The 112th Congress: The year in review
Contents

FEATURES

Presidential Address: The next hundred years 8

COVER STORY: The 112th Congress: The year in review 11
John Hedstom, JD

Controlling state health care costs: Massachusetts forges ahead 17
Andrew L. Warshaw, MD, FACS, and Jon H. Sutton

2012 Executive Director’s annual report 22
David B. Hoyt, MD, FACS

A look at the College’s first registry: The Bone Sarcoma Registry 32

STATEMENTS

Statement on concussion and brain injury 38

Statement on Council of Medical Specialty Societies’ Code for Interactions with Companies 39

COLUMNS

Looking forward 5
David B. Hoyt, MD, FACS

What surgeons should know about... Choosing not to participate in the CMS incentive programs 40
Sana Gokak, MPH

ACS Clinical Research Program: Multiple ipsilateral breast cancers: Can the breast be preserved? 43
Judy C. Boughey, MD, FACS; Kari Rosenkranz, MD, FACS; and Heidi Nelson, MD, FACS

A look at The Joint Commission: Building consensus on ways to minimize overuse of five treatments 46

NTDB® data points: No humour 47
Richard J. Fantus, MD, FACS

NEWS

Dr. Pellegrini selected as next President-Elect of the College 49

ACS Regents and Governors elected at Annual Business Meeting 51

Royal College of Surgeons of Edinburgh honors ACS President Dr. A. Brent Eastman 54

Chapter news 56
Mark Chou

From the Archives: Archives page on ACS website now offers descriptions of Dr. Martin’s collected papers 58

College accepting nominations for 2013 Jacobson Promising Investigator Award 59

ACS, Philadelphia health care leaders discuss physician-led quality improvement initiatives 60

Members in the news 62
ACS financial update 2012 63
Gay L. Vincent, CPA

Disciplinary actions taken 65

SCHOLARSHIPS

Oweida Scholar expresses gratitude for valuable Clinical Congress experience 66
Stephanie Allen Lilly, MD, FACS

Heller School Executive Leadership Program scholarships available 68

Call for applicants for ACS–Emerson Clinical Scholar 69

INDEX

Bulletin index: Volume 97, numbers 1–12 70

MEETINGS CALENDAR

Calendar of events 88
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.
Officers and Staff of the American College of Surgeons

Officers
* A. Brent Eastman, MD, FACS, FRCS (Ed) (Hon) San Diego, CA PRESIDENT
R. Phillip Burns, MD, FACS Chattanooga, TN FIRST VICE-PRESIDENT
John M. Daly, MD, FACS Philadelphia, PA SECOND VICE-PRESIDENT
Courtney M. Townsend, Jr., MD, FACS Galveston, TX SECRETARY
Andrew L. Warshaw, MD, FACS Boston, MA TREASURER
David B. Hoyt, MD, FACS Chicago, IL EXECUTIVE DIRECTOR
Gay L. Vincent, CPA Chicago, IL CHIEF FINANCIAL OFFICER

Officers-Elect
(take office October 2013)
* Carlos A. Pellegrini, MD, FACS, FRCS(Ed)(Hon) Seattle, WA PRESIDENT-ELECT
Layton F. Rikkers, MD, FACS Madison, WI FIRST VICE-PRESIDENT-ELECT
John T. Preskitt, MD, FACS Dallas, TX SECOND VICE-PRESIDENT-ELECT

Board of Regents
* Julie A. Freischlag, MD, FACS Baltimore, MD CHAIR
* Mark C. Weisler, MD, FACS Chapel Hill, NC VICE-CHAIR
* John L. D. Atkinson, MD, FACS Rochester, MN Margaret M. Dunn, MD, FACS Dayton, OH * A. Brent Eastman, MD, FACS, FRCS (Ed) (Hon) San Diego, CA James K. Elsey, MD, FACS Atlanta, GA Henri R. Ford, MD, FACS Los Angeles, CA

Gerald M. Fried, MD, FACS, FRCS Montreal, QC
* Barrett G. Haik, MD, FACS Memphis, TN B. J. Hancock, MD, FACS, FRCS, FRCSC Winnipeg, MB Enrique Hernandez, MD, FACS Philadelphia, PA Lenworth M. Jacobs, Jr., MD, FACS Hartford, CT L. Scott Levin, MD, FACS Philadelphia, PA * Mark A. Malangoni, MD, FACS Philadelphia, PA Raymond F. Morgan, MD, FACS Charlottesville, VA * Leigh A. Neumayer, MD, FACS Salt Lake City, UT Valerie W. Rusch, MD, FACS New York, NY Marshall Z. Schwartz, MD, FACS Philadelphia, PA Howard Snyder III, MD, FACS Philadelphia, PA Beth H. Sutton, MD, FACS Wichita Falls, TX Steven D. Wexner, MD, FACS Weston, FL Michael J. Zinner, MD, FACS Boston, MA

*Executive Committee

Board of Governors/Executive Committee
Lena M. Napolitano, MD, FACS Ann Arbor, MI CHAIR
Gary L. Timmerman, MD, FACS Stouff Falls, SD VICE-CHAIR
William G. Cioffi, Jr., MD, FACS Providence, RI SECRETARY
James C. Denneny III, MD, FACS Knoxville, TX Lorrie A. Langdale, MD, FACS Seattle, WA Fabrizio Michelassi, MD, FACS New York, NY Sherry M. Wren, MD, FACS Palo Alto, CA

Advisory Council to the Board of Regents
(Past-Presidents)
Kathryn D. Anderson, MD, FACS Corona, CA
W. Gerald Austen, MD, FACS Boston, MA
John M. Beal, MD, FACS Valdosta, GA
L. D. Britt, MD, FACS Norfolk, VA
John L. Cameron, MD, FACS Baltimore, MD
Edward M. Copeland III, MD, FACS Gainesville, FL
Gerald B. Healy, MD, FACS Boston, MA
R. Scott Jones, MD, FACS Charlottesville, VA Edward R. Lawns, MD, FACS Boston, MA
LaSalle D. Leftall, Jr., MD, FACS Washington, DC
Lloyd D. MacLean, MD, FACS Montreal, QC
LaMar S. McGinnis, Jr., MD, FACS Atlanta, GA
David G. Murray, MD, FACS Syracuse, NY
Patricia J. Numann, MD, FACS Syracuse, NY
Richard R. Sabo, MD, FACS Bozeman, MT
Seymour I. Schwartz, MD, FACS Rochester, NY
George F. Sheldon, MD, FACS Chapel Hill, NC
Frank C. Spencer, MD, FACS New York, NY

Executive Staff
EXECUTIVE DIRECTOR David B. Hoyt, MD, FACS
DIVISION OF ADVOCACY AND HEALTH POLICY Don E. Detmer, MD, FACS Medical Director
Frank G. Opelka, MD, FACS Associate Medical Director Christian Shalgian

AMERICAN COLLEGE OF SURGEONS FOUNDATION
Martina H. Wojcik, Executive Director

ALLIANCE/AMERICAN COLLEGE OF SURGEONS
CLINICAL RESEARCH PROGRAM
Heidi Nelson, MD, FACS Chair
CONVENTION AND MEETINGS
Felix Niespodziewski Director
DIVISION OF EDUCATION
Ajit K. Sachdeva, MD, FACS, FRCS Director
EXECUTIVE SERVICES
Barbara L. Dean Director
FINANCE AND FACILITIES
Gay L. Vincent, CPA Director
HUMAN RESOURCES AND TALENT MANAGEMENT
Michelle McGovern Director
INFORMATION TECHNOLOGY
Howard Tanzman Director
DIVISION OF INTEGRATED COMMUNICATIONS
Lynn Kahn Director
JOURNAL OF THE AMERICAN COLLEGE OF SURGEONS
Timothy J. Eberlein, MD, FACS Editor-in-Chief
DIVISION OF MEMBER SERVICES
Patricia L. Turner, MD, FACS Director
PERFORMANCE IMPROVEMENT
Will Chapleau Director
DIVISION OF RESEARCH AND OPTIMAL PATIENT CARE
Clifford Y. Ko, MD, MS, FACS Director
Cancer:
David P. Winchester, MD, FACS Medical Director
Trauma:
John Fildes, MD, FACS Medical Director

Dec 2012 BULLETIN American College of Surgeons
**Author bios**

**DR. ALLEN LILLY** (a) is a general surgeon at Androscoggin Valley Hospital, Berlin, NH.

**DR. BOUGHEY** (b) is an associate professor of surgery, Mayo Clinic, Rochester, MN, and co-principal investigator of ACOSOG Z11102.

**MR. CHOU** is a Program Coordinator in the American College of Surgeons (ACS) Division of Member Services.

**DR. FANTUS** (c) is director, trauma services, and chief, section of surgical critical care, Advocate Illinois Masonic Medical Center, and clinical professor of surgery, University of Illinois College of Medicine, Chicago. He is Past-Chair of the ad hoc Trauma Registry Advisory Committee of the ACS Committee on Trauma.

**MS. GOKAK** (d) is Quality Associate, Regulatory Affairs, ACS Division of Advocacy and Health Policy, Washington, DC.

**MR. HEDSTROM** (e) is Deputy Director, Legislative Affairs, ACS Division of Advocacy and Health Policy, Washington, DC.

**DR. HOYT** (f) is Executive Director of the ACS.

**DR. NELSON** (g) is the Fred C. Andersen Professor of Surgery and Chair, division of surgery research, Mayo Clinic, Rochester, MN, and Program Director of the Alliance/ACS Clinical Research Program.

**DR. ROSENKRANZ** (h) is an assistant professor of surgery, Dartmouth Hitchcock Medical Center, and medical director, Norris Cotton Cancer Center Comprehensive Breast Program, Lebanon, NH. She is co-principal investigator of ACOSOG Z11102.

**MR. SUTTON** (i) is Manager, State Affairs, ACS Division of Advocacy and Health Policy, Chicago, IL.

**MS. VINCENT** is Chief Financial Officer of the ACS.

**DR. WARSHEW** (j) is W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School; and senior consultant, International and Regional Clinical Relations, Massachusetts General Hospital and Partners Healthcare of the Massachusetts General Hospital, Boston. He is the ACS Treasurer and Chair of the ACS Health Policy and Advocacy Group.
Looking forward

by David B. Hoyt, MD, FACS

As of press time, more than 600 health care leaders had attended these forums, and approximately 400 additional people had participated in the programs remotely via live stream or teleconferencing.

The American College of Surgeons (ACS) launched its *Inspiring Quality* campaign in May 2011. Since then, these forums have been presented in cities across the nation and have enabled the ACS leadership to inform policymakers and the public of the College’s 100-year commitment to analyzing clinical data and using this knowledge to set standards that lead to better quality care.

As of press time, more than 600 health care leaders had attended these forums, and approximately 400 additional people had participated in the programs remotely via live stream or teleconferencing. Furthermore, 43 Fellows served on panels at the forums, telling their own stories about how quality programs, such as the College’s National Surgical Quality Improvement Program (ACS NSQIP®), have enabled them to reduce complications, achieve better outcomes, and reduce spending. Other panelists have included 17 nonsurgeon stakeholders, such as policy leaders, hospital administrators, clinical researchers, and so on.

Following is a summary of each ACS Surgical Health Care Forum to date. Due to space constraints, it is impossible to provide many details about each of the programs or to list all the panelists. However, I do want to provide Bulletin readers with a brief synopsis of each event and to acknowledge the Fellows who were instrumental in arranging the meetings. For more details about the forums, go to [www.inspiringquality.facs.org/national-tour/](http://www.inspiringquality.facs.org/national-tour/).

**Tour highlights**

Our first stop on the Inspiring Quality tour was Washington, DC. For this inaugural session, key ACS officials and staff met with U.S. representatives, senators, and congressional staff to discuss the College’s quality improvement programs, including our cancer, trauma, and clinical trials programs, as well as ACS NSQIP. College leaders who participated (with their titles at the time) are as follows: L.D. Britt, MD, MPH, FACS, FCCM, FRCS(Eng)(Hon), FRCS(Ed)(Hon), FWACS(Hon), ACS President; Carlos A. Pellegrini, MD, FACS, FRCS(Eng)(Hon), Chair, Board of Regents; Don E. Detmer, Medical Director, Division of Advocacy and Health Policy (DAHP); Clifford Y. Ko, MD, MS, FACS, Director of ACS NSQIP and the Division of Research and Optimal Patient Care; Frank G. Opelka, MD, FACS, Associate Medical Director of the DAHP, and ACS lobbyists.

Subsequently, we have presented the following forums:

- On July 18, 2011, Dr. Britt and I hosted a session at the College’s headquarters in Chicago, IL. U.S. Sen. Mark Kirk (R-IL) provided the keynote address, and a panel of surgeons from local medical centers discussed how ACS quality programs are helping their hospitals achieve better quality of care and reduce health care costs.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at [lookingforward@facs.org](mailto:lookingforward@facs.org).
An estimated 500 Americans viewed the event information and live stream on the ACS website.

• Then, on August 30, 2011, the College presented a forum at Johns Hopkins University School of Medicine in Baltimore, MD, with U.S. Sen. Ben Cardin (D-MD) providing the keynote address. This session was hosted by the current Chair of the ACS Board of Regents, Julie A. Freischlag, MD, FACS, and health care leaders from throughout Maryland were in attendance.

• The first forum of 2012 was presented on March 2 at Scripps Memorial Hospital in La Jolla, CA. A panel of experts representing San Diego area institutions led a discussion titled Inspiring Quality in Surgical Health Care—Quality Improvement Programs that Improve Outcomes and Reduce Costs. A. Brent Eastman, MD, FACS, the College’s current President, moderated the program, which focused on the critical elements of successful quality programs.

• For its fifth Surgical Health Care Quality Forum, on April 11, the ACS hosted aviation industry leaders in Seattle, WA. This event focused on how the aviation industry has used checklists, standardization, culture shifts, and transparency to improve flight safety and how those processes may be used in surgery to improve patient safety and reduce unnecessary costs. Dr. Pellegrini, now ACS President-Elect, hosted the event, and U.S. Rep. Jim McDermott (D-WA) provided opening remarks.

• On June 4, a panel of experts gathered in Boston, MA, to discuss the College’s proposition that quality surgical care not only delivers better patient outcomes, but also delivers better financial outcomes. This forum featured keynote speaker Stuart Altman, PhD, Economist and Health Policy Expert, Brandeis University, Waltham, MA. Andrew L. Warshaw, MD, FACS, Chair of the ACS Health Policy and Advocacy Group and ACS Treasurer, and ACS Regent Michael J. Zinner, MD, FACS, hosted.

• Next, we traveled to Chattanooga, TN, August 3 to participate in the 2012 Tennessee ACS Annual Chapter Meeting. This session highlighted the Tennessee Surgical Quality Collaborative—the first ACS NSQIP collaborative to form a three-way quality improvement relationship between hospitals, payors, and surgeons. The forum featured keynote speaker State Sen. Bo Watson (R), and was hosted by Joseph B. Cofer, MD, FACS, professor and residency program director, department of surgery, University of Tennessee College of Medicine-Chattanooga.

• The ACS hosted its eighth Surgical Health Care Quality Forum September 10 at The Health Museum in Houston, TX. Keynote speaker U.S. Rep. Sheila Jackson Lee (D-TX), commended the ACS for proactively working to improve health care quality and urged surgeons and physicians to be involved in health care policy discussions moving forward. ACS Regent H. Randolph Bailey, MD, FACS, cohosted the program with Barbara Lee Bass, MD, FACS, a former ACS Regent.

• On October 12, the College hosted a forum in Philadelphia, PA, featuring keynote speaker U.S. Rep. Jim Gerlach (R), who encouraged surgeons to add their knowledge to the health care policy process and ensure the right programs are implemented or sustained to most effectively improve care and reduce costs. Co-hosting the event were Marshall Z. Schwartz, MD, FACS, and Howard M. Snyder III, MD, FACS, both ACS Regents.
The College’s leadership is pleased that these forums have been so well-received and useful in terms of spreading the message that the College has been and continues to be the leader in developing programs to measure and improve the quality of surgical care.

In addition to these ACS Surgical Health Care Forums, we hosted two smaller-scale events for key congressional staff in Salt Lake City, UT, and Rochester, MN. These meetings were hosted by ACS Regent Leigh A. Neumayer, MD, FACS, and Robert Cima, MD, FACS, associate professor of surgery at the Mayo Clinic, respectively.

At press time, the College was scheduled to present two more forums before the year’s end. The first was set for Friday, November 16, in New York, NY, with Fabrizio Michelassi, MD, FACS, Lewis Atterbury Stimson Professor and chairman, department of surgery, and surgeon-in-chief, NewYork-Presbyterian/Weill Cornell Medical Center, hosting. The final forum of the year was scheduled to take place December 12 at the American Cancer Society Center in Atlanta, GA. ACS Past-President LaMar S. McGinnis, Jr., MD, FACS, and John Sweeney, MD, FACS, W. Dean Warren Distinguished Professor of Surgery at Emory University in Atlanta, will host.

What’s next?
The College’s leadership is pleased that these forums have been so well-received and useful in terms of spreading the message that the College has been and continues to be the leader in developing programs to measure and improve the quality of surgical care.

The forums were widely promoted via social media channels and generated media coverage in national, local, and trade media outlets, including: HealthLeaders; FierceHealthcare Hospital Impact blog; WBUR CommonHealth blog, a Boston National Public Radio (NPR) affiliate; KUOW-FM, a Seattle NPR affiliate; Knoxville News-Sentinel; Chattanooga Times Free Press; The Tennessean; and Tennessee Medicine. Furthermore, the archived forum videos had generated nearly 900 views on YouTube as of press time.

In the coming months, we will be working with our consultants at Weber Shandwick to conduct a review of the ACS Surgical Health Care Forums and will be compiling a list of lessons learned from this experience. That report should be completed in the spring of 2013. Meanwhile, we will continue to spread the word about the College’s enduring commitment to ensuring that all surgical patients have access to quality, cost-effective care. ♦
There are serious challenges ahead in this new century and the American College of Surgeons (ACS) needs its young, diverse leadership at every level,” Dr. Eastman said in his Presidential Address. “It can be a wonderful two-way street, with you contributing your energy and fresh vision, and the more senior among us offering support and crucial leads as to how things get done,” said Dr. Eastman, a general, vascular, and trauma surgeon from San Diego, CA.

After acknowledging the important accomplishments of the College’s founders as the organization enters its Centennial year, Dr. Eastman outlined four key issues that present challenges for the future—access to quality health care, rural surgery workforce shortages, surgical education, and international outreach (see Figure 1, page 9).

“The American College of Surgeons is committed to a policy of high-quality, safe, appropriate, and affordable surgical care. But as [ACS] Past-President L.D. Britt [MD, FACS] has said, “There is no quality without access,”” noted Dr. Eastman. He urged surgeons at all levels to “speak wisely and forcefully” as advocates for expanded access to optimal care and to get involved in shaping public policy.

With regard to surgeon workforce shortages and maldistribution, particularly in rural areas, Dr. Eastman called for training that is “broad and emphasizes self-reliance,” and he cited the Rural Trauma Team Development Course (RTTDC) created by
the ACS Committee on Trauma as an example of the kind of training necessary for surgeons working in this environment. (For more information on the RTTDC, go to http://www.facs.org/trauma/rttdc/index.html.)

Changes in surgical education pose another significant challenge to current and future surgical leaders, according to Dr. Eastman. “As wonderfully as the Halsted model worked for training 20th century surgeons—including my generation of the 1960s and 1970s—it does not fit the 21st century reality,” observed Dr. Eastman.

Another challenge that surgeons must contend with in the 21st century is the global disease burden. Both Initiates and senior surgeons need to be cognizant of the access, workforce shortages, and other surgical issues that affect surgical patients throughout the world. “I believe that international collaboration is essential to the future of our profession on this planet,” asserted Dr. Eastman. He noted that during the Clinical Congress he would be participating in the ACS International Relations Committee meeting, where he would be able to confer with the presidents of international surgical colleges and societies. “We have much to do together,” he said.

Dr. Eastman also underscored the importance of international collaboration by offering Initiates a look at what he termed “the hundred-year class of Fellows of the American College of Surgeons,” a
multicultural group of many different backgrounds and origins.

“So, let me introduce you further to one another and tell you what you told me in our survey of your Fellowship class this summer,” said Dr. Eastman. “You are 1,377 strong. A little over 1,000 of you are men and 300 women. Your average age is 41 and you have been in practice typically four years or more. [A total of] 83 percent of you are residents of the U.S. and Canada, but a full 17 percent—232 of you—are our new international Fellows from 49 different countries and every continent in the world. And, not to be outdone in internationality, one-third of the North Americans here have parents born elsewhere, including all parts of Asia, the Middle East, Africa, Europe, and Latin America.” (See Figures 2 and 3, page 9.)

“What reverberates here is the fact that although the American College of Surgeons was established first of all for the reform of surgery in the United States and Canada—Franklin H. Martin always envisioned a world fellowship of surgeons,” continued Dr. Eastman (see Figure 4, this page). “He had been inspired by the Royal College of Surgeons of England, after which he modeled the robes and ceremony you see tonight, and he spent much of his long tenure as Secretary traveling and establishing friendships with leading surgeons of Central and South America and of Australia and New Zealand.”

Dr. Eastman urged initiates to never forget “the great privilege you have as a fully-qualified surgeon wherever you are in the world.

“I suspect nearly all of you new Fellows have stories about how you chose medicine, and then surgery as a career, and about your mentors,” said Dr. Eastman. “And I hope—when things get tough—that you can find a way to dip into that early well of inspiration and admiration and feel refreshed for the work ahead.

“My greatest wish for you, the newest Fellows of the American College of Surgeons, is the joy of a life in surgery that has been mine,” Dr. Eastman said as the final slide (Figure 5, this page) was displayed to the accompaniment of Beethoven’s “Ode to Joy.”
The 112th Congress:
The year in review
by John Hedstrom, JD
Following a few tumultuous years of debate regarding the future of the nation’s health care system, 2012 moved at a much slower pace as both parties infused more politics into the debate with an eye toward the national elections in November. However, the American College of Surgeons (ACS) remained focused on advancing its health policy agenda throughout the year. This article summarizes the ACS’ steadfast efforts to lobby for the primary issues of concern to Fellows.

**Physician payment: Groundhog Day**

At press time, one month before the elections, payment issues had yet to be resolved, but were on the agenda for the lame-duck Congress in late November and December. Throughout the final months of the year, the ACS has been advocating for legislation that would avert the annual cuts to Medicare physician payment.

For the past decade, surgeons have consistently advocated for permanent reform of the Medicare payment formula. In that time, Congress passed more than a dozen short-term patches, although its members have been unable or unwilling to permanently reform Medicare’s physician payment system. Because of Medicare’s flawed payment formula, known as the sustainable growth rate (SGR), Medicare physician payments are currently scheduled to be reduced by 27 percent on January 1, 2013, according to the Congressional Budget Office. Consequently, the cost of permanently fixing this problem grows exponentially. In 2005, a permanent fix would have cost less than $50 billion. Today, a 10-year freeze in payments would cost $271 billion. In just a few short years, this cost could grow to more than half a trillion dollars. Over the past year, when presented with two opportunities to fully repeal the SGR by offsetting the cost to repeal with funds unbound by the winding down of the wars in Iraq and Afghanistan, otherwise known as Overseas Contingency Operations funds, Congress chose to push off the issue, leaving surgeons to face a cut in payments at the beginning of the year.

If that weren’t enough, passage of the Budget Control Act and the failure of the so-called “Super Committee” that was established to specify an additional $1.2 to $1.5 trillion in federal spending cuts will result in $1.2 trillion in mandatory cuts to federal programs on January 2, 2013. The Medicare portion of these mandated cuts is expected to reduce Medicare physician reimbursement by 2 percent. This reduction is separate from and in addition to any cuts resulting from the SGR.

Meanwhile, sequestration will have a major effect on a number of health programs, including the following cuts:

**HIGHLIGHTS**

- At press time, Medicare payment issues had yet to be resolved, and the ACS was advocating for legislation that would avert annual cuts in reimbursement.
- The ACS convened a Medical Liability Reform Summit in October to discuss traditional tort reforms and other alternatives.
- The ACS is monitoring legislation that could affect the stability of the surgical workforce.
- The College is calling upon legislators to ensure adequate funding to the nation’s trauma and emergency medical services system.
Congressional Year in Review

The volatility and instability of the current system not only threaten Medicare beneficiaries’ access to care but also make it next to impossible to adopt meaningful reforms.

• National Institutes of Health: $2.5 billion (8.2 percent)
• Centers for Disease Control and Prevention: $490 million
• U.S. Food and Drug Administration: $318 million
• Graduate medical education (GME) funding put at risk
• Department of Defense armed services health care: $3.2 billion
• Prevention and Public Health Fund: $76 million

The volatility and instability of the current system not only threaten Medicare beneficiaries’ access to care but also make it next to impossible to adopt meaningful reforms. A number of other factors, such as the Independent Payment Advisory Board (IPAB), threaten physician reimbursement in the future. The IPAB will be tasked with controlling spending by cutting providers and a number of payment modifiers for programs such as the Physician Quality Reporting System, e-prescribing, and meaningful use of electronic health records, which are moving from incentives for participation to penalties for nonparticipation.

Medical liability reform—Restoring balance to the legal system

Medical liability reform continues to be a significant priority for the ACS and its members. For more than a decade, many Fellows of the College and their practices have seen their liability insurance premiums skyrocket, regardless of whether they have ever been sued.

This October, the ACS convened its first Medical Liability Reform Summit. The all-day session examined different solutions being tested in the states and health systems to address the medical liability system and its impact on patient care and physicians. This proactive program brought renowned experts from around the country to delve into such topics as safe harbors, alternative dispute resolution, disclosure and offer programs, and health courts. In early 2013, the ACS plans to make available to the members summary articles from the Summit.

In a number of states, surgeons are having difficulty obtaining medical liability insurance, and for those who are able to find coverage, the cost is often prohibitively high. Although legislatures in some states have addressed this issue through various means, some state courts have overturned liability legislation, and others have enacted laws too weak to keep premiums reasonable. Many surgeons are moving to states where strong medical liability reforms are in place so they can continue practicing or they are choosing to retire early, further reducing an already insufficient workforce. At the same time, reimbursement from Medicare and other insurers is declining, providing no way to offset the continuing escalation in premium costs. This situation has forced some practices to borrow money in order to pay malpractice premiums.

The College has long advocated for the federal adoption of health care liability reforms similar to those enacted in California under the Medical Injury Compensation Reform Act of 1975, including:

• Reasonable caps on noneconomic damages
• Protections for physicians providing Emergency Medical Treatment and Labor Act (EMTALA) mandated care
• Alternatives to civil litigation, such as health courts and early disclosure and compensation offers to encourage speedy resolution of claims
• Protections for physicians volunteering services in a disaster or local or national emergency
• Limits on plaintiff attorney contingency fees
• Protections for physicians who follow established evidence-based practice guidelines
• Collateral source payment offsets that prevent duplicate payments for the same expense
• “Fair share” rule
• Periodic payment of future damage awards greater than $50,000
• Application of punitive damages only when there is clear and convincing evidence that the defendant intended to injure the claimant

This past year saw a number of medical liability reform bills come before Congress, many of which the College supports. Examples include:

• Rep. Phil Gingrey (R-GA) and Sens. Roy Blunt (R-MO) and Mark Kirk (R-IL) introduced the Help Efficient, Accessible, Low-cost, Timely Healthcare Act (HEALTH),
which the Congressional Budget Office estimates will generate more than $57 billion in savings to the federal government over 10 years and reduce overall national health care spending by 0.5 percent. This legislation includes many of the policies that the College supports.

In addition, the ACS supports more targeted legislation, such as the Health Care Safety Net Enhancement Act (H.R. 157) sponsored by Rep. Pete Sessions (R-TX). This legislation will benefit physicians who comply with EMTALA mandates, which require physicians to provide stabilizing care to patients who go to hospital emergency departments, regardless of ability to pay. The problem is notably severe for surgeons who provide complex, high-risk surgical care to severely injured patients. The likelihood of not receiving reimbursement and high liability risk are broadly acknowledged as key contributors to the growing shortage of specialists participating in emergency on-call panels. The Health Care Safety Net Enhancement Act will help to address this growing problem by providing Public Health Service Act liability protections to physicians who provide EMTALA-mandated care.

The Good Samaritan Health Professionals Act (H.R. 3586) is another targeted bill, which Reps. Cliff Stearns (R-FL) and Jim Matheson (D-Ut) introduced. Rapid medical response in a disaster can greatly decrease loss of life and improve outcomes for patients who desperately need care. However, when a disaster strikes, the needs of victims often overwhelm the services available locally. The medical profession has a long history of stepping forward to assist disaster victims. Unfortunately, the Volunteer Protection Act, enacted specifically to encourage such actions, failed to address the issue of liability protections for health care providers who cross state lines to aid disaster victims. The Good Samaritan Health Professionals Act will ensure that health professionals who wish to provide voluntary care in response to a federally declared disaster can do so without worrying about potential liability.

These three liability reform bills were passed by the House during the current session of Congress but stalled in the Senate. The ACS will continue to support a wide range of policies aimed at improving the liability climate in the U.S., expanding access to on-call surgeons, and ensuring that providers are able to volunteer during an emergency.

### Surgical workforce—Protecting the current and future generations

A growing body of evidence points to an ongoing and increasing shortage of surgeons available to serve the nation’s aging and growing population. According to the Association of American Medical Colleges’ Center for Workforce Studies, the U.S. will face a shortage of 46,000 surgeons and medical specialists in the next decade—a startling and troubling statistic for both surgeons and patients.

Furthermore, this summer, the ACS Health Policy Research Institute (HPRI) at the University of North Carolina’s Cecil J. Sheps Center for Health Services Research, Chapel Hill, NC, released updated maps illustrating the distribution of general surgeons and surgeon specialists per 100,000 populations across the U.S. in 2006 and 2011. The maps contain data that are reflective of all 3,107 counties in the U.S. They indicate that in the time frame studied, 181 counties lost all of their surgeons, whereas 161 gained at least one surgeon by 2011 after having none in 2006, and 680 counties and county-equivalent areas had no surgeons in both 2006 and 2011. Visit the following link to access the surgical workforce maps: http://www.acshpri.org/maps.html.

The ACS is carefully monitoring legislation and activities that could affect the surgical profession and patient access to high-quality care, and continues to advocate for policies that are designed to strengthen the surgical workforce.

The ACS endorsed and is advocating for passage of the Resident Physician Shortage Reduction Act of 2011 (S. 1627). Sens. Bill Nelson (D-FL), Charles Schumer (D-NY), and Senate Majority Leader Harry Reid (D-NV) introduced this legislation, which seeks to bolster the U.S. surgical workforce and health care infrastructure by increasing the number of Medicare-supported residency positions. More specifically, the bill would increase the number of residency slots nationally by 3,000 each year from 2013 through 2017, totaling 15,000 slots. In 1997, the Balanced Budget Act froze
For more than a decade, many Fellows of the College and their practices have seen their liability insurance premiums skyrocket, regardless of whether they have ever been sued.

the number of residents for which a hospital could claim Medicare payment based on the number of residents that each hospital trained in 1996. Although the ACS would prefer that Congress lift the present caps on GME funding entirely, the ACS supports this legislation for taking an important step toward addressing physician workforce shortages.

Under the Resident Physician Shortage Reduction Act, half of the new residency slots must be used for shortages in specialty residency programs as defined by the Health Resources and Services Administration. The measure also directs the National Health Care Workforce Commission to study the physician workforce and identify specialties that are experiencing shortages. A report on the findings must be submitted to Congress by January 1, 2014. The proposed law also directs the U.S. Comptroller General to conduct a study on strategies for increasing the diversity of the health care workforce. Results of the study must be made available to Congress no later than two years after the date of the bill’s enactment.

The ACS has joined a number of other health care organizations, including the American Medical Association, the American Hospital Association, and the National Rural Health Association, in supporting the Conrad State 30 Improvement Act. This legislation, which Sens. Kent Conrad (D-ND) and Jerry Moran (R-KS) introduced, expands and permanently reauthorizes the Conrad State 30 Program, which allows international physicians who are in the U.S. on J-1 visas to obtain a waiver of the J-1 requirement to return home for two years in exchange for three years of practice in a medically underserved area. Each state is currently allowed 30 such waivers—hence the legislation’s name. This popular program has been extended multiple times since its inception in 1994, and has brought more than 9,000 physicians, including surgeons, to rural and underserved communities in all 50 states.

**Strengthening the trauma system**
The public assumes that when they or a loved one are seriously injured, lifesaving trauma and emergency care will be provided when and where they need it. Unfortunately, the availability and accessibility of high-quality trauma and emergency care is not guaranteed. The challenges facing trauma centers, trauma systems,

THE FALTERING U.S. TRAUMA AND EMS SYSTEM

- Trauma is the leading cause of death for Americans younger than 44 years old.
- Trauma costs the nation $80 billion annually, and $326 billion is estimated for lifetime productivity losses for almost 50 million injuries that require medical treatment.
- 35 million people are treated each year for traumatic injuries.
- Severely injured trauma patients treated at Level I trauma centers have a 25 percent reduction in mortality. Conversely, nearly one in four patients is more likely to die when not initially taken to a Level I trauma center, and mortality increases 3.8 times if a severely injured patient is treated initially at a non-trauma hospital instead of direct transport to a Level I trauma center.
- A total of 45 million people lack access to a trauma center within one hour following injury, during which time definitive treatment can make the difference between life and death.
- One in five people is more likely to survive a traumatic injury in a state with established trauma systems than in one without; there is a 20 percent reduction in the risk-adjusted odds of death in the state with a trauma system.
- At least 21 trauma centers have closed over the past decade, including St. Vincent’s in New York, NY, which treated 848 patients on September 11, 2001.
and physicians are profound. Although studies clearly show the value and cost-effectiveness of trauma care compared with other medical interventions, the federal government has yet to make the necessary investments to ensure access for all Americans and, as a result, a fragile trauma and emergency medical services (EMS) system is faltering, as underscored by the statistics in the sidebar on page 15.

The Affordable Care Act (ACA) authorized a total of $224 million in funding for trauma and EMS programs and activities. The provisions included in the ACA were derived from legislation that received strong bipartisan support over many years. This funding amounts to 71 cents per person, and would ensure system readiness and protect the public. Specifically, this federal investment would support:

• The National Trauma Center Stabilization Act, which reauthorized the national Trauma Center Stabilization Act and authorized two grant programs:

  — Trauma Care Center Grants: $100 million per year for a program of federal grants to trauma centers would allow them operating funds to maintain their core missions, to compensate them for losses from uncompensated care, and to provide emergency awards to centers at risk of closure.

  — Trauma Service Availability Grants: An additional $100 million per year would be channeled through the states and used for a number of activities intended to address shortfalls in trauma services and improve access to and the availability of these essential lifesaving services.

• Reauthorization of the Trauma Care Systems Planning and Development Act (TCSPDA) and incorporation of a new Regionalization of Emergency Care Pilot Program. The ACA authorizes $24 million for all grant programs provided under the TCSPDA, of which $12 million was intended to be designated for implementation of the Regionalization of Emergency Care Pilot Program.

• Reauthorization of the Trauma Care Systems Planning Grants to support state development of trauma systems.

• Authorization of funding for no fewer than four multi-year pilot projects to design, implement, and evaluate innovative models of regionalized emergency care systems.

The outcome from a survivable injury should not be a matter of chance. Funding critical trauma programs is a worthwhile investment of federal dollars because they help to ensure the public’s expectations of a high-quality and coordinated trauma and EMS system. Such investments are a prudent use of taxpayer dollars to improve patient outcomes and cost savings.

With 2012 coming to a close and Congress rushing to get a package together, including another SGR short-term patch, many of these issues will return in 2013. The ACS will continue to advocate on behalf of its members on these issues and many others at the federal and state level.
The debate over federal health care reform has raged for many years, and passage of the Affordable Care Act (ACA) increased the volume of this discussion. In June, the U.S. Supreme Court ruled that the ACA was constitutional, giving proponents of the ACA plenty to cheer about, while opponents vowed to continue their fight against it.

Health care reform, though, is not just a federal issue. State legislatures have grappled with reform measures, especially with respect to Medicaid, for decades. Adding fuel to efforts to reform Medicaid are falling state revenues and a rising number of Medicaid recipients—both of which may be attributed to the recession. These factors have created intense pressure on state budgets and forced states to find ways to cut costs in their Medicaid programs.

In the waning days of its 2012 legislative session, the Commonwealth of Massachusetts General Court took on phase two of reforming the state’s health care by adopting broad cost-control legislation (S. 2400, now Chapter 224 of the Acts of 2012). The first phase of this effort, of course, was the enactment of universal coverage legislation in the state in 2006; as a result of this provision, 98.1 percent of Massachusetts residents now have health insurance. Since that legislation, which only addressed insurance coverage, was enacted, Massachusetts legislators sought to resolve the cost-control question three times, culminating most recently in Chapter 224.

This article offers insights into what the new law does and how it may affect Massachusetts surgeons. It explains some of the critical components of the law and outlines the ongoing concerns that should be addressed as the law is implemented.

Medical liability reform
A major victory for physicians is the inclusion of alternative medical liability reform measures. Specifically, the statute creates a disclosure, apology, and offer (DA&O) program. Under DA&O, providers may disclose mistakes and apologize to patients for those errors, or simply make a statement expressing regret, sympathy, condolences, or compassion for...
an unanticipated outcome without fear of these statements being used against them in a judicial or administrative proceeding.

The statute also imposes a 182-day pre-litigation period during which patients and physicians may work to settle a claim. Patients must make their intention of filing a claim known to their physicians in order for the pre-litigation period to start, and there are deadlines throughout this period for responses from physicians and plaintiffs.

Each notice of intent must include the following information:

- Factual basis for the claim
- Applicable standard of care for the condition
- An explanation of how the standard of care was allegedly breached
- A description of the action that should have been taken to comply with the standard of care
- An explanation of how the breach of the standard of care caused the injury
- The names of all of the health care providers whom the patient intends to notify in relation to the claim

Within 150 days of receipt of the notice of intent, a health care provider should respond with a written statement that includes:

- A factual basis for the defense to the claim
- The standard of care the health care provider claims to be applicable
- An explanation of how the health care provider was or was not in compliance with the applicable standard of care
- Information about why the alleged negligence of the health care provider was or was not a proximate cause of the patient’s alleged injury

Although the American College of Surgeons (ACS) supports traditional medical liability reforms (caps on noneconomic damages and so on), the ACS also recognizes that some states are politically or constitutionally unable to achieve passage of these reforms. Therefore, the College supports DA&O liability reforms, although imperfect, as a means of possibly improving the medical liability climate.

Key elements of the law

The statute contains other significant cost-containment measures in addition to the medical liability reforms. In most instances, these provisions and their effect on surgeons are dependent on the rules that will be written to implement them, but it is worthwhile at this point to review some of the major measures in the statute.

To begin, the statute seeks to save Massachusetts an estimated $200 billion over 15 years through the establishment of statewide targets for annual increases in health care costs. From 2013 to 2017, the target is equal to the potential annual growth rate of the gross state product (GSP), and from 2018 to 2022, the target will be one-half percentage point below the annual growth in the GSP. This goal is certainly an ambitious one, especially in light of the fact that, in recent years, the state’s health care costs have grown an average of 6.8 percent, whereas Massachusetts’ GSP growth has been closer to 3.6 percent. Fortunately, the law provides an opportunity in 2018 to modify the target.

Implementation of new health care payment formulas will be facilitated by requiring the state’s Medicaid program, employee health care program, and all other state-funded health care programs to transition to these methodologies. These new models are intended to incentivize the delivery of high-quality, coordinated, efficient, and effective health care while reducing waste, fraud, and abuse. In addition, targeted Medicaid rate increases in 2014 of 2 percent to acute care hospitals, non-acute care hospitals, and providers of primary care services up to $20 million will be authorized for those providers who demonstrate a significant transition to a new payment system.

Provisions designed to boost transparency, accountability, and quality are woven into various sections of the statute. For instance, health care provider systems are required to register with the state and report regularly on financial performance, market share, cost trends, and quality measures. Over time, a special commission will be appointed to determine and quantify the factors that are contributing to price variation among providers. Those provider groups with spending that exceeds the target may be required to file a performance improvement plan.

Needless to say, technology plays a big role in implementing the statute. For example, $30 million is
available to eligible health care providers to invest in and accelerate the ongoing statewide adoption of interoperable electronic health records (EHRs). In addition, physicians will be required as a condition of licensure to demonstrate competence in the use of EHRs, and patients must be allowed to access their personal EHR.

To address concerns with regard to workforce shortages, particularly in primary care, the statute establishes a new primary care residency program supported by the Department of Public Health. Access to primary care services, whether through accountable care organizations (ACOs) or the medical home model, is seen as one more way to improve quality and limit health care spending. Not only does the statute establish and/or expand loan repayment and loan forgiveness programs, it expands the role of physician assistants (PAs) and nurse practitioners (NPs) to act as primary care providers in order to improve access to cost-effective care.

Where concerns exist
Numerous elements of the cost-containment law should be of concern to surgeons and other physicians. The following measures deserve the surgical community’s attention:

• With regard to the expanded scope of practice for PAs and NPs, the medical and surgical community has typically maintained a unified voice in ensuring that scope-of-practice expansions do not have a negative effect on the safety and quality of patient care. Is it appropriate for PAs to be designated as primary care providers? Should NPs sign forms that previously only physicians could sign? What happens to physician supervision of these health care providers?

• Workforce shortages are a looming problem, not only in primary care but also in the medical and surgical specialties. This statute’s efforts to address workforce shortages focuses on pri-
The Massachusetts e-Health Institute oversees health care innovation, technology, and competitiveness; conducts the regional extension center program for the coordination and implementation of electronic health records systems by providers, and develops a plan to ensure that all providers implement EHR systems.

The Health Care Workforce Center Advisory Council offers recommendations to the Healthcare Provider Workforce Center on the following: trends in access to primary care and physician subspecialties, nursing, physician assistant, and behavioral, substance use disorder, and mental health services; the development and administration of the loan repayment program; and solutions to address identified health care workforce shortages.

The Massachusetts Health Information Technology Council works with state agencies and private stakeholders to develop a statewide health information exchange.

The Special Commission on the Health Care Payment System reviews public payor reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on health care providers and health insurance premiums; examines whether public payor rates and rate methodologies provide fair compensation for health care services; and promotes high-quality, safe, effective, timely, efficient, culturally competent, and patient-centered care.

The independent task force seeks to study and reduce the practice of defensive medicine and overuse of medical resources, including but not limited to imaging and screening technologies.

The special task force studies and investigates issues related to the accuracy of medical diagnosis.

The Special Commission on Graduate Medical Education (GME) examines the economic, social, and educational value of GME and recommends a fair and sustainable model for the future funding in the commonwealth.

The Special Commission on Provider Price Reform reviews variation in prices among providers and the factors involved in variation and recommends steps to reduce provider price variation.

Requirements to report cost and quality information to the state could be burdensome to individual physicians or small groups. Large groups or hospital systems with already established EHRs may have less difficulty complying with these mandates. It will be critical for organized medicine to work through the regulatory process to limit the burden these requirements place on providers. In particular, quality measures for surgeons will need to reflect the realities of surgical practice, and existing surgical quality measures should be used.

Implementation of alternative payment methodologies through patient-centered medical homes or ACOs may be beneficial to some physicians, but global payment methodologies are inapplicable in some situations. Some fee-for-service care will continue to exist alongside the alternative payment methodologies, and surgeons will need to be vigilant in ensuring that fee-for-service remains an option.

The statewide targets for rising costs may be overly ambitious. This issue is of particular concern given the failed experiment at the federal level of tying annual increases in physician reimbursements to the nation’s economic growth, through the so-called “sustainable growth rate” (SGR) formula. Congress has had to intervene every year since imposition of the SGR to avoid mounting reductions in physician reimbursement and will have to do so again by the end of this year to avert a 27 percent cut. Although providers will not be penalized for failing to meet the state targets, they will be required to file a corrective action plan if they exceed them.
The College has strongly supported the expansion of loan programs and residency training programs to meet future workforce needs in both primary and specialty care.

A surgeon’s view from Massachusetts
In Massachusetts, media and government attention to health care costs has increased steadily since adoption of the 2006 health care reform law. Initially, this scrutiny led to the appointment of several commissions to study the issue and two reports from the state’s attorney general regarding costs and quality. Chapter 224 adds the first real teeth to the debate by attempting to limit overall health care spending growth in Massachusetts. Whether the limits are realistic, achievable, or enforceable remains to be seen. At the very least, they are a reminder to surgeons of the importance of focusing on the cost question, eliminating unnecessary or duplicative costs, and redesigning care to be as affordable and as high-quality as possible.

Going forward
The medical and surgical community in Massachusetts must engage in the rulemaking process and participate in the appointment of the various commissions, committees, and councils created by the law (see list in sidebar, pages 19 and 20). State specialty societies must join with the Massachusetts Chapter of the ACS, the Massachusetts Medical Society, and other health care organizations to nominate physicians to serve on these bodies, and to carefully review and comment on proposed regulations developed to implement the statute. The final version of Chapter 224 can be downloaded at http://www.malegislature.gov/Laws/Session-Laws/Acts/2012/Chapter224.5

REFERENCES
Executive Director’s annual report

by David B. Hoyt, MD, FACS
This has been another busy and exciting year for the American College of Surgeons (ACS), and our Board of Regents, Officers, Board of Governors, volunteers, and staff are to be commended for their role in developing and launching several important new initiatives.

Internally, we have made great progress in implementing the Culture-Driven Performance Improvement Project, which began last year in consultation with GE Healthcare. We have hired Michelle McGovern as Director of Human Resources and Talent Management and have created a new position—Director of Performance Improvement (PI)—which Will Chapleau has filled. Since the effort began last year, we have identified 180 PI initiatives, trained 10 PI officers, and begun work on 10 projects. The entire staff is working to steadily improve the College’s capacity to serve the Fellows and Members.

Advocacy and Health Policy
Surgeons remain deeply concerned about the prospect of payment cuts stemming from the use of the sustainable growth rate (SGR) in setting the Medicare fee schedule. The College has been a leading advocate for repealing and replacing the SGR. In January, ACS leadership met with key members of Congress to urge them to permanently repeal the SGR and to use war drawdown savings, also known as Overseas Contingency Operations funds, to cover the costs of repeal. In a historic move, the leadership of the ACS, the American College of Physicians, the American Academy of Family Physicians, and the American Osteopathic Association visited Capitol Hill to deliver a strong, unified message on this proposal.

The College also has been working on a proposal to replace the SGR with a value-based update (VBU). The College has solicited feedback from throughout the surgical community as well as from other stakeholders. A request for proposal (RFP) has been developed that we anticipate will provide data supporting the VBU as a leading plan for addressing the problems associated with the SGR.

The College has worked with Congress on other important issues, including liability reform. The ACS supported several tort reform efforts that passed in the House of Representatives but were blocked in the Senate. The House passed two additional ACS-backed bills as part of larger reform efforts:

• The Good Samaritan Health Professionals Act (H.R. 3586), which would provide volunteer health professionals who provide urgently needed care in a declared emergency with the same immunity they have in their home state
• The Health Care Safety Net Enhancement Act (H.R. 157), which would address the high liability risk associated with care provided under the Emergency Medical Treatment and Active Labor Act

The ACS continues to lead efforts to bolster the surgical workforce by increasing the number of residency positions. The ACS supported legislation that would expand the number of Medicare-supported physician training positions by 15 percent.

The ACS has provided extensive responses to proposed rules that affect surgical practice, and has developed important resources to help surgeons comply with existing regulations. Examples include:

• Submitted comments on the Electronic Health Record Incentive Program Stage 2 proposed rule.
• Provided feedback on the 2013 Medicare physician fee schedule and the Outpatient Prospective Payment System/Ambulatory Surgical Center proposed rules.
• Offered educational materials pertaining to the Medicare eRx Incentive Program through the ACS website, meetings, and publications. Additionally, the College has a step-by-step guidance document related to this program, and provides one-on-one assistance on requesting a significant hardship exemption.

The College remains actively involved in quality improvement efforts. ACS nominee Stephen B. Edge, MD, FACS, recently was appointed Co-Chair of the National Quality Forum’s (NQF) Cancer Maintenance Endorsement Project, which is evaluating measures for cancer care. The ACS also continues to lead the Surgical Quality Alliance and remains active in the AQA (once known as the Ambulatory Quality Alliance), the NQF, and the Physician Consortium for Performance Improvement (PCPI). The College has nominated Frank Opelka, MD,
FACS, Associate Medical Director of the Division of Advocacy and Health Policy, to chair the PCPI.

Two other highlights of the year for the ACS Division of Advocacy and Health Policy are as follows:

• Under the Direction of the Health Policy and Advocacy Group, health policy research efforts are being moved into the Washington Office.
• The Chapter Lobby Day Grant Program was very well-received in 2012, with 16 states receiving funds.

Research and Optimal Patient Care
The Division of Research and Optimal Patient Care programs has begun implementing the PI initiative strategies noted previously in this report. In August, the division convened an all-day ACS Registry Retreat, during which important areas of distinction, and opportunities for improving efficiencies, expertise, and products were discussed.

This division continues to manage the College’s Continuous Quality Improvement (CQI), Cancer, and Trauma programs—all of which are integral to ensuring that the College enjoys another 100 years of Inspiring Quality.

CQI programs
The ACS National Surgical Quality Improvement Program (ACS NSQIP®) currently comprises more than 500 hospitals. More than 900 surgeons and other stakeholders participated in the seventh annual ACS NSQIP conference in July, which was well-received.

The College is participating in the Centers for Medicare & Medicaid Services (CMS) public reporting pilot program, known as Hospital Compare. Approximately 30 percent of ACS NSQIP hospitals are participating, which is markedly higher than was originally anticipated.

Other ACS NSQIP highlights are as follows:

• Real-time, risk-adjusted reports are now available for five ACS NSQIP measures that NQF has endorsed.
• The Centers for Disease Control and Prevention and ACS NSQIP have entered into a formal agreement to study surgical site infections.

• Efforts are under way to encourage surgeon champions to expand ACS NSQIP participation.
• Data from ACS NSQIP’s participant use file have been cited in more than 100 publications in 2012.

In addition to these important milestones, strides have been made in transforming the ACS Case Log into a Surgeon Specific Registry (SSR). The College has completed work with the American Board of Surgery (ABS) to identify procedures and procedure-specific variables for the SSR. Both the ABS and the American Board of Colon and Rectal Surgery have endorsed SSR for Maintenance of Certification (MOC) Part IV.

Following a meeting with CMS in June, the College submitted approximately 100 measures for use in the 2014 Physician Quality Reporting System (PQRS), including ACS/ABS-developed measures, a risk calculator developed by ACS NSQIP, and a Consumer Assessment of Healthcare Providers and Systems measure. Moreover, the College’s SSR vendor has become CMS-endorsed for submitting outcomes data to the PQRS—an achievement that will be of increasing relevance as the nation moves toward pay for performance.

The College currently has four Clinical Scholars-in-Residence and six confirmed for July 2013. These scholars conduct research in a broad range of areas, including cancer, health policy, vascular surgery, and so on. They have been invited to give presentations at meetings of the American Surgical Association and the Society of Surgical Oncology, as well as at the ACS Clinical Congress. Their research has been conducted with funding from the National Institutes of Health and the American Cancer Society. One Clinical Scholar played a key role in developing the new best practice guidelines in geriatric surgery.

Furthermore, the American Society for Metabolic and Bariatric Surgery and the ACS have joined forces to create the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. As a result, 700 bariatric surgery programs are now accredited by a single program.

Committee on Trauma (COT)
The COT presented its 90th annual meeting in Chicago this year, with more than 200 members and guests attending the event. Arthur Cooper, MD, FACS, re-
More than 900 surgeons and other stakeholders participated in the seventh Annual ACS NSQIP Conference in July, which was well-received.

The committee presented the 35th annual Residents Trauma Papers Competition in March. All U.S. and Canadian COT regions were represented; papers from Colombia and Taiwan were also submitted to the competition.

Two rural trauma workgroups have been established: one group to determine whether telemedicine is a useful and effective tool for use in rural trauma centers; the other to survey PI outreach programs between higher- and lower-level trauma centers and determine what makes a program effective.

The Total Quality Improvement Program (TQIP) now has 154 participating hospitals. The 2012 TQIP Annual Scientific Meeting and Training took place in October with Carolyn M. Clancy, MD, Director of the Agency for Healthcare Research and Quality (AHRQ), serving as the keynote speaker. Other TQIP activities are as follows:

• A total of 38 hospitals have enrolled in the Pediatric TQIP pilot program.
• TQIP is partnering with Michigan, Georgia, and Arkansas to form state collaboratives.
• A TQIP Best Practices project team has been assembled to develop a tool kit on care of the elderly trauma patient.
• Three risk-adjusted benchmark reports have been disseminated to TQIP participants along with online analytic tools.
• Monthly TQIP educational materials have been distributed to registry staff, and hospitals have received quarterly progress reports showing participation and average scores.

The National Trauma Data Bank (NTDB®) established a Trauma Center Inventory WorkGroup and compiled an initial list of more than 2,000 trauma centers. The NTDB received 110 research data set requests, conducted an annual call for data yielding more than 774,000 records from 744 hospitals, and distributed the NTDB Annual, Pediatric, Data Quality, Benchmark, and Pediatric Benchmark reports.

The Trauma System Evaluation and Planning Program has established a Trauma Joint Operating Committee of the ACS COT and the National Association of State EMS Officials, and is developing and field-testing an International Program Quality Review tool. The College also has completed a pilot trauma system benchmarking process in four states, finished work on a program policy and procedures manual, completed a staff and reviewer's guide to conducting site visits, and developed a PI matrix for report processing. The Trauma System Evaluation and Planning Program has scheduled and completed more than 200 North American site visits and an international verification site visit in Copenhagen, Denmark.

From August 2011 to August 2012, the Advanced Trauma Life Support® (ATLS®) course was presented 1,583 times to 27,007 health care professionals with promulgation in Iran and the Czech Republic. ATLS also has welcomed a 17th Region—ATLS-Middle East.

The ATLS Student Manual, Ninth Edition was released in September and includes free access to an ATLS app, which is designed to serve as both a bedside reference tool and supplemental educational resource.

Furthermore, ATLS’ e-learning project is on track for release early next year, and the ATLS course management system is being enhanced to now accommodate the Rural Trauma Team Development Course (RTTDC) and the Disaster Management and Emergency Preparedness (DMEP) course reports.

Updates on other COT-sponsored educational programs are as follows:

• The DMEP e-course is nearing production, and more than 600 students have been trained in 38 stand-alone courses since August 2011.
• The Advanced Surgical Skills for Exposure in Trauma (ASSET) DVD has been finalized; 59 courses have been held in the U.S. and Canada since last August with more than 400 students trained.
• The second edition of Advanced Trauma Operative Management (ATOM) course materials has been well received with 98 courses held in 10 countries since last August and more than 400 students trained.
• The RTTDC course has been offered 116 times since last August and has trained 2,040 students.

In addition, the COT has a Facebook page; more than 710 people have “liked” the page. The COT Twit-
Cancer Programs

The Commission on Cancer (CoC®) currently accredits 1,503 cancer programs, and 472 cancer programs are scheduled for survey by June 30, 2013. The CoC presented the Outstanding Achievement Award to 106 cancer programs surveyed in 2011.

In addition, the CoC issued new standards for accreditation this year—Cancer Program Standards 2012: Ensuring Patient-Centered Care. A series of webinars on the new standards began in December 2011, and a series of video vignettes addressing the requirements for each standard was released in October.

A best practices repository for accredited cancer programs was established, and the CoC is currently in discussions with the leadership of the Department of Veterans Affairs (VA) to expand CoC accreditation to all VA facilities. Workgroups met this fall to examine the accreditation needs of pediatric facilities and to investigate the possibility of international accreditation. The CoC also is developing a new Cancer Quality Improvement Report for CoC-accredited cancer programs.

A market research initiative identified opportunities for the CoC to expand its visibility, and a new business development component of the CoC was established this fall to work on recruitment and expansion. A print ad was placed in the Best Hospitals issue of U.S. News and World Report, and a new brochure—Improving Cancer Care through CoC Accreditation—was released.

Other notable COC accomplishments and goals include the following:

- Workgroups are assessing opportunities for public reporting of NCDB data.
- The Rapid Quality Reporting System was released in September 2011; more than 350 facilities are participating.
- A National Cancer Data Base participant use data file was released in August to 69 facilities.
- The CoC Clinical Scholar-in-Residence, Richelle Williams, MD, completed her two-year tenure with the CoC in June, and Jennifer Paruch, MD, a third-year general surgery resident at the University of Chicago Pritzker School of Medicine, began her work in July.
- The ProvenCare® Lung Cancer Collaborative pilot has been expanded with six additional facilities. More than 400 patients have been accrued to the study to date.
- Under the aegis of the Alliance for Clinical Trials in Oncology, the American College of Surgeons Clinical Research Program was established to validate and disseminate effective strategies to increase surgeon participation in clinical trials.

Another cancer program, the National Accreditation Program for Breast Centers (NAPBC), accredits 431 breast cancer centers in 48 states, with 252 additional centers scheduled for initial accreditation or reaccreditation in the coming year. The NAPBC averages five to 10 new applications each month. Other developments related to the NAPBC include:

- Approved for membership status with the CoC; James Connolly, MD, FACS, NAPBC Vice-Chair, appointed as the program representative
- Developed three breast-specific quality measures
- Organized the Collaborative Quality Improvement Committee to align the current quality measures and simplify data entry systems
- Began publication of a quarterly newsletter with a circulation nearing 4,500 and growing
- Placed an ad in the U.S. News and World Report Best Hospitals (August 2012) issue

In addition, the American Joint Committee on Cancer (AJCC) unveiled the Cancer Staging Atlas, 2nd edition at the 2012 Clinical Congress, in Chicago, IL. In addition, preparations are under way for publication of the eighth edition of the Cancer Staging System.

Education

The Division of Education continues to establish benchmarks and standards in surgical education, training, validation, and accreditation with the overarching goal of promoting excellence and expertise in surgery through cutting-edge programs, products, and resources. This year, new emphasis has been placed on helping surgeons and residents navigate transitions in their careers.
To improve the College’s media relationships, we have created an online newsroom offering timely background materials for reporters.

A number of ACS educational programs and products are designed specifically for practicing surgeons. For example, in addition to providing Category 1 continuing medical education (CME) credits, the College offers Certificates for Self-Assessment Credits and for Verification of Knowledge and Skills following successful completion of Postgraduate Courses at the Clinical Congress. These credits may be applied toward MOC. Special Certificates also are available for patient safety, trauma and critical care, ethics, and palliative care.

Surgical Education and Self-Assessment Program (SESAP™) 14 has been well-received, and SESAP enrollment numbers and revenues have continued to increase progressively over the past 10 years.

Additionally, the ACS Comprehensive General Surgery Review Course continues to be oversubscribed, and course participants have demonstrated significant increases in posttest scores over their pretest scores. Likewise, Selected Readings in General Surgery (SRGS) and SRGS Connect continue to be well-received, and readers continue to take advantage of the opportunities to earn self-assessment credits offered via this publication.

The College continues to develop and offer many educational programs and products for residents and medical students. The transition from residency to practice was addressed at a National Invitational Conference that the College cosponsored with the Accreditation Council for Graduate Medical Education. This conference resulted in the development of specific recommendations across several important domains. The transition from medical school to residency training is being addressed through the following:

• The ACS/Association of Program Directors in Surgery (APDS)/Association for Surgical Education (ASE) Entering Surgery Resident Prep Curriculum, which is scheduled for pilot testing this fall
• The ACS Fundamentals of Surgery Curriculum™, which has attained national prominence and has experienced continuous growth since its launch
• The ACS Surgery Resident Objective Structured Clinical Examination
• The ACS/APDS National Surgical Skills Curriculum

In addition to these efforts, the Division of Education has been heavily engaged in national dialogues

DIVISION OF EDUCATION:
ADDITIONAL 2012 HIGHLIGHTS

• The most recent version of Fundamentals of Laparoscopic Surgery, FLS 2.0, has been released.

• Ajit Sachdeva, MD, FACS, Director of the Division of Education, has continued to play an important leadership role in the Council of Medical Specialty Societies, serving as president and chair of the board of directors.

• Dr. Sachdeva was awarded the Margaret Hay Edwards Achievement Medal for Outstanding Contributions to Cancer Education by the American Association for Cancer Education and the Award for Outstanding Contributions to Healthcare Simulation by the Society for Simulation in Healthcare.

• The Division of Education received the National Media Award for its Patient Education Program from the American Society of Colon and Rectal Surgeons.

• The Committee on Ethics has created a new Workgroup on Ethics in Surgery to promote scholarship in surgical ethics and to advance ethics education in surgery.

• A committee of surgeons and sleep experts was appointed to address the impact of fatigue.
relating to restructuring of the general surgery curriculum, resident duty hours, and transition of postgraduate year (PGY)-1 surgery residents from direct to indirect supervision. Discussion has also started regarding whether a structured fellowship is needed to help with the transition from training to practice. These discussions will help to shape national policies in these domains.

An International Scholars Program was initiated this year, and two scholars were offered the opportunity to attend the Clinical Congress and visit an ACS-Accredited Education Institute.

The total number of ACS-Accredited Education Institutes has grown to 69, and new applications for accreditation continue to be received. Furthermore, a consortium of ACS-Accredited Education Institutes has been created, and standing committees have been established to pursue new directions to advance the field of simulation-based surgical education and training. A newsletter has been launched to enhance communication between the ACS-Accredited Education Institutes and facilitate discussion of best practices.

The Patient Education Program continues to establish new benchmarks. A principal anchor of the program is a set of Home Skills Training Kits. Evidence is mounting that the Ostomy Home Skills Kit has had positive effect on patient care and has been well-received.

In 2011, the Division of Education accredited more than 1,700 CME activities, providing more than 24,000 credits to more than 160,000 physicians. In addition, the Joint Sponsorship Program has continued to grow; in 2011, 93 activities were accredited through the program.

Other Division of Education highlights for the year appear in the sidebar on page 27.

### Integrated Communications

The Division of Integrated Communications released the redesigned *Bulletin* in September, marking the first time in 23 years that the magazine has undergone a full-scale overhaul. In addition, a *Bulletin* microsite has been created to provide a Web-based alternative to the print version.

The College is working with a consultant to conduct an audit of the public website ([www.facs.org](http://www.facs.org)), the members’ portal ([efacs.org](http://efacs.org)), and social media initiatives. The consultants produced a report that identified strategies for effective content management. As a result, a public website redesign will begin in 2013, as well as the integration of what is now the members’ portal into the main site.

To increase the visibility of the College’s advocacy efforts, a full-time Communications Manager was hired to work in the Washington Office. Since then, the College has steadily increased communications to Fellows regarding advocacy and health policy initiatives, most notably through the launch of a monthly e-newsletter, *The ACS Advocate*.

As part of the College’s Centennial celebration, two publications were given as gifts to 2012 Clinical Congress attendees: *A Century of Surgeons and Surgery: The American College of Surgeons 1913–2012*, by David L. Nahrwold, MD, FACS, and Peter J. Kernahan, MD, PhD, FACS, and *Remembering Milestones and Achievements in Surgery: Inspiring Quality for a Hundred Years 1913–2012*. To further commemorate the ACS’ 100th anniversary, the Division of Integrated Communications worked with a consultant to develop an interactive historical timeline that was unveiled at the Clinical Congress.

The Inspiring Quality campaign has significantly helped to strengthen the College’s brand(s). Members of the College’s leadership have participated in seven Inspiring Quality forums in 2012, with stops in San Diego, CA; Seattle, WA; Boston, MA; Chattanooga, TN; Houston, TX; Philadelphia, PA; and New York, NY.

Over the past year, the College has made considerable progress in creating a strong social media presence. The ACS now has 1,717 “likes” on Facebook, 6,063 followers on Twitter, and 217 YouTube subscribers, and it is expected that these numbers will continue to rise.

To improve the College’s media relationships, we have created an online newsroom offering timely background materials for reporters. The past quarter yielded strong media coverage for the ACS.

One outgrowth of our PI initiative was the recognition that the College could benefit from the creation of a marketing function. To this end, a cross-divisional staff team has been convened to help identify specific marketing needs and to prioritize them. At press time, it was anticipated that a marketing manager would be hired by the end of the year.
Member Services

An important role of the Division of Member Services is to provide staff support to the ACS Advisory Councils. One significant change that occurred in this area is the College’s new Advisory Council on Rural Surgery. The Advisory Councils also have extended their support for the Central Judiciary Committee’s (CJC) plan to conduct specialty-specific reviews, and the councils have made nominations for the Residency Review Committees, the CoC, and the COT.

Member Services is working with other ACS divisions, specifically Accounting, Finance, and the Foundation, to assess all ACS scholarship and fellowship offerings. This task is likely to be completed by the end of the year.

Operation Giving Back (OGB) participated in the development of the World Health Organization Resolution on Surgery and Anesthesia. This year, OGB also collaborated with other ACS Divisions to expand global networking and collaboration, worked with the U.S. Department of Health and Human Services and other ACS Divisions to develop a multispecialty expansion team, and planned sessions for presentation at the Clinical Congress.

The Young Fellows Association (YFA) continues to expand its influence and to seek new methods of encouraging young surgeon involvement in the ACS. The YFA increased visibility to Initiates through the provision of written materials in registration packets and increased personal contact through the YFA Communications Committee. The YFA also conducted a comprehensive review of all ACS committees to identify those that would benefit from YFA representation. Furthermore, the YFA participated in joint planning of the 2012 Leadership/Advocacy Conference with the College’s Division of Advocacy and Health Policy and fostered the growth of a mentorship program that is now in its second year.

The Resident and Associate Society conducted a resident needs assessment and a survey of program directors, moderated/cosponsored several sessions at the 2012 Clinical Congress, and is increasing its social media presence.

The CJC reviewed new cases and made recommendations for disciplinary action. The College has been managing the Society of Surgical Chairs for two years. Since then, a memorandum of understanding with the Association of Academic Surgical Administrators has been developed to facilitate a joint meeting at Clinical Congress, and membership has reached 164.

Another important milestone of the past year—the College now has 103 chapters, the newest in Egypt.

ACS Foundation

The ACS Foundation’s mission is to promote and expand voluntary philanthropy from Fellows and friends to support the College’s quality, education, and outreach programs. In fiscal year (FY) 2012, the Foundation received 1,612 gifts from individuals and organizations.

Through the efforts of the Communications and Donor Relations Director, the Foundation significantly expanded its customized donor communication program for the following purposes:

- Appropriately recognize the loyalty and program interests of current donors
- Better inform past donors about the use and impact of their giving
- Improve donor relations through personalized communication with Foundation volunteers and staff
- Provide a more customer-oriented online and real-time donor experience

Major donations were received from both Fellows and organizations to support the following current and future programs in patient care, quality, and education:

- The Murray F. Brennan, MD, FACS, International Scholarship
- The Thomas R. Russell, MD, FACS, Scholarship
- The Olga Jonasson Lectureship
- The Uniformed Services University of the Health Sciences’ endowed fund
- The Carlos A. Pellegrini Fellowship of the China-Hong Kong Chapter

The ACS Foundation submitted 78 funding requests to corporations, private foundations, and not-for-profit organizations in FY 2012, and 61 grants were received. Notably, Genentech renewed its support for the Surgical
Oncology Scholar-in-Residence and Coloplast provided a renewal grant and donated product to expand the Surgical Patient Education Program on Ostomy Skills.

The Corporate and Foundation Relations Committee hosted its annual Medical Industry Breakfast at the Clinical Congress to foster dialogue on key topics, and is supporting the College’s review of the issue of credentialing medical industry representatives.

The ACS Foundation continues to encourage planned gifts to the organization. The Mayne Heritage Society recognizes Fellows who inform the Foundation they have taken this step to invest in the future of the College and its programs. In the last year, the ACS Foundation sought to expand membership in this group through the One Hundred by One Hundred campaign.

In partnership with the Division of Integrated Communications, the Foundation has continuously improved its print and electronic communications. The Foundation has developed a portfolio of vehicles to recognize donors, announce major gifts, and provide useful information on philanthropy issues.

Furthermore, in FY 2012, 19 chapters and societies made donations. The ACS Foundation’s Board members or local volunteers attended 25 chapter meetings as well as meetings of the Southeastern and Southwestern Surgical Congress and the Western and Central Surgical Associations.

**Other activities**

The College remains fiscally sound (for more information about the College’s finances, see the report on page 63), and is in the process of streamlining some of its accounting activities to cut waste. Specific actions include the following:

- The College now leases more than 200,000 square feet of property and receives rent income from several businesses and associations in Chicago and Washington, DC.
- The ACS contracted with an investment consultant, Cambridge Associates, LLC.
- The College created an opportunistic investment allocation of up to 10 percent to take advantage of market dislocations, and the organization entered into its first two private investments.

**ACS SOCIAL MEDIA PRESENCE**

Twitter.com/AmCollSurgeons
Twitter.com/ACSTrauma

Event Hashtag #ACS100 identifies tweets related to the College’s Centennial celebration, as well as highlights people and events from our 100-year history.

YouTube.com/AmCollegeofSurgeons
Facebook.com/AmCollSurgeons
Facebook.com/ACSTrauma
Facebook.com/RASACCS

For more assistance or if you have questions or comments about the American College of Surgeons' social media sites, e-mail socialmedia@facs.org.
As always, the Information Technology department played a critical role in ensuring the success of many of the projects described in this report, including:

- Enhanced system use to support ACS-Accredited Education Institutes
- Updated electronic links to the ABS to meet new CME requirements
- Initiated video conference pilot
- Actively participated in the College’s PI initiative
- Worked with CQI to list the SSR as a PQRS registry with CMS

The staff in Convention and Meetings played an important role in the 20 F Street South Terrace Tent installation, which was celebrated with a hospitality industry opening reception in July. In addition, this area manages several associations and added four more groups since July 1: the American Broncho-Esophagological Association, the American Cochlear Implant Alliance, the American Rhinologic Society, and the American Society of Pediatric Otolaryngology.

Finally, I want to acknowledge the excellent support we all receive from the people in Executive Services. These individuals fulfill my daily staffing needs and provide management for the meetings of the Board of Regents and its Executive Committee, as well as direction and support for the Bylaws Committee, the Nominating Committee of the Board of Regents, the Honors Committee, and the Search Committees. In addition, they support the President, the President-Elect, and the Chair of the Board of Regents.

Executive Services staff members also manage the new Committee on Optimal Access and two prestigious annual events, namely the President’s Dinner and the Jacobson Innovation Award Dinner. For the past two years, Executive Services has been responsible for coordinating the 2012–2013 Centennial celebration. Furthermore, the staff in Executive Services is actively engaged in the PI program.

**Conclusion**
As this report demonstrates, all divisions and service areas of the College are working together to expand and improve the College’s programs and services. I am truly grateful for the ongoing support of the Board of Regents, the Officers, the Past-Presidents, the Board of Governors, the loyal volunteers, and the ACS staff. I look forward to continuing to work with all of you to create a more dynamic and influential American College of Surgeons that is well-positioned to meet the challenges of the next 100 years. ◆
To help commemorate the American College of Surgeons’ (ACS) 100th anniversary, the Bulletin of the American College of Surgeons is reprinting articles centered on the issues and developments that have defined the character and integrity of the organization throughout its history. This month, the Bulletin is reprinting the introductory text to the January 1926 issue, which highlighted the ACS’ first registry—the Registry of Bone Sarcoma, which was initiated, and originally managed, by Ernest Amory Codman, MD, FACS.

In his introductory remarks, ACS Founder Franklin H. Martin, MD, FACS, notes that “from this small beginning” other registries might evolve that would be useful in advancing medical and surgical science. He was right. Since then, the College has developed other important registries, including the National Cancer Data Base and the National Trauma Data Bank®. Both of these repositories have expanded in recent years and play a vital role in the College’s ongoing research efforts, which are integral to ensuring that surgical patients receive high-quality surgical care.

The establishment of the Registry of Bone Sarcoma in 1921 was a seminal event in the College’s history, and the January 1926 Bulletin described the findings that emerged from the study of the data collected in great detail. Following are introductory remarks from that Bulletin, which briefly summarize the College’s experience in establishing and managing the Registry of Bone Sarcoma.

A look at the College’s first registry: The Bone Sarcoma Registry

Figures from the 1926 Bone Sarcoma Registry.
THE officers and Regents of the American College of Surgeons wish to express their gratitude to Dr. E. A. Codman of Boston for having initiated and conducted for five years an activity of the College called the “Registry of Bone Sarcoma.” Most of the Fellows are acquainted with this hitherto small portion of our work and are familiar with Dr. Codman’s articles in Surgery, Gynecology and Obstetrics for March, 1922, and May, 1924, describing the methods of the Registry. Probably few of us have realized, as he has, the far-reaching value to medical science which may evolve from this small beginning. Registries of other rare surgical diseases or of new and hitherto undescribed diseases may be organized, and individuals or committees of the College may make similar collections of typical cases with roentgenological and pathological data and end results. The new Museum of the College should be the home of these collections and thus keep standard clinical entities, as Greenwich keeps standard time for the world. All the old, rare entities with which we are now familiar (although often confused by the great varieties of nomenclature applied to them) and the new entities which are constantly appearing can be thus standardized by collections of typical cases. This is a subject for thought, as the contribution of the original case reports by the individual Fellows of our organization is a necessary part of such work. We are indebted to the two hundred individuals who have registered cases of bone sarcoma and thus have made possible this first collection.

In order to illustrate this idea to you the Regents are printing on the succeeding pages “The Status of the Registry of Bone Sarcoma,” and material which appeared recently in a little book, “Bone Sarcoma,” compiled by Dr. Codman, in which he has interpreted the standard classification used by his Committee, which consisted of himself as Chairman, Dr. J. C. Bloodgood of Baltimore and Dr. James Ewing of New York. Dr. Codman has refused any royalty on the book which is reprinted herewith under a suitable arrangement with the publishers. This Bulletin is sent to the Fellows of the College in the hope that discussion of the subject may take place among them.

The Committee has performed a valuable service for all surgeons, roentgenologists and pathologists in bringing order out of chaos through the terminology of bone tumors, and it has achieved a sound basis for comparative statistics of therapeutic results.

A paper by Dr. Codman on the Registry (Part i, Twenty-Five Criteria for Establishing the Diagnosis of Osteogenic Sarcoma; Part ii, Thirteen Registered Cases of Five-Year Cures Analyzed According to These Criteria) will appear in the March, 1926, issue of Surgery, Gynecology and Obstetrics. It is clear that the Committee has succeeded not only in establishing a nomenclature but in collecting three series of cases which it considers typical of certain clinical entities, one of which is entirely new and sub judice. The proposed method of sending these boxes of standard cases to prominent pathologists and others interested for a kind of auditing, seems fair and sound. After these boxes have been carefully scrutinized by experts they can be stored at the College, whence they can be sent out to other laboratories for educational purposes.
It is with regret that the Regents have accepted the resignation of Dr. Codman as Chairman and Registrar of this Committee. The members of our special committees do not receive a salary for their services to the College, and Dr. Codman has repeatedly publicly stated that he does not and will not charge a fee for consultation on a registered case of bone sarcoma. His reasons for this are that in initiating the first registry he wished to preclude any idea that he was intending to specialize in this work, and that he has taken up the study as any general surgeon may investigate one field after another; but he does not feel that other members of the Committee should take this attitude, for lifelong study has made them true experts. The public in general should be able to pay for the special services of these experts, who would, as usual, omit charges in indigent cases.

As Dr. Codman’s successor as Chairman of the Registry of Bone Sarcoma we have been fortunate in receiving the acceptance of Dr. Dallas B. Phemister of Chicago. Data on cases to be registered and communications in reference to the Registry of Bone Sarcoma and its work should be sent to Dr. Phemister in care of the American College of Surgeons, 40 East Erie Street, Chicago.

To register a case send a brief clinical history, preferably but not necessarily with the patient’s name, and the reference number of your own hospital record. Send also a few typical roentgen-ray films or prints and a piece of the tissue or duplicate microscopic slides. A complete copy of your hospital record is desirable, but a good narrative abstract is sufficient. A discussion of the diagnosis and advice as to treatment will be sent to you at once if desired. At the end of a year the Registrar will write to you requesting a note on the progress of the case and give you the opinions of the consulting pathologists. Cases of supposed sarcoma of bone may be registered on roentgen-ray evidence alone, even if no operation has been done. It is desirable to register all cases of supposed bone sarcoma, cured or moribund.

By the Board of Regents
Rudolph Matas, President
John G. Clark
George W. Crile
James B. Eagleson
John M. T. Finney
Robert B. Greenough
Jasper Halpeny
Merritte W. Ireland
Allen B. Kanavel
Charles H. Mayo
Robert E. McKeechne
George Henry Murphy
Frederick W. Parham
Charles H. Peck
J. Bentley Squier
Franklin H. Martin, Director-General

January 1, 1926.

THE STATUS OF THE REGISTRY OF BONE SARCOMA

UP to June, 1925, 650 cases of supposed bone sarcoma were registered. These were classified by Dr. Codman as Registrar, according to the nomenclature published in Surgery, Gynecology and Obstetrics, May, 1924. (See Table I.)

From these figures it is obvious that the numbers of cases so far registered are quite insufficient for any statistical data of importance. However, under three headings: Osteogenic Sarcoma, Benign Giant Cell Tumor, and Ewing’s Tumor, enough cases are registered to make a preliminary analysis of some value of typical cases of each group. Accordingly the whole collection registered prior to June 1, 1925, has been separated into five large trunk-like boxes. (See Table II and Fig. 1.)
CODMAN: REGISTRY OF BONE SARCOMA

<table>
<thead>
<tr>
<th>Table I</th>
<th>With Slides</th>
<th>Without Slides</th>
<th>Death Already Reported</th>
<th>Death Not Yet Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metastases from carcinoma</td>
<td>22</td>
<td>3</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Periosteal-sarcoma</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Osteogenic tumors (benign)</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Osteogenic sarcoma (malignant)</td>
<td>90</td>
<td>43</td>
<td>119</td>
<td>124</td>
</tr>
<tr>
<td>Inflammation</td>
<td>31</td>
<td>14</td>
<td>3</td>
<td>42</td>
</tr>
<tr>
<td>Benign giant cell tumor</td>
<td>14</td>
<td>10</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Angioma, benign</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Angioma, malignant</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Ewing's tumor</td>
<td>66</td>
<td>4</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Myeloma</td>
<td>14</td>
<td>9</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Unclassified</td>
<td>305</td>
<td>119</td>
<td>206</td>
<td>40</td>
</tr>
<tr>
<td>Grand total</td>
<td>530</td>
<td>206</td>
<td>206</td>
<td>630</td>
</tr>
</tbody>
</table>

* Recent or imperfectly registered cases on which no late note has been received. Data insufficient for classification.

Box No. 1 has been sent to Dr. F. B. Mallory of Boston, No. 2 to Dr. Anatole Kolodny of Iowa City, No. 3 to Dr. Dallas B. Phemister of Chicago, No. 4 to Dr. James Ewing of New York and No. 5 to Dr. J. H. Wright of Boston. Each of these gentlemen has been asked to write a brief article for the Registry of Bone Sarcoma on the group of cases submitted to him so that he, as it were, may endorse or audit Dr. Codman's classification of each case and thus make the whole group a standard. For instance, Box No. 1 submitted to Dr. Mallory, contains 112 cases which Dr. Codman has selected as instances of typical benign giant cell tumor. It must be borne in mind that these 112 standard cases were not selected entirely on Dr. Codman's own authority, for on each case he has already had the written opinion of from five to fifteen consulting pathologists who have been studying the material of the Registry. Dr. Mallory, himself, will have seen most of these cases before, and he will now review them as a whole, as a standard series which the College can use in its Museum or continue to pass about for further opinions. We hope that while Dr. Mallory is making this final review of this material he will use it as the basis of a paper giving his reasons for believing that benign giant cell tumor is an abnormal repair phenomenon rather than a true neoplasm. The box can then be sent to one of the proponents of the theory that giant cell tumor is a neoplasm and is sometimes malignant. Box No. 1, with its 126 cases and the authoritative reprints written about them, can continue to pass about for educational purposes to whatever laboratories may desire to study the cases, each laboratory contributing a brief paper in turn, whereupon the box can be stored at the Museum of the College to await a future investigator.

The same plan will be followed with the other boxes, each automatically passing from laboratory to laboratory, giving those interested a chance to agree or disagree on the existence of each entity of our classification or on the individual cases.

In the meantime such new cases as are registered can be assembled in small boxes, containing about 10 cases each, and sent in rotation to the laboratories interested, as described in Surgery, Gynecology and Obstetrics, May, 1924.

Thus two sets of boxes will be rotating at the same time, i.e., first, the small boxes containing recently registered cases will be circulated as heretofore for diagnosis...
and prognosis until each case has been passed upon by about ten different pathologists; and, second, the large boxes containing groups of about 100 standardized cases already passed upon by many pathologists and now being sent for special study to the pathologists or surgeons who have already passed upon most of the cases.

Fig. 1. Cases used for storing and shipping records of bone sarcoma.

Before these larger boxes are stored in the Museum of the College it is hoped that they may move about sufficiently to establish more or less uniform ideas of the different types of bone tumors. After a few years these cases can be reviewed, at a time when there will be a record of most of the end results of the cases. Therapeutic data can then be compiled impartially on an agreed standard diagnosis.

At the present time any analysis of results would seem futile because of lack of uniformity in diagnosis and too short a lapse of time. It would be unwise to have the person who compiles the results also classify the cases. This classification is preliminary only and cannot be considered authoritative. Other competent persons should check up the selections, and this will be done automatically as these boxes pass about.

As far as results may be summarized on the existing data, the Committee on the Registry of Bone Sarcoma has reported that at present there is only one case of malignant bone sarcoma that may be considered a five-year cure by any method other than amputation. This is a case of Dr. Coley's (183) in which an exploratory operation was followed by mixed toxins and heavy radiation with radium. This remarkable case was not a typical osteogenic sarcoma, although clearly malignant histologically.

There are only 17 other malignant cases (Ewing's tumor, 4, and osteogenic sarcoma, 13) that may be considered five-year cures even by amputation plus radium and toxins. These cases will be reported upon later. Most of them are atypical. There are a few others still more atypical. Most of the successful cases are Dr. Coley's, and he deserves the thanks of all those interested in the Registry. In two of the cases it seems pretty clear that amputation alone would have been ineffective, for unoperated glandular or intraabdominal masses disappeared after radiation and toxins.

On the other hand nearly all cases diagnosed as "benign giant cell tumors" were living when last reported upon, whatever their treatment had been. The question in these cases is as to the best method of cure rather than the one method of cure. In benign giant cell tumors the beneficial result of radiation is well demonstrated by Cases 47, 158, 165, 166, 167, 169, 182, 204, 240, 295, 319, 320, 321, 322, 353, 374, 379, 381, 392, 402, 528, 536, 545, 587, 590.

As a matter of logic, radiation for bone tumors in general shows up as well as, if not better than, surgery. However, from all forms of treatment combined in typical malignant cases the percentage of good results is certainly very small. Many supposed recoveries of sarcoma were probably cases of benign giant cell tumor.

Registry of Bone Sarcoma
E. A. Codman, Chairman
Joseph C. Bloodgood, James Ewing
June 1, 1925.
The ACS recognizes the following facts:

- Multiple mild brain injuries or concussive events may be associated with long-term cognitive and memory impairment.
- Return to play before full recovery from a concussion may facilitate bodily injury because full athletic reflexes, judgment, and balance may still be impaired.
- A repeat head injury before full recovery from a concussion can result in a catastrophic neurological outcome.
- Even mild repetitive head injuries may be deleterious to the long-term well-being of the afflicted patient.

Supported by this evidence, the ACS supports efforts to promote, enact, and sustain legislation and policies that encourage:

- Appropriate head protection when participating in activities, either occupational or recreational, where a risk of traumatic brain injury exists.
- Education of coaches, athletic trainers, and medical personnel present at youth sporting events regarding the recognition and diagnosis of concussions and mild brain injuries.
- Policies that allow for intermittent baseline neuropsychological testing for participants in high-risk sports or activities.
- Immediate removal of a youth athlete from a practice or game when a concussion is suspected.
- Prompt medical assessment of a concussion victim by a health care provider familiar with current head injury treatment protocols and testing.
- Clearance by a qualified health care provider trained in the evaluation and management of concussions prior to returning to athletic practices, games, or other high-risk activities.
Statement on Council of Medical Specialty Societies’ Code for Interactions with Companies

The Board of Regents of the American College of Surgeons (ACS) adopted the Council of Medical Specialty Societies’ Code for Interactions with Companies during the Board’s October 2012 meeting. The code, which was released in June 2011, is available at http://www.bulletin.facs.org.

The ACS Board of Regents is responsible for monitoring and guiding College interactions with companies.

The code provides policies and procedures to reinforce and assist the College in maintaining actual and perceived independence of programs, policies and advocacy positions.

Related statements: ST-36—Statement on Guidelines for Collaboration of Industry and Surgical Organizations in Support of Continuing Education.*

The Centers for Medicare & Medicaid Services (CMS) oversees several programs that offer eligible professionals (EP) incentives for successful participation and penalties for nonparticipation. These programs include the Electronic Prescribing (eRx) Incentive Program, the Physician Quality Reporting System (PQRS), and the Electronic Health Record (EHR) Incentive Program. The deadlines for enrollment in some of these programs are already in place, and others are drawing near.

To help surgeons successfully comply with the requirements associated with participating in these programs, the American College of Surgeons (ACS) has continued to make available new or updated information concerning each phase of the programs’ implementation in the Bulletin, on the ACS website, and in other ACS communications. This column summarizes the different reporting options available and what happens when surgeons and other EPs elect to not participate in the programs. Table 1 on page 41 provides an overview of the incentives and penalties associated with the PQRS, eRx and EHR programs.

What is the penalty if I do not participate in the eRx Incentive Program?
EPs who choose not to participate in the eRx Incentive Program and who do not qualify for an automatic exemption may be penalized starting in calendar year (CY) 2014. To avoid a 2014 eRx payment penalty of 2 percent of the Medicare Part B physician fee schedule amount for covered professional services, health care professionals must meet one of the following criteria:

- Report electronically 25 times for denominator eligible visits from January 1 to December 31, 2012. Refer to Table 2 on page 43 for a list of the denominator eligible codes.

- Report electronically at least 10 times from January 1 to June 30, 2013, for any visit. The visit does not have to be associated with a denominator eligible code, but must be submitted in conjunction with a billable, covered procedure not associated with a global period.

- Apply for a 2014 significant hardship exemption by June 30, 2013, once the portal opens in early 2013. See the sidebar on page 41 for a list of the 2014 significant hardship exemptions.

- Be automatically exempt from the eRx Incentive Program. EPs who meet any one of the automatic exemptions do not have to apply or submit anything to CMS. EPs will be automatically exempt from the 2014 eRx Incentive Program penalty if they meet any one of the following:
  - EP is a successful electronic prescriber during the 2012 eRx 12-month reporting period of January 1 to December 31, 2012
  - EP is not an individual with a medical degree, doctor of osteopathic medicine, podiatrist, nurse practitioner, or physician assistant by June 30, 2013
  - EP does not have at least 100 Medicare Part B physician fee schedule cases containing denominator eligible codes as listed in Table 2, for dates of service from January 1 to June 30, 2013
  - At least 10 percent or more of the EPs Medicare Part B physician fee schedule charges are not from denominator eligible codes for dates of service from January 1 to June 30, 2013
  - The EP does not have prescribing privileges, and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1 to June 30, 2013

What is the penalty if I do not participate in the PQRS program?
EPs who choose not to participate or who are unsuccessful in their attempts to comply with the PQRS program face a payment penalty of 1.5 percent of the Medicare Part B physician fee schedule amount for covered professional services in CY 2015. EPs who are unable to satisfy any of the PQRS reporting...
requirements for this program in CY 2013 will be penalized in 2015. More information on the finalized PQRS reporting options is available in the 2013 Medicare physician fee schedule final rule found at http://www.ofr.gov/OFRUpload/OFRData/2012-26900_PI.pdf.

Note that EPs may still qualify to receive incentive payments for successfully participating in the PQRS program in CY 2013 and 2014. EPs who satisfy the requirements may be eligible to receive an incentive payment of 0.5 percent of their total Medicare allowed charges in CY 2013 and a 0.5 percent bonus in CY 2014 if they continue to satisfy the PQRS requirements.

What is the penalty for not participating in the Medicare EHR Incentive Program?
EPs who choose not to participate in the EHR Incentive Program will be assessed a penalty of 1 percent of professional services covered under the Medicare Part B physician fee schedule in CY 2015. An EP can avoid this penalty by becoming a Stage 1 meaningful use provider by July 3, 2014, and attesting as such no later than October 1, 2014. To avoid the 2015 EHR penalty, EPs who have already achieved their first year of meaningful use must complete their full calendar year reporting in 2013.

Note that EPs may still receive incentive payments for the Medicare EHR Incentive Program if they successfully meet the meaningful use requirements and complete their attestation to CMS by the specified date. EPs who began reporting Stage 1 requirements in CY 2011 or 2012 will be eligible for a full incentive payment of $44,000. EPs who begin reporting Stage 1 requirements in 2013 will be eligible to receive $39,000, and EPs who begin reporting in 2014 may qualify for a bonus of up to $24,000.

How will the bonuses and penalties affect my bottom line?
Each bonus payment is added to an EPs Medicare Part B fee schedule payment amount. For example, if an EP is eligible for bonus payments for all three programs in CY 2012 and has

<p>| TABLE 1. TOTAL CMS INCENTIVE PROGRAMS INCENTIVES AND PENALTIES 2011 AND BEYOND |</p>
<table>
<thead>
<tr>
<th>----------------------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
<th>-------------------</th>
</tr>
</thead>
<tbody>
<tr>
<td>PQRS</td>
<td>1.0%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>-1.5%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>eRx</td>
<td>1.0%</td>
<td>1.0%</td>
<td>-1.0%</td>
<td>0.5%</td>
<td>-1.5%</td>
<td>-2.0%</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>EHR-Medicare</td>
<td>2011: $18,000</td>
<td>2012: $18,000</td>
<td>2013: $18,000</td>
<td>2014: $18,000</td>
<td>2015: $18,000</td>
<td>2016: $18,000</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>2012: $12,000</td>
<td>2013: $12,000</td>
<td>2014: $8,000</td>
<td>2015: $8,000</td>
<td>2016: $4,000</td>
<td>2017: $4,000</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-4.0%</td>
<td>-5.0%</td>
</tr>
<tr>
<td></td>
<td>2013: 8,000</td>
<td>2014: $4,000</td>
<td>2015: $4,000</td>
<td>2016: $4,000</td>
<td>2017: $4,000</td>
<td>2018: $4,000</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-4.0%</td>
<td>-5.0%</td>
</tr>
<tr>
<td></td>
<td>2014: $4,000</td>
<td>2015: $4,000</td>
<td>2016: $2,000</td>
<td>2017: $2,000</td>
<td>2018: $2,000</td>
<td>2019: $2,000</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-4.0%</td>
<td>-5.0%</td>
</tr>
<tr>
<td></td>
<td>2015: $2,000</td>
<td>2016: $2,000</td>
<td>2017: $2,000</td>
<td>2018: $2,000</td>
<td>2019: $2,000</td>
<td>2020: $2,000</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-4.0%</td>
<td>-5.0%</td>
</tr>
<tr>
<td></td>
<td>2016: $2,000</td>
<td>2017: $2,000</td>
<td>2018: $2,000</td>
<td>2019: $2,000</td>
<td>2020: $2,000</td>
<td>2021: $2,000</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-4.0%</td>
<td>-5.0%</td>
</tr>
</tbody>
</table>

HARDSHIP EXEMPTIONS AVAILABLE FOR 2014* 
- Inability to electronically prescribe due to state or federal law, or local law or regulation
- The EP prescribes fewer than 100 prescriptions during a six-month payment adjustment reporting period
- The EP practices in a rural area without sufficient high-speed Internet access (G8642)
- The EP practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

*Some additional hardship exemptions were finalized after the final publication of the 2013 Fee Schedule. Any new information on these exemptions will be published in a future issue of the Bulletin.
$100,000 in Medicare allowed charges, the EP would be eligible for a $18,500 bonus—a $500 bonus for the PQRS program, and an $18,000 bonus for the EHR Incentive Program—if the EP began participating in the EHR Incentive Program in 2012. An EP is also required to participate in the eRx program in order to avoid a penalty in 2014 by meeting the criteria required to gain an incentive payment, minimally report to avoid the penalty, or claim an exemption. However, if an EP is eligible to receive the Medicare EHR incentive bonus, he or she is not eligible to receive the eRx bonus. Therefore, an EP who successfully participates in the PQRS, EHR, and eRx programs in the scenario described above could expect a total of $18,500 between the EHR and PQRS incentives.

In penalty in 2014, the provider will see a reduction of $2,000. Additionally, if an EP has $100,000 in Medicare allowed charges and is unsuccessful in meeting PQRS and EHR requirements and is assessed the 2015 penalties for both programs, total Medicare Part B payments will be reduced $2,500 due to a $1,500 penalty for the PQRS program and a $1,000 penalty for the EHR Incentive Program. (Note that each program has a different timeframe for assessment of the penalty.)

**What resources are available to assist with enrollment and participation in each program?**


The ACS is a professional partner of AmericanEHR Partners, which provides information on various EHR vendor ratings, podcasts that offer an overview of various components of the program, proposals from various vendors, disseminates e-newsletters, and more. To register with AmericanEHR, go to [www.americanehr.com/Home.aspx](http://www.americanehr.com/Home.aspx).
Multiple ipsilateral breast cancers: Can the breast be preserved?

by Judy C. Boughey, MD, FACS; Kari Rosenkranz, MD, FACS; and Heidi Nelson, MD, FACS

Thanks to modern imaging, clinicians are finding more occult breast disease and are now increasingly facing the dilemma of how best to treat multiple cancers within the same breast. Multiple ipsilateral breast cancers (MIBCs) are now detected at rates ranging from 13 to 75 percent, and this uptick in detection is thought to be one of the reasons for the national and international trend toward increasing mastectomy rates. Whereas the practical solution for most surgeons and patients has been to proceed with mastectomy, perhaps it is time to consider whether treatments used to preserve the breast for one cancer can be extended to patients with two or three tumors within the same breast.

Many surgeons recommend mastectomy for women with multiple tumors due to concerns about the high rates of local recurrence. Although it is historically well-founded, this belief is based on retrospective studies from the late 1980s and early 1990s—studies that were less inclusive of current multimodality practices. Older studies on this topic reported alarming rates of local recurrence for patients with multiple tumors, but they did not include many of the current-day therapies, such as adjuvant and neoadjuvant endocrine, chemo, and radiation therapy.

More current studies have concluded that local recurrence rates in women with MIBC who have negative surgical margins and are subsequently treated with appropriate adjuvant therapy are equivalent to local recurrence rates in women with unifocal disease. The largest of these trials, conducted by Gentilini and colleagues, reviewed 476 patients treated with breast-conserving therapy (BCT) for MIBC between 1997 and 2002. Despite significant nodal disease in the study population (55 percent of all patients were node positive), the local recurrence rate in this trial was 5.1 percent at five years. These results are considered equivalent to recurrence rates in the unifocal breast cancer population. Because breast conservation is associated with improved patient satisfaction, quality of life, and body image compared with mastectomy, we propose it is time to revisit the practice of mastectomy in this population.

ACOSOG Z11102 is a recently activated Alliance for Clinical Trials in Oncology study that will determine prospectively whether breast conservation is a safe surgical approach for patients with MIBC.
Perhaps it is time to consider whether treatments used to preserve the breast for one cancer can be extended to patients with two or three tumors within the same breast.

dose constraints due to volume of boost, or poor cosmesis. Additional endpoints include patient and physician perceptions of breast cosmesis, incidence of breast lymphedema, and adverse effects of radiation given larger or multiple lumpectomy cavities and boost areas.

Patients eligible for this study must meet the following criteria:

- Older than 40 years of age
- Greater than two foci of biopsy-proven breast cancer separated by > 3 cm of normal breast tissue
- Largest single tumor focus < 5 cm
- Invasive breast cancer or ductal carcinoma in situ, with minimum of one site with invasive disease
- Biopsy-proven disease at two sites within the same breast
- Mammogram < 60 days and magnetic resonance imaging < 45 days prior to registration
- cN0 or N1 disease

The schema for the trial illustrates that it is a registry (non-randomized) trial. (See figure, this page.)

This trial is the first prospective look at this increasingly common clinical scenario. Results will provide important data with which surgeons and radiation oncologists may inform patients and discuss surgical treatment options. If local recurrence rates
If local recurrence rates are shown to be acceptable for BCT in women with MIBC, rates of breast conservation in this population will increase.

REFERENCES

To help reach a consensus on ways to reduce the use of five common medical treatments that are sometimes employed unnecessarily, The Joint Commission and the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) recently sponsored a National Summit on Overuse to discuss strategies for improving the quality and safety of patient care.

A variety of key stakeholders, including representatives from physician organizations, specialty societies, government agencies, research institutions, and patient groups, came together at the summit to discuss the appropriate use of the following treatments and procedures:

- Tympanostomy tubes for middle ear effusion of brief duration
- Appropriate blood management
- Early term, non-medically indicated, elective delivery
- Elective percutaneous coronary intervention
- Antibiotics for uncomplicated viral upper-respiratory infections

Summit participants considered the existing evidence regarding the appropriate use of these five treatments and discussed ways to raise awareness among health care professionals and patients and to reduce overuse. Recommendations to effectively address appropriate use of these treatments to improve health care quality and reduce potential risk to the patient were developed using a consensus-building process. For example, the recommendations included the creation of educational tools for health care professionals and patients, dissemination of leading practices to health care professionals, standardized reporting of data, and the alignment of existing guidelines.

Podcasts on topics discussed at the summit are available, and are listed in the sidebar.

To listen to podcasts highlighting the summit’s events, visit The Joint Commission at www.jointcommission.org/podcast.aspx?CategoryId=12&F_All=y.

NATIONAL SUMMIT ON OVERUSE PODCASTS

- Overuse as it relates to quality of care: Mark R. Chassin, MD, FACP, MPP, MPH, president, The Joint Commission
- Overuse as it relates to a patient-centered approach to health care: Bernard M. Rosof, MD, chair, AMA PCPI
- Tympanostomy tubes for middle ear effusion of brief duration: David W. Roberson, MD, FACS, American Academy of Otolaryngology–Head and Neck Surgery
- Appropriate blood management: Aryeh Shander, MD, Society for the Advancement of Blood Management
- Early-term, non-medically indicated, elective delivery: Bryan T. Oshiro, MD, Loma Linda (CA) University Medical Center and Children’s Hospital
- Elective percutaneous coronary intervention: Carl L. Tommaso, MD, NorthShore University Health System, Skokie, IL
- Antibiotics for uncomplicated viral upper respiratory infections: Donna E. Sweet, MD, AAHIVS, MACP, American College of Physicians
Many people consider Hippocrates the father of Western medicine. More than 2,000 years ago, his beliefs and teachings focused on human beings having a body and a soul, and for the first time, illness was to be rooted in an imbalance of bodily fluids, rather than the result of displeasing the gods or other supernatural forces. According to Hippocrates, in order for someone to be free of illness, these fluids—collectively known as the four humours (derived from the Latin word “humour,” meaning fluid)—needed to remain in balance. The four humours are blood, yellow bile, black bile, and phlegm.

Approximately 500 years later, Galen, a prominent Roman physician, developed many of Hippocrates’ teachings into a comprehensive typology of temperament in his dissertation, *De Temperamentis*. He describes four temperaments that corresponded to one of the four humours: sanguine (blood), courageous and hopeful; choleric (yellow bile), easily angered and bad-tempered; melancholic (black bile), sleepless and irritable; and phlegmatic (phlegm/mucous), calm and unemotional.

The association between yellow bile and anger holds true today as it relates to diseases and injuries of the biliary tree. Many physicians have come across, at one time or another in their career, either a raging cholangitis, gangrenous cholecystitis, or serious hepatobiliary injury. These patients tend to be quite ill and have increased morbidity and mortality. Fortunately, traumatic injuries of the biliary tree/gallbladder are relatively rare occurrences. A recent retrospective review over a 12-year period at a single trauma center revealed 33 injuries in 30 patients (0.1 percent) out of 26,014 trauma admissions. There were 10 injuries to the gallbladder and 23 injuries to the biliary tree, with a median injury severity score of 25, a median length of stay of 19 days, and a 10 percent mortality rate.

To examine the occurrence of biliary tract injuries in the National Trauma Data Bank® (NTDB) research dataset for 2010, admissions medical records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Specifically searched were diagnosis codes 868.02 (injury to other intra-abdominal organs without mention of open wound into cavity, bile duct, and gallbladder) and 868.12 (injury to other intra-abdominal organs with open wound into cavity, bile duct, and gallbladder). A total of 413 such injuries were uncovered; 397 records contained a hospital…


The injuries may result in a leakage of bile, but there is “no humour” in a biliary tract injury.

discharge status, including 277 patients discharged to home, 54 to acute care/rehab, and 19 to skilled nursing facilities; 47 died (see figure, this page). These patients were 80.2 percent male, on average 33.1 years of age, had an average hospital length of stay of 17.3 days, an intensive care unit (ICU) length of stay of 9.3 days, an average injury severity score (ISS) of 21.8, and were on the ventilator for an average of 9.3 days. The mortality, hospital length of stay, ICU length of stay, ISS, and ventilator days for this group represent one of the highest subsets reported in this column to date.

The incidence of injury, overall severity, length of stay, and mortality in the NTDB review was similar to that of the study mentioned in the previous paragraph. These patients were seriously injured and required significant hospital care. The injuries may result in a leakage of bile, but there is “no humour” in a biliary tract injury.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. The NTDB Annual Report 2011 is available on the ACS website as a PDF file and as a PowerPoint presentation at www.ntdb.org. In addition, information regarding how to obtain NTDB data for more detailed study is available on the website. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgement

Statistical support for this article has been provided by Chrystal Caden-Price, Data Analyst, NTDB.
Dr. Pellegrini selected as next President-Elect of the College

Carlos A. Pellegrini, MD, FACS, FRCS(I)(Hon), The Henry N. Harkins Professor and Chair, department of surgery, University of Washington, Seattle, was named President-Elect of the American College of Surgeons (ACS) during the Annual Business Meeting on October 3. Dr. Pellegrini has been a Fellow of the College since 1982 and has played a leadership role in the organization, particularly as Chair of the Board of Regents (2010–2011).

A graduate of the University of Rosario Medical School, Dr. Pellegrini completed his internship and general surgery residency at Granadero Baigorria, Rosario University Hospital in Argentina. He completed a Fellowship in esophageal physiology and surgery and second general surgery residency at the University of Chicago, IL. In 1979, he was appointed to the faculty of the University of California-San Francisco (UCSF) where he developed and directed a center for gastrointestinal motility. During his tenure at UCSF, the surgical residents and medical students presented him with multiple awards for his outstanding skills as an educator. In 1993, he became the chairman of the department of surgery at the University of Washington, and in 1996, he became the first Henry N. Harkins Professor and Chair in recognition of his role in strengthening the department of surgery’s clinical, teaching, and research programs. He is a distinguished leader in minimally invasive gastrointestinal surgery and a pioneer in the development of video endoscopy for the surgical treatment of gastroesophageal reflux disease and esophageal motility disorders. He is credited with the development of the University of Washington’s Center for Videoendoscopic Surgery, the Center for Esophageal and Gastric Surgery, and the Institute for Simulation and Interprofessional Studies.

Dr. Pellegrini began serving on the ACS Board of Regents in 2002 and served on the Regents’ Finance, Honors, and Communications Committees. He is the outgoing Chair of the ACS Committee for the Accreditation Review of Education Institutes, and past-Chair of the Committee on Medical Motion Pictures (1991–1992), the Central Judiciary Committee, and the International Guest Scholarship Subcommittee of the International Relations Committee. He serves on the Steering Committee on Simulation-Based Surgical Education and the Task Force on the Resident 80-Hour Work Week and was Co-Chair of the 2012 Surgeons as Leaders Course. In addition, he was President of the Northern California Chapter of the ACS (1990–1992).


A prolific author of scholarly articles, chapters, editorials, and books, Dr. Pellegrini has served on the editorial boards of the Journal of Laparoendoscopic Surgery and Advanced Surgical Techniques, Journal of Gastrointestinal Surgery, Surgery, and Annals of Surgery. He also has served as an editorial reviewer for Gastroenterology, Archives of Surgery, and the American Journal of Gastroenterology.

The Vice-Presidents-Elect also were named at the Annual Business Meeting. Layton “Bing”
Rikers, MD, FACS, professor emeritus at the University of Wisconsin-Madison and Editor-in-Chief of Surgery News, is First Vice-President-Elect. John Preskitt, MD, FACS, a surgical oncologist at Baylor University Medical Center, Dallas, TX, is the Second Vice-President-Elect.

A Fellow since 1980, Dr. Rikers is the former A.R. Curreri Professor of Surgery and Chairman at the University of Wisconsin. He is a past-chairman of the American Board of Surgery and is president-elect of the American Surgical Association. Since 2003, he has developed and chaired Surgeons as Leaders: From Operating Room to Boardroom—an ACS course that prepares surgeons for the complex challenges of leadership.

Dr. Preskitt has been a Fellow since 1984 and was a Regent from 2000 to 2009. He chaired the Board of Governors’ Committee on Chapter Relations (1997–2000), the Committee on Ethics (2006–2009), and the General Surgery Coding and Reimbursement Committee (2006–2011). He served as President of the North Texas Chapter of the College from 1997 to 1998. He is currently clinical professor of surgery, Texas A&M Health Science Center Baylor campus, and is the director of surgical oncology at the Baylor Sammons Cancer Center in Dallas. ♦

PROVIDE YOUR PATIENTS WITH LEADING-EDGE, HIGH-QUALITY BREAST CARE

Seek accreditation from the National Accreditation Program for Breast Centers (NAPBC).

NAPBC accreditation is the best way for your center to offer patients every significant advantage in their battle against breast disease. NAPBC-accredited centers:

- Demonstrate a commitment to high standards of clinical practice and quality improvement by utilizing nationally recognized, multidisciplinary quality performance measures.
- Participate in data collection to monitor outcomes and improve the quality of care at local, state, and national levels.
- Promote patient and professional education for the treatment of breast disease.

Join the nationally recognized network of breast centers dedicated to providing quality breast health care with the full scope of resources and services to support the continuum of care.

MAKE A COMMITMENT TO PROVIDE HIGH QUALITY BREAST CARE TO YOUR PATIENTS.
APPLY FOR NAPBC ACCREDITATION TODAY!

To learn about the accreditation process, visit: www.accreditedbreastcenters.org

NAPBC
NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
ACS Regents and Governors elected at Annual Business Meeting

Julie A. Freischlag, MD, FACS, the William Stewart Halsted Professor, director of the department of surgery, and surgeon-in-chief at Johns Hopkins Hospital, Baltimore, MD, was elected Chair of the Board of Regents (B/R) of the American College of Surgeons (ACS), and Mark C. Weissler, MD, FACS, Joseph P. Riddle Distinguished Professor at the University of North Carolina, Chapel Hill, was elected Vice-Chair at the Annual Business Meeting during the 2012 Clinical Congress, in Chicago, IL.


She currently serves on the Advisory Council for Vascular Surgery and the Comprehensive Communications Committee.

Dr. Weissler, an otolaryngologist and chief of the division of head and neck oncology in the department of otolaryngology-head and neck surgery at the University of North Carolina, Chapel Hill, and a director of the American Board of Otolaryngology, has been a Regent since 2006 and was an ACS Governor from 2002 to 2007. A Fellow since 1989, he has been an active member of the following ACS committees: Committee on Ethics (2009–2012, Chair, 2011–2012); Pre- and Postoperative Care Committee (1993–2002); Advisory Council for Otolaryngology-Head and Neck Surgery (2002–present); Central Judiciary Committee (Chair, 2011–2012); Honors Committee (2008–2011); Member Services Liaison Committee (2006–2008); Committee on Informatics (2011–2014); Program Committee (Liaison, 2011–2013); and Committee on Education (2011–2012). Dr. Weissler also presently serves on the Scholarships Committee and the Comprehensive Communications Committee. He is a Past-President of the

**Regents**

In addition, the following surgeons were elected to the B/R and began their first three-year terms in October: John L.D. Atkinson, MD, FACS, Rochester, MN; Henri R. Ford, MD, FACS, Los Angeles, CA; Enrique Hernandez, MD, FACS, Philadelphia, PA; L. Scott Levin, MD, FACS, Philadelphia, PA; Beth H. Sutton, MD, FACS, Wichita Falls, TX; and Steven D. Wexner, MD, FACS, Weston, FL.

Dr. Atkinson is a professor of neurological surgery at the Mayo Clinic in Rochester, MN. A fellow since 1994, Dr. Atkinson served as Chair of the Advisory Council for Neurological Surgery, as a member of the Board of Governors (B/G) (2006–2012), and as a member of the Committee on Trauma. He served on the Program Committee (1997–2004) and on the Committee on Resident Education (2005–2011).

Dr. Ford is vice-president and surgeon-in-chief at Children’s Hospital of Los Angeles, CA, and is vice-chairman and vice-dean for medical education at the Keck School of Medicine of the University of Southern California. As a Governor (2005–2011), he served on the B/G Executive Committee (2009–2010) and as Vice-Chair of the Executive Committee (2010–2011), chaired (2008–2010) and was Ex Officio (2010–2011) of the Nominating Committee, and was a member of the B/G Committee on Surgical Infections (2006–2009) and Liaison to the Committee on Surgical Infections (2010–2011). He also was a Liaison to the B/G Committee on Chapter Relations. In addition, he served on the Committee on Trauma (2005–2011), the Committee for the Forum on Fundamental Surgical Problems (2006–2012), and the Board of Regents Member Services Liaison Committee (2010–2011). He currently is a member of the Program Committee and the Surgical Forum Representative for the Advisory Council for Pediatric Surgery.

Dr. Hernandez is The Abraham Roth Professor and Chair of the department of obstetrics, gynecology and reproductive science; director of the division of gynecologic oncology; and professor of pathology at Temple University in Philadelphia, PA. As an ACS Governor (2005–2011), he served on the Committee to Study the Fiscal Affairs of the College (2006–2011). He is a Past-President of the Metropolitan Philadelphia Chapter of the ACS (2001–2002).

Dr. Levin is the Paul B. Magnuson Chair of Orthopaedic Surgery, chair of the department of orthopaedics, and professor of surgery at the University of Pennsylvania School of Medicine in Philadelphia. He is a plastic and reconstructive surgeon at the University of Pennsylvania Health System, Philadelphia. Dr. Levin is a retiring ACS Governor (2006–2012) and, in that capacity, has served on the Governors’ Committee on Surgical Practices. After serving on the Advisory Council for Orthopaedic Surgery for 10 years (1998–2008), he was named Chair of the Council (2008–2012). He also served as a Liaison to the Program Committee (2011) and is presently on the Committee on Video-Based Education.
Dr. Sutton is a general surgeon in private practice in Wichita Falls, TX, and a clinical assistant professor of surgery at the University of Texas Southwestern Medical School, Dallas. She has served on the Board of Governors (2004–2010) and on the B/G Executive Committee (2008–2010), the B/G Committee on Chapter Relations (2005–2008), and the Governors’ Committee on Surgical Infections (2008–2010). She also has served on the College’s Committee on Patient Safety and Quality Improvement (2003–2009). She is a Past-President of the North Texas Chapter of the ACS (2001–2002) and chairs the Northern Texas Credentials Committee (1993–present). Dr. Sutton presently serves on the Nominating Committee of the Fellows and the Women in Surgery Committee.

Dr. Wexner is chair of the department of colorectal surgery at Cleveland Clinic Florida in Weston, clinical professor of surgery and affiliate dean for clinical affairs at Florida Atlantic University in Boca Raton. He has served as a member of the Advisory Council for Colon and Rectal Surgery (Chair, 2003–2005, and member, 1997–2003). As a Governor (2000–2006), he served on the Governors’ Committee on Socioeconomic Issues (2004–2006). He is a member of the Commission on Cancer (CoC®) and serves on the CoC’s Accreditation Committee and on the Committee on Video-Based Education. He is a Past-President of the South Florida Chapter of the ACS. He has served on the editorial board of the Journal of the American College of Surgeons since 2000, and served on the Board of Directors of the American College of Surgeons Professional Association-SurgeonsPAC (2005–2010).

Reelected to additional three-year terms on the Board of Regents were: Raymond F. Morgan, MD, FACS, Charlottesville, VA; Leigh A. Neumayer, MD, FACS, Salt Lake City, UT; and Marshall Z. Schwartz, MD, FACS, Philadelphia.

B/G Executive Committee
The Board of Governors reelected Lena M. Napolitano, MD, FACS, Ann Arbor, MI, as Executive Committee Chair; Gary L. Timmerman, MD, FACS, Sioux Falls, SD, as Vice-Chair; and William G. Gioffi, Jr., MD, FACS, Providence, RI, as Secretary. Also reelected to the Executive Committee of the Board of Governors were Lorrie A. Langdale, MD, FACS, Seattle, WA; and Sherry M. Wren, MD, FACS, Palo Alto, CA. ✦
Royal College of Surgeons of Edinburgh honors ACS President Dr. A. Brent Eastman

The Royal College of Surgeons of Edinburgh, or RCS(Ed), awarded Honorary Fellowship to A. Brent Eastman, MD, FACS, President of the American College of Surgeons (ACS), at a diploma ceremony held in October at Scotland’s Edinburgh College. In presenting Honorary Fellowship to Dr. Eastman, chief medical officer of Scripps Health, San Diego, CA, the RCS(Ed) recognized the role he played as co-founder of the San Diego trauma system. The RCS(Ed) further acknowledged Dr. Eastman’s decades-long impact on surgical advancement, particularly through his key role in improving the management of trauma care in several countries, as well as his substantial contributions to humanitarian relief internationally.

The San Diego trauma system serves as a model for trauma systems throughout the U.S., England, Australia, Brazil, Argentina, Canada, Mexico, South Africa, India, and Pakistan. In May 2012, an RCS(Ed) report indicated that Scotland was falling behind the rest of the world in its provision of care for victims of major trauma. The RCS(Ed) recommended the development of a trauma system across Scotland, based on the San Diego model, in an effort to improve the management of trauma care in Scotland.

“Dr. Eastman is the pre-eminent trauma surgeon in the United States and a world authority on the development of trauma systems,” according to RCS(Ed) President David Tolley, MB, FRCS, FRCS(Ed). The San Diego model designed by Dr. Eastman has resulted in fewer trauma deaths, from 22 percent of preventable deaths to less than 1 percent over a period of approximately 25 years, Dr. Tolley said.

“He is also a natural leader, a quality that has extended beyond political and professional leadership to the practical leadership of humanitarian relief programs,” Dr. Tolley said. “In the immediate aftermath of Hurricane Katrina in 2005, he led a support team in response to a request from the federal government, and again in 2010, he was one of the first response surgeons to the earthquake in Haiti, where he had to amputate the limbs of many individuals trapped in the rubble of the main hospital in conditions likened to those last observed in the American Civil War.

“There is a shared theme between Dr. Eastman’s aspirations for the American College of Surgeons and our own objectives for RCS(Ed). Both organizations recognize the need to respond to the challenges of training young surgeons in the fewer working hours available each week and share a desire to provide equality of access to the highest standards of surgical care for our patients. These are international problems, and in admitting Dr. Eastman to the Honorary Fellowship, I believe we have taken a small step forward towards working together more closely to address these and other issues common to the worldwide surgical community and to the patients we serve,” Dr. Tolley added.
Highest Standards, Better Outcomes

Jim Henry, Incorporated would like to extend a heartfelt congratulations and gratitude to every American College of Surgeons Member and Fellow, on the occasion of the College’s Centennial Celebration. For 60 years, Jim Henry has served the College with responsive, hands-on customer service and outstanding quality awards and recognition. As we celebrate our own 75th anniversary in business, we look forward to many more years of successful partnership with the American College of Surgeons.
Egyptian Chapter presents first conference

The recently established Egyptian Chapter of the American College of Surgeons (ACS) presented its inaugural conference in collaboration with the College September 6–9 at the Sonesta Hotel in Cairo.

Representing the ACS at the meeting were then-President Patricia J. Numann, MD, FACS, and Patricia L. Turner, MD, FACS, Director of the Division of Member Services. The program was chaired by Sherif Omar, MB, BCh, FACS, Egyptian Chapter President; Alaa Ismail, MB, BCh, FACS, ACS Governor; Adel Foad Ramzy, MD, FACS, Senior Advisor; and Mohey Elbanna, MB, BCh, FACS, Secretary/Treasurer.

The program included a presentation by Moustafa Hasan, MB, BCh, FACS, titled Current Guidelines of Trauma and Emergency (Acute Care) Surgery.

Other topics discussed at the conference included the following:

- Healthcare advocacy and leadership: Role of Egypt Chapter of the ACS
- Stewardship and modernizing surgical education and training
- Rural surgery in the U.S. and Egypt
- Recent trends in minimally invasive and robotic surgery
- Scott Helton, MD, FACS, director of liver and pancreatic surgery and director of the hepatopancreatobiliary fellowship training program at Virginia Mason Medical Center, Seattle, WA, presented the annual clinical update titled Significance and Management of Major Vessel Involvement in Carcinoma of the Pancreas
- Donald Jenkins, MD, FACS, consultant, division of trauma, critical care, and general surgery; and associate professor of surgery, Mayo College of Medicine; and medical director, trauma center, Mayo Clinic, Rochester, MN, gave the 15th Annual “Mo” Henig Trauma Lecture, Military Care of the Wounded
- The following speakers participated in a panel discussion on Crisscrossing the Globe: Trends in Getting Started and Giving Back:
  - Kathleen Casey, MD, FACS, Director, Operation Giving Back, addressed humanitarian outreach among surgeons
  - Timothy Flynn, MD, FACS, senior associate dean for clinical affairs, University of Florida (UF) College of Medicine and chief medical officer for Shands at UF, Gainesville, spoke on surgical workforce issues

Michigan Chapter hosts guest lecturers, paper competition

The Michigan Chapter of the American College of Surgeons (MCACS) presented its 59th Annual Meeting and 61st Resident Surgeons Competition May 16–18, at the Park Place Hotel in Traverse City, MI. More than 100 surgeons and surgical residents from throughout the state participated in this year’s event.

The meeting kicked off Wednesday evening with a new Remarkable Cases Reception, during which practicing surgeons, residents, and medical students presented eight unusual cases for roundtable discussion. The event was standing room-only and was so successful that the chapter intends to make it a permanent part of the conference.

Guest speakers at this year’s meeting included:

- Dr. Numann, who provided an update on College activities and gave a special presentation on the importance of organized medicine

by Mark Chou
• Timothy Robert B. Johnson, MD, FACS, professor, obstetrics and gynecology, University of Michigan Health System, Ann Arbor, discussed international medical education

• Gazi B. Zibari, MD, FACS, FICS, academic vice-chair, department of transplantation; professor of surgery, Malcolm Feist Endowed Chair in Transplantation at Louisiana State University (LSU) Health Sciences Center, Shreveport; and director, Willis-Knighton/LSU Health Sciences Center Regional Transplant Program, spoke on two decades of medical charity work in Kurdistan

Rounding out the program, Ira Kodner, MD, FACS, Solon and Bettie Gershman Professor of Surgery, division of general surgery, section of colon and rectal surgery, Washington University School of Medicine, St. Louis, MO, and director, Washington University Center for the Study of Ethics and Human Values, gave the Krishna K. and Pamela E. Sawhney Ethics in Surgery Lecture titled Surgeons and Ethics: You Bet!

A major focus of the annual event is the residents’ paper competition. This year, 67 abstracts were submitted for consideration, and the top 52 were selected for presentation (all abstracts presented are posted at www.michiganacs.org). This year’s winners were:

• Frederick A. Coller Award (First Place Overall): Jasneet Bhullar, MD, Providence Hospital and Medical Centers, Southfield, MI, Effects of Intraluminal Chemotherapy on Colorectal Cancer—Study in an Orthotopic Murine Mode

• Alexander J. Walt Award (Second Place Overall): Danielle Fritze, MD, University of Michigan, Thrombin Mediates Vagal Apoptosis and Dysfunction in IBD

• Education Award: Andrea Obi, MD, University of Michigan, Simulation-Based Evaluation of Conflicts between [Accreditation Council on Graduate Medical Education] Restrictions and Adequate Training Opportunities for Cardiothoracic Transplant Surgery

• Michigan Committee on Trauma Basic Science Award: Abubaker Ali, MD, Wayne State University, Detroit Medical Center, The Stress Hormone Epinephrine Increases IGA Transport across Respiratory Epithelial Surfaces

• Farouk N. Obied Clinical Trauma Award: Gerald Wright, MD, Grand Rapids Medical Education and Research Center, MI, The Effect of Splenectomy on Mortality in Blunt Severe Traumatic Brain Injury

• D. Emerick Szilagyi Michigan Vascular Prize: Sean English, MD, University of Michigan, Ann Arbor, Increased 18F-FDG Uptake in the Aortic Wall of Beta-Aminopropionitrile Exposed Rats May Be Predictive of AAA Rupture

• Gift of Life Transplantation Award: David Demos, MD, University of Michigan, Development of an Automated Perfusion System for Organ Procurement and Resuscitation

• Robert V. Danto Memorial Cancer Research Award: Sha’Shonda Revels, MD, University of Michigan, Racial Disparities in Esophageal Cancer Outcomes

Lastly, the 2012–2013 Michigan Chapter Council members were elected and installed at the meeting. For a listing of council members, visit the Michigan Chapter website at www.michiganacs.org. ♦
After 10 years of combing through 95 boxes of material, the Archivists for the American College of Surgeons (ACS) have completed descriptions of the collection of ACS Founder Franklin H. Martin, MD, FACS, and his wife Isabelle. The 54-page archival description, which is now available at www.facs.org/archives, includes the Martins’ scrapbooks of photos and memorabilia from 1901 to 1934 and more. Materials from the Martins’ scrapbooks have been available to researchers for several years, and the contents of one of the 43 volumes available through the Digital Collections link can be viewed on the ACS Archives website. However, this latest addition to the website is the first in-depth public look at all of the Martins’ papers.

David L. Nahrwold, MD, FACS, and Peter J. Kernahan, MD, PhD, FACS, consulted many of these records while conducting their research for the centennial history of the College, A Century of Surgeons and Surgery: The American College of Surgeons, 1913–2012. They were privy to records from the first two decades of the College’s history. No previous historian of the College had access to these materials; however, future historians and biographers of Dr. Martin will find the collection to be essential reading, providing intimate insight into the founding and early years of the College.

### Restoration and inventory
The papers were first discovered in 2001 in old, rusty metal filing cabinets stored in the College’s John B. Murphy Memorial Auditorium Building. Over the course of the next decade, the brittle memoirs were given de-acidification treatment, and rehoused in polypropylene, preservation-friendly sleeves for safe and easy handling by researchers. ACS Archivists Susan Rishworth and Dolores Barber then completed a thorough inventory of the records to develop item-level descriptions of all of Dr. Martin’s correspondence. An arrangement scheme became clear as more and more records were uncovered and the inventory grew.

Among the items in the collection are the following:

- Records of Martin’s early career as a gynecologist, including casebooks from 1891 to 1917
- Original records from now-defunct Chicago medical schools and hospitals that were instrumental in the founding of the ACS
- A full collection of memoirs, including documentation of Dr. Martin’s service as medical director of President Woodrow Wilson’s civilian arm of the Council of National Defense, on which he served during World War I with such luminaries as Samuel Gompers, Bernard Baruch, Julius Rosenwald, Howard Coffin, and Hollis Godfrey
- Item-level descriptions of all the correspondence from 1885 to 1935
- Background on his publications
- Photos
- Hundreds of sympathy letters after he died

The College encourages all members who are interested in learning more about the College’s history to delve into this thorough description of the Dr. Franklin Martin papers. For more information on accessing the papers, contact ACS Archivist Susan Rishworth at srishworth@facs.org.
The American College of Surgeons (ACS) is accepting nominations for the ninth Joan L. and Julius H. Jacobson II Promising Investigator Award to be conferred in 2013. This award recognizes outstanding surgeons engaging in research, advancing the art and science of surgery, and demonstrating early promise of significant contribution to the practice of surgery and the safety of surgical patients. The award, funded through a generous endowed fund established by the donors, is in the amount of $15,000. The ACS Surgical Research Committee will administer the award.

**Award criteria**

- Candidate must be board certified in a surgical specialty and must have completed surgical training in the last six years.
- Candidate must be a Fellow or an Associate Fellow of the College.
- Candidate must hold a faculty appointment at a research-based academic medical center. Candidate holding a military service position is also eligible.
- Candidate must have received peer-reviewed funding, such as a K-series award, from the National Institutes of Health (NIH), Veterans Administration, National Science Foundation, or U.S. Department of Defense merit review to support their research effort.
- Nomination documentation must include a letter of recommendation from the nominee’s department chair. Up to three additional letters of recommendation will be accepted.
- Only one application per surgical department will be accepted.
- Nomination documentation must include an NIH-formatted biographical sketch and copies of the candidate’s three most significant publications.
- Nominees must submit a one-page essay to the committee explaining why they should be considered for the award and discussing the importance of the research that they have conducted.

Special consideration will be given to surgeons who are at the “tipping point” of their research careers and have a track record indicative of early promise and potential (such as a degree program in research or K-award). Surgeon-scientists who are well established (such as recipients of NIH R01 grants) are not eligible.

**Nomination procedures**

To be considered for the award in 2013, submissions must be dated no later than March 1, 2013. Award criteria documents and nomination materials may be sent electronically to jacobsonpia@facs.org or via a flash drive mailed to: Carla Manosalvas, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Note that your essay and biographical sketch must be submitted as a Word document. Applicants are encouraged to verify that all necessary materials have been received before the deadline. For additional information, contact Ms. Manosalvas at jacobsonpia@facs.org or 312-202-5319.

Dec 2012 BULLETIN American College of Surgeons
The American College of Surgeons (ACS) in October held the ACS Surgical Health Care Quality Forum Philadelphia, the ninth stop in a national tour to drive discussions on effective quality improvement methods that surgeons, physicians, and hospitals are using to improve patient safety and reduce costs.

The Philadelphia forum focused on the importance of physician-led quality improvement initiatives in achieving better outcomes, citing the ACS National Surgical Quality Improvement Program (ACS NSQIP®) as a leading model that provides surgeons with reliable data to help pinpoint areas for improvement.

“We’re all faced with the challenges of navigating a complex and ever-changing health care system,” said Marshall Z. Schwartz, MD, FACS, professor of surgery and pediatrics at Drexel University College and pediatric surgeon-in-chief at St. Christopher’s Hospital for Children, Philadelphia, an ACS Regent, and event co-host. “The good news is we don’t have to re-invent the wheel to achieve the level of quality improvement and cost savings we need for health reform to be successful.”

“Using proven quality improvement methods like ACS NSQIP is a perfect example of what we as physicians can do together to support health reform,” added ACS Regent Howard M. Snyder III, MD, FACS, attending urologist at Children’s Hospital of Philadelphia, professor of urology in surgery at the University of Pennsylvania School of Medicine, Philadelphia, and event co-host.

Keynote speaker U.S. Rep. Jim Gerlach (R-PA), a member of the House Ways and Means Committee, cited parallels between the government’s health care reform efforts and quality improvement programs such as ACS NSQIP, which collects clinical, risk-adjusted, 30-day outcomes data in a nationally benchmarked database. He also addressed the need to link higher quality care to reimbursement.

“The mission of the Ways and Means Committee right now is to prevent the 27 percent cuts in Medicare reimbursement and extend it until we can come up with a proper formula for reimbursing physicians,” said Representative Gerlach. “[Surgeons] bring a credibility and knowledge that legislators don’t have, and I would
encourage you to advocate for these changes we need to have and the programs you want to save because they work.”

The forum emphasized the reduction of complications with a focus on surgical outcomes—an objective that is not new in Pennsylvania.

“Pennsylvania was the first state to publicly report hospital-acquired infections and that transparency has improved the appetite for quality improvement programs in our state and around the country,” said Larry R. Kaiser, MD, FACS, senior executive vice-president for health services and dean, Temple University School of Medicine; and president and chief executive officer, Temple University Health System, Philadelphia, PA. “Surgeons trust and embrace clinical data, which is why the Society of Thoracic Surgeons National Database and ACS NSQIP have been successful tools to reduce complications and improve patient care.”

“For 10 years, Geisinger has focused on an intervention framework to identify variation in care and re-engineer best practices, resulting in decreased costs and improved quality,” said Glenn D. Steele, Jr., MD, PhD, FACS, president and chief executive officer, Geisinger Health System, Danville, PA. “Surgery departments present a clear opportunity to define complications and implement and assess solutions, as there is a distinct starting and end point to support accurate measurement.”

Beyond improving patient care and reducing costs, ACS NSQIP is a valuable source of trusted information that surgeons use to compare themselves with their colleagues and that can be used by individuals to differentiate hospitals in their community.

“Using a program like ACS NSQIP allows us to benchmark ourselves against our colleagues as well as other hospitals across the country and create a national standard,” said John S. Kukora, MD, FACS, FACE, chairman, department of surgery, and program director, general surgery residency program, Abington Memorial Hospital (PA). “This [type of] reporting isn’t just for surgeons and hospital administrators. It can also inform consumers’ choices as they are armed with knowledge and can choose a hospital based on its performance record.”

While much of the panel focused on the profession’s quality improvement successes, one panelist pointed out enhanced ways to study and measure the successes of ACS NSQIP in hospitals around the country.

“From a business school perspective, continuous quality improvement [CQI] is a good idea in theory but rarely works in practice,” said Mark V. Pauly, PhD, Bendheim Professor, professor of health care management, professor of business economics and public policy, The Wharton School, University of Pennsylvania. “However, based on what I’ve seen thus far, I’m encouraged to believe ACS NSQIP is an exception to the rule, though more empirical evidence comparing outcomes data between hospitals with the program and those without is needed to convince health economists that CQI can be effective.”

To encourage health care leaders to share best practices on quality improvement in 2012, the ACS hosted community forums across the nation. To view the archived forum video and follow updates on upcoming tour locations, visit InspiringQuality.FACS.org or the College’s YouTube channel at http://www.youtube.com/AmCollegeofSurgeons.
Members in the news

**George John Alexander, MD, FACS**, a plastic surgeon in Las Vegas, NV, has assumed the presidency of the Clark County Medical Society. He is past-chief of plastic surgery at Mountain View Hospital in Las Vegas, and he is the former chief and the founder of the plastic surgery department at Mike O’Callaghan Federal Hospital, also in Las Vegas. He has been awarded two Surgeon General Awards for his accomplishments in plastic surgery. Dr. Alexander is also a recipient of the distinguished physician recognition award from the American Medical Association.

**Gregory R.D. Evans, MD, FACS**, chief of the Aesthetic and Plastic Surgery Institute at the University of California in Irvine, was elected to serve a one-year term as president of the American Society of Plastic Surgeons (ASPS) at the society’s annual scientific conference. Dr. Evans co-chairs the American College of Surgeons (ACS) Advisory Council Program Representatives and is a former member of the ACS Program Committee. He also served as a Specialty Society Representative on the College’s Advisory Council for Plastic and Maxillofacial Surgery.

**Geoffrey R. Keyes, MD, FACS**, was elected the new board president of the American Association for the Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF). Dr. Keyes previously served as the secretary, treasurer, and vice-president of AAAASF’s board. He is a past-president of the California Society of Plastic Surgeons, the Aesthetic Society Education and Research Foundation, and the Los Angeles Society of Plastic Surgeons and served as treasurer of the Rhinoplasty Society. Dr. Keyes is a former member of the ACS Committee on Trauma.

**J. Wayne Meredith, MD, FACS**, delivered the 2012 Annual Yandell-Polk Lecture on October 26 at the University of Louisville, KY. The focus of his lecture, titled On the Shoulder of Giants, was on the management of thoracic trauma. Dr. Meredith is the director of Surgical Sciences and the Richard T. Myers Professor of Surgery and chair of the department of general surgery at Wake Forest University School of Medicine, Winston-Salem, NC. He holds a cross-appointment at the Wake Forest School of Medicine, and is executive director of the Childress Institute for Pediatric Trauma, Winston-Salem. Dr. Meredith serves as general surgery residency program director and chief of surgery of Wake Forest Baptist Medical Center. He served as the Medical Director of trauma programs of the ACS from 2006 to 2010, and as treasurer and president of the Southern Surgical Association. He is a past-president of the American Association for the Surgery of Trauma. ♦
ACS financial update 2012

by Gay L. Vincent, CPA

The American College of Surgeons (ACS) consolidated financial statements for the fiscal years ended June 30, 2011 and 2012, were audited by McGladrey & Pullen LLP (McGladrey). The independent audit firm issued an “unqualified” opinion on the College’s consolidated financial statements.

The College ended its fiscal year on June 30, 2012, with a deficiency of operating revenue over operating expenses of $781,500 (prior year 2011, excess of $751,344). Operating revenues increased by approximately $6.1 million, whereas expenses increased by approximately $7.6 million compared with the previous fiscal year. A comparison of operating revenue by activity from 2012 and 2002 reflects the significant growth in the College’s quality improvement programs (see Figure 1, this page).

The College’s total assets declined by approximately $2.3 million due primarily to a negative 2.2 percent return on ACS investments. The College’s year-to-date return (January through June) as of June 30, 2012, was 3.2 percent and annualized over three years was 8.2 percent. The College’s investment portfolio is diversified as illustrated in the table on this page.

FIGURE 1. 2012 AND 2002: ACS OPERATING REVENUE BY ACTIVITY

<table>
<thead>
<tr>
<th>2012</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dues</td>
<td>Dues</td>
</tr>
<tr>
<td>Quality Programs</td>
<td>Quality Programs</td>
</tr>
<tr>
<td>Clinical Congress</td>
<td>Clinical Congress</td>
</tr>
<tr>
<td>Product Sales</td>
<td>Product Sales</td>
</tr>
<tr>
<td>5% Endowment Spending Rate</td>
<td>5% Endowment Spending Rate</td>
</tr>
</tbody>
</table>

INVESTMENT ALLOCATIONS

<table>
<thead>
<tr>
<th>2012 Percent allocation</th>
<th>2002 Percent allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. large cap</td>
<td>18</td>
</tr>
<tr>
<td>U.S. small cap</td>
<td>4</td>
</tr>
<tr>
<td>Global ex U.S. equity</td>
<td>18</td>
</tr>
<tr>
<td>Hard assets</td>
<td>15</td>
</tr>
<tr>
<td>Fixed income (bonds)</td>
<td>13</td>
</tr>
<tr>
<td>Emerging markets</td>
<td>11</td>
</tr>
<tr>
<td>Absolute returns</td>
<td>19</td>
</tr>
</tbody>
</table>
The occupancy rate of 20 F Street NW, the College’s Washington Office building, continues to increase and is currently at 77 percent. The financing for that building was recently renegotiated to achieve more favorable rates and fees. The interest rate on the promissory loan at June 2012 was 0.743 percent.

Contributions to the College and to the ACS Foundation have increased as reflected in Figure 2, this page.

The Board of Regents approved $1,524,000 in scholarships and fellowships for fiscal year 2014. Funding for scholarships comes from the following sources: annual dues contributions (13 percent), specific donor named funds (20 percent), and ACS Fellows and Scholarship funds (67 percent).
The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary actions at its June 8, 2012, meeting:

• Christopher J. Kovanda, a plastic surgeon from Maple Grove, MN, had his ACS Fellowship placed on probation with conditions for reinstatement. That action followed a disciplinary action from the Minnesota Board of Medical Practice after it was determined that he had engaged in sexual conduct with a patient.

• A colon and rectal surgeon has had a nonpublic disciplinary action taken against his ACS Fellowship following charges that he had violated the Bylaws, Article VII, Sections 1(f) and (i), when providing expert witness testimony in a medical malpractice lawsuit.

• Michael Omidi, a plastic surgeon from Los Angeles, CA, had his full ACS Fellowship privileges restored following a period of probation. Dr. Omidi fulfilled the conditions for reinstatement as determined by the Central Judiciary Committee (CJC) and approved by the Board of Regents in June of 2009.

The following disciplinary actions were taken by the Board of Regents at its September 29, 2012, meeting:

• George D. Griffin III, MD, FACS, an orthopaedic surgeon from Cincinnati, OH, had his Fellowship placed on probation with conditions for reinstatement of his full Fellowship privileges. This action was taken following disciplinary action by the State Medical Board of Ohio following allegations that he had failed to conform to minimal standards of care with respect to 14 patients.

• Kevin M. Lorenz, MD, an ophthalmic surgeon from Bismark, ND, was suspended from the College with conditions for reinstatement of his Fellowship. This action was taken following disciplinary action by the Montana Board of Medical Examiners and the North Dakota State Board of Medical Examiners. Those states took disciplinary action based on a determination that Dr. Lorenz had practiced medicine while under the influence of alcohol.

• Michael L. Smith, MD, FACS, a general surgeon from Williamston, NC, had his Fellowship placed on probation with conditions for reinstatement. This action was taken following disciplinary action by the North Carolina Medical Board finding that Dr. Smith was treating family members for non-minor, non-emergent medical conditions on more than one occasion.

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

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

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

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

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

• **Expulsion:** The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
I was honored and excited to attend the 2012 American College of Surgeons (ACS) Clinical Congress, in Chicago, IL, as the Nizar N. Oweida, MD, FACS, Scholar. I was able to participate in many skills and didactic Postgraduate Courses otherwise unavailable to me. The Clinical Congress gave me opportunities to connect with other rural surgeons from the New England area and throughout the country. I also was able to catch up with my residency program colleagues and attendings.

The first Postgraduate Course that I attended took place on the day I arrived, Saturday, September 29. I participated in the Challenging Surgical Emergencies Postgraduate Course, which provided an overview of difficult cases that often present themselves in the middle of the night. As a rural surgeon, I found it extremely useful to see how different situations could be managed with minimal support systems in place and which situations are best handled by immediate transfer to a tertiary care facility.

On Sunday I took part in a skills course that included a half-day lecture and a half-day hands-on lab. The course, Flexible Endoscopy for General Surgeons, enhanced my technical skills for endoscopies, which are frequent in my rural surgery practice. Tips for new techniques and different modalities of polyp removal were informative and helpful. It was wonderful to be able to meet the specialists at the hands-on lab and to interact with colleagues performing endoscopic techniques and maneuvers. Trying to remove all the different types of foreign bodies from the lab stomach was very entertaining.

On Monday I continued my education with a daylong Postgraduate Course on Benign Anorectal Disorders. Again, with no colorectal specialist in our rural area, we do see a myriad of issues involving the anal-rectal region. Being able to evaluate and determine comprehensive treatment options for these patients without having to send them to a tertiary facility to see a specialist is very valuable. I also appreciated the discussion, which included a number of questions to the panelists on how rural general surgeons handle benign anorectal disorders.

I had time to participate in a Meet the Expert Luncheon, which covered the subject of difficult ostomies. The informal luncheon actually turned into a lively discussion regarding such issues as ostomy placement, adequate length of the ostomy, which type of ostomy to place in different situations, and parastomal hernias.

On Tuesday, October 2, I attended a half-day lecture on Laparoscopic Colectomy. Every type of colectomy available was evaluated during a discussion of techniques for a laparoscopic and/or hands-on approach. The specialists discussed different approaches that could be used and varied ways to address port placement. This was a good
review for me as I continue to offer laparoscopic colectomy in my rural practice. After this morning session, I viewed some of the scientific exhibits, and then I was off to the rural surgery forum where I was presented with the Oweida Scholarship. During this event, I made connections with other rural surgeons, exchanged information, and heard stories of other rural surgeons’ struggles and successes.

Finally, on Wednesday, October 3, I wrapped up my experience at the ACS Clinical Congress by attending other panel sessions. My experience was enhanced by a sightseeing trip in Chicago, to the Willis Tower, the tallest building in the U.S.; Cloud Gate ("The Bean") in the city’s Millenium Park; and Navy Pier. My husband and I enjoyed dining at some wonderful Chicago restaurants, from pizza parlors to fine steakhouses. We also snuck in a night at the Second City Comedy Club.

Clinical Congress was a wonderful educational experience, an amazing opportunity to socialize and network, and a chance to enjoy the sights, sounds, and tastes of Chicago. I want to thank the Scholarship Committee and Mrs. Margaret (Nizer) Oweida for this wonderful opportunity. I gained a large amount of useful information, and I will incorporate these new skills into my rural surgery practice at Androscoggin Valley Hospital in Berlin, NH. In this way, being the Oweida Scholar benefitted not only me, but also the colleagues and patients with whom I can share this wealth of information.

ACS Members who are recertifying can now enjoy the ease of submitting their ACS CME credits directly to the American Board of Surgery (ABS).

From members’ MyCME page, click on the “Send CME to ABS” option at the top of the page.

Submission is quick and easy:
→ Review your transcript for accuracy and authorize transfer of credits
→ Have your ABS 13-digit authorization number ready

Log into the member Web portal at www.eFACS.org to get started
The American College of Surgeons (ACS) is offering scholarships to subsidize attendance and participation in the Executive Leadership Program in Health Policy and Management at the Heller School for Social Policy and Management, Brandeis University, Waltham, MA (http://heller.brandeis.edu/academic/exceed/index.html).

The 2013 course will take place June 9-15. The award is in the amount of $8,000 to be used toward the cost of tuition, travel, housing, and subsistence during the period of the program and the post-course follow-up period.

The College is funding two 2013 scholarships for general surgeons. The College is pleased that several surgical specialty societies also have agreed to co-sponsor a scholarship for a member in good standing of both the College and the respective surgical society to attend this intensive program. (See sidebar for list of participating societies that are supporting scholarships.)

The closing date for receipt of all application materials is February 1, 2013. All applicants will be notified of the outcome of the selection process by March 31, 2013.

Questions may be directed to the ACS Scholarships Administrator at kearly@facs.org, or 312-202-5281. Requirements and application instructions for the scholarships are available at http://www.facs.org/memberservices/research.html.

Send applications for this scholarship in a PDF format to kearly@facs.org, or to Scholarships Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

### Participating Societies

- American Association of Neurological Surgeons
- American Academy of Otolaryngology-Head and Neck Surgery
- American Association for the Surgery of Trauma
- American College of Surgeons
- American Pediatric Surgical Association
- American Society of Breast Surgeons
- American Society of Colon and Rectal Surgeons
- American Society of Plastic Surgeons
- American Surgical Association
- American Urogynecologic Society
- American Urological Society
- Eastern Association for the Surgery of Trauma Foundation
- New England Surgical Society
- Society for Surgery of the Alimentary Tract
- The Society of Thoracic Surgeons
- Society for Vascular Surgery

---

**We need your e-mail address**

Not sure if we have your current address? Go to the “My Page” area of the ACS Members-only Web portal at www.efacs.org to see what’s currently in our database and to make necessary changes so the College can keep you informed.

**If you have questions or problems, contact dues@facs.org. Include your Fellowship ID number in your note.**

---

**Important Note:** The American College of Surgeons does NOT provide your e-mail address to outside entities. E-mail addresses are used only for College communications.
Call for applicants for ACS–Emerson Clinical Scholar

Through an educational grant from the Emerson Charitable Trust, the American College of Surgeons (ACS) is offering a two-year research fellowship at St. Louis University or Washington University, St. Louis, MO. One ACS–Emerson Clinical Scholar position is available for a surgical resident who has completed two or three years of postgraduate training.

The goals of the fellowship are to advance the College’s quality improvement and health policy initiatives and to prepare a surgical resident for a career in academic surgery. The Clinical Scholar will apply data research methodologies to topics pertinent to the profession of surgery, using the wealth of data and expertise available through the College’s programs.

The fellowship recipient will reside in St. Louis while pursuing an advanced degree program or conducting research at either St. Louis University or Washington University. Potential areas of study include medical ethics, the economic sustainability of the health care system, and health care policy. The Clinical Scholar will also make visits each year to the ACS offices in Chicago, IL, and/or Washington, DC.

Benefits of the program

The scholar will be given opportunities to work with leaders in the selected field of study, to earn a master’s degree, and to participate more actively in the ACS.

The ACS will assign a mentor to meet regularly with the scholar, who will also benefit from the mentorship of surgeons active in the selected field of study. Hence, the scholar will receive guidance from multiple mentors of various backgrounds, who will ensure the greatest opportunity for success in the program. In addition, statistical and analytical staff will be available to provide ongoing training and support.

The Clinical Scholar also will have an opportunity to earn a master’s degree from the selected institution. Options include but are not limited to a master of business administration, master of public health, master of sustainability, or master of science in health outcomes research and evaluation sciences.

Funding and reporting requirements

This two-year fellowship is underwritten through an educational grant from the Emerson Charitable Trust. The fellowship award will total $195,000 over two years to support salary and benefits, conference registration and travel, statistical and administrative costs, and software and equipment.

The scholar will be expected to provide a detailed written report on the experience and accomplishments at the conclusion of the scholarship period. The scholar is also expected to submit papers or articles for publication.

Selection process

Applicants for the position of ACS–Emerson Clinical Scholar are required to submit a completed application, curriculum vitae, research proposal, personal statement, and letters of recommendation. These materials are collated for review by the Clinical Scholar Review Committee.

Timeline for position

- Application deadline: January 1, 2013
- Target for notification of appointment: January 31, 2013
- Starting date: July 1, 2013

Program questions should be directed to David Korajczyk, Director of Corporate and Foundation Relations, American College of Surgeons Foundation, 633 N. Saint Clair Street, Chicago, IL 60611, 312/202-5506, dkorajczyk@facs.org.

Completed applications with supporting documentation should be directed to Kate Early, International Liaison and Scholarships Sections, American College of Surgeons, 633 N. St. Clair Street, Chicago, IL 60611-3211, 312-202-5281, kearly@facs.org.
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMURAWAIYE, EMMANUEL, and EIN, ARLENE, and EIN, SIGMUND H.,</td>
<td>Recycling the retired surgeon: Surgical assisting—A Canadian’s perspective, 97, 4:27</td>
</tr>
<tr>
<td>ARMSTRONG, JOHN H., and SUTTON, JON H., ACS</td>
<td>adds input on policy at AMA House of Delegates meeting, 97, 10:68 - Advocacy for surgeons at the AMA House of Delegates, 97, 3:35</td>
</tr>
<tr>
<td>AMURAWAIYE, EMMANUEL, and EIN, ARLENE, and EIN, SIGMUND H.,</td>
<td>Recycling the retired surgeon: Surgical assisting—A Canadian’s perspective, 97, 4:27</td>
</tr>
<tr>
<td>ARMSTRONG, JOHN H., and SUTTON, JON H.,</td>
<td>ACS adds input on policy at AMA House of Delegates meeting, 97, 10:68 - Advocacy for surgeons at the AMA House of Delegates, 97, 3:35</td>
</tr>
<tr>
<td>BAILEY, PATRICK V.,</td>
<td>A crisis in the ED: Liability protection needed STAT, 97, 3:19 - Why the 2012 elections matter to you—the surgeon, 97, 10:26</td>
</tr>
<tr>
<td>BAILEY, PATRICK V., and NELSON, HEIDI, ACS Clinical Research Program: Alliance leads thoracic surgery trials for lung cancer in 2012, 97, 4:41</td>
<td></td>
</tr>
<tr>
<td>BAZZARELLI, AMY, and EMAMAULLEE, JULIET A., and LYONS, MEGAN V., and BERDAN, ELIZABETH</td>
<td>Women leaders in surgery: Past, present, and future, 97, 8:24</td>
</tr>
<tr>
<td>BIEDROSIAK, ISABELLE, and NELSON, HEIDI, ACS Clinical Research Program: The paradox of breast MRI: Does finding occult disease make a difference?, 97, 10:57</td>
<td></td>
</tr>
<tr>
<td>BERDAN, ELIZABETH, and BAZZARELLI, AMY, and EMAMAULLEE, JULIET A., and LYONS, MEGAN V.,</td>
<td>Women leaders in surgery: Past, present, and future, 97, 8:24</td>
</tr>
<tr>
<td>BERTAGNOLLI, MONICA M.,</td>
<td>New Alliance formed to address clinical trials in oncology, 97, 2:45</td>
</tr>
<tr>
<td>BIEBL, MATTHIAS, and PRATSCHKE, JOHANN</td>
<td>Invited commentary: Sanctity and organ donation’s societal value in an opt-out country: The Austrian experience, 97, 1:24</td>
</tr>
<tr>
<td>BILIMORIA, KARL, and KO, CLIFFORD Y.,</td>
<td>Clinical Scholars in Residence Program: A beneficial experience for surgical residents and the ACS, 97, 2:51</td>
</tr>
<tr>
<td>BLANG, ROSS, RAS Issues Symposium: Surgery at the end of life: For love or money? Reining in the scalpel, 97, 11:22</td>
<td></td>
</tr>
<tr>
<td>BLUMENCRANZ, PETER W., and NELSON, HEIDI, ACS Clinical Research Program: The clinically negative axilla: The dilemma of occult metastases in sentinel nodes, 97, 7:64</td>
<td></td>
</tr>
<tr>
<td>BOWHEYER, JUDY C., and ROSENKRANZ, KARI, and NELSON, HEIDI, ACS Clinical Research Program: Multiple ipsilateral breast cancers: Can the breast be preserved?, 97, 12:43</td>
<td></td>
</tr>
<tr>
<td>BROWN MATSEN, CINDY, RAS Issues Symposium: Surgery at the end of life: For love or money? An argument against heroic intervention, 97, 11:20</td>
<td></td>
</tr>
<tr>
<td>CASEY, KATHLEEN M., and KODERA, AKIYO, Fellows honored for volunteerism, 97, 9:74 - and SAKRAN, JOSEPH V., and KAFAFARANI, HAYTHAM M. A., and PRABHAKARAN, SANGEETHA, and NITZSCHKE, STEPHANIE, Enhancing American surgical training: Meeting the challenge of a globalizing world, 97, 7:20</td>
<td></td>
</tr>
<tr>
<td>CHANDLER, JAMES G., and MARVIN, MICHAEL R., and PRAGER, KENNETH M., and WOHLAUER, MAX V., Sanctity and organ donation’s societal value, 97, 1:12</td>
<td></td>
</tr>
<tr>
<td>CHARLES, ANTHONY, and KHOURY, AMAL, and MENDOZA, APRIL, Cultural competence: Why surgeons should care, 97, 3:13</td>
<td></td>
</tr>
<tr>
<td>CHEN, STEVEN, and MAYER, JOHN E. Jr., and MEARA, JOHN, and SHARMA, KETAN, and METZLER, IAN, Public reporting of health care data: A new frontier in quality improvement, 97, 6:6</td>
<td></td>
</tr>
</tbody>
</table>
Author index

CHOU, MARK, Chapter news, 97, 12:56
CIOFFI, WILLIAM G., Governors’ Committee to Study the Fiscal Affairs of the College, 97, 7:29
CIROCCO, WILLIAM C., Confronting the ethics, myths, and legends of restrictive covenants in the era of the contract surgeon, 97, 2:29
CURCI, MICHAEL, Task shifting overcomes the limitations of volunteerism in developing nations, 97, 10:9

D

DAGI, T. FORCHT, and HALVERSON, AMY L., and NEUMAYER, LEIGH, Leadership skills in the OR: Part II: Recognizing disruptive behavior, 97, 6:17
DEMMY, TODD, and SELZER, DON, and MEARA, JOHN G., Health information technology, meaningful use criteria, and their effects on surgeons, 97, 7:12

E

EARLY, KATE, In memoriam: Marion Rapp, former ACS International Liaison, remembered, 97, 2:55
ECONOMOPOULOS, KONSTANTINOS E., and GRABO, DANIEL J., and SAKRAN, JOSEPH V., and PRABHAKARAN, SANGEETHA, Surgical leadership across generations, 97, 8:30
EIN, ARLENE, and EIN, SIGMUND H., and AMURAWAIYE, EMMANUEL, Recycling the retired surgeon: Surgical assisting—A Canadian’s perspective, 97, 4:27
EIN, SIGMUND H., and AMURAWAIYE, EMMANUEL, and EIN, ARLENE, Recycling the retired surgeon: Surgical assisting—A Canadian’s perspective, 97, 4:27
EMAMAULLEE, JULIET A., and LYONS, MEGAN V., and BERDAN, ELIZABETH, and BAZZARELLI, AMY, Women leaders in surgery: Past, present, and future, 97, 8:24

F

FANTUS, RICHARD J., NTDB® data points: Assaulted, 97, 10:61
–NTDB® data points: Call a cab, 97, 5:55
–NTDB® data points: Gunned down, 97, 11:56
–NTDB data points: No humour, 97, 12:47
–NTDB® data points: Smarter than the average bear, 97, 4:47
–NTDB® data points: Surf’s up, 97, 8:74
–NTDB® data points: Twister, 97, 6:56
–NTDB® data points: Use your head, 97, 7:67
–NTDB® data points: Wipeout, 97, 9:70
–and FANTUS, RICHARD J. Jr., and FANTUS, ROBERT J., NTDB® data points: Seventy-five years of banking, 97, 3:50
–and NANCE, MICHAEL L., NTDB® data points: Annual Report 2011: Eightfold over eight years, 97, 1:63
FANTUS, RICHARD J. Jr., and FANTUS, ROBERT J., FANTUS, RICHARD J., NTDB® data points: Seventy-five years of banking, 97, 3:50
FANTUS, ROBERT J., and FANTUS, RICHARD J., and FANTUS, RICHARD J. Jr., NTDB® data points: Seventy-five years of banking, 97, 3:50
FILDES, JOHN, Citation for Enrique T. Ona, MD, FACS, FPCS, 97, 11:65
FLYNN, TIMOTHY C., Report on ACSPA/ACS activities, October 2011, 97, 2:58
FOX, JUSTIN P., and SEYFER, ALAN E., Setting the record straight: The real history of Poland’s syndrome, 97, 3:27
FRAHER, ERIN, and PILLSBURY III, HAROLD, and WEISSLER, MARK C., and RICKETTS, THOMAS, and GAUL, KATIE, and NEUWAHL, SIMON, HPRI data tracks: Trends in the otolaryngology workforce in the U.S., 97, 3:30
FRAHER, ERIN, and RICKETTS, THOMAS, and NEUWAHL, SIMON, and THOMPSON, KRISTIE, HPRI data tracks: Urology workforce trends, 97, 1:46
FRIEDMAN, JAMES, and METZLER, IAN, and DETMER, DON, and SELZER, DON, and MEARA, JOHN G., Health information technology, meaningful use criteria, and their effects on surgeons, 97, 7:12

Dec 2012 Bulletin American College of Surgeons
GANJAWALLA, KARAN, and KAUPS, KRISTA L., and MEARA, JOHN G., and METZLER, IAN, The critical state of graduate medical education funding, 97, 11:9

GARRY, JOHN, and MAA, JOHN, Progress report: Northern California Chapter’s legislative activities, 97, 11:28

GAUL, KATIE, and NEUWAHL, SIMON, and FRAHER, ERIN, and PILLSBURY III, HAROLD, and WEISSLER, MARK C., and RICKETTS, THOMAS, HPRI data tracks: Trends in the otolaryngology workforce in the U.S., 97, 3:30

GLASS, NINA E., and HAMED, OSAMA, and ZHENG, FEIBI, and MOUAWAD, NICOLAS J., Advanced degrees for surgeons and their impact on leadership, 97, 8:19

GLICKSON, JEANNIE, ACS Futures Committee takes a good, hard look at the year 2025, 97, 9:9

–Gynecologic oncology surgeons spare patients’ fertility, enhance quality of life, 97, 2:12

–Surgeons experience more ergonomic stress in the OR, 97, 4:20

GOKAK, SANA, What surgeons should know about… Choosing not to participate in the CMS incentive programs, 97, 12:40

–What surgeons should know about…The Medicare EHR Incentive Program, 97, 10:46

–What surgeons should know about…Participating in the Medicare eRx Incentive Program, 97, 5:6

–What surgeons should know about…Participating in the Medicare eRx Incentive Program, 97, 8:6

–What surgeons should know about…PQRS reporting in 2012, 97, 2:6

GOLDBERG, ROSS F., and KAAFARANI, HAYTHAM M.A., and SMITH, JILLIAN, and WINFIELD, ROBERT, Surgical leadership and political advocacy, 97, 8:14

GRABO, DANIEL J., and SAKRAN, JOSEPH V., and PRABHAKARAN, SANGEETHA, and ECONOMOPULOS, Konstantinos E., Surgical leadership across generations, 97, 8:30

GRILL, CHARLOTTE, Advocacy advisor: 2011 lobby day wrap-up: Ohio, Massachusetts, and Alabama, 97, 1:50

–State of the states: Defining surgery, 97, 5:27

–and MACIAS, ALEXIS, Enhancing surgical advocacy at the state level: The Day at the State Capitol grant program in action, 97, 11:24

–and MACIAS, ALEXIS, and SUTTON, JON, Expectations for state legislatures in 2012, 97, 2:36

GROBMYER, STEPHEN R., 2012 Japan Traveling Fellow reports on trip, 97, 10:78

GUILLAMONDEGUI, OSCAR, and MACIAS, ALEXIS, From surgeon to grassroots advocate: Chapter leaders engage in advocacy development, 97, 8:58

HALVERSON, AMY L., and NEUMAYER, LEIGH, and Dagi, T. FORCHT, Leadership skills in the OR: Part II: Recognizing disruptive behavior, 97, 6:17

–and SAUNDERS WALSH, DANIELLE, and RIKKERS, LAYTON, Leadership skills in the OR: Part I: Communication helps surgeons avoid pitfalls, 97, 5:8

HALVORSON, DANA, ACS takes a stand on policies impacting the surgical workforce, 97, 10:22

HAMED, OSAMA, and ZHENG, FEIBI, and MOUAWAD, NICOLAS J., and GLASS, NINA E., Advanced degrees for surgeons and their impact on leadership, 97, 8:19

HANKS, JOHN, In memoriam: William H. Muller, Jr., ACS Past-President, surgical leader, innovator, researcher, 97, 7:53

HARRIS, CATHERINE, and MABRY, CHARLES D., ACS Health Policy Advisory Council aims to empower Fellows as advocates, 97, 2:48

HARTIN, CHARLES W., JR., and LEIGHTLE, STEFAN W., Physician leadership and the future of surgical practice, 97, 5:15

HEDSTROM, JOHN, The 112th Congress: The year in review, 97, 12:11

HEDSTROM, JOHN E., and MOYE, CHANTAY P., Sustainable growth rate repeal: The bandages are running out, 97, 5:20

HOYT, DAVID B., 2012 Executive Director’s annual report, 97, 12:22

–Looking forward, 97, 1:4 (medical liability); 2:4 (Trauma, Critical Care & Acute Surgery Course); 3:4 (Joining Forces); 4:4 (performance improvement project); 5:4 (ACS Centennial); 6:4 (A Century of Surgery); 7:4 (improvements in education); 8:4 (Medicare payment); 9:7
Author index

(Centennial activities at Clinical Congress); 10:6 (hospital standards); 11:7 (John Pryor, MD, FACS); 12:5 (Inspiring Quality tour)

HUGHES, CHRISTOPHER D., and RAYMONVILLE, MAXI, and ROGERS, SELWYN O., and STEER, MICHAEL L., and MEARA, JOHN G., and SULLIVAN, STEPHEN R., Training global surgery fellows, 97, 8:46


HWANG, E. SHELLEY, and NELSON, HEIDI, ACS Clinical Research Program: Reframing treatment for ductal carcinoma in situ: Could less be more?, 97, 6:50

IBANGA, IKO, and KIM, GRACE J., and WEDDERBURN, RAYMOND V., Short-term surgical missions make a difference: A life-changing case in Ibi, Nigeria, 97, 11:31

Jackson, Jenny, and Barney, Linda, and Savarise, Mark, CPT 2012 brings with it new codes and code changes, 97, 1:26

— and Barney, Linda, and Savarise Mark, Socio-economic tips: Coding for skin replacement surgery in 2012, 97, 2:41

KAFARANI, HAYTHAM M. A., and PRABHAKARAN, SANGEETHA, and NITZSCHKE, STEPHANIE, and CASEY, KATHLEEN, and SAKRAN, JOSEPH V., Enhancing American surgical training: Meeting the challenge of a globalizing world, 97, 7:20

KAAFARANI, HAYTHAM M.A., and SMITH, JILLIAN, and WINFIELD, ROBERT, and GOLDBERG, ROSS F., Surgical leadership and political advocacy, 97, 8:14

KANDIL, EMAD, ACS Germany Traveling Fellow reports on his life- and career-changing experience, 97, 10:81

KAUPS, KRISTA L., ACS Board of Governors’ committee updates: Governors’ Committee on Physician Competency and Health, 97, 9:63

— and MEARA, JOHN G., and METZLER, IAN, and GANJAWALLA, KARAN, The critical state of graduate medical education funding, 97, 11:9

KHOURY, AMAL, and MENDOZA, APRIL, and CHARLES, ANTHONY, Cultural competence: Why surgeons should care, 97, 3:13

KIM, GRACE J., and WEDDERBURN, RAYMOND V., and IBANGA, IKO, Short-term surgical missions make a difference: A life-changing case in Ibi, Nigeria, 97, 11:31

KO, CLIFFORD Y., and BILIMORIA, KARL, Clinical Scholars in Residence Program: A beneficial experience for surgical residents and the ACS, 97, 2:51

KODERA, AKIYO, and CASEY, KATHLEEN M., Fellows honored for volunteerism, 97, 9:74


LALLY, KEVIN P., ACS Board of Governors committee updates: Governors’ Committee on Chapter Relations, 97, 7:27

LATIFI, RIFAT, Using telemedicine to strengthen medical systems in limited-resource countries, 97, 10:15

LEICHTLE, STEFAN W., and HARTIN, CHARLES W., Jr., Physician leadership and the future of surgical practice, 97, 5:15

LEICHTLE, STEFAN W., and SANTIN, BRIAN J., and LIEPERT, AMY E., Surgery at the end of life: For love or money?, 97, 8:36

— and LIEPERT, AMY E., and LEICHTLE, STEFAN W., and SANTIN, BRIAN J., Surgery at the end of life: For love or money?, 97, 8:36

LILLY, STEPHANIE ALLEN, Oweida Scholar expresses gratitude for valuable Clinical Congress experience, 97, 12:66

LUCHETTE, FRED A., and KUHLS, DEBORAH A.,
and RISUCCI, DONALD A., and BOWYER, MARK W., ASSET: An effective educational experience for practicing surgeons, 97, 7:31
LYONS, MEGAN V., and BERDAN, ELIZABETH, and BAZZARELLI, AMY, and EMAMAULEE, JULIET A., Women leaders in surgery: Past, present, and future, 97, 8:24

M

MAA, JOHN, and GARRY, JOHN, Progress report: Northern California Chapter’s legislative activities, 97, 11:28
MABRY, CHARLES D., and HARRIS, CATHARINE, ACS Health Policy Advisory Council aims to empower Fellows as advocates, 97, 2:48
MACIAS, ALEXIS, State STATs: When states practice medicine: Physician gag laws, 97, 2:39
–and GRILL, CHARLOTTE, Enhancing surgical advocacy at the state level: The Day at the State Capitol grant program in action, 97, 11:24
–and GUILLAMONDEGUI, OSCAR, From surgeon to grassroots advocate: Chapter leaders engage in advocacy development, 97, 8:58
–and SUTTON, JON, and GRILL, CHARLOTTE, Expectations for state legislatures in 2012, 97, 2:36
MARVIN, MICHAEL R., and PRAGER, KENNETH M., and WOHLAUER, MAX V., and CHANDLER, JAMES G., Sanctity and organ donation’s societal value, 97, 1:12
MATTOX, KENNETH, Alright, Let’s Call It a Draw: The Life of John Pryor, by John and Richard Pryor, 97, 11:8
MAYER, JOHN E. Jr., and MEARA, JOHN, and SHARMA, KETAN, and METZLER, IAN, and CHEN, STEVEN, Public reporting of health care data: A new frontier in quality improvement, 97, 6:6
McGINNIS, LaMAR S. Jr., Common origins: The two ACSs—100 years of collaboration to improve the lives of cancer patients, 97, 4:6
McGREEVY, JAMES M., Maximizing postgraduate surgical education in the future, 97, 2:19
McMURRAY HURTIG, ROBYN, Team approach minimizes risks in separating conjoined twins: An interview with Gary Hartman, MD, FACS, 97, 6:24
MEARA, JOHN G., and FRIEDMAN, JAMES, and METZLER, IAN, and DETMER, DON, and SELZER, DON, Health information technology, meaningful use criteria, and their effects on surgeons, 97, 7:12
MEARA, JOHN G., and METZLER, IAN S., Medical liability reform: Evidence for legislative and alternative approaches, 97, 1:6
MEARA, JOHN G., and METZLER, IAN, and GANJAWALLA, KARAN, and KAUPS, KRISTA L., The critical state of graduate medical education funding, 97, 11:9
MEARA, JOHN, and SHARMA, KETAN, and METZLER, IAN, and CHEN, STEVEN, and MAYER, JOHN E. JR., Public reporting of health care data: A new frontier in quality improvement, 97, 6:6
MEARA, JOHN G., and SULLIVAN, STEPHEN R., and HUGHES, CHRISTOPHER D., and RAYMONVILLE, MAXI, and ROGERS, SELWYN O., and STEER, MICHAEL L., Training global surgery fellows, 97, 8:46
MENDEZ, APRIL, and CHARLES, ANTHONY, and KHOURY, AMAL, Cultural competence: Why surgeons should care, 97, 3:13
MENG, MAXWELL V., and NELSON, HEIDI, ACS Clinical Research Program: What’s new in renal cell carcinoma, 97, 8:65
METZLER, IAN S., and CHEN, STEVEN, and MAYER, JOHN E. Jr., and MEARA, JOHN, and SHARMA, KETAN, Public reporting of health care data: A new frontier in quality improvement, 97, 6:6
METZLER, IAN, and DETMER, DON, and SELZER, DON, and MEARA, JOHN G., and FRIEDMAN, JAMES, Health information technology, meaningful use criteria, and their effects on surgeons, 97, 7:12
METZLER, IAN, and GANJAWALLA, KARAN, and KAUPS, KRISTA L., and MEARA, JOHN G., The critical state of graduate medical education funding, 97, 11:9
METZLER, IAN S., and MEARA, JOHN G., Medical liability reform: Evidence for legislative and alternative approaches, 97, 1:6
MOUAWAD, NICOLAS J., and GLASS, NINA E., and HAMED, OSAMA, and ZHENG, FEBI, Advanced degrees for surgeons and their impact on leadership, 97, 8:19
MOYE, CHANTAY, Advocacy in action: ACS hosts first annual Advocacy Summit, 97, 6:32
–New leadership at the helm of ACSPA-SurgeonsPAC, 97, 8:53
Author index

–and HEDSTROM, JOHN E., Sustainable growth rate repeal: The bandages are running out, 97, 5:20

N

NANCE, MICHAEL L., and FANTUS, RICHARD J., NTDB® data points: Annual Report 2011: Eightfold over eight years, 97, 1:63

NAPOLITANO, LENA M., Report on ACSPA/ACS activities, February 2012, 97, 5:38
–Report on ACSPA/ACS activities: June 2012, 97, 9:83

NELSON, HEIDI, Introducing the ACS Clinical Research Program of the Alliance, 97, 3:40
–and BAUER, THOMAS, ACS Clinical Research Program: Alliance leads thoracic surgery trials for lung cancer in 2012, 97, 4:41
–and BLUMENCRANZ, PETER W., ACS Clinical Research Program: The clinically negative axilla: The dilemma of occult metastases in sentinel nodes, 97, 7:64
–and BOUGHEY, JUDY C., and ROSENKRANZ, KARI, ACS Clinical Research Program: Multiple ipsilateral breast cancers: Can the breast be preserved?, 97, 12:43
–and DEMMY, TODD, ACS Clinical Research Program: Malignant pleural effusion research provides insights to improve surgical study design, 97, 11:52
–and HWANG, E. SHELLEY, ACS Clinical Research Program: Reframing treatment for ductal carcinoma in situ: Could less be more?, 97, 6:50
–and MENG, MAXWELL V., ACS Clinical Research Program: What’s new in renal cell carcinoma, 97, 8:65
–and YOU, YI-QIAN NANCY, ACS Clinical Research Program: A paradigm shift in rectal cancer treatment: The PROSPECT trial, 97, 5:35

NEUMAYER, LEIGH, and DAGI, T. FORCHT, and HALVERSON, AMY L., Leadership skills in the OR: Part II: Recognizing disruptive behavior, 97, 6:17

NEUWAHL, SIMON, and FRAHER, ERIN, and PILLSBURY III, HAROLD, and WEISSLER, MARK C., and RICKETTS, THOMAS, and GAUL, KATIE, HPRI data tracks: Trends in the otolaryngology workforce in the U.S., 97, 3:30

NEUWAHL, SIMON, and THOMPSON, KRISTIE, and FRAHER, ERIN, and RICKETTS, THOMAS, HPRI data tracks: Urology workforce trends, 97, 1:46

NITZSCHKE, STEPHANIE, and CASEY, KATHLEEN, and SAKRAN, JOSEPH V., and KAFAFARANI, HAYTHAM M. A., and PRABHAKARAN, SANGEETHA, Enhancing American surgical training: Meeting the challenge of a globalizing world, 97, 7:20

OLLAPALLY, VINITA, What surgeons should know about...Medicare and Medicaid audits, 97, 11:49
–What surgeons should know about... Modifications to ordering and certifying rules for physicians, 97, 9:60

PEEBLES, RHONDA, Chapter news, 97, 2:68, 6:58, 8:77

PELLEGRINI, CARLOS A., Citation for Prof. Emeritus Hector Orozco, MD, FACS, 97, 11:66

PEREGRIN, TONY, Cancer care closer to home: Dr. McKellar ensures rural patients get quality care, 97, 4:16
–A heart-to-heart with cardiothoracic surgeon and TV host Dr. Oz, 97, 5:23
–Leadership conference focuses on outcomes data and quality improvement, 97, 6:28
–The near-death of a president, and the birth of a career: An interview with Dr. Napolitano, 97, 9:44

PODRATZ, KARL C., Citation for Prof. Ignace Vergote, MD, PhD, 97, 11:69

PRABHAKARAN, SANGEETHA, and ECONOMOPOULOS, KONSTANTINOS E., and GRABO, DANIEL J., and SAKRAN, JOSEPH V., Surgical leadership across generations, 97, 8:30

Dec 2012 BULLETIN American College of Surgeons
THAM M. A., Enhancing American surgical training: Meeting the challenge of a globalizing world, 97, 7:20
PRAGER, KENNETH M., and WOHLAUER, MAX V., and CHANDLER, JAMES G., and MARVIN, MICHAEL R., Sanctity and organ donation’s societal value, 97, 1:12
PRATSCHKE, JOHANN, and BIEBL, MATTHIAS, Invited commentary: Sanctity and organ donation’s societal value in an opt-out country: The Austrian experience, 97, 1:24
RASICH, PAULA, From battlefield to bedside—and back again, 97, 8:41
RAYMONVILLE, MAXI, and ROGERS, SELWYN O., STEER, MICHAEL L., and MEARA, JOHN G., and SULLIVAN, STEPHEN R., and HUGHES, CHRISTOPHER D., Training global surgery fellows, 97, 8:46
RICKETTS, THOMAS, and GAUL, KATIE, and NEUWAHL, SIMON, and FRAHER, ERIN, and PILSBURY III, HAROLD, and WEISSLER, MARK C., HPRI data tracks: Trends in the otolaryngology workforce in the U.S., 97, 3:30
RICKETTS, THOMAS, and NEUWAHL, SIMON, and THOMPSON, KRISTIE, and FRAHER, ERIN, HPRI data tracks: Urology workforce trends, 97, 1:46
RIKKERS, LAYTON, and HALVERSON, AMY L., and SAUNDERS WALSH, DANIELLE, Leadership skills in the OR: Part I: Communication helps surgeons avoid pitfalls, 97, 5:8
ROGERS, SELWYN O., STEER, MICHAEL L., and MEARA, JOHN G., and SULLIVAN, STEPHEN R., and HUGHES, CHRISTOPHER D., and RAYMONVILLE, MAXI, Training global surgery fellows, 97, 8:46
ROSENBERG, LAWRENCE, and SCHLICH, THOMAS, Twenty-first century surgery: Have we entered uncharted waters?, 97, 7:6
ROSENKRAZ, KARI, and NELSON, NELSON, and BOUGHEY, JUDY C., ACS Clinical Research Program: Multiple ipsilateral breast cancers: Can the breast be preserved?, 97, 12:43
SAKRAN, JOSEPH V., and KAAFARANI, HAYTHAM M. A., and PRABHAKARAN, SANGEETHA, and NITZSCHKE, STEPHANIE, and CASEY, KATHLEEN, Enhancing American surgical training: Meeting the challenge of a globalizing world, 97, 7:20
SAKRAN, JOSEPH V., and PRABHAKARAN, SANGEETHA, and ECONOMOPOULOS, KONSTANTINOS E., and GRABO, DANIEL J., Surgical leadership across generations, 97, 8:30
SANTIN, BRIAN J., and LIEPERT, AMY E., and LEICHTLE, STEFAN W., Surgery at the end of life: For love or money?, 97, 8:36
SANTRY, HEENA P., From the Chair of the RAS-ACS: Leadership skills continue to serve past RAS-ACS Chairs in their current roles, 97, 8:9
SARAP, MICHAEL, Dispatches from rural surgeons: The value of chapter membership: The rural surgeon’s perspective, 97, 10:54
SAUNDERS WALSH, DANIELLE, and RIKKERS, LAYTON, and HALVERSON, AMY L., Leadership skills in the OR: Part I: Communication helps surgeons avoid pitfalls, 97, 5:8
SCHLICH, THOMAS, and ROSENBERG, LAWRENCE, Twenty-first century surgery: Have we entered uncharted waters?, 97, 7:6
SCHNEIDMAN, DIANE S., ACS NSQIP® conference participants inspired to take QI to the next level, 97, 10:63
—Capt. Brad Cooper provides an update on Joining Forces initiative, 97, 9:56
—Joining Forces and the ACS: Dr. Holcomb dedicates career to improving trauma care for soldiers and civilians, 97, 6:14
SCHWARTZ, MARSHALL Z., Citation for Prof. Lew- is Spitz, MB, BCh, PhD, FRCS, FRCS(Ed), 97, 11:68
SELZER, DON, and MEARA, JOHN G., and FRIED-
MAN, JAMES, and METZLER, IAN, and DETMER, DON, Health information technology, meaningful use criteria, and their effects on surgeons, 97, 7:12

SEYFER, ALAN E., and FOX, JUSTIN P., Setting the record straight: The real history of Poland’s syndrome, 97, 3:27

SHARMA, KETAN, and METZLER, IAN, and CHEN, STEVEN, and MAYER, JOHN E. Jr., and MEARA, JOHN, Public reporting of health care data: A new frontier in quality improvement, 97, 6:6

SHELLY, JILL, The ACS and the ABCs of how quality measures are established and implemented, 97, 9:49

SMITH, JILLIAN, and WINFIELD, ROBERT, and GOLDBERG, ROSS F., and KAAFARANI, HAYTHAM M.A., Surgical leadership and political advocacy, 97, 8:14

SMITH, LARRY N., Learning about health care in Africa: A physician’s experience in Lagos, Nigeria, 97, 2:24

STEER, MICHAEL L., and MEARA, JOHN G., and SULLIVAN, STEPHEN R., and HUGHES, CHRISTOPHER D., and RAYMONVILLE, MAXI, and ROGERS, SELWYN O., Training global surgery fellows, 97, 8:46

SULLIVAN, STEPHEN R., and HUGHES, CHRISTOPHER D., and RAYMONVILLE, MAXI, and ROGERS, SELWYN O., and STEER, MICHAEL L., and MEARA, JOHN G., Training global surgery fellows, 97, 8:46

SUTTON, JON H., and ARMSTRONG, JOHN H., ACS adds input on policy at AMA House of Delegates meeting, 97, 10:68

– Advocacy for surgeons at the AMA House of Delegates, 97, 3:35

– and ARMSTRONG, JOHN H.,

– and GRILL, CHARLOTTE, and MACIAS, ALEXIS, Expectations for state legislatures in 2012, 97, 2:36

– and WARSHAW, ANDREW L., Controlling state health care costs: Massachusetts forges ahead, 97, 12:17

THOMPSON, KRISTIE, and FRAHER, ERIN, and RICKETTS, THOMAS, and NEUWAHL, SIMON, HPRI data tracks: Urology workforce trends, 97, 1:46

VICKERS, SELWYN M., ACS Board of Governors’ committee updates: Governors’ Committee on Socioeconomic Issues, 97, 10:51

VINCENT, GAY L., ACS financial update 2012, 97, 12:63

WARSHAW, ANDREW L., Citation for Prof. Seiki Matsuno, MD, FACS, 97, 11:64

– and SUTTON, JON H., Controlling state health care costs: Massachusetts forges ahead, 97, 12:17

WEDDERBURN, RAYMOND V., and IBANGA, IKO, and KIM, GRACE J., Short-term surgical missions make a difference: A life-changing case in Ibi, Nigeria, 97, 11:31

WEISSLER, MARK C., and RICKETTS, THOMAS, and GAUL, KATIE, and NEUWAHL, SIMON, and FRAHER, ERIN, and PILLSBURY III, HAROLD, HPRI data tracks: Trends in the otolaryngology workforce in the U.S., 97, 3:30

WINFIELD, ROBERT, and GOLDBERG, ROSS F., and KAAFARANI, HAYTHAM M.A., and SMITH, JILLIAN, Surgical leadership and political advocacy, 97, 8:14

WOHLAUER, MAX V., and CHANDLER, JAMES G., and MARVIN, MICHAEL R., and PRAGER, KENNETH M., Sanctity and organ donation’s societal value, 97, 1:12

YOU, YI-QIAN NANCY, and NELSON, HEIDI, ACS Clinical Research Program: A paradigm shift in rectal cancer treatment: The PROSPECT trial, 97, 5:35

ZHENG, FEIBI, and MOUAWAD, NICOLAS J., and GLASS, NINA E., and HAMED, OSAMA, Advanced degrees for surgeons and their impact on leadership, 97, 8:19
ACCESS TO CARE (see: WORKFORCE ISSUES and HEALTH CARE REFORM)
ACCOUNTABLE CARE ACT (see: LEGISLATIVE AND GOVERNMENT ISSUES: FEDERAL)
ACCREDITATION (see: THE JOINT COMMISSION)
ADVOCACY AND HEALTH POLICY (see also: AMERICAN COLLEGE OF SURGEONS: Advocacy and Health Policy and LEGISLATIVE AND GOVERNMENT ISSUES)
Advocacy advisor: 2011 lobby day wrap-up: Ohio, Massachusetts, and Alabama (Grill), 97, 1: 50

AMERICAN COLLEGE OF SURGEONS Activities (see also: AMERICAN COLLEGE OF SURGEONS: Centennial and AMERICAN COLLEGE OF SURGEONS: Inspiring Quality campaign)
–2012 Executive Director’s annual report (Hoyt), 97, 12:22
–ACS, CDC work to avert surgical infections, other adverse outcomes, 97, 6:37
–ACS cited in Modern Healthcare article on rural surgeon shortage, 97, 6:47
–ACS Futures Committee takes a good, hard look at the year 2025 (Glickson), 97, 9:9
–ACS Health Policy Advisory Council aims to empower Fellows as advocates (Mabry, Harris), 97, 2:48
–ACS offers resources to help surgeons achieve meaningful use of EHR, 97, 6:41
–Leadership conference focuses on outcomes data and quality improvement (Peregrin), 97, 6:28
–Report on ACSPA/ACS activities, October 2011 (Flynn), 97, 2:58
–Report on ACSPA/ACS activities, February 2012 (Napolitano), 97, 5:38
–Report on ACSPA/ACS activities: June 2012 (Napolitano), 97, 9:83

Advocacy and Health Policy
–ACS Health Policy Advisory Council aims to empower Fellows as advocates (Mabry, Harris), 97, 2:48
–Advocacy in action: ACS hosts first annual Advocacy Summit (Moye), 97, 6:32
–Enhancing surgical advocacy at the state level: The Day at the State Capitol grant program in action (Grill, Macias), 97, 11:24
–From surgeon to grassroots advocate: Chapter leaders engage in advocacy development (Macias, Guillamondegui), 97, 8:58
–Progress report: Northern California Chapter’s legislative activities (Garry, Maa), 97, 11:28

Alliance/ACS Clinical Research Program
–ACS Clinical Research Program: Alliance leads thoracic surgery trials for lung cancer in 2012 (Bauer, Nelson), 97, 4:41
–ACS Clinical Research Program: The clinically negative axilla: The dilemma of occult metastases in sentinel nodes (Blumencranz, Nelson), 97, 7:64
–ACS Clinical Research Program: Malignant pleural effusion research provides insights to improve surgical study design (Demmy, Nelson), 97, 11:52
–ACS Clinical Research Program: Multiple ipsilateral breast cancers: Can the breast be preserved? (Boughey, Rosenkranz, Nelson), 97, 12:43
–ACS Clinical Research Program: A paradigm shift in rectal cancer treatment: The PROSPECT trial (You, Nelson), 97, 5:35
–ACS Clinical Research Program: The paradox of breast MRI: Does finding occult disease make a difference? (Bedrosian, Nelson), 97, 10:57
–ACS Clinical Research Program: Reframing treatment for ductal carcinoma in situ: Could less be more? (Hwang, Nelson), 97, 6:50
–ACS Clinical Research Program: What’s new in renal cell carcinoma (Meng, Nelson), 9, 8:65
–Introducing the ACS Clinical Research Program of the Alliance (Nelson), 97, 3:40
–New Alliance formed to address clinical trials in oncology (Bertagnolli), 97, 2:45

American College of Surgeons Professional Association (ACSPA)
–New leadership at the helm of ACSPA-SurgeonsPAC (Moye), 97, 8:53
<table>
<thead>
<tr>
<th>Subject index</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>–Report on ACSPA/ACS activities, October 2011 (Flynn), 97, 2:58</strong></td>
</tr>
<tr>
<td><strong>–Report on ACSPA/ACS activities, February 2012 (Napolitano), 97, 5:38</strong></td>
</tr>
<tr>
<td><strong>–Report on ACSPA/ACS activities: June 2012 (Napolitano), 97, 9:83</strong></td>
</tr>
<tr>
<td><strong>Annual meeting (see: AMERICAN COLLEGE OF SURGEONS: Clinical Congress)</strong></td>
</tr>
<tr>
<td><strong>Archives</strong></td>
</tr>
<tr>
<td><strong>–College’s historical collection of rare books achieves new visibility, 97, 3:45</strong></td>
</tr>
<tr>
<td><strong>–Fellows in Archives photo identified, 97, 1:61</strong></td>
</tr>
<tr>
<td><strong>–From the Archives: Do you recognize the people in this photo from the 1959 Clinical Congress?, 97, 5:47</strong></td>
</tr>
<tr>
<td><strong>–From the Archives: Archives page on ACS website now offers descriptions of Dr. Martin’s collected papers, 97, 12:58</strong></td>
</tr>
<tr>
<td><strong>–From the Archives: Learn about ACS history through the papers of Eleanor K. Grimm, 97, 7:56</strong></td>
</tr>
<tr>
<td><strong>Awards</strong></td>
</tr>
<tr>
<td><strong>–College accepting nominations for 2013 Jacobson Promising Investigator Award, 97, 12:59</strong></td>
</tr>
<tr>
<td><strong>–College seeks nominations for Jacobson Promising Investigator Award, 97, 1:57</strong></td>
</tr>
<tr>
<td><strong>–Dr. Jack McAninch receives 2012 Distinguished Service Award, 97, 9:72</strong></td>
</tr>
<tr>
<td><strong>–Dr. Sheldon honored with Lifetime Achievement Award, 97, 11:60</strong></td>
</tr>
<tr>
<td><strong>–Dr. W. Hardy Hendren III receives 2012 Jacobson Innovation Award, 97, 8:51</strong></td>
</tr>
<tr>
<td><strong>–Fellows honored for volunteerism (Casey, Kodera), 97, 9:74</strong></td>
</tr>
<tr>
<td><strong>Bulletin of the American College of Surgeons</strong></td>
</tr>
<tr>
<td><strong>–ACS Bulletin: 1919 Hospital Standardization Series report, 97, 10:30</strong></td>
</tr>
<tr>
<td><strong>–American College of Surgeons Bulletin No. 1: Requirements for Admission to Fellowship, 97, 9:18</strong></td>
</tr>
<tr>
<td><strong>–Bulletin gets first makeover in more than 23 years, 97, 9:73</strong></td>
</tr>
<tr>
<td><strong>–The Bulletin of the American College of Surgeons: Keeping Fellows informed for nearly 100 years, 97, 9:17</strong></td>
</tr>
<tr>
<td><strong>–A look at the College’s first registry: The Bone Sarcoma Registry, 97, 12:32</strong></td>
</tr>
<tr>
<td><strong>–A message from the Editor, 97, 1:53</strong></td>
</tr>
<tr>
<td><strong>–Correction notice, 97, 5:53, 7:63, 8:62</strong></td>
</tr>
<tr>
<td><strong>–Cruise to South America: The College’s first international outreach effort, 97, 11:36</strong></td>
</tr>
<tr>
<td><strong>–Letters, 97, 6:54</strong></td>
</tr>
<tr>
<td><strong>Business and finance</strong></td>
</tr>
<tr>
<td><strong>–ACS financial update 2012 (Vincent), 97, 12:63</strong></td>
</tr>
<tr>
<td><strong>Centennial</strong></td>
</tr>
<tr>
<td><strong>–Celebrate the ACS Centennial at Clinical Congress, 97, 7:63</strong></td>
</tr>
<tr>
<td><strong>–Celebrate the Centennial with a tour of ACS headquarters and Archives, 97, 9:79</strong></td>
</tr>
<tr>
<td><strong>–College will celebrate 100th anniversary with commemorative publication, 97, 4:33</strong></td>
</tr>
<tr>
<td><strong>Chapters</strong></td>
</tr>
<tr>
<td><strong>–Calendar of events, 97, 9:6, 10:84, 11:76</strong></td>
</tr>
<tr>
<td><strong>–Chapter news (Peebles), 97, 2:68, 6:58, 8:77</strong></td>
</tr>
<tr>
<td><strong>–Chapter news (Chou), 97, 12:56</strong></td>
</tr>
<tr>
<td><strong>–Enhancing surgical advocacy at the state level: The Day at the State Capitol grant program in action (Grill, Macias), 97, 11:24</strong></td>
</tr>
<tr>
<td><strong>–From surgeon to grassroots advocate: Chapter leaders engage in advocacy development (Macias, Guillamondegui), 97, 8:58</strong></td>
</tr>
<tr>
<td><strong>–Progress report: Northern California Chapter’s legislative activities (Garry, Maa), 97, 11:28</strong></td>
</tr>
<tr>
<td><strong>Clinical Congress</strong></td>
</tr>
<tr>
<td><strong>–2012 Clinical Congress Preliminary Program, 97, 7:36</strong></td>
</tr>
<tr>
<td><strong>–Celebrate the ACS Centennial at Clinical Congress, 97, 7:63</strong></td>
</tr>
<tr>
<td><strong>–Highlights of the 97th Annual Clinical Congress, 97, 1:33</strong></td>
</tr>
<tr>
<td><strong>–Join Town Hall Sessions at ACS Clinical Congress, 97, 7:60</strong></td>
</tr>
<tr>
<td><strong>–March 31 is deadline to claim CME credit for 2011 Clinical Congress, 97, 3:43</strong></td>
</tr>
<tr>
<td><strong>–New Advisory Council for Rural Surgery offers several programs during Clinical Congress, 97, 9:80</strong></td>
</tr>
<tr>
<td><strong>–New postgraduate courses offered at Clinical Congress, 97, 7:60</strong></td>
</tr>
<tr>
<td><strong>–Patient safety sessions to be presented at 2012 Clinical Congress, 97, 7:61</strong></td>
</tr>
<tr>
<td><strong>–Use revised code for flight discount for Clinical Congress, 97, 7:55</strong></td>
</tr>
<tr>
<td><strong>Commission on Cancer</strong></td>
</tr>
<tr>
<td><strong>–CoC accepting applications for 2013 scholar-in-residence, 97, 6:47</strong></td>
</tr>
<tr>
<td><strong>–Common origins: The two ACSs—100 years of collaboration to improve the lives of cancer patients (McGinnis Jr.), 97, 4:6</strong></td>
</tr>
</tbody>
</table>
**Subject index**

- One CoC clinical scholar departs, and another steps in, 97, 6:46
- Outstanding achievement award granted to 106 CoC facilities, 97, 5:44

**Disciplinary actions**
- Disciplinary actions taken, 97, 3:47, 6:38, 12:65

**Executive Director**
- 2012 Executive Director’s annual report (Hoyt), 97, 12:22
- Looking forward (Hoyt), 97, 1:4 (medical liability); 2:4 (Trauma, Critical Care & Acute Surgery Course); 3:4 (Joining Forces); 4:4 (performance improvement project); 5:4 (ACS Centennial); 6:4 (A Century of Surgery); 7:4 (improvements in education); 8:4 (Medicare payment); 9:7 (Centennial activities at Clinical Congress); 10:6 (hospital standards); 11:7 (John Pryor, MD, FACS); 12:5 (Inspiring Quality tour)

**Fellows and Members**
- ACS Fellows appointed to NQF advisory groups, 97, 4:37
- ACS President Dr. Numann attends Clinical Congress of Philippine College of Surgeons, 97, 3:37
- Dr. Armstrong named Florida Surgeon General, Secretary of Health, 97, 8:54
- Dr. Borman to serve on outpatient payment panel, 97, 4:38
- Dr. Britt and Dr. Gullane named honorary fellows at RCS meeting, 97, 4:35
- Dr. Fogarty inducted as first NAI fellow, 97, 5:33
- Dr. Greene receives SAGES award for endoscopy education, 97, 6:45
- Dr. Hughes elected to six-year term on American Board of Surgery, 97, 4:33
- Dr. Hughes named rural health care practitioner of the year, 97, 5:34
- Dr. Moalem recognized for leadership in endocrine surgery, patient care, 97, 4:40
- Dr. Patricia L. Turner among four new AMA Foundation board members, 97, 10:71
- Dr. Sachdeva honored with SSH award for contributions to health care simulation, 97, 4:39
- A heart-to-heart with cardiothoracic surgeon and TV host Dr. Oz (Peregrin), 97, 5:23
- Members in the news, 97, 2:52, 6:44, 10:73, 12:62
- The near-death of a president, and the birth of a career: An interview with Dr. Napolitano (Peregrin), 97, 9:44
- Royal College of Surgeons of Edinburgh honors ACS President Dr. A. Brent Eastman, 97, 12:54
- Team approach minimizes risks in separating conjoined twins: An interview with Gary Hartman, MD, FACS (McMurray Hurtig), 97, 6:24

**Governors, Board of**
- ACS Board of Governors committee updates: Governors’ Committee on Chapter Relations (Lally), 97, 7:27
- ACS Board of Governors’ committee updates: Governors’ Committee on Physician Competency and Health (Kaups), 97, 9:63
- ACS Board of Governors’ committee updates: Governors’ Committee on Socioeconomic Issues (Vickers), 97, 10:51
- ACS Board of Governors’ committee updates: Governors’ Committee to Study the Fiscal Affairs of the College (Cioffi), 97, 7:29
- ACS Officers, Regents, and Board of Governors’ Executive Committee, 97, 1:42
- ACS Regents and Governors elected at Annual Business Meeting, 97, 12:51

**Health Policy Research Institute**
- HPRI data tracks: Trends in the otolaryngology workforce in the U.S. (Neuwahl, Fraher, Pillsbury III, Weissler, Ricketts, Gaul), 97, 3:30
- HPRI data tracks: Urology workforce trends (Neuwahl, Thompson, Fraher, Ricketts), 97, 1:46
- HPRI representatives visit Lord Ribeiro at U.K.’s House of Lords, 97, 8:60

**Honorary Fellowships**
- Citation for Prof. Seiki Matsuno, MD, FACS (Warshaw), 97, 11:64
- Citation for Enrique T. Ona, MD, FACS, FPCS (Fildes), 97, 11:65
- Citation for Prof. Emeritus Hector Orozco, MD, FACS (Pellegrini), 97, 11:66
- Citation for Prof. Lewis Spitz, MB, BCh, PhD, FRCS, FRCS(Ed) (Schwartz), 97, 11:68
- Citation for Prof. Ignace Vergote, MD, PhD (Podratz), 97, 11:69
- Five prominent surgeons accorded Honorary Fellowship in the ACS, 97, 11:63

**Inspiring Quality campaign**
- ACS, Philadelphia health care leaders discuss physician-led quality improvement initiatives, 97, 12:60
- At Houston forum, health care leaders, Rep. Sheila Jackson Lee talk quality improvement, 97, 11:71
- Inspiring Quality health care forum in San Diego: Qual-
Subject index

ity improvement programs increase health care value, 97, 5:31

–Surgical and aviation experts discuss safety and quality at Seattle IQ forum, 97, 6:39

–Surgical quality forum focuses on how QI can help curb health care costs, 97, 8:61

–Tennessee IQ forum focuses on new model for improving quality and reducing costs, 97, 10:74

Journal of the American College of Surgeons (JACS)
JACS rises in prominence among surgical journals, 97, 9:82

Meetings
–Calendar of events, 97, 9:6, 10:84, 11:76, 12:88

Officers and staff
–A. Brent Eastman, MD, FACS, installed as 93rd ACS President, 97, 11:58

–Call for nominations for ACS Officers-Elect, 97, 1:54, 2:54

–Call for nominations for the ACS Board of Regents, 97, 2:54

–College hires new HR Director and promotes staffer to lead PI effort, 97, 9:81

–Dr. Pellegrini selected as next President-Elect of the College, 97, 12:49

–In memoriam: Marion Rapp, former ACS International Liaison, remembered (Early), 97, 2:55

Operation Giving Back (see also: VOLUNTEERISM)
–Nominations sought for 2012 volunteerism and humanitarian awards, 97, 1:55

Presidential Address
–Presidential Address: The next hundred years, 97, 12:8

Regents, Board of
–ACS Officers, Regents, and Board of Governors’ Executive Committee, 97, 1:42

–ACS Regents and Governors elected at Annual Business Meeting, 97, 12:51

–Call for nominations for the ACS Board of Regents, 97, 1:53

–J. David Richardson, MD, FACS, elected Chair of ACS Board of Regents, 97, 1:52

Research and Optimal Patient Care
–ACS and ASMBs unify bariatric surgery accreditation programs, 97, 4:34

–ACS NSQIP® conference participants inspired to take QI to the next level (Schneidman), 97, 10:63

–Clinical Scholars in Residence Program: A beneficial experience for surgical residents and the ACS (Bilimoria, Ko), 97, 2:51

–Florida initiative uses ACS NSQIP® processes to measure and improve care, 97, 8:57

–NQF endorses two ACS NSQIP® quality measures, 97, 3:39

Resident and Associate Society of the American College of Surgeons (RAS-ACS) (see also: EDUCATION AND TRAINING and YOUNG SURGEONS)
–Advanced degrees for surgeons and their impact on leadership (Zheng, Mouawad, Glass, Hamed), 97, 8:49

–From the Chair of the RAS-ACS: Leadership skills continue to serve past RAS-ACS Chairs in their current roles (Santry), 97, 8:9

–RAS Issues Symposium: Surgery at the end of life: For love or money?: An argument against heroic intervention (Brown Matsen), 97, 11:20

–RAS Issues Symposium: Surgery at the end of life: For love or money?: Reining in the scalpel (Blagg), 97, 11:22

–Surgery at the end of life: For love or money? (Liepert, Leichtle, Santin), 97, 8:36

–Surgical leadership across generations (Prabhakaran, Economopoulos, Grabo, Sakran), 97, 8:30

–Surgical leadership and political advocacy (Goldberg, Kaafarani, Smith, Winfield), 97,8:14

–Women leaders in surgery: Past, present, and future (Emamaullee, Lyons, Berdan, Bazzarelli), 97, 8:24

Scholarships/fellowships
–2012 Claude H. Orgain, Jr., MD, FACS, Traveling Fellowship available, 97, 5:51

–2012 Health Policy Scholars announced, 97, 8:72

–2012 Japan Traveling Fellow reports on trip (Grobbmyer), 97, 10:78

–2012 Japan Traveling Fellow reports on trip (Grobmyer), 97, 10:78

–ACS Germany Traveling Fellow reports on his life- and career-changing experience (Kandill), 97, 10:81

–2012 Osweda Scholar announced, 97, 9:89

–2013 Traveling Fellowship to Germany announced, 97, 3:49

–2013 Traveling Fellowship to Japan available, 97, 3:48

–ACS K08/K23 awards will supplement NIH applications due October 12, 97, 10:77

–ACS offers international scholarships for surgical education, training, 97, 5:53

–Apply by September 4 for ACS Resident Research Scholarships, 97, 8:70

–Call for applications for ACS–Emerson Clinical Scholar, 97, 12:69

–Faculty Research Fellowships beginning in 2012 awarded, 97, 9:92
Subject index

Heller School Executive Leadership Program scholarships available, 97, 12:68
IRC announces two new travel awards for 2013, 97, 5:49
International Guest Scholarships available for 2013, 97, 5:50
Oweida Scholar expresses gratitude for valuable Clinical Congress experience (Allen Lilly), 97, 12:66
November 1 closing date for Faculty Research Fellowship applications, 97, 8:69
Six Resident Research Scholarships awarded for 2012–2014, 97, 9:91
Year 2012 ANZ, Japan, and German Exchange Travelers announced, 97, 9:90

Statements
Joint statement by the ACS and SAGES on FLS completion for general surgeons who perform laparoscopy, 97, 5:30
Statement on concussion and brain injury, 97, 12:38
Statement on Council of Medical Specialties’ Code for Interactions with Companies, 97, 12:39

Testimony
Dr. Hoyt, Dr. Opelka present ACS views on Medicare payment issues, 97, 9:79

Trauma (see also: TRAUMA)
2012 COT Residents Trauma Papers Competition winners announced, 97, 5:45
New ATLS® Ninth Edition includes bedside reference app, 97, 10:70
NTDB® data points: Annual Pediatric Report 2011: Fatal at any age (Fantus, Nance), 97, 2:66
NTDB® data points: Annual Report 2011: Eightfold over eight years (Fantus, Nance), 97, 1:63
NTDB® data points: Assaulted (Fantus), 97, 10:61
NTDB® data points: Call a cab (Fantus), 97, 5:55
NTDB® data points: Gunned down (Fantus), 97, 11:56
NTDB® data points: No humour (Fantus), 97, 12:47
NTDB® data points: Seventy-five years of banking (Fantus, Fantus, Fantus), 97, 3:50
NTDB® data points: Smarter than the average bear (Fantus), 97, 4:47
NTDB® data points: Surf’s up (Fantus), 97, 8:74
NTDB® data points: Twister (Fantus), 97, 6:56
NTDB® data points: Use your head (Fantus), 97, 7:67
NTDB® data points: Wipeout (Fantus), 97, 9:70
Trauma meetings calendar, 97, 2:53, 3:43, 4:40, 5:33, 6:51, 7:61, 8:55

CANCER (see also: and AMERICAN COLLEGE OF SURGEONS: Commission on Cancer and AMERICAN COLLEGE OF SURGEONS: Alliance/ACS Clinical Research Program)
Cancer care closer to home: Dr. McKellar ensures rural patients get quality care (Peregrin), 97, 4:16
Common origins: The two ACSs—100 years of collaboration to improve the lives of cancer patients (McGinnis Jr.), 97, 4:6
Gynecologic oncology surgeons spare patients’ fertility, enhance quality of life (Clickson), 97, 2:12

CLINICAL TRIALS (see: AMERICAN COLLEGE OF SURGEONS: Alliance/ACS Clinical Research Program)
CPT 2012 brings with it new codes and code changes (Barney, Savarise, Jackson), 97, 1:26
General Surgery Coding workshops planned for remainder of 2012, 97, 5:32
Socioeconomic tips: Coding for skin replacement surgery in 2012 (Barney, Savarise, Jackson), 97, 2:41

DIVERSITY
Cultural competence: Why surgeons should care (Khoury, Mendoza, Charles), 97, 3:13

EDITORIAL
Looking forward (Hoyt), 97, 1:4 (medical liability); 2:4 (Trauma, Critical Care & Surgery Course); 3:4 (Joining Forces); 4:4 (performance improvement project); 5:4 (ACS Centennial); 6:4 (A Century of Surgery); 7:4 (im-
provements in education); 8:4 (Medicare payment); 9:7 (Centennial activities at Clinical Congress); 10:6 (hospital standards); 11:7 (John Pryor, MD, FACS); 12:5 (Inspiring Quality tour)

EDUCATION AND TRAINING
ASSET: An effective educational experience for practicing surgeons (Kuhls, Risucci, Bowyer, Luchette), 97, 7:31
Advanced degrees for surgeons and their impact on leadership (Zheng, Mouawad, Glass, Hamed), 97, 8:19
The critical state of graduate medical education funding (Metzler, Ganjawalla, Kaups, Meara), 97, 11:9
Enhancing American surgical training: Meeting the challenge of a globalizing world (Sakran, Kaafarani, Prabhakaran, Nitzschke, Casey), 97, 7:20
HPB Surgery Fellowship Match opens for 2012–2013, 97, 6:60
Joint statement by the ACS and SAGES on FLS completion for general surgeons who perform laparoscopy, 97, 5:30
March 31 is deadline to claim CME credit for 2011 Clinical Congress, 97, 3:43
Maximizing postgraduate surgical education in the future (McGreevy), 97, 2:19
Register now for ACS Comprehensive General Surgery Review Course, 97, 4:45
Training global surgery fellows (Sullivan, Hughes, Raymondville, Rogers, Steer, Meara), 97, 8:46

ELECTRONIC HEALTH RECORDS (see: LEGISLATION: Federal)

ETHICS
Invited commentary: Sanctity and organ donation’s societal value in an opt-out country: The Austrian experience (Biebl, Pratschke), 97, 1:24
RAS Issues Symposium: Surgery at the end of life: For love or money?: An argument against heroic intervention (Brown Matsen), 97, 11:20
RAS Issues Symposium: Surgery at the end of life: For love or money?: Reining in the scalpel (Blagg), 97, 11:22
Sanctity and organ donation’s societal value (Marvin, Prager, Wohlauer, Chandler), 97, 1:12
Statement on Council of Medical Specialties’ code for interactions with companies, 97, 12:39
Surgery at the end of life: For love or money? (Liepert, Leichtle, Santin), 97, 8:36
Take the ethical challenge on e-FACS.org, 97, 3:41

EVIDENCE-BASED MEDICINE (see: QUALITY OF CARE and VALUE-BASED CARE)

FUTURE OF SURGERY
Physician leadership and the future of surgical practice (Leichtle; Hartin Jr.), 97, 5:15
ACS Futures Committee takes a good, hard look at the year 2025 (Glickson), 97, 9:9
Health information technology, meaningful use criteria, and their effects on surgeons (Friedman, Metzler, Detmer, Selzer, Meara), 97, 7:12
Twenty-first century surgery: Have we entered uncharted waters? (Rosenberg, Schlich), 9, 7:6

GERIATRIC SURGICAL PATIENT CARE
ACS and AGS collaborate on landmark guidelines for geriatric surgical patient care, 97, 11:74

GLOBAL SURGERY
Cruise to South America: The College’s first international outreach effort, 97, 11:36
Enhancing American surgical training: Meeting the challenge of a globalizing world (Sakran, Kaafarani, Prabhakaran, Nitzschke, Casey), 97, 7:20
Training global surgery fellows (Sullivan, Hughes, Raymondville, Rogers, Steer, Meara), 97, 8:46
Using telemedicine to strengthen medical systems in limited-resource countries (Latifi), 97, 10:15

GUIDELINES AND STANDARDS (see: THE JOINT COMMISSION)

HEALTH CARE REFORM (see also: REIMBURSEMENT, and VALUE-BASED CARE)
Controlling state health care costs: Massachusetts forges ahead (Warshaw, Sutton), 97, 12:17

HISTORY (see: AMERICAN COLLEGE OF SURGEONS: Archives and AMERICAN COLLEGE OF Surgeons: Centennial)
ACS Bulletin: 1919 Hospital Standardization Series report, 97, 10:30
American College of Surgeons Bulletin No. 1: Requirements for Admission to Fellowship, 97, 9:18
The Bulletin of the American College of Surgeons: Keeping Fellows informed for nearly 100 years, 97, 9:17
Common origins: The two ACSs—100 years of collaboration to improve the lives of cancer patients (McGinnis Jr.), 97, 4:6
Cruise to South America: The College’s first international outreach effort, 97, 11:36
A look at the College’s first registry: The Bone Sarcoma Registry, 97, 12:32
Setting the record straight: The real history of Poland’s syndrome (Fox, Seyfer), 97, 3:27

IN MEMORIAM
In memoriam: Marion Rapp, former ACS International Liaison, remembered (Early), 97, 2:55
In memoriam: William H. Muller, Jr., ACS Past-President, surgical leader, innovator, researcher (Hanks), 97, 7:53

INDUSTRY RELATIONSHIPS
Statement on Council of Medical Specialties’ Code for Interactions with Companies, 97, 12:39

INFORMATICS (see also: TECHNOLOGY)
ACS influence spreads via Twitter, 97, 7:55
Health information technology, meaningful use criteria, and their effects on surgeons (Friedman, Metzler, Detmer, Selzer, Meara), 97, 7:12
Survey shows social media usage increasing among ACS Fellows, 97, 3:23
Using telemedicine to strengthen medical systems in limited-resource countries (Latifi), 97, 10:15

THE JOINT COMMISSION
A look at The Joint Commission: ASCs begin using wrong site surgery tool, 97, 10:60
A look at The Joint Commission: Building consensus on ways to minimize overuse of five treatments, 97, 12:46
A look at The Joint Commission: Flu vaccination standards set for ASCs and OBs, 97, 9:69
A look at The Joint Commission: JCR to engage surgeons and physicians to reduce adverse hospital events, 97, 6:52
A look at The Joint Commission: Joint Commission offers new HAI Portal, 97, 7:63
A look at The Joint Commission: Joint Commission Resources releases new antimicrobial stewardship resources, 97, 5:37
A look at The Joint Commission: New standard for surgical accountability measures, 97, 1:59
A look at The Joint Commission: New Targeted Solutions Tool to prevent wrong site surgery, 97, 4:43
A look at The Joint Commission: Resources for preventing hospital readmissions, 97, 3:46
A look at The Joint Commission: SafeCare offers quality framework in resource-restricted settings, 97, 8:63
A look at The Joint Commission: Surgical care measures show significant progress, 97, 11:54
A look at The Joint Commission: TJC works to improve infection control, 97, 2:56

LEADERSHIP
Advanced degrees for surgeons and their impact on leadership (Zheng, Mouawad, Glass, Hamed), 97, 8:19
From the Chair of the RAS-ACS: Leadership skills continue to serve past RAS-ACS Chairs in their current roles (Santry), 97, 8:9
Leadership conference focuses on outcomes data and quality improvement (Peregrin), 97, 6:28
Leadership skills in the OR: Part I: Communication helps surgeons avoid pitfalls (Halverson, Saunders Walsh, Rikkers), 97, 5:8
Leadership skills in the OR: Part II: Recognizing disruptive behavior (Halverson, Neumayer, Dagi), 97, 6:17
Physician leadership and the future of surgical practice (Leichtle; Hartin Jr.), 97, 5:15
Surgical leadership across generations (Prabhakaran, Economopoulos, Grabo, Sakran), 97, 8:30
Surgical leadership and political advocacy (Goldberg, Kaaafarani, Smith, Winfield), 97, 8:14
Women leaders in surgery: Past, present, and future (Emamaullee, Lyons, Berdan, Bazzarelli), 97, 8:24

LEGISLATIVE AND GOVERNMENT ISSUES (see also: MEDICARE/MEDICAID, PROFESSIONAL LIABILITY, and REIMBURSEMENT)
Why the 2012 elections matter to you—the surgeon (Bailey), 97, 10:26
Subject index

**Federal**
The 112th Congress: The year in review (Hedstrom), 97, 12:11
Sustainable growth rate repeal: The bandages are running out (Hedstrom, Moye), 97, 5:20
What surgeons should know about...Choosing not to participate in the CMS incentive programs (Gokak), 97, 12:40
What surgeons should know about...Participating in the Medicare eRx Incentive Program (Gokak), 97, 5:6
What surgeons should know about...Participating in the Medicare eRx Incentive Program (Gokak), 97, 8:6

**State**
Controlling state health care costs: Massachusetts forges ahead (Warshaw, Sutton), 97, 12:17
Expectations for state legislatures in 2012 (Sutton, Grill, Macias), 97, 2:36
State of the states: Defining surgery (Grill), 97, 5:27
State STATs: When states practice medicine: Physician gag laws (Macias), 97, 2:39

**M**
MEDICARE/MEDICAID (see also: CURRENT PROCEDURAL TERMINOLOGY and REIMBURSEMENT)
Dr. Hoyt, Dr. Opelka present ACS views on Medicare payment issues, 97, 9:79
Sustainable growth rate repeal: The bandages are running out (Hedstrom, Moye), 97, 5:20
What surgeons should know about...Choosing not to participate in the CMS incentive programs (Gokak), 97, 12:40
What surgeons should know about...The Medicare EHR Incentive Program (Gokak), 97, 10:46
What surgeons should know about...The Medicare Shared Savings Program (Desmarais), 97, 3:7
MILITARY SURGERY (see: TRAUMA)

**O**
OPERATING ROOM ENVIRONMENT
Leadership skills in the OR: Part I: Communication helps surgeons avoid pitfalls (Halverson, Saunders Walsh, Rikkers), 97, 5:8
Leadership skills in the OR: Part II: Recognizing disruptive behavior (Halverson, Neumann, Dagi), 97, 6:17
Surgeons experience more ergonomic stress in the OR (Glickson), 97, 4:20

OUTCOMES (see: VALUE-BASED CARE)

P
PATIENT EDUCATION AND PROTECTION (see: THE JOINT COMMISSION and QUALITY OF CARE)

PERFORMANCE MEASUREMENT (see: AMERICAN COLLEGE OF SURGEONS: National Surgical Quality Improvement Program and THE JOINT COMMISSION and MEDICARE/MEDICAID and QUALITY OF CARE)

PRACTICE MANAGEMENT (see also: CURRENT PROCEDURAL TERMINOLOGY and QUALITY OF CARE and REIMBURSEMENT)
ACS offers resources to help surgeons achieve meaningful use of EHR, 97, 6:41
Confronting the ethics, myths, and legends of restrictive covenants in the era of the contract surgeon (Cirocco), 97, 2:29
There isn’t an app for that: Banning recording in the office, 97, 2:47
What surgeons should know about...Choosing not to participate in the CMS incentive programs (Gokak), 97, 12:40
What surgeons should know about...Medicare and Medicaid audits (Ollapally), 97, 11:49
What surgeons should know about...The Medicare EHR Incentive Program (Gokak), 97, 10:46
What surgeons should know about...Modifications to ordering and certifying rules for physicians (Ollapally), 97, 9:60
What surgeons should know about...Participating in the Medicare eRx Incentive Program (Gokak), 97, 5:6
What surgeons should know about...Participating in the Medicare eRx Incentive Program (Gokak), 97, 8:6
What surgeons should know about...PQRS reporting in 2012 (Gokak), 97, 2:6

PROFESSIONAL LIABILITY
A crisis in the ED: Liability protection needed STAT (Bailley), 97, 3:19
Do you know how to stay out of trouble as an expert witness?, 97, 7:58
Medical liability reform: Evidence for legislative and alternative approaches (Metzler, Meara), 97, 1:6
QUALITY OF CARE (see also: AMERICAN COLLEGE OF SURGEONS: Inspiring Quality campaign; and AMERICAN COLLEGE OF SURGEONS: National Surgical Quality Improvement Program; and HEALTH CARE REFORM)
The ACS and the ABCs of how quality measures are established and implemented (Shelly), 97, 9:49
Cultural competence: Why surgeons should care (Khoury, Mendoza, Charles), 97, 3:13
Leadership conference focuses on outcomes data and quality improvement (Peregrin), 97, 6:28
NQF endorses SQA's Patient-Focused Care Survey, 97, 8:55
Public reporting of health care data: A new frontier in quality improvement (Sharma, Metzler, Chen, Mayer Jr., Meara), 97, 6:6

SOCIAL MEDIA (see: INFORMATICS)

VALUE-BASED CARE (see also: QUALITY OF CARE)
What surgeons should know about…Choosing not to
participate in the CMS incentive programs (Gokak), 97, 12:40
What surgeons should know about...The Medicare Shared Savings Program (Desmarais), 97, 3:7
What surgeons should know about...Participating in the Medicare eRx Incentive Program (Gokak), 97, 5:6
What surgeons should know about...Participating in the Medicare eRx Incentive Program (Gokak), 97, 8:6
What surgeons should know about...PQRS reporting in 2012 (Gokak), 97, 2:6
VOLUNTEERISM (see also: GLOBAL HEALTH CARE)
Fellows honored for volunteerism (Casey, Kodera), 97, 9:74
Learning about health care in Africa: A physician’s experience in Lagos, Nigeria (Smith), 97, 2:24
Short-term surgical missions make a difference: A life-changing case in Ibi, Nigeria (Kim, Wedderburn, Ibanga), 97, 11:31
Task shifting overcomes the limitations of volunteerism in developing nations (Curci), 97, 10:9
Using telemedicine to strengthen medical systems in limited-resource countries (Latifi), 97, 10:15

W

WOMEN IN SURGERY
International women in surgery symposium set for spring 2012, 97, 1:61, 2:53
Third annual WIS international symposium approaches, 97, 5:44
Women leaders in surgery: Past, present, and future (Emamaullee, Lyons, Berdan, Bazzarelli), 97, 8:24

WORKFORCE ISSUES (see also: AMERICAN COLLEGE OF SURGEONS: Health Policy Research Institute)
ACS cited in Modern Healthcare article on rural surgeon shortage, 97, 6:47
ACS takes a stand on policies impacting the surgical workforce (Halvorson), 97, 10:22
Survey reveals most physicians unwilling to recommend health care as a profession, 97, 6:49

Y

YOUNG SURGEONS (see: AMERICAN COLLEGE OF
**January 2013**

- **Louisiana Chapter**
  - January 11–13
  - Hyatt Regency New Orleans, New Orleans, LA
  - Contact: Janna Pecquet, janna@laacs.org

**February 2013**

- **Puerto Rico Chapter**
  - February 21–23
  - TBD, San Juan, PR
  - Contact: Aixa Velez-Silva, genteinc@gmail.com

- **South Texas Chapter**
  - February 21–23
  - Houston Marriott at the Texas Medical Center, TX
  - Contact: Janna Pecquet, janna@laacs.org

**March 2013**

- **Medical Disaster Response**
  - March 17
  - Caesars Palace, Las Vegas, NV
  - Contact: Mary Allen, redstart@aol.com

- **Trauma, Critical Care, and Acute Care Surgery**
  - March 18–20
  - Caesars Palace, Las Vegas, NV
  - Contact: Mary Allen, redstart@aol.com

**April 2013**

- **113th Annual Congress of the Japan Surgical Society**
  - April 11–13
  - Fukuoka International Congress Center, Japan
  - Contact: Katsuhiko Yanaga, MD, PhD, FACS, kyanaga@jikei.ac.jp

- **XXII International Course**
  - American College of Surgeons
  - April 26
  - Salta, Argentina
  - Contact: Rodolfo L. Faraco, MD, FACS, rfaraco52@gmail.com

**May 2013**

- **Ohio Chapter Meeting**
  - May 2–4
  - Sheraton at Capital Square, Columbus
  - Contact: Jennifer Starkey,
    jennifer@executive-office.org

- **Virginia Chapter Meeting**
  - May 3–5
  - Hilton Virginia Beach, VA
  - Contact: Susan McConnell,
    smcconnell@ramdocs.org

- **Maine and New Hampshire Chapter Meeting**
  - May 17–19
  - Harborside Hotel Marina and Spa, Bar Harbor, ME
  - Contact: Jennifer Starkey,
    jennifer@executive-office.org

**June 2013**

- **Point/Counterpoint–Acute Care Surgery**
  - June 2-5
  - Gaylord National Hotel, National Harbor, MD
  - Contact: Melissa Anderson,
    andersma@evms.edu

**Future Clinical Congresses**

- **2013**
  - October 6–10
  - Washington, DC

- **2014**
  - October 26–30
  - San Francisco, CA

- **2015**
  - October 4–8
  - Chicago, IL

---

*Dates and locations subject to change.*