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Future meetings

Clinical Congress
2006 Chicago, IL,
October 8-12
2007 New Orleans, LA,
October 7-11
2008 San Francisco, CA,
October 12-16

Spring Meeting
2006 Dallas, TX,
April 23-26
2007 Las Vegas, NV,
April 21-24
2008 To be announced

On the cover: The College launches e-FACS.org, the new Web portal (see article, page 12). Photo courtesy of Getty Images.
### NEWS

**A “thank you” from Louisiana**

*Lester W. Johnson, MD, FACS*

**A look at JCAHO:**

*The Joint Commission and the ACS*

**April 23-26:**

*34th Spring Meeting to be held in Dallas, TX*

**Association of Women Surgeons meets in San Francisco**

**ACS seeking nominations for Officers-Elect and the Board of Regents**

**Trauma and Critical Care 2006 scheduled for March**

**Trauma meetings calendar**

**Health policy scholarships available for 2006**

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**Letters**

**NTDB™ data points:**

*Annual report 2005, dataset version 5.0*

*Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS*
SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM. These CD-ROMs run in the PC and Mac environments and offer you the ability to keyword-search throughout the CD.

ONLINE CME: Courses from the ACS’ Clinical Congresses are available online for surgeons. Each online course features video of the introduction, audio of session, printable written transcripts, post-test and evaluation, and printable CME certificate upon successful completion. Several courses are offered FREE OF CHARGE. The courses are accessible at: www.acs-resource.org.

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PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children), and financial planning for surgical practice.

NEW! PROFESSIONALISM IN SURGERY: CHALLENGES AND CHOICES: Professionalism is an essential component of surgical practice, and one of the six core competencies defined by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education. This CD-ROM presents 12 case vignettes, each including a scenario followed by multiple choice questions relating to professional responsibilities of the surgeon within the context of the case. The program provides the opportunity to earn online CME credit, with a printable certificate upon successful completion.

For purchase and pricing information, call ACS Customer Service at 312/202-5474 or visit our E-LEARNING RESOURCE CENTER at www.acs-resource.org.

For more information contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.
From my perspective

This organization has always been fairly discreet about its accomplishments, refraining from activities that smack of self-promotion. In the past, this sort of quiet modesty was admirable and helped the College maintain a highly professional image.

However, it may be time for us to rethink whether it is really to the benefit of our profession and our patients to continue to maintain a low-key posture about what we are doing to improve quality of care. The College is striving to be a recognized leader in the quality movement, and certainly some members of the federal government are realizing how useful our experience and data can be in rebuilding this country’s health care system. Similarly, it behooves us to help consumers better understand the value of surgical care and to help them determine which providers are best able to meet their needs.

The past

Some of you may recall that for many years the American College of Surgeons sponsored a national consumer advertising program. The purpose of what was called the “Surgery by Surgeons” campaign was sixfold: to communicate to the public the College’s position that operations should be performed only by qualified surgical specialists; to provide the public with information needed to assess a surgeon’s qualifications; to explain the surgeon’s overall role in patient care; to emphasize the importance of patient choice in the selection of a surgeon; to increase public awareness of the American College of Surgeons; and to emphasize ACS Fellowship as a surgical credential the public should look for when facing the possibility of having an operation.

Although this was a long-term program sponsored by the College, it was conducted in what many of us now might consider to be a low-key way. Full-page ads were placed in consumer magazines, and commercials were aired on the radio. Daily national and local newspapers and television were not used for this program because of cost considerations and because, at the time, using such highly visible communications vehicles was not considered to be an appropriate thing for the College to do.

I should point out that the College has not been unique in its reluctance to “blow its own horn.” Until recently, it was considered unprofessional for physicians, hospitals, and national medical and health care organizations to overtly advertise themselves or their services. In fact, many medical organizations, including the College and the American Medical Association (AMA), prohibited or dissuaded their members from advertising. In 1975, however, the Federal Trade Commission (FTC) filed an antitrust lawsuit against the AMA, charging that its ban on physician advertising discouraged competition and unfairly disadvantaged consumers. After years of legal wrangling, the FTC won the lawsuit in 1982, and since then, the AMA has lifted its ban, and physicians have been free to promote their services in whatever way they find comfortable. These days, it’s almost impossible to open a newspaper or watch a television program without seeing an ad promoting the services of a physician or a health care center. And national organizations have also become more aggressive in that regard. As many of you may know, the AMA is currently running a national advertising program on television; as Michael D. Maves, MD, FACS, executive vice-president and chief operating officer of the AMA, explained during the American Urological Association Lecture at the 2005 Clinical Congress, this is just one aspect of its “branding” effort.

What we offer

The American College of Surgeons has always stood for promoting the highest standards of patient care. Unfortunately, with the cancellation of

“It is time to break out of the mode of quiet modesty and let people know who we are, what we do, and what we stand for.”
our long-term advertising program, we lost even a low-key mechanism for providing the surgical profession and the College with consistent public visibility. Thus, the public in general does not know what we do and how our work benefits them.

My guess is that most people are unaware of the high standards that surgeons must meet to be part of this Fellowship. We need to once again educate the public about what it means to be board certified and why board certification is a prerequisite for ACS Fellows. We need to explain how and why we discipline those individuals who engage in unethical or negligent activities.

We also need to tell consumers about some of the programs we offer to ensure that they receive safe and appropriate care. For instance, the public should be made aware of the College’s Advanced Trauma Life Support® (ATLS®) program, which has trained thousands of health care professionals here and overseas in the safe and effective provision of urgent care.

Our Committee on Trauma (COT), which introduced the ATLS program, also operates the National Trauma Data Bank™, which tracks information about patients who receive emergency treatment for purposes of improving the care of injured patients through systematic efforts in prevention, treatment, and rehabilitation. Although reporters routinely mention our trauma programs in their reports on emergency care, patients should know more about how we verify these centers and what it means to receive the COT stamp of approval.

Likewise, the public should be more familiar with the efforts led by our Commission on Cancer (CoC). They should know how the CoC’s Approvals Program encourages hospitals, treatment centers, and other facilities to improve oncological care through prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease, support services, and end-of-life care. Patients should be aware of how the National Cancer Data Base is working to improve cancer treatment by providing physicians, cancer registrars, and others with a means of comparing how they manage cancer patients with cancer care professionals elsewhere.

The public should also know about our clinical trials programs and how these efforts may lead to more effective and safer treatment options for individuals suffering from various types of cancer and hernias.

**Getting the word out**

Unquestionably, the American College of Surgeons is engaged in numerous activities aimed at ensuring that surgical patients receive the safest and best possible surgical care. The question is, how do we let them know about our efforts?

Many of us believe that the time has come for the College to reinstitute a public relations program—and to take a more aggressive and visible approach than we have used in the past. Some suggestions for improving the College’s public visibility that we’ve received include hiring a public relations firm, developing an advertising program, and working with a publicist. Perhaps we should become more vocal regarding public health issues and speak out on the physical repercussions of obesity, smoking, and alcohol and drug abuse. As another means of communicating with the public, efforts are under way to develop and publish a book that explains the surgical experience and what is involved in having an operation in a way that the general population can understand.

No doubt, many Fellows have very strong opinions about whether and how we should employ these approaches. That’s why I wanted to use this month’s column to initiate a dialogue about this subject. We need to start moving ahead with whatever strategies we decide to implement so that our patients will be better equipped to deal with the imminent changes that will be occurring as this country rebuilds our health care system.

It is time to break out of the mode of quiet modesty and let people know who we are, what we do, and what we stand for. As always, your comments regarding how we accomplish this objective would be most welcome.

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
Dateline Washington

prepared by the Division of Advocacy and Health Policy

CMS issues 2006 Medicare fee schedule

On November 1, the Centers for Medicare & Medicaid Services (CMS) released a final rule on Medicare physician payment policies for 2006. The new regulations—which, at press time, were scheduled to take effect January 1—address several key issues first raised in a proposed rule published in August 2005. Of particular importance, CMS announced an across-the-board 4.4 percent reduction in physician payments, with a fee schedule conversion factor of $36.1770 (compared with $37.8975 in 2005). The pay cut is attributable to the fee schedule’s use of the sustainable growth rate (SGR) as a prospectively determined expenditure target for restraining the rate of growth in Medicare spending for physician services. For more information about the 2006 fee schedule, see the article on page 8.

Congress poised to act on Medicare and trauma funding

At press time, Congress was still debating legislation centered on issues of concern to surgeons. Following is a brief summary of some of the more pertinent bills awaiting passage by the end of the year.

• Medicare. During the last week of October, the Senate Finance Committee approved a broad budget bill that includes a 1 percent increase in Medicare payment to physicians in 2006. The 1 percent increase would replace the 4.4 percent cut in 2006 described previously. However, the budget package fails to address prospective cuts of 4 to 5 percent per year in 2007 and beyond because it allows Medicare to retain the SGR. In addition, the budget bill includes quality-reporting requirements for physicians in 2007 and 2008 and establishes a pay-for-performance (P4P) program starting in 2009.

A related bill, H.R. 3617, the Medicare Value-Based Purchasing for Physicians’ Services Act of 2005, would not only stop Medicare payment cuts in 2006 but would repeal the SGR to avert cuts in 2007 and subsequent years and would base future Medicare payments on rising practice costs. In addition, this legislation would implement P4P based on quality measures such as those developed through the Surgical Care Improvement Project and the ACS National Surgical Quality Improvement Program.

• Trauma funding. On October 27, 2005, the Senate approved its version of the fiscal year (FY) 2006 Labor-Health and Human Services (HHS)-Education appropriations bill (H.R. 3010), which allocates $3.5 million to the Health Resources and Services Administration’s Trauma-Emergency Medical Services (EMS) Program. However, this program remained in jeopardy because the House version, passed June 24, 2005, provided no financial support for it. At press time, the legislation was under review in a conference committee charged with reconciling the disparities between the Senate and House versions of the legislation, both of which provide $141.7 billion in discretionary spending for the Departments of Labor, HHS, and Education.

More up-to-date information on these and other bills was published in December 2005 issues of ACS NewsScope.
CMS has established a voluntary program to report evidence-based, consensus quality measures for Medicare beginning January 1. During the first phase of implementation, CMS is collecting information on a set of 36 measures using a dedicated set of Healthcare Common Procedure Coding System (HCPCS) codes, called G-codes, which will supplement the claims data physicians currently submit to CMS with clinical data. The goal of the program is to introduce a process for participating physicians to begin reporting quality data and receiving feedback on their performance. Participation in the program or relative performance on the measures will not affect reimbursement, nor will the information be publicly reported. A fact sheet describing both the program and the measures is posted at http://www.cms.hhs.gov/media/press/release.asp?Counter=1701.

The Emergency Medical Treatment and Active Labor Act (EMTALA) technical advisory group (TAG) met October 26–28, 2005, to consider proposals aimed at addressing the shortage of specialists who take emergency call. The TAG also discussed inappropriate transfers and the effect of specialty hospitals on EMTALA-mandated care. After hearing testimony from several organizations, the TAG offered the following recommendations to CMS: (1) hospitals with specialized capabilities should not be required to maintain dedicated emergency departments (DEDs), and (2) hospitals with specialized capabilities that do not have DEDs should have the same responsibilities under EMTALA as those with DEDs. The TAG also called for CMS to move from the EMTALA regulations to Medicare a requirement that hospital emergency departments maintain a list of on-call physicians.

The EMTALA TAG advises CMS on regulations related to EMTALA and their application to physicians and hospitals. It comprises 19 members, including four College Fellows: general surgeon Richard Perry, MD, FACS, Phoenix, AZ; pediatric surgeon David Tuggle, MD, FACS, Oklahoma City, OK; orthopaedic trauma surgeon James Nepola, MD, FACS, Iowa City, IA; and neurosurgeon John Kusske, MD, FACS, Orange, CA. For more information about the TAG, go to http://www.cms.hhs.gov/faca/emtalatag/default.asp.

HHS Secretary Mike Leavitt recently announced adoption of “foundation standards” for the electronic prescribing (e-prescribing) of Part D drugs covered by Medicare. The final rule regarding the standards was published in the Federal Register on November 7, calling for e-prescribing to coincide with the implementation of Medicare’s new prescription drug benefit beginning January 1. E-prescribing enables a physician to transmit a prescription electronically to a patient’s pharmacy of choice. It is not only easier than paper prescriptions but may also improve patient safety and reduce costs by decreasing prescription errors and automating the process of checking for drug interactions and allergies. E-prescribing also will allow physicians, pharmacies, and patients to obtain timely evidence-based information on drugs and on patient eligibility.
What surgeons should know about...

The 2006 Medicare fee schedule
by Cynthia A. Brown, Director, Division of Advocacy and Health Policy

On November 1, 2005, the Centers for Medicare & Medicaid Services (CMS) released a final rule revising the Medicare physician payment policies for 2006.* The new regulations, which took effect January 1, address several key issues first raised in a proposed rule published in August 2005, on which CMS received approximately 15,000 comments from medical and surgical specialty organizations, including the College as well as individual physicians, patient advocate groups, and others.

Following are answers to questions surgeons may have about provisions in the rule that affect them most directly.

What is the 2006 fee schedule conversion factor, and how was it calculated?

Following a formula established by law, CMS announced that the physician fee schedule update for calendar year 2006 is –4.4 percent, producing a conversion factor of $36.1770 (compared with $37.8975 in 2005). The update was derived by applying an “update adjustment factor” of –7 percent to a Medicare Economic Index (MEI) of 2.8 percent, along with a –0.6 percent budget neutrality adjustment to account for changes made to certain relative value units (RVUs).

Why was a negative update adjustment factor applied to the MEI?

The –7.0 percent adjustment is required by law because of the sustainable growth rate (SGR), which was created as a means of restraining the rate of growth in Medicare spending for physician services. The SGR is a prospectively determined expenditure target that is tied to the size of the beneficiary population and overall economic growth. If spending growth under the fee schedule in a given year is below the SGR target rate, commensurate “bonus” percentage points are added to the MEI to determine the annual update in a subsequent year. On the other hand, when aggregate spending exceeds the SGR, the excessive percentage amount is deducted from the MEI. Regardless of how much actual spending falls short of or exceeds the SGR, Medicare law limits penalty deductions to no more than seven percentage points below the SGR and bonus increases to no more than three percentage points above the MEI.

In addition, the SGR is a cumulative target, meaning that adjustments are based on the difference between the cumulative amount of actual spending on physician services and the cumulative spending target since the base year of 1996. As a result, the system requires that excess spending in any single year be recouped in future years. The only way to achieve this objective is to reduce the fee schedule updates enough to offset the excess spending. With a “floor” on payment updates of MEI at –7 percent, it can take quite a few years to offset a period of high spending growth (see Table 1, page 9).

Throughout 2005, much was said in the Administration and in Congress about efforts to reform the payment system that is producing these across-the-board payment cuts. Why hasn’t the system been changed?

Because the physician payment system was established according to laws passed by Congress, CMS has limited options for reforming the system on its own. However, the College and others have argued that the agency has authority to take steps that would help ease the problem.

For example, in calculating physician spending under the SGR, CMS includes the cost of certain physician-administered drugs (such as chemotherapy drugs). Because of the proliferation of these drugs in recent years, this policy

*At press time, the regulation was scheduled for publication in the Federal Register on November 21, 2005. The full text can be viewed on the CMS Web site at http://www.cms.hhs.gov/physicians/.
has exacerbated the problem of “excessive” spending growth under the SGR. Arguably, rates of spending growth for these services do not belong under the spending target because their costs are not paid under the fee schedule and their prices are not influenced by the SGR. In the final rule on 2006 payment policies, however, the agency rejected comments requesting the removal of drug expenditures from the SGR calculations.

Congress has been considering legislation to eliminate the SGR entirely and base future physician payment updates on the MEI. But, because the budgetary “baseline” reflects future reductions in physician payments mandated by current law, the 10-year cost of enacting this common-sense reform has been estimated as high as $180 billion. At press time, Congress had not yet identified spending cuts it was willing to enact in order to offset the costs of comprehensive reform, nor had a one- or two-year solution been enacted along the lines of those short-term solutions passed to maintain positive updates in 2003, 2004, and 2005 (see Figure 1, right).

Table 1: Physician performance under the SGR

<table>
<thead>
<tr>
<th>Period</th>
<th>Cumulative allowed expenditures (in $ billions)</th>
<th>Cumulative actual expenditures (in $ billions)</th>
<th>SGR (%)</th>
<th>Actual growth rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/96-3/31/97</td>
<td>48.9</td>
<td>48.9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4/1/97-3/31/98</td>
<td>99.4</td>
<td>98.4</td>
<td>3.2</td>
<td>–2.2</td>
</tr>
<tr>
<td>4/1/98-3/31/99</td>
<td>152.0</td>
<td>148.9</td>
<td>4.2</td>
<td>–4.0</td>
</tr>
<tr>
<td>1/1/99-3/31/99</td>
<td>*</td>
<td>148.9</td>
<td>4.2</td>
<td>–1.5</td>
</tr>
<tr>
<td>4/1/99-12/31/99</td>
<td>*</td>
<td>188.4</td>
<td>6.9</td>
<td>–6.2</td>
</tr>
<tr>
<td>1/1/99-12/31/99</td>
<td>194.0</td>
<td>188.4</td>
<td>*</td>
<td>–4.9</td>
</tr>
<tr>
<td>1/1/00-12/31/00</td>
<td>253.4</td>
<td>246.5</td>
<td>7.3</td>
<td>–2.2</td>
</tr>
<tr>
<td>1/1/01-12/31/01</td>
<td>315.4</td>
<td>312.8</td>
<td>4.5</td>
<td>6.9</td>
</tr>
<tr>
<td>1/1/02-12/31/02</td>
<td>382.6</td>
<td>383.8</td>
<td>8.3</td>
<td>5.7</td>
</tr>
<tr>
<td>1/1/03-12/31/03</td>
<td>454.6</td>
<td>460.6</td>
<td>7.3</td>
<td>6.5</td>
</tr>
<tr>
<td>1/1/04-12/31/04</td>
<td>531.5</td>
<td>549.3</td>
<td>6.6</td>
<td>13.5</td>
</tr>
<tr>
<td>1/1/05-12/31/05</td>
<td>611.8</td>
<td>642.5</td>
<td>4.6</td>
<td>16.0</td>
</tr>
<tr>
<td>1/1/06-12/31/06</td>
<td>693.6</td>
<td>N/A</td>
<td>1.7</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Legislation was passed that changed the period used for calculating the SGR and measuring performance, making these figures immaterial.
Table 2: Diagnostic imaging services subject to multiple procedure payment reduction

<table>
<thead>
<tr>
<th>Family</th>
<th>Description</th>
<th>2004 Medicare allowed charges (in $ millions)</th>
<th>Payment impact of multiple procedure policy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Ultrasound (chest/abdomen/pelvis; non-obstetrical)</td>
<td>138</td>
<td>–3.4</td>
</tr>
<tr>
<td>02</td>
<td>CT and CTA (chest/thorax/abdomen/pelvis)</td>
<td>563</td>
<td>–9.5</td>
</tr>
<tr>
<td>03</td>
<td>CT and CTA (head/brain/orbit/maxillofacial/neck)</td>
<td>97</td>
<td>–1.3</td>
</tr>
<tr>
<td>04</td>
<td>MRI and MRA (chest abdomen/pelvis)</td>
<td>105</td>
<td>–2.4</td>
</tr>
<tr>
<td>05</td>
<td>MRI and MRA (head/brain/neck)</td>
<td>532</td>
<td>–3.1</td>
</tr>
<tr>
<td>06</td>
<td>MRI and MRA (spine)</td>
<td>540</td>
<td>–2.2</td>
</tr>
<tr>
<td>07</td>
<td>CT (spine)</td>
<td>24</td>
<td>–2.1</td>
</tr>
<tr>
<td>08</td>
<td>MRI and MRA (lower extremities)</td>
<td>166</td>
<td>–1.6</td>
</tr>
<tr>
<td>09</td>
<td>CT and CTA (lower extremities)</td>
<td>5</td>
<td>–1.0</td>
</tr>
<tr>
<td>10</td>
<td>MR and MRI (upper extremities and joints)</td>
<td>107</td>
<td>–1.4</td>
</tr>
<tr>
<td>11</td>
<td>CT and CTA (upper extremities)</td>
<td>2</td>
<td>–0.7</td>
</tr>
<tr>
<td></td>
<td>Total for all procedures subject to multiple imaging reductions</td>
<td>2,276</td>
<td>–4.2</td>
</tr>
</tbody>
</table>

CT = computed tomography  
CTA = coronary computed tomography angiography  
MRI = magnetic resonance imaging  
MRA = magnetic resonance angiography  
MR = magnetic resonance

Table 3: Change in payments for key surgical services

<table>
<thead>
<tr>
<th>CPT/procedure</th>
<th>2005 payment ($)</th>
<th>2006 payment ($)</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>19240, Removal of breast</td>
<td>996</td>
<td>952</td>
<td>–4.4</td>
</tr>
<tr>
<td>27130, Total hip replacement</td>
<td>1,396</td>
<td>1,336</td>
<td>–4.3</td>
</tr>
<tr>
<td>27447, Total knee replacement</td>
<td>1,508</td>
<td>1,443</td>
<td>–4.3</td>
</tr>
<tr>
<td>31255, Removal of ethmoid sinus</td>
<td>447</td>
<td>427</td>
<td>–4.5</td>
</tr>
<tr>
<td>33512, CABG, vein, three</td>
<td>2,044</td>
<td>1,956</td>
<td>–4.3</td>
</tr>
<tr>
<td>35301, Rechanneling of artery</td>
<td>1,129</td>
<td>1,078</td>
<td>–4.5</td>
</tr>
<tr>
<td>44140, Partial removal of colon</td>
<td>1,223</td>
<td>1,170</td>
<td>–4.3</td>
</tr>
<tr>
<td>49505, Repair inguinal hernia</td>
<td>468</td>
<td>448</td>
<td>–4.3</td>
</tr>
<tr>
<td>52601, Prostatectomy (TURP)</td>
<td>694</td>
<td>663</td>
<td>–4.5</td>
</tr>
<tr>
<td>63047, Removal of spinal lamina</td>
<td>1,047</td>
<td>1,004</td>
<td>–4.1</td>
</tr>
<tr>
<td>66984, Remove cataract, insert lens</td>
<td>684</td>
<td>653</td>
<td>–4.5</td>
</tr>
</tbody>
</table>

CABG = coronary artery bypass graft  
TURP = transurethral resection of the prostate
What is the SGR for 2006?

The initial estimate for the SGR for calendar year 2006 is 1.7 percent. This number is well below rates set in previous years because it reflects the 4.4 percent across-the-board payment reduction announced for 2006 payments.

Were any significant changes made in the fee schedule relative values?

In August 2005, CMS proposed using supplemental practice cost data submitted by the radiology, cardiology, radiation oncology, urology, dermatology, allergy/immunology, and gastroenterology specialties to refine certain practice expense RVUs in the fee schedule. The agency also proposed revising the methodology used to allocate indirect practice costs down to individual physician services. Because of budget neutrality requirements, payment increases that would have been produced by these changes in practice expense RVUs would have been offset by reductions in values assigned to services provided by other specialties, causing payment redistribution. In the final rule, CMS withdrew these proposals with the following three exceptions:

- Interim practice expense RVUs assigned for new service codes introduced in 2006;
- Practice expense values developed using supplementary data submitted by urology for drug administration codes used by that specialty; and
- A redistribution of savings from implementation of a payment policy change pertaining to multiple radiology procedures, described later in this article.

The agency plans to hold meetings early this year to obtain input on its proposed methodology changes. In addition, it plans to work with physician groups to develop a strategy for funding and fielding a multispecialty indirect practice costs survey that will help to ensure the data are up to date and that the methodology treats all specialties equally.

Were any changes made in the fee schedule to reflect the escalating costs of professional liability insurance?

CMS implemented a minor but positive change in the methodology used to calculate the malpractice RVUs listed in the Medicare fee schedule. In determining which liability risk factors to use in creating RVUs for an individual service, the agency now applies a “5 percent threshold.” So, beginning in 2006, CMS will view as an aberrant occurrence any service performed by individual specialties that provide that service less than 5 percent of the time. Their associated risk factors will be removed from the malpractice RVU calculation, in an effort to improve the accuracy and stability of this fee schedule component. An exception to the rule is being made for the evaluation and management (E/M) codes because all specialties do, in fact, provide these services.

What changes were made to relative work RVUs in the fee schedule?

CMS received relative work value recommendations from the American Medical Association/Specialty Society RVS Update Committee, or RUC, for 175 new and revised Current Procedural Terminology (CPT) codes,¹ and approximately 94 percent of them were accepted. Unfortunately, the agency rejected requests to consider codes describing backbench preparation of various organs for transplantation on the grounds that these are hospital organ acquisition costs that are not eligible for payment under the physician fee schedule.

In August 2005, CMS proposed to implement a new payment policy for multiple diagnostic imaging procedures that is similar to the rules applied to multiple surgical procedures. Was that policy adopted?

CMS adopted a new payment reduction policy for the technical component of certain diagnostic imaging procedures when more than one procedure is provided in a single session. For 11 service families (see Table 2, page 10), Medicare will make full fee schedule payments for only the first service provided in a single session; additional

¹All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.
INTRODUCING
e-facs.org

College
launches
Web portal
for its members

by George F. Sheldon, MD, FACS, Chapel Hill, NC
During the past decade, the American College of Surgeons has increased and expanded its communications with its members by embracing and employing electronic communications vehicles—the weekly electronic newsletter, ACS NewsScope, and regular “special alerts” sent via e-mail. In addition, the College’s Web site—www.facs.org—generates nearly 1 million hits per month. As our society becomes more computer literate and technologic advances provide new collaborative tools, the College is finding even greater opportunities to interact with its members. In summer 2004, at the suggestion of the Resident and Associate Society and the Committee on Young Surgeons, the Board of Regents approved in concept and with financial support the creation of a Web portal for this purpose.

The mission of the American College of Surgeons Web portal—e-FACS.org—is to expand the College’s role as an information resource on patient care for the various surgical specialties and on advances in bioscience, research, and health policy by providing its members with a personalized gateway to the Internet that will (1) filter and facilitate their access to Web-based information; (2) initiate and facilitate collaboration and exchange of ideas among members; and (3) provide a secure, single sign-on service that will be the entry point of access to organized Web information coming from the College and other validated and reputable sources.

A project of the College’s Informatics and Communications Committees, the portal has been in development for approximately 18 months. A Web Portal Steering Committee provides overall guidance with respect to the portal’s vision, while a Web Portal Editorial Board advises and assists the editor-in-chief in selecting material appropriate for the portal’s users, which include Fellows, Associate Fellows, surgical residents, and medical students.

**What is a portal?**

For those unfamiliar with the term, a Web portal is a secure, single-point-of-entry Web site configured for a specific community or organization. Many people use portals without even knowing they are doing so—well-known examples include Amazon.com, “My Yahoo,” and “My MSN.” Portals are built on the same technology used for Web sites, but they enhance the functionality and flexibility to cater to the demands of its users. There are five major differences between a Web site and a Web portal—authentication, personalization, customization, integration, and content management.

- **Authentication**—In addition to requiring a login to enter a portal, the portal also knows who you are through an authentication process. Authentication via single-sign-on also eliminates the need to remember many usernames and passwords when entering other sites through the portal.
- **Personalization**—A portal’s highly focused content eliminates the need to visit many different Web sites for information.
- **Customization**—Users select and organize their own content in a portal based on individual preferences.

**Getting started**

Note: To access the Web portal, you will need your eight-digit Fellowship ID number (which can be found on your Fellowship card or on the mailing label on your monthly package containing the Bulletin and the Journal of the American College of Surgeons).

After opening the Web browser of your choice (for example, Internet Explorer, Firefox, or AOL), enter www.efacs.org in the “open file” area of your browser. The first page you will see is the login page.

Before logging in to the portal, click on the “Quick Start Guide” under the login area of the page. This guide will provide you with instructions on how to log in, as well as a succinct review of what you will find in various areas of the College’s Web portal.

When you are ready to get started, enter your eight-digit Fellowship ID number as your username. Your password is your last name. Example:

Username: 12345678
Password: smith
• Integration—In a portal, relevant tools and information come from many sources and are displayed just for the user.

• Content management—Whereas content for a Web site is usually published by submitting it to a Web master or a Web team for posting, a portal provides content-authoring systems that allow nontechnical staff to create content. This content is routed to the managing editor for approval; after electronic approval, the content is immediately published on the portal (no coding required). As a result, the information a user needs and wants gets to him or her faster.

Web portal Editorial Board

The Web portal Editorial Board is made up of at-large members, community editors, and associate community editors (see box); Lazar J. Greenfield, MD, FACS, Associate Editor; Jerry Schwartz, Managing Editor; Linn Meyer, Director of Communications, and Howard Tanzman, Director of Information Technology (IT); and the author of the present article (Editor-in-Chief).

• At-large members—At-large members of the ACS Web portal Editorial Board focus on “big picture” issues. Responsibilities include recommending topics of interest to portal users; generating content, the sole criterion being relevance

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ACS Web portal Editorial Board

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   Community Editor, Vascular Surgery
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   Community Editor, Surgical Oncology
and usefulness; serving as peer reviewers when called upon to do so; and maintaining communication with regard to quality of portal content.

- **Community and associate community editors**—Although these editors and at-large members of the board are equally important in terms of hierarchy, community editors have a more detailed focus. These editors identify content for community areas, assuming responsibility for overall quality of intellectual content, and maintain activity on discussion boards. Each community editor selects a small group of experts—associate community editors—to assist in identifying and creating content for his or her community.

Currently, there are 17 at-large members, 44 community editors, and 138 associate community editors. At least one community editor has been assigned the task of acting as a liaison to the respective Advisory Council for each of the surgical specialties.

The communities

There are two types of communities in the portal: specialty communities and special interest communities.

- **Specialty communities** mirror the ACS Advisory Councils for the Surgical Specialties, with 10 subspecialties listed under general sur-

- **Special interest communities** are composed of (1) clinical areas that are not subspecialties under general surgery, and (2) nonclinical areas of special interest. Currently, there are communities designated for biomedical engineering, Canadian Fellows, career mentoring, geriatric surgery, history and philosophy, informatics, international surgery, residents, rural surgeons, senior surgeons, surgical journal editors, terrorism, translational oncology, uniformed services, and young surgeons.

Portal communities offer core content, editorials, reports, algorithms, discussion forums, automated news feeds, links to related Web sites/portals, important meeting dates, videos, recommended reading, accreditation/certification information, and more. Portal users are able to join as many communities as they wish.

In addition to these robust content areas, e-FACS.org offers members useful tools that include the ability to calculate and log continuing medical education credits, track resident hours, and enter information into case logs.

**How it all came about**

Early last year, key players from the Communications and IT staff and I participated in a design workshop with outside portal consultants to ensure that the organizational and user goals for e-FACS.org would be reflected on the home page and secondary page designs. Workshop participants defined user profiles that were then used as the basis for decision making with regard to content organization, nomenclature, and navigation. After grouping information into categories based on fundamental organization principles, content groups were ranked by order of importance to portal users.

The final designs for the portal’s home page and secondary pages were then developed by the vendor and approved by College staff last April. The design features easy-to-use navigation with links to College highlights, advocacy, member services, education, quality and safety, and specialties and communities, as well as a place for rotating advertisements from approved commercial sponsors. From the home page, users can also perform basic and detailed content searches, search for a colleague, look for upcoming events, and provide feedback regarding the features and navigation of the portal, as well as customize their own home page to include items that interest them in addition to content that will be provided for them by the College.

We are very pleased to now be able to announce the formal launch of e-FACS.org. Obviously, it will take several years to bring the portal to fruition (not to mention the fact that the portal will always be evolving to meet the increasing needs of its users), but the development phase and beta testing stages have provided us with excellent feedback that has helped us make the College’s Web portal as useful and user friendly as possible for our members at this point in time.

This is a very exciting project for the American College of Surgeons, and we greatly appreciate the Resident and Associate Society and the Committee on Young Surgeons for recommending it on behalf of the entire membership. We hope that you will visit e-FACS.org now and on a regular basis—if not daily—in the future. We believe the Web portal will make it easier for members to keep current on the wealth of information that is available on advances in surgery and related issues, and we are convinced that regular use of e-FACS.org and the information and features it offers will make all of our professional lives a little easier.

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**Dr. Sheldon** is Editor-in-Chief of e-FACS.org, the College’s Web portal. He is professor of surgery and social medicine and former chair of surgery, University of North Carolina-Chapel Hill. He is a former Regent and Past-President of the College.
This article contains a summary of changes in the 2006 Current Procedural Terminology (CPT)* that are relevant to general surgery and closely related specialties. Remember that this article may be useful to others in the office who perform coding functions. The changes are discussed in code sequence.

Necrotizing soft tissue infection
A note has been added after code +11008, Removal of prosthetic material or mesh, abdominal wall for necrotizing soft tissue infection, stating that code 49568 is to be used when mesh is inserted for closure following debridement of necrotizing soft tissue infection. However, no change has been made to the descriptor of code 49568, Implantation of mesh or other prosthesis for incisional or other ventral hernia repair. Consider making a notation in your book by code 49568 that it is to be used for such a closure and cross-reference that wording to the note after code +11008. That way, you will remember where you found the language in the event of an audit.

Skin replacement surgery
The section that was headed “Free Skin Grafts” in earlier editions of the CPT is now headed “Skin Replacement Surgery and Skin Substitutes”; it contains new notes on using the codes and a substantial number of new codes. Codes were added for autografts/tissue-cultured autografts, acellular dermal replacements, allograft/tissue-cultured allogeneic skin substitutes, and xenografts. Codes for application of bilaminar skin substitutes and allografts have been deleted.

Among other things, the notes tell the reader to separately report the surgical preparation and type of skin graft or skin substitute. The initial wound site preparation is reported either by code(s) 15000-15001 or the primary procedure (for example, radical mastectomy). Code 15000 is Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture; first 100 sq cm or one percent of body area of infants and children, and code +15001 is for each additional 100 sq cm or one percent of body area of infants or children. Note that language “or incisional release of scar contracture” was added to both codes.

The last paragraph of the new note says the codes in this section are not to be reported unless the skin graft or substitute is surgically anchored in place. Sutures and staples have traditionally been used and, as time went on, surgical techniques included such things as fibrin glues and steri-strips. More recently, skin substitutes have come to market that require no wrapping or a simple gauze wrap. It is in those situations, where no surgical anchoring is done, that the codes in this section are not to be used.

The last two sentences of the paragraph of the notes should read, “When any grafting services are performed in the office, the supply of skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately.” The note that appears in the book omits the phrase, “any grafting.”

Vascular procedures
The seven Category III codes (0033T-0049T) for reporting placement of an endovascular graft for the repair of the descending thoracic aorta have been moved to Category I codes (33880-33891). However, the codes have additional language in
the descriptor and extensive introductory language has been added, explaining what the codes include and what may be separately reported. Codes 34833 and 34834, for open iliac and brachial artery exposure, have been modified to allow them to be used for endovascular repair of the thoracic aorta.

A new code, 36598, Contrast injection(s) for radiologic evaluation of existing central venous access device including fluoroscopy, image documentation and report, has been established to report the evaluation of the position and function of an existing catheter. The procedure includes removal of any obstructive material, so notes direct the user not to report code 36598 with codes 36595 or 36596, removal of pericatheter or intracatheter obstructive material.

Codes 37184-37188 were added for mechanical arterial and venous thrombectomy in peripheral vessels. The new material also includes extensive notes explaining what is included in the codes and what may be reported separately. The new codes have a bull’s eye symbol in front of them, meaning the code includes moderate, or conscious, sedation. Code 37209 has been modified to permit its use for both venous and arterial catheter exchange during thrombolytic therapy. It was previously limited to arterial catheter exchange.

Finally, code 37718, Ligation, division, and stripping, short saphenous vein, and code 37722, Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below, were added. There are notes saying do not report codes 37718 or 37722 with each other or with the existing code 37700, Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions. There is a similar note under existing code 37735, Ligation and division and complete stripping of long or short saphenous veins of lower leg, with radical excision of ulcer and skin graft and/or interruption of communication veins of lower leg, with excision of deep fascia. That note says not to report code 37735 with codes 37700, 37718, 37722, and 37780. The descriptor for code 37780 is Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure).

**Bariatric surgery**

Code 43770 was added for laparoscopic placement of an adjustable gastric band and subcutaneous port. Codes were also added for laparoscopic revision (code 43771), removal (code 43772), and removal and replacement (code 43773) of the adjustable gastric band component only. Laparoscopic removal of both the adjustable gastric band and subcutaneous port is covered by code 43774. There are notes that say to report code 43770 with a –52 modifier, meaning a reduced service was performed, when only one component is replaced and report the unlisted gastric laparoscopic code (43659) when removal and replacement of both components is performed. A note explains that code 43770 includes any band adjustments throughout the postoperative period.

A revision was made to code 43848, for an open revision of a gastric restrictive procedure, to limit its application to gastric restrictive procedures other than adjustable gastric banding. Three new codes were added for open revision, removal, and removal and replacement of subcutaneous port only (codes 43886-43888).

**Intestine, rectum, and anus procedures**

A group of four new laparoscopic codes (44180-44188) were added for enterolysis, jejunostomy for decompression or feeding, non-tube ileostomy or jejunostomy, and colostomy or skin level cecostomy. Note that the code for enterolysis has the phrase “separate procedure” as part of the descriptor. The proper way to report extensive enterolysis when performed with another procedure is to report the primary procedure with modifier –22, which indicates an unusual procedural service was done. Your payor will probably want a copy of the operative note and perhaps a letter explaining how much more work was involved.

A laparoscopic add-on code (44213) was established for mobilization of the splenic flexure performed in conjunction with a partial colectomy. A laparoscopic repair code (44227) was added for closure of an enterostomy, with resection and anastomosis, in either the large or small intestine.

The phrase “separate procedure” was removed from codes 44310, Ileostomy or jejunostomy, non-tube, and 44320, Colostomy or skin level cecostomy, and replaced with notes telling CPT users not to report 44310 and 44320 with certain specified codes.

Code 45395 was added for a complete abdominopерineal proctectomy with colostomy performed.
laparoscopically. Code 45397 was added for laparoscopic proctectomy with a colo-anal anastomosis and creation of a colonic reservoir. The code also includes a diverting enterostomy if performed. A code was added for a laparoscopic proctectomy (code 45400) and another was added for a laparoscopic proctectomy with sigmoid resection (code 45402). There is a new unlisted laparoscopy procedure code for the rectum (code 45499). A code was added for a laparoscopic proctopexy (code 45400) and another was added for a laparoscopic proctopexy with sigmoid resection (code 45402). There is a new unlisted laparoscopy code for the rectum (code 45499). A code was added for a diagnostic anorectal examination requiring general, spinal, or epidural anesthesia (code 45990). There is a note informing CPT users not to report code 45990 with certain other procedures.

Code 46505 was created to report chemodenervation of the internal anal sphincter. Two codes were added to report the pouch advancement of an ileoanal pouch fistula or sinus. They are code 46710, which uses a transperineal approach, and code 46712, which uses a combined transperineal and transabdominal approach.

Category II codes

Category II codes, which were introduced in 2004, provided a way for reporting and tracking performance through a payor’s claims-processing system. These are not traditional procedure codes—they are codes that give clinical data and are reported in addition to the procedure that was performed. The codes do not have relative values attached to them, their use is optional, and they may not be used in place of Category I codes. They are in the form of four digits followed by the letter “F.” Examples are 1000F, Tobacco use, smoking, assessed; 1002F, Anginal symptoms and level of activity, assessed; and 2000F, Blood pressure measured.

In the 2006 CPT, the Category II section is much more robust than it has been previously, having gone from two diseases with 14 measures to six diseases with three dozen measures. Equally important is the addition of two modifiers that say the measure was considered but, because of medical or patient circumstances that are documented in the medical record, was not provided.

The codes are listed in full by type of service in the section of the CPT labeled Category II codes. In Appendix H, the measures are grouped by disease and more information is given about how they will be used. Each measure has a defined numerator and denominator that, when the division is done, represent the percentage of patients for whom the service was provided.

It is important that category codes be well understood by all physicians, including surgeons, if a payor in your area begins a pay for performance plan. It would not be surprising if some payors begin using the coronary artery disease measurements for patients who receive surgical treatment of the disease. Likewise, payors could request an orthopaedic surgeon treating osteoarthritis, either surgically or medically, to use the osteoarthritis measures.

The Centers for Medicare & Medicaid Services has established a series of “G” codes that it is using in a similar voluntary reporting program beginning January 3, 2006. A future Bulletin article will provide more detailed information about this program.

Category III codes

Code 0120T, Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma and Code 0133T, Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with injection of implant material into and along the muscle of the lower esophageal sphincter (eg, for treatment of gastroesophageal reflux disease) have been added. Remember that if a Category III code exists for a procedure, it must be used instead of a Category I unlisted code.

Dr. Bothe is associate dean and executive director, University of Chicago practice plan, Chicago, IL.
HIGHLIGHTS

of the 91st annual
CLINICAL
CONGRESS
The 91st Annual Clinical Congress of the American College of Surgeons in San Francisco, CA, featured a diverse assortment of general sessions on a variety of issues of interest to surgeons—including clinical procedures, practice-related topics, and issues related to policy and liability—and 39 postgraduate courses that presented learning opportunities on the most advanced procedures.

A total of 14,986 individuals attended the meeting. Among attendees, 8,986 were physicians; the rest included exhibitors, guests, spouses, and convention personnel.

**Highlights**

At the American Urological Association lecture, which immediately followed the Opening Ceremony, **Michael D. Maves, MD, FACS**, executive vice-president of the American Medical Association (AMA), presented Branding Medicine. In his lecture, using the experiences of the AMA in creating a brand as an example, Dr. Maves explained that a brand is what defines an organization’s place in the world, and that it can help to “elevate, celebrate, and make stronger” the field of medicine.

Newly installed President Dr. Anderson presided over the Convocation Sunday night.

ACS Secretary John O. Gage, MD, FACS, bearing the Great Mace, led the processional of ACS Regents and Officers during the Convocation. Seated on either side of the aisle were the surgeons who were being initiated into Fellowship that evening.
Also on Monday, James L. Cox, MD, FACS, delivered the John H. Gibbon, Jr., Lecture, Surgery for Atrial Fibrillation, and J. Patrick O’Leary, MD, FACS, presented Surgery’s Entry into Its Modern Era: Depicted by the Art of the Times as the Charles G. Drake History of Surgery Lecture. On Tuesday, the Scudder Oration on Trauma, Trauma in Transition: A Fantastic Voyage, was presented by C. Thomas Thompson, MD, FACS. Medical Progress and Health Care Access: Can They Be Reconciled?, the Ethics and Philosophy Lecture, was presented Wednesday by Daniel J. Callahan, PhD.

Also Wednesday, William C. Wood, MD, FACS, presented Evidence-Based Cancer Treatment for Populations or Individuals?, the Commission on Cancer Oncology Lecture; Timothy G. Buchman, MD, PhD, FACS, FCCM, presented the I.S. Ravdin Lecture, The Times of Our Lives: Physiologic Variability during Critical Illness and Recovery; and Jonathan L. Meakins, MD, FACS, presented the Distinguished Lecture of the International Society of Surgery, Evidence-Based Surgery: The Future?! And on Thursday, for the Martin Memorial Lecture, Donald Kennedy, PhD, presented Science and Politics: How Rich a Mixture Do We Want?

In celebration of the 100th anniversary of the Journal of the American College of Surgeons (JACS) (originally called Surgery, Gynecology & Obstetrics), JACS hosted Centennial Symposium: Cherishing the Past, Shaping the Future, which featured guest speakers from other medical journals and was moderated by Seymour I. Schwartz, MD, FACS, JACS Emeritus Editor. JACS and Elsevier, its publisher, hosted a reception for attendees immediately after the symposium.

In conjunction with the College’s Advanced Trauma Life Support® (ATLS®) program’s meeting, in which members from 29 countries discussed pertinent issues related to the program, the ATLS celebrated its 25th anniversary.

The College, in conjunction with the Pfizer Medical Humanities Initiative, presented Surgical Volunteerism Awards to two Fellows in recognition of their efforts in helping the medically underserved. George F. Ellis III, MD, FACS, a urologist from Longwood, FL, and founder and chair of Primary Care Access Network, received the domestic volunteer award, and Domingo T. Alvear, MD, FACS, a pediatric surgeon from Harrisburg, PA, and founder of World Surgical Foundation, received the international volunteer award. The awards were presented by Courtney...
M. Townsend, Jr., MD, FACS, Chair of the Board of Regents at that time, and Raul Perea-Henze, MD, of Pfizer (see photos, page 22).

Another award, the 2005 Distinguished Philanthropist Award, was presented in absentia to Dr. and Mrs. Robert Wayne Hobson II, FACS, by the Fellows Leadership Society. Dr. Hobson is professor of surgery, chief of the division of vascular surgery, director of the vascular fellowships program, professor of physiology, and associate director of the program in vascular biology in the departments of surgery and physiology at the University of Medicine and Dentistry of New Jersey. Dr. and Mrs. Hobson received the award in recognition of their establishment of the Robert W. Hobson II and Joan P. Hobson Remainder Unitrust and their major gift to the College, as well as Dr. Hobson’s extraordinary contributions to his community, the country, and the profession of surgery.

The newest chapter, Iran, received its charter. Heshmatollah Kalbasi, MD, FACS, the first President of the Iran Chapter, accepted the charter from the Board of Governors (see photo, this page).

A memorial service for Claude H. Organ, Jr., MD, FACS, who passed away in June 2005, was held. The memory of Dr. Organ, the 84th President of the American College of Surgeons, was honored by Fellows and colleagues in the service, which was followed by a reception.

The ACS Web portal and case log system were presented for beta testing for Fellows. Attendees were able to see and experience first-hand these two new members-only online information services.

A glance at surgery of the past was provided at the Movie Classics of the Past Video Session, which featured videos of surgeries performed in 1953, 1956, and 1959.

Some highlights of the Clinical Congress were reported previously in the November 2005 issue of the Bulletin. The presentation of the Distinguished Service Award, the College’s highest honor, to Donald D. Trunkey, MD, FACS, of Portland, OR, is featured in that issue, as well as the announcement of the Honorary Fellowships bestowed on Bruce Benjamin, MB, DLO, FRACS, FAAP; Prof. Sir Alfred Cuschieri, FRS (Edin), MD, MD(Hon), ChM, FRCS (Edin, Engl), FRCPs (Glas)(Hon), FRCSI (Hon); and Prof. Sergio Pecorelli.

Officers installed

During the Convocation ceremony, Kathryn D. Anderson, MD, FACS, FRCs, was installed as the 86th President of the American College of Surgeons (see photo, page 21). Dr. Anderson is professor emeritus at the Keck School of Medicine, University of Southern California (USC), Los Angeles.

A Fellow of the College since 1975, Dr. Anderson is the first woman to be elected President of the American College of Surgeons. She has served as an active participant in and leader of numerous College activities, including service as a member of the Board of Governors (1986-1992), a member (1986-1992) and Chair (1990-1991) of the Advisory Council for Pediatric Surgery, a member of the Finance Committee (1992-1995), a member of the Honors Committee (1992-2002), a member (1995-2002) and Chair (1998-2002) of the Organization Committee, a member of the Communications Committee (1995-2002), an ex-officio member of the Board of Regents (1992-2002), ACS Secretary

In her Presidential Address, which was published in the December 2005 Bulletin, Dr. Anderson spoke of the need for humanity in delivery of health care, providing historical examples of crises in humanity and discussing what she perceives as the present-day crises.

Other newly installed Officers are J. Patrick O’Leary, MD, FACS, as First Vice-President, and William F. Sasser, MD, FACS, as Second Vice-President.

Dr. O’Leary is chair, department of surgery, Louisiana State University Health Sciences Center, New Orleans, LA. A Fellow since 1975, Dr. O’Leary served as Chair (2001-2003) and Vice-Chair (1999-2001) of the Executive Committee of the Board of Governors. He served on the Governors’ Committee on Chapter Activities (1997-1998), liaison member: 1998-2002, the Board of Regents’ Communications Committee (1999-2002), and was President of the Louisiana Chapter of the ACS (2000-2001). Dr. O’Leary currently serves on the Advisory Council for General Surgery and as a member of the Advisory Committee on Surgical Education and Self-Assessment Program.

Dr. Sasser is associate clinical professor of surgery, St. Louis University, St. Louis, MO. A Fellow since 1971, Dr. Sasser served as Secretary of the Executive Committee of the Board of Governors (1998-2001), as Chair of the Governors’ Committee to Study the

**New Officers-Elect**

**Edward M. Copeland III, MD, FACS,** of Gainesville, FL, was named President-Elect during the Annual Meeting of Fellows. Dr. Copeland is the Edward R. Woodward Professor of Surgery at the University of Florida College of Medicine (UFCM), Gainesville.

A Fellow since 1974, Dr. Copeland has been active within the College and has held many important posts. Immediate Past-Chair of the Board of Regents, Dr. Copeland has been a member of the Board since 1999; he has served as Chair of the Board’s Finance Committee and member of the Honors Committee since 2003. He was Secretary of the Board of Governors from 1994 to 1995, has served as Vice-Chair (2001) and Chair (2002-2003) of the Program Committee, and was Chair of the Governors’ Committee on Socioeconomic Issues (1995-1996), the Executive Committee of the Board of Governors (1995-1996), the Medical Motion Pictures Committee (1990-1993), and the Committee on Young Surgeons (1982-1983). Dr. Copeland has also been active on the American Board of Surgery, serving as chair (1990), vice-chair (1989), and a member of various committees from 1984 to 1988.

After receiving his bachelor of arts in chemistry at Duke University (1959), Dr. Copeland earned his medical degree (1963) at Cornell University Medical School. Dr. Copeland then completed his internship (1963-1964) and residency (1964-1969) at the Hospital of the University of Pennsylvania, where Dr. Copeland also completed several fellowships—including a research fellowship in the Harrison Department of Surgical Research (1966-1967) and a clinical fellowship through the American Cancer Society (1968-1969)—and was the chief resident of general surgery from 1968 to 1969. He also served as the advanced senior fellow in cancer surgery at the M.D. Anderson Hospital and Tumor Institute at the University of Texas Cancer Center in Houston, from 1971 to 1972.

Dr. Copeland was also active as a major in the U.S. Army, as a reserve commissioned officer in 1964, then on active duty from 1969 to 1971. He worked in the Third Field Hospital, Saigon, Vietnam, for which he earned a bronze star, and later served as assistant surgical consultant to the Office of the Surgeon General.

Dr. Copeland has been at the UFCM since 1982. Before his current post, he was professor and chair of the department of surgery from 1982 to 2003 and interim dean from 1996 to 1997. He has also served as the director of the University of Florida Shands Cancer Center (1994-1999). Before his tenure at UFCM, Dr. Copeland was with the University of Texas Medical School in Houston, as assistant professor (1972-1973), associate professor (1973-1976), and professor (1976-1982) of surgery. During this same time,
Past recipients of the College’s most prestigious honor, the Distinguished Service Award, gathered during the Congress. Left to right, front row: John O. Gage, James C. Thompson, Robert E. Hermann, LaMar S. McGinnis, Jr., Josef E. Fischer, and C. Barber Mueller. Back row: Richard B. Reiling, Frank Padberg, J. Roland Folse, and F. William Blaisdell.

Dr. Copeland has published more than 580 articles in the literature and has served on several editorial boards, including The Journal of the American College of Surgeons, The American Surgeon, The Journal of Parenteral and Enteral Nutrition, Surgical Oncology, and Current Opinion in General Surgery.

In other actions during the Annual Meeting of the Fellows, David L. Nahrwold, MD, FACS, Chicago, IL, was named First Vice-President-Elect, and Robert E. Berry, MD, FACS, Roanoke, VA, was named Second Vice-President Elect.

Dr. Nahrwold, a retired surgeon, has been a Fellow since 1971. He has been a member of the Board of Regents since 1995 and has been an active member of the Board of Governors, including member (1994-1995) and later Vice-Chair (1995-1996) then Chair (1996-1998) of the Executive Committee. He was also the Chair of the Nominating Committee of the Fellows (1991-1992) and has served on the Development Committee. Dr. Nahrwold has also served as Secretary and President of the Pennsylvania Chapter of the ACS.

Dr. Berry has been a Fellow since 1966. He was a member of the Board of Governors from 1991 to 1997 and is a Past-Chair of the Committee on Development. He has also served as President of the Virginia Chapter of the ACS.

The new slate of ACS Officers and Regents of the College is pictured on pages 36-39 of this issue.

**Board of Governors**

Mark A. Malangoni, MD, FACS, was elected to an initial one-year term as Chair of the Board of Governors. M. Margaret Kemeny, MD, FACS,
Julie A. Freischlag, MD, FACS, was re-elected to an additional one-year term as Secretary. Karen E. Deveney, MD, FACS, was elected to the Board of Governors Executive Committee. Re-elected to the Executive Committee was Valerie W. Rusch, MD, FACS.

Board of Regents
The Fellows of the College elected Gerald B. Healy, MD, FACS, to be Chair of the Board of Regents. Dr. Healy is otolaryngologist-in-chief, Children’s Hospital, Boston, MA, and is the first otolaryngologist in the College’s history to be selected to serve as Chair of the Board.

Dr. Healy has been a member of the Board of Regents since 1997 and a member of the Executive Committee of the Board of Regents since 2000 (Chair, 2003). He was elected Vice-Chair of the Board of Regents in 2003. As a Regent, he has served on the Advisory Council for Otolaryngology–Head and Neck Surgery (1997-2000), the Member Services Liaison Committee of the Board of Regents (Chair, 2003-2005), the Nominating Committee (2000-2001), and the Central Judiciary Committee (1998-2003; Chair, 2001-2003). In addition, Dr. Healy serves as a member of the Board of Regent’s Honors and Finance Committees (Chair, 2005).

Before he became a Regent, Dr. Healy served on the Board of Governors (1990-1996) and chaired the Advisory Council for Otolaryngology–Head and Neck Surgery (1995 to 1997).

Replacing Dr. Healy as Vice-Chair of the Board of Regents is Mary H. McGrath, MD, FACS.
Dr. McGrath is professor of surgery, division of plastic surgery, University of California, San Francisco. She has been a member of the Board of Regents since 1997. College committees on which Dr. McGrath has been active include the Communications Committee (Chair, 2005), Committee on Ethics (Chair, 2003), Nominating Committee (Chair, 2002), the Advisory Council on Plastic and Maxillofacial Surgery, the Committee on Emerging Surgical Technology and Education, the Committee on Development, the Committee on Pre- and Postoperative Care, the Committee on Education, and the Advisory Committee on Surgical Education and Self-Assessment Program (SESAP). Dr. McGrath also served on the Board of Governors (Executive Committee, 1996) and on its Committee on Ambulatory Surgical Care and Committee on Socioeconomic Issues.

The following individuals were re-elected to additional three-year terms on the Board of Regents (all MD, FACS): Alden H. Harken, Charles D. Mabry, Robin S. McLeod, and Carlos A. Pellegrini.

Awards and honors
In addition to the awards described previously in this article, several other awards were presented during last year’s Clinical Congress.

The Commission on Cancer’s (CoC) Cancer Fighter Award was presented to Donald L. Morton, MD, FACS, chief executive officer of the John Wayne Cancer Institute, Santa Monica, CA, and professor emeritus of surgical oncology at the University of California–Los Angeles, at the CoC’s annual meeting.

The first-ever ACS Outstanding Patient Ser-
vice Award was presented to Denton A. Cooley, MD, FACS, a renowned cardiovascular surgeon from Houston, TX. The award was given at the President’s Dinner by Thomas R. Russell, MD, FACS, ACS Executive Director, and Dr. Copeland (see photo, page 24).

Lenworth M. Jacobs, Jr., MD, FACS, received the National Safety Council Surgeons’ Award for Service to Safety. The award, which recognized Dr. Jacobs’ “continuous commitment to patient care through prevention programs, surgical excellence, and education,” was presented by Steven R. Shackford, MD, FACS, immediate past-president of the American Association for the Surgery of Trauma; John Ulczycki, director of the National Safety Council’s Transportation Safety Group; and J. Wayne Meredith, MD, FACS, Chair of the ACS Committee on Trauma (see photo, page 24).

The 2005 Surgical Forum volume was dedicated to Haile T. Debas, MD, FACS. Dr. Debas, executive director of the University of California–San Francisco Global Health Services, was honored with this dedication because of his extraordinary contributions to the field of surgical science and because he is an exemplary role model for young academic surgeons (see photo, page 25).

Recipients of the third annual Surgical Forum Excellence in Research Awards—which recognizes outstanding Surgical Forum papers—including the following: Jimmy C. Sung, MD, JD, H. Lee Moffitt Cancer, Tampa, FL; Eric I. Chang, MD, New York University School of Medicine, New York, NY; Lindsey N. Jackson, MD, The University of Texas Medical Branch, Galveston, TX; Cynthia L. Leaphart, MD, Children’s Hospital of Pittsburgh, Pittsburgh, PA; Adam Yopp, MD, The Mount Sinai School of Medicine, New York, NY; Allan Tsung, MD, University of Pittsburgh, Pittsburgh, PA; Grace J. Wang, MD, Brigham and Women’s Hospital, Boston, MA; Shadi Ghali, MD, New York University Medical Center, New York, NY; Michael A. Stroehlein, MD, Klinikum Cologne-Merheim, Cologne, Germany; Amod Tendulkar, MD, San Francisco Veterans Affairs Medical Center, San Francisco, CA; and Kelly R. Finan, MD, University of Alabama, Birmingham, AL. These awards were presented by Stanley W. Ashley, MD, FACS, Chair of the Committee for the Forum on Fundamental Surgical Problems (see photo, page 27).

The International Guest Scholars for 2005 were honored by the International Relations Committee. These scholars included the following: Daniel M. Maffei, MD, Buenos Aires, Argentina; Thierry Defechereux, MD, Liege, Belgium; Airton Schneider, MD, Porto Alegre, Brazil; Diana V. Stoyanova, MD, Sofia, Bulgaria; Ching-Hua Hsieh, MD, Kaohsiung Hsien, Taiwan; Renato A. Mertens, MD, FACS, Santiago, Chile; Ping Lan, MD, Guangzhou, China; Gaurav Agarwal, MS, Lucknow, India; Elias Kaperonis, MD, Zografou, Athens, Greece; and Juri Teras, MD, Tallinn, Estonia (see photo, page 28).

The third annual ACS Resident Award for Exemplary Teaching was presented to Robert Feezor, MD, a PGY-7 and administrative chief resident in the University of Florida general surgery program (see photo, page 29). The award is sponsored by the Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives. Dr. Feezor was selected by an independent review panel of the Subcommittee on Resident Education based on evidence of teaching excellence.
Volunteerism, patient safety, communication with the membership, and a greater influence in Washington, DC, were only a few of the College’s goals and highlights of 2005.

New Orleans and Operation Giving Back

Everyone in the College wants to thank all the volunteers from across the country and abroad for the support given during the human disaster in New Orleans and the Gulf Coast. The scenes on television were heart-wrenching, especially the human suffering witnessed at the New Orleans convention center, where the College met for the 2004 Clinical Congress. I am sure all of you shared my frustration and hopelessness for not being able to respond immediately to the needs of the citizens of the devastated regions. The stories of heroism and sacrifice that are now emerging attest to the kindness and strength of the human spirit shown by so many, including several of the Fellows who attended the 2005 Clinical Congress in San Francisco, CA.

As of October, however, the job had just begun. People needed to be relocated, new physicians found, lives mended both physically and mentally, students and residents allowed to continue their training, and the ability of this country to respond to a tragedy within its borders strengthened to ensure that every citizen has the rights and protections provided by the Constitution of the United States and by the Hippocratic Oath each of us has taken. The role that the American College of Surgeons should take in disaster situations will be thoroughly evaluated to have in place a method of quick response through our volunteer program, Operation Giving Back, under the leadership of Kathleen Casey, MD, FACS, and Paul Collicott, MD, FACS. At the Clinical Congress, we expressed our gratitude to these two individuals and their teams for providing information to volunteers through the Operation Giving Back Web site and for coordinating with the American Association of Medical Colleges the relocation of surgical residents. The American College of Surgeons should and will be part of the national response team to these disasters in the future.

ACS Web portal

The College’s new Web portal is a secure, single point of entry Web site that has the functionality and flexibility to cater to the demands of its users. (See related article, page 12.) The single sign-on service allows users to personalize and manage the information available to them. This members-only service is under the direction of George Sheldon, MD, FACS, as Editor-in-Chief, and Lazar Greenfield, MD, FACS, as Associate Editor. The editorial board is made up of individuals who represent all the surgical specialties and special interests such as surgical oncology, young surgeons, and history and philosophy, to name a few. The Web portal was introduced at the 2005 Clinical Congress, and I hope all attendees had the opportunity to visit the demonstration booth. Some of the helpful tools will be electronic case logs, online systems for tracking continuing medical education credits, scientific discussion forums, and clinical videos.

Timothy Eberlein, MD, FACS, has done a fantastic job as the new Editor-in-Chief of the Journal of the American College of Surgeons (JACS), and I am sure he would appreciate any and all input from the members. You now receive JACS along with the Bulletin in one package. In the last year, there has been a 30 percent increase in submissions to JACS, and time for first decision to publish has been dropped in some cases to as little as two weeks. JACS is now one of the timeliest publications in existence. A measure of its impact is the 12 percent increase in number of articles published and a 20 percent increase in citations. Because JACS is the official scientific journal of...
the American College of Surgeons, those high-impact articles that need rapid dissemination to the lay press can be relayed through the Communications section of the College, a unique feature only available to JACS.

**NSQIP**

Under the direction of R. Scott Jones, MD, FACS, the ACS National Surgical Quality Improvement Program (NSQIP) continues to grow as expected. Approximately 80 hospitals are in the enrollment stage and the volume of cases needed for enrollment has been lowered so that smaller hospitals can now participate. A multispecialty model has been developed that allows these hospitals to collect data on urology; neurosurgery; orthopaedics; ear, nose, and throat; plastic surgery; thoracic surgery; and gynecologic surgery. The goal is to reduce surgical morbidity and mortality by instituting best practice methods nationwide. Data currently being reviewed show that surgical morbidity was significantly reduced in the population studied. The Centers for Medicare & Medicaid Services (CMS) Improvement Program is expected to be functional this month. The ACS NSQIP will be recognized by CMS, thus providing further incentive for health care systems to enroll in the NSQIP.

**ACOSOG**

The American College of Surgeons Oncology Group (ACOSOG) received continued funding from the National Institutes of Health. Special thanks were given to Samuel Wells, MD, FACS, who initially organized the group and completed the successful funding renewal process. He has now stepped down as the Chair and Heidi Nelson, MD, FACS, Rochester, MN, and David Ota, MD, FACS, Durham, NC, are the new Co-Chairs. Collaborative resource management among ACOSOG, Duke University, and the National Cancer Data Bank of the American College of Surgeons has been strengthened.

**Meetings and conventions**

In the College’s role as a surgical umbrella organization, and with the help of all College support services, our Meetings and Convention staff continues to provide meeting and/or association management quite successfully for the Southeastern Surgical Congress, Pacific Coast Surgical Association, and the combined Otolaryngological Spring Meeting and the American Laryngological Association. At College headquarters in Chicago, rental space and support services are provided for the Society for Vascular Surgery and rental space for the Society of Thoracic Surgeons and the American Board of Thoracic Surgery.

**Practice management**

A commitment to practice management continues to be a high priority. The Practice Management Course for surgeons was taught to rave reviews at both the Clinical Congress and the Spring Meeting. The Division of Education has published a two-volume set of CD-ROMs aimed at residents and young surgeons.

**ACS-SurgeonsPAC**

The American College of Surgeons Professional Association and Political Action Committee (ACS-SurgeonsPAC), under the direction of Andrew Warshaw, MD, FACS, has had success in influencing legislators and their staff members on issues such as Medicare reimbursement, tort reform (especially at the state level), and resident work hours. The PAC is completing its second year in existence and anyone who doubts its value should invite Dr. Warshaw or a member of his committee to present the data to your state chapter. As has been noted, if every member of the College donated just $250 to the PAC, the sum total of money available for use would more...
The primary responsibility of the Board of Governors is to serve as the communications link between the Fellows of the College and the College’s leadership. Members of the Board of Governors are allocated by state, province, or country to represent the Fellows within. The Governors are surveyed annually in order for ACS leadership to better gauge the climate of the surgical environment in which ACS Fellows practice. At its annual business meeting at the 2005 Clinical Congress in San Francisco, CA, the Board reviewed the results of this year’s survey. The results indicated that the highest-ranking issues of concern to our Fellows are as follows:

- Professional liability/tort reform
- Physician reimbursement
- Health care reform
- Graduate medical education
- Physician competency measurement

The Board of Governors also reviewed the College’s activities in response to the 2004 survey. Overall, the Fellows are pleased with the work that the College is doing on their behalf.

The Board also heard reports from its six committees: Blood-Borne Infection and Environmental Risk continues to submit manuscripts for publication in the Journal of the American College of Surgeons, Chapter Activities completed its recruitment of StARs for its State Advocacy Representatives program, Fiscal Affairs finalized a long-term dues strategy, Physician Competency and Health will develop a statement on economic credentialing, Socioeconomic Issues nominated two recipients this year to receive surgical volunteerism awards, and Surgical Practice in Hospitals and Ambulatory Settings continues to work on revisions to the Guidelines for Optimal Ambulatory Surgical Care and Office-Based Surgery. In addition to the ongoing projects, the committees also continue to submit educational programs for the upcoming Clinical Congress and Spring Meeting.

Operation Giving Back

Operation Giving Back—another spin-off of the Board of Governors—was officially introduced at the 2004 Clinical Congress, and has had a busy and exciting year. Relationships have been established on the domestic and international fronts, volunteer resources have been researched and compiled, the online Web resource has been revised and expanded, and work has been initiated with the ACS Committee on Resident Education toward the creation of volunteer opportunities for residents.

In response to the ravages of Mother Nature, the program was extended well beyond its primary mission when it mobilized surgeons in response to two major natural disasters in 2004 and 2005. The Web site quickly adapted to serve as a means of conveying timely and pertinent information on everything from points of contact for responding to continuity of care for affected patients. The immediate and overwhelming response of ACS members is clear and compelling evidence of the need for information on how to assist in such situations.

Equally compelling was the difficulty expe...
I t remains a true pleasure for me to continue as your Executive Director of the College. I have now nearly completed my sixth year in this position. I have found the planning sessions and the reorganization of the College to be critically important as we attempt to create changes that will improve the environment for our surgical patients. It is quite remarkable today to observe the pace of transformation in health care, whether that change concerns political issues, education, or, ultimately, quality improvement and safety. I do believe that we are beginning to see some tangible results from the efforts that the College has put forth over the last several years, particularly in the area of quality, so that we can better meet the challenges that face us.

The late Claude H. Organ, Jr., MD, FACS, became President of the College in October 2003, and he often said he wanted his term to be remembered as the “Year of the Resident.” I do believe that the College is truly addressing the needs of young surgeons through our Resident and Associate Society, and we are also reaching out to medical students. Many of those young people were in attendance at the 2005 Clinical Congress in San Francisco, CA, and specific sessions had been organized for them. We continue to add true value to becoming a member of the American College of Surgeons so that residents can appreciate the importance of joining early in their training. Educational products, free attendance at meetings, subscriptions to our various publications, and online access to ACS Surgery: Principles & Practice are only some benefits of Resident membership. I am pleased to report that in 2005 we had a significant increase in the number of residents applying for membership.

Working with the various surgical boards, we are attempting to inform our Fellows about the changes in maintenance of certification and maintenance of licensure. The more frequent need to document continued professional development and linking it to one’s practice will certainly become a standard for the future. The means of meeting the requirements in the six core areas of competency have led to various courses and programs the College has developed. Hopefully they will be of value as Fellows in all disciplines meet the needs of the future by maintaining their certification and competency. It will be a much more vigorous process that will require appropriate documentation, a situation that I believe will be somewhat expedited by the use of electronic tools such as the College’s Web portal.

Another major thrust of the College today is the idea of accrediting institutions based on discipline-specific care of surgical patients. We have a long history of doing such work. The Commission on Cancer has long verified cancer centers throughout the U.S., and there are now more than 1,400 centers accredited through our programs. We have also been successful in verifying with trauma centers and various levels of care that can be delivered at institutions. Currently, there is very real interest in looking at other areas the College might accredit, such as bariatric programs and breast centers—the list could potentially go on and on. We are trying to implement this effort in a collaborative fashion by dealing with the various stakeholders in these new areas where there may be some disparity with respect to the quality of care. There seems to be a very real need for a professional group to begin accrediting institutions around systems of care for surgical patients.

A major movement in Washington revolves around the current payment structure for Medicare and how the program expects to pay physicians for their services in the future. Paying for performance—or, consumer-driven, value-based purchasing—links high-quality care to payments. A correction or fix in the current system seems inextricably associated with this concept. Clearly, as a College, we need to look seriously at this...
concept with respect to surgical procedures and to attempt to develop (for inpatients as well as outpatients) the means to evaluate surgical outcomes or processes of care leading to high quality. We must be at the forefront of developing these standards to assist our surgeons—an outcome that ultimately will benefit the surgical patient. Programs such as the National Surgical Quality Improvement Program and the Case Log System, which was showcased at the Clinical Congress, are significant efforts on our part.

In the area of education, it is becoming increasingly evident as we listen to Fellows and our Governors that Web- and video-based learning will become ever more important as the health care dollars shrink and surgeons have less discretionary funds for travel to distant meetings. We will attempt to continue to develop these types of educational products and are in the formative stages of developing the American College of Surgeons’ Accredited Educational Institutes, which will be established across the country for didactic and hands-on training. These will be places where surgeons can access educational material close to where they live in a cost-effective way and participate in the educational activities they need in order to advance and improve their practices.

We are continuing to try to increase the visibility of the American College of Surgeons through communications vehicles such as Surgery News, the Bulletin, ACS NewsScope, and, of course, the Journal of the American College of Surgeons. Electronic tools also further our ability to reach out to our Fellowship. We are attempting to market the College and let the public know more about what we are doing through press releases and by responding to inquiries from the public.

Finally, in the spirit of the “Year of Unity” as outlined by our Immediate Past-President, Edward R. Laws, MD, FACS, the College is working diligently with many of the other stakeholders in health care in order to really collaborate and cooperate with their efforts. We have a complete complement of delegates to the American Medical Association’s House of Delegates, and this year we have taken over the administrative activities of running the Surgical Caucus, which meets during the House of Delegates sessions. We continue to have strong relations with many other health and medical societies, including the Joint Commission on Accreditation of Healthcare Organizations, as well as with industry. It is clear that the problems in health care today are so significant and complex that no organization can possibly deal with resolving some of these important problems alone.

Again, it is a true privilege to serve as your Executive Director as we attempt to represent the surgical community and forge a better health care system that ultimately will benefit patients who require surgical care and treatment in our hospitals and outpatient settings.

Dr. Russell is Executive Director of the College.
Kathryn D. Anderson  
President  
*Pediatric surgery*  
Professor emeritus,  
department of surgery,  
University of Southern  
California  
*Los Angeles, CA*

J. Patrick O’Leary  
First Vice-President  
*General surgery*  
Chair, department of surgery,  
Louisiana State University  
Health Sciences Center  
*New Orleans, LA*

William F. Sasser  
Second Vice-President  
*Thoracic surgery*  
Associate clinical professor  
of surgery,  
St. Louis University  
*St. Louis, MO*

John O. Gage  
Secretary  
*General surgery*  
Private practice  
*Pensacola, FL*

John L. Cameron  
Treasurer  
*General surgery*  
Professor and chair,  
department of surgery,  
The Johns Hopkins  
University School of Medicine  
*Baltimore, MD*

Edward M. Copeland III  
President-Elect  
*General surgery*  
Edward R. Woodward  
Professor, department of  
surgery, University of Florida  
College of Medicine  
*Gainesville, FL*

David L. Nahrwold  
First Vice-President-Elect  
*General surgery*  
Emeritus professor of  
surgery, Feinberg School  
of Medicine, Northwestern  
University  
*Chicago, IL*

Robert E. Berry  
Second Vice-President-Elect  
*Thoracic surgery*  
Professor emeritus of surgery,  
University of Virginia School  
of Medicine  
*Roanoke, VA*
Board of Regents

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Chair  
Otolaryngology–head and neck  
Otolaryngologist-in-chief, Children’s Hospital  
Boston, MA

Mary H. McGrath  
Vice-Chair  
Plastic surgery  
Professor of surgery, division of plastic surgery, University of California–San Francisco  
San Francisco, CA

H. Randolph Bailey  
Colon and rectal surgery  
Clinical professor and chief, division of colon and rectal surgery, University of Texas Health Science Center  
Houston, TX

Barbara L. Bass  
General surgery  
Chair, department of surgery, Methodist Hospital  
Houston, TX

L. D. Britt  
General surgery  
Brickhouse Professor and chair, department of surgery, Eastern Virginia Medical School  
Norfolk, VA

Bruce Douglas Browner  
Orthopaedic surgery  
Gray-Gossling Professor and chairman, department of orthopaedic surgery, University of Connecticut Health Center, Farmington, CT, and director of orthopaedics, Hartford Hospital, Hartford, CT

Martin B. Camins  
Neurological surgery  
Clinical professor of neurological surgery, Mount Sinai Hospital and Medical School  
New York, NY

A. Brent Eastman  
General surgery  
Chief medical officer, Scripps Health, and N. Paul Whittier Chair of Trauma, Scripps Memorial Hospital, La Jolla, CA, and clinical professor of surgery, University of California, San Diego  
San Diego, CA
Board of Regents

Richard J. Finley
General surgery
Professor and head, division of thoracic surgery,
University of British Columbia Faculty of Medicine
Vancouver, BC

Josef E. Fischer
General surgery
Professor of surgery, Harvard Medical School, and chairman of surgery,
Beth Israel Deaconess Medical Center
Boston, MA

Barrett G. Haik
Ophthalmic surgery
Chair, department of ophthalmology,
University of Tennessee Health Science Center, College of Medicine
Memphis, TN

Alden H. Harken
Cardiothoracic surgery
Professor and chairman, department of surgery,
University of California–San Francisco, East Bay
Oakland, CA

Charles D. Mabry
General surgery
Private practice
Pine Bluff, AR, and assistant professor of surgery, practice management advisor to the chairman,
department of surgery, University of Arkansas for Medical Sciences
Little Rock, AR

Jack W. McAninch
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Professor of urology, University of California–San Francisco, and chief of urology,
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Board of Regents

Robin S. McLeod  
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Professor of surgery and health policy, management and evaluation,  
University of Toronto, and head, division of general surgery,  
Mt. Sinai Hospital  
Toronto, ON

Carlos A. Pellegrini  
General surgery  
Henry N. Harkins Professor and chairman, department of surgery,  
University of Washington  
Seattle, WA

Karl C. Podratz  
Gynecology (oncology)  
Joseph I. and Barbara Ashkins Professor of Surgery, and professor of obstetrics and gynecology,  
Mayo Clinic  
Rochester, MN

John T. Preskitt  
General surgery  
Attending surgeon, Baylor University Medical Center  
Dallas, TX

J. David Richardson  
Vascular surgery  
Professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine  
Louisville, KY

Thomas V. Whalen  
Pediatric surgery  
Professor of surgery and pediatrics, and chief of pediatric surgery, Robert Wood Johnson School of Medicine  
New Brunswick, NJ
A “thank you” from Louisiana

by Lester W. Johnson, MD, FACS, Rayville, LA

During the last several months, the citizens of Louisiana have experienced and learned much. In times of personal or societal disaster, there occurs a precious opportunity for those individuals who are adversely affected. It is perhaps only then that they are able to identify and fully appreciate those friends who will unconditionally stand by them.

It is important for the Fellows of the College to know that tens of thousands of their colleagues individually came, sent, or offered to come to the aid of Louisianans during the aftermath of Hurricane Katrina. Louisiana’s cares became their concern. In the first 48 hours alone, more than 50,000 hits were received on the College Web site from Fellows who understood the necessity of confronting the fierce urgency of now, who understood that in the unfolding of lives and opportunity, there is such a thing as being too late. Thomas R. Russell, MD, FACS, ACS Executive Director, and Paul E. Collicott, MD, FACS, Director, Division of Member Services, have also made themselves available to representatives of both the Louisiana and Mississippi Chapters in order to explore still other avenues in which the College may be of help. These discussions have been fruitful and are continuing.

Members of the Administration of the State of Louisiana have asked that I cast about and find words to express our thankfulness and depth of affection for those surgeons who have been friends to us during our ordeal. I suppose that no better words may be found than those Shakespeare chose for Polonius to offer in advice to his son Laertes, concerning the value of a true and lasting friendship:

Those friends you have, and their friendship tested,
Then grapple them to your soul, with hoops of steel.
—Hamlet, Act I, Scene III

The citizens of Louisiana will not forget their friends among the American College of Surgeons. Please know that should the necessity ever arise, we Louisianans may be counted on to uphold our part of a special friendship’s bargain.

Dr. Johnson is professor of surgery, Louisiana State University Health Sciences Center, Monroe, LA, and President of the ACS Louisiana Chapter.

A look at JCAHO

The Joint Commission and the ACS

Welcome to the first in a series of monthly articles on the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Each month, a different article will focus on JCAHO activities that are relevant to surgeons. For more information or to sign up for e-mail newsletters and information on JCAHO, visit www.jcaho.org.

JCAHO traces its roots back nearly a century to the founding of the American College of Surgeons. The work of visionary surgeon Ernest Amory Codman, MD, FACS, of Boston, MA, prompted the ACS to launch a hospital standardization program in 1917. In the 1950s, the ACS transferred the program to the newly formed JCAHO, where three members of the board of commissioners are still nominated by the ACS. For 2006, the three ACS commissioners for JCAHO are LaMar S. McGinnis, Jr., MD, FACS, David L. Nahrwold, MD, FACS, and Kurt Newman, MD, FACS.

In the more than 50 years since it was established, JCAHO has changed names, expanded its scope, and earned a reputation as an international leader in patient safety and quality.
April 23–26

34th Spring Meeting to be held in Dallas, TX

The American College of Surgeons invites you to attend its 34th Annual Spring Meeting, which will be held April 23–26, 2006, at the Wyndham Anatole in Dallas, TX.

To emphasize its strong support of general surgery, the American College of Surgeons devotes its annual Spring Meeting to the interests and needs of the practicing general surgeon. The objective of this meeting is to provide three days of comprehensive learning on the latest clinical and practice management topics vital to providing optimal surgical care. At the conclusion of the Spring Meeting, participants will possess an enhanced understanding of the multiple facets of surgical care that can be used both to raise the standards of surgical practice and improve the care of the surgical patient.

The College and the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) will co-sponsor joint sessions, ACS/SAGES 2006 Assembly: Inflammatory Bowel Disease and The Changing Face of Surgical Education: What Does It Mean to Surgeons in Practice? on Wednesday, April 26. ACS and SAGES are holding their respective meetings in a back-to-back format at the same location. Responding to the needs of general surgeons, this format provides an opportunity for participants to attend two exceptional surgical meetings and view more diverse commercial exhibits cost-effectively within one trip. The ACS Spring Meeting will be held April 23–26 and the SAGES meeting dates are April 26–29. Participants can register for each meeting at each organization’s respective Web site.

The Advisory Council for General Surgery has planned a program for the Spring Meeting that will be of interest to all general surgeons and residents. Beginning on Sunday, April 23, the Resident Programs will be held, including ACS Resident Members’ presentation of hypothesis-testing research at Clinical Abstract Presentations by Residents and unusual cases at Spectacular Cases by Residents. At Surgical Jeopardy, teams of surgical residents from across the country will compete with one another to test their surgical knowledge.

On Monday, April 24, the ACS will present the Excelsior Surgical Society/Edward D. Churchill Lecture, featuring Jay L. Grosfeld, MD, FACS, and ACS Highlights from the 2005 Clinical Congress Video-Based Education Sessions in San Francisco, CA.

On Sunday through Wednesday, General Session highlights include the following: Current Evaluation of the Acute Abdomen; Management of the Geriatric Surgical Patient; Pay for Perfor-
Preliminary Program

Program is subject to change.

General Sessions

Sunday, April 23

8:00–9:00 am
The Operating Room of the Future (GS01)
MODERATOR: Richard M. Satava, Jr, MD, FACS, Seattle, WA

The operating room of the future takes advantage of advances in robotic technologies. The new robotic scrub nurse (Penelope) from Columbia University and Columbia Presbyterian Medical Center demonstrates the efficiency of such robots. Current research is under way in developing an operating room with no people present (except the patient), in which the surgeon controls not only the intuitive surgical robot but has automatic tool changers and automatic supply dispensers that are voice controlled. This frees the scrub and circulating nurses for more intellectually challenging duties than simply passing instruments or supplies. Implications for prehospital and military applications are conceptualized.

9:00–10:30 am
Clinical Abstract Presentations by Residents (GS02)
CO-MODERATORS:
Steven D. Wexner, MD, FACS, Weston, FL
Barry J. Jenkins, MD, Augusta, GA

The authors of abstracts (surgical investigators in-training) will present summaries of hypothesis-testing research, completed or in progress, not previously presented or published.

9:00–10:30 am
Current Evaluation of the Acute Abdomen (GS03)
MODERATOR: David V. Feliciano, MD, FACS, Atlanta, GA

This session will provide an overview of the three common causes of acute abdomen and the influence of newer diagnostic modalities on the timing of diagnosis and initiation of therapy.

10:45 am–12:15 pm
Spectacular Cases from Residents (GS04)

ACS Advisory Council
for General Surgery

CHAIR: Mark A. Malangoni, MD, FACS, Cleveland, OH

VICE-CHAIR: David V. Feliciano, MD, FACS, Atlanta, GA

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John K. MacFarlane, MD, FACS, Vancouver, BC
Anthony A. Meyer, MD, FACS, Chapel Hill, NC
Fabrizio Michelassi, MD, FACS, New York, NY
Stephen E. Olson, MD, FACS, Burns, OR
Victor E. Pricolo, MD, FACS, Providence, RI
A. Frederick Schild, MD, FACS, Miami, FL
Jose L. Sorrentino, MD, FACS, San Juan, PR
Marc K. Wallack, MD, FACS, New York, NY

STAFF:
Paul E. Collicott, MD, FACS, Chicago, IL
Mark Peterson, Chicago, IL

Performance: What You Should Know; Using Best Evidence to Improve the Outcomes of Your General Surgery Patients; Upgrading Your General Surgery Practice; and Introduction of the ACS Web Portal for the Practicing General Surgeon.

Also, for the first time, coffee will be available to attendees at various times throughout the meeting.

The meeting will be held at the Wyndham Anatole, located 20 minutes away from the Dallas-Fort Worth Airport. In addition to being a premier meeting facility, the hotel features tennis courts, an 80,000 square-foot spa and fitness center, boutiques, a private seven-acre park with jogging track, and several dining options.

Make plans now to attend this important meeting. Information regarding the General Sessions and registration is included in this booklet. Online registration opens this month at www.facs.org.
CO-MODERATORS:
A. Frederick Schild, MD, FACS, Miami, FL
Juan C. Paramo, MD, FACS, Miami Beach, FL

Extraordinary cases will be presented by residents to a group of expert panelists for an interactive discussion.

10:45 am–12:15 pm
**Everything You Wanted to Know about the Spleen (GS05)**
MODERATOR: H. Leon Pachter, MD, FACS, New York, NY

For decades, the spleen has captured the imagination of poets, physicians, and surgeons. Among its many functions, the spleen filters out aged blood cells and is considered an integral organ closely associated with the ability to fight infection. Alternatively, the spleen may become involved by a variety of hematologic conditions. Many of these conditions are either completely or partially relieved by removal of the spleen (autoimmune thrombocytopenic purpura).

In other pathologic conditions such as myelofibrosis, and in some of the leukemias, splenectomy, while not curative, allows for patient comfort, reduces the need for transfusion requirements, and facilitates the administration of chemotherapeutic agents. The objective of the course is to: (1) review current indications for splenectomy; (2) delineate advances in laparoscopic splenectomy and its pitfalls; (3) detail methods of splenic preservation in the traumatic and nontraumatic setting; and (4) explore various methods in the management of splenic cysts that include cystectomy without splenectomy, decapsulation, and guidelines for laparoscopic approaches.

1:30–3:00 pm
**Endoscopic Approaches to Upper Gastrointestinal Bleeding (GS06)**
MODERATOR: Gregory V. Steigmann, MD, FACS, Denver, CO

The objective of this session is to understand current endoscopic methods and techniques for diagnosis and treatment of upper gastrointestinal bleeding, as well as management of recurrent bleeding after initial endoscopic treatment.

1:30–3:00 pm
**Palliative Care (GS07)**
MODERATOR: Anne C. Mosenthal, MD, FACS, Newark, NJ

This session will focus on the common and essential skills in end-of-life care for the practicing surgeon. Attendees will learn effective communication skills and basic steps necessary to conduct the “do not resuscitate” discussion, how and when to withhold and withdraw life support, and how to care for the imminently dying patient in the last days of life.

1:30–4:00 pm
**Surgical Jeopardy (GS08)**
MODERATOR: Mark W. Bowyer, MD, FACS, Burke, VA

Session attendees will pit their surgical knowledge against the best and brightest resident teams from around the country who will be competing with each other in a “Jeopardy”-style format. A large number of questions will be drawn from the Surgical Education and Self-Assessment Program so attendance at this session will be of value to surgeons preparing for their board examinations.

3:30–5:00 pm
**Management of the Geriatric Surgical Patient (GS09)**
MODERATOR: Ronnie A. Rosenthal, MD, FACS, New Haven, CT

Attendees will learn what special factors must be considered in preoperative decision making, intraoperative management, and postoperative care of elderly surgical patients.

3:30–5:00 pm
**Outcomes for Bariatric Surgery (GS10)**
MODERATOR: Edward H. Livingston, MD, FACS, Dallas, TX

The American College of Surgeons and the American Society for Bariatric Surgery have developed bariatric surgery center certification programs. Representatives from both organizations will discuss the differences and common ground between the two programs. Recent published studies have demonstrated relatively high mortality rates for high-risk bariatric surgery patients. Lacking from these studies has been guidance regarding risk stratification for prospective bariatric surgery patients. Proposed risk indices for these patients, allowing for prospective risk assessment of patients undergoing these operations, will be discussed.

**Monday, April 24**

8:00–9:30 am
**Current Management of Sigmoid Diverticulitis**
This session will address the standard of care evaluation and treatment of sigmoid diverticulitis and evolving areas of management.

8:00–9:30 am

Pay for Performance: What You Should Know (GS12)
MODERATOR: William A. Rough, MD, FACS, Mount Holly, NJ

Pay for performance (P4P) will be the most radical change in physician reimbursement since the relative value-based system was introduced. This panel presentation will provide up-to-the-minute information to practicing surgeons that will allow them to understand the details of P4P and consider adjustments in their office to be successful under this new system. Quality indicators, measurement, and reporting will be discussed, including ACS programs such as the National Surgical Quality Improvement Program. The interactive roles of the Centers for Medicare & Medicaid Services, private insurers, surgeons, hospitals, and patients in P4P will also be explored with ample time for the audience to direct specific questions to the panel.

8:00–9:30 am

Venous Disease (GS13)
MODERATOR: Anthony J. Comerota, MD, FACS, Toledo, OH

Considerable advances have been made in evaluation and treatment in patients with acute and chronic venous disease. This session reviews current risk factor assessment, prophylaxis, pharmacotherapy, and intervention designed to appropriately reduce the onset of acute deep venous thrombosis (DVT), manage those diagnosed with acute DVT, and reduce the morbidity of chronic venous disease. The participant should be able to identify the patient at high risk for venous thromboembolism, prescribe appropriate prophylaxis, understand current pharmacotherapy for acute DVT, integrate a strategy for thrombus removal for patients with acute DVT to reduce post-thrombotic morbidity, and recognize treatment options for acute venous disease.

9:45–11:15 am

Current Management of Soft Tissue Infections (GS14)

This session will discuss current information about the management of severe soft tissue infections that may be caused by different bacterial organisms.

9:45–11:15 am

Angioaccess (GS15)
MODERATOR: R. James Valentine, MD, FACS, Dallas, TX

Attendees will learn current recommendations for patients requiring permanent access for hemodialysis, including Dialysis Outcomes Quality Initiative criteria, preoperative evaluation, patency rates of standard access grafts, complex options for hemodialysis access, access graft surveillance, and endovascular and surgical options for failing access grafts.

11:15 am–12:15 pm

Excelsior Surgical Society/Edward D. Churchill Lecture (GS16)
INTRODUCER: Thomas R. Russell, MD, FACS, Chicago, IL
INTRODUCER: Mark A. Malangoni, MD, FACS, Cleveland, OH
INTRODUCER: Kathryn D. Anderson, MD, FACS, San Marino, CA
LECTURER: Jay L. Grosfeld, MD, FACS, Indianapolis, IN

This lecture is named for the Excelsior Surgical Society, a group of 80 medical officers who met for the first time in 1945 at the Excelsior Hotel, Rome, Italy. This lecture also honors Colonel Edward D. Churchill, a famous surgeon and consultant to the U.S. Army in the World War II Italian Theater, who presented the first keynote address at this meeting.

1:30–3:00 pm

Accelerated Partial Breast Irradiation (APBI) (GS17)
MODERATOR: James A. Edney, MD, FACS, Omaha, NE

APBI is a potentially important new modality to deliver radiotherapy in conjunction with breast-conserving surgery within an abbreviated time period as compared with traditional external beam radiation, which takes 6.5 weeks. In this session, the relative merits of the various approaches available to deliver APBI will be examined. These will include catheter-based partial breast brachytherapy, intracavitary...
brachytherapy (mammosite), 3-D conformal/external beam radiotherapy, and intraoperative radiotherapy (intrabeam).

1:30–3:00 pm
**Diagnosis, Surveillance, and Treatment of Dysplasia in the Gastrointestinal Tract (GS18)**
**Moderator:** Fabrizio Michelassi, MD, FACS, *New York, NY*

Attendees will be able to review the modalities for diagnosis and surveillance of dysplasia of preneoplastic conditions in the gastrointestinal tract. Presentations will focus on dysplasia in Barrett’s esophagus, intraductal papillary mucinous neoplasms, ulcerative colitis, and anal intraepithelial neoplasia. Modern strategies of operative treatment will be reviewed for each of the above conditions with special emphasis on functional outcomes.

1:30–3:00 pm
**Using Best Evidence to Improve the Outcomes of Your General Surgery Patients (GS19)**
**Moderator:** Thomas H. Cogbill, MD, FACS, *La Crosse, WI*

This timely topic will be explored from four different vantage points: rural general surgery practice, university teaching program, multispecialty group practice experience with a new procedure, and multispecialty group practice experience with an established procedure. Speakers will draw on their own unique perspectives to highlight the methods with which current best evidence has been incorporated into their practice to improve patient outcomes and will illustrate these methods with specific examples from their recent experience.

3:30–5:00 pm
**Current Role of Sentinel Lymph Node Biopsy in Cancer (GS20)**
**Moderator:** Marc K. Wallack, MD, FACS, *New York, NY*

This surgical forum will review the list of sentinel lymph node biopsy and then address its use in treating cancer of the breast and melanoma. Furthermore, there will be mention of new horizons with this technique.

3:30–5:00 pm
**Diagnosis and Management of Rectal Cancer (GS21)**
**Moderator:** Victor E. Pricolo, MD, FACS, *Providence, RI*

The objective of this session is to provide an understanding of the current diagnostic and staging modalities for cancer of the rectum. Participants will be informed of treatment options including surgery, chemotherapy, and radiation therapy for various stages of curable rectal cancer.

3:30–5:00 pm
**Fundamentals of Hepatic Surgery for the General Surgeon (GS22)**
**Moderator:** Joseph B. Cofer, MD, FACS, *Chattanooga, TN*

This session will cover the workup of the solid liver mass and describe the identification and treatment of benign liver lesions together with primary and metastatic liver lesions. In addition, this session will describe how to diagnose and treat common biliary tract injury, how to diagnose and treat primary hepatocellular cancer, when resection is indicated, and when to refer for transplantation. Finally, this session will discuss novel means of therapy.

**Tuesday, April 25**

8:00–9:30 am
**The Role of Laparoscopic Colectomy in General Surgery (GS23)**
**Moderator:** Eugene F. Foley, MD, FACS, *Charlottesville, VA*

This session will discuss the present role and indications for laparoscopic colon resections. In addition, it will debate the controversy about what training is necessary for surgeons to be competent to perform these procedures.

8:00–9:30 am
**Follow-Up Regimens for Resected Gastrointestinal Malignancies (GS24)**
**Moderator:** E. Christopher Ellison, MD, FACS, *Columbus, OH*

Attendees will learn the best and most cost-effective methods of monitoring patients who have resection of colorectal cancer, pancreatic endocrine tumors, primary hepatomas, pancreatic and biliary cancers, and gastric cancer. The speakers will focus on endoscopic surveillance; imaging, including positron emission
tomography; and serum tests. The session will close with a panel discussion on monitoring patients with resected gastrointestinal malignancies.

10:00–11:30 am

**Tricks of the Trade in Laparoscopic Resection of Solid Organs (GS25)**

**Moderator:** Leena Khaitan, MD, FACS, Atlanta, GA

During this session, minimally invasive approaches to surgery on the liver, spleen, adrenal gland, and pancreas will be discussed. By the end of this session, attendees will be well aware of which pathologic conditions may be amenable to minimally invasive solid organ surgery. They will learn the “tricks of the trade” and leave with a surgical armamentarium for solid organ surgery.

10:00–11:30 am

**Advanced Operative Techniques in Trauma for the Community General Surgeon (GS26)**

**Moderator:** Andrew B. Peitzman, MD, FACS, Pittsburgh, PA

This session will focus on challenges for the community general surgeon in trauma care. Operative approaches to abdominal injuries, thoracic, neck, and extremity vascular injuries will be discussed. Management based on available resources and expertise, definitive operative repair, and damage control concepts will be reviewed.

1:30–3:00 pm

**Update on Parenteral Nutrition (GS27)**

**Moderator:** Danny O. Jacobs, MD, FACS, Durham, NC

This session, targeted toward the practicing surgeon, will review the latest information available regarding nutritional support of surgical patients. Presenters will review indications for use of parenteral therapies including decision making and the latest data on efficacies. Insights and summaries of important research advances that may affect patient care in the near future will also be presented.

1:30–3:00 pm

**Crisis in Cancer Care: The Role of the American College of Surgeons in Evaluating and Improving the Quality of Cancer Care (GS28)**

**Moderator:** Steven B. Edge, MD, FACS, Buffalo, NY

Variations and disparities in the quality of cancer care that affect outcomes are widely documented. Surgery remains a cornerstone of cancer care, and a large body of evidence shows that variation in the quality of surgical care is a major issue. The improvement of the quality of cancer care for all Americans has become a national priority. The ACS Commission on Cancer (CoC) has long-defined standards for hospital cancer care programs, including standards for maintaining and using registries to monitor cancer care. The CoC has recently undertaken a major reorganization to enhance its programs to improve the quality of cancer care. New programs leverage the cancer registry network and the National Cancer Database for quality improvement. This session will examine the scope of the problem in quality improvement; the role the surgeon plays in contributing to and solving the problem; and the quality improvement activities of the CoC, including presenting the results of three major quality initiatives.

3:30–5:00 pm

**Introduction of the ACS Web Portal for the Practicing General Surgeon (GS30)**

**Moderator:** Richard J. Finley, MD, FACS, Vancouver, BC

Attendees will learn how to use the new ACS Web portal to gain access to ACS resources that are specific to their needs and those of their patients.
Wednesday, April 26

8:00–10:00 am
ACS/SAGES 2006 Assembly: Inflammatory Bowel Disease (GS31)
CO-MODERATORS:
  Steve Eubanks, MD, FACS, Columbia, MO
  Fabrizio Michelassi, MD, FACS, New York, NY

Current theories on etiology of inflammatory bowel disease will be reviewed. Attendees will gain an understanding of modern medical treatment of Crohn’s disease and ulcerative colitis. New advances in surgical treatment of inflammatory bowel disease will highlight bowel-saving and restorative surgical procedures with special emphasis on functional outcomes.

10:15 am–12:15 pm
The Changing Face of Surgical Education: What Does It Mean to Surgeons in Practice? (GS32)
CO-MODERATORS:
  Mark A. Malangoni, MD, FACS, Cleveland, OH
  Jeffrey L. Ponsky, MD, FACS, Cleveland, OH

This session will detail the developments in surgical training, skills training, and maintenance of certification and outline the role of the College in this process.

Video-Based Education

Monday, April 24

Highlights from the 2005 Clinical Congress Video Education Session (VE01)
7:00–9:30 pm
MODERATOR: Daniel B. Jones, MD, FACS, Boston, MA

Videotaped surgical procedures performed and narrated by general surgeons will be presented during this evening session. An interactive panel discussion will encourage participants to present questions or challenges to the coordinator and guest panelists. These videos were previously shown at the 2005 Clinical Congress.
Spring Meeting Program at a glance

Key:
GS = General Session
VE = Video-Based Education Session

Sunday

GS01
The Operating Room of the Future
8:00–9:00 am

GS02
Clinical Abstract Presentations by Residents
9:00–10:30 am

GS03
Current Evaluation of the Acute Abdomen
9:00–10:30 am

GS04
Spectacular Cases from Residents
10:45 am–12:15 pm

GS05
Everything You Wanted to Know about the Spleen
10:45 am–12:15 pm

GS06
Endoscopic Approaches to Upper Gastrointestinal Bleeding
1:30–3:00 pm

GS07
Palliative Care
1:30–3:00 pm

GS08
Surgical Jeopardy
1:30–3:00 pm

GS09
Management of the Geriatric Surgical Patient
3:30–5:00 pm

GS10
Outcomes for Bariatric Surgery
3:30–5:00 pm

Monday

GS11
Current Management of Sigmoid Diverticulitis
8:00–9:30 am

GS12
Pay for Performance: What You Should Know
8:00–9:30 am

GS13
Venous Disease
8:00–9:00 am

GS14
Current Management of Soft Tissue Infections
9:45–11:15 am

GS15
Angioaccess
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GS17
Partial Breast Irradiation
1:30–3:00 pm

GS18
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1:30–3:00 pm

GS19
Using Best Evidence to Improve the Outcomes of Your General Surgery Patients
1:30–3:00 pm

GS20
Current Role of Sentinel Lymph Node Biopsy in Cancer
3:30–5:00 pm

GS21
Diagnosis and Management of Rectal Cancer
3:30–5:00 pm
Tuesday

GS22
Fundamentals of Hepatic Surgery for the General Surgeon
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GS25
Tricks of the Trade in Laparoscopic Resection of Solid Organs
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GS26
Advanced Operative Techniques in Trauma for the Community General Surgeon
10:00–11:30 am

GS27
Update on Parenteral Nutrition
1:30–3:00 pm

GS28
Crisis in Cancer Care: The Role of the American College of Surgeons in Evaluating and Improving the Quality of Cancer Care
1:30–3:00 pm

GS29
Upgrading Your General Surgery Practice
3:30–5:00 pm

GS30
Introduction of the ACS Web Portal for the Practicing General Surgeon
3:30–5:00 pm

Wednesday

GS31
ACS/SAGES 2006 Assembly: Inflammatory Bowel Disease
8:00–10:00 am

GS32
The Changing Face of Surgical Education: What Does It Mean to Surgeons in Practice?
10:15 am–12:15 pm
Registration information

Registration for the 2006 Spring Meeting will open in January. Please visit www.facs.org for more information as it becomes available.

Registration location and hours
Registration will be held at the Wyndham Anatole.

Sunday, April 23 ................. 7:00 am–5:00 pm
Monday, April 24 ............... 7:30 am–5:00 pm
Tuesday, April 25 .............. 7:30 am–5:00 pm
Wednesday, April 26 .......... 7:30 am–11:00 am

Registration fees
Registration fees for the 2006 Spring Meeting will be available in January. Please visit www.facs.org for more information as it becomes available.

International attendees
International Fellows, guest physicians, and meeting attendees: Please be aware that the process of obtaining a visa to attend meetings in the U.S. takes much longer than in the past. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting. You may request a letter welcoming you to the meeting from the College by contacting the International Liaison Section at postmaster@facs.org or by fax at 312/202-5001.

Technical exhibits
To enhance the educational value of the meeting, more than 50 companies will display products or services related to the practice of surgery. Your registration includes coffee breaks Sunday, 10:30–10:45 am, 3:00–3:30 pm, and Monday, 9:30–9:45 am, 3:00–3:30 pm, in the exhibit hall.
Technical exhibits will be open on the following dates/times:

Sunday, April 23 ................. 10:00 am–3:30 pm
Monday, April 24 .............. 9:00 am–3:30 pm

Children
The ACS policy regarding children is as follows:

• Younger than 12: not permitted on Social Program tours
• Younger than 16: not permitted on exhibit floor or in scientific sessions
• 16 and older: must have a badge to enter exhibit area or meeting rooms.

This policy includes infants in strollers and arms.

Accreditation
The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CME credit
The American College of Surgeons designates this educational activity for a maximum of 27 Category 1 credits toward the American Medical Association Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity.

Compact discs
Selected general sessions will be recorded live and will be available for purchase on compact disc. Additional information will be available on site in Dallas, TX, at the National Audio Video booth near the registration area.

Postgraduate course syllabi on CD-ROM
A CD-ROM containing 14 select postgraduate course syllabi from the 2005 Clinical Congress will be available for purchase at the Spring Meeting registration desk.

Social Program
A Social Program will be offered during the Spring Meeting in Dallas, TX. A $50 nonrefundable advance registration fee is required for participation in the Social Program. The registration fee entitles you to attend scientific sessions and coffee breaks and to view the technical exhibits. Registered Social Program attendees will also receive a tote bag.

This year we will be offering the following tour: Private Wine and Cheese Pairing Class.

The tour has a required minimum and maximum number of participants. Advance registration is strongly recommended. The tour will be canceled if the minimum number is not reached, and tickets will be available for on-site purchase only if space allows. The tour operator reserves the right to change tour itineraries and make proper substitutions when necessary.

Meeting location and accommodations
The 34th Annual Spring Meeting will be held in Dallas, TX, where you can visit the Dallas Museum of Art or
the new Nasher Sculpture Center, shop at the NorthPark Center or the Galleria, or enjoy the music and vibrant nightlife of the West End or Deep Ellum.

The meeting venue is the Wyndham Anatole Hotel, conveniently located close to downtown and a quick trip to the shopping, dining, and other area attractions. All newly renovated guest rooms have voice mail, computer dataports, hair dryers, irons/ironing boards, coffee makers, and weekly newspaper delivery. Hotel amenities include a host of 11 restaurants and bars, 24-hour room service, concierge service, a world-class fitness center, a private seven-acre park, and one of the nation’s most extensive private art collections.

Reservations can be made by calling the hotel directly at the numbers listed below. Please indicate that you will be attending the ACS Spring Meeting in order to obtain the special group rates. Reservations can also be made online through a housing link on the Spring Meeting section of the ACS Web site at www.facs.org.

Wyndham Anatole Hotel
2201 Stemmons Freeway
Dallas, TX 75207
Hotel main phone: 214/748-1200
Hotel reservations: 214/761-7500
Wyndham central reservations: 800/WYNDHAM
Hotel guest fax: 214/761-7520
ACS group rate: $195 single/double plus tax

Reservations made after the housing deadline of April 1, 2006, or after the room block fills, are subject to space and rate availability. A deposit of one night’s stay is required when making your reservation, payable via check or credit card. The deposit is refundable if the reservation is cancelled at least 48 hours before your scheduled arrival date. Please also note that after check-in, an early departure fee of one night’s stay will apply if you choose to check out before your scheduled departure date.

Transportation
Special meeting saver airfares are available on United Airlines. Choose from the following savings options:

- Receive a 5 percent discount off the lowest applicable domestic discount fare, including first class.
- Receive a 10 percent discount off midweek coach fares, purchased seven days in advance.
- Obtain a 5 percent additional discount on the previously mentioned fares if tickets are purchased at least 30 days in advance of your travel date.

Area/zone fares based on geographic location are also available with no Saturday night stay required. Minimum stay (two nights) varies by airline; seven-day advance purchase required. (Zone fares are not available through online ticket purchase; please call United Airlines at the numbers listed below.)

These special discounts are available by calling the airline directly (independently or through a travel agent). Be sure to indicate the name of the meeting to which you will be traveling and refer to the ACS file numbers to obtain the special fares.

United Airlines
800/521-4041
8:00 am–10:00 pm (ET)
ACS File 501CR

Car rental
Avis is designated as the official car rental company for the 2006 Spring Meeting. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

Avis Reservations
800/331-1600
Web site: www.avis.com
AWD number: B169699
The American College of Surgeons Division of Education presents the **Personal Financial Planning and Management Course for Residents and Young Surgeons**, which uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children) and proper planning for financial stresses related to their surgical practice.

**Objectives**

At the end of the course, the participants will be able to describe:

- The essentials of personal financial management as they relate to young surgeons in practice and residents and their families.
- The impact of interest rates and time upon loans, compound interest, and the implications for debt management.
- The building blocks necessary for the surgeons to invest successfully.
- The importance of time in reducing the risk of investing.
- The basics of mutual funds, stocks, bonds, and other investment vehicles.
- How to evaluate and choose a financial advisor.

**Intended Audience:**

- Surgical residents and surgeons recently in practice.

**Orders may be placed through ACS Customer Service at 312/202-5474 or via the College’s Web site at: www.acs-resource.org**

For more information contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.
Each year, the Association of Women Surgeons (AWS) sponsors an educational conference, awards dinner, and networking breakfast in conjunction with the American College of Surgeons annual Clinical Congress. Kathryn D. Anderson, MD, FACS, the new President of the College, attended the annual networking breakfast, which was held on October 19, and spent time talking with students, residents, and other AWS members.

This year, the educational program, which drew a record 138 participants, featured a panel of three women surgeons: Barb Pettitt, MD, FACS; Rosemary Duda, MD, MPH, FACS; and Carla Pugh, MD, PhD, FACS. They discussed how they achieved success on their own terms and provided attendees with an understanding of the career choices that are available to surgeons and the inspiration to dare to be different.

Following the opening session of the program, which featured a keynote presenter—best-selling author and associate professor of education and organizational behavior at Stanford University—Debra Meyerson, PhD, presented Leading Changes through Tempered Radicalism. The course provided participants with a deeper understanding of the nature of contemporary gender discrimination and an approach to change that will enable participants to improve conditions for women without jeopardizing their careers.

On October 17, the AWS recognized outstanding women surgeons at its annual awards dinner. The AWS awards program recognizes individuals who have contributed exceptional service to women in surgery and the association, honors those who demonstrate great potential as future leaders in surgery, and encourages and supports female medical students pursuing a career in surgery. This year’s recipients of the following awards were recognized:

- The Nina Starr Braunwald Award: Karin Muraszko, MD, FACS
- The Honorary Member Award: Morris Kerstein, MD, FACS
- The Distinguished Member Award: Patricia Lowery, MD, FACS
- The Outstanding Woman Resident Award: Leora Balsam, MD
- The Patricia Numann, MD, Medical Student Award: Erika Manning

In addition, the 2006 AWS Foundation/Ethicon Endo-Surgery, Inc. fellowship was presented to Anjali Kumar, MD, and her mentor, Laura Esserman, MD, FACS, from the University of California at San Francisco.

In 2006, the AWS will celebrate 25 years of inspiring, encouraging, and enabling women surgeons to realize their professional and personal goals. Please mark your calendar and join us for the AWS 25th Anniversary Gala and Conference, October 6–7, 2006, in Chicago, IL. For more information, call 630/655-0392, e-mail info@WomenSurgeons.org, or visit www.WomenSurgeons.org.
ACS seeking nominations for Officers-Elect and the Board of Regents

The 2006 Nominating Committee of the Fellows (NCF) has the task of selecting nominees for the three Officer-Elect positions—President-Elect, First Vice-President-Elect, and Second Vice-President-Elect—of the American College of Surgeons. The NCF uses the following guidelines when reviewing the names of potential Officer-Elect nominees:

- Loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.
- Demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.
- Recognition of the importance of representing all who practice surgery.
- Consideration of women and members of other underrepresented populations encouraged.

The 2006 Nominating Committee of the Board of Governors (NCGB) has the task of selecting nominees for seats on the Board of Regents to be filled during the 2006 Clinical Congress. The guidelines used by the NCGB when reviewing the names of potential nominees for election to the Board of Regents are the same as for Officers-Elect, plus the following:

- Geography, surgical specialty balance, and academic or community practice are taken into consideration.
- Individuals no longer in active, surgical practice should not be nominated for election or re-election to the Board of Regents.

The surgical specialties that should be given priority consideration for nomination to the Board of Regents include the following:

- General surgery
- Otolaryngology—head and neck surgery
- Plastic surgery

Nominations for candidates for ACS Officers-Elect or the Board of Regents should be composed of one or two paragraphs about the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Please submit nominations to memberservices@facs.org.

The deadline for submitting nominations is Tuesday, February 28, 2006. If you have any questions, please contact Patricia Sprecksel at 312/202-5360 or psprecksel@facs.org.

Trauma and Critical Care 2006 scheduled for March

Trauma and Critical Care 2006 will present Techniques and Technology: Basics to Cutting Edge, March 20–22, at Caesars Palace, Las Vegas, NV.

Kenneth L. Mattox, MD, FACS, is program director. The program committee includes David B. Hoyt, MD, FACS; Jay A. Johannigman, MD, FACS; M. Margaret Knudson, MD, FACS; David W. Tuggle, MD, FACS; and program coordinator, Mary K. Allen.

The program objectives are to achieve the following:

- describe innovative and appropriate techniques and technology for optimal care of the injured patient in urban and rural settings
- describe operative techniques for the approach to and repair of traumatic injuries to abdominal organs and vessels and extremity vessels
- discuss techniques and
technology for optimal care in the critical care setting, including ventilator-associated complications, multiorgan dysfunction, coagulopathy, iatrogenic lesions, and sepsis

• apply concepts from trauma case studies to the practice setting
• describe the evolution of trauma epidemiology and management
• discuss practical exposure techniques and guidelines for management of difficult traumatic injuries of carotid, vertebral, and distal subclavian vessels; lumbar vein; esophagus; distal profundi femoris; and groin
• identify challenges and solutions in disaster preparedness and response, drawing on lessons learned from Hurricane Katrina and the recent London bombings
• discuss appropriate surgical response to uniquely challenging injuries with added complicating circumstances, including obesity, coagulopathy, and age of patient
• describe appropriate use of technique and technology in approaching the torn bronchus at the trachea and diaphragmatic rupture with bleeding in the chest
• discuss management of renal injury in a child in the rural setting
• contrast craniectomy following brain injury in the military versus civilian settings and in adults versus children
• discuss management, technology, and techniques for optimal care of diverse trauma-related issues, including complicated fractures for the nonorthopaedic surgeon, necrotizing fasciitis, interosseous devices prehospital and ER, burns, spinal cord injury, interventional radiology in children, prehospital adjuncts, and urologic injuries
• debate the value of more liberal use of vena caval filters in trauma patients
• discuss socioeconomic and ethical trauma-related issues, including the Emergency Medical Treatment and Active Labor Act, videotaping as a learning tool, futility, and transfers to trauma centers
• evaluate the benefit of knowledge gained and lessons learned in providing quality trauma care in the practice setting

Faculty members include the following: Karim Brohi, MD, London, UK; Henry C. Cleveland, MD, FACS, Denver, CO; Michael Coburn, MD, FACS, Houston, TX; Raul Coimbra, MD, FACS, San Diego, CA; Demetrios Demetriades, MD, PhD, FACS, Los Angeles, CA; Eric R. Frykberg, MD, FACS, Jacksonville, FL; David B. Hoyt, MD, FACS, San Diego, CA; Jay A. Johannigman, MD, FACS, Cincinnati, OH; M. Margaret Knudson, MD, FACS, San Francisco, CA; Fred A. Luchette, MD, FACS, Maywood, IL; Robert C. Mackersie, MD, FACS, San Francisco, CA; Kenneth L. Mattox, MD, FACS, Houston, TX; Norman E. McSwain, Jr., MD, FACS, New Orleans, LA; J. Wayne Meredith, MD, FACS, Winston-Salem, NC; Michael H. Metzler, MD, FACS, Las Vegas, NV; Scott H. Norwood, MD, FACS, Baton Rouge, LA; Patrick J. Offner, MD, FACS, Denver, CO; Peter Rhee, MD, FACS, Los Angeles, CA; Ali Salim, MD, FACS, Los Angeles, CA; Lynette Scherer, MD, FACS, Los Angeles, CA; C. William Schwab, MD, FACS, Philadelphia, PA; Michael J. Sise, MD, FACS, San Diego, CA; David W. Tuggle, MD, FACS, Oklahoma City, OK; Alex B. Valadka, MD, FACS, Houston, TX; and David H. Wisner, MD, FACS, Sacramento, CA.

Complete course information can be viewed on the American College of Surgeons Web site (www.facs.org/trauma/cme/traumtgs.html). For further information, contact the Trauma Office at 312/202-5342.

### Trauma meetings calendar

The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

- **Trauma and Critical Care 2006**, March 20–22, Las Vegas, NV.
- **Trauma and Critical Care 2006—Point/Couterpoint XXV**, June 5–7, Williamsburg, VA.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
Health policy scholarships available for 2006

The American College of Surgeons is offering health policy scholarships to subsidize attendance and participation in Leadership Program in Health Policy and Management, at the Heller School for Social Policy and Management at Brandeis University (http://www.heller.brandeis.edu/welcome/leadership_program.asp). The 2006 course takes place from May 29 to June 3. The award is in the amount of $8,000, to be used toward the cost of tuition, travel, housing, and subsistence during the period of the course.

One of the scholarships is reserved for general surgeons, and is fully funded by the College. The College is very pleased that a number of the surgical specialty societies have partnered with the ACS to co-sponsor a scholarship for a member in good standing of both the College and their society to attend this health policy intensive. The participating societies supporting scholarships are the American Academy of Ophthalmology, the American Academy of Otolaryngology–Head & Neck Surgery Foundation, the American Association of Neurological Surgeons, the American Society of Colon and Rectal Surgeons, the American Society of Plastic Surgeons, the American Urogynecologic Society, The Society of Thoracic Surgeons, and the Society for Vascular Surgery.

General policies covering the granting of the health policy scholarships are:

• The award is open to surgeons who are general surgeons or members in good standing of the one of the above societies, as well as of the American College of Surgeons. Applicants must be at least 30 years old, but younger than 55, on the date that the completed application is filed.

• The award is to be used to support the recipient during the period of the course. Indirect costs are not paid to the recipient or to the recipient’s institution.

• Applications for this scholarship consist of the following items:
  —One copy of the applicant’s current curriculum vitae
  —One copy of a one-page essay, discussing why
  the applicant wishes to receive the Health Policy Scholarship

• Application for this award may be submitted even if comparable application to other organizations has been made. If the recipient accepts a similar scholarship from another agency or organization, the Health Policy Scholarship will be withdrawn. It is the responsibility of the recipient to notify the Scholarships Section of the ACS, which administers this program, of competing awards.

• The Health Policy Scholarship must be used in the year for which it is designated. It cannot be postponed.

• The scholar is required to serve one year as a pro tem member of the health policy steering committee of both the ACS and his or her specialty society following completion of the course. This obligation includes participation in occasional meetings and as a reviewer or advisor as requested.

• A brief report of the scholar’s experiences and activities is due at the conclusion of the scholarship period. A simple accounting is also required.

The closing date for receipt of applications is February 1, 2006. All applicants will be notified of the outcome of the selection process by March 31, 2006.

Questions may be directed to the ACS Scholarships Administrator at 312/202-5281. Requirements for the Health Policy Scholarships are posted on the ACS Web site at www.facs.org.

Please send applications for this scholarship to: Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.
ACS CodingToday

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- Complete CPT, HCPCS Level II, and ICD-9 codes.

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Special discount pricing: Only $199 for the first user, $50 for each additional user—a $590 value!
ACS seeking nominations for
ACS/PMHI volunteerism award

The American College of Surgeons Board of Governors Committee on Socioeconomic Issues, in association with the Pfizer Medical Humanities Initiative (PMHI), is seeking nominations for the 2006 Surgical Volunteerism Award. Committee members are looking for ACS Fellows who are making a significant contribution to surgical care through volunteer actions. Candidates for this award may practice their surgical volunteerism either in a domestic, international, or military setting. All surgical subspecialties are eligible for consideration.

An application form and a brief narrative are required. The narrative should be submitted in English, and limited to 500 words, briefly describing why you believe your nominee deserves this award.

All nominations will be assessed on the following seven criteria:
- **Community impact:** The medical benefit on the local community/medical facility over the previous 12 months (20 points)
- **Humanitarianism:** The degree to which the volunteer displays true, selfless altruism (20 points)
- **Long-term effect:** The potential impact on the community/medical facility in the future—that is, training and facilities that have continued impact (15 points)
- **Number of people served:** The number of people helped as a direct result of the project or act of volunteerism (15 points)
- **Length of service:** The number of years participating in these activities (10 points)
- **Organizational leadership:** The organizational leadership and personal financial support and/or funds raised on the part of the candidate (10 points)
- **Frequency of service:** The frequency of service in terms of personal time volunteered over the last year (10 points)

A survey by the committee, conducted by the Institute for Health Policy of the Massachusetts General Hospital, determined that approximately 30 percent of U.S. and Canadian surgeons actively participate in more than 250 different volunteer domestic and international organizations. The College is seeking to identify and formally recognize those individual surgeons and volunteer programs.

At the 91st Clinical Congress in San Francisco, CA, last October, the College awarded the ACS/PMHI Surgical Volunteerism Awards to Domingo T. Alvear, MD, FACS, of Harrisburg, PA, and George F. Ellis III, MD, FACS, of Longwood, FL.

Dr. Alvear received his award for his humanitarian efforts in the international arena. He is the founder and president of World Surgical Foundation, Inc. Dr. Ellis received his award for his humanitarian efforts in the domestic arena. He is the founding chair of Primary Care Access Network. Courtney M. Townsend Jr., MD, FACS, Chair of the Board of Governors at that time, presented the awards in association with PMHI. Their plaques read: “In recognition of those surgeons committed to giving something of themselves back to society by making significant contributions to surgical care through organized volunteer activities.”

The nomination form is posted on the ACS Board of Governors’ Web site, http://www.facs.org/about/governors/boardgv.html. The deadline for submitting nominations is **Tuesday, February 28, 2006**.

Please send your form and narrative to Patricia A. Sprecksel, Administrator, Board of Governors, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. E-mail: psprecksel@facs.org, fax: 312/202-5021.
The American College of Surgeons and the National Ultrasound Faculty have developed “Ultrasound for Surgeons: The Basic Course” for surgeons and surgical residents on CD-ROM.

The objective of the course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications.

- Replaces the basic course offered by the American College of Surgeons.
- A printable CME certificate is available upon successful completion.
- CD will install the necessary software (PC or Mac).
- The learner is offered two attempts to pass a multiple-choice exam with a minimum score of 80% at the completion of the program.
- Residents must submit a letter from their director/chair to document residency status.
- Only one user per CD is allowed. Online access is needed to register the CD and to take the exam.
- $300 for nonmembers
- $225 for Fellows of the College
- $125 for residents with letter proving status*
- $90 for Resident and Associate Society (RAS) members (Additional $16 for shipping and handling of international orders)

*Non-RAS residents must supply a letter confirming status as a resident from a program director or administrator and are limited to one CD-ROM.

The CD can be purchased online at http://www.acs-resource.org or by calling Customer Service at 312/202-5474.

For additional information, contact Linda Stewart, tel. 312/202-5554, e-mail lstewart@facs.org

The American College of Surgeons (ACS) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The ACS designates this educational activity for a maximum of 4 Category 1 credits toward the AMA Physician’s Recognition Award (PRA). Each physician should claim only those credits that he/she actually spent in the activity. The American Medical Association has determined that physicians not licensed in the U.S. who participate in this CME activity are also eligible for AMA PRA Category 1 credit.
The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin and the “From my perspective” columns written by Executive Director Thomas R. Russell, MD, FACS.

Challenges in rural surgery

I read with interest Dr. Russell’s “From my perspective” (Bull Am Coll Surg. 2005;90(8):4-5) and Dr. Rinker’s article (Meeting the needs of rural general surgeons. Bull Am Coll Surg. 2005;90(8):13-18) in the August issue.

When I first started practice in 1984, I was recruited to go to a small hospital that was approximately 50 miles from a larger urban hospital.

At that time, this rural hospital was serviced by itinerant specialists, such as an orthopaedic surgeon who held a morning clinic once every two weeks, a urologist who came in approximately one day every two weeks, and a gastroenterologist who performed endoscopy once or twice a month. One of the reasons I was recruited was that I had experience in these areas and was able to augment services in the hospital.

Once I began to perform these procedures in the hospital with excellent results, I found myself the subject of continued criticism from these itinerant subspecialists who resented my involvement in what they considered their “turf.” Some of these specialists rotated through as many as five hospitals a week.

Ultimately, a complaint was made to the state medical board, even though the quality of my work was excellent and I never had been the defendant in any lawsuits. At the time, one of the problems in stating my case before the state medical board was that the general surgery community and experts I approached to defend me were not certain about the defensibility of the whole “rural surgery model.” Individual surgeons I approached would generally find the individual work I had performed to be satisfactory. However, they were uncomfortable with the concept of a general surgeon working in a rural surgery field.

I believe it is essential for the College to assist surgeons in setting high standards and in meeting them. The College should provide methods whereby surgeons can evaluate their own work objectively and gain assistance in such an evaluation. This will help them to correct problems in their work and to defend themselves against unreasonable criticism.

Particularly in view of pay for performance, or value-based purchasing for physicians, I believe it is important for surgeons to have a system that they understand and that they can use to counter unwarranted criticism and that will allow them to improve their own work and be able to market themselves if their work so merits.

The policy of the federal government toward smaller hospitals generally has been to reduce reimbursement to the point where smaller operating rooms can no longer function. I think that this is a simplistic approach because patients who go to larger hospitals may incur additional costs resulting from additional consultations and so forth. The College should create a system that will allow these things to be measured to determine which is the best area.

F. Andrew Morfesis, MD, FACS
Fayetteville, NC

Addressing ER shortages

I read with great interest your article in the Bulletin about the crisis in our emergency rooms (Bull Am Coll Surg. 2005;90(6):4-5). We are facing the same problems at our institution. As secretary of the medical staff, I have been asked to address this issue and find long-term solutions for this problem. We decided to hire groups of physicians to cover our emergency room for obstetrics-gynecology. This is working well and we now plan to do the same to address the shortage in our neurosurgery and cardiothoracic coverage.

We have found that this is a viable alternative and provides an immediate, quick fix for the problem. I am sure that others around the country will have ideas that might also be appropriate, and it would be appreciated if you could share these with us. This is a true crisis affecting our patients and we must all work together to resolve it.

Rafael Espada, MD
Houston, TX

The October “From my perspective” column (Bull Am Coll Surg. 2005;90(10):4-5) was right on the money. It was also one to two years late.

The combination of skyrocketing professional liability costs and decreasing reimbursements is making it impossible for the average surgeon in private practice to continue to run faster to accomplish all of the care tasks of the day. The sad reality of the situation is that payment from the in-network insured patients don’t even justify being on emergency department call. The reimbursements only make sense from a business/financial perspective if the treating surgeon is out of the insurance network. Only under those circumstances can the reimbursement be possible at an adequate level. This has created a quandary: leave the networks and become part of a greater issue of access to care for even elective or semi-urgent surgery, or stay in network and try to get off the emergency department coverage roster. Which better serves the greater good? We have clearly come to the point where both are no longer possible.

It’s amazing to consider that millions of people out there pay
for medical coverage to be under the care of a network, only to find on a daily basis that there are no services available to them despite paying high premiums and that they have to pay out of pocket for care. It is wrong to lay any responsibility for this on the backs of the already-beleaguered surgeons, most of whom just try to get through each day doing the right thing and hoping for some relief. Something has to change. The emergency department is no longer an issue related to providing charity care in the traditional sense. It is now all charity care, insured or not insured, if the surgeon is still within the insurance networks. All surgeons work hard, and all have to feed their families, leaving the emergency department call as more of a mandate than a considered choice.

This needs to change. The out-of-network fee system works financially but becomes a very unwelcome surprise to the patient and often sets up a system where the patient and treating physician are at odds regarding finances. This system should be about the care and medical relationship rather than an economic one. The number of uninsured persons nationally will swell enormously soon because people are beginning to realize that the coverage they pay such large dollar amounts for provides very little benefit.

N. A. Bertha, DO, FACS
Florham Park, NJ

Thank you for your comments in the October issue (Bull Am Coll Surg. 2005;90(10):4-5) regarding the increasing difficulties in securing emergency surgical services in community hospitals. You noted that one solution being discussed was a new category of health care professionals known as “surgical hospitalist.”

I thought you might be interested to know that here in Santa Rosa, CA, one hospital delivery system has been operating under such a system practically since 1997, and formally, under contract with Sutter Health, since 2000. It seems to serve our primary care and emergency room doctors well, as well as making a positive contribution to the hospital’s bottom line.

Chris Kosakowski MD, FACS
Santa Rosa, CA

I am refreshed to see others raising the issue of fatigue and surgical performance (Bull Am Coll Surg. 2005;90(10):4-5). As a former commercial pilot and general surgeon who left clinical practice at age 50, I believe it will only be a matter of time before the public demands assurances that people performing operative procedures are not impaired as a result of sleep deprivation.

The degradation in performance caused by fatigue is well documented in the trucking and aviation industries. Most surgeons are unwilling to accept fallibility. Often there are profound pressures for a surgeon to complete elective cases after working all night on call. The issue may be an unstated factor in early retirement. The medical economics are such that we cannot work at a reduced pace (40 hours/week) and earn more than $30,000/year.

My family and my health were more important than working in an environment that placed me at risk for creating preventable medical errors. I enjoyed the opportunity to care for patients after hours, but I could not tolerate the mental fog that persisted for several days after working 24 to 36 hours without a break. I am of the opinion that there should not be any residency work hour restrictions. Residency is the best environment to in which to determine one’s capacity for performing work. In private practice, there is little if any support system to fall back on.

I believe the College should take a leadership role in bringing the issue of fatigue to the public. It is more than just being on call—the medical economics today is more about throughput than quality of output. The ripple effect of a surgeon canceling five or six elective cases after an all-nighter is significant. The hospital and anesthesiologist would be the most upset; I have been fired by patients after I canceled their cases because of my personal fatigue and concern about performing surgery. It is well known that sleep deprivation has similar effects to alcohol ingestion.

We expect airline pilots to not be drunk when flying, so why should we have surgeons operating in a similarly impaired state caused by sleep deprivation?

Daniel P Congreve, MD, FACS
Bettendorf, IA

Pay for performance (P4P)

We in the Philippines launched the quality movement in 2003, and we have peer reviews composed of the presidents of all major medical societies in the country. We meet every month to discuss with them the errors committed by colleagues based on claims reimbursement. I guess there is an immediate call for action here. Unfortunately, many physicians still do not see this as an urgent call and still believe that their autonomy as a physician is being stepped on and violated. The response of physicians in developed countries and in developing countries seems to be the same. PhilHealth, the national Health Insurance of the Philippines (for which I am a vice-president for quality assurance) is willing to pay for good quality service, as studies show that monetary incentives work. However, how much of this incentive can really make our colleagues accept that to err is human, but to correct it is divine!

Good luck with your quality performance endeavors and I congratulate you. Hopefully we can work together toward the common
goal of bringing quality care to every patient.

Madeleine de Rosas-Valera, MD, MScCHHM Cambridge, MA

I am in disagreement with the concept of P4P. I believe this will make more income for the large groups with highly advanced computer systems, to the detriment of the surgeon in solo practice. It troubles me that the College and the American Medical Association have bought into the concept.

Perhaps my most meaningful surgery was done with the First Marine Division Danang RVN when I was paid a paltry sum compared with what my colleagues were making back in the States. In private practice, many of my most challenging and satisfying cases ended up with recompense of little or none.

I don’t think this concept will help the have-nots (that is, those without insurance, the poor, and the undocumented). Mark me down as being against the whole P4P project.

Richard R. O’Reilly, MD, FACS, FCCP Bakersfield, CA

I read with great interest Dr. Russell’s article regarding P4P in the August Bulletin (2005;90(8):4-5). I agree that physicians should be held to certain standards and be rewarded for performance. The insurance companies are part of the equation in the health care delivery system. They have created an unbearable burden of bureaucracy on the patients and providers at a cost of 25 percent to 31 percent of every health care dollar spent. Congress, the business industries, and payors and providers of health care should hold insurance companies to the same standard. Their premiums and profit margins have to be subjected to P4P as well. We hope that the American College of Surgeons will take the lead to accomplish this.

K. J. Lee, MD, FACS Past-President, American Academy of Otolaryngology– Head & Neck Surgery New Haven, CT

Addressing needs of surgical specialties
I appreciate the article entitled “ACS takes on specialty issues” (Bull Am Coll Surg. 2005;90(10):17-21). As an otolaryngologist who has been a member of the College for almost 20 years, I have long avoided the ACS meetings because I felt that the needs of non-general surgeons were not being addressed. This is a refreshing piece that shows that the College represents the interest of all surgeons. Thank you.

Earl H. Harley, MD, FACS Washington, DC

Tribute to Dr. Organ
It was with deep appreciation and pleasure that I read the September Bulletin. The superb tribute to Claude H. Organ, Jr., was well deserved for Claude for all the reasons mentioned in the article, plus other activities and contributions.

I had the privilege of knowing Claude and I am grateful indeed for the Bulletin’s portrayal of Claude’s life in such an excellent way.

Asa G. Yancey, Sr., MD, FACS Atlanta, GA

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.
WHAT SURGEONS SHOULD KNOW ABOUT, from page 11

procedures will be reimbursed at 50 percent. This policy change will be phased in, however, with subsequent procedures reduced by only 25 percent in 2006, and by 50 percent in 2007.

Savings from this payment policy change were redistributed to other fee schedule services through an across-the-board adjustment in practice expense RVUs.

The combined impact of the conversion factor reduction and the changes made to work, practice expense, and liability RVUs for key high-volume surgical services is shown in Table 3, page 10.

In 2005, CMS implemented a demonstration project that allowed higher reimbursement for certain chemotherapy services. Will that project continue in 2006?

Yes, the demonstration project will continue, although it has been modified significantly.

For 2005, CMS conducted a one-year demonstration for office-based oncology services, in which a $130 payment was made when patients undergoing chemotherapy were asked questions about their pain, nausea, and fatigue. CMS decided to continue the demonstration project for an additional year but changed the reporting requirements “in order to take a further step toward encouraging quality care and promoting best clinical practices....”

For 2006, reporting will no longer be specific to chemotherapy administration but instead will be associated with physician E/M visits for established patients with cancer. The demonstration is available only to office-based hematologists/oncologists who provide an E/M service (at levels 2 through 5) to an established patient who has one of 13 types of cancer. To qualify for the additional $23 per visit, the physician must submit a G-code pertaining to each of the following three issues: (1) the primary focus of the visit, (2) the current disease state, and (3) whether current management adheres to clinical guidelines.

CMS estimates that the revised demonstration project will increase payments to oncologists by approximately $150 million in 2006.

REPORT OF THE CHAIR OF THE BOARD OF REGENTS, from page 32

than triple that available to lobbyists who oppose our positions.

Thank you

Once again, Thomas Russell, MD, FACS, Executive Director, and his staff have done an excellent job. We have many irons in the fire. As Chair of the Board of Regents and on behalf of the members of the Board of Regents and the Officers of the College, I would like to thank Dr. Russell and his staff and also extend the heartiest thanks to the hundreds of volunteers who make the American College of Surgeons a great organization with diverse goals and accomplishments that all come together to provide the best and safest health care for our patients.

REPORT OF THE CHAIR OF THE BOARD OF GOVERNORS, from page 33

rienced by those willing to volunteer and the barriers they encountered, which had a negative impact on the delivery of care. It is hoped that issues such as the portability of medical licenses over state lines, credentialing of volunteers, and the provision of tort liability coverage to medical volunteers will be examined in a new light and with renewed importance in the aftermath of these disasters.

There remains much to be done. Operation Giving Back will continue to adhere to its mission of facilitating volunteerism on both the domestic and international fronts.
NTDB™ data points

Annual report 2005, dataset version 5.0

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV

The National Trauma Data Bank™ (NTDB) Version 5.0 is an updated analysis of the largest aggregation of trauma registry data that has ever been assembled. The NTDB currently contains a decade of data, almost 1.5 million records from 565 trauma centers in 45 states, Puerto Rico, and the District of Columbia. This total represents an increase of more than 370,000 records from the 2004 report.

The Annual Report Version 5.0 is based on 917,265 records from 2000 to 2004. NTDB has begun to use a rolling-year time frame for the annual analysis in order to focus on the most recent quality data. Prior to analysis, NTDB data are subjected to a quality screening for consistency and validity on such fields as age, sex, and length of stay.

The NTDB is committed to being the nonproprietary national repository for trauma center registry data. It is estimated that 70 percent of Level I and 53 percent of Level II centers in the U.S. contribute data to the NTDB. Our goal is to receive data on every patient treated in every trauma center in the U.S.

The purpose of this report is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in the U.S. The report has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation. This effort is in keeping with the mission of the College’s Committee on Trauma to develop and implement meaningful programs for trauma care.

This report marks our complete transition to the use of the mechanisms of injury and the external cause of injury code groupings that were developed by the international injury prevention community and published by the Centers for Disease Control and Prevention (CDC) in Morbidity and Mortality Weekly Report (1997;46(RR14):1-30). The CDC and international partners developed this framework to create a uniform reporting language for injury mortality and morbidity.

The NTDB is an exciting program that has the potential to significantly improve the care of injured patients in the U.S. The NTDB committee would like to thank all the trauma centers that contributed data and hope that this report will attract new participants.

Throughout the year, we will be highlighting these data through brief monthly reports in the Bulletin. The full NTDB Annual Report Version 5.0 is available on the ACS Web site as a PDF file 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.