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**ON THE COVER:** This issue inaugurates a new design for the ACS Bulletin. As part of the kickoff to the ACS Centennial celebrations, we look back at a sampling of past cover designs and reprint the first issue of the Bulletin from 1916 in its entirety (see pages 17–43).
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Twitter.com/ACSTrauma

Event Hashtags: Log into Twitter and enter these hashtags to find our updates quickly and easily:
#ACSCC12 is the official Clinical Congress hashtag on Twitter.
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The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

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Chicago, IL

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes

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# Calendar of events

## September 2012

**Kansas Chapter**  
September 8–9  
Wichita Airport Hilton Inn  
Wichita, KS  
Contact: Gary Caruthers, gcarauthers@kmsonline.org

**Surgeons as Educators**  
September 8–14  
Emory University Conference Center  
Atlanta, GA  
Contact: Krishina Hudson, khudson@facs.org

**Utah Chapter**  
September 13–14  
Contact: Lisa Marley, Lisa.Marley@hsc.utah.edu

**5th Annual ACS Accredited Education Institutes Postgraduate Course: Defining the Role of AEIs in Continuing Professional Development**  
September 14–15  
New Orleans, LA  
Contact: Kathy Johnson, kjohnson@facs.org

**Arkansas Chapter**  
September 22  
Jackson T. Stephens Spine and Neuroscience Institute  
Little Rock, AR  
Contact: Linda Clayton, lindac92@comcast.net

**Clinical Congress**  
Date: September 30–October 4  
McCormick Place West  
Chicago, IL  
Contact: registration@facs.org

## October

**Clinical Congress**  
September 30–October 4  
McCormick Place West  
Chicago, IL  
Contact: registration@facs.org

**Iowa Chapter**  
October 18–19  
University of Iowa Hospital and Clinics  
Iowa City, IA  
Contact: Sue Hyler, hylers@uihealthcare.com

**Seven Keys to Success for Surgeons (Basic Coding Course)**  
October 25–26  
Westin South Coast Plaza  
Costa Mesa, CA  
Contact: Jenny Jackson, jjackson@facs.org

## November

**Wisconsin Surgical Society—A Chapter of the ACS**  
November 2–3  
The American Club  
Kohler, WI  
Contact: wisurgical@att.net

**Connecticut Chapter**  
November 2–4  
Hartford Farmington Marriott  
Farmington, CT  
Contact: Chris Tasik, info@ctacs.org

## Future Clinical Congresses

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

**2014**  
October 26–30  
San Francisco, CA
Looking forward

by David B. Hoyt, MD, FACS

This year’s Clinical Congress should be one of the most exciting in recent memory, as it will mark the beginning of the American College of Surgeons’ (ACS) year-long Centennial celebration. Some of the special features that have been added to this year’s conference to commemorate the ACS’ 100 years of Inspiring Quality include several special panel sessions, an exhibit featuring a timeline of important achievements in surgery, book signings, a tour of the Archives, a cake-cutting ceremony, and much more.

Educational activities
Several panel sessions at this year’s Clinical Congress will focus on our profession’s rich history. Examples include the following, which are all scheduled to convene in McCormick Place West from 4:15 to 5:45 pm on their respective dates:

• Founders of Private Clinics and the Early History of the ACS, Monday, October 1
• Nobel Prize-Winning Surgeons, Tuesday, October 2
• The Committee on Trauma of the American College of Surgeons: Past, Present, and Future, Wednesday, October 3

Furthermore, an educational exhibit called 100 Years of Inspiring Quality—An Interactive Timeline will be set up in the third floor concourse of the convention center. The exhibit will feature a decade-by-decade look at milestones and accomplishments of the past century both in surgery and the College. Examples of events that will be featured in the exhibit include advances in transplant, trauma, cancer, cardiac, and minimally invasive surgery. The exhibit also will spotlight the College’s development of hospital standards, the Committee on Trauma, the Commission on Cancer, and other programs aimed at improving the quality and safe delivery of surgical care.

Insiders’ look at ACS history
In addition, all attendees will receive a copy of A Century of Surgeons and Surgery: The American College of Surgeons, 1913–2012, written by David L. Nahrwold, MD, FACS, and Peter J. Kernahan, MD, PhD, FACS. This book provides a complete and highly engaging look at the ACS’ history and was the central focus of this column in the June Bulletin (vol. 97, no. 6). The authors will be signing copies of the book from noon to 1:30 pm Monday, October 1, and 10:00 to 11:30 am Tuesday, October 2. Both signings will take place in McCormick Place West, Third Floor Concourse, in front of the Centennial timeline exhibit.

Along with A Century of Surgeons and Surgery, each attendee will receive a free copy of Remembering Milestones and Achievements in Surgery: Inspiring Quality for a Hundred Years. This high-gloss publication con-

I would encourage all surgeons to take some time during this year’s Clinical Congress to reflect on how far surgery has come in the last 100 years and how the ACS has continued its legacy of “Inspiring Quality.”

If you have comments or suggestions about the topics in this column, or about other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
tains a collection of articles on the evolution of surgical practice over the past century. The nearly 30 authors write from their hearts and minds on a spectrum of surgical achievements as well as select College contributions to the surgical profession.

Surgeons who are interested in personally viewing the College’s historic documents and artifacts are invited to tour the organization’s Chicago headquarters at 633 N. Saint Clair Street. The guided tour will take place at 11:00 am on Wednesday, October 3, and will give special attention to ACS Archives, which houses treasured pieces of our shared history. Examples include the casebooks, scrapbooks, and papers of the College’s Founder, Franklin H. Martin, MD, FACS, as well as the papers of Eleanor Grimm, his special assistant and recorder of the history of the College from its inception.

A time for celebration
To help us ring in the Centennial, all attendees are invited to join the College’s leadership for coffee, cordials, conversation, and a cake-cutting ceremony. This event will take place from 8:30 to 10:30 pm Tuesday, October 2, in the Grand Ballroom of the Hilton Chicago. The cake cutting will occur at approximately 10 pm.

Finally, I am proud to report that Illinois Gov. Pat Quinn and Chicago Mayor Rahm Emmanuel have declared September 30 to October 4 to be American College of Surgeons Week in the state and city. By issuing these proclamations, these political leaders are raising awareness among all residents of Chicago and Illinois of how the College’s achievements have significantly influenced the course of surgery in North America and throughout the world.

Keeping the legacy alive
The American College of Surgeons truly has a rich history. But as we look back on the many advances that have occurred over the past 100 years, the ACS leadership remains mindful of the fact that today’s surgeons and the surgeons of the future will continue to face many challenges in the coming years. Therefore, most of the 2012 Clinical Congress sessions will provide surgeons with opportunities to learn about state-of-the-art surgical procedures as well as the issues that affect their ability to provide optimal care to the surgical patient.

Nonetheless, I would encourage all surgeons to take some time during this year’s Clinical Congress to reflect on how far surgery has come in the last 100 years and how the ACS has continued its legacy of “Inspiring Quality.” With the road map our forbears have provided, we can surely look forward to 100 more years of leading the way to improved patient care.

Dave
ACS Futures Committee takes a good, hard look at the year 2025

by Jeannie Glickson
The nation’s current health care system is unsustainable, with cost as a percentage of GDP rising and more Americans becoming uninsured. To create a clearer vision for the future and more proactive policies on health care reform, ACS Past-President LaMar McGinnis, Jr., proposed the creation of a Futures Committee of the ACS. The committee considered four alternative scenarios for the future of health care:

- “Succeeding by Changing Just Fast Enough,” in which cost growth would drop just in time to avert a financial crisis
- “The Lost Decade,” in which the health care sector would continue “business as usual,” much to the nation’s detriment
- “Health Care Systemness,” which would center on public health and preventive care, as well as the development of ACOs and new reimbursement models
- “Integral Society and Health Care,” in which a major socioeconomic disruption would lead to a culture change with continuous quality improvement at its core

Peering into the future requires something of a mental leap. Members of the Futures Committee of the American College of Surgeons (ACS) took on that creative challenge by considering what surgery might look like in the year 2025, the quarter-century mark of the second millennium. They reviewed the past, the present, and current social, political, economic, and health care trends in the process of evoking a vision of tomorrow. Their discussions did not include surgical science of the future or technological advances.

“Essentially, futuring exercises help an organization create a long-term strategic plan,” said ACS Executive Director David B. Hoyt, MD, FACS. “It was a good exercise for the College and helped members of the committee realize the importance of systemness.” Systemness focuses on the significant attributes of health care, and involves creating solid structures for the greater good, as opposed to a collection of independent pieces.

To create a clearer vision for the future and more proactive policies, the ACS Futures Committee reflected on such questions as: What will the health care system look like in 2025? Who will have access to it? Who will pay for it? And what can we do now to build a proactive, responsive system that meets the needs of patients, legislators, surgeons, and other health care practitioners?

**Predict the future by creating it**

The Futures Committee was formed at the urging of ACS Past-President LaMar S. McGinnis, Jr., MD, FACS (see committee roster, page 14). In his final Presidential report to the ACS Board of Regents in 2010 recommending the formation of the committee, Dr. McGinnis emphasized that the best way to predict the future is to create it.

“Many other organizations have done futuring exercises with beneficial results,” he said, “and I think it’s important for the College to cast itself in a proactive rather than a reactive stance.” Dr. McGinnis oversaw a similar study by the American Cancer Society during his presidential year with that organization in 1995 and reminded surgeons that “other organizations are not our competitors. They are our compatriots.”

Dr. McGinnis views the futuring activity as a start toward systemic reviews at the ACS that will center on
“Cutting access and price are not socially responsible actions, and what we have driving decisions today is politics.”

—Frank Opelka, MD, FACS

not only health care issues but that will also focus on such general themes as health policy, medical economics, surgical science, technology, and education and training. This activity should be ongoing, according to Dr. McGinnis, “not episodic and not encumbered by hubris.”

“There was a kind of vision that early College leaders had. They realized that surgeons must work in the proper environment of a hospital, so the founders set out to standardize hospitals,” Dr. McGinnis said. “They set a goal, and in 1917, they created the hospital standards program, which eventually evolved into what we now know as The Joint Commission.” With their attention focused on the well-being of patients, the founders took actions that promoted a principle that continues to guide the College, he said.

“If you look back 100 years and consider what was happening then and how we defined what medicine was, you can view this current time of change and pain as an opportunity to address our mistakes and try to make them better,” said Futures Committee member Tyler Hughes, MD, FACS. “These are going to be tough times for patients and physicians,” Dr. Hughes said, “but we’ve been there before.”

**Four scenarios**

**Succeeding by Changing Just Fast Enough.** The reactive first scenario—Succeeding by Changing Just Fast Enough—would find the health care industry reducing its cost growth just ahead of a federal financial crisis. Employers would resist the high annual health insurance premium increases, and the system would shift to shared risk through global payments, bundled payments, and pay for outcomes. Under this scenario, most unnecessary services and medical errors would be eliminated in the system, but it could take as many as 15 years for most physicians and hospitals to make the transition.

The marketplace would become slightly more integrated, with various types of capitation—paying health care providers a set amount for each enrolled person assigned to them for a specified period of time—accounting for roughly 45 percent of all new costs. Hospital and physician fees would decline, and quality improvements would lower the costs of providing health care, minimizing waste and unnecessary therapies. A severe primary care shortage would partially resolve itself over time, as more medical students would realize the opportunities in primary care. For surgeons, the scenario would lead to more collaboration to control costs.

There would be a slow but steady movement toward the wider use of effective patient-centered medical homes (PCMHs), but without an engaged cultural change among providers. The marketplace would become somewhat more integrated, with accountable care organizations (ACOs) providing much of the care to patients. It is estimated that in this scenario, some 40 million Americans would be uninsured.

Today, health care spending consumes more than 17 percent of the nation’s gross domestic product (GDP), substantially more than in any other country in the world.1,2 Among developed countries, health care costs represent approximately 8.8 percent of their economies.2 The U.S. government’s current projections are that medical services will consume almost 20 percent of the nation’s GDP by 2021.3 In the Succeeding by Changing Just Fast Enough scenario, health care costs would continue to represent 17 percent of the GDP by 2025.

**The Lost Decade.** The second scenario, The Lost Decade, paints another reactive but even bleaker picture. The health care industry would stay fixed on “business as usual,” resulting in a system that in-

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**Reviewing alternative futures**

To help develop possible scenarios for the future of health care, the College worked with the Institute for Alternative Futures (IAF), based in Alexandria, VA. The committee met face-to-face only once but also communicated through a number of conference calls. During these discussions, committee members considered what health care might look like in 2025, and based on those discussions, the IAF created four scenarios.

Two of the possible scenarios were reactive and two were proactive. Committee member Karen Borman, MD, FACS, pointed to the advantages—and the drawbacks—of considering the scenarios. “Obviously, we can only theorize what health care might look like in 2025,” she said. “The further you go out in time, the vaguer your theories are. You can have the conversation; you just can’t have the work plan. You have to pick some things from each scenario and assume the future will look like parts of each,” she said.
Dr. Hoyt

flates government debt and significantly diminishes employer competitiveness. An anemic economic recovery would plunge into a double-dip global recession in 2014, when Greece defaults on its sovereign debt, according to this scenario. Health care professionals would not collaborate to improve efficiency and reduce errors and would receive increasingly austere Medicare reimbursements. Many hospitals would close, and most states would move Medicaid to a capitated plan, reducing rates and enrollment. Medical school enrollments would drop and, except for primary care, the demand for health care services would decline.

The Medicare eligibility age would increase to 67. Capitation would account for roughly 15 percent of the non-Medicaid market and 80 percent of Medicaid cases. In 2014, intermittent reductions would follow a 10 percent reduction in Medicare reimbursement. The number of uninsured Americans would rise to approximately 80 million that same year and level off at about 50 million in 2025. ACOs would advance little. Although many surgical practices would struggle—and some would be displaced and relocate, retire, or face bankruptcy—because of the decline in demand, revenues, and quality of care, it would still be possible to find pockets of excellence and concentrated demand.

As a means of controlling costs, a system of limited, or “tiered,” networks, setting up different copayments and providing patients with financial incentives for selecting more cost-effective physicians and hospitals, would be more widely used. This system would also cut insurance rates for employers.

The percentage of insurers moving to capitation and vouchers for Medicare and Medicaid would significantly increase. PCMHs would remain works-in-progress. Health care costs would spike in 2012 to 18 percent of GDP and drop to 13 percent in a depressed 2019 economy.

**Health Care Systemness.** In the more proactive third scenario, strong leadership and a shared vision among practitioners, patients, and industry would save the day, as a majority of stakeholders would realize that the current path is unsustainable. In this scenario, there would be proactive campaigns for public health and preventive care, along with the provision of well-planned and cost-effective care to patients. An honest dialogue among all parties would address responsibilities and entitlements. And almost all surgical procedures—roughly 80 percent—would be reimbursed under capitated or bundled payment models.

Innovations would center on such developments as a health advocate avatar—a vision of a patient as the master of self-care, with the avatar as the patient’s trusted assistant. Other features of this system would include: a knowledge portal; virtual care involving the support of a human being in a remote location; and automated care, with the support of a robot or computer—including implantable drug delivery systems. Patient self-management would reduce the demand and cost of providing care. The government would strive to blend global payment, capitation, and incentives to control the costs of Medicare and Medicaid. PCMHs would change the way community clinics deliver care and interact with patients. It is anticipated that the result of this scenario could result in improved health outcomes and reduced systemwide costs due to improved management of chronic conditions.

The number of uninsured would be manageable, in this third scenario. The lowest tier, including approximately 15 percent of the population, would be covered through Medicaid, which would provide good care, with the support of PCMHs and technology. The
middle tier, roughly 65 percent of the population, including Medicare patients and individuals with employer-based or individual health insurance policies, would receive good care but pay high deductibles. And the top tier would comprise approximately 20 percent of the population, including the affluent and patients with high-end coverage. Research would flourish in this scenario, and most of the market would be integrated with ACOs. Health care costs would represent 15 percent of a robust GDP.

**Integral Society and Health Care.** Finally, in the fourth scenario, and in what Dr. Hughes refers to as the “Kumbaya” vision of the future, the U.S. would move toward a higher level of consciousness. But this state of transcendence would occur after a period of struggle—after years of worsening economics, politics, and health care. A major environmental, climatic, socioeconomic disruption sometime between 2012 and 2014 would create this proactive change.

Corporate and civic leaders would unite to support the new system, ultimately transforming the culture. With investigations into the social determinants of health, chronic disease would drop 25 percent in a system relying on global payments and incentives for healthier outcomes.

Preventive care and health maintenance would help to reduce the demand and cost of health care in a culture of continuous quality improvement. The system would also effectively employ alternative medicine. Advanced PCMHs with accountability, patient engagement, and predictive and preventive medicine would become the norm. And life would not be prolonged needlessly—a concept essential for the future.

“Living longer is not necessarily better,” said Futures Committee member H. Randolph Bailey, MD, FACS. “And somehow, physicians have to come to grips with the reality that they don’t help much in the patient’s final illness. We need to convince patients and their families of that.”

ACOs would advance significantly in an integrated market. Capitation would increase to about 80 percent. Surgeons would grow into the role of “procedural biologists,” working collaboratively with other professionals. Health care teams would focus on specific organ systems and tailor procedures to each individual. In all, 3 percent of the population would choose to be uninsured. The low tier of coverage would involve Medicaid, which would provide good care through the use of medical homes and advanced technologies. The middle tier, about 75 percent of the population, would constitute the insured, including those on Medicare, who receive quality care. The top tier of affluent patients—about 10 percent of the population and those with high-end employer coverage—would receive concierge medicine, or direct care, where the patient pays an annual fee or retainer for the services of a primary care physician. The predicted percentage of health care costs to gross domestic product: 14 percent.

**Where are we headed?**

At the conclusion of the futuring exercise, committee members indicated the likelihood and the favorability of each scenario on a scale of one to 10. The Lost Decade (the second scenario) seemed the most likely to become a reality in the view of the participants, with a score of 6.17. The first scenario, Succeeding by Changing Just Enough, followed with a rating of 6. The third scenario, Health Care Systemness, seemed the third most likely to come to fruition, with an average score of 4.67, and the Integral Society and Health Care Scenario seemed
“Many other organizations have done futuring exercises, and I think it’s important for the College to cast itself in a proactive rather than reactive stance.”

—Dr. McGinnis

the least likely with a score of 2.33. But members of the committee preferred Health Care Systemness (7.08) and Integral Society and Health Care (6.25).

The least preferred outcome is the doomsday scenario, The Lost Decade (favored by just 1.25 of the committee), followed by Succeeding Just Fast Enough (4.75).

“I was disappointed that the group chose the most reactive scenario as the most likely,” said Dr. McGinnis. “But that was the majority opinion and the logical conclusion of the exercise.”

“Change will probably be incremental and messy,” said Futures Committee Chair Carlos A. Pellegrini, MD, FACS, FRCSE(Hon), “which makes it even more important that surgeons embrace the concept of the team approach for disease management. The College should position itself as a repository of information and engage in a two-way dialogue with the public, including reaching out to other professional organizations.”

“Surgeons need to define practice standards,” Dr. Pellegrini added. “This goes beyond the operation itself and involves questions about patient safety, who should practice, and who should be paid.”

Health care’s funding predicament
Committee members discussed the future, but by necessity, their focus is on what’s happening today. The health care environment today is a complex sociopolitical setting that focuses largely on the rising cost of health care. Most health policy experts agree that health care spending in the U.S. is rising at an unsustainable pace. Health expenditures in the U.S. neared $2.6 trillion in 2010, more than 10 times the $236 billion spent in 1980. The lingering impact of the “Great Recession” that began in December 2007 is high unemployment, which has contributed to the fact that nearly 50 million Americans are uninsured.

Committee member Frank Opelka, MD, FACS, sees only three options for controlling the cost of health care.

“You can change the price per unit, or you can reduce the number of people eligible for care. The third option is to totally change the way we purchase care, and the Affordable Care Act [the health care reform legislation enacted in 2010] is an attempt to do this,” Dr. Opelka said. “Cutting access and price are not socially responsible actions, and what we have driving decisions today is politics rather than policy.”
**Health care cost: A global problem**

According to ACS Futures Committee member J. David Richardson, MD, FACS, “Cost is an overwhelming global problem,” followed, he said, by access to care. “The payment models are probably broken, and we have to look for different ways of doing things. But I do not believe that we’re going to prevent our way out of spending money,” Dr. Richardson said. “As the U.S. population ages, they’re going to need health care, and I don’t care what we do, we’re not going to be able to prevent the growing demands.”

The “totally fallacious” assumption of the Affordable Care Act, Dr. Richardson continued, “is that if we manage care more efficiently and eliminate fraud and abuse, we can control the costs. Americans want a lot of health care. They come to the physician’s office armed with information from the Internet and with a list of tests they think they need. We consume a tremendous amount of health care as a nation, so if we’re going to continue doing that, we have to find a way to pay for it.”

Dr. Bailey agrees, at least in part. “Encouraging patient responsibility can help,” he said, “but all the doctors and computer calling and reminding patients to take care of themselves won’t stop the aging process and the need for health care. The (futuring) exercise pointed out clearly to me that business as usual is a pathway to disaster,” he added.

“It’s fine to think about the future,” Dr. Richardson said, “but Americans respond only to crises. Once the crisis hits, we’ll probably step up our response to health care and how we’re going to pay for it.”

“I am all in favor of planning strategically for the future, but looking ahead 10 to 15 years is too difficult,” said ACS Past-President and Futures Committee member L.D. Britt, MD, MPH, FACS, FCCM, FRCSEng(Hon), FRCSEd(Hon), FRCSI(Hon), FWACS(Hon). “There are still so many unknowns.”

Although the committee did not produce a watershed “Copernican Revolution,” as ACS Regent and Futures Committee member James Elsey, MD, FACS, pointed out, it nevertheless fulfilled an important function. “We need to go through exercises like this,” he said. “The years of transition are just beginning.”

“It’s not our job to change the economic landscape,” Dr. Elsey continued. “As surgeons, our job is to protect patients and to promote the College, which stands for excellence and quality standards of practice.”

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**No Pollyannaish solutions**

“We all generally agreed on a few things,” said committee member Mark A. Malangoni, MD, FACS. “We agreed that the current system is financially unsustainable, and as a group, we understood that rather than finding some Pollyannaish enlightenment, the U.S. will probably face a new crisis in health care, and it’s likely that different parts of each scenario will take place.

“The hope is that we can work with congressional leadership in some way to formulate effective responses,” Dr. Malangoni continued. “The problem is that Congress right now is pretty intent on putting off problems.”

Dr. Britt tends to think that health care will fall into the first scenario—changing just in time—but he remains optimistic. “Everything is up in the air right now, but if the College stays focused on patient safety and quality care, we’ll be all right,” he said. “It may take several years, but I believe the health care system will overcome the challenges.”

“It can only help to think about how we’re going to incorporate the changes,” added Futures Committee member Michael J. Zinner, MD, FACS. “I do find it a little hard to think about the future when I spend so much time dealing with what’s happening in the present.

“The doomsday scenario seems unrealistic to me, but so do the overly optimistic scenarios,” added Dr. Zinner. “In Massachusetts, we’re a good two to three years ahead of the rest of the country on health care reform,” he continued. The Massachusetts health care insurance reform law, enacted in 2006 under then Gov. Mitt Romney (R), mandates that nearly every resident obtain a state government-regulated minimum level of health care insurance coverage and provides free health insurance for residents earning less than 150 percent of the federal poverty level.²

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**Lucky to be a surgeon**

Like most surgeons, and in spite of the looming challenges, Dr. Bailey considers himself lucky: After 35 years of practice, he still looks forward to every workday. But he worries about the changing status of physicians in American society. “Unless something changes, the cost of going to medical school is making it way too difficult to become a doctor,” he said. “By the time
you begin practicing, you have spent and borrowed so much money that the whole idea loses its appeal.”

The goal of a futuring exercise is not to predict the future, but to reveal visions of what’s imaginable and desirable. Likewise, the ACS Futures Committee members left the job of predicting the future to the soothsayers and presented their informed thoughts about the present and, based on where we are now, where we are likely headed.

It is doubtful that the ACS Futures Committee will meet again as a group, but the issues that its members raised will likely remain prominent in discussions about health care’s future. In looking to the future, today’s surgeon can draw on the strengths of the U.S. health care system with the hope that the country and the profession will experience positive, proactive change.

“Everything is up in the air right now, but if the College stays focused on patient safety and quality care, we’ll be all right.”

—Dr. Britt

REFERENCES

This month, we are reprinting the very first issue of the *Bulletin*, published in January 1916.

The 2012 Clinical Congress, September 30 to October 4, in Chicago, IL, signals the beginning of the American College of Surgeons’ (ACS) Centennial celebration. To commemorate the College’s 100-year legacy of Inspiring Quality, the *Bulletin* will be publishing reprints of articles from past issues of the publication. Generally, the articles selected will center on important ACS initiatives—such as the issuance of the hospital standards and the development of the College’s trauma and cancer programs—as well as ongoing efforts to advocate on behalf of the surgical patient and the profession.

This month, we are reprinting the very first issue of the *Bulletin*, published in January 1916. When the College first began disseminating the *Bulletin*, the publication was quite true to its name—it was a notification to the membership regarding a specific ACS activity, initiative, or requirement. Many of the early issues centered on the process used to develop and implement the hospital standardization program or recounted events that took place at the Clinical Congress.

The issue reprinted here outlines Fellowship information for the organization, which was still in its infancy at that time. In addition to listing the Officers, Regents, and Governors, this issue features the Fellowship Pledge, defines the beginnings and goals of the organization, provides information about the Endowment Fund, discusses the College’s activities, outlines the requirements for Fellowship, describes convocation activities, comprises the Bylaws, and includes the first case log history sheets that applicants were required to submit.

Initially, the *Bulletin* was published periodically, whenever College leadership thought it was appropriate to do so. By the mid-1920s it became a quarterly magazine and a bimonthly starting in 1952. Monthly publication of the *Bulletin* began in 1970.

This reprint series will be published in every issue of the *Bulletin* up to, and including, the September 2013 issue. The *Bulletin* staff anticipates that Fellows will enjoy seeing how the publication and the College as a whole have evolved over the last century. We look forward to hearing from Fellows who would like to suggest articles to be reprinted, and who recall how specific articles had an impact on their profession. ♦
American College of Surgeons

Bulletin No. 1

Requirements for Admission to Fellowship

1916
FELLOWSHIP PLEDGE

RECOGNIZING that the American College of Surgeons seeks to develop, exemplify and enforce the highest traditions of our calling, I hereby pledge myself, as a condition of Fellowship in the College, to live in strict accordance with all its principles, declarations and regulations. In particular I pledge myself to pursue the practice of surgery with thorough self-restraint and to place the welfare of my patients above all else; to advance constantly in knowledge by the study of surgical literature, the instruction of eminent teachers, interchange of opinion among associates, and attendance on the important societies and clinics; to regard scrupulously the interests of my professional brothers and seek their counsel when in doubt of my own judgment; to render willing help to my colleagues and to give freely my services to the needy. Moreover, I pledge myself, so far as I am able, to avoid the sins of selfishness; to shun unwarranted publicity, dishonest money-seeking and commercialism as disgraceful to our profession; to refuse utterly all secret money trades with consultants and practitioners; to teach the patient his financial duty to the physician and to urge the practitioner to obtain his reward from the patient openly; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation. Finally, I pledge myself to co-operate in advancing and extending, by every lawful means within my power, the influence of the American College of Surgeons.
AMERICAN COLLEGE OF SURGEONS

REQUIREMENTS FOR ADMISSION TO FELLOWSHIP

30 NORTH MICHIGAN AVENUE
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Ernest F. Tucker ........................................................... Portland .............................................................. T. Casly Witherspoon ................................................... Butte
Herman Tucholske ..................................................... St. Louis .............................................................. John Murphy Withrow ................................................ Cincinatti
Paul Y. Tupper ........................................................... St. Louis .............................................................. Frank C. Witter .......................................................... Petoskey
Raymond C. Turck ..................................................... Jacksonville ....................................................... Casey A. Wood ........................................................... Chicago
W. G. Turner ............................................................. Montreal .............................................................. James Chaveen Wood ................................................. Cleveland
Edgar A. Vander Veer ................................................... Albany ............................................................... George Woolsey .......................................................... New York
J. J. A. Van Kaaloven ................................................... Los Angeles .......................................................... Arthur Wright ............................................................. Toronto
W. B. Van Lennep ........................................................ Philadelphia ......................................................... John Lawrence Yates ................................................... Milwaukee
C. Van Zwauwenzburg ................................................ Riverside ......................................................... James R. Yocom .......................................................... Tacoma
George Tully Vaughan ................................................ Washington ....................................................... Hugh Hampton Young .................................................. Baltimore
E. M. von Eurets ......................................................... Montreal .............................................................. E. Gustav Zinke .......................................................... Cincinnati

TERM EXPIRING 1917

Robert Abbe .............................................................. New York ............................................................... Carl Beck ................................................................. Chicago
Amos W. Abbott ........................................................ Minneapolis ......................................................... E. H. Beckman ............................................................ Rochester
E. Wyatts Andrews ..................................................... Chicago .............................................................. Frederic A. Bisely ........................................................ Chicago
Edward W. Archibald ................................................... Montreal ............................................................ Arthur Dean Bevan ..................................................... Chicago
Charles S. Bacon ....................................................... Chicago .............................................................. J. F. Bennie ............................................................... Kansas City
Samuel C. Baldwin ..................................................... Salt Lake City ....................................................... Douglas Bisell ............................................................ New York
J. M. Bailey ............................................................... Philadelphia ......................................................... John Bapt Blake .......................................................... Boston
Willard Bartlett ........................................................ St. Louis ............................................................... R. J. Blanchard .......................................................... Winnipeg
### BOARD OF GOVERNORS—Continued

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<td>Archibald MacLaren</td>
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<td>Myles Standish</td>
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REQUIREMENTS FOR ADMISSION TO FELLOWSHIP
IN THE AMERICAN COLLEGE OF SURGEONS

THE BEGINNING AND PURPOSES
OF THE COLLEGE

CLOSELY related to the advance made
by the medical profession during the
last decade is a movement initiated
by the surgeons of this continent which
finds its expression in the American College
of Surgeons. This College is not a teaching
institution. It is a society, or a college in
the original sense, whose "reason for exis-
tence lies in its disinterested and unselfish
efforts to elevate the standards of the pro-
fession, moral as well as intellectual, to
foster research, and to educate the public
up to the idea that there is a difference
between the honest, conscientious, well-
trained surgeon and the purely commercial
operator."* It aims to include within its
Fellowship those surgeons who are com-
petent in the science and technique of
surgery, and who have in them that moral
timber which characterizes a fine conception
of public service.

The College developed directly out of a
consciousness within the Clinical Congress
of Surgeons, first, that such an organization
would serve to inspire genuine advance, not
only on the human or moral side of the
practice of surgery, but also on the side of
the art and technique; and, second, that it
would serve as a safe-guard to the public in
the matter of honest and competent practice
of surgery. In the minds of these men the
motive was to foster high professional ideals
in medicine and to instruct the public as to
what these ideals mean. This motive in
November, 1912, found its first constructive
expression. The Congress, at that time,
appointed a committee of twelve surgeons
to consider the advisability of organizing
the College and it further empowered this
committee to proceed with the organization
if, after a thorough survey, such a step
were deemed wise.

Without delay, this committee of twelve
took up its task with great earnestness.
It sought the advice and guidance of
the surgeons of this continent who stood
out pre-eminently as leaders in each of the
divisions of surgery. Especially did it seek
counsel of the professors of surgery among
the stronger medical schools. In March,
1913, so abundantly was the committee
assured of the approval and support of these
men that it issued a call for a meeting of the
organization to be held in Washington on
May 5, 1913. About five hundred surgeons
were invited to this meeting and at the
appointed time most of those invited were
present.

At this meeting in Washington the College
was legally organized. By-laws, rules and
regulations were adopted after due con-
sideration, and the Board of Governors, the
Board of Regents, and the officers of the
College were elected. But, more than this,
by bonds which reached the deepest emo-
tions of these surgeons, they pledged their
active support. The College became to
them a "vision" for the full payment of the
surgeon's debt to his profession.

The details of organization, however,
which still remained to be perfected, were
quite beyond the conception of all except
the few who had become intimately asso-
ciated with the growth of the plan. These
details cannot here be related. In the
months which followed, the General Secre-
tary of the College received about five
thousand applications for Fellowship.

In order that action might be taken upon
these applications with the least unneces-
sary delay, the Regents promptly authorized
the appointment of Committees on Credentials.
These committees consist of the Central
Committee which reports directly to the
Regents, and of State and Provincial Com-
mittees which report to the Central Com-
mittee.

The Central Committee, consisting of
five Fellows of the College, holds its meetings

* President's address by Dr. J. M. T. Finney,
November 18, 1913.
Inaugural Issue of the Bulletin, 1916

AMERICAN COLLEGE OF SURGEONS

about once each week at the offices of the College. It reviews the data and correspondence on file in connection with each candidate.

The State and Provincial Committees, each consisting of from five to seven Fellows, are appointed in nearly every state in the Union and in four divisions of Canada. These committees also review the data concerning each candidate and report their recommendations to the Central Committee.

In appointing each of these committees, the Regents have asked that no recommendations for Fellowship be made if there were lack of information or doubt as to a candidate’s qualifications. These necessary precautions have caused delay in final action upon many cases which the Regents and officers of the College regret.

Details as to the number of Fellows admitted under this routine at each of the four Convocations are here given later. Also the data asked for on the formal application for Fellowship are given, together with a tentative plan of admission of candidates whose applications were filed after November 1, 1914.

THE ENDOWMENT FUND

On December 1, 1915, the College completed successfully an effort to secure, in cash and in promissory notes, an endowment fund of $500,000. A brief account of this effort and of the purposes of the fund may here be of interest.

In order to provide means for the organization of the College, an initial Fellowship Fee of fifty dollars from each Fellow was voted at the first meeting of the College. This sum was payable, twenty-five dollars on admission, and five dollars annually thereafter for five years. Realizing that the income to be derived in this way was but temporary, and desiring to place the College on a safe, independent, and financially adequate basis, the Fellows in June, 1914, voted to raise an endowment for the College of one million dollars. This plan provided that the endowment should be invested in perpetuity, the income only to be used for the constructive work of the College. It provided, further, that each Fellow be asked for a subscription of five hundred dollars. It was understood that all subscriptions should be contingent on the raising of five hundred thousand dollars by December 1, 1914, the first payment on the subscription to be made January 1, 1915.

Subscriptions to the amount of $113,000 were pledged at the first meeting, and it was the intention to push the plan among those Fellows who were absent from that meeting after the summer vacations. Because of the war, however, the Regents decided to ask those who had made subscriptions to give their consent to extend the time for obtaining the subscription one year, or until December 1, 1915, and the beginning for the payment of the subscription to January 1, 1916. This extension has been agreed to.

The subscription plan is a promise to pay in the form of a note-pledge, with a discretionary provision to pay in installments, the entire amount at one time, or to have the entire amount stand in the form of a promissory note, interest to be paid on all balances at the rate of five per cent per annum, the exact form of card being—

In case of death all unpaid balances are cancelled.

ENDOWMENT FUND

I hereby subscribe Five Hundred ($500.00) Dollars to the Endowment Fund of the American College of Surgeons, the amount to be paid as follows:

Jan., 1916 $................. Jan., 1919 $.................
Jan., 1917 $................. Jan., 1920 $.................
Jan., 1918 $.................

I further agree to pay interest on the balances due on this pledge at the rate of 5 per cent per annum, beginning January 1, 1916. It is further agreed that this subscription shall be void unless the subscription to the Endowment Fund equals $500,000 by December 1, 1915.

Signed..................................................

In all the history of medicine probably no other incident tells of such definite loyalty and sincerity on the part of the profession for its advancement toward an unselfish ideal of service. By these subscriptions the Fellows have made genuine sacrifice. And the significant fact in this connection is that the entire impetus of the College springs
REQUIREMENTS FOR ADMISSION TO FELLOWSHIP

from within its own membership. Necessarily that impetus implies reform. But there is a vast difference between reform preached at men and reform innate in the hearts of men which finds expression at their own initiative. Whatever impetus the College possesses, it originates among the surgeons themselves. It is not an extraneous force or an "uplift" movement. But, rather, out of the widely divergent views on many subjects among the Fellows, the aims of the College rise as those time-tried aspirations which are inherently the basis of all that is valuable in the vocation of surgery. The purposes of the College are concerned directly with matters of character and of training, with the betterment of hospitals and of the teaching facilities of medical schools, with laws which relate to medical practice and privilege, and with an unselfish protection of the public from incompetent service; in a word, they embody those ideals which have stood the test of centuries. Upon these the Fellows are united. These are the ideals which each Fellow, single-handed, has endeavored to foster, and the expression of them to-day through the College comes as a sort of mass-consciousness of the whole body of Fellows. The splendid fact is that the Fellows have grasped in an instant the meaning of the College by a process of fusion, and they have gladly made sacrifices for its success.

PROGRAM OF ACTIVITY

In all progress toward the fulfillment of the aims of the College, the Regents appreciate that public approval is an essential force; and to acquire public approval they realize that straight thinking, time, patience, and endless effort are the telling factors. They realize also that success lies only in the keeping of the fundamental principles for which the College was established clearly in the foreground. In this connection, the following lines of activity are now under consideration,—

1. Since the whole problem of the training of specialists for the practice of surgery is the primary purpose of the College, the Regents propose, at an early date, to present a clear conception of the College to the undergraduate medical students of this continent. The Regents, further, will ask each senior student of this group, who has in mind to specialize in general surgery or any branch of surgery, to register with the College. As these students, then, serve later as interns and as surgical assistants, they will be requested to report these facts to the College. The College, in turn, will systematically seek information as to the ability and character of such men; and the information thus obtained becomes the basis of admission to Fellowship in the College. In addition to this procedure, the Regents will insist upon the proper keeping of case histories, and they will endeavor to stimulate in these men in training right ideals of medical practice. In this program they ask the active coöperation of the faculties of the medical schools and of all practitioners of medicine.

2. Inasmuch as proper training in surgery is inseparably involved with the conduct and efficiency of hospitals, the College will seek accurate data on all matters which relate to hospitals. From time to time it will publish studies upon hospital problems, dealing especially with problems which have to do directly with the training of the surgeon, such as,—

(a) The responsibility of the hospital in the training of the interne and of the specialist.
(b) List of hospitals wherein special training is offered, and the facilities for such training.
(c) Among the various types of hospitals, what is adequate equipment for medical diagnosis?
(d) The keeping of records and the forms for these records.

3. The College will ask the faculties of medical schools to consider the advisability of conferring a supplementary degree of proficiency in general surgery and in the various specialties of surgery.

4. The College will issue readable monographs, educational in nature, to the press, to the general public, to hospital trustees,
and to the profession of medicine upon subjects of medical procedure and the whole meaning of fitness to practice surgery.

As one comes into wide acquaintance with the Fellows of the College and catches some fair notion of their earnestness, he sees the future of the organization not by means of logic. There is something more subtle and potent than argument. A determined optimism carries a momentum of its own. Without a logical process it seeks concrete expression; and, more than this, it really recreates circumstances through all shifts of weather or play of incident with a certainty not excelled by an utterly rational course. The Fellows of the College, in their widely scattered districts, fuse their consciousness of the organization with a splendid hope in their hearts to advance all that is important and valuable in the profession. This very attitude of mind is the first promise for the future of the College. It is a promise that admits of no defeat. It is a pledge of loyalty to medical patriotism, which means loyalty to the public welfare exercised through intellectual sincerity and scientific accuracy. It means a safeguard to the public, for it indicates where honest and adequate surgery may be found.

REQUIREMENTS FOR ADMISSION TO FELLOWSHIP

In submitting the following regulations for admission to Fellowship by examination, the Board of Regents is conscious of its trust to the profession of medicine, first, that the regulations shall be administered without favor or prejudice; second, that the regulations shall be effective in their scrutiny. Further, the members of the Board feel that the regulations as outlined below mark a passing stage in the development of the College. It is probable in the near future that, in addition to these requirements, the candidates for Fellowship will be asked to appear personally before an examining board for further verification of fitness.

1. The candidate shall be a graduate of medicine, licensed to practice medicine in his respective state or province, or accepted as a medical officer in the service of his respective country.

2. To be eligible for Fellowship without technical examination the candidate shall be a graduate of a medical school approved by the American College of Surgeons. If the candidate’s school of graduation is not accredited by the American College of Surgeons, he may be required to pass a technical examination in one or all subjects of the medical curriculum.

3. The candidate shall give evidence that he has served at least one year as an interne in a creditable hospital and two years as a surgical assistant, or he shall give evidence of an apprenticeship of equivalent value. Five to eight years after graduation in medicine, devoted to special training and to practice, are normally the time-requirement for eligibility to Fellowship. Due importance is attached to laboratory and research work.

4. The moral and ethical fitness of the candidate shall be determined by the reports of surgeons whose names are submitted by the candidate himself, and by such other reports and data as the Credentials Committee and the administration of the College may obtain.

5. The professional activity of the candidate shall be limited to the study, diagnosis and operative work in general surgery or in special fields of surgery, such as eye, ear, nose and throat, genito-urinary, orthopedics, and gynecology and obstetrics, as follows: First, if the candidate resides in a city of less than fifty thousand inhabitants, at least fifty per cent of his professional activity shall be limited to the practice of general surgery, or to practice within the special fields of surgery as stated. Second, in cities of over fifty thousand inhabitants, at least eighty per cent of the professional activity of the candidate shall be limited to the practice of general surgery, or to practice within the special fields of surgery. In other words, the College desires to admit to its Fellowship only those who are primarily specialists in surgery, and the minimum proportion of specialization which is accept-
12. The initial Fellowship fee is $100, payable upon notification of election to Fellowship. The initial Fellowship fee of candidates whose applications were filed at the executive offices of the College before November 1, 1914, is $50.

Annual dues of the College are stated in the following provisions:
1. That all Fellows who have subscribed $500 to the Endowment Fund of the College be exempt from annual dues.
2. That the total amount required of any Fellow in annual dues or other fees shall not exceed $500.

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**Requirements for Admission to Fellowship**

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<td>6. The candidate shall make formal application for Fellowship, giving specific information on the following subjects,—</td>
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<td>Assistantship as a surgeon.</td>
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<td>Teaching positions (past and present).</td>
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<td>Post-graduate work.</td>
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<td>Research and experimental work.</td>
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<td>Department of special practice and years devoted to same.</td>
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<td>Specialization.</td>
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<td>Medical societies of which applicant is a member.</td>
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<td>Writings, publications and research.</td>
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Blank forms for the purpose of making application may be had, upon request, from the Director of the College.

7. In making application for Fellowship the candidate shall sign a declaration which reads as follows,—

“I hereby promise upon my honor as a gentleman that I will not, so long as I am a Fellow of the American College of Surgeons, practice division of fees in any form; neither by collecting fees for others referring patients to me; nor by permitting them to collect my fees for me; nor will I make joint fees with physicians or surgeons referring patients to me for operation or consultation; neither will I in any way, directly or indirectly, compensate any one referring patients to me; nor will I utilize any man as an assistant as a subterfuge for this purpose.”

8. The Regents of the College reserve the right to alter, from time to time, regulations respecting the admission of Fellows to the College as they may think proper.

9. As evidence of his qualifications in the art and technique of surgery, the candidate is requested to submit the histories or records of fifty consecutive major operations performed by himself after the date of application for Fellowship.

The College has prepared a series of history-forms which indicate, in a general manner, first, the data desired in so far as they are applicable to each case, and, second, the form within reasonable limits in which these data should be submitted. These forms are given in this pamphlet, beginning on page 18. The College does not supply them for actual record-keeping. They are here given in the hope that they will serve as helpful suggestions for the better keeping of records, and that they will make more evident the nature of the records desired from candidates for Fellowship. Each surgeon should, for obvious reasons, possess various history-forms which are not only adequate but also adapted to his work. On such forms he should have accurately recorded the essential data in connection with each case, such as the family history of the patient; the operative record with the pre-operative diagnosis complete; post-operative history and end results; significant details of all analyses made in connection with the original diagnosis or with later complications; and details of the physical examination. These are, in general, the data requested in each of the fifty major operations.

The principles of record-keeping are the same for all work in surgery. The variations in the forms, as they may be adapted to the specialties of surgery, are variations chiefly of detail.

The original hospital records, it is assumed, may, upon request, be reviewed for verification with the records submitted. The name of the patient, however, need not be given in any record. The hospital number of each case should be given.

10. In addition to the complete histories of fifty consecutive major operations, as stated in the preceding paragraphs, the candidate is asked to submit in brief abstract a report of at least fifty other major operations in which he has acted as an assistant, or which he has performed himself.

11. Surgeons widely recognized by the profession as leaders of progress and exponents of finished technique, by a unanimous vote of the Board of Regents, may be admitted to Fellowship on recommendation of the Committee on Examination.

12. The fee of admission to Fellowship is two hundred dollars, payable as follows:
3. That the Board of Regents cancel the indebtedness of any Fellow of the College, without publicity, to whom, in its judgment, such dues are a hardship.

4. That no Fellow of the College be asked to contribute any fee whatever to the College, either after 65 years of age, or after he has retired from the active practice of surgery.

5. That the annual dues of the Fellows of the College be $25, payable January 1.

One hundred dollars within thirty days after notification of election, and twenty-five dollars on the first day of January annually thereafter for four years. The entire fee may be paid upon election if the candidate so desires.

The fee of admission to Fellowship to candidates whose applications were received before November 1, 1914, is fifty dollars.

APPLICATION FOR FELLOWSHIP
The application blanks are uniform and each candidate for Fellowship is requested to file an application blank filled out in detail and signed. The blank contains the following questions,—

Name. Address. Place and date of birth.
What school, academy, college or university did you attend? Date of graduation? Degrees?
What medical college or colleges did you attend? Date of graduation? Degrees?
In what hospitals have you been an intern, resident or assistant? From— to—?
In what hospitals have you been a staff member and in what capacity?
In what teaching capacity have you been active?
What other appointments have you held?
What post-graduate studies have you pursued in America and where?
What post-graduate studies have you pursued abroad and where?
What official positions have you held?
How many years in special practice and where?
What department of special practice?
What percentage of your work is surgical?
What research or experimental work have you done?
Of what medical societies are you a member?
Give the names of five prominent surgeons as references, at least three of whom are from your own state.
Give the names of books and contributions to medical and surgical literature of which you are the author, with date and place of publication.

CONVICTIONS
The first Convocation was held in Chicago on November 13, 1913. The Fellowship address was delivered by Sir Rickman J. Godlee, Bart., President of the Royal College of Surgeons of England. Fellowships were conferred upon 1069 candidates and Honorary Fellowships upon the following:


At this time Sir Rickman presented to the College greetings from the Royal College of Surgeons of England, as follows,—

“We, the Council of the Royal College of Surgeons of England, have heard with much interest of the approaching inauguration of the American College of Surgeons. We hereby convey to it our hearty good wishes, and express the hope that it may have a successful career and fill a position beneficial alike to the Profession and to the Community.

“We cannot forget the important advances in the Science and Art of Surgery achieved by many distinguished Surgeons in the Continent of America during the past, and are proud to have enrolled upon our list of Honorary Fellows the names of some of the most active workers in these fields at the present day.

“In accepting the invitation for our President to take a part in the opening Ceremony we desire to show how we appreciate the intention of the American College to strengthen the bonds that already unite the Medical Profession amongst English-speaking peoples. It is a sentiment which always meets with a cordial response in this country, and it is one which this College will endeavour to support by all the means in its power.

“In witness whereof we have caused the Common Seal of the College to be hereunto affixed this 9th day of October, 1913.

President RICKMAN J. GODLEE
Vice-Presidents G. H. MAYNARD, FREDERIC EVENSEN”

At the second Convocation, held in Philadelphia on June 22, 1914, Fellowships were conferred upon 1065 candidates. The Fellowship address was delivered by Dr. James G. Mumford. Honorary Fellowships were conferred upon the following: Edmond Souchon of New Orleans, Francis J. Shephard of Montreal, and Thomas Addis Emmet of New York.
THE BY-LAWS

The third Convocation was held in Washington, D.C., on the evening of November 16, 1914. Fellowships were conferred upon 646 candidates. The Fellowship address was delivered by Dr. Edward H. Bradford, dean of Harvard University Medical School. Honorary Fellowships were conferred upon Dudley P. Allen of Cleveland, William C. Gorgas of Washington, Lewis Stephen Pilcher of Brooklyn, Sir Thomas George Roddick of Montreal, and J. William White of Philadelphia.

The fourth Convocation was held in Boston on October 29, 1915. Fellowships were conferred upon 484 candidates. The Fellowship address was delivered by President E. J. James of the University of Illinois. Honorary Fellowships were conferred upon David William Cheever of Boston, Wilfred Thomason Grenfell of Labrador, Stephen Smith of New York, and Louis McLane Tiffany of Baltimore.

ACADEMIC ROBE

After due consideration the Board of Regents adopted a distinct Fellowship gown which, in their judgment, will add dignity, uniformity, and distinction to the Convocations of the College. The gown adopted consists of a body of navy blue mohair. A scarlet velvet facing five inches wide extends around the neck and down each side of the front. The cap is of the same material with a scarlet tassel.

THE BY-LAWS

I. Name. The name of the corporation shall be the American College of Surgeons.

II. Object. The object of the College shall be to elevate the standard of surgery, to establish a standard of competency and of character for practitioners of surgery, to provide a method of granting Fellowships in the organization, and to educate the public and the profession to understand that the practice of surgery calls for special training and that the surgeon elected to Fellowship in this College has had such training and is properly qualified to practice surgery.

III. THE COLLEGE. 1. The College shall consist of all members of the corporation. Such members are to be designated as Fellows. The College shall vest the general management of the corporation in a Board of Governors. The Board of Governors shall, in turn, vest the details of the management in a board of trustees to be known as the Board of Regents.

2. The College shall hold an annual meeting on the day and at the place selected for the annual meeting of the Board of Governors.

IV. BOARD OF GOVERNORS. 1. The original Board of Governors shall consist of the surgeons invited by the Organization Committee to serve as Founders of the College, who have qualified as Fellows. The members of this first Board of Governors shall also be known as the Founders of the American College of Surgeons.

2. The original Board of Governors shall be divided by lot into three classes to serve one, two, and three years, respectively. At the annual meeting in 1914, and at the annual meeting in each year thereafter, the Fellows of the College shall elect (in a manner to be determined by the Board of Regents) fifty surgeons from among the Fellows of the College to membership on the Board of Governors, each to serve for a term of three years; thirty of these members are to be elected from a list of nominations, consisting of three members each nominated by the following sixteen surgical associations and societies of North America, and one each from the United States Army and from the United States Navy,—

2. Surgical Section of the American Medical Association.
5. Division of Surgical Specialties of the Clinical Congress of Surgeons of North America.
7. Southern Surgical and Gynecological Association.
8. Western Surgical Association.
10. American Association of Obstetricians and Gynecologists.

Twenty members shall be elected at large to represent surgeons of North America not affiliated with the above societies or associations. In case of failure of any of
the above named organizations to make its quota of nominations, or in case of duplication of nominees, the Board of Regents shall nominate members from among the Fellows at large for the vacancies so caused in the list of nominees. The Board of Regents shall in the same manner fill all vacancies in the current membership of the Board of Governors due to death, resignation, or other causes.

3. The Board of Governors shall at its first meeting elect from among its own membership twelve who shall be members of the Board of Regents; this group shall be divided into three classes of four members each, whose terms of office shall expire in one, two, and three years, respectively. As the term of service in each class expires, their successors shall be elected, each for a term of three years, by the Board of Governors in a manner to be determined by the Board of Regents. Not more than three of each class shall be selected from one country. In event of death or resignation of any member of the Board of Regents, his successor shall be elected at the next regular or special meeting of the Board of Governors, but the Board of Regents may appoint a member of the Board of Governors to serve as Regent until this election takes place.

4. The Board of Governors shall meet in executive session annually for the transaction of business, which business shall include the election of members of the Board of Regents and the election of officers as provided in Article IV, Section 3, and other routine business which may be brought before it by the Corporation or the Board of Regents. Such meetings shall be called by the General Secretary at the direction of the Board of Regents. Special meetings of the Board of Governors may be called by the General Secretary at any other time at the request of the Board of Regents. Members of the Board of Governors shall be expected to attend other formal meetings and Convocations called by the Board of Regents for the purpose of conferring Fellowships and the transaction of other business.

5. Fifty members of the Board of Governors shall constitute a quorum for the transaction of business.

V. Officers. The officers of the College shall be a President of the College, a First Vice-President, a Second Vice-President, a Director, a General Secretary, and a Treasurer. With the exception of the Director, these officers shall be appointed by the Regents from among their own number, each to serve for a term of one year, or until his successor is elected.

(a) The President of the College shall preside at all regular and special meetings of the College and of the Board of Governors, and at all Convocations for the conferring of Fellowships.

(b) The First Vice-President shall preside at all meetings of the College in the absence of the President, and in the event of the death or resignation of the President, shall assume the duties of that officer.

(c) The Second Vice-President shall preside at all meetings of the College in the absence of the President and of the First Vice-President, and in the event of the death or resignation of these two officers, shall assume the duties of the President.

(d) The Director shall be the chief executive officer of the College. He shall be elected by the Board of Regents and hold office during the pleasure of the Board. Under control of the Board of Regents and of the Executive Committee, he shall have general charge of all matters of administration of the Corporation. He shall prepare and submit to the Board of Regents and to the Executive Committee plans and suggestions for the work of the College. He shall have power to appoint and remove subordinate employees of the College. He shall submit to the Board of Regents, at least thirty days in advance of the annual meeting, a written report of the operations and of the business of the College for the preceding fiscal year, together with his recommendations for the work and for the appropriations of the succeeding fiscal year. He shall attend all meetings of the Executive Committee and of the Board of Regents.

He shall be the legal custodian of all property of the College whose custody is not otherwise provided for. He shall audit all expenditure and disbursement of funds of the College in accordance with the direction of the Board, or of the Executive Committee.

(e) The General Secretary shall keep all records of the Corporation, of the Board of Governors, and of the Board of Regents. He shall mail to the proper addresses all notices of regular and of special meetings of the College, of the Board of Governors, and of the Board of Regents, and shall have a general supervision of the business affairs of the Corporation under the direction of the Board of Regents.

(f) The Treasurer shall receive all funds of the College and disburse the same on checks, signed by him and countersigned by the Director or by the General Secretary. He shall make a report in writing to the Board of Regents at each meeting of that Board of the moneys received and expended, and shall furnish a detailed statement of the financial condition of the College at each annual meeting of the Board of Regents. The Treasurer shall furnish a bond to the Board of Regents for the faithful performance of his trust.

VI. Board of Regents. 1. The Board of Regents shall consist of fifteen members as follows: The President of the Corporation, the General Secretary, the Treasurer, and twelve others elected from among the Fellows by the Board of Governors in a manner to be determined by the Board of Regents.

2. The Officers of the Board of Regents shall be a Chairman and a Secretary.

(a) The Chairman of the Board of Regents shall be elected from among the members of the Board of Regents for a term of one year and shall preside at all meetings of the Board. In the event of his death or resignation, the office shall be filled by election at the next meeting of the Board.

(b) The General Secretary of the Corporation shall be the Secretary of the Board of Regents.

3. The duties of the Board of Regents shall be those ordinarily performed by a governing board, namely: To transact all formal business upon which the Board of Governors is carrying out the object of the organization; to regulate and to conserve the property...
THE BY-LAWS

interests of the College; to adopt rules and regulations for the admission of Fellows; to fix initial fees and annual dues of Fellowship; to create, appoint, and direct all standing committees; to elect Fellows to the College; to call all meetings of the Corporation not already provided for; to arrange Convocations or other meetings for the conferment of Fellowships; to transact all business not otherwise provided for that may pertain to the organization.

4. Eight members of the Board of Regents shall constitute a quorum for the transaction of business.

5. Regular meetings of the Board of Regents shall occur once in twelve months at the call of the General Secretary. Special meetings may be convened at any time by the General Secretary, or on a request to him made in writing and signed by thirty members of the Board of Governors, or by eight members of the Board of Regents.

VII. EXECUTIVE COMMITTEE. 1. There shall be an Executive Committee, consisting, first, of the President of the College, of the General Secretary, and of the Treasurer; and, second, of five other Regents elected by the Board of Regents by ballot for a term of three years, who shall be eligible for re-election, provided, however, that, of the members of the Committee first elected by the Board of Regents, after the adoption of these by-laws, two shall serve for one year, two for two years, and one for three years, and such members of the Committee shall determine their respective term by lot. Should the term of service, however, of any member of the Executive Committee terminate as a member of the Board of Regents, his term of service upon the Executive Committee also thereby terminates.

2. At least thirty days prior to the annual meeting of the Board of Regents, a Nominating Committee, consisting of the Chairman of the Board and of two Regents appointed by him, shall send notices by mail to all members of the Board of the vacancies in the Executive Committee to be filled at the ensuing annual meeting, and shall invite suggestions of names of Regents to be nominated as members of the Executive Committee. The nomination of this Committee shall be voted upon by the Board of Regents.

3. During the intervals between the meetings of the Board, the Executive Committee shall exercise all the powers of the Board of Regents in the management and direction of the business and the conduct of the affairs of the Corporation, except that it shall not have power to elect Fellows, or to regulate initial fees or annual dues of Fellowship. It shall have supervision of the property of the Corporation, and shall determine the investment of its funds.

(b) The Executive Committee may, in its discretion, appoint such sub-committees as it may deem necessary or desirable for the proper transaction of the business of the Corporation.

(c) Whenever any vacancy shall occur in the Executive Committee, or in any office of the Corporation, by death, resignation or otherwise, it shall be filled by appointment by the Executive Committee for the remainder of the current corporate year.

(d) The Executive Committee may adopt rules and regulations for the conduct of its meetings and the management of the affairs of the Corporation, not inconsistent with the laws of the state of the incorporation of the College, and with the by-laws of the College.

(e) The Executive Committee may hold its meetings at such place or places as it may from time to time determine. A majority of the Executive Committee shall constitute a quorum for the transaction of business.

VIII. FELLOWS. 1. The Fellows of the College shall be graduates in medicine who are licensed to practice medicine in their respective states and provinces, or medical officers of the federal services who have made an application for Fellowship (such application being endorsed by three Fellows of the College, one of whom shall be a member of the Board of Governors), who meet the qualification requirements that shall from time to time be established by the Board of Regents, and who shall be elected to Fellowship by the Board of Regents on recommendation of the Committee on Credentials, and who shall have signed the roll.

2. Each individual elected to Fellowship in the College shall be designated as a Fellow of the American College of Surgeons and shall be authorized and encouraged to use the letters F. A. C. S. after his name on professional cards, in professional directories, and in articles published in surgical literature.

IX. PUBLICATIONS. The Board of Regents shall issue each year a directory containing the names and addresses of the Fellows of the American College of Surgeons, arranged by states, provinces and colonies.

X. Any Fellow of the College may be expelled for conduct which, in the opinion of the Board of Regents, is derogatory to the dignity of the College or inconsistent with its purposes. Such expulsion must be voted by a majority vote of the whole Board of Regents at any meeting, at which meeting the Fellow against whom charges are made shall be invited to be present, and may appear or may be represented, in a manner to be determined by the Board of Regents.

XI. These by-laws may be amended by a majority vote of those present at any regular or special meeting of the Board of Governors, or at a meeting called for the purpose on request made in writing by a hundred members of the Corporation, provided that such proposed amendments are included in the call of the meeting at which such action is contemplated.
AMERICAN COLLEGE OF SURGEONS

HISTORY SHEETS

The following history sheets are here given primarily as a guide to candidates for Fellowship in the American College of Surgeons as to the data and the arrangement thereof which are asked in partial fulfillment of the requirements for admission. But in addition to these purposes, the Regents of the College hope that these forms may prove of interest and of value to others concerned in the keeping of such records.

During many months these sheets have from time to time been submitted for criticism to surgeons, pathologists, and hospital superintendents; and for kind help received from these men the Regents wish here to acknowledge their indebtedness. Further criticism of these forms is respectfully invited. By holding them always subject to suggestions for improvement, it is hoped that through various revisions they may increase in usefulness.

These sheets may be reprinted by anyone who so desires. They are not offered for sale by the College; nor does the College in any way assume responsibility for their sale.

Soley as a matter of convenience the announcement is here made that these forms may be purchased from the Fairthorn Company, 500 Sherman Street, Chicago. This company printed the forms for the College and will ship quantities of them as desired to any address, by express prepaid, upon receipt of cost as follows,

Single blanks: per thousand (excepting Form 4) $4.50. Form 4 (2 sheets) $9.00. Per hundred, 80 cents. Form 4, $1.60.

Sets of 15 forms: per thousand sets, $64.00; per hundred sets, $10.00.

Name of hospital may be added on order of 1000 or more at an extra cost of $1.00 per 1000.

Communications concerning the purchase of these forms should be addressed to the Fairthorn Company. Suggestions for the improvement of the forms should be addressed to the Director of the College, 80 North Michigan Avenue, Chicago.
INAUGURAL ISSUE OF THE BULLETIN, 1916

HISTORY SHEET
EYE RECORD

Name
Address
Diagnosis
Family History
History of Case
Condition at time of examination
Examination:
O. D. V.
O. S. V.
Under Mydriatic:
O. D. V.
O. S. V.
Ophthalmoscopic Exam.
Perimetric Exam.
Photometric Exam., etc.
Tension
Treatment
Progress of Case

Form 5.

HISTORY SHEET (1)
NOSE, THROAT AND EAR RECORDS

Name
Address
Diagnosis
Family History
Complaint of Patient, with history of symptoms from onset of trouble
Examination: Intranasal condition:
Condition of pharynx, post nasal space and larynx
Condition of external auditory canal, membrane tympani, Eustachian tubes, mastoid
Transillumination of maxillary and frontal sinuses and of the mastoid process
X-Ray examination of nasal accessory sinuses and of the mastoid process

Form 4a.
HISTORY SHEET (2)
NOSE, THROAT AND EAR RECORDS

Functional Examination of the Hearing:
Whisper: Right ear ____________ Weber ____________ Schwabach ____________
Left ear ____________
Rinne: Right ____________ Lower tone limit: Right ____________ ot ____________ Right
Left ____________ Left ____________ Left ____________
Galphin Whistle: Right ____________
Left ____________

Record for Labyrinth Cases with Vestibular Involvement:
History of Dizziness ____________
Staggering ____________
Falling ____________
Romberg ____________
Tinnitus ____________
Deafness ____________
Spontaneous Nystagmus: Looking straight ahead ____________
“to right ____________
“to left ____________
Spontaneous Pointing, shoulder from above: Right ____________
Left ____________
Turning Tests: To Right, character and duration ____________
Pointing, shoulder from above, Right ____________
Left ____________
To Left, character and duration ____________
Pointing, shoulder from above, Right ____________
Left ____________
Caloric Tests: Douching right ear, onset of nystagmus ____________
Pointing, shoulder from above, Right ____________
Left ____________
Douching left ear, onset of nystagmus ____________
Pointing, shoulder from above, Right ____________
Left ____________
Fistula Tests: Right ____________
Left ____________

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OPERATIVE RECORD

Name ____________________________ Case No. ____________________________ Date of Operation ____________________________

Surgeon ____________________________ Assistants ____________________________
Anesthetist ____________________________ Instrument Nurse ____________________________
Anesthetic ____________________________ Sponge Nurse ____________________________

Began ____________________________ Closed ____________________________

Remarks as regards mucus, pulse, respiration, etc. ____________________________

Pre-operative diagnosis complete ____________________________

Operation ____________________________

Began ____________________________ Closed ____________________________

Findings (normal and abnormal): ____________________________

Gross ____________________________

Microscopic ____________________________

What was done ____________________________

Technique ____________________________

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Recorded by ____________________________
**HISTORY SHEET**

**POST-OPERATIVE**

Name: ___________________________ Case No. ___________________________

Post-operative record until discharged, with summary of temperature chart:

________________________________________

________________________________________

________________________________________

Follow-up record after discharge; and results:

________________________________________

________________________________________

________________________________________

Form 6.

---

**EXAMINATION OF STOMACH AND INTESTINAL CONTENTS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Case No.</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Test meal given: ___________________________ When removed: ___________________________

How removed: ___________________________

Lavage given: ___________________________

Quantity obtained: ___________________________

Color: ___________________________

General appearance: ___________________________

Odor: ___________________________

Mucus: ___________________________

Swallowed: ___________________________

From stomach: ___________________________

Found in eye of tube: ___________________________

Blood: ___________________________

Clots: ___________________________

---

**CHEMICAL**

Reaction litmus: ___________________________

Dimethylaminobenzene: ___________________________

Congo red: ___________________________

Boas' reagent: ___________________________

Giemsa's: ___________________________

Quantitative free HCl: ___________________________

Total acid: ___________________________

Lactic acid present: ___________________________

How tested: ___________________________

Bile: ___________________________

Blood: ___________________________

How tested: ___________________________

Moisture of stomach (method): ___________________________

Absorptive power: ___________________________

Fermentation: ___________________________

---

**MICROSCOPIC**

Pus cells: ___________________________

Blood: ___________________________

Mucosa: ___________________________

Yeast: ___________________________

Moulds: ___________________________

Sarcinae: ___________________________

Oppen-Boas: ___________________________

Epithelial cells (kind): ___________________________

Starch: ___________________________

Other constituents: ___________________________

Examined by: ___________________________

Form 7.
EXAMINATION OF BLOOD

Name ____________________________ Case No. __________ Date __________

Red blood corpuscles ____________________________ Nucleated red cells __________
No. per cm³ ____________________________

Poikilocytosis ____________________________ Anisocytosis ____________________________

Polychromatophilia ____________________________

Leucocytes ____________________________
No. per cm³ ____________________________ Differential count

Lymphocytes ____________________________ Average per cent. ____________________________ Normal per cent. ____________________________
Large mononuclear and trans. ____________________________ Neutrophilic myelocytes ____________________________
Polymorphonuclear neutrophiles ____________________________ Eosinophilic myelocytes ____________________________
Polymorphonuclear eosinophiles ____________________________ Basophiles ____________________________

Hemoglobin ____________________________
Color Index ____________________________
Coagulation time ____________________________
Blood cultures (medium) ____________________________

Material organisms ____________________________
(Widal) ____________________________
(Wasserman) ____________________________
Miscellaneous ____________________________

Firm 3

EXAMINATION OF URINE

Name ____________________________ Case No. __________ Date __________

Specific gravity ____________________________ Reaction ____________________________

ROUTINE COMPLETE EXAMINATION

Single ____________________________
Color ____________________________ Quantity: 24 hrs. ____________________________
Sediment ____________________________ Cloudy ____________________________ Odor ____________________________
Albumin ____________________________ Sugar ____________________________
Acetone ____________________________ Diacetic Acid ____________________________
Casts ____________________________ r. b. c. ____________________________
w. b. c. ____________________________ Other cells ____________________________
Crystals ____________________________ Amorphous ____________________________
Miscellaneous ____________________________

Firm 3

SPECIAL QUALITATIVE EXAMINATIONS

Mucin ____________________________ Bile ____________________________ Indican ____________________________ Hb ____________________________

Diaz ____________________________
Drugs ____________________________ Miscellaneous ____________________________
Other reducing substances ____________________________ Other albuminous bodies ____________________________
Bacteriologic ____________________________

SPECIAL QUANTITATIVE EXAMINATIONS

Sugar (kind ____________________________ test sol. ____________________________ ) gms. per liter per cent
Albumin (method ____________________________ ) gms. per liter per cent
Total solids ( ____________________________ coefficient) gms. per liter
Urea ( ____________________________ method) gms. in 24 hrs.

Firm 3

Examined by ____________________________
HISTORY SHEET
PHYSICAL EXAMINATION

Name: ____________________________

Case No. ____________________________

Date ____________________________

Complete physical examination, including special tests such as X-ray, auscultation, etc., not included in other charts:

PREGNANCY RECORD

Name: ____________________________

Address: ____________________________

Case No. ____________________________

Date: ____________________________

Age: ____________________________

Nationality: ____________________________

Occupation: ____________________________

S. M. W.: ____________________________

Gravida: ____________________________

Family history: ____________________________

Previous illness: ____________________________

Menstruation, age at first: ____________________________

Frequency: ____________________________

Duration: ____________________________

Amount: ____________________________

Pain: ____________________________

Marriage: ____________________________

Health of husband: ____________________________

Previous pregnancies: ____________________________

S. M. W.: ____________________________

Edema: ____________________________

Abortion, number: ____________________________

Stage of gestation: ____________________________

Cause: ____________________________

Previous labors: Spontaneous: ____________________________

Instrumental: ____________________________

Previous puerperium: ____________________________

Fever: ____________________________

Children: ____________________________

Weight at b. wt.: ____________________________

No. living: ____________________________

Health: ____________________________

Cause of death: ____________________________

Last menstruation: ____________________________

Conception: ____________________________

Ex. Gest.: ____________________________

Last. Gest.: ____________________________

Health during pregnancy: ____________________________

R. S. M. W.: ____________________________

Edema: ____________________________

Headache: ____________________________

Bowel: ____________________________

Urine: ____________________________

Uterine contraction: ____________________________

EXTERNAL EXAMINATION

Pulse: ____________________________

Temperature: ____________________________

Weight: ____________________________

Teeth: ____________________________

Lungs: ____________________________

Circulation: ____________________________

Blood pressure: ____________________________

Adrenalectomy: ____________________________

Edema: ____________________________

Varicose veins: ____________________________

Thyroid: ____________________________

Breasts: ____________________________

Nipples: ____________________________

Sex: ____________________________

Abdomen (by inspection, palpation, auscultation): ____________________________

Size and shape of uterus: ____________________________

Fetus, movements: ____________________________

Size: ____________________________

Position: ____________________________

Station: ____________________________

Heart tones: ____________________________

Location and rate: ____________________________

Perineal condition: ____________________________

Vulva: ____________________________

Perineum: ____________________________

Anus: ____________________________

Discharge: ____________________________

Measurement: Sp. gr.: ____________________________

Outlet measurements: ____________________________

Examined by: ____________________________

Date: ____________________________

SUBSEQUENT EXTERNAL EXAMINATION

Date: ____________________________

Blood Pressure: ____________________________

Weight: ____________________________

Urine, amount: ____________________________

Sp. gr.: ____________________________

Total solids: ____________________________

Albumen: ____________________________

Sugar: ____________________________

Casts: ____________________________

Examined by: ____________________________

Date: ____________________________

INTERNAL EXAMINATION

Vagina: ____________________________

Portio: ____________________________

Os. membranaceus: ____________________________

Presentation: ____________________________

Position: ____________________________

Station: ____________________________

C. d.: ____________________________

C. v.: ____________________________

Examined by: ____________________________

Date: ____________________________

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Sept 2012 BULLETIN American College of Surgeons
### Inaugural Issue of the Bulletin, 1916

**Labor Record**

<table>
<thead>
<tr>
<th>Name</th>
<th>Case No.</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal pains</td>
<td>labor began</td>
<td>preparation</td>
</tr>
</tbody>
</table>

#### External Examinations

<table>
<thead>
<tr>
<th>P. T.</th>
<th>Bl. pr.</th>
<th>Contractions</th>
<th>Intervals</th>
<th>Press.</th>
<th>Position</th>
<th>Station</th>
<th>Heart tones</th>
<th>Hour</th>
<th>Examiner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

#### Internal Examinations (Vaginal or Rectal)

<table>
<thead>
<tr>
<th>Method</th>
<th>Cervix</th>
<th>Os.</th>
<th>Membranes</th>
<th>Presentation</th>
<th>Position</th>
<th>Station</th>
<th>Gloves</th>
<th>Hour</th>
<th>Examiner</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

#### Operation

<table>
<thead>
<tr>
<th>Kind</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Placenta, method of delivery

Post partum condition (30 minutes after labor), patient able to walk, etc.

First 24 hours

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

#### Puerperal Record

<table>
<thead>
<tr>
<th>Name</th>
<th>Case No.</th>
<th>Date of confinement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Puerperium

![Graph or table]

#### Summary

<table>
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<tr>
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<table>
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<table>
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#### Condition on Discharge

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<table>
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Examined by: Date:
## NEWBORN RECORD

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**When born**
Condition, respiratory anomalies injuries

**Length**
weight  head measurements

**Treatment of eyes**
treatment of cord  cord off

**Temperature, (rectal) 30 minutes after birth**
Temperature one hour after birth

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**Eyes**
breasts

**Genitalia**

**Nursing, first**

**Artificial feeding, indication**

**Colic, frequency**

**Date of discharge**
weight

**Eyes**
breasts

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## POST-MORTEM SHEET

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Form 14.
The near-death of a president, and the birth of a career:
An interview with Dr. Napolitano

by Tony Peregrin

She was a second-year medical student on rotation in the emergency department (ED) at George Washington (GW) University Medical Center in Washington, DC, the day the trauma team ended up saving the life of the leader of the free world. The assassination attempt on President Ronald Reagan happened more than 30 years ago, but Lena M. Napolitano, MD, FACS, FCCP, FCCM, recalls the day’s events as if they transpired yesterday. In fact, the remarkable teamwork Dr. Napolitano witnessed in the ED that day, March 30, 1981, inspired the young medical student to select surgery as a career, and today continues to inspire her as an educator and leader in the area of trauma and critical care.

Experiences at GW

“I was doing my four years at GW, and at that point I had no plans of going into surgery as a career,” recalls Dr. Napolitano, a trauma surgeon, professor of surgery, and associate chair of surgery at the University of Michigan Health System, Ann Arbor. “But sometimes one incident can truly change your life. What was interesting to me as a medical student—although I was on the sidelines for this event—was witnessing the fact that a trauma team could save a life. The rapid care President Reagan received in those first few minutes clearly saved his life, and probably more so for Mr. Brady, who had a severe traumatic brain injury.” (James Brady, White House Press Secretary at the time, was hit in the head by a bullet.)

Joseph Giordano, MD, FACS, chief of vascular surgery at GW at that time, led the trauma team and supervised the care President Reagan received.1 Dr. Giordano—one of Dr. Napolitano’s early mentors—had been responsible for getting GW verified by the American College of Surgeons (ACS) Committee on Trauma as a Level I trauma center. Trauma patients’ risk of death is significantly lower when care is provided in Level I trauma centers compared with non-trauma centers, according to a national evaluation of trauma center care’s impact on...
mortality (2006), and research suggests continued efforts at regionalization of trauma care are key.2 “The prompt life-saving care delivered at GW, within minutes of his life-threatening injury, was life-saving for President Reagan, with the trauma team providing blood resuscitation for treatment of hemorrhagic shock, tube thoracotomy for hemothorax, and early surgical intervention with thoracotomy for ongoing hemothorax. Dr. Giordano spent four years setting up the Level I Trauma Center at GW and on that fateful day it saved the life of the President,” explained Dr. Napolitano.

Dr. Napolitano made the decision to stay at GW for her general surgery residency training, and she completed her surgery residency at GW, as well. All of the surgery chief residents (three men and Dr. Napolitano) in her year chose to pursue a career in trauma and critical care.

“It is interesting to take a look back,” noted Dr. Napolitano. “My career path could have been very different. When I saw the trauma team interaction on that day it really solidified my career path in trauma and critical care, which is what I do now. Everything happens for a reason. I became passionate about trauma and critical care because of what I saw that day.”

Glass ceiling
An important component of sustaining a teamwork environment in the OR is the development and recruitment of a diverse roster of health care professionals. “A glass ceiling remains for women at the higher level,” admitted Dr. Napolitano. “But at the lower level it really doesn’t exist anymore. For residents—it’s gone. We treat them alike, male or female, it makes no difference. So, that really is incredible, and kudos to the surgical leadership as a whole for moving this forward. When we look at taking a particular med student, we don’t think of gender. We think of letters of recommendation, and we think of accomplishments, which is a huge change from how it used to be. Remember, I was the one female in my class of surgical residents. Now many surgical residency programs are 50 percent women.”

According to a 2010 report published by the Association of American Medical Colleges (AAMC), of the 129,929 medical school faculty surveyed, 35 percent are women, and 65 percent are men.3 Nonetheless, “We aren’t seeing many women in the positions of associate professor, professor, and chair, and that is a problem,” she said. “To be fair, some of that has to do with what women desire—some desire a family and reduced workload. On the other hand, some leaders think women might not do as good a job as men can in these positions. Of all full professors in surgery, only 8 percent are women. Of the 158 total chairs in the Society of Surgical Chairs, only five are women.”4

Dr. Napolitano, an advocate of not only gender equality, but also overall diversity in surgical leadership, said disparities in medical school faculty should be addressed for the following reasons:

• Physician leaders develop health policies that influence regulation, financing, and delivery of health care.
• Those who serve as medical school faculty set research agendas, influence medical education, and serve as role models for the recruitment and retention of both minority and majority students.
• These physician leaders do more to address disparities than individually care for patients; they are in positions to address disparities by influencing health care training and health systems as a whole.

According to Dr. Napolitano, Chair of the ACS Board of Governors (B/G), only 7 percent of the Governors are women, and other minorities are also underrepresented on the B/G—which is why one of the Board’s goals in 2012 is to increase diversity in the nomination and selection process in an effort to better represent the ACS Fellows. In contrast, 20 percent of the ACS Board of Regents are women, fully representing the surgical workforce, based on the results of the most recent AAMC faculty report, which indicates that as of 2010, 19 percent of all surgical faculty are women.3

B/G 2012 goals
In addition to increasing diversity in the B/G nomination and selection process, B/G leadership—which includes Dr. Napolitano, Chair, along with Vice-Chair Gary L. Timmerman, MD, FACS, and Secretary Wil-
liam G. Cioffi, MD, FACS—have established specific goals for the board in 2012, and they include the following:

- Increased communication with B/G (electronic newsletter, webinars)
- Strategic planning—committees (examine current B/G committee structure and alignment and interaction with other ACS committees)
- Ten-year review of annual B/G survey (review survey process; new survey to be completed by July 30, 2012)
- National and international chapter activities (rejuvenate and reactivate chapters)

“We are eager to hear from individual ACS Fellows with regard to issues that they feel are important to the surgical community, and will strive to bring these issues forward to the ACS leadership. Please don’t hesitate to contact me,” said Dr. Napolitano.

Mentoring

Dr. Napolitano’s career trajectory was set in motion the day President Reagan and Mr. Brady were rushed into the ED some 30 years ago, but barring witnessing a life-changing moment such as saving the life of a sitting president, some medical students require a little guidance when contemplating their future.

“I suggest students and residents contemplate all of their options—and the role of a mentor is very important in that regard,” said Dr. Napolitano. “As a resident, you can’t possibly know everything that is going on in the surgical world or even in the world of medicine, and mentors can help steer you in the right direction. Residents can be on as many as 10 different surgical services and love them all, but what will probably sway them is a good role model. If they see surgeons who are happy and successful and enjoy coming to work every day—then they will want to be like them. Having a superb role model is very important, and that is particularly true for women.”

For each new generation of residents, work-life balance has become a greater concern, and a strong mentor can help students find a good match for their skills, while taking into consideration their life goals, according to Dr. Napolitano. “I was extremely fortunate to have excellent mentors throughout my training and career, many of them leaders in American surgery, including Dr. Giordano, Dr. Barbara Bass [MD, FACS], Dr. Anton Sidawy [MD, FACS], Dr. Anthony Meyer [MD, FACS], and many more.”

Resident duty hours

Resident duty hours—which were developed at least in part to contribute to growing demands for work-life balance—is a topic Dr. Napolitano has followed closely. Like many other surgical educators, Dr. Napolitano appreciates efforts to help residents enjoy work-life balance, but also has concerns about their effects on the surgical workforce and patient care.

“In addition to the potential for increased errors due to lack of continuity [of care] and increased hand-offs, other possible negative impacts [of duty-hour restrictions] include reduced clinical exposure and inadequate preparation for independent surgical practice,” said Dr. Napolitano. “We are concerned about their competency, but not just competency—the confidence level. Residents might not feel confident in their training, and as a result, they feel the need to go on to one-, two-, three-year fellowships for additional surgery training in an area of surgical specialty. Nearly 80 percent of graduating general surgery residents pursue additional training in a surgical subspecialty at present.”

Increasing surgical specialization of our trainees is resulting in a significant shortage of general surgeons. According to statistics from the federal Health Resources and Services Administration, by 2020 demand is set to outstrip supply in several specialties, with non-primary care specialties in general projected to experience a shortage of 62,400 physicians. General surgery is predicted to be among the hardest hit, with a shortage of 21,400 surgeons. The number of practicing general surgeons is expected to fall to 30,800 by 2020 from 39,100 in 2000. The American Surgical Association convened a focused meeting to address the general surgery workforce shortfall, and recommendations to address this shortage have recently been published, including enhancing the number of general surgery trainees and the breadth of training, and incorporating more flexibility and breadth in general surgery residency training.
Furthermore, work-hour restrictions may negatively affect the quality of care that trauma patients receive. Citing a recent study of 107,000 neurosurgical trauma patients conducted by the University of Florida, Gainesville, Dr. Napolitano noted that the Accreditation Council for Graduate Medical Education (ACGME) resident duty-hour restrictions were associated with an increase in complications, and no change in mortality for the teaching hospitals. (In the non-teaching hospitals, there was no change in complications and mortality.)

“My concern is that we don’t have a lot of data that shows reducing work hours will result in a positive impact, and that, at the fellow and attending level, there has not been the same reduction in work hours,” explained Dr. Napolitano. “I believe that the management of duty hours should parallel a change in the culture of medicine that addresses the effects and consequences of uninterrupted consecutive duty hours for the medical profession as a whole—including staff physicians and nonresident learners.”

**Quality of care**

Dr. Napolitano is a member of and holds leadership positions in numerous professional organizations in surgery, trauma, and surgical critical care. A common motivation for her involvement in these organizations is an emphasis on quality of care. Delivering consistent quality care for Dr. Napolitano means developing and fostering a strong teamwork environment—similar to the collaborative team effort she saw in action at GW that fateful day in 1981.

“Teamwork is everything. Of course, it doesn’t always happen perfectly, and so that is an issue we continue to have to move forward with,” said Dr. Napolitano. “Let me tell you a quick story: Yesterday, I had a first start case at 7:30 am. It was not a complicated case. I was in the room to do the time out, and I expected everyone to be there and be prepared. We did our time out, go through everything we do for the patient, and I asked the residents to go scrub in, while I prepped the patient. We did the operation, and it went fine. At end of case, we debriefed in an environment where everyone is invited to speak their minds as equals. Well, our scrub nurse said she felt pressured. And I said, ‘What do you mean?’ and she said ‘I felt that you were rushing me.’” And I said, ‘We were rushing you! We should be ready to start the case at 7:30, especially since there was another case afterward. There’s no reason to lollygag around here, and if you were not prepared and didn’t have your hands washed because you had that extra cup of coffee, well, there’s a problem.’ The team can always do better—myself included. Sometimes people get lax or sometimes

**Staffing of the ICU**

The ACGME resident duty-hour standards can also impact the staffing needs of intensive care units (ICUs), as the restrictions may result in a restructuring of the workflow plan—particularly because residents provide the bulk of care in these units. “One of the most important issues facing us in trauma and critical care is the challenges in the future of its workforce,” explained Dr. Napolitano. “Significant shortages are projected for surgical intensivists and trauma surgeons. We train far fewer surgical intensivists annually than medical intensivists. Of more than 2,100 residents enrolled in critical care fellowships annually, only 160 (7.6 percent) in 2009 were surgical critical care fellows. We need to be certain that we have a strategic plan for succession planning in trauma and surgical critical care.”

According to an article written by Dr. Napolitano and colleagues, and published recently in *The Journal of Trauma*, an analysis of the critical care workforce revealed an estimated 35 percent shortage of intensivists by 2020, as a result of the aging population and the growing demand for intensivists, particularly surgical intensivists. Surgical critical care in the U.S. is particularly challenged by a significant shortfall of surgical intensivists, according to Dr. Napolitano, with only 2,963 surgeons currently certified in surgical critical care by the American Board of Surgery, and even fewer surgeons (1,407) recertified in surgical critical care as of 2011.

“We encourage students to pursue a career in trauma/surgical critical care by having them rotate with us as third- and fourth-year medical students. In particular, having a fourth-year medical student rotate as a sub-intern on our trauma/burn service and in our surgical ICUs is exciting for them as they have the opportunity to care for the critically ill and injured—and this can sometimes solidify their career choice.”
people don’t work to the best of their abilities, but we need to strive to do so,” said Dr. Napolitano.

“As a general surgeon, I might have 10 different teams I work with, while a neurosurgeon will work with the same scrub nurse and the same OR team because of their specialty training and needs. I get all the trainees in the OR,” she said with a chuckle.

“Team-building and interaction is very important in regard to improving care, and making sure we don’t forget something, whether we are in the OR, in the trauma bay, or in the ICU. And there must always be a team leader to optimize team performance and patient outcomes. Training residents to be effective team leaders is an important component of our mentoring in acute care surgery.”

One key approach to improving quality care—for all members of a surgical team—is the analysis of accurate outcomes data. Dr. Napolitano called the ACS National Surgical Quality Improvement Program (NSQIP®) “the benchmark for quality care in surgery” and finds the number of participating hospitals in the program—nearly 500 hospitals use ACS NSQIP tools and reports currently—to be an encouraging sign. However, she also noted the challenges related to both the number of competing programs currently available in the marketplace and the staffing required to collect high-quality data used to track outcomes.

“The validity of ACS NSQIP is quite clear,” added Dr. Napolitano. “A recent study compared ACS NSQIP to the Agency for Healthcare Research and Quality Patient Safety Indicators (AHRQ-PSI) method for assessing inpatient adverse events, and identified that AHRQ-PSI identified less than one-third of the ACS NSQIP clinically important adverse events. The measurement of surgical quality is dependent on the reliability of the method used, and this study clearly documented the superiority of the ACS NSQIP program.”

“For the future, I think everyone is hopeful that with electronic medical records there will be an electronic transfer of data into ACS NSQIP, and less humans running around to collect data,” she said. “This will be a big help with our quality efforts in surgery.”

**REFERENCES**

Multi-stakeholder, consensus-based quality measurement is central to the delivery of safe, accessible, patient-centered, and affordable care. The Institute of Medicine’s report *To Err Is Human*, published in 1999, has been credited as the impetus for shifting the U.S. health care system toward an emphasis on improved quality of care achievable through new initiatives, such as public reporting and pay for performance.\(^1\) This changing environment led to the creation of multi-stakeholder organizations charged with improving quality and reducing cost.

Through effective partnerships, the American College of Surgeons (ACS) has served as a motivating force in the drive to improve the quality of surgical care. The ACS has played a leadership role, and is recognized as a key contributor to the development, validation, and implementation of national quality measures.

The College has contributed its insights and services to a number of national organizations, agencies, and programs that are involved in creating a road map for improved quality of care and developing strategies aimed at creating change in health care delivery. This article outlines the roles of these various entities and details the College’s contributions to their endeavors.

**Creating a road map**

With the passage of the Patient Protection and Affordable Care Act (ACA), the federal government has demonstrated a commitment to ensuring the delivery of safer and more transparent, efficient, and patient-centered care. This commitment is articulated through the identification of national priorities and financial incentives designed to drive the types of changes in practice that are believed to lead to less waste and higher quality care. Also crucial to this commitment are mandates requiring the public reporting of information on physicians, including the upcoming mandatory reporting of quality measures on Medicare’s Physician Compare website.\(^2\)

The National Quality Strategy (NQS) is the framework outlined in the ACA and subsequently
interpreted and developed by the Secretary of the U.S. Department of Health and Human Services (HHS) with multi-stakeholder input. The NQS is designed to guide the development and prioritization of quality measurement. The NQS also forms the backdrop for the national quality initiatives with the aim of developing a “transparent collaborative process that shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health,” as mandated in the ACA.3

As a result of this mandate, the NQS provides a context for quality measurement, measure development, and measure alignment across federal reporting initiatives, as well as analysis of where stakeholder resources can be used to increase efficiency and accountability in health care. The NQS pursues three aims: better care, healthy people/healthy communities, and more affordable care. To accomplish these aims, NQS focuses on the following priorities: health and well-being, prevention and treatment of leading causes of mortality, person and family-centered care, patient safety, effective communication and care coordination, and affordable care (see Figure 1, page 51).4

NQF’s priority setting efforts

National Priorities Partnership (NPP). What sets NQF apart among quality care organizations is that it was selected by HHS to fulfill a provision in the ACA which requires a consensus-based entity to convene multi-stakeholder groups to provide input to HHS on the development of the NQS.5 As mentioned previously, the foundation of the NQS is to build a national consensus on how to measure quality and facilitate stakeholders to align their interests. In response to this mandate, the NQF convened the NPP to identify goals and measures of the NQS priorities, to provide annual input to HHS on progress toward the goals, and to offer guidance on strategic opportunities for improvement.5 The NPP is represented by 51 national organizations inclusive of public and private stakeholder groups.

Measure Applications Partnership (MAP). For the first time in national quality measure development, the ACA made way for significant enhancements to the traditional federal rulemaking process by provid-

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<th>Common acronyms associated with quality measures</th>
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ing a forum for public and private partnership to provide feedback prior to rulemaking. HHS selected the NQF to provide this pre-rulemaking input. To fulfill this expectation, the NQF convened the MAP, which is charged with identifying core measures and prioritization of measure gaps in federal quality programs and measure alignment across programs, settings, levels of analysis, populations, and between public and private sector programs (see Figure 2, this page). The MAP consists of four main workgroups: clinician, hospital, post-acute care/long-term care, and dual eligible beneficiaries—all of which are overseen by the Coordinating Committee. This committee includes members representing consumers, businesses, and purchasers, labor, health plans, clinicians and providers, communities and states, and suppliers. As noted in Table 1, page 52, the ACS is actively involved in MAP and the development of its recommendations through member appointments and by providing comments on various measures that the Centers for Medicare & Medicaid Services (CMS) has chosen for inclusion in federal quality incentive programs.

Leaders in developing quality measures

AMA Physician Consortium for Performance Improvement (PCPI). One of the leading measure developers in physician QI is the PCPI, convened by the American Medical Association. The PCPI is a nationally recognized organization that has set the standard for the development of physician-level quality measures among a broad range of clinical topics encompassing structure, process, and outcome measures. PCPI focuses on clinically meaningful, evidence-based performance measures, which are reviewed by PCPI member-appointed work groups, which may include members with expertise in performance measurement methodology and clinical content. Members may include purchaser, employer, health plan, and consumer and patient representatives. Measures are also vetted through public comment and PCPI member voting. This broad-based approach to measure development works to minimize bias and to measure what is important and actionable for physicians.

PCPI tests measures for feasibility, reliability, validity, and unintended consequences through their testing protocol that further establishes the evidence base for each PCPI measure. These measures are continuously subject to an ongoing process of testing and maintenance that prepares measures for measure endorsement and implementation.

As a result of PCPI’s evidence-based, cross-specialty, multidisciplinary process, this group has been the leading steward in measure development for national accountability and quality improvement physician programs, such as the Medicare Physician Quality Reporting System (PQRS) and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program Stage 1 (EHR Meaningful Use Program). The PCPI has developed more than 280 measures, and more than 57 percent of measures in PQRS in 2011 and 45 percent of measures in the Stage 1 EHR Meaningful Use Program have been developed by the PCPI. PCPI has also taken the lead in enabling use of measures in EHRs.
As part of this initiative, PCPI created the National Quality Registry Network (NQRN), which facilitates the standardization and interoperability of quality data across patient registries.10 The ACS—in collaboration with the Surgical Quality Alliance (SQA)—has partnered with PCPI on the development, maintenance, and endorsement of the PCPI Perioperative Care Measure Set. The ACS and SQA have provided evidence-based data to support and refine the measures aimed at improving the use of appropriate antibiotic and venous thromboembolism prophylaxis. As part of this partnership, which resulted in well-validated measures, PCPI perioperative care measures have been selected to be included in federal quality improvement programs, enabling the surgical community to more easily participate in the PQRS. The College also contributes to PCPI’s efforts through representation on the PCPI executive committee, fellow appointments to various work groups, and through public comment to ensure that measures developed by PCPI account for the unique nature of surgery.

Other Measure Developers. CMS and the Agency for Healthcare Research and Quality (AHRQ) are the leading federal agencies in quality measure development. Several independent not-for-profit organizations also have focused their efforts on consensus-based measure development, including The Joint Commission and the National Commission for Quality Assurance (NCQA). Lastly, in addition to the PCPI and the ACS, several professional medical societies have fo-

### TABLE 1. ACS representation within national quality organizations

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<thead>
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<th>Organization</th>
<th>Role</th>
<th>Representative</th>
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<tr>
<td><strong>AQA</strong></td>
<td>Strategic Planning Workgroup, chair</td>
<td>David Hoyt, MD, FACS</td>
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<td>ACS representative</td>
<td>Frank Opelka, MD, FACS</td>
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<tr>
<td><strong>National Quality Forum (NQF)</strong></td>
<td>Consensus Standards Approval Committee</td>
<td>Frank Opelka, MD, FACS</td>
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<td>Common Formats Technical Expert Panel</td>
<td>Don Detmer, MD, FACS</td>
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<td>Patient Outcomes: All-Cause Readmissions Steering Committee</td>
<td>Bruce Hall, MD, PhD, FACS</td>
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<td>Regionalized Emergency Medical Care Services Project Steering Committee</td>
<td>John Fildes, MD, FACS</td>
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<td>National Priorities Partnership, Affordable Care representative</td>
<td>Frank Opelka, MD, FACS</td>
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<td>National Priorities Partnership Patient Safety Workgroup, co-chair</td>
<td>Frank Opelka, MD, FACS</td>
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<td>Patient Safety: Complications Endorsement Maintenance Steering Committee</td>
<td>John Clarke, MD, FACS</td>
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<td></td>
<td>ACS member representative</td>
<td>Bruce Hall, MD, PhD, FACS</td>
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<td></td>
<td>ACS member representative</td>
<td>Mary Maniscalco-Theberge, MD, FACS</td>
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<td></td>
<td>Cancer Endorsement Maintenance Project Steering Committee</td>
<td>Stephen Edge, MD, FACS</td>
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<td>MAP Hospital Workgroup, chair</td>
<td>Frank Opelka, MD, FACS</td>
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<td>MAP Ad Hoc Safety Workgroup, chair</td>
<td>Frank Opelka, MD, FACS</td>
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<td>MAP Coordinating Committee, ACS representative</td>
<td>Frank Opelka, MD, FACS</td>
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<td></td>
<td>MAP Cancer Care Workgroup, chair</td>
<td>Frank Opelka, MD, FACS</td>
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<tr>
<td><strong>Physician Consortium for Performance Improvement (PCPI)</strong></td>
<td>National Quality Registry Network Task Force/Leadership Council</td>
<td>Clifford Ko, MD, MSHA, FACS</td>
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<td></td>
<td>Executive committee</td>
<td>Frank Opelka, MD, FACS</td>
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<td>ACS member representative</td>
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<td>Anesthesiology and Critical Care Work Group member</td>
<td>Heidi Frankel, MD, FACS</td>
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<td><strong>Quality Alliance Steering Committee (QASC)</strong></td>
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<tr>
<td><strong>Surgical Quality Alliance (SQA)</strong></td>
<td>Surgical Quality Alliance, chair</td>
<td>Frank Opelka, MD, FACS</td>
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TABLE 2. Sample quality measure step-by-step
(While this is a sample case study, this is not reflective of all processes for measure development.)

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<td>correspond with the priorities outlined by the NPP</td>
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<td>Measure developers</td>
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<td>Measure developers submit measures for NQF endorsement</td>
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<td>NQF uses its Consensus Development Process to review each measure</td>
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<td>Measures endorsed for 3 years before reevaluated</td>
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<td>NQF</td>
<td>Endorsed measures are included in the NQF measure library and ready</td>
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<td>After three years, NQF reevaluates measures based on the measure</td>
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<td>evaluation criteria while keeping in alignment with the NPP</td>
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<td>Measure developers</td>
<td>Measure developers update measures specifications, provide updated</td>
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<td>evidence, measure testing results, or any other necessary information</td>
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Validating quality measures

National Quality Forum (NQF). The NQF is an independent not-for-profit organization that has set the standard for the science of quality measurement validation in the national quality landscape. NQF provides quality measures with “NQF endorsement” based on a rigorous multi-stakeholder consensus-based measure review. NQF endorsement represents the gold standard in measure development. To receive endorsement, measures must meet the following criteria:

- Importance to measure and report to keep focus on priority areas to maximize positive effects on health care quality
- Scientifically acceptable, so that the measure, when implemented, will produce reliable and valid results about the quality of care
- Useable and relevant to ensure that intended users (consumers, purchasers, providers, and policymakers) can understand the results of the measure and find them useful for quality improvement and decision making
- Feasible to collect with data that can be readily available for measurement
- Assess related and competing measures

NQF’s consensus development process (CDP) is based on transparency and multi-stakeholder consensus to determine whether each measure meets the endorsement criteria. Each workgroup that reviews a measure for possible endorsement has representation from the following NQF Councils: Consumer Council; Health Plan Council, Health Professionals Council, Provider Organizations Council, Public-Community Health Agency Council; Purchaser Council; Quality Measurement, Research and Improvement Council; and Supplier and Industry Council. The Consensus Standards Approval Committee (CSAC), which includes a diverse set of health care stakeholders, determines if consensus was met among...
As the national quality landscape evolves, the ACS will continue to strengthen its leadership and guidance as national quality organizations work to implement ACA mandates throughout the health care system redesign.

Implementing quality measures

AQA. The AQA—once known as the Ambulatory Quality Alliance—is a multi-stakeholder quality organization that focuses on facilitating measure implementation by addressing the gap between quality measurement and improvement. The AQA represents more than 100 organizations including clinicians, consumers, purchasers, and health plans. The mission of the AQA is to improve patient safety, health care quality, and value in all settings where members develop consensus and promote strategies for quality measure implementation, collect and aggregate relevant data, and report relevant information on this data to inform decision making and with the aim to improve patient outcomes.12

Guided by David B. Hoyt, MD, FACS, ACS Executive Director and chair of the Strategic Planning Committee, the AQA has revised its role in the health care system redesign with the creation of a strategic plan to meet the needs of the quality community. As outlined in the strategic plan, the AQA plans to work with other quality organizations to facilitate alignment across public and private efforts.

The AQA also plans to analyze and promote “best practices” to fill the gap between measurement and improvement. This effort includes identifying measures that had the most success in driving improvement and investigating additional levers of QI such as certification and professionalism. Lastly, the AQA plans to work on...
providing guidance to HHS on quality initiatives such as the NQS and public reporting programs. The ACS has been consistently represented on AQA workgroups and committees and will continue to work in collaboration with the AQA as the strategic plan is implemented.¹²

The Quality Alliance Steering Committee (QASC). This committee is a collaborative effort of a variety of stakeholders vested in the implementation of quality improvement initiatives that focus on making information on quality improvement and the cost of care consistent, useful, and widely available to consumers, providers, and public and private payors. Through the High Value Health Care Project, the QASC is developing a solution for more efficient data aggregation and integration, measuring cost and efficiency for high-priority clinical conditions, and advancing equity in health care among racial and ethnic groups.¹³ The ACS works in partnership with the QASC through representation on their committees to ensure that initiatives are inclusive of the needs of surgical patients.

Sample step-by-step quality measure case study

Table 2 on page 53 illustrates the steps involved to increase the likelihood for the inclusion of a quality measure in a federal quality reporting program (or ensuring that a bad measure is not included), and it is a long, multi-layered process. The College has been heavily involved in measure development and endorsement, and monitors and acts at all levels of the measure development enterprise to help ensure that the perspective of the surgical patient is at the center of measure development.

As the national quality landscape evolves, the ACS will continue to strengthen its leadership and guidance as national quality organizations work to implement ACA mandates throughout the health care system redesign. The College aims to deliver evidence-based information from the surgical perspective so that quality measurement, endorsement, and implementation will be accurately and fairly implemented according to surgery’s unique nature. ACS input is more important now than ever as we work with quality organizations to interpret ACA mandates, ensuring that efforts accurately measure and publicly report care delivered to surgical patients. ◆

REFERENCES

Capt. Brad Cooper provides an update on Joining Forces initiative
by Diane S. Schneidman

In May 2011, U.S. Navy Capt. Bradley Cooper was on his way to the Pentagon when he received a phone call from the White House asking him to interview for the job of Executive Director of the then-newly launched Joining Forces program. Captain Cooper said that—as a third-generation servicemember who has done 10 overseas deployments and who is still on active duty—he was honored and excited to be given this opportunity.

“At the end of the day, I gravitate toward projects that really deliver in a positive way, and I saw that the First Lady [Michelle Obama] and [Second Lady] Dr. [Jill] Biden really had a vision to deliver greater support from America to military members and military families,” he said.

He was particularly impressed that Ms. Obama, Dr. Biden (an EdD), and their staffs had been in touch with thousands of military members and their families to determine how the private sector could best assist veterans and their loved ones in leading productive civilian lives. As a result of this outreach, they determined that the three pillars of Joining Forces would be employment, education, and wellness.

**Milestones in wellness**

Needless to say, the pillar that the ACS is most capable of and committed to reinforcing is the one centered on wellness. As Dr. Hoyt stated in his column on Joining Forces, only about half of the nation’s veterans seek their care at Veterans Affairs (VA) or Department of Defense (DOD) hospitals and health care facilities.* According to Captain Cooper, veterans who seek health care services outside of the VA system do so for various reasons, including living a good distance from a VA hospital or clinic.

“About 10 to 20 percent of those veterans who served overseas have PTSD [post-traumatic stress disorder] or TBI [traumatic brain injury]. We came to the conclusion that until we at least can give health care providers throughout the nation some rudimentary knowledge of what PTSD and TBI are, we were never going to be able to holistically address this problem,” he said. “We’d have the 50 percent who go to the DOD and VA facilities get themselves on a positive trajectory, while the other half would be

going to health care providers throughout the country who have little to no understanding of these problems. What's their outcome likely to be? It's probably not going to be as positive.”

To ensure that more health care professionals understand how to provide appropriate care to veterans living with these conditions, “We convened the leadership of major medical associations around the country in January to see where each association could educate their members and constituencies on PTSD and TBI,” Captain Cooper said.

Surgeons specifically need to be aware of how PTSD and TBI manifest themselves in patients, so that when they have contact with patients who are facing these challenges, they understand what types of care these individuals require. “So, let’s say I’m a surgeon in Des Moines [IA], and I’ve had contact with a veteran who has done two or three or four tours of duty in Iraq and Afghanistan. Just to be able to have a conversation with some awareness of what PTSD and TBI are puts me in a position where I’m able to understand what types of care this veteran needs to seek. I’m able to say, ‘There are certain health care providers in the area that you need to see,’” Captain Cooper explained.

“In the surgeons’ case, they don’t need to be on the same level of understanding as a psychiatrist or licensed counselor, but having a fundamental, basic knowledge of PTSD and TBI would certainly be helpful toward ensuring that their patients get the care they need,” he added.

To help ensure that more health care professionals possess at least this rudimentary understanding of PTSD and TBI, Joining Forces convened a group of more than 30 medical organizations in Washington, DC, this past January and asked them to educate all of the members of their associations and disciplines about these conditions.

**Health care association initiatives**

The College has accepted that charge and has responded through the development of a Web page, [http://www.facs.org/trauma/joiningforces/index.htm](http://www.facs.org/trauma/joiningforces/index.htm), which contains links to sites that may be useful to surgeons who want to learn more about how they can assist returning veterans and their families. In addition, the College is developing a new section of the Advanced Trauma Life Support® manual, which will focus on PTSD. And, as mentioned in previous Bulletin pieces regarding Joining Forces, the College will present a panel discussion at the 2012 Clinical Congress titled “Joining Forces: How We Can Help Our Returning Veterans.” (See sidebar on page 59 for details.)

Other medical organizations that have partnered with the College through Joining Forces are doing their part to ensure that health care professionals are better equipped to care for veteran populations. The Association of American Medical Colleges (AAMC), for example, has established a collaborative network to exchange critical research and cutting-edge discoveries in PTSD and TBI. This network, called iCollaborative, is available at [https://www.aamc.org/icollaborative/joiningforces](https://www.aamc.org/icollaborative/joiningforces) and contains approximately 58 examples of educational resources that medical schools and training centers are sharing and incorporating into their curricula.

“One of the reasons we wanted to get the schools together is because some of their efforts on treating PTSD and TBI have been somewhat ‘silod.’ For example, they’re doing great research at Wake Forest University [in Winston-Salem, NC], but how does that information get shared? The AAMC already had an existing collaborative network, so they rejiggered that network slightly to accommodate the Joining Forces network. Then we used that network to release government information on procedures, policies, and guidelines for treating PTSD and TBI into the private sector,” Captain Cooper said.

“In terms of specific examples, the University of Pittsburgh [PA] is doing great research work on PTSD and TBI. They did a study and then they posted it a couple of months ago on the AAMC portal so that other institutions could see their results. I think we will see more of that as we move forward. That’s a quantum leap from what we had before in terms of sharing this kind of information,” he added.

Other health care organizations are doing their part as well to spread the word about how their members can help veterans. Examples include the following:

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You can’t just talk about someone’s mental health without looking at their life more holistically—without talking about their job and, quite candidly, their education.

The American Medical Association (AMA) established a website, www.ama-assn.org/go/joiningforces, which contains resources to assist physicians in assessing and treating veterans and their families. As the owner of the nation’s largest continuing medical education (CME) credit system, the AMA will encourage other groups and institutions that offer CME programs to offer courses addressing these issues. The AMA also is offering programs on these topics and is disseminating to its members educational information to increase physician awareness regarding critical mental health issues affecting the military.

The National Board of Medical Examiners is working with other Joining Forces partners to incorporate health issues affecting service members and veterans into the broad range of examinations it prepares for the education and licensure of medical students, practicing physicians, and other health care professionals.

The American Academy of Neurology (AAN) is advocating for programs that support veterans and their caregivers, publishing articles for members on the need to increase their capacity and expertise regarding PTSD and TBI, developing further CME on the diagnosis and treatment of veteran patients, and providing tools and resources on TBI and concussion medicine.

The American Academy of Pain Medicine presented five symposia on pain management in veterans during the organization’s annual meeting and formed a special interest group for military and VA health care professionals.

The American College of Emergency Physicians is highlighting veterans’ issues at its annual government services symposium and formed a task force charged with expanding PTSD and TBI awareness.

The American Osteopathic Association has committed to providing educational sessions on military and veteran medicine at its conferences and is disseminating articles on PTSD, TBI, and post-combat depression.

Employment and education
Joining Forces is making significant progress with respect to the other two pillars of the program, especially employment. “We’ve probably seen the most growth in employment. In the last year, we’ve had about 2,100 companies that have hired or trained 125,000 veterans and military spouses just through Joining Forces, and these same companies have committed to hiring another 250,000 in the next couple of years,” Captain Cooper said. Companies that have committed to providing employment to former military personnel include Boeing, Brink’s, The Disney Company, General Electric, Hewlett-Packard, Honeywell, Lockheed Martin, NBC Universal, Comcast, Sears Holdings, Siemens Corporation, and Wal-Mart.

Job placement after military service is of paramount importance to ensuring that all aspects of their lives can continue to be fulfilling. “Obviously, when you have a job and an income the other things in your life are going to be much more vibrant. You can’t just talk about someone’s mental health without looking at their life more holistically—without talking about their job and, quite candidly, their education,” Captain Cooper noted. Joining Forces encourages companies, organizations, and institutions to hire veterans for the dedication and quality of work they are likely to bring to the workplace. “At the end of the day, it makes good business sense because of the talent that you’re hiring,” Captain Cooper said. “We’ve used that from a message standpoint to spread the word that we’re not looking for companies to hire veterans because it’s patriotic, which is nice, but because of the type of talent they get.”

With regard to the third pillar—education—Joining Forces has focused largely on fulfilling the needs of the children of service members. Organizations are increasing the number of educators who are trained in issues that affect military children, including frequent moves, parental separation, and so on. They also are disseminating best practices for supporting veterans who are pursuing college educations. Last April, for instance, the U.S. Department of Education hosted a community college summit focused on ways colleges can foster supportive learning environments for veterans.

In addition, Joining Forces has presented a public awareness campaign featuring Tom Hanks, Oprah Winfrey, Steven Spielberg, as well as major league
baseball players, NASCAR drivers, and representatives of other national institutions, in an effort to educate Americans about all that veterans and their families have given over the last decade.

“Joining Forces has very much evolved based on the feedback we’ve gotten and the milestones we’ve reached, in some cases much faster than we thought. We always knew that the three pillars were solid. What could be achieved was unknown. We clearly live in a grateful nation, but how grateful and how understanding of the issues that impact veterans, for example in terms of the role of employment, was unknown,” Captain Cooper said. It is now clear that “there is a sea of goodwill out there, and we’re always looking for ways to help translate that goodwill and desire to help into ways that are meaningful and impactful.”

2012 Clinical Congress session
Joining Forces: How We Can Help Our Returning Veterans
Time: 9:45–11:15 a.m.
Date: Tuesday, October 2
Location: McCormick Place West, Room W 192
Moderator: A Brent Eastman, MD, FACS, ACS President-Elect
Co-Moderator: Michael F. Rotondo, MD, FACS, Chair, ACS Committee on Trauma

Topics and Speakers:
Joining Forces: The Structure and Goal of the Program
Capt. Todd Veazie, Washington, DC

The Scope and Impact of the Problem
Jonathan Woodson, MD, FACS, Boston Medical Center, MA

Military Service versus Work in the Civilian Community
John B. Holcomb, MD, FACS, University of Texas Medical School, Texas Medical Center, Houston

Perspective of a Returning Veteran
S. Sgt. Richard Gonzalez, San Diego, CA
The Centers for Medicare & Medicaid Services (CMS) recently published a final rule that makes improvements to the requirements set forth in an interim final rule from 2010 related to the ordering and certification of certain Medicare items and services. This final rule implements a provision of the Affordable Care Act (ACA).*†

A major modification in the final rule that benefits surgery eliminates the requirement that physicians be enrolled in Medicare to order, certify, or refer the services of physician specialists. This article provides details regarding this modification and other changes in the final rule, as well as what surgeons should know about the current requirements.

How will the elimination of the requirement that physicians must be enrolled in Medicare to order, certify, or refer specialist services affect my practice?

Because CMS no longer requires physicians to be enrolled in Medicare to order or refer patients for specialist services, surgeons can rest assured that their claims will be paid, even when they provide services to patients who were referred by nonenrolled physicians. Furthermore, if nonenrolled surgeons refer patients to other specialists, those physicians’ claims will be paid as well.

However, if surgeons order or certify durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), or home health, imaging, or clinical laboratory items and services, the surgeon should be enrolled in Medicare or validly opt out in order for Medicare to pay the claims submitted by those entities.

What changes does the final rule make regarding ordering and certifying items and services for Medicare beneficiaries?

The ACA requires that Medicare claims for DMEPOS and home health services be paid only if the items or services were ordered or certified by a physician (or if permitted, a nonphysician [NPP]) who is enrolled in Medicare. Such claims must include the National Provider Identifier (NPI) of the ordering or certifying physician. The ACA authorized the extension of these policies to all other categories of items or services under Medicare.

The interim final rule in 2010 implemented these policies and extended identical policies to imaging, laboratory, and specialist items and services. The final rule, however, limited the affected items or services only to DMEPOS and home health, imaging, and clinical laboratory items and services. Specialist services were specifically removed from this list in the final rule, meaning that a physician or NPP who refers to specialists will not be required to be enrolled in Medicare.

CMS also points out that the ordering and certification requirements do not apply to Part B or Part D drugs.

In addition, the interim final rule specified that if any of the affected items or services were ordered or certified by a resident or intern, claims for such services would be required to identify the teaching physician (by legal name and NPI) as the ordering or certifying supplier. In contrast, the final rule allows interns and residents, if permitted by the state to be licensed to order and certify services, to enroll in Medicare to order and certify. This makes it unnecessary for the teaching physician’s legal name and NPI to be included on claims for items or services ordered or certified by residents or interns.

It is important to note that physicians and NPPs should use their Type 1 NPI (issued to individual practitioners) when
Because CMS no longer requires physicians to be enrolled in Medicare to order or refer patients for specialist services, surgeons can rest assured that their claims will be paid, even when they provide services to patients who were referred by nonenrolled physicians.

certifying or ordering, even if they are being reimbursed under a Type II NPI (issued to an organization, facility, or practice).

How can a physician or NPP meet the ordering and certifying requirements?

An ordering or certifying physician can meet the ordering and certifying requirements one of four ways (see sidebar, this page).

A physician or NPP must fall into one of these four categories to order or certify DMEPOS and home health, imaging, or clinical laboratory items and services for Medicare payment.

Notably, although the interim final rule specified that all ordering or certifying physicians or NPPs must have approved enrollment records or valid opt-out records in PECOS, the final rule modifies this policy to recognize enrollment and opt-out records in Medicare legacy systems. As such, any Medicare enrollment record, not just PECOS, satisfies the ordering and certifying requirement. The final rule, however, notes that the legacy systems are being phased out and will no longer be used in the near future.

When will the requirement to have the ordering or certifying physician’s or NPP’s NPI on claims become effective?

The effective date of the ordering and certifying policies in the final rule dates back to July 6, 2010, but CMS has not yet turned on the automated edits that would deny claims due to lack of an enrollment record. Currently, noncompliant claims are only flagged with a note that the claim may not be paid in the future. In the final rule, CMS also clarifies that the ordering or certifying practitioner must be enrolled at the time the service is performed, not the date of written orders or certifications.

When will CMS turn on the automated edits, and will such edits result in claim denials or rejections?

CMS repeatedly stresses in the final rule that the agency would provide advance notice to physicians before turning on the edits. CMS specifically states that the automated edits will be turned on only after all physicians and eligible professionals have been asked to revalidate their Medicare enrollment and have been given the opportunity to complete that process through their respective Medicare Administrative Contractors. CMS further states that edits will only apply to those claims with a date of service on or after the date the edits are activated. According to the final rule, CMS plans to conduct outreach using CMS listservs, Medicare Learning Network articles, and open-door forums to inform providers of the date when the edits will be turned on. The American College of Surgeons (ACS) will monitor these channels in order to rapidly update Fellows of the date that CMS will turn on the automated edits.

An ordering or certifying physician can meet the ordering and certifying requirements one of four ways:

• The physician recently enrolled in Medicare or completed a revalidation and thus has a Provider Enrollment, Chain and Ownership System (PECOS) record. PECOS is an alternative to the paper-based Medicare enrollment process, and allows physicians to enroll, change, view, or check the status of a Medicare enrollment application via the Internet.

• The physician enrolled in a legacy Medicare system before PECOS was established in 2002.

• The physician validly opted out of Medicare, resulting in a PECOS record.

• The physician has not validly opted out of Medicare, but may enroll exclusively for ordering or certifying purposes. Such physicians may do so via the Internet-based PECOS: https://pecos.cms.hhs.gov/pecos/login.do, or by submitting a CMS-855-O paper application: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855o.pdf.
Whereas the interim final rule stated that claims failing to meet the ordering and certifying requirements would be rejected, the final rule states that claims will instead be denied, thereby providing affected providers and suppliers with the usual Medicare appeals rights.

How long must documentation of orders or certifications be maintained, and who must keep track of such documentation?

Under the final rule, both the individual who orders or certifies and the provider or supplier that furnishes the ordered or certified items or services must maintain documentation for seven years from the date of the service.

Where can I find additional information?

- The final rule is available at the following website: http://www.gpo.gov/fdsys/pkg/FR-2012-04-27/pdf/2012-9994.pdf
- This article follows a previous Bulletin article related to billing Medicare for orders and referrals: http://www.facs.org/ahp/pubs/whatsurg1011.pdf
- A provider or supplier can look up an NPI in the NPI registry at the following website: https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do

CMS repeatedly stressed in the final rule that the agency would provide advance notice to physicians before turning on the edits.
Acknowledging the multiple challenges surgeons currently face, the Board of Governors’ Committee on Physician Competency and Health has continued its efforts to both delineate these issues and provide educational programs and support services aimed at promoting physician well-being. The previous chairs and members of the committee have laid a solid groundwork upon which the present committee has expanded.

The Committee on Physician Competency and Health’s responsibilities include developing recommendations on the maintenance of physical and mental wellness in the Fellows as well as addressing issues related to surgical competency with an emphasis on credentialing and practice within expected community standards.

**Surgeon stressors**

Most physicians are aware that wellness encompasses the physical, emotional, and spiritual aspects of life. Input from Fellows of the College indicates that many surgeons are either personally or professionally coping with significant stressors that have the potential to negatively affect not only their individual well-being, but also their ability to provide optimal patient care.

Surgical education and training are intensely rigorous, and the transition to practice may be even more stressful. Contemporary surgical practice is replete with challenges, including providing patient care to an enlarging population of increasing medical complexity, and coping with declining resources and reimbursement, yet with increasing administrative burdens.

Adding to these stresses are the demands associated with maintaining work-home balance, functioning as an effective part of a health care team, meeting the professional requirements for certification, while functioning in a litigious environment.

The subsequent transition from active practice to retirement is one that many surgeons approach with trepidation and denial, and has
been shown to be a difficult phase for practicing surgeons.

**Measuring well-being**

Although abundant anecdotal information regarding surgeon stress and stressors existed, no studies had been performed that examined how these problems affected large numbers of surgeons.

Using an anonymous electronic tool developed by Gerald J. Bechamps, MD, FACS, and members of the Physician Competency and Health Committee, the College conducted a study of the Fellows in 2008. Nearly 8,000 Fellows responded to the survey, which asked questions related to both personal characteristics and professional obligations. Also included were questions designed to measure burnout and depression, career satisfaction, perception of quality of life, and issues related to the occurrence of medical error. Significant findings from this survey included a high prevalence of burnout and depression, as well as a considerable occurrence of suicidal ideation. Nonetheless, most surgeons said they enjoyed a good quality of life and level of career satisfaction.

With the College’s support, another anonymous electronic survey of the Fellows was completed in 2010, with questions addressing interpersonal relationships, work-life balance, coping mechanisms, and substance abuse. Of the nearly 7,200...
Although stress and intense demands are inherent to the surgical lifestyle, it is essential to identify and develop successful tactics to address them.

respondents, nearly one-quarter reported involvement in a medical liability lawsuit in the past two years. Additionally, probably because of the achievement-driven, highly responsible surgeon personality, work performance and attendance will be maintained, although the surgeon may be struggling significantly in all other aspects of life. It is also clear that, likely due to this commitment to patient care, direct harm to patients as a result of surgeon impairment is exceedingly rare.

A literature review also indicates that the prognosis for successful outcomes when alcohol abuse and dependence are treated is very good, with most surgeons being able to return to active practice. Participation in an established program, with ongoing support from the hospital or academic department and colleagues, as well as long-term, supervised monitoring are also essential to a successful recovery.

Avoiding burnout

Additional areas of assessment from the 2010 survey have looked at the role of personal health care practices and strategies in avoiding burnout in surgeons. According to the study, surgeons who had seen their primary care provider within the past year were found to have better overall quality of life scores and to be current with recommended health screenings. Making a deliberate effort to maintain a perspective on work-life balance as well as identifying personal values and priorities in life and gaining a sense of meaning from work were found to counteract burnout.

ACKNOWLEDGEMENTS

The author would like to acknowledge the previous Chairs of the Governors’ Committee on Physician Competency and Health: Kenneth W. Sharp, MD, FACS; Gerald J. Bechamps, MD, FACS; and John B. Hanks, MD, FACS, who have provided exemplary leadership in developing the scope of the committee’s work. Additionally, Tait Shanafelt, MD, and his colleagues at the Mayo Clinic have continued to provide outstanding technical and data analysis support.

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Although stress and intense demands are inherent to the surgical lifestyle, it is essential to identify and develop successful tactics to address them.

Looking forward
Although recognition and acknowledgement of these issues is critically important, further steps must be taken to properly aid our colleagues. These actions include: (1) assuring the individual who is struggling with these issues that they are not alone and need not continue in isolation; (2) encouraging group practices and surgery departments to put into place support mechanisms for prevention, recognition, and assistance; (3) identifying and sharing available resources; and (4) educating the surgeon that the prognosis is good for recovery and that there is a strong likelihood of continuing to function competently.

The Governors’ Committee on Physician Competency and Health has been engaged in an extensive effort to produce a resource document for both the surgeon and departments of surgery that addresses surgeon well-being. We anticipate that this document will be available electronically in the near future.

The challenges mentioned here are certainly not limited to surgeons practicing in North America; studies in other parts of the world show similar findings. The committee welcomes the input and participation of international colleagues.

A large number of manuscripts have already been published from the survey data; several more are under way. Additionally, we anticipate another survey of ACS Fellows. With significant recent changes in employment patterns as well as recognition of the stresses of career transitions and important differences between the genders, it is imperative that we broaden our understanding and then use this knowledge to guide our progress. The issues confronting surgeons are wide-ranging and have crucial implications for the individual surgeon—and the profession. ◆

References
Announcing the Surgical Standards Manual Project: A call for volunteers

by Kelly Hunt, MD, FACS; Leslie Kohman, MD, FACS; and Heidi Nelson, MD, FACS

Surgeons involved in the daily care of cancer patients are familiar with the American Joint Committee on Cancer Staging Manual and the College of American Pathologists (CAP) guidelines. The American College of Surgeons Clinical Research Program (ACS CRP) asserts that the time is ripe to develop a similar manual that provides details regarding surgical standards, complete with checklists (see sample checklist, this page). The first public Town Hall meeting on this surgical standards project—Resolving Controversies in Cancer Care: American College of Surgeons Clinical Research Program: An Expert Forum and Open Discussion—will take place 7:00–7:45 am October 3, during the 2012 Clinical Congress in Chicago, IL.

Time is ripe

Many, if not all, of the essential elements of the manual have been developed in the context of either clinical trials or as part of Commission on Cancer (CoC®) standards for accreditation. This list includes standardization practices developed for sentinel lymph node harvest in breast cancer and laparoscopic colectomy studies. The introduction of the sentinel lymph node surgery for breast cancer brought to the surgical community a well-defined procedural and training program to ensure high rates of accuracy, while the introduction of laparoscopic surgery and other forms of less invasive oncologic surgery brought us...
surgical checklists and surgeon credentialing practices. Some standards developed within the CoC, such as the 12 lymph node count for colon cancer, have evolved to become nationally recognized quality metrics. In essence, substantial efforts have been made to standardize surgical procedures and establish measurable metrics for those cancers covered by the National Cancer Institute’s Cooperative Groups and the CoC. Now, the ACS CRP Cancer Care Standards Development (CCSD) Committee has accepted the challenge of collating all available surgical standards to launch the first edition of a surgical standards manual.

**Developing the manual**

It is difficult to predict with certainty what the final draft of such a manual will look like. It may resemble previously published surgical standards projects with checklists and summary recommendations.* In an ideal world, this sort of guidebook would assess the level of evidence in support of recommended standards and suggest areas in need of more research. However, the scope of the manual will be restricted to the intraoperative experience; that is, from skin incision to skin closure. The standard will not attempt to duplicate the efforts of National Comprehensive Cancer Network guidelines, which already cover pre- and postoperative diagnostics and therapeutics. Current plans are to cover surgical procedures for the most common solid malignancies (see sidebar, this page).

The process for developing standards will be transparent and inclusive, using input from as many relevant societies, organizations, groups, and volunteers as possible. To manage the process, three diseases at a time will undergo review with a core team from the Alliance and the CoC. Volunteers from relevant groups will be solicited, and drafts will be vetted appropriately.

If you or someone you know has an interest in participating in this process, contact Kelly Hunt, MD, FACS, co-author of this article and chair of the CCSD Committee, at khunt@mdanderson.org, or Carla Amato-Martz, ACS CRP program manager, at cmartz@facs.org.

Plan to attend the Town Hall meeting (TH11) on October 3 to get more information about our progress and offer your input.◆

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In order to receive accreditation from The Joint Commission (TJC), ambulatory surgery centers (ASCs) and office-based surgery (OBS) practices must establish an annual influenza vaccination program for licensed independent practitioners and staff. This TJC accreditation requirement took effect July 1. The Joint Commission standard on influenza vaccination previously applied only to hospitals and long-term care facilities, but has been expanded to include all accredited organizations, including those accredited under the ASC and OBS programs.

In addition to the 2012 requirement to establish a vaccination program, the standard will require surgery centers and practices to:

- Phase in other actions designed to improve vaccination rates, specifically the requirements to set incremental goals for meeting a 90 percent coverage rate by 2020
- Develop a written description of the methodology used to determine influenza vaccination rates
- Improve vaccination rates according to established goals at least annually starting in 2013

Although the standard will require ASCs and OBS practices to provide influenza vaccination at sites and times accessible to licensed independent practitioners and staff, it is important to note that vaccination itself is not mandatory for accreditation.

**Rationale**

The rationale for the expansion of the standard is straightforward: Vaccination is the single most effective method for preventing influenza deaths and illnesses across all health care settings. Despite the evidence supporting this rationale, the U.S. Department of Health and Human Services (HHS) reports that vaccination rates for health care professionals remain below 60 percent. Furthermore, the Centers for Disease Control and Prevention (CDC), the Association for Professionals in Infection Control and Epidemiology (APIC), and the Society for Healthcare Epidemiology of America (SHEA) have all also recommended influenza vaccination for all health care professionals.

In 2010, HHS issued an action plan in which it called on The Joint Commission to help meet national objectives for increasing influenza vaccination rates. That plan noted that expanding requirements to outpatient settings is a fundamental component of improving patient outcomes and protecting health care professionals.

The Joint Commission last year sought input from accredited organizations, including ASCs and OBS practices, on the expanded standard. This field review drew more than 2,000 responses, although a breakdown of responses from specific accredited organizations is not available at this time. Most respondents indicated that their organizations have offered influenza vaccination to staff and licensed independent practitioners for five years or more.

Before recommending approval, The Joint Commission Professional and Technical Advisory Committees also considered concerns about resource allocations necessary to comply with the expanded requirements.

For more information about the influenza vaccination standard, visit TJC at http://www.jointcommission.org/r3_issue3/. Information is available about the elements of performance for the vaccination standard that took effect July 1, as well as specifics about three of the elements of performance that will be phased in by July 1, 2013, for ASCs and OBS practices, reference information, and outstanding issues related to performance measures for vaccination rates.
last month’s Bulletin article focused on surfing and its associated injuries. This month we are looking at a different type of surfing—car surfing. A disturbing trend has emerged over the last 20 years—individuals are standing on top of moving cars to replicate the act of surfing. The term “car surfing” arose in the mid-1980s and describes a risky, thrill-seeking activity that involves riding on the exterior of a moving motor vehicle while another individual drives.

The most recent analysis at a national level was conducted by the U.S. Centers for Disease Control and Prevention and published in the October 17, 2008, issue of the organization’s Morbidity and Mortality Weekly Report. The review revealed 58 car surfing deaths and 41 nonfatal injuries from 1990 through August 2008. Most occurrences were in the south and midwest (75 percent); involved males (70 percent); and occurred in a younger population—with the 15-to-19-year-old age range representing the majority of these occurrences.*

What is the attraction to an activity that seems so intuitively dangerous? Numerous reality television shows glamorize “stunts” such as car surfing. The smartphone video camera has created transient stars out

The term “car surfing” arose in the mid-1980s and describes a risky, thrill-seeking activity that involves riding on the exterior of a moving motor vehicle while another individual drives.

of the individuals involved in these foolish and dangerous acts. The more outrageous the activity, the greater the odds that the video will go viral. Literally thousands of videos on the Web involve car surfing. Some even depict a fatal outcome. The widespread availability of these videos, coupled with the invincible attitude of youth, can be a recipe for disaster.

To examine the occurrence of car surfing injuries in the National Trauma Data Bank® (NTDB®) research dataset for 2010, medical admissions records were searched using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Specifically searched codes included external cause of injury E code E818.1 (other noncollision motor vehicle traffic incident or passenger injury that includes a fall, jump, or being accidentally pushed from motor vehicle while in motion).

A total of 1,542 records, including the subset of car surfing injuries, were uncovered. In all, 1,278 records contained a hospital discharge status, including 1,036 patients discharged to home, 134 to acute care/rehab, and 53 to skilled nursing facilities; 55 died. These patients were 58.6 percent male, on average 29.2 years of age, had an average hospital length of stay of 5.3 days, an intensive care unit length of stay of 4.8 days, an average injury severity score of 11.9, and were on the ventilator for an average of 5.8 days. A total of 812 were tested for alcohol, and 47 percent were found to have alcohol present (see Figures, page 70).

Anyone who has ridden a wave on the ocean knows how difficult surfing can be. One small break of the wave or a twist of the board will render the surfer off balance and send him or her flying. When car surfing, even at slow speeds a slight swerve of the wheel or bump in the road is enough to make riders lose their balance. Water is hard enough when hitting it head-on after falling off a surfboard, but concrete is far more unforgiving in a wipeout from the hood of a car.

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

Acknowledgement
Statistical support for this article has been provided by Chrystal Price, data analyst, NTDB.
Dr. Jack W. McAninch receives 2012 Distinguished Service Award

Jack W. McAninch, MD, FACS, of San Francisco, CA, will receive the American College of Surgeons (ACS) 2012 Distinguished Service Award, the College’s highest honor, during the annual Clinical Congress in Chicago, IL, September 30 to October 4. The award honors Dr. McAninch’s commitment to ACS initiatives and principles, his work as a surgeon and leader, and his dedication to educating students and surgeons.

Dr. McAninch serves as chief of urology at San Francisco General Hospital and as vice-chairman and professor of urology at the University of California, School of Medicine, San Francisco (UCSF). A graduate of the University of Texas Medical Branch, Galveston (1964), he completed an internship in surgery and a residency in urology at Letterman Army Medical Center, San Francisco (1964–1969).

In acknowledging Dr. McAninch’s work as a clinical academic surgeon who has published more than 400 scholarly papers, the ACS Board of Regents noted his “outstanding clinical and academic contributions to the field of genitourinary trauma and reconstructive surgery” in his professional positions at Letterman Army Medical Center (1973–1975), San Francisco General Hospital (1977–present), and UCSF (1977–present). Dr. McAninch’s career as an academic surgeon started at UCSF with a position as assistant professor of urology, and two years later, he became vice-chairman of the UCSF department of urology. In 1979, he was named an associate professor and in 1986 was appointed professor in the department of urology. He has been director of the UCSF urology residency program since 2002.

Dr. McAninch served as First Vice-President of the College (2008–2009), as a member of the Board of Regents (1998–2007), and as a member of the following ACS Committees: Regents Honors, Nominating, Finance, Communications, Member Services Liaison, Executive, and Organization. He was a member (1990–1993), program representative (1991–1996), and Regent representative (1998–2007) of the ACS Advisory Council for Urology; a member of the Board of Governors (1992–1998); a member and Chair of what is now known as the Comprehensive Communications Committee (2006–2011); and Co-Chair of the Patient Education Committee (2006–2010).

Dr. McAninch is also being recognized for his “exemplary leadership of many professional organizations,” including his service as president of the American Urological Association (AUA), the American Board of Urology, the Society of International Urology, the Western Section of the AUA, the Society of Genitourinary Reconstructive Surgeons, and the Northern California Urological Society. He is an Honorary Fellow of the Royal College of Surgeons of England.

The Board of Regents also acknowledged Dr. McAninch’s “expertise in education and instruction of his fellow surgeons through more than 100 invited visiting professorships and the mentoring of 24 fellows in urologic trauma and reconstructive surgery who all hold full-time academic positions at U.S. academic medical centers.”
Bulletin gets first makeover in more than 23 years

For the past nine months, the graphic designers in the American College of Surgeons Division of Integrated Communication have pooled their collective talents and experience in an effort to redesign the Bulletin of the American College of Surgeons. This is the first edition of the Bulletin that follows this new format.

This redesign represents the first full-scale makeover for the magazine in more than 23 years. The primary goal in creating this new, contemporary look for the publication was to provide ACS members with a more reader-friendly format. We have added color-coded tabs for the various sections of the magazine, including features, columns, and news. We’ve added boxed “highlights” to longer feature stories, so readers can determine at a glance whether the subject matter interests them. We’ve also added more pull quotes to add further emphasis to the key points of feature stories.

Three people in the Division of Integrated Communications deserve all the credit for developing and implementing the redesign: Mary Beth Cohen, Tina Woelke, and Bernie Kagel. They are to be commended for completing this project and creating what we believe is a more visually appealing and easier-to-read publication.

Please let us know what you think of the redesign, and, as always, we welcome your story ideas.

Diane Schneidman
Editor-in-Chief
dschneidman@facs.org

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Fellows honored for volunteerism

by Kathleen M. Casey, MD, FACS, and Akiyo Kodera

The Board of Governors’ Committee on Socioeconomic Issues has announced the recipients of the 2012 American College of Surgeons (ACS)/Pfizer Surgical Humanitarian Award and Surgical Volunteerism Awards. As in previous years, the committee received many exceptional nominations, reflecting the remarkable commitment of the Fellows of the College to the care of the underserved.

Surgical Humanitarian Award

The ACS/Pfizer Surgical Humanitarian Award recognizes ACS Fellows who have dedicated a substantial portion of their careers to ensuring that underserved populations receive surgical care. And while this work may constitute a large part of their career, they have done so without expectation of commensurate compensation. This year, two such extraordinary individuals will receive this award.

Catherine R. deVries, MD, FACS, FAAP, of Salt Lake City, UT, has been selected to receive the 2012 Surgical Humanitarian Award for dedicating 20 years of her career to improving urological care around the world (see photo, page 75).

A practicing pediatric urologist, Dr. deVries began her international volunteer career during residency training when she visited Honduras with the not-for-profit, Interplast. Recognizing the still unmet needs of children with genitourinary conditions and anomalies, she started to develop a model of care tailored to the conditions they faced in settings with limited resources.

In 1994, Dr. deVries founded International Volunteers in Urology, the first not-for-profit organization specifically focused on teaching urology in resource-poor settings. Using a comprehensive, sustainable approach that is adaptable to a variety of settings and cultures, IVU (since renamed IVUmed) oversees highly skilled professional teams that train physicians and nurses throughout Asia, Africa, and the Americas in almost all areas of urology.

The far-reaching impact of these educational partnerships can be seen in countries such as Vietnam, where early IVUmed trainees have established a urology training center in Ho Chi Minh City, which treats more than 1,000 patients annually and trains local physicians to work throughout the country. In Honduras, local partners now conduct their own surgical outreach workshops. Similar successes have been achieved in the 30 countries where IVUmed is active and further leveraged by a wide range of international partnerships.

IVUmed’s impressive growth from a small nonprofit to the leading organization for global urological care and education.

Her commitment to global surgery extends beyond her work at IVUmed: She serves as a member of the World Health Organization’s (WHO) Global Alliance to Eliminate Filariasis and the Global Initiative for Emergency and Essential Surgery Committee (GIEESC). She was the first female member of the Board of Chairmen of the Société Internationale d’Urologie (SIU), where she chairs the International Relations Committee. She is also a member of the Alliance for Surgery and Anesthesia Presence Today.

Dr. deVries teaches at both the University of Utah School of Medicine, Salt Lake City, and Stanford (CA) University School of Medicine on such topics as surgery and public health, and engineering innovations for the developing world. She recently founded the Center for Global Surgery at the University of Utah, a unique collaboration among the engineering, business, and medical schools with involvement across eight surgical divisions and anesthesia. She is the center’s director.

Dr. deVries graduated from Harvard University, Boston, MA, before receiving a master’s degree in pathology from Duke University, Durham, NC, and a medical degree from Stanford University. She completed her urology residency at Stanford, followed by a fellowship in...
Russell E. White, MD, MPH, FACS, FCS (EASC), will receive the Surgical Humanitarian Award for a career dedicated to improving surgical care in Bomet, Kenya, where he serves as chief of surgery and surgery residency director at Tenwek Mission Hospital (see photo, this page).

Born in the Belgian Congo, where his parents worked as medical missionaries, Dr. White was later raised in northern Michigan. Educated at Roberts Wesleyan College, Rochester, NY, and the University of Michigan Medical School, Ann Arbor, he pursued a master of public health degree at Harvard University during his general surgery residency at Brown Medical School, Providence, RI, followed by a thoracic surgery fellowship at Frenchay Hospital in Bristol, England. Throughout graduate school and postgraduate training, he engaged in volunteer medical work in both the local community and Africa. He relocated to Kenya in 1997 to pursue full-time the post of chief of surgery at Tenwek, a 300-bed tertiary referral hospital with a catchment of more than 8.5 million.

Dr. White has a special interest and expertise in esophageal cancer, the most common malignancy in Kenya. His presence at Tenwek has influenced its evolution into the busiest center in Kenya for palliative and curative treatment of esophageal cancer as evidenced by his caseload of approximately 2,000 patients and his extensive research on the etiology, screening, and treatment of this disease. In addition, Dr. White recently established a cardiac surgery program to address the high local incidence of rheumatic heart disease. Through Dr. White’s leadership, Tenwek actively collaborates with many academic and governmental institutions in the U.S. and Africa on these efforts.

Dr. White was instrumental in establishing Tenwek’s general surgery residency program in 2008 and has overseen it since as program director. One of the first surgical residencies in Kenya located outside Nairobi, the program is accredited through the College of Surgeons of East, Central and Southern Africa (COSECSA) and the Pan-African Academy of Christian Surgeons. The five-year program is now at full maturity with 10 active residents and will graduate its first class at the end of 2012. Since 1997, Dr. White has overseen a one-year rotating internship that accommodates another 16 surgical trainees and has helped develop the family practice residency program.

Dr. White spearheaded the funding and construction of multiple hospital facilities to accommodate these training programs and to improve the hospital’s surgical, endoscopy, and radiology facilities. Dr. White’s involvement in surgical education extends beyond the hospital and across borders. He serves as an oral examiner for COSECSA and coordinates the writing of their qualifying exams; collaborates on surgical and oncology training programs in Malawi, Zambia, and South Sudan; is an associate professor of surgery at Brown University; and supervises surgical residents on rotations to Tenwek. He is also on the staff at Rhode Island Hospital, where he works with medical students and residents.
**Surgical Volunteerism Award**
The ACS/Pfizer Surgical Volunteerism Award recognizes ACS Fellows and members committed to giving back to society through significant contributions to surgical care as volunteers. This year, three such awards will be granted.

**Brendan C. Brady, MD, FACS,** will receive the Surgical Volunteerism Award for domestic outreach in recognition of his extraordinary service to the underserved migrant population in the Finger Lakes region of upstate New York (see photo, this page).

A Buffalo, NY, native and resident, Dr. Brady received his undergraduate education at Canisius College in Buffalo and the University of Toronto, ON, from which he graduated. After completing medical school at the State University of New York at Buffalo and residency at Buffalo General Hospital, Dr. Brady practiced general surgery with the Canandaigua Medical Group in Buffalo for the next 30 years.

When his children were out of college, Dr. Brady revisited his initial motivation to pursue medicine: to help those most in need. He engaged in volunteer work initially with InterVol, a Rochester, NY, community-based not-for-profit organization, using his own vacation time for several years to provide relief for the sole surgeon at the Rosebud Sioux Reservation in South Dakota.

It was a 2004 encounter with a migrant farmworker, however, that motivated Dr. Brady to contact and offer his services to Finger Lakes Migrant Health (since renamed Finger Lakes Community Health), a community health center providing basic health care to approximately 8,600 migrant farm workers in upstate New York. Understanding the significant barriers this itinerant population faces in accessing quality surgical care, such as lack of transportation, language, and cultural barriers, as well as financial costs, Dr. Brady established a surgical clinic to augment the primary care and mobile health services provided by the agency. In addition to consulting and treating patients at the monthly clinic, Dr. Brady made arrangements with F. F. Thompson Hospital in Canandaigua, NY, to address more serious conditions at reduced rates by offering his services gratis. As a result of these efforts, migrant farm workers in the Finger Lakes area are able to receive surgical care otherwise unavailable. Many have had operations, such as hernia repair, that enable them to continue working so they can provide for themselves and their families. As Dr. Brady approaches retirement, his efforts are focused on developing a network of surgeons that will provide predictable, affordable, and high-quality care for the migrant population.

For 20 years, Dr. Brady also has served on the Board of Directors and as an officer of the Monroe Plan, an initiative that provides the underserved in the greater Rochester area with stable health insurance and access to physicians and other health care providers. Dr. Brady’s dedication to the underserved also extends overseas; since 2006, he has volunteered each year at the Hôpital Sacré-Coeur in Milot, Haiti, through the Center for the Rural Development of Milot Foundation, Inc.
Raymond R. Price, MD, FACS, will receive the Surgical Volunteerism Award for international outreach in recognition of his contributions toward improving surgical care in Mongolia and other countries, as well as his commitment to promoting the importance of surgery worldwide (see photo, page 76).

Dr. Price practices general and trauma surgery with the Intermountain Surgical Specialists in Salt Lake City, UT. He also is director of graduate surgical education at the Intermountain Medical Center and adjunct associate professor in the departments of surgery, family practice, and preventative medicine at the University of Utah. He is a founding member and associate director of the university’s Center for Global Surgery.

Dr. Price’s passion for global outreach developed while serving as a missionary in Thailand during his undergraduate years at the University of Utah. While at Harvard Medical School and during surgical residency at Brigham and Women’s Hospital he volunteered extensively to support refugees from Southeast Asia. Over the past decade, he has focused on improving education and access for surgical care globally, particularly in resource-poor areas in Indonesia, Mexico, Ethiopia, Ecuador, China, Belize, Nigeria, Haiti, and Mongolia.

Dr. Price’s most significant work has been in Mongolia, where he has guided the country’s transition toward laparoscopic surgery through his role as the medical programs director for the Swanson Family Foundation. His collaboration with the Health Sciences University of Mongolia and the Mongolian Ministry of Health has led to the establishment of laparoscopic surgery in the capital and the creation of regional treatment and diagnostic referral centers throughout Mongolia. These efforts also have provided a vehicle to improve and expand basic and emergency surgical care through education and infrastructure enhancements.

Dr. Price has been granted the Medal of Honor from the Mongolian Minister of Health, honorary membership in the Mongolian Surgical Society, and professorship at the University of Mongolia, all in appreciation for this work.

Dr. Price is actively involved in many national and international surgical efforts, including the ACS Committee on Trauma at both state and national levels, and the International Medical Surgical Response Team West. He is the ACS Governor from Utah and chairs the Governors’ Subcommittee on International Chapters. He serves on the International Committee of the Society of American Gastrointestinal and Endoscopic Surgeons, is a member of the Alliance for Surgery and Anesthesia Presence Today, as well as the WHO GIEESC, and is a former medical advisor and current board member of the humanitarian alliance, Ascend. At the Center of Global Surgery at the University of Utah, Dr. Price and Dr. deVries have developed and promoted sustainable approaches to surgical care in resource-poor areas.

Robin T. Petroze, MD, will receive the Surgical Volunteerism Award for outreach during residency for her collaboration with the medical...
leadership in Rwanda to improve the quality and availability of surgical care (see photo, page 77).

Dr. Petroze is a general surgery resident and research fellow at the University of Virginia (UVA), Charlottesville, and a research fellow at the faculty of medicine at the National University of Rwanda. Originally from Fort Mitchell, KY, Dr. Petroze graduated from the University of Kentucky in 2003, and volunteered for a year as an English and science teacher at St. Vincent Strambi High School in rural Jamaica. While attending the University of Cincinnati (OH) College of Medicine, she volunteered in health clinics in underserved areas throughout the city. Her first encounter with global health was with the Cincinnati-based Village Life Outreach Project in rural Tanzania, an experience she credits with teaching her the importance of partnership and sustainability in international development. As an intern at UVA, she traveled with Medical Ministry International to the Dominican Republic to participate in surgical outreach.

In 2010, Dr. Petroze was awarded a Fogarty International Clinical Research Fellowship to study the burden of surgical disease in Rwanda, which included conducting a nationwide hospital survey to define surgical capacity; developing and implementing a trauma registry at the two university teaching hospitals; and conducting a nationwide population study to determine surgical needs at the community level. For each project, Dr. Petroze initiated numerous collaborative efforts, working closely with the Rwandan Ministry of Health, the academic medical community, and community surgeons. She further worked to foster communication and collaboration among local and international surgical partners in Rwanda by helping to organize the first Strengthening Rwanda Surgery meeting. In addition, Dr. Petroze was a volunteer instructor for a 2011 Advanced Trauma Life Support® course that certified every surgeon in the country and was later invited to assist the Ministry of Health in developing a national injury care and prevention plan. Dr. Petroze’s collaborative approach, her focused advocacy efforts, and her deep respect and appreciation for the local surgeons have led the Rwandan surgical community to fully embrace her efforts. In recognition of her active engagement and work with the department of surgery at the National University of Rwanda, including encouraging research among her peers, advocating for surgical capacity building with the Ministry of Health, and volunteering time to teach and mentor medical students, in 2011, she was named a research fellow by the faculty of medicine at the university.

Dr. Petroze is completing an MPH at UVA and is involved in developing sustainable programs for international surgical education and development. She has been instrumental in developing an educational exchange between the University of Virginia and the surgical training program at the National University of Rwanda. The extraordinary contributions made by Drs. deVries, White, Brady, Price, and Petroze will be formally recognized at the annual Board of Governors dinner Tuesday, October 2, during the annual ACS Clinical Congress in Chicago, IL. Congress attendees are invited to hear them speak about their ongoing work and the inspiration behind it at the panel session, Humanitarian Surgical Outreach at Home and Abroad: Reports of the 2012 Volunteerism and Humanitarian Award Winners (PS107), Monday, October 1, 9:45 am to 1:00 pm. Attendees will also have the opportunity to meet them and others dedicated to surgical volunteerism in all its many forms at a volunteer networking reception later that evening at the Murphy Auditorium.

Full details on these events will be available in the Clinical Congress Program Book and on the Operation Giving Back website at http://www.operationgivingback.facs.org.
Dr. Hoyt, Dr. Opelka present ACS views on Medicare payment issues

David Hoyt, MD, FACS, Executive Director of the American College of Surgeons (ACS), spoke on Medicare payment reform during a July 18 House Energy and Commerce Health Subcommittee hearing. The goal of the hearing, titled Using Innovation to Reform Medicare Physician Payment, was to explore possible options for replacing the flawed sustainable growth rate (SGR) formula that is used to calculate Medicare reimbursement. Largely because of the SGR, a 27.5 percent cut in Medicare physician payments is scheduled to take effect January 1.

Witnesses and members of Congress at the hearing strongly agreed that the SGR should be replaced. Dr. Hoyt shared the College’s experience with quality programs and discussed the framework of the College’s draft SGR replacement proposal, the Value Based Update. Go to http://www.facs.org/ahp/testimony/index.html to view Dr. Hoyt’s written statement.

On July 11, Frank Opelka, MD, FACS, Associate Medical Director of the ACS Division of Advocacy and Health Policy, represented the College at a Senate Finance Committee Roundtable on this same issue. Go to http://www.facs.org/ahp/testimony/index.html to view Dr. Opelka’s statement.

The meeting, titled Medicare Physician Payments: Perspectives from Physicians, gave members of Congress a chance to hear the physician community’s suggestions for reforming the Medicare physician patient system, while encouraging health care providers to deliver high-quality, high-value health care.

Representatives from four other health care organizations—the American Medical Association, the American Academy of Family Physicians, the American College of Cardiology, and the American Society of Clinical Oncology—also participated in the roundtable. This meeting was the third in a series that the Senate Finance Committee has scheduled to examine the current state of the Medicare physician payment system. Go to http://www.finance.senate.gov/hearings/hearing/?id=077b0e7-303d-a032-324ea68349a2b to learn more about what the ACS is doing to help Congress fix the broken Medicare reimbursement system.

Celebrate the Centennial with a tour of ACS headquarters and Archives

The American College of Surgeons (ACS) invites all College members to take advantage of their time away from Clinical Congress sessions to tour the headquarters at 633 N. Saint Clair St. in Chicago, IL. The 45-minute tour, which will include the ACS Archives, will begin on Wednesday, October 3, at 11:00 am, allowing participants to get a special glimpse into the organization’s rich 100-year history.

The ACS purchased the current headquarters building, a modern blue-green marble and silver glass structure, and staff moved there in January 1998. The College leases floors 1 to 17 to the Hyatt Magnificent Mile Hotel, floors 18 and 19 to the Feinberg School of Medicine, Northwestern University, and floors 20 and 21 to Draft FCB. The ACS office staff members are housed on floors 22 through 28, where there are also the offices of several surgical societies, including the Society of Vascular Surgeons, the Society of Thoracic Surgeons, the American Board of Thoracic Surgeons, and the American Association for the Surgery of Trauma.

During the tour, guided by ACS Archivist Susan Rishworth, participants will have the opportunity to view the ACS Archives, including some ACS special artifacts. Among these treasured pieces of the College’s history are the casebooks, scrapbooks, and papers of the College’s Founder Franklin H. Martin, MD, FACS, as well as the papers of Eleanor Grimm, his trusted assistant who recorded the history of the College from its inception. Also on display will be casebooks of Fellows applying for membership in the 1930s and 1940s and mementos of the College’s 1923 voyage to South America for its 10th anniversary celebration.

Preregistration is required for the tour, and sign-up sheets will be available at the Archives section of the ACS Resource Center in McCormick Place West. The tour will commence on the ground floor lobby of the headquarters building. Transportation to the College headquarters from McCormick Place will be provided by the Brown Bus Line (Route 6). The bus will unload at the Hyatt Hotel, where visitors can gain access to the College through its main entrance on Saint Clair Street.
New Advisory Council for Rural Surgery offers several programs during Clinical Congress

J. David Richardson, MD, FACS, Chair of the American College of Surgeons (ACS) Board of Regents, has identified the importance of developing College programs and services that are designed to support and promote rural surgery. As part of this commitment to surgeons who practice outside metropolitan areas, the Board of Regents established the ACS Advisory Council for Rural Surgery (ACRS) during its June 2012 meeting. The fact that this is the only new advisory council created in the past 50 years attests to the necessity of its establishment and its relevance to ACS leaders.

The mission of the ACRS is to identify, investigate, and rectify the challenges associated with rural surgical practice. For example, rural surgeons must contend more frequently than their urban counterparts with limitations of support, resources, personnel, continuing education, and reimbursement.

To address these complex issues, the ACRS will work to develop broad-based training through rural residency tracks, and to improve recruitment, retention, mentoring, and post-residency education for rural surgeons.

All of the council’s efforts reflect the College’s commitment to ensuring that the nation’s 60 million rural patients have access to high-quality surgical care and to addressing the challenges facing rural surgeons.

An active start
The ACRS will present its first educational program, Advanced Skills Training for Rural Surgeons: Complex Wound Care and Specialized Diagnostic Techniques, the day before the 2012 Clinical Congress, on September 29, from 8:15 am to 5:45 pm, at the Northwestern Center for Advanced Surgical Education, 240 E. Huron, LC-460, in Chicago, IL. Chairing the program will be two members of the ACRS—Amy L. Halverson, MD, FACS, assistant professor of surgery at the Feinberg School of Medicine, Northwestern University, and a colon and rectal surgeon at Northwestern Memorial Hospital, Chicago; and Philip R. Caropreso, MD, FACS, a general surgeon from Keokuk, IA. The course will provide hands-on skills instruction in central lines, breast surgery, plastic surgery, and breast ultrasound. For more information about the course, contact skillscourses@facs.org.

Several other programs during the Clinical Congress, which will take place September 30 to October 4 at McCormick Place West in Chicago, will center on rural surgery. The following is a sampling of the sessions:

• Disparities in Access to Surgical Care will be presented at 11:30 am on Monday, October 1, in room W 179. This session will focus on the needs of rural and underserved communities and the patients who reside in these areas.

• The Ninth Annual Rural Surgeons Open Forum and Oweida Scholarship Presentation will take place from 4:15 to 5:45 pm, on Tuesday, October 2, in room W 194. The Advisory Council on Rural Surgery sponsors this open forum to encourage direct communication between rural general surgeons and a panel of leaders in American surgery. Representatives from the Board of Regents, the Board of Governors, the executive staff, and the ACS Health Policy Research Institute have been invited to participate.

• Careers in Rural Surgery will be presented at 11:30 am on Wednesday, October 3, in the Hyatt McCormick Place Conference Center, Room 12A.

In addition, all rural surgeons and their spouses are invited to attend the ACRS-hosted dinner on Monday, October 1, which will take place at Maggiano’s Little Italy, 516 North Clark St., in Chicago, starting at 7:30 pm. The cost per person is $55.75. To reserve a space and to pre-pay, contact Tyler Hughes, MD, FACS, at tylerh@mcphersonhospital.org, by September 14. This event will provide rural surgeons with a chance to network and connect with each other.

For more information about the ACRS, go to http://www.facs.org/about/councils/advrural/advrural.html.
College hires new HR Director and promotes staffer to lead PI effort

David B. Hoyt, MD, FACS, Executive Director of the American College of Surgeons (ACS), recently announced that the College has filled two key positions on its executive team.

Michelle McGovern joined the College on July 30 as Director of Human Resources (HR). Ms. McGovern has 20 years of experience in human resources and most recently served as senior vice-president of human resources at Mesirow Financial, Chicago, IL, where she was responsible for all of the company’s human resources activities. She previously served as vice-president of human resources for General Growth Properties, a real estate leasing company. Ms. McGovern’s experience also includes employment as a senior employee relations manager for Claire’s Boutiques and a human resources generalist for the Chicago Board Options Exchange.

Ms. McGovern holds a master’s degree in human resources and industrial relations from Loyola University in Chicago and serves on the board of the Human Resources Management Association of Chicago. Dr. Hoyt noted that Ms. McGovern’s breadth of human resources experience—from employee recruitment and retention and benefits administration to leadership development and performance management systems—will be crucial in developing the College’s world-class workforce.

Will Chapleau, who has managed the College’s Advanced Trauma Life Support® (ATLS®) program for six years, assumed the newly created position of Director of Performance Improvement (PI), although he will continue to oversee the ATLS program until his replacement is hired. In his new post, Mr. Chapleau will lead the transition from a GE-led PI initiative at the College to an internal program. He brings to the position a unique background as a licensed nurse with experience in emergency and critical care and 36 years as a licensed paramedic, including his work as chief of the Chicago Heights, IL, Fire Department, and its director of emergency medical services (EMS) and the Emergency Management Agency.

Mr. Chapleau has lectured on EMS and trauma topics in more than 40 countries and has been an EMS educator for 28 years. He has written four published EMS textbooks as well as numerous journal articles. Mr. Chapleau serves as chair of Prehospital Trauma Life Support and has participated with boards of the National Association of Emergency Medical Technicians, the National Association of EMS Educators, and the Society of Trauma Nurses. Since 2000, he has worked as an instructor and as a member of the executive council of Advanced Trauma Care Nursing. He earned an associate degree in fire science administration from Prairie State College in Chicago Heights as well as an associate degree in nursing from Western Illinois University, Macomb.
**JACS rises in prominence among surgical journals**

In terms of impact in the surgical world, the *Journal of the American College of Surgeons* (JACS) continues to grow in stature, reports JACS Editor-in-Chief Timothy Eberlein, MD, FACS. JACS’ “impact factor”—referring to the average number of citations per article published in a scientific or social science journal during the two preceding years—rose to 4.549, up from 4.241 in 2010. This most recent distinction raises JACS to sixth in impact factor among 198 scholarly surgical journals. JACS ranked seventh in 2010.

A scholarly journal’s impact factor is an indication of its relative prestige within its field. Impact factors are calculated annually for journals that are indexed in the *Journal Citation Reports*, published by Thomson Reuters, providing quantifiable information about the world’s leading journals. For comparison’s sake, in 2003, JACS had an impact factor of 2.071 and was ranked 25th among surgical journals.

Under Dr. Eberlein’s leadership, JACS has undergone a number of changes that have helped raise its prestige and presence. According to independent readership surveys, JACS is far and away the most widely read of all general surgery journals. JACS continues to attract more groundbreaking authors, largely through its collaboration with surgical societies, such as the Southern Surgical Association. JACS also publishes peer-reviewed articles, and is committed to expediting the peer-review process. The time to first decision from the time of submission is just over three weeks.

Dr. Eberlein credited JACS’ continued rise in prominence to the two managing editors, Anne Magrath and Anne Wolfe, as well as the publisher, Elsevier.

Recently, work began on a Chinese edition. The inaugural issue of the Chinese version of JACS will be published in November 2012.

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To learn about the accreditation process, visit: [www.napbc-breast.org](http://www.napbc-breast.org)
Report on ACSPA/ACS activities: June 2012

by Lena M. Napolitano, MD, FACS, FCCP, FCCM

AMERICAN COLLEGE OF SURGEONS PROFESSIONAL ASSOCIATION (ACSPA)

As of May 22, the ACSPA’s political action committee (PAC)—ACSPA-SurgeonsPAC—raised $332,801. In all, 35 percent of the U.S. Governors contributed. A total of 100 percent participation from all U.S. Governors is expected. Also the ACSPA-SurgeonsPAC contributed to 99 candidates, leadership PACs, and party committees.

AMERICAN COLLEGE OF SURGEONS (ACS)

Member Services
The Executive Committee of the Board of Governors held several telephone conference calls. The Board of Governors committee chairs and other ACS leaders participated. The Executive Committee has set the following goals for 2012:

• Increase communications with Board of Governors via webinars and electronic newsletters
• Standardize and increase diversity for Board of Governors nomination and selection process
• Conduct 10-year review of annual Board of Governors survey
• Review overall role of Board of Governors in ACS
• Examine current Board of Governors committee structure
• Align/interact with other ACS committees
• Evaluate for redundancy, synergy

The Nominating Committee of the Board of Governors (NCBG) expressed its perspective on some inconsistencies and uncertainties that challenged the committee in its deliberations, and used the NCBG members’ collective experience to make recommendations for the future. The aim was to ensure the continued identification and selection of outstanding leaders who represent the diverse membership of the ACS through a process that is fair and transparent. The NCBG asked the Board of Regents to conduct a review of the current specialty allocation of the Board of Regents to determine if this allocation accurately reflects the specialty membership of the ACS, and to revise the ACS Bylaws for consistency of language (such as “surgical” versus “clinical practice”) and to include a clear definition of “active practice.” The Board of Regents delegated this task to its Bylaws Committee for review and action.

Advisory Council for Rural Surgery
The College had previously been asked to appoint dedicated staff for rural surgeons and to continue and expand its current activities in the rural surgery arena. The Board of Regents subsequently approved an Advisory Council for Rural Surgery as well as its initial membership. The members are listed in the sidebar on this page (see related story, page 80).

ADVISORY COUNCIL FOR RURAL SURGERY

• Tyler G. Hughes, MD, FACS, McPherson, KS—Chair
• Joseph A. Blansfield, MD, FACS, Danville, PA
• David G. Borgstrom, MD, FACS, Cooperstown, NY
• R. Phillip Burns, MD, FACS, Chattanooga, TN
• Nadine R. Caron, MD, Prince George, BC
• Phillip R. Caropreso, MD, FACS, Keokuk, IA
• Julie A. Conyers, MD, FACS, McCall, ID
• Karen E. Deveney, MD, FACS, Portland, OR
• James K. Elsey, MD, FACS, Lawrenceville, GA
• Amy L. Halverson, MD, FACS, Chicago, IL
• Sara L. Hartsaw, MD, FACS, Gillette, WY
• Don K. Nakayama, MD, FACS, Macon, GA
• Mark W. Puls, MD, FACS, Alpena, MI
• J. David Richardson, MD, FACS, Louisville, KY
• Michael D. Sarap, MD, FACS, Cambridge, OH
• Mark T. Savarise, MD, FACS, Sandpoint, ID
• Lauren Smithson, MD, Southfield, MI
• Robert P. Sticca, MD, FACS, Grand Forks, ND
• Gary L. Timmerman, MD, FACS, Sioux Falls, SD
Advocacy

In February, Congress passed a 10-month short-term sustainable growth rate (SGR) patch that averted the scheduled 27.4 percent cut in Medicare’s physician payment rate. Most of the cuts that paid for the latest “doc fix” came from the health care sector. In addition, the bill drained about $5 billion from the Affordable Care Act’s Prevention and Public Health Fund.

The ACS led the physician charge to eliminate the SGR formula using Overseas Contingency Operations (OCO) funds—unspent monies for military operations abroad. The ACS pointed out that using the OCO funds would enable Congress to eliminate all of the accumulated and future scheduled payment cuts that the SGR has created, while producing a more accurate and fiscally responsible budget. Use of unspent OCO funds to offset the cost of repealing the SGR has almost universal support from organizations representing physicians, hospitals, and senior citizens.

The ACS leadership met with key members of Congress to urge them to permanently repeal the flawed SGR formula and to use war drawdown savings. Despite the medical community’s hard work and the efforts of some legislators, Congress is poised again to postpone repeal and permanent reform. The ACS continues to urge Congress to find the political will to pass permanent repeal legislation and better serve American patients.

At the urging of the ACS and other groups, several members of the House of Representatives sent a letter to congressional leaders in support of moving forward with a permanent repeal of the SGR formula and of offsetting the full cost of repeal with unused OCO funds.

The ACS has been actively involved in other areas of concern including:

- Centers for Medicare & Medicaid’s (CMS) proposed rules to promote program efficiency, transparency, and burden reduction
- CMS’ two final rules to reduce regulatory burdens
- CMS’ final rule on ordering and referring requirements for physicians (see “What Surgeons should know about…” on page 60 for details)
- ICD-10 implementation
- Good Samaritan Health Professionals Act
- Health Care Safety Net Enhancement Act
- Health information technology/electronic health records
- Workforce shortage issues
- Drug shortages and other issues in U.S. Food and Drug Administration (FDA) user fee reauthorization bills
- Pandemic All Hazards Preparedness Reauthorization Act
- Government Accountability Office Study on Trauma

The ACS supported liability legislation passed in the House as part of the package to repeal the Independent Payment Advisory Board. In a twist on the liability reform debate in the 112th Congress, many U.S. representatives believe that medical liability reform is an issue that should be decided at the state level.

The ACS, along with its colleagues in the health care community, supported the following appropriations requests for FY 2013:

- Funding for the Children’s Hospital Graduate Medical Education program, which provides federal funds to the nation’s freestanding children’s hospitals to help them maintain their physician training programs
- $32 billion funding request for the National Institutes of Health (NIH)
- $224 million in funding for trauma and emergency medical services programs and activities
- $5 million for the Pediatric Subspecialty Loan Repayment Program
- Funding for the Emergency Medical Services for Children (EMSC) program at the authorized level of $28,940,625
- $2.013 million in fiscal year (FY) for a national emergency database
- Funding for the trauma and emergency medical services programs in Fyys 2013 and 2014
- Funding for the NIH, National Cancer Institute, and National Institute on Minority Health and Health Disparities
- Funding for the Centers for Disease Control and Prevention cancer programs, as cuts would reduce the number of people being served by life-saving screening and outreach programs
- Funding for the Health Resources and Service Administration
Patient Navigator Program to help cancer patients navigate the health care system and overcome barriers to access cancer care.

- Funding for the FDA to further integrate cutting-edge science that will streamline the translation of cancer research from early-stage discovery to clinical application.

With regard to health policy research, the ACS is exploring research opportunities in five health policy areas: alternative payment, medical liability reform, graduate medical education/workforce, registry data harmonization, and trauma.

With regard to state affairs, most state legislatures have met and adjourned. Issues that the state legislatures have addressed over the past six months include budget deficits and the contribution of ever-increasing Medicaid costs. In addition, legislators were less inclined to take on controversial local issues due to this being an election year.

From the standpoint of surgery and surgical issues, the ACS has tracked more than 1,300 pieces of legislation relating to four core areas: medical liability reform, quality/patient safety, workforce/surgical practice, and physician payment.

The Chapter Lobby Day Grant Program was very well-received for 2012, with 16 state chapters receiving funds to assist those chapters in conducting a lobby day at their state capitol. These events were completed by July. Reflecting the reality that each state is different, a few states simply “tagged along” with their state medical societies for a Doctors Day at the capitol. Others sponsored their own lobby days, or hosted a legislative reception and dinner for legislators, U.S. Supreme Court members, and other elected officials.

**Education**

Advances continue to be made in redesigning the Clinical Congress program to address the spectrum of learning needs of general surgeons and surgeons from across the surgical specialties. The Clinical Congress program addresses a range of important clinical and nonclinical topics and includes the desired balance between review sessions and presentations of original scientific work. The overarching goal is to offer the attendees a range of education and training opportunities from which they can select specific sessions and courses to address their specific needs and comply with various national imperatives and mandates. The program is organized into tracks with a block structure that includes a variety of different sessions and courses. In addition to opportunities to earn Category 1 continuing medical education (CME) credits, special certificates of verification are provided for successfully completing postgraduate courses. Also, attendees are able to earn credits for patient safety, trauma and critical care, ethics, and palliative care. Special certificates documenting achievement of the aforementioned credits are provided by the College.

**NEW POSTGRADUATE COURSES IN THE 2012 PROGRAM**

- Surgical Critical Care Board Review
- Trauma Techniques: From Top to Bottom
- Bundled Care and the Future of Surgical Health Care: Delivery and Outcomes
- Advanced Hepatopancreaticobiliary Ultrasound
- Practical Applications of Ultrasound in the ICU: ECHO and Thoracic
- Telemedicine In Surgery: Building a Virtual Practice
- Robotic Pelvic Surgery
- Management of Diabetic Lower Extremities
- Advanced Skills Training for the Rural Surgeon: Complex Wound Care and Specialized Diagnostic Techniques
- Advanced Leadership Skills
The 2012 Clinical Congress Program comprises 23 tracks and includes 11 named lectures, 106 panel presentations, 23 didactic and skills postgraduate courses, 127 scientific papers, more than 350 poster presentations and presentations in the Owen H. Wangensteen Surgical Forum, 24 video-based Education Sessions, and 55 Meet-the-Expert Luncheons. In addition, 17 Town Hall Meetings will be convened. A new track has been added for informatics, and a few sessions related to the ACS Centennial have been included. More than 1,700 speakers and faculty will participate in the 2012 Clinical Congress program. New postgraduate courses in the 2012 program are listed in the sidebar on page 85.

Each postgraduate course of the 2012 Clinical Congress will offer the opportunity to earn a special certificate of verification based on the College’s 5-Level Verification Program. Several courses have been taken to higher levels of verification using the expertise of the College. Of the didactic postgraduate courses, nine will offer Level I Verification and two will offer Level II Verification. Of the skills postgraduate courses, three will offer Level I Verification, seven will offer Level II Verification, and two will offer Level III Verification. Also, postgraduate courses will offer the opportunity to earn self-assessment credits.

New technology continues to be introduced in the Clinical Congress Program. The new electronic platforms should help attendees to customize their Clinical Congress experiences.

Enrollment in the Surgical Education and Self-Assessment Program (SESAP™) 14 since its release is 7 percent higher than the enrollment for SESAP 13 for the comparable period. Development of SESAP 15 is proceeding well and it will be released in October 2013.

A total of 36 sessions from the 2012 Clinical Congress have been selected for webcasting, and a new package, Webcast Pick 12 of 2012, will be offered this year. This option includes a choice of 12 of the 36 webcast sessions and provides individuals the opportunity to select the webcast sessions most relevant to their practices. Two additional packages are available: the Webcast Package, which includes all 36 sessions, and the Complete Best Value Package, which includes all 36 webcast sessions, 33 webcast sessions from the 2011 Clinical Congress, and 43 selected audio recordings of panel presentations and named lectures. The webcasts (but not the audio recordings) offer opportunities to earn Category 1 CME Credits. Posttests have been added to the Webcasts to provide a more robust learning experience and to offer self-assessment credits. The Complete Webcast Package offers the opportunity to earn up to 103.5 Category 1 CME credits, including credits for self-assessment. 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.

Fundamentals of Laparoscopic Surgery (FLSTM) is a collaborative program between the College and the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) that has had a significant impact on residency education. A newly revised edition of FLS, entitled FLS 2.0, has been released. The didactic, online study guide of this edition features hundreds of new photographs, illustrations, links, and videos. More than 90 percent of the content has been revised and four topics areas have been added: preoperative considerations, intraoperative considerations, basic laparoscopic procedures, and postoperative care and complications. All residency programs that have active FLS accounts have received the new version at no charge.

The surgical patient Ostomy Home Skills Kit is based on current guidelines and standards for surgical patient education. It provides information on complications during the postoperative period and helps with acquisition of skills to manage ostomies. The Pediatric Ostomy Skills Kit is currently being developed. The booklet has been completed and the DVD is in the final stages of production.

The College provides Category 1 CME credits for its educational programs, as well as educational programs of other surgical organizations participating in the Joint Sponsorship Program.
The rigorous and evolving standards of the Accreditation Council for Continuing Medical Education (ACCME) must be met for continuing accreditation of the College as a provider of CME credits. In calendar year 2011, the ACS accredited a total of 1,770 activities, which provided more than 24,000 credits to more than 160,000 physicians. These activities included live courses, Internet-based activities, enduring materials, and Journal CME activities. Of these programs, 1,677 were directly sponsored (ACS activities) and 93 were activities through the Joint Sponsorship Program.

Journal of the American College of Surgeons (JACS)

The JACS app rolled out in May, and is available in the iTunes App Store. JACS articles are available through the app, and full text is free to Fellows and subscribers. The app allows the user to browse JACS and read articles on a smartphone or iPad. It has a full suite of features, including bookmarking key articles, e-mailing useful images or articles, and playing videos that are part of JACS’ online content.

Submissions of original scientific articles, the main focus of content in JACS, increased 40 percent from 2007 to 2011. JACS continues to see an increase in the number of international submissions and published articles.

The JACS CME program continues to be an important service JACS offers to Fellows.

ACS CENTENNIAL CELEBRATION ACTIVITIES

- All 2012 Clinical Congress attendees will receive a copy of A Century of Surgeons and Surgery: The American College of Surgeons, 1913–2012, a complete history of the College written by David L. Nahrwold, MD, FACS, and Peter J. Kernahan, MD, PhD, FACS.
- A magazine commemorating the Centennial. The magazine will include articles by Fellows of the College, features on the surgical specialties, and historical vignettes gleaned from the archives. A copy will be given to all ACS members (2012).
- Proclamation letters from Chicago’s Mayor and Illinois’ Governor (2012).
- Prominent billboards on expressways into Chicago (2012).
- Ads and features about the Centennial on shuttle vision (buses) during the Clinical Congress (2012–2013).
- Interactive timeline exhibit at Clinical Congress, focusing on 100 years of the ACS juxtaposed with a century of major worldwide events (2012–2013).
- Special participation by and recognition of our major exhibitor partners (2012–2013).
- Chicago Police Department bagpipers to lead the audience from the ACS Convocation to the celebratory reception at the 2012 Clinical Congress.
- Expanded celebratory reception following the Convocation at the 2012 Clinical Congress, along with a cake-cutting event on Tuesday evening after the Board of Governors Dinner.
- Special “100 Years” logo featured on all publications, badges, signage, podiums, social invitations, menus, flyers, letterheads, and so on (2012–2013).
- Featured historical topics and highlighting the Centennial in the presidential theme and major lectures at the 2012 and 2013 Clinical Congresses.
and subscribers. To enhance the educational value of the program, in April 2012 the program was expanded to four questions per article, requiring a score of at least 75 percent to obtain credit. The JACS CME website was redesigned by the ACS Information Technology (IT) department and gives the user a more streamlined, friendly experience. Users will be able to select articles based on specialty and subject, which will be more useful for meeting Maintenance of Certification requirements. Increasing numbers of Fellows and subscribers are attaining CME credit using the JACS CME website: from May 1, 2011, through April 30, 2012, 95,566 JACS CME credits were earned by 3,378 people, averaging more than 28 credits per person.

**ACoS IT**

The ACS is a complex organization with a diverse set of programs and services. Its IT infrastructure to support these programs contains more than 30 software applications, including but not limited to:

- Membership management
- E-commerce
- Breast accreditation management system
- Cancer accreditation management system
- Trauma course management
- Trauma verification
- Clinical Congress management
- Online CME

These programs are being migrated to a single constituent management platform. In addition, the College is also managing a number of quality databases including the ACS National Surgical Quality Improvement Program, The National Trauma Data Bank®, the Trauma Quality Improvement Program, Bariatric Surgery, the National Cancer Data Base, and the Surgeon Specific Registry.

**American College of Surgeons Foundation**

The Board of Regents approved the appointment of Steven C. Stain, MD, FACS, to the ACS Foundation Board of Directors. In addition, the Foundation board reported that Patrick Ryan had been confirmed as the speaker for the Fellows Leadership Society Recognition Luncheon at the 2012 Clinical Congress.

**ACS Centennial event planning**

The American College of Surgeons will celebrate its 100th anniversary in 2013. The process of incorporation for the College was begun in 1912. The centennial celebration will start at the 2012 Clinical Congress in Chicago, IL, where the organization is headquartered, and will continue throughout the 2013 Clinical Congress in Washington, DC. Some of the centennial celebration activities are listed in the sidebar on page 87.

The JACS app rolled out in May, and is available in the iTunes App Store. JACS articles are available through the app, and full text is free to Fellows and subscribers. The app allows the user to browse JACS and read articles on a smartphone or iPad.
2012 Oweida Scholar announced

Stephanie M. Allen Lilly, MD, FACS, of Berlin, NH, has been selected to receive the 2012 Nizar N. Oweida, MD, FACS, Scholarship of the American College of Surgeons (ACS). During her residency, Dr. Allen pursued a career path in rural general surgery and completed the Integrated General Surgery Residency Program at the University of Connecticut Health System, Hartford. This residency training program combines the benefits of a university program with community-based training. The clinical experience, which includes many complex operative cases and exposure to a large, experienced faculty, has quickly adopted advances in minimally invasive surgery.

In 2006, Dr. Allen Lilly began serving as an attending surgeon at the northernmost regional health care center in New Hampshire, at Androscoggin Valley Hospital, in Berlin.

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

The Oweida Scholarship helps young surgeons practicing in small towns and rural communities attend the Clinical Congress and benefit from the educational experiences it provides. The Executive Committee of the Board of Governors awards the scholarship annually.

The requirements for this award are posted to the College website, at http://www.facs.org/memberservices/oweida.html. The application deadline for the 2013 Oweida Scholarship is December 14, 2012.

NOW AVAILABLE from the American College of Surgeons

Transfer your ACS CME credit to the American Board of Surgery electronically!

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

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

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

Log into the member Web portal at www.eFACS.org to get started
The International Relations Committee of the American College of Surgeons (ACS) sponsors three academic surgeon exchange programs. In all three cases, the College sends a talented, young North American surgeon to the annual surgical meeting of the participating country. After the meeting, they have the opportunity to tour several sites tailored to their specific research interests. In exchange, the College accepts one of the participating country’s young academic surgeon-scholars to attend the College’s annual Clinical Congress. Arrangements are in place with the Royal Australasian College of Surgeons with the ACS Australia-New Zealand (ANZ) Chapter, the Japan Surgical Society with the ACS Japan Chapter, and the German Surgical Society with the ACS Germany Chapter.

The exchange traveler for 2012 from Australia is John R. Beers, MBBS, FRACS. A consultant plastic and reconstructive surgeon at the Alfred Hospital in Kew, Victoria, he has written extensively on reconstructive surgery, including hand surgery, burn repair, and limb salvage. He is also one of the authors of The Intern Manual. His U.S. counterpart, Vikram S. Kashyap, MD, FACS, co-director of Harrington-McLaughlin Heart and Vascular Institute of Case Western Reserve University, Cleveland, OH, attended the Annual Scientific Congress of the Royal Australasian College of Surgeons in Kuala Lumpur, Malaysia, in May 2012.

In October 2012, the College will welcome the Japan Exchange Fellow, Shuhei Komatsu, MD, PhD, assistant professor of digestive surgery at Kyoto Prefectural University, Japan. Dr. Komatsu’s research focuses on surgical oncology, laparoscopic surgery, and studies of the biomarkers that affect inheritance of cancer. Stephen R. Grobmyer, MD, FACS, Edward M. Copeland III Chair in Breast Cancer Research at the University of Florida, Gainesville, attended the Japan Surgical Society meeting in Chiba in April 2012. (His report will be published in the October Bulletin of the American College of Surgeons.)

The College’s other exchange partner is Germany. ACS Traveling Fellow Emad Kandil, MD, FACS, Edward G.T. Schlieder Chair of Surgical Oncology at Tulane University School of Medicine in New Orleans, LA, attended the German Surgical Society’s annual meeting in Berlin in April. (His report will be published in the October issue of the Bulletin.) His German counterpart, Marco Niedergethmann, MD, PhD, of Mannheim, Germany, will attend the ACS Clinical Congress this year and will visit several surgical sites with the guidance of his mentors at home and in the U.S. Dr. Niedergethmann is a surgical oncologist interested in liver and bile duct surgery and pancreatic surgery.
Six Resident Research Scholarships awarded for 2012–2014

Six Resident Research Scholarships for 2012 were awarded earlier this year. The scholarships are offered to encourage residents to pursue careers in academic surgery and carry awards of $30,000 for each of two years, beginning July 1, 2012. These scholarships are sponsored by the Scholarship Endowment Fund of the College.

The recipients of these scholarships are as follows:

**Prassana Alluri, MD**, resident in surgery, University of Michigan, Ann Arbor.  
*Research project:* An Integrated Approach Towards Targeted Therapy for Prostate Cancer and Other Epithelial Cancers.

**Christopher Tignanelli, MD**, resident in surgery, University of North Carolina, Chapel Hill.  
*Research project:* Targeting KRAS Mutant Colorectal Cancer.

**Benjamin Bryner, MD**, resident in surgery, University of Michigan, Ann Arbor.  
*Research project:* Development of an Artificial Placenta for Premature Infants.

**Mahua Dey, MD**, resident in neurosurgery, University of Chicago.  
*Research project:* Role of Plasmacytoid Dendritic Cells in Malignant Glioma Progression.

**Leonid Cherkassky, MD**, resident in surgery, Brown University, Providence, RI.  
Research being undertaken at Memorial Sloan-Kettering Cancer Center, New York, NY.  
*Research project:* Immunomodulation of the Malignant Pleural Mesothelioma Microenvironment by TGF-β Inhibiting Cancer-Antigen Targeted T Cells.

**Lung-Yi Felix Lee, MD**, resident in surgery, University of Wisconsin-Madison.  
*Research project:* Targeting Nrf2 in Hepatic Stellate Cells: a Novel Strategy to Mitigate Ischemia-Reperfusion Injury.

The description and requirements for these research-oriented scholarships are posted on the College website at [http://www.facs.org/memberservices/acsscholar.html](http://www.facs.org/memberservices/acsscholar.html).

The Scholarship Endowment Fund provides income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Fellows wishing to make tax-deductible gifts to fund these vital programs are encouraged to contact the ACS Foundation at 312-202-5139.
Faculty Research Fellowships beginning in 2012 awarded

The American College of Surgeons (ACS) awarded its Faculty Research Fellowships for 2012 earlier this year. These two-year fellowships are offered to surgeons entering careers in surgery or a surgical specialty and carry awards of $40,000 per year from July 1, 2012, through June 30, 2014.

Faculty Research Fellowships are sponsored by the Scholarship Endowment Fund of the College. The Franklin H. Martin, MD, FACS, Faculty Research Fellowship of the American College of Surgeons honors the founder of the ACS. The C. James Carrico, MD, FACS, Faculty Research Fellowship for the Study of Trauma and Critical Care honors the late Dr. Carrico. The Louis Argenta, MD, FACS, Faculty Research Fellowship is presented by Kinetic Concepts, Inc., to support research in wound healing and is presented in honor of Dr. Argenta, who is a plastic surgeon; this fellowship is one year in length.

The recipients of these fellowships are as follows:

- **Franklin H. Martin, MD, FACS, Faculty Research Fellow:** Derrick C. Wan, MD, assistant professor of surgery, Stanford University, CA. *Research project:* Epigenetic Regulation of Adipose-Derived Stromal Cell Differentiation.

- **C. James Carrico, MD, FACS, Faculty Research Fellow:** Rachel G. Khadaroo, MD, FACS, FRSCS, assistant professor of surgery, University of Alberta, Edmonton. *Research project:* The Role of Oncostatin M in Organ Injury Following Acute Intestinal Ischemia/Reperfusion.

- **Louis Argenta, MD, FACS, Faculty Research Fellow:** Kimberly J. Riehle, MD, acting assistant professor of surgery, University of Washington, Seattle. *Research project:* Improving Regeneration in the Fibrotic Liver.

- Additional Faculty Research Fellowships for 2012–2014 were awarded to:
  - **Philip Wai, MD, assistant professor of surgery, Loyola University Medical Center, Maywood, IL. Research project:** Inhibition of Circulating Osteopontin Inhibits Growth and Metastasis of Hepatocellular Cancer.
  - **Parsia A. Vagefi, MD, assistant in surgery, Massachusetts General Hospital, Boston, MA. Research project:** Creation of Chimeric Pig Liver Xenografts Utilizing Baboon Bone Marrow Transplantation: The Potential of Surrogate Tolerance.

The description and requirements for this program are posted on the College website at [http://www.facs.org/memberservices/acsfaculty.html](http://www.facs.org/memberservices/acsfaculty.html). The application deadline for the 2013 Faculty Research Fellowships is November 1, 2012.

The Scholarship Endowment Fund was established to provide income to fund scholarships and fellowships awarded by the Board of Regents. Direct contributions to support the Scholarship Endowment Fund are welcome. Fellows wishing to make tax-deductible gifts to fund these vital programs are encouraged to contact the ACS Foundation at 312-202-5338.