Fertility-sparing surgery inspires hope
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Chapter news
Rhonda Peebles
A few months ago, I wrote about the Point/Counterpoint for Acute Care Surgery course that takes place annually under the direction of L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), Past-President of the American College of Surgeons (ACS).* As follow-up to that piece, this column focuses on another program that encompasses acute care—Trauma, Critical Care & Acute Care Surgery, which is presented annually at Caesars Palace in Las Vegas, NV.

Long-running program

This year marks the 45th anniversary of the ACS’ continuing medical education sponsorship of a course on trauma and emergency care in the Western states. Approximately five years ago, this course expanded its focus from trauma and critical care to include acute care surgery, bringing early recognition to this emerging discipline. The goal of this program has always been to provide clinicians with the skills they need to make complex surgical decisions and apply advanced surgical techniques.

Four Fellows of the College have chaired this program—John Batdorf, Cuthbert Owen, Henry Cleveland, and for the past 20 years, Kenneth Mattox (all MD, FACS). Dr. Mattox is Distinguished Service Professor in the Michael E. DeBakey Department of Surgery at Baylor College of Medicine in Houston, TX. Under Dr. Mattox’s leadership, the Trauma, Critical Care & Acute Care Surgery Conference has become the largest program of its type. Word-of-mouth endorsements have led to this course being oversubscribed for the past 12 years, and of the more than 1,300 attendees each year, approximately 80 percent or greater are physicians. Indeed, it is now one of the longest-running and best-attended trauma programs in the world.

The course is designed to provide clinicians with an understanding of the following:

- Innovative and appropriate techniques and technology for optimal care of the injured or seriously ill patients in urban and rural settings
- Treatments, techniques, and technology for optimal care in the critical care setting
- Application of concepts gleaned from urban and rural trauma and acute care surgery cases to the practice setting
- Practical exposure techniques and guidelines for management of injuries
- Appropriate surgical response to injuries and illness with added complicating factors
- The ethical dilemmas of trauma and critical care
- Management, technology, and techniques for optimal care of diverse trauma and critical care-related issues

The selected faculty includes the best and most inspiring surgical educators, and time is allotted to provide significant interaction among the faculty and the attendees. Dr. Mattox designs the course content to provide information that promotes positive change in practices, and the vast majority of calls and e-mails he receives after the conference indicate that this goal is being achieved.

Dr. Mattox designs the course content to provide information that promotes positive change in practices, and the vast majority of calls and e-mails he receives after the conference indicate that this goal is being achieved.

conference, I can attest to the repeated success of this program.

The next offering of this program will occur March 26–28, at Caesars Palace in Las Vegas. This year’s program committee comprises Dr. Mattox; Raul Coimbra, MD, PhD, FACS, the Monroe E. Trout Professor of Surgery and chief of the division of trauma, surgical critical care, and burns at the University of California, San Diego, School of Medicine; Matthew J. Wall, Jr., MD, FACS, professor, DeBakey Department of Surgery, and chief of thoracic surgery at Ben Taub General Hospital in Houston; Alison Wilson, MD, FACS, director of the Jon Michael Moore Trauma Center and chief of trauma, emergency surgery and surgical critical care at West Virginia University in Morgantown; and Mary Allen, program coordinator and administrative associate for the DeBakey Department of Surgery at Baylor.

Disaster management

Five years ago, Dr. Mattox added a mini-course titled Medical Disaster Response, which takes place immediately before the Trauma, Critical Care & Acute Care Surgery Course. Medical Disaster Response focuses on the clinical realities of providing care in mass casualty/disaster situations—practical knowledge that surgical and emergency providers can take home and implement to improve institutional disaster response plans. The information presented is relevant to all members of the institution-based trauma care team—physicians, nurses, other hospital personnel, field personnel, and others—and emphasizes that the trauma center, regardless of level, is the foundation of the disaster medical response system. This course is one of the few that solely focuses on the clinical and medical aspects of disaster planning and management, rather than on the civic, public health, incident command, and shelter issues.

The objectives of this year’s program are to help attendees carry out the following activities:

• Develop strategies for triage, surge, regional collaboration, and communication
• Generate policies to manage inhospital and community-wide decreases in services during disaster situations
• Apply concepts and lessons learned from previous mass casualty events and military experience
• Make the difficult ethical decisions unique to disaster and mass casualty situations

The course is specifically designed for frontline clinical personnel who are thrust into disaster situations and are trying to save lives and limbs, often with limited space and resources. As in the Trauma, Critical Care and Acute Care Surgery Course, faculty are selected for their expertise and first-hand experience in medical disaster response, and the program is designed to present maximum content in formats most conducive to learning.

Specific catastrophic situations that will be examined at this year’s meeting include the tornado that devastated Joplin, MO, and the bombing and shooting rampage that occurred in Oslo, Norway, in 2011. Medical Disaster Response 2012 will take place March 25 at Caesars Palace.

Preparing surgeons

The ACS Committee on Trauma and the College as a whole continue to take great pride in the presentation and co-sponsorship of courses that provide surgeons and allied providers with the skills and knowledge they need to care for critically injured patients. I would encourage all Fellows to visit http://www.facs.org/trauma/cme/traumtgs.html to learn about the trauma courses the College cosponsors. To learn about or register for Trauma, Critical Care and Acute Care Surgery and/or Medical Disaster Response 2012, go to the website, www.trauma-criticalcare.com.

David B. Hoyt, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
What surgeons should know about...

PQRS reporting in 2012

by Sana Gokak

The Centers for Medicare & Medicaid Services (CMS) has continued the Physician Quality Reporting System (PQRS) into 2012 as required under the Medicare Improvements for Patients and Providers Act of 2008. The Affordable Care Act authorized incentive payments for eligible professionals who successfully participate in the program through 2014. The incentive payment for the 2012 reporting year is 0.5 percent of the total allowed charges for Medicare Part B professional services covered under the physician fee schedule and furnished during the reporting period. For reporting years 2013 and 2014, eligible professionals can earn an incentive payment of 0.5 percent of their total estimated allowed charges for Medicare Part B physician fee schedule covered professional services furnished during the respective reporting periods. Beginning in 2015, eligible professionals who fail to satisfactorily report PQRS measures will be subject to a payment penalty.

Table 1. PQRS payment incentives and penalties

<table>
<thead>
<tr>
<th>Reporting year</th>
<th>Incentive</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>0.50%</td>
<td>–</td>
</tr>
<tr>
<td>2013</td>
<td>0.50</td>
<td>–</td>
</tr>
<tr>
<td>2014</td>
<td>0.50</td>
<td>–</td>
</tr>
<tr>
<td>2015</td>
<td>–</td>
<td>1.50%</td>
</tr>
<tr>
<td>2016 and beyond</td>
<td>–</td>
<td>2.00</td>
</tr>
</tbody>
</table>

Table 2. 2012 PQRS changes

<table>
<thead>
<tr>
<th>2011 PQRS</th>
<th>2012 PQRS</th>
</tr>
</thead>
<tbody>
<tr>
<td>In 2011, “Group Practice Reporting Option (GPRO) I” and “GPRO II” were available to group practices. GPRO I consists of 200 or more physicians, and GPRO II consists of two–199 eligible professionals.</td>
<td>In 2012, CMS seeks to eliminate the distinction between GPRO I and GPRO II for group practices. The two groups will instead be consolidated such that a group practice GPRO will consist of 25 or more eligible professionals.</td>
</tr>
<tr>
<td>In 2011, CMS allowed for individual measures as well as measure groups to be reported via claims for the six-month reporting period.</td>
<td>In 2012, CMS no longer allows physicians to report the individual measures or measure groups via claims for the six-month reporting period.</td>
</tr>
<tr>
<td>In 2011, CMS allowed individual measures and measure groups to be reported via registries during the six-month reporting period.</td>
<td>In 2012, CMS will retain the six-month reporting option for reporting measure groups via registry only. Physicians will no longer be able to use the six-month reporting period to report the individual measures via registry.</td>
</tr>
<tr>
<td>In 2011, CMS had one option for the electronic health record (EHR)-based method of reporting PQRS. It required an eligible professional to report at least three PQRS measure for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.</td>
<td>In 2012, CMS has created an additional option for reporting via the EHR-based method of reporting. 1. The first option is streamlined with the EHR Incentive Program. During the 12-month reporting period, you can report three Core Clinical Quality measures (if any denominators are zero, then you have to do three alternate core) and report three of the 38 additional Clinical Quality Measures for the EHR Incentive Program. 2. The second option is the same as the option in 2011. It requires an eligible professional to report at least three PQRS measures (not necessarily core measures) for 80 percent of applicable Medicare Part B FFS patients of each eligible professional. A list of these EHR measures can be found at: <a href="http://www.facs.org/ahp/pqri/2012/ehr-reporting.pdf">http://www.facs.org/ahp/pqri/2012/ehr-reporting.pdf</a>.</td>
</tr>
</tbody>
</table>
adjustment or penalty. Table 1, page 6, summarizes the payments during these years.

What are some of the differences between the requirements in the 2011 PQRS and the 2012 PQRS?

In the Medicare physician fee schedule final rule for calendar year (CY) 2012, released on November 1, 2011, CMS finalized several changes to the PQRS for 2012. Major program changes are highlighted in Table 2, page 6.

It is important to note that 2012 PQRS includes 210 individual quality measures and 22 measures that are part of a 2012 measures group. For a copy of the 2012 PQRS measure list, visit https://www.cms.gov/PQRS/Downloads/2012_PhysQualRptg_ImplementationGuide_MeasuresList_12152011.zip and click on “measures list.” Whereas 2011 PQRS quality measures may have been updated for the new program year. Surgeons who are not currently reporting in the 2011 PQRS should review the 2012 PQRS Measure Specifications Manual for updates and changes.

How do I use the measure specifications manual?

The first step for implementing PQRS in your office is to use the 2012 PQRS Measure Specifications Manual to identify measures applicable for professional services that your practice routinely provides. Next, select those measures that make sense based on prevalence and volume in your practice, as well as your individual or practice performance analysis and improvement priorities. The 2012 PQRS Measure Specifications Manual can be found at http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

This article outlines the process of claims-based reporting for PQRS 2012—in this case, perioperative measure

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**Table 3. 2012 Measure Specifications Manual (pages 61-62): Measure #21: Perioperative Care: Selection of Prophylactic Antibiotic—First or Second Generation Cephalosporin**

<table>
<thead>
<tr>
<th>Surgical procedure</th>
<th>CPT code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integumentary</td>
<td>15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369</td>
</tr>
<tr>
<td>Spine</td>
<td>22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042</td>
</tr>
<tr>
<td>Hip reconstruction</td>
<td>27125, 27130, 27132, 27134, 27137, 27138</td>
</tr>
<tr>
<td>Trauma (fractures)</td>
<td>27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814</td>
</tr>
<tr>
<td>Knee reconstruction</td>
<td>27440, 27441, 27442, 27443, 27445, 27446, 27447</td>
</tr>
<tr>
<td>Vascular</td>
<td>33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35151, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35635, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830</td>
</tr>
<tr>
<td>Spleen and lymph nodes</td>
<td>38115</td>
</tr>
<tr>
<td>Esophagus</td>
<td>43045, 43100, 43101, 43107, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496</td>
</tr>
<tr>
<td>Stomach</td>
<td>43500, 43501, 43502, 43510, 43520, 43525, 43560, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870</td>
</tr>
<tr>
<td>Small intestine</td>
<td>44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Surgical procedure</th>
<th>CPT code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biliary surgery</td>
<td>47420, 47425, 47460, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47730, 47740, 47760, 47800, 47802, 47900</td>
</tr>
<tr>
<td>Pancreas</td>
<td>48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48554, 48556</td>
</tr>
<tr>
<td>Abdomen, peritoneum, and omentum</td>
<td>49215, 49568</td>
</tr>
<tr>
<td>Renal transplant</td>
<td>50320, 50340, 50360, 50365, 50370, 50380</td>
</tr>
<tr>
<td>Neurological surgery</td>
<td>22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33430, 33436, 33446, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 33572, 33521, 335241, 35271</td>
</tr>
<tr>
<td>General thoracic surgery</td>
<td>0236T, 19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32488, 32488, 32489, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35226, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 64746</td>
</tr>
<tr>
<td>Foot and ankle</td>
<td>27702, 27703, 27704, 28192, 28193, 28293, 28315, 28420, 28445, 28485, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737</td>
</tr>
</tbody>
</table>

Procedure 44120: Enterectomy, resection of small intestine; single resection and anastomosis

Example claim form
cate that it is a claims and registry measure, meaning it can be reported using either the claims-based or the registry-based method. This article looks at the claims-based method only. The Current Procedural Terminology (CPT)* codes and patient demographics identify the patients who are included in measure #21, otherwise known as the denominator. Beginning on page 61 of the 2012 PQRS Measure Specifications Manual, there is a listing of all surgical procedures and CPT codes that qualify patients as eligible to meet this measure’s inclusion requirements (see Table 3, pages 7–8). It is important to review the CPT codes associated with each measure reported. Also, please note that the included procedure codes may change from year to year, so review the 2012 measure specifications before beginning to report for this year.

I’ve identified a patient in the denominator for measure #21; now what?

CPT II codes, or quality data codes (QDCs), are used to report the clinical action required by the measure on the claims form. For measure #21, there are three choices: 4041F, 4041F with 1P, and 4041F with 8P. 4041F indicates documentation of order for cefazolin or cefuroxime for antimicrobial prophylaxis (written order, verbal order, or standing order/protocol); 4041F with 1P modifier indicates order for first or second generation cephalosporin not ordered for medical reasons; and 4041F with

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*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.

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Table 4. PQRS 2012 Reporting options matrix

<table>
<thead>
<tr>
<th></th>
<th>Claims-based methods</th>
<th>Registry-based methods</th>
<th>EHR-based methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full-year period</strong></td>
<td>1. At least three PQRI measures (one–two if less than three apply), for 50 percent of applicable Medicare Part B FFS patients of each eligible professional</td>
<td>4. At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional</td>
<td>8. A. During the 12-month reporting period, you can report three core measures (if any denominators are zero, then you have to do three alternate core) and report three out of the 38 additional measures for the EHR Incentive Program or B. At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional</td>
</tr>
<tr>
<td>Measures groups</td>
<td>2. One measures group for at least 30 Medicare Part B FFS patients</td>
<td>5. One measures group for at least 30 Medicare Part B FFS patients</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>3. One measures group for 50 percent of applicable Medicare Part B FFS patients of each eligible professional (at least 15 patients during reporting period)</td>
<td>6. One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least 15 patients during the reporting period)</td>
<td></td>
</tr>
<tr>
<td><strong>Half-year period</strong></td>
<td>Individual measures Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Measures groups</td>
<td>Individual measures Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>7. One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least eight patients during the reporting period)</td>
<td></td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

---

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8P modifier indicates order for first or second generation cephalosporin not ordered, reason not specified. Please note that both the CPT code and the appropriate CPT II code should be submitted on the same claim form.

Can you provide a step-by-step overview of the process for submitting a claim form?

CPT II codes can be reported on claim form CMS 1500 or via electronic form ASC X12N 837. The Figure on page 9 is an example of the CMS 1500 claim form.

Based on Figure 1, the steps for reporting via claims include the following:

Step 1: Look in the measure specifications for measure #21 to see if this procedure, 44120, is listed in the table of surgical procedures for which there are indications for a first or second generation cephalosporin prophylactic antibiotic. If so, continue to step 2.

Step 2: On the CMS 1500 claim form, the CPT procedure code 44120 is listed on line 1.

Step 3: On line 2, the CPT II code 4041F with 1P is listed, which indicates the order for first or second generation cephalosporin not ordered for medical reasons. Note that the CPT II code may be one of three options, as discussed earlier in this article.

Step 4: Lines 3 through 6 are CPT II codes that correspond to other PQRS measures (#20, #22, and #23). Measures #20, #22, and #23 are often reported by eligible professionals when measure #21 is reported because these four measures are perioperative care measures. CPT procedure code 44120 corresponds with these perioperative measures as well, so the CPT II codes are listed on the same claim form.

Step 5: Be sure billing software and the clearinghouse can correctly submit PQRS CPT II codes or QDCs.

Step 6: Regularly review the remittance advice notice from the carrier to ensure the denial remark code N365 is listed for each QDC submitted. This indicates that claims have made it to the CMS national claims history file.

Surgical practices that follow these steps should be able to successfully report via claims in PQRS 2012 to receive incentive payments. There are various ways to report for PQRS, and this article has only covered the claims-based method for individual measures. Please refer to the correct measure specifications manual if you choose another method. Table 4 on page 10 is a matrix that lists all six options for reporting in PQRI 2012.

For more background information regarding the PQRS program, go to http://www.cms.hhs.gov/pqrs/ and access the resources posted at http://www.facs.org/ahp/pqri/index.html. If you have any further questions regarding PQRS, contact Sana Gokak at sgokak@facs.org.

Sana Gokak, is a Quality Associate in the Division of Advocacy and Health Policy, Washington, DC.
Gynecologic oncology surgeons spare patients’ fertility, enhance quality of life

by Jeannie Glickson
A recent celebration at the Memorial Sloan-Kettering Cancer Center in New York, NY, an onlooker would view many sights not commonly seen in a cancer center. A boisterous group enjoyed food and drinks in a brightly lit room filled with colorful crepe paper and balloons. The guests, many of them young children, laughed and clapped at a clown hired for the occasion.

This joyous gathering marked the 10-year anniversary of Sloan-Kettering’s use of fertility-sparing surgical procedures. In attendance were most of the 20 children born to mothers who received treatment for first-stage cervical cancer with a radical trachelectomy (removal of the cervix). Annually, 10 to 15 patients receive the radical trachelectomy at Sloan-Kettering.

Today, fertility-sparing procedures are also commonly performed in young women with ovarian cancer. If only one ovary is cancerous, and the cancer is in Stage 1A, fertility-sparing surgery becomes a hopeful option for patients still wanting to conceive. The surgery might include removal of the cancerous ovary, but would leave the unaffected ovary and the uterus.

**Diagnosis no longer ends pregnancy hopes**

In 1943, George Papanicolaou, MD, and Herbert F. Taut, MD, published “Diagnosis of uterine cancer by the vaginal smear” in the *Yale Journal of Biology and Medicine*. The study set in motion the worldwide use of the Pap smear to test for cervical cancer. Since World War II, the Pap test has become the most widely used cancer screening method in the world, detecting cervical cancer during its most treatable early stages. Thanks to a vaccine that fights the human papillomavirus, which causes most cervical cancer, along with enhanced screening, cervical cancer—once among the most common cancers affecting U.S. women—now ranks 14th in frequency.

Nonetheless, each year in the U.S., approximately 12,200 new cases of invasive cervical cancer are diag-

**Opposite, background photo:** Dr. Abu-Rustum and John P. Díaz, MD, in the operating room. Foreground: A child held in the arms of her mother—a fertility-sparing patient—at the 10-year anniversary party. (Photo courtesy of Memorial Sloan-Kettering Cancer Center.)

This page: Surgical partners Yukio Sonoda, MD (seated left) and Dr. Abu-Rustum enjoy the 10-year anniversary celebration with Sloan-Kettering fertility-sparing patients and their children.
through the abdomen or vaginally—the surgeon removes the fatty tissue around the cervix, the surrounding lymph nodes, and upper two centimeters of the vagina. The surgeon then attaches the uterus to what remains of the vagina, and replaces the cervix with a cerclage that allows the patient to carry an embryo. In most cases, the cerclage is permanent and will require that any offspring be delivered via cesarean section.

Before performing the trachelectomy, the surgeon conducts a lymphadenectomy—removing lymph nodes in the patient’s pelvis and examining them under a microscope to determine if the cancer has spread. If the cancer has spread to the lymph nodes, the surgeon halts the trachelectomy, opting instead for a more radical treatment of the cancer, according to Sloan-Kettering’s Nadeem R. Abu-Rustum, MD, FACS, FACOG, director of minimally invasive surgery and director of resident and medical student education. “Only women with 1B disease or less, generally meaning that the cancer is limited to the cervix, and has not spread to the lymph nodes, are eligible for this fertility-sparing surgery,” Dr. Abu-Rustum said.

“The trachelectomy completely changes the way surgeons look at young women with cervical cancer,” explained Dr. Abu-Rustum. A generation ago, he said, surgeons treated most women with invasive cervical cancer with a radical hysterectomy, including the removal of the uterus, cervix, ovaries, fallopian tubes, and a portion of the upper vagina, as well as tissue around the cervix and the pelvic lymph glands. Depending on the stage of the cancer, Dr. Abu-Rustum added, female patients still receive chemotherapy or radiation therapy.

Through a cone biopsy, a more extensive form of cervical biopsy, Dr. Abu-Rustum said, the surgeon often can remove abnormal tissues that are in the cervix, leaving behind a margin free of abnormal cells. A large cone biopsy or a simple trachelectomy in select patients is sufficient for treating select early-stage cancers, he said.

**Candidates for the procedure**

“First and foremost, the patient has to have the desire to preserve fertility,” said Julian C. Schink, MD, professor of obstetrics and gynecology at Northwestern University Feinberg School of Medicine and chief of the division of gynecologic oncology at the Robert H. Lurie Comprehensive Cancer Center of Northwestern Memorial Hospital in Chicago, IL. “It’s a complicated decision, but as surgeons, we can help patients understand what’s possible today. We’ve broken down major barriers to fertility preservation.”

Oncologists must address a number of myths on the subject of cancer treatment, according to Dr. Schink. “One of the biggest myths,” he said, “is that any treatment beyond the treatment for cancer will compromise the patient’s health. This is just not true.”

Dr. Schink also emphasized the importance of recognizing patients as a diverse group with unique needs and goals. “Patients have a wide range of desires, and what works for one patient may not work for another. Many patients don’t want their fertility preserved, and their immediate response is, ‘I never wanted to have children anyway,’” Dr. Schink said.

“Just because someone can do this procedure does not mean that they should. There is a lot that goes into determining who is a candidate and in what cases it will be successful,” agreed Stephanie V. Blank, MD, assistant professor in the division of gynecologic oncology at New York University School of Medicine, NY. “Obviously, I would not recommend fertility treatment if it compromised the patient’s health. We evaluate the patient’s fertility before we take any extra steps because we want the steps to be useful.”

“Not everyone offers these procedures, but certainly consideration of fertility has become a standard part of treatment decision making in women of childbearing age,” Dr. Blank said.

Appropriate and extremely thorough patient counseling should come at the very beginning of the decision-making process. “It’s very important that the expertise of a gynecologic oncologist be available to the patient,” Dr. Blank added. Attaining this input often requires referral of patients who live in low-population areas to large medical centers.

At the Mayo Clinic, as with all accredited cancer centers, the decision of whether a patient is appropriate for fertility-sparing procedures rests on the circumstances of each case.

“It’s a three-way decision,” said Dean E. Morback, PhD, assistant professor within the Mayo Clinic’s division of reproductive endocrinology and director of the in vitro fertilization and fertility testing laboratories. “It’s a decision that fertility specialists, the oncology team, and the patient must make. Our job is to make sure that patients know all their options.”
“You have to be very strict with the criteria you use for deciding which patients are suitable for these procedures,” added Dr. Blank. “Fertility-sparing procedures cannot compromise our patients’ health.”

Although some patients with cervical cancer address the fertility issue immediately, David M. Kushner, MD, division chief and medical director, gynecologic oncology, University of Wisconsin School of Medicine and Public Health, Madison, generally finds that at the beginning of the experience, patients want mostly to hear about a cure for their disease. As patients begin to believe in their survival prospects, he said, those who are in the childbearing years start thinking about their fertility.

“Talking about their fertility is difficult for some patients,” Dr. Kushner said, “because the discussion is about the effect that treatment is going to have on them for the rest of their lives. But it’s an important conversation, and many will say five years later, ‘I am so glad that we talked it through rationally.’”

Radical trachelectomy changes outlook

“Many surgeons once considered fertility-sparing procedures taboo because the focus was always on cancer survival,” according to Dr. Kushner. “Even today if the uterus is not going to be used for reproductive functions, we remove the uterus and cervix.”

Dr. Kushner noted that when the fertility-sparing trachelectomy first came into practice, the stitch around the cervix often failed, resulting in a high rate of miscarriages and pre-term deliveries. This unraveling of the stitch is less common today, he said, because surgeons have learned that leaving a small (one centimeter) piece of residual cervix improves term delivery rates without affecting cancer treatment.

When a patient receives radiation to treat cervical cancer, other organs tend to shut down, Dr. Kushner said. Using a procedure that has become standard, Dr. Kushner and his team will transpose the ovaries in a woman still of childbearing age—maintaining the blood supply but moving the eggs away from the uterus, often into the upper abdomen near the liver.

“As surgeons, we are always thinking of ways that we can improve the quality of life, and as gynecologic surgeons, providing ways to maintain patients’ sexuality and ability to reproduce,” Dr. Kushner added.

Directly impacting patients’ lives

“It’s rewarding to have this kind of impact on a patient’s life,” Dr. Kushner said. “I get fabulous holiday cards from many of the patients, and it is especially gratifying when we see patients with their babies at follow-up appointments.”

For example, being diagnosed with Stage 1 cervical cancer was devastating news to 37-year-old patient Kathleen,* an Illinois resident who received treatment from Dr. Kushner. Kathleen had no symptoms of the cancer, which was discovered only when she sought help from her primary physician after unsuccessful efforts to become pregnant.

“After I was diagnosed, I thought immediately about my ability to have children,” Kathleen said. “When I found out about the procedure that would give me the chance to conceive and carry a child, it was a ‘no-brainer.’” Although she is still trying to get pregnant, undergoing the procedure has given her hope.

Ovarian cancer

Several different types of cancer can occur in the ovaries, the seventh most common type of cancer among American women, and of approximately 26,000 cases diagnosed each year about 15 percent occur in girls or younger women.7

*To maintain confidentiality, patients are identified by first name only.
If diagnosed early, the survival rate for ovarian cancer is approximately 90 percent, among the highest for all cancers. However, because there are few external symptoms of ovarian cancer, and there is little or no screening for it, the disease often goes unnoticed and begins to metastasize to both ovaries and to the abdomen.

During a routine physical examination, a gynecologist discovered a cyst in 33-year-old patient Tracey, of Queens Astoria, NY, and ordered an ultrasound. When the ultrasound indicated cancer confined to the left ovary, Tracey, who has a family history of cancer, sought the help of Dr. Blank.

“My initial thought after being diagnosed was just that I wanted to live,” Tracey said. “But I had a huge bundle of emotions to deal with. All of my thoughts about my future were tied up with wanting to start a family.”

Dr. Blank removed the left ovary and fallopian tube from the patient and followed up with three rounds of chemotherapy. In February 2010, approximately 12 months after Tracey’s chemotherapy ended, she gave birth to a baby girl.

“I trust everything Dr. Blank tells me,” Tracey said. “I didn’t realize that after I had my daughter I would still be living with the fear of recurrence, but that fear is even stronger now that I have my daughter. Dr. Blank always tells me that my feelings are normal and that the majority of fertility-sparing surgical patients do not have recurrences. Sometimes I joke with her that I ask her the same questions because I need to hear her reassurance.”

Preserving the patient’s oocytes

Embryo cryopreservation, a long-used technique based on infertility therapies such as in vitro fertilization, refers to the freezing, storage, and thawing of oocytes. But two requirements for this procedure prohibit some women from pursuing this option: (1) radical surgery, chemotherapy, or radiotherapy must be delayed for two to three weeks, and (2) a partner’s or donor’s sperm must be available. To use embryo cryopreservation, a woman must use hormone medications that stimulate multiple eggs to grow at once and undergo a surgical procedure to harvest her oocytes, which are then combined with a partner’s or donor’s sperm to create an embryo. The embryo is then frozen for use at a later time.

Chicago resident Noelle, a 38-year-old ovarian cancer patient of Dr. Schink at Northwestern Memorial Hospital, was a suitable candidate for this procedure. When Dr. Schink told her he could harvest and preserve her eggs, Noelle recalls that the prospect of cryopreservation eased the pain of a cancer diagnosis.

“I felt like this was a way of saving part of myself,” Noelle said. “When you have cancer, so much seems to be taken away from you. This was one thing that I felt I had control over.” Dr. Schink and the nursing staff at Northwestern provided ongoing support and information. “They were sincere and kind in the way they treated me, and they always made me feel like I was their only patient,” Noelle said. “They didn’t feel sorry for me. They were there to support me.”

Today, Noelle offers her support to other cancer patients by volunteering for the Imerman Angels, a not-for-profit organization that matches individuals diagnosed with the same type of cancer for one-on-one supportive relationships.

New technology

Researchers at the Mayo Clinic have discovered promising fertility technology that should give cancer patients new reasons for hope, said Jani R. Jensen, MD, assistant professor of obstetrics-gynecology, at the Mayo Clinic in Rochester, MN. “One of our procedures is to remove the whole ovary and then cut strips off the surface, and often we find immature eggs during the dissection process. One possibility is that we can freeze the tissue pieces and potentially implant them in the patient at a later time. Another possibility is to harvest the immature eggs and try to treat them with medications in the lab to mature them and subsequently freeze them for later use.”

The essential factor is how much time the patient has to undergo the procedures, according to Dr. Jensen. “In some cancer cases, chemo has to be started the same day as the diagnosis,” she said. “To grow enough eggs to be able to harvest, we usually need two to three weeks.”

Also, through a process called in vitro maturation, the Mayo Clinic is experimenting with a technology, now being tested on animals. Immature eggs that are harvested from the ovarian tissue strips are cultured outside the mother’s womb and treated with hormones until they become mature. Then the immature eggs are fertilized with sperm and used to create an embryo.

“We currently don’t know much about the developmental potential of these embryos, and we worry that they may be particularly fragile compared to embryos...
created with our standard techniques,” according to Dr. Jensen. “However, particularly for patients in whom it would be dangerous to transplant ovarian tissue back—such as those women with ovarian cancer—this may be one of their only options. We see in vitro maturation of immature eggs to create embryos as a significant possibility for the future, and it’s an area of active interest for us.

“We recently purchased a special incubator with a microscope—known as an embryoscope—that allows us to watch these embryos develop over time in a highly controlled environment,” Dr. Jensen added, “We believe this will give extra support to these embryos and also teach us a lot about how these embryos grow.”

Effects of chemo, radiation on fertility
New approaches to sparing fertility make it possible for many gynecologic cancer patients to bear children. But many forms of cancer treatment have unavoidable effects on reproductive health. Chemotherapy induces cell damage, and its impact on fertility depends on the type, dose, and length of treatment. Certain alkylating agents, according to Dr. Jensen, attack cancer cells but can also damage healthy reproductive cells.

“Certain drugs are more toxic to the reproductive organs than others,” according to Dr. Schink. Chemotherapy and radiation can be gonadotoxic, compromising the functioning of the ovaries and affecting the physical function of the uterus, he said. The degree of severity of fertility decline depends on many factors: age and ovarian reserve status at the initiation of therapy and type of therapy and dose. Cyclophosphamide, a drug widely used in combination chemotherapy regimens, can cause direct destruction of egg cells and is linked to follicular depletion.10 Other agents such as vincristine, Adriamycin, and platinum agents are mutagens and can cause chromosome rearrangements and deletions in cells. Ovarian failure or premature menopause might not occur directly after chemotherapy or radiation, but often the ovarian reserve is affected, and long-term fertility may be compromised.11

Team support for fertility-sparing surgical patients
A patient with a cancer diagnosis who is a potential candidate for a fertility-sparing procedure needs support—first, to help her make a decision about her fertility, and then, to guide her through the cancer experience. A multidisciplinary team approach to caring for cancer patients is part of the standards that the Commission on Cancer requires of all accredited cancer centers.12

At Northwestern Memorial Hospital, the division of fertility preservation offers an interdisciplinary approach to care with a fast, direct path to fertility preservation. The oncology team involves 17 full-time employees, including a licensed clinical social worker, psychologists, a psychiatrist, a psychiatric nurse practitioner, dietitians, and a fertility patient navigator.

“Our patients are the beneficiaries of our collaborative approach to care,” Dr. Schink said. “You need an oncologist who believes that the patient’s survival is the first priority, and you need a fertility team that respects some cancer patients’ desires to have children. You need strong players on both sides.”

“Every female patient who undergoes fertility preservation surgery meets with a clinical psychologist who remains available to the patient and her family should she want to use these services,” said Kristin N. Smith, fertility patient navigator for Northwestern Memorial Hospital’s oncology program. “We also have reproductive endocrinologists and urologists who make themselves available to newly diagnosed patients and survivors who want to address fertility after cancer.”

Team support enhances the patient’s experience—but sometimes the strongest support can come from other patients. Dr. Blank’s patient, Tracey, said she often yearns for a support group with other women who have experienced similar conditions. “When this happens, it raises a host of feelings and questions that you might not otherwise have,” she said. “I think it would be valuable to connect with people who have gone through the same thing.”

Cancer’s impact on the whole being
Each year, approximately 80,000 women in the U.S. receive a diagnosis of gynecologic cancer, which has an immediate, all-encompassing impact on their lives. But gynecologic surgeons continue to employ fertilization-sparing techniques that change the rules about what happens to women who are diagnosed during their childbearing years.

For today’s gynecologic oncologists, the technological advances have produced a more optimistic future for many women and families and have enhanced the concept of what’s possible.

Fertility-sparing procedures are the wave of the present and the future, and Dr. Schink is convinced
that the numbers will continue to rise. He points out that Northwestern was one of the early movers of the procedure, and patients would travel to Chicago to benefit from the expertise of the hospital's surgeons and staff.

“Some of our demand has declined, because patients can receive the same procedures at many other locations around the country,” Dr. Schink said. “That’s a good thing.”

Acknowledgment

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Maximizing postgraduate surgical education in the future

by James M. McGreevy, MD, FACS

Most practicing surgeons agree that their surgical residency was the most exciting time of their medical career. However, looming changes right now promise to make the residency experience an even better one.

Within the next few years, residency programs will transform from an apprenticeship model, which has served well for almost 100 years, into a formalized curriculum-driven experience where competence, not time, defines the duration of training. Residents will be required to demonstrate progress toward defined milestones, including an ability to assess their progress in training and develop a learning program based upon their clinical experiences. Deliberate practice, reflection, and portfolios are established components of adult learning that will help develop these skills in postgraduate educational experience.

Surgical training in the past

In order to fully appreciate what is happening in postgraduate surgical education now, it is important to understand the history of this topic. Until the 1920s, physicians who wanted surgical training would travel to the clinics run by respected surgeons, such as the Murphy Clinic in Chicago, IL, or the Gross Clinic in Philadelphia, PA. The master surgeon at institutions such as these would demonstrate operative techniques in open operating rooms.
context of what they already know. Furthermore, postgraduate surgical education will be driven by explicit and measurable criteria. Progress toward defined milestones and a resident’s ability to assess that progress will determine fitness to practice. Program directors are struggling to implement these changes, which represent a major cultural shift. This training paradigm will require that surgical educators exert more active and individualized effort. The system will no longer tolerate so-called surgeon teachers who allow the resident to watch an operation and never say a word. Residents will have to work harder as well and will be expected to develop a practice of lifelong learning and continuous self-improvement.

Effecting these major changes will require training programs to develop solid curricula built upon good goals and objectives. When residents show up to work on their first day, they deserve to know precisely what is expected of them. Residents should be given a list of explicit expectations that they can use to monitor their educational progress, rather than hope that they can survive this one-month rotation unnoticed. Residents should expect immediate feedback on their daily performance because the value of feedback decays with time. In the present day, most residents usually do not get feedback until months after they leave a rotation, when a typical evaluation system processes faculty opinion. The ideal program will schedule mid-rotation and end-of-rotation evaluation sessions for all.

In the future, residents should expect feedback that facilitates effective self-assessment in relation to a standard defined by their peers’ performance. A self-evaluation followed by faculty critique is one method that might be used in the development of the habit of lifelong learning. Educational leaders suggest that a portfolio is essential to lifelong, self-directed learning.

Two concepts from educational psychology that form the foundation of an effective portfolio and give the portfolio vitality and vibrancy are deliberate practice and reflection.

RESIDENCY IN THE FUTURE

The future postgraduate educational experience will be better than it was in the past because residents will be evaluated based upon their demonstrated competence with manual skills and cognitive tasks, both of which will be measured by valid instruments. They also will be given immediate feedback, so that they can incorporate new knowledge within the

William Halsted, MD, FACS, instituted the first surgery house staff training system in the U.S. when he developed the Surgery Residency at Johns Hopkins Hospital. Dr. Halsted adapted the German training system for surgery by taking medical students into the hospital as resident physicians, meaning that they actually lived in the hospital. Dr. Halsted advanced the residents as he saw fit, until he believed they were ready for independent practice. Some residents were in the Hopkins Program for up to 13 years. Mark Ravitch, MD, FACS, a true renaissance surgeon who finished his academic career at the University of Pittsburgh, PA, was in the Hopkins system for eight years when Alfred Blalock, MD, FACS, was named chair. Dr. Ravitch did not finish that program for several more years. Dr. Blalock’s second chief resident was William Watson, MD, FACS, who underwent an 11-year training program, including two years of neurosurgery.

This training model changed somewhat over the next 50 years. By the 1970s, residents no longer had to live in the hospital. They made a little more money, they were allowed to marry as house staff, and the American Board of Surgery defined the length of the residency as five years.

Nonetheless, surgical training was still akin to an apprenticeship. House staff spent long hours in the operating room watching the senior residents work. They were expected to learn almost everything by observation. Formal evaluation meetings were rare; the most common form of feedback was simply an invitation to return for another year. The plan was a pyramid; all the interns competed for few chief positions.

Today, the Surgery Residency Review Committee has eliminated pyramid programs, has required that residents receive regular evaluations, and has placed limits on work hours. However, the biggest change in postgraduate education since Dr. Halsted introduced a structured, academic, and scientifically based training system is just around the corner.

Deliberate Practice

K. Anders Ericsson, PhD, an academic psychologist at Florida State University, Tallahassee, has devoted a lifetime to researching expert performance. His research has focused on the question, “What makes expert performers different from the rest of
The system will no longer tolerate so-called surgeon teachers who allow the resident to watch an operation and never say a word.

As residents enter their postgraduate experience, their mentors should encourage deliberate practice. According to Dr. Ericsson, there are three steps to this process. First, the mentor must identify for the student the representative tasks that capture the essence of expertise in a domain. For instance, what are the basic and essential steps in successful cannulation of the internal jugular vein? A good surgical resident can write these steps without much effort. Second, students must have immediate feedback while learning a procedure. And third, students must have the opportunity to practice the procedure over a long period of time. Interestingly, Dr. Ericsson found that for all high performers studied—chess grandmasters, violin and piano virtuosos, and so on—a decade of deliberate practice at a minimum was required to create an expert. Most surgical residencies provide the minimum time to acquire surgical skills. Deliberate practice theory applies to every clinical activity residents will be asked to master in the surgery residency. Mentors and dedicated surgery educators must cultivate a habit of distilling clinical activity to essential representative tasks. The best time to do this is at the scrub sink just before the operation. Similarly, the best time for the faculty member to give immediate feedback to the learner is at the end of the operation while the team is applying the dressing and assisting in the emergence from anesthesia.

Through his observations of expert performers, Dr. Ericsson described three constraints on deliberate practice. The first was the time and energy required of the students, as well as their access to teachers, material, and facilities. Residents can overcome this first hurdle by maintaining a high energy level and being proactive about their education. Surgeons must create an atmosphere in their operating room that encourages residents to talk about what is on their minds.

The system will no longer tolerate so-called surgeon teachers who allow the resident to watch an operation and never say a word.
The second constraint is that deliberate practice is not inherently motivating; it is hard work and can be seemingly unrewarding in the short-term. Residents must have passion and clear career goals to achieve a high level of performance during residency. This passion usually resides within the excellent student, but requires the enthusiasm of an excellent teacher to blossom fully.

Third, deliberate practice is effortful activity that can be sustained only for a limited time each day. Dr. Ericsson found that experts concentrated their practice periods into meaningful activity but allowed for recovery between sessions. The limits on work hours will produce more rested residents. Hopefully, few programs still exist that give the tacit hint that a good house officer will stay at work in violation of the work-hours policy.

Many will argue that surgeons innately practice skills that they feel the need to learn, such as knotting, cardiac auscultation, or electrocardiogram reading. Deliberate practice theory adds two important features to such informal practice: the distillation of an activity to its essential component tasks and quality, timely feedback.

**REFLECTION**

Another powerful concept from educational psychology that enhances the benefits derived from deliberate practice is reflection. The properly practiced habit of reflection can help students to define the representative components of a professional activity, and, with the task of getting feedback, to define just what is needed to deliberately practice.

John Dewey introduced the reflective process to education in 1933. He defined reflective thought as an active, persistent, and careful consideration of any belief or supposed form of knowledge in light of the grounds that support it and the further conclusions to which it tends. This concept is more abstract than most pragmatic surgeons are willing to accept. Fortunately, later scientists have refined Dewey’s concepts and thereby provided guidance on the use of reflective thought for improved learning.

The reflection process as refined by Kolb involves four steps. After a learning experience, such as observation in the operating room or in the clinic, students do the following:

- Take stock of what they know and what they do not know by actively reconstructing the clinical experience
- Reflect on what they need to know and extract the salient features that are important for deliberate practice as defined by the context of their current knowledge
- Seek feedback on the state of their current knowledge and their current knowledge gaps
- Plan deliberate practice of the identified concepts the next time they enter the operating room or clinic

According to David Boud, PhD, this process of reflection involves recalling and detailing salient events, with a re-examination of those events in light of one’s existing knowledge for the purpose of integrating new knowledge into one’s conceptual framework. Reflection is actually the basis of a generalized movement on the part of many governing bodies in medical education to foster lifelong learning habits in physicians. Practice-based learning (PBL) is the cornerstone of continuous professional improvement. The Accreditation Council of Graduate Medical Education requires program directors to teach PBL along with the other five general competencies. The Association of American Medical Colleges (AAMC) now requires diplomats of the 22 specialty boards that comprise the AAMC to provide evidence of PBL for purposes of recertification. Due to the fact that PBL will be a part of everyone’s professional life, reflection on one’s personal medical practice, even as an intern, will be rewarding.

How does this process differ from what happens today? Don’t many physicians evaluate their practice? Isn’t the most frequent question in mortality and morbidity conferences, “What will you do differently next time?” The truth is, no. Most physicians become so busy that they eliminate the habit of reflection that may have informed their residency training. Schön writes,

> As practice becomes more repetitive and routine... [t]he practitioner may miss important opportunities to think about what he is doing.... He learns, as often happens, to be selectively inattentive to phenomena that do not fit the categories of his knowing-in-action, then he may suffer from boredom or ‘burn-out’ and afflict the people around him with the consequences of his narrowness and rigidity.

Students who successfully complete medical school have demonstrated a superior ability to evaluate and assimilate knowledge. Mentors in surgery...
residencies must emphasize the important fact that the way students learn to incorporate new information may be as important as the new information itself. Most medical school instructors believe that half of what is learned will be obsolete in five years. Many of those same instructors claim that the rate of obsolescence has accelerated. Dedicated surgery educators must encourage residents to actively maintain the learning skills that they successfully developed in college and medical school. In this time of change, surgery residents will find deliberate practice and reflection helpful as clinical experience grows more tightly restricted.

**PORTFOLIO**

Another tool to maximize postgraduate surgical education is a personal portfolio. The word “portfolio” comprises two Latin words: “portare,” meaning “to carry” and “folio” meaning “leaves.” It refers to a selection of a student’s work compiled over a period of time and used for assessing performance or progress. A personal portfolio should document self-directed learning.

Residents who record everything that they encounter in clinical situations that they do not understand, as well as everything they have difficulty remembering, will build records of self-instruction. The portfolio will grow and become a primary resource for review before major standardized exams. Mentors should help residents to develop their own system of recording reflections on the clinical educational experience and encourage the use of that record as a guide for deliberate practice when residents return to the clinical arena the next day.

**CHARGE TO SURGICAL EDUCATORS**

In the coming years, surgical training will be remarkably more complex, more difficult, and more rewarding than in the past. Feedback will play a paramount role in developing the surgeons of the future. Without feedback, residents will not progress. Residents should seek and demand quality feedback, and surgical educators should be prepared to provide it.

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**Editor’s note**

This is an abridged version of a presentation that Dr. McGreevy delivered at an Alpha Omega Alpha induction ceremony at Mount Sinai Medical School, New York, NY.

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*Dr. McGreevy is professor of surgery, department of surgery, University of Utah, Salt Lake City.*
Africa has long been a destination for medical and religious missions. As far back as the mid-1400s, Britain and other European countries sent missionary teams into the interior of what was at that time referred to as “The Dark Continent.” In later years, medical teams worked to understand the diseases that were killing not only the native inhabitants of this region, but also the members of various exploratory and other expeditions.

In the late 1800s, compassion was not always the driving force behind humankind’s desire to understand and treat sleeping sickness, malaria, and yellow fever. The value of Africa’s natural resources and the developing concept of social Darwinism were likely the most compelling reasons for understanding, and eventually curing, these deadly diseases.¹²

In spite of the imperialistic intent of some past missions to Africa, I felt compelled to join the long roll of medical missionaries who went to Africa for the right reasons.

Above: Lagos students in their uniforms, heading to school.
Expectations

Having read of David Livingstone, pioneering medical missionary from Scotland, and with visions of Noble Prize Laureate Robert Koch, MD, in my head, the mission team from Trinity United Methodist Church of Gainesville, FL, arrived in Lagos, Nigeria, on July 3, 2010, with a broad range of responsibilities. The medical team was to staff a medical clinic at the West African Theological Seminary (WATS). I had come prepared to look for and diagnose Madura foot, leishmaniasis, sleeping sickness, malaria, and even dengue fever. The clinic provided care for a diverse group—from PhD candidates who were in school at the seminary and their family members, to local people who came from many socioeconomic levels. Walking to the clinic on the first day, I noticed the cleanliness of the children and their clothes, and the meticulous manner in which mothers cleaned their homes—and how that contrasted so sharply with the overall sanitation of the neighborhood. Young women walked to work or school in polished high-heeled shoes dodging water and mud puddles all the way. Cars and motorcycles navigated potholed roads to avoid deep puddles and open ditches on either side of the road. People urinated and defecated in public with abandon.

The team arrived at the clinic and followed the directions of Florence, the matron who was organizing the operation. Florence told me that “the drums had been sounding” for some time before our arrival, and she expected we would have busy clinics. She was correct.

Reality

Expecting to see unique tropical diseases that I had only read about, I set out to see my first patient. It was then that I began to realize that I was about to begin practicing the true art of medicine. I have to thank my medical school professors, my residency training, and my 25 years of medical practice for giving me a strong understanding and appreciation for physical diagnosis. At first, I believed that my medical impressions would comprise the diagnosis and that there would be little opportunity for confirmatory testing. To a certain extent that was true, but I quickly learned that sophisticated laboratory testing and diagnostics were close at hand and reasonably priced. All health care services (provided on a cash-only basis) seemed very responsive to the patients’ needs.

Throughout my daily work, I kept waiting to evaluate a patient with an unusual disease process, but instead, I found myself treating every general medical condition that American physicians treat today. Over the course of my eight days in clinic, the team saw patients from three weeks to 85 years of age, performed routine physicals and well-baby visits, and reassured the worried-well. Multiple patients were experiencing peri- and postmenopausal symptoms. I counseled patients on family planning issues and explained the ovulatory cycle repeatedly for young married couples. Concerns about sexual health were common, and counseling again played the biggest role in these situations. Prostatitis, or BPH, was common and Hytrin was a commonly prescribed drug. For these patients, prostate levels were easily obtained in local laboratories.

Hypertension was ubiquitous, and, in many cases, the patient knew about it but had little interest in staying on medications. I came to recognize as normal that most of the patients had what appeared to be elevated diastolic blood pressure. This seems to be in keeping with data about African Americans in the U.S.³

Adult-onset diabetes was another common but growing diagnosis. The carbohydrate-rich, low-protein diets and overweight-to-obese Nigerians prompted many sessions on the merits of diet and exercise in order to control weight, blood sugars, and blood pressure. The challenge, the team discovered, was convincing patients to take the medications rather
than use the herbal “remedies” prescribed by the local shaman. Routine exercise is not a traditional practice for the average hard-working Nigerian.

Over the course of the trip, the team encountered some interesting pathology. I found two patients with aortic stenosis, both having a mid-systolic, II/VI systolic ejection murmur confirmed on an echocardiogram. Two potential prolactinoma patients were evaluated and diagnosed. Both women were postpartum and had not breast-fed for 18 months but were still lactating and could not conceive. Laboratory testing, bromocriptine, and referral were my only recourse, but consultation with Moses Ekhakite, MD, informed me that prolactinomas were quite common.

I treated foreign bodies in ear canals and found several children with acute otitis media. One child had chronic otitis with a small anterior perforation that had started draining. She was started on Cortisporin otic suspension and Augmentin elixir. The patient was referred to an otolaryngologist for follow-up and repair.

Despite my best efforts, I was unable to find and treat a patient for malaria, typhoid, or any other tropical disease. Many patients are treated for malaria simply based on symptoms and not on laboratory documentation. This unrestrained treatment protocol and the over-the-counter availability of Chloroquine probably account for malaria’s near-universal resistance to the drug in Africa. Overuse of malaria prophylaxis has added to the progressive resistance from the most fatal malarial species, falciparum. Europeans do not recommend prophylaxis, particularly for travel in urban areas, because the risk for contracting the disease is low.

Near the middle of my stay, I finally came across a patient who potentially had cutaneous leishmaniasis (CL). Four years earlier, she had been treated for an anterior tibial compartment syndrome with fasciotomy and drainage. The wound healed slowly but never completely resolved. The girl stated that it started from a bug or fly bite on the back of her calf. History revealed that she had been treating it with gentian violet (purple staining) and penicillin powder with no success. Her wound was classic in appearance for CL, with a whitish covering, fine granulation tissue underneath, and rough patchy edges. There were several options available for treatment, including Amphotericin-B, Diflucan, and Paromomycin. The first trial was for Diflucan, given its safety and availability in the country. She was also referred to the state hospital for biopsy and a possible skin graft.

During our off hours, I made a trip to visit the local Sikenu Hospital, owned and operated by the physician who staffed the WATS clinic one day a week. A graduate of the Nigerian University of Medicine, Dr. Ekhakite was very knowledgeable and well-trained. He was kind enough to show us around his facility, and I was impressed by the volume and breadth of his general medical practice. He had a small lab to test for malaria and typhoid (white out test), and he performed 2-D ultrasounds with some skill. In his operating room, he performed appendectomies, hernia repairs, cholecystectomies, cesarean sections, prostatectomies, and minor procedures. Dr. Ekhakite’s recovery room was adequate, and his four-bed inpatient ward served the community well. We referred a five-year-old child to the hospital who, for two days, had been suffering from diarrhea, nausea, and vomiting with moderate dehydration. She was evaluated and treated by Dr. Ekhakite with IV fluids, antiemetics, and bowel rest. Typhoid testing was negative but she was treated for 24 hours with IV antibiotic therapy. Follow-up visits revealed her gradual improvement.

The highlight and low point of my physical diagnostic experience came when I evaluated a professor teaching at the seminary. She was of Northern European descent, blue-eyed, blonde, and fair-skinned. She denied any family history of tremors, although she had been out of the country for many years. She complained of a mild tremor in her hands and tiredness. Further questioning revealed that she had lost her zest for her mission. She had noted some difficulty sleeping, swallowing, and recent constipation, and her gait had slowed. A physical exam revealed bilateral resting hand tremors with subtle pill rolling that improved with movement. She had a resting head bobbing or tremor. Her tongue had a mild tremor, and her reflexes were asymmetric but present. Finger to nose normal, gait slowed but improved with walking. Upper extremity range of motion demonstrated classic right greater than left cogwheel rigidity.

Why was diagnosing a patient with Parkinson’s disease the highlight of my experience? Several years ago, I, too, was diagnosed with Parkinson’s. As a result, I was in a position to provide the patient with information and insight. I spent time discussing my clinical impression with her, the various treatments available, and what she may expect in the future. We discussed the pathophysiology of the disease and decided on a trial of Sinemret 25/100. I saw her five days...
later and she was already feeling better. Her mood, gait, and tremor had improved. I did convince her to seek a second opinion from a neurologist back in her hometown in the U.S., which she arranged.

The most logistically difficult case I encountered was a patient whom Dr. Ekhakite referred to me. The patient was a 36-year-old female, G3-P2-A0, 29-week gravid with biopsy-proven metastatic lymphoepithelioma in the left neck. She was a non-smoker and non-drinker and was asymptomatic except for a 3-4 cm swelling in the left tail of the parotid, post-auricular area. A computed tomography (CT) scan revealed only the left neck masses with no other nodes or neck masses present. A chest CT was negative, and a biopsy had been reviewed both in Nigeria and in Britain, with findings consistent with Epstein-Barr virus and lymphoepithelioma. Her case was complicated by her pregnancy. Dr. Ekhakite suggested steroids to accelerate the child’s surfactant pulmonary maturation, with the aim of delivery in several weeks followed by definitive treatment for the woman. After further consultation, it was recommended that she undergo a biopsy of her nasopharynx, base of tongue, and a needle biopsy of left parotid. She was also scheduled for high-resolution CT of her head and neck, with attention to the nasopharynx with bone windows. She was referred to the U.S. for treatment. A letter to the U.S. consulate for an emergency medical visa was submitted; however, due to embassy issues, costs, and expediency, the patient elected to seek treatment in India instead.

Final impressions

I had been conditioned, over the years, to believe that Africa was a continent where death and disease lurked behind every tree and within every flying insect. The reality is quite different. I found few to no unusual diseases in the urban areas of African cities. Lagos, a city of 18 million, has an integrated and competent health care delivery system. Pharmacies were adequately stocked with state-of-the-art medicines. Hospitals—although not elaborately designed when compared to such facilities in the U.S.—are privately owned and staffed by trained and capable physicians and nurses who have access to reliable medical laboratories. None of these facilities would likely meet The Joint Commission’s accreditation standards, but all provided excellent care with compassion and had good outcomes overall.

Surprisingly, Nigeria is beginning to experience
motivated, educated, and capable. I learned a lot from my experience there, and I recommend it to all who have ever wanted to give back in this fashion.

References


Dr. Smith is a retired otolaryngologist from Gainesville, FL, and an adjunct assistant professor in the health sciences department at Santa Fe College, Gainesville.
Confronting the ethics, myths, and legends of
restRICTive COVENANTS
in the era of
the contract surgeon

by William C. Cirocco, MD, FACS
More and more physicians are opting for salary-structured hospital or institutional employment. A number of economic factors have contributed to this trend. For young physicians, these positions more frequently offer loan repayment, benefits, and/or enticing signing bonuses. Older, established physicians may transition from private practice to employed positions due to concerns about reimbursement. Indeed, according to a 2010 Medical Group Management Association survey, 65 percent of established physicians were hired into hospital-owned practices in 2009.¹

Surgeons and other physicians who are considering making the shift into employed status need to have the negotiation and decision-making skills necessary to arrive at equitable contractual agreements with their employers. In particular, an understanding of restrictive covenants (RCs), which may be contained within these contracts, is not only relevant, but perhaps even critical for surgeons who are involved in these discussions.

ASCRS survey

To determine the effects of RCs on surgeons, in 2003, the American Society of Colon and Rectal Surgeons’ (ASCRS) Young Surgeons Committee (YSC) electronically surveyed individuals who had completed their colorectal surgery residency training programs in the last decade to determine their experience with contracts and RCs (see Table 1, this page). Of the 157 returned surveys, 132 respondents (84 percent) had signed a contract, and 53 percent of these contracts contained a RC. Of the 24 respondents (35 percent) who had contracts containing a RC and subsequently changed employment, 15 (63 percent) stated the RC was enforced—with an adverse effect noted by eight of the 15 (see Table 2, this page). The demographics of seven of the eight respondents are displayed in Table 3, page 31, and vignettes from these seven respondents are summarized in Table 4, page 31. The remaining seven out of 15 respondents who faced enforcement of the RC did not experience an adverse effect because three respondents voluntarily moved out of state (apparently without regret), another respondent noted resolution when the former employer retired, and still another had the foresight to stipulate in the original RC that upon leaving the group, she could continue her practice of colorectal surgery and merely discontinue doing general surgery cases.³

Case in point

The most detailed description of the consequences of an enforced RC was provided in vignette number 7. In this case, an enforced RC created a monopoly on the practice of colorectal surgery in a large Midwestern community within a state that had only five active, board-certified colorectal surgeons.

A vice-president and medical director for Blue Cross and Blue Shield (BCBS) testified in court that a lone colorectal surgeon would be unable to serve the needs of this population. More specifically, the testimony indicated that “the covenant’s restrictions leave the area with one colorectal surgeon for 700,000 potential patients, a ratio…(he) characterized as dangerous…. Seriously ill patients are faced with long waits for appointments.”⁴ BCBS routinely monitors the availability of appointments to specialists and nonspecialists. Forcing a patient to wait three to four weeks for an appointment is considered unacceptable.

Table 1. ASCRS survey questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Since graduating from your colon and rectal surgery fellowship, have you accepted a job in which you had to sign a contract or written agreement?</td>
<td>630</td>
<td>(100%)</td>
</tr>
<tr>
<td>2. Did that contract or written agreement contain a restrictive covenant?</td>
<td>630</td>
<td>(25%)</td>
</tr>
<tr>
<td>3. Have you changed jobs since signing that contract or written agreement?</td>
<td>630</td>
<td>(84%)</td>
</tr>
<tr>
<td>4. If you changed jobs, was the restrictive covenant enforced?</td>
<td>630</td>
<td>(63%)</td>
</tr>
<tr>
<td>5. Was there an adverse effect due to the enforcement of the restrictive covenant? Please describe the adverse effect.</td>
<td>630</td>
<td>(55%)</td>
</tr>
<tr>
<td>6. Demographic data at time of enforcement: Age, sex, marital status, time in practice with restrictive covenant, and type of practice with restrictive covenant: academic, private, other.</td>
<td>630</td>
<td>(63%)</td>
</tr>
</tbody>
</table>

Table 2. ASCRS survey responses

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of surveys sent</td>
<td>630</td>
<td>(100%)</td>
</tr>
<tr>
<td>Total number of survey respondents</td>
<td>157/630</td>
<td>(25%)</td>
</tr>
<tr>
<td>Number that signed a contract</td>
<td>132/157</td>
<td>(84%)</td>
</tr>
<tr>
<td>Contract contained a RC</td>
<td>67/132</td>
<td>(53%)</td>
</tr>
<tr>
<td>Change in employment</td>
<td>24/67</td>
<td>(35%)</td>
</tr>
<tr>
<td>RC enforced</td>
<td>15/24</td>
<td>(63%)</td>
</tr>
<tr>
<td>“Adverse” effect of RC</td>
<td>8/15</td>
<td>(53%)</td>
</tr>
</tbody>
</table>
if the patient has colorectal cancer, rectal bleeding, or other acute colorectal disease. “The district court also heard testimony (from the plaintiff) that patients requiring colorectal surgery whose surgeries were performed by general surgeons rather than members of the colorectal subspecialty have higher death rates than patients treated by colorectal surgeons.”

The district court ruling upheld the RC in this case, but two years later the decision was overturned on appeal. In the published text of the appellate court decision eliminating the RC was the explanation that a RC “is valid and enforceable if the restraint is reasonable under the circumstances and not adverse to the public welfare.”

Considerations and deliberations on RCs

In determining whether a RC is “reasonably necessary,” most courts weigh the three factors outlined in the legal treatise known as the Restatement (Second) of Contracts, which are as follows: (1) the employer's need to protect a legitimate business interest; (2) the hardship or injury to the former employee; and (3) the likely injury to the public. The hardship/injury to the former employee is assessed for reasonableness in terms of the geographic, temporal, and activity limitations it imposes. Table 5, page 32, lists typical arguments of public harm to patient interests by RCs as suggested by Sandra S. Benson, JD, an assistant professor of business law.

Physician specialty is another important matter for the courts to consider, including whether a physician is in a “unique specialty,” the physician is in a geographic area of physician shortage, or enforce-

Table 3. Demographics of 7 of 8 respondents who experienced an “adverse effect” from an enforced RC

| Number having an “adverse” effect of enforced RC | 8* |
| Age (mean, range) | 36.3 years (range 32–41 years) |
| Sex (men/women) | 5 men/2 women (71% men) |
| Married | 7/7 (100%) |
| Time in practice before RC enforced (mean, range) | 2.9 yrs (range, 1–6 years) |
| Type of practice (private practice/academic) | 6/7 private practice (86%) |

*One of the eight respondents did not provide any demographic data or a personal description of the effects of the enforced RC.

Table 4. Vignettes from 7 of 8 respondents experiencing an “adverse effect” from an enforced RC

1. Had to locate office at a distance from original hospital. This resulted in use of another hospital that is now my main place. Years later when I hired a new surgeon and did not have any restrictive covenants, he bolted down the street with my other partner’s referrals. We did not even charge him for “good will.” I now believe in restrictive covenants to a degree!

2. It cost me $200,000 to get out.

3. Essentially had to move out of town or not practice for two years. The acute cost of moving and the long-term cost of starting all over as an employed salaried MD in a new practice is substantial.

4. Had to move out of state, completely disrupting my family’s place in the community that we had lived in for almost five years, selling a house I had built, leaving a teaching position that I loved. Now we are trying to rebuild our “community life” and expect this to take several years again. Otherwise, left an area I loved, but have found work without a problem.

5. A lot of time and money went into fighting it and it was eventually dropped.

6. If I set up practice within a certain limit of miles I would have to pay a very large fee.

7. I was duped into a “handshake” deal, but after leaving an academic position and moving to town (now without leverage) I was forced to sign a contract containing a RC a few months later. After six years building the practice, I was “financially” forced out of the practice (all referrals, therefore all billings, were intercepted by my so-called “associate”) and essentially out of the state when I lost a district court decision over the RC which included a 25-mile radius around 12 hospitals (100-mile diameter). Because of this decision (and my removal from the area), the district court had effectively created a monopoly on colorectal surgery in this Midwestern state with only three other board-certified colorectal surgeons—all located 200 miles away. As a matter of public policy, this ruling was overturned by the state Court of Appeals two years later by unanimous decision. My former associate’s petition to the state Supreme Court to overturn the appellate court decision was denied six months later. It took nearly three years (and significant expense) to complete the legal proceedings and return to practice without restrictions.

The district court ruling upheld the RC in this case, but two years later the decision was overturned on appeal. In the published text of the appellate court decision eliminating the RC was the explanation that a RC “is valid and enforceable if the restraint is reasonable under the circumstances and not adverse to the public welfare.”

Considerations and deliberations on RCs

In determining whether a RC is “reasonably necessary,” most courts weigh the three factors outlined in the legal treatise known as the Restatement (Second) of Contracts, which are as follows: (1) the employer's need to protect a legitimate business interest; (2) the hardship or injury to the former employee; and (3) the likely injury to the public. The hardship/injury to the former employee is assessed for reasonableness in terms of the geographic, temporal, and activity limitations it imposes. Table 5, page 32, lists typical arguments of public harm to patient interests by RCs as suggested by Sandra S. Benson, JD, an assistant professor of business law.

Physician specialty is another important matter for the courts to consider, including whether a physician is in a "unique specialty," the physician is in a geographic area of physician shortage, or enforce-
ment of a RC creates a monopoly. Furthermore, in a state Supreme Court ruling cited by the appellate court in this decision, “it is well settled that only a legitimate business interest may be protected by a noncompetition covenant. If the sole purpose is to avoid ordinary competition, it is unreasonable and unenforceable.”

Another factor to consider in these matters is compliance with the federal government regulations established under Stark Law, phase III. If a hospital is paying recruitment monies to guarantee a physician’s salary, then it may be argued that imposing a RC would be “unreasonable.” In effect, the federal government has negotiated for the new physician and has taken the risk to add the physician (not the medical practice); therefore, the RC may be removed or challenged in court. According to Ms. Benson, “There is virtual certainty that a practice cannot have a noncompete agreement with a new physician who is paid hospital recruitment monies.”

In general, the employer must provide a benefit to the employee in exchange for adding a RC to an employment contract. Making a job offer contingent on agreeing to a RC probably satisfies this requirement because the employee is receiving a benefit (a job) in exchange for signing the RC. However, if the new employer did not state that a RC had to be included in the contract until the employee had left previous employment to work for the new employer, or if the employee had previously begun work before signing the contract, the RC may be rendered unenforceable.

The district court ruling in vignette number 7 was overturned by the appellate court based on transgressions of several of the aforementioned criteria. To begin with, terms of the RC “effectively froze the former employee physician out of the entire…metropolitan area and gave the former employer physician a monopoly.” Those restrictions, including a “25-mile limitation on office placement and the prohibition of practice in the entire metropolitan…area exceeded reasonable scope,” were therefore concluded to be “overbroad,” “unenforceable,” and “injurious to the public welfare.”

Regarding public welfare, the appellate court stated:

[T]he district judge did not specifically address this factor, concluding generally that enforcement of the noncompetition covenant was not against public policy. He did recognize that [the vice-president and medical director of BCBS] had expressed concern over…[the plaintiff’s] ability to handle all of the patients who needed help, but he discounted the testimony because he [the judge] had not heard what ratio of surgeons to potential patients would be adequate…. [The defendant’s] argument that he bore no burden to establish such a ratio is correct. It was enough that he demonstrated one doctor was not enough. Two necessarily would be better than one, even if not optimal.

Given the dearth of colorectal specialists in this state, together with the plaintiff’s own testimony that colorectal surgeons, not general surgeons, should be operating on colorectal disease, “enforcement of the covenant threatens the health” of this community. Upon notification of the appellate court decision, the plaintiff petitioned the state Supreme Court to review the unanimous appellate court decision. This petition was formally denied six months later and the defendant was finally allowed to return to his colorectal practice unencumbered by any restrictions to practice anywhere in the state.

### Involvement of the ACS

The issue of RCs was taken up by the ASCRS YSC and the American College of Surgeons (ACS) Committee on Young Surgeons (CYS). The ASCRS executive council deferred any statement on the subject of RCs to the ACS, given the College’s superior resources (including legal counsel); however, the College did not, at that time, have an official statement or opinion on RCs.

The only prominent society with an opinion on the subject up until 2004 was the American Medical Association (AMA). In 1933, the AMA published the opinion that RCs were unethical because they interfered with reasonable competition and prevented

### Table 5. Arguments of public harm to patient interests by RCs

- Shortage of physicians of that specialty in the area
- Disruption in continuity of care or quality of care
- Harm to patient’s freedom to choose their physician
- Detriment to ability to obtain emergency care
- Inability to be treated at hospital of choice
- Negative impact on hospital, such as teaching facility
the patient’s free choice of physicians. However, in 1960, this position changed with the following AMA statement: “There is no ethical proscription against suggesting or entering into a reasonable agreement not to practice within a certain area for a certain time, if it is knowingly made, understood and consistent with local law. Ethically, such agreements are not forbidden.”

This statement disregards the effect of RCs on patients, including access to their physician of choice and the consequent disruption of the physician-patient relationship. In 1980, this was acknowledged in an opinion that RCs among physicians were not in the public interest, and as of 1994 the AMA Code of Ethics, developed by the Council on Ethical and Judicial Affairs (CEJA), officially “discourages” any such agreement between physicians that restricts the right of a physician to practice medicine for a specified period of time or in a specific area of medicine after the termination of employment, partnership, or corporate agreement. At least 11 states forbid or severely limit RCs among physicians and 18 states have statutes regarding RCs. In states where RCs are allowed, the courts must weigh business interests versus harm to the public (patients) when deciding these cases. Interestingly, courts typically look to the medical community (state, regional, and national medical societies) for direction in deciding these cases.

The issue was taken to the ACS CYS, which developed a statement on RCs. The CYS Chair Chad Rubin, MD, FACS, presented the statement to the ACS Board of Regents at the College’s 90th Annual Clinical Congress in New Orleans, LA, on October 9, 2004. This Statement on Restrictive Covenants was ultimately adopted by the ACS Board of Regents at the 104th Annual ASCRS Convention in Philadelphia, PA, on June 13, 2005. ST-49 reads, in part, “Any restrictive covenant that interferes with the uninterrupted delivery of qualified surgical care to patients is considered unethical,” and the ACS “also recommends the review of all contracts with an attorney who is familiar with local laws and precedents prior to signing any contract.”

This is sage advice, as the best way to avoid such conflicts is to refuse to sign any contract that contains a RC. Otherwise, any legal battle in a state that allows RCs will be stacked against the employee. S. Allan Adelman, JD, former president of the American Health Lawyers Association, warns that “Noncompetes are getting negotiated out of contracts more than they’re being struck down by the courts.” He further noted that “Today, doctors are becoming savvier. They’re consulting legal counsel, and they’re pushing back on some things, including non-competes.”

There are more RCs challenged in court by physicians than any other profession. However, there may be unintended repercussions from such litigation because “physicians who sue their former employers become very unemployable in the future.”

Another important aspect of this litigation that took center stage was the issue of access to “the uninterrupted delivery of qualified surgical care to patients.” The ACS has used the access argument effectively over the years to beat back threats to Medicare funding that would have a direct impact on access to physicians (including surgical specialists) for Medicare participants (mainly senior citizens). RCs also threaten access to qualified surgical care but not just for the Medicare population; RCs pose a risk for all age groups in a given community. Moreover, RCs tear apart the surgeon-patient relationship, the basic underpinning of the mission of the ACS.

Directions for the future

Interestingly, RCs are prohibited among lawyers in the U.S. The American Bar Association in 1969 adopted a code of professional conduct that included a disciplinary rule prohibiting RCs between attorneys, using the logic that RCs interfere with the client’s freedom to choose a lawyer. In striking down a RC against a physician, the Tennessee Supreme Court cited the prohibitions against RCs in the legal profession and profoundly stated that there was “no practical difference between the practice of law and the practice of medicine,” and further determined that a patient’s right to choose a physician is fundamental and cannot be denied by a RC. Increased competition improves the quality of medical care and keeps costs affordable. According to Peter M. Sfikas, chief counsel for the American Dental Association and an adjunct professor of law at the Loyola University of Chicago (IL) School of Law, the right to freedom of choice of a physician, the right to continue an ongoing relationship with a physician, and the benefits derived from having an
increased number of physicians practicing in a given community all outweigh the business interests of an employer.22 In a point/counterpoint regarding the proposition “Noncompete clauses in employment contracts violate a physicist’s freedom to practice his or her profession,” one conclusion reached was that “competition is American; prohibiting competition is not.”23

With respect to the ethics of RCs, the legal profession has led the way, leaving the medical profession to play catch-up in eliminating RCs in employment agreements. A return to the AMA’s original pre-1960 position that RCs are unethical would be a blow for common sense, preserve the physician-patient bond, and would once again raise the bar of ethics in the medical profession back to the standard set by our colleagues in the legal profession.

Unlike other areas of the law, where the cases tend to be consistent and build on each other over time, RC cases tend to be “inconsistent and scattered.”24 U.S. courts are looking for direction from the medical community in deciding these cases. Strong language against the existence of RCs (rather than the vagaries of current AMA terms, such as “discourages”) incorporated into medical society position statements, which comment on “unethical” practices, is necessary. It is noteworthy that the AMA’s CEJA uses much stronger, uncompromising language when presenting its opinion regarding RCs and training programs, stating, “It is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program.”25

Furthermore, it has been proposed that if state medical boards were to ban RCs, then the courts in those states would subsequently refuse to enforce RCs, allowing for swift dismissal of lawsuits brought by employers directed against physicians.26 It is obvious that state legislatures that have banned RCs among physicians have most effectively eliminated any and all litigious issues related to RCs.

A growing problem

Given the trend of surgeons becoming contract employees entering into written agreements with their employers, contractual disputes will become a reality for an increasing number of ACS Fellows. These disputes will trend away from the typical young versus old, inexperienced versus experienced, surgeon versus surgeon cases (as in vignette number 7) and morph into a hospital/institution versus individual surgeon scenario. These cases will be adjudicated based on the prevailing laws of the state of origin of the dispute. In those states that allow physician contracts to include a RC, any and all statements from state/local/national medical societies (as well as surgical societies) commenting on ethical standards regarding the enforcement of RCs will be helpful to the courts assigned to these cases. It should be noted that the appellate court decision in vignette number 7 was a very narrow decision only made possible by the severe lack of surgical specialists serving that particular population of potential patients. The prevailing myth that RCs never hold up in court is obviously erroneous.

Hopefully, all 50 states and U.S. territories will enact legislation to ban RCs in physician contracts, as it seems that we physicians refuse to condemn this unethical behavior as the legal profession did long ago. Physicians must arm themselves with information to avoid these legal traps, lest they find themselves at the mercy of the local judiciary. Other surgical societies should adopt ST-49 (or their own version) and the AMA’s CEJA should void their 1960 opinion on RCs and return to their pre-1960 position that contractual provisions that interfere with reasonable competition or prevent the patient’s free choice of physician are unethical. Physicians and surgeons should form alliances with patients who want to sustain their right to see their physician of choice. This basic right to health care should trump any and all business concerns, similar to the constitutional right to legal representation. The lawyers had it right all along, although paradoxically they also contribute to this quagmire by typically insisting on the inclusion of RCs in physician contracts that they draw up. The attorneys know (and physicians should recognize) that all practices or practice groups eventually come to an end either through lateral movement, retirement, death, or disability. They’ve got us coming and going. We should at least spread the word about RCs. We have no one to blame for this mess but ourselves. As the comic-strip character Pogo discovered, “The enemy is us,” but we can also be the solution. We can choose ethics and patient rights over business interests.

In a treatise titled “Banish the Restrictive Cov-
Dr. Cirocco is a colorectal surgeon in Grosse Pointe Woods, MI, and a clinical associate professor of surgery at Wayne State University in Detroit, MI.

References

20. Benson S, Beatty Y. Noncompetes: What can practices do?
State legislatures are geared up for 2012, with most legislative sessions convening between January and July. At this point in time, surgeons should start thinking about issues that might affect their practices and their patients, as well as what they can do to serve as physician advocates.

As part of this process, it may be helpful to look at what took place in 2011 in the state legislatures and to think about trends that may carry over into 2012. Taking stock of the political landscape as well as the economic factors in a state can be useful toward identifying potential issues that may come before state legislatures.

Although unable to predict what will occur in the state legislatures this year, the State Affairs staff in the American College of Surgeons’ Division of Advocacy and Health Policy is able to safely make some educated guesses regarding what to expect in the upcoming year. This article reflects on some of the trends that emerged in 2011 and builds upon those observations to predict what lies in store with respect to state-level activities in 2012.

Overview of 2011

One of the most significant factors affecting state legislatures in 2011 was declining revenue and the impact on state budgets. Unlike the U.S. Congress, state legislatures are required by law to adopt balanced budgets. When revenues are down, states have limited options: raise taxes, cut spending, or both. Since the start of the recession, budget gaps across the country have totaled $510.5 billion, resulting in cuts to Medicaid, education, transportation infrastructure, veterans’ programs, law enforcement, and so on.* In the case of Illinois, the legislature enacted a 67 percent increase in the state income tax and a 46 percent increase in the business income tax, yet still faces shortfalls in revenue needed to meet current and future expenditures.†

Another state budget problem is increasing expenditures for Medicaid. High unemployment results in many more citizens applying for and receiving Medicaid, which greatly increases the cost of the program at a time when state revenues are falling. During the worst of the recession, federal funds were made available to states to help pay for the expanding Medicaid population, but those dollars have dried up, forcing states to deal with an even greater revenue shortfall.

From an issue perspective, in 2011 the College identified a number of areas of interest to surgery, including the following, which are described in greater detail on pages 7–11 of the November 2011 Bulletin‡:

Medical liability reform

The number of medical liability reform bills introduced and passed at the state level substantially increased in 2011. With the Republican Party in control in many states, and states continuing to face extreme budget crises, the climate was favorable for passing medical liability reform. Many states considered medical liability reform as a means of ensuring affordable access to health care for their constituents, with more than 30 new tort reform laws passed. The ACS identified a total of 63 medical liability reform-related bills that were introduced at the state level, with big wins in Alabama, North Carolina, Oklahoma, South Carolina, and Tennessee.

Scope of practice

Efforts to expand scope of practice among non-physician providers commonly include granting allied health care providers independent prescriptive authority, rights to independent practice, diagnostic and/or surgical authority, and other privileges for which these individuals may not be educated or trained. The ACS tracked 122 scope-related bills in 2011, illustrating how prevalently these bills were introduced at the state level.

Surgeons in Kentucky experienced a significant scope-of-practice setback with passage of S.B. 110, which permits optometrists the authority to perform some corrective laser operations and cosmetic procedures, as well as the ability to administer pharmaceutical agents and emergency inoculations.
Nonphysician health care professionals in New York, such as podiatrists and dentists, continued to push for scope expansion. For example, podiatrists sought permission to treat ankles and all soft-tissue structures of the leg below the knee. Single-degree dentists sought passage of legislation that would have permitted them to perform surgery on the head and neck. Both bills were defeated with strong opposition from the medical community.

**UEVHPA**

The Uniform Emergency Health Volunteer Practitioner Act (UEVHPA) is model legislation (http://www.facs.org/fellows_info/statements/st-63.html) that allows state governments to give reciprocity to other states’ licensed medical professionals in disaster situations, so that they may provide emergency services without meeting the crisis state’s licensing requirements. It uses a national registration system to confirm that physicians and health practitioners are appropriately licensed and in good standing in their respective states, so that their licensees can be recognized for the duration of emergencies in other states. Nevada enacted the UEVHPA in June 2011, joining 13 other states that passed this legislation in previous years.

**Trauma/injury prevention**

One of the most significant legislative trends of 2011 centered on addressing the problem of student athlete concussions, with nearly 30 states introducing and 20 passing legislation designed to better protect student athletes (see figure, this page). These bills sought to protect student athletes through implementation of the following guidelines:

- Inform and educate youth athletes, their parents, and guardians, and require them to sign a concussion information form
- Remove a youth athlete who appears to have suffered a concussion from play or practice
- Require a youth athlete to be cleared by a licensed health care professional trained in the evaluation and management of concussions before returning to play or practice

Trauma system funding remains a major issue at the state level; however, budget deficits got in the way of passing and implementing legislation to provide dedicated funding streams. In fact, Illinois enacted a bill that redistributes funds from trauma centers to non-trauma center hospitals in emergency medical system regions without non-designated trauma centers, and the Minnesota legislature considered, but did not pass, a bill to completely eradicate the state’s trauma system.

**Physician gag laws**

Several state legislatures considered legislation to restrict the ability of physicians to ask patients about firearms in the home, with Florida actually passing such legislation. This type of legislation fits into the broader category of what is commonly referred to as “physician gag laws.” For a more detailed discussion of these laws, see the article on page 39.

**What does the future hold?**

The bills and laws described in this article cover just a few of the many issues that were debated in state legislatures in 2011 and that are likely to return this year. Legislative predictions for 2012 include the following:

- Even though 30 states have passed concussion legislation over the past few years, it will remain a hot topic. Major athletic organizations, such as the National Football League and the National Collegiate Athletic Association, have done a tremendous job of educating and promoting youth concussion awareness, and it is likely that the remaining state legislatures will take up this important and relatively noncontroversial public health issue.
- With the success of expanding optometry scope of practice in Kentucky, it is likely a few more states will see similar bills introduced. It is difficult to identify which states, though, so surgeons should be alert to the possibility in their own states. From a general scope-of-practice expansion perspective, almost every state...
state legislature will see some type of bill, because many nonphysician groups are attempting to expand their scope.

• While only a few states considered physician gag laws relating to firearms, it is very likely these bills will be reintroduced in the states where they failed in 2011, and they will be introduced for the first time in many others.

• Budgets will continue to be very tight, with additional cuts to Medicaid and other programs. If economic activity improves a bit, state revenues may increase to help take a little pressure off state budget writers. Regardless, state budgets will be the primary focus of state legislatures, especially those with shorter sessions.

• Major medical liability reform will remain a high priority for surgeons, even though only a limited number of states do not have caps on noneconomic damages. Of those that do not have a cap in place, significant legislative or constitutional barriers exist to passing such legislation; in other words, the lower-hanging fruit has already been picked. However, due to the high number of states with Republican legislatures in control, there is always a chance to pass medical liability reform, even in those states where it has been difficult in previous sessions.

• Elections will be major drivers of legislation this year. Legislators are less likely to take on controversial or complex issues during an election year, so really big issues may be deferred until next year, and some legislative sessions may be shorter in order to allow legislators to spend more time in their districts pressing the flesh. From a political perspective, some state legislatures may adopt ballot initiatives on social issues to drive more voters to the polls in the hope of increasing participation in the presidential election.

Final thoughts

Regardless of what legislation is introduced in state legislatures, the State Affairs staff stands ready to assist surgeons and chapters with their state advocacy efforts. Many resources are available on the State Affairs website (http://www.facs.org/ahp/statelegislation.html), including a link to the College’s members-only Web portal, which contains a state legislative tracking page. Surgeons can also get more involved in state advocacy through their ACS chapters; by participating in the State Advocacy Representative program (contact Charlotte Grill, cgrill@facs.org, or Alexis Macias, amacias@facs.org, for further information); or by simply responding to action alerts via the Surgery State Legislative Action Center and sending a letter to state legislators.
When states practice medicine: Physician gag laws

by Alexis Macias

As a physician, you ask your patients a number of personal questions during the course of exams in order to provide the best care. Imagine if you were unable to ask those questions, thus diminishing your standard of care and undermining the physician–patient relationship. Throughout the 2011 legislative session, a few state legislatures aimed to do just that by introducing a number of physician gag order laws prohibiting health care providers from asking about gun ownership and safety.

Florida legislative efforts

Early last year, the Privacy of a Firearm Owners Act (H.B. 155) was introduced in the Florida legislature. Sponsored by the National Rifle Association (NRA), the original language of the bill would have prohibited health care professionals from asking patients or guardians, in cases involving children, if firearms are present in the home. The bill included criminal penalties, making violations of the legislation a third-degree felony punishable by a fine of up to $5 million or a maximum of five years in jail.

In late March, the bill was amended to reflect compromise language agreed upon by the Florida Medical Association and the NRA. Essentially, the amended bill stated that health care professionals could inquire about firearms in the house when they, in good faith, believed that the information was relevant to the patient’s medical care or the safety of the patient or other parties. All criminal penalties were removed from the bill, but patients could notify the Florida Board of Medicine if they felt “unnecessarily harassed” about firearms during an examination by their health care provider.

In June 2011, Florida Gov. Rick Scott (R) signed this bill into law. Soon thereafter, a group of physicians filed a lawsuit against Governor Scott to overturn the law. The plaintiffs included the Florida chapter of the American Academy of Pediatrics, the Florida chapter of American College of Physicians, and the Florida chapter of the American Academy of Family Physicians. The physicians argued that the law restricted their constitutional right to free speech. In September, U.S. District Judge Marcia Cooke ruled that the law violated the First Amendment and ordered a temporary injunction blocking it from taking effect. Both parties have forgone appealing the temporary injunction decision and are seeking a decision for a permanent injunction. It is expected that arguments in the permanent injunction case will be heard early this year.

Gag laws in other states

Florida legislators were not the only ones debating the privacy of firearm owners. The NRA sponsored similar legislation in five other states: Alabama, Minnesota, North Carolina, Oklahoma, and West Virginia.

The Alabama legislature considered a bill (H.B. 516) late in the session that shared many similarities with the Florida bill. The language of H.B. 516 contained three main components:

- Prohibiting a health care provider from asking a patient or patient’s guardian whether a gun is in the home
- Prohibiting documentation in a patient’s chart if the question regarding gun ownership was asked
- Prohibiting a health care provider from denying treatment for a patient based upon the patient’s refusal to answer the question—or, if answered, based on the answer provided

Whereas H.B. 516 provided some exemptions to when health care providers could ask about gun ownership, in the course of emergency treatment and mental health emergencies as well as disclosures to police officer conducting active investigations, it was not as broad as the Florida bill, and only allowed physicians to inquire about guns during a “mental health or psychotic episode where the patient’s conduct or symptoms reasonably indicate that the patient has the capacity of causing harm to himself, herself, or others.” The bill moved quickly through the state’s House Public Safety and Homeland Security Committee but was killed upon adjournment of the legislature.
The **North Carolina** Senate introduced the No Firearms Questioning of Patients during a Medical Exam bill (S.B. 765), prohibiting health care providers from questioning patients about firearms when providing health care to patients unless the health care provider first informed the patient of four things:

- That the health care practitioner would like to question the patient or family about firearms
- The purpose of the questions
- That patients are not obligated to answer questions regarding firearm ownership
- That the health care provider cannot refuse treatment to a patient if he or she does not answer the questions

The bill saw little movement in the Senate before dying upon adjournment of the legislature in August.

The **West Virginia** legislature introduced firearm owner privacy legislation (H.B. 3085) for the second time since 2003. The bill would have amended the West Virginia Medical Practices Act to include a section that would have allowed for professional discipline of health care practitioners who ask patients if they own or possess firearms when the inquiry has “no relationship to the practice of medicine or the medical condition of the patient and is for the purpose of gathering statistics or to justify patient counseling, unless the inquiry is related to a medical complaint made by the patient.” H.B. 3085 specified that the state medical board could refuse to issue, suspend, or revoke any license if it concluded a physician had violated this section of the Medical Practice Act. H.B. 3085 saw little movement during the session and died upon adjournment.

Bills introduced in **Minnesota** (H.F. 1717) and **Oklahoma** (S.B. 858) were similar to those introduced in the previously mentioned states. Neither bill saw movement during the 2011 session and died upon adjournment of the legislatures.

**Organized medicine’s position**

The American College of Surgeons (ACS) is committed to protecting the relationship between physicians and patients, as well as to educating patients about unsafe habits and behaviors. The College’s Committee on Trauma, in conjunction with the ACS Board of Regents, created a statement that recognizes the impact of firearm injuries and supports a number of gun safety efforts. These activities include developing and promoting programs directed at the prevention of firearm injuries by improving safe and knowledgeable transport, storage, and use of firearms, as well as making firearm injury a reportable condition.*

Other organizations, such as state medical societies and specialty societies, also oppose physician gag laws. In fact, during the November 2011 American Medical Association (AMA) House of Delegates meeting, the House passed a resolution (Resolution 219) that would oppose any restrictions on physicians being able to inquire and talk about firearm safety issues and risks with their patients. The statement also mandates that the AMA will oppose any law restricting physicians’ discussions with patients and their families about guns as an intrusion in medical privacy.†

It is important that the relationship between a physician and patient is not compromised through legislative means. Nonetheless, it is anticipated that a number of physician gag order bills will be introduced in the upcoming 2012 state legislative sessions, and the College will work with ACS chapters to implement appropriate grassroots advocacy initiatives. For additional information on physician gag laws, contact Alexis Macias at amacias@facs.org.

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Ms. Macias is Regional State Affairs Associate, Division of Advocacy and Health Policy, Chicago, IL.
Coding for skin replacement surgery in 2012
by Linda Barney, MD, FACS; Mark Savarise, MD, FACS; and Jenny Jackson, MPH

In 2012, comprehensive changes were made to the skin substitute codes, including the addition of new introductory language and the creation of eight new Current Procedural Terminology (CPT)* codes that describe topical application of skin substitute grafts (see Table 1, page 42). The 24 codes that previously described skin substitute grafts have been deleted from the guidelines. However, codes that describe surgical preparation for grafting (15002–15005) and autografts (15040–15261) have not changed.

The revised skin replacement surgery guidelines instruct coders on how to correctly report codes that reference measurements of 100 sq. cm or 1 percent of body area of infants and children. When determining the involvement of body size, the measurement of 100 sq cm is applicable to adults and children 10 years of age and older; percentages of body surface area apply to infants and children younger than 10 years of age. The measurements apply to the size of the recipient area. Procedures involving the wrist and/or ankle are reported with the anatomic codes for the arm or leg. Additionally, the graft is anchored using the provider’s choice of fixation, and when services are performed in the office, routine dressing supplies are not reported separately. These codes are not intended to be reported for the application of non-graft wound dressings (for example, gel, ointment, foam, liquid) or injected skin substitutes.

These codes were specifically created for treatment of wounds in burn and trauma patients. These codes were not intended to be used for abdominal wall fascial repair or fascial support—in other words, underlay or overlay support.

Definitions
A new subheading called “definitions” has been added that provides a more thorough explanation of surgical preparation, autografts/tissue cultured autografts, and skin substitute grafts. Surgical preparation describes the initial services related to preparing a clean and viable wound surface for placement of an autograft, flap, skin substitute graft, or for negative pressure wound therapy. Autografts/tissue-cultured autographs include the harvest and/or application of an autologous skin graft. Skin substitute grafts include non-autologous human skin (dermal or epidermal, cellular and acellular) grafts (such as homograft, allograft), non-human skin substitute grafts (for example, xenograft), and biological products. Both autografts and skin substitute grafts include removal of current graft and/or simple cleansing of the wound, when performed.

When a primary procedure requires an autograft or skin substitute graft for definitive skin closure (for example, radical mastectomy, deep tumor removal), report 15100–15278 in conjunction with the primary procedure.

The new CPT codes for skin substitutes include a change in reporting based on the wound surface areas and anatomic locations. In years past, the codes were defined based on the first 100 sq cm and then each additional 100 sq cm. CPT 2012 introduces four new sets of primary and add-on codes based on wounds “up to” 100 sq cm and wound surfaces “greater than or equal to” 100 sq cm. CPT continues to define the codes by anatomic location. Codes 15271 and 15275 are reported for the application of the first 25 sq cm of skin substitute grafts for total wound surface areas up to 100 sq cm. Each additional 25 sq cm graft is reported with add-on codes 15272 and 15276. Codes 15273 and 15277 are reported for the application of the first 100 sq cm of skin substitute grafts for total wound surface areas greater than or equal to 100 sq cm. Each additional 100 sq cm of graft are reported with add-on codes 15274 and 15278. Codes 15273, +15274, and 15277, +15278 are intended to describe the more intense services for the burn patient.

For multiple wounds, sum the surface area of all wounds requiring grafts from the same anatomic site and report the applicable primary code and add-on code in multiples, as appropriate.

Table 2 on page 43 summarizes the coding matrix for the new skin substitute graft codes.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.
Table 1. New skin replacement surgery codes 2012

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲15150</td>
<td>Tissue cultured skin autograft, trunk, arms, legs; first 25 sq cm or less</td>
</tr>
<tr>
<td>▲+15151</td>
<td>Tissue cultured skin autograft, trunk, arms, legs; additional 1 sq cm to 75 sq cm</td>
</tr>
<tr>
<td>▲+15152</td>
<td>Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof</td>
</tr>
<tr>
<td>▲15155</td>
<td>Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less</td>
</tr>
<tr>
<td>▲+15156</td>
<td>Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 25 sq cm wound surface area, or each additional 1% of body area of infants and children, or part thereof</td>
</tr>
<tr>
<td>▲+15157</td>
<td>Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof</td>
</tr>
<tr>
<td>•15271</td>
<td>Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less</td>
</tr>
<tr>
<td>•+15272</td>
<td>Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof</td>
</tr>
<tr>
<td>•15273</td>
<td>Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children</td>
</tr>
<tr>
<td>•+15274</td>
<td>Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof</td>
</tr>
<tr>
<td>•15275</td>
<td>Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area</td>
</tr>
<tr>
<td>•+15276</td>
<td>Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof</td>
</tr>
<tr>
<td>•15277</td>
<td>Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children</td>
</tr>
<tr>
<td>•+15278</td>
<td>Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof</td>
</tr>
<tr>
<td>•+15777</td>
<td>Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk)</td>
</tr>
</tbody>
</table>

**Biological implants**

A new add-on code, 15777, *Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk)*, has been established. For bilateral breast procedures, report 15777 with modifier 50. For implantation of synthetic mesh or other prosthesis for open incisional or ventral hernia repair or closure of a necrotizing soft tissue infection wound, report 49568 in conjunction with 49560–49566 or 11004–11006, as appropriate. Code 15777 is not to be used for the topical fixation of skin substitute graft to a wound surface, which should be reported with new codes 15271–15278.

**Clinical examples**

A 27-year-old male is admitted to the burn center with a 75 sq cm burn wound on the right thigh and a 75 sq cm wound on the left thigh. You excise the burns...
down to viable subcutaneous tissue and apply a skin substitute graft.

The reportable procedures in this case are as follows:

- 15002, Surgical preparation, trunk, arms, legs, first 100 sq cm
- +15003, Surgical preparation, trunk, arms, legs, additional 100 sq cm, or part thereof
- 15273, Skin substitute graft, trunk, arms, legs, first 100 sq cm
- +15274, Skin substitute graft, trunk, arms, legs, additional 100 sq cm, or part thereof

Both wounds are from the same anatomic location listed in the code descriptor (legs), thus, the wounds are added together for a total of 150 sq cm. Surgical preparation of 150 sq cm wounds of the right and left thighs is reported with codes 15002, first 100 sq cm, and +15003, additional 100 sq cm, or part thereof. The application of skin grafts to the right and left thighs is reported with codes 15273, first 100 sq cm, and +15274, additional 100 sq cm, or part thereof.

A mechanic was admitted to hospital with burns on both arms and hands, after his gasoline-saturated clothing was ignited from a spark. Surgical excision of the burn tissue from his right hand beginning at the wrist was performed two days ago (reported separately). He now undergoes application of 250 sq cm of skin substitute graft on his arms and 180 sq cm of skin substitute graft on his hands and fingers.

The reportable procedures in this case are as follows:

- Arms:
  - 15273, Skin substitute graft, trunk, arms, legs, first 100 sq cm
  - +15274, Skin substitute graft, trunk, arms, legs, additional 100 sq cm, or part thereof
  - +15274-59, Skin substitute graft, trunk, arms, legs, additional 100 sq cm, or part thereof

- Hands, fingers:
  - 15277, Skin substitute graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, first 100 sq cm
  - +15278, Skin substitute graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, additional 100 sq cm, or part thereof

The arms and hands and fingers are listed in different anatomic locations; thus, it would not be appropriate to add the wound sizes together. Procedures involving the wrist and/or ankle are reported with codes that include arm or leg in the descriptor. Instead, report 15273 and 15274 for the application of skin grafts of the arm, and codes 15277 and 15278 for application of skin grafts of the hands and fingers.

A 45-year-old female is admitted to the hospital with burns on the face, ears, and feet measuring a total of 225 sq cm. Surgical excision of the burn tissue was performed three days ago (reported separately). She undergoes application of 225 sq cm of skin substitute grafts on her face, ears, and feet.
The reportable procedures in this case are as follows:

15277, Skin substitute graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, first 100 sq cm
+15278, Skin substitute graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, additional 100 sq cm, or part thereof
+15278, Skin substitute graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, additional 100 sq cm, or part thereof

The appropriate codes to use for application of the first 100 sq cm of skin substitute grafts for total wound surface areas greater than or equal to 100 sq cm, and each additional 100 sq cm, are 15277 and 15278. The parenthetical instructions following add-on code +15276 instruct that it may only be used in conjunction with code 15275. Therefore, it would not be appropriate to report add-on code +15276 in conjunction with 15277 for the additional 25 sq cm.

A 50-year-old male is admitted to the hospital with a grease burn on his right arm. You excise the burns down to viable subcutaneous tissue and apply a skin substitute graft.

The reportable procedures in this case are as follows:

15002, Surgical preparation, trunk, arms, legs, first 100 sq cm
15273, Skin substitute graft, trunk, arms, legs, first 100 sq cm

Surgical preparation of 100 sq cm wounds of the right arm is reported with code 15002, first 100 sq cm. The application of the first 100 sq cm of skin substitute grafts for total wound surface areas greater than or equal to 100 sq cm is reported with code 15273.

A 50-year-old female undergoes a unilateral total (simple) mastectomy with immediate placement of a tissue expander for reconstruction. A 75 sq cm piece of acellular dermal matrix is sutured to the subpectoral pocket rim before the skin flaps are brought together. The skin is closed primarily.

The reportable procedures in this case are as follows:

19303, Mastectomy, simple, complete
19357, Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion
15777, Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk)

The simple unilateral mastectomy is reported with code 19303. The implantation of acellular dermal matrix is reported with 15777.

Payor issues to consider
CPT instructs the use of modifier 51 on subsequent stand-alone codes. Some Medicare payors may not require the use of this modifier, thus it is critical to obtain written instructions from the payors for accurate claim format submission. Modifier 51 accurately identifies the subsequent procedure as nonprimary and subject to the multiple procedure payment formula.

Remember, never append modifier 51 to an add-on code because the add-on code has already been revalued for intraoperative work only.

Some payors may require modifiers on the add-on codes or may require the add-on codes to be reported in units. Verify with the payors the appropriate format for claim submission and payment processing.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain time, excluding holidays.

Editor’s note
Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.

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New Alliance formed to address clinical trials in oncology

by Monica M. Bertagnolli, MD, FACS

The American College of Surgeons Oncology Group (ACOSOG), the Cancer and Leukemia Group B (CALGB), and the North Central Cancer Treatment Group (NCCTG) recently merged to form the Alliance for Clinical Trials in Oncology. The Alliance is a new National Cancer Institute (NCI)-sponsored cancer cooperative group, joining three other groups including the cancer research group known as ECOG-ACRIN (the American College of Radiology Imaging Network and the Eastern Cooperative Oncology Group), NRG (formerly National Surgical Bowel and Bladder Project and Radiation Therapy Oncology Group and Gynecologic Oncology Group), and SWOG (formerly the Southwest Oncology Group).

The mission of the Alliance is to reduce the impact of cancer by uniting a broad community of scientists and clinicians from many disciplines—each committed to discovering, validating, and disseminating effective strategies for the prevention and treatment of cancer. Presently, the Alliance is conducting 187 clinical trials, concentrating on eight types of cancer: breast, gastrointestinal, genitourinary, respiratory, leuko-
nia, lymphoma, myeloma, and neuro-oncology.

The Alliance member groups all have a long history of working successfully in teams to conduct scientific research, and this capability is evident in the Alliance's structure. The Alliance is organized into six programs, each led by a principal investigator for the new NCI funding application, which is to be submitted this year (see figure, page 45). These programs and their respective principal investigators are as follows:

- **The Office Of The Group Chair.** Located at Brigham and Women's Hospital in Boston, MA, this office is responsible for the Alliance's administrative and fiscal affairs and provides support for scientific leadership and institutional membership services. Monica M. Bertagnolli, MD, FACS, the author of this article, is the principal investigator for this program.

- **The Statistics and Data Management Program.** Based at the Mayo Clinic in Rochester MN, this program supports the activities of the group by achieving the highest standards for the conduct of clinical trials in terms of study design, statistical methodology, data management, protection of patients and their data, and regulatory compliance. The principal investigator for this program is Daniel J. Sargent, PhD, professor of oncology and professor of medicine, director of the medical oncology breast program, and medical oncology director, gynecologic oncology at the University of Chicago, is the principal investigator for this program.

- **The Translational Research Program.** With the advent of molecularly driven oncology, this program plays a major role in the development and execution of most Alliance clinical trials. This program facilitates the scientific agenda of the Alliance by supporting the basic and translational researchers who work within Alliance committees in the fields of biomarker development, imaging, pharmacogenomics, and population pharmacology, pathology, and biorepository operations. This program also promotes successful collaboration between Alliance committees and researchers within Specialized Programs of Research Excellence (SPOREs), cancer centers, and other research groups. The principal investigator is Phillip Febbo, MD, associate professor in the department of medicine (hematology/oncology) at the University of California, San Francisco.

- **The Cancer Control Program.** This program serves as a research base for the Alliance Community Clinical Oncology Programs, which are distinct research networks funded by NCI's Division of Cancer Prevention. The Cancer Control Program has six scientific domains: cancer prevention, symptom intervention, health outcomes, comparative effectiveness research, cancer in the elderly, and cancer health care disparities. Alliance researchers conduct specific trials in these areas and add research questions in these fields to large Alliance phase III treatment trials. This approach maximizes the opportunity to understand overall patient benefit as it relates to specific cancer treatments and their effects on outcomes. Jan C. Buckner, MD, professor of oncology at the Mayo Clinic, is the principal investigator.

- **ACOOG.** The American College of Surgeons (ACS) has collaborated with former ACOSOG members on projects aimed at defining and improving the quality of cancer care. This ACS cooperative group relationship will continue in the Alliance through its ACS Clinical Research Program (ACS-CRP). The ACS-CRP comprises four committees: cancer care standards, research development, education, and membership. Heidi Nelson, MD, FACS, assistant professor of surgery and chief of colorectal surgery at the Mayo Clinic, is the principal investigator.

The Alliance's Cancer Care Standards Research Committee will use the College's National Cancer Data Base to design and conduct studies that inform cancer care standards. Published results will be presented to the appropriate sections of the Commission on Cancer (CoC) for consideration during standards development and adoption by ACS-CRP programs. Hence, outcomes research in the Alliance will have an immediate connection to an organization able to apply results to improve cancer care.

The ACS-CRP Research Development Committee will use the resources of the CoC and the NCDB to inform the design of Alliance clinical trials and comparative effectiveness trials. The CoC's Education Committee will
keep investigators aware of ongoing studies, provide education on surgical credentialing for studies, provide regular updates in the ACS Bulletin, and disseminate findings from Alliance clinical trials to members to decrease time from clinical trials to incorporation into clinical practice. The Membership Services Committee will further the relationship with the CoC toward maximizing the participation of surgeons in the Alliance.

More than 460 investigators attended the first Alliance scientific committee meetings in September 2011 and more than 1,000 individuals attended the Alliance group-wide meeting November 17–19, 2011.

Dr. Bertagnolli is the group chair of the Alliance for Clinical Trials in Oncology, and chief of the division of surgical oncology at Brigham and Women’s Hospital, Boston, MA.

There isn’t an app for that: Banning recording in the office

With the proliferation of mobile communications devices, many patients use their time in physicians’ offices to text, surf the Internet, update social media, and make phone calls. They also may be tempted to use smartphones and similar devices to record consent discussions or for medication and follow-up instructions with surgeons and office staff.

Recording discussions about health care via video or audio is not a substitute for listening, however, and could put surgeons and their staff at significant risk, according to experts at The Doctors Company, the official medical liability insurance provider for members of the American College of Surgeons. Surgeons should prohibit video or audio recording in the office. These recordings breach the confidentiality rights of other patients and infringe on the privacy rights of surgeons and their employees. In many states, it is illegal to record without prior consent.

To prevent patients from using their mobile devices to record their in-office experiences, The Doctors Company recommends the following steps:

- Post a sign in the reception area that states, “To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices. Thank you for your understanding and compliance.”
- Issue a written policy prohibiting the use of recording devices during office visits, and include the statement in patient intake handouts.
- Watch for indications that a patient is recording conversations, and politely ask that they discontinue this activity.
- Remind patients that they or their caregiver may take notes during office visits to help them remember important information, and emphasize that the conversation will be documented in the medical chart.

For more tips, articles, and information from The Doctors Company, go to http://thedoctors.com/knowledgecenter.
ACS Health Policy Advisory Council aims to empower Fellows as advocates

by Charles D. Mabry, MD, FACS, and Catharine Harris

The decisions our federal and state legislators make—or fail to make—have an extraordinary impact on our ability to care for our surgical patients. Although many surgeons consider these political decisions to be out of their control, the advocacy efforts of individual surgical professionals, aided by the American College of Surgeons (ACS) Division of Advocacy and Health Policy staff can, in fact, help to influence and shape the decisions made on Capitol Hill. Surgeons who want to make a difference for their patients must get involved in the legislative and political process and become surgeon advocates.

With that goal in mind, the ACS Board of Regents authorized the creation of the Health Policy Advisory Council (HPAC)—a subcommittee of the Health Policy and Advocacy Group (HPAG)—to support the College’s position on legislative and regulatory efforts. The Regents want to encourage improved two-way communication between the Fellows and the College, so that the Fellows will have up-to-date information on important legislative and regulatory matters and can then communicate back to the ACS how those issues would affect their patients and practices.

Composed of a Chair and Vice-Chair, a 10-member Regional Coordinating Committee, and one or two At-Large Counselors from each College chapter, the HPAC is designed to serve as a member-representative body that aims to increase participation in advocacy by Fellows of the College and improve the organization’s clout on Capitol Hill. The specific goals of the HPAC include the following:

• Facilitating a two-way communication pathway between Counselors and Fellowship at-large through the dissemination, collection, synthesis, and provision of feedback on advocacy and health policy issues to the HPAG

• Increasing surgeons’ voices on Capitol Hill by fostering an extensive grassroots advocacy network

• Providing a platform and structure for the College to mentor and develop future members of other health care committees by developing expertise on regulatory and legislative issues

Members of the HPAC are a diverse group, consisting of Regents, Governors, young surgeons and residents, Health Policy Scholars, and other College members with expressed interest or expertise in health care policy. Special efforts are made to ensure that all specialties have representation on the HPAC.

The HPAC is scheduled to have two face-to-face meetings annually: one in the fall at the Clinical Congress, and one in the spring at the ACS Advocacy Summit. These meetings will be supplemented with regular webinars and teleconferences throughout the year.

Health Policy Advisory Group Regional Coordinating Committee

Charles D. Mabry, MD, FACS, Chair
Howard Snyder, MD, FACS, Vice-Chair
Ronald Gross, MD, FACS, Region 1 Chief (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)
Charles Coren, MD, FACS, Region 2 Chief (New York and New Jersey)
Leonard Weireter, MD, FACS, Region 3 Chief (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia)
John Theodore Perry, MD, FACS, Region 4 Chief (Alabama, Florida, Georgia, North Carolina, South Carolina, Puerto Rico, and Virgin Islands)
To be determined, Region 5 Chief (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)
Daniel Frey, MD, FACS, Region 6 Chief (Arkansas, Louisiana, Kentucky, Tennessee, Mississippi, and Texas)
James Gigantelli, MD, FACS, Region 7 Chief (Iowa, Kansas, Missouri, Nebraska, and Oklahoma)
Sara Hartsaw, MD, FACS, Region 8 Chief (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming)
Albert Kwan, MD, FACS, Region 9 Chief (Arizona, New Mexico, Nevada, and California)
John Mayberry, MD, FACS, Region 10 Chief (Alaska, Hawaii, Idaho, Oregon, and Washington)
Though still in its early stages, members of the HPAC Regional Coordinating Committee met for the first time at the 97th Annual Clinical Congress in October 2011, in San Francisco, CA. The following individuals participated in that meeting (all MD, FACS): Charles D. Mabry, Chair (co-author of this article); Howard Snyder, Vice-Chair; Ronald Gross; Charles Coren; Leonard Weireter; Daniel Frey; James Gigantelli; Sara Hartsaw; Albert Kwan; and John Mayberry.

In a similar structure to the ACS Committee on Trauma, each Region Chief is assigned specific states for which they oversee the Counselors (see figure, page 48). Counselors, who comprise the core membership of the HPAC, will complete a variety of district-based activities, each with the aim of helping to build personal relationships between surgeon advocates and their elected officials. These activities will include delivering legislative updates to their state chapter, distributing grassroots Action Alerts to Fellows within their chapter and inspiring maximum participation, conducting targeted recruitment efforts for key districts within the chapter on an as-needed basis, attending and promoting the College’s annual Advocacy Summit, and showing a commitment to the American College of Surgeons Professional Association Political Action Committee (ACSPA-SurgeonsPAC) by making an annual contribution and attending local political events as a representative of the ACSPA-SurgeonsPAC.

Fellows of the College should anticipate regular updates from their representatives on both the Regional Coordinating Committee and their HPAC counselor.

HPAC Counselors-At-Large will be appointed throughout 2012. Any member of the College who would like to be considered for the position of a HPAC counselor should contact Catharine Harris in the Division of Advocacy and Health Policy at charris@facs.org or 202-337-2701.

Dr. Mabry is a general surgeon in private practice, and an associate professor of surgery at the University of Arkansas for Medical Sciences, Little Rock. A former Regent of the College, Dr. Mabry is the chairman of the Health Policy Advisory Council, and serves on the General Surgery Coding and Reimbursement Committee and Health Policy and Advocacy Group of the ACS.

Ms. Harris is Legislative Coordinator, Division of Advocacy and Health Policy, Washington, DC.

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- Additional resources and a patient evaluation form.

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Oral presentations

- Surgical Forum*
  Program Coordinator: Kathryn L. Matousek, 312-202-5336, kmatousek@facs.org
  (15 Excellence in Research Awards were given in 2011)
  Accepted Surgical Forum abstracts will be published in the September Supplement of the Journal of the American College of Surgeons (JACS)

- Scientific Papers*
  Program Coordinator: Kay Anthony, 312-202-5325, kanthony@facs.org

Poster presentations

- Scientific Exhibits (Posters)
  Program Coordinator: Carla Manosalvas, 312-202-5385, cmanosalvas@facs.org

Video presentations

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

Submission information

- Abstracts are to be submitted online only.
- Submission period begins after November 1, 2011.
- Deadline: 5:00 pm (CST), March 1, 2012.
- Late submissions are not permitted.
- Abstract specifications and requirements for each individual program will be posted on the ACS website at www.facs.org/education/. Review the information carefully prior to submission.
- Duplicate submissions (submitting the same abstract to more than one program) are not allowed.

*Accepted authors are encouraged to submit full manuscripts to JACS.
Clinical Scholars in Residence Program:

A beneficial experience for surgical residents and the ACS

by Karl Bilimoria, MD, MS; and Clifford Y. Ko, MD, MS, MSHS

The American College of Surgeons (ACS) is now accepting applications for the 2013–2015 Clinical Scholar in Residence positions. The Clinical Scholars in Residence Program is a two-year on-site fellowship in surgical outcomes research, health services research, and health care policy. The program was initiated in 2006 for the purpose of advancing the College’s quality improvement initiatives and to offer opportunities for residents to work on the ACS’ quality improvement programs. More specifically, Clinical Scholars perform research relevant to ongoing projects in the ACS Division of Research and Optimal Patient Care.

About the program

The primary objective of the fellowship is to address issues in health care quality, health policy, and patient safety, with the goal of helping the Clinical Scholar in Residence prepare for a research career in academic surgery. The ACS Clinical Scholars have worked on projects and research within the ACS National Surgical Quality Improvement Program (NSQIP®), the National Cancer Data Base, the National Trauma Data Bank®, guideline development, and accreditation programs. Scholars are assigned to the appropriate group within the ACS based on their interests and the College’s needs.

In addition, participants earn a master’s degree in health services and outcomes research or health care quality and patient safety during their two years at ACS headquarters in Chicago, IL. The goal of this aspect of the program is to educate clinicians to become effective health services and outcomes researchers. The health services and outcomes research curriculum focuses on these issues within institutional and health care delivery systems, as well as in the external environment that shapes health policy centered on quality and safety issues. The program takes approximately two years to complete. All coursework is done at Northwestern University’s downtown Chicago campus, one block from the ACS headquarters. The ACS also offers a variety of educational programs that Clinical Scholars may benefit from, including an Outcomes Research Course, the Young Surgical Investigators Course, and the Clinical Trials Course.

The ACS assigns internal mentors to meet regularly with each Clinical Scholar. Scholars also have opportunities to interact with various surgeons who are affiliated with the ACS and the Division of Research and Optimal Patient Care. Whereas mentorship is one of the most important aspects of the fellowship, having guidance from multiple individuals from diverse backgrounds will provide the best opportunity for success. In addition, a core of ACS staff statisticians and project analysts serve as invaluable resources to the Clinical Scholars in Residence.

Past successes

Since its inception, surgical residents from throughout the U.S., including California, Connecticut, Colorado, Illinois, Louisiana, and Ohio, have participated in the Clinical Scholars program. These individuals say that they have had excellent, productive experiences that have been useful in launching their careers in the field of academic surgery. With five scholars having already completed the program and three scholars currently participating, the residents have demonstrated great dedication to outcomes research and the improvement of the quality of surgical care.

The ACS Clinical Scholars have presented their findings at numerous national meeting presentations and in high-impact, peer-reviewed publications, in addition to having contributed a great deal to the ACS quality improvement programs. Furthermore, scholars have gone on to gain prestigious fellowships in several fields, including surgical oncology and pediatric surgery.

Apply now

The 2013–2015 scholars will begin their work July 1, 2013. Applications for these positions...
are due by March 15, 2012. Currently, applicants are required to have funding from their institution or another grant mechanism, although support through the ACS may become available in the future.

For more information about the program and the application requirements, go to www.facs.org/ropc/clinicalscholars.html, or send an e-mail to clinicalscholars@facs.org.

Dr. Bilimoria is a surgical oncologist and director of the Surgical Outcomes and Quality Improvement Research Center at the Feinberg School of Medicine, Northwestern University, Chicago, IL. He is also an ACS faculty scholar.

Dr. Ko is the Director of the ACS Division of Research and Optimal Patient Care, Chicago, IL.

Members in the news

Craig S. Derkay, MD, FACS, a professor of otolaryngology and director of pediatric otolaryngology at Eastern Virginia Medical School, Norfolk, VA, received the Sylvan E. Stool Award for lifetime achievement in teaching and service from the Society for Ear, Nose and Throat Advances in Children. The award was presented to Dr. Derkay at the society’s 39th annual meeting in Kansas City, MO.

Gerard M. Doherty, MD, FACS, has been appointed chief of surgery at Boston Medical Center and chair of the department of surgery at Boston University School of Medicine effective January 1. Dr. Doherty’s research interests include a series of projects aiming to regenerate parathyroid cells for replacement of lost tissue in people who are permanently hypoparathyroid.

In addition to serving for the past decade as chief of general surgery at the University of Michigan Health System, he is the President of the Michigan Chapter of the American College of Surgeons.

Michel Gagner, MD, FRCSC, FACS, FASMBS, FICS, AFC(Hon), a clinical professor of surgery, was awarded a medal from the National Assembly of France by the faculty of medicine of Montpellier, France, last summer. Dr. Gagner was presented with the honor in recognition of his efforts in the development of laparoscopic surgery and bariatric surgery.

Additionally, Dr. Gagner received the Excel Award during the annual meeting of the Society for Laparoendoscopic Surgery last fall for his pioneering work in laparoscopic surgery. Established in 1991, the Excel Award has been presented to 25 surgeons who have made outstanding contributions to laparoscopy, endoscopy, and minimally invasive surgery.

Wei-Ping Andrew Lee, MD, FACS, Baltimore, MD, professor and director of the department of plastic and reconstructive surgery at the Johns Hopkins University School of Medicine, was elected president of the American Society for Surgery of the Hand in the fall of 2011.

Manucher Nazarian, MD, FACS, a cardiovascular surgeon from Fort Worth, TX, received the American Heart Association’s Leader with Heart Award early last year. This award recognizes physicians who have had an inspirational and influential impact on the community. During his career, Dr. Nazarian established cardiology programs at Texas Health Harris Methodist Hospital and at other medical facilities in Fort Worth.

Walter F. Pizzi, MD, FACS, was awarded a certificate of merit from the New York City Police Department last spring in recognition of 40 years of service as a police surgeon. Dr. Pizzi, chair emeritus of the Regional Emergency Medical Services Council NYC, Inc. was presented with the award by Raymond W. Kelly, police commissioner of the New York City Police Department.

Dr. Pizzi, of Richmond Hill, Queens, New York, NY, was a member of the American College of Surgeons Committee on Trauma (COT) from 1978 to 1988. From 1974 to 1979, Dr. Pizzi was Chair of the New York-Brooklyn State COT, and from 1989 to 1995 he was Chief, Region II, Committees on Trauma.

Luis H. Serentill, MD, FACS, clinical assistant professor of sur-
The following continuing medical education courses in trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

- **Point/Counterpoint XXXI, Acute Care Surgery**, June 11–13, National Harbor, MD. For information, contact 757-446-8967
- **Advances in Trauma Conference**, December 7–8, Kansas City, MO

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

International women in surgery symposium set for spring 2012

The Third Annual International Women in Surgery Career Symposium will take place May 31 through June 2, 2012, and will be hosted by Johns Hopkins University in Baltimore, MD. American College of Surgeons President Patricia J. Numann, MD, FACS, Lloyd S. Rogers Professor of Surgery Emeritus at the State University of New York Upstate Medical University in Syracuse, will deliver the keynote address.

The symposium will promote personal and professional growth in women surgeons and provide interactions with surgical leaders and pioneers who have advanced the roles of women in surgery. Sharona B. Ross, MD, FACS, will serve as chair for the symposium, and Julie A. Freischlag, MD, FACS, will be the co-chair.
Call for nominations for ACS Officers-Elect

The 2012 Nominating Committee of the Fellows has the task of selecting nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The following guidelines are used by the Nominating Committee when reviewing the names of potential candidates for nomination as Officers of the College:

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

Nominations should include a paragraph or two on the potential contributions each candidate can offer in terms of what he or she can do for the members of the College. Submit nominations to officerandbnominations@facs.org by Wednesday, February 29, 2012.

If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Fellows, at psprecksel@facs.org or by calling 312-202-5360.

Call for nominations for the ACS Board of Regents

The 2012 Nominating Committee of the Board of Governors has the task of selecting six nominees for pending vacancies on the Board of Regents, to be filled during the 2012 Clinical Congress in Chicago, IL. The following guidelines are used by the Nominating Committee when reviewing the names of candidates for potential nomination to the Board of Regents:

- Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.
- The Nominating Committee recognizes the importance of achieving representation of all who practice surgery.
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If you have any questions, contact Patricia Sprecksel, Staff Liaison for the Nominating Committee of the Board of Governors, at psprecksel@facs.org or by calling 312-202-5360.

For informational purposes only, the current members of the Board of Regents who will be considered for re-election are Julie Freischlag, MD, FACS; Raymond Morgan, MD, FACS; Leigh Neumayer, MD, FACS; Marshall Schwartz, MD, FACS; and Mark Weissler, MD, FACS.
In memoriam

Marion Rapp, former ACS International Liaison, remembered

by Kate Early

Marion Rapp, former International Liaison for the American College of Surgeons (ACS), passed away November 24, 2011, at 91 years of age from colon cancer. Ms. Rapp began her lengthy career at the College in January 1953 as Personal Assistant to then College Director, Gen. Paul R. Hawley, MD, FACS(Hon). She actually accepted a salary cut in order to work for D. Hawley, whom she admired deeply. Dr. Hawley was an innovative leader, who was the first to provide insurance benefits to the College’s staff, and he bequeathed the Hawley Fund, which initiated the International Guest Scholarships program.

After Dr. Hawley’s retirement in 1969, Ms. Rapp held a number of positions of increasing responsibility at the College, primarily in the Fellowship Department, now known as the Division of Member Services. For many of those years, she was the College’s International Liaison, serving thousands of International Fellows, Honorary Fellows, and guest physicians. As recently as the 2011 Clinical Congress in San Francisco, CA, surgeons were asking for news of her.

Ms. Rapp was intelligent, discerning, courteous, no-nonsense, stubborn, and very kindhearted. She appreciated good and honest work and was proud of the many excellent employees she helped to cultivate and train. She remained in contact with her favorite surgeons and was honored at the International Scholars luncheon in 2006.

Ms. Rapp retired in September 1999 after nearly 50 years of service, making her one of the College’s longest-serving and most dedicated employees. Even years after her retirement, she remained available to answer work-related questions.

The late C. Rollins Hanlon, MD, FACS, Dr. Hawley’s successor, made the wise decision to interview Ms. Rapp, audiotaping many of her stories about the College and the famous surgeons she had known. These recordings are housed in the ACS Archives. For more information about these recordings, contact Susan Rishworth, ACS Archivist, at srishworth@facs.org.

Ms. Early is the International Liaison in the ACS Division of Member Services, Chicago, IL.

Miss Rapp in 1955 (left), and in 1993 with International Guest Scholar Nobuyasu Kano, MD, PhD, FACS.
The Joint Commission (TJC) continually works to improve infection control methods in health care. During 2011, TJC announced a number of new infection control initiatives, including a new National Patient Safety Goal, educational materials, and a new infection control standard.

TJC’s new standard for the Infection Prevention and Control chapter will become effective on July 1. The new standard focuses on the improvement of influenza vaccination rates in all Joint Commission-accredited health care settings when patient care, treatment, or services are provided on-site. It will apply to all staff and licensed independent practitioners. The goal of the influenza vaccination standard is for organizations to do the following:

- Establish an influenza vaccination program for staff and licensed independent practitioners
- Set incremental goals for meeting the 90 percent vaccination target rate in 2020 established in the national influenza initiatives by the U.S. Department of Health and Human Services’ Action Plan to Prevent Healthcare-Associated Infections: Influenza Vaccination of Healthcare Personnel
- Measure and improve influenza vaccination rates for staff and licensed independent practitioners
- Set incremental goals for meeting the 90 percent vaccination target rate in 2020 established in the national influenza initiatives by the U.S. Department of Health and Human Services’ Action Plan to Prevent Healthcare-Associated Infections: Influenza Vaccination of Healthcare Personnel

A new infection control related to TJC’s National Patient Safety Goal (NPSG) was also developed in 2011, and became effective January 1 of this year. The NPSG focuses on catheter-associated urinary tract infections (CAUTIs) and is applicable to hospital and critical access hospital accreditation programs. TJC’s Patient Safety Advisory Group, a group of external national experts on patient safety issues, recommended that the CAUTI NPSG be partially adopted since CAUTIs represent the most frequent type of health care-associated infection, (HAI), and currently represent as much as 80 percent of the total HAIs in hospitals.

In 2011, a new R³ Report from TJC was developed to provide hospitals with in-depth information about the 2012 CAUTI NPSG. The R³ Report offers hospitals and critical access hospitals a deeper understanding of the new requirements to use evidence-based practices to prevent CAUTIs. The R³ Report provides information on the specific elements of performance for the NPSG. The elements of performance in the new NPSG are derived from the evidence-based implementation strategies in A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, which was first developed in 2008 and jointly published by TJC with the Society for Healthcare Epidemiology of America and other partner organizations.

The Joint Commission also jointly published an update to the compendium in the fall of 2011, which can be found on the Society for Healthcare Epidemiology of America’s website. The compendium contains a variety of scientifically based and practical recommendations for acute care hospitals to assist in the prevention of common HAIs.

The compendium assists health care professionals in infection control by doing the following:
- Synthesizing the best evidence for the prevention of surgical site infections, central line-associated bloodstream infections, ventilator-associated pneumonia, Clostridium difficile, methicillin-resistant Staphylococcus aureus, and CAUTIs
- Highlighting basic HAI prevention strategies plus advanced approaches for outbreak management and other special circumstances
- Recommending performance and accountability measures to apply to individuals and groups working to implement infection prevention practices

The 2011 update takes a closer look at some of the questions that frequently arise in regard to the recommended methods of hand hygiene after contact with patients who have contracted a Clostridium difficile infection. TJC also released a monograph in February focusing on the importance of increasing diphtheria and acellular pertussis (Tdap) vaccination programs in health care titled Tdap Vaccination Strategies for Adolescents and Adults, Including Health Care Personnel—Strategies from Research and Practice. The monograph was created to help health care organizations
implement or enhance Tdap vaccination programs for health care workers and other individuals who may acquire pertussis and spread it to patients, including other staff and family members. The monograph explains that Tdap vaccination programs are important for health care organizations due to the increased rates of pertussis over the last two decades, primarily in adolescents and adults who have waning immunity from previous pertussis vaccinations or infection. The spread of pertussis has been documented in various health care settings, including outpatient clinics, hospitals, and emergency departments throughout the nation. Joint Commission Resources (JCR), an affiliate of TJC, is helping increase the staff vaccination rates of health care providers with its annual Flu Vaccination Challenge, which kicked off its program for the 2011–2012 flu season in the fall of 2011. For the 2011–2012 flu season, participating health care organizations are encouraged to achieve at least a 75 percent flu vaccination rate among staff and to strive for the 85 percent or 95 percent tier. JCR will recognize organizations that meet the challenge with a bronze, silver, or gold recognition award for their dedication to helping their staff and patients remain healthy by vaccinating against the flu. Last flu season, participating health care organizations reached an 80 percent flu vaccination average among staff during, which is 16 percent higher than the national average. In addition to TJC’s new standards and educational materials on infection control, its Center for Transforming Healthcare continues to make an investment in producing new tools to guide health care efforts to effectively address hand hygiene compliance and surgical site infections more effectively. For more information on how TJC is working to improve infection control in health care, visit the following links:

- http://www.jointcommission.org/infection_control.aspx

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.
American College of Surgeons Professional Association (ACSPA)

As of September 2011, the ACSPA-SurgeonsPAC (political action committee) had contributed to the campaigns of 84 candidates, leadership PACs, and party committees, and had raised $412,135. This total was less than what the PAC raised at the same point in 2010; however, the decrease in contributions is not a cause for alarm because PACs commonly experience decreased revenues during non-election years. A total of 56 percent of the U.S. Governors of the College contributed, and 89 percent of the Officers and Regents made contributions as well. Current fundraising challenges include the difficult economy, general dissatisfaction with the performance of political institutions, and intrinsic inertia. The ACSPA-SurgeonsPAC resumed telephone fundraising, which resulted in a significant increase in funds.

American College of Surgeons (ACS)

Board of Governors
The Executive Committee of the Board of Governors held its four telephone conference calls scheduled for the year. In addition, two face-to-face meetings were held during the Clinical Congress in San Francisco, CA.

The Board of Governors’ annual survey communicates the concerns and recommendations of the Fellows regarding major issues related to surgery to the College’s leadership. The results of the survey were presented to the Board of Regents as it considers future endeavors. The top five issues of concern to the Fellows of the College in 2011, as reported by the Governors, were as follows:
- Physician reimbursement
- Health care reform
- Professional liability/malpractice
- Medical education/graduate medical education
- Workforce issues for academic/community practice

The Board of Governors and the Board of Regents held a joint session during the annual business meeting of the Governors. The session featured
the following speakers: L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), then-President of the ACS; Carlos Pellegrini, MD, FACS, FRCSI, then-Chair of the Board of Regents; David Hoyt, MD, FACS, ACS Executive Director; Don Detmer, MD, FACS, Medical Director, ACS Division of Advocacy and Health Policy; Frank Opelka, MD, FACS, Associate Medical Director, ACS Division of Advocacy and Health Policy; Andrew Warshaw, MD, FACS, Chair of the ACS Health Policy and Advocacy Group (HPAG); Christian Shalgian, Director, Division of Advocacy and Health Policy; and Timothy C. Flynn, MD, FACS, Chair of the Board of Governors (author of this report). These presentations focused on advocacy and health policy updates relative to the Affordable Care Act, Medicare’s sustainable growth rate payment formula, accountable care organizations, and the HPAG.

ACS scholarships
The Board of Regents approved a new health policy scholarship to be co-sponsored by the Society for Surgery of the Alimentary Tract. It will come into effect for the years 2012–2014, and then continue on a year-by-year basis thereafter. Full details about the scholarships, fellowships, and awards that are either fully or partially funded by the ACS can be viewed at http://www.facs.org/memberservices/research.html.

Committee on Optimal Access
The Board of Regents approved a proposal for the College to take a more visible role in addressing the documented health care disparities in surgery. The Board also approved the establishment of a Regental Committee on Optimal Access, which is charged with assessing health care disparities in surgery and developing strategic initiatives to address such inequalities.

World Health Assembly resolution
The Board of Regents approved a recommendation that the ACS express strong support for the concepts expressed in a draft Resolution on Surgical Care and Anesthesia, and that such support be conveyed to the U.S. representative member of the Executive Board of the World Health Assembly (WHA), along with any suggestions for further strengthening the resolution. The Regents believe that the WHA needs to formally recognize surgical care and anesthesia as a global priority. The recommendation is consistent with the College’s mission of promoting access to quality, safe, appropriate surgical care through its dedication to improving the care of the surgical patient and safeguarding standards of care in an optimal and ethical practice environment.

The draft resolution was reviewed, discussed, and approved for support by the ACS International Relations Committee, the International Surgical Society leaders present at the Clinical Congress in San Francisco, CA, and the U.S. chapter of the International Surgical Society. In addition, each of these bodies agreed to elicit support for the resolution from their respective organizations. The Board of Governors also overwhelmingly endorsed the concept that the development of health care systems for any nation must include access and support for appropriate surgery and anesthesia in equal relationship to other critical health care components.

ACS membership dues
At the recommendation of the Board of Governors Fiscal Affairs Committee and the Board of Regents Finance Committee, the Board of Regents approved a long-term dues policy to include an incremental dues increase based on the change in the consumer price index, not to exceed 3 percent. It was also suggested that the increase not be automatic and that it be reviewed and approved annually by the Board of Regents.

Public profile
Excellent progress has been made on the Inspiring Quality initiative. Two community forums took place as part of the Inspiring Quality national tour: one in Chicago, IL, and the other in Baltimore, MD. Dr. Britt and Dr. Hoyt co-hosted the Chicago program, and Julie Freischlag, MD, FACS, hosted the Baltimore forum. Both forums were well-received.

Dr. Hoyt continues to oversee ongoing planning for future community forums. As of September, initial planning was under way for community fo-
The College’s activities in Washington, DC, on behalf of its Fellows, continue to be of utmost interest and importance. To ensure that it adequately communicates the multitude of efforts in both the advocacy and public policy arenas on a regular basis, the College will be adding a Communications Manager in the DC office.

Advocacy

- Some recent advocacy efforts on behalf of the ACS membership include the following:
  - ACS leaders briefed members of Congress and key congressional staff regarding the Inspiring Quality initiative and the utility of ACS quality programs in developing health care policies
  - Joined with other physician organizations in calling on the White House and Congress to address Medicare physician payments in debt ceiling legislation
  - Praised bipartisan deficit reduction effort to address Medicare payment issues
  - Warned Fellows about the potential implications of debt ceiling on Medicare payments
  - Met with key congressional committees about ACS quality efforts and their role in development of Medicare payment reforms, and the need to repeal the sustainable growth rate (SGR)
  - Opposed MedPAC recommendation to cut Medicare payments for surgical care
  - Led letter-writing effort in opposition to graduate medical education cuts
  - Stated support for Ambulatory Surgery Center (ASC) Quality and Access Act of 2011
  - Physician organizations opposed recommended payment cuts for imaging services
  - Coalition successfully advocated for removal of imaging payment cuts from trade legislation
  - Achieved success in pandemic all hazards preparedness reauthorization
  - Worked with U.S. House of Representatives to request that the U.S. Government Accountability Office conduct a study on trauma
  - An ACS trauma surgeon hosted HHS Region 1 meeting regarding support for trauma funding
  - Supported orthopaedic colleagues in injury prevention
  - Joined in support of funding for pediatric loan repayment program
  - Supported an ACS Fellow who was honored with re-introduction of congressional gold medal legislation
  - Submitted comment letters related to accountable care organizations and shared savings programs
  - Submitted comment letter in response to fiscal year (FY) 2012 Inpatient Prospective Payment System proposed rule
  - Submitted comment letter in response to
Health Insurance Portability and Accountability Act Accounting for Disclosures Proposed Rule
• Submitted comment letter in response to the calendar year (CY) 2012 Medicare Physician Fee Schedule Proposed Rule
• Submitted comment letter in response to the CY 2012 Medicare Outpatient Prospective Payment System and ASC Payment System Proposed Rule
• Submitted comment letter in response to Clinical Laboratory Fee Schedule Signature on Requisition Proposed Rule
• Submitted input for Patient-Centered Outcomes Research Institute’s Tier 1 topics
• Submitted comment letter in response to the fourth 5-Year Review of the Resource-Based Relative Value Scale Proposed Rule
• Submitted comment letter in response to the E-Prescribing Proposed Rule

Medical liability reform. There was a substantial increase in the number of bills introduced and passed at the state level that call for implementing large-scale medical liability reform. With more than 30 new tort reform laws passed in 2011, this was truly a banner year for this type of legislation. The College tracked 63 medical liability reform-related bills, a number much higher than in previous years. States that passed these types of laws include Alabama, North Carolina, Oklahoma, South Carolina, and Tennessee.

Coding workshops. The ACS continues to contract with Karen Zupko and Associates to provide a series of coding workshops. As in previous years, two all-day sessions occurred on consecutive days. The first day is an introductory course designed for surgeons and coding staff with limited experience. The second day is an advanced course intended for individuals with solid coding experience. Physicians receive continuing medical education (CME) credits for each workshop completed and certified professional coders receive continuing education units through the American Academy of Professional Coders. The 2012 Coding Workshop schedule includes the following dates and locations: February 16–17, Las Vegas, NV; April 26–27, Chicago, IL; May 3–4, New York, NY.

ACS Health Policy Research Institute (ACS HPRI)
• Ongoing projects for the HPRI include the following:
  • Maintaining a longitudinal database of surgeons. Central to the work of the Institute is the management of comprehensive workforce data for the ACS. Maintaining and updating a longitudinal surgeon workforce database is essential to the HPRI’s goals, and the data are integral to responding to many policy questions and completing projects. Through the compilation and analysis of the AMA and the American Association of Medical Colleges data, the HPRI has developed longitudinal data on surgical specialist workforce trends, demographic characteristics, geographic distribution, and training background. These data can and have been used to develop a forecasting model that compares the effects of potential policy scenarios.
  
  With this information, the HPRI has developed a series of documents for distribution among members of the U.S. Congress, the White House, the ACS, and other relevant stakeholders. Among these documents are eight fact sheets available in print and on the HPRI website. The most recent fact sheet, the Geographic Distribution of General Surgeons: Comparisons Across Time and Specialties, discusses the geographic equity of surgeon distribution. A total of 12 new fact sheets describing the surgical subspecialties are currently under development. The specialty-specific fact sheets will describe workforce trends since 1980 and future projections through 2025 in each specialty. These fact sheets will also include the number of board-certified specialists in each specialty. Specialty societies will be able to use this information to anticipate demand, address training issues (such as graduate medical education allocation, fellowships, and so on), and/or reassess their field of practice.
  
  • Publishing the U.S. Atlas of the Surgical Workforce. The atlas provides a picture of the supply and geographic distribution of physicians and institutions providing surgical services in an effort to help practitioners, policymakers, and patients anticipate current and future surgeon distribution and identify places with limited access to surgical
services. It allows users to view the surgeon-to-population ratios and the five-year percent change of total surgeons, surgical subspecialty groupings, total physicians, and primary care physicians at the state and county level. County-level demographic and health indicator variables have been added. They include, but are not limited to, population (total, age 0–19, age 65+), number of hospital beds per population, availability of surgical service, and number of Medicare eligibles. In 2012, the HPRI will update the surgeons supply data, add facility data (hospitals/burn centers/trauma centers and availability of surgical services), and identify potential surgical health professional shortage areas.

New HPRI projects include the following:

- Developing innovative models of surgical staffing. Rural communities across the U.S. have long struggled to maintain surgical services in local hospitals, and recent data show further contraction of the rural surgical workforce. Efforts to provide access to surgeons have frequently involved nontraditional staffing arrangements for surgeon payment, staffing, and contractual employment obligations. One of these models involves the use of surgical hospitalists, who often provide emergency department (ED) call coverage to hospitals. Anecdotal evidence suggests that this model of employment is becoming more common as a strategy to recruit surgeons and maintain essential surgery call coverage. However, wide variation in the details of these arrangements is common. Furthermore, very little information is available regarding the impact of this surgical hospitalist model on the delivery and organization of surgical care in a hospital or community or how such staffing models might succeed or fail in rural health care environments. Using a semi-structured case-study approach, we examined this surgical hospitalist staffing model in hospitals. Initial conclusions from key informant interviews show that this strategy is currently used to address both rural surgery shortages as well as urban hospital issues with providing 24 hours of ED call coverage. Our goal is to produce information that is useful to communities, especially rural ones, in addressing current or anticipated shortages in the surgical workforce.

- Analyzing surgical service areas and under-surgeons. The U.S. Health Resources and Services Administration defines and administers programs related to Health Professional Shortage Areas (HPSAs) based on primary care resources. To date, they have primarily been used to place or provide support for primary care physicians and have remained the same since they were constructed using 1990s data. However, primary care HPSAs do not adequately capture all health professional shortage areas. To address this problem for surgeons, the HPRI is developing a proposal for a HPSA designation for areas that have critical shortages of general surgeons. This project is currently identifying the appropriate geography to use in a surgery HPAs as well as benchmarks for the resources necessary to provide access to surgical services. One immediate use for the new HPSA designation would be helping the Centers for Medicare & Medicaid Services (CMS) direct Medicare bonus payments to general surgeons working in HPSAs. The ACA calls for CMS to pay a 10 percent Medicare bonus to general surgeons working in HPSAs (Subtitle F, Section 5501). However, the overarching issue will be to identify systems and regions at risk for lower quality care and poor access due to a shortage of resources that support surgery (such as hospitals, technology, critical staff).

- Creating a Surgical Workforce Projection Model. Over the past year, the HPRI has developed the Surgical Workforce Projection Model. The model is a user-friendly predictor of the supply of surgeons in the U.S. It will allow users to forecast future supplies of surgeons by head count and full-time equivalent by age, gender, race, geographic location, and specialty. The model is primarily intended to be a tool for policy analysis—allowing users to generate and compare “what if” scenarios regarding changes in graduate medical education and other policy levers.

- Generating an educational program model for surgeon re-entry into the workforce. It is becoming increasingly common for surgeons to leave clinical practice for some period during their career and then seek re-entry into the workforce. Currently, there is no standardized/certified program that ensures that surgeons who are attempting to re-enter practice can demonstrate surgical com-
petence. There is also little structure provided to surgeons to help them overcome the barriers that make it difficult for them to attain needed competencies. In addition to developing a model program that could be adopted by state medical boards, the HPRI is drawing on the unique data housed at the North Carolina Health Professions Data System to describe the demographic and practice characteristics of surgeons who leave and re-enter practice. These data will identify the age and points in the career trajectory that surgeons are most likely to leave or re-enter practice and will provide much-needed information about the length of these absences. This project is timely as the AMA and multiple state medical boards are currently developing recommendations regarding physician re-entry to the workforce.

*Offering Graduate Medical Education (GME) policy options for surgery, including all-payer approaches.* The GME training pipeline for surgeons is undergoing a period of rapid and potentially deleterious change. The introduction of direct-entry training (for example plastic or vascular) has created the potential for a very rigidly specialized surgery workforce. At the same time, there are mounting pressures to cut back on federal and state support for GME. Currently, it is impossible to predict the potential effects of these changes in GME on the surgery workforce of the future. The HPRI, with funding from the ACS, has developed a workforce projection model that can assess these changes. The project will assess the effects of direct-entry as well as the shift of unused slots to primary care or to new locations and regions as directed in the ACA.

**ACS NSQIP**

Hospitals in the ACS National Surgical Quality Improvement Program (NSQIP) must have a dedicated surgical clinical reviewer (SCR) to capture and submit their data. Beginning in January, new SCR quarterly training will be available in-person at the College at its headquarters in Chicago, IL, as an option for sites that do not wish to participate in remote training.

The 2011 ACS NSQIP National Conference took place at the Westin Copley Place in Boston, MA, July 24–26, 2011. More than 800 individuals attended the conference, and more than 400 took part in a preconference session. Atul Gawande, MD, FACS, of Brigham and Women’s Hospital and Harvard Medical School, presented the keynote address. This year’s conference also featured the winners of the first resident abstract competition and multiple presentations from participating sites and health care quality leaders. The 2012 ACS NSQIP National Conference will take place July 21–24, 2012, in Salt Lake City, UT, at the Grand America Hotel and will include multiple preconference sessions.

In another important development, in April 2011, CMS presented a proposal to the ACS to work with the College on pilot testing and voluntary public reporting of quality data. The ACS responded back with its technical and business proposal in May 2011 and was informed it had secured the contract in September 2011.

**Education**

- National concern about the negative consequences of sleep deprivation has resulted in new regulations and more stringent oversight. The new program requirements articulated by the Accreditation Council for Graduate Medical Education include greater restrictions on resident duty hours, most notably in the first year of training. Concerns about the short- and long-term consequences of these restrictions on patient care and on the education and training of surgery residents are widespread. The importance of self-regulation and professionalism in recognizing and mitigating the impact of fatigue has been articulated by the College in a number of reports prepared by the ACS Division of Education. This area of focus is relevant to both surgeons in practice and residents in training. Recognition and mitigation of fatigue to support peak performance in surgery requires comprehensive study, as well as development of specific strategies that will bear the patients and the surgical profession in good stead. A special committee is being appointed to address this issue. Dr. Pellegrini will chair this committee, which will comprise surgeons from various specialties, as well as renowned sleep experts.
The Surgical Education and Self-Assessment Program™ 14 (SESAP™) is founded on cutting-edge principles of contemporary surgical education and meets the new stringent requirements of the American Board of Surgery (ABS), especially as they relate to Part 2 of Maintenance of Certification (MOC), which involves self-assessment and lifelong learning. It is also very useful in helping surgeons prepare for the recertification examination, which surgeons must take to fulfill requirements for Part 3 of MOC. The 15 content categories of SESAP 14 include 655 problem-focused questions, insightful critiques, and selected references. SESAP 14 is available in a variety of formats that have been especially designed to address different learning needs and offers the opportunity to earn a maximum of 70 Category 1 CME Credits—10 more credits as compared with previous editions of SESAP. Enrollment in SESAP 14 was 7 percent higher as compared with enrollment for SESAP 13 for the comparable period. The SESAP enrollment numbers and revenues have progressively increase over the past nine years across each successive edition of SESAP.

The development of SESAP 15 content has begun. The College is pursuing further redesign of the SESAP educational model. This will help in meeting new regulatory requirements.

A newly revised edition of Fundamentals of Laparoscopic Surgery (FLS), FLS 2.0, has been released. More than 90 percent of the content has been revised and four topic areas have been added: preoperative considerations, intraoperative considerations, basic laparoscopic procedures, and postoperative care and complications.

A total of 33 of the 2011 Clinical Congress sessions have been selected for webcasting, which provides users with the opportunity to earn up to 121 Category 1 CME Credits. A new package, Webcast Pick 11 of 2011, has been introduced this year, which offers ACS Fellows the choice of 11 of the 33 webcast sessions for purchase, allowing the learner to select the webcast sessions most relevant to their practice. For 2011, pretests were to be added to the posttests to provide a more robust learning experience. The Complete Best Value Package includes all 33 webcast sessions, a complete package of 115 audio recordings of Panel Sessions and Named Lectures, and access to 42 webcasts from past Clinical Congresses.

Efforts are under way to convert Volumes 1–3 of the Practice Management Course for Residents and Young Surgeons from the CD-ROM format to an online format. New modules are being added to this important program. A new module will also be added to the Personal Financial Planning and Management for Residents and Young Surgeons program.

Journal of the American College of Surgeons (JACS)

The JACS CME website continues to be popular among Fellows and subscribers. From January 1 through September 28, 2011, a total of 63,758 JACS CME credits were earned by 2,625 individuals, averaging more than 24 credits per person.

Operation Giving Back (OGB)

More than 15,000 unique visitors conducted approximately 41,000 page views of the OGB website (http://www.operationgivingback.facs.org). The number of surgeons who have completed profiles in “My Giving Back” has increased to nearly 1,800.

ACS Foundation

The ACS Foundation priorities for fiscal year 2012 include the following:

- Secure philanthropic gifts to support the College’s program priorities
  — Build a portfolio of giving priorities—“products” that can inspire larger gifts
  — Develop customized outreach vehicles that appeal to Fellows’ interests.
  — Demonstrate impact of gifts in ACS programs and services
- Build infrastructure to grow Mayne Heritage Society membership
  — Articulate the benefits and meaning of planned giving to ACS constituents
  — Better identify and reach out to qualified Mayne Heritage candidates
  — Enhance and increase recognition of Mayne Heritage Society members
• Increase collaboration to grow philanthropic giving to the College
  —Strengthen interactive partnership with College division leaders and staff
  —Nurture a culture of philanthropy through shared initiatives and successes
  —Identify and pursue goal-oriented cultivation and solicitation projects with Foundation volunteers

HealthCareers (Job Bank)
A total of 508 active jobs and 395 résumés are posted on the website. This is a valuable service for all members of the College, and is free for our Resident Members.

Resident-Associate Society (RAS)
The RAS worked diligently on many projects with great results. Some of these projects include the following:
• E-mailed resident needs-assessment survey, and distributed surgical caps as reward for completing survey
• Surveyed program directors to obtain better understanding of recruitment/retention opportunities
• Increased contact with international surgical trainee organizations

Young Fellows Association (YFA)
ACS President Patricia J. Numann, MD, FACS, hosted a round table discussion, which was followed by a networking reception. The College’s young Fellows and 2011 Initiates were invited to attend.
The YFA hosted its inaugural mentoring program. Mentors and mentees were solicited via a SurveyMonkey questionnaire. The program’s objective, vision, and so forth, are as follows:
• Objective: Strengthen young Fellows’ engagement and participation in the ACS
• Vision: Develop a strong, healthy, active and vibrant YFA
• Hypothesis: Direct connections and interviews with a focus on engagement in YFA/ACS activities will improve Fellows’ knowledge, attitude, and behavior
• Aims: The YFA Membership Work Group will design and conduct a small pilot mentorship program of at least 10 mentor-mentee pairs, with a mentor/mentee package to be compiled and sent to the pairs
  • Mentor–mentee interactions: Should include at a minimum a phone conversation between the mentor/mentee, a face-to-face meeting, a goal generated by the pair, a follow-up phone discussion, and an exit interview for the pairs
  • Outcomes: Generate at least 14 ideas for improving young Fellows’ activity and participation in the ACS

New chapter
The Board of Regents approved the formation of the College’s 37th international chapter: the ACS Egypt Chapter. This brings the total number of ACS chapters to 104: 37 international, two Canadian, and 65 U.S.

ACS centennial event
The ACS will celebrate its 100th anniversary in 2013. The process of incorporation for the College was begun in 1912, and the 2012 Clinical Congress will be in Chicago, the headquarters city of the organization. The centennial celebration will start with the 2012 Clinical Congress and continue throughout the 2013 Clinical Congress in Washington, DC.
The 2011 Annual Report of the National Trauma Data Bank (NTDB) is an updated analysis of the largest aggregation of U.S. and Canadian trauma registry data that has ever been assembled. In total, the NTDB now contains more than 5 million records. The 2011 Annual Report is based on 722,824 records, submitted by 697 facilities, from the single admission year of 2010. The 2011 Annual Pediatric Report is based on 146,953 2010 admission year records. The NTDB classifies pediatric patients in this report as patients that are less than 20 years of age.

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

When looking at the number of incidents by mechanism of injury, falls, motor vehicle-related, and those that classify as struck by/against account for more than two-thirds of the records and 40 percent of all deaths. In contrast, firearm-related injuries comprise a much smaller number—less than 5 percent of all records—but are related to close to 30 percent of all reported deaths. Taking this finding one step further and examining the case fatality rate by mechanism of injury and age, one can see that firearms are fatal at any age. The firearm case fatality rate dwarfs the case fatality rate for other mechanisms of injury (see figure, this page).

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

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

Dr. Fantus 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 Committee on Trauma.

Dr. Nance is Templeton Professor of Surgery and director, pediatric trauma program, Children’s Hospital of Philadelphia, PA.

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Dr. Fantus 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 Committee on Trauma.

Dr. Nance is Templeton Professor of Surgery and director, pediatric trauma program, Children’s Hospital of Philadelphia, PA.
To report your chapter’s news, contact Rhonda Peebles at 888-857-7545, or via e-mail at rpeebles@facs.org.

**Egypt Fellows form new chapter**

The Fellows located in Egypt have formed the newest chapter of the American College of Surgeons (ACS), which was approved by the Board of Regents October 27, 2011. The Egypt Chapter is the 104th chapter of the College. Currently, the ACS has 65 domestic chapters, two chapters in Canada, and 37 international chapters (including Egypt). The officers for the new Egypt Chapter are M. Sherif Omar, MB, BCh, FACS, President; Osama Soliman, MB, BCh, FACS, President-Elect; Mohey Elbanna, MB, BCh, FACS, Treasurer/Secretary; and Alaa El-din Ismail Abd El-Mottaleb, MC, BCh, FACS, Governor.

**MSS-ACS announces humanitarian scholarship recipients**

Last fall, during the annual meeting of the Minnesota Surgical Society—A Chapter of the ACS (MSS-ACS), the chapter awarded three humanitarian scholarships to one medical student and two residents who are participating in an international surgical elective in a resource-poor setting. The scholarships are intended to support the recipients’ work in a developing country. The recipients for 2012 include Abraham Markin* ($500), Niles Batdorf, MD* ($750), and Javariah Asghar, MD* ($750).

**Wisconsin Chapter convenes**

The Wisconsin Surgical Society—ACS Chapter convened November 3, 2011, in Kohler, WI (see photo, this page). In addition to an election of new officers and presentations by residents, David B. Hoyt, MD, FACS, Executive Director, updated chapter members on current ACS activities and programs.

**Arizona Chapter holds annual meeting**

The Arizona Chapter held its 2011 annual meeting November 4–6 at the Scottsdale Plaza, AZ. Thomas Whalen, MD, MMM, FACS, presented an update on College activities. In addition to presentations on infection control, minimally invasive surgery, and critical care surgery, a competition for residents was held during the annual meeting. The competition winners included the following residents: Karole M. Davis, MD,* and Tom Kleisli, MD* (see photo, page 69). Additionally, Thomas Wachtel, MD, MMM, FCCM, FACS, was awarded the chapter’s Distinguished Service Award. Dr. Wachtel served

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*Denotes Associate Fellow, Resident, or Medical Student membership in the College.

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Wisconsin Chapter, front row, left to right: Terry Gueldner, MD, FACS; Ron Wenger, MD, FACS; Rodney Malinowski, MD, FACS, Immediate Past-President; Marilu Bintz, MD, FACS; and Shau Kothari, MD, FACS, President-Elect. Second row, left to right: Clifford Cho, MD, FACS; Gordon Telford, MD, FACS; Charles Cheng, MD, FACS, Cancer Liaison Chair; Gwenn Pavlovitz, MD, FACS; Benjamin Jarman, MD, FACS; Mark Abraham MD*; and Steve Kappes, MD, FACS. Third row, left to right: Dean Klinger, MD, FACS, President; Eric Anderson, MD*; Tina Yen, MD, FACS; Brian Lewis, MD, FACS; Steve Shapiro, MD, FACS; Dave Schultz, MD, FACS; Ryan Groesch, MD*; Christopher Fox, MD, FACS; and Ron Martini, MD, FACS.
as program director at Phoenix Integrated Surgical Residency for four years, and he directed the Level I trauma center at Scottsdale Healthcare.

Connecticut Chapter conducts 44th annual meetings

The Connecticut Chapter hosted its 44th annual and scientific meeting on November 2, 2011, at the Farmington Marriott. The chapter was honored to have former ACS President L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FWACS(Hon), present the James Foster Memorial Lecture. Michael Deren, MD, FACS, was awarded the Distinguished Service Award for his dedication to the improvement of surgery and patient care. Dr. Deren has held numerous leadership roles in the Connecticut State Medical Society (CSMS) and the American Medical Association, and he was elected the chapter’s Secretary-Treasurer during the annual meeting. Also, the Legislator of the Year award was presented to Representative Chris Murphy in recognition of his service to physicians and patients.

During the annual and scientific meeting, residents presented more than 50 papers on topics in the areas of clinical oncology, trauma, bariatric, plastic, and specialty surgery. The first Connecticut Surgical Residents’ Workshop, Surgical Decision Making: How to Choose a Fellowship, was offered at the meeting and was moderated by Jennifer Bishop, MD, Chair, Residents Committee.

Following the workshop, the fourth annual Surgical Skills Competition was held (see photo, this page). Created to form a unique partnership with industry, eight surgical residency programs competed in the following sessions: Cholecystectomy (SILS), Fascial Closure & Ostomy Maturation, Laparoscopic Ventral Hernia Repair, Lap Side-Side Bowel Anastomosis, Thoracoscopic Stapling, Excise Partial Pumkinectomy,” The VAC-O-Lantern Sim Man Trauma Simulation, and Vascular Anastomosis. St. Mary’s Hospital took first place in this year’s competition.

The chapter announced an agreement with the CSMS to provide advocacy services, including assistance with drafting legislative testimony, signing on to CSMS-supported legislative testimony, providing regular legislative updates to the council, and advising on legislative activity. The agreement was largely the result of the work the chapter and CSMS did as partners on Doctor’s Day, which allowed the chapter to leverage the ACS Lobby Day grant that was awarded in 2011.

Utah Chapter hosts ACS President

The Utah Chapter, in conjunction with the department of surgery at the University of Utah School of Medicine, Salt Lake City, UT, hosted the Utah Chapter Symposium, which featured Patricia J.
Numann, MD, FACS, the College’s President, as keynote speaker on October 7, 2011, in Salt Lake City. In addition, Dr. Numann served as the visiting professor for grand rounds on October 5 (see photo, this page), and she presided over the surgical interest group roundtable. Dr. Numann also participated in the kick-off Town Hall Meeting for Breast Cancer Awareness Month on October 6. During her visit, Dr. Numann delivered remarks on patient and surgeon safety in the operating room and on learning how to acquire new skills for clinical practice.

Metropolitan Philadelphia Chapter hosts annual meeting
The Metropolitan Philadelphia Chapter hosted its 2011 Annual Meeting at the Union League of Philadelphia. Dr. Hoyt presented an update on the College’s activities and programs during the dinner meeting.

Chapters receive advocacy grants
The College has awarded grants to chapters to support their advocacy activities. For 2012, a total of 16 chapters will receive grant support, which is an increase from 2011 when 10 chapters received grant support. Each chapter that was awarded a grant will be required to match (or exceed) the College’s contribution. The chapters that will be awarded grants this year include Alabama, Northern California, Connecticut, Florida, Georgia, Illinois, Indiana, Kansas, Maine, Massachusetts, Michigan, North Carolina, Ohio, Oregon, Tennessee, and Virginia.

The Subcommittee on Advocacy and Coalitions—a component of the Governors’ Committee on Chapter Activities—helped to review the grant applications. This grant program is managed by the Division of Advocacy and Health Policy–State Affairs. For more information about the grant program, contact Jon Sutton, Manager, State Affairs, at jsutton@facs.org, or at 1-800-621-4111.

2012 Leadership Conference
Hundreds of ACS members from across the country and across specialties will converge on Washington, DC, for the 2012 Leadership Conference and Advocacy Summit, March 25–27, at the JW Marriott in the nation’s capital.

The Leadership Conference, March 25–26, will focus on the theme “Surgical Leadership for Quality and Safety” and will offer separate, concurrent sessions for young surgeons, residents, chapter leaders, and chapter executives (administrators and executive directors). Concurrent sessions on March 25 will include the ACS National Surgical Quality Improvement Program (NSQIP®) Leaders’ Panel Discussion, Legal Concerns for ACS Chapters, Quality Improvement Leadership Skills, and Financial Skills for Chapter Leaders. The March 26 Leadership Conference program will feature the Health Policy Town Hall with ACS leaders, and keynote speaker will be David R. Flum, MD, MPH, FACS, the director of the Surgical Outcomes Research Center, a multidisciplinary research center established by the U.S. Department of Surgery that encourages and supports the use of outcomes research to improve the quality of surgical care at the local, regional, and national level.

The Advocacy Summit will immediately follow the Leadership Conference on March 26, with the afternoon devoted to advocacy education, specifically designed to accommodate varying levels of advocacy experience. On March 27, College members will visit Capitol Hill, where they will address many issues affecting ACS members, including liability reform, quality improvement, trauma, surgeon workforce, and so on. The ultimate goal of the Advocacy Summit is to prepare participants to become long-term advocates for surgical patients.

Registration for the Leadership Conference and Advocacy Summit is available online at http://www.facs.org/ahp/summit/. For questions about the Leadership Conference, March 25–26, will continue on page 72.
2012 chapter meetings

For a complete listing of the ACS chapter education programs and meetings, visit the ACS website at [http://www.facs.org/about/chapters/index.html](http://www.facs.org/about/chapters/index.html).

(AP) following the chapter name indicates that the ACS is providing AMA PRA Category 1 Credit™ for this activity.

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<thead>
<tr>
<th>Date</th>
<th>Chapter</th>
<th>Location/Information</th>
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<tbody>
<tr>
<td>February 16–18</td>
<td>South Texas (AP)</td>
<td>Location: The Westin Riverwalk, San Antonio, TX&lt;br&gt;Contact: Janna Pecquet, 504-841-0145, e-mail: <a href="mailto:janna@laacs.org">janna@laacs.org</a></td>
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<tr>
<td>February 17–18</td>
<td>North Texas (AP)</td>
<td>Location: City Place Conference Center Dallas, TX&lt;br&gt;Contact: Nonie Lowry, 913-402-7012, e-mail: <a href="mailto:nonie@lp-etc.com">nonie@lp-etc.com</a>&lt;br&gt;ACS Representative(s): David B. Hoyt, MD, FACS</td>
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<td>February 24–25</td>
<td>Puerto Rico</td>
<td>Location: La Concha Resort San Juan, PR&lt;br&gt;Contact: Axia Velez-Silva, 787-277-0674, e-mail: <a href="mailto:genteinc@gmail.com">genteinc@gmail.com</a>&lt;br&gt;ACS Representative(s): Patricia J. Numann, MD, FACS</td>
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<tr>
<td>March 5</td>
<td>Rhode Island</td>
<td>Location: Bravo Brasserie Providence, RI&lt;br&gt;Contact: Megan Turcotte, e-mail: <a href="mailto:mturcotte@rimed.org">mturcotte@rimed.org</a>&lt;br&gt;ACS Representative(s): Carlos A. Pellegrini, MD, FACS, FRCSI</td>
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<tr>
<td>March 22–24</td>
<td>Peru</td>
<td>Location: Sheraton Lima Hotel &amp; Convention Center Lima, Peru&lt;br&gt;Contact: Danilo Bambaren Gastelumendi, MD, FACS, e-mail: <a href="mailto:dabambaren@yahoo.com">dabambaren@yahoo.com</a>&lt;br&gt;ACS Representative(s): A. Brent Eastman, MD, FACS</td>
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<tr>
<td>March 23–24</td>
<td>Metropolitan Washington, DC (AP)</td>
<td>Location: JW Marriott, Washington, DC&lt;br&gt;Contact: Jennifer Starkey, 877-835-5809, e-mail: <a href="mailto:jennifer@executive-office.org">jennifer@executive-office.org</a></td>
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<td>April 13–14</td>
<td>North Dakota and South Dakota (AP)</td>
<td>Location: Watertown Event Center, Watertown, SD&lt;br&gt;Contact: Terry Marks, 605-336-1965, e-mail: <a href="mailto:tmarks@sdsma.org">tmarks@sdsma.org</a>&lt;br&gt;ACS Representative(s): Patricia J. Numann, MD, FACS</td>
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<tr>
<td>April 21</td>
<td>New York (AP)</td>
<td>Location: Albany Medical Center, Contact: Amy Clinton, e-mail: <a href="mailto:nycofacs@yahoo.com">nycofacs@yahoo.com</a>&lt;br&gt;ACS Representative(s): Patricia J. Numann, MD, FACS</td>
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<tr>
<td>April 22–25</td>
<td>Chile</td>
<td>Location: Sheraton Hotel Convention Center, Santiago, Santiago, Chile&lt;br&gt;Contact: Celia Aldana M., 562-235-8934, e-mail: <a href="mailto:caldana@acschile.cl">caldana@acschile.cl</a>&lt;br&gt;ACS Representative(s): Patricia Turner, MD, FACS; Patricia J. Numann, MD, FACS; Carlos A. Pellegrini, MD, FACS, FRCSI</td>
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<tr>
<td>April 26–29</td>
<td>Virginia (AP)</td>
<td>Location: Inova Fairfax Hospital, Fall Church, VA&lt;br&gt;Contact: Susan McConnell, 804-643-6631, e-mail: <a href="mailto:smcconnell@ramdocs.org">smcconnell@ramdocs.org</a></td>
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<tr>
<td>May 4–5</td>
<td>Ohio (AP)</td>
<td>Location: Hilton Toledo, Toledo, OH&lt;br&gt;Contact: Jennifer Starkey, 877-677-3227, e-mail: <a href="mailto:jennifer@executive-office.org">jennifer@executive-office.org</a></td>
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ship Conference, contact Rhonda Peebles in the Division of Membership Services at rpeebles@facs.org. For questions about the Advocacy Summit, contact Catharine Harris in the Division of Advocacy and Health Policy at charris@facs.org.

Chapter executives convene in Chicago
For the fifth year in a row, more than 15 chapter executives (see photo, this page) representing 21 chapters convened at the ACS headquarters in Chicago, IL, to obtain updates on College programs and activities. The winter education program was held December 5–6, 2011, and featured presentations by ACS staff on the following topics and/or sections: patient education resources; NSQIP collaboratives and other quality improvement programs; Commission on Cancer/State Chairs; activities and programs of the Division of Education; CME program for chapters; federal and state legislative/regulatory updates; and ACS communications programs and strategies.

In addition, the College’s legal counsel, Paula Cozzi Goedert, Esq., presented an update on legal issues that may affect chapters, and she was featured in a session entitled Stump the Expert.

Donor recognition: ACS chapters step up
The ACS recognizes the chapters for their vital role in promoting quality care, education, and communication, and gratefully acknowledges their generosity. In 2011, a number of chapters made donations to the ACS Foundation, including Arizona; Florida; Hawaii; Indiana; Japan; Kansas; Maine; Massachusetts; Metropolitan Washington, DC; Nebraska; North Carolina; Ohio; South Carolina; South Dakota; South Florida; Southern California; Southwestern Pennsylvania; Tennessee; Virginia; and Wisconsin Surgical Society—A Chapter of the American College of Surgeons.

Many chapters make unrestricted gifts, which support the current operations of the College; others support specific programs. All chapter gifts are valuable and deeply valued. Over the past 10 years, chapters have donated a total of $226,805—which is an impressive show of support. We thank all ACS chapters for their contributions.

Chapter anniversaries

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<tr>
<td>January</td>
<td>Northern California</td>
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<td>Louisiana</td>
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<td>February</td>
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<td>Australia-New Zealand</td>
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<td>South Florida</td>
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<td>Iowa</td>
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<td>Italy</td>
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<td>Lebanon</td>
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<td>Montana-Wyoming</td>
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<td>Eastern Long-Island, NY</td>
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<td>Peru</td>
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<td>South Korea</td>
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<td>Washington State</td>
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Ms. Peebles is in the Division of Member Services, Chicago, IL.