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Titles and locations current at the time articles were submitted for publication.

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Looking forward

by David B. Hoyt, MD, FACS

n February 2013, this column announced the launch of the American College of Surgeons’ (ACS) Transition to Practice (TTP) Program in General Surgery. I am pleased to report that the program is off to a successful start. The ACS TTP Steering Committee, led by J. David Richardson, MD, FACS, Past-Chair of the Board of Regents, has reviewed and given preliminary approval to 14 sites (see sidebar, this page). Perhaps most importantly, two of these institutions are making excellent progress in pilot testing the program: the Mercer University School of Medicine, Macon, GA, and the University of Tennessee Health Science Center College of Medicine-Chattanooga.

program design and purposes
The TTP Program is designed to help residents successfully transition to independent practice in general surgery. Young surgeons who participate in the one-year program, known as Associates, are given the opportunity to experience increasing autonomy in a broad-based clinical setting, build their competence and confidence in general surgery, develop practice management skills, and gain practical experience for the next phase of their careers.

Each program has a TTP Chief, who provides overall program leadership and quality and oversight—typically the chair of the department of surgery or the surgery residency program director. Each institution also has one or more Senior Associate(s) who are in full-time surgical practice at the facility and who serve as clinical mentors.

Institutions are afforded a great deal of flexibility in how they design each Associate’s program, but all programs focus on honing surgical skills through hands-on involvement in a general surgery service.

mercer’s experience
Thus far, the Senior Associates and Associates who have been participating in the TTP pilot programs have been very satisfied with the experience. William P. Pannell, MD, FACS, is the Senior Associate for the program run through Mercer Medical College and a general surgeon at Crisp Regional Hospital in Cordele, GA. For many years, Crisp Regional has partnered with state medical schools to provide medical students and residents with opportunities to be exposed to clinical practice. Then, in the summer of 2012, Dr. Pannell was approached regarding the possibility of pilot testing the TTP program. In the summer of 2013, Heidi Haun, MD, became Crisp’s first Associate.

“Dr. Haun basically wanted one thing,” Dr. Pannell said. “She wanted to do cases. She wanted experience.”

Since starting the program in July 2013, Dr. Haun has participated in rounds and in-house consultations with the Senior Associates. Soon she was allowed to start taking cases, barring any objections from the patients.

university of Florida/ St. Vincent’s Health System, Gainesville/Jacksonville, FL
• Mercer university School of Medicine, Macon, GA
• university of Louisville School of Medicine, Ky
• Louisiana State university Health Sciences Center at Shreveport School of Medicine, Shreveport
• Anne Arundel Medical Center, Annapolis, MD
• Wake Forest university School of Medicine, Winston-Salem, NC
• the ohio State university College of Medicine, Columbus
• Geisinger Health System, Danville, PA
• Alpert Medical School of Brown university, Providence, RI
• Medical university of South Carolina, Charleston
• the university of tennessee Health Science Center College of Medicine, Chattanooga
• university of texas Health Science Center at San Antonio, university of texas School of Medicine at San Antonio
• eastern virginia Medical School, Norfolk
• Gunderson Health System, La Crosse, WI
Thus far, the Senior Associates and Associates who have been participating in the TTP pilot programs have been very satisfied with the experience.

The Senior Associates have been available for immediate assistance whenever necessary, including her call times. “Gradually we have withdrawn to the ‘shadows’ and watched her become the great surgeon we knew she could be,” Dr. Pannell said.

Dr. Haun plans to practice in rural Ghana, where she will have very limited access to other surgeons and, therefore, will need to feel at ease working autonomously. “While I felt my skills were sufficient for starting practice, I believe my confidence was not quite up to par, as I had few opportunities to operate solo during residency,” she said. “I have been operating solo since the beginning, but have assisted my Senior Associates with their more complex cases and continue to invite their assistance for my larger cases.”

In addition to performing general surgery operations, Dr. Haun has assisted the obstetrician-gynecologists at the hospital with many procedures, including cesarean sections, hysterectomies, and removal of ovarian cysts. “I believe that I will be well prepared for rural surgery in West Africa at the end of this year,” Dr. Haun said.

**university of tennessee’s experience**

Like Dr. Haun, Benjamin E. Kellogg, MD, TTP Associate at the University of Tennessee-Chattanooga since August 2013, was interested in participating in the program so that he could work with mentors who would guide him toward more autonomous practice.

“I learned all the technical skills in surgery during residency, but I didn’t feel completely ready to practice autonomously. “Transition to practice’ really is the best way to describe this experience. It has allowed me to more gradually start operating on my own,” Dr. Kellogg said. The first few months, he was rotating with three or four general surgeons with broad-based practices and becoming more familiar with breast, colon-rectal, and endocrine operations.

At press time, Dr. Kellogg was mostly providing care to patients at a satellite office of the University of Tennessee in the rural town of Dayton. In the three months he had been there, he was handling many cases on his own under the mentorship of Craig Swafford, MD, FACS, a general surgeon and assistant professor of surgery at the University of Tennessee. Dr. Kellogg and Dr. Swafford have formed a close, positive working relationship through this experience. In fact, Dr. Kellogg, a Tennessee native, has signed a contract to begin practicing in the Dayton office.

R. Phillip Burns, MD, FACS, professor and chair of the department of surgery at the University of Tennessee, and the TTP Chief at that institution, said that “almost all of the work he’s done is in areas where we have faculty but don’t have residents.” Dr. Kellogg has helped to fill those gaps, making the program mutually beneficial to the Associate and the sponsoring institution. “We look forward to him completing the program and then becoming a faculty member,” Dr. Burns said.

“The program is going great. It has achieved what I thought it would,” which is to provide the opportunity for a young surgeon to experience firsthand the practice of general surgery, added Dr. Burns, Past-First Vice-President of the ACS and a member of the TTP Program Steering Committee.

**need your help**

The TTP Program is off to a fantastic start, and the College looks forward to hearing more success stories next year as other institutions initiate their programs. I encourage the chairs of departments of surgery and residency program directors at medical schools and training programs not yet participating in the TTP Program to explore this opportunity. I also encourage attending surgeons to offer graduating residents the benefit of their mentorship by serving as Senior Associates.

We all are acutely aware of the problems facing the general surgery workforce and surgical education and training. The TTP Program addresses these concerns in a proactive manner. With your help and participation we can ensure that surgical patients will continue to have access to the care they need for years to come.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Dual eligible beneficiaries:

• Criteria for coverage under both Medicare and Medicaid and the demographics of dual eligibles are reviewed.
• Barriers to accessing surgical care for this patient population are described.
• Problems with care coordination and their effects on patient outcomes are examined.
• Provisions in the ACA that are designed to improve care for dual eligibles are summarized, and their implications are discussed.
• Several state demonstration projects established under the ACA to help eliminate disparities in care for dual eligibles are described.
• Opportunities for the ACS and its chapters to play a role in improving the health care provided to dual eligibles are explored.

Roles for surgeons under health care reform

Patients who qualify for both Medicare and Medicaid, known as “dual eligibles” or “duals,” are the most socioeconomically vulnerable and costly patient population in the health care system. In 2007, duals comprised 21 percent of the Medicare population but accounted for 31 percent of total Medicare costs; they represented 15 percent of the Medicaid population, but 39 percent of total Medicaid costs. Poor care coordination and lack of financial alignment between Medicaid and Medicare results in poor access, increased costs, and decreased quality of care for duals. Inadequate care coordination contributes to hospital readmissions and increased use of acute care services for preventable conditions for duals. An estimated $20 billion could be saved annually by improving coordination of primary, acute, and long-term services and by eliminating duplicate services.

The Affordable Care Act (ACA) contains several provisions that are designed to address these problems. For example, it encourages states to integrate care and coordinate benefits for duals through state demonstration programs. In addition, the ACA established two new offices within the Centers for Medicare & Medicaid Services (CMS): the Medicare-Medicaid Coordination Office, also known as the Federal Coordinated Health Care Office (FCHCO), and the Center for Medicare and Medicaid Innovation (Innovation Center). The FCHCO aims to align care coordination and financing mechanisms for all Medicare and Medicaid beneficiaries, whereas the Innovation

by Shilpa S. Murthy, MD; Joel S. Weissman, PhD; David C. Grabowski, PhD; Kristin McDonald; Krista L. Kaups, MD, MSc, FACS; and John G. Meara, MD, DMD, MBA, FACS
Inadequate care coordination contributes to hospital readmissions and increased use of acute care services for preventable conditions for duals. An estimated $20 billion could be saved annually by improving coordination of primary, acute, and long-term services and by eliminating duplicate services.

Center will test novel payment and service delivery models, including global payments and capitation.\textsuperscript{17,18} Although these reforms are needed, there is a paucity of information regarding how surgical services will be integrated into state demonstration programs or how transitions from a fee-for-service (FFS) model to capitated programs will affect surgeons’ compensation. Unfortunately, sparse data are available on surgical patient demographics, readmission rates, and use of surgical services by the dual eligible population. Limited data document a lack of access to surgical care and decreased overall survival after surgical resection compared with Medicare-only patients.\textsuperscript{6,19} As a result, the surgical community has an opportunity to contribute to the understanding of this population in terms of assessing demographics, readmission rates, quality and access barriers, and current use of surgical services.

The American College of Surgeons’ National Surgical Quality Improvement Program (ACS NSQIP\textsuperscript{®}) and the Inspiring Quality campaign stimulated a dialogue on innovative quality improvement programs across the nation.\textsuperscript{20,21} Because of this initiative, members of the ACS have the opportunity to advocate for the integration of surgical quality improvement strategies within state demonstration programs to improve care, costs, and overall outcomes for duals.

\textbf{Characteristics of dual eligibles: dual eligible benefit structure}

Medicare is a federally funded program that provides health insurance to individuals who are 65 years of age and older or who have Social Security disability insurance.\textsuperscript{1} People who have amyotrophic lateral sclerosis, end-stage renal disease (ESRD), or who require a kidney transplant also qualify for Medicare coverage, regardless of age.

Medicaid, on the other hand, provides health care coverage to low-income individuals and is funded by both the federal and state governments. The individual states define who among their residents qualifies for Medicaid coverage and which services are covered under the program, but most cover provider services, nursing home care, and home health services.\textsuperscript{3-5,13,14} Medicaid pays for acute care services, whereas Medicaid pays for long-term and social support services (see Figure 1, this page).\textsuperscript{22} All Medicare beneficiaries are subject to cost sharing.

\textbf{Medicare benefits}

\begin{itemize}
  \item Inpatient care in hospitals (Part A)
  \item Skilled nursing facility, hospice, and home health care (Part A)
  \item Physician and other providers’ services (Part B)
  \item Outpatient care, physician-administered drugs, durable medical equipment, and home health care (Part B)
  \item Preventive services (Part B)
  \item Prescription drugs (Part D)
\end{itemize}

\textbf{Medicaid benefits}

\begin{itemize}
  \item Full duals receive complete Medicaid state plan benefits package and assistance with Medicare premiums, deductibles, and cost sharing, and may receive, at the state’s discretion, additional home and community-based services, if eligible
  \item Partial duals receive Medicaid assistance with Medicare premiums and full or partial assistance with Medicare deductibles and other cost-sharing requirements through Medicaid Savings Programs, but do not receive other Medicaid-covered services
\end{itemize}

sharing, meaning they pay an annual deductible and coinsurance on medical services. For duals, Medicaid covers these shared costs.\textsuperscript{13}

Approximately 9 million Americans qualify for dual eligibility, and 7 million are “full duals,” meaning they receive full benefits from both Medicare and Medicaid. The remaining 2 million beneficiaries are “partial duals,” meaning they do not qualify for full Medicaid benefits.\textsuperscript{1} Full duals receive Medicaid benefit packages, whereas partial duals are ineligible for certain Medicaid services, such as hearing, vision, and dental programs that some states offer.\textsuperscript{22} However, partial duals can become full duals if they spend down their assets during prolonged hospitalizations or nursing home stays.\textsuperscript{1}

Policymakers are aware of the high costs associated with caring for this population. In a tight economy, state budgets are strained, and the resources required to provide health care to duals may compromise other state spending priorities. At the federal level, policymakers are continually looking for ways to find savings in the system, and are increasingly aware of the need to address the comprehensive care needs of duals. These efforts are hindered by separate funding streams, varying health care coverage rules among health plans, and multiple health care providers, all of which increase the complexity of coordinating care, providing quality care, and controlling costs between federal Medicare programs and state Medicaid programs.\textsuperscript{1,4}

**demographics**

Many dual eligibles live in poverty, nearly two-thirds lack a high school diploma, more than half are female, and a high proportion are minorities (see Figure 2, this page).\textsuperscript{4} Many duals have cognitive and functional limitations, live in long-term care facilities, have increased rates of chronic conditions, and experience higher annual mortality rates in comparison with Medicare-only patients (see Figure 3, page 13).\textsuperscript{1,3,4,23,24} These socio-economic and medical conditions increase the challenges of care coordination, leading to greater hospitalization rates when compared with Medicare-only beneficiaries (26 percent versus 18 percent in 2008).\textsuperscript{3}

Duals who are 65 years of age or older likely have three or more chronic conditions, require assistance with daily living, and reside in nursing facilities.\textsuperscript{2,4,9,23} These elderly patients are potentially high-risk surgery candidates who are predisposed to developing postoperative complications and may require more intensive and prolonged follow-up care. State demonstration programs that integrate postoperative care coordination into their initiatives may be able to improve overall outcomes and decrease costs.
Costs

In 2009, Medicaid costs for dual eligibles were $129 billion, and Medicare spending for duals was $132 billion; so, total health care costs for these patients exceeded $250 billion dollars.\(^1\) Dual eligible Medicare beneficiaries incurred costs of $14,169 per person, which was nearly twice that of Medicare only beneficiaries ($7,933).\(^3\) The most costly 10 percent of duals account for more than 60 percent of Medicare spending for duals, and costs for this top-tier group accounted for 15 percent of total Medicaid expenditures in 2008.\(^1\,^3\)

Beneficiary characteristics differ between duals with Medicare spending that is less than $2,500, defined as low-cost duals, and duals with Medicare spending greater than $40,000, defined as high-cost duals.\(^25\) The latter group of patients are more likely to live in long-term care facilities, have ESRD (11 percent versus <1 percent low-cost duals), diabetes (50 percent versus 21 percent low-cost duals), or heart conditions (60 percent versus 29 percent low-cost duals).\(^3\,^4\,^25\)

Additionally, 39 percent of duals (3.6 million) are younger than 65 years of age and disabled, and Medicare spending for disabled, young duals is lower than spending for duals age 65 and older ($13,661 per capita versus $16,445 per capita on average).\(^3\,^4\) This disparity likely is attributable to decreased patterns of service use due to the fact that younger duals are less likely to live in a facility and generally have fewer than three chronic conditions.\(^2\,^4\,^24\) Overall, there appears to be a younger, healthier low-cost dual population with lower utilization rates and costs to the health care system than elderly, high-cost duals (see Figure 4, page 14).\(^3\) It is unknown whether such a dichotomy exists within the surgical patient population. Further research is needed to determine which factors predict high costs and what quality initiatives surgeons can implement to efficiently deliver care to this population.

Barriers to surgical access

A paucity of data is available on duals’ access to and use of surgical services. However, few studies on select populations suggest a lack of access to surgical care and decreased postoperative survival.\(^6\,^19\,^26\,^27\) A study in Michigan used statewide Medicaid and Medicare data to evaluate all treatments of non-small cell lung carcinoma (NSCLC) in duals versus Medicare-only patients. In a study of 2,626 patients, duals were half as likely as Medicare-only patients to undergo lung resections even when controlling for multiple factors. Surgical resection narrowed but did not close the survival gap between duals and Medicare-only beneficiaries.\(^19\)

**Note:** ADLs are activities of daily living, and include self-care tasks.

**Source:** Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & use File, 2008.
Another study in Michigan used a similar methodology to compare the likelihood of surgical consultation and resection between duals who had NSCLC or colon cancer with their Medicare-only counterparts. In a study of more than 3,000 patients, duals were half as likely to be evaluated by a surgeon, although the likelihood of resection was not significantly different between duals and Medicare-only patients. These studies begin to define the problem but are limited given that they were performed in one state and were confined to lung and colon cancer patients only. Whether these findings can be generalized to all surgical patients is questionable due to differences in disease processes, regional variations, age, and types of surgical treatment.

Causes of surgical disparities between duals and other patients are likely multifactorial; for example, educational disparities lead to poor health literacy, non-adherence to treatment plans, and gaps in communication between health care provider and patient. Additionally, geographic isolation could present transportation barriers likely leading to delayed surgical care. Lastly, access to physicians may be limited due to poor Medicaid reimbursement rates and, consequently, some physicians may not accept dual patients.

Fragmented care coordination

Duals often have more than one co-morbidity, which multiple health care providers manage, thereby increasing the complexity of care coordination needed between Medicaid and Medicare. Care is provided through a system of disjointed programs funded by different state and federal governmental agencies. For duals, fragmentation occurs due to differences in state eligibility criteria and services provided by Medicaid.

Poor-quality care leads to hospital readmissions, thereby increasing the use of acute care services for preventable conditions for duals. In 2008, duals represented one-third of all Medicare hospital stays that had preventable primary diagnosis of pressure ulcers (36 percent), asthma (32 percent), and diabetes (32 percent). Patients with pressure ulcers had the highest cost per stay ($15,000). One-fourth of hospitalizations for duals were for urinary tract infections (UTI), chronic obstructive pulmonary disease (COPD) exacerbation, and bacterial pneumonia. Women accounted for most dual-eligible hospital stays, accounting for more than three out of four stays for injurious falls, asthma, and UTIs.

Experts estimate that $20 billion could be saved annually by eliminating duplicate services, decreasing acute care visits, and better integrating...
Medicaid and Medicare. For example, quality improvement initiatives focused on development of standardized protocols that visiting nurses could use to avert postoperative wound infections and pressure ulcers likely would decrease the number of preventable hospital admissions. Through state demonstration programs, surgeons potentially have the opportunity to design and advocate for postoperative care coordination services.

**misaligned payments**

Nursing home care also is an area of high incurred costs due to misaligned reimbursement incentives. Medicare and Medicaid both pay for nursing home care; these services are differentiated by referring to Medicare coverage as skilled nursing facility (SNF) and Medicaid coverage as nursing facility care. Medicare coverage requires prior hospitalization, whereas Medicaid covers long-term nursing home care. When a nursing home beneficiary is admitted to the hospital, Medicare pays the hospital costs, and when patients return to nursing homes the institution receives higher Medicare SNF payments rather than Medicaid rates. Nursing homes that hospitalize residents for preventable conditions likely fail to provide adequate medical care. Recent studies support this claim and demonstrate that compared with Medicare-only beneficiaries, duals are likely to be discharged to mediocre SNFs with lower nurse-to-patient ratios. Lack of adequate nursing care could lead to poor-quality care, contributing to readmission rates for preventable conditions. Due to these concerns, CMS moved toward encouraging the development of value-based payment demonstration projects in 2009, rewarding SNFs that reduced preventable hospital admissions. It is important for surgeons to be involved in the development of policies related to quality improvement programs in nursing homes. Their involvement could lead to decreased hospital readmissions for preventable postoperative complications and, in turn, improve quality of care while decreasing costs.

**aCa policy solutions and implications**

The ACA contains several provisions aimed at improving care coordination and financing for duals. The ACA-created FCHCO is tasked with integrating and coordinating Medicare and Medicaid benefits and finances; additionally, the Innovation Center is charged with testing novel payment and service delivery models. Other policies in the ACA call for establishing medical homes for Medicaid patients, waiving Medicare Part D cost sharing for full duals, and increasing federal expenditures to support state expansion of home- and community-based services for long-term care. The key ACA policy likely to improve outcomes for duals is establishment of state demonstration programs.

**state demonstration programs**

In July 2011, CMS announced national efforts to integrate care and coordinate benefits for duals through state demonstration programs. Design contracts and financial alignment proposals between states and CMS are required and, once approved, memorandums of understanding (MOU) between CMS, the state, and health plans are created. Currently, nine states have finalized MOUs; three (Massachusetts, California, and Washington) started enrolling beneficiaries in 2013, and the rest will implement programs in 2014. The federal government pays all health care costs in a demonstration program's budget, but states pay for long-term costs of care. CMS plans to limit enrollment to 2 million dual eligibles in demonstration projects nationally. California, Illinois, Massachusetts, New York, Ohio, South Carolina, and Virginia will test a capitated financial alignment model, and Washington will test a managed fee-for-service model. Minnesota will test only integration of administrative functions without a CMS financial alignment model. Following are summaries of the demonstration projects in various states.
In 2009, Medicaid costs for dual eligibles were $129 billion, and Medicare spending for duals was $132 billion; so, total health care costs for these patients exceeded $250 billion dollars.

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Massachusetts’ One Care model

Massachusetts Medicaid (MassHealth) and Medicare will join with three health plans to offer One Care to dual-eligible patients. For a period of time, duals may voluntarily enroll in One Care. After this time period has passed, they will be enrolled in a managed care plan and may opt out of One Care.16

Three health plans participating in One Care are Commonwealth Care Alliance, Fallon Total Care, and Network Health. Massachusetts created managed care entities called Integrated Care Organizations (ICOs), which provide patient-centered medical homes and coordinate behavioral health services, clinical care services, and prescription drugs, and provide community-based services as an alternative to other high-cost services, based on enrollees’ needs. Long-term care support coordinators will be hired independently of the health plans and will come from community-based organizations.16,31,32

CMS will combine Medicare and Medicaid funds to provide a blended capitated payment to ICOs. CMS will contribute Medicare Parts A, B, and D services to the ICO blended rate. The state contributes to the ICO rate through Medicaid. The capitation rate will be risk-adjusted based on Medicare Advantage and Medicaid risk-adjustment rating categories and high-cost risk pools.

Duals may lose their current providers after enrolling in the new ICOs. When a beneficiary enrolls in an ICO, patients have a 90-day transition period during which they may continue to receive care from their current provider. After this time period ends, duals may only continue to receive care from providers that are part of the ICO network. CMS and the state will both be responsible for oversight of ICOs; additionally, CMS will monitor and evaluate programs by funding independent evaluators.

One Care’s structure is based on a pilot program, the Massachusetts General Hospital (MGH) Physicians Organization Care Management Program, which succeeded in controlling costs and improving quality of care.5,21,31,32 The MGH Physicians Organization Care Management Pilot Program was successful.
largely due to time and resource investment. Case managers with substantial experience engaged in intensive training and nurses with strong clinical and leadership skills were hired. Communication was a key component, with weekly e-mail reports serving as an important feedback mechanism. MGH information technology was adapted and changed as needed to suit the program. All these components are built into the One Care model and are strategies that could potentially be used to design surgical care coordination programs into state demonstration programs.

California’s Cal MediConnect
California Medicaid (Medi-Cal) and Medicare are scheduled to launch Cal MediConnect in April in eight counties. Cal MediConnect is a care coordination program similar to Massachusetts One Care, targeting dual eligible beneficiaries. An estimated 465,000 beneficiaries will be enrolled in Cal MediConnect.

Participating health plans provide all Medicare and Medicaid services, including primary and acute care services, prescription drugs, behavioral health, and long-term support services (LTSS). Dental, vision, and nonemergency transportation services, which were not covered under Medi-Cal, will now be compensated. Health plans allow enrollees to continue care with current Medicare providers for six months and their Medicaid providers for 12 months. Plans also include interdisciplinary care teams comprising experts in cultural competency and social services. Health plans are financed through capitated models similar to One Care.16,17,33–35

Washington and Minnesota demonstration programs
Washington State’s demonstration program differs in that it will use Medicaid-driven medical home networks to coordinate Medicare and Medicaid services using a FFS model. Providers will continue to receive FFS reimbursements from both Medicare and Medicaid covered services. Any savings in this demonstration program will be determined retrospectively. The state

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Overall, state demonstration programs could reveal ways to improve care coordination while decreasing costs and improving overall health outcomes for duals.

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implications and future directions

The goal of the ACA is to improve health care quality and slow spending growth in the health care system. This approach aligns with the goals of ACS NSQIP and the ACS Inspiring Quality campaign. Nationally, hospital readmission rates for preventable surgical conditions are being used as quality indicators through the Hospital Readmissions Reduction Program administered by CMS. ACA provisions authorize CMS to progressively reduce Medicare payments to hospitals with high readmission rates.31 Dual eligibles experience higher readmission rates than non-duals, likely because of their poor access to care, low socioeconomic status, and poor baseline health status.36-38

As a result, those hospitals and surgeons that disproportionately care for a higher number of duals may be penalized financially. Physician practices and hospitals may be unable to absorb these financial reductions, further widening the gap in resources and equity in care for duals. Furthermore, recent studies demonstrate that, compared with Medicare-only beneficiaries, duals are discharged to poorer-quality SNF facilities due to failures in discharge planning.7 Improving care coordination and discharge planning as well as
designing pre- and postoperative surgical care quality improvement programs through state demonstration programs may be beneficial in reducing admissions for preventable conditions, improving access to quality care, and lowering costs. These are potentially key areas where state demonstration programs, the College, and ACS state chapters can align.

At the state level, the Inspiring Quality campaign brings together local and national health care leaders to participate in policy discussions to improve surgical quality and identify gaps in care. Currently, no plans exist to integrate surgical quality improvement programs into state demonstration programs. The Physician Group Practice Demonstration program, an accountable care organization demonstration project, lowered surgical readmissions for duals through quality- and cost-targeted initiatives. Similar success for duals can potentially be achieved in state demonstration programs.

Further research by surgeons characterizing surgical demographics and use of surgical services by duals before and during implementation of the ACA and demonstration programs is essential and will support innovative quality improvement programs. Prospectively monitoring and evaluating state demonstration programs to determine changes in reimbursement rates as payments transition from a FFS model to capitated programs will be important to determine the effects on access to surgical care. When possible, the surgical community should be in discussions with CMS and the states to advocate for inclusion of surgical services in demonstration programs. The ACS is positioned to take a leadership role in advocating for access to quality surgical care for all dual-eligible patients.

ReFeReNCeS (CoNtInuED)

Trauma and emergency care under the Affordable Care Act

by Naveen F. Sangji, MD, MPH, and Kristin McDonald
In 2008, a tour bus carrying 53 people rolled down an embankment in Mexican Hat, UT, killing nine people and seriously injuring 35. The first ambulance arrived on the scene one hour after the accident, and, in fact, some of the victims had to be transported to hospitals in county vans. The closest medical facility with a trauma center (Level IV) was located 117 miles away in Moab, and the nearest Level I trauma center was 190 miles away, in Arizona. Most of the victims were treated 75 miles away from the accident at a facility without a trauma center, and the rest were sent even farther away to various Level I and II trauma centers. Two victims died en route to medical facilities. Since this incident occurred in the four-corner area—a region of the U.S. consisting of the southwestern corner of Colorado, northwestern corner of New Mexico, northeastern corner of Arizona, and southeastern corner of Utah—counties in all of those states had to be alerted to the disaster. A Utah Department of Health report on the incident concluded that the preparation weaknesses resulted from decreases in grants and funding at state and local levels and a lack of focus on “inclusive, regionally coordinated prevention efforts.”

Trauma care and trauma systems have come under scrutiny in the wake of several natural disasters and man-made tragedies, such as the Mexican Hat incident, and most recently after the Boston Marathon bombings in 2013. However, the suffering and burden of mass-casualty events is staggering and merits consistent attention from policymakers at the federal and state levels, to ensure that the necessary systems are in place before they are needed—and not simply in times of tragedy.

Although the U.S. Congress scrutinized emergency room care during the health care reform debates, trauma care was, by and large, ignored initially. However, because of strong advocacy from the trauma community and the leadership of several legislators, trauma and emergency care systems eventually received the attention necessary to improve access and care for the injured patient.

The American College of Surgeons (ACS) played a leading role in securing language in the Affordable Care Act (ACA) of 2010 that pertains to patient access to day-to-day trauma care, surge capacity, and trauma research. This article provides an update on the status of those provisions, highlights the major components related to trauma care and trauma systems in the ACA, and discusses the College’s ongoing efforts to secure funding for the authorized programs. We also address surge capacity issues in current systems.
Trauma care and trauma systems have come under scrutiny in the wake of several natural disasters and man-made tragedies, such as the Mexican Hat incident, and most recently after the Boston Marathon bombings in 2013.

**The necessity of trauma systems**

Unintentional injury is the leading cause of death in the U.S. for individuals one to 44 years of age and the fifth leading cause of death overall. In 2011, more than 182,000 people lost their lives to trauma, and 68 percent of these deaths were from unintentional injuries. More specifically, approximately 34,000 people lost their lives in motor vehicle accidents, and almost 27,000 to falls. In 2009, approximately 38.9 million people sought emergency medical attention for nonfatal injuries.

Trauma adds significantly to the nation’s health care costs. Injuries cost the health care system $80 billion in 2000. The National Safety Council found that the total cost of unintentional injuries was $693.5 billion in 2009, including medical costs, lost wages, and productivity.

Rapid assessment and treatment of severe traumatic injury can mean the difference between life and death. The type of facility where treatment is rendered has been shown to have a significant bearing on mortality as well. A study comparing outcomes for moderate to severe injuries at Level I trauma centers with hospitals lacking a trauma center showed that after adjustment for case mix, the risk of death one year after injury was 25 percent lower for patients treated at Level I trauma centers. The difference was greater for severe injuries than for moderate injuries.

Unfortunately, though, approximately 17 percent of U.S. citizens live more than an hour’s drive from a Level I, II, or III trauma center. Rural populations and the poor residing in both urban and rural settings have less geographic access to trauma care. Furthermore, trauma centers have been closing at an unprecedented rate over the last three decades. Between 1990 and 2005, a total of 339 trauma centers—almost 30 percent of the 1,132 trauma centers in existence in 1990—closed their doors. By 2007, 24 percent of the U.S. population had to travel farther to reach a trauma center than in 2001. Closures have been attributed to the high cost of trauma care and low rates of reimbursement. Trauma systems have fared no better. A 2009 survey of ACS state society chairs revealed that only two-thirds of all states had a trauma system, even at the most basic level, and most did not have adequate funding to maintain those systems.

The development of well-organized, collaborative, and regionalized trauma systems has featured prominently in the College’s efforts to improve quality of care. ACS Past-President A. Brent Eastman, MD, FACS, a general, vascular, and trauma surgeon who was Vice-Chair of the Board of Regents at the time, focused his remarks during the 2009 Scudder Oration on “the development of inclusive trauma for every citizen and traveler, in every state and province, wherever the dart lands.” (The Scudder Oration is presented annually at the ACS Clinical Congress.) According to the Health Resources and Services Administration’s (HRSA) definition, ideal trauma systems encompass prevention, triage, treatment, and rehabilitation at a statewide level, with the goal of reducing trauma morbidity and mortality and with data collection and analysis to demonstrate effectiveness of the program. These systems have demonstrable benefits.

A retrospective study of trauma-related deaths in Montana before and after the implementation of a voluntary statewide trauma system showed a significant decrease in the preventable death rate (PDR), from 13 percent before the implementation of a trauma system to 8 percent one year after the system was put in place.

**Surge capacity response**

Surge capacity response is a crucial element of any trauma system. In 2008, the U.S. House Committee on Oversight and Government Reform published a report on surge capacity at Level I trauma centers in seven major cities. This effort was undertaken in response to a 2004 train bombing in Madrid, Spain—which resulted in 177 fatalities and more than 2,000 injuries—to determine whether U.S. hospitals had the capacity to respond to a similar level of casualties. This report showed severe emergency department overcrowding, with each city having fewer available treatment spaces in all of their Level I trauma centers combined than a single hospital in Madrid. Multiple hospitals were on diversion, and more than half were operating above capacity. The average institu-
tions could accommodate fewer than 25 percent of the patients admitted to a single Madrid hospital. The Centers for Disease Control and Prevention (CDC) estimates that federal support for mass-casualty disasters is unlikely to be issued in less than 72 hours—far too late to benefit severely injured patients. State-level surge capacity is, therefore, a critical component of disaster response.

**trauma-related provisions in the ACA**

The ACS worked closely with other specialty organizations and legislators to secure language in the ACA that would support efforts to improve access to quality trauma care. More specifically, the College lobbied for reauthorization of the Trauma Care Systems Planning and Development (TCSP) and the National Trauma Center Stabilization (NTCS) Acts, as well as new language related to the regionalization of emergency care, trauma service availability grants, and pediatric emergency care.

**The TCSP Act**

The TCSP Act was enacted in 1990 (Title XII of the Public Health Service (PHS) Act, 1211-1232) in response to a 1986 General Accounting Office (GAO) report, which indicated that severely injured individuals in most areas of the U.S. did not have access to trauma systems. Since 1990, the TCSP has provided $31.4 million to help states and U.S. territories develop and implement statewide trauma care systems. However, the act went unfunded in 2006 and 2007. In 2007, former President George W. Bush signed legislation resurrecting the TCSP and authorized $46 million through fiscal year (FY) 2012, under the auspices of HRSA. This law established a program to develop research and training projects to improve trauma care, improve the availability and quality of trauma care in rural areas, and create a new grant program for states to broaden access and communication using national standards and protocols. However, securing appropriations for the program proved difficult.

The ACS worked with members of Congress to ensure reauthorization of the program in health care reform legislation. These efforts came to fruition in the Senate version of the ACA. Section 3504 of the law reauthorized the program through 2014. The program also was moved from HRSA to the Office of the Assistant Secretary for Preparedness and Response (ASPR) at the recommendation of the Office of Management and Budget (OMB), the U.S. Department of Health and Human Services (HHS), and ASPR, with support from the trauma community, which believed it might be easier to secure funding through the Office of the ASPR. Authorization for the program was set at $12 million per year. The funds have yet to be appropriated; however, ACS has continued to advocate for appropriations for the program, along with champions of the legislation, Reps. Gene Green (D-TX) and Michael Burgess, MD (R-TX), and Sens. Patty Murray (D-WA) and Jack Reed (D-RI).

**Regionalization of Emergency Care Pilot Program**

Section 3504 of the ACA also includes new legislation (Title XII of the PHS Act, 1201-1204), which authorizes $12 million annually through 2014 for no fewer than four multi-year “pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.” These projects, run under the auspices of the ASPR, would be designed by state or private entities to do the following:

- Coordinate public health, safety, and emergency services and trauma centers
- Establish a communications system to direct patients to the most appropriate medical facility
- Track pre-hospital and hospital resources in real time
- Include a data management system for pre-hospital, hospital, and inter-facility destination decisions and outcomes
- Submit data to the ACS National Trauma Data Bank®, National Emergency Medical Services Information System, and appropriate federal and state registries
The ACS worked closely with other specialty organizations and legislators to secure language in the ACA that would support efforts to improve access to quality trauma care. 

There is a required level of non-federal matching, and the reports must be publicly available.

The National Trauma Center Stabilization Act

Trauma centers across the country have been facing downgrades and closures due to uncompensated care, workforce shortages, liability costs, and outlays to support the infrastructure. The NTCS Act was introduced in the U.S. Senate in 2007 as an amendment to Title XII of the Public Health Service (PHS) Act to support trauma centers with a high pool of uncompensated care for part or the entire amount of the uncompensated care costs. The level of compensation was tiered based on the proportion of uncompensated care provided by the center. The amount authorized annually in this bill through 2014 was $100 million, but it was never appropriated. ACA Section 3505 included two trauma grant programs under HRSA, the reauthorized Trauma Care Center Grants (Title XII of the PHS Act, 1241-1246) and a new program called the Trauma Service Availability Grants (Title XII of the PHS Act, 1281-1282).

The Trauma Care Center Grants include three awards: uncompensated care awards, core mission awards, and emergency awards. The uncompensated care awards provide tiered funding based on the proportion of uncompensated care delivered or Medicaid patients served. This program would provide critical funding to centers that are at risk of closing due to high levels of uncompensated care and/or Medicaid patients. The Core Mission Grants support such activities as education and outreach, patient stabilization and transfer, and coordination with local and regional systems. The Emergency Grants provide relief to centers at imminent risk of closing or in areas that have experienced natural disasters. The legislation specifically requires the centers seeking funds to be verified by the ACS or designated as such by an equivalent state or local authority. The legislation also supports ACS guidelines for trauma care registries. It authorizes $100 million for the first year and “such sums as may be necessary” through FY 2015. These funds had not been appropriated at press time.

The Trauma Service Availability Grants provide funding to states for trauma centers that serve as safety nets as per the criteria described for the Trauma Care Center Grants. These grants provide funds to support physician compensation, address overcrowding, increase access in underserved areas, and enhance surge capacity and collaboration among centers. This program is authorized at $100 million annually through FY 2015. The funds had not been appropriated at press time.

ACS efforts to secure appropriations

Despite authorization in the ACA, it has been difficult to secure appropriations for these trauma programs. Legislators intent on repealing the ACA are unwilling to allocate funds even for programs that were established before the ACA was enacted. The ACS has made sustained efforts to secure appropriations for these programs through HHS and Congress. The College, along with other specialty organizations, sent a letter to and met with ASPR Nicole Lurie, MD, and HRSA Administrator Mary Wakefield, PhD, RN, requesting that the administration include funding in the President’s FY 2013 budget for these programs.

The ACS drafted sign-on letters in 2012 to the House and the Senate Committee of Appropriations Subcommittees on Labor, HHS, and Education requesting $28 million in appropriations for these programs for FY 2013. Signatories included Representatives Green and Burgess. The ACS also drafted a sign-on letter that Senators Reed and Murray sent to HHS Secretary Kathleen Sebelius requesting funding for these programs. In addition, the ACS and other trauma champions have met frequently with HRSA, ASPR, congressional aides, the White House staff, and the OMB to advocate for these programs. The ACS Leadership & Advocacy Summit and the ACS Committee on Trauma (COT) advocacy agendas also are geared toward discussion of trauma-related issues with representatives in Congress.
Pediatric research
The ACS has long advocated for emergency and trauma care for children. ACS Division of Advocacy and Health Policy staff assisted in drafting new language in Section 3504 of the ACA, which amends Title IV of the PHS Act (Part H, Sec 498D), and addresses pediatric emergencies.21 The law authorizes pediatric emergency medical research to be carried out under the auspices of the ASPR based on the recommendations of the Institute of Medicine (IOM). Authorized for “such sums as may be necessary” through 2014, federal agencies such as the National Institutes of Health, CDC, HRSA, and others, would collaborate on pediatric emergency medicine and medical care systems.

The ACS also has supported funding for the Wakefield Emergency Medical Services for Children (EMSC) program, which awards grants to states and medical schools to expand and improve trauma and critical care emergency services for children.27 ACA Section 5603 reauthorizes the program through 2015, with annual authorizations between $25 million and $30 million.28 The ACS supports this program annually, signing on to letters to the House and Senate appropriators requesting full funding. Congress allocated $21 million to the program for FY 2013—a victory in the prevailing fiscal environment.

Surge capacity and preparedness
The ACS is very mindful of the gaps in the nation’s trauma and emergency care systems and the problems they create in the event of a natural or man-made disaster. In 2012, House Energy and Commerce Committee Chair Fred Upton (R-MI) and Ranking Member Henry Waxman (D-CA) submitted a letter to the Government Accountability Office requesting an assessment of the surge capacity within the health care systems, their ability to handle mass casualties, the impact of federal grant programs on preparedness, and gaps in data collection related to the adequacy of these systems.29 Additionally, the ACS-drafted letter to HHS Secretary Sebelius included a request to address the current surge capacity and preparedness in hospitals in the event of a catastrophe, and HHS efforts to ensure preparation for mass-casualty scenarios apart

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The lack of regionalized trauma systems was considered a major weakness in the preparation for and response to the 2008 Mexican Hat mass-casualty incident. An IOM workshop assessed this event, as well as a flood disaster in Arkansas in 2010 resulting in 20 fatalities. Based on this assessment, the IOM concluded that there was a need for availability of regionalized trauma centers, a multistate response system, the ability to track patients, and enhanced communications to overcome the challenges of emergency care, particularly regarding events of this nature. A recent article published in the Journal of the American Medical Association cites preparedness, including drills, command training, and communication improvements, as some of the factors contributing to the successful response to the Boston Marathon bombings in 2013.

The trauma programs in the ACA are geared toward addressing these shortfalls where they exist. Unfortunately, these programs are in danger of losing authorization in the coming years. Some members of Congress view programs that have been unfunded during a period of authorization as nonessential and are unlikely to reauthorize them. Failure to reauthorize these programs would be a wasted opportunity to strengthen and improve trauma care and trauma systems nationwide. The table on this page outlines the years for which authorization for each of the trauma programs described will expire. The lack of appropriations has prevented these programs from being used and proving their value with data and success stories in recent years. The current level of bipartisan bickering is also an obstacle to reauthorization of these programs.

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The ACS and other members of the trauma community will continue to lobby for appropriations for the programs in their last year and for their reauthorization. In Washington, DC, the goal is to achieve consensus among representatives on both sides of the ACA debate regarding the value of these programs. Hearing from constituents has the greatest effect on policymakers, and ACS Fellows can make an impact by delivering messages supporting these programs to their elected officials.

A new effort is also under way to provide local stories highlighting the necessity of trauma systems to representatives. For example, various stakeholders in Texas have decided to undergo an ACS COT-led region-by-region review of its trauma systems and capacity. The results from this review, particularly any major shortfalls, will be presented to policymakers at both the state and federal levels. It is anticipated that by updating elected officials on the status of trauma in their districts and educating them on the programs that exist to address shortfalls, trauma care will gain a new group of champions who will advocate for the reauthorization and funding of these programs. Currently, Texas has two strong champions of trauma care—Representatives Burgess and Green. The ACS is working closely with these legislators to increase support of these programs. If the Texas model proves effective, this effort could be replicated in other states.

There are drawbacks to this region-by-region review strategy. It is time-consuming, the results are unpredictable, and it requires grassroots involvement and advocacy from local surgeons, hospitals, emergency medical services, and patients. However, this type of concerted effort may be the best chance to obtain critical funding for trauma centers and to develop statewide trauma systems to ensure that every individual in the country has access to appropriate and timely trauma care.

**References (Cited)**


Is your office helping you prevent wrong site surgery?

The Pennsylvania Patient Safety Authority (the Authority) was established in 2002 under the state’s Medical Care Availability and Reduction of Error Act to collate for analysis preventable adverse events and near-misses at acute health care facilities. Hospitals, ambulatory surgery centers, and other facilities are required to report these events to the Authority. These reports are then analyzed to develop evidence-based best practices for the delivery of health care that may be implemented to reduce the risk of harm from these serious events and incidents.

One preventable adverse event that the Authority has focused on is wrong site surgery. The Authority has determined that wrong site surgery occurred, on average, once in every 63,603 procedures performed in operating suites and ambulatory surgical centers in Pennsylvania from July 2010 to June 2011. These data represent a 45 percent decrease in incidence from July 2007 to June 2008, when the Authority began a wrong site surgery prevention program.1 The decrease has been attributed to the collaborative efforts of the surgeons, anesthesia professionals, and perioperative staff at, now, 76 facilities in the state who have implemented best practices for preventing wrong site surgery.2-5

The best practices focus on preventing misinformation from entering the operating room (OR) and avoiding misperceptions in the surgical suite.6 One of the best practices calls for ensuring that detailed, accurate information is communicated from the surgeon’s office to the perioperative area.4 This
Wrong site surgery defined

Wrong site surgery may occur in one of several ways, including operating on the wrong patient, performing the wrong procedure, operating on the wrong body part, or performing the procedure on the wrong side of the body. Although the likelihood of doing wrong site surgery is very low for any individual operation, the consequences are high. Any wrong site event dissipates the patient’s trust and adds significantly to health care costs. Claims payments for wrong site surgery average $158,560 adjusted to 2013 dollars. In addition, the volume of operations performed at an institution enhances the risks of wrong site procedures accumulating over time; for example, research suggests that there is a 5 percent risk for every 3,263 procedures, a 10 percent risk for 6,702 procedures, and a 20 percent risk for 14,193 procedures performed.

Reports in Pennsylvania

From July 2004 to June 2013, the Authority received 541 reports of wrong site procedures occurring in operating suites and ambulatory surgical centers. A review of these reports reveals that 59 patients (11 percent, or one out of every nine patients) experienced wrong site surgery due to the facility receiving incorrect or incomplete information from the surgeon’s office. Those miscommunications resulted in the following:

- A total of 34 (58 percent) operations on the wrong side
- Two (3 percent) at the wrong spinal level
- Eight (14 percent) at another wrong location, such as the wrong finger
- A total of 15 (25 percent) involving the wrong procedure

The proportion leading to wrong procedures is significantly higher than in the registry as a whole (8 percent, p<0.001 by the chi-square test).

The proportion of wrong site events resulting from incorrect or incomplete information from the surgeon’s office was significantly higher, according to the chi-square test, than in the registry as a whole for wrong-side colectomies (accounting for all of the seven in the registry), wrong-side ureteral stents (seven of 29), insertions of the wrong device (six of 13),wrong site otolaryngology procedures (five of 19), and wrong site vascular procedures (three of six).

As noted in the table on page 30, a single piece of misinformation was implicated in 34 cases of wrong site surgery, two pieces of misinformation in 23 cases, and three pieces in the remaining two cases. The 11 types of misinformation that were provided also are listed in the table. Information that was incorrect or insufficiently specific when scheduling the case or obtaining the consent was, by far, the most common cause, and mentioned in 50 of the 59 reports. The 47 reports that mentioned only incorrect and/or inadequate information for the schedule and/or consent represented the identified causes of 9 percent of all 541 wrong site procedures—one out of every 11.
Misinformation: examples

The types of misinformation that occur between referring physicians’ offices and the surgeon’s office and the operating suite are wide ranging. The following contextually de-identified excerpts from reports of wrong site surgery to the Authority illustrate the results of incorrect and/or insufficient information from the surgeon’s office:

- Procedure was inaccurately scheduled from physician’s office as [a] lumpectomy with sentinel lymph node biopsy. Consent was obtained for lumpectomy with axillary node dissection. Patient was injected for sentinel node biopsy.

- Patient needed right popliteal thrombectomy. Consent obtained for left popliteal thrombectomy. Time-out performed prior to start of case; consent checked... Skin incision made in the left leg.

- Patient...found to have colon mass in right colon on colonoscopy. Patient referred to surgeon...scheduled for left colectomy. Patient admitted for left colectomy; permit was for left colectomy; and left colectomy was done.

Patient returned [later]...for follow-up colonoscopy—found to have the same mass as prior.

- Patient signed permit for laryngoscopy with biopsy. Patient was aware that the biopsy was to be of his tongue; however, it was to be done on the left side. Instead, it was done on the right side.

- Patient was scheduled for an L3-4 hemilaminectomy and excision of herniated disk. No laterality was identified by the physician when scheduling, nor was laterality identified on the consent. In pre-operative holding, the lumbar area of the back was marked. The surgeon performed a left L3-4 hemilaminectomy and excision of herniated disk. [In postoperative follow-up,] the surgeon realized the procedure was done on the incorrect side.

- Doctor’s office incorrectly scheduled the case. Schedule read ureteroscopy with possible insertion of stent. Patient’s consent read right ureteroscopy with possible insertion of stent... A surgical time-out was completed in the room and staff confirmed with the consent and the surgeon: right ureteroscopy with possible insertion of stent. After completing the procedure, the surgeon...
reviewed his office record and noted that the procedure should have been completed on the left side.

**Best practices**
The Authority has developed a set of best practices for surgeons to use to prevent wrong site surgery. These guidelines include the following:4,5

- Provide accurate and sufficient information when scheduling the procedure. Information about the type and location of the procedure is sufficient if the perioperative staff can identify any deviation between what was intended and what is being done.

- Provide accurate and sufficient information when obtaining the consent—ideally when the patient makes the decision to have the procedure done.

- Provide accurate and sufficient information on the history and physical examination.

- Have office staff check all documents necessary for the procedure for consistency and identify any inconsistencies requiring reconciliation. This can be done with the aid of a simple checklist or monitoring tool.9,10

- Make sure that all documents needed for the procedure accurately reflect the office notes and diagnostic reports.

- If information changes, verify with the appropriate perioperative services that all the updated information has replaced the original information.

By adhering to these standards, office staff can help prevent wrong site surgery. ◆

**Note**
Some of the information in this article was presented at the 2013 Annual National Surgical Quality Improvement Program (ACS NSQIP®) National Conference in San Diego, CA.

**References**

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The aging surgeon:
When is it time to leave active practice?

by Kevin Garrett, MD, FACS, and Krista L. Kaups, MD, MSc, FACS

Editor’s note: The following is the third in a series of excerpts from Being Well and Staying Competent: Challenges for the Surgeon, a guidebook issued in 2013 by the ACS Board of Governors’ Committee on Physician Competency and Health. The complete document is posted on the American College of Surgeons members-only portal at www.efacs.org.

Unlike some other professions, surgery has no mandated or commonly accepted retirement age. In recent decades, surgeon age as a marker of performance has been the subject of much debate and some scholarly research.1-5 Questions commonly raised include:

• How does the aging process affect surgical skills and judgment?

• Do the changes associated with aging occur uniformly in all surgeons?

• Is self-evaluation of skills and judgment reliable?

• Is objective assessment of surgical skills and judgment feasible or practical?

• What options are available for the surgeon who is considering a change of practice?
age is just a number
According to data from the American Medical Association, many surgeons continue to practice beyond the “standard” retirement age of 65. As the baby boomer generation reaches retirement age, it is anticipated that an increasing number of these surgeons will continue to practice as well. Nonetheless, the number of trained general surgeons relative to a growing and increasingly aging population is on the decline, and a mandatory retirement age for surgeons would likely exacerbate this shortage.

Surveys of surgeons indicate there is no consensus in favor of a mandated retirement age nor widespread agreement on when a surgeon should retire, ultimately leaving the decision to the individual. A high sense of value and satisfaction experienced during active clinical practice is cited as the most common reason surgeons continue to practice. On a less positive note, inadequate retirement planning, both due to financial concerns and a lack of nonsurgical interests to replace clinical practice, may contribute to a prolonged surgical career.

The Age Discrimination in Employment Act of 1967 (ADEA) protects individuals who are 40 years of age or older from employment discrimination. In direct contrast to the ADEA, numerous professionals are subject to mandatory retirement age—most notably air traffic controllers, airline pilots, Federal Bureau of Investigation agents, and other federal law enforcement officers. Professions with a mandatory retirement age seem to support the viewpoint that performance is inversely proportional to age, causing some to advocate a “one size fits all” compulsory retirement age for surgeons—regardless of performance status and without empiric data to support this position.

More nuanced observations, however, suggest that the relationship between age and performance may be more complex. Stamina, cognition, and fine-motor skills decrease with age, but not uniformly across populations, and some learned tasks and physical memory are remarkably preserved over time. In neuropsychological testing, decreases in cognitive processing efficiency as well as skills related to attention span, reaction time, and visual learning occur with age, as well as a decline in memory, particularly recall. Specific cognitive testing of surgeons, however, showed that the decline in reaction time was less than that of comparison groups and most practicing surgeons older than age 60 performed comparably to younger colleagues in all areas of cognitive testing.

Age may be inversely related to clinical performance in primary care, but for most procedures, surgeon age is a poor predictor of operative risk. Nonetheless, for some complex procedures (pancreatectomy, coronary artery bypass graft, carotid endarterectomy, and so on), surgeons older than 60 years of age with low procedure volumes relative to younger surgeons have slightly higher mortality rates than their younger cohort. Aging surgeons who gradually decrease the volume of these procedures may experience a counterproductive deterioration in the skill sets necessary for safe conduct suggesting that an “all or none” approach to complex procedures is better to maintain skills and a safe practice.

assessing skills
Unfortunately, self-assessment of performance is often inaccurate. In a study of 359 surgeons, subjective perception of cognitive changes did not correlate well with objective assessments. Other studies have supported the finding that physicians are unable to accurately self-assess performance and knowledge, with those surgeons receiving the weakest external assessment also proving to be least effective at self-assessment. From a credentialing standpoint, ongoing professional practice evaluations and focused professional practice evaluations are designed to respond to aberrations in per-
performance, frequently after an occurrence when colleagues or hospital administrators are moved to limit or terminate the surgeon’s practice. Hence, these assessments are of little help for planning purposes.

Patients, colleagues, payors, hospital administrators, plaintiffs’ attorneys, and physicians all have a stake in this issue, which calls for an urgent response from the surgical community. The profession must be able to assure patients that their surgeons are trained to deliver safe care. The profession must also be able to prove that it has developed thoughtful, proactive, logical policies or risk the imposition of external regulation.

Available data support the claim that age alone is an inadequate criterion for determining when an individual should retire. The authors recommend an individualized approach for credentialing bodies to apply focused psychomotor assessments of practicing surgeons at defined intervals—analogous to those required to maintain a driver’s license at an advanced age—as a requisite for ongoing practice. Suggested ages for beginning this type of testing range from 62 to 75, with 65 years old appearing to be a more common threshold.

Considering the fact that personal health care issues may contribute to the decline of cognitive and technical skills, periodic medical evaluation is an essential part of the assessment. Whereas the individual surgeon may fail to recognize or may deny diminishing skills, peer evaluation by direct observation also is important. Case review may be insufficient to evaluate subtle changes in decision making or waning technical abilities. It is also essential that these appraisals be applied equally and be carried out in a confidential manner that maintains the dignity of the surgeon. For example, Stanford University Medical Center, CA, recently endorsed a policy requiring medical staff ages 75 and older to have a “physical examination, cognitive screening and peer assessment of...clinical performance” every two years. “If the findings...point to potential concerns for patient safety, the service chief and the credentials committee will, on a confidential basis, consider the results and recommend further evaluation as necessary.”

transitioning away from practice

The authors recommend that hospitals and departments of surgery explore ways to take advantage of the aggregate expertise of their senior practitioners by allowing them to continue, if appropriate, performing adequate numbers of less complex procedures without impinging on the productivity and satisfaction of their younger colleagues. The cumulative wisdom and clinical experience of the senior surgeon is an invaluable asset that should be honored and maintained.

For the surgeon who would like to continue to be engaged in surgical practice, assisting in operations, focusing on an office-based or an academic practice, staffing clinics, and rounding on clinical services are activities that offer the opportuni-
ty to stay involved with reduced work hours and flexible scheduling. Another vital role for the senior surgeon is mentoring junior colleagues, ranging from offering informal advice to developing a departmentally defined relationship. The experienced surgeon’s knowledge is also valuable for the teaching of surgical topics and anatomy to both residents and medical students. Additional opportunities for the surgeon who is reducing clinical practice time include administrative and quality/performance improvement activities, such as establishing and implementing American College of Surgeon National Surgical Quality Improvement Programs or cancer programs in their institutions.

The authors further recommend that surgeons seek professional guidance at the start of and throughout clinical practice to plan financially for retirement. Recent economic downturns have adversely affected retirement planning for many individuals, making careful preparation all the more important. Although many surgeons do pay close attention to the financial aspects of retirement, some of them give less consideration to planning for meaningful activities to pursue once the decision to retire is made. Development of (and perhaps some trial and error participation in) activities before full-time retirement from practice is important. For most surgeons, it is unrealistic to anticipate personal fulfillment in an abrupt transition from a busy surgical practice to a few hours of sports activities a week. In the maintenance of well-being throughout one’s professional life, meaningful endeavors and relationships are essential.

ReFeReNcEs

The Measure Applications Partnership

The Measure Applications Partnership (MAP) provides pre-rulemaking guidance to the U.S. Department of Health and Human Services (HHS) for the inclusion of performance measures in public reporting and performance-based payment programs. This column discusses what surgeons need to know about the recommendations provided by the American College of Surgeons (ACS) on performance measures before they are included in federal regulations. This input is critical because the MAP identifies quality measures for more than 20 federal programs, many of which affect the delivery of and access to surgical care.*

What is the function of the map?
For the first time in national quality measure development, the Affordable Care Act (ACA) made way for significant enhancements to the traditional federal rulemaking process by providing a forum for public and private partnerships to provide feedback on quality measures before they are included in federal regulations. HHS selected the National Quality Forum (NQF) to provide this pre-rulemaking input guided by the three-part aim of the National Quality Strategy: better care, better health, and lower cost.* The NQF is an independent not-for-profit organization that has set the standard for the science of quality measurement validation and provides quality measures with NQF endorsement based on a rigorous multi-stakeholder consensus-based measure review.

To fulfill the ACA mandate, the NQF convened the MAP, which is charged with identifying core measures and prioritizing measure gaps in federal quality programs. The MAP provides guidance to foster alignment across quality programs, settings, levels of analysis, populations, and between public and private sector programs.† The MAP comprises four main workgroups: Clinician Workgroup, Hospital Workgroup, Post-Acute Care/Long-Term Care Workgroup, and Dual-Eligible Beneficiaries Workgroup—all of which are overseen by a MAP Coordinating Committee. Multi-stakeholder workgroups include members representing

The ACS believes that surgeons, in consultation with their patients, working through their specialty societies and with quality measurement experts, are the most qualified to determine the appropriate metrics to measure surgical care for federal quality programs.

consumers, purchasers, labor, health plans, clinicians and other providers, communities and states, and suppliers.†

what is pre-rulemaking and the significance of providing guidance to hhs?
Each December, HHS provides a list of measures under consideration across 20 federal programs for the upcoming calendar year to the MAP for review. The MAP’s third cycle of pre-rulemaking recommendations were submitted earlier this year, and they provided feedback for 234 measures under consideration.‡ The MAP workgroups convene to review measures for programs relevant to their care setting or patient population and provide a final report to HHS in February. This process is guided by the MAP’s Measures Selection Criteria, which the MAP has developed to assist in identifying ideal measures for use in federal programs.‡ The pre-rulemaking process is an upstream approach to the implementation of measures to allow for increased transparency and multi-stakeholder input.

how does the map affect surgical care?
As part of the ACA, HHS is mandated to implement various programs that will measure surgical care, including metrics reported on Physician Compare and included in the Value-Based Payment Modifier pay-for-performance program. The ACS believes that surgeons, in consultation with their patients, working through their specialty societies and with quality measurement experts, are the most qualified to determine the appropriate metrics to measure surgical care for federal quality programs.§ Therefore, guidance from surgeons is critical in the MAP process to help identify measures that have the following attributes:

• Are clinically relevant for the assessment of provider function
• Meet the highest standards of validity and reliability to avoid misclassification
• Are equitable and feasible
• Are truly effective in assisting patient choice and access
• Are designed to stimulate surgical care improvement.§

how does the College contribute to the map?
As an organizational member of the MAP Coordinating Committee and through Fellow appointments, the ACS has played a leadership role in the MAP and is a recognized key contributor. Currently, Frank Opelka, MD, FACS, Associate Medical Director of the ACS Division of Advocacy and Health Policy, chairs the MAP Hospital Workgroup, and is the ACS organizational representative to the MAP Coordinating Committee. Erica Whitacre, MD, FACS, director of the Breast Center of Southern Arizona, is a breast surgeon in Tucson, and serves as a surgical subject matter expert on the MAP Clinician Workgroup. The ACS also is actively involved in the development of the MAP’s recommendations and provides comments to the Measure Applications Partnership Pre-Rulemaking Report Public Comment Draft each January.◆
Rural surgery is a global issue: The perspective of an Argentine surgeon

by Carlos L. Ledesma, MD, MAAC; tyler G. Hughes, MD, FACS; Carlos A. Pellegrini, MD, FACS, FRCS(I)(Hon); and Mark W. Puls, MD, FACS

editor's note: As some readers may know, one of the authors, Dr. Ledesma, died January 26, 2014, just before this column was finalized for publication. The other authors have included him in the byline because he gave the talk that served as the impetus for publishing a column on rural surgery in Argentina. Dr. Ledesma's close friend, Dr. Pellegrini, attended the conference where the presentation was given, and translated it for use in this column. Dr. Ledesma died following a long battle against a malignant pheochromocytoma. He will be sorely missed by his wife and family and by the medical community of Viedma.

Rural surgery is an important component of the health care delivery system of any nation. All nations have rural areas, and all nations have difficulty providing surgical care to rural patients. More than 90 percent of unintentional injury deaths occur in low- and middle-income countries. The poorest third of the world’s population receives only 3.5 percent of the surgical procedures provided worldwide. To illustrate this discrepancy, a review of 132 district-level health facilities in eight low- and middle-income countries revealed that only 48 percent were capable of performing an appendectomy.

Despite the vast differences between nations of the world, the barriers that prevent delivery of surgical care to rural areas can be quite similar. As a global surgical community, we can all learn from the successes of rural surgeons throughout the world.

The leadership of the American College of Surgeons (ACS) is aware of the problems that rural surgeons face and the issues that threaten the very viability of surgical care in communities outside of metropolitan areas. The current President of the ACS and one of the authors of this article, Carlos A. Pellegrini, MD, FACS, grew up as a son of a physician in Amenabar, Argentina, a province of Santa Fe and a community of approximately 400 people, and has considerable familiarity with the special problems that rural surgeons face.

In March 2013, Dr. Pellegrini attended the National Congress of Surgical Residents meeting in Rosario, Argentina. During the meeting, several Argentine surgeons were asked to speak about their careers. Dr. Pellegrini felt that the most compelling presentation was given by Carlos L. Ledesma, MD, a rural surgeon from Viedma, Argentina. (Drs. Pellegrini and Ledesma trained as surgical residents together and have remained close friends.) Dr. Ledesma spoke of his 40-year experience as a rural surgeon, described the differences between rural surgical practice and general surgery practice in a large town, and discussed what he believed were the fundamentals to success for a rural surgeon. Dr. Pellegrini was struck by the similarity of issues that rural surgeons face in Argentina and in the U.S. and found Dr. Ledesma’s insight and wisdom impressive.

The path to rural practice
How Dr. Ledesma became a rural surgeon is an interesting story in itself. He grew up in Rosario, a large Argentine city. After medical school, he began surgical residency at the National University of Rosario Hospital, a large university program of world...
renown. Dr. Ledesma performed well as a resident, and it was clear that he would become a successful surgeon. In 1974, while still a resident, Dr. Ledesma and his chair, Juan M. Acosta, MD, FACS(Hon), published a seminal article in the *New England Journal of Medicine*, “Gallstone Migration as a Cause of Acute Pancreatitis,” which plainly established the relationship between common bile duct stones and pancreatitis. Dr. Ledesma clearly was destined for great things in the field of surgery.

In Argentina, health care is available to all citizens. Patients with the financial means mostly choose to be cared for at private hospitals. For all others, care is provided at no cost at public hospitals. It is widely understood that public hospitals are somewhat second-rate in comparison with private hospitals. In fact, in 1974, the government of Argentina initiated a program to improve the quality of public hospitals. One goal of the initiative was to attract top physicians to public hospitals by paying them salaries similar to the earnings of physicians in the private sector. A pilot program was started in the region of Río Negro, a province of Argentina, and a competition was held to select the surgeon who would take this position. It was a highly sought-after position, and both Dr. Ledesma and Dr. Pellegrini applied for it; as fate would have it, Dr. Ledesma won the competition.

After completing his residency in 1974, Dr. Ledesma and his young family moved...
to Viedma, the capital of Rio Negro with a population of approximately 20,000 citizens. His surgical practice flourished, but after several years, funding for the government program ended. Dr. Ledesma decided to stay in Viedma and he continued to practice there until his death in January.

Reflections on Rural Surgery

In his talk at the conference, Dr. Ledesma reflected on his career as a rural surgeon. When he first started his practice in Viedma, it became clear that his training had inadequately prepared him for the variety of surgical problems that he would encounter. He had to learn aspects of gynecologic surgery, orthopaedics, urology, pediatric surgery, and plastic surgery. For a rural surgeon to succeed, he or she must be willing to learn and practice elements of these other surgical specialties and, therefore, Dr. Ledesma strongly felt that specialized training in these areas is necessary.

It quickly became apparent to Dr. Ledesma that the pace of life in Viedma was much different than it was in Rosario. He described a “framework of relative peace and quiet,” which was a major change from the “frenzy” he had experienced through medical school and in training. He and his family found this change welcoming. A rural surgeon must be motivated to embrace this lifestyle and must develop a real sense of commitment to the members of the community that he or she serves.

“When you work in a very small town, the care that you provide [to] your patients is a lot more personalized,” Dr. Ledesma said. “You generate a stronger feeling and relationship between the physician, the patient, and the family.” A rural surgeon must be comfortable working with patients and their families in this way. Dr. Ledesma found it very easy to embrace this more personalized relationship and considered it a great benefit in practicing rural surgery.

Dr. Ledesma also learned that the size of the community can play a role in whether a rural surgeon can maintain a viable practice. He believed that a community needs to have a population of at least 10,000 to support a rural surgeon. He said he had seen attempts to set up a rural surgical practice in smaller communities, and, despite initial enthusiasm, these practices usually failed because they were often unable to sustain a hospital or clinic with the infrastructure needed to provide a viable practice for a rural surgeon.

The rural surgeon must be able to adapt to practice in a smaller medical community. For example, the surgeon will have fewer colleagues to offer help and advice. “One of my friends, a surgeon in another small town, was telling me that every time he was washing his hands in preparation for an operation just prior to entering the operating room, he felt lonely and compared himself to the bullfighter that is about to enter a major event where his life depends on his ability to make the outcome go his way,” Dr. Ledesma observed.

He said that the way to combat these feelings of isolation is to form very close relationships with the other individuals in the medical community, so that everyone functions as a member of a team. “Offering consultation, advice, and support to others becomes a much more important element of one’s life when one lives in a smaller community,” he said.

A rural surgeon will be working in a setting where the infrastructure of the hospital and support staff are considerably smaller than in a large hospital. Hence, rural surgeons must be more active in the preoperative and postoperative care of patients. A rural surgeon needs to understand the level of care that he and his medical team are able to provide and must know when to refer a patient to a larger center.
Dr. Ledesma stressed the need for continued professional development. It is important to remain current and to learn new surgical techniques. It certainly is easier for rural surgeons to participate in educational programs in the Internet era, but it is up to them to make continued professional development a priority. He also emphasized the importance of being active in surgical organizations. He was a longtime member of the Argentine Association of Surgeons and attended their Clinical Congress every year. He and his local colleagues organized an annual Spring Congress of the Argentine Association of Surgery in their region. These activities helped the surgical community in their region function as a team, which has been valuable in bringing new surgical techniques, such as laparoscopic surgery, to their area.

Common concerns
Dr. Ledesma clearly thrived as a rural surgeon and derived a deep level of satisfaction from his work. At the conclusion of his talk, he stated, “Small communities provide for a special and a different quality of life. The peace inherent to the smaller community, the proximity to home and family, the ability to take the kids to school, to see patients and friends alike, to engage in community affairs, and to be considered a leader within the environment is very much a part of the life I cherish. To me, the ability to walk to work, to come back home for lunch with the family, to see friends in the community every single day, and to realize the impact that I have in that community provides meaning and purpose to my life, and the very best quality of life I could ever have dreamed of.”

Rural surgery clearly is a worldwide issue, with all nations struggling to deliver surgical care to rural areas. Despite major differences in nations, it is clear that many of the issues facing rural surgery are similar from nation to nation. The fundamentals for success for a rural surgeon in Argentina are the same fundamentals that would bring success in America, and in many other nations. As rural surgeons, we need to function as a worldwide team, to learn from the success of others, and to work together to solve the common problems facing rural surgery.

References
Surgery is more than a set of technical skills—it is a profession that demands a high level of commitment and lifelong dedication. Historically, the education of enthusiastic medical students transcended grand lecture halls and involved observation of master surgeons. In fact, in the early years of formal surgical education, students entered into apprenticeships where they essentially lived with their surgical mentors to learn the intricacies of treating surgical diseases, and they traveled abroad to attain skills and knowledge not taught at their home institutions.

The technological revolution has made the transmission of large volumes of information around the world much simpler. With the click of a mouse, data and audiovisual media can be sent to a recipient within seconds, while video streaming allows for a real-time exchange of information. Although this method of exchanging knowledge may seem more practical and time-efficient, it is much less personal, and the art of surgical care, education, and collaboration is diminished.

For this reason, the conference setting remains a vital and cherished medium for the dissemination of surgical knowledge. Surgeons from around the globe attend these meetings to learn, discuss, and share their experiences in patient care. The American College of Surgeons (ACS) Clinical Congress is a prime example of this format, with thousands of surgeons congregating annually to meet the experts and attend the educational and scientific sessions.

The leadership of the Resident and Associate Society of the College (RAS-ACS) maintains that opportunities for the exchange of scientific knowledge should begin at the trainee level and for this reason has developed an International Exchange Scholarship Program. This program, which began in 2011, is modeled on the ACS International Relations Committee’s (IRC) International Guest Scholarships program.

**program structure and purpose**
For more than 40 years, the IRC has offered International Guest Scholarships and international traveling fellowships. Surgeons outside the U.S. and Canada have actively sought these scholarships, which are contingent upon satisfying the IRC’s requirements. Most notably, the applicant must be a surgeon who has completed formal training and has been practicing for at least one year. Hence, surgical residents were ineligible for these awards.

The RAS-ACS International Exchange Scholarship Program was established with the support of the IRC and the ACS Division of Member Services. The objective of this program is to encourage the international exchange of surgical information concerning training paradigms, health care delivery models, and research opportunities, in addition to establishing and fostering professional and academic collaborations and friendships.

This program is more than a scholarship to fund an international surgical resident’s attendance at the Clinical Congress and RAS-ACS events—it is an exchange. A reciprocal commitment is necessary, which means the nation from which the RAS-ACS accepts its exchange scholar must host a RAS-ACS member at its respective national meeting. The RAS-ACS oversees the International Exchange Scholarship Program, and the RAS-ACS Membership Committee reviews and
This program is more than a scholarship to fund an international surgical resident’s attendance at the Clinical Congress and RAS-ACS events—it is an exchange. A reciprocal commitment is necessary, which means the nation from which the RAS-ACS accepts its exchange scholar must host a RAS-ACS member at its respective national meeting.

selects the candidates and coordinates the program’s activities. (The program is partly funded by the IRC.)

inception and status
The RAS-ACS International Exchange Scholarship Program was initially a joint venture between the ACS and the Royal College of Surgeons in Ireland (RCSI). Through a competitive selection process specified by each institution, a surgical trainee was selected and awarded the opportunity to attend the major surgical meeting by the respective host nation.

By the 2012–2013 academic year, Australia-New Zealand, Italy, and Lebanon had joined Ireland as exchange locations. Consequently, four international guest scholars now travel to the U.S. and four North American surgical residents travel abroad. Efforts are under way to expand this opportunity, with a focus on engaging nations in Africa, South America, and Asia.

The selection process is competitive. Scholarships are awarded to current RAS-ACS members in good standing from North America. At the beginning of the calendar year, a call for applicants is issued through the e-newsletter that all Residents and Associate members receive. Applicants must submit an essay indicating how they will use the scholarships, and a blinded scoring process is employed. Reviewers include senior RAS-ACS Executive Committee members and ACS Fellows. The results are announced toward the end of the academic year (May or June) to allow sufficient time for planning international visits and satisfying international travel requirements.

Scholars have the opportunity to attend an international meeting in the host nation and receive a generous stipend that may be used for airfare, sustenance, and lodging. Scholarship recipients must provide a full written report of their activities and experiences overseas.

For guest scholars visiting from abroad, the program affords them the opportunity to attend the ACS Clinical Congress. They are formally recognized at the RAS-ACS annual business meeting with an award and the scholarship funds. They are automatically enrolled in a variety of RAS-ACS events and lectures, skills courses, and presentations aimed at residents. International scholars are encouraged to become RAS-ACS members, resulting in the waiver of their Clinical Congress registration, and they may avail themselves of the many other benefits of ACS membership. The scholars are also invited to multiple events coordinated by the IRC, including several receptions and the IRC annual business meeting. Future plans that the RAS-ACS Membership Committee is considering include providing assistance in visiting local hospitals in the Clinical Congress host city, as well as a variety of extracurricular activities.

preliminary impact
It is too soon to assess the true impact of this exchange program. With increasing exposure through electronic media and the Bulletin, over the last year there was nearly a 400 percent increase in the applications for this RAS-ACS International Exchange Scholarship Program. The RAS-ACS Membership Committee is currently assessing the impact and outcomes of this program.

It is clear that the reaction to the IRC’s International Guest Scholarship program has been positive. A survey conducted
in 2003 measured the impact of the IRC’s Guest Scholarships program. All scholarship recipients from 1968 to 2003 were queried. The response rate was 46 percent, and virtually all of the respondents noted a positive impact from the program, with 47 percent saying it was extremely helpful and 38 percent noting that it afforded them an opportunity not otherwise available. Most importantly, 86 percent of the respondents noted that they encouraged others to apply for the program.

The current RAS-ACS leadership began investigating the impact of the International Exchange Scholarship Program with its own survey. The survey was sent to the International Exchange participants with a 25 percent response rate. Of those respondents, 75 percent attended the Clinical Congress and 25 percent attended an international meeting. Participants were asked to evaluate the accommodations, the comparative activity of the host country’s meeting, the attitude of those surgeons they encountered, extra costs, and if they would recommend the program to their colleagues. Two subjective questions addressed the experience as well as potential improvements that could be made. Three-quarters felt the accommodations were as expected. All the respondents felt that the host country’s meeting was more active than their home meeting, and the level of collegiality they encountered uniformly exceeded expectations. All respondents would either most likely or definitely recommend the program to their colleagues.

**scholars’ perspectives**
The response from the resident scholars has been overwhelmingly positive. Following are excerpts from some of the participants’ reports:

- **Valentina Giaccaglia, MD**, a postgraduate year (PGY)-6 resident from La Sapienza University of Rome, Italy, attended the 2012 Clinical Congress. “It was very interesting to share my experience with colleagues from other countries, and I am extraordinarily grateful for the opportunity to get new scientific and clinical knowledge from the best surgeons coming from all over the world. I am very grateful for the hospitality extended to me by so many people during my visit. I look forward to scientific collaboration and friendship with surgical colleagues in the U.S. I thank the American College of Surgeons for this unique opportunity and hope many other colleagues will have the chance to benefit from the International Exchange Program.”

- **Leigh Anne Dageforde, MD**, a PGY-6 resident at Vanderbilt University Medical Center, Nashville, TN, visited the RCSI and participated in their Millen Symposium in Dublin. “The RCSI had arranged a comprehensive and busy visit for me[...]. The ‘language’ of surgery is universal and provides an instant connection with others working in the field[...]. The exchange was a great experience. The consultants, registrars, and administrators were extremely welcoming. Furthermore, I appreciated the opportunity to learn about surgery in a different health system, which may have some similarities to our own in the near future[...]. I would highly recommend this experience to other residents and am thankful...”

for all the RCSI did to welcome and educate me.”

• **Alecio Vinci, MD**, a PGY-4 resident at San Matteo University in Pavia, Italy, participated in the 2013 Clinical Congress in Washington, DC. “I have personally been exposed to a cutting-edge surgical environment letting me enhance the skills needed to be a proficient and competent surgeon.” In describing the conference, he noted that it “represented an occasion for a mutual exchange of experience, information, and methods between countries with different specialist training program[s] and career paths.” Finally, Dr. Vinci noted that he was “impressed by the organization specifically designed for residents and...pleased to be involved in the majority of educational opportunities offered by [RAS-ACS] during the Clinical Congress.”

• **Laura Wang, MD**, a PGY-5 resident in general surgery, was the representative surgical trainee of the Royal Australasian College of Surgeons. She “was thoroughly impressed at the size and level of organization of the RAS-ACS committee. Each day [of the 2013 Clinical Congress] was packed with many interesting and [thought-provoking] academic sessions. Many concurrent sessions for each subspecialty were run by the who’s who of international thought leaders of each field. In addition to the academic and scientific sessions, I was struck by the number of sessions on cost-effective health care, leadership, and life-balance.... It was an absolute honor and privilege to be awarded the John Buckingham Scholarship this year. The ACS meeting was not only academically interesting but also a unique opportunity to meet trainees and consultants from around the world. The academic and social networking events were very well-organized, and I would not hesitate to encourage other Australian general surgery and subspecialty trainees to apply for this grant in the coming years.”

**Future considerations**

Building on the strong foundation that the IRC provided, the RAS-ACS has successfully implemented an international exchange scholarship program for surgical trainees that the RAS-ACS would like to expand in future years. To achieve this goal, the RAS-ACS has focused on establishing an annual timeline to allow for proper planning for residents. Support from program directors and the institutions of selected scholars is important and continued funding through the ACS, the IRC, and support groups is imperative to allow for fruitful progress of the program. Finally, international chapter involvement and identification of mentors to host surgical trainees are paramount. ♦
community-based physicians and hospitals need to participate in clinical trials

by thomas L. Bauer, Sr., MD, FACS, and Judy C. Boughey, MB, BChir, FACS

Clinical trials provide patients and their physicians with an opportunity to advance the science and treatment options for cancer patients. Accrual is critically important to the success of clinical trials, as slow accrual can lead to closure of the trials and, subsequently, failure to answer important clinical questions. As funding decreases, appropriate accrual is a key element in the success of open trials. Most cancer care is provided in community-based settings; therefore, it is imperative that community cancer centers participate in national clinical trials, and engagement of community cancer surgeons does make a critical difference.

The Alliance for Clinical Trials in Oncology group formed from the merger of the Cancer and Leukemia Group B, the American College of Surgeons Oncology Group, and the North Central Cancer Treatment Group. The Alliance is composed of 137 member networks; 73 are community cancer programs, and 64 are academic institutions. The Alliance includes both community and academic programs that are not members of the Alliance can enroll patients through the Cancer Trials Support Unit (CTSU).

achieving success
Thomas L. Bauer, Sr., MD, FACS, a co-author of this month’s column, is an example of a community surgeon who has been successful in enrolling patients into national clinical trials. He acknowledges that no one surgeon, radiation oncologist, or medical oncologist can achieve success in this area working alone. Rather, each health care professional should be an advocate for improving the care of our patients by having clinical trial opportunities available for them.

This endeavor requires working with clinical trial coordinators, institutional review board leaders, and cancer registrars to convince the hospital administrators of the importance and need to participate in cancer research through cooperative group clinical trials. The clinical trials coordinators are very important members of the team. They frequently call the oncologists or surgeons when a patient is a candidate for an active trial. Active discussions about trials at cancer conferences keep everyone informed about active or upcoming trials.

talking to patients
Being able to explain clearly to patients the advantages of participating in a clinical trial is an important skill. Physicians who understand and believe in the trial can explain the value of participation to patients with enthusiasm and assure them they are not being used as “guinea pigs.” When patients understand that a proposed trial may help them in the future or help a family member or friend, they almost always are willing to participate.

Increasingly, clinical trials provide patients with treatment options that may otherwise be unavailable to them, such as novel drugs, new technologies, and less invasive surgery.

Having spent more than 40 years treating cancer patients, the last 20 as a full-time breast surgeon, Dr. Bauer has witnessed the advances and changes in the clinical care of breast cancer patients as a result of outcomes from well-designed clinical trials. He discusses with patients how a trial comparing lumpectomy...
Physicians who understand and believe in the trial can explain the value of participation to patients with enthusiasm and assure them they are not being used as “guinea pigs.” When patients understand that a proposed trial may help them in the future or help a family member or friend, they almost always are willing to participate.

plus radiation with mastectomy proved that the two treatments were essentially equal in outcomes. Illustrating with an example allows patients to better understand the value of trials.

His practice at York Hospital, PA, was invited to be part of the U.S. Department of Defense National Sentinel Node Trial, and by participating in that study, cancer patients entering the trial benefited from the physicians’ early training in and adoption of sentinel lymph node surgery for staging of clinically node-negative breast cancer. York Hospital was fourth out of 53 centers nationally in accrual.

The questions addressed in trials are often the very questions that physicians consider routinely in their clinical practice. For a breast surgeon in community practice, the question regarding preoperative MRI—Alliance A11104. With all the debate surrounding MRI, the authors encourage community colleagues to enroll as many of their patients as possible to help resolve this controversy.

Another example is the option of breast-conserving operations for women found to have more than one focus of disease in the breast. The Alliance Z11102 study evaluates the option of breast-conserving therapy for women with multiple ipsilateral breast cancers. This timely question for physicians and patients provides an opportunity for patients to consider breast-conserving therapy, in cases where mastectomy previously may have been recommended.

Other Alliance and cooperative group studies address a multitude of clinically relevant and important questions across multiple disease sites and provide opportunities for physicians and their patients to help advance cancer treatment. Community physicians should play an active role in ensuring the success of these trials.

**References**


ACS returns books to the Illinois College Medical Library: A look at their history

by Robert Berry

Until last year, only five titles remained in the once extensive library of the Illinois College (IC) medical department (1843–1848) in Jacksonville. On October 11, 2013, the American College of Surgeons (ACS) returned the remaining volumes of the peripatetic library to the campus—165 years after the closing of the medical department.

The oldest in the collection is a Latin text on anatomy published in 1703. The 71 books that were transferred back to IC are from the former library of the Morgan County Medical Society and were donated to the College in 1941. The transfer of these books to IC was accomplished through the efforts of Susan Rishworth, the most recent ACS Archivist. (Ms. Rishworth retired in December 2013.)

iC medical department

David Prince, MD (1816–1889), is the common thread in this story. He was the professor of anatomy and surgery in the IC medical department and a charter member of the Morgan County Medical Society. Of the 71 books transferred, 12 are from Dr. Prince’s private library, donated to the society’s collection in 1906 by his sons. Research into Dr. Prince’s life and writings revealed the history of the medical department’s library.

IC was founded in 1829. The IC medical department opened November 16, 1843, one month before Rush Medical College in Chicago, making it the first medical school in Illinois. A total of 14 students attended a 16-week course of lectures, and six of those students graduated in 1845 with a medical degree. The medical department was established by the IC board of trustees with the understanding that the medical faculty would be independent of the literary school.

Carl E. Black, MD, FACS, wrote a book and an article describing the history of the medical department: Illinois’ First Medical School and “A pioneer medical school.”* These publications, which support many of the quotations in this column, are available in the IC’s Schewe Library. In the first year of the medical department, the board of trustees leased the “north attic” of Beecher Hall to the medical faculty. Instruction was static, with lectures, texts, charts, and a connected skeleton. In July 1844, the medical faculty purchased and remodeled a two-story barn at the corner of Mound Road and Lincoln Avenue. The remodeled building had four rooms, one of which was used for dissecting instruction. Secondary accounts report the medical department was closed in 1848 because it was unpopular with the community and the literary school faculty over the “anatomical question.” The concern was related to the source of cadavers for dissection. Dr. Prince attempted to quiet rumors by explaining the cadavers came from abroad and not from the local cemeteries. However, Samuel Willard, MD, an 1848 graduate of the medical department, said that the facility closed because the teachers no longer could subsidize the medical department and take promissory notes from students in lieu of compensation.

The medical school at Jacksonville, though short lived (1843–1848), left a deep impress on the

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T.J. Pitner, MD, donated a large portion of his private library, some of which was in the transfer, and Greene Vardiman Black, MD, the father of Dr. Carl Black and the acknowledged Father of Modern Dentistry, donated a first edition of his two-volume *Operative Dentistry* (1908).

medical history of Illinois. In its first catalogue, issued in 1843, it is announced that “there is a respectable medical library belonging to this institution, embracing the best modern works upon the various branches of medicine. Students will also have access to the private libraries of the Professors, which contain the best medical periodicals in the French, German and English languages. It is recommended that each student provide himself with a medical dictionary; and some good modern work on each of the branches which he wishes to pursue in connection with the lectures.”

With the closing of the doors of the medical department of Illinois College in 1848, the fate of its library, for the growth of which much money and energy had been spent, assumed an increased interest. Contrary to what usually happens to a virtually abandoned collection of that kind, the course of this one is fairly clear. For almost half a century it remained “stored away in dusty uselessness,” as Dr. (Carl) Black remarked, “in the old library in Beecher Hall.”

Dr. Kampmeier further described the library as containing “many very old books, valuable historically and as book rarities, a number of them in Latin.” The library remained stored in Beecher Hall for 46 years until it was turned over in trust to the Morgan County Medical Society in 1894 “to make it serviceable for physicians and students.” Formalities regarding the transfer were exchanged at the June 1894 meeting of the society.

**Transfer to the Medical Society**

The Morgan County Medical Society began formal meetings in 1866. At a meeting at the Young Men’s Christian Association, more commonly known as the YMCA, in 1888, the members appropriated $100 for purchasing books. Soon after, Dr. Prince came in with several books, put them in an empty bookcase, and declared, “This is the beginning of the Library of the Morgan County Medical Society.” The library grew as many donations and bequests followed. T.J. Pitner, MD, donated a large portion of his private library, some of which was in the transfer, and Greene Vardiman Black, MD, the father of Dr. Carl Black and the acknowledged Father of Modern Dentistry, donated a first edition of his two-volume *Operative Dentistry* (1908).

An opportunity for a permanent home for the society’s library came in 1903. The Jacksonville Public Library Association had been operating a subscription reading room when it secured a $40,000 pledge from Andrew Carnegie. At that point the association was able to meet Mr. Carnegie’s requirement for City Council approval of a separate property tax to support the new library building. Under an agreement with the library board of directors, the society moved its library to the Carnegie Public Library Building and arranged to hold its meetings there as well. Two years later, Dr. Carl Black, then the society’s librarian, convinced the members to raise a subscription for cataloguing the medical library. At the end of 1905, he reported the society’s library contained 1,789 books (319 duplicates from gift collections) that had been “properly accessioned, catalogued, plated, labeled, and shelved.” More than 16,000 reference cards were created for articles and clinical notes in the accumulated medical journals—both foreign and domestic.

By 1940, both the medical library and the Jacksonville Public Library collection had grown to the point that public library directors asked the medical society to remove its collection. The medical society boxed up the library and took it to Passavant Hospital in Jacksonville. The hospital did not have a librarian but did offer space for storage.
The ACS steps in
In late 1940, Dr. Black initiated correspondence with the ACS Archivist, Margueriete Prime, inviting her to visit Jacksonville to review the collection of books, biographies, and monographs. After Ms. Prime’s visit on December 3, 1940, she wrote to Dr. Black stating, “Of the 4,000 volumes, 600 would be of use to the College Library.” Ms. Prime wrote a note to the ACS associate director, Bowman Crowell, MD, FACS, stating, “Dr. Black does not realize with the exception of foreign journals, AMA [American Medical Association] publications, and possibly twenty-five books, everything is in the [ACS] library.”

Dr. Black wrote to Dr. Crowell on May 10, 1941, reporting that the society had voted to donate the library, and it would be delivered by truck on May 20. “Any books not wanted, give away or throw away. Keep as far as possible books with names of former society members Prince, Read, Pierson, Pitner, or Illinois College Medical Department,” Dr. Black wrote. In his response on May 14, Dr. Cowell wrote, “We do not need AMA Journals and Annuals of Surgery.”

Nonetheless, two trucks carrying six tons of medical books and journals arrived at the ACS headquarters in Chicago, IL, on May 20. Ms. Prime issued an announcement of the donation to the ACS members. She recounted some of the history of the collection, including a summary of authors. “Possibly the most interesting item in the entire group is comprised of the handwritten [version] of Notes on Surgery From the Lectures of Dr. Physick, Professor of Surgery in the University of Pennsylvania, 1812–1813 by Dr. Daniel Pierson,” observed Ms. Prime. Philip Syng Physick, MD, was one of the foremost surgeons of his time, having among his patients U.S. Supreme Court Chief Justice John Marshall, President Andrew Jackson, and First Lady Dolly Madison. Dr. Pierson’s notebook was among those returned to return to their “home”
As time passed, the ACS library of historical and rare books expanded. In recent years, many books in the library were distributed to university medical libraries in several states, according to Ms. Rishworth. Two years ago, a project was started to create a database of the remaining ACS historical and rare books. When the database was completed last year, the author of this column, an IC alum, requested that books with faceplates identifying the original holders as the Morgan County Medical Society and IC be separated; 71 books were identified as such, and they are the titles that were returned to IC. Some authors of these books are easily recognized, including Antoine Lavoisier; Joseph Lister, MD; Daniel Drake, MD; and Benjamin Rush, MD.

Permission to transfer the books to IC was requested and granted in September 2013. These 71 books are a very small representation of the 4,000 books donated to the ACS by the Morgan County Medical Society in 1941. Nevertheless, they provide a glimpse into the past, allowing us to see the studiousness of 19th century physicians in Morgan County and the wide range of medical literature available to them. Upon signing off on the transfer, Ms. Rishworth said, “I am glad to see them going to a good home.”
Physicians invited to play a larger role in standards process

Surgeons and other physicians know The Joint Commission for its accreditation of hospitals and development of the standards that guide many aspects of an institution’s daily operations and have an impact on physicians. Because the guidelines affect physicians, The Joint Commission strives to include them in the standard-setting process.

The Joint Commission’s goal is to help health care institutions—and the practitioners in those facilities—to improve the quality and safety of patient care. That rationale should underlie every standard The Joint Commission sets. The evidence for this rationale comes both from formal studies and from the experience of experts in practice—surgeons, other physicians, nurses, pharmacists, and so on.

Making certain that surgeons and their physician colleagues understand the reason for relevant standards and that they have a clear understanding of the meaning of the standards is a goal of a number of initiatives that The Joint Commission is undertaking. These efforts include engaging physicians about their experience with the standards through focus groups and other outreach efforts to inform staff when changes are needed. Physicians also can influence the development of new or revised standards by participating in the field review or submitting questions via an online standards question form available at https://web.jointcommission.org/sigsubmission/sigionlineform.aspx.

Physicians are encouraged to take advantage of the form and send their thoughts about specific standards to The Joint Commission.

Physician questions
Most questions and concerns about standards that come to The Joint Commission from physicians fall within the following categories:

• Standards not related to quality and safety. The Joint Commission has heard from physicians that certain standards do not support the quality and safety of patient care. For example, the requirement to create a summary list for recurring outpatients by the third visit has been problematic in terms of implementation and frequently questioned as to how it contributes to quality and safety when the outpatient areas in question do not provide primary care-type services. A frequently asked questions (FAQ) document was developed to explain the limits of the requirement’s applicability. The Joint Commission staff systematically review any standard that is thought not to support quality of care and to determine if the standard needs to be updated or deleted.

• Standards that generate ongoing debate. In some cases, there are divergent opinions on what would be the best requirement. For example, a number of standards in the “Medical Staff” chapter of the hospital and critical access hospital accreditation manuals have been vigorously debated among physicians. Topics covered in this chapter include guidelines for determining which clinicians are allowed to complete the admitting history and physical examination, the relationship between the organized medical staff and the medical staff executive committee, and the use of volume of procedures performed in the privileging process. The Joint Commission often finds that issues that elicit ongoing, passionate debate tend to be based less on data and more on strong opinions. Although it is impossible to satisfy all stakeholders, The Joint Commission attempts to elicit all major points of view and to create a clear rationale for the final requirement.

• Relationship of The Joint Commission standards to Conditions of Participation (CoP) established by the Centers for Medicare & Medicaid Services (CMS). A number of The Joint Commission requirements are actually CMS CoP and must be addressed through accreditation standards and/or elements of performance if accreditation is to qualify the organization for Medicare payments. Changes in CoP sometimes necessitate revisions in The Joint Commission standards language to maintain alignment between the requirements. For example, The Joint Commission has made changes in the Medication Management and Leadership...
SUMMARY OF THE STANDARDS DEVELOPMENT PROCESS

- New or revised requirements are identified through the scientific literature or the joint Commission’s standing committees and advisory groups, accredited organizations, professional associations, and consumer groups, and input from physicians, health care workers, or others.
- The draft standards are developed using input from external task forces, focus groups, experts, and other stakeholders.
- Technical Advisory Panels (TAPs) are assembled when complex technical or controversial issues are involved.
- The draft standards are reviewed by relevant Joint Commission Professional and technical Advisory Committees (PtACs) composed of outside experts and the Standards and Survey Procedures (SSP) Committee, a committee of the Board of Commissioners, both of which include experts from the American College of Surgeons.
- The draft standards are distributed nationally for review and made available for comment on the Standards Field Review page (http://www.jointcommission.org/standards_information/field_reviews.aspx) of the Joint Commission website.

If needed, the draft standards are revised and again reviewed by the TAP, other experts, and relevant PtACs.

- The draft standards are approved by the SSP Committee and provided to the Board for a comment period. Once that period of time has passed, the standards are final unless the Board seeks further discussion.
- Surveyors are educated about how to assess compliance with the standards.
- The approved standards are published. Prepublication versions of the standards are posted on the website (http://www.jointcommission.org/standards_information/prepublication_standards.aspx) until they are published in the printed accreditation manuals or the Joint Commission e-dition, the electronic version of the accreditation and certification manuals.
- Once a standard is in effect, ongoing feedback is sought through a Comment on a Standard form (http://www.jointcommission.org/standards_information/comment_standard.aspx) for the purpose of continuous improvement.

Chapters for hospitals and critical access hospitals to reflect revised CoP. The Joint Commission engages in ongoing dialogues with CMS about ways they can work together to help health care organizations improve patient care and patient outcomes.

Misinterpretation of requirements within a standard. On occasion, the intent of a standard is misunderstood. One example is the standard associated with physician privileging and re-privileging, which uses a combination of Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation. These two processes are used to address separate issues in privileging and are quite different. The most common misinterpretation is the level of complexity required in these two evaluations. Occasionally, The Joint Commission finds interpretations of these requirements that go significantly beyond the intent. While an organization may implement processes that exceed the Joint Commission requirements, different methods to reduce misunderstandings of the requirements themselves are under review.

STANDARDS DEVELOPMENT

Physicians also often ask questions such as, “Why is this standard phrased the way it is? What does this standard have to do with quality and safety? How was this standard developed?”

The standards are based on available scientific evidence with extensive input of experts in the topic area and from the field. New and revised standards undergo an extensive vetting process that can take one year or more to complete. During this time, opportunities are provided for physicians and others to voice their opinions about the proposed standards. A summary of the standards development process appears in the sidebar on this page.

The Joint Commission provides a Standards Online Question form (https://web.jointcommission.org/sigsubmission/sigonlineform.aspx) as one of the means of soliciting questions about the standards. Physicians are also invited to visit the Standards page (http://www.jointcommission.org/standards_information/standards.aspx) on the Joint Commission website for more information.
The inclination toward rank ordering items into lists dates back to Dick Clark’s American Bandstand show of the late 1950s, which he ended with the top 10 records of the week. Over the ensuing years, several publications, including People magazine, Cosmopolitan, the New Yorker, and the Wall Street Journal, adopted this listing technique. Today one can search for “top 10 list” on the Internet and find close to 1.6 billion hits. The top hit will likely be related to the David Letterman Show (now the Late Show with David Letterman), which popularized these lists and made them part of pop culture since airing a segment called “The Top Ten Things That Almost Rhyme With Peas” 30 years ago. Along with the Late Show’s iconic “Top 10 List” one can find the top 10 most venomous snakes, the top 10 sources of renewable energy, and so on.

**Top 10 Complications**

Since 2011, the top 10 list of complications has been a part of the National Trauma Data Bank® Annual Report. A medical complication is defined as “a secondary disease or condition that develops in the course of a primary disease or condition and arises either as a result of it or from independent causes.”* On occasion, in spite of a medical team’s best efforts, complications may occur. Complications can contribute to morbidity, mortality, an increased length of stay, and delays in recovery from traumatic injuries. According to the National Trauma Data Standard 2013 Admissions Data Dictionary, 22 complications are listed as possible choices to be entered into the field for hospital complications.

The National Trauma Data Bank (NTDB®) Annual Report 2013 includes a table listing the 22 complications with their frequencies (see Table, page 54) and a graph (see Figure, page 54) that displays the top 10 complications reported in 2013 admission year medical records. These cases accounted for 74,265 (83 percent) of the total of 89,971 reported complications. In fact, the top two complications, pneumonia (17,094) and urinary tract infection (12,484), comprise one-third of all of the complications listed.


**Growing Concern**

Government payors for the past several years have been taking a hard look at complications

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*The Nt DB Annual Report 2013 is available on the ACS website as a PDF file and as a PowerPoint presentation at www.ntdb.org.*

In addition, information regarding how to obtain Nt DB data for more detailed study is available on the website.
and the resultant increase in health care costs. Public databases are tracking hospital-specific rates on complications, mortality rates, and safety profiles. The health care payment paradigm continues to shift and with it, care for certain complications will no longer be reimbursed. Landing on the top 10 list is often a prestigious honor, but not when it comes to complications.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. The National Trauma Data Bank Annual Report 2013 is available on the ACS website as a PDF file at www.ntdb.org.

In addition, information about how to obtain NTDB data for more detailed study is available on the website. To learn more about submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org. 

HoSPItAL CoMPLICAtIoNS

<table>
<thead>
<tr>
<th>COMPLICATIONS</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>17,094</td>
<td>2.05</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>12,484</td>
<td>1.50</td>
</tr>
<tr>
<td>Acute lung injury/Acute respiratory distress syndrome (ARDS)</td>
<td>7,870</td>
<td>0.94</td>
</tr>
<tr>
<td>Deep Vein Thrombosis (DVT) / thrombophlebitis</td>
<td>5,927</td>
<td>0.71</td>
</tr>
<tr>
<td>Drug or alcohol withdrawal syndrome</td>
<td>5,849</td>
<td>0.70</td>
</tr>
<tr>
<td>Cardiac arrest with CPR</td>
<td>5,713</td>
<td>0.69</td>
</tr>
<tr>
<td>Acute kidney injury</td>
<td>5,571</td>
<td>0.67</td>
</tr>
<tr>
<td>Unplanned intubation</td>
<td>4,463</td>
<td>0.54</td>
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<tr>
<td>Decubitus ulcer</td>
<td>3,699</td>
<td>0.44</td>
</tr>
<tr>
<td>Unplanned return to the ICU</td>
<td>2,931</td>
<td>0.35</td>
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<tr>
<td>Extremity compartment syndrome</td>
<td>2,664</td>
<td>0.32</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>2,483</td>
<td>0.30</td>
</tr>
<tr>
<td>Severe sepsis</td>
<td>2,312</td>
<td>0.28</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>2,008</td>
<td>0.24</td>
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<tr>
<td>Stroke / CVA</td>
<td>1,901</td>
<td>0.23</td>
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<tr>
<td>Unplanned return to the OR</td>
<td>1,566</td>
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<tr>
<td>Organ/space surgical site infection</td>
<td>1,548</td>
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<tr>
<td>Superficial surgical site infection</td>
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<td>Catheter-Related Blood Stream Infection</td>
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<tr>
<td>Deep surgical site infection</td>
<td>822</td>
<td>0.10</td>
</tr>
<tr>
<td>Graft/prosthesis/flap failure</td>
<td>436</td>
<td>0.05</td>
</tr>
</tbody>
</table>
| Osteomyelitis                              | 252    | 0.03    

t op 10 CoMPLICA tIoNS

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For almost a year, trauma surgeons, federal law enforcement personnel, and emergency responders have led an effort aimed at increasing the number of survivors of active shooter or mass-casualty incidents. An important part of this initiative calls for all law enforcement officers to be trained and equipped to control bleeding, a goal set forth by the Hartford Consensus, a collaborative group comprising leaders from the American College of Surgeons (ACS), the Federal Bureau of Investigation (FBI), the Major Cities Chiefs Association (MCCA), and the Prehospital Trauma Life Support program.

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“Controlling hemorrhage has to be a core law enforcement tactic,” said Alexander Eastman, MD, MPH, FACS, chief of trauma at the University of Texas (UT) Southwestern/Parkland Memorial Hospital, Dallas, and a Dallas Police Department Lieutenant. “We saw the dramatic impact of this tactic in the Tucson, AZ, shooting in 2011. With training and tourniquets, law enforcement officers will save lives—many lives.”

The principle of more training and equipment is central to the findings of the Hartford Consensus, according to “The Hartford Consensus: THREAT, A Medical Disaster Preparedness Concept,” an article published in the March issue of the *Journal of the American College of Surgeons (JACS)*. A companion piece, originally published in the September 2013 *Bulletin*, “Joint Committee to Create a National Policy to Enhance Survivability from Mass-Casualty Shooting Events: Hartford Consensus II,” calls for a broad educational strategy and a robust evaluation of the implementation of THREAT in order to quantify its benefits in the management of active shooter and mass-casualty events. THREAT is an acronym for the needed response to mass shooting events developed by the Hartford Consensus: T−Threat suppression, H−Hemorrhage control, RE−Rapid Extrication to safety, A−Assessment by medical providers, and T−Transport to definitive care.

Hartford Consensus in action: Law enforcement gets equipment, training to control bleeding

Hartford Consensus in action: Law enforcement gets equipment, training to control bleeding
Law enforcement officers are typically the first to the scene of such an incident, but they lack the medical training and equipment to treat the victims.

The Hartford Consensus is already having an impact. In concert with ACS and the MCCA, more than 36,000 police officers in Los Angeles, CA; Philadelphia, PA; Houston, TX; Phoenix, AZ; Dallas; New Orleans, LA; Tampa, FL; and Washington, DC, will receive bleeding control kits and training this year. The Hartford Consensus also urges cities to develop an integrated response system customized to the needs of their community and focused on the importance of initial actions to control hemorrhage.

“We can no longer wait until casualties are brought out to the perimeter,” said ACS Regent Lenworth M. Jacobs, MD, MPH, FACS, vice-president of academic affairs and chief academic officer and director, Trauma Institute at Hartford Hospital, CT. “We must prepare respondents to safely intervene, control bleeding, and save lives.”

Another recommendation of the Hartford Consensus is to educate and equip the public to respond to the needs of victims. However, activating that type of response effort means that tourniquets and other equipment need to be broadly available in schools, offices, shopping centers, churches, and other public places.

“Just as automatic external defibrillators are easily usable and quickly available to the public, so should easily applied tourniquets be available in a similar manner and locations,” said Norman McSwain, Jr., MD, FACS, medical director, pre-hospital trauma life support, Tulane University School of Medicine, New Orleans. “It’s not a complicated process, and it will save lives.”

“We need to expand the pool of first responders,” added Michael F. Rotondo, MD, FACS, Chair, ACS Committee on Trauma. “With proper training, under the right circumstances anyone can act as a rescuer.”

**HealthLeaders Media:**

**Accreditation improves bariatric outcomes**

An article in the February 6 *HealthLeaders Media,* “Better bariatric surgery outcomes depend on data, accreditation,” underscores the effectiveness of the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), which has created a single accreditation process for bariatric centers. View the MBSAQIP website at [http://www.mbsaqip.org](http://www.mbsaqip.org). In 2012, the American College of Surgeons (ACS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) combined their bariatric programs to form MBSAQIP. This collaboration is establishing national standards for accreditation and quality improvement that require facilities to undergo a peer-evaluation process, follow data submission requirements, and demonstrate experience in managing bariatric surgery patients before, during, and after procedures to receive accreditation.

The article notes that accreditation has significantly reduced mortality rates from a bariatric operation, a “dangerous and potentially fatal procedure, requiring proper training and technical skill.” Today, nearly 750 inpatient and outpatient bariatric centers throughout the U.S. participate in the MBSAQIP, but 20 percent of the nation’s 900 bariatric surgery programs remain unaccredited. Access the *HealthLeaders Media* article online at [http://www.healthleadersmedia.com/content/QUA-300726/Better-Bariatric-Surgery-Outcomes-Depend-on-Data-Accreditation](http://www.healthleadersmedia.com/content/QUA-300726/Better-Bariatric-Surgery-Outcomes-Depend-on-Data-Accreditation).
Surgeons, anesthesiologists develop resource standards for optimal pediatric care

The American College of Surgeons (ACS) has published new comprehensive guidelines that define the resources the nation’s surgical facilities need to perform operations effectively and safely in infants and children. The standards—published in the March issue of the Journal of the American College of Surgeons—also have the approval of the American Pediatric Surgical Association and the Society of Pediatric Anesthesia.* Representatives of these organizations as well as invited leaders in other pediatric medical specialties, known as the Task Force for Children’s Surgical Care, developed the consensus recommendations over the past three years.

“The intent of these recommendations is to ensure that all infants and children in the U.S. receive care in a surgical environment matched to their individual medical, emotional, and social needs,” said Keith T. Oldham, MD, FACS, task-force chair and the surgeon-in-chief at Children’s Hospital of Wisconsin, Milwaukee.

Many studies show better results—including fewer complications and shorter hospital stays—when newborns and children undergo surgical procedures in environments that have expert resources for pediatric patients, compared with non-specialized centers.

In its report, the Task Force for Children’s Surgical Care defined the proper surgical environment for children as one “that offers all of the facilities, equipment, and, most especially, access to the professional providers who have the appropriate background and training to provide optimal care.”

The task force assigned levels of resources, as the ACS has done for trauma centers for decades. The classification for children’s surgical centers is as follows:

• **Level I (highest level):** Possesses adequate resources to provide comprehensive surgical care and perform both complex and noncomplex surgical procedures in newborns and children of all ages, including those with the most severe health conditions and birth defects. Is staffed 24 hours a day, seven days a week with properly credentialed pediatric specialists, including pediatric and subspecialty surgeons, pediatric anesthesiologists, pediatric diagnostic and interventional radiologists, and pediatric emergency physicians. Has a Level IV neonatal intensive care unit (NICU), the highest level of critical care for newborns.

• **Level II:** Possesses adequate resources to provide advanced surgical care for children of all ages, including those who have accompanying (“comorbid”) medical conditions. Operations would typically be performed by a single surgical specialty. Personnel include a board certified pediatric surgeon, pediatric anesthesiologist, and pediatric radiologist with other pediatric specialists readily available for consultation, and has an emergency physician and an intensive care unit that both have pediatric expertise. Has a Level III or higher NICU.

• **Level III:** Possesses adequate resources to provide basic surgical care and perform common, low-risk surgical procedures in children older than one year who are otherwise healthy. Has a general surgeon, anesthesiologist, radiologist, and emergency physician, all of whom have pediatric expertise. Has a Level I NICU (well-newborn nursery) or higher.

Both Level II and III surgical centers must be able to stabilize and transfer critically ill children to a hospital with higher-level resources. All children’s surgical centers must have at least one pediatric surgical nurse, a pediatric rapid response team of critical care professionals available at all hours, and an in-house physician with Pediatric Advanced Life Support certification or equivalent qualifications. Furthermore,

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Many studies show better results—including fewer complications and shorter hospital stays—when newborns and children undergo surgical procedures in environments that have expert resources for pediatric patients, compared with non-specialized centers.

All areas of these centers must have the resources needed to perform pediatric resuscitation. Additional guidelines for ambulatory, or outpatient, surgical centers include having preoperative and recovery areas dedicated to pediatric patients. Also according to the task force report, a pediatric anesthesiologist at an ambulatory surgical center should administer or supervise the administration of a general anesthetic or sedative to all infants younger than one year old.

Acknowledging that the standards are high, ACS Executive Director David B. Hoyt, MD, FACS, a member of the Task Force for Children's Surgical Care, added, “I think many hospitals will rise to these new standards by adding resources.” In designating the resources that children’s surgical centers need, the Task Force for Children's Surgical Care reportedly relied on published scientific evidence and expert opinion. According to Dr. Oldham, supporting evidence included the success of the ACS’ nationwide classification and verification system for trauma centers. By helping ensure that injured patients receive care at the appropriate level, the trauma system has saved many lives, he noted.

Plans are under way to develop criteria for evaluating existing facilities that perform children’s surgical procedures. The ACS will oversee the site verification process, which Dr. Oldham anticipates will become available sometime this year.

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Melina Kibbe, MD, FACS, appears on 60 Minutes segment

Melina Kibbe, MD, FACS, recently commented on sex disparities in medical research during a segment on 60 Minutes, which aired on February 9. Dr. Kibbe is Edward G. Elcock Professor of Surgical Research, division of vascular surgery, Northwestern University Feinberg School of Medicine, Chicago, IL, and deputy director of Northwestern University’s Institute for BioNanotechnology in Medicine. Correspondent Lesley Stahl conducted the interview, which focused on the conclusion of a growing number of scientists that differences between the sexes are understudied.

Dr. Kibbe, who recently launched a review of 1,091 articles published in leading surgical journals, noted that only 3 percent of the reported studies included males and females. “What’s more alarming,” she added, “is that 34 percent of the articles don’t even state the sex of the animal or the cell.” Ms. Stahl also interviewed Teresa K. Woodruff, PhD, the Thomas J. Watkins Professor of Obstetrics & Gynecology at the Feinberg School of Medicine and professor of molecular biosciences at Northwestern University’s Weinberg College of Arts and Sciences.

Go to 60 Minutes Overtime at http://www.cbsnews.com/news/sex-matters-who-has-the-softer-heart/ to view Ms. Stahl’s extensive interview with Dr. Kibbe, much of which was posted online only.

Register now for 2014 Rural Surgery Symposium, May 9–10, in Chicago

The 2014 Rural Surgery Symposium, titled Advocacy, Economics, and Patient Care, will take place at American College of Surgeons (ACS) headquarters in Chicago, IL, May 9–10. Register online for this limited-space meeting. The symposium will address issues that affect rural surgery, trends in rural surgery practice, and ACS resources for rural surgeons. Tyler G. Hughes, MD, FACS, an ACS Governor and Chair of the ACS Advisory Council for Rural Surgery, McPherson, KS; and David C. Borgstrom, MD, FACS, a Member of the Advisory Council for Rural Surgery, Cooperstown, NY, are the Symposium Directors.

Symposium participants will gain an understanding of national and local influences on surgical care in rural America as well as how changes in surgical education may affect future rural surgical care. Participants will also attend sessions examining the influences of health care reform on surgical care in rural America and staffing needs in rural health care.

Symposium topics are listed in the sidebar. To register, go to the ACS website at http://www.facs.org/about/councils/advrural/symposium.html.

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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.

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Brooklyn and Long Island Chapter and Nassau Surgical Society host combined meeting

On December 4, 2013, the Brooklyn and Long Island Chapter of the American College of Surgeons (ACS) and the Nassau Surgical Society hosted a combined 12th Annual Clinic Day meeting in Uniondale, Long Island, NY. With 418 attendees, this chapter meeting was the largest of the year in the U.S. An educational program highlighted 11 surgical specialties represented at Clinic Day, including cardiothoracic, general surgery, obstetrics/gynecology, ophthalmology, orthopaedic, otolaryngology, plastic surgery, transplant/vascular surgery, trauma and emergency surgery, and urology. A number of renowned speakers from across the U.S. delivered remarks at the educational program. The well-received luncheon keynote speaker was Christian Shalgian, Director of the ACS Division of Advocacy and Health Policy. This year’s Clinic Day also included an abstract poster competition for resident surgeons. The top 11 posters at the event received awards.

ACS Foundation represented at southern California Chapter meeting

Edward H. Phillips, MD, FACS, and Jonathan R. Hiatt, MD, FACS, represented the ACS Foundation as Chapter Philanthropic Champions (CPCs) at the Southern California Chapter meeting in January.
The Foundation’s Committee on Chapter and Affiliate Relations started the CPC program to promote chapter philanthropic support for College programs, such as quality initiatives, professional development, and research. Drs. Phillips and Hiatt both highlighted the Foundation’s mission and the many benefits of philanthropy, including the opportunity to be recognized as a contributor to the Foundation’s 1913 Legacy Campaign. The Legacy Campaign is a fundraising initiative launched in honor of the College’s Centennial. Foundation donors were recognized at the chapter meeting.

san diego Chapter announces registration for 2014 spring dinner meeting
The San Diego, CA, Chapter will host its 2014 Spring Chapter Dinner Meeting at the University Club atop Symphony Towers, May 7. Scheduled speakers include Dustin Corcoran, MBA, chief executive officer of the California Medical Association, who will address the question, An Update on Covered California. How Is It Really Working? Mr. Corcoran also will provide an Update on the Status of the Drug and Alcohol Testing of Doctors Medical Negligence Lawsuits Initiative Statute. Registration and information for the meeting is available at www.sdcacs.org. For further information or to register, contact the chapter administrator, Jim Cox, at surgeons@sdcacs.org or 619-579-2946.

northeast mexico Chapter holds planning meeting
The Northeast Mexico Chapter held its first chapter meeting of the year on February 4, at the Restaurante Regio in Monterrey, Mexico, with 14 Fellows in attendance. Two Fellows who passed away in 2013, Rene Villarreal, MD, FACS, and Salvador Chapa, MD, FACS, were remembered at the meeting. In addition, two new chapter members, Eduardo Gonzalez, MD, FACS, and Eduardo Garcia, MD, FACS, were introduced.

Topics discussed at the meeting included academic activities that would encourage residents and other young surgeons to get involved in chapter and ACS activities, as well as the planning of an upcoming ACS Tri-Chapter Mexico meeting. The Mexico Federal District Chapter, the Mexico Nor-Occidental Chapter, and the Northeast Mexico Chapter will cohost a meeting May 2–3 in San Miguel de Allende. The tri-chapter meeting will center on trauma surgery and will feature presentations by Fellows from all three chapters.

italy Chapter collaborates with endoCAS Center for training and research
The Italy Chapter has announced that it will collaborate with the EndoCAS Center on the campus of the Cisanello Hospital in Pisa, Italy, to offer new educational opportunities for surgeons. EndoCAS received accreditation from the College in June 2013 as a Center of Excellence for Training and Research. EndoCAS is the only Italian surgical center accredited by the ACS as a Focused Accredited Education Institute. Surgeons who worked on the agreement between the chapter and EndoCAS include...
the Kansas Medical Society, the Kansas Chapter of the American Academy of Family Physicians, and the Kansas Chapter of the ACS collaborated on Kansas Lobby Day 2014 on January 22. Kansas Chapter members are pictured, from left: Joshua M. Mammen, MD, FACS, Kansas City; Dale P. Denning, MD, FACS, Lawrence; Pamela J. Steinle, MD, FACS, Smith Center; Scott D. Coates, MD, FACS, Chanute; Douglas W. Fain, MD, FACS, Prairie Village; Jennifer McAllaster, MD, Lawrence; Rex M. Joyce, MD, FACS, Leawood; Justin Rosen, ACS staff; and James J. Hamilton, Jr, MD, FACS, Topeka.

Alessandro M. Paganini, MD, PhD, FACS, President of the Italy Chapter; and Franco Mosca, MD, FACS, director of EndoCAS. The mission of the EndoCAS Center is to become a leading institution for the training of residents, surgeons, and medical students to perform minimally invasive procedures. Educational activities at the center include clinical sessions, live transmission of operations, hands-on training with models, and state-of-the-art commercial surgical simulations.

The officers for the UAE Chapter are Safwan Taha, MB, ChB, FACS, President; Mohd Yasser AlKayyal, MD, FACS, Vice-President; and Omar Bekdache, MD, FACS, Secretary/Treasurer. Mohamad Yaman, FRCS(C), FACS, is the Governor.

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Fellows in the United Arab Emirates establish new chapter
Fellows in the United Arab Emirates (UAE) have formed the newest chapter of the ACS; the Board of Regents approved the chapter at its February meeting in Chicago, IL. The UAE Chapter is the 104th chapter of the College. Currently, the ACS has 66 domestic chapters, including two in Canada. With the addition of the UAE, the College now has 38 international chapters. The officers for the UAE Chapter are Safwan Taha, MB, ChB, FACS, President; Mohd Yasser AlKayyal, MD, FACS, Vice-President; and Omar Bekdache, MD, FACS, Secretary/Treasurer. Mohamad Yaman, FRCS(C), FACS, is the Governor.

Chapter executives meet at ACS headquarters for winter learning event
Nearly 20 ACS chapter executives and their staff convened at the College’s headquarters for the annual Winter Learning Event, December 12–13, 2013, to network, hear the latest information about ACS programs, and receive expert legal advice. Staff of the various divisions of the College addressed the following topics during the day-and-a-half program: the development of a new ACS website; the ACS National Surgical Quality Improvement Program and other quality improvement programs; the Commission on Cancer (CoC); continuing medical education for chapters; social media and website maintenance for chapters; and the Surgeon Specific Registry and the Physician Quality Reporting System. In addition, Jennifer Rosen, MD, FACS,
member of the CoC, described the Young Fellows Association’s mentoring program, and Chapter Executive Jennifer Starkey spoke on resident involvement at the chapter level. The program also included tours of the ACS Archives and the Murphy Memorial Auditorium Building.

The College’s long-time legal counsel, Paula Cozzi Goedert, Esq., presented legal issues of interest to chapter executives, including rules for accepting sponsorships and exhibitors for chapter events and advertising revenue. Planning is now under way for the 2014 Chapter Learning Event, which will include an extended session on writing for the Web, among other topics.

**ACS Latin American and Caribbean Chapters will host regional meeting in July**

The 40th Congresso Colombiano Avances en Cirugia, held in conjunction with a regional meeting of the College’s Latin American and Caribbean chapters and the Association of Surgery, will take place July 28–31, 2014, in Cartagena, Columbia, at the Convention Center Julio Cesar Turbay. For more information go to www.ascolcirugia.org.
Chapter leadership succession planning helps to build stronger chapters

by John Rioux, MD, FACS

One of the most challenging aspects of chapter management is succession planning. As with most organizations, the executive committee of a chapter comprises a president, vice-president (president-elect), treasurer, and secretary. Many of these officeholders go on to accept other leadership positions after their term in one role is completed. The four-officer succession plan provides the best training ground for assuming the presidency of a chapter. Committee or subcommittee chairs who distinguish themselves with excellent performance on a particular project are often looked upon as leadership material. The more committees and subcommittees that a chapter has, the larger the pool of potential officers.

The leadership ladder
Most chapters have a core group of councilors and often a group of committee chairs. Many councilors represent surgery training programs, state medical societies, or other groups and institutions. The College’s Women in Surgery Committee, Health Policy and Advocacy Group, and ACS National Surgical Quality Improvement Program (ACS NSQIP®) collaboratives, Young Fellows Association, Resident and Associate Society (RAS), Committee on Trauma, Commission on Cancer, and Regents’ Committees—including Nominating, Finance, and Membership committees—serve as other reservoirs of future leaders.

Often Governors representing the chapters will serve on these committees in overlapping roles. Some chapters reward officers after their years of service by nominating them to serve as Governors. Governors often benefit the chapter by acting as conduits of information from the ACS leadership to the chapter. Their attendance at the spring Leadership & Advocacy Summit in Washington, DC, as well as an array of Governors’ meetings at the Clinical Congress, ensures that they are up-to-date on College programs and initiatives.

The duties of each officer will vary from chapter to chapter and often will overlap with key committee or subcommittee appointments. Examples of chapter officers’ duties can be found in the American College of Surgeons Chapter Guidebook on the ACS website at http://www.facs.org/about/chapters/

Terms and responsibilities
The term of office for Executive Committee members may be one or two years, each schema having its advantages and disadvantages. A one-year term requires more mentorship of younger council members so they can enter a leadership position earlier in their chapter involvement. A two-year commitment may be more of a challenge for some members because it may essentially mean eight years of involvement if the usual succession from secretary to treasurer to vice-president to president is followed. A two-year term does have the advantage that the first year becomes a “training year,” serving as a foundation for an active, successful second year. When the nominating chair or president approaches prospective officers to assess their willingness to accept the position, a frank conversation between the chair or president and the prospective officer is paramount. This discussion should inform the prospect of the time commitment involved in either a one- or two-year position and the expectations of moving up on the leadership ladder.

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When the nominating chair or president approaches prospective officers to assess their willingness to accept the position, a frank conversation between the chair or president and the prospective officer is paramount.

At the 2013 Leadership Summit, I offered a PowerPoint presentation of chapter officers’ duties, which is available on the ACS website at http://www.facs.org/about/chapters/rioux-leadership2013.pdf.

Duties of each committee chair should also be clearly outlined in the chapter bylaws. Committee chairs destined for officer positions should ideally lead more than one committee over a period of several years so they gain exposure to the breadth of College and Chapter priorities. Within the framework of strategic planning, chapters interested in developing a particular focus (such as advocacy) should consider “promoting” a strong chair of the key committee charged with leading the related activity into the secretary’s spot, so that they may begin the ascent to the presidency.

A president with a strong background in a particular area will help the chapter strengthen its influence in that arena. Chapter leaders should pick a focus and foster the leadership growth of individuals who excel in that capacity.

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The American College of Surgeons (ACS) hosted the ACS Surgical Health Care Quality Forum North Carolina on February 19, one in a series of state-specific forums designed to encourage local participation in the national discussion of methods for improving health care quality in the U.S. Participants in this 16th stop on the College’s Inspiring Quality (IQ) Tour, which began in 2011, focused on ways to improve patient safety and reduce costs.

Co-hosting the event, which took place at the University of North Carolina (UNC) at Chapel Hill, were Timothy M. Farrell, MD, FACS, President of the North Carolina Chapter of the ACS and professor of surgery, division of gastrointestinal surgery, UNC School of Medicine; and Mark C. Weissler, MD, FACS, Vice-Chair of the ACS Board of Regents and Joseph P. Riddle Distinguished Professor of Otolaryngology/Head and Neck Surgery and division chief of head and neck oncology, UNC Neurosciences Hospital.

The forum featured a panel of health care leaders who discussed the political realities of improving the nation’s health care system, as well as the importance of collaborating and using proven programs to increase the value of health care.

Forum speakers underscored the importance of quality from a broad policy and public health perspective, but also shared tangible solutions at the delivery level that measurably improve patient safety and outcomes.

“With our strong health systems and commitment to research and development, North Carolina is well positioned to be a leader in the new health care provider economy, and that includes thinking about how we harness advances to create better health outcomes,” said keynote speaker Rep. David Price (D-NC). “Going forward, policymakers cannot focus solely on improving...
Speakers from UNC Hospitals and the UNC Health Care System discussed programs that have helped them achieve quality improvement, including the ACS NSQIP, which provides reliable surgical data to more than 500 hospitals and pinpoints areas for improvement.

health care accessibility. Efforts to improve quality, such as those developed by the ACS, must go hand-in-hand with promoting expanded access.”

Speakers from UNC Hospitals and the UNC Health Care System discussed programs that have helped them achieve quality improvement, including the ACS National Surgical Quality Improvement Program (ACS NSQIP®), which provides reliable surgical data to more than 500 hospitals and pinpoints areas for improvement.

“Progress in health care quality will come from organizations that are willing to challenge their own outcomes and learn from others,” said keynote speaker William L. Roper, MD, MPH, dean of the school of medicine, vice-chancellor for medical affairs, and chief executive officer of the UNC Health Care System. “Accountable care organizations, patient-centered medical facilities, and greater integration will lead to enhanced care that is safer, more cost-effective, and better for patients overall. By working together, health care organizations can identify solutions to quality issues, and achieve better outcomes for patients.”

David B. Hoyt, MD, FACS, ACS Executive Director, added, “Institutions that really commit to improving quality can have a dramatic effect on patient outcomes. For example, hospitals that have standardized their processes, are accountable for performance, use the right data, and have engagement at all levels have helped the country lower overall blood stream infection rates by 45 percent over the past five years.”

Dr. Farrell closed the forum by urging continued collaboration between surgeons, hospital administrators, and payors. “We gathered today to discuss what we have done as a community to improve quality thus far, but there is much more that must be done. Let’s commit to quality measurement using reliable, risk-adjusted data, and to creating an environment where these data can be freely shared across peer institutions to drive the important work of quality improvement.”

Dr. Weissler concluded, “This forum was a unique opportunity to get all the key stakeholders in the room—from health plans to academia, government, and hospitals—and learn from each other about how we can work together toward the same vision and mission of advancing our health care system.”

The full video of the North Carolina forum is available at InspiringQuality.facs.org and on the College’s YouTube channel. ●
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Applications being accepted for the ACS Traveling Fellowship to Japan for 2015

The International Relations Committee of the American College of Surgeons (ACS) has announced the availability of the ACS Traveling Fellowship to Japan. This fellowship is intended to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America. Applications for the Fellowship will be accepted through June 2, 2014.

Requirements
The scholarship is available to a Fellow of the ACS in most of the surgical specialties who meets the following requirements:

• Has a major interest and accomplishment in clinical and basic science related to surgery
• Holds a current full-time academic appointment in Canada or the U.S.
• Is younger than 45 years of age on the date the application is filed
• Is enthusiastic, personable, and possesses good communication skills

Activities
The Fellow is required to spend a minimum of two weeks in Japan and engage in the following activities:

• Attend and participate in the annual meeting of the Japan Surgical Society (JSS), which will be held in Nagoya, April 16–18, 2015
• Attend the Japan ACS Chapter meeting during the JSS meeting
• Visit at least two medical centers outside of the annual meeting city before or after the JSS conference to lecture and to share clinical and scientific expertise with local surgeons

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

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

Financial support
The College will provide $7,500 (U.S.) to the successful applicant, who will also be exempt from registration fees for the JSS annual meeting.

The Fellow must meet all travel and living expenses. Senior JSS and ACS Japan Chapter representatives will consult with the Fellow about the centers to be visited in Japan, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow must make travel arrangements in North America to have access to reduced fares and travel packages for travel in Japan.

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

Applications for this traveling fellowship are available at http://www.facs.org/memberservices/acsjapan.html or by e-mailing the International Liaison at kearly@facs.org.

The successful applicant and an alternate will be selected and notified by November 30, 2014. ✦
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

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may 2–4
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Contact: Susan McConnell, smcconnell@ramdocs.org, http://www.virginiaacs.org/

australia– new Zealand Chapter
may 7
Singapore
Contact: Monique Whear, Monique.Whear@surgeons.org

san diego Chapter
may 7
university Club Atop Symphony towers, San Diego, CA,
Contact: Jim Cox, elcajonJim@cox.net, elcajonJim@cox.net

ohio Chapter
may 9–10
Cleveland, OH
Contact: Jennifer Starkey, jennifer@acschapters.com, www.ohioacs.org

michigan Chapter
may 14–16
Petoskey, MI
Contact: Angie Kemppainen, akemppainen@msms.org, www.michiganacs.org

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Contact: David Hunter, davhunter@hotmail.com

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Albany, NY
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Stowe, VT
Contact: Jeanne M. Kunkle, jeanne.kunkle@vtmednet.org

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