission Center for Transforming Healthcare on this surgical site infection project, we’ve made meaningful progress in learning how we can reduce the SSI rate in colorectal surgical patients and concomitantly produce savings in costs. These results give the surgical community further impetus to continue working to solve this critical surgical care quality issue,” added Clifford Y. Ko, MD, MS, FACS, Director of ACS NSQIP and the ACS Division of Research and Optimal Patient Care. “The problem has been identified, and the targeted steps we’re taking are helping us to solve it. As increasingly more hospitals and individual providers get involved to study, learn, and improve upon their results, the benefits will be enormous for everyone but most importantly for our patients.”

“Reducing surgical site infections is a very real challenge, but one that must be addressed if we want to make health care more reliable in terms of patient safety,” Mark R. Chassin, MD, MPH, FACP, president of The Joint Commission, said during the press conference. “These seven organizations are leading the way in finding specific solutions to the complex problem of surgical site infections.”

Solutions for colorectal SSIs will be added to the Targeted Solutions Tool (TST) this year after the solutions and improvement tools from this project are pilot tested in other health care organizations. The TST provides a step-by-step process to assist Joint Commission-accredited health care organizations in measuring performance, identifying barriers to excellent performance, and implementing the center’s proven solutions that are customized to address specific barriers. Targeted solutions are now available for improving hand hygiene, hand-off communications, and wrong site surgery. Accredited organizations can access the TST and solutions on their secure Joint Commission Connect extranet.

For detailed information regarding the contributing factors and targeted solutions identified in the SSI project, visit the Joint Commission Center for Transforming Healthcare project website at http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=4.
2012 Pediatric Report:

Devastating at any age

by Richard J. Fantus, MD, FACS, and Michael L. Nance, MD, FACS

The 2012 Annual Report of the National Trauma Data Bank (NTDB®) is an updated analysis of the largest aggregation of U.S. and Canadian trauma registry data ever assembled and, in fact, was the focus of this column in the January 2013 issue of the Bulletin. In total, the NTDB now contains more than 5 million records. The 2012 Annual Report is based on 773,299 records, submitted by 741 facilities, from the single admission year of 2011. This month we turn our focus to the 2012 Pediatric Report, which is based on 148,495 admission year records from 2011. The NTDB classifies pediatric patients in this report as patients who are younger than 20 years of age.

The mission of the American College of Surgeons (ACS) Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center data. The purpose of this report is to inform the medical community, the public, and decision makers about a variety of issues that characterize the current state of care for injured pediatric patients in the U.S. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

For example, when looking at the number of incidents by intent, the overwhelming majority (greater than 88 percent) are classified as unintentional and carry a relatively low case-fatality rate of 1.28 percent. However, there is a disturbingly high case-fatality rate when it comes to the smaller group of self-inflicted injuries. Although this group accounts for approximately 1 percent of the total records, it carries the highest case-fatality rate of more than 13.5 percent. This type of information could be very useful for injury control/prevention and education because self-inflicted injuries are devastating at any age (see figure, page 60).

Many dedicated individuals on the ACS COT, including the Pediatric Surgery Subspecialty group, along with those committed to caring for pediatric patients at trauma centers across the nation, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, the goals in the coming years

The NTDB 2012 Pediatric Report 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.
Many dedicated individuals on the ACS COT, including the Pediatric Surgery Subspecialty group, along with those committed to caring for pediatric patients at trauma centers across the nation, have contributed to the early development of the NTDB and its rapid growth in recent years.

include improving data quality, updating analytic methods, and enabling more useful inter-hospital comparisons. These efforts will be reflected in future NTDB reports to participating hospitals as well as in the annual Pediatric Report documents.

Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The National Trauma Data Bank 2012 Pediatric Report is available on the ACS website as a PDF file and a PowerPoint presentation at www.ntdb.org. In addition, information is available on the website regarding how to obtain NTDB data for more detailed study. To submit your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.◆
In memoriam:

Joseph E. Murray, MD, FACS, opened doors for transplant surgeons

by Thomas E. Starzl, MD, PhD, FACS

It is an honor to pay tribute to and to celebrate the life of the 1990 Nobel Laureate, Joseph E. Murray, MD, FACS. Dr. Murray, a former Regent and First Vice-President of the American College of Surgeons (ACS), died November 26, 2012, at Brigham and Women’s Hospital (previously the Peter Bent Brigham Hospital), Boston, MA, after suffering a hemorrhagic stroke at his home on Thanksgiving night. He was 93 years old.

First name in transplantation

Throughout the last half century, the first name to be mentioned in any discussion of organ transplantation has been Dr. Joseph E. Murray. The reason, from a purely historical perspective, is really quite simple. Dr. Murray and his associates at the “Brigham” made three remarkable contributions that have resisted the normal erosions of time and obsolescence.

The first event took place two days before Christmas 1954, with the successful transplantation of a kidney from one identical twin to the other. It was anything but a casual stunt. Research in renal transplantation had been an important activity at the Brigham for several preceding years. There, the fledging specialty of nephrology was being developed by John Merrill, MD. The first artificial kidney in America had been constructed at this hospital. And the medical and surgical departments, under the leadership of George Thorn, MD, and Francis D. Moore, MD, FACS, had committed their resources to what was generally conceived to be a fantasy.

But was it really a fantasy? Years ahead of its time, the Brigham already had equipped itself with all the ingredients of a modern interdisciplinary transplantation unit. The group understood perfectly that success without immunosuppression could be expected only with genetic identity of the donor and recipient. The efforts that were made to be sure of this condition were extraordinary and ultimately included skin grafting. It is no distortion of history to say that the tissue matching of today between non-twin donors and recipients is an attempt to come as close as possible to the ideal conditions of the landmark Brigham case.

The successful operation marked the beginning of a revolution. However, the tabulation of kidney transplant patients surviving today who otherwise would be dead gives a woefully incomplete impression of the ultimate impact of this case. Until 1954, the treatment of organ failure had consisted of palliative measures designed to slow or compensate for the declining function of the organ in question. With the option of transplantation, the philosophy by which the organ-specific medical disciplines were practiced would be changed forever: first in nephrology and ultimately with all of the other specialties. Complete replacement of the failing engine now could be envisioned.

Before such dreams could be realized, however, it would be necessary to control the immune response that had been scrupulously avoided in
the identical twins cases. The attention of the Brigham team already was riveted on this problem. More than four years later, on January 24, 1959, the key step was taken by Dr. Murray and his associates. It consisted of transplanting a kidney allograft from a fraternal (not identical) twin to his dizygotic brother who had been conditioned with total body irradiation. The transplanted kidney functioned for more than 20 years without a need for maintenance immunosuppression.

For the first time (in any species), the genetically determined immune barrier to organ transplantation had been broken down. I have always thought that this second contribution by Dr. Murray and his Brigham associates 53 years ago was the most important one ever made to either the basic or clinical literature of organ transplantation. The validity of the observations in this case reported by Dr. Murray and his friend, Dr. Merrill, were confirmed by further experience in France.

The stage was now set for Dr. Murray’s third epochal contribution—namely the clinical introduction of drug immunosuppression. On April 6, 1962, Dr. Murray transplanted a kidney from a recently deceased cadaver under azathioprine-based immunosuppression. The graft functioned for 17 months and provided the world with its first example of truly prolonged human organ allograft function using drugs alone.

This was a wonderful story. What could have resulted in institutional and personal ignominy ended in triumph. What might not be so apparent is the fierce determination and faith that sustained Dr. Murray and his colleagues through what they have called their “dark years.” Dr. Murray was the perfect leader because he possessed to an unusual degree those qualities that hold men and women together through tough times: skill, intelligence, genuine kindness, and unfailing integrity. He was the focal point around which others, on his team and around the world, could rally.

**Man of many interests**

Dr. Murray was born on April 1, 1919, in Milford, MA. His father, William, was a district court judge, and his mother, Mary, was a teacher. A man of many interests, Dr. Murray received a bachelor’s of arts degree in the humanities in 1940 from Holy Cross College in Worcester, MA. While attending Harvard Medical School, he met his future wife, Virginia Link, at a Boston Symphony Orchestra recital. He earned his medical degree from that institution in 1943 and joined the U.S. Army Medical Corps in 1944.

He was a Major at Valley Forge General Hospital in Pennsylvania, working as a plastic surgeon to reconstruct the hands and faces of soldiers burned and maimed on the battlefield during World War II. He then returned to Harvard Medical School in 1947 and was board certified in general surgery in 1952 and in plastic surgery in 1954. He worked his way through the academic ranks and by 1970 was a full professor at Harvard and chair
of the plastic and reconstructive surgery department at Brigham and Women’s and Boston Children’s Hospital. He retired from the active faculty at Harvard Medical School in 1989 but continued to serve as an emeritus professor. The following year, Dr. Murray was awarded the Nobel Prize in Physiology or Medicine. The award was announced during the 1990 ACS Clinical Congress in San Francisco, CA, and was shared with the late E. Donnall Thomas, MD, an oncologist at the Fred Hutchinson Cancer Research Center in Seattle, WA. Dr. Murray was the recipient of numerous other awards including the Frances Amory Prize of the American Academy of Arts and Sciences, Boston (1962); the gold medal of the International Society of Surgeons, Brussels, Belgium (1963); a prize of the American Association of Plastic Surgeons (1969); the ninth Ferdinand C. Valentine medal and award of the New York Academy of Medicine (1970); the National Kidney Foundation Gift of Life award (1979); and the Medawar Prize of The Transplantation Society (2002).

Dr. Murray served as an ACS Regent from 1970 to 1979 and as First Vice-President from 1969 to 1970. He also was a prominent member of other medical and surgical associations, having served as president of the American Association of Plastic Surgeons (1964–1965), chair of the American Board of Plastic Surgery (1969–1970), and president of the Boston Surgical Society (1975).

**A builder**

If there is a unifying theme in Dr. Murray’s life, it is that of a builder. He began his plastic surgery career by building new faces and body parts for people who had been maimed physically and emotionally by war, accidents, and cancer. It was not surprising that he next turned to transplantation to rescue patients who could be healthy, were it not for the failure of a vital organ. In the long run, he built a stadium called the specialty of organ transplantation, began to populate it with high-minded people whom he trained, and welcomed with open arms those of us whom he did not even know.

Organ transplantation has become a grand multilayered international superstructure. But it still rests on the three seminal cornerstones placed by Dr. Murray between 50 and 58 years ago: the identical twins, the fraternal twin experience of 1959, and the drug-immunosuppressed kidney cases of the early 1960s. What else is there to say to this plainspoken guy named Joe except “thank you for what you have done.”

Dr. Murray is survived by his wife; three sons, Richard of Scituate, MA, J. Link of Jamestown, RI; and Thomas of Dallas, TX; three daughters, Virginia of Plymouth, MA, Margaret Murray Dupont of Lafayette, CA; and Katherine Murray Leisure, MD, of Plymouth; and 18 grandchildren.
Franklin Martin Papers

ARCHIVAL DESCRIPTION NOW AVAILABLE!
Visit the ACS website History and Archives page

After a 10-year effort, the ACS archivists have completed a 54-page archival description of the 95 boxes of papers of ACS founder, Franklin Martin, MD, FACS, and his wife Isabelle.

The downloadable pdf description on facs.org/archives includes:

- Materials from Dr. Martin's early career, such as casebooks (1891–1917) and records of the Chicago hospitals and medical schools with which he was associated
- Martin's diaries and scrapbooks (1901–1934), which the Martins called their “Memoirs,” including 10 volumes documenting his experiences as Medical Director of President Woodrow Wilson's civilian arm of the Council of National Defense
- Descriptions of Martin's correspondence and hundreds of sympathy notes from after his death
- And much more!

The personal papers of Eleanor K. Grimm, Martin's special assistant, are also available on facs.org/archives. They include more than 1,000 pages of her correspondence and photos with many more insights into the early history of the College and its early leaders, all free text searchable.

Also on the History and Archives page are links to our Digital Collections samples; all existing presidential addresses presented at the annual Clinical Congresses, including their dates and locations; Distinguished Service Award recipients; monthly highlights from the Archives featuring notable individuals or documents found in the archives; a brief history of the College, and more. Just click on “Online Resources.”

We hope that after viewing the Digital Collections you will return to the History and Archives page to complete a one-minute Web survey. Your feedback is important to us.

Contact Susan Rishworth, Archivist, at srishworth@facs.org for more information.
MyATLS, the mobile trauma services app developed by the American College of Surgeons Committee on Trauma (ACS COT), ranked in the top 100 of all medical apps only a month after its September 29, 2012, debut. MyATLS has already been downloaded in 116 nations, reaching some countries where Advance Trauma Life Support® (ATLS®) training content had not been available, such as Morocco, the Philippines, and Turkey.

The total number of downloads is 8,885 for IOS and Android devices, and MyATLS ranked as the 89th top-grossing iPad application in the Apple Store’s medical category and as the 176th top-grossing iPhone application in the same category. MyATLS content comes from the ninth edition of the ATLS Student Course Manual, which was released in tandem with the app.

“The impact of MyATLS has been unquestionable, providing a first-rate mobile ATLS reference tool for all providers of trauma care in both the rural and developing world setting, as well as in the busy emergency room. We’re very encouraged by the enthusiastic interest and positive feedback from over 8,000 IOS and Android users in over 100 countries and hope to see this demand continue to grow,” according to trauma surgeon and MyATLS content developer George Brighton, MD, Barnstaple, UK.

MyATLS marks the first time that physicians and first responders to emergency medical situations have access to a mobile ATLS app ready for use at the patient’s bedside, in areas of the hospital with restricted Internet access, or in the field. “MyATLS puts information needed by trauma practitioners at their fingertips,” said Karen Brasel, MD, FACS, ATLS Committee Chair.

Furthermore, the MyATLS mobile app enhances the educational content and visual presentation of the print version of the ATLS Manual. The app consists of interactive algorithms, calculators, animations, Just in Time videos demonstrating key skills, summaries of chapters from the course manual, and other important features, such as skill station guides. “It’s organized according to the familiar ATLS concepts and chapters, supplemented with several high-quality videos demonstrating lifesaving procedures. Helpful to both the novice and experienced provider, it allows proven ATLS concepts to be delivered beyond the traditional structure of an in-person ATLS course,” Dr. Brasel explained.

It can be downloaded by users in advance via the Web for use in the hospital or in the field. The app is native to the device on which it is downloaded, so users do not need Internet access to use the app in the field.

“We look forward to seeing MyATLS play its key educational role as a companion for students of ATLS courses across the world,” Dr. Brighton said.

“The impact of this app on surgical residency education worldwide is amazing— with favorable responses and constructive feedback—we feel this app is truly a game changer,” added vascular surgeon Wesam Abuznadah, MB, ChB, FRCSC, FACS, a MyATLS Content Specialist, and ATLS National Educator in Jeddah, Saudi Arabia.

The app is available at no extra cost to all users who purchase the ninth edition of the course manual and as a stand-alone product via MyATLS.com. For more information, go to http://www.facs.org/trauma/atls/.
The American College of Surgeons (ACS), in association with Pfizer, Inc, is accepting nominations for the 2013 Surgical Volunteerism Award(s) and Surgical Humanitarian Award. All nominations must be received by Friday, February 22, 2013.

The ACS/Pfizer Surgical Volunteerism Award—offered in four potential categories each year—is given in recognition of surgeons who are committed to giving back to society by making significant contributions to surgical care through organized volunteer activities. The awards for domestic, international, and military outreach are intended for ACS Fellows in active surgical practice whose volunteer activities go above and beyond the usual professional commitments or retired Fellows who have been involved in volunteerism during their active practice and into retirement. ACS members who have been involved in significant surgical volunteer activities during their postgraduate surgical training are eligible for the resident award. Surgeons of all specialties are eligible for each of these awards.

For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism in this case does not refer to uncompensated care provided as a matter of necessity in most practices. Instead, volunteerism should be characterized by the prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gain.

The ACS/Pfizer Surgical Humanitarian Award is given in recognition of an ACS Fellow whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for surgeons who have dedicated a significant portion of their surgical careers to full-time or near full-time humanitarian efforts rather than routine surgical practice. Examples include a career dedicated to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received compensation for this work does not preclude a nominee from consideration and, in fact, may be expected based on the extent of the professional obligation.

Nominations will be evaluated by the Socioeconomic Issues Committee of the ACS Board of Governors, with final approval of award winners by the Executive Committee of the Board of Governors.

Potential nominees should make note of the following conditions:

- Self-nominations are permissible but require at least one outside letter of support
- Renomination of previous nominees is encouraged but requires an updated application
- Supplemental materials should be kept to a minimum and will not be returned

The nomination website is open for electronic submissions and may be accessed through the “Announcements” section of the Operation Giving Back website at http://www.operationgivingback.org. Nomination forms can also be requested by mail if needed. Contact Akiyo Kodera, Operation Giving Back Program Coordinator, with such requests or any questions at akodera@facs.org.
RQRS increases compliance rates to NQF quality measures for cancer care

Participation in the Rapid Quality Reporting System (RQRS) considerably increases how well Commission on Cancer (CoC)-accredited cancer programs report adherence to quality measures of breast and colorectal cancer, according to research findings presented November 30 at the American Society of Clinical Oncology Quality of Care Symposium in San Diego, CA.

“Cancer care is unique in that it requires extensive coordination with providers across disciplines to ensure patients receive all of their treatments. Patients are not only getting surgical treatment but also chemotherapy, radiation, and possibly hormone therapy,” noted Erica McNamara, MPH, Lead Study Author and Quality Improvement Information Analyst in the Cancer Programs section of the American College of Surgeons (ACS) Division of Research and Optimal Patient Care. “[The RQRS] is built to provide an extra layer of support in the coordination of that care.”

The RQRS is a Web-based data collection and reporting system that operates in real clinical time using information gathered through the College’s National Cancer Data Base (NCDB), a nationwide oncology repository of cases treated at CoC-accredited institutions. The RQRS officially launched in September 2011 with 66 test sites at CoC-accredited cancer centers across the country.

Study researchers examined data from 64,129 breast and colorectal cancer cases treated between 2006 and 2010 at 64 RQRS-participating cancer programs nationwide. They assessed how well the cancer programs adhered to five National Quality Forum (NQF)-endorsed quality performance measures before and after RQRS participation.

The analysis found that all five compliance rates rose considerably with RQRS participation, ranging from an 18 percent increase for adjuvant chemotherapy for stage III colorectal cancer to a 38 percent increase for hormone therapy in AJCC T1cN0M0, or stage II or III hormone receptor positive breast cancer. “We expected to see performance increases, but these results were higher than we initially expected,” Ms. McNamara said.

Importantly, the compliance rates were analyzed across demographic lines. “In the baseline data, we see apparent differences in compliance rates for some of these standards of care across age groups, race, and insurance coverage categories,” said Andrew Stewart, Study Coauthor and NCDB Senior Manager at the ACS. “But the results from this analysis suggest that those differences may actually have been more of a reflection of incomplete data and information in the registries than a reflection of differences in care delivery to subpopulations of patients.”

Still, given the complexity of the cancer care system, patients may miss out on important treatments waiting for their care to be pieced together by an interdisciplinary team that may work at different locations. The RQRS addresses this issue by putting specialists, surgeons, and patient navigators in contact with one another to share information routinely and quickly through such features as regular monthly reports. Ms. McNamara noted as an example that if patients nearing the end of their treatment period have not started care for a required therapy, an automatic “red alert” is sent from the NCDB to the cancer program team.

“We know that many cancer treatments take longer than six months to administer, so by tracking patients in real clinical time, RQRS not only prompts participating programs to follow-up on patient care throughout the entire treatment period, it also feeds back performance rates and comparisons based on current patients and clinical practice, not two- or three-year-old data,” Ms. McNamara explained.

“We estimate that somewhere between 30 and 40 percent of cancer centers participating in RQRS are catching patients with some regularity within their delivery systems,” Mr. Stewart added.

Recognizing the potential value of this program, the Centers for Medicare & Medicaid Services recently contracted with the ACS to implement the RQRS at 11 cancer hospitals across the country to support some of their public reporting activities through Hospital Compare—a website designed to help patients compare the quality of care offered at hospitals.

For more information about the RQRS, go to http://www.facs.org/cancer/ncdb/rqrs-gettingstarted.pdf.
The American College of Surgeons (ACS) and the American Cancer Society hosted the Surgical Health Care Quality Forum Georgia on December 12, 2012, the eleventh in a series of national discussions on how quality improvement efforts enhance surgical patient safety and reduce costs.

“We are at a critical period in health care delivery where we have the opportunity to be leaders in bringing quality improvement programs to Georgia in an effort to benefit our patients and reduce costs,” said forum co-host LaMar McGinnis, Jr., MD, FACS, Atlanta, Past-President of the College and senior medical advisor and liaison to the American Cancer Society.

“Regulators are continuing to realize the value of using clinical outcomes data versus administrative claims data to measure and track quality,” added ACS Executive Director David B. Hoyt, MD, FACS. “As CMS [the Centers for Medicare & Medicaid Services] and others start tying these measures to value-based purchasing programs, hospitals have a reputational and financial incentive to participate in programs like ACS NSQIP® [ACS National Surgical Quality Improvement Program] to achieve better outcomes and decrease costs.”

Presenters discuss quality programs
A panel of Georgia health care leaders discussed ways that state hospitals, academic institutions, health plans, and government agencies are using quality improvement data to improve patient outcomes and increase the value of health care.

Keynote speaker Kenneth E. Thorpe, PhD, Robert W. Woodruff Professor and chair, department of health policy and management, Rollins School of Public Health, and executive director, Emory Institute for Advanced Policy Solutions, presented the “bigger picture” of health care quality improvement. “While surgical quality and outcomes are clearly key drivers for health reform and cost, focusing on evidence-based care coordination models and chronic disease prevention will also be critical to managing quality improvement and cost-containment moving forward. For example, chronic disease accounts for 84 percent of health care spending, and those patients also have high rates of preventable hospital admissions and readmissions,” he said.

Other panelists described their institutions’ quality improvement efforts. Ryan Fagan, MD, MPH, medical epidemiologist, Centers for Disease Control and Prevention (CDC), Surveillance Branch, Division of Healthcare Quality Promotion, Atlanta, said, “Earlier this year, the CDC teamed up with ACS to more closely analyze infectious and non-infectious complications that affect surgical patients. By marrying infection information that hospitals report to the CDC National Healthcare Safety Network with ACS NSQIP measures and leveraging electronic health records, we will be able to effectively target and

Georgia Surgical Quality Collaborative
During the forum, presenters announced the creation of the Georgia Surgical Quality Collaborative, a statewide effort to encourage information-sharing among hospitals and use ACS NSQIP® to focus on improving surgical outcomes. Led by the Georgia Chapter of the ACS, nine hospitals have agreed to participate in the collaborative.

“This collaborative is a significant milestone to improve care for surgical patients in our state because it allows us to create a positive learning environment among all participating hospitals and work together to determine where improvement is needed most,” said co-host, John Sweeney, MD, FACS, W. Dean Warren Distinguished Professor of Surgery and chief, division of general and gastrointestinal surgery, department of surgery, Emory University School of Medicine, Atlanta. “As it stands, hospitals can’t fix errors if they don’t know a problem exists. Examining and comparing clinical outcomes data with our peers from each corner of the state will help us move the needle to improve patient outcomes and reduce overall health care costs.”

College and American Cancer Society team up to present Atlanta IQ forum
prevent SSI [surgical site infection] and related complications.”

Ana Pujols McKee, MD, executive vice-president and chief medical officer of The Joint Commission, also spoke on SSIs, noting “The Joint Commission’s Center for Transforming Healthcare has worked with ACS and seven other institutions to reduce superficial incisional SSI by 45 percent and all types of colorectal SSI by 32 percent. Participating hospitals have saved more than $3.7 million by avoiding 135 infections and decreasing the average hospital stay over a two-and-a-half year period.” (See related story, page 57.)

Carl R. Boyd, MD, FACS, a general/critical care surgeon at Memorial Health University Medical Center and professor of surgery at Mercer University School of Medicine, Macon, GA, voiced his support for using ACS NSQIP to improve surgical outcomes and noted, “The measurable improvement in complication rates seen with a standardized approach utilizing proven best practices will lower the cost of care, but more importantly, will result in preventable pain and suffering for the patient.”

Likewise, Bryant W. Wilson, MD, FACS, a general surgeon with Piedmont Healthcare, said, “NSQIP offers our surgeons valuable information on the quality of our care. But more importantly, the program has given our surgeons a tremendous opportunity to come together as a group to improve the care of our patients.”

According to Otis Webb Brawley, MD, FACP, chief medical and scientific officer and executive vice-president of the American Cancer Society; professor of hematology, oncology, and medicine at Emory University School of Medicine; and professor of epidemiology, Emory Rollins School of Public Health, “Improving the health care system will require equal resolve by physicians and patients to access and utilize information in order to make rational care decisions. We, as physicians, also need to address variations in care and begin standardizing more treatment protocols, including postoperative medical therapies for cancer patients.”

Bruce Feinberg, DO, vice-president and chief medical officer of Cardinal Health Specialty Solutions, and host of The Weekly Check-Up on WSB Radio in Atlanta, moderated a panel discussion featuring the following: Jerry Dubberly, PharmD, chief, Medicaid Division, Georgia Department of Community Health; Alexandra Leopold, regional vice-president, provider engagement and contracting, Blue Cross Blue Shield of Georgia; Dane C. Peterson, chief executive officer, Emory Hospital Midtown; and Karen Waters, RN, MHA, senior vice-president, professional services and strategic planning, Georgia Hospital Association.

To view the archived Georgia forum video and follow updates on upcoming tour locations, go to InspiringQuality.FACS.org or http://www.youtube.com/AmCollegeofSurgeons.
You’re reading articles every month in the *Journal of the American College of Surgeons*...

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Call for nominations for ACS Board of Regents

The 2013 Nominating Committee of the Board of Governors (NCBG) will select nominees for pending vacancies on the Board of Regents that will need to be filled during the 2013 Clinical Congress. The NCBG uses the following guidelines when reviewing the names of candidates for potential nomination to the Board of Regents:

• 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 in service and active participation on ACS committees or in other components of the College.
• The Nominating Committee members recognize the importance of representing all individuals who practice surgery.
• Geography, surgical specialty balance, and academic or community practice are other factors taken into consideration.
• The College encourages consideration of women and other under-represented minorities.

Individuals who are no longer in active surgical practice should not be nominated for election or reelection to the Board of Regents.

All nominations must include a letter of recommendation, a personal statement from the candidate detailing his or her ACS service, and the name of one reference. Surgical specialty societies, ACS advisory councils, ACS chapters, and other entities that are nominating as such, must provide a description their of selection process and the total list of applicants reviewed. Any attempt to contact members of the NCBG by a candidate or on behalf of a candidate will be viewed in a negative manner and possibly result in disqualification of the candidate. Applications submitted without the requested information will not be considered.

The deadline for submitting nominations is Thursday, February 28, 2013. Submit nominations to officerandbrnominations@facs.org

Should you have any questions, contact 312-202-5360.

For information only, the current members of the Board of Regents who will be considered for reelection are the following (all MD, FACS): Margaret Dunn, Howard Snyder, and Michael Zinner.

Stay current by using
ACS member e-mail forwarding benefit

The American College of Surgeons (ACS) is offering a new member benefit that maintains a permanent address for all e-mail communications from the College. The benefit ensures that all e-mail from the ACS is promptly sent to your current e-mail account and that the College can reach you for years to come, even if your employment changes—for example, if you retire or move on from a residency or fellowship program.

Go to http://efacs.org/emailforward to register for the benefit. Registration for this service is quick, easy, and free. If you have questions about the new service, contact the ACS Division of Member Services at ms@facs.org.
Call for nominations for ACS Board of Governors

Help the American College of Surgeons (ACS) keep pace in a changing health care environment and meet the goals of its Inspiring Quality: Highest Standards, Better Outcomes initiative by nominating your brightest, most engaged, responsible, and forthright members to three-year terms on the ACS Board of Governors (B/G). Nominations for the 2013 process must be submitted to your local chapter/surgical specialty society by **February 28, 2013**. The B/G is the representative body of the ACS. The membership at-large nominates two-thirds of the Governors, who are elected during an Annual Meeting of the Fellows at the ACS Clinical Congress. Certain surgical societies, chapters, and federal medical services may nominate Governors up to a level of one-third of the Board of Governors.

The Governors act as a liaison between the Board of Regents and ACS Fellows and as a clearinghouse for the Regents on general assigned subjects and local problems. Governors must attend Convocations and other formal meetings of the Fellows and the Governors. The Governors’ work includes assisting in establishing chapters of the College, serving as ex officio members of the governing group of the chapter and of the local Committee on Applicants, aiding in selecting personnel of committees organized within their areas, and helping to investigate special cases of Fellowship applicants.

A Board of Governors’ Ad Hoc Committee explored the role and responsibilities of Governors and the selection criteria for nominating members to the Board of Governors who can meaningfully represent their communities. An inclusive, transparent B/G depends on members who can actively serve as a link to the local community and a resource for the ACS. For more information, go to [http://www.facs.org/about/governors/candidates.html](http://www.facs.org/about/governors/candidates.html). If you have questions, contact 312-202-5360.

Call for nominations for ACS Officers-Elect

The 2013 Nominating Committee of the Fellows (NCF) will select nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The NCF 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 Nominating Committee recognize the importance of achieving representation of all who practice surgery.

The College encourages consideration of women and other under-represented minorities. All nominations must include a letter of recommendation, a personal statement from the candidate detailing ACS service, and the name of one individual who can serve as a reference. In addition, nominating entities, such as surgical specialty societies, ACS Advisory Councils, and ACS chapters, must provide a description of their selection process and the total list of applicants reviewed. Any attempt to contact members of the NCF 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 Thursday, **February 28, 2013**. Submit nominations to officerandbrnominations@facs.org. If you have questions, contact 312-202-5360.
Jim Henry, Incorporated would like to extend a heartfelt congratulations and gratitude to every American College of Surgeons Member and Fellow, on the occasion of the College’s Centennial Celebration. For 60 years, Jim Henry has served the College with responsive, hands-on customer service and outstanding quality awards and recognition. As we celebrate our own 75th anniversary in business, we look forward to many more years of successful partnership with the American College of Surgeons.
Report on ACSPA/ACS activities: October 2012

by Lena M. Napolitano, MD, FACS, FCCP, FCCM

AMERICAN COLLEGE OF SURGEONS PROFESSIONAL ASSOCIATION (ACSPA)

As of September 2012, the ACSPA-SurgeonsPAC (political action committee) raised $522,570 from a combined effort of 1,888 members of the College and staff. This was $137,230 more than what the ACSPA-SurgeonsPAC raised at the same point in 2011, and bringing a total of $1,188,261 raised for the 2011–2012 congressional election cycle. A total of 71 percent of the 214 U.S. Governors contributed $69,140 (average contribution $455). In the 2011–2012 cycle, the ACSPA-SurgeonsPAC contributed to 106 candidates, leadership PACs, and party committees. For more information about the ACSPA, go to http://www.facs.org/acspa/index.html.

AMERICAN COLLEGE OF SURGEONS (ACS)

Member Services
The Executive Committee of the Board of Governors met nine times (from January to October) via telephone conference calls. In addition, the committee met face-to-face twice during the 2012 Clinical Congress.

The Board of Governors’ annual survey communicated to the College’s leadership the concerns and recommendations of the Fellows regarding major issues in surgery. The results of the survey were presented to the Board of Regents for consideration, as this body determines future College endeavors. The top seven issues of concern to the Fellows of the College in 2012 as reported by the Governors are listed in the sidebar on this page.

The Board of Governors also responded to a survey on general surgery residency education. Following are some of the findings:

• A total of 94 percent of the Governors said changes are necessary in general surgery residency education.

• A total of 75 percent stated that the current system of training residents allows chief residents to graduate with significant gaps in their education.

• A total of 56 percent stated they do not believe that general surgery chief residents have adequate surgical training to transition to the attending surgeon role.

The top seven issues of concern to the Fellows of the College in 2012

• Health care reform
• Professional liability/malpractice
• Physician reimbursement
• Medical education/graduate medical education
• Competency
• Workforce issues for academic/community practice
• Credentialing for new technology

The Board of Governors and the Board of Regents held a joint session during the annual business meeting of the Governors. The session featured keynote speakers R. Phillip Burns, MD, FACS, ACS First Vice-President; Frank R. Lewis Jr., MD, FACS, director of the American Board of Surgery; and J. David Richardson, MD FACS, Immediate Past-Chair of the Board of Regents. Their presentations focused on the future of surgical residency training.
The Board of Regents approved the Board of Governors’ Committee on Physician Competency and Health document titled Being Well and Staying Competent: Challenges for the Surgeon. The document replaces The Impaired Surgeon manual and will be posted on the Members-only section of the College’s website.

The Regents also approved a Statement on Concussion and Brain Injury. The statement was published in the December 2012 issue of the Bulletin and has been posted on the College’s website at http://www.facs.org/fellows_info/statements/statement.html.

Operation Giving Back (OGB)
In October 2011, it was agreed that a letter would be sent to Nils Daulaire, MD, MPH, the U.S. representative to the World Health Assembly (WHA), in support of the concept that “development of healthcare systems for any nation must include access and support for appropriate surgical care and anesthesia in equal relationship to other critical healthcare components.” Efforts to support the Resolution for Surgery and Anesthesia continue on multiple fronts. A toolkit has been assembled with supporting research, talking points, sample letters, and published articles related to the importance of an official declaration of the need to support the surgical and anesthesia workforce, training, and patient access on a global scale. The toolkit is intended to supplement the presidential visits and assorted other efforts to inform and recruit support from international surgical leaders, including the College’s international Governors. Efforts are under way to garner support among U.S. representatives and senators to endorse these concepts and develop a formal resolution.

For example, Fellows have met with U.S. senators to explore the most effective advocacy efforts that may be pursued with the U.S. delegate to the WHA.

The OGB received 16 requests for and distributed 436 copies of the recently discontinued eighth edition of the Advanced Trauma Life Support® (ATLS®) manual to ACS members involved in humanitarian activities. Recipients include surgeons working in Ecuador, Ethiopia, Haiti, Jordan, Malawi, Nepal, Philippines, Peru Sierra Leone, Thailand, Uganda, and Vietnam.

Other OGB activities include work in the following areas:

- International medical societies and health association network
- Medical student and resident issues
- OGB communications
- OGB publications
- Partnership activities and outreach
- Rwanda visit
- OGB-sponsored Clinical Congress sessions and events

During 2012, 44,066 unique visitors from 178 countries have accessed the OGB website (http://www.operationgivingback.facs.org/) approximately 121,930 times, which represents an increase in site traffic of more than 12 percent over the past year.

A total of 204 volunteer opportunities were published in various outlets, and 22 were new or updated opportunities. New partnerships have been established with the Rwanda Human Resources for Health Program and the National Association of Free and Charitable Clinics.

The number of surgeons who have completed profiles in “My Giving Back” has increased to approximately 2,000. The OGB website consists of 901 pages. It is also worth noting that Pfizer, Inc. has generously extended its support for OGB and the ACS/Pfizer Volunteerism and Humanitarian Awards for another year.

Resident Associate Society of the College (RAS-ACS)
The RAS-ACS continues to update all of its processes to allow greater transparency and increase membership. Projects include:

- Analyzing data from resident needs assessment survey
- Analyzing data from program directors survey
- Conducting essay competition

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• Expanding international scholarships from one to four
• Revising Surgical Jeopardy expansion proposal
• Increasing RAS representation on College committees
• Moderating/co-moderating Clinical Congress session
• Leading Town Hall lectures at Clinical Congress
• Increasing social media presence
• Planning proposed spring RAS meeting

Young Fellows Association (YFA)
The YFA continues to update all of its processes to allow greater transparency and increase membership. Projects include:

• Presentation of a slide show during the robing of Initiates for Convocation, and YFA flyers in registration packets.
• Presentation of the annual Leadership Conference. The 2012 conference was well-attended and well-received, with participants giving positive feedback on the subject matter and format of sessions. The YFA is working closely with the ACS Division of Advocacy and Health Policy (DAHP) to expand the vision for future conferences.
• The Mentorship Program was expanded in 2012 from 10 mentors/mentees to 15.

• The YFA successfully secured a position on the ACS Program Committee.

Advocacy
The College worked on a number of advocacy and health policy issues this past year, including reimbursement, health care reform, medical liability, graduate medical education, and so on.

Reimbursement. The College led the physician charge to eliminate the sustainable growth rate (SGR) from the formula used to calculate Medicare reimbursement and to pay for the costs of repealing the SGR through the use of the unspent Overseas Contingency Operations (OCO) funds. The College pointed out that using the OCO funds would enable Congress to eliminate all of the accumulated and future scheduled payment cuts that the SGR has created, while producing a more accurate and fiscally responsible budget. Use of unspent OCO funds to offset the cost of repealing the SGR has almost universal support from organizations representing physicians, hospitals, and Medicare beneficiaries.

The College leadership met with key members of Congress to urge them to permanently repeal the SGR and to use war drawdown savings to do so. Despite the medical community’s hard work and the efforts of some legislators, Congress is poised again to postpone repeal and permanent reform. The College continues to urge Congress to find the political will to pass permanent repeal legislation and better serve patients. At the urging of the College and other groups, several members of the House of Representatives sent a letter to congressional leaders in support of moving forward with a permanent repeal of the SGR formula and offsetting the full cost of repeal with unused OCO funds.

On July 11, Frank Opelka, MD, FACS, Associate Medical Director of the DAHP, represented the College at a Senate Finance Committee roundtable titled Medicare Physician Payments: Perspectives from Physicians. On July 18, David Hoyt, MD, FACS, Executive Director of the College, spoke on Medicare payment reform during a House Energy and Commerce Health Subcommittee hearing titled Using Innovation to Reform Medicare Physician Payment. The goal of the roundtable and hearing was to explore possible options for replacing the flawed SGR formula used to calculate Medicare reimbursement. Drs. Opelka and Hoyt shared with key members of Congress the College’s experience with quality programs, such as the National Surgical Quality Improvement Program (ACS NSQIP®), and discussed the framework of the College’s draft proposal for replacing the SGR.

Representatives of the College and several medical and
surgical organizations discussed with key congressional staff concerns related to the Centers for Medicare & Medicaid Services’ (CMS) proposed rule on Stage 2 “meaningful use” for the Electronic Health Records (EHR) Incentive Program. The College and other provider groups crafted a letter to share with congressional staff that focuses on the unique challenges that physicians in small practices face with respect to implementing EHR, including limited finances, time, and staff. The letter also includes several specific concerns on criteria set in the proposed rule as well as suggested congressional actions and plausible fixes.

On August 24, 2012, CMS and the Office of the National Coordinator for Health Information announced the release of the highly anticipated Stage 2 final rule for the EHR incentive program. The Health Information Technology for Economic and Clinical Health Act states that eligible providers—including physicians, other health care professionals, and hospitals—may qualify for Medicare and Medicaid incentive payments when they adopt and meaningfully use certified EHR technology. The College has been closely following the development of the EHR requirements and has issued comments to CMS concerning the Stage 2 proposed rule. At the time of the October 2012 Board of Regents meeting, the College’s DAHP staff was reviewing the final rule and intended to provide substantive details on the final rule.

The College sent a letter to CMS, expressing surgeons’ concerns regarding the fiscal year (FY) 2013 Inpatient Prospective Payment System (IPPS) proposed rule. The letter also offered support for a series of modifications to the proposal. On August 3, 2012, CMS released the final rule on the FY 2013 Medicare IPPS. Under the regulation, hospitals will receive, in the aggregate, a 2.3 percent payment increase over FY 2012 for inpatient care. In addition, the rule finalizes the inclusion of two illnesses on the hospital-acquired conditions list.

CMS also made a number of changes to the Hospital Inpatient Quality Reporting (IQR) program, including a reduction in the number of Hospital IQR program measures for FY 2015 from 72 to 59 and the addition of a safe-surgery checklist measure for FY 2016. In response to comments on the proposed rule, which was released earlier this year, CMS clarified that it is not mandating the use of a specific checklist with any required number of surgical timeouts; rather, hospitals and surgeons may adapt the checklist to fit their unique needs and environments. In addition, CMS did not finalize a proposal regarding the redistribution of residency slots, which could have negatively affected general surgery residencies.

On July 6, CMS released the proposed calendar year (CY) 2013 outpatient prospective payment system/ambulatory surgical center payment rule. The final rule was released November 1, 2012, and became effective January 1, 2013. The College analyzed the rule and submitted comments.

The Affordable Care Act (ACA) requires that CMS implement a value-based payment modifier that would apply to Medicare fee-for-service payments starting with some physicians on January 1, 2015, and to all physicians and groups by January 1, 2017. The value-based payment modifier is intended to pay physicians differentially based on the quality of care they provide and the cost of that care. It would incorporate the use of physician feedback reports, which are confidential reports that quantify and compare the quality of care furnished and costs among physicians and physician group practices, relative to the performance of other physicians. The College submitted a letter that discusses proposals on the value-based payment modifier.

Health care reform. The U.S. Supreme Court issued its ruling on the ACA last summer. The Court upheld the entire law with a small exception related to the federal government’s power to terminate state Medicaid funds. The College will continue to support prudent implementation of those provisions of the law that benefit surgeons, surgical care, and surgical patients as well as...
work to change those aspects that are not beneficial. Both political parties and most stakeholders agree that change must occur within our health care system. However, the vigorous public debate over the ACA reflects wide differences of opinion on the best pathway to reform. The College remains focused on its mission of advancing its health policy agenda, which seeks to safeguard the surgical patient and create a practice environment that is conducive to surgeons’ ability to uphold the highest professional standards. The ACS maintains that any new health care system must promote quality care, improve patient access, and, ultimately, reduce costs while improving patient outcomes.

The ACS Inspiring Quality campaign—an important part of a century of implementing quality improvement programs—has demonstrated the potential to make positive changes to the nation’s health care delivery system. Ensuring patients have access to consistent, high-quality care is a central pillar of real health care reform. It puts the patient first and supports physicians as the drivers of change. The challenges facing the health care system, including Medicare, are complicated and carry significant fiscal implications as well as the potential for unintended consequences on access to care. The College believes every physician and health care provider should commit to being a responsible steward of the nation’s health care resources and work to find a balance between fiscal prudence, the delivery of high-quality care, and preservation of the physician-patient relationship.

Medical liability. The Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that a physician provide care to stabilize all patients who present at a hospital emergency department regardless of their ability to pay. The poor likelihood of reimbursement and high-liability risk associated with the complex, high-risk surgical care provided for severely injured patients who present in an emergency department are broadly acknowledged as the key factors contributing to the growing shortage of specialists participating in emergency on-call panels. The Health Care Safety Net Enhancement Act (H.R. 157)—legislation introduced by Rep. Pete Sessions (R-TX)—would address this growing problem by providing Public Health Service Act liability protections for physicians providing EMTALA-mandated care. On March 22, 2012, the House passed by voice vote an amendment introduced by Reps. Charlie Dent (R-PA) and Sessions that attached H.R. 157 to the Protecting Access to Healthcare Act of 2011 (H.R. 5), which the House also passed.

H.R. 157 language was included as an amendment to H.R. 5, which, among other provisions, calls for repealing the controversial Independent Payment Advisory Board established under the ACA and seeks to institute medical tort reform across the country. The College will continue to advocate for this important legislation.

Graduate medical education. The College submitted letters that were circulated in both chambers of Congress in support of funding in FY 2013 for the Children’s Hospital Graduate Medical Education (GME) Payment Program. Administered by the Health Resources and Services Administration, the program provides federal funds to the nation’s freestanding children’s hospitals to help them maintain their GME programs.

Workforce. A growing body of evidence points to a worsening shortage of surgeons available to serve our nation’s aging and growing population. With this looming crisis in the surgical workforce, the College is concerned that focusing efforts only on specialties that fall under the broad rubric of primary care could have severe consequences for surgical patients. The ACS supports primary care physicians and acknowledges that they provide a needed service for all patients. However, primary care can be provided by a spectrum of health care professionals. In contrast, surgeons are uniquely qualified to perform necessary and lifesaving procedures that no other professional is trained to safely and effectively provide. Surgery and surgical patients
are under great stress because the number of physicians who are qualified to provide surgical services to patients is declining. The College has been fighting to ensure that patients continue to have access to high-quality surgical care by supporting policies and initiatives that will strengthen the surgical workforce.

The College’s Health Policy Research Institute (ACS HPRI) released updated maps that illustrate the distribution of surgeons and general surgeons per 100,000 population across the U.S. in 2006 and 2011. The maps track the “absolute” and “percentage” change in surgeons per population for the same period. The data are reflective of all 3,107 U.S. counties. Similar maps for surgical subspecialties will be added this year. The ACS HPRI is also working to distribute an updated Surgery Workforce Atlas—a Web-based set of maps that shows, county by county and state by state, where shortages of surgeons and other physicians threaten patient access to high-quality, affordable care.

The College supported the Resident Physician Shortage Reduction Act of 2011 created to bolster the surgical workforce and the health care infrastructure by increasing the number of residency positions. The Act expands the number of Medicare-supported physician residency training positions by 3,000 annually from 2013 through 2017.

Significant research conducted by the ACS HPRI was highlighted during a recent interview conducted by C-SPAN’s Washington Journal host, Steven Scully. Mr. Scully and Atul Grover, MD, chief public policy officer at the Association of American Medical Colleges, discussed various health care issues, including the shortage of physicians across the nation. Dr. Grover indicated that ACS HPRI projections show a decrease of 3,340 active practice surgeons between 2013 and 2028 if the number of surgeons trained remains flat and if GME caps remain in place. The caps were included in the 1997 Balanced Budget Act and froze the number of residents for which a hospital could claim Medicare payment based on the number of residents each hospital trained in 1996. Presently, Medicare limits the number of training programs it supports at approximately 80,000.

Just before the start of the August 2012 recess on Capitol Hill, the Senate passed a three-year extension to the current Conrad State 30 Program through September 30, 2015. (The program was set to expire at the end of September 2012.) In July, Dr. Hoyt sent a letter in support of the Conrad State 30 Improvement Act, which seeks to expand and permanently reauthorize the Conrad State 30 Program. This program allows international physicians who are in the U.S. on J-1 visas to obtain a waiver of the J-1 requirement to return home for two years in exchange for three years of practice in medically underserved areas. Each state is currently allowed 30 waivers per year, and the program has brought thousands of physicians, including surgeons, to rural and underserved communities in all 50 states. This legislation has been referred to the Senate Committee on the Judiciary for consideration.

American College of Surgeons Foundation

Foundation history highlights are listed in the sidebar on page 80. What is next?

• A compelling “case for support” that explains value proposition for philanthropy
• Greater differentiation of benefits for major donors
• Greater peer-to-peer fund seeking activity
• Emphasis on major gifts to support major programs
• Deferred and legacy giving: Mayne Heritage Society
• Engagement in giving by foreign-born Fellows now in U.S.

Communications/public profile

The Bulletin of the American College of Surgeons redesign debuted in September 2012. The newly designed publication reflects a number of enhancements intended to increase reader engagement. In addition, a Bulletin microsite
has been created to provide a Web-based alternative to the print version. The microsite eventually will also contain some Web-exclusive Bulletin features.

Since the hiring of a full-time Communications Manager for the Washington Office, the College has steadily increased its communications to Fellows regarding advocacy and health policy initiatives on their behalf. Most notable was the August launch of a monthly e-newsletter titled The ACS Advocate.

As part of the ACS Centennial celebration, the College has produced two publications. A Century of Surgeons and Surgery: The American College of Surgeons 1913–2012 is a hardcover book that provides a detailed historical account of the College’s first 100 years. The second publication, titled Remembering Milestones and Achievements in Surgery: Inspiring Quality for a Hundred Years 1913–2012, is a collection of articles by luminaries on milestones across the surgical specialties. Both publications were given as gifts to all attendees at the 2012 Clinical Congress.

To showcase the past century of leadership, innovation, and quality surgical care, and to celebrate the ACS’ 100th anniversary, the College developed an interactive historical timeline. The timeline, unveiled at Clinical Congress, will be shared via traditional and social media networks.

During 2012, the College made considerable progress in creating a strong social media presence for the College. The following statistics demonstrate this:

• Facebook: 1,717 “likes”
• Twitter: 6,063 followers
• YouTube: 217 subscribers

The recently completed content audit and strategy development for the online properties were the precursors to the redesign of the College’s public website (facs.org) and the integration of what is now the members’ portal (efacs.org) into the main site, with password-protected member-only content.
Attend a 2013 Coding & Reimbursement Workshop

SAVE THESE 2013 DATES

FEBRUARY 14-15
Hilton Orlando Lake Buena Vista/Orlando, FL

MARCH 7-8
Encore at Wynn Las Vegas/Las Vegas, NV

APRIL 11-12
Hyatt Chicago Magnificent Mile/Chicago, IL

MAY 10-17
Wyndham Baltimore Peabody Court/Baltimore, MD

AUGUST 22-23
Loews Vanderbilt Nashville/Nashville, TN

OCTOBER 24-25
The Westin Las Vegas/Las Vegas, NV

NOVEMBER 7-8
Hyatt Chicago Magnificent Mile/Chicago, IL

• 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

100 years
Recipient of the 2012 ACS International Guest Scholarship reports on experience

by Alvaro Sanabria, MD, MSc, PhD, FACS

As the recipient of the 2012 International Guest Scholarship of the American College of Surgeons (ACS), I visited three places in the U.S. that provide services and procedures related to my practice as a head and neck surgeon.

MD Anderson Cancer Center
First, I went to the University of Texas MD Anderson Cancer Center in Houston where I worked with Randal S. Weber, MD, FACS, professor of surgery and chairman of the department of head and neck surgery. This enormous patient-focused medical center offers numerous treatment alternatives to cancer patients. My visit there inspired me not only to develop and institute a standardized treatment plan, but also to open my mind to integration of other therapies that may improve the patient’s quality of life.

Other surgeons whom I had the pleasure of meeting at MD Anderson Cancer Center include: Ehab Hanna, MB, BCH, FACS, professor of surgery; Mark Chambers, DMD, MS, professor and chief, section of oral oncology and maxillofacial prosthodontics; and Ann Gillenwater, MD, professor, department of head and neck surgery. All three surgeons were very kind people and exceptional teachers who generously explained to me their clinical and surgical decisions. I also met Mariann Crapanzano, managing editor of Head and Neck Journal, whose advice enlightened me about the possibilities of writing for surgeons from developing countries. As a consequence of my stay, I am developing a protocol to validate an MD Anderson symptom inventory for head and neck cancer patients.

Georgia Health Sciences University
Next, I visited the Georgia Health Sciences University in Augusta, to work under the supervision of David Terris, MD, FACS, professor and chair, department of otorhinolaryngology. There, I met my personal objective of assisting in the performance of robotic thyroidectomy. Dr. Terris was a gracious host with incredible technical skills who leads a very strong program on robotic thyroid surgery. Although robotic surgery requires resources that are far from the capabilities of most Colombian medical centers, the opportunity to observe and understand the advantages and disadvantages of this new technology is very useful in order to decide on immersion in this field. I also met Clementino Arturo Solares Rivera, MD, FACS, an extraordinary skull-base surgeon who showed me the most advanced surgical procedures in this field.

Memorial Sloan-Kettering Cancer Center
I went to Memorial Sloan-Kettering Cancer Center in New York, NY, under the supervision of otolaryngologist Bhuvanesh Singh, MD, FACS. At Memorial Sloan-Kettering, I had the privilege of meeting two world leaders in head and neck surgery—Jatin Shah, MD, FACS, chairman of the head and neck service, and Ashok Shaha, MD, FACS, a general surgeon and associate professor of surgery at Cornell University Medical School and adjunct professor of surgery at State University of New York-New York City.

I enjoyed my stay at Sloan-Kettering not only because of the educational service meetings, but also because it provided the opportunity to observe a successful model that combines demanding clinical activities with basic science and clinical research. The charisma of physicians who treat patients and their commitment to each patient, combined with the rational use of technological resources, was very impressive and gave me a clear indication that good oncological care is possible with an interdisciplinary and coordinated approach and not exclusively dependent on technology.

On the last day of my stay, I also had the pleasure of meeting Snehal G. Patel, MD, FRCS, a head and neck cancer surgeon, who generously offered me the opportunity to use wonderful Caisis software, which will help me compare local practices and results to leaders in the head and neck oncology field.

I observed surgical procedures and clinical visits in all the hospitals, and this experience
allowed me to understand that the differences between Colombian cancer centers and the most important oncological centers in America are not the physical resources or money, but the discipline in following established protocols and the ability to work as a team.

**ACS Clinical Congress**

Finally, I attended the ACS Clinical Congress in Chicago, IL. It was my first time attending this event, and it was extraordinary to see surgeons from the entire world sharing experiences and talking about the most diverse areas of surgical knowledge. I really enjoyed the lectures that I attended on education, professionalism, and leadership. Although they were not the most crowded sessions, for me, as a Colombian academic surgeon, they were informative and exciting. It was encouraging to observe American surgeons who are worried about the present and future of the profession demonstrate a commitment to developing alternatives to maintain the integrity of surgical practice.

The organization of the Clinical Congress was impeccable, and all the activities were designed to offer a highly educational experience. I attended the International Relations Committee meeting, which helped me to recognize the importance of networks for surgeons outside the U.S. I appreciate the opportunity the College provides to foreign surgeons to participate with the ACS International Relations Committee. I would like to thank Kate Early, ACS International Liaison, who made this experience enriching and successful. Her dedication to us was remarkable; she always had a smile and was always available to help us.

I met interesting colleagues from around the world. The interchange of experiences was motivating, and I can say I made some friends. I can also say that I learned a lot from them—most importantly, novel ways to approach surgical problems.

As a practicing surgeon, at this point of my professional life, the most important lesson was to learn that the differences in clinical results between my country’s hospitals and American hospitals are the consequence of personal attitudes and actions. The barriers we usually use to explain these differences, such as economic or social issues, do not exist. The success of American surgery is the result of surgical professionals’ hard work, discipline, and commitment to excellence—elements difficult to measure and assess, but that can be perceived while visiting American surgical institutions and attending the Clinical Congress. These experiences change the way we view the world. As one colleague told me at the Clinical Congress Convocation, the International Guest Scholarship changes the way you approach your responsibilities, slowly but constantly. The results are generally observed decades after completing the scholarship.

Thanks to the College and all the individuals who made my participation possible. It will be a pleasure to return the favors to the College and other colleagues.◆
Calendar of events

**FEBRUARY 2013**

**North Texas Chapter**  
**February 15–16**  
Cityplace Conference Center, Dallas, TX  
Contact: Nonie Lowry, nonie@lp-etc.com, http://www.ntexas.org/

**Peru Chapter**  
**February 20–22**  
Lima Sheraton Hotel and Convention Center, Lima, Peru  
Contact: Danilo Bambaren Gastelumendi, dabambaren@yahoo.com

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

**South Texas Chapter**  
**February 21–23**  
Houston Marriott at the Texas Medical Center, TX  
Contact: Janna Pequet, janna@laacs.org, http://www.southtexasacs.org/

**Idaho, Montana, and Wyoming Chapters**  
**February 21–24**  
Sun Valley Resort, Sun Valley, ID  
Contact: Shanna Hardman, shanna.hardman@hcahealthcare.com

**Lebanon Chapter**  
**February 25**  
TBD, Beirut  
Contact: Mohamad Tarek Berjawi, dr_berjawi@hotmail.com, http://www.facs-lebanon.org/

**Oklahoma Chapter**  
**February 28–March 1**  
Renaissance Hotel Oklahoma City, OK  
Contact: Jennifer Starkey, jennifer@executive-office.org, http://www.okfacs.org/aws/ACS/pt/sp/OK_home_page

**March 2013**

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

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

**April 2013**

**Metropolitan Washington, DC, Chapter**  
**April 6**  
Hyatt Regency Capitol Hill  
Contact: Jennifer Starkey, Jennifer@acschapters.org, http://www.dcfacs.org/aws/ACS/pt/sp/DC_home_page

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

**2013 Leadership Conference and Advocacy Summit**  
**April 13–16**  
Mandarin Oriental Hotel, Washington, DC  
Contact: ACS Division of Advocacy and Health Policy, ahp@facs.org, 202-337-2701, http://www.facs.org/ahp/summit/index.html.

**Chile Chapter**  
**April 14–17**  
Hotel Sheraton Convention Center Santiago, Chile  
Contact: Ivan Alcoholado, MD, FACS, ialcoholado@alemana.cl, http://www.principal.acschile.cl/

**August 2013**

**FUTURE CLINICAL CONGRESSES**

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

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

**2015**  
October 4–8  
Chicago, IL

*Dates and locations subject to change.*