Health care entitlement reform:
A LOOK AT THE FUTURE
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continued on next page
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For approximately 12 years, surgeons have been operating under the annual threat of enormous Medicare payment cuts due to the flawed sustainable growth rate (SGR) formula that is used to calculate reimbursement. Each year, Congress has intervened to prevent these cuts from occurring by passing short-term patches. Although the American College of Surgeons (ACS) appreciates these efforts, we also have maintained that a long-term solution is needed and have called for repeal of the SGR.

It appears that Congress has now reached the tipping point with regard to SGR reform and seems more willing than ever to take meaningful action. The “What surgeons should know about” column on page 39 provides an overview of the status of congressional proposals to repeal the SGR. In this column, I focus specifically on what the College has done in the last year or two to assist Congress in the development of a realistic and equitable payment system.

Lawmakers are listening
It is important to note that Congress has heard the message that the College has been delivering on its Inspiring Quality Tour and is seeking to develop a new payment model that will reward health care professionals who take steps to measure and improve their outcomes and, thereby, reduce the cost of delivering patient care. Furthermore, the three congressional committees that oversee the Medicare payment system—the Senate Finance, House Ways and Means, and House Energy and Commerce Committees—have repeatedly sought the ACS’ input on their payment reform proposals. In fact, we are one of a handful of physicians’ organizations to have testified before all three legislative bodies. At those hearings, in meetings with committee staff, and in written correspondence, the College has advocated for implementation of a Value-Based Update (VBU)—a patient-centered model aimed at improving quality while controlling spending.

In addition, the College weighed in on proposals that the committees developed. The House Energy and Commerce Committee released its plan at the end of May 2013 and approved the Medicare Access and Quality Improvement Act, H.R. 2810, on July 31. Two critical provisions in H.R. 2810 establish the following:

- A 0.5 percent increase in the physician payment rate over the next 10 years and each year thereafter
- A benchmarking system that would allow all physicians to share in bonus payments if they achieve a requisite score with respect to their ability to provide high-quality, cost-effective care

The College supports these concepts and other elements of the bill but has concerns about some other provisions.

taking a stand
The Senate Finance and House Ways and Means Committees issued a bipartisan, bicameral legislative proposal to repeal the SGR at the end of October. The College’s leadership and advocacy and health policy staff reviewed the plan thoroughly and met several times to discuss it, with a focus on the following four elements:

- A 10-year freeze on physician payment
- Establishment of a Value-Based Payment Program that would measure and rank participating physician performance using a composite score system and under which the only way for a provider to get a bonus payment would be for another to take a cut
- Implementation of an Alternative Payment Model (APM) path, which would allow qualifying physicians to receive incentives and avoid certain requirements through successful participation in Accountable Care Organizations, bundling, and other advanced APMs
- Efforts to address the valuation of physician service codes, including special attention to the global payment for surgical services

In early December, the ACS Board of Regents voted unanimously to oppose the joint plan because of...
It is important to note that Congress has heard the message that the College has been delivering on its Inspiring Quality Tour and is seeking to develop a new payment model that will reward health care professionals who take steps to measure and improve their outcomes and, thereby, reduce the cost of delivering patient care.

the 10-year physician payment freeze and the fact that the legislation provides inadequate incentives for the provision of value-based care. The ACS and a number of surgical specialty societies sent letters to the Finance and Ways and Means Committees expressing our concerns.

After receiving our comments, the House Ways and Means Committee made good-faith changes, including providing positive payment updates of 0.5 percent per year for three years, beginning in 2014. Accordingly, the ACS withdrew its opposition to the Ways and Means draft legislation; however, we maintained our opposition to the Senate Finance version, which had not been amended. On December 12, 2013, both committees moved forward with their markups and passed their proposals.

In addition, prior to adjournment for the holidays, Congress passed a three-month 0.5 percent Medicare physician payment increase as a bridge to allow for negotiations on permanent repeal of the SGR as part of the year-end budget deal. The 24 percent reimbursement cut is now scheduled to take effect April 1. At press time, Congress was facing the difficult task of combining the three committee-passed bills into a single proposal that can pass in both the House and Senate. Additionally, the difficult problem of deciding how to offset the sizeable cost of the package had been left unresolved. The ACS intends to play an active role in resolving the Medicare physician payment issue before the cuts take effect this spring and will continue to advocate on behalf of our Fellows and patients.

**now is the time**

Another important development that occurred involved the Congressional Budget Office issuing a memo, in which the agency estimates that the cost of eliminating the SGR has shrunk to $116 billion, down from nearly $300 billion. With these new data and considering the strides made in 2013, the College’s leadership truly believes that this moment in time presents a rare window of opportunity to finally repeal the SGR and contribute to the creation of a more equitable, sustainable Medicare physician payment system.

We will likely be calling on you in the coming days to participate in grassroots advocacy efforts to achieve repeal. I anticipate that you will be eager to offer your support to help eliminate this persistent thorn in the profession’s side.

In addition, the College’s leadership and advocacy staff will continue to work with Congress and other stakeholders. We remain committed to reforming the Medicare payment system and creating a new value-based model that will positively affect our patients’ access to quality care. ♦

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
editor’s note: The following two articles on new approaches to Medicare are the first in a series of four articles on entitlement program reform that will be published in the Bulletin. The third article, on Medicaid expansion, will be published in the March 2014 issue, and the fourth will run in the April 2014 Bulletin.
Members of Congress have long acknowledged that the present course of Medicare spending is financially unsustainable. The number of eligible beneficiaries is climbing in record numbers as more and more baby boomers enter the Medicare pool. As American life expectancy increases, beneficiaries are drawing out of the system far more than they contributed to it. The fact that this demographic shift is occurring in the midst of a prolonged recession and when efforts to expand coverage to the uninsured are under way due to the passage of the Affordable Care Act (ACA), means that the conditions are ideal for a “perfect storm” of innovation in health care and an opportunity exists to create better value for the billions of dollars that are spent annually on health care.

Development of a value-based health care system is the challenge of the current decade. However, Congress continues to explore cost-shifting legislation rather than system-wide improvements that would translate into cost savings. For example, the House Ways and Means Committee released draft legislation last year that would increase cost sharing for Medicare Parts B and D and for home health care. This article provides an overview of these components of Medicare, a breakdown of the various provisions in the bill, a look at the literature on cost-sharing, and a discussion of the politics behind the proposed legislation.
By 2023, the number of beneficiaries of Part B and Part D is expected to increase to 64 million and 50 million, respectively.

source: CBO, May 2013 Medicare Baseline.

Medicare Part B and Part D expenditures are expected to increase significantly by 2023. Net of receipts, Part B and D outlays are expected to reach $313 billion and $143 billion, respectively, by 2023.

source: CBO, May 2013 Medicare Baseline.

**Costs and projections**

**Medicare Parts B and D.** According to estimates from the Congressional Budget Office (CBO), 20 percent of the U.S. population will be more than 65 years old in 2050, and 4 percent of these senior citizens will be older than age 85, accounting for the fastest-growing demographic in the next 36 years. Needless to say, expenditures on Social Security and Medicare are expected to skyrocket.

Medicare currently covers 52 million Americans. Medicare spending has increased steadily from 1965 to the present and accounts for the second largest component of federal mandatory spending. Medicare was 2.2 percent of gross domestic product (GDP) in 2000 and is projected to reach 3.5 percent of GDP in 2023, when it is expected to cover 69 million Americans. Medicare Parts B and D account for more than half the costs and, subsequently, seem like logical places to look for federal savings.

Medicare Part B covers physician care, laboratory tests, preventive services, clinical research, mental health care, and durable medical equipment. Medicare Part D, established under the Medicare Modernization Act (MMA) of 2003, was implemented in 2006 and provides prescription drug benefits. Figure 1, this page, shows the expected increase in the number of Part B and Part D beneficiaries over the next decade. Figure 2, this page, shows how total expenditures for Parts B and D will increase, as well as the net outlays on these programs by the federal government. The difference in the costs and the net outlays by the government in the graphs for Parts B and D respectively
represents the cost of the program that is shifted to the beneficiary in the form of premiums and copayments. The net federal outlays in 2023 for Parts B and D are expected to be $313 and $143 billion, respectively.2

As originally conceived in 1965, Medicare Part B was to have a standard monthly premium for all beneficiaries set at 25 percent of the annual cost per enrollee, with the federal government providing the rest of the funding. The MMA introduced “means testing” and an income-based Part B premium that took effect in 2007. As a result, higher-income beneficiaries saw their premiums rise from 35 percent to 80 percent of the cost of services (see Table 1, this page).

The modified adjusted gross income (MAGI) thresholds have been indexed to inflation since 2007. For services covered by Part B, including physicians’ services, beneficiaries are responsible for 20 percent of the cost after payment of the annual deductible ($147 in 2013). Part D premiums were fixed at 25.5 percent of the national average cost of the standard drug benefit since 2006. The standard benefit in 2013 includes a $325 deductible and 7 percent coverage up to $2,970. For costs greater than that threshold, beneficiaries pay a certain percentage of the costs based on whether the drugs are generic or brand-name, until a catastrophic limit of $4,750 out-of-pocket spending (the “donut hole”) is reached. Beyond that, beneficiaries receive 95 percent coverage.5 The ACA phases out the donut hole in 2020, at which time beneficiaries will pay 25 percent of drug costs until the catastrophic limit is reached.

tABLE 1.
Medicare Part B AND Part D Costs Sharing of the Medicare Base on MAGI, 2013

<table>
<thead>
<tr>
<th>MAGI (For Individual)</th>
<th>Cost Sharing of the Medicare Base on Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$85,000 or less</td>
<td>standard premium ($104.90)</td>
</tr>
<tr>
<td>$85,000–107,000</td>
<td>35% ($146.90)</td>
</tr>
<tr>
<td>$107,000–160,000</td>
<td>50% ($209.80)</td>
</tr>
<tr>
<td>$160,000–214,000</td>
<td>65% ($272.70)</td>
</tr>
<tr>
<td>$214,000 or greater</td>
<td>80% ($335.70)</td>
</tr>
</tbody>
</table>

Income-related Part D payments are calculated based on the national average monthly Part D premium in a given year. Source: Centers for Medicare & Medicaid Services, 2013 Medicare Costs.

Figure 3.
Home Health Care Ends 2002–2011

Home health care use has increased significantly from 2002 to 2011. Source: MedPAC: Health care spending and the Medicare program, June 2013.

Figure 4.

Home health care costs have more than doubled between 2001 and 2012. Costs are projected to continue to rise through 2023. Source: MedPAC: Health care spending and the Medicare program, June 2013; CBO: May 2013 Medicare Baseline.
In 2011, the ACA established income-based Part D premiums. The national average monthly Part D premium in 2013 was $31.17, although this varied across plans and regions. Table 1 shows how the premiums ranged according to income, from an additional $11.60/month to $66.60/month. The ACA froze Part B and Part D income brackets at 2010 levels until 2019. Without inflation adjustment, the MAGI thresholds will increase the number of beneficiaries paying income-adjusted premiums. In 2012, this income-adjusted premium applied to 5 percent of Part B beneficiaries and 3 percent of Part D beneficiaries.

Home Health Care. Medicare beneficiaries who are home-bound and need intermittent services (nursing, home health aide assistance, physical/occupational/speech-language therapy, or pathology therapy) and medical supplies are eligible for home health care services coverage under Medicare. These services are provided most commonly to patients with diabetes, hypertension, heart failure, and skin ulcers. The agencies are paid prospectively for each episode of care lasting 60 days. The home health care benefit as created in 1965 originally included a 20 percent copayment for home health services. Congress repealed this copay in 1972 because of concerns related to financial hardship for the elderly; therefore, no cost-sharing measures apply to home health services at present. The number of users and episodes requiring home health care services has risen substantially in the last decade. Figure 3, page 13, depicts these trends, which translated into $18.6 billion of federal spending in 2012. This movement has been lucrative for home health care agencies, where for-profit agencies’ average profit margin was 15.7 percent in 2011. Medicare costs for these services may reach $32 billion by 2023 (see Figure 4, page 13).

ways and means Committee proposals

On July 19, 2013, the House Ways and Means Health Committee, chaired by Dave Camp (R-MI), released draft legislation to reform cost sharing in Medicare. The bill has an estimated savings of $54 to $60 billion over 10 years. This bill would increase the Part B deductible, increase the Part B and Part D income-adjusted premiums, and add a copayment for home health care.

For new enrollees in 2017, Part B deductibles will increase by $25 in 2017, 2019, and 2021. MAGI-adjusted premiums for Part B and Part D will increase starting in 2017 (see Table 2, page 15). Consequently, cost sharing across all income brackets above $85,000 will rise and will freeze the brackets from inflation adjustments until 25 percent of beneficiaries are subject to the premiums. A $100 copayment will be required per episode of home health services beginning in 2017, unless hospitalization precedes the episode. Beneficiaries enrolled before 2017 will be exempt from this requirement.

Implications of the proposed bill. Although cost sharing has traditionally been part of Medicare financing and means testing has been in place since 2007, the average Medicare beneficiary is already subject to tremendous health care costs. In 2012, 50 percent of beneficiaries were estimated to have an income of $22,500 or less. The top 5 percent had an income greater than $88,900. Approximately 44 percent of beneficiaries have three or more chronic conditions and 15 percent have two or more functional limitations. Recipients have not only seen premiums and deductibles increase, but also out-of-pocket costs, including copayments, coinsurance, and uncovered services, such as dental, hearing, vision, and long-term care. Medicare households spend more than 15 percent of their income on health care compared with
5 percent for non-Medicare households.14 In 2010, the average beneficiary paid 27 percent of their Social Security benefits to cover premiums and cost sharing.14 The proposed bill will increase receipts for Medicare and may lower costs through decreased use of services. However, ample evidence in the literature suggests that such cost savings in one area, through increased cost sharing, will result in greater costs elsewhere in the system.

Approximately $50 to $56 billion of the savings in this bill come from freezing the MAGI brackets for Parts B and D premiums indefinitely.11,12 Freezing these brackets will result in a growing share of the elderly who would not be considered high-income by today’s standards and who would encounter higher premiums over the next two decades. Kaiser projections reveal that 26 percent of Part B beneficiaries will pay income-adjusted premiums by 2035, if the brackets are frozen as proposed in this bill (see Figure 5, this page). However, this number would be 9 percent if inflation adjustments were to continue. The rest would, therefore, be subject to the higher premiums without being high-income as defined by current standards. The income threshold for the lowest bracket in 2035 will be the equiva-

**TABLE 2.**

<table>
<thead>
<tr>
<th>MAGI (individual tax return N)</th>
<th>Cost sharing of Montly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $85,000</td>
<td>standard premium*</td>
</tr>
<tr>
<td>$85,000–$92,333</td>
<td>40.0%</td>
</tr>
<tr>
<td>$92,333–$99,667</td>
<td>46.5%</td>
</tr>
<tr>
<td>$99,667–$107,000</td>
<td>53.0%</td>
</tr>
<tr>
<td>$107,000–$124,667</td>
<td>59.3%</td>
</tr>
<tr>
<td>$124,667–$142,333</td>
<td>66.0%</td>
</tr>
<tr>
<td>$142,333–$160,000</td>
<td>72.5%</td>
</tr>
<tr>
<td>$160,000–$178,000</td>
<td>79.0%</td>
</tr>
<tr>
<td>$178,000–$196,000</td>
<td>85.8%</td>
</tr>
<tr>
<td>$196,000 or greater</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

*25% for Part B; 25.5% for Part D.

Notably missing in the proposed bill at press time were caps on out-of-pocket spending for beneficiaries for which these bipartisan organizations have advocated.

**References**


**Political Considerations**

The House Ways and Means Committee proposal is a Republican bill, and although it draws upon recommendations from several bipartisan organizations that support cost-sharing increases, the bill does not address any of the financial protections for beneficiaries suggested by those groups and is unlikely to garner sufficient Democratic support to pass. For example, the Medicare Payment Advisory Commission (MedPAC)—an independent federal body established in 1997 to advise Congress on issues related to Medicare—recommends a $150 home health care copayment per episode, as well as a $500 combined Part A and Part B deductible and an out-of-pocket maximum of $5,000. The Simpson-Bowles Commission, which President Obama created in 2010 to identify policies to
improve fiscal sustainability, proposes an increase of income-related premiums and lower income thresholds, but also proposes a combined deductible and income-related out-of-pocket spending limits.\textsuperscript{20} The Bipartisan Policy Commission, a not-for-profit organization founded in 2007 by former Senate majority leaders, proposes a reduction in subsidies for higher income beneficiaries, but also proposes an annual out-of-pocket limit of $5,315 and federalizing cost-sharing assistance for low-income beneficiaries.\textsuperscript{21} The CBO proposes a 10 percent copayment for home health care episodes, as well as an out-of-pocket maximum of $5,500.\textsuperscript{22}

Notably missing in the proposed bill at press time were caps on out-of-pocket spending for beneficiaries for which these bipartisan organizations have advocated. A number of advocacy groups have expressed opposition to the higher Medicare Part B and Part D premiums and the home health care copayment proposed in this bill, citing the increased financial burden to the elderly over the next few decades. These organizations include the National Association for Home Care and Hospice, the American Federation of Labor and Congress of Industrial Organizations, Leadership Council of Aging Organizations, and the Medicare Rights Center.\textsuperscript{23-26} In addition, prominent Democrats, including Ranking Subcommittee Member Jim McDermott (D-WA), have spoken out in opposition to the bill, citing “cherry-picking” from the various bipartisan proposals.

**Conclusion**

Radical changes will have to occur to the Medicare program if it is to remain financially viable over the next 40 years. Although cost sharing has always been a part of Medicare, increases in overall health care costs have led to increased spending not only by the federal government but also by individual beneficiaries. The proposed bill would increase cost sharing for Medicare beneficiaries for Parts B and D and home health care. A large segment of the beneficiaries live near the

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**References (Continued)**

poverty level and cannot afford higher fees eroding their fixed Social Security income. Whereas a number of bipartisan organizations support elements of the Ways and Means plan, opponents draw upon the vast literature on cost sharing, which demonstrates that cost sharing decreases use of both necessary and unnecessary health care services, resulting in worse patient outcomes and greater use of more costly services, especially among low-income patients.

Medicare outlays do have to be offset by increased receipts and decreased costs to prevent the program’s financial collapse. However, merely shifting the costs to elderly beneficiaries will not address overall rising costs. Savings must be system-wide, and all stakeholders must contribute to the effort. Good stewardship of these funds means discouraging the delivery of futile care, which consumes a large part of the outlays in the last six months of life. Pharmaceutical companies have been protected from allowing Medicare Part D to negotiate prices. This loophole will need to be addressed to decrease overall Part D costs. There should be greater transparency and uniformity in hospital charges to encourage lower costs. Surgeons must support efforts to ensure our elderly, low-income patients have access to high-quality surgical care without additional financial burdens.

References (Cont’d)

With more baby boomers reaching retirement age and health care costs continuing to rise, it is clear that Medicare is in need of reform. The current system is unsustainable. Total federal Medicare spending has more than doubled in the past decade, and this trend is predicted to continue without government intervention.1 For example, the Hospital Insurance (HI) Trust’s (Part A trust fund) expenditures are expected to surpass revenue in 2016, leading to insolvency by 2029.2 In 2011, national health care expenditures (NHE) comprised 17.9 percent of the gross domestic product (GDP). Medicare comprises 21 percent of NHE.3 Studies comparing quality of care of beneficiaries in high- and low-cost regions of the U.S. showed that higher costs do not translate to better care.4 Furthermore, to obtain comprehensive, affordable medical coverage, beneficiaries often enroll in up to four different plans (see Figure 1, page 20).

Medicare’s structure and administration is outdated partially because of the fact that little reform has occurred since its inception. Originally, the program was modeled on the most popular insurance plans of the time. Those plans have since reformed; Medicare has not. For example, most private insurers today have just a single deductible for both hospital and outpatient care.5 Merging Medicare Parts A and B would bring the program more in line with how other insurance plans are structured and make the delivery of services more cost-effective and efficient.

**a brief history of medicare**

The concept of Medicare has been discussed and debated since the 1940s. It was formally established in 1965, and officially implemented in 1966 with the intention of reducing the financial burden on the elderly and improving access to care for those Americans over the age of 65. In 1972, disabled and end-stage renal disease patients regardless of age were added to the program.6 At that time, hospital care was quite costly and thus it was prioritized to be included in the legislation.
However, many physicians’ organizations opposed the concept of government-regulated health insurance, which made provider service inclusion a challenging notion. Consensus could not be reached on precisely which services would be covered under Medicare, so a two-part system was established. The original two-part system was modeled on the major private insurers of that time—Blue Cross for Medicare Part A, which covered hospital-based services, and Aetna for Part B, which covered outpatient care. Neither included prescription, dental, vision, or long-term care services.

**present-day Medicare**

According to the Centers for Medicare & Medicaid Services (CMS), in 2010, approximately 46 million people were enrolled in Part A. Medicare Part A covers the following:

- Inpatient medical/surgical hospitalization (up to 90 days per benefit period plus 60 lifetime reserve days)
- Inpatient psychiatric care (190-day lifetime limit in psychiatric hospitals); hospice care
- Skilled nursing facility (SNF) services
- Up to 100 home health visits after a three-day hospitalization

Although Medicare Part A doesn’t charge a monthly premium for most beneficiaries, the deductible cost scheme can be quite complex. (See Table 1, page 21, for a summary of Part A beneficiary out-of-pocket expenditures as of 2013.)

Part A is financed through 2.9 percent of payroll taxes, of which 1.45 percent is paid by employees and 1.45 percent is from employers. These payments go into what is known as the Medicare Part A HI trust fund. Current workers are paying for future beneficiaries, which makes Part A an entitlement service. In any given year when the revenue of the HI trust exceeds the benefits it pays out, the trust fund exchanges the excess funds for securities. In years when the benefits are greater than revenues, the trust can redeem these securities with interest to compensate for the shortfall.

Part B covers a much broader range of services, including physician visits and consultations, surgical procedures, diagnostic tests, outpatient care, mental health services, durable medical equipment, preventive care, clinical research, ambulance transport, second opinions before an operation, and home health visits without a previous hospital stay, as well as those visits beyond the 100-visit threshold following a three-day hospital stay. The beneficiary out-of-pocket expenditures of Part B are demonstrated in Table 2, page 21.

According to CMS, in 2010, 43 million Americans were enrolled in Medicare Part B. Part B is not an entitlement program, and enrollment is primarily voluntary. It is partially funded by premiums paid by the beneficiary. Currently premiums cover approximately 25 percent of Part B costs, whereas the rest is funded **continued on page 22**
### Table 1.
**Medicare Part A Benefit Out-of-Pocket Spending 2013**

<table>
<thead>
<tr>
<th>Part A</th>
<th>2013 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>if you don’t qualify for free premium, you pay $441</td>
</tr>
<tr>
<td>Deductible</td>
<td>$1,184 for each benefit period</td>
</tr>
<tr>
<td>Hospital care</td>
<td>Days 1–60: no additional cost beyond deductible</td>
</tr>
<tr>
<td></td>
<td>Days 61–90: $296 coinsurance per day of each benefit period in 2013</td>
</tr>
<tr>
<td></td>
<td>Days 91 and beyond: $592 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime) in 2013</td>
</tr>
<tr>
<td>Skilled nursing facility care</td>
<td>Days 1–20: $0 for each benefit period in 2013</td>
</tr>
<tr>
<td></td>
<td>Days 21–100: $148 coinsurance per day of each benefit period in 2013</td>
</tr>
<tr>
<td></td>
<td>Days 101 and beyond: all costs</td>
</tr>
<tr>
<td>Home health care</td>
<td>$0 for home health care services</td>
</tr>
<tr>
<td>Hospice care</td>
<td>$0 for hospice care; $5 copayment for prescription drugs</td>
</tr>
<tr>
<td>Blood</td>
<td>All costs for the first 3 units unless the hospital can get it from a blood bank</td>
</tr>
</tbody>
</table>

### Table 2.
**Medicare Part B Benefit Out-of-Pocket Spending 2013**

<table>
<thead>
<tr>
<th>Part B</th>
<th>2013 Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>stratified costs based on yearly income; beneficiaries pay $104.90, $146.90, $209.80, $272.70, or $335.70</td>
</tr>
<tr>
<td>Deductible</td>
<td>$147 per year</td>
</tr>
<tr>
<td>Physician and other medical services</td>
<td>20% of Medicare-approved amount</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>20% of Medicare-approved amount</td>
</tr>
<tr>
<td>Outpatient mental health services</td>
<td>20% of Medicare-approved amount</td>
</tr>
<tr>
<td></td>
<td>20-40% of Medicare-approved amount for treatment in hospital outpatient clinic</td>
</tr>
<tr>
<td></td>
<td>35% of Medicare-approved amount for treatment in doctor’s outpatient department</td>
</tr>
<tr>
<td>Clinical laboratory services</td>
<td>$0 if Medicare-approved</td>
</tr>
<tr>
<td>Home health care</td>
<td>$0</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% of Medicare-approved amount</td>
</tr>
<tr>
<td>Blood</td>
<td>All costs for the first 3 units unless the hospital can get it from a blood bank. If from blood bank, beneficiary pays copayment for blood processing and handling services and Part B deductible.</td>
</tr>
</tbody>
</table>
by federal general revenues, making this component of Medicare akin to federally subsidized insurance. To compensate for the high cost of health care, up to 90 percent of Medicare beneficiaries enroll in a supplemental coverage plan (see Figure 2, this page, for an example from 2009). These plans cover costs such as copayments, deductibles, and coinsurances, which are not covered by Part A and B. Medigap is a popular option, with 10 million beneficiaries enrolled among the various plans. There are as many as 10 different plans offered in every state. The cost and benefits offered vary both by state and type of plan.

### Plan to Merge Parts A and B

Proposals to merge Medicare Part A and Part B have emerged at a time when the U.S. is still struggling to overcome the economic downturn of 2008. As a result, both federal and state governments are seeking to trim their finances. Meanwhile, total federal spending on Medicare has doubled in the past 10 years, with no respite projected in the foreseeable future. Furthermore, Medicare costs accounted for 16 percent of the annual federal budget in 2012, and 21 percent of total health care spending. The current proposal calls for Medicare reform such as a unified Part A and Part B deductible are partially a result of this economic maelstrom.

As of June 2013, 80 percent of Medicare beneficiaries indicated that the current system is working well. However, as more and more baby boomers become eligible for Medicare coverage, it will become increasingly difficult for the current system to remain fiscally viable without some measure of reform. A unified deductible is an attractive cost-cutting compromise that would not require a complete overhaul of the modern Medicare system. Various health policy groups and congressional leaders have offered plans to merge the two parts. Table 3 on page 23 summarizes a selection of the most popular proposals.

### Possible Effects on Patients

A merger of Parts A and B would affect all stakeholders in the Medicare system, perhaps most notably Medicare patients. In 2011, the Kaiser Foundation analyzed the Congressional Budget Office’s (CBO) proposal of a $550 combined deductible, a 20 percent flat coinsurance rate on virtually all services, and a $5,500 cap to determine what the plan would mean for beneficiaries and the federal government. The Kaiser report showed that 71 percent of beneficiaries would see a rise in costs, averaging $180 per year; 5 percent would see a decrease in costs, averaging $1,570; and 24 percent would see no change. Two main factors contributed to whether beneficiaries would experience an increase or a decrease in costs. The first factor is individual health status and anticipated use of services. Beneficiaries who would have higher costs with a merged deductible are patients who use health care services less frequently, require no hospitalization, and who are relatively healthy.

In contrast, beneficiaries with lower out-of-pocket costs under a reformed system are those who had or have hospitalizations, use post-acute care or high-cost outpatient services, and are generally in poor health.
The second factor is whether they have supplemental insurance—including Medigap plans, employer-based retiree coverage, and Medicaid—and the type and generosity of this coverage. For the 39 percent of beneficiaries with employment-based coverage, 87 percent would experience a rise in out-of-pocket costs averaging $50 for a given year, $40 of which is an increased premium. These beneficiaries tend to be healthier. Among those beneficiaries who have Medigap, 93 percent would see rises averaging $140 for a given year. For Medicaid beneficiaries, 83 percent would see no change because Medicaid pays the premium and deductible for dual eligibles unless they are in a state that does not pay coinsurance in full. Lastly, of the 4 million beneficiaries lacking supplementary insurance, 56 percent would have a rise in out-of-pocket costs due to the combined deductible, 4 percent would see a decrease in costs, and 40 percent no change.

A basic subgroup analysis based on income and race/ethnicity showed lower-income and minority patients would be less affected than high-income and Caucasian beneficiaries. This disparity results from the Medicare and Medicaid Savings Program that helps to cover all cost-sharing.

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**Summary of Effects on Patients**

**Benefits of the Restructure**

- Patients may become more price-sensitive and, therefore, better informed consumers who seek out value-based care and are less likely to overuse services.
- Patients would be part of a simplified system with comprehensive coverage from a single source.
- They would have greater financial security because of annual caps on out-of-pocket spending.
- There would be decreased need for supplemental insurance.
- The system would offer one large, pooled funding source.

**Disadvantages of Restructure**

- Patients might forego needed care because most cost sharing is on them, which could lead to higher costs and worse outcomes in the long run.
- Costs could be particularly high for certain patient groups and current proposals lack a clear framework.

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**Table 3. Outlines of Medicare Restructuring Proposals**

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Deductible</th>
<th>Coinsurance</th>
<th>Cost-sharing Limit</th>
<th>Medigap Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Commission on Fiscal Responsibility and Reform (2010)</td>
<td>$550</td>
<td>20%</td>
<td>$7,500</td>
<td>Eliminates coverage for first $500 and caps coverage in cost sharing at 50% of the next $5,000</td>
</tr>
<tr>
<td>Rivlin-Domenici Debt Reduction Task Force (2010)</td>
<td>$560</td>
<td>20%</td>
<td>$5,250</td>
<td>Unspecified</td>
</tr>
<tr>
<td>Rivlin-Ryan Proposal (2010)</td>
<td>$600</td>
<td>20%</td>
<td>$6,000</td>
<td>Eliminates coverage for first $500 and caps coverage in cost sharing at 50% above $500</td>
</tr>
<tr>
<td>Lieberman-Coburn Proposal (2011)</td>
<td>$550</td>
<td>Unspecified</td>
<td>$7,500 – $22,500, depending on income</td>
<td>Eliminates coverage for first $550 and caps coverage in cost sharing at 50% above $500</td>
</tr>
</tbody>
</table>
In 2009, a Medicare Payment Advisory Commission (MedPAC) report indicated that among beneficiaries who subscribed to Medigap supplemental coverage, Medicare spending was 33 percent higher, and among beneficiaries with employer-sponsored supplemental insurance, Medicare spending was 17 percent greater. For Part B services, these figures are even higher (50 percent rise for Medigap and 30 percent for employer-sponsored plans). These findings showed a significant inverse relationship between enrollee cost-sharing demand and Medicare spending. Lower out-of-pocket costs for the patient translated to substantial Medicare spending.

In light of these findings, the Kaiser Foundation also analyzed the new restructure proposal if the following Medigap restrictions were applied: plans do not cover the initial combined $550 deductible and more than 50 percent of the $5,500 out-of-pocket limit. Overall, 24 percent would see a reduction in out-of-pocket spending, mainly due to decreased premiums because policies cover a smaller share of claims and less use; 26 percent would have no change; and 50 percent would see an increase in out-of-pocket costs for the patient translated to substantial Medicare spending.

In any given year under the merger described here, the higher out-of-pocket cost would be balanced with the greater amount of money they will save if they are hospitalized or require expensive care in the future. However, a combined deductible may have other unintended consequences. One possibility is that the increased cost would deter some beneficiaries from seeking necessary care, which ultimately could lead to worse health outcomes that may require more complicated care and hospitalization in the future. This scenario would then lead to increased costs. Few studies on the effects of cost sharing on the elderly have been done, and they have yielded mixed results. Several showed a correlation with decline in health status, while others showed no effects. Another issue is the lack of a clear framework for how to handle low-income beneficiaries who are not in a position to pay a higher deductible.

Nonetheless, combining Medicare Parts A and B would likely yield myriad improvements in efficiency. A unified deductible would create a more modern, streamlined, and accessible system for patients. The system would be unified rather than compartmentalized and fragmented. Such a system would share one large pool of money without any arbitrary distinctions between which services are classified under Part A and Part B. A unified system would also lead to a smoother transition from employer-based insurance to Medicare among new retirees.

<table>
<thead>
<tr>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• significant financial savings for Medicare and total health expenditures</td>
</tr>
<tr>
<td>• Bipartisan support</td>
</tr>
<tr>
<td>• Improved fraud and abuse detection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Possible political concerns because Medicare Parts A and B are under two different jurisdictions</td>
</tr>
</tbody>
</table>
This scenario would then lead to increased costs. Few studies on the effects of cost sharing on the elderly have been done, and they yielded mixed results.

effects on the federal government

In Kaiser’s analysis without Medigap restrictions, total Medicare spending decreased by $4.2 billion in 2013.12 Furthermore, according to the CBO, Medicare spending would decrease by $32.2 billion between 2013 and 2021.16 Additionally, total health care spending would decrease by $0.7 billion in 2013, according to Kaiser’s analysis. If Medigap restrictions are implemented, the savings would be even greater, with Medicare totaling $8.8 billion savings in a single year and, according to the CBO, $92.5 billion from 2013 to 2021. Meanwhile, total health care expenditures would decrease by $9.5 billion.

It is also important to note that a unified Medicare system would promote flexibility. Having two disparate financing systems restricts potential options for restructuring.5 Many of the recognized efficiencies in the private insurance sector stem from a unified, single coverage system. One centralized record allows for utilization review and management to enhance quality of care. Centralization is also crucial in detecting fraud and system abuse. For example, a 1999 Medicare Part A and B audit of SNF claims showed that roughly $47 million in improper payments were made, which could have been avoided under a unified reimbursement system.2

However, a merger of Medicare Parts A and B could have a somewhat negative effect on the HI trust fund. The trust funds as a warning signal for future financing concerns. When reserves in the HI trust fund reach a critically low level, it alerts Congress and policymakers to potential solvency issues.3 Moreover, federal general revenue is not used to subsidize Part A, but it is the main funding source for Part B. If the two were to merge, federal general revenue support might increase or beneficiary premiums could substantially rise, with the trust fund losing its function as an “alarm clock.”15

The proposal to merge Medicare Parts A and B has had bipartisan support since 1999. In fact, a recent white paper presented on August 29, 2013, by the chairs of the House subcommittees that oversee Medicare Parts A and B, respectively—the health subcommittees of the Ways and Means Committee and the Energy and Commerce Committee—expressed support for merging A and B. The legislators’ stated goals are to make Medicare easier to navigate, protect seniors, and reduce costs.16

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continued on next page
effects on hospitals and surgeons

None of the existing data and policy analyses evaluate how a restructuring would affect hospitals and surgeons. If final legislation were to resemble a plan similar to the CBO model, then a speculated outcome may be more price-sensitive, quality-oriented patients. This outcome would align well with the current paradigm shift in health care delivery overall, which heavily focuses on quality and cost-effectiveness. However, research has shown that when beneficiaries had more cost-sharing responsibility, they used more acute care services and fewer outpatient services. Specifically, they had less scheduled inpatient admissions and underwent fewer procedures that they considered too expensive and that were for non–life-threatening conditions.\(^7,17\) Thus, there could potentially be a decline in elective surgical services requiring inpatient admission and a rise in acute surgical services. The magnitude of this possible shift is currently unknown.

In addition, with the already existing decline in employer-sponsored supplemental coverage and a merger like the one proposed here, rates of Medigap participation will likely decline. Thus, Medicare billing will be simplified because there will only be one Medicare program to bill, rather than Part B and supplementary insurance.

Conclusion

Combining Parts A and B deductibles likely would be a worthwhile step toward modernizing Medicare. It would yield a comprehensive health care package with an improved cost-sharing structure, and potentially saves the federal government billions of dollars. Administrative improvements would lead to increased flexibility and room for a new financing structure.

However, with the benefits of change come challenges. One of the biggest challenges would be managing potential increases in financial demands on beneficiaries, as it appears a significant portion of patients would incur higher service fees and deductibles. It also may be difficult to merge an entitled service with a voluntary one.

Even accounting for these difficulties, there is convincing evidence of the potential benefit of the merge for very sick patients and the federal government. Even though costs may be higher for many beneficiaries, they will not be prohibitive. The effects for hospitals and surgeons, on the other hand, are not well-defined beyond a potential shift in case mix of more acute rather than elective admissions. ✪

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References (Citable):  
2014 fee schedule and CPT code changes will affect surgical practice

HiGHLiGHt s

- An overview of provisions in the Medicare physician fee schedule final rule and changes in CPT coding that will affect physician reimbursement in 2014
- Key elements of the final rule for the fee schedule center on the potential reduction in payment due to the conversion factor update, payment for in-office procedures, PQRs reporting options, public reporting via CMS’ Physician Compare website, and the value-based payment modifier
- Fundamental changes in CPT coding affect consultation codes, drainage of skin and subcutaneous structures, complex repair, skin flaps and grafts, breast biopsies and imaging, and other surgery-related codes

by Linda M. Barney, MD, FACS; Sana Z. Gokak, MPH; Jenny J. Jackson, MPH, CPC; Mark T. Savarise, MD, FACS; Jill S. Sage, MPH; and Vinita M. Ollapally, JD
Editor’s note: This article was posted electronically with the January Bulletin so that surgeons would have access to the important information it provides regarding changes in Medicare payment that took effect last month. Due to delays in the release of the final rule on the fee schedule, this information was unavailable when the print version of the January Bulletin went to press, so we are publishing it this month.

New payment policy and coding and reimbursement changes set forth by the calendar year (CY) 2014 Medicare physician fee schedule (MPFS) final rule took effect January 1, 2014. The fee schedule, which the Centers for Medicare & Medicaid Services (CMS) updates annually, lists payment rates for Medicare Part B services. The American College of Surgeons (ACS) submitted comments related to the MPFS proposed rule on September 5, 2013, which provided feedback to CMS on a number of policies that were outlined in the final rule, which was released in November 2013.

Concurrently, the American Medical Association (AMA) released Current Procedural Terminology (CPT®) code changes and revisions for 2014, which physicians and other qualified health care professionals will use as a guide to appropriately code for services rendered to patients.

Although the MPFS and CPT changes introduce important payment and coding policy changes that affect all physicians, this article focuses on updates particularly relevant to surgery and related specialties, beginning with highlights from the MPFS.

Cy 2014 conversion factor
Under the final MPFS for CY 2014, payments to physicians would have been reduced by more than 24 percent for services rendered in CY 2014, barring congressional action. Just before adjournment in December 2013, Congress passed a three-month 0.5 percent increase in the Medicare physician payment rate as a bridge to allow for negotiations on a permanent repeal of the sustainable growth rate (SGR) formula, which is the root cause of the payment reductions. The cut is now scheduled for April 1.

Nonetheless, other updates in the final MPFS rule will result in a CY 2014 conversion factor that differs from the CY 2013 conversion factor. These provisions center on potentially misvalued services, the Physician Quality Reporting System (PQRS), the Physician Compare website, and the value-based payment modifier.

Potentially misvalued services
In the MPFS proposed rule, CMS indicated that payment for services provided in the physician’s office typically should not exceed payment for the same services provided in either the hospital outpatient department (OPD) or in an ambulatory surgical center (ASC). However, CMS identified more than 200 services for which payment in the physician office does, in fact, exceed the costs for these services when provided in the OPD or ASC. The agency proposed to limit the payment in the physician office setting to the OPD or ASC rate.

The ACS comment letter stressed that the methodology used by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) to calculate values under the physician fee schedule is appropriate and that these payment rates should not be based on OPD and ASC payment rates, which are calculated using a different set of factors. Based on comments from the ACS and other stakeholders, CMS decided not to implement this proposal in the final rule.

PQRS
The PQRS is a Medicare quality reporting program that provides payment incentives and payment adjustments to eligible professionals (EPs) who satisfactorily report data on quality measures for covered services...
Just before adjournment in December 2013, Congress passed a three-month 0.5 percent increase in the Medicare physician payment rate as a bridge to allow for negotiations on a permanent repeal of the sustainable growth rate formula, which is the root cause of the payment reductions.

furnished during a specified reporting period. CMS finalized several key changes for PQRS 2014, including a new reporting option for individual EPs.

**QDRC**

In addition to the claims-based, electronic health record (EHR)-based, and traditional registry-based reporting options, beginning in 2014, EPs also may report via the new Qualified Clinical Data Registry (QCDR) reporting option. A QCDR is a CMS-approved entity that collects medical and/or clinical data to track patients and diseases for purposes of improving quality of care.

A QCDR differs from a traditional PQRS registry in several ways. This option was created to provide opportunity for EPs to simultaneously use existing high-quality clinical registries for quality improvement and for meeting PQRS reporting requirements. In theory, QCDRs provide more flexibility in participating in PQRS than other reporting options, allowing EPs to report on a variety of measure types, including those from the Consumer Assessment of Healthcare Providers and Systems Clinician and Group (CG-CAHPS) survey, measures that the National Quality Forum (NQF) has endorsed, current PQRS measures, measures used by medical boards or specialty societies, and measures used in regional quality collaboratives.

In addition, QCDRs must have benchmarking capacity, the ability to track at least one outcome measure, provide timely feedback reports, and risk adjust when appropriate. All of these capabilities are intended to result in the reporting of measures that are more relevant, clinically appropriate, and actionable for surgeons when compared with the measures currently available as reporting options through PQRS. For the QCDR, individual EPs must report on nine measures selected by the QCDR that cover at least three National Quality Strategy (NQS) domains for 50 percent of applicable patients to whom each measure applies.

**Traditional PQRS reporting options**

Traditional PQRS reporting allows for reporting on individual measures, or, alternatively, on measures groups. For individual measure reporting via the claims- and registry-based options, CMS finalized reporting on nine measures covering at least three NQS domains for 50 percent of the applicable Medicare Part B fee-for-service (FFS) patients.

For the measures group reporting option, there were also a few key changes. CMS eliminated the option for EPs to report on measures groups through the claims-based reporting option. Therefore, the only available option to report on measures groups in 2014 will be the registry-based reporting option. In addition, CMS finalized a new PQRS measures group relevant to surgery, the general surgery measures group, which includes measures relevant to procedures such as ventral hernias, appendectomies, and cholecystectomies.

**physician Compare website**

The Physician Compare website (http://www.medicare.gov/physiciancompare/search.html) is designed to help patients locate and obtain information on Medicare-participating physicians. In its response to the MPFS proposed rule, the ACS urged CMS to make additional improvements to the Physician Compare website to ensure that both the search function and underlying demographics of the data on the website are accurate. In the final rule, CMS acknowledges that the agency is reevaluating how information is presented on the website and will continue to seek input from specialty societies. CMS also noted that it will be issuing a report to Congress by January 1, 2015, on the development of the Physician Compare website.

Furthermore, CMS finalized several of its proposals for adding new information via the Physician Compare website, including performance rates for all quality measures that group practices submit through the Group Practice Reporting Option (GPRO) Web interface in 2014; performance on certain quality measures...
collected under the 2014 PQRS GPRO through the traditional registry and EHR reporting mechanisms; performance on patient experience measures for group practices of 25 or more professionals who choose to voluntarily report CG CAHPS in 2014; performance on a specific set of 20 measures by individual EPs reporting through an EHR, registry, or claims for PQRS 2014; and performance rates for measures included in the cardiovascular prevention measures group reported by individual EPs for PQRS 2014.

value-based payment modifier
The Affordable Care Act (ACA) requires that CMS apply a value-based payment modifier to physician payments, starting with some physicians in 2015 and extending to all physicians by 2017. Application of the value-based payment modifier will result in Medicare paying physicians differentially based on the quality of care they provide.

2015 payment adjustment
The value-based payment modifier will initially apply to physicians within groups of 100 or more EPs in 2015 based on their performance in 2013. EPs, which are counted for the calculation of group size, include physicians and certain other nonphysician practitioners. CMS plans to separate these groups of EPs into categories based on whether they successfully participate in one of the PQRS GPROs. The payment modifier for group practices that satisfactorily report the PQRS quality measures associated with the GPRO they select will be set at zero initially, which would prevent the value-based payment modifier from lowering their Medicare rates in 2015. These physicians may either keep the 0 percent update or pursue a higher modifier amount based on their performance with respect to quality and cost measures, an option described as “quality tiering.” Physicians attempting to earn a higher value-based payment modifier amount through quality tiering would also be at risk, based on their quality and cost scores, for a payment decrease of up to 1.0 percent in 2015. Physicians in groups of 100 or more EPs that did not meet the PQRS reporting requirements for 2013 would have a modifier amount of –1.0 percent applied to their claims submitted under the MPFS in 2015.

2016 payment adjustment
The final MPFS comprises several changes to the value-based payment modifier that would apply in 2016, based on performance in 2014. For the 2016 payment adjustment, CMS will apply the value-based payment modifier to groups of 10 or more EPs, down from 100 or more in 2015. The final rule also makes quality tiering mandatory for groups of 10 or more, but only groups of 100 or more will be subject to a downward adjustment. In other words, physicians in groups of 10 to 99 EPs will either receive a 0 percent update or an upward adjustment based on their performance with respect to quality and cost measures, and physicians in groups of 100 or more EPs would receive either an upward, downward, or 0 percent adjustment. CMS also finalized a policy that would apply a modifier amount of –2.0 percent to claims submitted in 2016 by physicians in groups of 10 or more that fail to meet the PQRS reporting requirements for 2014.

An improvement to the value-based payment modifier that would take effect in 2016 is that, in addition to the group reporting options, CMS will allow EPs in groups of 10 or more to report individually on PQRS. Therefore, if at least 50 percent of the EPs in the group avoid the CY 2016 PQRS payment adjustment using any reporting option available under PQRS, the entire group will avoid the 2016 value-based payment modifier adjustment of –2.0 percent.

The ACS comment letter on the proposed rule strongly advocated that CMS include an option to allow individual PQRS reporting, in addition to group PQRS reporting under the GPRO, to count toward avoiding the value-based payment modifier penalties. The ACS comment letter also successfully persuaded CMS to lower the threshold of EPs from 70 percent to 50 percent within a group that is required to meet the individual PQRS reporting criteria.
Another refinement to the value-based payment modifier for 2016 relates to the benchmarks used to compare physician costs. Under the current policy for 2015, a national average will be calculated for each of the cost measures under the value-based payment modifier, and the costs of physicians are compared with this national mean. However, CMS acknowledged that this approach compares all specialties using the same benchmark for each cost measure, despite the fact that some specialties have inherently higher costs than others. Consequently, CMS refined the methodology to create a different cost benchmark for each specialty to only compare physicians’ costs with other physicians within the same specialty.

Cpt coding changes
The CPT 2014 manual comprises several new codes and code changes pertaining to general surgery and its closely related specialties. The following is a summary of these modifications

- **Interprofessional telephone/Internet consultations**

  In 2014, four new codes have been established in the evaluation and management (E/M) section of the manual describing interprofessional telephone/Internet consultative services, as follows:

  - CPT code 99446, *Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5–10 minutes of medical consultative discussion and review*

  - CPT code 99447, *Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 11–20 minutes of medical consultative discussion and review*

  - CPT code 99448, *Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 21–30 minutes of medical consultative discussion and review*

  - CPT code 99449, *Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review*

  CPT codes 99446–99449 are for reporting interprofessional telephone/Internet consultation, defined as an assessment and management service in which a patient’s treating physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist in the diagnosis and/or management of the patient’s problem without the need for the patient’s face-to-face contact with the consulting physician. These codes are typically provided in complex and urgent situations where a timely consultation may be infeasible—for example, due to geographic distance. The consultant reports these codes, which are time-based according to the amount of time spent in medical consultative discussion and review.

- **Skin, subcutaneous, and accessory structures**

  CPT code 10030, *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* has been established to report the bundled service of image-guided percutaneous fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), for soft tissue (eg, extremity, abdominal wall, neck). Code 10030 should be reported for each collection drained with a separate catheter. Code 10030 is not used to report image-guided fluid collection drainage, (percutaneous or transvaginal/transrectal) of visceral,
peritoneal, or retroperitoneal; these services should be reported using codes 49405–49407.

Note that CPT reporting convention requires that any image-guided procedure must include permanent images and a written report describing the imaging findings and intervention.

**Complex repair**
The code previously used to report complex repair of the eyelids, nose, ears and/or lips measuring 1.0 cm or less (13150) has been deleted. To report this service the anatomically correct and appropriate size simple (12001–12021) or intermediate (12031–12057) repair codes should be reported. In addition, code 13151, Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm was revised to be the parent code for this anatomic area.

**Other flaps and grafts**
In 2014, CPT code 15777, Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure) has been revised; the “eg” within the parenthetical has been replaced with “ie.” Therefore, code 15777 should only be used to report the implantation of biologic implant in the breast and trunk. The implantation of biologic implants for soft tissue reinforcement in tissues other than breast and trunk should be reported with the unlisted code 17999, Unlisted procedure, skin, mucous membrane, and subcutaneous tissue.

**Breast**
The codes previously used to report breast biopsies and image guidance (19102, 19103, 19290, 19291, 19295, 77031, 77032) have been deleted and replaced with new bundled breast biopsy codes (19081–19086) and bundled breast localization codes (19281–19288).

Six new codes have been created to describe breast biopsy with imaging guidance, two for each of three imaging modalities:

- For stereotactic guidance: 19081, Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance; 19082, Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

- For ultrasound guidance: 19083, Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance; 19084, Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

- For MRI guidance: 19085, Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance; 19086, Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

Separate codes for vacuum-assisted biopsy have been deleted—all percutaneous needle biopsy devices are now considered similar for purposes of coding.

Eight new codes have been created in 2014 to describe placement of breast localization device with imaging guidance, two for each of four imaging modalities:

- For mammogram: 19281, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance

- For ultrasound: 19282, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance

- For MRI: 19283, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance

- For stereotactic: 19284, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance
The CPT 2014 manual comprises several new codes and code changes pertaining to general surgery and its closely related specialties. The following is a summary of these modifications.

*graphic guidance: 19282, placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)*

• For stereotactic: 19283, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance; 19284, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

• For ultrasound: 19285, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance; 19286, placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)

• For MRI: 19287, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance; 19288, Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

When image guidance is used, a report and permanent images must be generated. The second code for each modality is an add-on. When more than one biopsy or localization device placement is performed using the same imaging modality, use the appropriate add-on code to report the service. If additional biopsies are performed using different imaging modalities, report the primary code for each additional modality.

The surgical excision codes have not changed. CPT codes 19100, Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure) and 19101, Biopsy of breast; open, incisional are used to report breast biopsies performed without imaging guidance. Additionally, when an open incisional biopsy is performed after image-guided placement of a localization device, 19125 is reported.

*Excision and resection*

The 2014 revised guidelines for the excision of subcutaneous soft tissue tumors and radical resection of soft tissue tumors now indicate that codes in these families are used to report the excision or radical resection of connective tissue tumors only. For additional clarity on the use of the radical resection of soft tissue tumors codes, the example within the parenthetical of the code descriptors “malignant neoplasm” has been removed and replaced with “sarcoma.”

For the excision of benign lesions of cutaneous origin, for example, sebaceous cyst, report codes 11400–11446 and for radical resection of tumor(s) of cutaneous origin, for example, melanoma, report codes 11600–11646.

*Appendix C*

In 2014, Appendix C of the CPT manual contains guideline revisions; users will note that some clinical examples previously provided have been deleted from this appendix. The guidelines now appropriately identify the intended use of the clinical examples; the examples are not intended to replace the use of key components (or time when it becomes the controlling factor for the extent of the visit), descriptors, or guidelines that accompany the codes to determine the level of code to report. However, the clinical examples are intended to be used as educational information to assist in identifying the correct service code.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain Time, excluding holidays, or go to www.facs.org/ahp/pubs/tips/index.html.
Health care policymakers have expressed growing concern in recent years regarding an imminent emergency care crisis in the U.S. In May 2013, the department of surgery at Emory University, Atlanta, GA, hosted an inaugural Acute Care Surgery Conference under the direction of one of the authors, A.L. Jackson Slappy, MD, FACS, and the chair of Emory’s department of surgery, John Sweeney (see photo, page 35). This conference was designed to examine the role of acute care surgery in addressing the emergency care crisis.

More than 70 attendees heard presentations from Emory faculty regarding current issues in health care policy, efforts to standardize care, and the effects of implementation of an acute care surgery program on patient safety, quality, and outcomes. The conference explored acute care surgical practice models, fellowship training, future trends, and quality and administrative issues related to implementation of a dedicated emergency surgery program.

This article provides an overview of the meeting, discusses its relevance in the context of the emergency care workforce shortage, and makes recommendations on future directions for trauma and acute care surgery.

The featured speakers at the conference are listed in the sidebar on page 35.

Will acute care surgery and surgicalists help to avert an emergency care crisis?

by A.L. Jackson Slappy, MD, FACS; John Sweeney, MD, FACS; John O’Shea, MD, MPA; and John Maa, MD, FACS
Conference highlights

ACS Past-President L.D. Britt, MD, MPH, DSc(Hon) FACS, FCCM, FRCS(Eng)(Hon), FRCS(Ed)(Hon), FWACS(Hon), FRCS(1)(Hon), FCS(SA)(Hon), Brickhouse Professor and Chairman, department of surgery, Eastern Virginia Medical School, Norfolk, VA, discussed the renaissance of trauma surgery in the 21st century and the future of acute care surgery. Over the last decade, the field of trauma surgery has been reinvigorated by the emergence of the acute care surgeon, who shares with the surgical hospitalist the core concept of serving as a dedicated emergency surgeon. The continued evolution of these disciplines may inspire medical students and residents to focus their future careers on the timely and high-quality delivery of care to the emergency surgical patient, and resolve the emergency surgical care crisis in America.¹

Dr. Britt discussed the training and practice patterns that surgeons should have to be classified as acute care surgeons. He said acute care surgeons must have trauma fellowship training and be in an active practice that includes the provision of critical care and emergency general surgery services. Dr. Britt noted that 16 acute care surgery fellowships nationwide have now graduated 40 surgeons since he first proposed the American training paradigm for the acute care surgeon in 2007.²

John Nelson, MD, FACP, past-president and founder of the Society of Hospital Medicine, shared insights into acute care surgical practice, models, and quality and administrative issues involved in implementation. Dr. Nelson described the initial challenges that the hospitalist movement faced and noted parallels...
Over the last decade, the field of trauma surgery has been reinvigorated by the emergence of the acute care surgeon, who shares with the surgical hospitalist the core concept of serving as a dedicated emergency surgeon.

in the evolution of the dedicated emergency surgeon. Identifying an adequate number of surgeons to staff an acute care surgery program, negotiating appropriate strategic support, demonstrating an improvement in quality of care, and documenting a return on investment for the institution are essential to the continued success and viability of the program, he said.

In addition, Dr. Nelson noted that to assist in coordinating the expansion of the field, the Society of Hospital Medicine launched a dedicated website focused on acute care surgery and the surgical hospitalist movement. To track the growth in this field, existing programs are invited to register at http://www.hospitalmedicine.org/Content/NavigationMenu/Membership2/HospitalFocusedPractice/Specialties_Surgical/Specialties_Surgical.htm for collaboration and further research.

John O’Shea, MD, MPA, Senior Health Policy Advisor to the U.S. House Energy and Commerce Committee and co-author of this article, shared his insights on the Affordable Care Act (ACA), the congressional process, and the implications for the future of surgery. Dr. O’Shea reviewed the recent history of health policy issues that affect surgeons, such as medical liability; the Emergency Medicine, Trauma, and Active Labor Act; and Medicare physician payment reform.

Dr. O’Shea focused on the key provisions that will affect surgical practice, including Medicaid expansion, the introduction of the insurance exchanges, the medical device tax, and the Independent Payment Advisory Board. He concluded by sharing some valuable lessons that he has learned as a congressional committee advisor, stressing the importance of clinician leadership in health reform and suggesting future strategies for surgeons to enlighten the health reform debate by working collaboratively with members of Congress and their staffs.

Finally, conference attendees discussed the ongoing debate over how to properly categorize full-time, hospital-based surgeons, including those who provide acute care services. Conference participants were polled regarding their preference for the term “surgical hospitalist” or “surgicalist.” Surgicalist was clearly the preferred title, and it was noted that some nurse practitioners and physician assistants have chosen to use the term “surgical hospitalist” to describe their practice.

The authors believe a potential solution to this nomenclature issue is for emergency surgery programs that include board-certified trauma and critical care surgeons to use the name “acute care surgery,” and for programs that involve general surgeons without trauma and critical care fellowship training to use “surgicalist” in their title. Nationwide, there are approximately 200 Level 1 trauma facilities. The general surgeons practicing at other U.S. hospitals where these physicians provide trauma care services would, under the proposed nomenclature change, be called “surgicalists.”

solving the emergency care crisis

The conference took place at a time when many public officials are seeking to address the shortage of emergency health care professionals, particularly in rural areas. Various government entities have been working to resolve the emergency care crisis. The U.S. Department of Health and Human Services (HHS) has proposed the creation of a General Surgery National Health Service Corps to deploy board-certified surgeons for several-month rotations across rural America. This concept was first advanced by former Emory University chancellor Michael Johns, MD, FACS, in a 1993 Journal of the American Medical Association article. For this concept to work, it is essential to identify where to recruit physicians who are willing to relocate temporarily.

One potential target group is the new generation of acute care surgeons and surgicalists, who are mastering the delivery of emergency care. Another possibility is to harness the altruism of surgeons who seek to address global disparities in health care, and persuade them to travel to rural U.S. hospitals instead.

Another possible strategy is to focus on funding programs that are designed to strengthen emergency care. The ACA authorized $224 million to support existing systems of trauma care and to stimulate research into new models of innovation for regionalization and emergency care coordination. The American College of Surgeons (ACS) has called upon HHS
Another possible strategy is to focus on funding programs that are designed to strengthen emergency care. The ACA authorized $224 million to support existing systems of trauma care and to stimulate research into new models of innovation for regionalization and emergency care coordination.

Secretary Kathleen Sebelius to implement this provision, but the President’s budget proposals for fiscal years 2010 to 2013 have excluded a specific request for the appropriation of the necessary funds. This omission is somewhat surprising as a trauma and emergency care bill, S.B. 1873, introduced by then-Sen. Barack Obama (D-IL) in the 110th Congress in 2007, would have allocated $12 million for fiscal years 2008 through 2013 for the design and implementation of regionalized systems of emergency care (see figure, this page). Although the bill did not pass the Senate Committee on Health, Education, Labor and Pensions, portions of it were used to craft the ACA. The crisis in emergency care has only intensified since 2007, and surgeons should call upon their members of Congress to fund the trauma sections of the ACA.

**success in mass-casualty care**

As Kate Heilpern, MD, chair of the department of emergency medicine at Emory, noted at the conference, the emergency department is often a mirror for society’s problems, including the misuse of guns, the underuse of seatbelts, and the hazards of drinking and driving. The tragedies at Sandy Hook Elementary School in Newtown, CT, the Boston Marathon, and the Navy Yard in Washington, DC, further underscore the need for federal and state legislation to address the epidemic of gun violence, which is consistent with the ACS Statement on Firearm Injuries, and the need for dedicated acute care health care professionals.

The heroism and lifesaving care offered by the first responders, paramedics, law enforcement, and surgical and emergency medicine providers on April 15, 2013, at the Boston, MA, Marathon bombing were highlighted in an essay by Atul Gawande, MD, FACS, in the *New Yorker*. In it, he describes firsthand his experience at the Brigham and Women’s Hospital and provides accounts from other health care professionals involved in caring for the wounded. All of the patients transported from Copley Square to Boston hospitals survived, and the three fatalities were all pronounced at the scene. Dr. Gawande...
As lawmakers seek to pass additional reforms, the authors believe these efforts should be aimed at inspiring and incentivizing a new generation of physicians to dedicate their careers to acute care emergency surgery.

explains why the outcome was so favorable, in the following excerpt:\textsuperscript{7}

What prepared us? Ten years of war have brought details of attacks like these to our towns through news, images, and the soldiers who saw and encountered them. Almost every hospital has a surgeon or nurse or medic with battlefield experience, sometimes several. Many also had trauma personnel who deployed to Haiti after the earthquake, Banda Aceh after the tsunami, and elsewhere. Disaster response has become an area of wide interest and study. Cities and towns have conducted disaster drills, including one in Boston I was involved in that played out the scenario of a dirty-bomb explosion at Logan Airport on an airliner from France.

His reflections highlight the need for continued research in emergency and trauma care.

Bright future of emergency surgery

The battle on Capitol Hill over health care reform has continued since the enactment of the ACA, culminating in a federal government shutdown last fall. As lawmakers seek to pass additional reforms, the authors believe these efforts should be aimed at inspiring and incentivizing a new generation of physicians to dedicate their careers to acute care emergency surgery. We encourage physicians to share stories from the clinical front lines to attract the media and move Capitol Hill to enact new laws ensuring all Americans receive safe, efficient, and high-quality care.

The mass-casualty events that have occurred in recent years and the inaugural Acute Care Surgery Conference at Emory provide a window of opportunity to remind Congress and the President of the importance of continued research in trauma and emergency care coordination, regionalization, and mass-casualty preparedness. It also is a good time to ask our elected officials to appropriate the $224 million to fund the trauma and emergency medical services programs authorized in the Public Health Service Act provisions in the ACA.

As an outgrowth of the Acute Care Surgery Conference in Atlanta, a Capitol Hill briefing on the topic is being planned in an effort to share the key findings of the meeting with legislators. At press time, a date had not yet been set for the meeting, but we believe there is a special opportunity to transform emergency surgical care and solve the larger challenges facing emergency rooms throughout the national and worldwide. ◆
The 113th Congress focused a great deal of its health policy efforts last year on permanently repealing the Medicare sustainable growth rate (SGR) formula and reforming the physician payment system. Proposed legislation was passed out of all three committees of relevance—the Senate Finance Committee, the House Ways and Means Committee (just prior to congressional adjournment in December), and the House Energy and Commerce Committee in July 2013.

During the holidays and into the new year, the committees were scheduled to begin negotiations, internally and with interested stakeholders, including the American College of Surgeons (ACS), to develop a single bipartisan, bicameral bill.

At the close of 2013, Congress passed a two-year budget deal that includes a House amendment to prevent a cut in physician payments under Medicare. Is this a temporary fix, and what can physicians expect in 2014?

Yes, this is a temporary fix. Congress passed a three-month, 0.5 percent increase in the Medicare physician payment rate as a bridge to allow for negotiations on permanent repeal of the SGR. The short-term patch averts the scheduled cut to the payment rate, in excess of 24 percent, on January 1. The cut is now scheduled to take effect April 1, which coincides with the next round of sequestration cuts. Medicare physician payment rates would be cut an additional 2 percent on April 1. For more information on sequestration and what it means for health care, visit the following Web page: www.facs.org/ahp/medicare/sequestration.html.

How costly would repeal be at this point?
The yearlong collaboration between Congress and interested stakeholders, including the ACS, took flight because the current environment represents the best chance for repeal in a decade, as the estimated cost of eliminating the SGR and implementing a new approach has shrunk to $116 billion, down from nearly $300 billion, according to the Congressional Budget Office (CBO).* Since 2003, Congress has enacted 15 short-term patches to stop the Medicare physician payment cuts, spending more than $146 billion cumulatively. By paying the minimum on the “credit card” for the last decade, Congress has spent more than the current cost of full repeal, and, as many surgeons know, fiscal uncertainty makes it difficult for physician practices to invest in the infrastructure needed to better serve patients.

On October 30, 2013, the Senate Finance and the House Ways and Means Committees released a draft proposal for repealing the SGR and fixing the Medicare physician payment system. The proposal was based on draft legislation that the House Energy and Commerce Committee approved last summer. What provisions in the proposal are of concern to the ACS?
The ACS has identified four critical concerns:

- The proposal called for a 10-year freeze on payment increases. The College believes that mandate would serve as an unsustainable business model and advocated that any repeal of the SGR include a positive annual update. A freeze does not keep pace with the cost of providing care, nor does it offer physicians the financial ability to invest in the infrastructure necessary to transition to the new system.

- The proposal’s value-based payment (VBP) program would measure and rank participating

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Physicians’ performance on a composite score system. The ACS strongly opposed the VBP’s tiered model of redistributing payments because the only way for a provider to get a positive bonus payment would be for another provider to take a cut. The ACS has long advocated for incentives based on physicians achieving a threshold or benchmark, so that all providers could strive for and achieve positive updates in reimbursement.

The proposal’s alternative payment model (APM) is a positive, incentive-based program that allows participating physicians to avoid the VBP program and its potential penalties. Qualifying physicians would secure a required percentage of revenue in alternative payment models, including Accountable Care Organizations (ACOs), medical homes, or bundled payments. The ACS has concerns with regard to this provision because most, if not all, surgeons fall outside the proposed models—operationally, geographically, or economically—which places surgeons at a disadvantage compared with other providers. The ACS maintains that a process for the approval of other alternative payment models, such as the Clinical Affinity Groups proposed in our Value-Based Update (VBU) proposal, should be in place.

10-year freeze and VBP’s tiered model remain unchanged. The ACS and other surgical societies issued a letter in opposition to the Senate Finance Committee bill to repeal the SGR. On the other hand, the House Ways and Means Committee made good-faith changes in its version of the SGR legislation, which addresses some of the College’s concerns and provides more stability for surgeons and the surgical patient. Both committees passed their proposals out of committee on December 5, 2013. Download the letter to the Senate Finance Committee at www.facs.org/ahp/medicare/index.html.

I understand that the Senate Finance and House Ways and means Committees released a second version of their joint proposal. Did the second draft include any significant, positive changes? The APM process was much improved and provided a more viable pathway for surgeons. In addition, the provisions directly targeting global surgery payment and administering a 10 percent penalty for noncompliance were removed. However, the
During the protracted efforts to produce legislation to fully repeal the SGR and reform the Medicare physician payment system, the ACS spearheaded a grassroots advocacy campaign to reaffirm the House’s commitment to repeal the SGR using the ACS’ SurgeonsVoice program.

proven ability to provide high-quality care to patients. Two critical provisions included: (1) a 0.5 percent increase in the physician payment rate over the next 10 years (and each year thereafter); and (2) a benchmarking/threshold system that allowed all physicians to share in bonus payments if they achieved the requisite score, which measures their quality and resource use. These provisions are in marked contrast to the 10-year freeze and tournament-style payment system in the Senate Finance proposal.

what actions will the College take over the coming months to ensure that the sgr is repealed in a meaningful and equitable manner?

Over the past year, Congress has repeatedly sought to tap the medical community for feedback on numerous issues regarding the physician payment system. The ACS remains committed to permanently repealing the SGR and reforming the physician payment system, as well as streamlining existing quality programs, encouraging alternative payment models, and generally moving to a system that rewards high-quality, efficient care. ACS Advocacy and Health Policy staff will continue to work with Congress to forge a new patient-centric, quality-based health care system.

For more information about the College’s position on the SGR, go to www.facs.org/ahp/medicare/index.html.

The SURGEONSvoice Pr oGr AM

Last year, the aCs launched Surgeonsvoice, a grassroots program for members. what is Surgeonsvoice?

in partnership with the ACs Division of Advocacy and Health policy staff in Washington, the Surgeonsvoice program launched in October 2013 to enhance grassroots advocacy for recruiting, educating, and motivating Fellows to use their influence to change the dynamic in Washington, DC. Surgeonsvoice helps members build critical relationships with legislators in their home state, and provides members with access to a grassroots advocacy tool kit complete with a comprehensive handbook, issue briefs, and PowerPoint presentations, as well as draft letters to Congress, advocacy and health policy webinars, the latest news and information, and a section for members to tell their stories. Access Surgeonsvoice.com using your ACs member ID and password.

how has Surgeonsvoice affected the debate on repealing of the sgr?

During the protracted efforts to produce legislation to fully repeal the sGr and reform the Medicare physician payment system, the ACs spearheaded a grassroots advocacy campaign to reaffirm the House’s commitment to repeal the sGr using the ACs’ Surgeonsvoice program. As a result, 259 bipartisan members of the House, led by reps. Bill Flores (r-tx) and Dan Maffei (D-NY), sent a letter to speaker John Boehner (r-oH) and Minority Leader Nancy Pelosi (D-CA) urging Congress to permanently repeal the flawed Medicare sGr formula and replace it with a system that rewards quality while controlling costs.

With the partisan gridlock in Washington dominating the headlines in 2013, the significance of this achievement must not be underestimated, as more than half of the House is now on record supporting a full repeal of the sGr. This effort also demonstrated the power of Surgeonsvoice and the ability of ACs Fellows to influence legislators through grassroots advocacy.

FEB 2014 Bulletin American College of Surgeons
The quest for safe surgical care: Are we missing the obvious?

by Jeffrey Shuhaiber, MD

Given the increasing case complexity, the introduction of new diagnostic and therapeutic tools for use in the operating room (OR), and collaboration with other interventionists, the need for safe surgical procedures has become even more essential. Safety remains the surgical profession’s highest priority. The performance of safe operations has been associated with following a checklist of items detailed by the World Health Organization (WHO) and endorsed by a number of medical associations. Although checklists provide a template for safe conduct, they are limited. This column focuses on the coordination of the surgical team and each member’s behavior as necessary foundations for safe operations.

Communication is key

Although all professional teams strive for excellence in patient care, a universal understanding of what constitutes a safe OR environment remains elusive. A recent review of existing literature on information transfer and communication during surgical procedures demonstrated that deficits in information transfer and communication adversely affect patient care. Furthermore, the evidence suggests that certain non-technical aspects of performance may affect technical performance. Ongoing evidence of the technical or clinical benefits of teamwork training in medicine is weak. But there is strong evidence supporting the use of checklists to minimize errors. Despite the use of complex checklists and advanced computer technology in the surgical environment, errors continue to occur, nonetheless. These errors may be due to the lack of a formal definition and identification of each team member’s roles and expectations, which would function as a continuous qualitative team performance assessment. The safety measure for each individual on the team is missing.

Teams are composed of individuals, each with unique visions, hopes, and fears driving his or her behavior. The strength of the team simply reflects the cumulative strength of each individual, and the weakest individual can detrimentally override the collective strength of other members.

Poor communication and mitigated speech—in which team members do not say what they mean when speaking with team members of differing power or position—undermine teamwork in the OR. Many people who work in the OR suffer from power distance. The greater the perceived difference in social status between individuals—the power distance—the more difficult it becomes for an individual of lower “team” status to communicate directly with the superior.

Team members at any level should feel free to speak up to prevent patient harm at any time. Authoritative speech by the superiors not within the context of patient care can inactivate team members and perhaps distract them from the overall conduct of the operation.

Avedis Donabedian, MD, MPH, a U.S. health care quality theorist, emphasized that quality of care encompasses not only technical excellence of care but also the humanity and manner with which it was delivered. One can extend this theory to all the individuals on any surgical team. This distinction is now commonplace. Surgeons always have had the best interest of their patient in hand; however, demonstrations of caring and compassion are now viewed as components of quality of care. Maxwell extended these
Surgeons always have had the best interest of their patient in hand; however, demonstrations of caring and compassion are now viewed as components of quality of care.

measures further to identify six dimensions of quality: technical excellence, social acceptability, humanity, cost, equity, and relevance to need.  

In our field, we all at some time witness two broad categories of surgeons—those who not only have excellent technical abilities, but also excellent leadership and communications skills, and those with excellent technical skills but less ability to lead and interact with other team members.

team safety breeds patient safety

Patient safety often is nothing more than a reflection of team safety. No matter how we interact, it cannot be at the expense of our focus on the patient. Teams in which all members are focused on safety will deliver safe care and more often avoid patient harm even under the most difficult circumstances.

What is safety? A comprehensive definition could be the state of being safe—the condition of being protected against physical, social, spiritual, financial, political, emotional, occupational, psychological, or other types of harm. Most research has focused on the physical harm to the patient resulting from surgical error and poor technical performance. Few studies have focused on the role of individual team members. Yet it is individuals—from surgeons to assistants and nurses, as well as those who help in patient transportation—who contribute to the safe surgery and overall care during the patient’s hospital stay. At the same time, the intangible aspects of their environment, such as poor communication, mitigated speech, social interactions, and perceptions may influence these caregivers.

Historically, the attending or consultant surgeon or the senior nurse has been the “go to” person at times when safety is compromised or when team members believe a patient is at risk of injury. Other teams take a collaborative approach, leveling the playing field so that all team members are given equal weight. In other ORs, team members are polarized, with one person having seniority over the other team members.

How teams are structured and work together is often determined by years of institutional history and customs. These teams, with different inter-member behavior, can go on not comprehending the full effect of their working relationships on patient safety.

r e f e r e n c e s


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A safe surgical team is one with members who provide sufficient quality of care, reliability, availability, and maintainability to execute a surgical procedure without causing any errors leading to harm to the patient or any other team member.

**what is a safe surgical team?**
A safe surgical team is one with members who provide sufficient quality of care, reliability, availability, and maintainability to execute a surgical procedure without causing any errors leading to harm to the patient or any other team member. Members from all levels of professions create a safe environment. They also build cognitive systems to competently resolve any conflicts that may arise.

Of course, it is important to realize that safety is relative. While eliminating all risk is unlikely and costly, it is those inter-member interactions that continue to influence the entire team in either a positive or negative manner. An overall team culture may be influenced by respectfully giving and receiving rewards, constructive critique, collaboration, empathy, and continued succession. A number of organizations and government agencies promulgate safety standards for consumer products, the transportation industry, and so on. However, surgical teams currently lack defined standards of what is a safe team. Standards are rarely discussed in surgical, nursing, anesthesia, and technical training, let alone in practice.

**Building safe, competent surgical teams**
Building a near 100 percent safe team can be achieved through collaboration among physicians, nurses, and administrators, as well as outside consultants. Fostering trust and safety in all interactions is essential, as are transparency and lack of ambiguity in leadership and communication. The constant turnover of nurses, residents, physician assistants, and sometimes surgeons who do not fit in with the institutional culture will never rectify conflicts without ignoring negative emotions that hinder safe practice and team success. Turnover has both a direct and indirect effect on patient experience, outcome, and safety. A team that sees a common goal of patient care and smooth conduct of surgical procedures yet is willing to share their fears, hopes, differences, and disagreements among

**References (CoNt iNu eD)**

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A team that sees a common goal of patient care and smooth conduct of surgical procedures yet is willing to share their fears, hopes, differences, and disagreements among themselves also allows for improvement and innovation.

**Our responsibility**

In the large perspective of patient care, the relationship between safety and quality is nothing more than a continuum. Although many prominent nonsurgeon thinkers have defined quality in many different ways, the most important aspect—patient safety—remains our priority.\(^9,12,16\) When trying to make headway with quality and safety, simplifying the underlying problem(s) and background for each team can help. Surgeons are the natural leaders in the OR; yet, in a high-stress working environment, they may feel powerless to change systemic problems and their environment.\(^17\) In my experience, introducing safety concepts in the OR is sometimes met with resistance, and even when changes are made, not all team members have been in agreement.

Overall, we should always maintain risk-averse behavior. And while we should be accepting of new technology, protocols, and operative procedures, we must adopt these innovations only when we are certain they will not put the patient or team at risk. It is our responsibility to deliver the best care possible and to find ways to improve quality and quantity of life for our patients.

A high versus low turnover of team members is not without its advantages to both patient and team alike. Truly appreciating this fact can deliver benefits extending to the entire organization and health care system. Understanding that both the surgeon and his or her team have the reciprocal supportive functional ethos during surgical procedures is desirable and much needed. There can be no more important value than being at our best collectively when taking human life into our hands. This value cannot be fulfilled with advanced technology alone, but rather in combination with our behavior. Continuous collective reflection and resolution of team frustrations may lead to safe team growth and development. Investment in the team members is necessary for the optimal delivery of safe surgical care. ♦

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**References**


Less invasive option for small hepatocellular carcinoma: Thermal ablation as first-line therapy?

by Flavio G. Rocha, MD, FACS; Judy C. Boughey, MB, BCh, FACS; and Heidi Nelson, MD, FACS

As its use by both liver surgeons and interventional radiologists increases, the role of ablation in HCC needs to be more rigorously studied to identify which population derives the most benefit.

Is resection or transplant the only option for cure for patients with hepatocellular carcinoma (HCC)? Or, with advances in technology, are less invasive options appropriate, and if so, for which patients?

HCC is the sixth most common cancer and third leading cause of cancer death worldwide.1 Unlike Asia, where endemic hepatitis B (HBV) is the leading cause of HCC, in the U.S., the most common risk factors include alcoholic liver disease, hepatitis C infection, and nonalcoholic steatohepatitis. HCC in these types of patients typically arises in the background of cirrhosis, although the exact mechanism of carcinogenesis is not understood. Therefore, in addition to patient and tumor factors, HCC therapy must address the functional capacity of the liver.

The Barcelona Clinic Liver Cancer (BCLC) group has proposed and validated a therapeutic staging system to optimize treatment of HCC (see Figure 1, page 47).2 While resection and transplantation have demonstrated the highest survivals for HCC, most patients are ineligible for these modalities due to advanced liver disease and limited organ availability.

Thermal ablation, which was limited to use in unresectable disease, has now been used more frequently in early stage disease. Its use as potentially curative therapy in early stage tumors has reported outcomes nearly equivalent to hepatectomy in retrospective studies.3,4 As its use by both liver surgeons and interventional radiologists increases, the role of ablation in HCC needs to be more rigorously studied to identify which population derives the most benefit. The decision on modality should be based on patient and disease factors and not influenced by referral pattern or the door through which the patient entered the hospital system.

**Techniques**
The most common types of thermal ablation are radiofrequency (RFA) and microwave (MWA). RFA uses an alternating current, whereas MWA uses electromagnetic radiation to generate frictional heat in tissues. However, when applied close to large blood vessels, that energy can be absorbed and diverted away from tumor cells as...
a heat sink. Both RFA and MWA can be delivered percutaneously, with laparoscopic assistance, or during open surgery. Ultrasound guidance is typically used for probe placement (see Figure 2, page 48). The percutaneous approach avoids the risks of laparotomy with faster recovery. However, tumors on the capsule near the diaphragm, peritoneum, or bowel cannot be safely treated through this route. Laparoscopy allows for liver mobilization to ablate lesions in those locations while limiting surgical morbidity. However, tumors in the hilum or hepatic vein confluence cannot be ablated thermally due to the potential for injury to biliary and vascular pedicles. In addition, incomplete ablation can occur in larger lesions, and ablation is typically not recommended for lesions greater than 3 centimeters.

**trials**

Only two randomized controlled trials (RCT) on thermal ablation and resection in HCC have been reported in literature published in the U.S., both conducted in China. The first RCT compared 180 patients with a single tumor smaller than 5 centimeters and Child’s A cirrhosis between percutaneous RFA or open resection. The groups were evenly matched with respect to tumor size, alpha-fetoprotein, liver function, and indocyanine green clearance. However, 19 patients from the RFA group crossed over to the surgery group. No difference was found in overall or disease-specific survival in the intention-to-treat analysis between groups, but resection was associated with one death and more complications (55 percent versus 4 percent, p<0.05) than RFA. The second trial compared 230 patients with HCC within Milan criteria with percutaneous RFA or open resection. The groups consisted predominantly of HBV patients with Child’s A and B cirrhosis and were evenly distributed, with the exception of slightly larger tumors in the RFA group.

A total of 25 patients were lost to follow-up (seven RFA, 18 surgery), and seven patients in the RFA group crossed over to the surgical group. The tumor recurrence rate was higher in the RFA group compared with the surgery group (69 percent vs. 52 percent, p<0.02), although the majority of recurrences were in the liver away from the ablation site. The five-year overall and disease-free survival rates were significantly higher in the surgery group (75 percent and 51 percent) than the RFA group (54 percent and 28 percent, p<0.001). No hospital deaths occurred, but more complications arose in the surgery cohort than in RFA (28 percent versus 2 percent, p<0.05), resulting in a longer length of stay. Both trials had significant shortcomings, including problems with group allocations, number of patients with cirrhosis, small sample size, and short follow-up.
Given the paucity of level I evidence and the discrepancy in the methodology and results from existing RCTs, thermal ablation as treatment for early HCC clearly requires further investigation. Clinical trials performed via U.S. cooperative groups are sorely needed, as the HCC population is significantly smaller and different from the one in Asia. With the continued evolution and evaluation of this technology, it may be possible for thermal ablation to become the first-line option for very early HCC (BCLC 0).

### References

The 2013 Pediatric Report of the National Trauma Data Bank® (NTDB®) is an updated analysis of the largest aggregation of U.S. and Canadian trauma registry data ever assembled. In total, the NTDB now contains more than 5 million records. The 2013 Annual Report is based on 773,299 records, submitted by 803 facilities, from the single admission year of 2012. The 2013 Pediatric Report is based on 152,884 admission records from 2012. The NTDB classifies pediatric patients in this report as patients who are younger than 20 years old.

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

**disturbing findings**

When reviewing the records of patients who were tested for either alcohol or illicit/prescription drugs, for example, a disturbing trend surfaces. A total of 34,923 pediatric patients were tested for blood alcohol, and 7,202 (21 percent) tested positive. Of the 19,057 patients tested for drugs, 6,684 (36 percent) tested positive for illegal drug use, while another 2,755 (14 percent) tested positive for prescription drug use. This type of information could be very useful for injury control/prevention and education targeted to at-risk pediatric populations. Our children should grow up to become something more than consumers of alcohol and drugs (see Figures 1 and 2, page 50).

Many dedicated individuals on the ACS COT, including the Pediatric Surgery Subspecialty group, along with dedicated individuals caring for pediatric patients at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, the NTDB 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 NTDB data for more detailed study is available on the website.
the goals in the coming years include improving data quality, updating analytic methods, and enabling more useful inter-hospital comparisons. These efforts will be reflected in future NTDB reports to participating hospitals, as well as in annual Pediatric Reports.

Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The National Trauma Data Bank 2013 Pediatric Report 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.◆
The Illinois chapters of the American College of Surgeons (ACS) and Blue Cross and Blue Shield of Illinois (BCBSIL) are collaborating on a program that offers selected hospitals in the state the opportunity to join the Illinois Surgical Quality Improvement Collaborative (ISQIC)—a program designed to improve the safety and quality of surgery in the state. BCBSIL is funding the collaborative, which will use data from the College’s National Surgical Quality Improvement Program (ACS NSQIP®) to analyze the surgical practices and outcomes of participating hospitals and identify specific improvements that will be effective in reducing surgical complications, the length of inpatient stays, readmission rates, and deaths.

Each hospital will receive customized performance reports noting areas of poor performance that will become the focal point of improvement efforts for that institution. The ISQIC Coordinating Center will offer quality improvement training and support, develop Illinois-specific performance results, and perform research around the initiative.

“The goal of the collaborative is to use detailed surgical performance data to identify opportunities for improvement and have hospitals work together through sharing their experiences and practices in order to develop effective and self-sustaining improvements that truly benefit patient care,” said Karl Y. Bilimoria, MD, MS, FACS, a surgical oncologist at Northwestern University Feinberg School of Medicine, Chicago, IL, and director of ISQIC.


Dr. Bilimoria
The Lancet Commission on Global Surgery met for the first time January 17–18 at Harvard Medical School in Boston, MA. The focus of the commission’s work will be on surgery in low- and middle-income countries (LMICs), encompassing all perioperative specialties as well as nonclinical aspects of surgical care, including management, financing, and infrastructure.

The commission will engage a multidisciplinary panel of experts and decision makers from around the world, who will convene for a series of three structured meetings. During these three meetings, the commissioners will develop the principal publication and strategize on how to elevate surgery to a priority position on the global health agenda. A fourth meeting will focus on implementation of the commission’s recommendations with key stakeholders from LMICs.

The primary tangible output will be a 25,000-word document published in The Lancet, which will contain several key messages to the global community regarding augmentation of surgical care, metrics to gauge progress, and recommendations for key stakeholders. A number of primary research papers to further delineate topics of relevance, as well as a series of teaching cases to demonstrate methods of surgical care delivery will be presented. This initial work of the commission is intended to create a foundation for sustained advocacy through The Lancet and other vehicles over the next decade.

Chairing the commission are John G. Meara, MD, DMD, FACS, plastic surgeon-in-chief, Boston Children’s Hospital, and director of the program in global surgery and social change, Harvard Medical School, Boston; Andy Leather, MB, BS, MS, FRCS, director, King’s Center for Global Health at King’s College, and consultant surgeon at King’s College Hospital National Health Service Trust, London, UK; and Lars Hagander, MD, PhD, MPH, consultant pediatric surgeon, Lund University, Sweden, in collaboration with The Lancet.

The commission welcomes involvement and conversation with any interested parties. A public website (http://gscommission.com/) has been established, which will initiate a community forum, allowing people to post comments and recommendations and engage in conversation regarding the commission. Further discussions and updates will be generated through a social media campaign using Twitter (https://twitter.com/GSCommission) and Facebook (https://www.facebook.com/GSCommission). The results of these conversations will be presented to the commissioners to help guide their work.

ACS supports December *Health Affairs* theme issue on emergency care

The December 2013 issue of *Health Affairs* focuses on “The Future of Emergency Medicine: Challenges and Opportunities” and is available at [http://www.healthaffairs.org](http://www.healthaffairs.org). The following organizations joined the American College of Surgeons (ACS) in providing support for the special issue: Hospital Corporation of America, the American Hospital Association, the Emergency Medicine Action Fund, the American College of Emergency Physicians, the Jewish Healthcare Foundation, the Society for Academic Emergency Medicine, and Medical Emergency Professionals. The College provided grant funding for the issue.

Included in the issue is an article titled “Sustaining a Coordinated, Regional Approach to Trauma and Emergency Care Is Critical to Patient Health Care Needs,” by ACS Immediate Past-President A. Brent Eastman, MD, FACS; Ellen J. MacKenzie, PhD, professor and chair, Fred and Julie Soper Professor in Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; and Avery B. Nathens, MD, FACS, Toronto, ON, an ACS Governor who previously served on the ACS Committee on Trauma. The article may be viewed at [http://content.healthaffairs.org/content/32/12/2091.full](http://content.healthaffairs.org/content/32/12/2091.full).

Other articles in this special issue explore media-propelled myths of emergency care; the controversies surrounding the Emergency Medical Treatment and Active Labor Act; the past, present, and future of emergency care; the development of integrated networks of care; quality measures; and efforts to reduce costs. ♦

COT to host 33rd Point/Counterpoint Surgery Conference June 1–4

The American College of Surgeons (ACS) Committee on Trauma (COT) will present its 33rd annual Point/Counterpoint Acute Care Surgery Conference, June 1–4, at the Gaylord National Resort and Convention Center in National Harbor, MD. ACS Past-President L. D. Britt, MD, MPH, DSc(Hon), FACS, FCCM, FRCS(Eng)(Hon), FRCS(Ed)(Hon); FWACS(Hon); FRCS(I)(Hon), FCS(SA)(Hon), Brickhouse Professor and Chairman, department of surgery, Eastern Virginia Medical School, Norfolk, VA, is the Course Director. The conference is designed for general surgeons and other specialty surgeons, as well as emergency physicians and intensivists, residents, nurses, and paramedics who participate in a high-performance acute care team.

The conference will begin with a general session on Trauma Management and Controversies, moderated by Dr. Britt. At a luncheon on the first day, ACS Executive Director David B. Hoyt, MD, FACS, will deliver a state-of-the-art lecture, Surgery and Quality Metrics: How Are We Doing?

At a general session in the afternoon, Trauma System Development and Mass Casualty Management, ACS Regent Lenworth M. Jacobs, Jr., MD, MPH, FACS, will participate in a discussion of Mass Casualty Preparedness: Is There a “Best Practice?” On the second day of the conference, Dr. Britt will moderate a general session at a continental breakfast titled Emergency General Surgery: Standard-of-Care Management? Later in the morning, ACS Treasurer and former ACS Governor William G. Gioffi, Jr., MD, FACS, will deliver the Charles Wolferth, Jr., MD, Memorial Lecture on Acute Care Surgery: What Should Dictate a Change in Our Practice Patterns? Patricia L. Turner, MD, FACS, Director of the ACS Division of Member Services, will speak on Laparoscopic Washout With Primary Repair for Perforated Acute Diverticulitis: Deviation from the Standard of Care? In addition, Dr. Britt will moderate a session, Emergency General Surgery: Ongoing Controversies. At a continental breakfast on the final day of the conference, Dr. Britt will moderate a general session on Critical Care, Advances and Ongoing Controversies.

Using the point/counterpoint format, a speaker offers a case in favor of a specific treatment option, and another speaker offers evidence against it. An audience discussion then follows. For more information on the conference and to register online, visit the course website at [http://www.pointcounterpoint-acs.com/](http://www.pointcounterpoint-acs.com/). ♦
The American College of Surgeons (ACS) presented the 2013 Clinical Trials Methodology (CTM) Course December 6–10, 2013, at the College’s headquarters in Chicago, IL. A total of 39 students and 13 faculty members participated in the course.

In addition to the didactic sessions that took place over each of the four mornings, the student participants from various surgical specialties were divided into six teams. Each team, under the mentorship of a senior surgeon and a biostatistician, developed a proposal for a clinical trial. The proposals were distributed to faculty and students on the last night of the course and were formally presented the last day of the course. The students evaluated the strengths and weaknesses of each proposal. The students and faculty then scored the proposals in accordance with the National Institutes of Health criteria for feasibility, innovation, and significance. After declaring the winner based on the combined faculty and students’ scores, the course director, Kamal M.F. Itani, MD, FACS, and William Henderson, PhD, senior biostatistician, Colorado School of Public Health, Aurora, provided the critiques for each proposal based on faculty comments.

**proposals**
The proposal with the best score, “ACUTE, Acute Uncomplicated Type B Aortic Dissection with Endovascular Repair,” was developed by Kristofer M. Charlton-Ouw, MD, FACS, assistant professor, department of cardiothoracic and vascular surgery, University of Texas–Houston; Randall R. De Martino, MD, MS, assistant professor, surgery, Mayo Clinic, Rochester, MN; Susan Graham, RN, research coordinator, Coastal Vascular & Interventional Research, Pensacola, FL; Mila H. Ju, MD, MS, resident, McGaw Medical Center, Northwestern University Program, Chicago, IL; Daniel Kendrick, MD, resident, University Hospital–Case Medical Center, Cleveland, OH; Saad Shebrain, MB, BCh, FACS, assistant professor, surgery, and associate program director, Western Michigan University School of Medicine, Kalamazoo; and Matthew R. Smeds, MD, assistant professor, University of Arkansas for Medical Sciences, Little Rock.

The faculty mentors were Peter Nelson, MD, FACS, associate professor of surgery and molecular pharmacology and physiology, University of South Florida Morsani College of Medicine, Tampa; and Robert Anderson, PhD, associate professor, biostatistics, division of epidemiology and biostatistics, School of Public Health, University of Illinois at Chicago. The other five proposals were as follows: “The Tester Trial,” Trial of EMR vs. Surgery for T1b Esophageal Cancer; “The TUMMY Ache Trial,” Trying to Understand Medical Management in the Young with Appendicitis; “The POWERS Trial,” Preoperative Optimization with Enteral Rehabilitation and Smoking Cessation in Radical Cystectomy; “The VIP Trial,” Looking at Vancomycin Instillation Prophylaxis in Spine Surgery; and “The CrIS CRInGL Study,” Looking at Critically Ill Surgical Care Randomized Insulin Plus or Minus Glucagon-like Protein. These proposals represented a spectrum of challenges in surgery where higher-level evidence is lacking.

**positive feedback**
Several participants reported that the course offered them an excellent learning experience, lauding the valuable mentorship provided and the opportunities to connect with other health care professionals who share their research interests. Participants noted that sharing meals and networking with faculty and colleagues during the five
days of the course added to the educational opportunity. The groups agreed to remain in contact with each other and pursue funding for their proposals. A survey conducted in 2010 revealed that 61 percent of previous course participants obtained peer review funding to conduct a clinical trial. In that survey, 81 percent of the participants reported that the CTM Course fostered their interest and facilitated involvement in clinical trials.*

The next course is scheduled to take place in November or December 2015. ◆

ACS to cosponsor seminar at SESC Scientific Meeting

The American College of Surgeons (ACS) and the Southeastern Surgical Congress (SESC) will convene a joint half-day seminar on February 23, 2:15–5:45 pm. The seminar will be presented during the SESC’s annual scientific meeting, February 22–25, at the Westin Savannah (GA) Harbor and Savannah International Trade and Convention Center.

ACS leaders and staff who are scheduled to speak and the topics they will address at the seminar include:

• **Andrew Warshaw, MD, FACS**, ACS President-Elect and Chair of the ACS Health Policy and Advocacy Group, and Christian Shalgian, Director of the ACS Division of Advocacy and Health Policy, will provide an update on legislative and health policy.

• **Charles D. Mabry, MD, FACS**, Pine Bluff, AK, a Past-Regent and current Chair of the ACS Health Policy Advisory Council, will address the question, For Whom Will We Work?

• **Lewis Flint, MD, FACS**, Editor-in-Chief, *Selected Readings in General Surgery*® (SRGS®), will speak on Guidelines for Patient Care—the ACS Perspective.

For more information, go to the SESC program website at http://www.sesc.org/aws/SESC/pt/sp/home_page. ◆

Are you taking advantage of all the American College of Surgeons has to offer?

ACS members are dedicated to promoting the highest standards of surgical care through education and advocacy for Fellows and their peers. The College serves as an international forum through which surgeons can reinforce the values, ideals, and ethics that characterize the surgical profession.

MEMBERSHIP HAS BENEFITS

- Access to a broad range of CME programming, including resources to support Maintenance of Certification
- Subscriptions to ACS publications that bring you cutting-edge research and news from the College and surgical community
- Access to College-sponsored insurance programs
- Free access to the College coding consultation hotline, career opportunities, and resume posting
- And much more

THERE IS STRENGTH IN NUMBERS

Our members represent every surgical specialty, practice setting, and stage of practice. Their views and concerns help shape the College’s agenda for the future.

If you aren’t a member of the American College of Surgeons, apply for Fellowship today. If you are already a member, maintain your status and consider getting involved in the College’s efforts to make a difference.

Together, we can bring about positive change for our patients and partners—and for the surgeons of the future.

Information on becoming a member of the College and an application form are available online at [www.facs.org/memberservices/documents.html](http://www.facs.org/memberservices/documents.html) or contact Cynthia Hicks, Credentials Section, Division of Member Services, at 800-293-9623 or [chicks@facs.org](mailto:chicks@facs.org).
Call for nominations for ACS Officers-Elect

The 2014 Nominating Committee of the Fellows (NCF) will select nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President Elect, and Second Vice-President Elect. The NCF will use the following guidelines:

• Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship, along with an unquestioned devotion to the highest principles of surgical practice.
• Nominees must have demonstrated leadership qualities that might be reflected by service and active participation on ACS Committees or in other components of the College.
• Members of the Nominating Committee recognize the importance of achieving representation of all who practice surgery.
• The College encourages consideration of women and other under-represented minorities.

All nominations must include:
• A letter of recommendation
• A personal statement from the candidate detailing ACS service (for President-Elect position only)
• A current curriculum vitae
• The name of one individual who can serve as a reference.

In addition, nominating entities, such as surgical specialty societies, ACS Advisory Councils, and ACS chapters, must provide a description of their selection process and the total list of applicants reviewed. Any attempt to contact members of the NCF by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification. Applications submitted without the requested information will not be considered.

The deadline for submitting nominations is February 28, 2014. Submit nominations to officerandbrnominations@facs.org. If you have questions, call Betty Sanders, ACS Senior Administrator, Board of Governors, at 312-202-5360. ◆

Call for nominations for ACS Board of Governors

Help the American College of Surgeons (ACS) keep pace in a changing health care environment and meet the goals of its Inspiring Quality: Highest Standards, Better Outcomes initiative by nominating your chapter’s brightest, most engaged, responsible, and forthright members to serve a three-year term on the ACS Board of Governors. Nominations for 2014 appointments must be submitted to your local ACS Chapter or surgical specialty society by February 28, 2014.

The Board of Governors is the representative body of the ACS. The membership-at-large nominates two-thirds of the Governors, who are elected during the Annual Meeting of the Members at the ACS Clinical Congress. Certain surgical specialty societies, ACS chapters, and federal medical services nominate one-third of the Board of Governors.

The Governors shall act as a liaison between the Board of Regents and the Fellows, and serve as a clearinghouse for the Regents on general assigned subjects and local problems.

A Governor’s duties include:
• Provide bi-directional communication between the Board of Governors and the Fellows
• Actively participate in a minimum of one Board of Governors Workgroup
• Attend the spring Leadership Summit (spring meeting attendance is not required for international governors)
• Participate in Board of Governors’ meetings, Convocation, and the Annual Meeting of Members at the annual Clinical Congress
• Complete an annual survey
• Attend chapter or specialty society meetings
• Assist in establishing an ACS chapter and serve on the chapter governing board
• Participate in local Committee on Applicants meetings and interviews
• Provide reports to the ACS chapter or specialty society and the Board of Governors Communications Pillar
• Promote ACS Fellowship in state and specialty society
• Welcome new Fellows into the ACS

An inclusive, transparent Board of Governors depends upon members who can actively serve as a link to their local community and as a resource for the ACS. For more information, go to http://www.facs.org/about/governors/candidates.html. If you have questions, call Betty Sanders, ACS Senior Administrator, Board of Governors, at 312-202-5360. ◆
The American College of Surgeons (ACS), in association with Pfizer, Inc., is accepting nominations for the 2014 Surgical Volunteerism Awards and Surgical Humanitarian Award until Friday, February 28.

The ACS/Pfizer Surgical Volunteerism Award, offered in four categories, recognizes surgeons who give back to society and contribute to surgical care through organized volunteer activities. ACS Fellows in active surgical practice whose volunteer activities exceed professional commitments, or retired Fellows who have been involved in volunteerism during their active practice and into retirement are eligible for domestic, international, and military outreach awards. Resident Members and Associate Fellows (ACS Members) who have been involved in significant surgical volunteer activities during their postgraduate surgical training are eligible for the Resident award. Surgeons of all specialties are eligible for each of these awards.

The ACS/Pfizer Surgical Humanitarian Award honors surgeons who have dedicated a significant portion of their surgical careers to full-time or near full-time humanitarian efforts beyond routine surgical practice. Examples include a missionary career in surgery, the founding and ongoing operations of a charitable organization that provides surgical care to the underserved, or surgical volunteer outreach during retirement. Compensation for this work may be expected and does not preclude a nominee from consideration.

The ACS Board of Governors (B/G) Surgical Volunteerism and Humanitarian Awards Workgroup will evaluate the nominations, and the B/G Executive Committee will approve the final award winners.

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

The nomination website is open for electronic submissions and may be accessed through the “Announcements” section of the Operation Giving Back website at http://www.operationgivingback.facs.org/. Contact ogb@facs.org with any questions.
Disciplinary actions taken

The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary actions at its October 5, 2013, meeting:

• Peter A. Bernardo, MD, FACS, a general surgeon from Salem, OR, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following action by the Oregon Medical Board placing limitations on his license regarding laparoscopic colectomy procedures.

• Michael A. Maddaus, MD, FACS, a cardiothoracic surgeon from Minneapolis, MN, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following action by the Minnesota Board of Medical Practice restricting his license and ordering him to participate in the Health Professionals Services Program.

• Robert S. Mathews, MD, FACS, an orthopaedic surgeon from Lancaster, PA, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following action by the Pennsylvania Board of Medicine placing his license on probation after finding that he had engaged in a sexual relationship with an employee while concurrently treating her and that he failed to document an initial medical history and physical examination, reevaluations, or appropriate counseling regarding the conditions diagnosed and medications prescribed.

• Larry D. Tice, MD, FACS, a neurosurgeon from Grand Junction, CO, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following action by the Colorado Medical Board placing his license on probation for five years based on a determination of unprofessional conduct regarding five patient cases.

The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary actions at its June 7, 2013 meeting:

• Deborah L. Aaron, MD, FACS, a general surgeon from Santa Fe, NM, had her Fellowship placed on probation with conditions for reinstatement. This action was taken following action by the New Mexico Medical Board placing her license on probation with terms and conditions for failure to comply with an earlier Stipulation with the State.

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

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

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

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

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

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

• **Expulsion**: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
Chapter news

2014 Leadership and Advocacy Summit March 29 to April 1

Senior leaders, Governors, chapter officers, surgical residents, and members of the American College of Surgeons (ACS) from across the globe will convene for the 2014 Leadership and Advocacy Summit, March 29 to April 1, at the JW Marriott in Washington, DC.

The Leadership Summit will take place Sunday, March 30, and will focus on the theme of building leadership skills and emotional intelligence. Presenters for the event will include: Bruce Gewertz, MD, FACS, a vascular surgeon at Cedars-Sinai Medical Center, Los Angeles, CA; Scott Halford, speaker and author on emotional intelligence, critical thinking, leadership, and influence, Complete Intelligence, LLC, Glendale, CO; ACS President Carlos Pellegrini, MD, FACS; and John Rioux, MD, FACS, Chair of the ACS Governors’ Chapter Activities Domestic Workgroup. The event will again feature breakout sessions by state and/or region. A new session at the Leadership Summit will focus on Chapter Success Stories, during which officers of several ACS chapters will share their chapters’ achievements since the 2013 Leadership Summit.

The Advocacy Summit will immediately follow the Leadership Summit, starting Monday, March 31, with a half day devoted to advocacy education specifically designed to accommodate varying levels of experience. On April 1, ACS members will visit Capitol Hill, where they will discuss with their legislators and congressional staff the many issues affecting surgeons and patients. The ultimate goal of the Advocacy Summit is to prepare participants to become long-term advocates for surgical patients.

Registration for the Leadership and Advocacy Summit is available online. For information on the Leadership Summit, contact Donna Tieberg, Division of Member Services, at dtieberg@facs.org or 312-202-5361. For details on the Advocacy Summit, contact Sara Morse, Division of Advocacy and Health Policy, at smorse@facs.org or 202-672-1512.

massachusetts Chapter celebrates 60th annual meeting

The Massachusetts Chapter of the ACS held its 60th Annual Meeting December 7, 2013, at the Westin Copley Place, Boston. A total of 141 individuals attended the meeting, including 75 residents and medical students. Massachusetts Chapter President Terry Buchmiller, MD, FACS, offered opening remarks and welcomed everyone to Boston. The meeting featured a poster session and a resident paper competition. Guest speaker Frank G. Opelka, MD, FACS, Associate Medical Director, ACS Division of Advocacy and Health Policy, spoke on how the Affordable Care Act will affect surgeons. Other presenters included ACS Governor David McAneny, MD, FACS, who spoke on the new ACS grassroots advocacy program, the Surgeons’ Voice, and Andrew L. Warshaw, MD, FACS, ACS President-Elect, who gave an update on College advocacy efforts. A panel discussion, Examining the Marathon Bombing Response—Why It Was Different than Other Mass Casualty Events, was presented with an introduction by Lisa A. Patterson, MD, FACS, ACS Committee on Trauma State Provincial Chair. Timothy C. Counihan, MD, FACS, chairman, department of surgery, Berkshire Medical Center, Pittsfield, MA, was the panel moderator. The chapter also held its Annual Business Meeting.

The Massachusetts Chapter recently announced that it has renamed its basic science oral presentation award in memory of Joseph E. Murray, MD, FACS, who was a member of the chapter and had received the Nobel Prize for Medicine in 1990. The chapter was honored to welcome Mrs. Joseph Murray; their daughters, Virginia Murray and Katherine Murray Leisure; and Dr. Murray’s assistant, Nancy Erlichman, as guests of the chapter. Francis D. Moore, Jr., MD, FACS, a general surgeon at Brigham and Woman’s Hospital, Boston, was the luncheon speaker and gave a presentation titled Joseph Murray, The Man.

Another highlight of the meeting was the Third Annual Resident Top Gun Competition, in which teams of three general surgery residents from each...
of the 10 training programs in Massachusetts demonstrated their laparoscopic skills, such as extracorporeal knot tying, transferring of objects from one hand to another, and pattern cutting. The winner of the competition was the team from Lahey Clinic, Burlington, comprising Megan Applewhite, MD; Andrew Gagnon, MD; and Victor Kim, MD. The team received the Massachusetts Chapter of the ACS Cup to showcase at their institution for the upcoming year.

The chapter looks forward to its 61st Annual Meeting, December 6, 2014, at the University of Massachusetts Medical School Albert Sherman Center in Worcester. To view the complete program and highlights from the 2013 meeting, go to www.mcacs.org.

**Boston marathon bombing the focus of recent Massachusetts advocacy day**

Surgeons, their colleagues, and staff participated in a November 19, 2013, Advocacy Day at the Statehouse event sponsored by the Massachusetts Chapter of the ACS. Approximately 100 participants gathered in the Great Hall of Flags at the Massachusetts State House, including 60 members of the Massachusetts Chapter, various trauma center professionals, legislators, and legislative aides. The schedule of activities for Advocacy Day focused on The Surgical Experience and Impressions of the Marathon Bombing on April 15. A panel discussion took place, featuring the following: Frederick Heaton Millham, MD, FACS, a general surgeon at Newton-Wellesley Hospital, Waban, and chairman of the State Trauma Committee; George Velmahos, MD, FACS, chief of trauma surgery at Massachusetts General Hospital, Boston; Peter Burke, MD, FACS, chief of trauma services, Boston Medical Center; and Russell Nauta, MD, FACS, a general and critical care surgeon at Mount Auburn Hospital, Cambridge. Steven Baddour, a partner in the law firm of McDermott Will & Emery LLP, Boston, moderated.

In addition, the second Dr. John Collins Warren Award was presented to Robert DeLeo (D), Speaker of the Massachusetts House of Representatives. Massachusetts Senate President Therese Murray (D) presented citations to representatives of all the state’s trauma centers in recognition of their extraordinary efforts in response to the Marathon bombing.

Finally, attendees met with their legislators and/or their staff and distributed a “white paper” outlining the state of Massachusetts trauma plan. To download the white paper, go to www.mcacs.org.

**New Jersey Chapter makes pilgrimage to Dublin, Ireland**

In April 2013, eight surgeons from the New Jersey Chapter of the ACS and their spouses made a pilgrimage to Dublin to visit the Royal College of Surgeons of Ireland (RCSI). The group was hosted by Patrick “Paddy” J. Broe, MB, MCh, FRCS(I), president of the RCSI, who gave a tour of Dublin’s Beaumont Hospital. The travelers were treated to a formal lunch at the RCSI’s headquarters and heard three RCSI paper presentations. The evening’s events included a formal dinner in the Royal College’s private dining hall with Fellows of the RCSI and their spouses.

The following morning, one New Jersey Chapter member had the opportunity
New Jersey Chapter visit to Ireland.
From left: Prof. John Hyland, MB, MCh, FACS, Governor, Ireland Chapter of the ACS; Michael Goldfarb, MD, FACS, chapter President; Steven Binenbaum, MD, FACS, chapter member; Fred Weber, MD, FACS, chapter President-elect and ACS Governor; Louis Ladocsi, MD, FACS, chapter member; Jay Chandler, MD, FACS, chapter member; Michael spedick, chapter vice-President; Steven Fletcher, chapter Past-President; Ronald Chamberlain, MD, FACS, chapter member; Prof. Patrick J. Broe, MB, MCh, Fr Csí, President of the r Csí; and Prof. Pierce Grace, MB, MCh, Fr Csí.

To experience the Irish Health System firsthand. As four of the New Jersey surgeons made their way to play golf, one suffered an acute myocardial infarction. He was quickly taken to a local hospital, resuscitated, and in a very efficient manner was provided with a coronary stent. The patient made an uneventful recovery and was able to return home in a week’s time.

Later in the trip, the New Jersey touring group visited Northern Ireland and learned about “The Troubles.” All tour attendees returned to the U.S. with wonderful memories, a sense of the practice of medicine and surgery on another continent, and the knowledge that they had created warm friendships and bonds with the surgeons of Ireland. This year, the New Jersey Chapter pilgrimage will be to Sicily, Italy. For more information on this upcoming trip, contact Andrea Donelan at the New Jersey Chapter, njsurgeons@aol.com or 973-539-4000.

Wisconsin Chapter holds 2013 Annual Meeting

Tom DeMeester, MD, FACS (left), professor emeritus, department of surgery, Keck school of Medicine, University of Southern California, Los Angeles; and shanu Kothari, MD, FACS, President of the Wisconsin surgical society. Dr. DeMeester was the Beaumont Lecturer for the annual meeting of the Wisconsin Chapter of the ACS, November 8–9, 2013, at the American Club, Kohler, Wi.

Left to right: Dr. Kothari and other Wisconsin surgical society members—Jon Gould, MD, FACS; Guilherme Campos, MD, FACS; Jacob Greenberg, MD, FACS; and Matthew Goldblatt, MD, FACS—enjoy the networking reception at the annual group’s conference.

Michigan Chapter hosts legislators at meet and greet

After a busy day at the State Capitol in Lansing, the Michigan Chapter of the ACS hosted a meet-and-greet reception with legislators on November 13, 2013. At the reception, chapter officers met with a group of state senators, representatives, and legislative aides to discuss health care-related issues up for action in the
current session of the Michigan Legislature. Foremost among the chapter’s goals was to voice strong opposition to the efforts of special interest groups to gut Michigan’s no-fault auto insurance program, which currently protects citizens from dire economic consequences after sustaining catastrophic injury in vehicular accidents. Chapter officers also expressed their unequivocal support for Michigan H.B. 4354, which would shield surgeons and other practitioners who treat emergency room patients from liability lawsuits unless clear and convincing evidence is presented that the provider’s actions constituted gross negligence.

The surgeons also conveyed serious patient safety-related concerns regarding Michigan S.B. 2, which would broadly expand the scope of practice for nurse practitioners. Surgeons and legislators in attendance at this year’s Advocacy Day concurred that it was a mutually beneficial event, one that the Michigan Chapter intends to make an annual occurrence.

affordable Care act and electronic health records focus of keystone Chapter meeting
The 2013 Annual Scientific Meeting of the ACS Keystone Chapter took place November 8, 2013, at the Henry Hood Center for Health Research at Geisinger Medical Center in Danville, PA. More than 90 attendees participated in the event, which included resident paper and poster competitions. Glenn Steele, Jr., MD, PhD, FACS, president/chief executive officer of Geisinger Health System, gave the keynote address on the Affordable Care Act, while Carol Bishop, associate director of practice economics and payor relations at the Pennsylvania Medical Society, led a discussion on meaningful use of electronic health records.

Mark Bowyer, MD, FACS, professor of surgery; chief, division of trauma and combat surgery; and director of surgical simulation at the Uniformed Services University of the Health Sciences, Bethesda, MD, hosted the chapter’s annual Resident Jeopardy Contest. Seven resident teams competed in the contest, with Stanley Ogu, MD, and Nils-Tomas McBride, MD, both representing Easton (PA) Hospital, winning the trophy. Oral and poster abstract winners were Kathryn Jaap, MD, and Ayana Allard-Picou, MD, both from Geisinger Medical Center, taking first and second place, respectively, in the oral competition. Luiz Foernges, MD, of Geisinger Medical Center took first place and Kavita Vakharia, MD, of Hershey Medical Center, took second place in the poster competition.

Connecticut surgical Quality Collaborative meets in conjunction with chapter
The Connecticut Surgical Quality Collaborative (CtSQC) held its quarterly meeting in conjunction with the 46th Annual and Scientific Meeting of the Connecticut Chapter of the American College of Surgeons Professional Association (CTACSPA) in Farmington. Scott Ellner, DO, FACS, vice-chair of surgery at St. Francis Hospital, Hartford, CT, and co-founder of the CtSQC, gave introductory remarks and explained that the collaborative’s next task is to
seek funding from insurance industry partners that benefit from the CtSQC’s work.

Other featured speakers included Robert Brenes, MD, chief resident at Saint Mary’s Hospital, Waterbury, CT, and Philip Corvo, MD, FACS, chairman of surgery at Saint Mary’s and co-founder of the CtSQC. The meeting concluded with remarks from Craig Miller, ACS National Surgical Quality Improvement Program (ACS NSQIP®) Data Manager, concerning newly available collaborative data reports. The CtSQC includes both ACS NSQIP and non-ACS NSQIP institutions and enjoys active participation from 90 percent of the hospitals in Connecticut.

The Annual and Scientific Meeting of the CTACSPA kicked off with a Commission on Cancer session featuring a special presentation by Greer Gay, RN, PhD, Manager, Research Unit, ACS National Cancer Data Base. The program also included a chapter Committee on Trauma meeting, a Senior Surgeons Breakfast, and a Young Surgeons and Residents Breakfast. The meeting’s annual Resident Paper Competition showcased the work of more than 40 residents from programs across the state. Research was presented in the areas of trauma, surgical oncology, general surgery, and specialty surgery. The chapter’s annual James Foster, MD, FACS, Memorial Lecture was presented by Karen Richards, Administrative Director of the ACS Division of Research and Optimal Patient Care, who spoke about the ACS NSQIP.

The lunchtime keynote speaker was Patrick V. Bailey, MD, FACS, Vice-Chair of the American College of Surgeons Professional Association’s political action committee, known as the ACSSPA-SurgeonsPAC. Dr. Bailey presented an insightful report on the College’s advocacy efforts in Washington, DC. The afternoon featured sessions on Social Media for Physicians, Navigating Healthcare Exchanges for Surgeons, Coding for Residents, and How to Choose a Fellowship. The day ended with the Connecticut Chapter’s signature event, the Resident Skills Competition, in which residency program participants compete in laparoscopic and robotic surgical skills challenges. The group from Saint Mary’s Hospital was the champion team for 2013. The Connecticut Chapter also presented its Distinguished Service Award to H. David Crombie, MD, FACS, who, after a distinguished career in surgery, went on to a second career as the editor of Connecticut Medicine, the journal of the Connecticut State Medical Society. The Chapter also presented its Legislator of the Year Award to Prasad Srinivasan, MD (R), the only physician currently serving in the Connecticut General Assembly.

Pennsylvania band promotes “health care with attitude”

“Health care with attitude”—that’s the mantra of five-piece rock band Malpractice, featuring David Dexter, MD, FACS, ACS Governor representing the Northwestern Pennsylvania Chapter and a member of the Governors’ Chapter Activities Domestic Workgroup. Dr. Dexter, a general and trauma surgeon, is the lead singer for a versatile rock group that came together in March 2012 as a “basement band” playing rock music from the 1980s through the 2000s. “It was an idea I had with a hospital administrator to replace a [disc jockey] used routinely at the [University of Pittsburgh Medical Center] Hamot Hospital summer picnic. We recruited...
Northwestern Pennsylvania Chapter. “Malpractice” band members.

Front left, Paul Mirone, MD, family medicine, guitar and vocals.

Back left, Jeff Larson, CRNP at VAMC, bass and vocals.

Center and on table, Mike Marino, lead guitar, is a guitar instructor, but his wife is a uPMC Hamot nurse.

David Dexter, MD, FACS, general and trauma surgeon, lead vocals.

Right with the sticks, Rob Chandler, DO, family medicine, plays drums and vocals.

“Band members, and off we went,” Dr. Dexter said. Band members rehearsed for 11 months before their first public appearance in front of more than 300 people.

The demand for performances by Malpractice has steadily increased, as has the band’s following. They have played numerous gigs since their inception, including a recent fundraiser for the Howard Hanna Children’s Free Care Fund and Shriners Hospital. Requests for the band are now flooding in, with bookings in place through the fall of 2014. The band gave a New Year’s Eve performance, sharing the stage with another local band. Another Howard Hanna fund-raiser is on tap for the band for later this year, and a promotional t-shirt is in the works. The group of five, whose members are mostly in the medical field, seem to have “made it” in the local band community, and Dr. Dexter reports they “will do this as long as we continue to have this much fun.”

Information on Malpractice can be found on the band’s Facebook page at https://www.facebook.com/pages/Malpractice/608721332505528.

A PUBLICATION OF AMERICAN COLLEGE OF SURGEONS PROFESSIONAL ASSOCIATION (ACSPA)

THE ACS ADVOCATE

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editor’s note: Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities. Following are brief excerpts from news stories published from September through December 2013 that mention key ACS programs and initiatives, including research findings that appear in the Journal of the American College of Surgeons, and research highlights from the 2013 Clinical Congress. To access the news items in their entirety, visit the online ACS Newsroom at http://www.facs.org/newsroom/acs-in-the-news.html.

Congress poised to permanently fix its Medicare payment glitch
National Public Radio, December 19

“Still, it’s not yet a done deal. For one thing, while physician groups are united in their opposition to the current payment system, they don’t all agree on the details of the bills that are emerging. The bill approved by the Senate Finance Committee, for example, has drawn the opposition of the American College of Surgeons.

“One big problem is that the bill would freeze physician pay at its current level for the next decade. ’To really... send the message to physicians that things are going to be frozen for 10 years doesn’t seem like an appropriate policy issue,’ says David Hoyt, the group’s executive director.”

Bariatric surgery isn’t “one size fits all”
CNN, December 10

“[Alan Craig] Wittgrove [MD, FACS]’s ground-breaking operation changed all that. More than 90% of bariatric procedures are now minimally invasive, and in-hospital mortality rates have dropped to 0.10%, according to a 2011 study published in the Journal of the American College of Surgeons. [Jaime] Ponce [MD, FACS, president of the American Society for Metabolic and Bariatric Surgery] says laparoscopic bariatric surgery is now as safe as or safer than gallbladder removal, one of the most routine surgical procedures in America.”
Media around the world, including social media, frequently report on American College of Surgeons (ACS) activities.

two medicare incentive programs get a little tougher
Medscape, December 4
“Organized medicine objected to this heavier reporting requirement after CMS [Centers for Medicare & Medicaid] proposed it in July. In a letter to the agency, James Madara, MD, the executive vice president and chief executive officer of the American Medical Association (AMA), called the increase from 3 to 9 quality measures ‘an unreasonable leap’ and suggested setting the new bar at 5 measures. The American College of Surgeons and the American Academy of Family Physicians (AAFP) also questioned the new standard, with the AAFP arguing it would impose more of a burden on primary care physicians than specialists, many of whom will be allowed to report fewer than 9 quality measures because not as many of the measures apply to them.”

Bmi isn’t the main factor in choosing the right weight loss operation
United Press International, November 22
“The study found that patients who exhibited higher levels of uncontrolled eating were more likely to have type 2 diabetes, poorer quality of life, a higher weight loss goal, and greater tolerance for assuming risk and chose to go in for a gastric bypass. While those who chose laparoscopic banding had lower body mass index, patients had similar risk preferences and eating behavior as those who had a gastric bypass....The study is published in the December issue of the Journal of the American College of Surgeons.”

Just say no: 10 Common medical tests that may do more harm than good
Forbes, November 14
“So far this fall, more than 15 medical academies, societies, and colleges, including the American College of Surgeons, the American Academy of Dermatology, and the American Academy of Family Physicians, have released new lists of procedures to be avoided. More than 35 medical groups have now made more than 250 recommendations as part of the campaign, which launched in April 2012.”

how hospitals Can make Quality stick
U.S. News & World Report, November 6
“The best way to improve a hospital’s surgical quality—and sustain that improvement—is through access to timely clinical data, panelists said at a Tuesday afternoon session of the Hospital of Tomorrow, a U.S. News & World Report conference.
The session, called ‘Making Quality Stick,’ highlighted the value of data gathered by the American College of Surgeons...National Surgical Quality Improvement Program ([ACS] NSQIP), a registry that collects clinical, risk-adjusted, 30-day outcomes data used by 500 hospitals throughout the United States.”

tourniquets gain new respect
Wall Street Journal, October 22
“After the Newtown shooting, Dr. [Lenworth M.] Jacobs was among the medical experts asked by the American College of Surgeons and the Federal Bureau of Investigation to draft recommendations for the best way to respond to such events. Those recommendations, called the Hartford Consensus, included a call for wider use of tourniquets.” (Subscription required for viewing.)

double mastectomies may not increase life expectancy
Huffington Post, October 8
“One particular group of women who are opting...
to remove healthy breasts is those who have already been diagnosed with cancer in one breast. In just the last decade, the number of women who, once diagnosed with early stage cancer in one breast, have opted to not only remove the cancerous breast but also their healthy breast has more than doubled.

“Unfortunately, new research presented at 2013 Clinical Congress of the American College of Surgeons shows that opting to do so may only increase life expectancy by a maximum of six months, which is nearly inconsequential when noting that most women survive to live another 20 or 30 years, or more.”

**prophylactic mastectomy offers minimal gain in Breast Cancer**

*Medscape*, October 8

“The survival benefit for contralateral prophylactic mastectomy among women who do not have a BRCA gene mutation is less than 1% at 20 years, a new computer model suggests.... These findings, which come at a time of increasing demand for the procedure by women with cancer in one breast, were presented here at the American College of Surgeons 2013 Annual Clinical Congress.”

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**appendix removal isn’t riskier on weekend, study says**

*U.S. News and World Report*, October 7

“Having your appendix removed on a weekend is as safe as having the surgery on a weekday, but you may end up paying more, a new study shows.

“The findings were to be presented Monday at the annual meeting of the American College of Surgeons in Washington, D.C.”

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**study examines surgery risks in stented patients**

*MedPage Today*, October 7

“The timing of the operation relative to when the stent was implanted was a weaker predictor, and the stent type—drug-eluting versus bare-metal—was not significantly associated with adverse events at all. In addition, whether antiplatelet therapy was stopped or continued was not related to the likelihood of having a MACE after surgery, the researchers reported online in the *Journal of the American Medical Association*. The results were presented simultaneously at the American College of Surgeons meeting in Washington.”

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**5 questions to ask before surgery**

*CNN.com*, September 25

“Dr. Karl Bilimoria, a surgeon at Northwestern University and the American College of Surgeons, advises that identifying and addressing these questions may help ensure a healthy recovery after an operation. In August, Bilimoria and researchers at the American College of Surgeons released an online tool that allows patients, in collaboration with their doctors, to estimate what their risks may be in undertaking an operation.”

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**skin-Cancer groups push for more Checkups**

*Wall Street Journal*, September 2

“While skin cancers such as basal and squamous cell cancers can be disfiguring, they are highly curable. Melanoma is curable if caught early and surgically removed, but can quickly thicken, spread elsewhere in the body and turn lethal. Recurrence of melanoma 10 or more years after treatment is more common than previously thought, occurring in more than 1 in 20 patients, according to a study in July in the *Journal of the American College of Surgeons.”*
MAKE A DIFFERENCE. JOIN US IN WASHINGTON, DC.

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- **Engage** influential decision makers
- **Connect** with ACS leaders and learn how to get involved
- **Lead** discussions on innovative ways to face leadership and surgical challenges
- **Enhance** your leadership skills by attending professional development sessions

The Advocacy Summit part of this event is an opportunity to rally surgery’s collective grassroots advocacy voice. Join discussions with other surgeons, legislators, and health care experts as they examine ways to advocate effectively for legislation that will advance the practice of surgery.

The Leadership Summit part of this event offers attendees the chance to meet with ALL levels of ACS leadership. Attendees will also refine their leadership and social interaction skills via outstanding presentations and participate in regional and state breakout sessions to brainstorm for the year ahead. CME credit will be available for this event.

Visit [www.facs.org/ahp/summit](http://www.facs.org/ahp/summit) for schedule of events, registration, hotel, and contact information.
2014 international scholars and awardees selected

During the 2013 Clinical Congress, the American College of Surgeons (ACS) Board of Regents approved 12 International Guest Scholarships for 2014. The International Guest Scholarship (IGS) program enables talented young academic surgeons from countries outside of the U.S. and Canada to attend and participate in the Clinical Congress and then tour surgical institutions in North America that offer programs that match their professional interests. The College’s International Relations Committee administers the program.

The 2014 International Guest Scholars are: Fernando Bonilla, MD, Montevideo, Uruguay; Roland S. Croner, MD, FACS, Erlangen, Germany (Murray F. Brennan Scholar); Luke Harper, MD, La Montagne, Reunion; Huang-Kai Kao, MD, Taoyuan, Taiwan (Louis C. Argenta Scholar); Subodh Kumar, MB, BS, FACS, New Delhi, India; Keishi Sugimachi, MD, PhD, Beppu, Japan (Elias Hanna Scholar); Stephen Tabiri, MD, Tamale, Ghana; Mallika Tewari, MB, BS, MS, Varanasi, India (Dr. Abdol and Mrs. Joan Islami Scholar II); Dezso Tóth, MD, Debrecen, Hungary; Ioannis K. Toumpoulis, MD, Athens, Greece (Stavros Niarchos Foundation Scholar); Benjamin W. Turney, MB, BCHir, Oxford, U.K. (Dr. Abdol and Mrs. Joan Islami Scholar I); and Carl Wahlgren, MD, Stockholm, Sweden.

The requirements for applicants for the 2015 International Guest Scholarships will be published in a future issue of the Bulletin, and are posted at http://www.facs.org/memberservices/igs.html.

**Pellegrini Traveling Fellow**
The Carlos Pellegrini Traveling Fellow for 2014 is Jiang-Tao Li, MD, of Hangzhou, China. This related program was created via a grant from the ACS China-Hong Kong Chapter as an IGS-like award designated for a surgeon from China.

**Community Surgeons Travel Awards**
The Community Surgeons Travel Awards program is now in its third year. It also enables Clinical Congress attendance for international surgeons. This program permits a broader age range for applicants and does not require an academic or research background.

The 2014 Community Surgeons Travel Awardees are: Vivek Bindal, MB, BS, New Delhi, India (Baxiram S. and Kankuben B. Gelot Awardee); Saud Majid Chaudhery, MB, BS, Islamabad, Pakistan; Eyo Effiong Ekpe, MB, BS, Uyo, Nigeria; Yousuf Aziz Khan, MB, BS, Sindh, Pakistan; Haidar M. Muhsein, MB, ChB, Najaf, Iraq; and Ayodeji O. Oladele, MB, ChB, FWACS, Ile-Ife, Nigeria.
American College of Surgeons Official Jewelry & Accessories designed, crafted and produced exclusively by Jim Henry, Inc.

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<td>#S25 Cross Townsend Medalist with 23/K Gold Plated Emblem $135</td>
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<td>#S14.1 Solid 10K Gold $1650</td>
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<td>#S15 Gold-Filled Emblem $65</td>
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<td>#S29 Gold Electroplated (set of 9) $35</td>
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<td>Miniature Key (Not Shown)</td>
<td>Men’s Bow Tie (Untied) (Not Shown)</td>
<td>Blazer Patch</td>
</tr>
<tr>
<td>#S7 Single Gold-Filled $70</td>
<td>#S22 Dark Blue $35</td>
<td>#S30 Hand embroidered $35</td>
</tr>
<tr>
<td>#S8 Single 14K Gold $450</td>
<td>#S23 Maroon $35</td>
<td>Shipping/Handling/Insurance</td>
</tr>
<tr>
<td>Charm (Not Shown)</td>
<td>Women’s Scarf - Silk (Not Shown)</td>
<td>Domestic (48 contiguous states) $15</td>
</tr>
<tr>
<td>#S9 Single Gold-Filled $75</td>
<td>#S24 36” x 36” cream w/ dark blue and maroon border</td>
<td>Alaska, Hawaii, Puerto Rico $30</td>
</tr>
<tr>
<td>#S10 Single 14K Gold $525</td>
<td></td>
<td>Foreign $40</td>
</tr>
<tr>
<td>Miniature Charm</td>
<td></td>
<td>Form No. 91579-09/13</td>
</tr>
<tr>
<td>#S11 Single Gold-Filled $65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#S12 Solid 14K Gold $350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#S13 Sterling Silver w/ 18” Sterling Silver Necklace $65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#S14-1 Sterling Silver Charm $50</td>
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</tbody>
</table>

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SCHOLARSHIPS

2014 ACS Japan, Germany Traveling Fellows selected

John T. Mullen, MD, FACS, a surgical oncologist at Massachusetts General Hospital and associate professor of surgery at Harvard Medical School, Boston, has been selected as the 2014 ACS Japan Traveling Fellow. As the Japan Traveling Fellow, Dr. Mullen will participate in the annual meeting of the Japan Surgical Society in Kyoto, April 3–5. He will attend the ACS Japan Chapter meeting during that event and will travel to several surgical centers in Japan to interact with his peers and observe surgery.

Jeffrey M. Farma, MD, FACS, assistant professor of surgical oncology, Fox Chase Cancer Center, Philadelphia, PA, has been selected as the 2014 ACS Germany Traveling Fellow. Dr. Farma will participate in the annual meeting of the German Surgical Society in Berlin, March 25–28, 2014. He will attend the ACS Germany Chapter meeting and visit multiple surgical centers in Germany.

Requirements for the Year 2015 Traveling Fellowship to Germany and Japan will be published in an upcoming issue of the Bulletin and will be posted at http://www.facs.org/memberservices/research.html.

Dr. Mullen
Dr. Farma

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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

**FEBRUARY**

**Puerto Rico Chapter**
February 20–22
San Juan, Puerto Rico
Contact: Aixa Velez, genteinc@gmail.com, http://www.acspuertoricochapter.org/

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

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

**Montana, Wyoming, and Idaho Chapters**
February 21–23
Jackson, WY
Contact: Janis Black, jblack@wyosurgeons.com

**New Jersey Chapter**
March 8
Iselin, NJ
Contact: Andrea Donelan, jsurgeons@aol.com, http://www.nj-acs.org/

**7th Annual Consortium Meeting of the aCS-Accredited Education Institutes**
March 21–22
Chicago, IL
Contact: Catherine Wojcik, cwojcik@facs.org

**Medical Disaster Response**
March 30
Las Vegas, NV
Contact: Mary Allen, redstart@aol.com

**Trauma, Critical Care, and Acute Care Surgery**
March 31–April 2
Las Vegas, NV
Contact: Mary Allen, redstart@aol.com

**MINNESOTA SURGICAL SOCIETY**
April 14
Minneapolis, MN
Contact: Nonie Lowry, nonie@lp-etc.com, www.mnsurgicalsoc.org

**North Dakota and South Dakota Chapter**
April 25–26
Sioux Falls, SD
Contact: Terry Marks, tmarks@sdsma.org

**Indiana Chapter**
April 25–26
Carmel, IN
Contact: Carolyn Downing, cdowling@ismanet.org, http://www.infacs.org/

**FUTURE CLINICAL CONGRESSES**

2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL

**MARCH**

**Metropolitan Washington, DC Chapter**
March 8
Washington, DC
Contact: Jennifer Starkey, Jennifer@acschapters.com, http://www.dcfacs.org/

**APRIL**

**Japan Chapter**
April 3
Kyoto, Japan
Contact: Kazuhiko Yoshida, MD, FACS, kaz-yoshida@jikei.ac.jp

**FUTURE CLINICAL CONGRESSES**

2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL