ACS Closed Claims Study reveals

FAILURES TO COMMUNICATE
FEATURES

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On the cover: The ACS Closed Claims Study has revealed many failures of communication between surgeons and their staff and patients (see article, page 11). Photo courtesy of Punchstock.
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.
The word is out: Unless we can come together and solve some of these issues, others will be more than happy to do it for us in a way that satisfies their own interests.

Players and process

Key panels involved in vetting quality measures include the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI), the National Quality Forum (NQF), and the AQA (formerly the Ambulatory care Quality Alliance). In this process, ideally, medical organizations, such as the College, present evidence-based clinical guidelines to the AMA PCPI. Once this body has approved the standards, they are submitted to the NQF for consensus-based endorsement and to attain national recognition. The AQA then works with physician organizations, the Centers for Medicare & Medicaid Services (CMS), employers, and health insurers to introduce the measures into the marketplace.

The ultimate objective of this process is to arrive at a common set of widely accepted measures so that the data may be aggregated and shared for purposes of quality enhancement and public reporting and, eventually, pay for performance. In other words, it is likely that these groups are writing the libretto for the next health care system, determining how care will be delivered and how physicians and other providers will be evaluated and paid.

In addition to playing an active role in all of these consortia and their surgery-related workgroups, the College has formed the Surgical Quality Alliance (SQA). This panel comprises representatives of approximately two dozen surgical specialty societies and is dedicated to ensuring that quality measures account for the unique nature of surgery.
Progress through collaboration

All of these coalitions are making progress in carrying out their missions, and I am pleased to say that the various members are listening to each others’ concerns. For example, ACS health policy staff and I recently attended an AQA meeting in Washington, DC. Participating in this program were a host of stakeholders, including employers, the government, insurers, medical organizations, and consumers. As Janet Corrigan, PhD, MBA—president and chief executive officer of the NQF—recently observed, the quality landscape is densely populated.

The fact that such diverse constituents have come together to examine the problems inherent in the existing system and to work together to build a better one is refreshing on an idealistic plane. On a more practical level, however, it also demonstrates that we all realize the relevance of seizing this opportunity to create a more accessible, quality-driven system.

The word is out: Unless we can come together and solve some of these issues, others will be more than happy to do it for us in a way that satisfies their own interests. Indeed, we might find ourselves in another situation like the one that brought us managed care, with businesspeople rather than health care professionals and patients deciding how medical services are delivered. Some firms already are venturing into what they call care-focused purchasing, which suggests how employers and payors can be certain that they are getting real value for their health care dollar.

It is not enough to simply have a seat at the negotiating table. To truly contribute to this potentially historic sea change, we need to be able to offer recommendations that are supported with scientifically valid data. Opinions are always controvertible. Facts are solid and indisputable. Therefore, the guidelines and protocols that we develop must be evidence-based, measure a sizable section of the physician population that will be using them, be risk-adjusted, and indicate who will be responsible for ensuring their implementation. It is for this reason that the College has worked so hard to develop the ACS National Surgical Quality Improvement Project and to expand the National Cancer Data Base and the National Trauma Data Bank®.

Developments

We also anticipate that the SQA will be instrumental in bringing surgery’s perspective to the AQA. During the AQA meeting, the alliance approved the following six measures that the College brought forth on behalf of surgery and the SQA: (1) place order for timely administration of prophylactic antibiotics; (2) timely delivery of prophylactic antibiotics; (3) selection of appropriate cephalosporin for antibiotic prophylaxis; (4) discontinuation of prophylactic antibiotics within 24 hours (noncardiac); (5) discontinuation of prophylactic antibiotics within 48 hours (cardiac); and (6) place order for venous thromboembolism prophylaxis.

One would anticipate that competent surgeons already carry out these activities almost reflexively. However, because they are such necessary steps toward avoiding infection, we believe they represent a good starting point. Our primary objective at this time is to determine what is best for patients and how to avert trouble at the “sharp end of care.”

In addition, the AQA approved quality measures drawn from assessments of dermatology, rheumatology/clinical endocrinology, ophthalmology, neurology/radiology, orthopaedics, and consumer issues.
Other highlights of the meeting included reports from the AQA’s workgroups. One concern raised during these discussions was the cost of care. Employers and third-party payors in particular are demanding greater disclosure and transparency in billing. They want to know the value of the care provided to individuals who are covered under their health plans. Some participants believe that if physicians and other providers are unable to supply this information and fulfill this need, policymakers will choose to implement a single-payor system, giving the government and insurance carriers greater control over spending.

Another concept discussed during the workgroup presentations was the “harmonization” of quality measures. That is to say, the AQA wants to start looking at how the metrics for one condition can be aligned with measures for other diseases. For example, the harmonization workgroup is considering aligning diabetes metrics with those for coronary artery disease. Undoubtedly, such efforts will need to be developed in the future, but I believe they signal the desire for greater collaboration across all specialties.

Possibilities

Given all these objectives, it would seem likely that the new system will focus on two overriding concerns: positive outcomes and transparency with regard to cost. These are the two factors that we need to use as guideposts in determining our input into value-based purchasing.

Furthermore, I believe that surgery is in a better position to measure outcomes and report billing because we deliver services on an episodic basis. Other specialties provide care across a broader continuum in which it may take years to determine the outcome and certain costs may be hidden.

The American College of Surgeons intends to remain actively involved in all programs that are centered on identifying the factors that lead to high performance and quality improvement. We know this movement is too important in determining the future of patient care to allow other special interests to write the script.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
On January 1, changes in Medicare physician fee schedule policies became effective. The changes were announced in the final rule that the Centers for Medicare & Medicaid Services (CMS) released in the fall. Some of the new policies are based on the results of the mandated five-year review of physician work values in the fee schedule, which produced significant payment increases for evaluation and management (E/M) services. Because all changes must be budget neutral, these hikes are offset by a 10.1 percent across-the-board reduction in work values for all physician services. However, the American College of Surgeons successfully persuaded CMS to implement corresponding increases in the relative values attributable to the E/M services encompassed in the global surgical package. This provision helps to mitigate the effect of the budget neutrality adjustment.

At the time the regulation was published, the fee schedule conversion factor for 2007 was scheduled to be reduced by 5 percent as a result of the sustainable growth rate (SGR) system used to determine Medicare payment updates. Fortunately, Congress took action before adjourning in December and instead froze the 2007 conversion factor at the 2006 rate of about $37.90. Taking into account this change, CMS estimates of the combined impact of the five-year review and other announced policy changes (such as reductions in payments for certain imaging services) on the surgical specialties in 2007 are:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac surgery</td>
<td>3%</td>
</tr>
<tr>
<td>Colon and rectal surgery</td>
<td>0</td>
</tr>
<tr>
<td>General surgery</td>
<td>-1</td>
</tr>
<tr>
<td>Hand surgery</td>
<td>-2</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>-3</td>
</tr>
<tr>
<td>Obstetrics-gynecology</td>
<td>1</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>-3</td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>-1%</td>
</tr>
<tr>
<td>Otolaryngology – head and neck surgery</td>
<td>0</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>-1</td>
</tr>
<tr>
<td>Thoracic surgery</td>
<td>3</td>
</tr>
<tr>
<td>Urology</td>
<td>0</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>-6</td>
</tr>
</tbody>
</table>

To avert the 5 percent conversion factor cut, the College and other specialty organizations engaged in a grassroots campaign targeting members of the lame-duck Congress. The ACS and other surgical specialty societies also joined forces to publish an advertisement in USA Today, asking the public to request that their elected officials stop the cut and thereby preserve patient access to care.

For details about the new payment policies, see “What surgeons should know about...” on page 8.

As a result of the mid-term elections in November 2006, Democrats regain control of Congress later this month. As of press time, the Democrats had gained 29 House seats (with 10 contests still undecided) and six Senate seats. The Republican members of the House Ways and Means Committee—which handles legislation pertaining to health care spending—who were voted out of office are as follows: Clay Shaw of Florida lost to Ronald Klein, J. D. Hayworth of Arizona conceded to Harry Mitchell, Melissa Hart of Pennsylvania lost to Jason Altmire, and Chris Chocola of Indiana conceded to Joseph Donnelly. In addition, Ways and Means Health Subcommittee Chair Nancy Johnson (R-CT) lost her bid for reelection to Chris Murphy (D-CT). Senate Republican losses included the following: Rick San-
torum (PA) to Bob Casey, Jr.; Conrad Burns (MT) to Jon Tester; Jim Talent (MO) to Claire McCaskill; Mike DeWine (OH) to Sherrod Brown; George Allen (VA) to James Webb; and Lincoln Chafee (RI) to Sheldon Whitehouse.

ACS Executive Director Thomas R. Russell, MD, FACS, participated in an October 23 press conference in Washington, DC, that the Surgical Care Improvement Project (SCIP) organized to launch a patient information campaign. The campaign urges patients to speak with their health care providers about how to avoid surgery-related complications, such as infection, blood clots, and heart attacks. To facilitate these conversations, a consumer tip sheet with questions patients should ask their surgeon or physician before undergoing an operation has been developed. The AARP and the National Partnership for Women and Families are distributing the document to the public.

SCIP was created as part of a broad-based effort to achieve a 25 percent reduction in surgical complications by 2010. The American College of Surgeons is an active participant in SCIP, which also comprises U.S. Department of Health and Human Services officials and other physician, hospital, nursing, accreditation, and consumer organizations. During the press conference, Dr. Russell noted that SCIP “is about bringing all the members of the surgical team together and implementing known measures, which will decrease adverse events that are preventable and no longer acceptable.” The tip sheet and additional information about SCIP can be found at http://www.ofmq.com/qiosc SCIP.html.

Leaders of organizations that represent ambulatory surgery centers (ASCs) and health care professionals recently formed a group called the ASC Quality Collaboration. The purpose of this panel, which includes Dr. Russell, is to engage in a mutual effort to identify specific quality measures for care provided in ASCs and, ultimately, other outpatient settings. The measures will be useful in efforts to implement pay-for-performance, respond to state data-collection initiatives, develop consumer information, and benchmark information for quality improvement.

In addition, the ASC Quality Collaboration has engaged an expert workgroup to develop standard surgery measures. Initial workgroup meetings identified measures that have been vetted by other groups, including SCIP, the Joint Commission on Accreditation of Healthcare Organizations, and the Surgical Quality Alliance. The ASC Quality Collaboration intends to work with CMS to make the quality measures a key element of the revamped ASC payment system, which is expected to be implemented in January 2008. For more information, go to http://www.jointcommission.org/Library/JCAHOnline/jo_10_06.htm, and scroll down to “Group Forms to Promote Standard Quality Measurement in Ambulatory Surgery Centers.”
The 2007 Medicare physician fee schedule

by Barbara Peck, Senior Regulatory Associate, Division of Advocacy and Health Policy

The 2007 Medicare physician fee schedule brings with it massive changes that will have a significant effect on all aspects of surgical reimbursement. Unfortunately, its impact is negative in almost all instances. The fee schedule, which was released in November 2006 and went into effect on January 1, includes major adjustments to almost every component of the Medicare physician reimbursement formula.

To review, the Medicare physician reimbursement formula comprises five key elements. First, each code on the Medicare fee schedule is assigned a work relative value unit (RVU) based on the time and intensity of the physician’s work in providing the service. Each code is also assigned a practice expense RVU, which accounts for the direct expenses (such as equipment and supplies) associated with providing the service and a portion of the indirect expenses (such as rent). Each code is also assigned a professional liability insurance (PLI) RVU. Geographic practice cost index (GPCI) adjustments are made to the work, practice expense, and PLI RVUs to account for the geographic differences in providing services. After the GPCI adjustments are made, the work and practice expense and PLI RVUs are added together to create the total RVUs for a specific code. Finally, the sum is multiplied by the Medicare conversion factor to determine final payment. If any portion of the formula is reduced, total payment for the code is reduced. All of this information is listed on the Medicare physician fee schedule.

What will be the Medicare physician update for 2007?

The 2007 update to the Medicare physician fee schedule conversion factor will be a freeze for the second year in a row and the conversion factor will remain at $7.8975. Initially, a 5 percent cut was predicted, but Congress took action on the last day of the lame duck session in December to avert the cut. In January 2006, a similar cut initially went into effect, but it was repealed in February when Congress passed the Deficit Reduction Act of 2006 (DRA), which froze the Medicare conversion factor at the 2005 level.

Between July 1 and December 31, 2007, physicians who report on at least three quality measures through the Physician Voluntary Reporting Program (PVRP) will receive a 1.5 percent increase in their payments. This one-time bonus payment will apply to all Medicare claims submitted by the physician. Fellows should watch for more information in the future on the PVRP and the potential bonus payments.

The 2007 conversion factor freeze marks the fifth year in a row that Congress has had to take action to prevent a cut to the conversion factor. The conversion factor was reduced by 5.2 percent in 2002, but Congress took action in 2003, 2004, 2005, and 2006 to avert additional cuts.

Why does Congress have to take action every year to prevent a cut to the Medicare conversion factor?

The conversion factor is calculated based on the sustainable growth rate (SGR), which sets an annual expenditure target for Medicare physician services. Since 2002, aggregate spending on physician services has exceeded the targets; by law, these overages must be repaid through cuts to the conversion factor. These overages have been fueled by an increase in the volume and intensity of services provided to Medicare beneficiaries. In particular, there has been yearly double-digit growth in evaluation and management (E/M) services, imaging, and laboratory tests. Surgery and major procedures have the lowest growth rates, and general surgery has the lowest overall growth rate of any specialty, coming in at an average of 0.6 percent per year.
Although a 5 percent cut to the conversion factor in 2007—had Congress not taken action—would have hit surgeons hard, under the SGR, it could be worse. There is a cap on how much the conversion factor may be cut in a single year, and if not for the cap, the conversion factor would be reduced 28 percent in 2007 to make up for the increase in expenditures since 2002.

Unfortunately, because the cuts are being spread out over multiple years, the conversion factor is currently slated to be decreased approximately 5 percent every year until 2015. Under current law, it is estimated that by 2015, the conversion factor will have been whittled down to $23.87.

What is the five-year review of work?

Every five years CMS must comprehensively review all work relative values and make any needed adjustments. To carry out this exercise, physician organizations, including the College, and the Centers for Medicare & Medicaid Services (CMS) may request that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) review the value of a specific code. If compelling evidence is presented to prove that the level of work or intensity of the code has changed, the value of the code will be raised or lowered accordingly. The changes must be budget neutral, meaning they cannot cost the Medicare program more money. Hence, if some values increase, others in the system decrease proportionately. On January 1, the changes for the third five-year review were implemented.

How will the five-year review affect payment rates?

The results of the five-year review will shift more than $4 billion in the Medicare fee schedule to E/M codes. A coalition of medical specialties, led by the American College of Physicians, brought forward many E/M codes for revaluation. The RUC recommended that CMS drastically increase the value of several E/M codes, including 99213 (intermediate office visit), the most used code in the fee schedule. The amount of money needed to cover these increases is more than Medicare physician spending on general, cardiac, colorectal, and vascular surgery and neurosurgery combined. To pay for the increases to the E/M codes, all of the work RVUs on the fee schedule will be reduced by approximately 10 percent.

How is the five-year review budget neutrality adjustment being implemented?

CMS is implementing a new component of the fee schedule called the “work adjuster.” Under this plan, the actual work RVUs for each code will be published at their full value. Before reimbursement is made, however, the total work RVUs will be multiplied by 0.893. For example, if a code has a value of eight work RVUs, this figure will be multiplied by 0.893 for a value of 7.14, and the reduced value will be used to determine total RVUs and, therefore, payment. This calculation has a particularly negative effect on codes that are work-heavy, including most surgical codes.

Are all surgical codes being cut 10 percent as a result of the five-year review?

Not all surgical codes are being cut 10 percent. The E/M increases are also being applied to the E/M codes that are built into the global surgical payments. How much a code will increase depends on the number and type of E/M services in the global payment. On the Medicare physician fee schedule, the actual work RVUs for many surgical codes will show an increase that is related to the increased value of the E/M codes. However, these increases will be too small to cover the 0.893 work adjuster discussed previously. In total, most surgical codes will be cut 3 percent to 7 percent, depending on how many E/M visits are built into the codes.

Are the values of any surgical codes increasing as a result of the five-year review?

Yes, some surgical code values are increasing. During the five-year review, many surgical codes also were reviewed, and the American College of Surgeons, which represents general surgery on the RUC, requested that more than 30 codes be revalued during the five-year review. All of
the codes—including 19180 (removal of breast), 44120 (removal of small intestine), 44130 (colectomy) and the remainder of the colectomy family of codes, and 38100 (splenectomy)—received increases in their work RVUs between 5 percent and 30 percent. Many of the surgical specialty groups, including cardiothoracic, vascular, and orthopaedic surgery and neurosurgery, also submitted codes for revaluation and generally fared well. Unfortunately, some of the increases will have a negligible effect after the work adjustment is applied and the conversion factor is cut. For example, CMS approved a 20 percent increase to the RVUs for a kidney transplant, but after the work adjuster is applied, the code will only be increased by 10 percent.

What changes are being made to the practice expense component, and how will they affect payment?

The 2007 fee schedule also includes significant changes to the practice expense component. Nine specialties, including dermatology and gastroenterology, will receive significant increases in their practice expenses. Of course, these changes will be budget neutral and will be funded through cuts to other specialties. Beginning January 1, the final methodology will be phased in over four years. General surgery will see a slight increase—1 percent—at the end of the phase-in, whereas neurosurgery, ophthalmology, and orthopaedic and cardiothoracic surgery will undergo cuts of 2 percent to 4 percent. Surgeons may be interested to know that budget-neutrality adjustments are already applied to both the direct practice expenses and indirect expenses for each code. These adjustments translate to Medicare paying for 61 percent of direct expenses and 35 percent of indirect expenses. These changes are not new in 2007, but they help explain why it often seems as though the Medicare reimbursement level is too low to even cover expenses.

What changes are being made to the GPCIs?

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 put a three-year limit on GPCI adjustments made to the work RVUs. Essentially, under the provision, work RVUs cannot be decreased because of the GPCI adjustment. If a physician payment area has a work GPCI of less than 1.0, which would decrease the work RVUs under the payment formula, the GPCI adjustment is frozen at 1.0 and no adjustment is made. Nationwide, 58 of the 89 physician payment areas received a 1 percent to 2 percent benefit from this provision, which was slated to end December 31, 2006. The legislation passed by Congress in December to avert the 5 percent cut to the conversion factor also extended this provision for one more year until December 31, 2007.

Are there additional cuts to imaging services?

Yes, there are additional cuts. As a result of the DRA, on January 1, diagnostic imaging procedures reimbursed under the Medicare fee schedule—including imaging that takes place in a physician office or independent diagnostic testing facility—will be reimbursed at the lesser rate between the fee schedule and the Hospital Outpatient Prospective Payment System. For many magnetic resonance imaging procedures performed in physician offices, this will translate to a 0 percent to 49 percent cut in the technical component portion of the payment. Cuts for other types of imaging modalities, including ultrasound and X ray, vary by procedure. All surgeons who own in-office imaging equipment will see a significant drop in reimbursement for the technical component. In addition, some specialties that perform advanced imaging services, including vascular surgery, will also experience further payment cuts.

On a positive note, CMS decided to hold the multi-imaging procedure discount, which was implemented last year, at 25 percent instead of raising it to 50 percent as originally proposed.
ACS Closed Claims Study reveals

CRITICAL FAILURES TO COMMUNICATE

by

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Hospital chart reviews and root cause analysis of adverse events have indicated that communication is extremely important to quality care, so much that the Accreditation Council for Graduate Medical Education (ACGME) includes interpersonal and communication skills as one of the six core competencies. Claims analysts for liability insurance companies have made similar observations from their reviews of closed claims files. Among the claims reviewers’ alarming findings of a closed claims study recently conducted by the American College of Surgeons, 90 of 460 claims (19.8%) were filed largely, if not entirely, because of failures in communication.

This report will share the findings of these 90 claims from the Closed Claims Study relevant to the impact of communication on patient safety and liability. If data and dogma specifically related to issues of communication from the past left us as surgeons nonplussed, that should no longer be the case.

The Closed Claims Study

The ACS Closed Claims Study represents the first of its kind; the relevance to surgeons is maximized because general surgeons from among our ranks designed the standardized data collection form, collected the data from claims pertaining only to general surgeons, and dictated the narrative reviews. Whereas another excellent current closed claims study has focused on the very important subject of systems of care and errors,* the ACS study focuses in tandem on the equal importance of surgeons at the point of service and errors, including communication failures.

The ACS Closed Claims Study was conducted under the guidance of the American College of Surgeons’ Patient Safety and Professional Liability Committee. Between April 2004 and February 2006, 40 Fellows of the College conducted reviews of 460 liability claims, a claim in this instance referring to a closed claim against a general surgeon, meaning one that had run its course. All claims are recent, having closed during 2003 and 2004. Data were collected from five different liability insurance companies with a nationwide distribution. The data have been electronically tabulated at the University of Washington (Seattle) by professionals in the anesthesiology department who have become experts in the field by virtue of their involvement in the American Society of Anesthesiologists’ Closed Claims Study since 1984.

Communication failures

Problems stemming from failures in communication occurred predominantly with patients and/or families (36 claims), nurses (19 claims), laboratory personnel (1 claim), and physicians (35 claims). Problems arose from both the failure to listen to or solicit information (47 claims) and the failure to convey information (46 claims). In regard to listening, reviews indicated that defendant-surgeons heard selectively, weighing input in favor of the best scenario. This led to inertia and errors of omission. As an example, a patient in the recovery room after a vascular procedure was reported to have no foot pulses with pain, pallor, and coolness on the left. The surgeon, taking call for the surgeon who actually performed the procedure, told the concerned nurse that he was told not to expect pulses and increases the pain medication. Much too late, the patient was found to have a clotted left limb and a flawed outflow anastomosis. This was corrected but too late. The delayed diagnosis and treatment ultimately led to amputation.

Defendant-surgeons also failed to solicit more information than volunteered by others with less insight, hoping that all was well rather than probing for confirmation or evidence to the contrary. For example, a resident called the attending during the night and reported admitting a patient with abdominal pain and who he thought was constipated. Ordinarily, one would expect that the admission of a patient with a diagnosis of constipation to a surgery service would require explanation, but the attending asked no questions. The patient expired that same night. Autopsy findings revealed a ruptured aneurysm, and a review of the records revealed that the patient was anemic and hypotensive in the emergency department before admission.

Whether poorly prioritized or oversolicited, the precious commodity of time was all too often lacking in the reviewed claims, resulting in the failure on the part of defendant-surgeons to convey important information. Consider the example of a general surgeon and a neurosurgeon sharing the care of a patient with multiple injuries in the emergency department. The computed tomography scan was negative for intracranial hemorrhage, and a decision was made to transfer to a different facility. Before transfer, the patient’s neurological condition deteriorated, but the general surgeon in attendance, without communicating first with the neurosurgical consultant, misguided transferred the unstable patient, making a bad outcome presumably worse.

Communication failures occurred in cases involving surgical procedures (70 of 414 claims) and in cases in which no surgical procedure was performed by the defendant-surgeon (20 of 46 claims). When care involved surgery, the communication error occurred predominantly during the preoperative period in 26 cases, during surgery in nine claims, and during postoperative care in 35 claims.

Preoperative communication breakdown

Of the 26 failures during preoperative care, 14 were major contributors to subsequent substandard intraoperative performance. These cases included the following:

• Performing the wrong procedure in six claims, including the surgeon who operated for an anal fissure and performed fissurectomy and sphincterotomy but added hemorrhoidectomy based on newfound intraoperative observations. During the preoperative consent process, the surgeon failed to obtain the information that the patient was totally opposed to hemorrhoidectomy because of the previous bad experience of a friend. The consent did not include hemorrhoidectomy.

• Operating at the wrong site, which occurred in three claims, for example, the surgeon who failed to confirm the site of a cutaneous malignancy for wide excision from among several sites shaved by a dermatologist and proceeded to excise the wrong site.

• Injuring unintended organs, as happened in two claims. One example is the surgeon who, while removing a cystic hygroma, caused nerve injury, a possibility that was neither discussed with or consented to by the patient.

• Operating unnecessarily, as occurred with one claim. In this case, a lymph node regressed after the decision to biopsy and before surgery, but the surgeon failed to visit with and examine the patient in the day surgery department before surgery. The patient was prepared and draped and the surgeon gowned and gloved. The surgeon concluded that the node was not palpable because of the patient’s positioning. The area was explored and no pathologic tissue was found.

• Inducing aspiration pneumonia, which occurred in one claim. In that example, the surgeon failed to be sure that the anesthesiologist knew that the patient had a full stomach with an air fluid level on an imaging study.

• Operating prematurely, as was the case in one claim. In that example, the surgeon failed to learn from the radiologist or gastroenterologist about leaking contrast at a sphincterotomy site before proceeding with laparoscopic cholecystectomy. Confusion was created by the tandem procedures; the treatment of a bileoma in the postoperative period was compromised.

Data show that preoperative failures in communication also were responsible for adverse events in the postoperative period in seven claims. A surgeon in one example was called to the operating room by a gynecologist who had injured the rectosigmoid region. The surgeon found a profound injury and performed an end-transverse colostomy and a mucus fistula. The patient did well and three weeks after surgery wanted the ostomy reversed. When the surgeon refused, the patient found a second surgeon who proceeded to close the ostomy without communicating with the first surgeon to learn about the severity of the injury. After reversal, pelvic peritonitis required additional operative procedures, including a second ostomy, in the face of additional complications.

In addition, among these preoperative failures, five claims were precipitated, even though the defendant-surgeons met the standard of care. Their paltry efforts failed to provide patients enough information with which to understand
that the adverse events experienced were a consequence of surgical disease, comorbidities, or other problems and that the events occurred in spite of, not because of, the surgeons. For example, a patient required an amputation after a bypass graft failed and sued because the surgeon did not adequately explain preoperatively that graft failures occasionally occur in spite of properly performed surgery.

Operating room communication breakdown

Communication problems in the operating room were relatively infrequent but nonetheless important. Problems such as the following were found during the claims review:

• Wrong site surgery in one claim, as in the case of one nurse who picked the patient up from the holding area, another nurse who prepared the patient for surgery, and another nurse who draped the patient for femoropopliteal bypass, followed by the surgeon entering the room and, with no questions asked, proceeding to operate on the wrong limb.

• Retained foreign body in two claims; in one example, after counting sponges, the circulating nurse reported that, excepting the sponges on the operative field, the count was correct. The surgeon heard only that the count was correct.

• Inappropriate use of medications in three claims, such as a colonoscopy where a patient was inadequately sedated and, without soliciting information regarding the medications already given, the surgeon asked the nurse to give additional sedation. Belatedly, after a severe complication from hypoxia, it was revealed that the patient had been profoundly overdosed; a faulty intravenous line led to the subcutaneous infusion of sedatives, the effects of which were delayed.

• Flawed assistant surgeon or consultant surgeon interactions occurred in three claims. In one example, a victim of penetrating trauma was found at laparotomy to have small bowel injuries. The attending surgeon resected two segments. At that point, the attending was called to the emergency department and left the less-experienced assistant surgeon to continue. Inadequately informed as to how to proceed, the assistant established intestinal continuity between the most proximal and most distal limbs and anastomosed the excluded segment to itself, creating a perfect circle. The recovery was delayed and a second operation was required at a later date.

Postoperative communication breakdown

The failure to deal diligently with the consequences of intraoperative errors and other postoperative complications during the postoperative period also breaches the standard of care. Of the 35 cases involving failed communication during postoperative care, complications were caused or aggravated in 24 patients. Twelve claims involved problems with diagnosis, including the example of a patient who called daily after discharge following laparoscopic repair of a ventral hernia and was told each time that all was well but, on the third day, after reporting to the emergency department in desperation, was found to have an iatrogenic small bowel injury. The other 12 claims involved problems with treatment, such as the case where the nurse called the surgeon and reported that a patient who had a thyroidectomy earlier that day was complaining of trouble swallowing and anxiety. The oxygen saturation was 97 percent. The surgeon ordered additional sedation. When the nurse called the second time, the surgeon reported to the bedside but too late to prevent permanent disability caused by delayed treatment of a wound hematoma.

Even though the basic complication in the majority of these cases was inevitable, the delay or failure to diagnose or treat that resulted from flawed communication drastically increased the severity of the complication. For example, prompt diagnosis and/or treatment of complications such as postoperative infection, thrombosis, or bleeding would have prevented permanent disability; disastrous outcomes occurred instead when failure to communicate resulted in delays that led to organ system failure, amputation, or exsanguination.

Among the remaining 11 cases of postoperative failure, quality was not adversely affected by failed communication. Among these claims, the standard of care was met in 10. In these cases, as with similar claims involving preoperative care, defendants suffered litigation solely because
they failed to spend the time required to provide the insight and satisfaction necessary to defuse anger and mistrust. In the remaining case, dishonesty and deception did not affect outcome, but failed ethics—such as the case of a patient who suffered a significant though self-limiting musculoskeletal injury during transfer from operating table to stretcher but was informed of the event by a different health care provider and not the surgeon—will never meet standards.

Claims involving no surgical procedure

Problems in the subset of claims involving care by surgeons that did not include a surgical procedure were unique. Communication failures occurred in 70 of 414 (16.9%) of claims involving an operation and 20 of 46 (45.6%) of claims in which no surgical procedure was performed. This difference seems startling, but upon reflection, it might be expected since nonoperative care precludes the diluting effect of intraoperative and postoperative misadventures. It is enlightening to know that surgeon-defendants could have eliminated errors and/or litigation in almost half of nonoperative cases simply through improved communication. Nine diagnosis errors, seven treatment errors, and five suits with no errors resulted from these failures. In one example, a surgeon discharged a patient after observation for blunt abdominal trauma, noting that there was no pain or complaint but failing to confirm with the nurse that repeated doses of pain medications had been given just before the surgeon’s visit. Given the opportunity, the nurse could also have reported a not-as-yet recorded temperature spike. The patient expired at home later the same day. The autopsy revealed a perforated hollow viscus.

Reviewers’ observations

The claims reviewers made some general observations aside from the data that were collected. Many were humbled by the realization that they, too, had communicated poorly on occasion but without resulting litigation. In fact, closed claims drastically underreport errors of all kinds in that near misses are not included and a large majority of injured patients never file a claim. Reviewers also observed that communication problems resulted from the failure to diligently spend enough time to accomplish ordinary tasks rather than the failure to possess skill and brilliance to accomplish extraordinary feats. No tort law holds us as surgeons to a standard of perfection where technical skills are concerned. To err is human. But failures in the area of professional behavior are inexcusable, and diligently spending the required time certainly falls into that rubric.

Addressing the problem

In view of the documented extreme importance of communication in maximizing the effectiveness and safety of our surgical skills, the ACS Division of Education offers Fellows a course entitled “Surgeons As Effective Communicators: Sharpening Skills for Critical Moments.”
three-day course helps participants use effective verbal and nonverbal communication skills across the spectrum of surgical encounters, especially in difficult situations and settings. Real-life clinical and administrative scenarios are used, such as handling adverse outcomes and errors, tense situations in the operating room, patients refusing life-saving treatment, angry or litigious patients, grieving families, unreasonable requests from superiors, difficult staff who require counseling, and impaired or incompetent colleagues. Participants gain practical experience through planned and impromptu scenarios involving trained actors and surgeon actors. Personal videotapes and feedback are provided to each participant by the course faculty, led by Chair L. D. Britt, MD, MPH, FACS. The next course will be offered in fall 2007.

Discussions are under way regarding development of a CD-ROM to enhance knowledge and skills in this competency. In addition, the Disclosing Surgical Error: Vignettes for Discussion DVD demonstrates two approaches used by a surgeon to disclose to the patient’s family a major technical error that occurred in the operating room. Techniques that are effective and techniques that need to be improved are demonstrated in the scenarios. The vignettes can be used as free-standing trigger tapes for small group discussions with surgeons, surgical residents, and medical students, or the vignettes may be incorporated into a comprehensive course or curriculum. This DVD was supported by a grant from the Agency for Healthcare Research and Quality and is available at no cost at [https://web2.facs.org/timssnet464/acspub/frontpage.cfm?product_class=keepcur](https://web2.facs.org/timssnet464/acspub/frontpage.cfm?product_class=keepcur). A second DVD presenting recent research findings on disclosure and additional vignettes and discussion items is slated to be released at the end of this year.

Conclusions

The effect of failure to communicate on surgical patient safety and liability is profound. Among the 460 claims reviewed in the ACS Closed Claims Study, 90 were filed largely as a consequence of failed communication. Even when the standard of care was met, as it was in 25 percent of this subset of cases, failed communication led to anger, mistrust, and litigation. Of greater importance, though, reviewers found that poor communication led to preventable adverse events in some cases and increased both the morbidity and mortality of adverse events regardless of their cause in others. It follows that if we communicate well, we will reduce anger and mistrust, the number of preventable adverse events, the morbidity and mortality of many other adverse events regardless of their causes, and litigation as secondary gain. Realizing these benefits, the ACS Division of Education is aggressively providing Fellows with programs and materials on the competency of communication.

Acknowledgments

This article contains a summary of changes in the 2007 Current Procedural Terminology (CPT)* that are relevant to general surgery and closely related specialties. This article may be useful to office staff who perform coding functions. The first section, on renumbered codes, discusses codes that appear throughout the CPT. The remainder of the article presents changes in code sequence.

**Renumbered codes**

As part of an ongoing effort to improve the taxonomy of CPT, a number of codes were moved to different sections of the book and renumbered but had no changes made to the terminology. The table on page 18 presents the moved and renumbered codes most frequently used by general surgeons. It is especially important that surgeons performing breast surgeries use the new code numbers for all mastectomies done in January because claims filed with old code numbers will probably be denied.

An important explanatory note was added for new code 19105, Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma. As the descriptor indicates, the code is reported once for each fibroadenoma treated. However, the new note explains that the code is reported only once for adjacent lesions treated with a single cryoprobe insertion.

In addition to the codes listed in the table, several vascular and numerous radiology codes were also moved and renumbered. Codes of special interest to general surgeons include several “supervision and interpretation” codes, fluoroscopic guidance codes, mammography and other breast codes, and the code for intraoperative ultrasonic guidance. A complete list of codes that were moved is provided in the CPT in a new Appendix M.

**Skin replacement surgery**

Four new codes have been developed to better describe the differing work that is done to surgically prepare a site for a skin graft or skin substitute. The descriptor for code 15002 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, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children. Code 15004 contains the same descriptor except the anatomic sites—face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits—are substituted for those in code 15002. Codes 15003 and 15005 are add-on codes for preparation of each additional 100 square centimeters or 1 percent of the body area of infants and children. The notes following the codes direct the user to report separately the application of the graft or skin substitute, whether immediate or delayed.

Panniculectomy and abdominoplasty

Two new codes replace code 15831, Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty), which was deleted. Code 15830, Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen, infraumbilical panniculectomy, is a new code describing the removal of excessive skin and subcutaneous tissue. A note tells users not to report code 15830 with intermediate wound closure, complex wound closure, or adjacent tissue transfer or rearrangement. Code 15847 is a new add-on code describing a more extensive abdominoplasty that includes umbilical transposition and fascial plicaton. The descriptor for code 15847 is \textit{Excision, excessive}.

### Codes renumbered in the 2007 CPT

<table>
<thead>
<tr>
<th>Deleted CPT 2006 code</th>
<th>CPT 2007 code</th>
<th>Code descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>19140</td>
<td>19300</td>
<td>Mastectomy for gynecomastia</td>
</tr>
<tr>
<td>19160</td>
<td>19301</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy)</td>
</tr>
<tr>
<td>19162</td>
<td>19302</td>
<td>Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy</td>
</tr>
<tr>
<td>19180</td>
<td>19303</td>
<td>Mastectomy, simple, complete</td>
</tr>
<tr>
<td>19182</td>
<td>19304</td>
<td>Mastectomy, subcutaneous</td>
</tr>
<tr>
<td>19200</td>
<td>19305</td>
<td>Mastectomy, radical, including pectoral muscles, axillary lymph nodes</td>
</tr>
<tr>
<td>19220</td>
<td>19306</td>
<td>Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)</td>
</tr>
<tr>
<td>19240</td>
<td>19307</td>
<td>Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle</td>
</tr>
<tr>
<td>47716</td>
<td>47719</td>
<td>Anastomosis, choledochal cyst, without excision</td>
</tr>
<tr>
<td>48005</td>
<td>48105</td>
<td>Resection or debridement of pancreas and peripancreatic tissue for acute necrotizing pancreatitis</td>
</tr>
<tr>
<td>48180</td>
<td>48548</td>
<td>Pancreaticeojunostomy, side-to-side anastomosis (Puestow-type operation)</td>
</tr>
<tr>
<td>49805</td>
<td>49402</td>
<td>Removal of peritoneal foreign body from peritoneal cavity</td>
</tr>
<tr>
<td>0120T</td>
<td>19105</td>
<td>Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma</td>
</tr>
</tbody>
</table>
skin and subcutaneous tissue (including lipectomy); abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication).

Another note under code 15847 directs users to report other abdominoplasty procedures using code 17999, Unlisted procedure, skin, mucous membrane and subcutaneous tissue.

**Vascular procedures**

Code 35381, which combined thromboendarterectomy of the femoral, popliteal, or tibioperoneal arteries, has been replaced by discrete codes for each artery. Code 35302 is for the superficial femoral artery, code 35303 is for the popliteal artery, and code 35304 is for the tiboperoneal trunk artery. Code 35305 is for the initial tibial or peroneal artery and 35306 is an add-on code for each additional procedure done on a tibial or peroneal artery. There are notes explaining that a thromboendarterectomy and an atherectomy of the same artery cannot be reported together and that the entire series of thromboendarterectomy codes includes harvesting a saphenous or upper extremity vein if performed.

Four new codes were added to the bypass graft using vein family, and two were added to codes for bypass grafts using synthetic material. The new descriptors follow the pattern for other codes in the series, describing the inflow and outflow arteries. Codes to report aortic reconstructions using vein conduit are 35537 for an aortoiliac graft, 35538 for an aortobi-iliac graft, 35539 for an aortofemoral graft, and 35540 for an aortobifemoral graft. Notes tell the user not to report codes 35537 and 35538 or codes 35539 and 35540 together. Code 35541, for aortoiliac or bi-iliac grafts, and code 35546, for aortofemoral or bifemoral grafts, were deleted. Analogous codes for aortobiiliac (35637) and aortobiiliac (35638) grafts, were added to the synthetic bypass grafting series of codes; there are similar notes prohibiting the two codes with each other and with the aortobifemoral code. Code 35641, for aortoiliac or bi-iliac grafts, was deleted.

Four codes in the same sections were revised to provide greater clarity and one code was deleted. In code 35501, Bypass graft, with vein; carotid, the wording has been changed to Bypass graft, with vein; common carotid-ipsilateral internal carotid, to clarify that the graft origin and insertion lie on the same side of the patient’s neck. An identical change was made in the wording of code 35601, the parallel code for a synthetic graft. In code 35509, the word “contralateral” has been inserted, so the terminology now reads, Bypass graft, with vein carotid-contralateral carotid, clarifying that the bypass is from one side of the neck to the other. Code 35306, which is used to report a carotid-subclavian graft, described the same work as code 35307, a subclavian-carotid graft. The difference between these two codes was limited to the direction of blood flow inside the bypass. Therefore, the terminology for code 35306 was revised to Bypass graft, with vein carotid-subclavian or subclavian-carotid, and code 35307 was deleted.

Two codes were added to report open revision of a femoral anastomosis of a synthetic bypass graft in the groin. Code 35883 is for use of a non-autogenous patch graft such as Dacron, ePTFE, or bovine pericardium. Code 35884 is for use of an autogenous vein patch graft. Introductory notes advise application of the bilateral modifier (~50) when appropriate, in addition to warning the user not to report code 35883 or 35884 with certain other revision procedures.

**Gastric neurostimulation**

Category I codes have been added to report open and laparoscopic placement and removal of neurostimulator electrodes in the antrum of the stomach for the treatment of gastroparesis. Code 43647 is for the laparoscopic implantation or removal of the neurostimulator electrodes and code 43648 is for the laparoscopic revision or removal of the electrodes. Code 43881 is for open implantation or replacement of the neurostimulator electrodes and code 43882 is for the open revision or removal of the electrodes.

Category III codes have been added to report open and laparoscopic placement and removal of neurostimulator electrodes in the lesser curvature of the stomach for the treatment of morbid obesity. Code 0155T is for the laparoscopic implantation or replacement of the neurostimulator electrodes and code 0156T is for the laparoscopic revision or removal of the electrodes. Code 0157T is for open implantation or replacement of the neurostimulator elec-
trodes and code 0158T is for the open revision or removal of the electrodes.

Notes associated with both sets of codes direct the user to codes elsewhere in CPT for insertion of the neurostimulator and for electronic analysis and programming of the generator.

**Colectomies**

Changes were made to the open total colectomy codes to make performing a rectal mucosectomy optional. The descriptor for code 44157 is *Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed*. Code 44158 is for a total colectomy, with proctectomy, with ileoanal anastomosis and creation of an ileal reservoir. It also includes loop ileostomy and rectal mucosectomy if performed. Codes 44152 and 44153, which included rectal mucosectomy in all cases, were deleted. The descriptor for code 44152 is *Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, with or without loop ileostomy*. The descriptor for 44153 is *Colectomy, total, abdominal, without proctectomy; with rectal mucosectomy, ileoanal anastomosis, creation of ileal reservoir (S or J), with or without loop ileostomy*. Those two procedures should now be reported with code 44799, *Unlisted procedure, intestine*.

**Peritoneal catheters**

Code 49421, for the open placement of an intraperitoneal cannula or catheter, has been in the CPT for some time. Now codes have been added for the laparoscopic placement and revision of an intraperitoneal cannula or catheter. Code 49324 is for the laparoscopic placement of a permanent intraperitoneal cannula or catheter. Code 49325 is for the laparoscopic revision of a previously placed intraperitoneal cannula or catheter, including removal of intraluminal obstructive material if performed. Code 49326 is an add-on code for an omental tacking procedure; it is to be used only with codes 49324 and 49325.

Codes were created for the insertion of a subcutaneous intraperitoneal catheter extension with an exit site on the chest wall. Code 49435 is an add-on code for the extension itself. It is used with code 49324, laparoscopic placement of permanent intraperitoneal cannula or catheter, or code 49421, open placement of an intraperitoneal cannula or catheter. Code 49436 was added to allow reporting of a delayed creation of an exit site by exteriorizing the external limb of a catheter that was embedded subcutaneously at the time of the catheter placement procedure. The descriptor for code 49436 is *Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter*. The process of embedding the external limb of the catheter is considered a component of placement procedures, codes 49421 and 49324; therefore, it is not reported separately.

**Porcine plug for anal fistula**

Code 0170T has been added for repair of an anorectal fistula with a plug made of porcine small intestine submucosa. For repair of an anal fistula using fibrin glue, use code 46706, *Repair of anal fistula with fibrin glue*.

**Acknowledgment**

The authors wish to thank Robert M. Zwolak, MD, FACS, and John Crabtree, MD, FACS, for reviewing portions of this article.

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Dr. Bothe is chief quality officer, Geisinger Health System, Danville, PA.
HIGHLIGHTS
of the 92nd annual
CLINICAL CONGRESS

American College of Surgeons
Founded by Surgeons of the United States & Canada Est. 1913
At the American College of Surgeons’ 92nd annual Clinical Congress in Chicago, IL, highlights included a wide variety of general sessions that focused on educational, practice-related, and clinical topics and 34 postgraduate courses where attendees learned some of the most advanced procedures.

Among the 17,097 attendees in Chicago, 10,215 were physicians; the remaining attendees were exhibitors, guests, spouses, and convention personnel.

**Lectures**

The American Urological Association lecture, held immediately following the Opening Ceremony on Monday morning, was presented by Andrew C. von Eschenbach, MD, FACS, Acting Commissioner of the U.S. Food and Drug Administration. Dr. von Eschenbach discussed how medicine is transforming from a concentration on treatment of disease to a focus on genetics and molecular biology in the interest of disease prevention.

Other lectures held Monday were the John H. Gibbon, Jr., Lecture, General Thoracic Surgery: An Oxymoron, presented by G. Alexander Patterson, MD, FACS, and the Charles G. Drake History of Surgery Lecture, The Impact of the Civil War on American Medicine and Surgery, delivered by Arnold G. Diethelm, MD, FACS.

The Scudder Oration on Trauma—Physiology for the 21st Century: An Iconoclastic Analysis of Cardiopulmonary Function in Sepsis and Critical Illness—was presented by Frank R. Lewis, Jr., on Tuesday. Disclosing Medical Errors to Patients: A Challenge for Physicians, this year’s Ethics and Philosophy Lecture, was presented Tuesday by Wendy Levinson, MD. On Wednesday, Charles M. Balch, MD, FACS, presented the Commission on Cancer Oncology Lecture, Melanoma: A Model of Evidence-Based Oncology Practice (see photo, page 23); Michael R. Harrison, MD, FACS, gave The Fetus Becomes a Surgical Patient: Science/Fiction, for the I. S. Ravdin Lecture in the Basic Sciences; and Henrik Kehlet, MD, FACS(Hon), delivered the Distinguished Lecture of the International Society of Surgery, Fast Track Surgery—From Here to Where? Lastly, on Thursday, for the Martin Memorial Lecture, Clinical Congress attendees thronged the Exhibit Hall throughout the week, viewing recent scientific and technical achievements.

Overleaf: Background photo: Officers and Regents of the College, along with distinguished guests, gathered onstage during the Opening Ceremony. Inset photos, clockwise from upper left: Dr. Copeland delivering his Presidential Address at the Convocation, Distinguished Philanthropist awardee Dr. Jurkiewicz at the FLS Luncheon, AUA Lecturer Dr. von Eschenbach, and Chicago Mayor Richard J. Daley speaking at the FLS Luncheon. All photos by Charles Giorno Photography.
Participants in a workshop on image-guided diagnosis, ultrasound, and stereotactic imaging.

Above: Dr. Balch delivering the Commission on Cancer Oncology lecture.

Surgeons check their messages during the meeting.

Dr. De Angelis delivering the Martin Memorial Lecture.

Right: Recipients of the Commission on Cancer Outstanding State Chair Performance Award were honored during the Cancer Liaison Breakfast. Pictured from left to right (all MD, FACS): Danny M. Takanishi, Jr., Honolulu, HI; Alan G. Thorson, Omaha, NE; and Michael S. Bouton, Fort Smith, AR.
Dr. Tarpley (center) received the 2006 ACS/Pfizer Medical Humanities Initiative Surgical Volunteerism Award for international volunteer services.

Dr. Tarpley is pictured with Mark A. Malangoni, MD, FACS, Chair of the Board of Governors (left), and Raul Perea-Henze, MD, senior director, Pfizer Global Medical Relations.

Dr. Jurkiewicz (left) and Mrs. Jurkiewicz (not pictured) received the Distinguished Philanthropist Award. Dr. Jurkiewicz is pictured with Richard B. Reiling, MD, FACS, Chair of the Committee on Development.

During the annual Trauma Banquet, past presenters of the Scudder Oration on Trauma gathered for a photo. Front row, left to right (all MD, FACS): Kenneth L. Mattox, J. David Richardson, Frank R. Lewis, Jr., Gerald W. Shaftan, and George F. Sheldon. Back row, left to right (all MD, FACS): Norman M. Rich, Frank L. Mitchell, Jr., Donald D. Trunkey, Charles E. Lucas, Erwin R. Thal, C. Thomas Thompson, Anna M. Ledgerwood, J. Alex Haller, Jr., and Basil A. Pruitt, Jr.
Catherine De Angelis, MD, MPH, presented Scientific Conflict of Interest: Fact and Friction (see photo, page 2).

Awards, honors, and celebrations

The Association of Women Surgeons (AWS) celebrated its 25th anniversary with a dinner and awards ceremony, including conferral of the AWS Foundation’s Nina Starr Braunwald award, which recognizes outstanding contributions to the advancement of women in surgery, to the College.

In conjunction with the Pfizer Medical Humanities Initiative, the College conferred the Surgical Volunteerism Award. John L. Tarpley, MD, FACS, FWACS, a general surgeon from Nashville, TN, was recognized for his 28 years of providing volunteer surgical services to medically underserved patients in Nigeria. Dr. Tarpley accepted this award at the Board of Governors’ dinner (see photo, page 24).

At the Fellows Leadership Society (FLS) luncheon, Dr. and Mrs. Maurice J. Jurkiewicz, FACS, were presented the 2006 Distinguished Philanthropist Award (see photo, page 24). This important honor recognizes the contributions to the field of surgery and the welfare of patients by Dr. Jurkiewicz—a Past-President of the Col-
lege—and the planned estate gift to the College from him and his wife.

As reported in the November issue of the Bulletin, Patricia J. Numann, MD, FACS, of Syracuse, NY, received the 2006 Distinguished Service Award, the College’s highest honor (see photo, page 25). Also reported in that issue were this year’s six recipients of Honorary Fellowship in the College: Sen. Sirpa L. Asko-Seljavaara, MD, Prof. Jorge Cervantes, Prof. Clair Nihoul Féketé, Prof. Armando Marquez-Reveron, Prof. Maurice E. Müller, and Prof. Niall O’Higgins.

At the annual meeting of the Commission on Cancer (COC), Carlos A. Perez, MD, FACR, professor emeritus of radiation oncology at the Washington (St. Louis) University’s Mallinckrodt Institute of Radiology, was conferred the Cancer Fighter Awards Trust 2006 Cancer Fighter of the Year award in honor of his national leadership in radiation oncology, research, treatment, education, and patient care. The COC meeting also served as a forum for the Cancer Fighter Awards Trust 2006 Beahrs Memorial Lifetime Achievement Award, which was named in honor of Oliver H. Beahrs, MD, FACS, who passed away in January 2006. Robert V.P. Hutter, MD, FACS, emeritus professor of pathology at St. Barnabas Medical Center in Livingston, NJ, was the recipient.

David R. Boyd, MD, FACS, was honored with this year’s National Safety Council Surgeons’ Award for Service to Safety (see photo, page 25). This award recognizes Dr. Boyd’s “visionary
leadership in trauma systems development and trauma care, and a lifelong commitment to the care of trauma patients, prevention of injuries, and development of systems.”

The 2006 Surgical Forum Volume was dedicated to Jonathan L. Meakins, MD, FACS. Recipients of the Surgical Forum Excellence in Research Awards—established in 2003 to recognize surgical residents who submit outstanding papers to the Surgical Forum—were as follows: Charles J. Aprahamian, MD, University of Alabama at Birmingham; Adil H. Haider, MD, MPH, Johns Hopkins Hospital, Baltimore, MD; Eric J. Hanly, MD, Johns Hopkins University & Walter Reed Army Medical Center, Baltimore, MD; Rishi Kundi, MD, Weill-Cornell Medical College, New York, NY; Wai-Yee Li, MB ChB, MRCS, Children’s Hospital, Los Angeles, CA; Ian F. Lytle, MD, University of Michigan, Ann Arbor; David Machado-Aranda, MD, Providence Hospital, Southfield, MI; Kimberly J. Riehle, MD, University of Washington, Seattle; Tracy M. Scott, MD, University of British Columbia, Vancouver; William E. Stansfield, MDCM, University of North Carolina, Chapel Hill, NC; and Monika Tataria, MD, Stanford University, Stanford, CA (see photo, page 26).

International Guest Scholars and traveling Fellows honored by the International Relations Committee included the following: Wendy A. Brown, MBBS, PhD, FRACS, Prahran, Victoria, Australia; Julio Cesar Morales, MD, Guatemala, Guatemala; Jeong-Hwan Chang, MD, PhD, Gwangju City, South Korea; Susumu Eguchi, MD, PhD, Nagasaki, Japan (Japan Exchange Fellow); Mehmet Haciyanli, MD, Izmir, Turkey; Luis H. Lopez, MD, Leon, Guanajuato, Mexico; Sarder A. Nayeem, MBBS, PhD, FACS, Dhaka, Bangladesh; Ronnie T. Poon, MBBS, MS, FRCS(Ed), FACS, Hong Kong, China; Hernan P. Sacoto, MD, Cuenca, Ecuador; Dirk L. Stippel, MD, Cologne, Germany (German Exchange Fellow); Zsolt Toth, MD, PhD, Pecs, Hungary; and Ashish Wakhlu, MS, MCh, Lucknow, India (see photo, page 26).

The fourth annual ACS Resident Award for Exemplary Teaching was presented to Jillian Coolen, MD, a PGY-4 resident in obstetrics and gynecology at the University of Alberta in Edmonton (see photo, page 28). 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. Coolen was selected by an independent review panel of the Committee on Resident Education.
Dr. Coolen, recipient of the Resident Award for Exemplary Teaching (third from right), pictured with (left to right): Karl C. Podratz, MD, FACS, Regent; Thomas R. Russell, MD, FACS, Executive Director; Dr. Copeland; Mary Maniscalco-Theberge, MD, FACS, Vice-Chair, Committee on Resident Education; and Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education.

Winners of the ACS Scientific Exhibit’s “Posters of Exceptional Merit” were honored during the convention. Barbara L. Bass, MD, FACS, Chair of the Program Committee (front row, fourth from left), presided over the ceremony.
To celebrate the recently completed restoration of the John B. Murphy Memorial Building—former site of ACS headquarters—tours were offered during the Clinical Congress.

**Spotlight on ACS programs**

To commemorate the launch of the Surgeons Diversified Investment Fund, explanatory general sessions were offered to meeting attendees. In addition, a booth on the Exhibit Floor provided information to individuals who were interested in learning more.

**Officers installed**

Edward M. Copeland III, MD, FACS, a surgical oncologist from Gainesville, FL, was installed as the 87th President of the American College of Surgeons during the Convocation ceremony (see photo, page 27). Dr. Copeland, a Fellow of the College since 1974, is the Edward R. Woodward Distinguished Professor of Surgery at the University of Florida College of Medicine, Gainesville.

Dr. Copeland has been an active participant in and leader of numerous College activities. He has served as Chair of the Board of Governors (1995–1996) and of the Board of Regents (2003–2005). He was Secretary (1994–1995) and Chair (1995–1996) of the Board of Governors’ Executive Committee as well as a member of the Committee on Socioeconomic Affairs (1995–1996), the Committee to Study the Fiscal Affairs of the College (1994–1995), and the Committee on Physicians’ Health (1992–1994).

Dr. Copeland’s committee work on the Board of Regents has included Chair of the Executive (2003–2005), Finance (2003-2005), and Member Services Liaison (2001–2003) Committees, and Vice-Chair of the Executive Committee (2002–2003) and the Board (2002–2005). Dr. Copeland has also served in leadership roles on numerous other College committees, including as Chair (2002–2003) and Vice-Chair (2001) of the Program Committee; Executive Chair (1990–1993) and Executive Vice-Chair (1988–1990) of the Medical Motion Pictures Committee; and as Chair of the Committee on Young Surgeons (1982–1983). He has also served as a member of the Executive Compensation Committee (2003–2006), Nominating Committee of the Fellows (1991–1992), Committee on Video-Based Education (1987–1997), and Committee on Young Surgeons (1978–1983). In addition, Dr. Copeland has been actively involved as a member of the College’s Commission on Cancer.

Dr. Copeland’s Presidential Address, which he indicated was “more of a Convocation address,” focused on mentoring and how it has an influence on being a surgeon, discussing the “old” and “new” systems of residency and his own personal journey into a surgical way of life. This lecture may be read in its entirety in the December issue of the Bulletin.

Past-Presidents of the College met during the Clinical Congress for their annual luncheon. Pictured left to right, front row (all MD, FACS): Frank C. Spencer, New York, NY; Edward R. Laws, Charlottesville, VA; Maurice J. Jurkiewicz, Atlanta, GA; and W. Gerald Austen, Boston, MA.

Back row: David G. Murray, Syracuse, NY; C. Rollins Hanlon, Chicago, IL; LaSalle D. Leffall, Jr., Washington, DC; and George F. Sheldon, Chapel Hill, NC.
New Officers-Elect

At the Annual Business Meeting of Members, Gerald B. Healy, MD, FACS, was named ACS President-Elect (see photo, page 32). Dr. Healy, who hails from Boston, MA, is the Gerald B. Healy Chair in Pediatric Otolaryngology and professor of otology and laryngology at Harvard Medical School as well as otolaryngologist-in-chief at Children’s Hospital in Boston.

Dr. Healy became a Fellow in 1977 and has been an active participant in College governance. He was Chair of the Board of Regents, a member of the Board of Regents and its Honors Committee since 1997, and Chair of its Finance Committee since 2005. Since 2000, he has been the Chair of the Executive Committee of the Board of Regents. In addition, Dr. Healy was Chair (1995–1997) and Governor (1991–1996) of the Advisory Council for Otolaryngology–Head and Neck Surgery and Member (1998–2001) and Chair (2001–2003) of the Central Judiciary Committee. From 1996 through 1998, Dr. Healy was also the President of the Massachusetts Chapter of the ACS.

Dr. Healy received his undergraduate degree from Boston College in 1963 and his medical (MD) degree from Boston University in 1967. He performed a surgical internship (1967–1968) and residency (1968–1969), followed by a residency in otolaryngology (1969–1972), all at University Hospital in Boston.

Former chief of otolaryngology at Valley Forge Army Medical Center (1972–1973, Phoenixville, PA) and William Beaumont Army Medical Center (1973–1974, El Paso, TX), Dr. Healy eventually ended up in Boston. From 1975 to 1976, he was the associate director of otolaryngology at the Boston Veterans Administration Hospital. From 1976 to 1979, he was associate otolaryngologist-in-chief at The Children’s Hospital in Boston, where

David L. Nahrwold, MD, FACS, First Vice-President, and Robert E. Berry, MD, FACS, Second Vice-President, were also installed as officers during the Convocation.

A Fellow since 1971, Dr. Nahrwold, of Northbrook, IL, is a retired surgeon. From September to December 1999, he was Interim Director of the College. He has been a member of the Board of Regents and an active member of the Board of Governors, including serving as a member (1994–1995), Vice-Chair (1995–1996), then Chair (1996–1998) of the Executive Committee. Dr. Nahrwold also was Secretary and President of the Pennsylvania Chapter of the ACS.

Dr. Berry, of Roanoke, VA, has been a Fellow since 1966. He has served as a member of the Board of Governors (1991–1997), Past-President of the Virginia Chapter of the ACS, and Past-Chair of the ACS Committee on Development.

Past recipients of the College’s most prestigious honor, the Distinguished Service Award, gathered for their annual luncheon. Pictured in the front row, left to right (all MD, FACS): Frank Padberg, Chicago, IL; LaMar S. McGinnis, Jr., Atlanta, GA; Murray F. Brennan, New York, NY; Robert E. Hermann, Bratenahl, OH; and C. Barber Mueller, Hamilton, ON.

Back row: David L. Nahrwold, Chicago, IL; Richard B. Reiling, Charlotte, NC; John O. Gage, Pensacola, FL; Josef E. Fischer, Boston, MA; Donald R. Trunkey, Portland, OR; and C. Thomas Thompson, Tulsa, OK.
Irvene Hughes (third from right), retiring Program Coordinator of the Advanced Trauma Life Support® (ATLS®) system, was lauded at this year’s trauma banquet. Among those expressing their gratitude for Irvene’s years of service were the Past-Chairs of the ATLS subcommittee (left to right, all MD, FACS): Richard M. Bell, Steven N. Parks, Brent E. Krantz, Christoph R. Kaufmann, Paul E. Collicott, and John B. Kortbeek (current ATLS Chair).

Daniel Clarke Wharton Finney, MD, FACS (far right), and his family stand before a painting of Dr. Finney’s grandfather, J.M.T. Finney, the first President of the American College of Surgeons. Dr. Finney’s uncle and cousin were also surgeons and ACS Fellows. Dr. Finney viewed the painting during the Congress while visiting the newly renovated Murphy Memorial Auditorium. Pictured from left to right: Mary Finney Tanneberger, Margaret W. Finney, Eleanor Jean Finney, and Dr. Finney.
he is currently otolaryngologist-in-chief. Also at The Children’s Hospital he was surgeon-in-chief (1995–1998) and a trustee (1994–1998).

Dr. Healy has been an active participant in professional organizations. He has been vice-president (1998–1999) and president (1999–2000) of the American Laryngological Association and is currently executive vice-president of the American Board of Otolaryngology (since 1998); president of the American Laryngological, Rhinological, and Otological Society (since 2000); and vice-president of the International Bronchoesophagological Society (since 2001).

In addition to having published in more than 130 journals and more than 30 books and monographs, Dr. Healy has served on the editorial boards or as a reviewer for many medical publications, including The Laryngoscope, Annals of Otology, Rhinology, and Laryngology, and Diagnostic and Therapeutic Endoscopy.

Also at the Annual Business Meeting of Members, Fellows named Mary H. McGrath, MD, FACS, of San Francisco, CA, as First Vice-President-Elect, and Paul Friedmann, MD, FACS, of Springfield, MA, as Second Vice-President-Elect.

Dr. McGrath is a professor of surgery in the division of plastic surgery at the University of California–San Francisco and has been a Fellow since 1983. In addition to being the current Vice-Chair of the Board of Regents, she has also served as Chair of the Nominating, Communications, and Ethics Committees of the Board of Regents. Dr. McGrath has also been active in the Board of Governors and has served as a member, vice-chair, or liaison to many College committees.

Dr. Friedmann is executive director of Pioneer Valley Life Sciences Institute. A Fellow since 1971, he has served on the Program Committee, Executive Committee of the Board of Governors, and has been a member or liaison of various College committees as well as Chair of the Advisory Councils for General Surgery. In addition, he is the former President of the Massachusetts Chapter of the College.

**Board of Regents**

During Clinical Congress, Josef E. Fischer, MD, FACS, was named Chair and L. D. Britt, MD, FACS, was named Vice-Chair of the Board of Regents. Julie A. Freischlag, MD, FACS, Raymond F. Morgan, MD, FACS, and Mark C. Weissler, MD, FACS, were named Regents of the College.

**Board of Governors**

Valerie W. Rusch, MD, FACS, was elected to a one-year term as Chair of the Board of Governors. Elected for a one-year term as Vice-Chair was Kirby I. Bland, MD, FACS. A one-year term as Secretary of the Board of Governors will be served by Karen E. Deveney, MD, FACS.
For generations, the American College of Surgeons has promoted a noble and patient-centered effort to improve surgical care. Our Mission Statement greets each visitor as they enter our headquarters building and is permanently displayed in the Regents’ Room. This serves to remind the College leadership of what must be the focus and purpose of our continuous professional development. Our mission celebrates that we are “dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.”

As we stand on the foundation of a great history, we must redesign our house of surgery to be responsive to the new era that 21st century medicine presents. We must not just look at the world as it affects us, but how we have an impact on the world of our patients. We must respond that we are willing to self-inspect and make change where it benefits the patient and the profession.

Your leaders understand that there are stresses associated with the ongoing practice of surgery. One of those stresses is professional liability, and it is, without question, the main concern of a majority of our Fellows. The College has relentlessly tried to achieve a reasonable solution to this ever-present problem at both the state and federal levels. There has been some success in a limited number of states but almost no inroads have been made at the federal level.

Recently, the College commissioned the Committee on Patient Safety and Professional Liability to review a group of bad outcomes from a unique perspective, conducting a study identified as the ACS Closed Claims Pilot Project. This effort was led by the committee’s Chair, F. Dean Griffen, MD, FACS (see related article, page 11). It involved a review of closed claims from records kept by liability insurance companies nationwide on incidents affecting Fellows of the College. Its purpose was to identify frequent costly errors and to develop strategies to improve safety and decrease liability and, hopefully, premiums. A surprising and somewhat amazing finding of that review was that in a significant number of claims, unprofessional behavior was a prominent factor that initiated legal action against the surgeon. Similar findings have been made by other liability carriers.

Our organization promotes the fact that we will safeguard the well-being of our patients. Thus, patient safety is a critical and expected mission affecting every intervention that we initiate and conduct. Our Fellows must exercise leadership on this and demonstrate that we understand that breaches in professionalism do have an impact on patient safety.

So how does all this affect the professional liability crisis? Does the closed claim study indicate that we should initiate a new approach in our strategy to relieve Fellows of the burden of ever-increasing liability risks and the ongoing increase in insurance premiums? Can we be part of the solution? Are the trial lawyers the only problem, or do we have some responsibility?

Dr. Griffen’s study would tend to indicate that self-examination on issues surrounding professionalism may be one solution that we should strongly consider. Are we troubled across our profession with inappropriate behavior toward either patients or coworkers? How do we choose to deal with these issues if we identify them and who is affected by these breaches?

Surgery in the 20th century was led by icons, some of whom governed in a monolithic way, sometimes instilling fear in those whom they treated, employed, or trained. Medicine in the 21st century, however, is following a different pathway. Regulatory organizations involved in licensing, accreditation, and certification now insist that physicians be versed in how to participate in systems-based care. In order to answer these demands, surgeons must begin to understand the concept of teamwork and professionalism while struggling to remain at
the center of the patient care circle. There is no question that the environment in which we work is plagued by uncertainty, loss of collegiality, falling reimbursement, a changing scope of practice, rising expectations, and changing relationships between physician and patient. However, we must divorce ourselves of the attitude that it is others who are always the problem and not us. Unfortunately, there are circumstances where we are the problem. Thus, we must examine ourselves and put our own house in order.

A recent report on behavior conducted by the American College of Physician Executives demonstrated that more than 90 percent of the membership surveyed were dealing with significant professional and behavior problems with physicians in their organizations.* These problems included issues such as verbal insults, disrespect, and even physical abuse. In that survey, physicians plagued by these problems were typically skilled and busy but, when questioned, were felt to be fearful of an uncertain atmosphere, declining autonomy, income loss, and large amounts of debt with increasing overhead. The pattern identified usually involved an individual who regularly threatened and demeaned coworkers and patients with profanity or was verbally or physically abusive.

Of note, many of these individuals were identified as having either substance abuse problems or were bipolar. This professional breach has an amazing impact on patients who may well respond with lawsuits, but it also significantly affects staff, resulting in frequent turnover, many lawsuits, and excessive cost to the organization in dealing with this behavior.

So, what is the solution and how does it result in diminished liability? Organizations, departments, group practices, and physician offices must define behavior, develop assessment plans, implant quality of life issues for members, and set a due process in place that will deal with the aberrant behavior but still safeguard the rights of the individual physician. Maintenance of good records of behavioral activities of every member of your organization is mandatory, as is seeking assistance from professionals who can help you deal with these troubling problems. Physicians must be taught appropriate behavior skills early in their medical education. They must be given support to deal with stress and, above all, we must ingrain a responsive and sensitive physician-patient relationship. Dr. Griffen will tell you that his analysis and analyses performed by others reveal that, even in cases where serious errors have occurred, surgeons who have a positive relationship with their patients rarely get sued.

In conclusion, develop a proactive code of conduct for yourself and your colleagues. Seek training on how to better interact with the patient and the environment of the 21st century. Deal with the problem and confront it. Help the individuals who are troubled and are visibly seeking assistance by continuously acting out. Finally, follow up when help has been initiated to ensure that the individual has ongoing success. After all, in helping ourselves and our colleagues, we are helping our number one priority: our patients!

It has been a real pleasure for me this year to serve as the Chair of the Board of Governors. In this report, I aim to give you some idea of what the governors view as the major issues confronting the College and surgeons in practice, to tell you about some of our accomplishments in 2006, and to highlight Operation Giving Back (OGB), an initiative of the Governors a few years ago.

Each year the U.S., Canadian, and international Governors receive a survey to identify the top five issues that respondents believe the College should be dealing with on a national basis and international basis for the future. In the last survey, the number one issue—which has been consistently in the top five over the last few years—is professional liability and tort reform, which are linked with risk management and patient safety. For U.S. and Canadian Governors, professional reimbursement and Medicare and Medicaid are obviously of more importance, but health care reform is important for all. Graduate medical education represents a high degree of importance for all Governors. Competency measurements also represent a very high level of interest, particularly among the international and Canadian Governors and Fellows.

Included among Board of Governors activities for 2006 was a member survey on the issues of personal health—physical as well as psychological. The goal is to gain some understanding of members and to link the results of this survey with some of the initiatives related to behavioral problems in and outside of the operating room.

The Board of Governors has approved a procedure for assisting ACS chapters in distress. The Governors’ belief is that although at this time there aren’t many struggling chapters, there should be a way to rescue them and bring them back into the fold and prevent them from becoming inactive.

The Board has also recommended the establishment of a humanitarianism award and will be working with the College and its development office to secure funding to initiate this award.

There is also a Board initiative to improve patient safety in the operating room. This year’s Governors’ panel focused on patient safety in the operating room, and we hope to carry this initiative forward and make it available to all across the U.S. and beyond.

Among upcoming projects, the Board is going to reexamine its membership criteria and will be revising the current survey to include emerging issues, which include fragmentation of surgery and access to care.

OGB has garnered a very high level of interest. The OGB Web site receives approximately 100,000 hits per month. At the Board of Governors meeting in October, unanimous support for OGB was reaffirmed. That particular department, under the leadership of Kathleen Casey, MD, FACS, is working to develop domestic and international opportunities for surgeons, residents, and medical students. The business plan for OGB has been finalized and approved by the Board of Regents.

Again, it was a pleasure serving as the Chair of the Board of Governors for the past year, an honor that I will always remember.

Dr. Malangoni is professor of surgery, Case Western Reserve University, and Chairperson, department of surgery, and surgeon-in-chief, MetroHealth Medical Center, Cleveland, OH. He is the Immediate Past-Chair of the Board of Governors.
In preparation for this report, I reviewed the results of this year’s Board of Governors’ survey. The Governors continue to express concern about such issues as physician reimbursement, medical liability, and regulatory burdens, but also acknowledge that the health care delivery system is being truly redefined at this point.

We are experiencing a time of great transition, moving into a new era of value-based purchasing, which is centered on improving the quality and reducing the cost of health care. Hence, the College needs to focus on how it can meet the evolving challenges this new system poses for surgeons and their patients. I believe that assisting in this transition and helping surgeons meet the public’s new expectations is one of the foremost responsibilities that the American College of Surgeons can accept at this time. Our organization is rising to these demands by broadening the scope of our health policy, research, education, and membership activities.

**Health policy**

Many federal policymakers recognize that the current Medicare reimbursement system is critically flawed, particularly in its reliance on the sustainable growth rate (SGR) to calculate the annual conversion factor update. These individuals have expressed particular interest in replacing the current methodology with a system that links reimbursement to the value of the services surgeons and other physicians provide. Hence, the College is striving to develop quality measures and performance indicators that account for the unique nature of surgery.

To this end, we have become active participants in various groups that seek to vet quality measures, such as the American Medical Association’s Physician Quality Improvement Consortium, the National Quality Forum, Ambulatory Care Quality Association, and the Hospital Quality Alliance. In addition, we have formed the Surgical Quality Alliance, which comprises two-dozen surgical specialty societies working together to establish surgery-specific metrics of care. Developing these standards is a difficult and resource-intensive process, because it involves largely unexplored territory. Nonetheless, surgery’s involvement in developing these measures will be paramount to determining our future standing in the health care system and the reform debate.

In addition to advocating for a more quality-centered approach to reimbursement, the College is taking a new look at liability and why physicians are sued. This year, our Professional Liability and Patient Safety Committee conducted a closed-claim study in three major U.S. cities; results indicate that judgments against surgeons typically occur when the defendants display inadequate communication skills or otherwise behave unprofessionally. These results are discussed in the article by F. Dean Griffen, MD, FACS, in this issue of the Bulletin (see page 11). The results should be carefully considered as we redefine our approaches to resolving surgeons’ exposure to liability.

The Institute of Medicine also promulgated an interesting set of reports that focus on the fragmented delivery of emergency services. To avert a full-blown emergency workforce crisis, the College is working with the various surgical specialties to pinpoint the problems in emergency room coverage and to identify gaps in specialty services. Causes of this problem are complex, but clearly emergency rooms are being used too frequently by patients who are experiencing non-emergency events, and surgeons decline taking call for multiple rea-
sions, including reimbursement, liability, and lifestyle concerns. The College has actively supported and participated in the Institute of Medicine’s efforts to address this chronic problem.

To increase surgery’s visibility in Washington, we are finalizing plans to move the Washington Office to a more spacious site closer to Capitol Hill. We anticipate that we will be able to accommodate the Washington-based staffs of multiple specialty societies and build a more unified house of surgery.

In an effort to further enhance our role in the policymaking arena, we are working to establish a Health Policy Institute. Under its auspices, we intend to study and promulgate policies that will benefit surgical patient care.

**Research and Optimal Care**

Because many of the changes in health policy focus on quality improvement, the College is seeking to generate meaningful data on surgical care. This effort necessitates a critical analysis of the information that the College has available through its National Cancer Data Base and the National Trauma Data Bank®. These repositories contain information that may be useful in developing quality indicators and measures.

The College also is adopting a more academic orientation with the goal of conducting more research and issuing scientific papers. Presently, two surgical residents are working full-time at our headquarters as part of this initiative through our recently launched clinical scholars program.

To take the lead in the quality movement, we also will need to expand our accreditation programs. Currently, we accredit trauma, cancer, and bariatric surgery centers. Furthermore, the development and promulgation of guidelines and protocols for surgical care will be an important change in direction for the College. We anticipate that the advisory councils will take the lead in this effort.

The ACS National Surgical Quality Improvement Program (ACS NSQIP), which is a risk-adjusted tool for assessing surgical outcomes and, therefore, a potentially valuable quality improvement mechanism, has now been incorporated into more than 100 hospitals. A remaining challenge will be to develop modules of ACS NSQIP that are specific to the areas of concentration in each medical center.

Another critical area for the College will be fostering our clinical trials programs. It is imperative that the ACS continue to develop clinical trials, not only in oncology but for other disease systems as well, to help advance scientifically proven, safe new operations, devices, and techniques.

In the near future, we anticipate that the Agency for Health Research and Quality will begin selecting patient safety organizations as required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. We are hopeful the agency will give consideration to our Patient Safety Center currently in development.

**Education**

In 2006, the College launched the ACS Program for the Accreditation of Education Institutes. To receive the College’s stamp of approval, these regional educational centers must meet rigorous standards and offer programs that will help surgeons sharpen their cognitive and technical skills through the use of state-of-the-art training instruments. We also foresee the need to develop additional e-learning products, as these tools replace more traditional learning forums.

In addition, we anticipate that hospital credentialing bodies will turn to organizations like the College to verify that surgeons seeking privileges have provided accurate information about their skills, knowledge, and participation in continuing education activities. Likewise, as the boards proceed with their efforts to institute maintenance of certification standards, surgeons will be pressed to report on their surgical activity and outcomes. Through the NSQIP program as well as the electronic Case Log System we have created, we hope to facilitate opportunities for surgeons to keep track of what they are doing and their outcomes to fulfill maintenance of certification requirements.

In addition, we have made strides in edu-
cating medical students about a career in surgery and addressing their needs and those of residents.

The College is also launching a patient education program. This effort will continue to evolve, and hopefully the ACS will become a real resource for patients who want to know more about the surgical experience and how to prepare for it. This activity is one aspect of a larger, major visibility program to increase the public’s knowledge about the College’s various programs.

Membership

Reaching out to the entire surgical community in a unified way will be a key part of ensuring this organization’s future viability. The American College of Surgeons is really the only surgical association that can represent and meet many of the needs of surgeons in all specialties. Hence, most of our programs have been developed to help all surgeons meet the demands of a changing environment, which will be much more complicated and undoubtedly more regulated.

Participation in the ACS Case Log System, Operation Giving Back’s opportunities for volunteerism, and the Web portal are just some of many benefits we provide to ACS members. We are also attempting to assist Fellows in their travels needs and to help other smaller professional associations handle their management responsibilities.

In addition, we are expanding our educational programming focused on practice management and the financial aspects of running an efficient practice. The College also has launched a mutual fund to assist in prudent investing. This mutual fund is based on the principles that have served the College’s endowment fund so successfully for the last 15 years.

Conclusion

Clearly, in my seven years as Executive Director of the ACS, the pace of change has become much faster and our involvement more urgently necessary than ever. I think many surgeons, patients, and policymakers realize that the current health care system is unsustainable and must be reformed to improve quality and reduce costs. As professionals, we must seize this opportunity and not deny that change is coming. I remain optimistic and enthusiastic about the College’s role and that we have set in motion the programs needed to meet the evolving expectations of the profession and this organization. As always, everyone’s support and interest is truly appreciated.
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### ACS Coding Hotline: Unusual questions

**by the Division of Advocacy and Health Policy**

This column lists some questions recently posed to the ACS Coding Hotline and the responses. As a benefit of membership in the College, ACS Fellows and their staff may consult the hotline 10 times annually without charge. If your office has coding questions, please contact the Coding Hotline at 800/227-7911 between 7:00 am and 5:00 pm Mountain Time, holidays excluded.

#### Around the corner

**January**

The following will be implemented January 1:
- The 2007 Medicare fee schedule
- The 2007 CPT codes
- The Medicare national Correct Coding Initiative (NCCI), version 13.0
- The Medicare Medically Unlikely Edits (MUE), version 1.0. A description of these edits will appear here in a future issue of the Bulletin.

**February**

Economedix will hold two teleconferences this month. The first, on February 14, is “Medicare Update for 2007.” The second, on February 28, is “Advanced CPT Coding.” For more information and to register, go to [http://yourmedpractice.com/ACS/](http://yourmedpractice.com/ACS/).

**Reminder:** The NPI numbers are required on Medicare claims submitted on or after May 23, 2007. If you have not submitted an application for your NPI, you need to do so immediately.

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**How do I code when the physician is performing a percutaneous common iliac vein balloon angioplasty, placement of a 14 mm x 50 mm wall stent, another balloon angioplasty of the same area, and a follow-up angiogram to make sure the patient has good flow in the common iliac vein?**

The following procedure codes would be used to reflect the procedures performed: Code 37205, *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel,* and code 75960–26, *Transcatheter introduction of intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel.* The code for placement of the stent includes the preplacement and postplacement angioplasties. The modifier –26, *Professional Component,* is appended to the radiology code since the physician is supervising and interpreting the images as well as dictating a report of his or her findings but does not own the equipment.

**What code do you suggest using when the physician is taking down one part of a previous anastomosis? The physician is taking down or disconnecting the stomach and common bile duct anastomosis, reconnecting or anastomosing the common bile duct to a different part of the stomach, and then suturing the old connection site of the stomach?**

Use the procedure code 47760, *Anastomosis of extrahepatic biliary ducts and gastrointestinal tract,* with a modifier –22, *Unusual Procedural Services.* The modifier –22 covers the additional work of closing the old anastomosis. Increase the fee appropriately and send the...
How do I code a gastrojejunostomy Roux-en-Y when the physician does an anastomosis of the stomach to the jejunum and an anastomosis of the jejunum to the jejunum for duodenum exclusion? No stomach was resected.

The appropriate procedures codes to use are code 43820–51, Gastrojejunostomy; without vagotomy and code 44130–51, Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure). These codes cover both the anastomosis sites and complete the Roux-en-Y.

The patient’s diagnosis is adenocarcinoma of the fourth portion of the duodenum with right lobe liver metastasis. The procedure performed was resection of right lobe lesion of liver, resection of the fourth portion of the duodenum with primary duodenojejunostomy, and resection of ischemic ileotransverse colostomy with creation of new ileotransverse colostomy. A Moss gastrojejunostomy tube was inserted and advanced through the pylorus and placed into the duodenum.

The following procedure codes should be used: Code 47120, Hepatectomy, resection of liver; partial lobectomy; code 44160–59–51, Colectomy, partial, with removal of terminal ileum with ileocolostomy; code 44120–51, Enterectomy, resection of small intestine; single resection and anastomosis; and code 43830–22, Gastrostomy, open; without construction of gastric tube (eg, Stamm procedure) (separate procedure). The modifier –22 is for placement of the gastrojejunostomy tube into the duodenum. Increase the fee for modifier –22 and send the hard copy of the operative note and a cover note to explain the extra work and the use of the modifier –22.

A thoracic surgeon and a vascular surgeon operated on a patient with a pancreatic tumor with perivascular invasion. Do they need to code the excision of the pancreatic tumor with modifier –62, Two Surgeons? The thoracic surgeon excised the tumor and then asked the vascular surgeon to ligate the vessels that were surrounding the tumor.

The correct code for both surgeons to report is code 32503, Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; without chest wall reconstruction(s), which includes all of the vascular work.

There are two modifiers that can be used: Modifier –62, Two Surgeons, or modifier –80, Assistant Surgeon. (Modifier –82, Assistant Surgeon [when qualified resident surgeon not available] is used in teaching institutions in place of modifier –80.) Which modifier you use depends on whether the two surgeons have agreed they will report modifier –62; if so, both should have prepared operative reports on their respective portions of the operation. If the vascular surgeon did not prepare a separate operative report, he should report code 32503 with the appropriate assistant surgeon modifier.

When 12 out of 20 lymph axillary lymph nodes are excised, would this be coded as code 38740, “superficial,” or as 38745, “complete”?

If the procedure code 38740, Axillary lymphadenectomy; superficial is chosen, use modifier –22, Unusual Procedural Services; if coded as 38745, Axillary lymphadenectomy; complete, use modifier –52, Reduced Services. The fee will increase or decrease depending on which modifier is used. A copy of the operative note and a cover note explaining the additional work involved will be required if modifier –22 is used. Documentation may also be required if modifier –52 is used.

The physician performs a hemicolectomy and a resection of the small bowel. Would...
this be reported as code 44160 or small and large bowel resections?

If two resections were done and two separate anastomoses were completed, then the code 44120–51, Enterectomy, resection of small intestine; single resection and anastomosis, and code 44140–51, Colectomy, partial; with anastomosis, would be correct. If one resection and one anastomosis is performed, use code 44160, Colectomy, partial, with removal of terminal ileum with ileocolostomy.

I need codes for aortic and bi-iliac artery stent placement for exclusion repair of common iliac artery aneurysm. I also need the code for coil embolization of the hypogastric artery. This was done 10 times. Can it be reported multiple times?

Use code 34812–50, Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral, for the bi-iliac exposure and use code 34825–50, Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel, for placement of stents. Use code 34802, Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis using modular bifurcated prosthesis (one docking limb), to report the aortic repair. The code for coil embolization is code 37204, Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck. This is reported once for every vessel field. If it is reported more than once, append modifier –59, Distinct Procedural Service.

What code should I use for closure of an anal fissure in the subcutaneous tissue when the physician is using an anal plug?

Use code 46270, Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutane-
The American College of Surgeons invites you to attend its 35th annual Spring Meeting, which will be held April 22–25, 2007, at the Paris Las Vegas Hotel, Las Vegas, NV.

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 American College of Surgeons and the Society of American Gastrointestinal Endoscopic Surgeons (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. This year SAGES will kick off Surgical Spring Week, followed by the ACS’ Spring Meeting.

As part of the 2007 Surgical Spring Week, ACS will cosponsor two very important sessions with SAGES on Sunday, April 22: ACS/SAGES 2007 Joint Symposia: Esophageal and Gastric Disease and Establishing a Skills Program: What You Need to Know. Participants can register for both meetings at both organizations’ respective Web sites.

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 Monday, April 23, the resident programs will be held. ACS Resident Members will present hypothesis-testing research at Clinical Abstract Presentations by Residents and unusual cases at Spectacular Cases from Residents. During Surgical Jeopardy, teams of surgical residents from across the country will compete with one another to test their surgical knowledge.

Also to be featured on Monday are the Excelsior Surgical Society/Edward D. Churchill Lecture, presented by Kirby I. Bland, MD, FACS, and Highlights from the 2006 Clinical Congress Video-Based Education Sessions.

From Monday through Wednesday, April 23–25, general session highlights include the following:
Management of Unexpected Findings at Laparotomy; How Do I Stay Certified As a Surgeon?; Town Forum Discussion on the Future of General Surgery; Management of Benign Breast Disease; New Technology in Laparoscopy, Including Robotics; Multidisciplinary Tumor Conference: Challenging Gastrointestinal Cases; Everything You Wanted to Know about Gastrointestinal Stromal Tumor; Management of Common Postoperative Complications; Injuries to the Bile Ducts; Update on Nonoperative Approaches to Blunt Abdominal Trauma; and How to Free Yourself from Insurance and Practice Surgery.

Make plans now to attend this important meeting. Information regarding the general sessions and registration is included on the following pages. Online registration opens this month at www.facs.org.

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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Joseph B. Cofer, MD, FACS, Chattanooga, TN
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Michael E. Fenoglio, MD, FACS, Denver, CO
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Gerald M. Fried, MD, FACS, Montreal, QC
Michael J. Hart, MD, FACS, Seattle, WA
Anthony A. Meyer, MD, FACS, Chapel Hill, NC
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Stephen E. Olson, MD, FACS, Burns, OR
Victor E. Pricolo, MD, FACS, Providence, RI
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

Preliminary Program

Program is subject to change.

General Sessions

Sunday, April 22

9:45 am–5:15 pm
Fundamentals of Laparoscopy Postgraduate Course
CHAIR: Nathaniel J. Soper, MD, FACS, Chicago, IL
CO-CHAIRS:
Lee L. Swanstrom, MD, FACS, Portland, OR
Gerald M. Fried, MD, FACS, Montreal, QC

1:00–5:00 pm
ACS/SAGES 2007 Assembly: Foregut Symposium (GS01)*
CO-CHAIRS:
Steve D. Schwaitzberg, MD, FACS, Boston, MA (SAGES)
David V. Feliciano, MD, FACS, Atlanta, GA (ACS)

Session I: Esophageal Disease
1:00–3:00 pm
CO-MODERATORS:
Richard C. Karl, MD, FACS, Tampa, FL (ACS)
Steven R. DeMeester, MD, FACS, Los Angeles, CA (SAGES)

Session II: Gastric Disease
3:30–5:00 pm
CO-MODERATORS:
Mark A. Malangoni, MD, FACS, Cleveland, OH (ACS)
Frederick Greene, MD, FACS, Charlotte, NC (SAGES)

This combined session will be an update on management of selected diseases of the esophagus and gastroduodenal area. Options for management of gastroesophageal reflux will be discussed, as will laparoscopic versus open operative approaches for esophagectomy. The role of Helicobacter pylori in ulcerative diseases of the stomach and duodenum will be reviewed along with operative approaches for complications of ulcers. Finally, the role of gastric pacing to treat obesity will be discussed.

Objectives are as follows: (1) to update endoscopic

*For more information and to register for this course, go to the SAGES Web site at www.sages.org.
and laparoscopic approaches to gastroesophageal reflux; (2) to compare laparoscopic and operative techniques of esophagectomy; (3) to review acid-peptic-Helicobacter disease in the stomach and duodenum, including operative management of complications from ulcers, and (4) to discuss gastric pacing for obesity.

1:00–5:00 pm
ACS/SAGES Establishing a Skills Program: What You Need to Know (GS02)
CO-MODERATORS:
  Randy S. Haluck, MD, FACS, Hershey, PA
  Lenworth M. Jacobs, Jr., MD, FACS, Hartford, CT

  Recently, there has been more recognition of the importance of training and documentation of technical skills. Although there are many tools available for skills training, an understanding of sound principles of education must be at the foundation. This course is designed to explain some principles of education and available tools for training. Additional material on establishing a skills training program will be presented.

  During this session, participants will be exposed to the following: (1) Principles of education for skills training; (2) various approaches to skills training; (3) advantages and disadvantages of different types of teaching tools, such as animal models and computer simulators; and (4) practical considerations for skills education, such as costs, resident time management, and training of “outside” groups.

1:30–3:00 pm
Management of Benign Breast Disease (GS03)
MODERATOR: Toncred M. Styblo, MD, FACS, Atlanta, GA

  This session will discuss the natural history of commonly encountered benign breast diseases, including abnormalities associated with an increased risk of breast cancer. The practical management of benign breast diseases also will be discussed, including both clinical and imaging evaluation, indications for tissue characterization, and surgical treatment and follow-up.

3:15–4:45 pm
Options for Ventilator Support in Severe ARDS (GS04)
MODERATOR: Lena M. Napolitano, MD, FACS, Ann Arbor, MI

  This session will focus on a variety of innovative strategies for mechanical ventilation in patients with severe acute respiratory distress syndrome (ARDS). We will discuss the open lung approach, permissive hypercapnia, low tidal volume ventilation, and optimal positive end-expiratory pressure. High-frequency oscillatory ventilation, airway pressure release ventilation, bi-level ventilation, recruitment maneuvers for alveolar recruitment, prone positioning, and other approaches will also be discussed. Optimal approaches for the treatment of severe hypoxemia in severe ARDS will be reviewed.

Monday, April 23

8:00–9:30 am
Surgeons As Interventionalists (GS05)
MODERATOR: Enrico Ascher, MD, FACS, Brooklyn, NY

  This panel will show that endovascular procedures performed by vascular surgeons can be safely and effectively extended to include the treatment of pathologies other than peripheral arterial disease. These include embolization for gastrointestinal bleed, chemoembolization for hepatic tumors, and other conditions not currently addressed by the majority of vascular surgeons.

8:00–9:30 am
Thoracic Trauma for the General Surgeon (GS06)
MODERATOR: Thomas M. Scalea, MD, FACS, Baltimore, MD

  Thoracic trauma and injury to the chest is common following both blunt and penetrating trauma. Fortunately, most injuries require little in the way of intervention (supportive care or chest tube). Serious injuries, however, may require operative management. In this session, we will review indications for thoracic exploration with emphasis on operative approaches and operative technique. We will outline the principles of damage control as used for thoracic trauma. Finally, we will discuss some new, exciting options for thoracic injury.

8:00–9:30 am
Clinical Abstract Presentations by Residents (GS07)
CO-MODERATORS:
  Joshua M.V. Mammen, MD, Cincinnati, OH
  Eric G. Weiss, MD, FACS, Weston, FL

  The abstract authors (surgical investigators in-training) will present summaries of hypothesis-testing research, completed or in progress, not previously presented or published.
9:30–11:00 am
Management of Unexpected Findings at Laparotomy (GS08)
MODERATOR: Thomas H. Cogbill, MD, FACS, La Crosse, WI

This session will focus on the management of unexpected findings at laparotomy. Emphasis will be on small bowel tumors, Meckel’s diverticula, gynecologic pathology, liver masses, and vascular disease.

9:30–11:00 am
How Do I Stay Certified As a Surgeon? (GS09)
MODERATOR: Michael S. Nussbaum, MD, FACS, Cincinnati, OH

This session will review the current process for maintenance of certification (MOC) and the rationale and benefits of participating in MOC. This will include details on the four components of MOC: professional standing, lifelong learning and self-assessment, cognitive expertise, and evaluation of performance in practice and a timeline for current diplomates to enter the process.

9:30–11:00 am
Spectacular Cases from Residents (GS10)
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.

11:15 am–12:15 pm
INTRODUCTOR: Thomas R. Russell, MD, FACS, Chicago, IL

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

INTRODUCTOR: Edward M. Copeland III, MD, FACS, Gainesville, FL
LECTURER: Kirby I. Bland, MD, FACS, Birmingham, AL

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 keynote address at this meeting.

1:30–3:00 pm
Laparoscopy in Trauma (GS12)
MODERATOR: R. Stephen Smith, MD, FACS, Wichita, KS

This session will provide attendees with an overview of the application of current videoscopic technology in the evaluation and treatment of injured patients. Topics will include current indications for diagnostic laparoscopy in trauma, therapeutic laparoscopy in trauma, the controversial use of laparoscopy in blunt trauma, the complementary use of laparoscopy and thoracoscopy in trauma, and pitfalls and complications of trauma laparoscopy.

1:30–3:30 pm
Town Forum Discussion on the Future of General Surgery (GS13)
CO-MODERATORS:
Michael J. Hart, MD, FACS, Seattle, WA
C. Suzanne Cutter, MD, FACS, Long Island City, NY

The purpose of the forum will be to solicit information and opinions concerning the changes within general surgery and future directions of the specialty of general surgery.

1:30–4:00 pm
Surgical Jeopardy (GS14)
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 that 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 who are preparing for their board examinations.

2:00–5:00 pm
How to Free Yourself from Insurance and Practice Surgery (GS15)
MODERATOR: William A. Rough, MD, FACS, Mt. Holly, NJ

Third-party payors have consistently behaved badly toward contracted physicians. They restrict patient care through referral and precertification requirements; reduce reimbursements with little recourse for physicians; and add to overhead with increasing paperwork, office staff time, and unfunded mandates. This session will show attendees how to extricate their practice from the grasp of the payors and negotiate fee for service and out-of-network reimbursements.
Many agree that the training of general surgery residents has suffered in the last several years from a combination of factors, including the proliferation of subspecialty fellowships, which potentially diminish the operative experience of general surgery residents; the reduction in work hours, which potentially reduces clinical experience; and the perceived loss of interest in traditional general surgical practice. This panel discussion will focus on ways to reinvigorate general surgical training. Possible topics for presentation include the projected manpower needs in general surgery, methods for enhancing the operative experience of general surgery residents, developing electronic tools and simulations to improve learning, and strategies to attract residents to general surgical careers.

Tuesday, April 24

8:00–9:30 am
Options for Open Operative Management of Inguinal Hernias (GS17)
MODERATOR: Parviz Amid, MD, FACS, Los Angeles, CA

The most frequently performed operations within the scope of this topic are as follows: (1) Pure tissue repairs such as Bassini and Shouldice; and (2) mesh repairs, including mesh in front of the transversalis fascia (Lichtenstein repair), mesh behind the transversalis fascia (Kugel repair), and mesh both in front and behind the transversalis fascia. In addition, there is a current multicenter study in Europe for using glue (fibrin glue) instead of sutures for mesh fixation.

Presentations of these operations by an expert in each procedure with special attention to postherniorrhaphy, chronic pain, and the concept of watchful waiting, followed by randomized control trials, will be given.

8:00–9:30 am
New Technology in Laparoscopy, Including Robotics (GS18)
MODERATOR: Richard M. Satava, MD, FACS, Seattle, WA

New instrumentation in laparoscopy, next-generation robots, and other very advanced technologies are rapidly emerging onto the clinical surgical arena. This session looks at these technologies to help practicing surgeons in the following ways: (1) Identify technologies (procedures and instruments) that can soon be implemented into their clinical practice; (2) understand the fundamental principles behind the new technologies and how these principles will change their practice even outside of the operating room (such as shorter stay, more efficiency, and so on); and (3) get a glimpse of some very advanced technologies (such as femtosecond lasers or tissue engineering) that may replace their current surgical procedures or open opportunities in completely new directions for their practice.

9:30–11:00 am
Alternatives to Blood Transfusion (GS19)
MODERATOR: Walter L. Biffl, MD, FACS, Providence, RI

This session will review the adverse immunomodulatory consequences of blood transfusion. Alternatives to blood transfusion will be discussed, including the following: (1) Perioperative strategies, such as preoperative autologous blood donation, intraoperative strategies to reduce blood loss, and postoperative strategies to avoid anemia; (2) current practices and transfusion alternatives in the critically ill, including restrictive transfusion strategies and erythropoietin; and (3) the current status and future of blood substitutes.

9:30–11:00 am
Current Options for Angioaccess in Patients Requiring Hemodialysis (GS20)
MODERATOR: A. Frederick Schild, MD, FACS, Miami, FL

This session will consist of a panel of nationally known experts on vascular access surgery. The topics will include the newest techniques and technologies for creation of vascular access, complications and how to prevent them, the benefits of primary autologous fistulae versus nonautologous fistulae, and how to evaluate the end-stage renal patient as to the best site and type of access to create. There will be adequate time for questions at the end of the presentations.

9:30–11:30 am
Multidisciplinary Tumor Conference: Challenging Gastrointestinal Cases (GS21)
MODERATOR: Frederick L. Greene, MD, FACS, Charlotte, NC

This interactive session will highlight four cases presented by surgeon members of the panel. Each individual representing a discipline will discuss his or her opinion regarding case management. The discussion will then be turned over to the audience. They will be given options for case management and select the one they would most likely use. The results will be discussed
among audience and panel members. Sponsored by the Commission on Cancer.

1:00–2:30 pm
Everything You Wanted to Know about GIST (GS22)
MODERATOR: Fabrizio Michelassi, MD, FACS, New York, NY

Over the last decade, the incidence of gastrointestinal stromal tumors (GISTs) has increased substantially because of increased awareness and recognition. GISTs are now considered the most common sarcoma of the gastrointestinal tract and account for approximately 5 percent of all small bowel malignancies. This session will focus on diagnosis, imaging, treatment, and appropriate follow-up of GISTs. The use of imatinib mesylate, a specific tyrosine kinase inhibitor, will be discussed with specific reference to the two ongoing American College of Surgeons Oncology Group intergroup North American studies.

1:00–2:30 pm
Management of Common Postoperative Complications (GS23)
MODERATOR: Joseph B. Cofer, MD, FACS, Chattanooga, TN

During this session, there will be a number of presentations regarding common postoperative complications. We will specifically discuss such issues as postoperative pulmonary complications, respiratory failure, acute renal insufficiency, postoperative infections, sepsis, and postoperative fever. We will also discuss wound complications, deep venous thrombosis, perioperative myocardial infarction, and pulmonary embolus. Finally, we will discuss specific complications common to such routine procedures as cholecystectomy, colectomy, mastectomy, and hernia repair. The session will end with an open discussion.

1:00–3:00 pm
American Surgical History for the Practicing Surgeon (GS24)
MODERATOR: Thomas H. Cogbill, MD, FACS, La Crosse, WI

Attendees can expect to learn more about their surgical heritage, with a focus on innovative American surgeons.

2:30–4:00 pm
Injuries to the Bile Ducts (GS25)
MODERATOR: Henry A. Pitt, MD, FACS, Indianapolis, IN

This session will review the multidisciplinary management of patients with injuries to the bile ducts. Four presentations by nationally recognized experts in surgery, interventional radiology, and therapeutic endoscopy will provide attendees with the following information: (1) Keys to prevention, identification of “high-risk” patients, how these patients present, and how to classify injuries; (2) management of bilomas, bile ascites, and anastomotic strictures and outcomes of percutaneous management; (3) management of cystic duct leaks, injuries after liver transplantation, and injuries with “intact” ducts and outcomes of endoscopic management; and (4) management of injuries discovered intraoperatively, reconstruction of “disconnected” ducts, and short-term and long-term outcomes of surgical management.

2:30–4:00 pm
Management of Chronic Ulcerative Lesions of the Lower Extremities (GS26)
MODERATOR: Peter Gloviczki, MD, FACS, Rochester, MN

This session focuses on recognizing the possible etiologies of chronic ulcerative lesions of the lower extremities as well as preventive measures that can be applied in high-risk patients. Advances in management such as use of topical hydrophilic agents, the current role of hyperbaric oxygen therapy, and directed surgical therapy will be discussed, as well.

3:30–5:00 pm
Diagnosis and Management of Uncommon Pancreatic Neoplasms (GS27)
MODERATOR: Juan M. Sarmiento, MD, FACS, Atlanta, GA

At the end of the session, participants will be expected to be able to do the following: (1) Differentiate by imaging the conditions, solid and/or cystic, mimicking pancreatic adenocarcinoma; (2) suspect the existence of malignancy in benign-appearing lesions of the pancreas; (3) understand the physiopathology of the mechanisms leading to formation of pancreatic masses other than adenocarcinoma; (4) define a protocol for the work-up of these patients and recognize the value of each diagnostic intervention; (5) have the basic knowledge to delineate a plan of treatment for patients with uncommon pancreatic neoplasms and to define a surgical strategy, if indicated; (6) evaluate objectively the role of surgery in the treatment of metastatic disease from rare pancreatic tumors; and (7) understand the effect of adjuvant therapy on the management and long-term survival of these patients.
3:00–4:30 pm

**Management of Skin Neoplasms for the General Surgeon (GS28)**

**Moderator:** Marshall M. Urist, MD, FACS, Birmingham, AL

Attendees of this session will learn the current methods for diagnosis, assessment, and management of the three common types of skin cancers (squamous cell, basal cell, and melanoma) and more unusual histological varieties that are encountered by general surgeons.

**Wednesday, April 25**

8:00–9:30 am

**Management of Chronic Pancreatitis (GS29)**

**Moderator:** David B. Adams, MD, FACS, Charleston, SC

Attendees of this session can expect to learn current principles in the surgical management of chronic pancreatitis, including the following: (1) An understanding of the pathogenesis of chronic pancreatitis; (2) indications, operative risks, and outcomes in surgical management of chronic pancreatitis; (3) the role of resection and drainage procedures in the management of dilated and nondilated duct chronic pancreatitis; (4) use of the Puestow, Frey, Whipple, Longmire, and Beger procedures in the management of chronic pancreatitis; and (5) employment of major and minor duct sphincterplasty in the management of chronic pancreatitis associated with sphincter of Oddi dysfunction and pancreas divisum. The emerging role of total pancreatostomy with auto-islet transplantation in the management of chronic pancreatitis will also be discussed.

8:00–9:30 am

**Update on Nonoperative Approaches to Blunt Abdominal Trauma (GS30)**

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

The objective of this session is to review the current status of nonoperative management of blunt abdominal trauma. We will discuss the indications and risks of nonoperative management in general, as well as for specific organ injuries.

9:30–11:00 am

**Current Diagnosis and Management of Deep Venous Thrombosis (GS31)**

**Moderator:** John T. Owings, MD, FACS, Sacramento, CA

Attendees will be provided with current standard of prophylaxis against both DVT and pulmonary embolism and the current state of the art of pulmonary embolism. Attendees will also be given information regarding treatment options of DVT and pulmonary embolism and will include inpatient and outpatient therapies.

**Video-Based Education**

**Monday, April 23**

2:30–5:00 pm

**Highlights from the 2006 Clinical Congress Video-Based Education Sessions (VE01)**

**Moderator:** Horacio J. Ashun, MD, FACS, Pleasant Hill, CA

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 2006 Clinical Congress.
Spring Meeting Program at a glance

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

Sunday

Fundamentals of Laparoscopy Postgraduate Course
9:45 am–5:15 pm

GS01
ACS/SAGES 2007 Assembly: Foregut Symposium
1:00–5:00 pm

GS02
Establishing a Skills Program: What You Need to Know
1:00–5:00 pm

GS03
Management of Benign Breast Disease
1:30–3:00 pm

GS04
Options for Ventilator Support in Severe ARDS
3:15–4:45 pm

Monday

GS05
Surgeons As Interventionalists
8:00–9:30 am

GS06
Thoracic Trauma for the General Surgeon
8:00–9:30 am

GS07
Clinical Abstract Presentations by Residents
8:00–9:30 am

GS08
Management of Unexpected Findings at Laparotomy
9:30–11:00 am

GS09
How Do I Stay Certified As a Surgeon?
9:30–11:00 am

GS10
Spectacular Cases from Residents
9:30–11:00 am

GS11
Excelsior Surgical Society/Edward D. Churchill Lecture
11:15 am–12:15 pm

GS12
Laparoscopy in Trauma
1:30–3:00 pm

GS13
Town Forum Discussion on the Future of General Surgery
1:30–3:30 pm

GS14
Surgical Jeopardy
1:30–4:00 pm

GS15
How to Free Yourself from Insurance and Practice Surgery
2:00–5:00 pm

VE01
Highlights from the 2006 Clinical Congress Video-Based Education Sessions
2:30–5:00 pm

GS16
New Trends in the Training of General Surgery Residents
4:00–5:30 pm

Tuesday

GS17
Options for Open Operative Management of Inguinal Hernias
8:00–9:30 am

GS18
New Technology in Laparoscopy, Including Robotics
8:00–9:30 am
GS19
Alternatives to Blood Transfusion
9:30–11:00 am

GS20
Current Options for Angioaccess in Patients
Requiring Hemodialysis
9:30–11:00 am

GS21
Multidisciplinary Tumor Conference: Challenging Gastrointestinal Cases
9:30–11:30 am

GS22
Everything You Wanted to Know about GIST
1:00–2:30 pm

GS23
Management of Common Postoperative Complications
1:00–2:30 pm

GS24
American Surgical History for the Practicing Surgeon
1:00–3:00 pm

GS25
Injuries to the Bile Ducts
2:30–4:00 pm

GS26
Management of Chronic Ulcerative Lesions of the Lower Extremities
2:30–4:00 pm

GS27
Diagnosis and Management of Uncommon Pancreatic Neoplasms
3:30–5:00 pm

GS28
Management of Skin Neoplasms for the General Surgeon
3:00–4:30 pm

Wednesday

GS29
Management of Chronic Pancreatitis
8:00–9:30 am

GS30
Update on Nonoperative Approaches to Blunt Abdominal Trauma
8:00–9:30 am

GS31
Current Diagnosis and Management of Deep Venous Thrombosis
9:30–11:00 am
Registration information

Registration for the 2007 Spring Meeting will open this month. Please visit www.facs.org for more information as it becomes available.

Registration location and hours

Registration will be held at the Paris Las Vegas Hotel.

Sunday, April 22 ...................... 11:00 am–5:00 pm
Monday, April 23 ...................... 7:30 am–5:00 pm
Tuesday, April 24 ..................... 7:30 am–5:00 pm
Wednesday, April 25 ............... 7:30 am–11:00 am

Registration fees

Registration fees for the 2007 Spring Meeting will be available this month. 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 it did 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: 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.

Exhibit hours will be available in January. Please visit www.facs.org for more information as it becomes available.

Children

Children younger than 16 years of age may not participate as a social guest. Young adults aged 16 and older must be registered as guests and pay the registration fee to participate in Spring Meeting activities.

If child care arrangements are needed, the Paris Las Vegas Hotel recommends the following independent business that provides babysitting/nanny services within the community:

Nannies & Housekeepers U.S.A.
3585 E. Flamingo Rd., Ste. 204
Las Vegas, NV 89121
Phone: 702/451-0021 (Contact: Rita)
http://www.nahusa.com/index.htm

Nannies & Housekeepers U.S.A. requests a minimum notice of four hours for booking a nanny, with a four-hour minimum requirement and a four-hour cancellation policy. All of their nannies must be at least 18 years of age with a minimum of one year of experience with verifiable references. Every nanny is meticulously screened (Social Security check, drug test, criminal check) and must have current certification in cardiopulmonary resuscitation and first aid.

Accreditation

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

CME credit

The American College of Surgeons designates this educational activity for a maximum of 23 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Compact discs

Selected general sessions will be recorded live and will be available for purchase on compact disc. Additional information will be available at the National Audio Video booth on site at the meeting.

Postgraduate Course Syllabi on CD-ROM

A CD-ROM containing select postgraduate course syllabi from the 2006 Clinical Congress will be available for purchase at the Spring Meeting.

Meeting location and accommodations

Experience the passion, excitement, and sophistication of the City of Light while visiting the entertainment capital of the world. The meeting will be held at the Paris Las Vegas Hotel, located 10 minutes away from McCarran International Airport and in the heart of the famous Las Vegas strip. In addition to being a premier meeting facility, the hotel features spacious guestrooms, custom European furniture, and luxurious marble bathrooms. At the end of the day, relax in the Paris Las Vegas’ two-acre rooftop pool, or pamper yourself in the 26,000 square-foot Spa by Mandara. And what would a trip to Paris be without experiencing a true culinary excursion in one of the hotel’s 10 restaurants.

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

Paris Las Vegas
3655 Las Vegas Blvd. South
Las Vegas, NV 89109
Reservations: 888/266-5687
Hotel main: 702/946-7000
Fax: 702/946-4405
ACS group rate: $162 single/double, plus tax

Reservations made after the housing deadline of March 30 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 two weeks before your scheduled arrival date.

Transportation
ACS has arranged special meeting discounts on United Airlines. These special discounts are available by booking with United 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 number to obtain the special fares.

Area/zone fares based on geographic location are also available with no Saturday night stay required:

Minimum stay (two nights) and a seven-day advance purchase required. (Zone fares are not available through online ticket purchase; please call United Airlines.)

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

Purchase your ticket online at www.united.com and receive a 10 percent discount off the lowest applicable fares.

Car rental
Avis is designated as the official car rental company for the 2007 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
ACS seeking nominations for the Board of Regents

The 2007 Nominating Committee of the Board of Governors has the task of selecting a nominee for a pending vacancy on the Board of Regents to be filled during the 2007 Clinical Congress in New Orleans, LA. The following criteria are used by the Nominating Committee when reviewing candidates for potential nomination to the Board of Regents.

• 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
• Geographic location, surgical specialty balance, and academic or community practice

The College encourages consideration of women and other underrepresented minorities. Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents.

The surgical specialty that should be given priority consideration for this nomination is urological surgery.

Nominations should include a paragraph or two on 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 February 28.

If you have any questions, please contact Patricia Sprechsel, Staff Liaison for the Nominating Committee of the Board of Governors, at 312/202-5360 or psprecksel@facs.org.

Seeking nominations for ACS Officers-Elect

The 2007 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons: President-Elect, First Vice-President-Elect, and Second Vice-President-Elect.

The following criteria are used by the Nominating Committee when reviewing the potential candidates for nomination as officers of the College.

• 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

The College encourages consideration of women and other underrepresented minorities for officer positions.

Nominations should include a paragraph or two on 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 February 28.

If you have any questions, please contact Patricia Sprechsel, Staff Liaison for the Nominating Committee of the Fellows, at 312/202-5360 or psprecksel@facs.org.
2007 International Guest Scholars selected

During the 92nd annual Clinical Congress in Chicago, IL, the Board of Regents awarded 10 International Guest Scholarships for 2007.

This program, administered by the College’s International Relations Committee, enables talented young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress, then make tours of surgical institutions in North America, tailored to their interests.

The 2007 International Guest Scholars are as follows: Marcelo Alberto Beltran, MD, Ovalle, Chile; Kwok-Leung Cheung, MBBS, FACS, Nottingham, England; Luis Mariano Ferreira, MD, Buenos Aires, Argentina; Jonathan Golledge, MB, BChir, MChir, FRACS, Townville, Australia; Marc L. Guifo, MD, Yaounde, Cameroon; Maarit Anita Heikkinen, MD, Tampere, Finland (Abdol Islami Scholar); Alexander Julianov, MD, Stara Zagora, Bulgaria; Reginald V.N. Lord, MBBS, FRACS, Darlinghurst, Australia; Rina Maria Pereira Porta, MD, Sao Paolo, Brazil; and Taejin Song, MD, FACS, Ansan City, South Korea.


2007 ACS Japan Traveling Fellow selected

Luis A. Fernandez, MD, FACS—assistant professor in the division of organ transplantation at the University of Wisconsin Medical School in Madison—has been selected as the 2007 ACS Japan Traveling Fellow. As the Japan Traveling Fellow, Dr. Fernandez will participate in the annual meeting of the Japan Surgical Society in Osaka, Japan, April 11–13. He will attend the ACS Japan Chapter meeting during that event and will travel to several surgical centers in Japan.

Dr. Fernandez’s expertise is in living donor liver transplantation and its clinical, ethical, and cultural implications. He also has received an NIH award to perform research on islet transplantation.

Requirements for the 2008 Traveling Fellowship will be published in a future edition of the Bulletin. They will also be posted on the College’s Web site, at http://www.facs.org/member-services/research.html.

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, Critical Care, & Acute Care Surgery—2007, March 26–28, 2007, Las Vegas, NV.
- Trauma, Critical Care, & Acute Care Surgery 2007—Point/Counterpoint XXVI, June 4-6, 2007, Atlantic City, NJ.

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.
The American College of Surgeons, in association with the Pfizer Medical Humanities Initiative (PMHI), is seeking nominations for the 2007 Surgical Volunteerism Award. This award honors ACS Fellows who are making a significant contribution to surgical care through volunteer actions. For the purpose of this award, volunteer efforts fall outside the usual work environment, through periodically donated clinical or educational surgical activity without compensation. Candidates for this award may practice their surgical volunteerism either in a domestic, international, or military setting. All surgical subspecialties are eligible for consideration.

A nomination form and a brief narrative (limited to 500 words in English) are required. The narrative should detail the nature of your nominee’s volunteer outreach with particular attention to the following criteria:

- **Altruism:** Provide insight into the nominee’s motivation for engaging in such volunteer activities, along with pertinent examples of his or her humanitarianism, where appropriate
- **Impact:** Elaborate on the impact of the volunteer’s efforts on the community served, specifying, when possible, the frequency and length of service and number of people affected
- **Influence:** Detail the tangible and sustainable results of the nominee’s volunteer efforts, with attention to positive influence on colleagues or residents, facilities or programs established as a result of the nominee’s efforts, and quality of care issues.

Nominations will be evaluated by the Socioeconomic Issues Committee of the Board of Governors, with final approval of award winners by the Executive Committee of the Board of Governors.

Please note the following considerations:

- Supplemental materials should be kept to a minimum
- Self-nominations are permissible but require an outside letter of support
- Previous nominations can be resubmitted with an updated application

The nomination form is posted on the Operation Giving Back Web site at [www.operationgivingback.facs.org](http://www.operationgivingback.facs.org). The deadline for receiving nominations is **February 28**.

Please send the nomination and narrative to Kathleen M. Casey, MD, FACS, Director, Operation Giving Back, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611; kcasey@facs.org; fax: 312/202-5021.
The American College of Surgeons Division of Education welcomes submissions to be considered for presentation at the 93rd annual Clinical Congress to be held October 7–11, 2007, in New Orleans, LA.

Please visit the ACS Web site at www.facs.org for abstract specifications and requirements. Note the following submission guidelines:

- Only online submissions will be accepted
- Submission period ends **March 1**
- Late submissions are not permitted
- Duplicate submissions (one abstract submitted to more than one program) are not permitted

Types of presentations and program coordinator contact information are as follows:

**Oral presentations**
- Surgical Forum
  *Program Coordinator:* Kathryn Koenig-Matousek, 312/202-5336, kkoenig@facs.org
- Papers Session
  *Program Coordinator:* Beth Cherry, 312/202-5325, echerry@facs.org

**Poster presentation**
Scientific Exhibits
  *Program Coordinator:* Mary Kate Colbert, 312/202-5385, mcolbert@facs.org

**Video**
Video-Based Education
  *Program Coordinator:* GayLynn Dykman, 312/202-5262, gdykman@facs.org

For additional information, please contact Linda Stewart at lstewart@facs.org, or tel. 312/202-5354.
ACSPA-SurgeonsPAC

From December 1, 2005, to August 31, 2006, the ACSPA-SurgeonsPAC (http://www.facs.org/acspa/index.html) had raised $84,512. The telephone fundraising campaign also remains productive.

Of the 216 U.S. members of the Board of Governors, 109 (50%) have contributed to the PAC. The names of all leaders who contributed to the PAC, and those who donated $1,000 or more in 2006 were listed at the PAC booth during the Clinical Congress.

Contributions were made to 131 candidates, leadership PACs, and party committees for the November 2006 mid-term elections, when all representatives and one-third of senators were up for reelection. ACSPA-SurgeonsPAC plans to continue its focus on candidates who advocate for health care issues and support issues of importance to surgical practice today, including Medicare physician payment and medical liability reform.

American College of Surgeons

ACS Foundation

On September 1, 2005, the Internal Revenue Service approved a tax-exempt status for the ACS Foundation (http://www.facs.org/acsfoundation). From September 1, 2005, through August 31, 2006, the Foundation received a total of $1,181,622 in cash gifts and new pledges.

Members of the Fellows Leadership Society (FLS) attended the FLS luncheon at the Clinical Congress in Chicago, IL, where Dr. and Mrs. Maurice J. Jurkiewicz, FACS, received the 2006 Distinguished Philanthropist Award. In addition, 24 new Life Members were recognized.

Surgeons Diversified Investment Fund

The ACS has launched a new mutual fund, called the Surgeons Diversified Investment Fund (SDIF). SDIF (http://www.surgeonsfund.com) is a diversified mutual fund created expressly as a benefit by the College
for its members, their families, employees, and affiliate groups. The College has spent the past two years developing and refining this investment concept. SDIF seeks to provide long-term capital appreciation and income through the fundamental investing principles—asset allocation, diversification, and rebalancing—that are believed to be the necessary ingredients for a successful investment program and that are used by the College’s endowment fund.

The College has developed SDIF because it realizes that its members are facing new and complex financial challenges. The College believes that the principles employed in managing its endowment funds are the same principles that its members need assistance with when managing their own funds. For more information about SDIF, please contact Savi Pai, President, SDIF, at 800/208-6070 or 312/202-5056, or e-mail spai@facs.org.

**Operation Giving Back (OGB)**

The Board of Regents approved an updated business plan for OGB. OGB was formed in 2004 as a surgical volunteer initiative for members of the College. It is dedicated to facilitating surgical involvement in volunteerism among all surgical specialties, at all stages of the profession, with an equal emphasis on domestic and international service. In the two years since its inception, OGB has evolved from a promising concept into a vibrant ACS program fostering collaboration between surgeons, volunteer agencies, and specialty societies.

The sustained level of interest in OGB positions it and the ACS to be catalysts in the effort to address the needs of the underserved and uninsured in the U.S. and internationally. With the approval of the updated business plan, OGB has received permission to operate for another year.

The following information provides an update on OGB activities over the past year.

- September 1, 2006, marked the first anniversary since OGB’s Web site went live, and in that time, it has consistently received more than 100,000 hits each month from visitors from 93 countries as well as inquiries from surgeons of all specialties, surgical residents, medical students, surgical nurses, and physician assistants.
- OGB has partnered with more than 65 organizations and is in the active process of partnering with an additional 23 agencies.
- ACS/OGB lent support to the Robert Wood Johnson Foundation’s campaigns—Covering Kids and Families and Cover the Uninsured—which addressed medical coverage for the uninsured; OGB served as a visible partner in both campaigns.
- OGB has provided information on ways to contribute to the ongoing needs of the Gulf Coast hurricane victims on its Web site.
- OGB is working with the College’s state advocacy staff to create a database of issues relevant to volunteerism in each state.
- OGB has initiated the process of exploring possible collaboration with the College’s cancer program on cancer care outreach within the U.S. and its territories.
- Kathleen Casey, MD, FACS, OGB Director, participated in the Leadership Program in Health Policy and Management at Brandeis University. Course topics relevant to advancing the OGB program included sessions on national health economics and policy. Continued engagement with fellow attendees and Brandeis faculty for networking purposes is ongoing.
- Two resident presentations were made at the well-attended general session on volunteerism held during the Clinical Congress. The continued high level of interest of ACS members in volunteering galvanizes efforts to find and/or create additional avenues and mechanisms of humanitarian outreach.
- A volunteerism networking reception was held during the Clinical Congress to provide a forum for collegial exchange of ideas among ACS members and other Clinical Congress attendees involved in supporting surgical volunteering efforts.

For more information about Operation Giv-
ing Back, please visit the OGB Web site at http://www.operationgivingback.facs.org.

Web portal
New content and resources are continually added to the College’s Web portal. George F. Sheldon, MD, FACS, Editor-in-Chief, has been developing the portal’s editorial board. In addition, the following enhancements have been made:

• New PubMed portlets were added to the Communities & Specialties area.
• Community introductions were moved to separate pages, providing quicker access to resources on each community’s homepage.
• New links to all discussion forums were added to each community to facilitate collaboration among peers.
• New headings were added to each of the Community and Specialty areas to enhance organization of content and provide faster searchability.
• Audio and videos were highlighted in color to make them easier to locate.

Portal staff members have been working closely with other divisions of the College to expand the portal’s usefulness. Staff of the Division of Member Services developed a complimentary, 30-day trial membership feature, which provides access to e-FACS.org to interested surgeons, physicians in surgical clerkships, members of the surgical team, and medical students. For more information, visit http://www.facs.org/memberservices/trialmembership.html.

Media activity and the IOM report
Results were presented on the media outreach activities that had been undertaken in an effort to leverage the June 14 release of the Institute of Medicine (IOM) reports on emergency and trauma care in order to build awareness and support for key ACS messages. The key messages were as follows:

• Access to high-quality trauma system care is the best hope for anyone who is seriously injured or experiencing a life-threatening illness.
• A growing surgeon/specialist shortage puts patients at risk.
• Trauma systems are geographically arbitrary and inequitable across the U.S.
• Our health care system and problems with reimbursement and liability issues discourage surgeon participation in trauma centers and emergency department coverage.

The results of media placement efforts featuring interviews with Thomas R. Russell, MD, FACS, ACS Executive Director, as the ACS spokesperson and focusing on the College’s key messages were as follows:

• Television: 12 broadcasts on eight stations
• Radio: 43 broadcasts/feeds
• Print: Coverage with ACS core messages, more than 17 million impressions; coverage with the surgeon/specialist message, more than 33 million impressions

Efforts were undertaken to do targeted local media outreach in conjunction with IOM workshops that were scheduled during the rest of 2006. The workshops focused on the findings and recommendations within the reports. For more information, visit http://www.facs.org/news/emergcarecrisis.html.

Committee on Trauma (COT)
The COT Subcommittee on Injury Prevention and Control has completed a grant-supported effort to develop materials on alcohol screening and referral that can be used by hospitals. This work was a cooperative effort with the National Highway Traffic Safety Administration, the National Institute on Alcohol Abuse and Alcoholism, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention (CDC). Following approval by the federal partners, the materials will be offered to hospitals. In addition, a series of training programs is being planned to train the medical personnel who will perform the screening and intervention of patients.

The Rural Trauma Committee continues to beta test the Rural Trauma Team Development Course. This course will be key in
improving trauma care in rural areas and developing rural trauma systems in the U.S. In addition, a study has been designed to show the effectiveness of this course.

The Subcommittee on Disaster and Mass Casualty Management has initiated a grant-sponsored project to determine the lessons learned from surgical experiences in Iran and Afghanistan. A series of meetings and conference calls is planned and will include COT surgeons who have served in Iran and Afghanistan. This project is funded by the CDC.

For more information on all of the ACS Trauma programs, please visit http://www.facs.org/trauma/index.html.

**Update on advocacy efforts**

ACS Advocacy and Health Policy activities in 2007 will be directed toward increasing public and policymaker awareness of the contributions made by surgeons to patient care and quality improvement and the unique stresses confronting the profession. New programs will be piloted in an effort to improve grassroots participation by surgeons in the policymaking process. The College will resume publication of *Socioeconomic Factbook*, issue a new edition of *Physicians as Assistants at Surgery*, progress toward establishing an ACS Institute for Health Policy Research, and create a new electronic advocacy newsletter. Issues that the College focused on in 2006 (and will likely continue in 2007) included medical liability reform, provider taxes, non-physician scope of practice, trauma system funding and development, and regulation of office-based surgery.

In late July, Dr. Russell and Frank Opelka, MD, FACS, met with Mark B. McClellan, MD, PhD, then the Administrator of the Centers for Medicare & Medicaid Services (CMS), to discuss how systems for quality improvement in surgical care must differ from current systems that focus mainly on office-based primary care and chronic disease management. The team-centered approach was discussed in detail, and Dr. McClellan encouraged the College to submit a proposal to test the ACS NSQIP as a quality improvement tool that can be used in an incentive-based payment system.

In June, CMS released its proposed rule for the five-year review of physician work values in the Medicare fee schedule, as well as a new methodology for determining practice expense payments. The College submitted comments on August 21.

On July 27, Dr. Opelka testified on behalf of the College at a House Energy and Commerce Health Subcommittee hearing, urging Congress to take action to prevent the pending Medicare payment cut scheduled to take effect January 1 and outlining how current reimbursement policies are having a detrimental effect on surgical practices and service lines. Dr. Opelka updated subcommittee members on the College’s efforts to develop quality measures for potential use in a pay-for-performance (P4P) program. He also noted that because of the unique nature of surgery, a P4P system designed for hospitals or primary care physicians may not be applicable to surgery. In addition, Dr. Opelka outlined a proposal calling for repeal of the flawed sustainable growth rate in the formula used to determine Medicare payment and replacing it with the service category growth rate proposed by the ACS and the American Osteopathic Association.

In April, CMS released a proposed rule calling for major refinement to the diagnostic related groups (DRGs) used to determine hospital payment. In general, the changes will decrease hospital payment for surgical DRGs and increase payment for medical DRGs; in addition, the rule called for changes to indirect medical education payments, and the inclusion of surgical infection prevention as a hospital quality measure. The College submitted comments in June, questioning CMS’ methodology and calling for a phase-in of the changes.

Earlier in the year, CMS announced a new audit program, Medically Unbelievable Edits (MUE), which compares to a predetermined number the actual number of times that a
procedure is performed on the same patient by the same physician in a single day. The originally lengthy list of MUEs was pared down significantly after receiving outside comments. CMS accepted all of the College’s recommended changes. The list of edits became effective January 1.

There are new proposed Correct Coding Initiative edits, based on Current Procedural Terminology coding changes that, at press time, were scheduled for January 1. The American Medical Association (AMA) and other national medical and surgical specialty societies were provided with a list of these edits and offered an opportunity to comment on them before implementation. The edits of concern to surgery were reviewed by members of the College’s General Surgery Coding and Reimbursement Committee (GSCRC). Staff sent a formal response to the AMA.

The College is participating in a new multispecialty practice expense survey. The data collected will help value surgical practice expense relative value units (RVUs). The GSCRC is currently editing the survey instrument developed by the AMA to ensure that all practice costs incurred by surgeons are adequately accounted for. After the survey is completed, it will be sent to physicians, most likely in the spring of 2007. After the data are analyzed in 2008, they can be used to set practice expense RVUs in the 2009 Medicare physician fee schedule. The GSCRC will play a vital role in developing the survey instrument, analyzing the data, and implementing the new values.

For the second year in a row, Pres. George W. Bush proposed terminating the Emergency Medical Services for Children (EMSC) program. Again, advocates including the College vigorously defended the EMSC program against elimination and submitted a letter to the House and Senate Appropriations Committees requesting $25 million for the program in fiscal year (FY) 2007. The House committee voted to restore EMSC funding to $19.8 million for FY 2007, and the Senate committee voted to approve funding at $20 million. Final work on these bills was expected to be completed in a lame duck congressional session after the elections.

In July, the Senate Health, Education, and Pensions Committee approved the Pandemic and All-Hazards Preparedness Act (S.3678). The legislation reauthorizes the 2002 Public Health Security and Bioterrorism Response Act, which focused on bioterrorism preparedness. The College pressed to ensure that trauma systems were recognized in the bill. As a result, trauma systems are included as part of the nation’s preparedness goals under the bill and the reauthorized hospital preparedness grant program requires eligible grantees to form partnerships that include at least one hospital that is a designated trauma center.

The College sent a letter of support of the Health Partnership Act that was introduced in May. This legislation would authorize grants to states, regional entities, and others to pursue innovative strategies to increase health insurance coverage, ensure patients receive high-quality and appropriate care, improve the efficiency of health spending, and use information technology to improve infrastructure.

One Voice Against Cancer (of which the College is an active member) supported an amendment to the Senate’s final budget resolution that successfully added $7 billion for the health and education programs that contain funding for cancer initiatives. The College used its Federal Legislative Action Center to focus grassroots activity on convincing House members to follow the Senate’s lead as funding levels were determined for cancer programs and research.

President Bush appointed John E. Niederhuber, MD, FACS, to serve as the 13th Director of the National Cancer Institute (NCI). Dr. Niederhuber has been a professor, cancer center director, National Cancer Advisory Board chair, external advisor to NCI, grant reviewer, and laboratory investigator supported by NCI and NIH. He is also a former chair of the College’s Commission on Cancer Executive Committee.
The College’s Patient Safety and Professional Liability Committee (PSPLC) devoted considerable attention to the results of its Closed Claims Study and plans to conduct educational efforts based on the results of the pilot. Other PSPLC activities include the following:

- The committee continues to monitor the development of regulations that will implement a federal mandate and allow private sector, not-for-profit entities to establish patient safety organizations.

- On the committee’s recommendation, the College submitted comments in opposition of a proposal by the Health Resources and Services Administration to include adverse actions taken by peer review organizations and accrediting agencies as reportable events.

In August 2006, the College participated in a coalition exhibit at the National Conference of State Legislatures annual meeting. The exhibit, Physicians Advocating for Patients, provides a strong presence for the medical profession in reaching out to state legislators and their staff.

The ACS Coding Hotline continues to receive calls. The availability of this free hotline service for the Fellows has been highlighted at all of the ACS coding workshops and in a number of issues of ACS NewsScope. The hotline averages approximately 500 calls a month from Fellows and their office staff.

ACS Coding Today, a Web-based coding tool endorsed by the College, has undergone a major redesign in response to comments received from Fellows and other users. Plans are also under way to incorporate ACS-developed coding tips and information, including Physicians as Assistants at Surgery, into the tool so that it serves as a more complete resource for surgeons and their office staff.

The annual meeting of the AMA House of Delegates (HOD) was held in June. During the meeting, a resolution authored by the College and cosponsored by a number of surgical specialty societies was referred for consideration by the AMA Council on Medical Education in the context of the AMA’s Initiative to Transform Medical Education. The resolution called for supporting the transition from medical student to resident through the development of a disease-based prerequisite curriculum that focuses on a multidisciplinary style of medical practice.

Separately, a report from the Council addressed the impact of increasing specialization and declining generalism, which generated considerable debate. Testimony from the College and others expressed concern that the term “generalist physicians” might be interpreted in a way that would allow the AMA to pursue policies to improve reimbursement only for primary care physicians. Ultimately, the recommendation approved on the HOD floor did not address the specialties’ concerns. The issue will likely be addressed again.

The AMA’s Council on Ethical and Judicial Affairs (CEJA) presented a report detailing ethical obligations of physicians when working with manufacturer representatives. The report was returned to CEJA for additional work. The Reference Committee noted the College’s statement on this subject and suggested that it be widely disseminated and used by CEJA.

Several ACS Fellows were elected to AMA offices: William G. Plested III, MD, FACS, was inducted as President; Peter W. Carmel, MD, FACS, was reelected to the Board of Trustees; Charles J. Hickey, MD, FACS, was elected to the Council on Constitution and Bylaws; Lee R. Morisy, MD, FACS, was elected to the Council on Science and Public Health; and Patricia L. Turner, MD, FACS, the College’s delegate to the AMA Young Physicians Section, was elected by the Section to be its Alternate Delegate to the HOD.

For further information on advocacy efforts, please visit the College’s Advocacy Web page at http://www.facs.org/ahp/index.html.

Establishment of a patient safety committee

The Board of Regents approved a request to restructure the current Committee on Patient Safety and Professional Liability and replace
it with a new Committee on Patient Safety and Quality Improvement. The legislative and regulatory efforts pertaining to medical liability reform fall naturally within the stated purpose of the Health Policy Steering Committee. In addition, the Health Policy Steering Committee will consider establishing a separate Task Force on Professional Liability.

The new Committee on Patient Safety and Quality Improvement will be responsible for supporting the College’s involvement in the National Quality Forum, the Physicians Consortium for Performance Improvement, the National Committee on Quality Assurance, the AQA, and Hospital Quality Alliance, as well as related panels involved in the development and implementation of performance measures for surgeons and other providers. The new committee will also advise the College on issues related to patient safety, including any future effort to establish a patient safety organization as envisioned by federal legislation passed in 2005.

National Surgical Quality Improvement Program

ACS National Surgical Quality Improvement Program (NSQIP)—a risk-adjusted, outcomes-based program to measure and improve the quality of surgical care—is available to all eligible hospitals in the U.S. that meet the minimum volume requirements, complete a hospital participation agreement, and assign staff to the program. As of September 2006, 125 hospitals were enrolled in the program, including two Canadian hospitals and one U.S. Department of Defense hospital. An additional 75 hospitals are in the application/enrollment process. For more information, visit https://acsnsqip.org/login/default.aspx.

The first annual ACS NSQIP conference was held in June. Presentations focused on best practices and how to use ACS NSQIP data to improve quality at the local level. An article about the conference appeared in the October Bulletin (Campbell DA Jr. ACS NSQIP convenes first national conference. Bull Am Coll Surg. 2006;91((10):31-34).

Staff from the program has worked with the College’s Information Technology department and the Division of Education to incorporate outcomes data from the ACS NSQIP into the ACS Case Log System. The addition will allow individual surgeons to analyze their outcomes in relation to national averages.

Update on educational offerings

Program planning for the 2007 Clinical Congress followed a new and enhanced interactive process that facilitated development of a comprehensive and well-balanced program of the highest quality. A special effort was made to solicit and select educational interventions that address maintenance of certification (MOC).

Based on information from needs assessments and advances in surgical practice and surgical education, 20 sessions from the 2006 Clinical Congress have been selected for Web casting following the meeting. The Web casts offer opportunities to earn continuing medical education (CME) credit. Web casts of sessions from Clinical Congresses 2002–2006 and Spring Meetings 2004–2006 are available or are soon to be released. These Web casts will also provide opportunities to earn online CME credit.

The 2007 Spring Meeting will be held in Las Vegas, NV, April 22–25, following the annual meeting of the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES). The program—where 32 general sessions will be held—is being planned by the Advisory Council for General Surgery in collaboration with the Division of Education. Joint programming between the ACS and SAGES will take place on Sunday, April 22. The 2007 meeting represents the last of three years of joint programming with SAGES.

The Resident and Associate Society (RAS) of the College is collaborating in the planning of the Spring Meeting’s Resident Program. Three sessions will be presented at the 2007 Spring Meeting.

For the first time, 10 sessions focusing on patient safety will be recorded and made avail-
able on CD-ROM following the 2006 Clinical Congress. These will be available as Web casts as well. Both the CD-ROMs and the Web casts of these sessions will offer opportunities to earn CME credit.

A new Web page, Technical Skills Education in Surgery: A Web-Based Resource, has been developed to provide information on contemporary teaching, learning, and assessment methods to address technical skills. Launched in July 2006, this searchable resource features critical reviews of more than 150 peer-reviewed articles from the technical skills education literature. The program should be useful to surgeons involved with development and implementation of technical skills education and to surgical residents interested in this field.

The Case Log System, which was launched in October 2005, had more than 42,000 cases entered in the database as of early September 2006. The system was conceived and designed to support practice-based learning and improvement (PBLI) and will be especially useful in steps I and IV of the PBLI cycle. The next step will involve benchmarking of each participating surgeon’s data with aggregate data from other surgeons enrolled in the program, in order to identify learning needs in step I of the PBLI cycle. Databases that are being considered for benchmarking purposes include the ACS NSQIP.

An educational primer is being developed to assist surgeons with interpretation and benchmarking of data and to provide guidance regarding the use of outcomes data in the PBLI cycle. Utility of the system beyond the PBLI function is also being discussed. A dialogue has been established with the American Board of Surgery regarding the possibility of allowing surgeons to use the system to submit cases for MOC. In addition, the College will permit use of the system for submission of cases in the Fellowship application process.

An innovative new course—Effective Teamwork to Enhance Surgical Patient Safety—that involves use of the latest simulation and immersive educational principles was developed and pilot tested in April 2006 with a small group of College leaders, a practicing surgeon, and a young surgeon. The course was extremely well received by the attendees, and planning is under way to design an interactive course that can be implemented at surgery departments across the country.

The ACS Patient Education Program was launched in December 2004 to address the pivotal role of patients within the context of systems-based practice and patient safety. An ACS patient education Web page (http://www.facs.org/patienteducation) has been designed to provide reliable patient education for a variety of resources.

The College has undertaken major steps to make educational resources available through its Web portal. The education pages went live in May 2006. The educational materials may be accessed by scrolling through the five major content areas of the Division of Education. A system has been established to help surgeons record and track their CME activities. Data from all of the College’s CME programs will be seamlessly transferred to the respective College member’s My CME Page.

For further information on education efforts, please visit the College’s Education Web page at http://www.facs.org/education/index.html.

Accreditation efforts/bariatrics

The American College of Surgeons Bariatric Surgery Center Network Accreditation Program was rolled out in May 2005. As of September 10, 2006, there were 15 fully approved and 24 provisionally approved bariatric centers. In addition, 15 hospitals were in the contract negotiation phase and a number of publications are under review by the Bariatric Advisory Committee.

Staff is in the process of developing additional marketing materials and is developing a targeted marketing plan for both inpatient and outpatient facilities. For more information, visit http://www.facs.org/cqi/bscn/index.html.
The model for the Accreditation of Education Institutes of the College was formally approved by the Board of Regents in June 2005. Following pilot testing, the program was formally launched in October 2005. In February 2006, the Board of Regents approved the two Accreditation Review Committees (surveyors) for the program. As of September 11, 2006, 30 surveyors had been trained.

At the first meeting of the Accreditation Review Committee, seven institutes were reviewed and approved for level I accreditation for three years. The accreditation process will be rolling in nature, and additional institutes will be accredited. One of the two Accreditation Review Committees will meet every six months to review applications.

**Surgery News**

The College continues to focus on providing useful and current information to Surgery News (http://www.facs.org/surgerynews/index.html) readers. Although a concerted effort is being made to put more socioeconomic content on the first pages of each issue of the newspaper and to expand that content as time goes on, the overriding philosophy behind the development of the newspaper’s content is to provide a balanced menu of scientific, socio-political, and educational information, which reader feedback indicates is ideal, and reader feedback will continue to be an important factor in editorial development.

**Journal of the American College of Surgeons (JACS)**

As of August 31, 2006, JACS (http://www.journalacs.org/home) had provided 91,368 CME credits. Many Fellows have expressed their appreciation of this CME program.

As of October 1, 2006, credit earned for one article read and two questions answered equals 1.0 CME credits (previously .50 CME credits). There will be no retroactive change in credits received through September 30, 2006. This increase is in accordance with CME credits for other journals and related items (such as Surgical Index).

**Committee on Diversity Issues**

The Committee on Diversity Issues updated its mission statement earlier this year. The committee is now drafting a Statement on Disparities. Last spring, the committee posted a diversity survey on the College’s Web site. An expanded survey has been distributed to the respondents of the preliminary survey in order to obtain more relevant data on the effect of ethnic origins in education, training, and establishing practice for surgeons. For more information, visit http://www.facs.org/about/committees/index.html#diversity.

**RAS update**

RAS activities include a survey that is in progress to aid in developing the Resident As Teacher, Leader, and Manager course, which is cosponsored by the College’s Resident Education Committee. The results of this survey will ensure that this course encompasses relevant and practical topics, and input is sought from program directors and residents.

The RAS is completing a year focused on fostering increased communications between its members and the College. The RAS eNewsletter has increased in the number of issues published and has expanded its content relevant to the issues of medical students and young surgeons. Visit http://www.facs.org/ras-acs/index.html for more information.

**Committee on Ethics**

The Committee on Ethics (http://www.facs.org/education/ethics/index.html) met in June 2006. One of the agenda items focused on Resident Members of the College. The committee members expressed an interest in adding a Resident Member to the committee and developed the following guidelines:

- The term should start when the resident is a PGY-2 or PGY-3.
- The resident should be willing to serve a three-year term in order to enhance the learning experience.
- A statement of personal interest and curriculum vita should be submitted for residents being considered.
• A letter should be submitted by the resident’s program director, stating that the resident will be given time to attend the meetings.

Committee on Young Surgeons
During the past year, the Committee on Young Surgeons focused its work on two primary educational activities: the 2006 Leadership Conference and the general sessions at Clinical Congress. The committee cosponsored a general session on marketing strategies with the RAS and anticipates possible, additional collaboration on practice-management education programs with RAS in the future. In addition, this year’s Initiates’ Program focused on time-management strategies for young surgeons. For more information, visit http://www.facs.org/memberservices/cys/index.html.

Leadership Conference 2006
The 2006 Leadership Conference was held in June 2006 at the Washington Court Hotel in Washington, DC. More than 130 chapter leaders and young surgeons attended the education program. The three-day program was divided into several segments to present various topics: contract negotiation, young surgeons’ membership needs, leadership development, ACS NSQIP, health policy and P4P, and legislative briefings. The last morning was devoted to Capitol Hill visits.

The Arthur Ellenberger Award for Excellence in State Advocacy was presented to Thomas R. Gadacz, MD, FACS, of Evans, GA. Dr. Gadacz was honored for his efforts to change his state’s certificate of need program to recognize general surgery as an individual specialty. In addition, attendees had the opportunity to hear a panel discussion on current health policy issues presented by members of Congress who are also physicians.

For more detailed information on the conference, please visit http://www.facs.org/fellows_info/bulletin/2006/collegenews0906.pdf.
A look at the Joint Commission

Improve performance with office-based surgery accreditation

Surgeons working outside the traditional hospital operating room face a unique set of challenges in the patient safety arena. The Joint Commission’s Office-Based Surgery (OBS) Accreditation Program provides these surgeons with the tools to manage the potential hazards they encounter and improve practice performance.

The OBS Accreditation Program was created in 2001, specifically as a quality oversight tool for surgical practices with four or fewer practitioners. There are approximately 300 organizations accredited under the OBS program. To search for an accredited OBS organization, visit the Joint Commission’s Quality Check Web site at www.qualitycheck.org.

Practices that should consider this accreditation option include oral/maxillofacial, pediatric, endoscopic, plastic and dermatologic surgery, urologic, and orthopaedic practices and ophthalmic surgery clinics.

The Accreditation Manual for Office-Based Surgery Practices contains standards designed to facilitate continuous operational improvement within a practice. The manual also facilitates self-assessment of the practice’s performance against the OBS standards, a customized subset of the Joint Commission’s ambulatory care standards, which maintain the integrity of the ambulatory care accreditation process and ensure the highest level of patient care and safety.

Organizations in the OBS accreditation program undergo a scheduled initial survey and thereafter are surveyed unannounced on a triennial basis. Following the initial survey, a typical on-site survey of an OBS facility lasts one day. Practices that have more than one office and still meet all of the criteria for OBS participation require a multiple-day survey. Surveyors for the OBS accreditation program are clinicians from the outpatient surgery and ambulatory care field who have specific knowledge, training, and experience in smaller surgery settings.

The OBS accreditation program uses the tracer methodology. At the beginning of the on-site survey, the surveyor selects patients from an active patient list and “traces” that patient’s experience, looking at services provided by various care providers within the organization, as well as “hand-offs” between them.

Surgical practices must meet all of the following criteria to be eligible for accreditation under the OBS standards:

• The organization or practice is composed of four or fewer licensed independent practitioners (LIPs) performing operative or invasive procedures. Multisite office-based surgery practices are also limited to a combined total of four or fewer LIPs.

• The organization or practice must be physician-owned or operated, for example, a professional services corporation, private physician office, or small group practice. “Physician” in this case includes dentist or podiatrist.

• Invasive services are provided to patients. (Practices only providing procedures such as excisions of skin lesions, moles, warts, and abscess drainage limited to the skin and subcutaneous tissue are typically not surveyed under the OBS standards.)

• Local anesthesia, minimal sedation, moderate sedation, or general anesthesia is administered. Laser eye surgery using topical anesthesia does apply.

Organizations seeking Medicare certification through the Joint Commission (deemed status surveys) must be surveyed under the Comprehensive Accreditation Manual for Ambulatory Care.

More information on the OBS accreditation program is available on the Joint Commission Web site at www.jointcommission.org, under the “Accreditation Programs” tab located at the top of the page.
The 2006 Annual Report of the National Trauma Data Bank® (NTDB), Version 6.0 is an updated analysis of the largest aggregation of trauma registry data ever assembled. The NTDB now contains more than 2 million records. This 2006 report is based on 1,191,215 records from 2001 through 2005. The NTDB uses a rolling five-year time frame for the annual analysis in order to focus on the most recent, highest-quality data. Before analysis, NTDB data are subjected to a quality screening for consistency and validity.

The mission of the American College of Surgeons Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center registry data. We estimate that 67 percent of level I and 56 percent of level II trauma centers in the U.S. have contributed to the NTDB.

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 our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.

Many dedicated individuals on the COT, as well as at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, our goals in the coming years include improving data quality, updating analytic methods, and enabling more useful interhospital comparisons. These efforts will be reflected in future NTDB reports to participating hospitals as well as in future annual reports. The new 2006 report has a new cover (see picture, above).

Throughout the year, we will be highlighting the work of the NTDB through brief monthly reports in the Bulletin. The full NTDB Annual Report Version 6.0 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.