Applying SURGICAL APPS
FEATURES

COVER STORY: Applying surgical apps:
Smartphone and tablet apps prove useful in clinical practice 10
Kathleen M. O’Neill; Hampus Holmer; Sarah L. M. Greenberg, MD;
and John G. Meara, MD, FACS

RAS-ACS Symposium essays:
Residents debate pros and cons of online patient rankings 19
Maya Babu, MD, MBA

Choosing a physician in the Yelp era 20
Chandy Ellimoottil, MD; Adam O. Kadlec, MD; Ahmer Farooq, DO;
and Marcus L. Quek, MD

Patient rankings: Why patient feedback should affect our delivery of care but not our pay 22
Andrew Li, MD; Alfred Yoon; Andrew Vardanian, MD; Phuong Nguyen, MD;
Justin Sacks, MD, FACS; Chad Gordon, DO; and Reza Jarrahy, MD, FACS

Patient feedback makes us better surgeons 24
Meera Gupta, MD, MSCE

Legislated mints on the pillow 27
Ross Blagg, MD

The ACS NSQIP® Quality In-Training Initiative: Educating residents to ensure the future of optimal surgical care 30
Joseph V. Sakran, MD, MPH; Rebecca L. Hoffman, MD;
Clifford Ko, MD, MSHS, FACS; and Rachel R. Kelz, MD, MSCE, FACS

IM nailing makes basketball player’s recovery a snap 36
Devin Rose
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4|
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Looking forward

by David B. Hoyt, MD, FACS

The pace of change in health care is staggering. Public demands that health care professionals and institutions improve quality, efficiency, and cost-effectiveness grow increasingly forceful. The surgical boards continue to move forward with implementation of Maintenance of Certification (MOC) requirements. Technological advances that may require mastery of a whole new skill set continue to enter the marketplace. Sometimes the pressure to keep up can feel overwhelming.

The American College of Surgeons’ (ACS) leadership is working hard to help surgeons cope with and influence many of these changes. We are looking ahead and conducting a strategic planning process centered on four pillars: quality, education, advocacy, and member services. As we move ahead with our strategic plan, the ACS leadership and staff are using as guideposts our five core values—professionalism, excellence, innovation, introspection, and inclusion. We are approaching this endeavor with excellent communication, team spirit, and a sense of fun. This month, I provide a brief summary of the progress we are making.

The strategic view

As we have looked back at the College’s 100-year history these past months, the Fellowship was reminded that a key function of the ACS has been and remains ensuring that surgical patients receive quality care. We also learned that development of meaningful, reliable quality measures and best practices is a highly complex process with many variables, including convincing all members of the operating team that their compliance with evidence-based guidelines, checklists, and other instruments will help them to improve their outcomes. The ACS is seeking to increase surgeon involvement in quality improvement and awareness of techniques that are effective in providing high-quality care. Reimbursement and quality are likely to be linked in the future.

Another traditional area of focus for the College is surgical education, and the ACS is continually updating existing and developing new programs, courses, and processes to help surgeons engage in the educational opportunities they need to provide optimal patient care and to keep pace with MOC requirements. We also are

As we move ahead with our strategic plan, the ACS leadership and staff are using as guideposts our five core values—professionalism, excellence, innovation, introspection, and inclusion.
These times represent an opportunity to provide unprecedented leadership, if we are willing to seize it.

developing programs aimed at providing residents with the experiences they need to confidently and competently enter active practice.

As key elements of the Affordable Care Act are progressively implemented and new regulations are established, surgeons need to advocate for changes that ensure that surgical patients have access to the care they need. Surgeons and the College need to advocate for policies and legislation that will allow us to train and sustain a strong surgical workforce. And surgeons need to advocate for sensible and equitable payment policies. The ACS is strategizing for the future and developing new programs to encourage grassroots advocacy.

We have reorganized many of the activities that fall under the purview of Member Services, including the structure and expectations of the Board of Governors, in an effort to be certain that the College’s leadership can more effectively take the pulse of the Fellowship and your evolving concerns. We are planning to revitalize the Advisory Councils and chapters in the near future as well.

Staying true to our values

As I write this column, the Fellows and staff of the ACS are getting ready to conclude our Centennial celebration at the 2013 Clinical Congress in Washington, DC. Meanwhile, the U.S. Congress was shut down due to disagreements over the nation’s health care system and, more specifically, implementation of the Affordable Care Act. In light of the confusing discourse, it is more important than ever that the ACS recommit to working on behalf of our patients.

These times represent an opportunity to provide unprecedented leadership, if we are willing to seize it. Think of what our predecessors were up against in establishing the first standards for hospitals and surgical education, which we now take for granted.

As we go through this strategic planning process and begin implementing the changes we need to make, remember our five values:

• **Professionalism** is marked by accountability, honesty, responsibility, loyalty, and respect. These characteristics are inherent in all surgeons who are working to provide their patients with quality care, and in the ACS leadership’s and staff’s efforts on their behalf.

• **Excellence** involves aspiring to and working to exceed internal and external standards. It means having a can-do attitude about work. Surgeons put their all into everything they do to care for their patients.

• **Innovation** is marked by a willingness to take risks, creativity, and imagination. Surgeons are fearless problem solvers. They are remarkably curious and investigate everything, following clues as to what is causing a problem and developing new ideas about how to approach it. A surgeon with a goal will pursue it using every strategy possible until the objective is fulfilled.

• **Introspection** involves being open to feedback on how one can improve and acknowledging personal limits. As a group, the ACS can act independently with confidence as we advocate for what the evidence shows is best for our patients and our profession.

• **Inclusion** means working with our colleagues to do what is best for our patients—whether it means working with the other health care professionals on high-performance surgical teams to deliver quality care or working with other medical and surgical organizations to advocate for our patients.

We have a lot of work ahead of us as we seek to bring transformative changes to the ACS. But as long as we stay true to our values and focused on strengthening the four pillars of quality, education, advocacy, and member service, we will see the rewards. ✦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Applying surgical apps: Smartphone and tablet apps prove useful in clinical practice

by Kathleen M. O’Neill; Hampus Holmer; Sarah L. M. Greenberg, MD; and John G. Meara, MD, FACS
Smartphone and tablet applications (apps) have become an integral part of clinical practice, research, and education for many physicians. Studies have demonstrated that 85 percent of attending surgeons, fellows, and residents in the Accreditation Council on Graduate Medical Education (ACGME) training programs own a smartphone, and more than 50 percent of them use a variety of apps in clinical practice.1

From a surgical standpoint, the $27 billion mobile app market has generated apps that can do everything from surgical simulation, to procedure illustration, to provision of instantaneous access to libraries of information.2 Searching for “surgery” on the iTunes App Store brings up more than 900 related apps; the same search on Google Play delivers approximately 500 results. Navigating this veritable jungle of apps can be a time-consuming and confusing process.

What are the best surgical apps? How are they actually used in practice? Have they changed the delivery of surgical care? This article addresses these questions by examining apps for clinical practice, research, and education with the help of some tech-savvy surgeons. And how did we find these app experts? Well, naturally with the assistance of apps and by sending out messages via the American College of Surgeons’ (ACS) Twitter account (@AmCollSurgeons).

**Apps for clinical practice**

Most physicians currently in clinical practice did not have access to apps during training, yet many are finding this type of technology can revolutionize the way they practice by facilitating preoperative, intraoperative, and postoperative care. Quoc-Dien Trinh, MD, a urologic oncologist at Brigham and Women’s Hospital, Boston, MA, describes how using apps such as drawMD to explain surgical operations to patients means he no longer has to carry around cumbersome stock drawings of anatomy. Now Dr. Trinh makes personalized drawings for patients using the anatomy templates on the app and can easily e-mail these images to them for future reference.
Apps such as Evernote and Notability offer users the opportunity to write electronic notes, collect documents, store photographs, and record audio, while keeping all of this information together in a categorized searchable electronic database.

Contrary to the absence of apps during the training of most current surgical attendings, many present-day surgical trainees have never practiced medicine without them. For example, general surgery residents at the Medical College of Wisconsin, Milwaukee, are given iPads for use during rounds to access electronic health records (EHRs) and retrieve information. Apps that allow access to EHRs such as Citrix Receiver comprise a burgeoning field. Even patients have the opportunity to access their personal medical records through apps. For example, the Kaiser Permanente app allows health plan members to access their EHRs, review test results, book appointments, and refill medication prescriptions.

In addition to the availability of mobile EHRs, access to current guidelines at the point of care is a valuable advancement for trainees and clinicians. Several such guidelines in app format include the National Comprehensive Cancer Network’s (NCCN) guidelines for cancer care available via the NCCN Guidelines by Epocrates app; the American College of Chest Physicians’ antithrombotic therapy guidelines available through the CHEST app; and the Johns Hopkins ABX Guide app, which provides an impressive compilation of antimicrobial recommendations and guidelines, including some for surgical prophylaxis and treatment of surgical site infections.

Tablets and smartphones are rapidly replacing handwritten notes and pocket reference books for many trainees. Apps such as Evernote and Notability offer users the opportunity to write electronic notes, collect documents, store photographs, and record audio, while keeping all of this information together in a categorized, searchable electronic database. Similarly, trainees no longer have to tote around pocket-sized reference books as many of these are now virtual and subsequently are immediately accessible. “Of course you still have to know all the basics, but we really don’t have to keep everything in our heads anymore,” said Paula Termuhlen, MD, FACS, general surgery residency program director at the Medical College of Wisconsin, Milwaukee. “I am certain that readily accessible information will increase patient security and reduce human error.”

Edward Bender, MD, FACS, a cardiothoracic surgeon at Cape Thoracic & Cardiovascular Surgery, Cape Girardeau, MO, has been creating his own apps for the iPhone since 2007, some of which address the issues of patient security and human error. When Dr. Bender first started creating apps, none of the existing apps were particularly relevant to surgery. His first app, a risk calculator for cardiothoracic surgery called the euroSCORE calculator, uses recommendations from the Society of Thoracic Surgeons and allows for point-of-care calculation of operative risk to assist in decision making.

“Without the app, many surgeons only use the scoring system retrospectively to assess risk,” Dr. Bender said. The potential for future surgeon-created apps complementing clinical care delivery is considerable. The ACS National Surgical Quality Improvement Program (ACS NSQIP®) is in the process of developing an app for the ACS NSQIP Risk Calculator. As another example, one of many apps enabling physicians to create mobile apps for their patients that could be used to track postoperative pain medication use, vitals, inputs and outputs, and other information.3,4

Apps may also be used for operative planning and intraoperative assistance. For example, Mobile MIM is a U.S. Food and Drug Administration (FDA)-approved free iPad and iPhone app that allows viewing of numerous imaging modes including X ray, ultrasound, computed tomography, magnetic resonance imaging, positron emission tomography, and single-photon emission computed tomography when users cannot access other imaging workstations. This app, which pairs the Mobile MIM viewer with MIMCloud, a Health Insurance Portability and Accountability Act-compliant Internet server that allows users to store and share medical imag-
es, has sophisticated functions, including multiplanar reconstruction and radiodensity measurement. Images can be securely downloaded and subsequently viewed in any setting, whether during discussions with patients or in planning operations.

Surgeons are also starting to use iPads and other tablet devices intraoperatively for image viewing and operative assistance. Some surgeons, such as a group from Kobe University in Japan, place sterile covers over iPads and then use imaging software such as OsiriX to view interactive digital imaging and communications in medicine (DICOM). Thus, surgeons are able to view images on a Picture Archiving and Communication System (PACS) without needing to scrub out or leave the operating table.

Similarly, Fraunhofer MEVIS has recently created an app that takes 3D images and reconstructs the location of deep structures such as blood vessels or tumors in a patient’s liver. Not only does this capability allow for better preoperative planning, but it can also provide intraoperative support. Using an iPad and integrated camera, these 3D reconstructions can be superimposed on the liver itself during the operation, rendering intrahepatic structures “visible.” Overall, the potential for app usage in clinical surgical practice is extensive: coding assistance, dictation modalities, preoperative planning, intraoperative decision making, postoperative monitoring, guideline reviewing, EHR accessing, and radiology viewing. For a representative sample of these apps that facilitate clinical care in surgery, see Table 1, this page.

### Apps for research and literature review
In addition to influencing clinical practice, apps can have a large impact on the accessibility of journal articles. Dr. Termuhlen said she uses journal apps to stay up-to-date on the latest literature. “I read so many more articles now that I have access to them from anywhere. I bring my iPhone everywhere, and screen through abstracts whenever I have a few minutes of downtime,” she said. For keeping current on innovations in surgery, Dr. Trinh recommends Twitter’s smartphone app. By following leaders in his field on Twitter, he is able to keep up with groundbreaking scientific and clinical advances and journal articles.

### Table 1. CLINICAL PRACTICE APPS

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Cost</th>
<th>Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>drawMD</td>
<td>drawMD allows surgeons to visually explain operations to patients through drawings of anatomic images. It is available for multiple specialties including orthopaedics, general surgery, otolaryngology, vascular, urology, transplant surgery, female pelvic surgery, OB/GYN, and thoracic surgery.</td>
<td>Free</td>
<td>iPhone, iPad</td>
</tr>
<tr>
<td>OsiriX HD</td>
<td>OsiriX HD is a DICOM image viewer for iPhones or iPads that allows users to assess high-quality images both in and out of the OR.</td>
<td>$29.99</td>
<td>iPhone, iPad</td>
</tr>
<tr>
<td>Citrix Receiver</td>
<td>Citrix Receiver provides secure access to the hospital network for access to EHR.</td>
<td>Free</td>
<td>iPhone, iPad, Android</td>
</tr>
<tr>
<td>Epocrates</td>
<td>Epocrates is a comprehensive drug database that includes drug interactions, medical tables, and calculators. Similar to Micromedex, it is one of several extensive medication references. Franco and colleagues found Epocrates to be the most commonly used smartphone app among residents and fellows.</td>
<td>Free</td>
<td>iPhone, iPad, Android</td>
</tr>
<tr>
<td>Calculate by QxMD</td>
<td>This app has more than 150 searchable calculators, risk assessment, and scoring tools sorted by specialty. It was ranked as one of the top 10 free medical apps for the iPad by iMedicalApps, an organization that reviews medical and health care apps.</td>
<td>Free</td>
<td>iPhone, iPad, BlackBerry, Android</td>
</tr>
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### TABLE 2. ACS APPS*

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Cost</th>
<th>Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>American College of Surgeons Clinical Congress</td>
<td>The annual ACS Clinical Congress has its own app that allows users to access the conference schedule, create a personal schedule, search for speakers or sessions, and read the Clinical Congress News.</td>
<td>Free</td>
<td>iPhone iPad Android BlackBerry</td>
</tr>
<tr>
<td>Journal of the American College of Surgeons</td>
<td>The JACS app keeps users updated on the most important advances in surgery, allowing them to read journal articles, share articles, receive notifications on new content, and view embedded videos.</td>
<td>Free</td>
<td>iPhone iPad</td>
</tr>
<tr>
<td>Advanced Trauma Life Support (ATLS)</td>
<td>This app provides ready access to resources delineated within the ACS ATLS course.</td>
<td>Free (additional content can be purchased within the app)</td>
<td>iPhone iPad</td>
</tr>
</tbody>
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*List of apps current as of press time.

### TABLE 3. RESEARCH AND LITERATURE REVIEW APPS

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Cost</th>
<th>Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twitter</td>
<td>Twitter is a social media app that may be used to spread ideas and communicate in surgery. Users can create an account and follow the ACS, hospitals, researchers, or colleagues and join or initiate conversations.</td>
<td>Free</td>
<td>iPhone iPad Android</td>
</tr>
<tr>
<td>Docphin</td>
<td>Docphin is an app for aggregating relevant journal articles, allowing for easy scrolling through abstracts to keep current on the latest research.</td>
<td>Free</td>
<td>iPhone iPad Android</td>
</tr>
<tr>
<td>The Lancet</td>
<td>The Lancet app is one of many individual journal apps that provide access to journal articles.</td>
<td>Free</td>
<td>iPad</td>
</tr>
<tr>
<td>Read by QxMD</td>
<td>Read by QxMD allows access to full journal article text by using institutional subscriptions, providing users an interface to read and organize pertinent literature.</td>
<td>Free</td>
<td>iPhone iPad</td>
</tr>
</tbody>
</table>
Some surgeons, such as a group from Kobe University in Japan, place sterile covers over iPads and then use imaging software such as OsiriX to view interactive digital imaging and communications in medicine.

Some journals—such as the New England Journal of Medicine, The Lancet, the British Medical Journal, Plastic and Reconstructive Surgery, Annals of Surgery, and The Journal of Trauma and Acute Care Surgery—have apps that provide access to articles. The ACS has an app for the Journal of the American College of Surgeons (JACS), which allows a user to read journal articles, save articles for later, or download PDFs. (See Table 2, page 14, for an overview of all the apps offered by the College.) A user also may create a personal library of articles across journals for future reference by saving them to a file hosting service such as Dropbox, which allows customers to store documents and photos in sharable folders for instantaneous access from numerous devices, both online as well as offline.

Another valuable app for organizing and staying current on the latest research is Docphin. Docphin, similar to Read by QxMD, acts as an integrated portal to the journal article libraries of institutions or hospitals. Users save their institutional login to their device for portable access to libraries of information. With the iPad app recently launched this summer along with its existing iPhone and Android interface, Docphin allows users to browse the latest abstracts from their favorite journals, obtain alerts when articles with certain keywords are published, and read landmark papers in each field. However, as Dr. Trinh noted, apps for journal articles are still in their infancy. He hopes that eventually these apps will become more sophisticated by allowing users to publicly comment, highlight content of interest, post links, and discuss findings, thereby creating a virtual community of readers that will help inform and put new journal articles into the context of the literature at large. (For an overview of several representative research and literature review apps, see Table 3, page 14.)

Apps for education
Apps are also revolutionizing clinical education. As Dr. Termuhlen observed, “Instant access to information is more efficient, and the graphic nature of the iPad is great for surgeons since most of us are visual learners.”

Dr. Termuhlen said that iPads allow surgeons to present graphic information in an accurate and visually appealing way and anticipates the creation of atlases and maps that could revolutionize the teaching of anatomy and surgical techniques.

In terms of delivering more traditional textbook-based content, apps continue to be of limited use, and those text-based apps that do exist are often quite expensive. For example, at press time, the Sabiston Textbook of Surgery was available from the App Store for $204.99 and Zollinger’s Atlas of Surgical Operations could be purchased for $249.99. Nonetheless, apps create the opportunity for future widespread availability of interactive multimodality textbooks and learning resources.

Moving beyond traditional print textbook content, iBook Author allows users to create textbooks and other types of books for the iPad (see Table 4, page 16). These iBooks could be used for patient reference, trainee instruction, or individual review by taking text, pictures, videos, and interactive diagrams and turning them into customized textbooks. One example is the Cleft Lip & Palate Program book developed by Boston Children’s Hospital, MA. In addition to books, informational resources such as UpToDate have mobile apps of summarized, easily accessible, and searchable information that is readily available and allows for the immediate answering of questions.

More interactive educational apps range from quiz apps, including Surgery Board Weapon for the American Board of Surgery In-Training Examination and board review, to those that actually allow a user to perform simulated surgeries. Although simulation in app form is still in its infancy, simulation apps are starting to appear, such as Touch Surgery and vCath. As Dr. Bender said, ‘Apps in surgery don’t have to be dry. They can be ‘game-ified,’ or made fun in the form of a contest or a game.” An example is the Are You Smarter than Your Attending? app, which was a medical quiz app offered in 2012 by CVOffice—a developer of mobile applications for health care professionals—presented in collaboration with the American Association for Thoracic Surgery. The quiz questions were writ-
ten by the American Board of Thoracic Surgery, and at the end of the 10-week competition two winners were awarded a free journal subscription and free meeting tuition.

The College offers an educational app, MyATLS, to complement and build upon the Advanced Trauma Life Support® (ATLS®) course. Available for use on an iPad or other tablets, it allows users to access key resources, including algorithms, calculators, and video, regarding trauma care. In addition, there is an informative, yearly app for the annual ACS Clinical Congress that includes scheduling capabilities, session descriptions, room locations, and more.

Apps are also being used for case and knowledge assessment. Jonathan P. Fryer, MD, FACS, assistant professor of surgery at Northwestern University’s Feinberg School of Medicine, Chicago, IL, described how the faculty at that institution use an iPhone app to assess residents’ levels of autonomy and skill in the operating room based on resident self-assessment and attending evaluation.

For attending surgeons, apps could provide opportunities for continuing medical education (CME). Although existing apps such as Epocrates CME and MedPage Today offer alternatives for fulfillment of medical CME requirements, they currently offer a paucity of surgery CME opportunities. However, the potential for future interactive surgical education and assessment tools is great.

Some surgeons believe something is lost when a user switches from a paper format to digital. Luke Selby, MD, a general surgery resident at North Shore Long Island Jewish Health System, NY, described how apps can be ideal for quick and immediate references during the day, but how reading large chapters or articles can be hard on an iPhone. “It’s great for looking up quick facts, but I don’t like to read textbooks or articles on the iPhone,” he said. “I know that some read on their iPhone or iPad, but I definitely still prefer books.”

Apps can affect education outside the U.S., as well. Robert Riviello, MD, director of global surgery programs at the Center for Surgery and Public Health at Brigham and Women’s Hospital, Boston, said that putting textbooks and teaching materials onto iPads could be a cost-effective way to bring these materials to resource-poor settings and aid in clinical education abroad. Health eVillages is already engaged in these types of efforts. The not-for-profit organization provides tablet computers with custom-made educational apps to support health professionals in selected low-income countries.

Apps may also be an effective means of communication in low-resource settings. Milind Chitnis, MD,
The College offers an educational app, MyATLS, to complement and build upon the ATLS course. Available for use on an iPad or other tablets it allows users to access key resources, including algorithms, calculators, and video, regarding trauma care.

Concerns

Although apps may add much to clinical education and health care delivery, several issues must be taken into consideration as they are incorporated into surgical practice. To begin, there is little to no oversight over the quality of the medical information apps provide, nor is there a medical, surgical, or government body that offers validation or approval of content unless the app is considered a medical device. For mobile apps that meet the criteria of medical devices and that could create risks to patient safety if they did not function correctly, the FDA has created a guidance document to delineate its regulatory authority. These regulations only apply to those apps that meet the definition of a medical device and are used either as an accessory to a regulated medical device, or transform a mobile platform into a regulated medical device. For mobile medical apps that meet this criteria, manufacturers have to satisfy requirements previously associated with the applicable device classification, including such factors as registration, quality system regulation, and labeling.

A recent article by Connor and colleagues showed that only 35 percent of hernia apps had identified medical professional involvement in their design or content. Similarly, a recent article indicated that most apps related to weight-loss surgery were developed without any health professional guidance or input.

As Dr. Trinh noted, the Apple Store screens for technical bugs but does not allow for rigorous peer review to guarantee the quality of the medical content. “The apps industry is the Wild West,” Dr. Bender added. “There is no peer review process, and it isn’t likely that we will have one any time soon since developers can just make disclaimers to avoid taking responsibility for the contents. Of course, each app must comply with Apple’s rules, ensuring that no copyright laws are broken or inappropriate content included, but it’s up to the user to be suspicious about their

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sources of information.” Dr. Bender suggests that professional societies like the ACS could play a key role in ensuring high-quality apps are identified and used in the future.

In addition to concerns regarding content, apps often contain advertising that allows companies to directly target physicians, potentially indirectly influencing prescribing and treatment practices. Connor and colleagues reported that 96 percent of the apps evaluated could be tied to commercial interests or links.13

Apart from verification concerns regarding content accuracy and the external or commercial influences of some surgical apps, Dr. Bender also warned users about the possible hazards of blind reliance on apps. “We must never forget the immeasurable variables of the patient-doctor relationship,” he said, reaffirming that “the calculator is just one of our tools.”

**Conclusion**

Applications for smartphones and tablet computers have permeated many areas of surgical practice including health care delivery, education, and literature review. Some surgeons have found creative ways to integrate apps into their surgical work. At the same time, however, potential areas of concern regarding apps use in surgical care remain. As the world of apps continues to expand and become more innovative, it is important that the surgical community investigate different ways in which apps can complement the profession while continuing to be mindful of the ways in which they influence clinical practice. ◆

**Authors’ note**

Tables 1, 3, and 4 show representative lists of apps for surgeons in the categories of clinical practice, research and literature review, and education. These lists were developed by the authors based on information from the interviews featured in this article as well as review of the literature.

**REFERENCES (CONTINUED)**


Each year, the Resident and Associate Society of the American College of Surgeons (RAS-ACS) hosts a symposium at the Clinical Congress featuring a debate on a timely issue in surgical training or practice. The Issues Committee of the RAS-ACS solicits a list of topics from residents, fellows, and attending surgeons from across the country.

In addition to the symposium debate, the Issues Committee coordinates an essay competition open to all RAS members. The top “pro” and “con” essayists are invited to serve as panelists at the symposium, and the second-place pro and con essays are featured in the Bulletin. This year, the Issues Committee had a tie for second place in both categories.

Our topic for this year’s symposium and essay competition was Patient Rankings: Should Patient Feedback Affect Our Pay and Delivery of Care? The number of online websites that post patient feedback and reviews after surgeon encounters has exploded in recent years. Survey instruments, such as the Hospital Consumer Assessment of Healthcare Providers Survey, request patient feedback on multiple aspects of hospitalizations and physician-patient interactions and will soon be tied to payment as part of health care reform.

What role do patient rankings play in improving care? Should existing methods for obtaining patient feedback (online, surveys, and so on) be tied to surgeon payment? These questions and others are addressed in the following essays.

by Maya Babu, MD, MBA
Choosing a physician in the Yelp era

In early 2013, my sister gave birth to twins in Austin, TX, and I made plans to visit soon thereafter.* Born at 37 weeks gestation, the babies were healthy and were discharged from the hospital on schedule. By day five, they were scheduled for their first visit with the pediatrician, and I agreed to accompany my sister to mitigate any anxiety about visiting a new physician.

The appointment went smoothly. A friendly staff person greeted us, we did not wait long, and the office was clean. The pediatrician examined my sister’s twins and explained that their slight weight loss was within the normal range; otherwise, they were growing as expected. He was confident, had good bedside manner, and gave us specific, clear instructions about feeding, sleeping habits, and potential problems.

My sister was new to the Austin area, so I wondered how she had selected him among hundreds of other local pediatricians. She said that she chose him after reading what several patients wrote on Yelp.com, a user-based review website of local businesses and services. I was not surprised by this revelation in light of what I learned in the process of writing a recent manuscript on online physician reviews.¹ I explained that physicians often have only a few reviews available on websites like Yelp, and it is unclear whether the sites accurately reflect health care professionals’ skills or expertise. She then asked a simple question: “Well, how do you suggest I find the best pediatrician in Austin, Texas?” Despite being a physician and health services researcher, I did not have a simple answer.

Growing trend

In medicine, the “best” is difficult to define. One could argue that performance level may be determined by reputation, years of experience, patient satisfaction, or a predetermined quality metric, such as clinical process or outcome measures. The government, insurers, professional organizations, and for-profit companies have tried to determine the best mix of these variables. The problem is that the average health care consumer does not know what validated metrics are or where to find them.

On the other hand, physician review websites (PRWs), with user-generated ratings, are easily accessible to anyone with minimal Internet experience. Considering that Yelp recently announced 108 million unique views in the second quarter of 2013, it is clear that online reviews represent the latest step in the evolution of word-of-mouth marketing.¹ Given the prevalence of informational asymmetry in the health care system, it is natural for patients to seek reviews about their health care providers. In response to this demand, PRWs have rapidly multiplied.

Even though many health care practitioners do not want to be rated on a PRW, most are, in fact, ranked or have their basic information featured on at least one site.² According to recent data from the Pew Research Center (PRC), 20 percent of Internet users have visited PRWs, but only 2 or 3 percent have submitted reviews.³ A recent poll by the University of Michigan Health System, Ann Arbor, found that 25 percent of parents (n=2,137) consider online ratings a very important tool when finding a pediatrician.⁴ Furthermore, 30 percent of these parents selected a pediatrician based on favorable online ratings, whereas 30 percent have also ruled out a physician because of poor ratings.

These numbers may not seem impressive in comparison with the recent Yelp announcement or with the PRC finding that 80 percent of Internet users have read online reviews for product or service information. Still, it should be assumed that PRWs and their users will continue to grow. Jha and colleagues demonstrated that physicians assessed on RateMDs.com (one of the earliest PRWs) escalated from 2,475 in 2005 to 112,024 in 2010.⁵

Although the potential for increased use of PRWs exists, the research remains limited, as outlined by the following questions:

*Editor’s note: In this article, the first-person references are those of Dr. Ellimoottil.
The merits of these sites may be debatable, but as more patients are drawn to PRWs, physicians and professional organizations will be challenged to eventually accept them or provide an alternative that is just as accessible, understandable, and applicable to all physicians.

Do patients use PRWs to gather facts (such as a physician’s office location and hours) or subjective information?

Do PRWs affect how patients select a physician?

Do the reviews affect patient perceptions about a physician with whom they have a longstanding relationship?

For other products and services, studies have shown that online reviews play an important role in consumer behavior. It is unknown at this point if these online reviews also relate to how patients respond to physicians.

The arguments for and against PRWs are straightforward. Advocates contend that PRWs represent the patient’s experience, yield physician feedback, and use easy-to-understand metrics. Critics, however, maintain that these websites are unreliable for the following reasons: they feature too few reviews, the authenticity of the reviews is unverifiable, the information may be inaccurate or outdated, and patient complaints may be associated with factors that are out the physician’s control or unrelated to clinical competence, such as rude office staff.

Although PRW metrics are less than comprehensive and may be inaccurate measures of physician skill, these sites have successfully accomplished what government agencies and professional organizations have been unable to do—broadly disseminate user-friendly, search engine-optimized information on physician quality. The merits of these sites may be debatable, but as more patients are drawn to PRWs, physicians and professional organizations will be challenged to eventually accept them or provide an alternative that is just as accessible, understandable, and applicable to all physicians. Despite millions of dollars in grant funding directed toward developing instruments to measure quality, no alternative to the PRW currently exists. Although outcomes research is certainly important, without wide public dissemination of results by researchers, the private market will maintain a stronghold in this domain. If no alternative is developed and current PRWs gain greater acceptance over time, more patients may be encouraged to submit reviews, thereby creating larger samples and potentially more reliable reviews.

Regarding my sister’s initial question, I decided to use several popular PRWs to look up pediatricians in Austin, TX. The top-rated group had only 14–20 reviews. I asked if she was happy with her current choice, and she confirmed that she had no plan to switch. Relieved I did not have to make a decision that could potentially affect the twins’ health for the next 18 years, I turned my attention to a less critical issue: namely, where to eat dinner. With little hesitation, we picked the best Tex-Mex restaurant around—the one with 598 positive reviews on Yelp.
Patient rankings: Why patient feedback should affect our delivery of care but not our pay

by Andrew Li, MD; Alfred Yoon; Andrew Vardanian, MD; Phuong Nguyen, MD; Justin Sacks, MD, FACS; Chad Gordon, DO; and Reza Jarrahy, MD, FACS

At our core, surgeons are physicians, not technicians. Stedman’s Medical Dictionary defines a surgeon as a “physician who specializes in surgery.” As physicians, we are healers. In fact, the word “physician” is derived from the word “physic,” which in turn comes from the Old French word “fisike” from about the 12th century, which refers to the concept of “natural science and the art of healing.” Historically, the ill have placed tremendous trust in their healers, for better or for worse. What might not be readily apparent, however, when considering what defines a physician is the important role that healers play as educators.

Closer inspection reveals that medical and surgical practice and education within the U.S. are similar fields. Both involve a special relationship between an educator (physician/teacher) and a learner (patient/student). Importantly, both continue to face challenges regarding cost-effectiveness and performance evaluation. The crux of the issue lies in the idea that the learner has the ability to provide critical feedback that may enhance educator performance. This suggests that the learner and educator can switch roles—an idea not often acknowledged in either field. This article addresses how patient feedback should be incorporated into the delivery of quality health care and how education reform is helping to set a preliminary example for medicine to follow.

The educator-learner relationship

The task of a teacher partially relies on the quality of information that he or she brings to the classroom. Just as crucial is the method by which the teacher delivers that information to the students. A teacher with a wealth of knowledge who cannot speak the language of the students will invariably fail at his or her task. Conversely, a communications expert with no knowledge of basic science will have minimal success in teaching chemistry. Therefore, if either the quality of information or the method of delivery is poor, the successful development of the teacher-student relationship will suffer. Similarly, with each patient encounter, a physician must not only possess an impressive fund of knowledge, he or she must also effectively convey that information to the patient, such as explaining the meaning of a diagnosis and the treatment plan. This challenge is compounded by the limited time allotted for these patient encounters as well as the frequently tense environment that often accompanies someone who is ill, uncomfortable, and anxious.

In the last 10 years, education reformers across the U.S. have been redoubling their efforts to improve teaching quality, and for good reason. In a report comparing 12 countries, including the UK, France, Japan, and Canada, the U.S. took a significant lead over others in the amount spent on education per school-age child. However, of the 12 countries surveyed in this report, the U.S. ranked only ninth and 10th in standardized science and mathematics scores, respectively. Similarly, the U.S. is the leader in the amount spent per person on health care costs compared with all the other member nations of the Organisation for Economic Co-operation and Development (OECD), a conglomerate of 34 nations. Yet in a recent National Institutes of Health-sponsored study, when compared with 17 other wealthy nations, the U.S. occupied the bottom of the list in nine measures, including infant mortality, heart and lung disease, sexually transmitted infections, and adolescent pregnancies. What these rankings suggest is a discrepancy between the amount spent on education and health care and the measured outcomes in these two areas. Although the factors contributing to these discrepancies are innumerable, there is good logic in studying the relationship between the educator and learner, for it is this relationship that essentially defines the practice of both medicine and education.

Evaluating performance

Recently, debates have been waged regarding the use of student performance and standardized test scores to evaluate the effectiveness of teachers. However, while test scores may indicate whether a school system is suc-
Better communication has also been correlated with improved patient outcomes, including measures such as blood pressure, blood glucose levels, and emotional health.

References


Surgeons pride themselves on rigorous training, discipline, and sacrifice in order to provide quality care to their patients. However, they may lose sight of the fact that therapeutic success also depends on patients’ willingness to accept surgeon education along with their own discipline and sacrifice to put the knowledge into practice. Effective communication is a key component that unifies the physician and patient, allowing each to learn from the other.

Need for further study

Overall, patient feedback for surgeons is vital in that it provides an opportunity for a surgeon to improve on multiple levels. However, its role in physician reimbursement should depend on whether positive patient feedback correlates with better patient outcomes, and this must be validated by future research.

NOV 2013 BULLETIN American College of Surgeons
Patient feedback makes us better surgeons

by Meera Gupta, MD, MSCE

The assessment of surgical resident accomplishment is based on attending performance appraisals, standardized tests, and the evaluation mode in training modules. Residency remains an apprenticeship, where classroom teaching and on-the-job training on hospital wards and in operating room theaters optimizes clinical skills. Resident experiences with timely teaching concepts such as quality improvement, patient safety, high-value/cost-conscious care, and patient centeredness are limited, as these topics have not yet fully emerged in the core surgical residency curriculum.

Patient-centered care

Patient feedback surveys of hospitals and providers such as Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS) rarely play a role in the process of resident education and evaluation because a patient’s hospital “retail” experience is viewed as a low priority for a typical resident. In fact, the average resident time spent with a surgical patient on morning rounds is 2.7 minutes. This period includes entering the room, discussing overnight events, examining the wound, changing dressings, and delivering the care plan. Not surprisingly, teams solicit questions from patients only 7.7 percent of the time. When asked about their hospital experience, patients report lack of time with residents, fragmentation of care among teams, poor communication with patients/family members, lack of appropriate explanations of the care plan, and the need for better patient-centered care among hospital staff. As a result, newly minted surgeons will enter a world of patient-dominated feedback and public reporting but lack the skills to handle it.

Patient-centered care is not a novel concept. In physician and educator Lewis Thomas’ autobiography The Youngest Scientist: Notes of a Medicine-Watcher the author describes the physician’s focus on diagnosis, discovery, and identification of effective treatments. In 1937, Dr. Thomas observed, “If being in a hospital bed made a difference, it was mostly the difference produced by warmth, shelter, food, and attentive, friendly care, and the matchless skill of the nurses in providing these things. Whether you survived or not depended on the natural history of the disease itself. Medicine made little or no difference.”

Dr. Thomas recognized that the most important focus remained with the patient experience, with successful health care delivery achieved through engagement, communication, and empathy. The struggle to balance the multiple aspects of patient care has existed for decades, and many patients have provided recommendations over the years on how to improve health care delivery. Most of this advice was useful, identifying actionable items and opportunities for improvement while also protecting surgeons from overexposure.

Public reporting

Today, patients have a voice through publicly reported surveys and unregulated social media (Facebook, Twitter, HealthGrades.com, and others), which allow users to compare and evaluate surgeons in a Web-based setting.
Many physicians have received patient feedback for decades and now receive reports on outcomes but have done little to change the way they deliver care.

In the near future, patient feedback may be used as a measure of health care quality, which will affect our reimbursement and quite possibly the sustainability and viability of our surgical practice. In 2001, the Institute of Medicine (IOM) report Crossing the Quality Chasm provided six core aims for quality. In response to the IOM’s recommendations, surgeons now report on several of these measures such as surgical site infections, the Centers for Medicare & Medicaid Services’ Surgical Care Improvement Program measures, and Agency for Healthcare Research and Quality patient safety indicators. Many physicians have received patient feedback for decades and now receive reports on outcomes but have done little to change the way they deliver care. Instead, they continue to shy away from the aim of providing patient-centered care.

Now, in a health care environment in which transparency in performance is expected, financial incentives are associated with improved quality measures over public reporting alone. Therefore, internal and public reporting has proven to be an insufficient catalyst for change. Financial incentives are now driving the profession to shift its focus. We have seen successful industries achieve satisfaction, promotion, and loyalty from their customers. In doing so, Virgin Airlines, for example, has secured its financial stability, reduced marketing costs, and avoided lawsuits. By adopting similar strategies, the health care industry will undoubtedly see similar benefits. Patient feedback informs these strategies and leads to improvements in health care quality, justifying use of patient feedback to motivate better delivery of care and reimbursement.

However, scorn and resistance to patient feedback systems are strong and many physicians believe that the process is flawed for the following reasons:

- A single negative review may dramatically change a percentile ranking
- Response rates are low (~26 percent)
- At least 30 surveys in one period are necessary to draw meaningful conclusions
- Only angry people respond to surveys
- Surveys are delayed by 30 days from discharge
- Patients don’t accurately recall their experiences

REFERENCES


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Due to the fact that supportive evidence is low, physicians have become resistant to the idea of bringing the patient experience into his or her practice.

These are just a few of the commonly held beliefs among health care providers regarding patient feedback systems. These views are mostly supported by anecdotal information, and research that validates these views is minimal. Studies that attempt to link patient satisfaction with cost, quality of care, and outcomes are also conflicting.

**Health care consumerism**

Through standardized surveys that focus on waiting times, pain management, and communication skills, the “government has fully embraced the ‘patient is always right’ model, betting that increased customer satisfaction will improve the quality of care and reduce costs.” Due to the fact that supportive evidence is low, physicians have become resistant to the idea of bringing the patient experience into his or her practice. Perhaps this resistance is due in part to shortcomings in our understanding of how high-quality health care is related to the patient experience and health-related outcomes. Health care providers struggle with trying to please patients who may receive the best medical care but may not have retail-level satisfaction, and vice versa. Surgeons may resort to pleasing the patient for better scores by over-treating, performing extraneous tests, and even providing them with Vicodin “goodie bags” on their way out the door. This behavior is not the right solution.

Catherine Lee, vice-president of service excellence at McLeod Regional Medical Center, comments, “We are really good at caring about what you think of us. We are not good at caring about what you actually think,” resonating to the fact that the content behind rankings is most important, yet we repeatedly fail to use it to drive improvement. The focus on patient centeredness has been insufficient, but incredibly beneficial with serious contributions to safety in recognizing and responding to challenges such as literacy and management of disease.

Patients are physician educators and serve as facilitators for change in health care delivery. We have demonstrated that with a powered sample and timely set of results, most hospitalized patients are pleased, offer constructive feedback in real time, provide us with opportunities to improve care, and fuel physician communication curricula; physician HCAHPS scores reflect this change. Patient feedback and reviews are not unreasonable, standardized surveys are not to blame, and financial incentives are essential to secure our practice.

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In the 19th century, Florence Nightingale began collecting data to evaluate medical outcomes. Using data to improve surgical outcomes has since vastly improved quality of care. Recently, patient satisfaction data have been made available to the public and are now being collected using the Hospital Consumer Assessment of Healthcare Providers Survey (HCAHPS), a government-run evaluation centered on the following topics: communication with physicians and nurses, hospital staff responsiveness, pain management, communication about medicines, discharge information, hospital cleanliness, and hospital quietness. With health care reform, such survey results will affect hospitals, and thereby surgeon reimbursement. Hospitals are at risk of losing up to 2 percent of their funding by 2017.

Like many idealistic, well-intentioned endeavors, these surveys have real-world consequences. Altering pay based on subjective surveys will increase costs to the medical system with no evidence that these surveys will improve the quality of care.

Subjective factors
According to Jean Moody-Williams, Director of the Quality Improvement Group, Centers for Medicare & Medicaid Services, “The majority of (survey) measures...have to do with communication...things that are universal regardless of the state of your facility.” But in fact, HCAHPS responses are not universal. A major dilemma in citing satisfaction as a reliable measure is that the patient population is vastly diverse. People interpret questions differently and have varying criteria for what determines a desirable hospital experience.

Researchers found significant disparities in HCAHPS ratings related to race, ethnicity, and socioeconomic status. Others found that not only were there significant differences in ratings between Hispanic and non-Hispanic patients, but there were significant differences among Hispanics depending on their country of origin. The mode of survey further complicates results. Anastario and colleagues found that modes of surveying that increase the proximity of respondents to the interviewer/visit produce more favorable results (for example, telephone/handout surveys are more favorable than mail-in). The very fact that there is a difference in results among these survey modes raises the question of their validity.

Where’s the value?
The Institute of Medicine (IOM) defined quality as the “degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the current professional knowledge.” In our current health care market we aim to achieve value, which is a function of increased quality and decreased cost. However, using HCAHPS to alter pay actually increases costs without evidence that it improves quality. According to Kevin Slave, chief executive officer of East Orange Hospital in New Jersey, the facility has “some of the best infection-control outcomes...but if you looked at the equipment and furniture, it maybe is not as shiny and new as in a suburban hospital.” East Orange Hospital has begun upgrading its televisions to flat screens to lift scores. Grady Memorial Hospital, Atlanta, GA, reportedly invested approximately $4 million on upgrades in an effort to raise its survey scores. Collecting and analyzing the survey data is also expensive and requires trained personnel.
In our current health care market we aim to achieve value, which is a function of increased quality and decreased cost. However, using HCAHPS to alter pay actually increases costs without evidence that it improves quality.

Such increased resource use has not been shown to improve desired health outcomes. To the contrary, a study published in the Archives of Internal Medicine showed that the most satisfied patients actually had a 44 percent higher mortality rate. The most satisfied patients also spent 9 percent more on prescription drugs and had an 8 percent increase in overall health care spending in comparison with less satisfied counterparts.10 Although many physicians already have trouble denying patient requests, linking patient satisfaction to pay may increase the use of imaging studies, prescription drugs, and other tests not medically warranted but that patients demand, thereby increasing defensive medicine and overall system utilization.11

Satisfaction, not quality

Adoption of the mantra that “the customer is always right” in medicine can have serious consequences that extend beyond added costs. For example, a patient or his or her family may not understand the need for early tube feeding, ventilator support, noisy oxygen saturation alarms, or aggressive respiratory/physical therapy, but withholding any of these in hopes of better comfort could be detrimental. Although the IOM definition of quality encompasses outcomes “consistent with the current professional knowledge,” a 2004 poll found that respondents cared more that their physicians listened to their concerns and questions than whether their physicians were up-to-date on the latest medical research and treatment.8,12 This further illustrates the difficulty in equating patient satisfaction with quality of medical care.

It is also important to note that monetary incentives to provide quality patient care already exist. Good patient relationships decrease lawsuits.13 Patients can choose providers based on widely available Internet ratings, and surgeons must provide good interpersonal care to maintain business. Personal recommendations

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Although many physicians already have trouble denying patient requests, linking patient satisfaction to pay may increase the use of imaging studies, prescription drugs, and other tests not medically warranted but that patients demand, thereby increasing defensive medicine and overall system utilization.

have shown to be 2.6 times more likely to influence a purchase in health care than in other industries.\(^\text{14}\)

Adjusting pay based on HCAHPS results has been touted as a means for transforming patients into consumers in a free-market economy—so let us consider this concept’s applicability to other consumer markets.\(^\text{3}\) If my heating repair technician tracks mud through my house, can I decide to slash payment even though my heat is fixed? No. I have the option of reporting it, or I can leave a negative online survey, but I cannot reduce payment after the service has been rendered. In a free-market economy the consumer’s power is that he or she has a choice, not a tail-end regulation.

In an age of evidence-based medicine, I question how a policy can be enforced with such a paucity of evidence that its implementation will improve health care value. HCAHPS is only a part of the current health care reform’s pendulum swing, and similar to many paradigm shifts, the swing will likely overshoot before eventually settling on a rational solution.

In The Icarus Deception: How High Will you Fly?, Seth Godin writes, “When we humanize the person at the other end...we grant them something precious—personhood.”\(^\text{15}\) As physicians, we have felt that connection with our patients. It is always unique and cannot be contrived. It is an experience in humanity that should never be disparaged. For government to legislate exactly what factors lead to that immeasurable connection taints the physician-patient relationship with impersonal checkboxes, while adding costs to an already expensive and complex medical system with no evidence that it will increase value in American health care. ◆

REFERENCES (CONTINUED)


On this, the 100th anniversary of the founding of the American College of Surgeons (ACS), the surgical profession finds itself at a pivotal moment in history both for the College and the U.S. health care system. The national emphasis on quality improvement and patient safety has set the stage for the next 100 years of ACS efforts to improve the standards of care for the surgical patient. As regulatory criteria have become more stringent due to an increasing public demand for better outcomes, higher efficiency, and lower resource utilization, it would behoove surgeons to understand and influence the measurement of surgical quality and the standards proposed to achieve exceptional clinical results.

For surgeons to maintain a stronghold on the performance metrics set forth on behalf of our patients, we must fully understand how quality is measured and how to evaluate our own performance as well as that of our service lines and hospitals. Surgeons must be well-versed in quality science and engaged in quality improvement initiatives to keep these efforts relevant, effective, and focused on the unique needs of surgical patients.

To date, quality improvement knowledge is not well-integrated into surgical education, yet the fundamentals of quality science and the associated...
skills are increasingly essential for a successful career as a surgeon. Given its 100-year experience in measuring, analyzing, and improving surgical quality, the ACS is well-positioned to bolster this important endeavor now and in the future by making it easy to incorporate quality science into surgical education. With this objective in mind, the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) launched the Quality In-Training Initiative (QITI) at the 2011 annual meeting.

100 years of quality improvement

Surgeons have been informally leading the way to quality improvement in health care outcomes for more than a century, ever since Ernest Amory Codman, MD, FACS, a Boston, MA, surgeon, recognized that to improve hospital conditions, those institutions needed to track patients after delivery of care to ensure that their treatment was effective. The concept became known as the “end-result idea” and laid the foundation for the ACS’ development of the hospital standardization program in 1917.1,2 At the time, Dr. Codman’s idea was controversial to say the least; however, he had the insight to realize that fulfillment of his vision would be years in the making.

The ACS led the effort to ensure that hospitals met at least the five minimum standards for accreditation established through the hospital standardization program. Eventually, the hospital survey and accreditation program grew so large that the ACS joined forces with the American Medical Association and other health care organizations to form the Joint Commission on Accreditation of Hospitals (now known as The Joint Commission) in 1951.3 As time went on, the unstructured peer-review method began to transform into an objective outcome-driven process. In 1966, Avedis Donabedian, MD, published his landmark article “Evaluating the quality of medical care,” which gave a general definition of quality while at the same time proposing a structure-process-outcomes model to measure quality.4 The Joint Commission adopted a more rigorous standard based on this model in the 1980s.

In the late 1980s, the U.S. Congress began cracking down on the Department of Veterans Affairs (VA) with respect to the quality of surgical care provided in the nation’s 133 VA hospitals. The disparity in the operative mortality rate between VA hospitals and the private sector hospitals led Congress to pass P.L. 99-166, which mandated that VA hospitals provide annual risk-adjusted surgical data comparing VA outcomes with national standards, thereby paving the way for the development of the National VA Surgical Risk Study. With the implementation of the study in 44 VA hospitals from 1991 to 1993, the ability to provide comparative measurements in surgical quality across hospitals for multiple procedures became a reality.5 As the rest of the VA hospitals began to recognize the utility of such a database, the National Surgical Quality Improvement Program (NSQIP) was born and implemented in all VA medical centers.6

As the rate of morbidity and mortality began to plummet in VA medical centers, the private sector took notice.7 A pilot program was initiated in 1999 at three nongovernmental medical centers (Emory University, Atlanta, GA; University of Michigan, Ann Arbor; and the University of Kentucky, Lexington) to demonstrate that NSQIP’s comparative measurements in surgical quality could be applied in private sector hospitals. Shortly thereafter, in 2001, a critical mass of private sector hospitals interested in NSQIP teamed up with the ACS to complete the private sector study in 18 hospitals. The collaboration was supported by the Agency for Healthcare Research and Quality (AHRQ) with the goal of achieving prior findings of comparative measurements of surgical quality within private hospitals.

Since the College’s inception, quality of surgical care has been one of the core guiding principles of the organization (see timeline, page 32). The continued success of the NSQIP within the private hospitals resulted in the ACS rolling out the program nationwide in 2004, and the formalization of the modern ACS NSQIP. As of July 2013, more than 500 hospitals are enrolled in ACS NSQIP, and the program has become recognized as the most valid and reliable national surgical outcomes data registry available.8

QITI
A new generation of young surgeon leaders in quality improvement (QI) already exists. In fact, some surgeons are opting to acquire formal training in clinical research and education in lieu of more traditional
pursuits in the basic sciences. Accordingly, surgeons working on education, QI, and the advancement of surgical outcomes through health services research identified an opportunity to translate their knowledge regarding optimal patient outcomes into a future in which surgeons will promulgate a culture of continuous quality improvement. The opportunity came in the form of a union between QI leaders and surgical educators seeking to expand surgical education programs to include coaching future surgeons in QI. To this end, the ACS NSQIP QITI was launched with three main objectives:

• Enable easy manipulation of ACS NSQIP outcomes data to provide standardized reports with benchmarking for use in graduate surgical education
• Develop a national quality improvement curriculum tailored to the needs of the American public centered on real issues in surgical patient care
• Foster a new culture/environment across all surgical programs to teach residents to become surgeons with a quality conscience through collaboration among academic hospitals

The QITI is a partnership between the ACS and hospitals with at least one surgical training program that has Accreditation Council on Graduate Medical Education approval. QITI aims to improve the quality of surgical care now, through data-driven initiatives made possible through the collaboration of ACS NSQIP and teaching hospitals, and in the future, through the use of outcomes data and a QI curriculum for use in graduate medical education. The initiative is designed to equip all surgical residents with the skills needed to address the quality improvement needs of surgical patients to ensure that surgical outcomes continue to improve across the generations.

The QITI is a proactive response to the need to engage surgical residents in quality improvement to protect surgical patients in the future. Thankfully, the importance of this endeavor has been independently recognized by a multitude of governing bodies that provide external motivation for widespread programmatic acceptance. Additionally, as the nature of the support of the governing bodies comes in the form of unfunded mandates, general surgery residency program directors need the help and support of programs like the QITI to meet the new requirements. The role of the QI experts within ACS NSQIP is paramount to developing a curriculum that is focused on the real needs of the patients and providers based not on theories, but on actionable, practical solutions suited to making a difference in the delivery of surgical care.

Congress weighed in on the matter with passage of the Health Care and Education Reconciliation Act in 2010. The legislation proposed that resident physicians “participate in continuous quality improvement projects to improve health outcomes of the population the physicians serve.” Furthermore, government control over Medicare spending, the primary financial support for graduate medical education (GME), seems to be moving toward the implementation of an outcomes-based model that will tie financial support to performance-based standards. These standards have yet to be defined, but it has been suggested that they will reward programs that train residents in quality measurement and improvement, evidence-based medicine, multidisciplinary teamwork, care
coordination across settings, and health information technology. The Medicare Payment Advisory Commission has identified these skills as vital to the success of future innovations to improve the value of our health care delivery system.

Along the same lines, the ACGME defines the goal of a surgical residency program as “to prepare residents to function as qualified practitioners of surgery at the advanced level of performance expected of board-certified specialists.” The ACGME created the core competencies, including practice-based learning and improvement (PBLI) and systems-based practice (SBP), to guide the outcomes approach to accreditation. Additionally, the new clinical learning environment review (CLER) program will focus on patient safety and quality improvement as key areas of interest. These efforts recognize that embedding the principles of continuous quality improvement in young surgeons may be the first step in moving from a culture of compliance toward a culture committed to quality. Program directors often struggle to demonstrate proof of training in PBLI and SBP. The distribution of ACS NSQIP data coupled with formal quality improvement training will encourage surgical trainees to develop these skills using real-life experiences. The QITI will permit program directors to easily satisfy the ACGME requirements for SBP and PBLI while providing trainees with critical skills for their future success as surgeons.

Evidence-based data supports the use of a collaborative approach to address the unique needs of hospitals focused on GME. Other institutional collaborations consisting of data feedback and training in continuous quality improvement techniques to each hospital have resulted in a reduction in mortality and morbidity, improvements in processes of care, and cost-savings across institutions. A partnership between the quality improvement/patient safety personnel and medical educators within each institution, as proposed by the QITI, will unite graduate medical education with efforts to improve the quality of surgical care locally. The QITI also brings together the hospitals that specialize in GME nationally. In so doing, the teaching hospitals will have the opportunity to evaluate aggregated data and foster a relationship designed to improve patient care within all teaching hospitals.

The QITI aims to combine validated outcomes data with a detailed curriculum for QI along with the strength of multidisciplinary collaboration to instill the principles of QI in each surgical resident before they enter independent surgical practice. The ability to use the ACS NSQIP to collect resident-specific and team-specific data and generate outcome reports has proved feasible and required little additional work for chart abstractors. Trainees will follow a structured outline, with a year-by-year curriculum allowing residents to learn how to interpret and use applicable outcomes data to create quality improvement projects and initiatives within their own institutions.

The educational components are being developed with several objectives in mind. The first goal is to develop a flexible patient safety and quality improvement curriculum that incorporates sharing of hospital-, resident-, and team-specific outcomes data with surgical residents and among QITI-participating hospitals. The second is to illustrate that an educational initiative based on surgical outcomes satisfies ACGME requirements and can ensure success in the CLER program through a tangible commitment to QI across each surgical program.

**Future of surgical quality improvement**

The future of the quality improvement movement in surgery depends not simply on bringing the issues into surgeon consciousness, but requires enthusiasm for improved patient outcomes, active involvement in quality improvement efforts, action in response to performance metrics, alignment of patient and provider goals, and strong leadership in redefining the cultural norm. The resident curriculum may be formalized, but for the rest of us, we should also endeavor to learn the material provided by the QITI.

Consider the possibilities. Imagine a world where operating room turnover time would match the amount of time it takes to talk to a patient’s family and check in your next patient. A world where all of the people caring for each patient are familiar with the history, physical examination, and plan as outlined in the medical record; where if the surgeon did a great operation, he or she could rest assured that the patient would recover uneventfully and receive optimal patient care delivery system.
The QITI aims to combine validated outcomes data with a detailed curriculum for QI along with the strength of multidisciplinary collaboration to instill the principles of QI in each surgical resident before they enter independent surgical practice.

care with all of the proper medications prescribed and given as ordered; and where adherence to best practices was expected. Imagine an environment where everyone treated each patient as if he or she were family members. Imagine a world where someone would share data with you regarding your clinical outcomes and identify opportunities for personal improvement and systematic improvements.

Alternatively, imagine a world where surgeons are considered technicians and no one listens to the voice of reason that often speaks up for the needs of the surgical patient. Imagine an environment where a surgeon’s vast knowledge of patient disease and ability to assuage a patient’s anxiety by providing a detailed description of the surgical experience are not valued. Imagine a world where your parent or child went in for an operation and developed a surgical site infection that required months of dressing changes and resulted in depression.

Either of these scenarios could become reality. The choice will be determined by each of us. If surgeons are to remain fully engaged and valued in the transition toward a new health care delivery system, then we must learn to understand and speak the language of quality improvement. Colleagues from a diverse set of medical specialties outnumber us, and therefore our commitment to and knowledge of quality improvement must be more robust if we are to have the same leveraging power.

Although a major component of value-based purchasing centers on surgery (for example, the Surgical Care Improvement Project), very few of these programs are integrated into the formal surgical residency curriculum. At present, an obvious disconnect exists between the emphasis on surgical outcomes from a national health care perspective and the lack of emphasis on training surgeons to understand and apply these outcomes to improve quality and patient safety.

Successful improvement in surgical outcomes nationwide requires a concerted effort by surgical programs nationally to educate residents not only in the language of surgery, but also in the language of quality. Engaging residents in quality improvement necessitates more than asking them to participate in a discrete improvement project, whereby they may feign fluency by concentrating on the immediate results.

True understanding of the language of quality is gained via a longitudinal approach to the subject matter, and teaching residents that engagement in quality improvement over the lifetime of their career is what translates into lives saved. The QITI provides a unified strategy that is designed to become the standard for the integration of a quality curriculum into surgical education, so that all residents enter practice with a basic understanding of performance improvement and outcomes-based practice.

To bring about a successful future of high-quality, safe, and affordable health care in surgery, the QITI strives to lead the development of a new norm, transitioning the surgical community into the next 100 years by embedding the values of quality and patient-centered care early on in training. Thomas H. Lee, MD, posits that in order to fix health care, a “frame shift” must occur in the traditional way in which medicine is practiced, as a result of which the delivery of high-quality care is no longer measured as much by volume as by how patients fare after treatment.

The current notion that volume trumps outcome is manifest in the way that progress is monitored and feedback is generated in the surgical training process. Typically, the ACGME case requirement/log (a measure of volume) is the only objective measure of residents’ progress; most other feedback involves subjective evaluations. And although it may be difficult to objectively evaluate resident development in the core competencies, even a subjective evaluation/discussion of how a resident’s patients do after surgery is lacking. Existing fears that subpar outcomes may be inappropriately tagged to an individual resident probably would be assuaged if we could truly move beyond a culture of blame to one of continuous quality improvement. By showing residents how their technical and clinical skills translate into real patient outcomes, the QITI will help foster a patient-centered learning environment focused on the delivery of high-quality care.

Closing thoughts
Having the flexibility to deliver education in quality improvement science in ways that engage surgeons is vital, and a curriculum focused on a variety of practical activities with tangible outcomes will allow us to
get to the heart of the matter. Improving the quality of surgical care is now, and has always been, the College’s primary mission. Surgeons want to be in the operating room and other health care settings providing top-notch surgical care, but more so, we want to know that our patients will experience optimal outcomes. Whether adhering to a checklist to minimize surgical site infection or following national guidelines to prevent venous-thromboembolism, the knowledge that our patients will survive to enjoy the fruits of our labor makes all of the hard work and dedication worthwhile.

Generating a buzz and an excitement around the significant difference that surgeons can make in patient care with detailed knowledge of quality improvement techniques is vitally important if we expect surgeons to understand how quality is measured, evaluate their own data, and implement change to improve outcomes in the future. How better to learn the value of these proficiencies than to start evaluating the data during the intern year?

The QITI is in its infancy, and yet the practical, real-time approach to teaching quality science appears to inspire action and improvement. The program will only get better with time. In the end, the path to cultural reform will lie in collaboration with master clinicians, experts in QI, and experts in surgical education all contributing to inspire surgical residents—the future leaders of our profession—to foster a culture of continuous quality improvement in an environment of patient-centered care.

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This month, players on the University of Louisville, KY, men’s basketball team will get back on the court for their first regular season game. And if he continues the progress he’s made since fracturing his leg last spring, Cardinals’ guard Kevin Ware could be right there with them. “He should be ready to go at it around late October,” Cardinals Coach Rick Pitino told ESPN.com as of press time. Mr. Pitino had said earlier this fall that he was “looking more like it’s going to be second semester for him to be 100 percent or close to it.”

A university spokesperson said it was still undetermined how much Mr. Ware would be able to do on the court when he is able to return.

“We’re not going to rush things,” said Kenny Klein, the university’s senior associate athletic director for media relations. (Personal phone communication with the author, September 23, 2013.) Mr. Klein said Mr. Ware has no pain at this point, and he’s been concentrating on his academics in addition to his rehabilitation.

He’s been doing a lot of cardio work, mostly on a stationary bike, Mr. Klein said, and lifting weight on his right leg. Earlier this fall, about six months after his injury, a video reportedly taken by a teammate during practice and posted to YouTube showed Mr. Ware dunking the ball. Mr. Klein noted that Mr. Ware appreciates all the support he’s received from fans during what can be a grueling process.
Severity of injury
This rapid recovery may come as somewhat of a surprise to anyone who was watching the game in which Mr. Ware was injured. Craig Roberts, MD, FACS, an orthopaedic surgeon and professor of surgery at the University of Louisville, had just come out of surgery and was in the physicians’ lounge on March 31, the day the Cardinals were playing the Duke Blue Devils in the Elite Eight in Indianapolis, IN. Roberts said that he saw the replay of Mr. Ware jumping up to block a three-point shot by a Duke player, but he was unable to really see the extent of the injury on the small TV. (Personal communication with the author, July 2013.) He later saw on a larger screen that Mr. Ware had come down awkwardly on his right leg, snapping his tibia and causing the bone to protrude through his skin.

The sight of the injury left coaches and players on both sides visibly shaken. A few of the Cardinals had tears in their eyes.

The compound tibial fracture, also called an open fracture, is an injury that is more typically associated with high-impact trauma, like a vehicle crash or a fall from a significant height, said Walter Virkus, MD, director of orthopaedic trauma services at Methodist Hospital in Indianapolis. (Personal communication with the author, July 2013.) Mr. Ware was taken to Methodist after he was injured with about six minutes left in the first half of the game. Dr. Virkus, who did not operate on Mr. Ware but is familiar with the case, estimated that he sees compound fractures on a weekly basis, but “it’s not something we regularly see in athletes.”

Dr. Roberts compared Mr. Ware’s leg position to a long tree branch or a pencil standing straight up and down that bends slightly off its axis. “Standing up, it’s strong, but if you angle it, it doesn’t take much to snap it,” he said. He’s seen similar injuries in football and soccer players, but many of them are closed, and the bone has no contact with the atmosphere.

How did it happen?
William De Long, Jr., MD, FACS, chief of orthopaedic surgery at St. Luke’s University Health Network, Bethlehem, PA, speculated that Mr. Ware’s injury was the result of an athlete trying to play through pain. “The catastrophe you saw on television was the product of a stress fracture that was occurring, and he ignored it,” Dr. De Long observed. (Personal communication with the author, September 27, 2013.)

Stress fractures occur when muscles become tired from overuse and can no longer absorb added shock. The muscle then transfers the shock to the bone, causing a tiny crack. Stress fractures in the feet and legs are common in sports like football, soccer, and basketball because of all the running involved, Dr. De Long said. They are called stress reactions at their onset and can be seen in magnetic resonance imaging tests but not a regular X-ray. As a stress reaction evolves, the person will feel more pain as the bone starts to crack, Dr. De Long said, although surgeons are still working to understand what happens during that process.

Cells in the bones are constantly remodeling themselves, Dr. De Long said. Some cells, called osteoblasts, make bone, while others, called osteoclasts, break it down. In a stress fracture, Dr. De Long said, “the theory is that the kinetics of the take away is faster than the rebuild,” but a working model for that theory has yet to be developed.

Besides athletes, stress fractures occur very frequently in military recruits, who often go from not being active to a six-week boot camp where they are forced to exercise vigorously. Dr. De Long estimated that Mr. Ware could have been having leg pain for 60 to 90 days before his injury occurred.

Operation speeds recovery
A surgical technique that didn’t fully take hold until the 1980s played a significant role in Mr. Ware’s rapid rebound, according to Dr. Roberts.

During the two-hour operation at Methodist, surgeons reset his tibia and cleaned out his open wound. Then they put a metal rod inside the bone cavity and secured it with an intramedullary (IM) nail, Dr. Roberts said. The IM nail is also called a Küntscher nail, named for Gerhard Küntscher, a German surgeon credited for developing the nailing technique for fractures of the long bones in the body. Dr. Roberts said Dr. Küntscher first used IM nails on soldiers who had fractured their
femurs during World War II. It took a long time for the technique to get from Germany to the U.S., and has been growing in popularity over the last few decades as a treatment for compound fractures.

“This is a huge advance,” Dr. Roberts said of IM nailing, as opposed to a cast. “It really took well into the late ’70s and early ’80s [to arrive at a point] where people believed this was a good option.”

Dr. De Long said the technique was just starting to take off when he began his career in surgery. Before the nailing technique became popular, orthopaedic surgeons could insert a rod into a broken tibia, but they had no way of locking it in, he said. As a result, it would only work for a break in the middle of the bone that was straight across. Other people with broken leg bones filled hospital beds as physicians used the traction technique. They placed pins through patients’ bones and had weights to pull on them and hold them in position, Dr. De Long said. After up to six weeks, patients could return home in a cast to continue healing.

Dr. De Long said IM nailing is a better technique because the patient can put weight on the leg and start exercising sooner, and there is much less restriction of movement than with a cast, which can lead to muscle atrophy and loss of bone mass.

Game on?

Despite the surgical advances used in his care and his strong recovery so far, Mr. Ware isn’t out of the woods just yet. According to Dr. Virkus, tibial fractures have a wide range of severity, and the healing depends on the health of the individual. Infection is the most common complication when the bone comes through the skin, and it can occur during the healing phase or after, Dr. Virkus said. The greater the damage to the bone, soft tissues, nerves, and blood vessels, the higher the risk of infection.

In a couple of years, Dr. Roberts said, it may be possible to remove the rod. However, surgeons are more selective about performing that procedure today than they were 20 years ago. The benefits need to outweigh the risks for the elective surgery, and there is a chance that the bone will break again, Dr. Roberts said.

Privacy rules prevented him from going into too much detail about Mr. Ware’s specific case, but Dr. Roberts noted that Mr. Ware has a supportive family and access to top rehabilitation and physical therapy during his recovery. His treating physicians even determined it was safe enough for Mr. Ware to join his team in Atlanta, GA, eight days after his injury. It was there that he cut down the net after the Cardinals won the National Championship game. “If somebody’s going to come back quickly, it’ll be him,” Dr. Roberts said.◆
In the Residency to Retirement column published in the January Bulletin, “Is medicine still a good profession? Reflections of a retired surgeon,” Paul Jordan, MD, FACS, presented a strong case in favor of a medical career.¹

I would tend to agree and believe that there are several aspects of surgical practice that affect one’s perception of the worthiness of making it one’s life’s work.

A calling to serve
The practice of medicine and surgery has long been considered a “profession” or a “calling.” A profession may be defined as “a vocation or occupation requiring advanced education and training, and involving intellectual skills, [such] as medicine.” A calling is “one’s occupation, profession, or trade” or “an inner urging toward some profession or activity.”²

One is often drawn to a life of service to others—such as entering religious studies to become a priest, nun, minister, or rabbi, or perhaps applying to schools to become a nurse or physician. The compulsion to pursue these fields may be the result of examples set by a family member or close friend, a personal epiphany, or an answer to prayers. Young men and women often aspire to study and practice medicine or one of its specialties due to an interest in the welfare and well-being of others and a desire to provide care to people suffering from physical or mental afflictions. This interest may also be derived from an aptitude for the biological sciences or information gleaned from reading, the Internet, or other sources.

In most cases, the medical student sees his or her life’s work as providing care or service to patients in the purest altruistic sense. Only later, when frustrating experiences as a clinical clerk, intern, resident, or fellow leaven this initial enthusiasm to always “do good,” is the aspiring physician faced with the reality of sometimes conflicting choices over what is in the patient’s best interests. These decisions may require a confrontation with the payor, including government programs and private insurers, and may result in situations that are stressful and less financially rewarding or convenient for the physician. At that point, the physician begins to become a “businessperson” and perhaps less of a physician.

In my medical school class, the majority of freshman students aspired to be primary care physicians. By the time we were in our senior year and ready to select our residency programs, though, most (nearly 80 percent) had chosen to enter a specialty rather than primary care. Many of these decisions were undoubtedly based upon the more favorable economics of specialty practice or lifestyle choices. However, 33 of our class of 110 selected general surgery or a surgical subspecialty.

The business of medicine
Although most physicians have faced the “business versus profession” dilemma, to our credit, day in and day out, we generally have given our patients our best efforts on their behalf and resisted as much as possible interference from insurers and the government in the health care decision-making process. In the final analysis, physicians who see the practice of medicine or surgery as a true profession, one of giving service to others, and who remain true to that calling, will be satisfied and grateful for the opportunity to earn their patients’ trust. Those whose primary interest is in running their practice as a business with fealty to the bottom line will probably enjoy less spiritual or intellectual fulfillment.

by Roger A. Meyer, MD, DDS, FACS
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In The Kitchen Shrink: A Psychiatrist’s Reflections on Healing in a Changing World, Dora Calott Wang, MD, an academic psychiatrist, laments the disintegration of the traditional physician-patient relationship and its replacement with a corporate, bottom line-driven health care system. “Doctors never used to sign off. Doctors once delivered patients from the womb, then cared for them through their lives.... Like family, the doctor-patient relationship was once a faithful one, until death did us part,” she writes.3

Dr. Wang writes about a conversation she had with a colleague who said, “the insurance companies make the decisions and physicians take the heat...,” to which she replied, “American medicine, a charitable enterprise to which society once contributed money, is now an industry from which profits are taken. During my years in medicine, I have witnessed it become an expensive system rigged toward not paying for health care.” Resisting this change and with a look toward the future, Dr. Wang tells one of her medical students, “Do all you can for your patients.... Never treat medicine as just a job, because then that’s all you’ll ever have, just a job.”3

Before the era of managed care began in the 1980s, most physicians offered a significant portion of their services gratis to the neediest of their patients. They did so with honor, dedication, pride, and a sense of mission. Now, in the era of escalating costs of running a practice and declining reimbursement from private and public health insurance plans, the physician is being squeezed financially to the point where sharp business practices have come to occupy a place of prominence in the successful medical or surgical practice, while truly needy, financially disenfranchised, or uninsured patients have been allowed to slip through the cracks. Those of us who practiced in the fee-for-service era initially and now practice in the managed care era find frustrating the loss of freedom to practice in a manner that most benefits the patient. The demand for adherence to the countless rules and regulations of government-run health care programs, such as Medicare and Medicaid, and the many employer-sponsored insurance plans that pay most of the (discounted) fees for our services, all too often, unintentionally or not, get in the way of good medical/surgical care.

Trend toward employment
An increasing number of physicians and surgeons are seeking employment in large, incorporated medical/surgical practices or choosing to become salaried hospital employees, or “hospitalists,” to avoid dealing with the escalating costs of running a practice. The solo practitioner or small group practice, even in small towns and rural areas, is rapidly becoming an endangered species. Hopefully, training programs developed specifically for the rural surgeon will reverse this trend.

Those of us who practiced part or all of our careers in the era of fee for service have a hard time accepting the concept of managed care, when those individuals responsible for making decisions about what is a covered service often are nonphysicians. We question whether some of these individuals are able to decide what is in the patient’s best interests rather than what is best for the corporate bottom line.

Recent medical school graduates who have no personal experience with fee for service will have less difficulty accepting the new medical care model, one of fealty to bureaucratically determined guidelines in which the physician is a “provider,” an employee who works a shift and offers covered services to patients who have been enrolled in a health care plan. Such a situation, unfortunately, could destroy the sacred trust that patients have placed in their physician as someone who is primarily entrusted with their best interests with respect to health care matters. Physicians in this new era must remember and jealously
The demand for adherence to the countless rules and regulations of government-run health care programs, such as Medicare and Medicaid, and the many employer-sponsored insurance plans that pay most of the (discounted) fees for our services, all too often, unintentionally or not, get in the way of good medical/surgical care.

guard their role as their patients’ advocate vis-a-vis the government and private health care insurance plans. If physicians continue to advocate for their patients, the bond between patient and physician may be preserved.

Encouraging the next generation

What does the physician/surgeon tell his or her children about the advisability of pursuing a career in medicine? In spite of a recent survey that showed that a majority of physicians “were unwilling to recommend health care as profession,” many physicians’ children continue to become physicians themselves, and they are happy with their decision. They knew what was going on in their parent’s professional life and still made the decision to join up.

If a child expresses interest in a parent’s profession, the parent must have done something to pique that interest. Parents should be honest in their description of their satisfaction, or lack thereof, with their life’s work. Discuss the good aspects—service, dedication, altruism, patient trust, satisfaction in a job well done, good income—as well as the drawbacks—long hours, selflessness, and sacrifice in one’s personal life, dissatisfaction with governmental or other bureaucratic restraints, the high costs of maintaining a practice.

In the end, children are notorious for resisting their parents’ advice. So, if 90 percent of 5,000 physicians who participated in a study advised their children not to enter medicine, maybe more of them will become physicians. None of my three children followed in my footsteps. However, one daughter is a hospital administrator and another daughter managed a freestanding plastic surgery center for 10 years and now works in a biomedical research facility. Having a physician as their father undoubtedly influenced their decisions to enter the medical field, albeit not as physicians. Most importantly, they are all happy in their lives, and that is the most a good parent can wish for his or her children.

Rather than recall the glory days of the past, which are only memories to those of us who entered practice then, let us look to the future. We must find ways to continue to inspire our medical students to envision their professional careers as a call to serving with dedication and self-sacrifice for their patients. In this way, the practice of medicine will again be a fulfilling profession and not just a job. Likewise, the foundation of their practices will be the physician-patient relationship and not an industry or a system.

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Reducing surgical site infections (SSIs) is a very real challenge—one that must be addressed to make health care more reliable and to improve patient safety. A new implementation guide published by The Joint Commission is designed to help health care organizations and health care professionals accomplish this goal by providing effective practices for implementing National Patient Safety Goal (NPSG) 07.05.01, which focuses on preventing SSIs. The practices were identified through a multi-phase process that included the participation of 17 Joint Commission-accredited hospitals and are now available in a guidebook titled The Joint Commission’s Implementation Guide for NPSG.07.05.01 on Surgical Site Infections: The SSI Change Project, which is available free of charge.

**A national issue**

Approximately 500,000 SSIs occur every year and contribute to increased length of stay, reduced quality of life, and death.† Although evidence-based practices (EBP) to prevent SSIs have been well-described in the infection prevention and control literature, studies indicate that many hospitals have yet to adopt EBP to decrease SSIs. **††** In an effort to help health care organizations and professionals reduce the risk of SSIs, The Joint Commission established a NPSG that focuses exclusively on this public health concern. Even though NPSG.07.05.01 specifies the evidence-based requirements for preventing or reducing SSIs through eight elements of performance (EPs), accredited health care institutions have informed The Joint Commission’s leadership that guidance and direction are needed for successful implementation. The Joint Commission’s SSI Change Project was launched in 2010 to focus on feedback from accredited organizations regarding NPSG.07.05.01. Specifically, The Joint Commission sought to learn, through an environmental assessment survey (EAS), effective implementation practices from currently accredited hospitals to successfully implement the SSI-focused NPSG (phase one of the SSI Change Project). The effective practices used to implement the SSI NPSG were confirmed through conference calls with select hospitals that participated in the EAS (see sidebar, page 43). The final result is the 2013 publication of a guide that offers accredited hospitals effective practices that may be used to implement NPSG.07.05.01.

**Joint Commission implementation guide**

The Joint Commission implementation guide defines 23 effective practices, includes supporting statements from participating hospitals, and offers a recommended method for using the guide. The effective practices are grouped into three major categories: effective practices for leadership, practitioner-focused effective practices, and effective practices for process improvement. The process category includes three subcategories: performance improvement-focused techniques, process improvement activities, and clinical interventions to decrease SSIs. A specific section focused on pediatrics.

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PARTICIPATING HOSPITALS
A total of 17 Joint Commission-accredited hospitals, including three pediatric hospitals, participated in learning conference calls to confirm the effective practices identified in phase one of the SSI Change Project. Participating institutions are as follows:

- Baptist Hospital, Miami, FL
- Children’s National Medical Center, Washington, DC
- Hillcrest Hospital, Mayfield Heights, OH
- Lucile Packard Children’s Hospital at Stanford, Palo Alto, CA
- Mercy Hospital, Part of Allina Health, Coon Rapids, MN
- Methodist Willowbrook Hospital, Houston, TX
- Mobile Infirmary Medical Center, AL
- New York University Langone Medical Center, New York, NY
- Our Lady of Lourdes Regional Medical Center, Lafayette, LA
- Saint Mary’s Regional Medical Center, Russellville, AK
- Sinai Hospital of Baltimore, MD
- Sonora Regional Medical Center, CA
- St. Christopher’s Hospital for Children, Philadelphia, PA
- St. Tammany Parish Hospital, Covington, LA
- United Regional, Wichita Falls, TX
- University Medical Center, Lubbock, TX
- Vail Valley Medical Center, CO

is included, which comprises eight effective practices for this patient population.

An interesting finding of the SSI Change Project was that organizations that successfully implemented NPSG.07.05.01 and decreased SSIs did so by addressing the evidence-based elements of performance as a whole, rather than focusing on each of the NPSG’s elements of performance separately. Additionally, organizations focused implementation efforts on one type of surgical procedure rather than many operations simultaneously. Migration of evidence-based practices occurred when practitioners of one surgical area became knowledgeable of successful SSI reductions in another area and subsequently adopted the evidenced-based practices.

Implementing the effective practices
Organizations can use the effective practices identified for implementing NPSG.07.05.01 in a number of ways. Whether the effective practices are discussed at the leadership level, addressed at a surgical multidisciplinary team or quality meeting, or specific effective practices are selected for implementation when performing a specific surgical procedure, it is recommended that any institution considering a serious assessment of the effective practices conduct a gap analysis.

A one-page worksheet in the implementation guide provides a template for organizations to conduct the gap analysis. By conducting a formal gap analysis for NPSG.07.05.01, organizations can create a plan, based on organizational priorities, for implementing all or a subset of the 23 defined effective practices. The multidisciplinary team involved in the surgical procedure should work together to conduct the gap analysis. All members need to be familiar with the effective practices for implementing NPSG.07.05.01 and their definitions. The team should also include a member of leadership who is responsible for resource allocation. With the gap analysis complete and with leadership support, the multidisciplinary team has a road map for implementing the effective practices associated with NPSG.07.05.01.

To download The Joint Commission’s Implementation Guide for NPSG.07.05.01 on Surgical Site Infections: The SSI Change Project, visit The Joint Commission website at http://www.jointcommission.org/assets/1/18/Implementation_Guide_for_NPSG_SSI_1.PDF.
The television industry we have today was born in the years just preceding World War II. The Radio Company of America introduced its new line of television (TV) receivers at the 1939 World’s Fair by broadcasting for the first time a televised presidential speech. By 1960, 85 percent of U.S. households had a television set, and in 1964, the predecessor of today’s current flat-screen technology was developed at the University of Illinois, Champaign-Urbana. Over the next 20 years, satellite broadcasting, color TV, and transatlantic broadcasts came about. The 1990s brought the digital age of television and by 1994, 99 percent of households had at least one TV.* The last 10 years have seen an explosion in flat-screen TV technology, along with decreasing prices for larger TVs.

A tipping point
As flat screens become larger and are placed on top of furniture as opposed to being mounted on a wall, they have a tendency to tip over and fall. Being so thin, the center of gravity is very narrow and prone to tipping if not properly secured to a surface. According to a recently published study in Pediatrics, Television-Related Injuries to Children in the United States, 1990–2011, children ages two through 11 watched an average of 26 hours of TV per week during the 2010–2011 season, and 215 children died from a falling TV between the years 2000 and 2011.† A child dies every three weeks from an unsecured TV set, and 96 percent of these children are younger than age 10. More than half of these deaths are a result of being crushed by TV sets that on average weigh 50 pounds (the equivalent of three bowling balls).‡

To examine the occurrence of pediatric injuries from falling televisions 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) E916.0, struck by falling object and age younger than 11. Overall, 1,009 records were uncovered: 784 contained a discharge status, including 738 patients discharged to home, 25 to acute care/rehab, and nine sent to skilled nursing facilities; 12 died. These patients were 60 percent male,

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A child dies every three weeks from an unsecured TV set, and 96 percent of these children are younger than age 10. More than half of these deaths are a result of being crushed by TV sets that on average weigh 50 pounds (the equivalent of three bowling balls).

**Watch out**

Bigger is better, especially when it comes to watching one’s favorite movie, soap opera, or sports team on a TV. People spend countless hours in front of their TV sets relaxing and getting informed with the evening news. Young children partake in educational broadcasts that stimulate learning in unique ways. However, it is important to remember to properly secure TVs. Many newer sets come with anti-tip attachments that are designed to be screwed directly into the furniture to minimize the risk of tipping over. Simple steps such as public education, provision of anchoring devices at the point of sale, strengthening standards for TV stability, and improved TV set design can go a long way to prevent these types of injuries. After all, it is what’s on TV that we are interested in—not who or what the TV could potentially land on.

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](http://www.ntdb.org). In addition, information regarding how to obtain NTDB data for more detailed study is available on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

**Acknowledgement**

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Carlos A. Pellegrini, MD, FACS, FRCS(I)(Hon), The Henry N. Harkins Professor and Chair, department of surgery, University of Washington (UW) Medicine, Seattle, was installed as the 94th President of the American College of Surgeons (ACS) on October 6 during Convocation ceremonies at the 2013 Clinical Congress in Washington, DC.

Dr. Pellegrini has been a Fellow of the College since 1982 and has played a leadership role in the organization, particularly as Chair of the Board of Regents (2010–2011). Dr. Pellegrini began serving on the Board in 2002 and has been a member of the Regents’ Finance (2010–2013), Honors (2002–2013), and Communications (2002–2003) Committees.

He has chaired several other ACS committees, including: the Committee for the Accreditation Review of Education Institutes (2009–2013), the Central Judiciary Committee (2003–2009), the Committee on Medical Motion Pictures (1991–1992), and the International Guest Scholarship Subcommittee of the International Relations Committee (1988–1989). He has been a member of the Committee on Education (2006–2012), the Executive Compensation Committee (2009–2011), and the Committee on Video-Based Education (1988–1994). Dr. Pellegrini also was Co-Chair of the 2012 Surgeons as Leaders Course and President of the Northern California Chapter of the ACS (1990–1991). At present, Dr. Pellegrini serves on the Steering Committee on Simulation-Based Surgical Education, the Task Force on the Resident 80-Hour Work Week, and the Health Policy and Advocacy Group.

A graduate of the University of Rosario Medical School, Dr. Pellegrini completed his internship and general surgery residency at Granadero Baigorria, Rosario University Hospital, in Argentina. He completed a fellowship in esophageal physiology and surgery and a second general surgery residency at the University of Chicago, IL.

In 1979, he was appointed to the faculty of the University of California-San Francisco (UCSF) where he developed and directed a center for gastrointestinal motility. During his tenure at UCSF, the surgical residents and medical students presented him with multiple awards for his outstanding skills as an educator.

Then, in 1993, he was appointed chairman of the department of surgery at the University of Washington, and in 1996, he was named the first Henry N. Harkins Professor and Chair in recognition of his role in strengthening the department of surgery’s clinical, teaching, and research programs.

“I believe in training residents to become ‘total’ physicians, not just technicians,” Dr. Pellegrini said of his teaching and learning philosophy. “In fact, I view learning as a lifelong process for all surgeons, and I myself endeavor to maintain the highest degree of professional competence as a surgeon.”

He is a world-renowned leader in minimally invasive gastrointestinal surgery and a pioneer in the development of video endoscopy for the surgical treatment of gastroesophageal reflux disease and esophageal motility disorders. He is credited with the development of the University of Washington’s Center for Videoendoscopic Surgery, the Center for Esophageal and Gastric Surgery, and the Institute for Simulation and Interprofessional Studies. He is a longtime member of the UW Medicine’s
highest decision-making bodies and chairs many committees that address a range of issues, including continuous professional improvement, diversity, executive search committees, and oversight of multidisciplinary practices.

A former member of the board of directors of the American Board of Surgery (2003–2009), he has served as president of a number of surgical societies, including the Society for Surgery of the Alimentary Tract (1999–2000), the American Surgical Association (2005–2006), the Society of Surgical Chairs (2007–2008), the World Organization of Specialized Studies of Diseases of the Esophagus (2010–2012), and the International Society of Digestive Surgery (2000–2002). He also served two consecutive terms as chair of the Digestive Disease Week Council and is active in many other national and international surgical associations.


He speaks four languages: English, French, Italian, and Spanish. Dr. Pellegrini and his wife, Kelly Yamaichi, enjoy spending their free time with their two sons Michael and John and their wives Kristine and Julie, and twin grandchildren who all live in San Francisco. Their two golden retriever siblings, Pancho and Melba, bring additional joy to their lives.

Vice-Presidents
The Vice-Presidents for the coming year also were installed Sunday evening during the Convocation. Layton “Bing” Rikers, MD, FACS, professor emeritus at the University of Wisconsin-Madison and Editor-in-Chief of Surgery News, is First Vice-President; and John T. Preskitt, MD, FACS, a surgical oncologist at Baylor University Medical Center, Dallas, TX, is Second Vice-President.

A Fellow since 1980, Dr. Rikers is the former A.R. Curreri Professor of Surgery and chairman, department of surgery, University of Wisconsin. He is a past-chairman of the American Board of Surgery and is president of the American Surgical Association. Since 2003, he has developed and chaired Surgeons as Leaders: From Operating Room to Boardroom—an ACS course that prepares surgeons for the complex challenges of leadership. Dr. Preskitt has been a Fellow since 1984 and was a Regent from 2000 to 2009. He chaired the Board of Governors’ Committee on Chapter Relations (1997 to 2000), the Committee on Ethics (2006–2009), and the General Surgery Coding and Reimbursement Committee (2006–2011). He was President of the North Texas Chapter of the College from 1997 to 1998. He is currently clinical professor of surgery, Texas A&M Health Science Center, Baylor campus, and director of surgical oncology at the Baylor Sammons Cancer Center in Dallas. ♦
Six prominent surgeons accorded Honorary Fellowship in the ACS

Honorary Fellowship in the American College of Surgeons (ACS) was awarded to six prominent surgeons from Germany, England, Mexico, Thailand, and Malaysia during the October 6 Convocation ceremonies that preceded the official opening of the 99th Annual Clinical Congress in Washington, DC. The granting of Honorary Fellowship is one of the highlights of the Clinical Congress. This year’s recipients are as follows:

Prof. Markus W. Büchner of Heidelberg, Germany, is a professor of surgery and the director of the department of general, visceral and transplantation surgery at the University Hospital Heidelberg, where he is also the managing medical director of the surgical clinic. Professor Büchner, who established himself as one of the world’s foremost pancreatic surgeons, heads the department of general/abdominal and transplant surgery and oversees four hospitals. His contributions include seminal papers on adjuvant treatment of pancreatic cancer, treatment strategies in necrotizing pancreatitis, and consensus guidelines for grading complications of pancreatic surgery. An advocate of evidence-based surgical treatment, he founded the German Surgical Study Center for Clinical Trials in 2002.

R. J. Heald, CBE, MChir, FRCS(Ed)(Eng), of Baginstoke, Hampshire, England, is professor of surgery at the University of Southampton, and consultant surgeon at the Basingstoke and North Hampshire Hospital National Health Services Foundation Trust. He is surgical director of the Pelican Cancer Foundation, which promotes excellence and educates health professionals in the management of patients with colon and rectal cancer. Led by Dr. Heald, the North Hampshire Hospital pioneered total mesorectal excision, a procedure for rectal cancer based on defined embryologic, anatomic, and pathogenetic principles.

J. Octavio Ruiz Speare, MD, FACS, of Mexico City, Mexico, at age 17 joined the Mexican army and embarked upon a military medical career that led to his current rank as general. His military experience sparked an interest in trauma, and he came to the U.S. for training to become an Advanced Trauma Life Support (ATLS®) instructor. After a devastating earthquake in Mexico, Dr. Ruiz committed himself to a career in trauma care. Since 1986, he has been in charge of Mexico’s ATLS program, which has trained more than 1,000 instructors and 45,000 students. Dr. Ruiz has also served as the chief of transplant surgery and chair of the department at the Military Hospital in Mexico, and later was appointed director of the hospital and chief of medical services for the Presidential General Staff.

Priyana Sakiyalak, MD, FACS, of Bangkok, Thailand, is responsible for the training of most cardiac surgeons in Thailand. When cardiac transplant became a reality, he established a clinical training program for that surgical discipline in Thailand. Dr. Sakiyalak graduated from Mahidol University of Medical Sciences, Siriraj Hospital, with honors and completed his residency in general surgery at Upstate Medical University in Syracuse, NY. He went on to pursue his interest in cardiac surgery at Case Western Reserve University, Cleveland, OH. Dr. Sakiyalak then returned to Bangkok, where he performed the first coronary artery surgery in Thailand and established a cardiothoracic surgery residency.

Norman S. Williams, MS, FMedSci, FRCS(Eng), of London, England, is an internationally recognized academic colorectal surgeon. He was director of the Academic Surgical Unit at the London Hospital from 1985 to 1995 and head of the Center for Academic Surgery, London Queen Mary’s School until 2011, when his peers elected him president of the Royal College of
Surgeons of England. Professor Williams is also the lead editor of the 26th edition of Bailey and Love’s textbook, Short Practice of Surgery. His seminal publication 30 years ago, which specified that a five-centimeter distal margin was not a prerequisite for a successful rectal cancer operation, has changed many patients’ lives.

Cheng-Har Yip, MB, BS, FRCS(Edin)(Glas), of Kuala Lumpur, Malaysia, is a consultant breast surgeon in Malaysia’s Sime Darby Medical Centre and holds appointments at the University of the West of England, Bristol, and is clinical professor on the faculty of medicine, University Tunku Abdul Rahman, in Kuala Lumpur, Malaysia. She is lead clinician for the Cancer Research Initiatives Foundation breast cancer research program. After becoming a Fellow of the Royal College of Surgeons (Glasgow) in 1985, Dr. Yip pursued academic surgery in the department of surgery, faculty of medicine, University of Malaysia, from which she retired as professor in September 2012. After breast training in the U.K., Dr. Yip created one of the first breast clinics in Malaysia at the University of Malaya Medical Centre, which now sees more than 300 new breast cancer cases each year. ✦
Mr. President, it is my privilege to present to you a distinguished surgeon and clinical scientist, Prof. Markus Büchler of Heidelberg, Germany, for Honorary Fellowship in the American College of Surgeons.

Professor Büchler trained in surgery in Heidelberg and Berlin, and in 1982 went to Ulm, Germany, with his mentor, Prof. Hans G. Beger. He earned his PhD in 1987, and in 1993 at the age of 37, he moved to the University of Bern, Switzerland, as professor and chair of visceral and transplantation surgery. In 2001, he was called back to Heidelberg to lead the department of general/abdominal and transplant surgery, where he has thrived and now oversees four hospitals.

Professor Büchler’s clinical and scientific interests have focused on the pancreas in particular, and he has established himself as one of the foremost pancreatic surgeons in the world with more than 1,800 published papers, averaging an extraordinary output of 100 papers annually since 2004. In fact, he was the most cited surgeon in Europe in 2012. His significant contributions include sentinel papers on adjuvant treatment of pancreatic cancer, treatment strategies in necrotizing pancreatitis, and highly used consensus guidelines for grading complications of pancreatic surgery. He has espoused the “uncinate first” technique of pancreaticoduodenectomy and still operates every day.

A strong advocate for evidence-based surgical treatment, he founded the German Surgical Study Center for Clinical Trials in 2002. To date, the center has produced 12 randomized controlled multicenter trials, including adjuvant treatment for pancreatic cancer and alternative techniques for pancreaticoduodenectomy in chronic pancreatitis and in pancreatic cancer. His 35-center trial examining the optimal timing of cholecystectomy for acute cholecystitis was the lead presentation at this year’s American Surgical Association meeting.

He also has contributed to multinational consensus statements for mandatory registration of clinical trials and for the responsibilities and rights of investigators regarding scientific data from clinical trials.

Six of his protégés have been appointed chairs of university departments of surgery, and eight have become chief in a community hospital. He impresses all with whom he interacts with the energy and the storm of new ideas and challenges that he generates.

He has the gift of motivating people—making each one feel most important at the time. Professor Büchler has been president of five major organizations, including the German Society for General and Gastrointestinal Surgery and the Deutsche Gesellschaft für Chirurgie (the German Surgical Society), Germany’s counterpart to the ACS. He has been awarded five honorary doctorates, 22 international honorary memberships, and has served on 46 editorial boards.

Markus and his lovely wife Hedwig have four children, including a son who is a medical student. An enthusiast of soccer and of his Mercedes AMG 63, Professor Büchler is an organizer of an interdepartmental card game called “skat,” which serves to promote collegiality as well as competition among the Heidelberg department chairs.

Mr. President, Prof. Markus Büchler is a role model of an academic surgeon: technically superb, scientifically accomplished, a leader in his field. It is particularly satisfying to present my friend, Markus, for Honorary Fellowship in the American College of Surgeons.
Mr. President, it is my privilege to present Prof. R.J. (Bill) Heald of Basingstoke, Hampshire, England, for Honorary Fellowship in the American College of Surgeons (ACS). A graduate of Cambridge University, Mr. Heald is professor of surgery at the University of Southampton, and consultant surgeon at the Basingstoke and Hampshire Hospital National Health Services Foundation Trust. He is surgical director of the Pelican Cancer Foundation, which promotes excellence and educates health professionals in the management of patients with colon and rectal cancer.

Led by Professor Heald, the North Hampshire Hospital team pioneered total mesorectal excision (TME), a procedure for rectal cancer based on defined embryologic, anatomic, and pathogenetic principles, which is the gold standard in the surgical management of patients with this disease.

Reciting his lengthy curriculum vitae would require the speed of an auctioneer. You’ll have to accept my executive summary of his extensive contributions.

Professor Heald is a passionate educator who has dedicated himself to training surgeons in the U.K. and the international surgical community in the conduct of TME. The cornerstone of his success as a teacher is the use of live video broadcast TME operations featuring dialogue with the audience. He has performed more than 400 such procedures in more than 30 countries since defining the “Holy Plane” of rectal cancer surgery in 1988.

His long list of honors and awards attests to the esteemed international reputation he enjoys among his peers. He also has close to 150 peer-reviewed publications in surgical literature, principally in the field of colorectal surgery. In addition to his teaching and publishing, he has participated in countless workshops, named lectures, postgraduate courses, master classes, and video productions worldwide.

In the past few months, he has assumed his new position as president of the colorectal group at the Champalimaud Foundation for the Unknown in Lisbon, Portugal.

I was privileged to spend a sabbatical period in Basingstoke in 1992, during which I reviewed the documentation of his results and learned the technique of TME firsthand. It was the experience of a lifetime, and I was immediately convinced of Mr. Heald’s genius for precise dissection of the planes in the pelvis. This careful dissection results in significantly less pelvic recurrence of cancer with a high cure rate, a more functional reconstruction with pelvic nerve preservation, and a reduced need for colostomy in all but the lowest of tumors. My time in Basingstoke began a close personal friendship between his family and mine that continues to grow today. I so admire Bill for everything he has accomplished. He uses every waking hour to good purpose, both in his professional life and social interactions. His students, colleagues, and patients adore him—not to mention his wife, Bounce, and their three lovely daughters and families.

I thank him for allowing me to participate in developing changes in rectal cancer management and for the numerous opportunities I have had as a result of my studies with him.

Bill Heald is the embodiment of the principle that dedication, hard work, and a thorough study of one’s subject will lead to improvements in patient care. I am therefore proud and tremendously pleased (he would say “chuffed”) to present my friend and colleague Prof. R.J. Heald, last year’s Commission on Cancer Oncology Lecturer, for a richly deserved encore—Honorary Fellowship in the ACS. ✦
Mr. President, it is my privilege to present to you Prof. J. Octavio Ruiz Speare of Mexico City, Mexico, for Honorary Fellowship in the American College of Surgeons (ACS). Professor Ruiz was born in Real del Monte, Hidalgo, Mexico. He obtained his medical training in the Military School of Medicine and completed his residency in general surgery at the Central Military Hospital in Mexico City. He continued his surgical education here in the U.S. at the University of Minnesota, Minneapolis, where he completed a residency in general surgery and a transplant fellowship. He went on to obtain a master’s degree in science in experimental surgery, also from the University of Minnesota.

The son of a silver miner, Professor Ruiz grew up in a small mining town that was well-known for its silver production. He and his family moved to Mexico City, and at age 17, he joined the army and embarked upon a military medical career that culminated in his current rank as general. His military experiences sparked his professional interest in trauma, so he came to the U.S. and became an Advanced Trauma Life Support® (ATLS®) instructor. Shortly following his return to Mexico, a devastating earthquake prompted Dr. Ruiz to dedicate himself to improving trauma care in Mexico. Since 1986, he has been in charge of the ATLS program in Mexico, which has trained more than 1,000 instructors and 45,000 students.

He has also served as the chief of transplant surgery and chair of the department of education at the Military Hospital in Mexico. He was next appointed as director of the hospital and chief of medical services for the Presidential General Staff.

Professor Ruiz is an excellent technical surgeon. He is the pioneer of transplant surgery in Mexico, where he introduced this concept in 1973. He has performed the largest personal series of kidney transplantations in Mexico, transplanting more than 2,000 kidneys. He is also the pioneer of laparoscopic surgery in Mexico.

He has served as the personal surgeon for two presidents of Mexico and was the attaché for President Clinton and Pope Paul II. Professor Ruiz is married to his wonderful wife, Olga. They have three children and six grandchildren. His daughter Gabriella has considerable interest in exquisite Mexican silver jewelry.

He has published extensively on trauma, surgical infections, and organ transplantation. He has been the recipient of numerous awards, including the Advanced Trauma Life Support Meritorious Service Award and the Trauma Achievement Award presented by the ACS Committee on Trauma.

It is a pleasure to present Prof. Octavio Ruiz—father, husband, compassionate surgeon, excellent technical surgeon, and a role model for future surgeons for Honorary Fellowship in the American College of Surgeons.
Mr. President, it is my privilege to present to you Prof. Prinya Sakiyalak of Bangkok, Thailand, for Honorary Fellowship in the American College of Surgeons. Professor Sakiyalak was born in Bangkok, where he obtained his medical degree with honors from Mahidol University of Medical Sciences, Siriraj Hospital. Following a residency in general surgery at Upstate Medical University in Syracuse, NY, he went to Case Western Reserve University, Cleveland, OH, to pursue his true love, cardiac surgery. Following completion of his cardiothoracic residency, he returned to Bangkok to introduce coronary artery surgery to Thailand and Southeast Asia. He performed the first coronary artery surgery in Thailand and established a cardiothoracic surgery residency. He is responsible for the training of most cardiac surgeons in Thailand. When cardiac transplant became a reality, he established a clinical and training program for that surgical discipline in Thailand.

Soon after returning to his home country, he began to accompany the King and Queen of Thailand on volunteer medical missions to serve the poor and became the personal physician to the Queen. In 1992, he attended and received a diploma from the National Defense College of Thailand, which he added to his certifications from the American Board of Surgery, the American Board of Thoracic Surgery, the Thai Board of Thoracic Surgery, and the Thai Board of Cardiology. He remained on the faculty of Siriraj Hospital, Mahidol University, for his entire career, becoming professor emeritus in 1998. Dr. Prinya, as he is called in Thailand, also has organized and participated in public service programs of the Heart Foundation, providing medical care to disadvantaged populations in outlying areas of Thailand. He remains active in teaching and service and has been honored five times by the King of Thailand for service to his country.

Dr. Prinya has remained loyal to his American training, becoming a Fellow of the American College of Surgeons in 1975 and serving as Governor for Thailand from 1991 to 1996. He is a generous host to visiting American colleagues.

Dr. Prinya personifies service. He has been president of the Heart Association of Thailand, ASEAN Federation of Cardiology, Society of Thoracic Surgeons of Thailand, and Royal College of Surgeons of Thailand. He serves on a number of editorial boards and contributes to their literature. He was also made an honorary member of the Asian Society for Cardiovascular and Thoracic Surgery in 2011.

Dr. Prinya and Usana, his wife of 46 years, have three children. Pranya is a cardiac surgeon and Fellow of the American College of Surgeons; Don is a hospital administrator; and Solaya is an executive financial analyst. They are all devoted to their Buddhist faith.

Additionally, Usana has been honored by the Queen three times. Dr. Prinya has a magnificent singing voice and is a noted songwriter. He has written the Thai lyrics of songs in several popular historical movies as well as the lyrics for the song for the Royal College of Surgeons of Thailand. Dr. Prinya still plays tennis most days. He is beloved by his family, friends, colleagues, and country.

President Eastman, it is with great pride that I present Dr. Prinya Sakiyalak, a surgeon of incredible dedication and service to our profession and his country, for Honorary Fellowship in the American College of Surgeons. ♦
Mr. President, it is my distinct privilege to present Prof. Norman Stanley Williams of London, England, for Honorary Fellowship in the American College of Surgeons. Professor Williams was born and educated in Leeds. Though not from a medical family, he was influenced by the program *Your Life in Their Hands* and became committed to surgery at an early age.

He has a most distinguished career as an internationally recognized academic colorectal surgeon. He was director of the Academic Surgical Unit at the London Hospital from 1985 to 1995 and head of the Center for Academic Surgery, London Queen Mary’s School until 2011, when he was elected by his peers to be president of the Royal College of Surgeons of England, a role defining international surgical leadership.

Professor Williams is sought worldwide for his insight and academic contributions, and he is the lead editor of the 26th edition of Bailey and Love’s textbook, *Short Practice of Surgery*. He has the unique ability to gather groups of individuals to provide consensus in the delivery of surgical health care. He has led basic scientists and clinical investigators to develop innovative and integrative trials that resulted in evidence-based advances in the management of bowel function.

His social awareness of the consequences to an individual receiving an abdominal wall stoma is said to have evolved from his empathy for a family member who had an ostomy at the time when such stomas were both crude and disfiguring. His seminal publication 30 years ago, which specified that a five-centimeter distal margin was not a prerequisite for a successful rectal cancer operation, has changed the lives of so many patients. His commitment to address the importance of bowel continuity, sphincter preservation, and restoration has been an inspiration to individual patients, and he has led the National Center for Bowel Research and Surgical Innovation.

His wife believes that he was transformed by working in California. He embraced the California ethic, lost 60 pounds, and grew a mustache so impressive that he was stopped at the Texas border! I like to think that much of his team-building success can be attributed to his commitment to rugby football. An excellent player (no doubt by appearance assuming the role of front row Prop forward) he has continued to be physically active and swims every day.

Norman Williams epitomizes the academic investigator committed to a focused interest, advancing the physical and emotional needs of the patient to the forefront and having the immense capacity to take a leadership role in health care delivery.

His interest in vigorous debate has been passed on to his two children; however, they have chosen to use that talent in the legal world. Medical succession will now rest with the next generation, his two granddaughters.

Mr. President, it is a privilege to recognize a surgical leader from the UK with major insights into health care delivery who is firmly grounded by his commitment to the welfare of the individual patient, and I am honored to present Prof. Norman Stanley Williams for Honorary Fellowship.
Mr. President, it is my privilege and honor to present to you Prof. Cheng-Har Yip of Kuala Lumpur, Malaysia, for Honorary Fellowship in the American College of Surgeons. Dr. Yip is a consultant breast surgeon in Malaysia’s Sime Darby Medical Centre and holds appointments at the University of the West of England, Bristol, and as clinical professor on the faculty of medicine, University Tunku Abdul Rahman, in Kuala Lumpur, Malaysia. She is lead clinician for the Cancer Research Initiatives Foundation breast cancer research program.

The daughter of a school teacher, Cheng-Har was born in the small Malaysian town of Kampar. The first in her family to graduate from college, she was conferred with a medical degree from the University of Malaya in 1981 and began her medical training at a time when only a handful of women in her country were surgeons. After becoming a Fellow of the Royal College of Surgeons (Glasgow) in 1985, Dr. Yip pursued an academic career in the department of surgery, faculty of medicine, University of Malaya, from which she retired as professor in September 2012.

Dr. Yip has two sons, one of whom is currently studying medicine. She first trained in general and pediatric surgery but then subspecialized in breast surgery, realizing that female patients with breast problems often prefer to see a woman surgeon. After breast surgery training in the UK, Dr. Yip created one of the first breast clinics in Malaysia at the University of Malaya Medical Centre, which now treats more than 300 new breast cancer cases each year. At the beginning, neither medical oncology nor palliative care services were available, so Dr. Yip learned to give her own chemotherapy and provide palliation, simultaneously running the hospital’s general surgery services. Cheng-Har Yip was a pioneer who acquired skills and started programs because her patients needed them.

Following a 1995 research grant to study Malaysian breast cancer epidemiology, in 2011 Dr. Yip was awarded a $5 million research grant from the Malaysian Ministry of Higher Education. She has more than 100 peer-reviewed publications and continues her role as research advisor to the Breast Cancer Research Programme, having established a tissue repository and breast cancer database at the Sime Darby Medical Centre.

Dr. Yip chairs multiple breast cancer guideline committees, was president of the Association of University Surgeons of Asia and the Asia Pacific Organization for Cancer Prevention, and is a council member of Breast Surgery International. She became the first woman president of the College of Surgeons of Malaysia in 2010. She has consulted for the World Health Organization, the International Atomic Energy Agency, the International Cancer Control Conference, and the Breast Health Global Initiative. In 2009, Dr. Yip was awarded both the Union for International Cancer Control 2009 Reach to Recovery International Health Professional Award and the Malaysian Greatest Women of Our Times award. In 2012, she was awarded the title of “Dato” from the Sultan of Perak in her home state. Most recently, in August 2013, Dr. Yip became president-elect of Breast Surgery International during the organization’s annual meeting in Helsinki, Finland.

Mr. President, it is with great pride that I present Dr. Cheng-Har Yip, breast surgeon, teacher, researcher, and patient advocate for Honorary Fellowship in the American College of Surgeons.
The new Administrative Director of American College of Surgeons (ACS) Cancer Programs, Lynn Erdman, RN, MN, OCNS, FAAN, joined the ACS September 23. The Administrative Director oversees the activities of the Commission on Cancer (CoC), National Cancer Data Base, National Accreditation Program for Breast Centers (NAPBC), American Joint Committee on Cancer, and the ACS Clinical Research Program. Ms. Erdman replaced Connie Bura, who is now President for the organization.

Ms. Erdman joined the ACS September 23.

Ms. Erdman

Lynn Erdman, RN, MN, OCNS, FAAN, hired as Administrative Director, ACS Cancer Programs

Experience
A Fellow of the American Academy of Nursing, Ms. Erdman has more than 30 years of clinical and administrative experience in the health care and not-for-profit sectors and brings a rich oncology clinical nurse specialist background to the ACS. Most recently, she served as national vice-president of community health for the Susan G. Komen Global Headquarters based in Dallas, TX. For nine months earlier this year, she also served as a member of the six-person, interim leadership team at Susan G. Komen, overseeing all operations and fiscal responsibilities during the search for a new president for the organization.

Ms. Erdman’s responsibilities at Komen included overseeing 2,000 community grants awarded across the nation, totaling more than $100 million. She worked with all Komen affiliates (more than 120 nationwide) and managed all national and some international corporate grants awarded to the organization. Ms. Erdman also was responsible for Komen’s educational materials and a help line for patients and families.

Previously, she worked for more than 25 years in hospitals and health care systems in various roles. Ms. Erdman served as divisional vice-president of medical affairs for the American Cancer Society, Atlanta, GA, developing effective partnerships with health care providers, researchers, other not-for-profit organizations, community health leaders, and volunteers and advocating for access to care. In addition, she was the founding director of the Presbyterian Cancer Center in Charlotte, NC, and was responsible for creating all programs from medical and surgical oncology to research, transplant services, and palliative care.

Recognition
Ms. Erdman holds a bachelor of science degree in nursing from the University of South Carolina, Columbia. She currently serves as consulting faculty for Duke University’s Graduate School of Nursing in Durham, NC.

She has written numerous articles and book chapters on topics related to oncology, state cancer plans, and customer service. She is a nationally recognized speaker, having presented more than 800 lectures in the U.S. and abroad on a range of issues, including cancer center and breast center development, state cancer plan implementation, advocacy, grant writing, clinical trials expansion, supportive care options, ethics in cancer care, and patient education.

Ms. Erdman has served on the national boards and task forces of many cancer organizations, including the Comprehensive Cancer Control National Partnerships, the CoC Steering Committee, and NAPBC, the Oncology Nursing Society, The Cancer and Leukemia Group B, the American Cancer Society, Oncology Supply, the Association of Community Cancer Centers, and Purdue Pharma, to name a few. She also was the first woman and first nurse to chair the breast and cervical cancer committee for the American Cancer Society and recently completed a government-appointed four-year term as chair of the North Carolina Advisory Committee on Cancer Coordination and Control.

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V98 No 11 BULLETIN American College of Surgeons
Dr. M. Gage Ochsner, co-founder of Ochsner Institute, dies at age 59

M. Gage Ochsner, MD, FACS, chief of trauma and surgical critical care at Memorial University Hospital and professor of surgery and academic chair, department of surgery, Mercer University School of Medicine, Savannah, GA, passed away earlier this year at age 59. He was the co-founder of Savannah’s M. Gage Ochsner Institute for Injury Research and Prevention—a multidisciplinary team of health care professionals who research, identify, and educate the community on the leading causes of preventable injury.

Dr. Ochsner played a significant role in developing Georgia’s statewide trauma system and was a valued member of the American College of Surgeons (ACS) Committee on Trauma (2010 to 2013).

Carl R. Boyd, MD, FACS, professor, department of surgery, Mercer University School of Medicine, announced that he is dedicating his recently published book, *Echoes from the Operating Room: Vignettes in Surgical History*, to Dr. Ochsner, and will donate all proceeds from book sales to the Ochsner Institute. To order a copy of the book online or make a donation to the Ochsner Institute, go to [http://www.memorialhealth.com/memorial-health-foundation.aspx](http://www.memorialhealth.com/memorial-health-foundation.aspx).

Dr. Ochsner is survived by his wife of 27 years, Judy Rochelle Ochsner, his daughter, Julia Katherine Ochsner, Chicago, IL, and his two sons, Mims G. Ochsner III (Trey); and Matthew Cousins Ochsner, both of Savannah. He is also survived by his mother, Paddy Cousins Ochsner.
Dr. Ronald Maier to receive 2013 Sheen Award

Ronald V. Maier, MD, FACS, the Jane and Donald D. Trunkey Endowed Chair in Trauma Surgery and vice-chairman, department of surgery, University of Washington (UW) School of Medicine, Seattle, will receive the 2013 Dr. Rodman E. Sheen and Thomas G. Sheen Award, which has been presented annually since 1968 to honor outstanding contributions to the medical profession. Dr. Maier will receive the award during the December 14 annual clinical meeting of the New Jersey American College of Surgeons (ACS) Chapter in Iselin, NJ, and will be the featured speaker at the meeting.

Highly qualified candidate
Dr. Maier is a professor of surgery at the UW School of Medicine. In addition, he is the director of the Northwest Regional Trauma Center and surgeon-in-chief at Harborview Medical Center, the Level I trauma center in Seattle.

Dr. Maier has served as a member of the ACS Committee on Trauma (COT), including as Chief, Region 10, and as Chair of the COT’s Injury Prevention and Control Committee, and currently serves on the Executive Program Committee. He has received numerous honors for his research, teaching, and clinical trauma work, including the John K. Stevenson Award for Teaching Excellence and Dedication to Resident Education (2012), the Scientific Achievement Award from the Shock Society (2004), the Flanck-Karl Award from the American Surgical Association (2008), the Lifetime Achievement Award in Trauma Resuscitation from the American Heart Association (2007), the Accreditation Council for General Medical Education’s Parker J. Palmer Courage to Teach Award (2010), and is a member of the Gold Humanism Honors Society. He has been a fellow of the American Association for the Advancement of Science since 1995.

Dr. Maier has presented his work worldwide, delivering more than 300 lectures on trauma, critical care medicine, and surgical immunology. He has contributed to 59 book chapters and more than 300 peer-reviewed articles. He has received continuous support from the National Institutes of Health (NIH) for more than 30 years totaling more than $20 million. In 2012, Dr. Maier and colleagues received NIH funding to study the impact of aging on the immune response to traumatic brain injury, and recently he and his colleagues received a Patient-Centered Outcomes Research Institute award to perform a randomized control trial of early intervention in the treatment and prevention of post-traumatic stress disorder.


Dr. Maier received his medical degree from Duke University Medical School, Durham, NC, and completed his surgical internship at the University of Texas Southwestern Medical School, Parkland Memorial Hospital, Dallas. Moving to Seattle with G. Tom Shires, MD, FACS, as chair, he completed a general surgery residency at the UW in 1978. From 1978 through 1981, he completed a two-year post-doctoral research fellowship and was a research associate in immunopathology for one year at Scripps Clinic and Research Foundation in La Jolla, CA.
The Sheen Award honors a full-time working physician involved in ongoing and promising teaching and medical research.

The Sheen Award
The Sheen Award honors a full-time working physician involved in ongoing and promising teaching and medical research. Philanthropist Thomas G. Sheen, in Atlantic City, NJ, created a perpetual trust “to further the study of medicine and to compensate an outstanding Doctor of Medicine Science in the United States each year.” The award honors the memory of his brother, Rodman E. Sheen, MD, a radiologist and X-ray pioneer who was injured so severely when a Roentgen tube exploded in his research lab that he never was able to return to medical practice. He died at age 47 in 1937. The annual award varies in amount, depending on the earnings of the estate, but since 1999, the award has been $25,000.

Today, the New Jersey-based Sheen Advisory Committee selects the nominees whose names are submitted by the vice-president/trust officer of the Bank of America, N.A. The advisory committee comprises 10 to 12 physicians, half of whom are surgeons, and the other half of whom represent a range of medical specialties. All committee members are from southern New Jersey where the Sheen family lived and worked. S. Stuart Mally, MD, FACS, the 1992 recipient of the ACS Distinguished Service Award, served as the original chair of the committee. A stipulation of the award is that a national medical organization serve as a consultant in the selection process. Since 1982, the ACS Honors Committee has developed the annual list of nominees and recommended candidates.

Nominees for the award must be medical research pioneers doing ongoing work of the highest quality. They must be involved in teaching and research in medicine and not retired or semi-retired, so that the award will be applied to future scientific work. ♦

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from the American College of Surgeons

Transfer your ACS CME credit to the American Board of Surgery electronically!

ACS Members who are recertifying can now enjoy the ease of submitting their ACS CME credits directly to the American Board of Surgery (ABS).

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→ Review your transcript for accuracy and authorize transfer of credits
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Log into the member Web portal at www.eFACS.org to get started
Members in the news

Karl Bilimoria, MD, FACS, assistant professor of surgery at Northwestern University’s Feinberg School of Medicine and director of the Surgical Outcomes and Quality Improvement Center Northwestern Memorial Hospital, Chicago, IL; and an American College of Surgeons (ACS) Faculty Scholar in the Division of Research and Optimal Patient Care; and H. David Reines, MD, FACS, vice-chair, surgery, Innova Fairfax Hospital, Falls Church, VA; professor, surgery, Virginia Commonwealth University, Richmond; and Past-President of and 2013–2014 Governor representing the ACS Metropolitan Washington Chapter, were appointed to the Agency for Healthcare Research and Quality (AHRQ) Quality Indicator Standing Work Group. This group, which held its first meeting September 12, provides feedback to AHRQ regarding refinement of current patient safety and quality, developing new measures, and identifying measures to retire. The group will focus on the life cycle of AHRQ quality indicators and address general issues related to the measurement cycle.

Richard L. Gamelli, MD, FACS, Maywood, IL, will receive the 2013 Loyola University Chicago Stritch School of Medicine’s highest honor, the Stritch Medal, in recognition of his research, patient-centered care, and contributions to medical education. Dr. Gamelli, the Robert J. Freeark Professor of Surgery and director of the burn center at Loyola University Medical Center, and Loyola’s Burn and Shock Trauma Research Institute, is senior vice-president and provost of health sciences at Loyola University. Dr. Gamelli will receive the award November 16 at Loyola’s annual Stritch Awards Dinner at the Field Museum of Natural History in Chicago.

Vijay Mittal, MD, FACS, President of the ACS Michigan Chapter, is one of only 40 scholars to receive a 2013 U.S. Department of State’s Fulbright Distinguished Scholar Award in Teaching and Research. Dr. Mittal is clinical professor of surgery at Wayne State University School of Medicine, Detroit, MI, and program director of general surgery residency at Providence Hospital and Medical Centers, Southfield, MI.

In his Fulbright proposal, “Global Surgical Education Evaluation and Uniformity,” Dr. Mittal expressed his desire to examine the surgical education system in India and explore the difficulties in transferring medical training and credentials earned in other parts of the world to the North American system, to achieve a level of parity. As a Fulbright Award recipient, Dr. Mittal will spend four months in India over the next year and will visit five major postgraduate institutions and five private hospitals to compare their medical education programs.

Dr. Mittal graduated from Amritsar Medical College in India and completed his surgical residency at the Post Graduate Institute of Medical Education and Research Chandigarh, where, in 1971, he performed the nation’s first kidney transplant.
Donald J. Palmisano, MD, JD, FACS, clinical professor of surgery and medical jurisprudence at Tulane University School of Medicine, New Orleans, LA, received the Tulane Medical Alumni Association Outstanding Medical Alumnus Award 2013, on October 4. A former president of the American Medical Association (2003–2004) and the Louisiana State Medical Society (1984–1985), Dr. Palmisano, the author of two books—On Leadership and the Little Red Book of Leadership Lessons—has testified before Congress many times on medical liability reform, patient safety, antitrust, health system reform, and patient privacy. 

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Dr. Sachdeva delivers named lectures, honored for contributions to surgical education

Ajit K. Sachdeva, MD, FACS, FRCS(C), Director of the American College of Surgeons Division of Education, was invited to deliver three distinguished named lectures earlier this year. In March, he served as the Boone Powell, Sr., Visiting Professor in Surgery, and delivered the Boone Powell, Sr., Lecture at Baylor University Medical Center, Dallas, TX.

Dr. Sachdeva delivered the Lloyd M. Nyhus Memorial Lecture at the University of Illinois, Chicago, in March, as well. In May, he delivered the Theodore A. McGraw, MD, Lecture at the Combined Meeting of the Academy of Surgery of Detroit and the Detroit Surgical Association, MI. During that visit, Dr. Sachdeva was awarded the Theodore A. McGraw, MD, Medal. 

From left: James W. Fleshman, MD, FACS; Dr. Sachdeva; Ronald C. Jones, MD, FACS. Drs. Fleshman and Jones are affiliated with Baylor University Medical Center, Dallas, TX.

Vijay Mittal, MD, FACS, left, with Dr. Sachdeva, at the Meeting of the Academy of Surgery of Detroit and the Detroit Surgical Association.
The American College of Surgeons (ACS) proudly announces the new Evidence-Based Decisions in Surgery online modules. Derived from practice guidelines to help address diagnoses and conditions most relevant to general surgeons, these “point-of-care” modules were developed through a rigorous, peer-reviewed process.

The modules are:

- Meant to be used in patient-focused interactions and patient education
- Electronically available on any mobile device, tablet, or computer
- Available to all ACS members

For more information, visit [www.facs.org/education/ebds](http://www.facs.org/education/ebds) or contact Sapna Dalal at sdlal@facs.org or 312-202-5568.
AJCC launches new brand identity

The American Joint Committee on Cancer (AJCC) introduced a new brand identity and logo at its 2013 annual meeting, which took place in September in Chicago, IL. The new AJCC identity, which focuses on leadership, education, and trust, also includes a new website and an AJCC Twitter account.

“I think we have created something that is distinctive and really represents us well,” said Carolyn Compton, MD, PhD, FCAP, outgoing AJCC Chair. Dr. Compton noted that the new identity is intended to revitalize the AJCC’s brand personality and to establish a contemporary look that will draw an immediate response when viewed.

The new AJCC logo, which represents the energy and expertise of AJCC volunteers who work to improve the care of cancer patients, consists of a torch with a flame and a multicolored helix spiraling around the torch. Dr. Compton noted that the torch is a symbol of knowledge and leadership, the flame for providing light and a path to knowledge, the colors for progression and melding of different elements or groups coming together to find solutions, and the helix to signify DNA and the AJCC’s commitment to science.

“We also wanted to convey a very focused message. We wanted to make certain that people understood our objectives as being the premier educational source for integrating staging and the hub for the cancer staging community,” Dr. Compton said.

“I have learned that cancer is in fact a complex, adaptive system—the opposite of a system which is linear and operates by Newtonian equations,” Dr. Compton added.

The AJCC continues to collaborate with the leading experts across all research disciplines in order to develop and apply the academically rigorous and scientifically validated standards for cancer. View the AJCC’s new website at http://cancerstaging.org/Pages/default.aspx.

Established in 1959, the AJCC, which is administered by the American College of Surgeons, formulates and publishes systems of classification of cancer, including staging and end-results reporting, that will be acceptable to and used by the medical profession for selecting the most effective treatment, determining prognosis, and continuing evaluation of cancer control measures. ♦

The Commission on Cancer is hosting a paper competition for physicians-in-training to foster the importance of oncologic research in support of its mission.

Eligibility*

- Abstracts by residents and fellows-in-training on topics specific to oncology and related to the mission of the Commission on Cancer will be considered.
- Abstracts that have been previously presented at a state, regional, or national meeting within 24 months will be considered.
- The manuscript must have not yet been published in a peer review journal and can only be submitted to one American College of Surgeons Chapter. Original research is encouraged.

*A Please see your specific State Chapter announcement for eligibility details and time frames.

Judging Criteria

Judging is based on originality, scientific merit, and clinical relevance to oncology and the mission of the Commission on Cancer are the main criteria.

Timeline

Papers will be accepted until June 30, 2014.

Awards

The national award winners will be announced August 15, 2014. The winner will receive a $1,000 honorarium and travel expenses to present his or her research to the Annual Meeting of the Commission on Cancer on October 26, 2014 in San Francisco, CA. The winning entry will be considered for publication in the Journal of the American College of Surgeons.

The authors of the second and third place winning abstracts will receive a $500 cash award and an invitation for a poster presentation of their research during the 2014 Annual Meeting of the Commission on Cancer.

FOR MORE INFORMATION...

American College of Surgeons
Commission on Cancer
Cancer Liaison Program
clp@facs.org

Or contact your Commission on Cancer State Chair
www.facs.org/cancer/coe/statecontact.html
College accepting nominations for 2014 Jacobson Promising Investigator Award

The American College of Surgeons (ACS) is accepting nominations for the 10th Joan L. and Julius H. Jacobson II Promising Investigator Award to be conferred in 2014. To be considered for the award, submissions must be dated no later than February 28, 2014.

The Jacobson Promising Investigator Award recognizes outstanding surgeons engaged in research, advancing the art and science of surgery and demonstrating early promise of significant contribution to the practice of surgery and the safety of surgical patients. The award is funded through a generous endowment established by the donors and administered by the ACS Surgical Research Committee.

Award criteria

- Candidate must be a Fellow or an Associate Fellow of the ACS.
- Candidate must be board-certified in a surgical specialty and must have completed surgical training in the last six years.
- Candidate must hold a faculty appointment at a research-based academic medical center or hold a military service position.
- Only one application per surgical department will be accepted.
- Candidates must have received peer-reviewed funding such as a K-series award from the National Institutes of Health (NIH), Veterans Administration, National Science Foundation, or U.S. Department of Defense merit review to support their research effort.
- Nominees must submit a one-page essay to the committee that explains why they should be considered for the award and describes the importance of their past and current research.
- Nomination documentation must include an NIH-formatted biographical sketch and copies of the candidate’s three most significant publications.
- Nomination documentation must include a letter of recommendation from the nominee’s department chair. Up to three additional letters of recommendation will be accepted.

Surgeons who are at the “tipping point” of their research careers with a track record indicative of early promise and potential (such as a degree program in research or K-award) will receive special consideration. Surgeon-scientists who are well-established (such as recipients of NIH R01 grants) are not eligible.

Nomination procedures

Award criteria documentation and nomination materials may be sent electronically to jacobsonpia@facs.org or copied on to a flash drive and mailed to Carla Manosalvas, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Note that essays and biographical sketches must be submitted as Word documents. Applicants are encouraged to verify that all necessary materials have been received before the deadline. For additional information, contact jacobsonpia@facs.org or 312-202-5319.

NOV 2013 BULLETIN American College of Surgeons
The Board of Governors of the American College of Surgeons (ACS) selected Amy E. Tan, MD, FACS, a general surgeon in Blue Hill, ME, to receive the Year 2013 Nizar N. Oweida, MD, FACS, Scholarship. Dr. Tan has served for 10 years in the rural, coastal New England town, and the Oweida Scholarship supported her attendance at the 2013 Clinical Congress in Washington, DC.

Dr. Tan said she believes that her patients appreciate having access to quality surgical care close to home. She greatly valued the opportunity to attend the 2013 Clinical Congress to learn more about using the latest in selected surgical techniques safely and consistently with sound clinical practice, skills that will help her provide her patients with the best possible care. During the Clinical Congress, Dr. Tan presented before the Scholarships Committee and the Rural Surgery Forum.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The $5,000 award subsidizes attendance at the annual Clinical Congress, including Postgraduate Course fees. The Oweida Scholarship assists young surgeons practicing in rural communities by giving them the opportunity to attend the Clinical Congress and benefit from the educational experiences it provides. It is awarded each year by the Executive Committee of the Board of Governors.

2014 scholarship

The Executive Committee is now accepting applications for the 2014 Nizar N. Oweida Scholarship. The Oweida Scholarship is available to an ACS member in any of the surgical specialties who meets the following requirements:

• Provides surgical services in a small town or rural community in the U.S. or Canada
• Is an ACS Fellow or Associate Fellow in good standing
• Is younger than 55 years of age on the date the application is filed

The Oweida Scholar will attend the 2014 Clinical Congress, October 26–30, in San Francisco, CA. The awardee will receive a stipend and preferential housing assistance and will deliver brief presentations at the annual meeting of the Scholarships Committee and the annual Rural Surgery Forum.

The requirements for this award are posted on the College website, http://www.facs.org/memberservices/oweida.html. The application deadline for the 2014 Oweida Scholarship is December 16, 2013. For more information, contact ACS Scholarships Administrator Kate Early at kearly@facs.org or 312-202-5281.
2013 Claude Organ Traveling Fellow announced

Dr. Chagpar

Anees B. Chagpar, MD, MPH, FACS, director of the Breast Center-Smilow Cancer Hospital at Yale University, New Haven, CT, received the 2013 Claude Organ Traveling Fellowship of the American College of Surgeons (ACS). Dr. Chagpar will use her award to travel to India to study how breast and other cancers are treated and managed there, which will help her plan partnering projects with cancer care institutions in the developing world. Dr. Chagpar spoke before the ACS Scholarships Committee at the 2013 Clinical Congress.

The Claude Organ Traveling Fellowship was established in memory of Dr. Organ, a Past-President of the ACS. The $5,000 award allows an outstanding young surgeon to attend an educational meeting or make an extended visit to an institution of his or her choice, tailored to his or her research interests. The annual Claude Organ Traveling Fellowship benefits young surgeons who are members of the Society of Black Academic Surgeons, the Association of Women Surgeons, or the Surgical Section of the National Medical Association.

The requirements for this award are posted to the ACS website, at http://www.facs.org/memberservices/organ.html. Information regarding the 2014 Claude Organ Traveling Fellowship will be published in a future issue of the Bulletin.

SRGS Rural Surgery Single Issue

Nonsubscribers can earn CME credit for this special issue.

This issue of Selected Readings in General Surgery immerses itself in topics of interest to rural surgeons. These include the characteristics of rural practice, challenges in recruitment and retention, and a selective review of common clinical problems encountered in rural practice: trauma care, cutaneous surgery, endoscopy, gynecology, laparoscopic surgery, and urology.

To order: Purchase online at www.facs.org/srgs/subscribe/individuals.html. Scroll to the bottom and select “SRGS Rural Surgery Single Issue with CME.”

If you are an ACS member or have an ACS username, please log in to the e-store using your existing username and password BEFORE you place your order.

An order form is available at www.facs.org/srgs/rural.html

Order by phone at 800-631-0033
Calendar of events

*Dates and locations subject to change. For more information on College events, visit http://www.facs.org/cmecalendar/index.html or http://web2.facs.org/ChapterMeetings.cfm

**NOVEMBER**

Connecticut Chapter
November 1
Farmington, CT
Contact: Chris Tasik,
info@CTACS.org, http://ctacs.org/

Keystone Chapter
November 8
Danville, PA
Contact: Lauren Ramsey,
lramsey@pamedsoc.org,
http://www.keystonesurgeons.org/

Wisconsin Surgical Society—a Chapter of the ACS
November 8
Kohler, WI
Contact: Terry Estness,
wisurgical@att.net,
http://www.wisurgicalsociety.com/

Maryland Chapter
November 9
Baltimore, MD
Contact: Jennifer Starkey,
maryland@marylandfacs.org

Arizona Chapter
November 9–10
Phoenix, AZ
Contact: Joni L. Bowers,
jonib@azmed.org,
http://www.azacs.org/

Massachusetts Chapter
November 19
Boston, MA
Contact: Elizabeth Chouinard,
echouinard@prri.com

**DECEMBER**

Brooklyn-Long Island Chapter
December 4
Uniondale, NY
Contact: Teresa Barzyz,
acsteresa@aol.com,
http://www.bliacs.org/

Massachusetts Chapter
December 7
Boston, MA
Contact: Crystal Beatrice,
cbeatrice@prri.com,
http://www.mcacs.org/

New Jersey Chapter
December 14
Iselin, NJ
Contact: Andrea Donelan,
njsurgeons@aol.com,
http://www.nj-acs.org/index.html

**JANUARY**

Southern California Chapter
January 17–19, 2014
Santa Barbara, CA
Contact: Jim Dowden,
jdowden@prodigy.net,
http://www.socalsurgeons.org//acs/index.html

Louisiana Chapter
January 17–19, 2014
New Orleans, LA
Contact: Janna Pecquet,
janna@laacs.org,
http://www.laacs.org/

**FEBRUARY 2014**

Puerto Rico Chapter
February 20–22, 2014
San Juan, Puerto Rico
Contact: Aixa Velez,
genteinc@gmail.com

South Texas Chapter
February 20–22, 2014
Austin, TX
Contact: Janna Pecquet,
janna@southtexasacs.org,
http://www.southtexasacs.org/

North Texas Chapter
February 21–22, 2014
Dallas, TX
Contact: Nonie Lowry,
events@lp-etc.com,
http://www.ntexas.org/

Montana, Wyoming, and Idaho Chapter
February 21–23, 2014
Jackson, WY
Contact: Janis Black,
jbblack@wyosurgeons.com

**FUTURE CLINICAL CONGRESSES**

2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL

2016
October 16–20
Washington, DC