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I n the December 2012 “Looking for-
ward” column, I provided details on
the American College of Surgeons
(ACS) Surgical Health Care Quality Fo-
rums that have taken place across the
nation. That column summarized each
ACS Surgical Health Care Forum, high-
lighting the specific theme of each ses-
son and its keynote speaker, typically
one of the nation’s leading authorities
on health care policy and legislation.

I also noted that the ACS would be
working with consultants at Weber
Shandwick to develop an account of
what the College’s leadership has learned
through this process. An in-depth report
titled Lessons Learned in the Pursuit of Qual-
ity Surgical Health Care is now available
online at http://www.facs.org/quality/
lessonslearned.html. I’d like to take this
opportunity to briefly highlight the six
points we uncovered in the course of this
national conversation.

Future of medicine
dependent on quality
To ensure that all Americans have ac-
cess to care now and in the future, pol-
cymakers, regulators, payors, and hos-
pital administrators are seeking means
of reducing health care spending and
variations in care. Studies published in
the Journal of the American College of Sur-
geons and elsewhere have shown that the
College’s National Surgical Quality Im-
provement Program (ACS NSQIP®) is an
effective instrument for achieving these
goals. Hospitals and other stakeholders
have used the information gathered and
analyzed through ACS NSQIP and other
registries to develop evidence-based best
practices and decrease surgical complica-
tions, which, in turn, have been proven
to lower costs and to ensure the provi-
sion of improved quality of patient care.

LESSONS LEARNED
• Quality improvement is the
  future of medicine
• Quality is measurable
• High-quality data are essential
  for quality improvement
• Quality thrives in a supportive culture
• Collaboration spurs innovation
  and higher quality
• Surgeons must lead on quality: In the OR,
  on Capitol Hill, and in the classroom
This message is resonating in Washington, DC. U.S. Sen. Ben Cardin (D-MD) participated in our Baltimore, MD, program in August 2011 and said surgeons and our efforts to develop and apply scientifically reliable clinical data can play an important role in improving the nation’s health care system. Pointing to studies that show the cost savings at hospitals that have used ACS NSQIP to reduce complications, Senator Cardin said, “The $250 billion dollars in cost savings caught my attention—that and lives saved. That’s a lot of money. That could go a long way in dealing with costs in health care, and that’s just surgery.”

Quality is measurable
A number of representatives from surgical institutions participating in the Quality Forums indicated that they are effectively using ACS NSQIP and other quality improvement programs to arrive at best practices. They further indicated that implementation of high-reliability systems of care enabled them to significantly reduce the rate of complications in their hospitals.

For example, at the New York, NY, forum in November 2012, Alfons Pomp, MD, FACS, FRCS(C), chief of laparoscopic and bariatric surgery at NewYork-Presbyterian/Weill Cornell Medical Center, described his hospital’s use of an in-house data collection system and ACS NSQIP to track complications and interventions. They found that although their mortality rate was relatively low, their morbidity rate was rather high due to surgical site infection (SSI), particularly among colorectal patients. The hospital formed a committee that developed protocols for skin prep, administration of prophylactic antibiotics, and documentation of dosing information. As a result, the medical center has cut SSIs for colorectal procedures by more than 50 percent.

High-quality data are essential
Hospitals are increasingly using ACS NSQIP and other registries—such as the National Cancer Data Base, the National Trauma Data Bank®, and the ACS Trauma Quality Improvement Program—to set quality targets, measure performance, and uncover areas of concern. Speakers repeatedly emphasized the importance of providing surgeons and surgical teams with risk-adjusted, verified, clinical data for tracking the results of quality initiatives and benchmarking against a national standard. They noted that surgeons and other members of the operating room (OR) teams at their institutions have been willing to change how they work when they are presented with performance data that they trust.

At the New York, NY, forum, Clifford Y. Ko, MD, MS, MSHS, FACS, Director of ACS NSQIP and the ACS Division of Research and Optimal Patient Care, pointed to a study that the College conducted with the Centers for Medicare & Medicaid Services, comparing ACS NSQIP data on 100,000 patients with claims data. This study showed that claims data indicated a high percentage of false positives for complications. Similarly, correlation when ranking hospitals based on clinical versus claims data was poor, underscoring the importance of knowing the source of one’s data when making clinical decisions.

Supportive culture needed
Studies have consistently shown that evidence-based care delivered by high-performance teams results in better patient outcomes. Hospitals and surgeons shared their experiences with instilling teamwork, fostering a quality-centered mindset, and creating culture change throughout the surgery department.

During the Quality Forum that took place in June 2011 at the ACS headquarters, Nathaniel Soper, MD, FACS, surgeon-in-chief at Northwestern Memorial Hospital, Chicago, IL, noted that his institution was “an early adopter of ACS NSQIP, and we knew that to improve outcomes, a culture change was necessary.” He went on to say that by creating a quality-driven culture, Northwestern Memorial ultimately saw an 80 percent reduction in adverse events and a 30 percent decline in liability claims.

Power of collaboration
Throughout the nation, surgeons, hospitals, and other stakeholders are developing and testing new means of improving the quality of surgical care. National and state-level collaborative efforts have enabled in-
Hospitals are increasingly using ACS NSQIP and other registries—such as the National Cancer Data Base, the National Trauma Data Bank®, and the ACS Trauma Quality Improvement Program—to set quality targets, measure performance, and uncover areas of concern.

Surgeons, health care professionals, medical institutions, and government agencies to share data and work together to improve quality of care.

Speakers at our Washington State forum discussed the Surgical Care Outcomes Assessment Program (SCOAP)—a voluntary, clinician-led collaborative that includes insurers, policymakers, professional organizations, physicians, nurses, hospitals, and the ACS Washington State Chapter. In addition, David R. Flum, MD, MPH, FACS, associate chair for research and surgery, and professor of surgery, health sciences, and pharmacy at the University of Washington, Seattle, described the state’s Comparative Effectiveness Research Translation Network. This network creates a “learning health care system,” Dr. Flum said, by linking data from medical records, insurance claims, patient surveys, and so on to help SCOAP hospitals assess the long-term effects of care complications in patients and the health care system.

The positive effect of other state-level collaborative quality improvement programs, including the Tennessee Surgical Quality Collaborative and the Florida Surgical Care Initiative, also were discussed during tour stops in Chattanooga and Winter Park, respectively.

Surgeons must lead
Continuous surgical quality improvement requires surgeon leadership not only at the hospital level, but also in addressing the concerns of federal and state policymakers. Federal agencies want feedback on how regulation affects practice in the OR. Members of Congress want to hear from surgeons regarding the effects of legislation. Policymakers are interested in hearing how quality improvement initiatives reduce spending and in exploring opportunities for collaboration. And, as we look toward the future of surgery, surgeons need to instill a quality focus in their medical students and trainees.

At the forum in Philadelphia, PA, in October 2012, ACS Regent Howard M. Snyder III, MD, FACS, urged physicians to be involved in health care reform. During the Boston, MA, session, in June 2012, Stuart Altman, PhD, economist, health policy expert, and The Sol C. Chaikin Professor of National Health Policy at The Heller School for Social Policy and Management at Brandeis University, Waltham, MA, reinforced the need for surgeon involvement in the formulation of health system reform. He noted, “In the past, we didn’t include physicians and surgeons in discussions on how to fix the American health care system because we thought they were part of the problem—a big mistake. We need them as part of the solution because they are American health care.”

Moving forward
These forums gave us insight into what the ACS is doing right with regard to Inspiring Quality and how we can further develop our programs to influence health policy and improve patient care. They provided opportunities for the ACS leadership to hear from surgeons and stakeholders about what quality means to them and how we can partner with them going forward. I hope each of you will take the time to read Lessons Learned in the Pursuit of Quality Surgical Health Care and to consider how you and your institutions can apply these findings to deliver optimal surgical care to your patients.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Insurance exchanges under the Affordable Care Act:

by Margo M. Hoyler; Margaret C. Tracci, MD, JD; Robert S. Jasak, JD; Jon H. Sutton; and John G. Meara, MD, FACS

HIGHLIGHTS
• Provides background on insurance exchanges and describes their intended purposes
• Discusses the two types of insurance exchanges established in the ACA: the American Health Benefits Exchange for individual purchasers and the Small Business Health Options Program for businesses with fewer than 100 employees
• Outlines how insurance exchanges would achieve the major aims of increased access to insurance, enhanced competition, market stabilization, and improved quality and uniformity among plans
• Examines potential threats to insurance exchanges, including low consumer and insurer participation, interrupted coverage, adverse selection, and runaway costs
• Explores the potential impact on surgical practice

Health care coverage in the U.S. is characterized by a patchwork of public and private health insurance programs and heavy reliance on employer-sponsored plans. Though longstanding, the private insurance marketplace has been marked by numerous inefficiencies and disadvantages to consumers, including limited competition, hidden costs, and insurers’ ability to exclude high-risk customers through medical underwriting or to limit high-risk coverage through price differentiation.1–4

The Affordable Care Act (ACA) was enacted in 2010 in an effort to reduce the number of uninsured Americans, ensure high-quality coverage for insured Americans, and stem the crisis of rapidly increasing national health care costs. An integral means of addressing these problems involves the establishment of insurance exchanges.5,6 This article describes the potential advantages and consequences of ACA insurance exchanges and explores how their implementation may affect the practice of surgery in the U.S.
Whereas the specifics of their design may vary, all ACA insurance exchanges are intended to address a few central aims: increased consumer access to insurance, enhanced competition among carriers, stabilization of insurance markets, and improved quality and uniformity of insurance coverage plans.

**History of insurance exchanges**

Based on Alain Enthoven’s concept of “managed competition,” an insurance exchange is an organized marketplace for the sale and purchase of health insurance.4,7,8 Exchanges are managed in order to promote access and informed decision making among consumers and to promote efficient risk-sharing mechanisms among insurers; they are competitive in order to reward quality, efficiency, and value among insurers and plans. To date, insurance exchanges have been implemented both in Europe and in the U.S., where they have operated on the federal, state, and industry levels.9,10 Notable examples include the Federal Employees Health Benefits Program (FEHBP), Health Insurance Purchasing Cooperatives (HIPCs) in Texas and Iowa, the Commonwealth Health Insurance Connector Authority (“Connector”) in Massachusetts, and purchasing pools formed by the Connecticut Business and Industry Association and the American Bar Association.4,8,11 Although some exchanges have expanded consumer choice and have dramatically improved consumer access to the insurance marketplace, they have not necessarily reduced premiums.12,13 Furthermore, a number of exchanges have failed outright due to an inability to achieve significant market share and economies of scale, adverse selection within and against the exchanges, and insurance company cherry-picking of healthy consumers to non-exchange plans.14 The ACA includes precautions to reduce the likelihood that its insurance exchanges will be similarly affected.

**Types of ACA exchanges**

The ACA establishes two types of insurance exchanges: the American Health Benefits Exchange (AHBE) for individual purchasers and the Small Business Health Options Program (SHOP) for businesses with fewer than 100 employees, although until 2016, states retain the discretion to limit eligibility to businesses with fewer than 50 employees.17 Through AHBE, individuals benefit from economies of scale to access a wider range of plans than otherwise may have been available to them. SHOP provides a similar service for small businesses. Notably, small businesses also have the option to self-insure or to pay for employee benefits through a private trust.14,18 Although some features of insurance exchanges are federally mandated, states have considerable flexibility in their design and implementation.19 States may operate their own exchanges, partner with other states to form a joint exchange, collaborate with the federal government, or rely on an exchange established and run by the U.S. Department of Health and Human Services. States may determine the number of exchanges they will offer, the number of plans included in each exchange (in addition to two federally sponsored plans), and the administrative structure of the exchange (public, private, or semi-private).20 They may merge individual and small group markets, and will ultimately have the option of including large groups (>1,000 employees) in the exchange consumer pool.14,17 Finally, states have discretion regarding the particulars of risk adjustment, the demands placed on insurance brokers and navigators, and any “essential services” beyond those mandated by the federal government.21

**Key aims**

Whereas the specifics of their design may vary, all ACA insurance exchanges are intended to address a few central aims: increase consumer access to insurance, en-
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<th>AIM</th>
<th>MECHANISM</th>
<th>THREATS</th>
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| Increased access to insurance coverage | Broader insurance reforms  
- Guaranteed issue  
- Ban on underwriting | “Churning” between Medicaid and exchanges  
Coverage gaps |
| Subsidies  
- Tax credits for individual purchasers whose annual income, based on most recent tax return, is less than 400% of the federal poverty level (FPL), but who are ineligible for Medicaid or any other public insurance program  
- Tax credits for small businesses with fewer than 25 employees and an average annual wage of less than $50,000; slated to increase from 35% to 50% in 2014  
- Cost-sharing subsidies for individual purchasers whose expected income is less than 250% FPL to offset the out-of-pocket costs | Subsidies may be inadequate  
False positives, negatives in calculated subsidy eligibility  
Ineffective competition may not reduce premiums |
| Streamlined enrollment  
- Centralized, online payment mechanisms  
- Exchanges determine consumers’ eligibility for plans and subsidies | |
| Enhanced competition between insurers | Consumer choice and informed decision making  
- Array of available plans  
- Independent “navigator” service to guide consumers  
- Coverage tiers based on actuarial equivalences  
- 90% of anticipated medical costs covered by premium = Platinum; 80% = Gold; 70% = Silver; 60% = Bronze | “Information overload” for consumers  
Limited health literacy among consumers  
Limited utility of actuarial data in predicting best plan for an individual consumer |
| Stabilization of insurance markets | Risk-spreading and risk adjustment (see Table 2, page 15) | Adverse selection  
- Within insurance exchanges, sicker consumers may choose more comprehensive plans  
- Outside of exchange, healthy consumers may choose self-insurance or “grandfathered” plans  
Cherry-picking by non-exchange plans  
Risk-adjustment calculations are imperfect |
| Increased coverage quality | Essential services  
- Ambulatory patient services  
- Emergency services  
- Hospitalization  
- Maternity and newborn care  
- Mental health and substance abuse disorder services  
- Prescription drugs  
- Rehab services and devices  
- Laboratory services  
- Preventive, wellness services, chronic disease management  
- Pediatric services including oral and vision care  
Network of essential providers  
Market mechanisms to foster high-quality plans | Grandfathered plans  
Self-insurance options  
Coverage gaps, churning |
hance competition among carriers, stabilize insurance markets, and improve quality and uniformity of insurance coverage plans.

### Increased access
To expand access to coverage, ACA exchanges are designed to streamline enrollment and help ensure affordability for a range of consumers. Exchanges must offer centralized, online mechanisms for plan enrollment and are responsible for determining purchasers’ eligibility for plans and subsidies. They must coordinate with other federal institutions, including the Centers for Medicare & Medicaid Services (CMS) and the U.S. Treasury Department, to ensure that consumers receive the maximum possible assistance in the form of tax credits and/or cost-sharing subsidies.2,22

### Enhanced competition
ACA exchanges are designed to promote competition between insurers.23 As they aim to expand consumers’ choice of plans, ACA exchanges must also offer independent “navigator” programs to educate and guide consumers through the plan selection and purchasing process.3 Furthermore, exchanges must categorize and rate plans based on actuarial equivalence data, thus presenting consumers with an intuitive indication of cost and value. The goal is improved market efficiency based on robust consumer choice.

In these and other ways, ACA exchanges attempt to resolve many impediments to competition that have traditionally characterized the marketplace. By offering consumers a range of options, exchanges could solve the previous problem of lack of accessible substitute products. By educating consumers and offering them broader plan selection, they could increase what was previously a limited ability to leverage coordinated consumer pressure for higher quality plans. By facilitating direct cost and value comparisons across plans and by enforcing eligibility criteria for plans included in the exchange (for example, MLRs and justified premium increases), they could limit health insurance companies’ ability to pass costs directly to the consumer.2 These changes are intended to help contain and reduce costs.

### Market stabilization
ACA insurance exchanges are designed to stabilize insurance markets through effective risk-spreading and risk-adjustment mechanisms.24 ACA-specific mechanisms (see Table 2, page 15) include transitional risk insurance, in which the federal government reimburses insurers a portion of the cost of previously uninsured patients, and transitional risk corridors, in which insurers contribute to a common fund to reimburse plans with unexpectedly high costs.25 In addition, the ACA allows for ongoing risk adjustment, such as the diagnosis-based risk assessment already implemented for Medicare Advantage plans. These risk assessments inform adjustments in federal reimbursement and guide direct monetary transfers between insurance companies with more and less healthy enrollees.24

Broader reforms under the ACA also are intended to stabilize insurance markets. For instance, guaranteed issue reduces the likelihood of cherry-picking as a means of distorting consumer risk pools, and the individual mandate incents low-risk consumers to participate in the market and effect risk-spreading. Exchange guidelines go further.14 Limited enrollment windows for AHBE plans encourage individuals to enroll at the beginning of the year, instead of waiting until they realize they may need medical services. Similarly, the SHOP requirement that employers select a coverage tier is meant to reduce adverse selection when employees select a particular plan. In addition, ACA exchanges permit “price rating” of plans only within a narrow range and according to a limited set of consumer characteristics, to help offset the anticipated costs of higher-risk consumers. Indeed, insurers may adjust premiums based only on age, tobacco status, family composition, location, and other variables. Many of the particulars of these adjustments, such as age bands and the premium increases assigned to them, remain in the purview of individual states.17,26

### Quality of coverage
The final central aim of the ACA and of ACA insurance exchanges is higher-quality insurance coverage. To this end, insurance exchanges are responsible for certifying all participating qualified health plans (QHPs). Under federal law, QHPs must offer “essential services”
across 10 categories of care and do so through a robust network of “essential providers” who can provide their services without unreasonable delay. These networks also must demonstrate particular attentiveness to the needs of disadvantaged populations.

States also may set their own quality standards above those of the federal government. Indeed, each state must select a “benchmark plan” that defines its essential benefits and sets the standard for all public and private plans. Of note, these standards do not apply to grandfathered plans for individuals and small and large groups, nearly half of which may fall short of the federal standards for new programs as of 2014.

Finally, even among eligible plans, insurance exchanges have full discretion over which plans to include in the exchange. State exchanges may operate as a certifying organization and clearinghouse for all QHPs or as “active purchasers” that contract and/or negotiate premiums with limited number of QHPs. Among those exchanges that choose the latter model, admission to the exchange and access to the large body of consumers it represents is seen as powerful leverage for creating high-quality, affordable plans.

**Predicted impact**

Insurance exchanges and the ACA are anticipated to have a dramatic effect on health care coverage in the U.S. The ACA is predicted to expand insurance coverage to an additional 30 million Americans by the year 2022, although some 30 million people will likely remain uninsured. Exchanges are also predicted to significantly reduce but not eliminate ethnic and racial disparities in insurance coverage. Similar results have been observed in previously implemented state exchanges. The manner by which individuals achieve

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**TABLE 2. MECHANISMS OF RISK SPREADING AND RISK ADJUSTMENT**

<table>
<thead>
<tr>
<th>RISK-SPREADING STRATEGIES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| Guaranteed issue         | Insurers in a given area must sell statutorily acceptable health insurance to any individual or family in that area who seeks coverage.
| Eliminate medical underwriting | Formal and informal health assessments cannot be used to determine premiums or to grant or deny coverage (exceptions: age, smoking status). |
| Advertising regulations  | Insurance plans must engage in at least a minimum amount of advertising to promote their plans and may not attempt to discourage less healthy individuals from purchasing their product. |
| Individual mandate       | Individuals who choose not to purchase insurance coverage must pay a penalty to the Internal Revenue Service. |
| Employer shared responsibility | Businesses with more than 50 full-time workers may be subject to an assessable payment if they do not offer employees and dependents an affordable health care plan that meets essential standards. |
| Small business selection of employee coverage tier | SHOP reduces the likelihood of adverse selection by permitting individual purchasers to choose plans but not coverage tiers. |

<table>
<thead>
<tr>
<th>RISK-ADJUSTMENT STRATEGIES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium adjustments</td>
<td>Premium adjustments based on age (&lt;3:1 ratio), tobacco use (&lt;1.5:1 ratio), family composition, and location to offset anticipated costs of higher-risk enrollees</td>
</tr>
<tr>
<td>Transitional insurance</td>
<td>Financial protection for insurers who offer coverage to previously uninsured individuals between 2014 and 2016, by subsidizing a percentage of payments above a previously determined threshold in relation to a patient’s risk-based predicted costs</td>
</tr>
<tr>
<td>Transitional risk corridors</td>
<td>Target health expenditures according to health status of insurance pool; insurance companies will pay into or receive funding from risk corridor program if spending is below or above previously established thresholds</td>
</tr>
<tr>
<td>Ongoing risk adjustment</td>
<td>Direct fund transfers between insurance companies with healthier patient pools to those with less healthy patient pools</td>
</tr>
</tbody>
</table>

coverage may also change, as large firms may choose to refer employees and retirees to the individual exchange for insurance coverage instead of offering them a unique benefits plan.34

Much regarding the future of exchanges, however, remains unknown. Not all states have decided on the structure and offerings of their insurance exchanges, and those that have indicate that there will be wide variation across jurisdictions (see Table 3, this page).31 In addition, there are significant threats and challenges to the successful implementation of ACA insurance exchanges, including low rates of consumer and insurer participation, interrupted coverage, adverse selection, and runaway costs.

**Consumer nonparticipation**

Insurance exchanges face the risk that too few consumers will participate to achieve large risk pools and ensure exchange viability.35 Potential causes of consumer nonparticipation include low health literacy, the complexity of exchange offerings, the limited utility of actuarial data in guiding individual consumers to the most appropriate plan, and prohibitive costs.31,15,36

The ACA’s individual mandate is a key mechanism for promoting consumer participation in insurance exchanges. For most individuals, the consequence of noncompliance is a tax penalty, set at the higher of two values: $695 per adult in 2016, indexed to inflation thereafter with lesser fees for children and an overall cap on family penalties, or 2.5 percent of the household income.37 However, a number of groups are exempt from the individual mandate or from the penalty. Such groups include individuals whose premiums would exceed a certain share of their income (8 percent in 2014).37 Furthermore, enforcement of the penalty for uninsured individuals is limited to action by the Treasury to collect through income tax returns, without authorizing additional mechanisms such as liens. In effect, non-filers or filers who are ineligible for an in-

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**Table 3. Insurance Exchange Design: States’ Choices**

<table>
<thead>
<tr>
<th>Exchange Status</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>State exchange</td>
<td>18 and District of Columbia</td>
</tr>
<tr>
<td>Partnership exchange</td>
<td>7</td>
</tr>
<tr>
<td>Default to federal (HHS) exchange</td>
<td>25</td>
</tr>
<tr>
<td>Undecided</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Exchange</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearinghouse (all QHPs included)</td>
<td>6</td>
</tr>
<tr>
<td>Active purchasers (select QHPs included)</td>
<td>7</td>
</tr>
</tbody>
</table>

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come tax refund are unlikely to be penalized, thus diminishing the incentive effect of the mandate. Finally, some groups (including large employers) are expressly excluded from participation in the exchanges, regardless of whether they are legally required to purchase or provide insurance coverage.

Although exchange navigators and insurance subsidies are intended to promote consumer participation in exchanges, nonparticipation is a salient risk to exchange viability, and the rate of consumer participation remains to be seen.

**Insurer nonparticipation**

Insurance exchanges are also vulnerable to low rates of insurer participation. Insurance companies may choose not to participate if risk-adjustment strategies are poor and if they maintain a sufficient number of consumers in grandfathered plans. Access to a large pool of potential customers and careful, ongoing risk adjustment are intended to encourage insurer participation. In fact, it is estimated that by 2021, the insurance industry will collect $205 billion in additional premiums, certainly incentivizing insurers to participate.

**Interrupted coverage**

Under the ACA, as noted, the expansion of insurance coverage will not reach all Americans. This unmet need is attributable in part to disruptions in coverage for those at the cusp of Medicaid eligibility, who may “churn” between Medicaid and exchanges due to income fluctuations and calculation errors. This risk is particularly salient in states that intend to delay or refuse Medicaid expansion, in light of the U.S. Supreme Court’s ruling that states need not expand Medicaid eligibility, as was initially mandated under the ACA.

**Adverse selection**

Adverse selection represents a formidable challenge to insurance exchanges as it does to the insurance market in general. Under the ACA, this risk may be exacerbated by grandfathered plans, which may offer limited coverage at favorable prices for healthy consumers.

The ACA is predicted to expand insurance coverage to an additional 30 million Americans by the year 2022, although some 30 million people will likely remain uninsured. Exchanges are also predicted to significantly reduce but not eliminate ethnic and racial disparities in insurance coverage.

**REFERENCES**


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and by the possibility that small business may choose to self-insure as long as their employees are healthy. As discussed previously, the ACA’s precautions to reduce adverse selection include the individual mandate and a range of risk-adjustment mechanisms. Within SHOP, employer selection of coverage tier may also reduce the risk that primarily less healthy individuals will purchase more generous coverage.

Costs

Health care costs remain a major concern; insurance exchanges can only control spending if they are administratively efficient, if the marketplace is competitive, and if adverse selection is prevented effectively. The ACA’s expansion of coverage may increase the likelihood of moral hazard and overconsumption of health care services by a larger patient population, although the law is expensive, regardless. Indeed, the cost of expanding coverage through the ACA is estimated at $1.168 billion from 2011 to 2022 (down from $1.252 billion before the U.S. Supreme Court ruling on Medicaid). By the year 2021, 50 percent of all U.S. health expenditures may be paid for by the local, state, or federal government. At press time, a $1.2 trillion budget sequester had taken effect on March 1. The impact of sequester spending cuts on ACA insurance exchanges was unclear: although Medicare cuts are restricted to 2 percent of the program budget and Medicaid and CHIP expenditures may be paid for by the local, state, or federal government. At press time, a $1.2 trillion budget sequester had taken effect on March 1. The impact of sequester spending cuts on ACA insurance exchanges was unclear: although Medicare cuts are restricted to 2 percent of the program budget and Medicaid and CHIP expenditures may be paid for by the local, state, or federal government.

Impact on surgeons

It is difficult to predict the precise impact of the ACA on surgeons and surgical practice, though it is possible to foresee effects on the surgical workforce, procedure reimbursement, and surgeon autonomy. Of note, much of the anticipated impact of the ACA is due not only to insurance exchanges but to broader changes required under the law.

Workforce issues

The ratio of general surgeons to overall population in the U.S. has declined in recent decades, and this trend has fueled concern that the country is facing an

REFERENCES (CONTINUED)

It is difficult to predict the precise impact of the ACA on surgeons and surgical practice, though it is possible to foresee effects on the surgical workforce, procedure reimbursement, and surgeon autonomy.

impending shortage of surgeons, particularly in rural areas.\textsuperscript{43-44} Indeed, estimates of surgeon shortages for the year 2030 range from a 9 percent shortage for general surgeons to 39 percent for thoracic surgeons, with deficits predicted in at least seven surgical specialties.\textsuperscript{45} Although the effect of an aging population has been incorporated in assessments of surgical workforce adequacy, the impact of increased insurance coverage and service use under the ACA has received limited attention.\textsuperscript{46,47} Nonetheless, it seems likely that the already strained surgical workforce will come under increasing pressure as 30 million Americans acquire health insurance coverage.

Safety net institutions

Safety net institutions, including most academic medical centers, and particularly those mandated to serve uninsured populations, face mounting challenges as private and for-profit hospitals and enterprises such as outpatient surgery centers seek to more aggressively court privately insured patients.\textsuperscript{48} This trend is facilitated by accountable care organizations (ACOs), bundling demonstration projects, and other arrangements that strongly incentivize participating providers and institutions to keep insured patients within their own networks. These safety net institutions will continue to absorb the costs of caring for Medicare, Medicaid, uninsured, and indigent populations.\textsuperscript{49} These costs may be all the more significant because “disproportionate share payments”—federal payments to institutions that provide care for a large number of uninsured patients—are slated to decrease under the ACA.\textsuperscript{48}

Reimbursement

Under the ACA, physician and hospital reimbursement will change in several ways. Reimbursement is expressively shifted toward primary care through efforts such as the Primary Care Incentive Program (PCIP). Although fee-for-service will remain the dominant model, cost-bundling, global payments, and new “pay-for-performance” models—including the value-based modifier (VBM), which would adjust physician reimbursement based on benchmarked measures of quality, cost, and patient satisfaction—are on the horizon.

REFERENCES (CONTINUED)

REFERENCES (CONTINUED)


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In addition, the ACA creates or advances a number of programs that provide incentives and penalties for compliance or noncompliance, respectively, including the Medicare Electronic Health Records Incentive Program and the Physician Quality Reporting System. The ACA also calls for the establishment of the Independent Payment Advisory Board to make recommendations on Medicare payment, which may inform private plans’ standards for coverage and reimbursement. Concurrently, CMS is actively re-evaluating reimbursement for “potentially misvalued codes,” such as gastrointestinal scoping.50 Finally, the federal government’s recently announced plan to sponsor insurance plans through state exchanges may effect de facto standards for all private plans in terms of services, consumer premiums, and provider reimbursement.

Surgeon autonomy

The ACA may have an effect on surgeon autonomy, both in terms of clinical decision making and the administration of a surgical practice. Growing regulatory demands, including the incentivized use of electronic medical records, might place a significant financial burden on smaller practices in addition to requiring practice adaptations by individual surgeons. Furthermore, ACOs, as outlined in the ACA, are intended to further integrate providers both horizontally (across physician specialty) and vertically (physicians and hospitals) with the goals of improving quality and limiting cost. This provision may foster or necessitate closer working relationships between surgeons and nonsurgeons but is also expected to result in changed patterns of specialist referral and will likely affect practice in other ways.51 Additionally, the Patient-Centered Outcomes Research Institute (PCORI) will promote and fund comparative clinical effectiveness research; eventually, this research will help establish an evidence-based standard of care to which surgeons and other providers could be held accountable.52 Of note, the PCORI is expressly prevented from conducting cost-effectiveness analyses or funding research projects that include a cost-effectiveness component.52,53
The ACA may have an effect on surgeon autonomy, both in terms of clinical decision-making and the administration of a surgical practice.
Surgical leadership

in the era of quality-based payment

by John V. White, MD, FACS; David Young, MD; Cindy Mahal-van Brenk, RN; and Jeffry A. Peters
Health care reform is changing the way both public and private insurers pay for surgical services. In the process, it also is redefining the role of the surgeon in the hospital operating room (OR).

Historically, payors have compensated surgical providers based on surgery volume. Under the traditional system, payment is based on the total cost of supplies, labor, and other resources required to perform a surgical procedure. Today, U.S. payors are increasingly tying payment to quality outcomes. The goal is to pay for clinical value as evidenced by quality processes, patient outcomes, and cost control. Quality-based payment for surgical specialists is also under consideration.

How does this shift affect surgeons? First, quality-based payment is changing the way hospitals evaluate their surgical staff. Previously, surgeons retained their hospital privileges if they avoided significant clinical or behavioral events. Now, many surgery departments are evaluating surgeons based on quality of care before, during, and after surgery. More importantly, quality-based payment is changing the value of surgical expertise within the financial ecosystem of the hospital. Surgical quality is no longer just a dimension of clinical care; it is a core driver of economic performance. In light of this movement, hospitals are increasingly looking to surgeons to provide organizational leadership in quality improvement.

This choice is a logical one. Surgeons are natural leaders and seasoned collaborators, and as a group they possess an extraordinary desire to improve. The challenge for surgeons will be applying their leadership skills to a wider field. New payment models are calling for more than isolated improvements; coordinated efforts to achieve comprehensive quality gains are required.

What skills and knowledge do surgeons need to be effective quality leaders? The key is to understand (1) the external forces that are shaping the quality landscape, and (2) how to drive the internal organizational processes that affect surgical quality and cost outcomes. The first step is to analyze the incentives, penalties, and opportunities that underlie new payment models.

### Six quality-based payment strategies

New payment models developed in the U.S. in recent years illustrate the challenges of identifying and rewarding quality, particularly in the area of surgical care. Payors are experimenting with a variety of approaches to quality-based payment. Prominent strategies include:

- Tying payment to evidence-based care processes
- Penalizing errors and “never events”
- Penalizing readmissions
- Linking payment to patient satisfaction
- Providing opportunities for shared savings
- Tying payment to clinical outcomes

Illustrates how Advocate Lutheran General Hospital in suburban Chicago, IL, has used ACS NSQIP® to launch several new initiatives designed to enhance OR processes and outcomes. This article discusses the results of these efforts.
New payment models developed in the U.S. in recent years illustrate the challenges of identifying and rewarding quality, particularly in the area of surgical care.

**Tying payment to evidence-based care processes.** One basic approach to quality-based payment is to link financial incentives to specific interventions and processes associated with quality care. The Centers for Medicare & Medicaid Services (CMS) is currently developing this model through the hospital value-based purchasing (VBP) program. Participating hospitals receive Medicare payment bonuses or reductions based on their overall performance on several clinical care measures. Roughly half are process measures drawn from CMS’ Surgical Care Improvement Project (SCiP), including antibiotic and venous thromboembolism prophylaxis. High-quality hospitals (or hospitals that demonstrate significant quality improvement) receive a bonus of up to 1 percent of base operating diagnosis related group (DRG) payments. Low-quality hospitals are penalized up to 1 percent of DRGs. (The program is budget-neutral, with the best taking dollars away from the worst.) The at-risk amount will increase incrementally to 2 percent in fiscal year 2017.¹

**Penalizing errors and “never events.”** Another approach to quality-based payment is to penalize medical errors and preventable complications. Starting in fiscal year 2015, Medicare will begin reducing payments to hospitals with high rates of certain hospital-acquired conditions (HACs), including surgery-related events, such as retained foreign objects, certain surgical site infections (SSI), and deep vein thrombosis (DVT)/pulmonary embolism (PE) after hip and knee replacements. Hospitals that land in the lowest quartile will be subject to a 1 percent reduction in payment.² Private payors have also adopted error penalties. Cigna, for instance, reserves the option of reducing payment for care related to mediastinitis following coronary artery bypass grafting and SSIs following orthopedic or bariatric surgery.³

**Penalizing readmissions.** Patients who experience an inpatient safety event are 47 percent more likely than other patients to be readmitted within three months.⁴ Under the Medicare hospital readmissions reduction program, DRG payments are reduced for hospitals with high readmission rates. The program initially targets care related to myocardial infarction, heart failure, and pneumonia, but it is expected to be extended to certain cardiovascular surgeries starting in 2015. DRG payment penalties are 1 percent in fiscal year 2013, increasing to 2 percent in 2014 and 3 percent in 2015.⁵

**Tying payment to patient satisfaction.** In addition to clinical process measures, the Medicare VBP program tracks patient satisfaction using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The survey—which is administered to a random sample of discharges, including surgery patients—focuses on patients’ perceptions of provider communication and responsiveness. The use of patient satisfaction in quality-based payment is controversial. Presumably, however, maintaining a patient-centered environment built on strong communication will help ensure overall quality and continuity of care.⁶

**Sharing quality-generated savings.** Several advanced payment models encourage quality by allowing hospitals and physicians to share in the savings generated by quality improvement. For example, Medicare’s bundled payments for care improvement initiative assigns a target price for defined episodes of care. Provider organizations that achieve lower costs (through reduced complications, lower readmissions, better resource use, and so on) are allowed to retain the full bundled payment. The shared savings model is also an element of most accountable care organizations (ACOs), including the Medicare Shared Savings Program and many private ACOs. Given the high cost of surgical complications, success under any of these arrangements will hinge upon surgical quality.

**Tying payment to clinical outcomes.** Payors are also developing methods for tying payment directly to patient outcomes. Directly linking outcome to payment is a challenging goal, but payors have expressed a strong interest in creating payment models that are based on quality results, not just quality processes. In 2015, for instance, the VBP program will add a composite patient safety measure that takes into account postoperative PE/DVT, sepsis, and wound dehiscence. Looking forward, the value-based update model that the American...
QUALITY-BASED PAYMENT MODELS

Recently developed payment models represent different strategies for identifying and measuring quality care. Model design ranges from a narrow focus on specific care interventions and adverse events to strategies for evaluating the full impact of care on patients and costs.

- **Care processes**
  - Bonus pay for higher compliance with SCIP protocols and other care processes.
- **Error penalties**
  - Reduced payment for hospitals with high rates of SSIs, blood clots, retained objects, etc.
- **Readmission penalties**
  - Reduced payment for hospitals with high 30-day readmission rates, by diagnosis.
- **Patient satisfaction**
  - Hospital score on HCAHPS survey; a component of many quality-based pay programs.
- **Shared savings**
  - Providers share savings from lower complications and readmissions, greater efficiency.
- **Clinical outcomes**
  - Payment linked to patient outcomes, achievement of quality and utilization goals.

Source: Surgical Directions

College of Surgeons (ACS) is in the process of developing would use clinical data registries to link Medicare payment to true surgical outcomes.

The payment models discussed in this article represent a spectrum of design strategies, ranging from a narrow focus on specific care interventions and adverse events to strategies for evaluating the full impact of care on patients and costs (see figure, this page). It is important to note the following two facts about all these models:

- Many programs and proposals incorporate design elements from several different models. For instance, the Medicare Shared Savings Program and many private ACOs have incorporated patient satisfaction metrics into performance measures.
- While the surgical profession is developing models that will allow surgeons to participate directly in quality-based payment, hospitals are mediating the initial impact. As illustrated earlier, new incentives and penalties primarily target hospital payments. Hospitals, in turn, are developing ways to identify and reward surgeons who help them achieve payment-favored quality goals.

The bottom line is that an effective response to quality-based payment must encompass not only efforts to improve clinical care in the surgical suite, but also initiatives to optimize the entire hospital surgery department. To be able to lead this transformation, surgeons need to master the entire range of organizational processes that affect surgical outcomes. Our experience in a large hospital OR shows that the key is to identify and control all of the processes that contribute to safe, quality surgery.

**Case study: Leading process improvement in the OR**

Advocate Lutheran General Hospital is a tertiary care hospital in suburban Chicago, IL, that has a longstanding commitment to quality care. In 2007, Lutheran General joined the ACS National Surgical Quality Improvement Program (ACS NSQIP®). As part of the facility’s commitment to the ACS NSQIP philosophy, surgery department leaders launched several new initiatives designed to enhance OR processes and outcomes.

The initiatives were based on the concept that a surgical procedure is the endpoint of multiple processes. Each process contributes to a safer outcome. For instance, pre-anesthesia testing yields important information about patient comorbidities. Workflows in central sterile produce surgical supplies that, if properly sterilized, reduce the likelihood of a costly postoperative infection. Time, of course, is a critical dimension. The window of opportunity for many of these processes is relatively short, and it all but vanishes during the operation itself. As with any system of processes, the key to a good outcome—a safe, quality surgical procedure—is to control all the variables. The goal at Lutheran General was to enhance surgical outcomes by controlling variables in the following four areas.

**Information.** Information is a critical component of surgical safety and quality. In surgical services, information enters the system through the scheduling process. Hospitals need to ensure they have scheduled the cor-
The bottom line is that an effective response to quality-based payment must encompass not only efforts to improve clinical care in the surgical suite, but also initiatives to optimize the entire hospital surgery department. To be able to lead this transformation, surgeons need to master the entire range of organizational processes that affect surgical outcomes.

rect patient, for the correct procedure, on the correct surgical site. Unfortunately, scheduling is poorly controlled in most ORs. Typically, scheduling staff will accept case requests via any route—phone call, fax, e-mail, or in person. Some schedule requests include full, accurate patient information, whereas others lack important detail. Surgery department leaders at Lutheran General recognized the opportunity to improve information capture by creating a single-path scheduling system. Under the new system, surgeons and their office staff are required to use a standardized fax form for all schedule requests. The form includes mandatory fields for capturing procedure details, patient comorbidities and other risk factors, anesthesia requirements, test orders, special equipment needs, and other valuable details.

The department also implemented a software system to manage documentation. The system receives all incoming faxes, digitizes the content, and indexes patient and procedure information. As additional documentation comes in—for example, imaging studies, lab results, and consults—the system assembles a comprehensive file for every case. Clinical staff members review each item upon arrival and triage content appropriately. The new scheduling/documentation process ensures all case information is available as needed throughout the preoperative process and on the day of surgery.

Patient risk factors. Although the importance of controlling risk factors is widely understood, different organizations use a wide variety of approaches to identify patient risk. Lutheran General addressed this problem by creating a standardized, evidence-based process for pre-surgical testing. The heart of the system is a pre-anesthesia testing (PAT) center that coordinates all patients preoperatively. Shortly after a case is scheduled, a member of the registration team contacts the patient by phone. Depending on the results of the telephone screening, the patient is triaged to either a normal prep timeline or scheduled for additional interventions. PAT staff use standardized testing protocols developed through collaboration between the anesthesia and surgery departments. The protocols prescribe test pathways and lab and imaging guidelines for normal and high-risk patients. An anesthesiologist performs a chart review for all high-risk patients and reviews all abnormal test results. PAT nurses actively monitor and manage cases starting three days before surgery. Standard protocols also identify medications to hold pre- and post-procedure. The new PAT process helps ensure that patient risk factors are effectively identified and completely managed before surgery.

Final assembly. Most manufacturers incorporate a final quality assurance inspection into the production process. In the case of surgery, performing a quality check after a procedure is obviously of limited value. Quality assurance needs to be incorporated into the surgical process before the procedure itself. Lutheran General addressed this need by developing a process known as the “daily huddle”—a 35-minute meeting that takes place every day at 2:00 pm. The meeting is attended by representatives from anesthesia, PAT, nursing, materials management, central sterile processing, and other perioperative services. After reviewing current-day issues, participants examine cases scheduled for the next day to verify that required tests are complete, required equipment will be available, and any specific risks have been addressed. Participants also evaluate the schedule as a whole to ensure effective flow of staff and resources. When a problem comes to light, staff members resolve the issue promptly or reschedule the case.

Controlling communication. Several national safety organizations have identified poor communication as a leading factor in medical error. Obviously, communication problems block the flow of information, including important information gathered preoperatively as well as critical information about what is occurring intraoperatively. In 2010, Lutheran General joined several other Advocate Health hospitals in a broad-spectrum effort known as the Safer Surgery Initiative. The initiative included several components aimed at improving OR communication. One was crew resource management (CRM), an aviation safety methodology that has made inroads into surgery in recent years. Surgeons,
anesthesiologists, and nurses received training on sharing information, raising safety concerns, respecting colleagues, and other skills of effective communication. The hospitals also adopted a modified version of the World Health Organization’s surgical safety checklist to support team communication and ensure consistent adherence to quality practices.

The initiative included changes aimed at improving communication postoperatively. Lutheran General implemented an anonymous error reporting system and took steps to encourage a “just culture” that facilitates non-punitive efforts to solve quality problems. Overall, the Safer Surgery Initiative helped improve surgical quality by ensuring that key information is communicated before, during, and after surgical procedures.

When Lutheran General launched these initiatives, the facility already had very good outcomes on a broad range of quality measures. Nevertheless, the surgery department’s efforts to control the processes that “feed” surgery resulted in significant improvement in a number of key metrics. The following outcomes data are based on ACS NSQIP reports:

• **Blood clots**: Lutheran General’s baseline for DVTs was 3.3 percent prior to implementing ACS NSQIP. By the end of 2007 (the hospital’s first year in the program), the rate had been reduced to 0.8 percent. In the fourth quarter of 2011, the DVT rate was down to 0.3 percent.

• **Urinary tract infection**: Starting from a baseline of 6.7 percent, the urinary tract infection (UTI) rate was reduced to zero by the end of 2007. The average quarterly UTI rate in 2011 was less than 0.4 percent.

• **Kidney failure**: The renal failure/insufficiency rate for surgery patients was 1.4 percent in the first quarter of 2007. In 2011, the average quarterly rate for this complication was less than 0.2 percent.

• **Respiratory outcomes**: In the first quarter of 2007, 2.6 percent of patients were on a ventilator longer than 48 hours, and 3.9 percent developed pneumonia. In 2011, the average quarterly V>48 rate was less than 0.3 percent. The postoperative pneumonia rate was 0.0 percent throughout the entirety of 2011.

• **SCIP measures**: Performance on SCIP measures has improved significantly, increasing from a compliance rate of approximately 85 percent to overall compliance exceeding 99 percent. Currently, Lutheran General exceeds national performance on 9 out of 11 SCIP measures.7

These gains have boosted overall surgery department quality from very good to exceptional. In 2010, the ACS cited Lutheran General for achieving the lowest rate of postoperative complications of all participants in ACS NSQIP.

**Cutting costs, improving efficiency**

Process initiatives have also helped Lutheran General improve performance on quality measures that affect costs. Lower complication rates have contributed to a reduction in length of stay (LOS) for surgery patients. For instance, Lutheran General’s LOS for complex aortic surgeries is approximately five days, compared with a U.S. average of approximately nine days. Rehospitalizations are also down. The U.S. 30-day readmission rate for surgery patients was 12.7 percent in 2009.8 Based on internal data, the Lutheran General rate was 9.3 percent in 2012 and trending downward, despite serving a high-acuity surgical population.

Comprehensive process improvement has also increased surgery department efficiency. Thanks to better initial information capture, stronger document management processes, standardized preoperative testing, and the daily huddle “quality check” process, fewer patients have unresolved issues on the day of a procedure. As a result, last-minute case cancellations have declined. Based on internal data, the same-day cancellation rate at Lutheran General decreased from 4.2 percent to 0.7 percent between 2009 and 2011. This, in turn, has helped the surgery department control costs by minimizing wasted supplies, staff time, and OR capacity.
Surgical department leaders can achieve significant improvements by coupling procedure-focused changes with broad, systems-focused interventions.

Valuable model
Lutheran General is not the only hospital to implement comprehensive perioperative process improvement. Hospitals across the country have used this approach to improve surgical quality and control costs. Of what value is the model to surgeons?

One benefit of the process-based approach is that it complements other improvement methodologies focused on best practices and continuous measurement and reporting. Surgical department leaders can achieve significant improvements by coupling procedure-focused changes with broad, systems-focused interventions. Comprehensive perioperative process improvement may even be the key to realizing the value of specific clinical processes, which by themselves do not seem to produce automatic outcome improvements.9

Another benefit of this approach is that it enables a comprehensive response to payment reform. Comprehensive organizational improvement has positioned Lutheran General to achieve excellent process metrics under the VBP program, minimize non-reimbursable never events, reduce re-hospitalizations penalized under the Medicare hospital readmissions reduction program, and control the full range of costs (complications, readmissions, supplies, labor, and so on) that are critical to success or failure under bundled payments and ACOs. The process-based approach also will help Lutheran General perform well under any future payment system focused on clinical outcomes, especially one built on ACS NSQIP domains. Indeed, perioperative process improvement at Lutheran General and other Advocate Health hospitals has already led to gains under private payor contracts. Surgeons who operate at Lutheran General and other system hospitals have access to gainsharing incentives negotiated through the system’s physician health organization, Advocate Physician Partners.

Ultimately, the value of this approach for surgeons is that it provides them with an opportunity to lead the response to payment reform. Surgeons—collaborating with anesthesiologists, hospitalists, and nurses—are in an excellent position to define the future of surgery by taking responsibility for the entire chain of perioperative processes. Surgeons who accept the challenge will not only provide better surgical care but will help build efficient and effective surgical service organizations that emerge from health care reform on a stronger footing than ever. ◆
The 113th Congress: A look at the year ahead

by John Hedstrom, JD

Anyone picking up a newspaper or watching a newscast these days no doubt reads and hears various aspersions cast upon Washington, DC, and its political denizens. Yes, Congress is back in session, and the town that is given to cliché appears to have picked up where it left off before the 2012 elections, with partisan bickering.

The only difference between death and taxes is that death doesn’t get worse every time Congress meets.

—Will Rogers, entertainer/actor/philosopher

Yet, there is serious business that must be conducted as numerous challenges face surgeons and surgical patients. The American College of Surgeons (ACS) is focused on advancing its health policy agenda amid the political minefield. This article is a prognostication of where the College’s primary agenda items are headed during the 113th Congress.

Physician payment

Prediction is very difficult, especially if it’s about the future.

—Niels Bohr, Danish physicist and philosopher

There are two distinct parts to the physician payment issue—present-day cuts to the Medicare physician payment rate and the future overhaul of the health delivery and payment system. At press time, sequestration went into effect and cut the Medicare physician payment rate by 2 percent with the nearly 30 percent sustainable growth rate (SGR) cut looming at the end of the year. The ACS acknowledges the need to reduce the nation’s deficit, but
the sequestration cuts carry some potential ramifications. Some members of the College, as well as various policymakers, may argue that 2 percent will not have a significant impact on surgery; however, it opens the door to future cuts as the national fiscal debate continues. The ACS believes the new payment and delivery system will produce significant savings in the Medicare budget, averting the need for explicit cuts to physician payment rates. Therefore, the College continues to oppose any cuts until a new delivery and payment system is in place.

Although Congress may appear divided in general, most lawmakers agree that the nation’s health care delivery and payment system must be overhauled in the near future. Both parties agree that the Medicare program must move toward a value-based payment model and away from the current fee-for-service, volume-based model.

In late February, the ACS responded to a joint proposal from the U.S. House Committee on Ways and Means and the House Committee on Energy and Commerce requesting input on how to redesign the delivery and payment system, including the permanent repeal of the SGR. The ACS asserts that any new payment system should be based on the complementary objectives of improving outcomes, quality, safety, and efficiency while simultaneously reducing growth in health care spending. In order for any alternative payment system to be successful, the ACS and other organizations believe it should meet the following objectives:

• Ensure that quality and safety are the highest priorities
• Require that specific quality metrics are achieved before any savings can be shared among payors or providers
• Maintain the primacy of physician leadership within a highly qualified team of health care professionals working with patients to determine evidence-based courses of clinical care
• Acknowledge that surgical care is delivered in a variety of geographic locations and facilities
• Allow for innovative responses that may be required to address patient needs in urgent or unique situations
• Preserve the ability of a surgeon to recommend the surgical treatment plan that best meets the patient’s needs as guided by best practices and evidence-based medicine

The future of the delivery and payment system remains unknown, except that changes are forthcoming in both the public and private sectors. The ACS believes in the objectives described earlier in this article and advocates on surgeons’ behalf to ensure the new system strikes a balance between fiscal prudence, delivery of high-quality care, and preservation of the trusted physician-patient relationship.

Medical liability reform

To do the same thing over and over again is not only boredom; it is to be controlled by rather than to control what you do.

—Heraclitus, Greek philosopher

Medical liability reform continues to be a significant priority for the ACS and its members. For more than a decade, the College advocated for the federal adoption of health care liability reforms like those enacted in California under the Medical Injury Compensation Reform Act (MICRA) of 1975, including reasonable caps on noneconomic damages, limits on plaintiff attorney contingency fees, and application of punitive damages only when there is clear and convincing evidence that the defendant intended to injure the claimant.

The current congressional makeup—and that of the foreseeable future—hinders the ability to advocate on this platform. With valuable lessons learned at its October 2012 Medical Liability Reform Summit (see the March 2013 issue of the Bulletin for a complete overview [volume 98, no. 3]), the ACS is proactively working with other national physician organizations to seek alternative solutions at the federal and state level, while continuing to support its longstanding position on MICRA-like reforms.
Surgical workforce

The life so short, the craft so long to learn.
—Hippocrates, Greek physician

The viability of the surgical workforce and the ability to train future generations of surgeons remains a top concern for the ACS. A growing body of evidence points to an ongoing and increasing shortage of surgeons available to serve the nation's aging and growing population. According to the Association of American Medical College’s Center for Workforce Studies, the U.S. will face a shortage of 46,000 surgeons and medical specialists in the next decade—a startling and troubling statistic for both surgeons and patients. Even the most ambitious plan would have only a modest effect in slowing the decline in the overall number of practicing surgeons over the next 15 years. These shortages will be felt most acutely in rural areas, where maldistribution has already left 1,144 counties with no general surgeons and nearly 900 counties without any practicing surgeons of any specialty. In addition, graduate medical education (GME), as well as indirect medical education funding, is a constant target for cuts as the nation deals with significant fiscal issues.*

Last year, a bipartisan group of senators requested that the Institute of Medicine (IOM) study the governance and financing of the GME program. Several proposals for addressing the shortage in general surgeons have been put forth, including a plan to increase the size of accredited surgery residencies along with a commitment to general surgery in residency selection criteria, increasing the flexibility and breadth in general surgery training, enhancing links with community-based hospitals, and seeking loan forgiveness opportunities for general surgeons. These recommendations could have a significant effect in addressing projected shortages. In December 2012, ACS Executive Director David B. Hoyt, MD, FACS presented the College’s views on physician training before the IOM. That meeting gathered perspectives from trainees, medical schools, researchers, medical societies, and other stakeholders. Dr. Hoyt spoke about shortages and the maldistribution of surgeons, as well as the effects of the 80-hour workweek on the readiness of surgeons emerging from training to enter practice, among other topics.

The ACS will remain a leading voice in addressing the critical shortages facing the surgical workforce.

A strong trauma system

The mission of the COT is to develop and implement meaningful programs for trauma care in local, regional, national, and international arenas. These meaningful programs must include education, professional development, standards of care, assessment of outcome, and financial accountability.

—ACS Committee on Trauma (COT) mission statement

The ACS and its coalition partners continue to advocate for trauma system funding to share information and disaster preparedness. Although many states have made great strides in developing effective trauma care systems, significant gaps in the nation’s trauma and emergency care delivery systems still exist. In addition, policymakers and organizations concerned about the state of trauma and emergency care must examine the details of those gaps and indicate how our current health care delivery systems would handle the surge capacity associated with a public health emergency or mass casualty event.

Last year, the Chairman of the House Energy and Commerce Committee, Rep. Fred Upton (R-MI), submitted a letter to the Government Accounting Office (GAO) requesting an assessment of the nation’s current trauma and emergency medical services programs. The GAO anticipates that the report will be completed by this summer.

The ACS will strongly advocate for the advancement of the organization’s policy objectives on the issues highlighted in this article and many others. Throughout the 113th Congress, College Advocacy and Health Policy staff will be reaching out to you to partner with us in achieving positive results regarding these issues.◆
Industry-sponsored clinical trials: The problem of conflicts of interest

by Shijing Jia; MD; Douglas Brown, PhD; Anji Wall, MD, PhD; Ira Kodner, MD, FACS; and Jason D. Keune, MD

HIGHLIGHTS
• Presents an ethical dilemma in which a pharmaceutical company asks a physician to participate in a clinical trial and offers to pay the physician for enrolling patients in a clinical trial
• Presents four options for resolving the dilemma:
  – Accept the offer and only reveal details relevant to informed consent
  – Accept the offer and inform patients of the reimbursement arrangement
  – Participate in the clinical trial without accepting reimbursement
  – Do not participate in the clinical trial
A pharmaceutical company invites a surgical oncologist at an academic medical center to participate in an industry-sponsored clinical trial of a novel adjuvant chemotherapy agent designed for use in the perioperative period. The protocol drug is in a phase III trial and is being compared with the standard chemotherapeutic adjuvant. The pharmaceutical company offers to reimburse the physician $500 per patient enrolled in the trial. The pharmaceutical company needs the physician to enroll 200 participants in a 12-month period.

This case illustrates a common conflict of interest in the practice of clinical medicine and surgery. A conflict of interest occurs when a primary professional responsibility is compromised, consciously or unconsciously, by a secondary interest. Because the surgeon in this example is eligible to receive significant monetary compensation for enrolling patients in the clinical trial, it may be difficult to remain focused on patient interests when explaining the purpose, risks, benefits, and rationale for the clinical trial to patients. Thus, the conflict of interest in this case is between the physician’s potential financial gain and his or her fiduciary duty to patients.

This article analyzes four possible options to respond to this ethical dilemma:

1. Participate in the clinical trial, accept the reimbursement, and disclose only the standard details of the trial to participants during discussions relevant to informed consent.
2. Participate in the clinical trial, accept the reimbursement, and include the reimbursement arrangement when disclosing the details of the trial to participants.
3. Participate in the clinical trial without accepting the reimbursement.
4. Do not participate in the clinical trial.

Option 1
Participate in the clinical trial, accept the reimbursement, and disclose only the standard details of the trial to participants during discussions relevant to informed consent. This course of action allows the surgeon to give potential enrollees the option of either participating in the clinical trial or receiving standard treatment. The physician assumes the patient has the capacity to make an informed decision about the choices based on his or her knowledge of all possible therapeutic options, including the drug in Phase III trial. The patient must understand the clinical significance and personal consequences of enrolling in a Phase III trial. As a patient’s trusted and oftentimes sole source of medical information and advice, the physician has the responsibility to educate and guide patients to a safe and suitable medical decision. In doing so, the physician must avoid or properly manage bias when disclosing all relevant information about the treatment options presented to ensure that the patient is making an informed and autonomous decision.

The primary problem with this approach is the added difficulty the surgeon faces in avoiding or managing potential bias when presenting information about trial participation. It will be tempting for the physician to rationalize the benefit of the trial drug or to underestimate the risk for adverse reactions. In a systematic review of the literature evaluating industry sponsorship of clinical trials, Golder and Loke noted that researchers involved in pharmaceutical-sponsored trials significantly minimized the risks associated with enrollment.1 Because many trials pay investigators on a per capita basis, participating physicians have a significant incentive to enroll a large number of patients. Reimbursement rates are not standardized, leaving each participating physician to consider where to draw the line between reasonable and excessive compensation. Disproportionate reimbursements heighten the incentive to recruit overzealously and thereby to jeopardize physician nonpartisanship, data integrity, and patient safety and autonomy.

Option 2
Participate in the clinical trial, accept the reimbursement, and include the reimbursement arrangement when disclosing the details of the trial to participants. The standard practice of informed consent requires that clinical trial participants be given adequate information to make informed and autonomous deci-
sions. The reimbursement amount per enrollee in this case begs the question: “Can a potential participant’s autonomy be respected without disclosure of the reimbursement amount and purpose?”

To address this concern and better respond to the conflict of interest created by per capita reimbursement, this option calls for the surgeon to disclose the reimbursement arrangement to participants, with explicit information about the potential personal gain available to the physician that would surpass the basic costs of drug treatment and patient care. Disclosing the reimbursement arrangement sterilizes the conflict of interest and shifts to the patient the task of determining the extent to which financial consideration is biasing the information that the physician provides.

This option calls for the patient to competently integrate the reimbursement information into the decision-making process. A review by Licurse and colleagues found that patients favored the disclosure of their physicians’ financial ties and, more importantly, an oversight committee to monitor and safeguard patient interests. This review suggests that patients recognize their limitations with regard to making informed decisions, especially in light of their inexperience with pharmaceutical industry proceedings. Sah noted that patients made decisions erratically when provided with the information of their physician’s financial gains and introduced the idea of “burden of disclosure” to describe the increased pressure to comply with a physician’s recommendation after a disclosure has been made. Patients struggle with reimbursement information, with many preferring to depend on an oversight body to assess and clarify these ethical and logistical issues.

This second option may create more confusion among potential trial participants, rather than improve the informed consent process. Also, it would be a mistake to assume that pharmaceutical companies will have robust and independent internal review boards. Disclosure of the reimbursement arrangement illuminates but does not eliminate conflict of interest.

Option 3
Participate in the clinical trial without accepting the reimbursement. By eliminating the financial conflict of interest in this case, this option maintains the patient’s autonomy by greatly reducing the risk of physician bias in recruitment. Without a need to disclose financial ties to the industry study sponsor, this option protects the physician’s trusting relationship with the potential participants.

However, conflicts of interest extend beyond financial gain. In many cases, physicians named as the primary investigator of a drug study may be credited with authorship for publication of positive studies. This additional incentive creates a range of disclosure quandaries similar to those associated with the reimbursement arrangement in this case. A physician in this situation may subconsciously exaggerate the benefits of the study, as was found to be the case in numerous studies across subspecialties. Industry-funded research tends to have more positive results, and the primary investigators of such studies tend to overstate the benefits and underestimate the harms of the protocol drug.

While this option does potentially eliminate the bias associated with financial gain, the physician would have to justify participating in a research study without reimbursement to offset costs. Research protocols require a significant amount of additional work from physicians and ancillary staff. A lack of reimbursement could be a disincentive for clinicians to participate in clinical trials.

Option 4
Do not participate in the clinical trial. The action most consistent with the ethical principle of nonmaleficence is to refuse participation in the clinical trial. This option resolves the ethical issues of conflicts of interest between patient care and personal gain and ensures that the physician does not subject patients to any additional risk.

However, without clinical trials to test new treatments, the potential for discovery or refinement of
new ideas and, thus, for treating patients in the future with more effective and appropriate medications will be forestalled.

**Ethical bottom line**

Industry has become increasingly involved in medical research—initiating clinical trials, sponsoring investigator patient recruitment, and often providing medications to patients who may not otherwise have access to treatment.5 Such involvement creates legitimate concern about conflicts of interest for physicians as they recruit for and assist with the implementation of industry-sponsored clinical trials. This concern is most acute when the participating physicians receive reimbursements that clearly cross the line between reasonable and excessive compensation.

Most academic medical centers have general guidelines for monitoring research revenue.6 The guidelines are less clear in community practice centers. They may not have ethics boards for monitoring the reimbursement arrangements of pharmaceutical-sponsored clinical trials. Such boards have no standard reimbursement rate for patient enrollment. Without specific monitoring teams in place, physicians are left to consider each research trial individually and to exercise self-discipline.

Physicians have an obligation to place the well-being of their patients before personal or professional gain. This obligation trumps the need to contribute to medical advancements or drug development. Patients ought to be in a position to decide whether to enroll in a clinical trial. They need to and should be in a position to trust their physicians to be impartial when presenting the information upon which they make these important decisions.

A primary task of the physician is to balance protecting the patient’s autonomy with offering treatments in which the benefit outweighs risks in an acceptable proportion. Many patients take their physician’s recommendations without serious reservations, though these recommendations are taken to represent independent judgments. Whereas patients always have the option of seeking a second opinion, at least in theory, they do not routinely pursue this course of action. Accordingly, it is crucial that physicians provide information in as unbiased a manner as possible when presenting treatment options to their patients. Before agreeing to enroll patients in an industry-sponsored clinical trial with significant financial compensation, physicians would do well to ask themselves, “Can I explain/justify the reimbursement arrangement to a respected colleague, to the nurse with whom I have worked for many years, or to an admiring medical student?”

**REFERENCES**

Since it was first established in 1913, the American College of Surgeons (ACS) has been a leading voice in opposition to fee splitting and other unethical practices among surgeons and other health care professionals. Indeed, to this day, Fellows pledge to “take no part in any arrangement or improper financial dealings that induce referral, treatment, or withholding of treatment for reasons other than the patient’s welfare.”

In March 1952, the U.S. Supreme Court ruled that the income tax deductions that two North Carolina opticians took for kickbacks to ophthalmologists on eyeglasses sold to their patients were ordinary and necessary expenses. The court maintained that because no public policy regarding these types of activities existed at the time that the opticians took the payments from the physicians, the court was forced to rule in the defendants’ favor.

The Supreme Court’s decision prompted the ACS Board of Regents to study the intricacies of fee splitting and to periodically issue statements defining and clarifying the College’s views on the matter. The first of these proclamations, “A Statement on Certain Unethical Practices in Surgery,” is reprinted in the following pages as part of the Bulletin’s commemoration of the College’s Centennial. The statement is preceded by an article describing the court case and the ACS’ response to it. These materials were published in the July–August 1952 issue of the Bulletin.
Supreme Court Decision Spurs College to Oppose Tax Deduction of Split Fees

Recognizing that, perhaps for the first time in the history of the American College of Surgeons’ fight against the evil of surgical fee-splitting, an effective weapon has been placed within the public’s reach, the Board of Regents in its meeting at White Sulphur Springs on April 14 and 15 unanimously adopted the view that a split fee is against public policy and therefore not a legitimate deduction for income tax purposes.

The Board authorized Dr. Paul R. Hawley, the Director, to notify the Commissioner of Internal Revenue of its action and to ask him to inform the College what policy the Bureau of Internal Revenue will pursue following the decision of the United States Supreme Court in the Lilly optical rebate case.

On March 10, the Supreme Court ruled in behalf of Thomas and Helen Lilly, North Carolina opticians, that the income tax deductions they took for kickbacks to eye doctors on eyeglasses sold to their patients were, in fact, ordinary and necessary business expenses. This reversed the position of the Commissioner of Internal Revenue, who had successfully argued through Tax Court and the Circuit Court of Appeals that a business deduction of a kickback was not allowable because it was medically unethical and against public policy.

Inasmuch as a representative of the Commissioner of Internal Revenue had told staff members of the College that a Supreme Court ruling on optical rebates involving a professional relationship on one side only would certainly apply in surgical fee-splitting involving a bilateral professional relationship, it appeared that the hope of controlling fee-splitting by the grinding economic necessity of paying income tax had been dashed to the ground. As a matter of fact, some doctors have interpreted the Court’s decision as having this effect.

Closer examination, both of the position of the Commissioner of Internal Revenue and the language of the Supreme Court ruling, shows that allowance of the deductions in the Lilly optical rebate case had changed nothing as far as surgical fee-splitting is concerned. A recent follow-up report on the Columbus Plan for controlling fee-splitting (see page 153) showed that there was no question in the mind of the Internal Revenue agent in charge in Columbus that a split between two doctors was disallowable as a business deduction.

He referred to Prentiss-Hall’s Federal Tax Service, Volume I, which said:

“In numerous cases the Commissioner of Internal Revenue has been upheld in disallowing expenditures on the ground that the payments violate a fixed public policy. The gist of these decisions is that to permit a violator to gain a tax advantage through deductions would, in effect, lessen the degree of punishment intended or would frustrate the purpose and effectiveness of this rule of public policy that has been violated.”

There is no question that fee-splitting is against public policy in the State of Ohio, where it is against the law, or in twenty-two other states which have laws prohibiting fee-splitting.

Examination of the Supreme Court ruling reveals that it directs its whole argument in behalf of Thomas and Helen Lilly, opticians, to the point that, at the time they claimed their deductions, optical rebating had not been defined as against public policy. It since has been by consent decree in the nation-wide antitrust suit against the opti-
judged of service to the Fellows because of the confusion which has arisen from the reports and gossip that has gone around about what the Bureau of Internal Revenue is doing on split deductions, a confusion further confounded by the Supreme Court decision in the Lilly case; 2. As a maximum, the College may be able to foster the sharply defined policy for which the Supreme Court pleads and, as a result, witness the day when the fee-splitting evil is at last an end.

Following the meeting of the Board of Regents, the following letter was mailed to the Commissioner of Internal Revenue.

15 April 1952

The Commissioner of Internal Revenue,
Bureau of Internal Revenue,
Washington 25, D. C.

Dear Mr. Commissioner:
The Board of Regents of the American College of Surgeons, the nation’s leading professional organization of surgeons with a membership of more than 17,500 Fellows, has considered the decision of the United States Supreme Court in the case of Thomas B. and Helen W. Lilly v. Commissioner of Internal Revenue, March 10, 1952, and has authorized me as The Director

1. To state the position of the American College of Surgeons which, since its establishment in 1913, has consistently opposed the secret division of fees between a surgeon and a referring physician as being a violation of medical ethics inimical to the best interests of the patient, and hence the public.

2. Because of confused reports upon the Bureau of Internal Revenue’s policies, a confusion now further confounded by the decision in the Lilly case, to request the Commissioner of Internal Revenue to inform the American College of Surgeons whether a physician may or may not, as a business expense, deduct from his taxable income that portion of a fee split with another doctor.

As a matter of information to the Commissioner, I inclose a resolution defining fee-splitting and the College’s attitude toward it, as adopted today by the Regents. I also inclose a pamphlet providing incidental information about the American College of Surgeons.

It is the fixed opinion of the Regents that fee-splitting is against public policy. It is against public policy in terms of the Code of Ethics of the American Medical Association, which represents the great majority of American physicians. It is against public policy in terms of the Fellowship Pledge taken by each Fellow of the American College of Surgeons. Obviously, it is against public policy in the twenty-three states which have laws prohibiting fee-splitting.
The weight of ethical and legal opinion, in the minds of the Regents, establishes in a sharply defined manner that fee-splitting is against public policy. Whereas fee-splitting is a common and prevalent evil in some areas of the United States, the fact that many thousands of qualified surgeons can and do practice surgery without splitting fees proves beyond doubt that fee-splitting is not a necessary expense of business in surgery.

Therefore, in the opinion of the Regents, it follows that split fees do not constitute a legitimate business deduction for income tax purposes. The Regents desire to make it a matter of record with the Commissioner of Internal Revenue that this is the official position of the American College of Surgeons.

The Regents recognize that this expression is in general agreement with the philosophy and position of the Commissioner of Internal Revenue in the Lilly case, which involved a rebate from opticians to ophthalmologists; and also possibly in agreement with the reasoning that an interpretation of optical rebates as being against public policy extends a fortiori to surgical fee-splitting.

As we understand it, this has been the attitude of various Internal Revenue agents, but that it by no means constitutes a general or directed policy for action throughout your field offices and districts. Clarification and uniformity of policy and enforcement are urgently needed both in the ultimate concern of the public in the Government's attitude toward an unethical practice and in fairness to surgeons who, as much as they may dislike fee-splitting, feel that they have been compelled to do so by community custom or economic necessity.

A Statement on Certain Unethical Practices in Surgery*

WHEREAS the essential of ethical financial relations in the medical profession is simply honesty, which requires the patient to be informed of the amount which is due to each physician for services rendered; and

WHEREAS the secret division of a fee between two physicians (commonly called "fee-splitting") is dishonest, against the public interest, and has long been considered unethical by responsible doctors of medicine; and

WHEREAS the payment of a referring physician by a surgeon for assistance during the operation without the knowledge of the patient, or the payment to the referring physician even with the knowledge of the patient, of an assistant's fee in excess of the amount customarily allowed for the service itself (commonly known as "inducement"), is likewise dishonest and unethical; and

WHEREAS deception of the patient as to the identity of the physician who performs an operation (a practice known as "ghost surgery") is likewise dishonest and unethical; and

WHEREAS the overcharging of a patient by a surgeon is unjust and encourages fee-splitting; and

WHEREAS the presentation of a combined unitemized bill by two physicians not formally associated each with the other is equivalent to fee-splitting; and

WHEREAS an itemized combined statement designating the amount due each physician, but out of proportion in any item to individual services rendered, is equally unethical; and

*Adopted by the Board of Regents, American College of Surgeons, April 15, 1952.
WHEREAS the payment or acceptance by physicians of rebates of fees for technical services or appliances has long been held to be unethical;

THEREFORE, BE IT RESOLVED that the American College of Surgeons make it a matter of record that it is unalterably opposed to all of the unethical practices enumerated above; and

BE IT FURTHER RESOLVED that the American College of Surgeons shall foster, promote, and practice the following measures to combat unethical practices in medicine:

1. Education of the public upon the value of the services of all physicians (including surgeons), emphasizing that each should be paid adequately and directly.

2. Education of the medical student, intern, resident, and young practitioner upon the evils of unethical relations through definite instruction in medical schools, hospitals, and medical societies.

3. Education of the surgeon as to the opposition of the American College of Surgeons to exorbitant fees, the presentation of unitemized combined statements, the presentation of itemized combined statements out of proportion to individual services rendered, the payment of referring physicians used as surgical assistants or anesthetists without such payments being known to the patient, and the employment of a referring physician on a salary which is related in any way to the number of referred patients.

4. Encouragement of governing boards of hospitals, which are in any way uncertain as to the possibility of fee-splitting by a staff member, or applicant, in the adoption of the requirement for staff membership of a statement by a qualified public accountant that no evidence of unethical financial relations appears on the books of the staff member or applicant.

5. Encouragement of hospitals, which are having difficulty in identifying the responsible surgeons, in the enforcement of a regulation that the patient or his legal representative shall sign, before operation, a properly executed and witnessed permit, in which the responsible surgeon is indicated.

6. Notification to clinics and their representative organizations that the College considers placement of referring physicians on the part-time payroll of a clinic as a dangerous practice subject to strong suspicion as to ethics.

7. Punishment by expulsion of any Fellow of the College who is known to be violating the principles stated above.
Transitioning to ICD-10

by Jenny J. Jackson, MPH, CPC, and Lee R. Morisy, MD, FACS

Are you prepared for the ICD-10 transition? The initial implementation deadline for the transition was October 1, 2013; however, in August 2012, the U.S. Department of Health and Human Services (HHS) released a final rule announcing a one-year delay of the implementation of the International Classification of Diseases, 10th Edition (ICD-10) to October 1, 2014.*

Health care providers throughout the nation currently use International Classification of Diseases, Ninth Revision, Clinical Modification, or ICD-9-CM. In 2009, HHS published a regulation requiring its replacement. The American College of Surgeons (ACS) encourages members to become familiar with the new code sets, understand the difference between ICD-9-CM and ICD-10, and prepare for how the change may affect their practices. Health care regulators believe that the transition to ICD-10 will have widespread effects on operational processes across health care.

What is the International Classification of Diseases?

In 2003, the Health Insurance Portability and Accountability Act (HIPAA) identified ICD-9-CM as the standard code set for reporting diagnoses and inpatient procedures. ICD is a diagnostic tool for epidemiology, health management, and clinical purposes. It permits the systematic recoding, analysis, interpretation, and comparison of mortality and morbidity data collected in different countries. It is also used to monitor the incidence and prevalence of diseases and other health problems around the world. Currently, ICD-9-CM includes both diagnosis and procedural codes.

ICD-10 is expected to be an expanded code set, including additional information for ambulatory and managed care and injuries. It also is expected to combine diagnosis and symptom codes to better define certain conditions, increase specificity through greater code length, and provide the ability to specify laterality.

Is ICD-9 obsolete?

The Centers for Medicare & Medicaid Services (CMS) states that ICD-9 is obsolete because

*All specific references to ICD-9 and ICD-10 codes and descriptions are © 2012 World Health Organization.
TABLE 1. DETECTING ICD-9 AND ICD-10 CODE SETS

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
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<tbody>
<tr>
<td>3 to 5 characters in length</td>
<td>3 to 7 characters in length</td>
</tr>
<tr>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 current codes</td>
</tr>
<tr>
<td>First character may be alpha (E or V) or</td>
<td>Character 1 is alpha; characters 2 and 3</td>
</tr>
<tr>
<td>numeric; characters 2–5 are numeric</td>
<td>are numeric; characters 4–7 are alpha or</td>
</tr>
<tr>
<td>Limited space for new codes</td>
<td>numeric</td>
</tr>
<tr>
<td>Limited code detail</td>
<td>Specific code detail</td>
</tr>
<tr>
<td>No laterality</td>
<td>Includes laterality</td>
</tr>
</tbody>
</table>

There is a belief that the terminology and classifications associated with ICD-9 are outmoded and inconsistent with current clinical practice. In addition, ICD-9 can no longer accommodate new codes that address advances in technology, new diseases, and advances in clinical practice.

Where did ICD-10 originate?
ICD-10 was endorsed by the 43rd World Health Assembly in May 1990 and came into use in World Health Organization member states starting in 1994.

What will ICD-10 identify?
Similar to ICD-9, ICD-10 comprises two categories of code sets. The first is ICD-10 clinical modification (ICD-10-CM), which providers will use in both the inpatient and outpatient setting to report diagnoses. The second is ICD-10 procedure coding system (ICD-10-PCS), which will be used in procedural coding for hospital inpatient and outpatient services.

The transition to ICD-10 will be significant and will affect most areas of a practice and, thus, its impact should not be underestimated.

How will I identify the difference between ICD-9 and ICD-10?
The difference between the ICD-9 and ICD-10 code sets may not be immediately evident. Table 1, page 42, provides an overview of characteristics to become familiar with while transitioning into using ICD-10. Table 2, page 42, provides examples of general surgery codes currently in ICD-9-CM and how they are proposed to appear in ICD-10-CM.

No, the implementation of ICD-10 does not affect CPT coding for outpatient procedures. ICD-10-PCS codes are for hospital inpatient procedures only.

What steps should I take to begin implementation of ICD-10 in my practice?
The implementation of ICD-10 will require coordination of all aspects of your practice. One of the most important first steps in the ICD-10 implementation process is to conduct a practice impact assessment, and CMS advises practices to complete this process. An impact assessment will result in awareness of the areas of the practice that will be most affected by the transition to ICD-10. It includes an analysis of how the practice will accept, process, and translate coded data under the ICD-10 system. The costs of implementation will depend on the size of the practice; the largest expenses are expected to be system upgrades and education.

Consider how ICD-10 will impact the following aspects of your practice:

- **Systems and vendor contracts:** Ensure vendors can accommodate ICD-10 needs and find out how and when the vendor plans to update existing systems. Review existing and new vendor contracts and evaluate vendor offerings and capabilities against the organization’s expectations.

- **Business practices:** Once ICD-10 is implemented, determine how the new codes will affect processes for referrals, authorizations/precertifications, patient intake, physician orders, and patient encounters.

- **Productivity:** Train staff to accommodate the substantial increase and specificity in code sets, physician workflow and patient volume changes, and the amount of time needed for testing.

- **Reimbursement structures:** Coordinate with payors on contract negotiations and new policies that reflect the expanded code sets.

The transition to ICD-10 will be significant and will affect most areas of a practice and, thus, its impact should not be underestimated. A smooth and successful transition requires proper planning and preparation. The ACS will continue developing resources for Fellows to address the implementation of ICD-10.

**Editor's note**
Accurate coding is the responsibility of the provider. This article is intended only as a resource to assist in the billing process.
Governors’ Committee on Physician Competency and Health
by Roger R. Perry, MD, MS, FACS

The Board of Governors’ (B/G) Committee on Physician Competency and Health serves the following purposes: (1) examine issues related to surgical competency, emphasizing credentialing and practice within expected community standards; and (2) promote maintenance of physical and mental wellness among Fellows of the American College of Surgeons (ACS). Thanks to the hard work of the members of the committee and outstanding leadership provided by previous Chairs, most recently Krista L. Kaups, MD, FACS, the committee has continued to address issues that affect every surgeon.

In the past, little data were available to indicate how stressors affect surgical practice. However, recent data have shown that none of us is immune to the effects of stress and the potential for burnout. The increasing demands of surgical practice—including more elderly patients with complex surgical problems, rapidly evolving technology, long hours, fewer surgeons available to take emergency room call, declining resources and reimbursements, and the decline in the general public’s overall view of the medical profession—contribute to stress. The current uncertainty about the direction of the entire health care system and the role that surgeons will play in the future are also factors to consider in maintaining mental wellness.

Member surveys
To help gather data on the current levels of stress among surgeons, the first survey of Fellows, spearheaded by Gerald Bechamps, MD, FACS, with the support of the College, was conducted in 2008. The survey was developed with the assistance of Tait Shanafelt, MD, and other physicians at the Mayo Clinic, Rochester, MN. A total of 7,905 fellows responded to the anonymous electronic survey. The results were startling. Among the most significant findings was a 40 percent rate of burnout among the respondents.1 Burnout is a syndrome characterized by emotional exhaustion and depersonalization.
surgeon burnout was associated with specialty choice (highest odds ratios in trauma, urology, otolaryngology, and vascular surgery), having children younger than age 21, number of hours worked per week, number of nights on call, and compensation based entirely on billings. Hours worked and number of nights on call increased the risk of burnout in both academic and private practice surgeons. Also of concern, nearly one-third of respondents screened positive for depression and 6 percent exhibited suicidal ideation.

Another survey of the Fellows was completed in 2010 with support of the College. Nearly 7,000 Fellows responded to this survey, which addressed interpersonal relationships, work-life balance, coping mechanisms, and substance abuse. The data showed that alcohol is by far the most widely used or abused substance.2 The rate of alcohol abuse or dependence was 15 percent among the entire group, which exceeds the rate in the general population. The rate for male surgeons was 14 percent and for female surgeons it was 25 percent. Not surprisingly, a strong association between alcohol abuse or dependence and burnout was noted. On a positive note, however, the literature has shown that surgeons who suffer from substance abuse have high rates of recovery if they participate in a structured program and agree to long-term supervised monitoring. These surgeons generally are able to return to active practice.

A new 2013 survey is due to be distributed shortly to the ACS membership, again funded through the generosity of the College. Dr. Shanafelt and his colleagues at the Mayo Clinic have again assisted in the development of the survey. This new survey differs from prior surveys in that the goal is to determine how accurately surgeons are able to assess their level of well-being and distress in comparison with their peers. The hypothesis is that physicians, and surgeons in particular, are not very good at making this assessment. Indeed, most physicians and surgeons are unable to recognize that they need help or to

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BEING WELL AND STAYING COMPETENT: CHALLENGES FOR THE SURGEON

- Introduction
- Physician personalities, stress, and burnout
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- Sleep deprivation
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make changes until a crisis occurs. This survey includes a self-assessment tool that will allow surgeons to compare their distress levels and level of well-being with a national sample of 7,000 physicians. Electronic follow-up contact will occur three to four weeks after the initial survey to see if participants have made any changes or plan to make changes based on their self-assessment. This trial will be the first conducted by the ACS, and one of the few trials to evaluate whether an electronic resource can help effect positive change.

Physician health document
The committee developed a booklet on the impaired surgeon in 1992, which was subsequently revised in 1995. Updating and revising the booklet to reflect new challenges facing surgeons today has been a major focus of the committee. Thanks to the hard work and strong leadership of Dr. Kaups, this new document, titled Being Well and Staying Competent: Challenges for the Surgeon, has recently been completed. This document is a complete rewrite and involved many hours of work by dedicated committee members, including conference calls and face-to-face meetings. This updated version is timely and addresses important physical and mental wellness topics and offers links to self-assessment tools and other online resources (see sidebar at the top of this page). Currently, Being Well and Staying Competent is available online in its entirety through the ACS Members-only portal at www.efacs.org. In addition, the *Bulletin* will periodically publish excerpts from the document, beginning with next month’s issue.

Looking ahead
The prior surveys are the source of, or have at least been cited in, a large number of publications, articles, and other documents (see bibliography,
Currently under examination are comparisons between rural and urban surgeons with respect to stressors and burnout level, and plans are being discussed to develop surveys for international Fellows. The issue of aging and competency is coming to the forefront. It is anticipated that this complex and difficult issue will necessarily be a major focus of the committee over the next few years. The new 2013 survey of the Fellows will need to be completed; the data will then be analyzed, and compared with findings from the two previous surveys. Thus far, the committee has depended on the generosity of the College for financial support. A stable funding source and mechanism will need to be developed so that the important efforts and productivity of the committee may continue.

Acknowledgments

It is important to note that the committee’s accomplishments to date are largely due to the hard work of each of the committee members, especially Dr. Kaups and Mick Oreskovich, MD, FACS. The author also acknowledges the major contributions of other prior committee members and past-chairs including Kenneth Sharp, MD, FACS; Dr. Bechamps; and John Hanks, MD, FACS.

Finally, Dr. Shanafelt and his colleagues at the Mayo Clinic must be recognized for their outstanding help with developing the surveys and analyzing the data.

BIBLIOGRAPHY (CONTINUED)

Documentation of services provided in the postoperative global period

by Linda Barney, MD, FACS; Jenny J. Jackson, MPH, CPC; Vinita M. Ollapally, JD; Mark T. Savarise, MD, FACS; and Christopher K. Senkowski, MD, FACS

Over the last year, the U.S. Department of Health and Human Services (HHS) has gradually increased its analysis of the value of global surgical packages. In particular, HHS has focused on the evaluation and management (E/M) services provided within the postoperative period, which are included in the value of the global surgical package. This article offers suggestions on how Fellows of the American College of Surgeons (ACS) may document services provided during the global period and explains why HHS is interested in the measurement of postoperative work.

What is the global period, and how do I determine the global period for a Current Procedural Terminology (CPT)* code?
Surgical procedures may be categorized as major or minor surgery. The inclusion of postoperative care services varies according to the procedure’s global period of 0, 10, or 90 postoperative days, as assigned by the Centers for Medicare & Medicaid Services (CMS). The global period for a given CPT code in the Medicare physician fee schedule is available at www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

How do CPT and Medicare define the surgical package?
CPT codes for surgical procedures typically include a variety of services. In CPT, the following services are always included in addition to the operation:

• Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
• Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical)
• Immediate postoperative care (including dictating operative note(s), talking with the family and other physicians or other qualified health care professionals writing orders; and evaluating the patient in the postanesthesia recovery area)
• Typical postoperative follow-up care

Medicare and CPT definitions differ in that Medicare also includes all additional medical or surgical services that surgeons must provide to

*All specific references to CPT (Current Procedural Terminology) codes and descriptions are © 2012 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.
treat complications during the postoperative period, except those requiring additional trips to the operating room.

**Do postoperative visits require the same documentation as standard E/M services?**

For billing purposes, postoperative visits do not require the same documentation as E/M services provided outside of the global period because no claim is submitted; it is, nevertheless, important to describe the medical necessity for the visit, including the patient’s recovery from the surgical procedure and continued treatment plan. The American College of Medical Quality defines medical necessity as “accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness, or injury.”

It is also important to document the face-to-face time spent with the patient and/or family—for example, in counseling. In addition, any diagnostic tests ordered, referrals, or consults recommended should be documented. The nature of the patient’s original presenting problem, underlying medical problems, and the severity of the original symptoms all influence the level of medical necessity and follow-up and should be documented postoperatively.

Although these reasons address the recent concerns regarding documentation for purposes of billing and valuation, it is also important to maintain thorough documentation for purposes of quality reporting efforts and to support good communication of the patient’s medical condition for the medical record.

**What should I do if only some of the postoperative visits included in a CPT code are provided?**

The surgical package was developed based on the typical case; hence, a physician may furnish more or fewer postoperative visits. In either case the global package covers the period of time for 10 or 90 days. However, the physician is prohibited from billing for E/M services in the global period, unless the service is separately identifiable—for example, related to different diagnosis.

Additionally, if you do not plan to provide any of the medically necessary postoperative visits, bill the original surgery CPT code with modifier 54 (surgical care only). The physician who takes responsibility for the postoperative visits would bill the same original surgery CPT code with modifier 55 (postoperative management only).

**How do I bill for an E/M service unrelated to the global surgical package?**

Modifier 24 (unrelated evaluation and management service by the same physician or other qualified health care professional during the postoperative period) is appended to an E/M service during the global period to indicate that the E/M service is unrelated to the surgery. For example, a surgeon performs a hernia operation that has a 90-day global period on June 15. On July 29, the patient

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The use of different methodologies for valuing the global surgical package has prompted HHS to examine whether all of the postoperative services considered part of the global surgical package are actually furnished to Medicare beneficiaries.

calls the office, concerned about a breast lump. The office visit for that service is correctly reported as an established patient visit with modifier 24 and a diagnosis of breast lump, clearly unrelated to the hernia operation. Modifier 24 is only used when the original procedure had a 10- or 90-day global period. There would be no reason to use it for an E/M service after a procedure with zero global days because no postoperative services are valued into these procedures.

What if my physician’s assistant provides services during my global period?
The ACS advises against reporting separately those services related to the surgical procedure performed by the surgeon, but provided by a nonphysician provider as part of the surgeon’s global period. However, appropriate documentation of medical necessity is required, including the patient’s recovery from the surgical procedure and continued treatment plan.

What if my fellow, resident, or intern sees my patient during the postoperative period?
The services provided by a resident or intern in a teaching setting are considered part of the global surgical package and may not be billed. However, most medical staff and hospital polices require, and the ACS recommends, that the surgeon see the patient even if the fellow, resident, or intern is involved. Postoperative care may not be abdicated solely to the fellow, resident, or intern. Additionally, appropriate documentation of medical necessity is required, including the patient’s recovery from the surgical procedure and continued treatment plan.

How is the global surgical package valued?
CMS first applied the concept of payment for a global surgical package in 1992. For each global surgical procedure, a single payment is established for the operation and related pre- and postoperative services that the surgeon provides during the global period. Global surgical packages have been valued in various ways. Typically, the global surgical package has been valued using a method known as “magnitude estimation,” which does not factor in the specific relative value units (RVUs) associated with the postoperative services in the global period. In some cases, however, the global surgical package has been valued by roughly adding the RVUs of the surgical procedure to the RVUs associated with all the pre- and postoperative services provided during the global period, based on the typical case.

Regardless of whether a global surgical package has been developed to include a typical number of postoperative services, a physician may furnish more or fewer postoperative visits. However, the physician
may not bill for E/M services in the global period unless the service is separately identifiable—for example, related to a different diagnosis.

**Why the increased interest from HHS?**
The use of different methodologies for valuing the global surgical package has prompted HHS to examine whether all of the postoperative services considered part of the global surgical package are actually furnished to Medicare beneficiaries. The HHS Office of Inspector General (OIG) published a report in 2012 titled *Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided* indicating that surgeons provide fewer postoperative services in the postoperative period than are identified in the global surgical package. The report recommended that CMS adjust the number of visits identified in the global surgical package to reflect the number of visits that actually occur.

The 2013 fee schedule indicated that the report’s finding was cause for concern. The ACS comment letter on the proposed 2013 fee schedule questioned the reliability of the OIG report, noting that an insufficient number of claims were reviewed to draw conclusions that could fairly apply to all global surgical packages. The OIG report fails to acknowledge that the number of visits included in the valuation of a global surgical package was never intended to be exact, and instead is based on an estimate of the “typical” patient and expected number of postoperative visits.

CMS also acknowledged that because surgeons are not required to document the related postoperative E/M services in the global period, documentation on the number and level of postoperative services provided is limited. Accordingly, CMS requested comments on methods of obtaining accurate and current data on services furnished as part of a global surgical package. In response, the ACS supported the process that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) established to collect data on the number and level of services provided. The RUC process values procedures based on the typical patient and typical visit. The visit data (for example, the typical number of hospital visits and office visits for a particular code) are gathered via a survey of the surgeons who typically perform the procedure. Because the RUC is a peer-review group, all specialties participate and judge the data as presented for billing purposes. Given that surgeons are not required to document postoperative services provided during the global period, the most accurate and generalizable information available is the data that the RUC collects, and this system should be retained.

At this time, CMS has not proposed to modify the current rules in a way that would require surgeons to submit claims for related postoperative services during the global period; however, given the backdrop of the HHS reports and CMS’ stated concerns, the ACS continues to encourage surgeons to maintain documentation on the medical necessity of all office visits conducted in the postoperative period.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain time, excluding holidays.◆

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Surgeons are no strangers to the elderly. As baby boomers age, older patient populations are becoming the norm for surgeons’ day-to-day practice. Recent estimates project that 20 percent of the U.S. population will be older than 65 years of age by 2030, and 70 percent of cancers and 85 percent of cancer-related deaths will occur in this population. Thus, the National Cancer Institute (NCI) has established federal policies and initiatives to encourage investigators to enroll a broader range of patients with cancer in clinical trials. Furthermore, age has become an important consideration in treatment decisions for cancer patients and their clinicians in this era of personalized medicine.

To assess the impact of federal policies on accrual patterns to cancer trials overall, our group examined patterns and predictors of enrollment in clinical trials for stage 0–IV solid organ malignant tumors within the California Cancer Registry. Less than 1 percent of the patients enrolled in cancer trials. Older individuals were less likely to be enrolled into cancer trials. Given the widening gap between the efficacy of cancer trials versus their effectiveness in real-world practice, we also assessed the overall implementation of guideline-recommended cancer care of various solid cancer sites in the U.S. in relation to demographics, including age, race, ethnicity, and geographic location. Consistently, we found that older people, ethnic minorities, and rural patients were less likely to receive guideline-recommended cancer care.

**Study examines accrual patterns**

Based on recent findings as noted earlier in this article, Z901101 is under way to closely assess accrual patterns and drop rates of older adults within a large cohort of surgical oncology trials. To gain additional insights into accrual patterns of the American College of Surgeons Oncology Group (ACOSOG), we initially compared the age distribution of individuals enrolled in select ACOSOG gastrointestinal cancer studies with the real-world setting of cancer patients, including patients at hospitals participating in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) and NCI tumor registries (see table, page 53). Fewer older adults were enrolled in ACOSOG gastrointestinal trials in comparison with those in real-world settings. Upon completion and after adjusting for other important clinical factors, we anticipate that these preliminary comparisons will show poorer enrollment patterns across other cancer sites.

**Impact on the real world**

The overarching goal of Z901101 is to improve surgeons’ understanding of current barriers to accrual of older adults into surgical oncology trials.
and to engage more surgeons in these trials. It is anticipated that Z901101 will inform future research strategies and policies in the following domains:

1. Development of future surgical oncology trials reflective of real-world experience and cancer burden distribution in the community (that is, the distribution of older adults in a new trial should match their distribution in the community).

2. Identification and mitigation of underlying factors at the level of patients, surgeons, and hospitals behind these anticipated low accrual rates in surgical oncology trials.

3. Aggressive efforts to include large health care systems, nonacademic centers, and Veterans Affairs hospitals through engagement of their surgeons who care for older patients in order to add heterogeneity to the study of performance status and comorbidities.

4. Continued assessment of whether the effectiveness of surgical oncology trials extends to a growing population of older persons. If so, we will seek to identify a subset of those within whom this benefit is observed. For example, would the benefit of perioperative systemic therapy for operable pancreatic cancer trials translate into a similar benefit in older persons in the real world?

In closing, older adults are projected to comprise a significant portion of a surgeon’s patient population. However, current surgical oncology trials are not designed to allow for widespread generalizability to their practice. Upon completion, Z901101 aims to shed additional insights into underlying barriers and stimulate future studies and policies to broaden the accrual of older adults and their surgeons in future surgical oncology trials.

**REFERENCES**


Hang ’em high

The film Hang ’Em High debuted in 1968 with Clint Eastwood starring as “Jed Cooper,” an innocent man who survives a lynching. Left for dead hanging from a tree, a stranger cuts him down and rescues him. The movie depicts a fictitious judge who mirrors the real-life legend Isaac Charles Parker, known as the “hanging judge” of the American Old West. Similar to Jed’s survival of a hanging, we also see survivors of hangman’s fractures that are typically a result of a motor vehicle crash.

Hanging was introduced as an execution technique during the invasion of the Roman Empire and has remained unchanged for the last 15 centuries.* Modifications were made to add a trap door, a standardized length of the drop, and positioning of the knot in a sub-mental location rather than a sub-aural location in an effort to make it a more humane and instantaneous process. Prior to these modifications, several unsuccessful hangings or protracted hangings that lasted until asphyxiation were reported, which explains why judges started sentencing prisoners “to be hanged from the neck until dead.”

The exact mechanism of those cases of instantaneous death was unknown until 1913, when anatomist and anthropologist Frederic Wood Jones published his work on the meticulous examinations of five cervical spines from judicial hangings, in which the knots all were placed in a sub-mental position.* The common finding was a fracture of the posterior arch of the axis caused by a violent jerk from the sub-mental knot throwing the victim’s head backwards (hyperextension) with longitudinal distraction, fracturing the axis and causing severe injury to the spinal cord, resulting in instantaneous death.

In 1965, neurosurgeon Richard C. Schneider, MD, and colleagues presented several cases of cervical fractures following car crashes.* The anatomist Gilbert Hamilton commented on the similarities between these traffic crashes and judicial hangings, and thus Dr. Schneider coined the term “hangman’s fracture.” His group extensively studied this type of fracture and noted that the third cervical vertebra forms a fixed point between the cranio-cervical junction and the lower cervical spine. Forces acting downward through the skull are distributed in three distinct vectors, and all three pass through the weakest point of the neural arch of the second cervical vertebra (axis). This occurrence leads to a fracture of the posterior elements of the second cervical vertebra, known as traumatic spondylolisthesis of the axis, or the hangman’s fracture. The injury occurs in


The NTDB Annual Report 2012 is available on the ACS website as a PDF file and as a PowerPoint presentation at www.ntdb.org.
In addition, information regarding how to obtain NTDB data for more detailed study is available on the website.
some of the judicial hangings, as noted earlier, and when the chin of an unrestrained occupant in a motor vehicle crash strikes against the windshield or dashboard, causing a violent hyperextension and compression force. Without the longitudinal distraction of a judicial hanging, the hangman’s fractures sustained in a motor vehicle collision may not be lethal. Since the term was coined initially, there have been several classification schemes based upon anatomic pattern of injury. The latest and most widely used scheme describes five variants (I, Ia, II, IIa, III) of hangman’s fractures, which help to provide clinical guidelines for management.

To examine the occurrence of hangman’s fractures in the National Trauma Data Bank® (NTDB®) research dataset for 2012, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Specifically searched was external cause of injury code (E-code) 805.02 (closed fracture of second cervical vertebra). A total of 11,514 records were found; 10,504 records contained a hospital discharge status, including 5,008 patients discharged to home, 2,784 to acute care/rehab, and 1,918 sent to skilled nursing facilities; 794 died. These patients were 50.8 percent male, on average 63.1 years of age, had an average hospital length of stay of 7.8 days, an intensive care unit length of stay of 6.3 days, an average injury severity score of 14, and were on the ventilator for an average of 8.5 days (see figure, this page). Of the 5,360 tested for alcohol, almost one-third were positive.

Advances in techniques for judicial hangings took place over the last 200 years, making it a more humane method of execution. England abolished judicial hanging in 1965, and the last hanging in the U.S. took place in Delaware in 1996. Hanging is still an option in only two states in the U.S.—New Hampshire and Washington.

Today, hangman’s fractures typically are encountered in patients involved in motor vehicle crashes. With the advent of the seat belt/shoulder harness, airbags, and headrests, automobiles now are engineered to try to prevent these injuries. However, failure to wear one’s seat belt/shoulder harness could result in a nonjudicial hanging.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. The NTDB Annual Report 2012 is available on the ACS website as a PDF file and as a PowerPoint presentation at www.ntdb.org. In addition, information regarding how to obtain NTDB data for more detailed study is available on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mmeal@facs.org.

Acknowledgement

Statistical support for this article has been provided by Chrystal Caden-Price, data analyst, NTDB.
Study shows ACS NSQIP data more useful than administrative data in tracking readmissions

A study published in the March issue of the *Journal of the American College of Surgeons (JACS)* shows that data collected through the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP*) may be more useful than administrative records in accurately tracking and evaluating information on hospital readmissions. Accurate monitoring of the causes of readmissions is becoming increasingly relevant as The Centers for Medicare & Medicaid Services (CMS) seeks to publicly report on readmission rates and has even begun withholding payment for readmissions involving certain hospital-acquired complications.

“If we’re going to try to reduce readmissions and improve care for surgical patients, we have to know why they are being readmitted,” said the study’s senior author, Karl Y. Bilimoria, MD, FACS, assistant professor of surgery and director of the surgical outcomes and quality improvement center at Northwestern University, Chicago, IL. “The CMS readmission data do not reliably offer that [information] to hospitals, and the more granular you can get with the information, the more actionable it will be locally for quality improvement and reduction of readmissions.”

Currently, more than one in 10 surgical patients experiences complications requiring hospital readmission, according to a 2012 study also published in JACS.*

**Comparisons of data**
Most hospitals use their own clinical patient records and administrative data to determine how patients fare after a surgical procedure. However, this approach has its limitations. Clinical patient records are considered the gold standard of patient tracking because the treating physician or other health care professional records the information in real time. However, internal review of patient records does not allow hospitals to compare their results with those of other institutions.

Administrative data are provided for billing purposes only and usually by someone with no clinical training. Furthermore, administrative records do not provide reasons for readmissions or indicate whether a readmission was planned or unplanned.

Hospitals participating in ACS NSQIP may review clinical patient data and compare their outcomes with those at other hospitals in the database, and in January 2011, ACS NSQIP began collecting key data on the frequency and causes of readmissions.

In their study, Dr. Bilimoria and the Northwestern research team sought to determine whether the information in ACS NSQIP accurately reflected patient medical records and how the information compared with administrative data.

**Data analysis**
The surgeons examined data on 1,748 patients in Northwestern Memorial Hospital’s ACS NSQIP database. Nearly 70 percent of the patients had operations that required a hospital stay, and nearly all came to the hospital able to function independently. Approximately 7.5 percent were readmitted within 30 days of their operations.

The investigators then assessed the accuracy of the ACS NSQIP data by comparing it with the readmission data in the patients’ medical records—a comparison that yielded a rate of 99.8 percent agreement with the patients’ charts. Only two readmissions were not captured in the ACS NSQIP data.

Additionally, two readmissions were misclassified because the patients were readmitted through the emergency department (ED), and patients who come through the ED are not always recognized as a readmission. The difference highlights the need for comparing sources of information in order to improve the quality of surgical patient care and tracking.

“Since seeing that inconsistency, we’ve been able to correct it,” Dr. Bilimoria said.

ACS NSQIP also had a 95.7 percent agreement with the patient charts on tracking whether the readmission was planned or

unplanned and nearly 80 percent agreement on the cause of the readmissions. Whereas the study found 99.5 percent agreement between the administrative data and patient charts on recording readmissions, agreement was significantly lower on the reasons behind the readmission (55.1 percent).

“Historically, the most used source of readmission data has been administrative data,” the authors wrote. However, Dr. Bilimoria said, “ACS NSQIP is as reliable as going through a chart. It’s certainly a better source than administrative data. “It’s the type of data you can use to identify opportunities for improvement,” Dr. Bilimoria added.

**Data at work**

Surgeons at Northwestern Memorial Hospital have used the data to improve their surgical site infection and urinary tract infection rates for surgical patients. “We keep an eye on all outcomes,” Dr. Bilimoria said. “If we’re average on one quality of care standard, we can recognize it and work toward becoming excellent.”

Other study participants are all affiliated with Northwestern Memorial Hospital and include Morgan M. Sellers; Ryan P. Merkow, MD; Amy Halverson, MD, FACS; Keiki Hinami, MD; Rachel R. Kelz, MD, MSCE, FACS; and David J. Bentrem, MD, FACS.

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**ACS Division of Education presents new Transition to Practice Program**

The American College of Surgeons (ACS) Division of Education has introduced the new ACS Transition to Practice Program in General Surgery. Through this program, residents making the transition to independent practice will:

- Obtain enhanced autonomous experience in broad-based general surgery
- Increase competence and confidence in clinical matters
- Gain exposure to aspects of practice management
- Experience mentoring with notable practicing surgeons
- Participate in experiential learning tailored to individual needs

ACS Executive Director David B. Hoyt, MD, FACS, offers an overview of the ACS Transition to Practice Program in his “Looking forward” column in the February 2013 Bulletin of the American College of Surgeons, available at [http://bulletin.facs.org/2013/02/looking-forward-february-2013](http://bulletin.facs.org/2013/02/looking-forward-february-2013). For additional information, contact the Division of Education at 312-202-5491 or ttp@facs.org.

The following institutions will offer the ACS Transition to Practice Program starting in July 2013:

- Gundersen Lutheran Health System, LaCrosse, WI
- Mercer University School of Medicine/Medical Center of Central Georgia, Macon
- Ohio State University Wexner Medical Center, Columbus
- University of Louisville School of Medicine, KY
- University of Tennessee College of Medicine, Chattanooga
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AMERICAN COLLEGE OF SURGEONS
Inspiring Quality: Highest Standards, Better Outcomes

100 years
ACS Board of Regents approves ACS Foundation Officers

NEW OFFICERS OF THE ACS FOUNDATION BOARD OF DIRECTORS

Dr. Stewart Dr. Daly Dr. Sharp Dr. Reiling

The American College of Surgeons (ACS) Board of Regents has approved new officers of the ACS Foundation Board of Directors for three-year terms that began in February 2013. The new officers are:

• Chair: Amilu Stewart, MD, FACS, member of admissions committee and former professor of surgery, University of Colorado Health Sciences Center, Colorado Springs; and Past ACS Second Vice-President and Chair of the Executive Committee of the ACS Board of Governors.

• Vice-Chair: Christopher J. Daly, MD, FACS, former associate professor of clinical surgery at the University of Pittsburgh (PA) Medical Center (UPMC), former associate professor with the Rangos School of Health Sciences at Duquesne University, Pittsburgh; and a past ACS Governor. Dr. Daly was an attending surgeon at several medical centers, including UPMC St. Margaret and UPMC South Side Hospitals.

• Secretary: Kenneth W. Sharp, MD, FACS, professor of surgery and vice-chair of the department of surgery, Vanderbilt University School of Medicine, Nashville, TN; and a former ACS Governor.

The ACS Board of Regents also elected Richard B. Reiling, MD, FACS, Charlotte, NC, to serve as Special Consultant to the Foundation. A Past Second Vice-President of the ACS, Dr. Reiling is the former vice-president and medical director of Presbyterian Cancer Center in Charlotte, NC, and served as clinical professor of surgery at Boonshoft School of Medicine, Wright State University, Dayton, OH.

Congratulations

FACS | Fellow
American College of Surgeons

You’re a Fellow of the American College of Surgeons.
Proudly display this honor by using the FACS designation on your business card, lab coat, website, and letterhead.

To download electronic files of the FACS artwork, go online to efacs.org and click on the “FACS Artwork” Quick Link in the lower left corner.

Questions? Contact ms@facs.org and include your Fellowship ID number in your note.

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes

100 years
Dr. David Winchester receives SSO Distinguished Service Award

David P. Winchester, MD, FACS, Medical Director of Cancer Programs at the American College of Surgeons (ACS), received the first Distinguished Service Award from the Society of Surgical Oncology (SSO) on March 8 during the organization’s 66th Annual Cancer Symposium at the Gaylord National Hotel in National Harbor, MD.

The award, created by the SSO’s executive council last September, is given to a surgical oncologist who has demonstrated outstanding contributions to cancer surgery, either through service to the SSO, research, or for enhancements to clinical care and efforts to improve the lives of cancer patients.

Dr. Winchester, who served as SSO president from 1997 to 1998, was honored for his efforts with the ACS Cancer Programs area of the ACS Division of Research and Optimal Patient Care and specifically for his leadership role in the Commission on Cancer (CoC). The multidisciplinary CoC comprises more than 50 national organizations that work together to optimize cancer care through professional and public education. The CoC is responsible for defining and establishing evidence- and consensus-based standards of cancer care and for monitoring compliance with those guidelines.

“Over the past 26 years of providing care to cancer patients and through my role with the ACS, I have witnessed tremendous progress,” Dr. Winchester said. “The College’s Cancer Programs remain dedicated to providing quality evaluation and management of patients. The SSO award is an honor for me personally, but it also is a tribute to the work of the College staff and countless professional volunteers.”

In addition to his role at the ACS, Dr. Winchester is attending surgeon, department of surgery, NorthShore University Health Systems, Evanston, IL, and clinical professor of surgery, University of Chicago (IL) Pritzker School of Medicine.

Clarification

A date was omitted from the article “What surgeons should know about...The Physician Compare website” on pages 52–53 in the February 2013 issue of the Bulletin of the American College of Surgeons (vol. 98, no. 2), available at http://bulletin.facs.org/2013/02/the-physician-compare-website/. The article should have indicated that “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 2013 patient experience of care data.”
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.
Disciplinary actions taken

The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary actions at its February 8, 2013, meeting:

• An otolaryngologist-head and neck surgeon was admonished following charges that this Fellow violated the ACS Bylaws when providing expert witness testimony in a medical malpractice lawsuit.

• Michael S. Ajemian, MD, FACS, a general surgeon from Waterbury, CT, and now residing in Abu Dhabi, UAE, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following disciplinary action by the Connecticut Medical Examining Board based on a determination that his continued practice of medicine represented a clear and immediate danger to the public health and safety.

• A general surgeon was admonished following charges that this Fellow violated the ACS Bylaws when providing expert witness testimony in a medical malpractice lawsuit.

• Joel B. Singer, MD, a plastic surgeon from Westport, CT, had his Fellowship suspended for two years with conditions for reinstatement. This action was taken following disciplinary actions by the Connecticut Department of Public Health and the Connecticut Facility Licensing and Investigations Section after multiple concerns were identified at the outpatient surgical facility that Dr. Singer owns and operates.

• Leon G. Josephs, MD, FACS, a general surgeon from North Easton, MA, had his full Fellowship privileges restored following a period of probation. Dr. Josephs met all of the conditions imposed by the Board in 2008, including the restoration of his full and unrestricted license to practice medicine in Massachusetts.

DEFINITION OF TERMS

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

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

• **Censure**: A written judgment, condemning the Fellow or Member’s actions as wrong. This is a firm reprimand.

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

• **Suspension**: A severe punitive action for a period of time, during which the Fellow or Member, according to the membership status: (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the Member’s name from the public listing and mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or Member is returned to full privileges and obligations of Fellowship.

• **Expulsion**: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
Longtime Director of the American College of Surgeons (ACS) Organization Department, John P. “Jack” Lynch, passed away March 5 at age 77. Mr. Lynch started at the College on April 25, 1977, as the Director of the Organization Department (now under the Division of Member Services umbrella) and held that position until his retirement on December 31, 2001.

“Epitome of a College staffer”
“He was the epitome of a College staffer—excellent in his work, devoted to and proud of the organization—and exemplary in his personal life,” noted David L. Nahrwold, MD, FACS, who met Mr. Lynch while serving on the Executive Committee of the Board of Governors.

Mr. Lynch worked with many levels of the Fellowship, including the Board of Governors, the ACS Chapter leaders, and members of various standing committees, according to Sally Garneski, Manager of Public Information and Electronic Publishing in the ACS Division of Integrated Communications.

“Jack was extremely well-liked by Fellows of the College, especially the Governors and the Chapter Officers. He was also well-liked by the Regents and Officers of ACS,” said Linn Meyer, former Director of the Division of Integrated Communications and currently Executive Consultant to the ACS. “He was staff to the Governors, and came to Executive Committee meetings, making sure we followed the proper procedures for the conduct of our meetings, in nominating new Governors, and managing the Governors’ committees,” said Dr. Nahrwold, Past-Chair of the ACS Board of Governors, Past ACS Regent, and former Interim Director of the ACS.

“Later, when I was Chair of the Board of Governors for two years, I insisted that I read all of the Governors’ reports and personally write the summary report to the Board of Regents. He was very patient with me and supported my deviation from normal practice, which was for the College staff to write the reports,” Dr. Nahrwold said. “He helped me put together the agenda for the annual meeting of the Governors. I was grateful that he helped me understand the culture of the College and its procedures, lessons that were invaluable to me later in my College activities.”

Dr. Nahrwold commended Mr. Lynch for his institutional knowledge and understanding of the politics in organized medicine—particularly his familiarity with The Joint Commission, the American Board of Medical Specialties, the individual medical and surgical boards, and the Accreditation Council on Graduate Medical Education.

“Delivering quality service is such a key success factor for any professional organization, and Jack directed a team that serviced all levels of the College’s membership so well, for so many years,” said Ms. Garneski, who began her career at the ACS in 1983 as an Executive Secretary in the Organization Department, reporting to Mr. Lynch. “I was fortunate to be part of that team when I first came to the College, and the experience is still continuing to serve me well 30 years later. He encouraged professional growth for College staff, and his support led me to pursue a position of more responsibility in the Office of Public Information of the ACS Communications Department a couple of years later.”

Dedication to service
Despite all of his accomplishments, Mr. Lynch is fondly remembered as humble, kindhearted, and self-effacing. “Jack was an extremely modest man. He did not seek recognition, nor did he state his views on controversial issues, I believe because he did not feel it was appropriate for him as a staff
member to influence decisions of the Fellowship,” Dr. Nahrwold said. “He never bragged about anything, except on one occasion when he said, ‘I have the greatest children.’”

“Jack was a truly good and kind person. I don’t think he had a mean bone in his body,” added Ms. Meyer.

In his retirement, Mr. Lynch volunteered at the Howard Area Community Center in Chicago, IL. Mr. Lynch wanted to better serve the low-income patients that the center assists and became a registered pharmaceutical patient advocate so that he could help patients complete their medication-related forms. He volunteered for a number of other community organizations as well, including the Evanston-Rogers Park Family Health Center and the Ignatian Lay Volunteer Corps. In July 2004, Mr. Lynch received a commendation from the Board of Commissioners of Cook County recognizing his dedication to volunteerism.

Mr. Lynch also devoted time during his retirement to reading, especially books on history, sociology, and religion, and cheering for the Chicago White Sox.

Mr. Lynch and his late wife Margaret M. (nee Gschwend) were the proud parents of six children—Terrence (Kath), Todd, Maureen (David OIF), Kathleen (John) White, Christopher, and the late Brian—and 11 grandchildren. Mr. Lynch had two siblings, Thomas Lynch and the late Nancy McGoldrick, and is survived by many nieces and nephews.
Community Surgeons Travel Awards for 2014 now available

The International Relations Committee of the American College of Surgeons (ACS) announces two Community Surgeons Travel Awards for surgeons ages 30 to 50. These $4,000 awards allow international surgeons to participate in the annual ACS Clinical Congress. Surgeons who work in community or regional hospitals or clinics in countries other than the U.S. and Canada or who are from struggling academic departments of surgery in low- or middle-income countries are eligible for the awards. Candidates from Southeast Asia will receive preference in this cycle. The office of the International Liaison must receive all applications and supporting documents for these awards before **July 1, 2013**.

Each awardee will receive gratis registration to the Clinical Congress and to one available Clinical Congress postgraduate course. The College will help awardees find affordable accommodations in the Clinical Congress host city. The 2014 Clinical Congress will take place in San Francisco, CA, October 26–30. The scholarship requirements are:

- Applicants must be graduates of medical schools.
- Age requirement refers to the date on which the completed application is filed.
- Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location following completion of all formal training (including fellowships and scholarships).
- Applicants must show evidence of commitment to high-quality surgery, surgical teaching, and improving access to surgical care in their community.
- Applicants must submit an online fully completed application form provided by the College. The application and accompanying materials must be typewritten and in English. Submission of a curriculum vitae only is insufficient.
- Preference will be given to applicants who have not already experienced training or surgical fellowships in North America.
- Applicants must submit independently prepared letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold a clinical or academic appointment or an ACS Fellow residing in their country. The letter from the chair or Fellow should directly address the applicant’s commitment to high-quality surgery, surgical teaching, and improved access to surgical care locally. Letters of recommendation should be submitted by the persons making the recommendations.
- The Community Surgeons Travel Awards must be used in the year for which they are designated. They cannot be postponed.
- Awardees must provide a written report upon their return home, specifically focusing on the value of the visit to the awardee and the potential beneficial effect to patients in the country of origin.
- Unsuccessful applicants may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

To be considered by the selection committee, applicants must fulfill all requirements. Find the application for the Community Surgeons Travel Award on the ACS website at [http://www.facs.org/memberservices/community-travel.html](http://www.facs.org/memberservices/community-travel.html).

Direct supporting materials and questions to: Administrator, International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, USA; kearly@facs.org or 312-202-5021 (facsimile).

All applicants will be notified of the selection committee’s decision in November 2013. Please submit completed applications and supporting documents early to allow time for processing.
The family and friends of the late Claude H. Organ, Jr., MD, FACS, established an endowment in 2007 through the American College of Surgeons (ACS) Foundation to provide funding for an annual fellowship to an outstanding young surgeon from the Society of Black Academic Surgeons, the Association of Women Surgeons, or the Surgical Section of the National Medical Association.

The fellowship, in the amount of $5,000, enables a U.S. or Canadian Fellow or Associate Fellow under age 45 who is a member of one of these organizations to attend an educational meeting or to make an extended visit to a chosen institution to pursue specific research interests. Applications are due June 3, 2013.

The full requirements for the Claude H. Organ, Jr., Traveling Fellowship are posted at http://www.facs.org/memberservices/organ. Application materials consist of the following items:

• An essay of up to two pages, describing why the applicant is applying for the Organ Fellowship and how it would be used
• The applicant’s current brief curriculum vitae
• One letter of nomination/recommendation from the applicant’s chair or mentor

Past awardees have used their fellowships to develop their careers in creative ways. The 2012 recipient Keith D. Amos, MD, FACS, spent two weeks at the Edinburgh Breast Unit of the General Western Hospital, in Edinburgh, Scotland, observing management of malignant and benign breast disease, surgical techniques, and ongoing clinical research projects. 2011 recipient Carla M. Pugh, MD, FACS, attended the ACS Clinical and Translational Research and Education Meeting. Melina Kibbe, MD, FACS, the 2010 recipient, participated in the Executive Leadership in Academic Management for Women program. Bridget Fahy, MD, FACS, 2009 awardee, joined the American Academy of Hospice and Palliative Medical Clinical Scholars. Patricia Turner, MD, FACS, who received the fellowship in 2008 and now serves as Director of the College’s Division of Member Services, performed collaborative research on patient history and surgical outcomes with the anesthesia outcome research group at the Cleveland Clinic.

The College expects to inform candidates and recipients of a decision by July 31, 2013. Submit questions and applications to the attention of the ACS Scholarships Administrator, at kearly@facs.org.

Apply by June 3 for 2013 Claude H. Organ, Jr., MD, FACS, Traveling Fellowship

Apply by May 10 for ACS/Triological Society Clinical Scientist Award

May 10 is the deadline for submitting applications for a competitive grant program co-sponsored by the American College of Surgeons and the Triological Society for supplemental funding to otolaryngologists-head and neck surgeons who have received a new National Institutes of Health-Mentored Clinical Scientist Development Award (K08/K23), or have an existing award with a minimum of three years remaining in the funding period as of June 1, 2013. This award, in the amount of $80,000 annually up to five years or for the remainder of the term of existing grants, will facilitate the research career development of otolaryngologists-head and neck surgeons, with the expectation that the awardee will have sufficient pilot data to submit a competitive R01 proposal before the end of the K award. Funding is dependent upon receipt of meritorious applications.

For further details, view the Triological Society’s website at http://www.triological.org/researchgrants.htm. For additional information, contact info@triological.org.
Calendar of events

**MAY 2013**

**Michigan Chapter**
May 17–18
Kalamazoo, MI
Contact: Angie Kemppainen, akemppainen@msms.org, http://www.michiganacs.org/

**Maine and New Hampshire Chapter**
May 17–19
Bar Harbor, ME
Contact: Jennifer Starkey, jennifer@executive-office.org, Maine Chapter: www.mainefacs.org, New Hampshire: http://www.nhfac.org/

**New York Chapter**
May 18
Fishkill, NY
Contact: Amy Clinton, nycofacs@yahoo.com, http://www.nysurgeon.org/

**Jamaica Chapter**
May 18–19
Kingston
Contact: David Hunter, MD, FACS, davhunter@hotmail.com

**Metropolitan Philadelphia Chapter**
May 20
Philadelphia, PA
Contact: Lauren Ramsey, ramsey@pamedsoc.org, http://www.metrophilasurgeons.org/

**Minnesota Surgical Society—A Chapter of the ACS**
May 23–24
St. Paul, MN
Contact: Nonie Lowry, nonie@lp-etc.com

**The National Accreditation Program for Breast Centers**
May 24
ACS Headquarters, Chicago, IL
Contact: Jennifer Fogarty, jfogarty@facs.org

**Florida Chapter**
May 24–25
Orlando, FL
Contact: Jennifer Starkey, jennifer@executive-office.org, http://associationdatabase.com/aws/ACS/pt/sp/FL_Home_Page

**Egypt Chapter**
May 24–May 27
Cairo, Egypt
Contact: Prof. Mohey Elbanna, MD, FACS, moheyelbanna@yahoo.com, http://www.egyptacs.net/

**Missouri Chapter**
May 30–June 2
Lake Ozark, MO
Contact: Denise Boland, bolanddd@health.missouri.edu, http://www.moacs.org/

**Austria-Hungary Chapter**
May 31–June 1
5th Annual Congress
Vienna, Austria
Contact: Albert Tuchmann, MD, FACS, info@tuchmann.at

**June 2013**

**Point/Counterpoint-Acute Care Surgery**
June 3–5
National Harbor, MD
Contact: Melissa Anderson, andersma@evms.edu

**Illinois Chapter**
June 6–June 8
Springfield, IL
Contact: Paul Pacheco, MD, FACS, pacheco7@gmail.com, http://www.ilchapteracs.org/

**Northern California Chapter**
June 8
San Francisco, CA
Contact: Christina McDevitt, nccacs@att.org, http://www.nccacs.org/

**Brooklyn-Long Island Chapter**
June 11
Garden City, NY
Contact: Teresa Barzyz, acsteresa@aol.com, http://www.bliacs.org/

**Alabama Chapter**
June 13–15
Point Clear, AL
Contact: Lisa Beard, alcollegesurgeons@yahoo.com, http://www.acsalabama.org/

**Washington and Oregon Chapter**
June 14–17
Lake Chelan, WA
Contact: Sue Lentz, sclentz@aol.com, http://www.wachapteracs.org/, http://www.oregonchapteracs.org/

**FUTURE CLINICAL CONGRESSES**

2013
October 6–10
Washington, DC

2014
October 26–30
San Francisco, CA

*Dates and locations subject to change.*