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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
As most of you know, the Surgeons Diversified Investment Fund (SDIF) was closed on April 20. The decision to close the fund was, in part, the result of a motion that the American College of Surgeons leadership made to the Board of Trustees of SDIF. The College’s recommendation came after months of carefully analyzing the current market conditions and the odds of improvement in the near future. Based on the evidence presented at its February meeting, the ACS Board of Regents concluded that the ongoing costs associated with SDIF were prohibitive at a time when the nation’s economic outlook is murky. In the end, the Board of Trustees of SDIF agreed with our recommendation and the fund was closed.

The questions we raised in making this decision are reflective of the ones we as individuals and as members of the medical professions must ask ourselves every day: How can we make the best use of our resources? What investments are wisest during an economic downturn? How can we cut waste? Where can we get help?

**SDIF**

The College created SDIF to help surgeons and residents attain a level of fiscal security in an era of rising practice expenses and dropping reimbursement. At the time, the financial markets were doing well, so it made sense to offer our members an opportunity to participate in a mutual fund specifically designed for surgeons.

The concept of SDIF was overwhelmingly supported by the ACS Board of Governors and the Board of Regents at the onset of its development and before its launch on September 22, 2006. SDIF’s initial performance was remarkably strong. The fund’s total return from September 22, 2006, to June 30, 2007, was considerably greater than the Standard & Poor’s 500/Lehman Brothers U.S. Combined Aggregate Index during the same period. SDIF returns continued in this positive direction until the summer of 2008, when the nation’s economy started its dramatic descent. In the third quarter of 2008, SDIF returns declined 10.11 percent, compared with a 6.01 percent drop in the Standard & Poor’s index. SDIF’s underperformance is attributable to its high exposure to international, emerging equity, and energy and commodities markets. Fourth quarter returns were also negative.

Ultimately, the Regents decided the time had come to recommend a liquidation of SDIF. Upon the closing of the fund, the College and SDIF representatives reached out to shareholders and urged them to redeem their shares.

**The broader view**

The economic downturn has forced most Americans to rethink how they spend and invest their money. People are cutting back on non-
essential goods and services and moving their savings into low-risk accounts. We are entering an age of newfound fiscal prudence and personal responsibility.

The ongoing belt tightening and cost cutting affect surgeons and other health care professionals and institutions on a number of levels. For instance, many businesses are being forced to lay off workers. Newly unemployed people are faced with the choice of buying into expensive COBRA plans (named for the law that established them, the Consolidated Omnibus Budget Reconciliation Act of 1986) or doing without health insurance coverage until they find another job at a company or organization that may or may not provide medical benefits. Some people in these circumstances (particularly individuals between the ages of 18 and 35) are opting to forgo insurance. Consequently, our nation’s medical and trauma centers are experiencing a rise in uncompensated and charitable care.

Furthermore, patients are postponing physician visits because they are worried about taking time off from work or about out-of-pocket expenditures. These patients often wait until their condition has become intolerable. Usually when an illness has reached this point, patients require expensive emergency care or must undergo extensive treatment involving costly resources.

In response to these problems, government and private payors are looking for ways to eliminate any wasteful spending that may exist. Hence, we are likely to see more bundled payments and gainsharing—concepts discussed previously in this column.* We also are going to need to participate in outcomes studies that will enable all stakeholders to determine which treatments are most cost-effective and will best serve the interests of our patients. And, we will need to take steps toward implementing electronic medical records, which are expected to help us avert costly errors and redundancies in care.

Physicians and patients will need to work together to make health care decisions that will yield value-based care. As medical professionals, we must serve as trusted advisors on preventive care and evidence-based treatment plans.

**Promising future**

The College is committed to helping its Fellows and Resident and Associate Members manage existing and prospective challenges. We chose to recommend the elimination of SDIF because it just wasn’t the right service for these times. Whereas we regret having to make this decision, we believe the College’s financial resources are better directed at the development of services, projects, and conferences that will enable surgeons to maintain their practices and financial solvency now and in the future. These efforts include further developing the American College of Surgeons National Surgical Quality Improvement Program as an outcomes-measurement tool, continuing to work with coalitions and consortia dedicated to improving quality and cost-effective care, becoming a more influential voice in the federal government’s efforts to reform health care and the Medicare physician payment system, and so on.

This nation—indeed, almost every developed country in the world—is going through a discouraging economic period, and we are all going to need to make some sacrifices for a while. But we have endured crises in the past only to emerge stronger and more robust than before. I believe this will happen again if we all take proactive and productive steps to prepare for the future.

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*See page 4 of the January 2009 Bulletin.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized the Centers for Medicare & Medicaid Services (CMS) to develop an incentive program for electronic prescribing, or e-prescribing. E-prescribing is defined as “the ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care.”* E-prescribing was quality measure 125 in the 2008 Physician Quality Reporting Initiative (PQRI); however, CMS has removed the measure for the 2009 PQRI and implemented a separate incentive program modeled after it. This revised approach allows eligible professionals to potentially be able to qualify for two incentive payments in 2009—one for participation in PQRI and one for e-prescribing. CMS’ goal in creating an incentive program for e-prescribing is to advance quality through safer, more coordinated prescription writing.

Who is eligible to participate in this program?

Eligible professionals are medical professionals for whom services listed in the CMS e-prescribing measure specifications represent at least 10 percent of their Medicare charges—that is, physicians, physical and occupational therapists, qualified speech-language pathologists, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals, and qualified audiologists. To view the CMS e-prescribing measure specifications, go to http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage.

How does one begin participating in this program?

There is no registration process for participating in the e-prescribing program. Simply begin reporting the measure in 2009 using the Medicare claims process.

What is the reporting period?

The e-prescribing reporting period is January 1 through December 31, 2009.

What are the incentive amounts?

For 2009, the incentive amount for e-prescribing is 2 percent; however, the Table below shows the changes for each year. Starting in 2012, there will be a penalty applied to those eligible professionals who are not e-prescribing.

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<thead>
<tr>
<th>Year</th>
<th>Incentive</th>
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<tbody>
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<td>2009</td>
<td>2.0%</td>
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<tr>
<td>2010</td>
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<td>2014 and beyond</td>
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Who will benefit from e-prescribing, and how will they be rewarded?

Four stakeholder groups—patients, payors, providers, and pharmacies—may benefit from e-prescribing. An e-prescribing system will help reduce patients’ out-of-pocket costs, improve their safety, and make filling prescriptions more convenient because they will no longer need to keep track of a paper script. Pharmacies will...
have the prescription in the system immediately. E-prescribing will make payors’ jobs easier as adverse medication errors are reduced and formulary compliance is increased, both of which will reduce costs. Providers will gain priceless time from e-prescribing, as the system will reduce administrative issues, illegible scripts, incorrect dosage, and drug selection. Lastly, e-prescribing will affect pharmacies by increasing coordination and clarification with providers while decreasing dispensing errors and costs.

How can an eligible professional e-prescribe successfully to receive the incentive amount?

For the 2009 reporting period, an eligible professional must report, using a qualified e-prescribing system, the e-prescribing measure in at least 50 percent of the cases in which the measure is reportable.

What are the 2009 system requirements?

According to the CMS e-prescribing measure specifications, a qualified e-prescribing system is one that is capable of the following:

• Generating a complete active medication list, incorporating electronic data received from applicable pharmacies and pharmacy benefit managers if available
• Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts
• Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
• Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan

What are the denominator codes?

The denominator codes for the e-prescribing measure are as follows: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, and G0109.

What are the numerator codes?

• G8443: All prescriptions created during the encounter were generated using a qualified e-prescribing system
• G8445: No prescriptions were generated during the encounter; provider does have access to a qualified e-prescribing system
• G8446: Provider does have access to a qualified e-prescribing system; some or all prescriptions generated during the encounter were printed or phoned in as required by state or federal law or regulations, patient request, or pharmacy system being unable to receive electronic transmission, or because they were for narcotics or other controlled substances.

Can an eligible professional report the e-prescribing measure for office visits as part of a global surgical package?

No, an eligible professional cannot report in this manner; only separately payable office services count toward the 10 percent of Medicare payments that determines one’s eligibility.

Can an eligible professional still report the e-prescribing measure in 2009 PQRI?

No, the measure cannot be reported in 2009, as the e-prescribing measure has been removed from the list of 2009 PQRI measures.

Do controlled substances count as part of the e-prescribing incentive program?

No, controlled substances do not count in this case, because the Drug Enforcement Agency (DEA) bans e-prescribing for controlled substances. However, the DEA has issued a proposed rule to permit e-prescribing for controlled substances under certain circumstances. Using G-code G8446, an eligible professional can report on the e-prescribing measure for controlled substances without using an e-prescribing system to do so.

Does an eligible professional have to participate in the PQRI to participate in the e-prescribing program?

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A combat surgeon remembered:

MAJ John P. Pryor, MD, FACS

by Stephen J. Regnier, Editor
Tell them of us and say:  
“For your tomorrow we gave our today”

—WWII Memorial

Editor's note: The following article is respectfully dedicated to all those men and women in our armed services who put themselves in harm’s way for the cause of freedom and to those individuals who have paid the ultimate price in the service of their country.

John P. Pryor, MD, FACS, 42, of Moorestown, PA—leader of the University of Pennsylvania’s trauma team and a decorated major in the U.S. Army Reserve Medical Corps—was killed by mortar shrapnel on Christmas Day 2008 in Iraq while serving as a combat surgeon. It was his second tour of duty in Iraq.

Dr. Pryor was the third American surgeon to die in combat in Iraq since the war began in March 2003. MAJ Mark D. Taylor, MD, 41, was killed when a rocket hit his living area in Fallujah on March 20, 2004. COL Brian D. Allgood, MD, 46, was senior medical officer in Iraq at the time of his death on January 20, 2007, resulting from the crash of a UH-60 Black Hawk helicopter.*

Dr. Pryor became a Fellow of the American College of Surgeons in 2003. By all accounts, he was a gifted surgeon with a keen sense of adventure. He traveled to Ground Zero on September 11, 2001, to volunteer his services and wound up deciphering and filling medical requests transmitted over rescue team radios. Dr. Pryor was a talented writer and a frequent contributor of opinion pieces to the Philadelphia Inquirer and the Washington Post. He was often interviewed by National Public Radio and ABC News.†

Following are the thoughts and remembrances of a number of friends and colleagues—including two prominent trauma Fellows (see sidebars on pages 10 and 11)—who knew Dr. Pryor as an insightful writer and speaker, a superb trauma surgeon with a gentle bedside manner and love for humanity, and a devoted family man.

SUNY Buffalo

James Hassett, MD, FACS—professor of surgery and vice-chair of education at the State University of New York (SUNY)—Buffalo—first met Dr. Pryor, then a third-year medical student at SUNY, in 1993. Dr. Hassett was the surgical clerkship coordinator.

“John was an exceptionally bright student,” Dr. Hassett said. “He demonstrated his skills in every venue and at every opportunity.” Dr. Pryor was in the 91st percentile in the U.S. Medical Licensing Examination 1 and received honors in virtually every clerkship. He was committed and engaged at the highest levels in multiple activities, according to Dr. Hassett.

Dr. Hassett became the associate program director of the surgical training program during Dr. Pryor’s first postgraduate year and continued in that capacity during his entire residency.

“Frankly, John Pryor was the best resident in his year group and our best resident over a 10-year time frame. His professional demeanor and clinical acumen were outstanding,” Dr. Hassett said. The surgical training department’s executive committee recognized Dr. Pryor’s skills, maturity, common sense, and professionalism by selecting him as its administrative chief resident. Dr.

†Visit www.drjohnpryor.com/links.cfm for samples of Dr. Pryor’s articles and interviews.
Hassett added that he encouraged Dr. Pryor to pursue an academic career and was happy to support his application for fellowship at the University of Pennsylvania, Philadelphia.

As a student and resident, Dr. Hassett knew Dr. Pryor to be bright and clinically gifted. He believes Dr. Pryor possessed four traits that made him both unique and successful: he engaged the world and his professional activities with a great deal of enthusiasm, he had the ability to express himself in a clear and precise way, he was a genuinely nice person who gave the best that he had and got others to do likewise, and he was unafraid and fearless when he thought he was right.

Dr. Hassett followed Dr. Pryor’s career as a fellow and member of the faculty at the University of Pennsylvania. “We invited him back to Buffalo to share his experiences with the surgical and academic community,” he said. “He was a hit.”

University of Pennsylvania

Dr. Pryor arrived at the University of Pennsylvania in 1999. After his fellowship in trauma surgery and critical care, he joined the faculty of the department of surgery and was serving as the trauma program director for the Hospital of the University of Pennsylvania (HUP) when he was deployed.

“JP was a magical man, with boundless energy and goodness,” said C. William Schwab, MD, FACS, chief of the division of trauma and critical care and one of Dr. Pryor’s mentors. “He was a devoted son, husband, father, colleague, and friend.

Into the heart of danger

John died doing what he was genetically programmed to do—care for his fellow men and women, give them a chance at survival and recovery, and return them as a functional member of society. John trained in his chosen profession to be the medical adventurer—that is an understandable underlying and unquenchable force that is present in each of us. Going to the heart of danger, both in the large inner-city hospital as well as in a war in way-off lands, we see the toughest of the tough; in the task that others might retreat or shirk from, John found his peace while attempting to piece together the most complex of cases.

John understood the illogic of his chosen field of trauma surgery. He understood that the streets of Philadelphia were just as dangerous as the venues of hostility in a country at war. He understood that he was predestined to be in the heat of the battle, whether it be Philadelphia or Mosul. It was his fate to patch up the secondary effects of man’s inhumanity to man. Yes, in an ideal world, preventive strategies would completely eliminate the area of surgical skill where John was most skilled and comfortable, but the need for John Pryors in the future will never be eliminated. Now and for the long foreseeable future, the acute care trauma critical care surgeon will be at the pinnacle of physicians in demand and needed in communities around the world, especially the U.S.

John represents the kind of surgical spirit that all surgeons possess. Yes, John Pryor has the trauma surgeon’s genome. There is no need for question or discussion. We each in our own way know exactly why John was in Iraq. On another day, the loss could have been any one of us.

To John:

As a soldier, we respect and salute you.
As a teacher, we seek to emulate you.
As a visionary, we support you.
As a surgeon, we recognize your master skills
As a human, we applaud and memorialize your unique and lasting contributions.

We each will rededicate our genetically predetermined professionalism to be built on the foundations of your work.

—Kenneth L. Mattox, MD, FACS, Houston, TX
He was an outstanding physician, gifted surgeon, teacher, and mentor. At his core were many great values, but his passion for service to others stood out to each and every one of us, every day.”

In Dr. Schwab’s office hangs a favorite quote, by Albert Schweitzer, that he believes captures the essence of John Pryor:

….Seek always to do some good, somewhere. Every man has to seek in his own way to realize his true worth. You must give some time to your fellow man. Even if it’s a little thing, do something for those who need help, something for which you get no pay but the privilege of doing it. For remember, you don’t lie in a world all your own. Your brothers are here, too.

Dr. Schwab noted that Dr. Pryor’s sudden death while serving as a physician on the battlefield “is a very personal loss for the many of us who have worked side by side with him in our emergency department, operating rooms, and intensive care units. All of us have lost one of our brothers.”

To hold the torch

Michael F. Rotondo, MD, FACS, first met Dr. Pryor in 1998 when he was an associate professor, vice-chief, and trauma medical director in the division of traumatology and surgical critical care in the department of surgery at HUP. Dr. Pryor was applying for a fellowship in trauma and surgical critical care and was interviewed by Dr. Rotondo.

“It did not take but a few moments to realize that he was incredibly hard-working and dedicated. But more than that, he had a special quality that immediately won me over. He was down-to-earth, passionate, caring, and, in his own way, he was everyman,” Dr. Rotondo said.

The year Dr. Pryor began his fellowship, Dr. Rotondo left to take a job as vice-chair and trauma chief at East Carolina University School of Medicine, Greenville, NC. However, he was able to follow Dr. Pryor’s professional progress through happenstance meetings and Dr. Rotondo’s continued ties with the university. Soon after Dr. Pryor took his first academic job at University of Pennsylvania, he would frequently call Dr. Rotondo for advice on either clinical or administrative matters. “I was always impressed with his willingness to learn and his zeal to improve himself. In his own way, he always made me feel valued by his interest in learning from me,” Dr. Rotondo said.

Invariably, Dr. Rotondo noted, Dr. Pryor would say “I won’t let you down…” or imply in some way that he had taken up the cause for excellence in care of the injured.

In his informal discussions with Dr. Schwab, they often spoke about Dr. Pryor as being in line of succession of important leaders in trauma care. “He would repeatedly pledge over and over his commitment to excellence and attention to detail on behalf of the patients. He cared about the work in a unique and special way,” Dr. Rotondo said.

By way of demonstrating Dr. Pryor’s awareness of the importance of the work that trauma surgeons do, Dr. Rotondo shared an e-mail that Dr. Pryor had sent out to his partners soon after his wife, Carmela, was hospitalized for a serious, life-threatening pelvic fracture after a car crash. Dr. Rotondo saved the e-mail because it meant so much to him. “It speaks volumes about John,” Dr. Rotondo said.

Subject: Thank You

Consider this my feeble attempt to thank you for everything you did for my wife Carmela, our children, and me during this unfortunate event.

When you work in a hospital, or a business, or a restaurant, you often tout your shop as the best—you call your partners the best and you lavish praise on the product, regardless of how
seriously you believe it to be true. When faced with a medical emergency with a family member as I was, the immediate reaction is to mobilize the best medical team possible. All thoughts of being polite, or having people involved because it is courtesy, or appropriate because you work with them, go straight out the window. Your mind immediately makes an assessment and you decide who the very best medical professionals you want to care for the most important person in your life, no matter if they are in your division, hospital or even specialty.

On Thursday, without hesitation, I wanted my wife brought directly to HUP and cared for by you. To be completely honest, I made a quick list of who I wanted in that trauma bay, and it was every single one of you. There were no gaps, no adjustments needed to the system, no resource human or other that I needed to mobilize other than getting her here. Standing in the trauma bay as a husband and observer, I felt no fear. I was completely at rest and I believed that she could not die because she was in your hands.

Curiously, the overwhelming emotion I had during this first day was pride. I looked at Dustin, Munish, Pat Kim, Adam, Jose running the code and it suddenly dawned on me that I had a hand in training this entire team. Without the ability to do anything, I was forced to just watch with such emotion as you all went on the same way you do 3,000 times a year, this time under the added pressure of the unusual situation. I love every single one you guys.

In the subsequent days I realized something else. We all have family, and we are all colleagues. Over the last days I feel that you are my family, as dear to me than anyone that I share a name with. I could not have made it without you, and I will not make it through the next few months without you.

Words will never be able to convey my gratitude—instead I promise to continue to work as hard as I can every single day to hold the torch that was ignited by Dr. Schwab and carried by Mike Rotondo…and continue to make this the best trauma center in the United States of America. I pray to God none of you ever need the services that we needed, but if anything like that is in the cards—I will make sure we (and the system) are all here for you.

—JP

A few days after Dr. Pryor died in the line of duty, Dr. Rotondo received word that his wife, Carmela, wanted to speak with him. Dr. Rotondo recalls that “her emotions were raw with grief,” but among other things she shared with him was that John considered him to be one of his principal role models.

“Though on some level I knew this to be the case, it was gripping and heart-wrenching to hear her say it, nevertheless. What greater and more humbling honor,” Dr. Rotondo said. “More importantly, how tragic and sad to have lost a man who in so many ways personified all that is right and good and just in human existence.”

Abu Ghraib

CAPT John Pryor was set to arrive in Baghdad the day MAJ Brad R. Wenstrup, MD, chief of surgical services at the 344th Combat Support Hospital (CSH), was going on two weeks’ leave. He and Dr. Pryor met at the Baghdad airport on February 22, 2006. “John showed how he proved to always be—polite, kind, excited to share his skills with all, and to learn whatever he could,” Dr. Wenstrup said.

A sense of humor can go a long way in a place like Abu Ghraib, according to Dr. Wenstrup, and in spite of the serious nature of the work, Dr. Pryor showed that he liked to laugh, and to make others do the same. The day Dr. Wenstrup returned from leave, Dr. Pryor was already
giving a grand rounds presentation. “John was gracious enough to welcome me back during the presentation and proceeded to tell everyone he had a photo of me on the beach while on leave,” Dr. Wenstrup said. Dr. Pryor then showed a Photoshopped photograph of Dr. Wenstrup, well-built and wearing a camouflage thong. “I knew it was going to be great to work with this guy,” he said.

Dr. Pryor was promoted from captain to major during his 2006 tour.

“All great teachers are great students too, and there was no ego involved with John’s work,” Dr. Wenstrup said. “He always accepted input from others, recognizing that each and every person had something to teach and share. I believe that John had great respect for the talents that God gave him and that his skills should be put to use and shared with others. Any time one worked with John, he or she came away with some new knowledge.”

The 344th CSH had been in Iraq for nine months before Dr. Pryor arrived. Dr. Wenstrup noted that “our spirit and morale were still high and John took advantage of that.” Dr. Pryor immediately began instructing all medical personnel to develop skills they might need at some point in their careers. He arranged for every medical assistant, medic, or nurse to become proficient in suturing techniques. He set up workshops to teach them.

When an American troop died at the CSH, which was rare, it seemed that Dr. Pryor took it personally. “I think John saw his saves as just doing his job. When nothing more could be done, John felt pain,” Dr. Wenstrup said. “I never had the slightest doubt that those soldiers lost had gotten every last bit of John’s energy and skill in the effort.”

Dr. Wenstrup said he believes that sometimes we find ourselves imitating those individuals we respect, and sometimes we do it unknowingly. “When I returned from Iraq, I often found myself saying, ‘That’s good stuff.’ I quickly realized where I learned that expression,” he said. “Thank you, John.”

Memorial fund

Dr. Pryor is survived by his wife, Carmela V. Calvo, MD, a pediatrician at St. Christopher’s Hospital for Children; a daughter, Danielle; sons, Francis and John Jr.; a brother, Richard; and his parents, Richard C. and Victoria.

A fund has been established to help his family. Donations may be directed to UPHS-Dr. John Pryor Fund, Ste. 750, 3535 Market St., Philadelphia, PA 19104-3309.
Bridging the gap between public health and surgery:
Access to surgical care in low- and middle-income countries

by Doruk Ozgediz, MD, MSc; Peter Dunbar, MD; Charles Mock, MD, PhD; Meena Cherian, MD; Selwyn O. Rogers, Jr., MD, MPH, FACS; Robert Riviello, MD, MPH; John G. Meara, MD, DMD; Dean Jamison, PhD; Sarah B. Macfarlane, MSc; Frederick Burkle, Jr., MD, MPH, DTM; and Kelly McQueen, MD, MPH, PLLC
Traditionally, public health in low- and middle-income countries (LMICs) has focused on low-cost, low-technology, preventive measures and primary health care. In contrast, surgery is perceived as a higher-cost, higher-technology, curative, individually focused intervention. Recent evidence, however, has documented the cost-effectiveness of essential surgical care in LMICs, and the concept of surgery as a population-based, preventive strategy is slowly becoming acknowledged within the public health community.1,2 The overall burden of disease that may be cured, palliated, or treated with surgical intervention is large and, arguably, rapidly growing—therefore, the utility of essential surgery must be revisited. Prominent public health experts, as well as surgeons, have also recently called attention to the longstanding neglect of surgery within global health and its crucial role in meeting the United Nations Millennium Development Goals (MDGs).3-5

With growing interest among the surgical and public health communities and publications stressing the need for additional evaluation, a working group of physicians, economists, epidemiologists, public health specialists, and other scholars formed over the last several years and convened in Seattle, WA, April 16–18, 2008. This Burden of Surgical Disease Working Group (BoSDWG) included members primarily from North American academic institutions, not-for-profit humanitarian organizations, and the World Health Organization (WHO), all engaged in research, training, and delivery of surgical services in LMICs. The major goals of the BoSDWG were to initiate discussion of essential questions related to global surgery, including the following:

1. What is the burden and distribution of surgical disease in LMICs?
2. What fraction of this burden is met by services currently provided, and what is the resulting unmet surgical need?
3. What contribution in training and service delivery is specifically made by the humanitarian sector?
4. What is the cost-effectiveness of surgical care and what additional resources (human, financial, physical) would ensure that patients in LMICs have more equitable access to surgical care?
5. How can essential surgical services be integrated into routine health systems surveillance and evaluation to measure “surgical indicators” for health services?

This article points to recent literature that begins to address these questions; summarizes conclusions, recommendations, and actions of the first BoSDWG meeting; and invites the global surgical community to engage in these efforts.

Global surgical initiatives

The questions concerning global surgery require a multidisciplinary approach, and a number of initiatives are already under way. The inclusion of chapters on surgery, emergency medical systems, and injury in the second edition of Disease Control Priorities in Developing Countries indicate that these services are recognized as essential components of health systems.1,4 Emergency obstetric care and essential trauma guidelines have also both been used to evaluate surgical needs in LMICs.7,8

The WHO Global Initiative on Emergency and Essential Surgical Care coordinates collaborations and reviews progress on universal access to emergency, surgical, and anesthesia services in LMICs. The WHO Integrated Management for Emergency and Essential Surgery toolkit provides guidance on policies, training technologies, and research focused on health systems strengthening through primary health care.9 Meanwhile, the recently launched WHO Safe Surgery Saves Lives initiative will review and promote policies, personnel, and equipment to improve patient safety.10 In addition, the Bellagio Essential Surgery Group—co-organized by the University of California–San Francisco, the Karolinska Institute, and several African centers—met again in July 2008 to discuss improving access to surgical services in Africa.11 The Center for Surgery and Public Health at Harvard University and Partners in Health are developing programs in global surgical delivery, training, and research.5,12 Global Partners in Public Health Informatics at the University of Washington has also focused on informatics in low-resource settings.13 The BoSDWG seeks to complement these and other initiatives in addressing the aforementioned questions.
The global burden of surgical disease

The initial Global Burden of Disease (GBD) Study was intended to evaluate the causes and consequences of 109 conditions and was unique in estimating not only mortality but also morbidity for designated conditions in disability-adjusted life years. Data from the GBD study have been updated and extended to 140 conditions and allowed for estimation of burden by selected risk factors (such as tobacco consumption, alcohol, and air pollution). Another round of estimates is under way and will maximize what can be learned from these data.

Previously, the GBD has been measured by the burden of specific conditions rather than by intervention category—in other words, the burden of disease avertable through specific interventions as opposed to the burden resulting from specific conditions. Surgery represents one of the many possible intervention categories; others include vaccinations, antimalarial treatment, and antiretroviral chemotherapy. Estimates of disease burden addressable by vaccination are comparable to current estimates addressable by surgical services. Measurement of the burden of disease avertable by surgery would allow comparison with other priority health interventions in LMICs.

As a first estimate, 11 percent of the GBD can be treated with surgery. This figure comprises injuries (38 percent), which account for the greatest surgical burden; malignancies (19 percent); congenital anomalies (9 percent); complications of pregnancy (6 percent); cataracts (5 percent); and perinatal conditions (4 percent). As part of this study, 18 surgeons around the world estimated the fraction of each disease in the GBD that was amenable to surgical treatment. While this was a useful first estimate, a more formal evaluation is necessary. Subsequent population-based surveys have suggested a potentially greater burden, which corresponds to observations of clinicians in the BoSDWG.

Furthermore, road traffic crashes and noncommunicable diseases—such as cardiovascular diseases, diabetes, and some cancers—in LMICs are projected to rise rapidly, depending on their rates of epidemiologic transition.

Some conditions that can be treated with surgical intervention were not part of the initial GBD study, and these conditions require a more comprehensive review. For example, it may be possible to estimate the burden of some common emergency surgical conditions, such as incarcerated hernias, bowel obstruction, and intestinal perforation. As part of further assessment of surgical burden, it will also be important to identify (and perhaps reclassify) problems such as obstetric fistulae that the GBD classifies as “sequelae” rather than “conditions.”

Measurement of surgical burden cannot begin without definitions, as emphasized in a recent feature in the Bulletin. The BoSDWG suggested a modification to the definition of a surgical condition from the Disease Priorities in Developing Countries study as follows: “any condition for which the most potentially effective treatment is an intervention that requires suture, incision, excision, manipulation, or other invasive procedure that usually, but not always, requires anesthesia.” This definition must be reviewed by a more globally representative group, and the implications of the definition must be carefully considered.

The proliferation of “vertical” programs in public health (including child health, maternal health, cancer, and trauma), many of which include effective surgical care, has also made it difficult to develop a coordinated approach. Surgical care intersects with many disease-focused programs. For example, a prospective study of children extrapolated that 85 percent of children will require surgical care by age 15. Of all surgical conditions, there has been considerable attention paid to emergency obstetrical care, in part because of the MDG to reduce maternal mortality. The cross-cutting nature of surgery suggests that improved surgical care will strengthen health systems overall and enhance progress toward achieving the MDGs.

Access to surgical care in LMICs

The burden of disease avertable through surgical care is a major unknown. In addition, there has been no systematic measurement of the met and unmet need for surgical care.

Rates of major surgery per unit population in low-income countries lag far behind high income countries (less than 1 percent). In LMICs, measurement is often limited to a hospital logbook.
that records procedures and immediate perioperative mortality. As a first step, retrospective data have recently been used to estimate the volume, composition, and global distribution of operations, using modeling techniques, but only 29 percent of countries had data on surgical volume.

With the exception of cesarean sections, there are no reliable estimates of the unmet need for routine operations, such as hernia repair, appendectomy, or bowel obstruction. Since the incidence, natural history, and epidemiology of these conditions has not been studied in LMICs, the incidence from high-income countries is extrapolated. Meanwhile, studies documenting varied disease epidemiology in high-income versus low-income countries challenge the validity of this extrapolation.

A further limitation of facility-based data collection is that the majority of patients with surgical conditions never reach a health facility. For example, surveys have shown that only one-third of injured patients reach a health facility in rural areas of LMICs. Surveys could be performed for specific “tracer” surgical conditions, such as hernias, or for other surgical conditions in aggregate. A significant challenge is that mortality data are much more available than morbidity data, as very few studies capture long-term disability associated with surgical conditions. The augmentation of mortality data with morbidity data should also be a focus for future efforts.

The science of health metrics is gaining increased importance.

Global Burden of Surgical Disease Working Group

The ACS is pleased to host the second annual meeting of the Global Burden of Surgical Disease Working Group (BoSDWG) in Chicago, IL, May 20–22, 2009. The BoSDWG is a collaboration of multidisciplinary professionals committed to establishing and maximizing the role of surgical care in addressing health care disparities in developing countries. The BoSD and ACS Operation Giving Back share a common commitment to enhanced global health through strategic engagement of the surgical community and strongly complement each other.

Kathleen Casey, MD, FACS, Director of Operation Giving Back, has been involved with the BoSD since its inaugural meeting. In her view, “The ACS is blessed with thousands of members who are passionate about the role of surgery on the global stage. With so many who are actively involved in international partnerships and outreach efforts, our collective wisdom can contribute to a better understanding of the scope of the situation, the utility of existing efforts, and where additional work or new approaches are needed. Surgical volunteers are well positioned to actively contribute to this work. We look forward to the deliberations of the 2009 meeting to identify ways to engage ACS members in the ongoing assessments of need and implementation of solutions.”

Thomas R. Russell, MD, FACS, Executive Director of the ACS, concurs: “The ACS advocates and works for access to quality, safe and appropriate surgical care. We support these dedicated professionals who have come together from an array of disciplines to examine and implement ways to execute that goal across a spectrum of health care settings.”

If you would like to join the ongoing efforts of this group, please contact Dr. Casey at kcasey@facs.org or 312/202-5458, or Kelly McQueen, MD, at kmcqueen@gmail.com.
in global public health to measure the effectiveness of health systems as well as the impact of health reforms and donor programs on health service delivery. The concept of “effective coverage” of essential health interventions is critical to this effort and its application to surgery has been explored by the BoSDWG, but further refinement and primary data are needed.

Surgery as a part of humanitarian service delivery

Many humanitarian nongovernmental organizations (NGOs) provide surgical services to vulnerable populations in LMICs. The impact of these organizations on the global burden of surgical disease has yet to be more formally evaluated. There have been preliminary estimates of the contribution of international volunteers to the health care workforce in Africa and of the impact of medical missions, but not all specific to surgical services. The few private and volunteer organizations that track patient data and outcomes usually use this information for internal resource planning. One U.S.-based organization has initiated electronic data collection and may soon offer this low-cost model to other NGOs.

Understanding the collective contribution of the humanitarian community would further measure whether the need for surgical services is met and the humanitarian sector’s impact on the global health workforce. These organizations also can share their lessons for cost-effective, sustainable service delivery and training of local personnel in austere medical environments. Greater coordination between these organizations would also identify regions with the greatest need and has the potential to provide primary data on regional rates of disease and outcomes of care.

Economic evaluation of surgical services

Since surgical services have generally not been considered a cost-effective intervention in LMICs, recent studies documenting the cost-effectiveness of essential surgical care have kindled interest within the public health community. In fact, the 2008 Copenhagen Consensus included surgery in its list of priority investments for the world’s poor.

These prospective studies of costs and outcomes of procedures in small hospitals must be more carefully evaluated and perhaps piloted elsewhere to validate these findings. This will also help define the role of surgery as part of the “minimum package” of health services to shape health policy in many LMICs. This package was initially estimated at $34/capita by the Commission on Macroeconomics and Health, but this estimate included emergency obstetric care as its only surgical input.

Another target for the BoSDWG is the development of “surgical indicators” to evaluate surgical services. These indicators could be integrated into a country’s health information systems, demographic health surveys, or the newer IN-DEPTH network of 37 international demographic surveillance sites. The surveillance sites are newer prospective population cohorts in sentinel locations in Africa that monitor key public health indicators. Even if these surveys only included one or several tracer surgical conditions, it would be a starting point to evaluate access to surgical care more systematically.

Actions of the BoSDWG

The BoSDWG hopes to collaborate with existing surgical initiatives to advance the evidence base for surgery as a component of public health. Several specific areas of focus included the following:

1. Definition of key surgical concepts with language meeting with consensus approval
2. Determining and advocating for methods to measure access to surgical care
3. Priority-setting for surgical procedures in resource-constrained settings
4. Evaluation of existing surgical evaluation tools and testing these tools with tracer conditions
5. Engagement of the NGO community to track and evaluate surgical data

A follow-up BoSDWG meeting is planned for spring 2009. To date, the BoSDWG has been a small U.S.-based group, and although many authors of this article and participants have contacts and relationships in LMICs, the BoSDWG recognizes the vital need to gain global partners in moving forward on these questions.

Several of the authors of this article are Fellows of the College, and other members of the BoSDWG interact closely with the leadership and members...
of the ACS. Thus, the BoSDWG would also like to call on the ACS—along with surgical associations in other specialties, academic centers, and NGOs across the world—to promote greater research, training, and service delivery in LMICs. Specifically, Operation Giving Back provides a strong foundation for greater College involvement. More broadly, sustainable organizational partnerships focused on surgical care—both between and within countries—have the potential to have an unprecedented impact at this critical juncture in global health where daunting challenges intersect with great opportunities.

The way forward

In the “Grand Challenges in Global Health” listed by the Bill and Melinda Gates Foundation in 2004, “problems” were carefully differentiated from “challenges.” The challenges were nearly all geared to infectious diseases, since it was suggested that these diseases accounted for “the greatest disparities in health between rich and poor countries.” Unfortunately, none of the grand challenges directly related to surgical care. The way forward for greater College involvement. More broadly, sustainable organizational partnerships focused on surgical care—both between and within countries—have the potential to have an unprecedented impact at this critical juncture in global health where daunting challenges intersect with great opportunities.

The way forward

In the “Grand Challenges in Global Health” listed by the Bill and Melinda Gates Foundation in 2004, “problems” were carefully differentiated from “challenges.” The challenges were nearly all geared to infectious diseases, since it was suggested that these diseases accounted for “the greatest disparities in health between rich and poor countries.” Unfortunately, none of the grand challenges directly related to surgical care. However, there are significant global health disparities related to surgical conditions, and the vast knowledge gap related to surgery in LMICs limits our understanding of these disparities. Critical bottlenecks for surgery and for the other grand challenges must be overcome. We hope this work will challenge the common perception that surgical care is a luxury in poor countries—at the most basic level, poor access to surgical care is a human rights issue that requires both evidence and advocacy.

Authors’ note

For further information on the Burden of Surgical Disease Working Group and the April 2008 meeting, visit www.gsd2008.org. To join the working group list-serv, send an e-mail to bosdworkinggroup@gmail.com.

Two of the authors (CM, MC) are staff members of the WHO. The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions or policies of the WHO.

References


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Partly as a result of earlier assessments that projected an oversupply of surgical specialists, the number of surgeons trained in the nation’s graduate medical education system has remained static for the past 20 years. However, the number of people living in the U.S. has steadily climbed over this time frame. At this point, U.S. population growth has far outpaced the supply of surgeons. As a result, the U.S. is beginning to see signs of an emerging national crisis in patient access to surgical care.¹
Thanks in large part to George F. Sheldon, MD, FACS, and the American College of Surgeons Health Policy Research Institute, evidence of surgical workforce shortages is well documented. Workforce shortages affect nearly all surgical specialties. According to 1996 and 2006 data on workforce numbers produced by the Dartmouth Atlas, general surgery, urology, ophthalmology, and orthopaedic surgery declined 16.3 percent, 12 percent, 11.4 percent, and 7.1 percent respectively.² Looking to the future, between 2005 and 2020, the Bureau of Health Professions projects an increase of only 3 percent among practicing surgeons, with declines projected in thoracic surgery (−15 percent), urology (−9 percent), general surgery (−7 percent), plastic surgery (−6 percent), and ophthalmology (−1 percent).³ In addition, the Archives of Surgery published an analysis last April that showed a decline of more than 25 percent of general surgeons between 1981 and 2005 in proportion to the U.S. population.⁴ To be sure, declines are present in both rural and urban areas; however, declines in rural areas appear to be the starting point for shortages at crisis dimensions.

Among Americans receiving health care, 54 million Americans do so in small and rural hospitals.⁵ Although some of the rural workforce challenges in those areas relate directly to the difficulty in recruiting surgeons to rural areas, some are also the result of a lack of workforce reinforcement. The level of on-call time is greatest in rural areas; some general surgeons are forced to take call 24 hours a day, seven days a week. In addition, older surgeons in rural areas know that retirement of a less stringent workload may be further off than planned. Surgeons in rural areas also have a lower day-to-day volume of the types of procedures they are expected to perform at any given moment, making them less certain about the quality of care they will be able to provide and increasing liability woes. As a result of these concerns, some surgeons choose to relocate for the relative professional security of a more populated place to practice.

Reasons for shortages

There are many reasons for the surgical workforce shortage. The long-term outlook for the future of surgery contributes to the difficulties in recruiting surgeons: prospects of reduced payment combined with higher practice costs, bigger liability premiums, and the heightened threat of being sued; a crippled workforce leading to demands for more time on call; heavier caseloads with less time for patient care; and a U.S. health care delivery system that is in flux. Given the rigors of a surgical residency, it is understandable that would-be surgeons are deterred from making the extra sacrifices necessary to enter the surgical workforce.

Not only are fewer medical students entering the field of surgery, but large numbers of aging, established surgeons are either decreasing their workloads or retiring. According to the American Medical Association’s Physician Characteristics and Distribution in the U.S. (2007 edition),⁶ approximately one-third of the surgical specialists who are key to ensuring adequate emergency call coverage are age 55 or older (general surgeons, 32 percent; neurosurgeons, 34 percent; and orthopaedic surgeons, 34 percent). Hence, it is critical that our nation’s medical schools and training institutions start producing more surgeons in these specialties (see Table 1, this page).

Other professional trends add to the imminent workforce crisis as well, including the growing movement toward subspecialization. Program directors, professors of surgery, and other individuals

| Total active general surgeons | 26,769 |
| General surgeons younger than age 55 | 15,426 (57.6%) |
| Age 55 or older | 11,343 (42.4%) |
| Family practice physicians, age 55 or older | 36.7% |
| Internal medicine physicians, age 55 or older | 32.3% |

who are familiar with residency matches report that approximately one-half of all general surgery residents go on to pursue fellowships and subspecialization. As their scope of service becomes narrower, a new and alarming trend has emerged: many surgeons no longer feel qualified to manage the broad range of problems they are likely to encounter in an emergency department or rural setting.

Working toward solutions

The American College of Surgeons regularly educates members of Congress and congressional staff on the workforce challenges facing surgery, as documented by the ACS Health Policy Research Institute. Most recently, the College presented a statement on workforce to the U.S. Senate Committee on Finance, highlighting the workforce problem and offering ideas for legislative solutions (available at www.facs.org/AHP/testimony/workforce031209.pdf).

Some of these solutions include recruitment efforts, such as supporting current residency programs and promoting the development of additional residency programs, particularly in rural areas (see Table 2, this page). The College is also working to develop incentives for medical students who are interested in pursuing a surgical career, as well as alleviating some of the current burdens facing medical students, residents, and young surgeons. Specific examples of solutions include the following:

• Preserving Medicare funding for graduate medical education and eliminating the residency funding caps established in the 1997 Balanced Budget Act
• Fully funding residency programs through at least the initial board eligibility
• Including surgeons under the Title VII health professions programs, including the National Health Service Corps program, making them eligible for scholarships and loan assistance in return for commitment to generalist practice following training
• Alleviating the burden of medical school debt and promoting rural/underserved care through loan forgiveness programs that stipulate work in rural/underserved areas
• Extending medical school loan deferment to the full length of residency training for surgeons
• Allowing young surgeons who qualify for the economic hardship deferment to utilize this option beyond the current limit of three years into residency
• Increasing the aggregate combined Stafford loan limit for health professions students

In addition, the College supports legislative efforts that retain and reinforce surgeons in rural areas and emergency rooms. Again, these solutions focus on incentives, as well as making efforts to alleviate the obstacles confronting surgical care. Solutions to retain and reinforce surgeons include the following:

• Create a new health professional shortage area (HPSA), separate from the traditional primary care HPSA, focused specifically on surgery with bonus payment structures for surgeons who provide services in designated areas
• Allow surgeons access to Medicare’s disproportionate share program, currently restricted to hospitals, when they operate on patients they see in the emergency department or as a result of care provided under the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA)

Table 2: Number of first-year ACGME residents/fellows, 2002–2007

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2002</th>
<th>2007</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>2,423</td>
<td>2,439</td>
<td>0.7</td>
</tr>
<tr>
<td>Neurological surgery</td>
<td>94</td>
<td>143</td>
<td>52.1</td>
</tr>
<tr>
<td>Obstetrics/gynecology</td>
<td>1,191</td>
<td>1,214</td>
<td>1.9</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>366</td>
<td>398</td>
<td>8.7</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>604</td>
<td>634</td>
<td>5.0</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>188</td>
<td>269</td>
<td>43.1</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>162</td>
<td>187</td>
<td>15.4</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>131</td>
<td>99</td>
<td>-24.4</td>
</tr>
<tr>
<td>Urology</td>
<td>177</td>
<td>214</td>
<td>20.9</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>91</td>
<td>119</td>
<td>30.8</td>
</tr>
<tr>
<td>Family practice</td>
<td>3,196</td>
<td>3,102</td>
<td>-2.9</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>8,129</td>
<td>8,635</td>
<td>6.2</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>2,517</td>
<td>2,697</td>
<td>7.2</td>
</tr>
</tbody>
</table>

• Provide tax relief to surgeons who perform EMTALA-related care, which could be based on overhead costs as related to the Medicare physician fee schedule
• Adjust Medicare practice expense pools for each specialty to account for uncompensated care related to emergency department or EMTALA-related care as is done for emergency medicine
• When hospitals pay stipends to surgeons who take emergency call, Medicare should recognize these costs as is currently done for critical access hospitals
• Provide liability reform for surgeons who perform EMTALA-related care
• Expand the Federal Tort Claims Act to include surgeons who provide services to patients who are referred through their primary care physician at a community health center

Finally, Congress is well aware that unpredictable and unreliable reimbursement exacerbates workforce challenges. The ACS will continue to strongly advocate for Medicare physician payment reform.

Although not all of the solutions to the surgical workforce crisis can be solved with legislation, the College is working hard to develop legislative solutions wherever possible. Achieving the goals set in the ACS Statement on Health Care Reform as well as the solutions mentioned in this article will go a long way toward addressing the causes of the surgical workforce crisis on the federal level.

State-level fixes

Surgical workforce issues are receiving greater attention in the states these days. Physician shortages, especially those in small communities or rural areas, have forced state policymakers and medical societies to assess the intensity of the problem and, in some cases, consider potential solutions.

At least 22 states have sought to study the workforce issue in recent years. In some cases, the focus of these studies has been on the shortage of primary care physicians, with less attention to specialty shortages. Other studies provide a more balanced review of the availability of physicians regardless of specialty. All of them, however, conclude that their respective states are experiencing or will experience a shortage of physicians.

Standard solutions reflect the following themes:
• Build more medical schools to increase the number of medical students with concurrent increase in residency training slots
• Recruit physicians to practice in the state
• Expand loan payment assistance and scholarship programs
• Create incentive programs for physicians to establish practice in rural areas

The following sampling of how states have engaged in addressing physician workforce issues can give a broad overview of the problem.

Colorado
In 2005, the Colorado Health Institute conducted a survey of physicians as part of the licensure renewal process. The intent was to collect, analyze, and disseminate Colorado physician workforce data to determine the age distribution of responding physicians, factors weighed in selecting with practice locations, primary care availability, and time spent in direct patient care. Colorado reflects national trends in these areas, including pending shortages of primary and specialty care. The report is available at http://www.coloradohealthinstitute.org/resourcePublications/publications.aspx.

Connecticut
The Connecticut State Medical Society conducted a physician workforce survey in 2008 with the following intentions:
• Assess Connecticut physicians’ satisfaction with their careers in medicine and their lives as physicians
• Identify problems associated with the supply of physicians in certain specialty areas in the state, determine possible causes of those problems, and assess their potential effect on patient access to care
• Examine the professional liability environment in Connecticut and assess its relationship to practice patterns and patients’ access to care
• Determine physician opinions on health care reform and, specifically, initiatives to improve access to medical care
• Measure the use of technology in Connecticut physicians’ practices

The survey revealed that 19 percent of the 1,077 respondents are contemplating a career
change, and 10 percent plan to move their practice outside of the state because of the practice environment. Work-hour increases have occurred for 47 percent of the respondents over the past three years, with urologists, neurosurgeons, and oncologists indicating they have increased their work hours substantially.


Florida

In early 2008, Joseph Tepas, MD, FACS, and Resident Member Darrell Graham, MD, undertook a more limited workforce survey, with 15 practicing surgeons from the ACS Jacksonville Chapter and 65 from the Florida Chapter—representing most of the general surgeons in Jacksonville and approximately 25 percent of the available general surgeons in the Florida Chapter of the ACS—participated. Highlights of the study are as follows:

• Within 10 years, half of the respondents will have retired from practice and will no longer be taking call.
• More than half of the “senior” practitioners who have been taking emergency call and who plan to retire within 10 years are taking call on average five nights per month.
• Approximately 30 percent of the surgeons who have been established in Florida for less than 10 years are working more than 10 nights of call per month.
• Whereas some level of call stipend is provided, it is not uniform and those who receive it believe it is an inadequate reflection of the responsibilities of emergency room support.

Following initial review of the completed surveys, Drs. Tepas and Graham asked every state legislator (senators and representatives) to complete a brief survey indicating their awareness of surgical workforce/on-call problems and their recommended solutions. Very few responded, and of those who did, most thought there was not an immediate concern in their districts. To request a copy of this survey, contact Dr. Tepas at Joseph.Tepas@jax.ufl.edu.

Georgia

The state government and the Medical Association of Georgia have written a number of workforce reports over the past few years. In fact, for many years, there has been a state agency, the Georgia Board for Physician Workforce (GBPW), focused on these issues. The GBPW is responsible for advising the governor and the general assembly on physician workforce and medical education policy and issues. The 15-member board works to identify the physician workforce needs of Georgia communities and to meet those needs through the support and development of medical education programs. Specific responsibilities include monitoring and forecasting the supply and distribution of physicians in Georgia; ensuring an adequate supply, specialty mix, and geographic distribution of physicians to meet the health care needs of Georgia; coordinating physician workforce planning with state funding for medical education; and the development and support of medical education programs required to meet physician workforce needs.

In October 2006, the GBPW released Update on Georgia’s Physician Workforce, Follow-Up Report to Is There A Doctor In The House? The update discussed significant physician workforce issues facing the state including the aging of the population along with rapid population growth, minimal or negative growth in critical specialties such as obstetrics/gynecology, a state of decline in general surgery, and continued growth in medical education debt. On the medical education issue, the report recommended that the state build sufficient capacity in all levels of the medical education system and ensure adequate funding for medical education.

To access a copy of this report or use the GBPW physician database, visit http://gbpw.georgia.gov/02/gbpw/home/0,2515,49259818,00.html.

Massachusetts

The Massachusetts Medical Society has been conducting annual physician workforce studies since 2002. These surveys provide a snapshot of the practice environment in the state. Some interesting findings in the 2008 study of almost 1,100 physicians include the following:

• 42 percent of practicing physicians are considering a career change
• 18 percent of physician respondents are considering a move out of the state if the practice environment does not change.
• 55 percent report that the amount of time needed to recruit physicians has increased, and 40 percent say that retaining existing physician staff had become more difficult.
• More than 70 percent of physician respondents report difficulty in referring patients to specialists.

The studies have also yielded a running scorecard by year of the specialties classified as facing critical or severe shortages. In 2008, specialties facing severe shortages included dermatology, emergency medicine, general surgery, neurology, neurosurgery, oncology, orthopaedics, psychiatry, urology, and vascular surgery. Specialties classified as in critical shortage included family medicine and internal medicine. The 2008 study is available at http://www.massmed.org/AM/Template.cfm?Section=Research_Reports_and_Studies.

State legislatures in 2009

A quick review of state legislative activity at the end of February indicated that only one state—Hawaii—is considering legislation this year that would directly address physician workforce issues. The Hawaii bill was introduced to assess a separate $60 physician workforce assessment fee at the time of renewal of medical licenses. Funds collected will be deposited to the John A. Burns School of Medicine special fund to support activities related to physician workforce assessment and planning. Some of these activities would include maintaining accurate physician workforce assessment information and providing or updating personal and professional information maintained in a secure database. At press time, the bill was still in committee in the state senate.

That only one state is considering legislation related to physician workforce issues is likely related to the fact that many state legislatures are dealing with severe budget shortfalls (at least partly as a result of exploding Medicaid costs) and are waiting to see what actions Congress takes toward health system reform. It does not, however, mean that state legislatures are not concerned about the issue; rather, it reflects the very serious impact the economy is having on the states.

Conclusion

Repairing the surgical workforce shortage will require considerable political will. Many of the solutions the College has identified are large in scope and envelop the structure of our health care system and the interests of many stakeholders. Certainly, it is time for policy researchers and policymakers to begin addressing these difficult issues, bearing in mind that no stakeholder has more to lose than the surgical patient.

References

The American Council of Graduate Medical Education (ACGME) does not require surgical residents to participate in the education of medical students. And given the demands of the operating room, sick patients, attending surgeons, managing the interns, and so on, perhaps you have triaged teaching the medical students to the bottom of the list of “things that must be accomplished in the confines of an 80-hour workweek”—or, admittedly, as was my case, it had become an afterthought at the end of a long day.

If your approach has been the same as mine, then please reconsider. I have come to realize that placing importance on the education of the medical students on our services is a worthwhile time investment. It is not only the medical students themselves that stand to benefit from this investment, but also you, your fellow residents, your institution, and the discipline of surgery itself.

• **Beneficiary: You.** You cannot teach what you don’t know. This point cannot be overstated. The reduction in resident work hours has not been accompanied by an increase in resident self-directed reading. If you struggle with finding an hour or two each day to devote to text and/or journal reading, taking a vested interest in the education of your medical students may be the motivation you need.

• **Beneficiary: Fellow residents.** Instead of becoming frustrated with the interns and junior residents because of their management of your patients, ensure that things run smoothly. That is, teach the medical students, with the entire team present, the way you handle commonly encountered problems and why. This way, no one with a long coat feels as though he or she is in remediation. And don’t forget repetition, especially in July, August, and September.
With a vested interest in the education and maturation of our medical students, we can help replenish the surgical pipeline with the best and brightest.

• **Beneficiary: The institution.** The sad truth about the medical students on our services is that few will elect careers in surgery. Medical students today largely value lifestyle above all else in choosing a specialty. But that fact should not change our attitudes or willingness to participate in their education. Approximately 30 percent to 50 percent of graduating medical students remain at their institutions for internship/residency. They will remember you, your level of interest in them, and what you’ve taught them. And if you did your job, you will have surrounded yourself with better doctors who less frequently make inappropriate consults. The old cliché, an ounce of prevention is worth a pound of cure, seems appropriate in this context.

• **Beneficiary: Surgery.** Although most medical students will not become surgeons, some will. You may even, by showing an interest in their education, sway some of the undecided students to opt for surgery. Who is in a better position to do so? Perhaps no one, not even the attending surgeons, according to two recent articles in *The American Journal of Surgery*, which purport surgical residents may have the biggest impact upon medical students and their career choices.

Nearly a decade ago, researchers monitored medical students from the University of Wisconsin–Madison to determine which students chose careers in general surgery. Although many of the strongest students chose surgical subspecialties, few of the top students entered general surgery residencies. This confounding trend has continued. I believe that no specialty has more to offer than general surgery in terms of technical demand, breadth of knowledge required, patient complexity, and job satisfaction. I know many general surgery residents share my views and, fortunately, we can make a difference. Studies have shown that students can be influenced to enter a career in surgery with early, positive exposure to surgical residents, attending surgeons, and the practice of surgery.

It is important to note, however, that we as residents cannot mentor our students if we do not first and foremost take an interest in their education. After all, obtaining an education is a student’s primary purpose.

All surgical residents probably know what mentorship means and hopefully have had a faculty mentor of their own, but it may not be obvious how mentorship applies to residents and medical students. First, it is important to realize that mentorship is, in essence, a form of influence. Mentors are the individuals we look up to and want to emulate. As residents, we are uniquely positioned to mentor our students. We have succeeded in many of the upcoming challenges facing medical students, such as applying for residency, interviewing, matching, acclimating to new programs, balancing the demands of life with the demands of being a resident, and so on. But does mentorship require time commitments and long-lasting relationships?

Mentorship doesn’t necessarily have to involve time commitments or relationships. Mentorship, as applied to residents and medical students, can occur effectively during the surgical clerkship. Furthermore, this setting is well suited to the application of the qualities reported to determine mentor credibility in academic surgery.

• **Motivate.** Motivation can be incredibly easy with good students or very difficult with the uninitiated. There clearly are myriad means to motivation but, whatever method you choose,
avoid using fear or threats, as these techniques result in failure.

• **Empower and encourage.** Make your students part of the team. Give them responsibilities in addition to printing your list each morning. Help them feel ownership in the care of the patients they are following.

• **Nurture self-confidence.** When a job is well done, say so. It is especially nice to do so in the presence of the attending surgeon.

• **Teach by example.** Example is, of course, the most powerful rhetoric.

• **Offer wise counsel.** Hold feedback sessions with your students (preferably more often than the last day of their rotation). Give constructive criticism. Everyone has strengths and weaknesses and there is always room for improvement. Merely saying “You did a really good job” or “We enjoyed having you on the service” is insufficient.

• **Raise the performance bar.** Students’ level of understanding and performance will increase as the rotation and academic year progress. Consequently, your level of expectations should also rise. Give your students increasing responsibility and freedom accordingly.

• **Shine in reflected light.** If your team is running smoothly, chances are the attending surgeon has noticed and may comment to this end. Give credit where credit is due. Thank the team, including the students. If you are functioning as an effective mentor, your team will have been working very hard for you.

Surgical residents can effectively serve as mentors without the addition of significant time demands or undo stress. With a vested interest in the education and maturation of our medical students, we can help replenish the surgical pipeline with the best and brightest. We can give back to the discipline in which we have chosen to dedicate ourselves. And in doing so, we can help ensure a bright future for surgery, our careers as surgeons, and the training of surgeons to follow us.

**References**


The focus of the patient safety movement is on system failure as a prime cause of patient injury—as opposed to the traditional risk management focus on human error.

Many organizations leading the national patient safety movement (such as the Institute of Medicine, the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, The Joint Commission, and the Leapfrog Group) share similar patient safety goals. If these goals are achieved and the health system environment becomes safer, it is reasonable to ask if this will result in a reduction in the frequency and severity of medical malpractice claims.

The potential for system improvements to reduce malpractice claims can be indirectly assessed by reviewing claims to see how frequently system errors either contributed to or caused the claim. Because The Doctors Company is the largest national insurer of physician and surgeon medical liability and insures more than 44,000 physicians who practice in every specialty and in every state, an analysis by The Doctors Company of the errors leading to these claims may be representative of errors occurring throughout our health care system.

The Doctors Company reviewed 363 consecutive closed claims from January 2004 through January 2006 that settled with indemnity payments between $100,000 and $500,000. For each claim, it was determined whether professional negligence, system error, both, or neither contributed to or caused the claim. The analysis is based on a proximate cause—not a root cause—analysis, reflecting the fact that the evaluation and resolution of a malpractice claim are focused on the proximate causes of patient injury. The system errors identified were then classified using the following modification of the 2006 national patient safety goals shared by the organizations leading this movement:

- Medication-related error
- Communication error
- Health care–associated infection
- Medical record error
- Identification error (wrong-site surgery)

Of these 363 claims, 63 percent showed provider error only, which is not surprising, because these are settled claims and settlement generally occurs only when all parties agree that there is some caregiver responsibility for the adverse event that caused the patient injury. Among the claims, 29 percent involved both provider and system error. Only 1 percent of claims involved only system error. Thus, system errors seldom occurred as isolated events and were almost always associated with provider error. However, a root cause analysis would probably reveal unrecognized system errors underlying some of the provider errors identified as proximate causes of these claims.

Since settlement requires concurrence of the patient and his or her attorney and the physician and his or her insurance company, one might expect that all settled claims would contain medical and/or system errors. Thus, it was a surprise that 7 percent of claims showed neither professional negligence nor system error, as shown in the following breakdown of error types.
Type of error  
Provider error only 63.0%  
Provider and system error 29.0  
System error only 1.0  
Neither provider nor system error 7.0

Total system errors  
Medication-related error 32.0%  
Communication error 27.0  
Health care–associated infection 18.0  
Medical record error 13.0  
Identification error (wrong-site surgery) 5.5  
Medical device failure 3.0  
Surgical fires 1.5

Medication-related errors, communication errors, health care–associated infections, and medical record errors together account for 90 percent of the total system errors. Four claims involving both provider and system error resulted from the failure of medical devices. Two claims involving both provider and system error resulted from surgical fires.

Medication-related errors  
Monitoring errors 43.0%  
Dosage errors 26.0  
Inappropriate medication errors 9.5  
Medication side effects 9.5  
Medication reconciliation errors 7.1  
Medication allergic reactions 4.8

Together, medication monitoring and dosage errors accounted for 69 percent of medication-related errors. Of the medication monitoring errors, one-third involved failure to properly monitor Coumadin. Internal medicine, family practice, and psychiatry together account for nearly one-half of medication-related errors. Reconciling patient medications across the continuum of care is a 2006 patient safety goal of The Joint Commission and the Institute for Healthcare Improvement’s “100,000 Lives Campaign.” Only three medication-related errors (1 percent) involved medication reconciliation.

Health care–associated infections  
Surgical site infections 67.0%  
Injection site infections 8.3  
Central line infection 4.2  
Miscellaneous infection sites 20.8

Surgical site infections account for two-thirds of the health care–associated infections. One claim involved a central line infection, and none involved ventilator-associated pneumonia.

Medical record errors  
Among errors involving the medical record, 35 percent resulted from absence of a written informed consent. An additional 35 percent of errors were associated with medication-related errors (four dosage errors and two medication reconciliation errors). Four errors involved physician failure to review charted abnormal laboratory results.

Discussion  
Appropriate prophylaxis to prevent venous thromboembolism is a patient safety goal of the Agency for Healthcare Research and Quality and the Surgical Care Improvement Project. In this analysis, 3 percent of the settled claims were for deep venous thrombosis and pulmonary embolism.

System errors contributed to or caused 30 percent of the 363 claims. The goals for reducing system error and promoting patient safety shared by the organizations leading the patient safety movement include eliminating medication-related errors, communication errors, health care–associated infections, medical record errors, and identification errors. Together, these five shared patient safety goals address 95 percent of the system errors uncovered in this proximate cause analysis of malpractice claims. These findings provide empirical support to the premise that our national patient safety goals address system failures accounting for a significant number of adverse outcomes.

Although this claims analysis shows that system errors alone seldom result in malpractice claims against physicians and other caregivers (1 percent), system errors in association with professional negligence account for a significant number of settled claims (29 percent). This suggests that the patient safety movement should continue to focus its strategies for improving patient safety on the complex interactions between health care professionals and the systems within which they provide care.

Dr. Troxel is medical director, The Doctors Company, Napa, CA.
Residents salute their mentors

The following articles are the third installment in a series of brief essays the Bulletin is publishing under the theme “My mentor.” These essays are the result of efforts made by the Resident and Associate Society (RAS) of the American College of Surgeons in launching its first essay contest asking residents, fellows, and new faculty to describe in 500 words or less the role that a mentor has played in their development.

In this series, you will read what several outstanding surgical trainees who responded to the contest have to say about the individuals who have mentored them. Through this series, members of the College and other Bulletin readers will learn about 10 extraordinary mentors who have provided both personal and professional guidance for their mentees at various stages of their training.

The leadership of the RAS believes that these mentors are more than just role models—they are pillars of strength and good examples for future generations of surgeons who are attaining technical and clinical skills, while also advancing their interest in research, education, and outreach in an increasingly challenging health care environment. The winner of this year’s essay contest will be announced at the 2009 Clinical Congress in Chicago, IL.
Words of gratitude: Israel Zighelboim, MD

by Nora Kizer, MD

The significance of mentors should never be taken for granted, as they provide an invaluable source of wisdom, support, and advice that is completely voluntary. They are the individuals who give us wings to let us become something we never imagined possible for ourselves. As very few people have the time or ability to be effective mentors, I consider myself lucky to have blossomed under someone who naturally fell into that role for me. My achievements in residency are due in large part to the efforts of a very capable and dedicated mentor, Israel Zighelboim, MD. It has been an unexpected experience that not only fills me with deep respect and appreciation for such selfless guidance, but also instills within me the same desire to positively influence and mold others in a similar fashion.

As a gynecologic oncology surgeon, Dr. Zighelboim did not have an abundance of leisure time on his hands. However, he never failed to find time to answer my questions or concerns. The sincerity and completeness of his guidance lent me a confidence that has helped increase my skills and made me a better physician and surgeon during my residency. On many occasions, he spent extra time to sit down with me and review articles, presentations, and methods of interpreting data, all of which has helped develop my research methods, my scientific writing skills, and my public speaking technique. Such assistance was not required or even expected of him, but because he willingly devoted his time and expertise to me, he provided meaningful educational opportunities that have improved my abilities.

His own wealth of knowledge is inspiring and continues to provide me with motivation to improve mine through reading and clinical education. Knowledge is a quality imperative within the surgical world, as it breeds the confidence that allows a surgeon to quickly assess and manage a critical situation effectively. Quite unsurprisingly, it is one at which my mentor excels. His knowledge extends into the operating room, where each movement and each step within the procedure is purposeful, well thought-out, and executed properly. I hope to imitate such style and competence myself when I am at the head of the surgical team. He is an enthusiastic teacher, both on the floor and in the operating room. His own drive pushes me to excel as a capable surgeon and an inspiring educator.

Lastly, he has been my unwavering support. During my journey through residency, there have been moments where I doubted my abilities or thought my aspirations impossible. Yet, I completed my first clinical research project, published my first articles, performed my first lymph node dissection, and learned how to discuss difficult end-of-life issues in a respectful manner, all as a result of his encouragement, support, guidance, and professionalism. I find it incredibly rewarding that someone whom I have grown to respect and admire would be so invested in my career. But this is the essence of the mentor-mentee relationship, and with this essay, I thank him.

Dr. Kizer is chief resident in the department of obstetrics and gynecology, Washington University School of Medicine, St. Louis, MO.
My mentor

Mentors—What we aspire to be:
Hasan Alam, MD, FACS

by Christian Shults, MD

It is with great enthusiasm that I write this essay describing how my relationship with Hasan Alam, MD, FACS, has had a positive impact on my personal and professional development. I worked with Dr. Alam during the 2006–2007 academic year and was a research fellow in his laboratory at Massachusetts General Hospital (MGH) in Boston. During that year, I met individually and weekly with Dr. Alam to discuss the progress of my research. Through our collaboration and those meetings, Dr. Alam ultimately became a trusted friend and mentor.

First and foremost, what was most meaningful to me was Dr. Alam’s example of success and fulfillment in an age of surgery wherein many are discontent and pessimistic. Aside from being an excellent clinician, Dr. Alam is genuinely passionate about research, and that passion for discovery, as well as his track record of success, made me very eager to work with him. His example and his life have renewed my belief that one can find fulfillment in surgery. Having come to the U.S. as an international medical graduate, Dr. Alam worked his way into a competitive residency, received his first of several R01 grants within two years of finishing residency, and is now a rising star in trauma and an associate professor of surgery at MGH. He is a living tribute to the notion that regardless of the odds, one may chart his or her own destiny if he or she is committed.

Our mentors become the stewards of our professional selves and facilitate our advancement into the professional world. What Dr. Alam has done so well is to create an environment with abundant opportunity for those who will take it and run. He has established a reputation and expectation of success and has continually dedicated whatever time required to review projects, abstracts, manuscripts, and presentations. I feel that my time spent with Dr. Alam has launched my professional surgical career, has given me exposure to the national stage, and has opened my eyes to many opportunities I would not have otherwise been aware of.

I can’t emphasize enough the importance of finding mentors, those who have become what we aspire to be. First and foremost, their examples validate and broaden our aspirations, and from them we learn attitudes, methods, and patterns of success. I think such relationships are both a source of inspiration and instruction for the mentored and, I imagine, quite gratifying to the mentor as well. Perhaps the greatest testament to this relationship is that it has endured beyond my time in the laboratory, as Dr. Alam has continued to support my efforts and continues to be genuinely interested and encouraging in my pursuits. I still look forward to our interactions, and I have no doubt that he continues to be committed to my success. For that, I am grateful.

Dr. Shults is a fourth-year postgraduate general surgery resident at Washington Hospital Center, Washington, DC.
S
pending the day with a surgeon was an honor beyond description for me as a gangly boy in sixth grade. If the medical community in my sleepy Iowa town was an army, John Kelley, MD, FACS, was our general. “Dr. John,” as he was universally known, was intelligent, funny, and eager to share the joys of surgery. I still remember his pager barking for attention that morning. A child had a lip laceration that would require stitches and the family was hoping Dr. John could be involved.

We jumped into his yellow Ford Bronco and sped toward the hospital. As he drove, he gently recited some of the more exciting points of managing skin lacerations in children. Whatever a dermis was, I thought, it certainly sounded fascinating. It was clear to me that Dr. John enjoyed his role as a teacher almost as much as I cherished being his apprentice.

We entered the hospital with purposeful strides. He assured me the boy’s gnarled lip was easily remedied. We raced to the locker room. His blue scrubs accentuated a svelte build not appreciable in his tweed jacket and red bow tie. He could have been a triathlete if such an event existed in his youth.

We moved to the operating room. Dr. John quickly introduced me to the nurses as he left to scrub. He proceeded to wash his hands the way a car enthusiast waxes a vintage Mustang. Methodically he prepared those dexterous fingers. The actual surgery, from my perspective, was a well-orchestrated blur of stitches, scissors, and blue towels.

In the years that passed, I spent a number of days learning from Dr. John. As my interest in medicine matured, he was there to offer guidance, support, and insight. His mentorship in my personal and professional development focused on the joy of medicine, our responsibilities to patients, and the power of a good laugh. In our numerous lunches, he never mentioned reimbursement, work hours, or lifestyle. Dr. John pursued medicine with a conviction I found intoxicating.

Dr. John retired in his 70s. Retirement provided my mentor more time to share stories over leisurely lunches followed by an obligatory stroll through the hospital. As I prepared for college, he encouraged me to study hard and stay focused. His smile couldn’t mask how much he missed the operating room and his role as a surgeon.

Dr. John died when I was in medical school. I was crushed he didn’t get to see me graduate. His funeral was a standing-room-only event. His former patients gave me hugs and told me about their ruptured appendix or their mother’s pneumothorax. These stories were shared with me not because Dr. John was my mentor, but because he was also my grandfather.

When I think about my grandfather, and the lessons he shared with me, I can’t help but smile. And when I do, I can appreciate the slightest trace of a well-healed lip laceration repaired by my mentor, and grandfather, Dr. John Kelley MacGregor.

Dr. MacGregor is a third-year general surgery resident in the department of surgery, University of North Dakota, Grand Forks.
In compliance...

with a RAC audit

by Debra Mariani, CPC, Practice Affairs Associate, Division of Advocacy and Health Policy

Medicare providers should prepare for the Recovery Audit Contractors (RACs) to continue with their original plan for completing audits, now that the protest of the award of the RAC’s contract has been resolved. The February 4 settlement means that the stop-work order has been lifted, and the Centers for Medicare & Medicaid Services (CMS) will now proceed with the implementation of the RAC program. This article can be used as a tool to help surgeons and office staff to handle and prepare for an audit and as a description of the process for appealing a RAC audit determination.

Things to consider

RACs choose issues to review based on data-mining techniques. Data mining is a process designed to explore data in search of consistent patterns and/or systematic relationships between variables and then to validate the findings by applying the detected patterns to new subsets of data. For example, with automated reviewing, the RAC will be able to make an overpayment or underpayment determination without reviewing medical records. To be aware of areas of possible audits, surgeons should stay abreast of the information in Office of the Inspector General (OIG) (www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf), Comprehensive Error Rate Testing (CERT) (www.ngsmedicare.com/ngsmedicare/DMEMAC/ReviewProcess/CERT/IndexCertDMEMAC.aspx), and Government Accountability Office (GAO) (www.gao.gov) reports. New issues will be posted on the RAC Web site (www.cms.hhs.gov/RAC). The audits can go back three years from the date the claim was paid, although RACs will not review claims submitted before October 1, 2007.

One of the most important steps a surgeon can take in dealing with a RAC audit is to build a strong response team. This group of allies should assign a point person to set up an organized operating system for handling the medical record request letters from the RAC. To accomplish this task, the entire staff needs to be made aware of such letters. The point person most likely will be the practice’s compliance officer. The team may include members from several areas of the practice, including finance, health information management, medical records, case management, and, most importantly, the physician. Even surgeons who have small offices should educate their staff and appoint one person to handle all areas of the RAC audits, denials, and demand letters. The most important piece of information the staff needs is what to do when this letter arrives. The RAC team should have policies in place for receiving, responding to, and following up with a RAC letter. If these policies are not in place, surgeons may lose any opportunity to overturn improper RAC determinations.

Keep in mind that there is a limit to the number of medical records the RAC can request: 10 for a solo practitioner, 20 for a partnership of two to five individuals, 30 for a group of six to 15 individuals, and 50 for a large group of 16-plus physicians. Once a practice receives a letter, the staff has 45 days to respond. If a practice stores its medical records off-site, a policy should be in effect for retrieving these records quickly.

Key senior personnel should gather facts that will help to ensure that the practice is submitting claims appropriately. Some internal audits may be a key factor in finding mistakes. In some cases, an external company can come in to do an audit of documentation and billing practices. All education and compliance issues should be documented and corrected to show that the practice is striving for compliance with all billing and coding practices.

One of the biggest problems found by RACs so far is improper diagnosis coding. This problem could be avoided by clearly documenting the patient’s diagnosis or the procedure’s medical necessity. Duplicate payment for a service is another area of concern. Surgical offices should have a policy in place to make sure that when a duplicate payment is received, the carrier is contacted for further instructions. All calls and instructions should be documented.
**Appeals process for RAC audits**

The same appeal policies that would be used for Medicare claims (Medicare Part A and Part B appeals process) apply to the RAC audit decisions. All providers may appeal any determination made by the RAC auditors. There is the informal appeal process and a formal appeal process.

- **Informal process**
  1. Providers can submit an appeal directly to the RAC within 15 days of receiving a notice to recoup an overpayment. This step is optional and not included in the five-level appeal processes described later in this article.
  2. The RAC considers the appeal to determine whether its decision is justified.

- **Formal process**
  The chart on page 38 depicts the formal appeal process.
  1. At the first level (redetermination) of the process, an appeal can be requested in writing within 120 days of initial determination (from the RAC) to the fiscal intermediary (or carrier or Medicare administrative contractor that usually pays claims).
     a. The fiscal intermediary will have 60 days to determine whether the RAC’s findings are justified.
     b. If the appealed claim is overturned, the fiscal intermediary will include appropriate payment with the redetermination letter.
     c. If the appeal is denied the fiscal intermediary will provide a written explanation.
  2. At the second level (reconsideration) of the appeal process, the provider may ask for reconsideration in writing for a review by a qualified independent contractor (QIC) if the fiscal intermediary renders an unfavorable decision.
     a. Physicians have 180 days to file a request for reconsideration.
     b. This request must be on a standard CMS form (go to [http://www.medicare.gov/Basics/forms/default.asp](http://www.medicare.gov/Basics/forms/default.asp)) or the reconsideration request form that comes with the fiscal intermediary redetermination letter.
     c. In this appeal, it is vital that the request be accompanied by all concerns, issues, and evidence to support the appeal.
     d. During this level of appeal, appearance by the surgeon and his or her staff is optional.
     e. The QIC has 60 days to make its decision.
  3. At the third level (administrative law judge, or ALJ, hearing) of the appeal process, which is the most formal form of appeal before a court date, the provider may request a hearing before an ALJ by filing the request in writing with the entity specified in the notice within 60 days of receipt of the QIC’s reconsideration notice.
     a. Oral testimony will be required.
     b. CMS and/or the fiscal intermediary may be requested to participate.
     c. The ALJ has 90 days from the date the hearing request is received.
     d. This decision is binding unless it is modified or reversed by the Medicare Appeals Council.
     e. The request must meet an amount in controversy of at least $120.
  4. At the fourth level (Medicare Appeals Council) of the appeal process, the provider can file a request for review with the MAC within 60 days of receipt of the ALJ’s decision.
     a. The MAC may review the ALJ’s decision.
     b. No appearance is required at this proceeding and there are no minimum requirements for the amount in controversy.
     c. The Medicare Appeals Council has authority to modify, reverse, or remand the case back to the ALJ.
     d. The MAC must issue a determination within 90 days of reviewing the ALJ’s decision. If the MAC cannot make a decision within the 90 days, it will inform the appellant of the right to move this decision to the federal district for judicial review.
  5. At the fifth level (U.S. District Court) of the appeal process, the provider must file a lawsuit in the federal district court within 60 days of receipt of the Medicare Appeals Council decision.
     a. Evidence presented at this level is limited to the administrative record.
     b. The Secretary of the U.S. Department of Health and Human Services is named as the defendant.
     c. The minimum amount in controversy at this level must be at least $1,220 (for 2009).

**To consider before appealing a RAC decision**

1. Is there clear documentation guidance from Medicare to support or rebut the determination?
2. Does the documentation meet the CMS guidelines?
3. Should legal counsel be involved?
4. Does the cost of the appeal outweigh the benefits?

To prepare for appealing audit determinations
1. List the factual and legal arguments for support of payment; this may consist of illustrations, medical summaries, graphs, or any other materials that support the appeal and should be easy for the decision makers to understand.
2. Documentation should be supported by the physician providing the services and being audited.
3. The treating physician can defend his judgment for the medical necessity of treatment.
4. Surgeons who are appealing audits may want to hire a legal defense to support medical judgment and documentation.

Once a provider appeals a decision, the RAC must stop pursuing the claim. Interest continues to accrue throughout the appeal process.

In summary, your best offense is an educated office that understands the issues regarding the RAC, including determining what role office staff plays in handling time-sensitive information and knowing your time limits for appeals and planning your responses. As the physician, knowing proper guidelines for documentation and coding will help you in the long run.
In January 2009, the surgical world lost a great light when David Coston Sabiston, Jr., peacefully expired at the age of 84 after a long illness. Having recovered significantly from a severe stroke in 1997, he was struck down again four years later in an episode that brought to a public end one of the most distinguished careers in modern surgical history.

American surgery’s last century is replete with the names of individuals distinguished in research or clinical practice, in administrative prowess or organizational achievement, or even as professional educators. Some have outstanding records in more than one of these categories, but it is rare to achieve world-class distinction in every facet of a surgical career. David Sabiston merits top honors in all of these areas: research, clinical practice, administration, and teaching, with his role as a teacher characterizing and crowning all his other achievements.

In January 2009, the surgical world lost a great light when David Coston Sabiston, Jr., peacefully expired at the age of 84 after a long illness. Having recovered significantly from a severe stroke in 1997, he was struck down again four years later in an episode that brought to a public end one of the most distinguished careers in modern surgical history.

Directors of surgical departments are expected to build their faculty roster, provide expert care for surgical patients, advance the frontiers of their profession, and arrange for teaching at all academic levels from medical students and house officers to junior and even senior attending surgeons. When David Sabiston accepted the James B. Duke Professorship of Surgery at Duke University in 1963, he embarked on a complex teaching enterprise that was successfully pursued over the next three decades. It was his deliberate, long-range plan to capture the interest of medical students who entered his orbit, to infuse them with a knowledge of surgery’s history and future prospects, and to select from the brightest of these students the house officers for his long and demanding residency program. Out of that residency program, with its obligate research component, would come the faculty members of his department. These individuals were stamped with the high principles and disciplined enthusiasm of their mentor, standing ready for recruitment to divisional and departmental chairs at other universities.

David Sabiston loved to teach at every level of the educational pyramid, from the beginning medical student to the audiences at his innumerable eponymous lectures throughout the world. He taught in the Socratic fashion, which can challenge and even terrify the individual on the other end of the exchange. Such terrors were mitigated or abolished by his diligent work in mastering the names and background of his medical student pupils, beginning with a reception at his home, presided over by his charming consort Agnes, universally known as “Aggie.” The end product of his long-range project in teaching was a formidable cadre of chief resident surgeons, doubling the biblical number of 72 disciples, with 88 ending up in academic pursuits and 24 serving as departmental chairs or division chiefs.

Teaching was David’s métier, pursued with unflagging determination in a schedule that emphasized precision in action and the value of hard work. A sense of history fostered his adoption of Sir William Osler’s motto that work was the “mas-
were many anecdotes about his over so long a tenure, there with such a dominant teacher directions. As might be expected out their careers in other loca-

tions in affectionate detail by his admiring associates. One also nds here a portrait of the family atmosphere afforded to residents and their wives under the guidance and solicitude of Agnes Sabiston, whose faithful support of her husband went on, in sickness and in health, for 54 years.

The repeated teaching awards to David Sabiston in multiple categories at Duke testify to the activity that provided him with his greatest satisfaction. National awards for teaching also came his way and he was honored by initiation of a Sabiston teaching award, cherished by those who aspired successfully to imitate their mentor.

His renowned Textbook of Surgery, subtitled “The Biological Basis of Modern Surgical Practice,” was erected on the text by Frederick Christopher and first sold in 1936 at a price (as I recall) of $8. Christopher edited five editions in 20 years before Loyal Davis took over for four editions, extending to the Sabiston era in 1972. This tenth edition was titled Davis-Christopher Textbook of Surgery, stressing “the biological principles and derangements which form the basis of disease.” It emphasized Sabiston’s continuing historical interests and teaching practice by including a 25-page account of “The Development of Surgery” by the distinguished historian, Gert H. Brieger, MD. This edition was highly regarded and eagerly purchased by students and surgeons throughout the world. My own presentation copy, in its pristine, aromatic state, even attracted the favorable attention of canine members of our household, as indicated by a significant defect at the top of the book’s spine, reflecting the munching of a young English bulldog, possibly correlative with David’s own Anglophile leanings. The book is revealingly dedicated to “medical students and residents, who through their concern, inquisitiveness and impressive abilities continuously stimulate improvements in the diagnosis and management of the sick”—a nice statement of the beneficial reciprocity between teacher and student.

Research and organizational achievements

As a member of Alfred Blalock’s full-time faculty some six decades ago, I first encountered David Sabiston during his surgical internship. It was an edifying experience to watch his early clinical development in concert with other brilliant
contemporaries such as James V. Maloney, Jr., and Frank C. Spencer. As one’s own career was fostered by the advice and sponsorship of Dr. Blalock, it was heartening to see such younger colleagues achieve academic prominence under the inspiration and skilled guidance of “the Professor.”

Sabiston rose rapidly to professorial status at Johns Hopkins after his laboratory years under Gregg and his sojourn in England. His research productivity flourished and his eminence as an educator was advanced by his 27 years as editor of *Annals of Surgery*. Despite these editorial labors, along with heavy responsibilities for his splendid surgical textbook, he found time for the arduous demands of teaching, because he considered it both important and enjoyable.

His research heritage in cardiovascular surgery was complemented by significant primary initiatives in clinical surgery, covering myocardial revascularization and thromboendarterectomy for chronic pulmonary embolism. For more than 30 years, his department was supported by a teaching grant from the National Institutes of Health and he facilitated the research careers of his residents and associates with unwavering intensity. The productivity of his associates in publication of peer-reviewed papers was an index of solid research that brought in massive, continuing extramural funding.

His extramural activities were prodigious, attested by hundreds of named lectures and by numerous visiting professorships in this country and abroad. He was given honorary membership in more than a dozen international surgical associations, societies, and colleges and was awarded a comparable number of awards, prizes, and medals by universities and associations.

He did not shirk the demanding work of national committees dealing with research and education, and he provided decades of professorial support for the Uniformed Services University of the Health Sciences. His extended work on various aspects of the report on Graduate Professional Education of the Physician under the sponsorship of the Association of American Medical Colleges is poorly known but highly important.

Finally, I note his monumental work with the American College of Surgeons. Initiated into Fellowship at the age of 33, he participated diligently in its programs before being recognized in 1972 as Secretary of the Board of Governors, followed by a year as Chair of that body until 1975, when he was elected to the Board of Regents. He served on the Board for nine years, occupying the Chair from 1982 to 1984 and serving as President of the College in 1985 to 1986. It was my privilege as Director of the College to work in close concert with him as he dealt serenely and effectively with many internal and external challenges. Despite the intractability of issues such as professional liability, he developed a particular interest and grasp of that daunting problem, maintaining a lively involvement even after demitting the presidency.

This presentation is necessarily an incomplete sketch of 50 active years in the life of a great surgeon, cut short in his prime by a devastating illness. It says nothing of his three daughters and five grandchildren who formed a devoted family complex under the faithful eye of his splendid consort. But it emphasizes the defining characteristic of his life as a teacher and hero for hundreds of young surgeons and others who came under his powerful influence. He was a man in full, who aimed to emulate his professor, Alfred Blalock; in this effort, he succeeded and indeed surpassed his mentor in the number of academic disciples from his own program. Formed in an uncompromising tradition, these surgeons represent a superlative legacy of this teaching colossus.

Fortitude under adversity

At his memorial service in the Duke University Chapel, a full congregation heard from Robert W. Anderson, MD, FACS, a successor chairman emeritus and president of the Sabiston Society. His account of some lighter moments in the Sabiston story were balanced by the inspiring account of Merel H. Harmel, MD, emeritus professor of anesthesiology. In Merel’s multiple visits to his longtime friend and associate during the final days of his 11-year disability, he never heard from David the slightest expression of self-pity for the heavy burden of illness that had been imposed on him. On the contrary, David demonstrated the same uncommon resilience and fortitude in his approach to death that had marked a life magnificently lived. Requiescat in pace.
Membership in the American College of Surgeons?

HERE’S WHY IT’S IMPORTANT:

AS A BODY REPRESENTING ALL OF SURGERY, THE COLLEGE:

• Provides a cohesive voice addressing societal issues related to surgery.
• Is working toward having an increasingly proactive and timely voice in setting a national tone and agenda with regard to health care.
• Is dedicated to promoting the highest standards of surgical care through education of and advocacy for its Fellows and their patients.
• Serves as a national forum through which surgeons can reinforce the values and ethics that traditionally have characterized the surgical profession.

THERE IS STRENGTH IN NUMBERS.

Our members represent every specialty, practice setting, and stage of practice. Their views and concerns are helping to 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 that status and consider getting involved in the work of the College.

Only by banding together and using our collective strength can we bring about positive change for our patients and ourselves—and for surgeons of the future.

HERE ARE SOME OF THE MANY BENEFITS BEING A MEMBER OF THE COLLEGE AFFORDS YOU:

• Free preregistration at the Clinical Congress
• Access to the College’s free coding consultation hotline
• Subscription to ACS NewsScope, the College’s weekly electronic newsletter
• Subscription to the Bulletin of the American College of Surgeons
• Subscription to the Journal of the American College of Surgeons
• Access to all College-sponsored insurance, credit card, and other helpful programs
• Free posting of resume on ACS Career Opportunities

Information on becoming a member of the College and an application form are available online at www.facs.org/dept/fellowship/index.html or contact Cynthia Hicks, Credentials Section, Division of Member Services, via phone at 800/293-9623, or via e-mail at chicks@facs.org.
Surgical groups join effort to call attention to workforce shortage

Surgical groups, led by the American College of Surgeons, along with other key health care stakeholders, have formed Operation Patient Access: Quality Surgical Care for All, an effort to bring into focus the urgent issues facing access to quality surgical care in the U.S. As part of this effort, more than 450 surgeons from around the country met with their elected representatives at the Joint Surgical Advocacy Conference, held March 22–24, to call attention to urgently needed policy changes to address gaps in the availability of quality surgical patient care.

“As policymakers examine how to reform this country’s health care system in the midst of the current economic crisis, there is a growing concern that the focus on cost controls will dominate discussions and decisions to the extent that access to quality surgical care will be further compromised,” said L. D. Britt, MD, FACS, Chair of the ACS Board of Regents. “Operation Patient Access is designed to help policymakers understand that patient access to quality surgical care is at risk and that we want to work with them to craft workable solutions that address access problems while preserving and improving high-quality surgical care.”

The shortage of general surgeons in the U.S. has been well documented and continues to be a major concern because these surgeons are mainstays in rural parts of the country and staff trauma centers in urban areas. Operation Patient Access released the following information that shows that the shortage and the resulting gaps in access to care are actually getting worse:

- The American College of Surgeons Health Policy Research Institute issued trend information in a new unpublished report that highlights research indicating the shortage of general surgeons has raised concerns about the access to care for underserved and rapidly aging populations in pockets of both rural and urban areas of the U.S.
- New research published in the March issue of the *Journal of the American College of Surgeons* reveals shortages of qualified surgeons in many regions of Maryland, especially in rural areas. The study states that excessive administrative demands and an aging physician and general population could push these shortages to critical levels over the next 10 years.

“One of the goals of Operation Patient Access is to spur dialogue and build consensus among stakeholders on how best to tackle and solve this problem because this is about making sure patients get the right care at the right time in the right place,” said Thomas Russell, MD, FACS, Executive Director of the American College of Surgeons. Some of

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**Operation Patient Access partners**

- American College of Surgeons
- American Academy of Ophthalmology
- American Academy of Otolaryngology–Head and Neck Surgery
- American Association of Neurological Surgeons
- American Association of Orthopaedic Surgeons
- American College of Osteopathic Surgeons
- American Osteopathic Academy of Orthopedics
- American Society of Plastic Surgeons
- American Urological Association
- Congress of Neurological Surgeons
- New England Rural Health Round Table
- The Society of Thoracic Surgeons
- Society for Vascular Surgery
- Texas Rural Health Association
- Utah Department of Health
- Wyoming Health Resources Network
the solutions being discussed by Operation Patient Access are to increase the number of residency programs, expand the National Health Services Corps, establish student loan forgiveness programs, provide more funding for graduate surgical education, reduce liability cost, and implement alternative payment methods for health care.

A key reason that patient groups support Operation Patient Access is to make sure that there are enough well-trained surgeons available to provide quality surgical care to those who need it when they need it.

“Susan G. Komen for the Cure supports the American College of Surgeons and its Operation Patient Access program,” said Diana Rowden, vice-president of health sciences at Susan G. Komen for the Cure. “Highly trained, experienced surgeons provide the treatment that is the foundation of breast cancer care, resulting in overall quality outcomes for women with breast cancer. These experts can and do provide women with the range of surgical options that are part of a comprehensive individualized treatment plan. A rigorous training program and extensive continuing education ensures that surgeons are qualified and current in their approaches to breast surgery.”

Other areas of surgery in which shortages are developing include orthopaedic surgery, neurosurgery, urology, obstetrics-gynecology, and cardiothoracic surgery.

“We’re facing a situation where 50 percent of the practicing cardiothoracic surgeons in this country are planning on retiring within 10 years, with more than 70 percent following within 13 years,” said John Mayer, MD, FACS, past-president of The Society of Thoracic Surgeons and current chair of the Council on Health Policy and Relationships for the Society. “This issue is compounded by the fact that we aren’t getting enough trainees into our cardiothoracic surgery fellowship programs. Between 2002 and 2007, thoracic surgery has seen a drop of 24 percent in the number of first-year trainees. This is a forbidding harbinger of things to come.”

2009 Oweida Scholar selected

Nathan C. Kanning, MD, of Sandpoint, ID, was recently selected to receive the 2009 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons. Having grown up on a Midwestern farm, Dr. Kanning decided to dedicate himself to surgery in a rural setting. He graduated in 2008 from Oregon Health Sciences University, Portland, OR, which has the only rural surgery training program in the U.S. He now works in a medical center in the Idaho panhandle near the Canadian border.

The Oweida Scholarship was established in 1998 in memory of Dr. Oweida, a general surgeon from a small town in western Pennsylvania. The $5,000 award subsidizes attendance at the annual Clinical Congress, including postgraduate course fees.

The purpose of the Oweida Scholarship is to help young surgeons practicing in rural communities attend the Clinical Congress and benefit from the educational experiences it provides. It is awarded each year by the Executive Committee of the Board of Governors.

The requirements for this scholarship are posted on the College Web site at http://www.facs.org/memberservices/oweida.html. The application deadline for the 2010 Oweida Scholarship is December 1, 2009.
Stanley W. Ashley, MD, FACS, named ACS Surgery Editor

Stanley W. Ashley, MD, FACS, has been named as the new Editor-in-Chief of ACS Surgery Principles & Practice, an official publication of the American College of Surgeons.

As the new Editor-in-Chief, Dr. Ashley brings experience and vision to ACS Surgery. “The opportunity to adapt ACS Surgery to the evolving needs of surgical residents and practicing surgeons is extremely exciting to me,” Dr. Ashley said.

Dr. Ashley is the Frank Sawyer Professor, vice-chairman of the department of surgery, and program director of the general surgery residency program at Brigham and Women’s Hospital/ Harvard Medical School, Boston, MA. He is also chief of general surgery for Harvard Vanguard Medical Associates.

Dr. Ashley is a gastrointestinal surgeon whose primary interests are diseases of the pancreas and inflammatory bowel disease. His research, which has been funded by the U.S. Department of Veteran Affairs and the National Institutes of Health, has examined the pathophysiology of small bowel and pancreas.

An author of more than 200 journal articles, Dr. Ashley serves on numerous editorial boards, including the Journal of the American College of Surgeons, the Journal of Gastrointestinal Surgery, and Current Problems in Surgery. He is a director of the American Board of Surgery and member of the Board of Trustees of the Society for Surgery of the Alimentary Tract.

“Dr. Ashley will be a wonderful new editor of ACS Surgery, who will build on the outstanding work Wiley W. Souba, MD, FACS, did in transitioning the original loose-leaf work into the modern era. Dr. Ashley will continue that trend by taking this excellent educational product to the next level,” ACS Executive Director Thomas R. Russell, MD, FACS, said.

In addition to many other changes, Dr. Ashley envisions adding operative videos to the online home of ACS Surgery, at http://www.acssurgery.com/.

He believes that these videos, teaching slide sets, and podcasts will enhance the educational experience for residents and practicing surgeons. He also would like the text to begin to integrate with the new general surgery residency curriculum being developed by the Surgical Committee on Resident Education. In addition, he hopes to expand the scope of the work by including chapters by a variety of experts with differing perspectives on general surgery and the subspecialties. By working with the publisher, BC Decker Inc., Dr. Ashley will promulgate the effort to make ACS Surgery an internationally adopted surgical reference.

Brian Decker, president and publisher of BC Decker Inc., said, “We are persuaded that Dr. Ashley’s stewardship will enhance the already remarkable success of ACS Surgery. The work draws its strength from its rich history, but its vitality stems from the fresh vision that Dr. Ashley brings to the enterprise. Since its first incarnation as Scientific American Surgery, this work has been the benchmark for innovation in surgical education. We expect the track record to be extended during the Ashley regime.”
The Executive Committee on Video-Based Education, through the Division of Education and Ciné-Med, has developed the interactive Multimedia Atlas of Surgery. Each volume presents a comprehensive list of surgical procedures, featuring:

- Narrated surgical video
- Didactic presentations
- Medical illustrations
- Expert commentary
- Foreword by Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education, American College of Surgeons

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Organ procurement risks raise concerns

Since 1990, five plane crashes related to organ procurement have occurred, four of which resulted in 10 deaths. After a crash in 2007 claimed the lives of several University of Michigan transplant team members and their pilots, Michael Englesbe, MD, an Associate Fellow of the College, and his colleagues in the university’s transplant department began to examine some of the hazards associated with organ procurement and to seek solutions to those problems. The results of an organ procurement survey conducted last year and sent to all members of the American Society of Transplant Surgeons are reported in the March issue of Surgery News, the official newspaper of the American College of Surgeons.

The survey is the only source of systematically collected data on the dangers of organ procurement travel, according to Dr. Englesbe. The survey findings confirmed existing impressions about the generally unsafe conditions inherent in organ procurement: bad weather, night travel, and the sense of urgency. “Most of the respondents (87 percent) said they simply do not feel very safe, especially when flying. And there was a broad consensus that there must be a better way to do it,” he said.

Dr. Englesbe is the lead author of two unpublished papers on the topic and will participate in a seminar to be held this coming spring with surgeons, reimbursement experts, and air medical transport representatives. Dr. Englesbe said that a goal of this symposium will be to produce a white paper that may then be used to guide the development of national policy on safety standards for organ procurement activities.

To learn more about the survey and changes in organ procurement practices, read the March issue of Surgery News at http://www.facs.org/surgerynews/.

ACS Career Opportunities

The American College of Surgeons’ online job bank

A unique interactive online recruitment tool provided by the American College of Surgeons.

An integrated network of dozens of the most prestigious health care associations.

Residents:

- View national, regional, and local job listings 24 hours a day, 7 days a week—free of charge.
- Post your resume, free of charge, where it will be visible to thousands of health care employers nationwide. You can post confidentially or openly—depending on your preference.
- Receive e-mail notification of new job postings.
- Track your current and past activity, with toll-free access to personal assistance.

Contact phaar@facs.org for more information.
Martin, Carrico Faculty Research Fellowships awarded by College

The American College of Surgeons Faculty Research Fellowships for 2009 were awarded by the Board of Regents in February. These two-year fellowships are offered to surgeons entering academic careers in surgery or a surgical specialty and carry awards of $40,000 per year from July 1, 2009, through June 30, 2011.

Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College. The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons honors the founder of the College. The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico.

The recipients of these fellowships are as follows:
- Franklin H. Martin, MD, FACS, Faculty Research Fellow: Tippi C. MacKenzie, MD, assistant professor, University of California–San Francisco. 
  Research project: In utero hematopoietic stem cell transplantation for tolerance induction.
- C. James Carrico, MD, FACS Faculty Research Fellow: Gregory H. Borschel, MD, affiliate faculty, department of biomedical engineering and assistant professor, division of plastic and reconstructive surgery, Washington University, St. Louis, MO.
  Research project: Controlled growth factor delivery for motor nerve injury.

Dr. MacKenzie Dr. Borschel

WHAT SURGEONS SHOULD KNOW ABOUT..., from page 7

No, reporting in PQRI is not required to participate in the e-prescribing incentive program.

Where can one learn more about the CMS e-prescribing incentive program?

To learn more about this program, go to http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp#TopOfPage and http://www.cms.hhs.gov/EAPrescribing/.

Six American College of Surgeons Resident Research Scholarships for 2009 were awarded by the Board of Regents in February. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2009. Unless otherwise noted, scholarships are sponsored by the Scholarship Endowment Fund of the College.

The recipients for these scholarships are as follows:

**Matthew D. Neal, MD**, resident in surgery, University of Pittsburgh, PA.

Research project: The role of enterocyte toll-like receptor signaling in the pathogenesis of intestinal barrier failure after trauma/hemorrhagic shock. (Dr. Neal’s scholarship is sponsored by Wyeth Pharmaceuticals).

**Yi Lu, MD**, resident in surgery, Brigham and Women’s Hospital and Children’s Hospital of Boston, MA.

Research project: Promoting...
axon regeneration and functional recovery after spinal cord injury by modulating the phosphatase and tensin homolog/mammalian target of rapamycin pathway. (Dr. Lu’s scholarship is sponsored by Ethicon.)

Pragatheeshwar Thirunavukarasu, MD, resident in surgery, University of Pittsburgh, PA.

Research project: Construction and preclinical development of an A34R deleted mutant vaccinia virus for virotherapy of peritoneal carcinomatosis.

Barbara Zarebczan, MD, resident in surgery, University of Wisconsin–Madison.

Research project: Notch 1 as a tumor suppressor in neuroendocrine cancers.

Fateh Entabi, MD, resident in surgery, University of Pittsburgh, PA.

Research project: Danger signals in ischemia-induced angiogenesis.

Erica N. Proctor, MD, resident in surgery, University of Michigan, Ann Arbor.

Research project: Targeting notch signaling in pancreatic cancer stem cells.

The requirements for these research-oriented scholarships offered by the College for 2010 will be published in a later issue of the Bulletin. This information will also appear on the College’s scholarships Web page at http://www.facs.org/memberservices/research.html. The Scholarship Endowment Fund was established to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Fellows wishing to make tax-deductible gifts to fund these vital programs are encouraged to contact the ACS Foundation at 312/202-5338.
2010 Traveling Fellowship to Japan available

The International Relations Committee of the American College of Surgeons has announced the availability of the 2010 ACS Traveling Fellowship to Japan.

Purpose
The purpose of this fellowship is to encourage international exchange of surgical scientific information. The ACS Traveling Fellow will visit Japan, and a Japanese Traveling Fellow will visit North America.

Basic requirements
The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:

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

Activities
The Traveling Fellow is required to spend a minimum of two weeks in Japan, engaging in the following activities:

- Attending and participating in the annual meeting of the Japan Surgical Society, which will be held in Nagoya, Japan, April 8–10, 2010
- Attending the Japan ACS Chapter meeting during that congress
- Visiting at least two medical centers in Japan (located in cities other than the city where the annual meeting convenes) before or after the annual meeting of the Japan Surgical Society to lecture and to share clinical and scientific expertise with the local surgeons

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and designated representatives of the Japan Surgical Society and the ACS Japan Chapter. The surgical centers to be visited will be determined, to some extent, by the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Japan.

The spouse of the successful applicant is welcome to accompany him or her. There will be opportunities for social interaction in addition to professional activities.

Financial support
The College will provide the sum of $7,500 to the successful applicant, who will also be exempted from registration fees for the annual meeting of the Japan Surgical Society.

The Traveling Fellow must meet all travel and living expenses. Senior Japan Surgical Society and representatives of the Japan Chapter will consult with the Fellow about the centers to be visited in Japan, the local arrangements for each center, and other advice and recommendations about travel schedules. The Fellow is to make his or her own travel arrangements in North America so that reduced fares and travel packages for travel in Japan are available.

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

Applications for this traveling fellowship may be obtained from the College’s Web site at http://www.facs.org/memberservices/acsjapan.html or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is June 1, 2009.

The successful applicant and an alternate will be selected and notified by November 2, 2009.
International Guest Scholarships available for 2010

The American College of Surgeons is offering International Guest Scholarships in 2010 to competent young surgeons from countries other than the U.S. or Canada who have demonstrated strong interests in teaching and research. The scholarships, in the amount of $8,000 each, provide the International Guest Scholars with an opportunity to visit clinical, teaching, and research institutions in North America and to attend and participate fully in the educational opportunities and activities of the American College of Surgeons’ Clinical Congress in Washington, DC, in 2010.

This scholarship endowment was originally provided through the legacy left to the College by Paul R. Hawley, MD, FACS(Hon), former Director of the College. In addition, a 1994 bequest from the family of Abdol Islami, MD, FACS, and gifts from others to the International Guest Scholarship endowment have enabled the College to expand the number of scholarship awards.

The scholarship requirements are as follows:

• Applicants must be medical school graduates.
• Applicants must be at least 35 years of age, but younger than 45, on the date that the completed application is filed.
• Applicants must submit their applications from their intended permanent location. Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).
• Applicants must have demonstrated a commitment to teaching and/or research in accordance with the standards of their respective home country.
• Applicants whose careers are in the developing stage are deemed more suitable for receipt of this scholarship than those who are serving in senior academic appointments.
• Applicants must submit a fully completed application form provided by the College on its Web site. The application and accompanying materials must be typewritten and in English. Submission of a curriculum vita only is not acceptable.
• Applicants must provide a list of all of their publication credits and must submit three complete publications (reprints or manuscripts) of their choosing from that list.
• Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department in which they hold academic appointment or a Fellow of the American College of Surgeons residing in their country. The chair’s or the Fellow’s letter must include a specific statement detailing the nature and extent of the teaching and other academic involvement of the applicant. Letters of recommendation should be submitted in envelopes and sealed by the writers.
• Applicants are required to submit a curriculum vita of no more than 10 pages.
• Applicants may submit a photograph. (Passport size is preferable.)
• The International Guest Scholarship must be used in the year for which it is designated. The scholarship cannot be postponed.
• Applicants who are awarded scholarships are expected to provide a full written report of the experiences provided through the scholarships upon completion of their tours.
• An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

International Guest Scholarships provide successful applicants with the privilege of participating in the College’s annual Clinical Congress in October, with public recognition of their presence. They will receive gratis admission to selected postgraduate courses plus admission to all lectures, demonstrations, and
exhibits, which are an integral part of the Clinical Congress. Assistance will be provided in arranging visits (following the Clinical Congress) to various clinics and universities of the scholars’ choosing.

To qualify for consideration by the selection committee, all of the requirements must be fulfilled. Formal American College of Surgeons International Guest Scholar applications are available online on the College’s Web site at http://www.facs.org/memberservices/igs.html. Supporting materials and questions should be directed to Administrator, International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211 USA; Fax: 312/202-5021

Completed applications, including all supporting documentation, for the 2010 International Guest Scholarships must be received at the office of the International Liaison Section before July 1, 2009. All applicants will be notified of the selection committee’s decision in November 2009. Applicants are urged to submit their completed application package as early as possible in order to provide sufficient time for processing.

A look at The Joint Commission

New for 2009: Accreditation decision methodology changes

Hospitals and ambulatory surgical centers that are surveyed this year can expect a change in the way their accreditation decision is determined.

In the past, thresholds were established for the number of standards an organization could be out of compliance with before triggering a recommendation for a conditional or preliminary denial of accreditation decision.

As part of The Joint Commission’s Standards Improvement Initiative—a multiyear improvement project to enhance the standards—a new scoring model was developed that focuses on the “criticality” of survey findings rather than on the volume of findings. This new model uses the number of noncompliant standards to determine whether an organization’s survey findings should be subject to a more intense review by Joint Commission central office staff.

The revised process also evaluates the magnitude and nature of the survey findings to determine if systemic problems exist across the organization (that is, similar issues identified across multiple departments or key systems).

Program-specific thresholds, based on the size and complexity of the surveyed organization and as measured in survey days, are used to determine if the survey findings should be reviewed by the central office staff. The review can result in one of the following outcomes:

• Issue an Accreditation Survey Findings Report with or without requirements for improvement; all requirements for improvement must be addressed by the organization through the Evidence of Standards Compliance (ESC) process.

• If the magnitude and severity of the survey findings is thought to warrant intensive follow-up with the organization, including a focused follow-up survey, a recommendation for conditional accreditation will be proposed for consideration by The Joint Commission’s Accreditation Committee.

• If an immediate threat to life exists within the organization or a situational decision rule was met, a recommendation for preliminary denial of accreditation will be proposed to the Accreditation Committee for its consideration.

For more information on the scoring and decision process, call The Joint Commission at 630/792-5900.
ACS Archives digital collections available online

The American College of Surgeons Archives announced the launch of its first samples of digital collections at last year’s Clinical Congress in San Francisco, CA. Since then, the link to the collections has been available on the Archives section of the ACS Web site at www.facs.org/archives, as well as on the History and Philosophy community page of the Web portal at http://efacs.org/history.

Four categories of records from the ACS Archives appear in the digital collections, including one volume out of the 48 of the memoirs of Franklin H. Martin, MD, FACS, and one volume of the 26 ACS History Notebooks, along with its index, compiled by Eleanor K. Grimm, Dr. Martin’s secretary. Besides samples from these two collections, which serve both as artifacts and original source documents recording the history, two other categories of records are found in the digital collections: photos of all the ACS Boards of Regents, from the earliest extant until 2006, and all issues of the Clinical Congress Daily News (now the Clinical Congress News) that have been located from 1911 to 1979. It’s also possible to browse through all these materials page by page.

On the Digital Collections link on the Archives site, researchers can perform an online search of names of Fellows who have been represented on the Board. With the full-text issues of the Clinical Congress Daily News, users can search names, surgical techniques, diseases, issues affecting surgeons, international guest surgeons, examples of postgraduate courses in surgery throughout the years, and much more.

The plan is to gradually add more resources each year to the Digital Collections. Feedback about use of the site is appreciated, and recommendations of items to add in the future can be submitted by filling out the brief survey form provided on the site just below the link for the Digital Collections.

Free access to the archives and its collections remains primarily a member benefit. Because of the Archives’ small staff and limited resources, nonmembers must pay a small service fee for reference assistance. Nevertheless, researchers are welcome to visit and peruse the collections in person at ACS Headquarters in Chicago, IL.

For more information about the Archives, contact ACS Archivist Susan Rishworth at 312/202-270 or srishworth@facs.org.
EXAMINE THE ETHICAL UNDERPINNINGS
OF THE ISSUES
YOU FACE EVERY DAY

A case-based educational resource for surgeons at all stages of their careers, **ETHICAL ISSUES IN CLINICAL SURGERY** has all the components needed to help surgeons and residents examine the ethical underpinnings of clinical practice and address the ethical issues they face every day caring for their patients.

*Ethical Issues in Clinical Surgery* was developed by the Committee on Ethics of the American College of Surgeons.

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- Professional obligations of surgeons
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- Glossary and additional resources

There are two versions of the book: one for course instructors and practicing surgeons that has CME credit available, and one for use with residents.

Pricing and ordering information can be found at [http://www.facs.org/education/ethicalissuesinclinicalsurgery.html](http://www.facs.org/education/ethicalissuesinclinicalsurgery.html) or by calling 312/202-5335.
AWS issues call for AWS Foundation Visiting Professor Program

The Association of Women Surgeons (AWS) has issued a call for applications for its AWS Visiting Professor Program, which allows women surgeons to share their expertise with medical students. This program provides medical schools with the opportunity to request top women surgeons as speakers and receive funding from the AWS Foundation and Ethicon Endo-Surgery Inc. Lecture opportunities heighten the visibility of women surgeons while encouraging women medical students to pursue similar careers. In addition, the Visiting Professor Program promotes dialogue between practicing surgeons and the academic community.

The AWS Foundation will match the chosen visiting professors with respective institutions and pay for travel and accommodations. Visiting professor responsibilities include the following:

• Travel to the institution selected by the AWS Foundation and participate in a two-day program; the visits usually involve lectures, discussion groups, patient evaluation, patient rounds, and possibly operative procedures arranged by the institution
• Interact with local women surgical faculty, residents, and medical students during sessions arranged by the institution
• Share information about the AWS and AWS Foundation at appropriate opportunities
• Make reservations for travel and accommodations
• Submit an expense form with back-up receipts to the AWS Foundation within 30 days after your presentation
• Submit a brief report summarizing the visit

Women surgeons who would like to be considered for the AWS Foundation/Ethicon Endo-Surgery Inc. Visiting Professor Program must complete the application and return it electronically to the AWS office by May 15, 2009. Institutions interested in being considered as a host site for a visiting professor must send a completed application by August 15, 2009.

Information, details, and applications can be found at http://www.womensurgeons.org/foundation/programs.htm.

ACS Foundation surpasses $1 million in gifts

The Board of Directors of the American College of Surgeons Foundation would like to extend its appreciation to all donors who have contributed gifts. So far this fiscal year, the gifts have totaled more than $1 million.

Through this generous support to the ACS Foundation, the College has been able to expand its significant accomplishments and provide even greater benefits, including the latest in education and research to benefit members of the College and surgical patients throughout the world. Resident research scholarships, faculty fellowships, named lectures, resident paper competitions, the Nora Institute for Surgical Patient Safety, and Operation Giving Back are only a few of the many programs supported by our donors.

The College recognizes there are several organizations that request financial support. During these challenging economic times, it is heartwarming to see the number of donors who choose to invest in the mission of the ACS.

To make a gift, visit the ACS Foundation Web site at http://www.facs.org/acsfoundation/ or call 312/202-5338.
American College of Surgeons Professional Association (ACSPA)

The ACSPA-SurgeonsPAC (http://www.facs.org/acspa/index.html) raised $684,509 in 2008. The average donation amount was $293. Although telephone fundraising continued to be a major component of the PAC’s fundraising efforts, more focus was placed on mailings and face-to-face fundraising.

Contributions for 2008 among ACSPA leaders were as follows:

- U.S. Governors: 60 percent
- U.S. Regents and Officers: 96 percent
- Health Policy Steering Committee members: 79 percent
- PAC Board: 94 percent

During 2008, contributions were made to 151 political candidates, leadership PACs, and party committees. In 2009, the ACSPA-SurgeonsPAC will continue to support congressional leaders and other members of Congress who support surgery’s legislative agenda.

A change for 2009 is that the PAC switched fundraising vendors, which will result in more results achieved for fewer dollars spent.

The PAC will continue to expand face-to-face fundraising programs, both via staff and Fellows, at various venues such as chapter meetings and Clinical Congress. Individual chapter and local involvement in PAC activities continues to be a major focus of future PAC development and growth.

American College of Surgeons

Board of Governors (B/G)

The Executive Committee of the Board of Governors (http://www.facs.org/about/governors/boardgv.html) held the first of five telephone conference calls scheduled for the year. The sixth meeting will occur during Clinical Congress in Chicago, IL, in October.

The Washington, DC, Office hosted a webinar for the Governors and other Fellows of the College. Additional Washington Office webinars are anticipated to be scheduled throughout the remainder of the year.
Two B/G webcasts were scheduled for 2009. The first webcast was held February 6. The webcasts are scheduled in conjunction with the Board of Regents meetings held in Chicago. The next webcast is scheduled for Friday, June 5, from 5:00 to 6:00 pm Central Time.

The Executive Committee and B/G committee chairs have begun planning the 2009 joint session of the Board of Governors and Board of Regents (http://www.facs.org/about/regents/regents.html). It is anticipated that the topic of interest will focus on workforce issues, though not related to work hours.

**Operation Giving Back (OGB)**

In 2008, there were more than 1.5 million hits to the OGB Web site (http://www.operationgivingback.facs.org) with an average of more than 1,000 page views per day. There were 238 distinct volunteer opportunities posted over the course of the year. The number of surgeons who have completed a volunteer profile in the “My Giving Back” feature of the OGB Web site continues to increase (currently more than 1,100).

The College and the U.S. Department of Homeland Security/Health Affairs co-convened a forum on the role of the trauma community in national disaster response paradigms. The meeting, attended by the leadership of the College along with representatives from several surgical organizations, was intended to explore possible collaboration with federal and state government agencies in times of disaster. Discussion centered on the critical role and underutilized services of trauma centers in national disaster response, advocacy and educational efforts related to disaster response from each of the groups in attendance, and the proposal of a centralized Disaster Responder Registry.

**ACS statement**

The Board of Regents approved the Statement on Medical and Surgical Tourism. The statement was developed by the College’s Committee on Perioperative Care and was published in the April 2009 issue of the Bulletin (see page 26); it is also available on the College’s Web site (www.facs.org/fellows_info/statements/st-64.html).

**ACS Bylaws**

The Board of Regents approved amendments to the Bylaws of the American College of Surgeons (http://www.facs.org/about/acsbylaws.html). During an interim meeting of the Board of Regents, the governance and structure of the College was discussed, resulting in a number of recommended revisions to the College’s Bylaws. Several revisions were merely housekeeping details whereas more substantial revisions related to the responsibilities of the elected Officers of the College.

**Advocacy**

The College hosted a meeting in Washington, DC, with members and staff from 13 surgical specialty societies to discuss how the College and the surgical community can work together on important health care reform and Medicare legislative issues in the coming year. The meeting resulted in the development of “Surgery’s United Agenda for Medicare Physician Payment Reform,” a document that expresses support for payment reforms including separate conversion factors based on type-of-service and opposition to payment increases for primary care that would reduce payments for other physician services. The College and the surgical specialty societies have been meeting and will continue to meet with members of the Congress and their staff regarding this document and the surgical community’s common position on these issues.

The College and 67 other physician organizations sent a letter on January 5 to the Medicare Payment Advisory Commission (MedPAC) supporting a 2.4 percent increase in Medicare payments and opposing MedPAC’s recommendations that payment be adjusted based on productivity. During MedPAC’s December and January meetings, several commissioners voiced opposition to the inclusion of the productivity adjustment in calculation of physician payment when other providers, namely hospitals, are not subject to such an adjustment. In response, MedPAC changed the recommendation to a straight 1.1 percent increase and removed previous language regarding price inputs and productivity.
MedPAC recommended limiting the payment rate increase for ambulatory surgery centers to 0.6 percent for services provided in 2010. The College joined other surgical societies to support a market basket update tied to the hospital outpatient prospective payment system. The group submitted a letter to MedPAC indicating that MedPAC’s recommendation to freeze or cut payments to ASCs is premature and does not take into account substantial payment reductions and payment system reforms that are under way. The College will continue to strongly oppose MedPAC’s recommendation to cut surgical payments in order to finance increased payments for other services. In addition, the College will continue to advocate for increased Medicare reimbursement rates that recognize the rising costs facing surgical practices.

Senate Finance Committee Chairman Max Baucus (D-MT) issued A Call to Action: Health Reform 2009, a white paper that outlined policy options for large-scale health reform and included a proposal to increase Medicare payments for primary care through a budget-neutral mechanism that would reduce payments for other physician services, including major surgical procedures. The College was joined by 13 surgical specialty societies in sending a letter expressing opposition to the white paper’s proposal for budget-neutral Medicare payment increases for primary care. The group met with Chairman Baucus’ staff to deliver the letter and discuss the surgical community’s opposition to the white paper’s proposal for budget-neutral payment increases for primary care.

The College has been working to ensure that funding for the Trauma-Emergency Medical Services program is included in the final House-Senate omnibus appropriations bill. The College will continue to work with both chambers to ensure funding for trauma care systems and services, as well as emergency medical services, trauma care research, and injury prevention.

The College, along with other surgical and medical organizations, developed a legislative agenda to address the ongoing surgical workforce crisis in emergency departments across the country. The College is working with its colleagues and staff on Capitol Hill to write legislation to be introduced in the current 111th Congress. The College continues to educate members of Congress on the emerging crisis in patient access to surgical care. The College has also emphasized the connection between surgical workforce shortages and trends in residency positions. The College has begun working with the National Rural Health Association, the Senate Rural Health Caucus, and the House Rural Health Care Coalition to create legislation that would address the underlying factors contributing to the surgical workforce crisis in rural areas.

The College supports a student loan initiative for residents. Medical school graduates are finding they owe an average of $130,000 when their educational loans come due. The College supports the reintroduction of legislation proposed in the last Congress that included acts that would remove the limits on tax deductions for student loan interest and provide relief by allowing young surgeons who qualify for the economic hardship deferment to use this option beyond the current limit of three years into residency, ensuring they will not have to begin repaying their loans or put their loans into forbearance during residency. The College joined other national organizations in urging the U.S. Secretary of Education to increase the aggregate combined Stafford loan limit for health professions students.

In December 2008, the Institute of Medicine released a report that proposed some modifications in resident duty hours. Although the report maintains the current limit of 80 hours, it proposes some major modifications in the structure of the 80-hour workweek. The American Council of Graduate Medical Education (ACGME) will study the impact of the recommendations. The College is working with the surgical specialty societies to develop a united response from surgery to send to the ACGME. Specifically, the College is asking its colleagues to focus on how the recommendations would affect patient care, education and training, budgets, and the well-being of surgical residents.

**ACS Health Policy Research Institute**

The work of the Institute has been officially ongoing since March 2008. Some of the Insti-
tute’s many activities and products between October 2008 and January 2009 include the following:

- Surgical workforce projections: the objective of this project is to analyze historical trends of the surgical workforce and project the future supply (by subspecialty, sex, race, and geography)
- Index of surgical under service: the objective of this research is to identify geographic patterns in the availability of surgical services, examining factors related to supply
- Surgical subspecialization tracking: the objective of this project is to examine trends in subspecialization over time
- Variation in outcomes for surgery-sensitive conditions associated with access to hospital-based surgical services: the objective of this study is to examine the effect of the availability of local general surgical expertise on patient outcomes for select “surgery-sensitive” (appendicitis, peritonitis, nonreducible hernias, bowel obstruction, ruptured spleen, and necrotizing fasciitis) disease processes
- 80-hour resident workweek: in the continuing debate about resident work hour restrictions, limited attention has been paid to the implications for surgical workforce planning; although the ACGME adopted an 80-hour workweek restriction in 2003, few studies have been conducted that investigate the effect of this limit on the supply, distribution, skill-mix, and competence of providers to whom surgical care, previously performed by residents, has shifted

Education

The College continues to participate in national discussion on restrictions on resident work hours following release of the Report of the Institute of Medicine (IOM) Consensus Committee. College leadership will appoint a small group that will be charged with the responsibility of addressing various nuances resulting from the IOM report and will be asked to develop a response for presentation to the ACGME.

A few of the many programs, products, or resources that were launched or significantly enhanced since October 2008 include the following:

- Professionalism in Surgery: Challenges and Choices—the second edition includes 24 vignettes.
- Objective Structured Clinical Examination (OSCE)—this 10-station ACS Surgery Resident OSCE focuses specifically on patient safety with case scenarios addressing critical and life-threatening situations that residents need to diagnose and manage from the beginning of their residency education and training.
- Multimedia Atlas of Surgery—the first volume of this atlas addresses colorectal surgery. The DVD and accompanying book was authored by leading surgeons in the field and focuses on 26 colorectal surgery procedures, both laparoscopic and open.
- Selected Readings in General Surgery (SRGS)—enhancements have been made in SRGS to augment the program’s relevance to practice and increase accessibility; SRGS is recognized by the American Board of Surgery as a program that may be use by surgeons to fulfill requirements of Part II of Maintenance of Certification, and a new Web site has been constructed to enhance its accessibility and online capabilities.
- Fundamentals of Surgery Curriculum—a total of 52 case scenarios of the curriculum have been launched since January 2009; there are 774 residents and 62 institutions currently enrolled in the program.
- Patient Education Program—the new ostomy skills program, which is currently being evaluated for its impact on skill acquisition, satisfaction, and confidence, provides patients with a comprehensive, interactive learning kit to help them acquire the requisite knowledge and skills to manage their care; the contents of the skill kit include a simple simulator and equipment for practice of skills, a skills instruction booklet with images to guide each step of skill acquisition, a skills self-assessment checklist, and a CD/DVD with demonstrations of each skill.

The “Find a Surgeon” Web site remains very popular. It may be accessed by the public through the Google search engine, the College’s Patient Education Web site, and the National Library of Medicine’s Doctor Directory. In addition, patients are being referred to the site by
the National Cancer Institute and insurance companies.

- The new model for Clinical Congress—launched at the 2008 Clinical Congress in San Francisco, CA, the new model will be further refined in 2009. There is also ongoing dialogue to redesign the Program Book beginning with the 2009 Congress.

ACS National Surgical Quality Improvement Program (ACS NSQIP)

This year’s national ACS NSQIP conference will take place July 19–21 at the Hilton San Diego Bayfront. Mark Chassin, MD, president of The Joint Commission, will provide the keynote address on Sunday, July 19. Dr. Chassin will speak on quality assurance and the future direction of The Joint Commission.

A call for abstracts was issued for this upcoming conference. The abstracts that were received are currently under review. The topics are diverse and range from local quality improvement initiatives and best practices to efficiency and cost savings.

HealtheCareers (Job Bank)

As of January 20, there were 1,261 active jobs listed on the HealtheCareers Web site (http://www.healthecareers.com/site_templates/ACS/index.asp?aff=ACS&SPLD=ACS) with 331 posted resumes.

ACS Case Log System

The number of cases in the system is now more than 600,000. The number of members using the system is now almost 1,400. In a recent survey of Case Log users, virtually all of the respondents indicated they would recommend the Case Log to their colleagues. Various reasons given for using the Case Log system included the following:

- Will help with Maintenance of Certification
- Want to understand practice patterns
- Want to understand outcomes
- Will help identify areas for improvement
- Will help with pay for performance

Communications

Revisions and augmentation of the member marketing DVD have been completed. The DVD highlights the benefits of membership in the College and is intended to be used at national meetings and by the chapters of the College.

Staff of the Division of Integrated Communications continues to maintain routine interaction with reporters representing both the lay and trade press. Highlights of the many calls received each week from reporters and interviews arranged by the division’s staff pertained to issues such as the surgeon shortage, surgical safety checklists, and the void in trauma care in the Galveston, TX, area in the aftermath of Hurricane Ike.

Web portal

Since October 2008, e-FACS.org has experienced unprecedented growth—the ACS Web portal enjoyed its largest single increase in visitors and usage since its launch three years ago. The fourth quarter has traditionally been the portal’s busiest quarter with members updating their continued medical education records by using the “My CME” feature.

One of the reasons for this latest success is the portal’s redesign, which was undertaken and completed last year. Reviews of the redesign indicated that it was having a positive impact on the portal’s usefulness.

Traffic to the College’s public Web site (http://www.facs.org/) has now reached more than 1.4 million hits per month. The average number of hits each day is approximately 45,331.

Dr. Zinner is
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We fight frivolous claims. We smash shady litigants. We over-prepare, and our lawyers do, too. We defend your good name. We face every claim like it’s the heavyweight championship. We don’t give up. We are not just your insurer. We are your legal defense army. We are The Doctors Company.

The Doctors Company built its reputation on the aggressive defense of our member physicians’ good names and livelihoods. And we do it well: Over 80 percent of all malpractice cases against our members are won without a settlement or trial, and we win 87 percent of the cases that do go to court. So what do you get for your money? More than a fighting chance, for starters. Our medical professional liability program has been sponsored by ACS since 2002. To learn more about our program for ACS members, call (800) 862-0375 or visit us at www.thedoctors.com.

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Underage and under the influence

by Richard J. Fantus, MD, FACS

This month is National Trauma Month, and this year’s focus is alcohol awareness and the dangers of underage drinking. Although drinking under the age of 21 is illegal, people aged 12 to 20 years drink 11 percent of all alcohol consumed in the U.S. The 2007 Youth Behavior Survey found that among high school students, during the past 30 days, 45 percent drank some alcohol, while 25 percent binge drank. Eleven percent drove after drinking alcohol and 29 percent rode with another driver who had been drinking alcohol (http://www.cdc.gov/HealthyYouth/yrbs/pdf/yrbss07_mmwr.pdf).

Youth who drink alcohol are more likely to have a large number of school absences and poor grades, be involved in fighting, get arrested for driving under the influence, exhibit memory problems, abuse other drugs, and experience changes in brain development that may have lifelong effects (http://cdc.gov/Alcohol/quickstats/underage_drinking.htm).

To raise awareness of the dangers of underage drinking and ways to prevent it, the American Trauma Society and the Emergency Medical Services for Children National Resource Center are launching “Kids KNOw Alcohol: Prevention through Education,” a campaign to educate parents and children. (For more information, visit www.amtrauma.org and www.childrensnational.org/emsc.)

In order to examine the occurrence of underage alcohol-related trauma in the National Trauma Data Bank Dataset 8.0, records were searched for patients aged 12 through 20 and by the field “alcohol present in blood.” Among the results, 74,252 records contained an age between 12 and 20 whereas 34,584 had a usable response of alcohol present or not present/not suspected, and 6,337 records indicated the patients were positive for alcohol.

Of the alcohol-present group, 5,744 records had discharge status recorded, including 4,890 discharged to home and 630 to acute care/rehabilitation; 35 were sent to nursing homes, and 189 died (see Figure, this page). These patients were 77.3 percent male and on average 18.3 years of age; they had an average length of stay of 6.4 days, an average injury severity score of 10.5, and 21.5 percent penetrating trauma.
In a population that for the most part should be considered as dependents, a striking 23.1 percent were self-pay. Among 4,230 of the alcohol-positive patients who were also tested for drugs, 1,794—more than 40 percent—tested positive.

Underage drinking is a complex problem and there is no simple answer. There are many unique proposals being offered by experts in the field. For parents, alcohol and drug education starts in the home and early on in a child’s development. That is where one can make an impact and hopefully avoid the situation of being underage and under the influence.

The full NTDB Annual Report Version 8.0 is available on the ACS Web site as a PDF and a PowerPoint presentation at http://www.ntdb.org.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgment

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