## Contents

### FEATURES

- **2013 payment policy and coding changes affecting surgical practice**
  Linda Barney, MD, FACS; Jenny Jackson, MPH, CPC; Vinita Ollapally, JD; and Mark Savarise, MD, FACS
  9

- **COVER STORY: 2012 state legislative wrap-up**
  Charlotte Grill and Alexis Macias
  18

- **2011–2012: A year of reaffirming the College’s past and anticipating the needs of the future**
  J. David Richardson, MD, FACS
  24

- **Highlights of the 2012 Clinical Congress**
  27

- **Bulletin** provides coverage of the dedication and inauguration of Murphy Memorial
  37

- **ACS Officers, Regents, and Board of Governors’ Executive Committee**
  45

*continued on next page*

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Contents continued

COLUMNS
Looking forward 7
David B. Hoyt, MD, FACS

What surgeons should know about... The importance of surgical workforce maps 49
Thomas Ricketts III, PhD, MPH; Chantay Moye; and Dana Halvorson

Dispatches from rural surgeons: College leaders answer the question, "Why is rural surgery an important issue now?" 54
Mark W. Puls, MD, FACS

From residency to retirement: Is medicine still a good profession? Reflections of a retired surgeon 58
Paul H. Jordan, Jr., MD, FACS

ACS Clinical Research Program: Borderline resectable pancreatic cancer: Pushing the technical limits of surgery 61
Matthew H.G. Katz MD, FACS; Syed Ahmad MD, FACS; and Heidi Nelson MD, FACS

A look at The Joint Commission: Using simulation to achieve high reliability 64
Richard J. Fantus, MD, FACS, and Michael L. Nance, MD, FACS

NTDB® data points: Annual Report 2012: More than 70 percent 65

NEWS
ACS in the news 67

Follow the ACS Centennial celebration online 68

Dr. Leonard Weireter appointed to NQF panel 69

Dr. Frank Opelka appointed chair of PCPI 69

ACS staffer receives NAEMT Lifetime Achievement Award 70

Call for nominations for ACS Board of Regents 71

Stay current by using new ACS member e-mail forwarding benefit 71

Call for nominations for ACS Board of Governors 72

Call for nominations for ACS Officers-Elect 72

New York health care leaders review data-driven approach to quality surgical care 74

SCHOLARSHIPS
2013 ACS Japan Traveling Fellow selected 77

2013 International Guest Scholars and Community Surgeons Travel Awardees selected 77

International ACS NSQIP® Scholarships now accepting applications for 2013 78

MEETINGS CALENDAR
Calendar of events 80

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Looking forward

by David B. Hoyt, MD, FACS

As I have reported previously in this column and in other communications with the Fellows, the staff of the American College of Surgeons (ACS) has been engaged in an ongoing performance improvement process for approximately 18 months. This effort has been conducted in cooperation with consultants from GE Healthcare and was initiated to help ensure that the ACS has a world-class workforce dedicated to helping you provide high-quality care to the surgical patient.

The current phase of this process is focused on defining our organizational values. To set the stage, ACS Executive Staff and our consultants developed a list of five organizational values to which all College employees should aspire, including Professionalism, Excellence, Innovation, Introspection, and Inclusion—or what I call PEI³.

After developing this list of values, we called upon staff from throughout the organization to help better define these values and determine what actions ACS employees could take to better uphold these principles. We agreed that their efforts to achieve these objectives should involve clear communication and a sense of fun.

The remainder of this column discusses each of the five values, the rationale for making them priorities, and the behaviors associated with achievement of these principles.

Professionalism

Professionalism is demonstrated through accountability, honesty, responsibility, loyalty, and respect. Professionals take actions and make decisions that are in the best interests of the organization. They maintain confidentiality and remain emotionally neutral while still demonstrating concern for coworkers’ welfare. They are devoted and committed to the organization and its values. They resolve conflict through “natural” collaboration and respect other points of view.

ACS staff must maintain a high level of professionalism because this organization serves the consummate professional—the surgeon. A professional attitude affects one’s ability to fulfill work responsibilities and the joy of working. It is integral to creating a conducive and supportive work environment.

We determined that to achieve the College’s standard of professionalism, staff must respect each other’s expertise and responsibilities, set goals and guidelines for the timely and effective completion of work, and respond to coworkers and ACS members regardless of circumstances or workload. Professionals should display a positive demeanor in the workplace and make decisions based on the best interests of the Members and staff. They should incorporate best practices from the field, recognize conflict, and work toward a reasonable resolution of problems.

Excellence

Excellence involves aspiring to and working to exceed internal and external standards. Excellent performers have a “can do” attitude, accept accountability for the work they produce, take initiative, are self-aware, and are committed to delivering high-quality products and services.

We determined that ACS staff should strive for excellence because the work we do affects surgeons and their patients, which means mediocrity is not an option. Furthermore, working toward excellence promotes a positive, meaningful work environment. Excellent performance helps to foster a sense of pride and confidence, which often leads to further consistently strong performance.

Excellence, we determined, is achieved when staff members see work through from start to finish and strive to go above and beyond the day-to-day expectations. Excellent performers actively listen and answer questions, they establish expectations, use their own skills and those of their colleagues to increase productivity and ensure that customers are satisfied, and create and adjust benchmarks for performance. They review and document processes for improvement and ensure quality of work is consistent with current industry standards.

Innovation

The ACS has defined innovation as profound, forward-thinking, transformative ideas and contributions that are likely to advance our organizational goals and individual effectiveness. Innovation is marked by a willing-

JAN 2013 BULLETIN American College of Surgeons
ness to take appropriate risks, creativity, and imagination. Innovators question the status quo and are open to new challenges.

Innovation is included in the College’s set of values because without it, the organization will stagnate and become obsolete. Furthermore, it provides employees with new opportunities for growth and thereby gives them a sense of empowerment and excitement.

Individuals and organizations are seen as innovators when they seek out process enhancements that will improve efficiency and effectiveness—because it’s the “right” thing to do. They assess and identify the needs of customers and community in order to provide relevant products and services and define and implement groundbreaking ideas. They actively participate in the development of new systems, processes, values, and solutions.

**Introspection**

The ACS has defined introspection as recognizing the importance and need for continuous self-improvement through professional training and self-assessment. Introspective individuals and organizations are open to feedback and confident in their abilities yet aware of their own strengths and weaknesses. They display emotional intelligence, are motivated to grow professionally, and are able to tap into their own resources and creativity.

Introspection was identified as an ACS value because it facilitates the continuous improvement process, encourages change and growth, and helps us all address challenges.

Individuals demonstrate introspection in the workplace when they acknowledge their personal limits and are willing to ask for assistance. They recognize areas for self-development and display a willingness to remain current in their areas of expertise. They seek and are open to constructive criticism and address change in a balanced way.

**Inclusion**

Inclusion involves creating an atmosphere that allows the organization to harness the staff’s collective intelligence. It involves proactive collaboration with appropriate stakeholders, teamwork, and communication. It calls for weighing a diverse range of perspectives and skills.

We determined that inclusion is an ACS value because it builds loyalty and trust, makes use of everyone’s talent, promotes better outcomes, decreases duplicative efforts, and encourages mutual support and commitment.

Individuals can be said to have achieved an inclusive approach to work when they encourage teamwork/collaboration throughout the organization, seek input from and consider the expertise of other staff, and share work-related information with coworkers outside of their immediate area in order to broaden perspectives.

**Continued growth**

In addition to setting benchmarks for achievement of the College’s organizational values, participants in this process set standards for individuals who exceed our expectations. Over time, we would expect many staff members to become exemplars of these attributes.

The key reason for taking the ACS staff through this performance improvement process is to ensure that the College can provide the services and products you need to offer high-quality care to surgical patients. As we move forward and begin educating staff on how to cultivate our organizational values, we ask that our Fellows share their views on staff performance and hold us accountable for upholding the highest standards of PEI*: Professionalism, Excellence, Innovation, Introspection, and Inclusion.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
2013 payment policy and coding changes affecting surgical practice

by Linda Barney, MD, FACS; Jenny Jackson, MPH, CPC; Vinita Ollapally, JD; and Mark Savarise, MD, FACS
Several changes to payment policy and coding and reimbursement are set to take effect in 2013. One catalyst for these changes is the calendar year (CY) 2013 Medicare physician fee schedule (MPFS) final rule, which the Centers for Medicare & Medicaid Services (CMS) released in November 2012. The fee schedule lists payment rates for Medicare Part B services and is updated annually. The American College of Surgeons (ACS) submitted comments related to the MPFS proposed rule on August 31, 2012, which indicated how policy changes could either positively or adversely affect physician payment rates.

Concurrently, the American Medical Association (AMA) released Current Procedural Terminology (CPT*) code changes and revisions for 2013 that will be used by physicians and other qualified health care professionals as a guide to appropriately code for services rendered to patients.

Although the MPFS and coding changes introduce several important payment and coding policies that will affect all physicians, this article focuses on updates particularly relevant to surgery and other related specialties starting in 2013, beginning with highlights from the MPFS.

**CY 2013 conversion factor**

Under the final MPFS for CY 2013, payments to physicians will be reduced by 27 percent for services rendered in CY 2013, unless Congress takes action on the controversial sustainable growth rate (SGR) formula; as of press time, Congress had not yet intervened.

The CY 2012 conversion factor, which was effective through December 31, 2012, was $34.0376. Application of the SGR and the resultant 27 percent cut will yield a CY 2013 conversion factor of $25.0008. Even if Congress does intervene before the rule takes effect January 1, other updates in the final MPFS rule will result in a CY 2013 conversion factor that differs from the CY 2012 conversion factor, although the CY 2013 conversion factor will be more comparable to the CY 2012 conversion factor.

Although not addressed in the MPFS, provisions in the Budget Control Act of 2011 (BCA), Public Law 112-25, also will affect physician payments under Medicare starting in 2013. The BCA was designed to raise the debt ceiling and reduce the deficit, but also resulted in an additional 2 percent cut to the Medicare program through a process called sequestration. This process was designed to prod the congressional “super committee” to adopt deficit reduction measures by November 2011. Because Congress and the White House failed to agree on alternative spending reductions that met the parameters of the legislation, BCA-related cuts will begin on January 2, 2013, and extend through the next eight years. At press time, Congress had not determined whether to leave the BCA-related cuts in place, replace some or all of them, postpone them, or cancel them entirely.

**Global surgical package and transitional care**

Many changes in the MPFS are based on the work of the AMA/Specialty Society Relative Value Scale Update Committee (RUC). In the proposed MPFS rule, CMS sought comments on methods for obtaining accurate and current data on evaluation and management (E/M) services and whether these services are provided as part of the global surgical package. The ACS expressed support for the AMA RUC’s deliberative process for evaluating the values of global surgical payments, including E/M services provided. The final MPFS rule does not make any changes to the methods for evaluating E/M services provided as part of the global surgical package, but CMS has indicated that it will continue to consider how to best measure the number and level of visits that occur within the global period.

The MPFS also addresses the significant work involved in coordinating services for a patient after discharge by creating a new code to describe a patient’s transition from care furnished by a physician during a hospital, skilled nursing facility, or community mental health center to care furnished by another physician, facility, or provider...

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health center stay to outpatient care furnished by the patient’s primary physician. However, the MPFS final rule finalizes CMS’ policy that physicians who report a global procedure may not report the new transition care management code. CMS maintains that surgeons typically would not be in a position to coordinate all aspects of a patient’s care transition because surgeons’ relationships with patients frequently end with the completion of the global period unless additional surgery is required.

In addition to other comments on this issue, the ACS stressed that surgeons reporting a 10- or 90-day global code should be allowed to report the new transitional care management code if all required work is performed and documented. The College explained that the transitional care management services covered under this new code are distinct from discharge-day management work included in the 10- or 90-day global periods.

Also related to transitional care management, CMS responded to comments from the ACS and other stakeholders by allowing physicians to report both a discharge management code and the new transitional care management code. This change aligns Medicare rules with CPT rules on this transitional care management code policy, as discussed later in this article.

Electronic Prescribing Incentive Program
The Medicare Electronic Prescribing (eRx) Incentive Program provides payment incentives and payment adjustments to physicians and certain nonphysician practitioners (NPPs) who meet specified criteria for the use of qualified e-prescribing systems. Among other updates in the final rule, CMS finalized both of the proposed new significant hardship exemptions as a way for physicians to avoid the 2013 and 2014 eRx penalties. Under the rule, individuals who may now claim the hardship exemptions include:

1. Eligible professionals (EPs) or group practices that achieve meaningful use during certain 2013 and 2014 eRx payment adjustment reporting periods

2. EPs or group practices that demonstrate intent to participate in the Electronic Health Records (EHR) Incentive Program and adopt certified EHR technology

CMS also stated that the agency will use the information collected in the EHR Incentive Program to determine which physicians qualify for these two exemptions so physicians will not have to proactively apply for them. The ACS was very supportive of the addition of these two new significant hardship exceptions to the eRx program.

Physician Quality Reporting System
The Physician Quality Reporting System (PQRS) is a Medicare quality reporting program that provides payment incentives and payment adjustments to physicians and certain NPPs who satisfactorily report data on quality measures for covered services provided during a specified reporting period. The rule finalizes CMS’ proposal to reduce the number of EPs comprising a PQRS group practice from 25 or more to two or more.

Additionally, CMS finalized a proposal to lower the threshold for reporting measures groups via a registry from 30 to 20 patients for both the 12-month and six-month reporting options. Of these 20 patients, at least 11 must be Medicare patients. CMS also lowered the threshold from 30 to 20 patients for reporting measure groups via claims for the 12-month reporting option. The ACS was generally supportive of these changes.

Previously, the three PQRS reporting options available to EPs were via registries, claims, or EHRs. In the final rule, CMS finalizes two additional reporting options. First is the administrative claims option, which would be a way for EPs to avoid the 2015 PQRS penalty. CMS indicated that the agency might, in the future, consider finalizing this reporting option as a way to avoid the 2016 PQRS penalty as well. CMS also finalized an alternative reporting option in which EPs and group practices would only have to report one measure or measures group using the claims, registry, or
EHR-based reporting mechanisms. This provision offers another way for EPs and group practices to avoid the 2015 PQRS penalties, with the exception that group practices will not be able to report using the claims-based or EHR-based reporting mechanisms. The ACS was largely supportive of CMS’ flexibility in adding these additional reporting options while additional improvements are made to the program that will allow for more meaningful participation in PQRS.

Physician Compare website

The Physician Compare website (http://www.medicare.gov/find-a-doctor/provider-search.aspx) is designed to help patients locate and obtain information on Medicare-participating physicians in their communities. In addition to other revisions to the Physician Compare website, the MPFS rule finalizes a proposal to publicly report patient experience of care data on Physician Compare. The data to be reported would be collected no earlier than 2013 and reported no earlier than 2014. This patient experience of care data will be limited to data reported via the PQRS group practice reporting option (GPRO) Web interface by groups of 100 or more EPs and by accountable care organizations. The ACS comment letter expressed concern that CMS will be unable to accurately collect data on patient experience of care and that some group practices will be unable to administer patient experience of care surveys in a reliable way. However, the final rule emphasizes that CMS will only post statistically valid, reliable, and applicable data.

In the MPFS final rule, CMS continues to consider allowing reporting on Physician Compare of measures that have been developed and the related data collected by approved specialty societies. The ACS comment letter requested clarification and additional details from CMS on the implementation of this concept. The final rule indicates that CMS will work with specialty societies to identify appropriate quality measure data that are already collected and available. CMS emphasized that any specialty society measures under consideration will be subject to the Measures Application Partnership pre-rulemaking process before they are considered for the Physician Compare website.

Value-based payment modifier

The Affordable Care Act (ACA) requires that CMS apply a value-based payment modifier to physician payments, starting with some physicians in 2015 and applied to all physicians by 2017. Application of the value-based payment modifier will result in Medicare paying physicians differentially based on the quality of care they provide.

The value-based payment modifier will initially apply to groups of physicians, which CMS plans to separate into categories based on whether they successfully participate in one of the PQRS GPROs. The payment modifier for group practices that satisfactorily report the PQRS quality measures associated with the GPRO they select will be set at zero initially, which would prevent the value-based payment modifier from lowering their Medicare rates. These physicians may either keep the 0 percent update or pursue a higher modifier amount based on their performance with respect to quality and cost measures. Those physicians attempting to earn a higher value-based payment modifier amount would also be at risk, based on their quality and cost scores, for a payment decrease of up to 1.0 percent. Physician groups that do not meet the PQRS group reporting requirements would have a modifier amount of –1.0 percent applied to their claims submitted under the MPFS. CMS outlines the details of this policy in the final MPFS rule; however, some of the changes in the final rule make the policy more flexible and less burdensome to physicians.

The first change in the final MPFS rule that allows more flexibility for physicians is related to the size of physician groups that would be subject to the value-based payment modifier starting in 2015 from groups of 25 or more EPs, which could include physicians and other specified NPPs, to groups of 100 or more EPs. The ACS comment letter urged CMS to increase the group size for the initial application
of the value-based payment modifier, given that the limited scope of the quality and cost measures currently included in the value-based payment modifier present significant challenges for single-specialty groups and larger groups are more likely to include multiple specialties.

In the final MPFS rule, CMS relaxes the requirements by allowing groups of 100 or more EPs to avoid the −1.0 percent downward value-based payment modifier adjustment if they self-nominate for either the PQRS GPRO Web-interface or registry-based reporting options and report at least one of these measures. This change rewards physician groups for attempting to report PQRS measures, even if they are unsuccessful at reporting all the measures required by the chosen reporting option, which was a requirement in the proposed rule.

Another improvement is that groups of 100 or more EPs may also avoid the −1.0 percent downward value-based payment modifier adjustment by, as a group, electing the PQRS administrative claims group reporting option. The physicians in the group then have the option of reporting PQRS measures as individuals, instead of as a group. This way, the physicians can avoid the value-based payment modifier penalty but still participate individually in PQRS. This added flexibility in the final rule addresses the ACS’ concerns that it would be inequitable to apply the −1.0 downward adjustment to physicians who are successful PQRS reporters but are not reporting using GPRO as the proposed rule required.

To read more about these and other changes in final MPFS rule, go to: http://www.ofr.gov/OFRUpload/OFRData/2012-26900_PI.pdf.

To read the ACS comment letter, go to: http://www.facs.org/ahp/2013-mpfs-comment-letter.pdf.

CPT coding changes
In addition to the changes stemming from the fee schedule, surgeons should also be aware of how changes to the 2013 CPT code set will affect them and their practices. The remainder of this article summarizes these modifications and their potential effects, beginning with the definition of a “qualified healthcare provider.”

Qualified health care provider
CPT does not specify who is or is not qualified to perform a service or procedure, other than to state that the practitioner must be “qualified.” In 2013, terminology has been revised throughout the 2013 codebook, CPT 2013 Professional Edition, to indicate “physicians or other qualified healthcare professionals” with the intent of provider neutrality. This change is a clarification of the difference between a qualified provider and a clinical staff member who may provide portions of a service under the supervision of a qualified provider but does not individually report a service with a CPT code.

Observation or inpatient hospital care
In 2013, the observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service have been further clarified to include typical time according to actual practice patterns. The following codes are used by physicians or other qualified health care providers to report observation or inpatient hospital care services: CPT code 99234, Observation or inpatient hospital care; typically 40 minutes is spent at the bedside and on the patient’s hospital floor or unit; 99235, Observation or inpatient hospital care; typically 50 minutes is spent at the bedside and on the patient’s hospital floor or unit; and 99236, Observation or inpatient hospital care; typically 55 minutes is spent at the bedside and on the patient’s hospital floor or unit.

Chronic care and transitional care management
New CPT codes for chronic care management, specifically complex chronic care management of multiple diseases, and post-discharge transitional care management have been added in 2013 (see table on page 14 for their full descriptors).
<table>
<thead>
<tr>
<th>CPT code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲15740</td>
<td>Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel.</td>
</tr>
<tr>
<td>32420</td>
<td>Code deleted. Pneumocentesis, puncture of lung for aspiration. (To report, use 32405.)</td>
</tr>
<tr>
<td>32421</td>
<td>Code deleted. Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent. (To report, see 32554.)</td>
</tr>
<tr>
<td>32422</td>
<td>Code deleted. Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure). (To report, see 32555.)</td>
</tr>
<tr>
<td>•32554</td>
<td>Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance.</td>
</tr>
<tr>
<td>•32555</td>
<td>Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance.</td>
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<tr>
<td>•32556</td>
<td>Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance.</td>
</tr>
<tr>
<td>•32557</td>
<td>Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance.</td>
</tr>
<tr>
<td>▲32551</td>
<td>Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure).</td>
</tr>
<tr>
<td>43234</td>
<td>Code deleted. Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure); (To report, use 43235.)</td>
</tr>
<tr>
<td>•0312T</td>
<td>Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming.</td>
</tr>
<tr>
<td>•0313T</td>
<td>Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator.</td>
</tr>
<tr>
<td>•0314T</td>
<td>Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator.</td>
</tr>
<tr>
<td>•0315T</td>
<td>Vagus nerve blocking therapy (morbid obesity); removal of pulse generator.</td>
</tr>
<tr>
<td>•0316T</td>
<td>Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator.</td>
</tr>
<tr>
<td>•0317T</td>
<td>Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed.</td>
</tr>
<tr>
<td>▲99234</td>
<td>Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problems requiring admission are of low severity. Typically 40 minutes is spent at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
<tr>
<td>▲99235</td>
<td>Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically 50 minutes is spent at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
<tr>
<td>▲99236</td>
<td>Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) requiring admission are of high severity. Typically 55 minutes is spent at the bedside and on the patient’s hospital floor or unit.</td>
</tr>
<tr>
<td>•9947</td>
<td>Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month.</td>
</tr>
<tr>
<td>•9948</td>
<td>Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month.</td>
</tr>
<tr>
<td>•9949</td>
<td>Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).</td>
</tr>
<tr>
<td>•9945</td>
<td>Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of at least moderate complexity during the service period, and face-to-face visit within 14 calendar days of discharge.</td>
</tr>
<tr>
<td>•9946</td>
<td>Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of high complexity during the service period, and face-to-face visit, within 7 calendar days of discharge.</td>
</tr>
</tbody>
</table>

▲ = new code, ★ = revised code
Complex chronic care management CPT codes 99487, Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month; 99488, Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month; and 99489, Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure), are defined as patient-centered management and support services provided by physicians, other qualified health care professionals and clinical staff, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

CPT codes 99487–99489 are reported once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care coordination role with a particular patient for the calendar month.

CPT codes 99495, Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of at least moderate complexity during the service period, and face-to-face visit, within 14 calendar days of discharge, and 99496, Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of high complexity during the service period, and face-to-face visit, within 7 calendar days of discharge, are used to report transitional care management services (TCM). These services are for an established patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transition from a hospital setting (including hospital inpatient status, rehabilitation hospital, long-term acute care hospital, observation status in a hospital, or skilled nursing facility/nursing facility) to the patient’s community setting (home, domiciliary, rest home, or assisted living).

As stated above, the final MPFS and CPT clearly state that only one physician may report these services within 30 days of discharge. In addition, a physician in a global period (10 or 90 days) may not bill TCM, thereby making these codes unusable for most postoperative surgical patient discharges. However, TCM may be reported by the same physician who provides only hospital or observation discharge management.

Island pedicle flap
The 2013 revised guidelines and descriptor for code 15740 now include the requirement of an anatomically named axial vessel: 15740, Flap; island pedicle requiring identification and dissection of an anatomically-named axial vessel.

To appropriately code for the services provided for random island flaps, V-Y subcutaneous flaps, advancement flaps, and other flaps from adjacent areas without clearly defined anatomically named axial vessels, use codes 14000–14302.

Thoracentesis, percutaneous pleural drainage, and open tube thoracostomy
Four new codes (32554–32557) have been created to describe needle thoracentesis and percutaneous pleural drainage with or without imaging. In addition, code 32551 for tube thoracostomy has been revised to indicate an open approach. With these coding changes, it will be important to focus on the procedural technique documented by the provider rather than the size of the drain placed.

The family of codes previously used to report thoracentesis have been deleted (32420–32422) and replaced with the following codes:

• 32554, Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance
• 32555, Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance
CODING HIGHLIGHT: TUBE THORACOSTOMY

A 35-year-old patient presents to the emergency room after a motorcycle accident. Breathing is faint and a large right hemothorax is diagnosed. The general surgeon creates an open incision, a thoracostomy tube is inserted into the pleural cavity for drainage and to promote lung expansion, and accumulated blood or fluid is evacuated. Reportable code(s) include:

32551, Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure).

• 32556, Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance

• 32557, Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance

CPT has revised code 32551, Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure), to clarify its use as an open surgical procedure. CPT has deleted the parenthetical reference of specific diagnoses that may have created confusion for coders. CPT has also deleted the illustration of “Insertion of Chest Tube” and the exclusionary parenthetical because they did not accurately depict open chest tube placement. (See the coding highlight in the sidebar on this page.)

Codes 32554–32555 should be reported for aspiration procedures intended only for transient needle or catheter insertion. Codes 32554–32557 should be reported for percutaneous catheter placement, sutured in place, and connected to a drainage system for ongoing drainage. Code 32551 should be reported for open chest tube placement, sutured in place, and connected to a drainage system for ongoing drainage.

CPT code 32551 includes an incision over the intended rib interspace, dissection of the subcutaneous tissues and chest wall muscles (including deep intercostal muscles and pleura). A finger is placed through this incision, the pleural cavity palpated, and loculations are broken up. A thoracostomy tube is inserted into the pleural cavity for drainage and to promote lung expansion and accumulated blood or fluid is evacuated. The tube is sutured in place.

Although the exclusionary parenthetical has been deleted, do not report 32551 when it is inherent to a larger procedure, including thoracic, cardiac, and some esophageal procedures where a thoracotomy or thoroscopic approach is applied, use only the primary procedure code.

Do not report imaging guidance in conjunction with 32551. However, diagnostic ultrasound may be
separately reported if a thorough evaluation of organ(s) or anatomic region, image documentation, and final written report are performed.

For bilateral open thoracostomy tube placement, append the modifier 50 to code 32551. Additionally, if more than one open thoracostomy tube is placed on the same side (for example, ipsilateral), on the same day, through a separate incision, it is appropriate to append modifier 59, distinct procedural service.

**Endoscopy**
Code 43234, previously used to report upper gastrointestinal panendoscopy using a small diameter endoscope, has been deleted as obsolete. To report diagnostic upper gastrointestinal endoscopy, see code 43235, *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure).*

**Laparoscopy**
Six new Category III codes are available to report laparoscopic implantation, revision, removal and/or reprogramming for vagus nerve blocking therapy for morbid obesity at the esophagogastric junction:

- **0312T**, *Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming*

- **0313T**, *Vagus nerve blocking therapy (morbid obesity); revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator*

- **0314T**, *Vagus nerve blocking therapy (morbid obesity); removal of vagal trunk neurostimulator electrode array and pulse generator*

- **0315T**, *Vagus nerve blocking therapy (morbid obesity); removal of pulse generator*

- **0316T**, *Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator*

- **0317T**, *Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed*

As stated in the 2013 *CPT Changes: An Insider’s View,* for open implantation, revision, or removal of gastric lesser curvature or vagal trunk (EGJ) neurostimulator electrodes, [morbid obesity], use 43999. For implantation, revision, replacement, and/or removal of vagus [cranial] nerve neurostimulator electrode array and/or pulse generator for vagus nerve stimulation performed other than at the EGJ [eg, epilepsy], see 64568–64570.

**Editor’s note**
Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process. ✪
2012 state legislative wrap-up

by Charlotte Grill and Alexis Macias
More than 30 states now have some form of medical liability reform in place. For the remaining states with little to no reform, passing this type of legislation can often be a very difficult process requiring work over many sessions and years.

The legislatures in several states—Montana, Nevada, North Dakota, and Texas—did not convene last year, and the legislatures in Arkansas, Oregon, and West Virginia held shorter budget sessions. Hence, a smaller volume of bills was considered at the state level in 2012. State Affairs staff at the American College of Surgeons (ACS) tracked more than 600 bills in 2012, reflecting a more focused approach to identifying the legislation most relevant to surgery. The majority of the bills monitored last year fell into the following categories:

- Medical liability reform
- Quality/patient safety (scope of practice, injury prevention)
- Workforce/surgical practice (Uniform Emergency Volunteer Health Practitioners Act [UEVHPA], Trauma System Funding and Development)
- Cancer care

This article provides an overview of how the state legislatures addressed these and other important state health care issues in 2012 and discusses the potential impact of the November elections.

Medical liability reform
More than 30 states now have some form of medical liability reform in place. For the remaining states with little to no reform, passing this type of legislation can often be a very difficult process requiring work over many sessions and years. Obstacles to passage of liability reform legislation include unfavorable political climates in states, strong opposition and lobbying from trial attorneys, and constitutional barriers. A few states did succeed this past year in achieving medical liability reform or in seeing their state courts uphold the constitutionality of caps on noneconomic damages.

In early August, a health care cost control bill was signed into law in Massachusetts (S. 2400, now Chapter 224). The bill established statewide health care cost growth goals and included language to facilitate medical liability reforms, such as a disclosure, apology, and offer (DA&O) policy. This reform is intended to improve transparency, reduce medical liability lawsuits, resolve negligence accusations more quickly, and im-
prove patient safety. Under this legislation, DA&O includes provisions for a six-month, pre-litigation resolution period that affords the time for the patient to provide all pertinent medical records and for providers to give full disclosure and make statements of apology, which will be inadmissible in court. (For a more detailed explanation of Chapter 224, see the December 2012 issue of the Bulletin.)

Oregon Gov. John Kitzhaber (D) issued a medical liability reform proposal to the state’s Patient Safety and Defensive Medicine Workgroup, which calls for medical liability claims to undergo a progressive, three-phase process: (1) early discussion and resolution; (2) mediation; and (3) litigation. The proposal provides a full overview of the three-phase approach as well as a flow chart that breaks down the various stages of the process. The proposal was developed using the following objectives: improve the practice environment to allow physicians to learn from medical errors and improve patient safety; more effectively compensate individuals who are injured as a result of medical errors; and reduce the collateral costs associated with the medical liability system, including costs associated with insurance administration, litigation, and defensive medicine. The governor has said he wants this legislation introduced and passed in 2013.

Many states that already have liability legislation in place continue to have to defend the laws in court, and 2012 was no exception.

In a 4–3 decision, the Missouri Supreme Court issued an opinion on July 31, 2012, ruling that the state’s $350,000 cap on noneconomic damages is unconstitutional. The basis for this determination was that the cap violates the right to trial by jury as guaranteed in the state’s constitution by interfering in the jury’s assigned role of determining damages. In this case, the jury had awarded $1.45 million in noneconomic damages, which were reduced to $350,000.

The Kansas Supreme Court on October 5, 2012, issued an opinion in Miller v. Johnson, upholding a $250,000 cap on noneconomic damages. The case marks the second time the Kansas Supreme Court has upheld the cap, which was enacted in 1988. In a 5–2 ruling, the Court found that the cap was constitutionally sound, observing that the legislature’s decision to enact the cap was rationally related to a valid legislative purpose and as such did not violate the state’s constitutional protections. The court also observed that the intent of the cap was to ensure patient access to quality health care and to promote the availability of affordable malpractice insurance for health care professionals in Kansas. The court recognized these objectives as legitimate state interests that promote the general welfare.

Scope of practice

Year after year, nonphysician health care providers continue to be aggressive in their efforts to expand their scope of practice to include treatments, procedures, and authority inconsistent with their education and training. Commonly seen scope-of-practice expansions include independent prescriptive authority, unsupervised practice, diagnostic and/or surgical authority, and other care privileges, which a nonphysician provider may not be educated or trained to safely and effectively execute.

A number of states, including Alabama, Illinois, and Indiana, dealt with scope expansion efforts on behalf of physical therapists. In Alabama, physical therapists were successful in their efforts when H.B. 163 was signed into law. The bill allows physical therapists to treat a patient without a physician referral. Physical therapists introduced similar bills in Illinois and Indiana, but neither was signed into law. In Oklahoma the physical therapists expanded their scope by introducing a bill (S.B. 1592) that would allow physical therapists to administer wellness checks or physicals. The bill was signed into law in April 2012.

Podiatrists in New York introduced a bill (A.B. 9293) that would allow them to treat the ankle and soft tissue structure of the leg below the knee after obtaining privileges to do so. After several previous attempts at scope expansion, the podiatrists were finally successful in 2012 when A.B. 9293 was signed into law.

As is often the case, scope expansion efforts are viewed as putting patients at risk when nonphysician practitioners practice beyond their education and training. However, there are times when scope-of-practice legislation enhances health care delivery. The state of Virginia, for example, passed two laws that successfully limit scope of practice for nonphysicians. The Medical Society of Virginia, in conjunction with the ACS

V98 No 1 BULLETIN American College of Surgeons
Commonly seen scope-of-practice expansions include independent prescriptive authority, independent practice, diagnostic and/or surgical authority, and other care privileges, which a nonphysician provider may not be educated or trained to safely and effectively provide.

Virginia Chapter, achieved passage of a definition of surgery law. The bill, S.B. 543, defines surgery as the structural alteration of the human body by incision or cutting into of tissue for the purpose of diagnostic or therapeutic treatment of conditions or disease processes using an instrument that causes localized alteration or transposition of live human tissue. The bill also states that no person shall perform surgery unless licensed by the Board of Medicine as a doctor of medicine, osteopathy, or podiatry. The second law passed in Virginia functioned as a collaborative agreement bill, H.B. 346, and states that nurse practitioners are a part of the health care team and shall only practice as part of a physician-led patient care team.

Maryland and Mississippi both passed truth-in-advertising legislation in 2012. Maryland introduced H.B. 957/S.B. 395, which mandates that physicians who claim to be board-certified disclose the full name of the certifying board and specialty. The bill also requires that the certifying body be an approved member of the American Board of Medical Specialties or the American Osteopathic Association. Mississippi’s truth-in-advertising law, S.B. 2670, requires that an advertisement identify the type of license a health care provider holds and that the health care provider post and communicate specific licensure to patients. Missouri, Vermont, Washington, and West Virginia also introduced truth-in-advertising legislation in 2012.

Injury prevention
As in previous legislative sessions, bills related to trauma issues occupied a large portion of the College’s state legislative affairs attention in 2012. Nearly 200 trauma-related bills were introduced at the state level. The majority of the trauma bills tracked throughout the year addressed injury prevention issues, such as graduated driver’s licenses, all-terrain vehicles (ATVs), and seatbelts and helmets, whereas a small number of bills focused on trauma systems and funding.

Michigan Gov. Rick Snyder (R) signed legislation (S.B. 291) that weakens the state’s motorcycle helmet laws. College State Affairs staff worked closely with the Michigan ACS Chapter to defeat this legislation, and for a while it looked as though the governor might even veto the bill. The law states that motorcycle helmets are required only for operators or passengers of motorcycles who are ages 19 and younger. Older riders and passengers are no longer required to wear a helmet. This legislation renders the enforcement of helmet usage exceedingly difficult because it can be challenging for a police officer to determine whether riders and passengers are at least 20 years old, and therefore, legally riding without a helmet. Whereas similar bills are showing up in other states, the College remains committed to its policy of supporting helmet usage for all motorcyclists. To read the ACS statement in support of motorcycle helmet laws, go to http://www.facs.org/fellows_info/statements/st-35.html.

The state of Maryland, meanwhile, passed H.B. 569 on October 1, 2012, which mandates that owners of mopeds and motor scooters display a title and decal. In addition, operators of these vehicles must possess a valid license or moped permit, carry proof of insurance, and wear a helmet.

The Hawaii legislature considered a bill (H.C.R. 2012 33) that would impose age restrictions on individuals who operate ATVs. The College submitted testimony to a House committee that held a hearing on the legislation, and the bill passed in the House. In the Senate, it was passed with amendments, and ended the session in the Judiciary Committee. Although it did not make it to the governor this session, the bill will most likely be reconsidered in 2013.

Numerous organizations, including the ACS, the National Football League, the American Medical Association, and the American Academy of Pediatrics have pledged support and advocated for states to pass important sports injury legislation. The model legislation, which many states have implemented, follows the guidelines that were established in Washington State’s law, known as the Zackery Lystedt Law. The three main tenets of the legislation are: (1) inform and educate youth athletes, their parents, and guardians and require them to sign a concussion information form; (2) remove from play or practice a youth athlete who appears to have suffered a concussion; and (3) require a youth athlete to be cleared by a licensed health care professional trained in the evaluation and management of concussions before returning to play or practice.

Forty states to date have passed legislation addressing the issue of youth concussion education and preven-
tion. More than 30 states passed these bills in 2010 and 2011. In 2012, states that passed this type of legislation included Arizona, Florida, Idaho, Kentucky, Tennessee, and Wisconsin. Only 10 states are without some sort of provisions in place to address student athlete concussion prevention: Ohio, West Virginia, South Carolina, Georgia, Mississippi, Tennessee, Arkansas, Montana, Nevada, and Wyoming. Most of these states have introduced legislation in previous sessions, but the bills did not pass. Nonetheless, most of these states will likely introduce this legislation again in the upcoming 2013 session.

Emergency volunteers
UEVHPA addresses the lack of uniformity in state laws, a problem that was revealed during the horrific hurricane season of 2005. Passage of UEVHPA allows state governments to give reciprocity to other states’ licensees who are emergency service providers, so that covered individuals may provide services without meeting the disaster state’s licensing requirements. It recognizes a national registration system to confirm that physicians and health practitioners are appropriately licensed and in good standing in their respective states, with their licensees recognized in affected states for the duration of the emergencies.


In 2012, UEVHPA was introduced in Mississippi and Pennsylvania. Pennsylvania’s bill, H.B. 2120, was assigned to the Committee of Emergency Preparedness and Veterans Affairs in January, and the ACS coordinated a letter of support along with the Pennsylvania ACS chapters, encouraging the Committee to pass the bill. No action had been taken at press time, but the Pennsylvania legislature is considered a full-time legislature that meets most of the year, and the ACS was continuing to advocate for passage of this legislation.

Cancer care
During the 2012 legislative session the College’s State Affairs staff began focusing on a number of new issues that affect the Commission on Cancer, cancer care, and cancer prevention. The bills tracked pertained to drug shortages, oral chemotherapy reimbursement, tanning bed restrictions, and anti-tobacco initiatives.

One of the more pressing issues in oncologic care is insurance reimbursement for oral chemotherapy. Virginia was the only state that tackled the issue by passing into law a bill, S.B. 450, that requires insurance companies to pay for oral chemotherapy at the same rate as intravenous chemotherapy treatments.

Legislators continue to tackle the issue of tanning bed usage by minors; currently, 30 states restrict access to tanning beds. New York bill A. 1074/S. 2917 amends the state’s current tanning law to further restrict teen usage. New York State’s previous law banned indoor tanning only for children 14 years of age and younger. The amendment to this law now restricts anyone 16 years of age or younger from using a tanning bed. Teens 17 and 18 years of age must provide written consent from a parent or guardian.

The expanded restrictions were signed into law in June. Hawaii and Illinois also considered tanning bed restrictions for minors, but neither bill passed. Anti-tobacco initiatives, such as tobacco taxes and smoking bans, continue to be popular at the state level. Hawaii failed to pass two bills that would have placed a tax on tobacco. Indiana legislators, however, passed a statewide smoking ban after several years of rejecting such bills. The smoking ban legislation, H.B. 1149, prohibits smoking in most public places and in the workplace with the exception of casinos and cigar bars.

State elections
On November 6, 2012, all eyes were on the road to the White House. Many voters did not realize that perhaps the most important elections were taking place at the state level. Whereas the federal elections focused heavily on the economy, the state races often were decided on matters unique to the individual states. On election day, a total of 6,030 (82 percent) of legislative seats were up for grabs in 44 states.3
The majority of the trauma bills tracked throughout the year addressed injury prevention issues, such as graduated driver’s licenses, all-terrain vehicles (ATVs), and seatbelts and helmets, whereas a small number of bills focused on trauma systems and funding.

Whereas the status quo was maintained in Washington, DC, with Democrats continuing to control both the White House and the Senate and Republicans maintaining control in the House of Representatives, the states experienced greater shifts with partisan control changing in eight states after the November 2012 elections. State legislatures such as Maine and Minnesota went from being Republican-controlled to Democratic. Republicans gained the Arkansas House and Senate, with the Senate having a Republican majority in place for the first time since Reconstruction. Colorado, which was previously a split legislature, voted in Democrats to unseat three Republican legislators and regain control of the House of Representatives, which they lost in the 2010 election. In Colorado, Democrats also control the Senate and the governor’s office.

Governors were elected in 11 states including: Delaware, Indiana, Missouri, Montana, New Hampshire, North Carolina, North Dakota, Utah, Vermont, Washington, and West Virginia. Republicans were hoping for big wins across the country as they poured tens of millions of dollars into efforts to gain control of more governors’ offices. The biggest victory for Republicans was in North Carolina, where Pat McCrory became the first Republican elected to the governor’s office since 1993. Republicans also held on to offices in Indiana and saw incumbents win in North Dakota and Utah. Democrats held on to offices in Delaware, Missouri, New Hampshire, Vermont, and West Virginia. Republicans now occupy 30 governors’ offices while the Democrats control 19; one governor, Gov. Lincoln Chafee of Rhode Island, is an Independent.

Supporting state grassroots advocacy
The State Affairs staff in the Division of Advocacy and Health Policy is always available to surgeons and ACS chapters when state-level legislative or regulatory issues arise. The state legislation Web page is accessible at http://www.facs.org/ahp/statelegislation.html and contains useful information related to various aspects of state grassroots advocacy and state legislative resources. For more information on the legislation discussed in this article or for answers to any follow-up questions, contact Charlotte Grill at cgrill@facs.org.
2011–2012:
A year of reaffirming the College’s past and anticipating the needs of the future

by J. David Richardson, MD, FACS
In keeping with the inauguration of the College’s Centennial year, we felt it appropriate to honor our past emphasis on quality while being forward thinking with regard to future needs of the next decade, if not the next century.

Chairs of the American College of Surgeons’ (ACS) Board of Regents (B/R) serve one-year terms that extend from the end of one Clinical Congress to the end of the succeeding one. My term as Chair of the B/R ended at the close of the 2012 Clinical Congress. During the time that I served in this role, the B/R approved several policies and programs that should serve the organization well, now and in the future.

Whereas the B/R sets the policies for the ACS, it is the ACS staff that ensures these policies are implemented. The B/R spent much of the last year carefully analyzing the structure and function of each division of the College and its role in carrying out the College’s historic mission of improving quality of care and patient access to care through enhanced surgical education. The ACS’ divisions are as follows: Research and Optimal Patient Care, Education, Member Services, Advocacy and Health Policy, and Integrated Communications. Each division offers myriad services designed to benefit the College’s membership and ultimately our patients.

Quality improvement: Inside and out

In keeping with the inauguration of the College’s Centennial year, we felt it appropriate to honor our past emphasis on quality while being forward thinking with regard to future needs of the next decade, if not the next century. Under the leadership of Executive Director David B. Hoyt, MD, FACS, the College has placed renewed emphasis on quality.

During the February 2012 meeting, the B/R closely examined the programs and initiatives carried out through the Division of Research and Optimal Patient Care. As a result of this review, the Regents issued a charge to enhance the ACS National Surgical Quality Improvement Program (ACS NSQIP®) with a goal of substantially increasing its presence in U.S. hospitals.

In addition to ACS NSQIP, the College works to improve quality of care through its extensive verification programs for trauma, cancer, comprehensive breast, and bariatric surgery centers. All of these efforts are growing, and the B/R examined each program in an attempt to ensure they are user-friendly and meeting the needs of both the public and health care providers.

Internally, ACS staff members have been heavily engaged in an internal continuous quality improvement process with a goal of streamlining functions and processes that will permit them to better serve the Fellows. The Division of Member Services, under the leadership of Patricia L. Turner, MD, FACS, has carefully examined its multiple programs with the goal of improving service to patients and Fellows.

It is nearly impossible to summarize all of the quality initiatives under way at the ACS, but suffice it to say the focus has been on doing our jobs better within the organization, as well as outwardly, to better serve patients.

Access to care

This past year, our second major area of concentration was on access to surgical care. For many years, the ACS Health Policy Research Institute (ACS HPRI) has conducted workforce studies through the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, Chapel Hill, under the leadership of ACS Past-President George Sheldon, MD, FACS, and Thomas Ricketts PhD, MPH, Co-Director of the ACS HPRI. These studies have uncovered serious workforce shortages throughout the U.S., and have correlated increases in mortality for several serious health conditions, including trauma, to the lack of access to surgical care.

It became apparent to the B/R that the lack of general surgical care in rural areas was a particularly acute problem. The B/R invited two rural surgeons,
ACS Governor Tyler Hughes, MD, FACS, a general surgeon in McPherson, KS, and Phil Caropreso, MD, FACS, a general surgeon in Keokuk, IA, to discuss their issues and needs at the Board’s February 2012 meeting. Following those discussions, the B/R established an Advisory Council for Rural Surgery—the first new Advisory Council created in several decades—to provide a forum for rural surgeons to share their concerns, and to serve as a nexus for political action to enhance access to surgical care in rural areas. (For more information on the discussions of rural surgery issues and the new Advisory Council, see the “Dispatches from rural surgeons” column on page 54 of this issue.)

**Surgical education**

The ACS Division of Education has continued to advance under the leadership of its Director, Ajit K. Sachdeva, MD, FACS, FRCSC.

During the Board’s June 2012 meeting, the B/R focused on concerns related to the unmet needs in the field of post-residency education. Approximately 80 percent of current general surgery trainees now pursue fellowship training following their residency training; however, there is no correlate training in the area of surgical care in many parts of the country, namely broad-based general surgery. During the meeting, then-ACS Vice-President-Elect, Philip Burns, MD, FACS, outlined concerns regarding whether or not current trainees are adequately prepared to practice. In response, the B/R appointed a special committee to examine the feasibility of accrediting post-residency fellowships in general surgery. If successful, these fellowships, which are envisioned to serve as a transition to practice, would serve to improve quality of care while potentially enhancing access to general surgical care.

As I leave the B/R, it is my fervent hope that my successors will continue to explore opportunities in which the ACS can broaden its involvement with surgical training. I firmly believe that many aspects of our current system of residency training are dysfunctional, if not broken, and that surgeons need to assume more responsibility for the training of future surgeons.

**Closing thoughts**

In addition to advocating for legislation and policies that will improve quality and access, it is important that the ACS Division of Advocacy and Health Policy, based in Washington, DC, continue to lobby for equitable payment for surgeons. Access to surgical care demands fair compensation for the providers of that care.

It has been a singular honor to have served nine years as an ACS Regent and doubly so to have been elected to serve as Chair this past year. The leadership of the ACS is in good hands from both the standpoint of the officers and the staff as we move toward our second hundred years. ♦
Highlights of the 2012 Clinical Congress
The 2012 Clinical Congress of the American College of Surgeons (ACS) provided surgeons, medical students, surgical residents, and other members of the operating room team with a unique opportunity to immerse themselves in a variety of educational experiences. Total registration for this year’s meeting was 14,138, including 8,604 physicians; the remaining attendees were exhibitors, guests, spouses, and convention personnel.

Centennial celebration begins
Adding to the excitement of this year’s meeting were activities heralding the start of the College’s yearlong Centennial celebration. A special exhibit titled 100 Years of Inspiring Quality—An Interactive Timeline was unveiled at this year’s meeting. This exhibit highlighted important developments in surgery and the many contributions ACS Fellows have made to patient care over the last 100 years. A brochure based on the timeline was distributed with the October 2012 issue of the Bulletin of the American College of Surgeons.

In addition to the presentation of the timeline, several special events related to the Centennial took place at the conference. David L. Nahrwold, MD, FACS, and Peter J. Kernahan, MD, PhD, FACS, participated in two book signings for A Century of Surgeons and Surgery: The American College of Surgeons, 1913–2012. Drs. Nahrwold and Kernahan spent the better part of the last four years researching and writing the book, which was provided free of charge to all Clinical Congress attendees.

Furthermore, the ACS headquarters and Archives were accessible to Clinical Congress attendees for a 45-minute tour that revealed some of the College’s treasured materials, including the casebooks, scrapbooks, and papers of ACS Founder Franklin H. Martin, MD, FACS. Also on display were the papers of Eleanor Grimm, Dr. Martin’s chief assistant and recorder of the history of the College from its inception, as well as mementos of the College’s voyage to South America in 1923.

The ACS leadership also hosted an evening of coffee, cordials, and conversation. During this social event, College leaders conducted a Centennial cake-cutting ceremony and showed a video highlighting the College’s unique place in American culture.

Each attendee also received a free, commemorative magazine, A Hundred Years of Inspiring Quality.

Convocation
A. Brent Eastman, MD, FACS, a general, vascular, and trauma surgeon from San Diego, CA, was installed as the 93rd President of the ACS during Convocation ceremonies Sunday, September 30. During the ceremony, Dr. Eastman presented his Presidential Address titled The Next Hundred Years to the College’s 1,377 Initiates.

Two Vice-Presidents assumed office during the Convocation as well: R. Phillip Burns, MD, FACS, as First Vice-President and John M. Daly, MD, FACS, as Second Vice-President.

In addition, Honorary Fellowship was conferred on the following international surgeons at the Convocation: Seiki Matsuno, MD, FACS, of Sendai, Japan; Enrique T. Ona, MD, FACS, of Manila, the Philippines; Hector Orozco, MD, FACS, Mexico City, Mexico; Lewis Spitz, MB, BCh, PhD, FRCS, FRCS(Ed), London, England; and Ignace B. Vergote, MD, PhD, Leuven, Belgium.

Photos accompanying this article were taken by Charles Giorno Photography and Oscar-Einzig Photography.
Named Lectures
As always, Clinical Congress featured several Named Lectures, starting with the Martin Memorial Lecture, presented immediately after the Opening Ceremony on Monday, October 1. **Michael R. Harrison, MD, FACS**, professor emeritus of surgery, pediatrics, gynecology, and reproductive sciences, and founder of the Fetal Treatment Center at the University of California, San Francisco, presented the lecture titled Surgical Innovation vs. Regulation.

Other Named Lectures presented at the 2012 Clinical Congress were as follows:

- **Robert A. Guyton, MD, FACS**, chief of cardiothoracic surgery and professor of surgery at Emory University School of Medicine, Atlanta, GA, presented the John H. Gibbon, Jr., Lecture titled Critical Aortic Stenosis—Who Now Is Inoperable?

- **Thomas J. Fogarty, MD, FACS**, founder of the Institute for Innovation, El Camino Hospital, Mountain View, CA, and clinical professor of surgery at Stanford University, presented the Charles G. Drake History of Surgery Lecture titled A Personal 50-Year Experience Relating to the FDA.

- **Ira J. Kodner, MD, FACS**, Solon and Bettie Gershman Professor of Colon and Rectal Surgery at Washington University Medical Center, St. Louis, MO, presented the Herand Abcarian Lecture titled Surviving Surgery As a Career.

- **Atul Gawande, MD, MPH, FACS**, general and endocrine surgeon and professor of surgery at Brigham and Women’s Hospital and professor, department of health policy and management, Harvard School of Public Health, Boston, MA, presented the Excelsior Surgical Society/Edward D. Churchill Lecture titled The Mass Production of Surgical Care.

- **Timothy C. Fabian, MD, FACS**, the Harwell Wilson Professor and Chairman, department of surgery, University of Tennessee Health Science Center, Memphis, TN, gave the Scudder Oration on Trauma titled Blunt Cerebrovascular Injuries: Anatomic and Pathologic Heterogeneity Creates Management Enigmas.

- **Carol-anne Moulton, MB, BS, PhD, FRACS**, staff surgeon and associate professor of surgery, University of Toronto, and scientist, University of Toronto Donald R. Wilson Centre for Research in Education, ON, presented the Olga M. Jonasson Lecture titled Peeking behind the Curtain: Surgical Judgment Beyond Cognition.

- **Ari Leppaniemi, MD, PhD**, chief, division of emergency surgery and surgical critical care at Meilahti Hospital, University of Helsinki Central Hospital, Finland, presented the Distinguished Lecture of the International Society of Surgery titled Humanitarian Missions—Can One Surgeon Make a Difference?

- **Peter A. Singer, MD, MPH, FRSC**, chief executive officer of Grand Challenges Canada, director of the Sandra Rotman Centre, and professor of medicine at the University of Toronto, presented the Ethics and Philosophy Lecture titled The Grandest Challenge: Global Health.

- **R.J. Heald, OBE, MChir, FRCS**, surgical director, Pelican Cancer Foundation, and professor of surgery at Basingstoke Hospital, Hampshire, UK, presented the Commission on Cancer Oncology Lecture titled Bowel Cancer Surgery: Tales of the Unexpected.
• Richard S. Hotchkiss, MD, professor of anesthesiology, medicine, surgery, molecular biology, and pharmacology, Washington University School of Medicine, St. Louis, MO, gave the I.S. Ravdin Lecture in the Basic Sciences sponsored by the I.S. Ravdin Society titled Immuno-Therapy—An Emerging Concept in the Treatment of Sepsis.

Awards and honors
Several surgeons were honored for their contributions to the ACS.

Jack W. McAninch, MD, FACS, FRCS(Eng) (Hon), received the American College of Surgeons Distinguished Service Award, the College’s highest honor, during the Convocation (see photo, page 29). The Board of Regents recognized Dr. McAninch with this year’s award because of his “steadfast and inspirational commitment to the initiatives and principles embodied by the American College of Surgeons,” his work as a surgeon and leader, and his dedication to educating medical students and surgeons in training.

ACS Past-President George F. Sheldon, MD, FACS, received the second Lifetime Achievement Award of the ACS during the Convocation ceremonies. “Dr. Sheldon’s devotion, skills, ethics, and love for service—his contributions to the art of surgery and the College—[are] why he was chosen to receive the Lifetime Achievement Award,” said Patricia J. Numann, MD, FACS, Immediate Past-President of the College.

The Fellows Leadership Society (FLS) of the ACS presented the 2012 Distinguished Philanthropist Award to Murray F. Brennan, MD, FACS, during the 24th annual FLS benefactor recognition luncheon (see photo, page 29). The award recognizes Dr. Brennan’s philanthropic endeavors, his service
to the surgical profession, and his all-encompassing support of the College.

Other awards were presented to surgeons for their commitment to trauma care. Norman E. McSwain, Jr., MD, FACS, a general and trauma surgeon in New Orleans, LA, and Donald D. Trunkey, MD, FACS, a general and trauma surgeon in Portland, OR, were accepted into the Order of Military Medical Merit during the annual Committee on Trauma (CoT) dinner (see photo, page 30). The Order recognizes excellence and promotes fellowship and esprit de corps among U.S. Army Medical Department (AMEDD) personnel, and membership in the organization denotes distinguished service that is recognized by the senior leadership of the AMEDD.

In addition, the National Safety Council presented its Surgeons’ Award for Service to David S. Mulder, MD, FACS, a cardiothoracic surgeon in Montreal, QC, during the COT dinner (see photo, page 30). The award recognizes Dr. Mulder for his dedication to “prevention of injuries, regionalization of trauma care, innovative studies, and lifelong commitment to the care of trauma patients.”

Two surgeons received the 2012 ACS/Pfizer Surgical Humanitarian Awards and three received Surgical Volunteerism Awards (see photo, this page). Catherine R. deVries, MD, FACS, FAAP, and Russell E. White, MD, MPH, FACS, FCS (EASC), each received the Surgical Humanitarian Award. Brendan C. Brady, MD, FACS, received 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. Raymond R. Price, MD, FACS, received the Surgical Volunteerism Award for international outreach for his contributions toward improving surgical care in Mongolia and other countries. Robin T. Petroze, MD, received 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.

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery. The 2012 Owen Wangensteen Surgical Forum on Fundamental Surgical Problems was dedicated to Dr. Harrison (see photo, this page), who presented the Martin Memorial Lecture. Residents honored with the Surgical Forum Excellence in Research Awards included: Jeff Chang, MS, MD; Sumanth Channapatna-Suresh, MD; Martin Egenti, MD; Alejandro Garcia, MD; Soyoung Lee, MD; Dana Lin, MD; Muhammad Rishi, MD; Benjamin Schmidt, MD; Daniel Shouhed, MD; Ian Udell, MD; Jessemae L. Welsh, MD; and Laura E. White, MD (see photo, page 32).

Jacqueline S. Jeruss, MD, PhD, FACS, a general surgeon at Northwestern Memorial Hospital and an assistant professor of surgery at Northwestern University’s Feinberg School of Medicine, Chicago, received the Joan L. and Julius H. Jacobson II Promising Investigator Award (see photo, page 32).

The tenth annual ACS Resident Award for Exemplary Teaching was presented to John L. Falcone, MD, MS, a fifth-year resident in general surgery at the University of Pittsburgh Medical Center in Pittsburgh, PA (see photo, page 32). The award is sponsored by the Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives. Dr. Falcone was selected by an independent review panel of the Committee on Resident Education.

Valerie W. Rusch, MD, FACS, Chair of the ACS Program Committee, and ACS Regent Leigh A. Neumayer, MD, FACS, presented the award for Best Scientific Exhibit to Philip J. Hanwright, a medical student continued on page 33

Posters of Exceptional Merit recipient Dr. Hanwright (holding the blue ribbon) with Dr. Rusch (front, middle) and Dr. Neumayer (between Dr. Rusch and Mr. Hanwright). Also pictured are authors of other posters that were presented at the 2012 Clinical Congress.

Jacobson Promising Investigator Awardee Dr. Jeruss (left) with Dr. Eastman.

Dr. Falcone, recipient of the Resident Award for Exemplary Teaching (center), pictured with (left to right): Dr. Sachdeva; David B. Hoyt, MD, FACS, Executive Director; Dr. Eastman; Kenneth K.W. Lee, MD, FACS, Residency Program Director, University of Pittsburgh School of Medicine, Pittsburgh, PA; Gayle E. Woodson, MD, FACS, Chair, Committee on Resident Education; and J. David Richardson, MD, FACS, Chair, Board of Regents.
at Northwestern University Feinberg School of Medicine, Chicago, for the exhibit titled Variations in Complication Rates for Elective Non-Reconstructive Breast Surgery: An Analysis of NSQIP Data from 2006–2010. The coauthors of this exhibit are as follows: Geoffrey Chow, MD; Colton H. McNichols; Caitlin Conner; Karl Y. Bilimoria, MD; and John YS Kim, MD (see photo, page 32).

Furthermore, the following medical students were honored for their Basic Science Research posters:

• **First place:** Charles A. Su, Cleveland Clinic Lerner Research Institute, Cleveland, OH: Prolonged Cold Ischemia Increases the Early Infiltration and Effector Functions of Activated Effector-Memory T Lymphocytes in Cardiac Allografts

• **Second place:** Ben E. Biesterveld, Medical College of Wisconsin, Milwaukee: Alterations of Intestinal and Tissue-nonspecific Alkaline Phosphatase Activity in a Neonatal Rat Model of Necrotizing Enterocolitis

• **Third place:** Analise B. Thomas, Vanderbilt University, Nashville, TN: Disruption of Hematopoietic Stem Cell Mobilization Prevents Transplantation Tolerance

The following medical students were recognized for their Clinical & Educational Research posters:

• **First place:** Lauren B. Nosanov, Children’s Hospital of Los Angeles, CA: Models of Preoperative Clinical Predictors of Perforation in Pediatric Appendicitis (see photo, this page)

• **Second place:** Michael A. Mooney, Weill Cornell Medical College, New York, NY: Diagnostic Radiation Exposure during Evaluation for Liver Transplantation

• **Third place:** Edward Chu, Mount Sinai School of Medicine, New York, NY: The Evaluation of Clopidogrel Use in Perioperative General Surgery Patients

The ACS Committee on Video-based Education sponsored two awards for outstanding videos created by prominent international surgeons. The 2012 Certificate of Merit Awards were presented to Joep Knol, MD, Jessa Hospital,
The International Guest Scholars for 2012, International Relations Committee (IRC) members and guests gathered during Clinical Congress. Front row, left to right: Jamal J. Hoballah, MD, FACS, Hamra, Beirut, Lebanon, IRC Vice-Chair; Dr. Komatsu; Dr. Ng; Dr. Muller; Dr. Tantiphlachiva; Dr. Trostchansky; Dr. Jallouli; Dr. Lin; Dr. Kurashima; Dr. Kesieme; Dr. Johnson; and Stephen A. Deane, MB, BS, FRCS, FACS, Fennell Bay, Australia, IRC Chair. Back row: Dr. Ojo; Dr. Lang; Dr. Lal; Dr. Enrique Sanabria; Dr. Gagua; Dr. Niedergethmann; Dr. Arkadopoulos; Dr. Grobmyer; Dr. Krauel; Dr. Beer; and Dr. Kashyap.

Hasselt, Belgium, for the video titled Laparoscopic Repair and Splenic Flexure Mobilization—Beware of the Pancreas; and Akimasa Nakao, MD, PhD, FACS, Nagoya Central Hospital, Japan, for Pancreatic Head Resection with Segmental Duodenectomy (PHSD) for Intraductal Papillary Mucinous Neoplasm of the Pancreas.

Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the ACS Division of Education, presented a pewter bowl to outgoing Committee on Video-based Education Chair Tonia M. Young-Fadok, MD, MS, FACS, in recognition of her contributions to the committee (see photo, page 33). Dr. Young-Fadok served on the committee for eight years, the last four as Chair.

The International Relations Committee welcomed the International Guest Scholars for 2012 and other guests at a luncheon October 4, including the following:

Nikolaos Arkadopoulos, MD, FACS, Kifissia, Greece Stavros Niarchos Foundation Scholar; John R. Beer, MB, BS, FRACS, Kew, Victoria, Australia; Alvaro Enrique Sanabria, MD, MSc, PhD, Bogota, Colombia; Zviad Gagua, MD, Tbilisi, Republic of Georgia; Stephen R. Grobmyer, MD, FACS, Japan Traveling Fellow; Mohamed Jallouli, MD, Sfax, Tunisia; Maria Antony Johnson, MB, BS, MS, Nagercoil, Tamil Nadu, India; Vikram S. Kashyap, MD, FACS, Australia-New Zealand Traveling Fellow; Emeka Blessius Kesieme, MB, BS, FWACS, Baxiriam S. & Kankuben B. Gelot Community Surgeon Travel Awardee, Ekpoma, Nigeria; Shuhei Komatsu, MD, PhD, Kamigyo-ku, Kyoto, Japan; Lucas Krauel, MD, Barcelona, Spain; Yo Kurashima, Sapporo, Japan, International Surgical Education Scholar; Pawanindra Lal, MB, BS, MS, FACS, continued on page 36
OTHER AWARDS AT CLINICAL CONGRESS

James F. McKinsey, MD, FACS, and Andre R. Campbell, MD, FACS, made a special presentation to Dr. Sachdeva on behalf of the ACS Committee on Medical Student Education. The ship’s compass was inscribed: “To Ajit K. Sachdeva, MD, FRCS, FACS, our guiding compass for the last 10 years, whose vision and contributions for medical student education will chart the course of our profession for decades to come.” From left to right: Michael D. Kluger, MD, FACS; James F. McKinsey, MD, FACS; Mary A. Hooks, MD, FACS; Celeste M. Hollands, MD, FACS; Dr. Sachdeva; Dr. Campbell; Nancy L. Gantt, MD, FACS; Stephen C. Yang, MD, FACS; and Jaime Ann Cavallo, MD. Not pictured: Christopher P. Brandt, MD, FACS; Rebecca Evangelista, MD, FACS; Ted A. James, MD, FACS; Thomas S. Riles, MD, FACS; and Susan Steinemann, MD, FACS.

L. D. Britt, MD, MPH, FACS (left), was recognized by the Division of Education for his exemplary leadership and outstanding contributions to the expanded Medical Student Program offered during the Clinical Congress for the past 10 years. Dr. Britt is pictured with Dr. Sachdeva.

Dr. Longaker (second from right) was recognized by the Division of Education for his service as Chair of the Committee for the Forum on Fundamental Surgical Problems. Dr. Longaker, whose term as Chair concluded at Clinical Congress, is pictured here at the April award presentation with ACS staff members (left to right) Julie A. Tribe, MSEd; Patrice G. Blair, MPH; and Kathryn Matousek.

On the occasion of the 10th anniversary of the expanded Medical Student Program held each year during the Clinical Congress, the Division of Education recognized those individuals who have showed exemplary leadership and made outstanding contributions to the program. Awards were presented by Dr. Sachdeva (center) to (from left to right): Dr. Neumayer; Dr. Campbell; Dr. Gantt; Celeste M. Hollands, MD, FACS; Dr. Britt; James F. McKinsey, MD, FACS; Susan Kaiser, MD, FACS; Mary Ann Hopkins, MD, FACS; Christopher P. Brandt, MD, FACS; and (not pictured) Julie A. Freischlag, MD, FACS, and Hilary A. Sanfey, MB, BCh, FACS.
FOR MORE INFORMATION
This article contains information that is discussed in greater depth in previous issues of the Bulletin. The following is a list of where these articles can be found.

September 2012  Dr. Jack McAninch receives 2012 Distinguished Service Award, page 72
Fellows honored for volunteerism, page 74

November 2012  Brent Eastman installed as 93rd ACS President, page 58
Dr. Sheldon honored with Lifetime Achievement Award, page 60
Five prominent surgeons accorded Honorary Fellowship in the ACS, page 63

December 2012  Summary of Dr. Eastman’s Presidential Address
Dr. Pellegrini named President-Elect, page 49
ACS Regents and Governors Elected at Annual Business Meeting, page 51

Elias Hanna Scholar, Delhi, India; Brian Hung-Hin Lang, MB, BS, MS, Hong Kong SAR, China; Hsin-Ching Lin, MD, FACS, Kaohsiung, Taiwan; Elmi Muller, MB, ChB, MMed, Cape Town, South Africa; Anthony Chi-Fai Ng, MB, ChB, MD, Hong Kong, China; Marco Niedergethmann, MD, PhD, Mannheim, Germany; Emmanuel Olorundare Ojo, MB, ChB, FMCS, Louis C. Argenta Scholar, Jos, Nigeria; Kasaya Tantiphlachiva, Bangkok, Thailand, International Surgical Education Scholar; and Julio Leon Troschtschansky, MD, FACS, Montevideo, Uruguay (see photo, page 34).

The Commission on Cancer presented the State Chair Outstanding Performance Award to the following surgeons: Peter Hopewood, MD, FACS, Massachusetts State Chair; Leslie Kohman, MD, FACS, New York State Chair; and Juan Carlos Paramo, MD, FACS, Florida State Chair (see photo, page 34).

In addition, Stephanie Allen Lilly, MD, FACS, a general surgeon at Androscoggin Valley Hospital, Berlin, NH, attended the Clinical Congress as the recipient of the 2012 Nizar N. Oweida Scholarship.

The Resident and Associate Society of the ACS presented a $500 award to the winner of the 2012 RAS essay contest—Mika Matthews, MD, a surgical resident at Ohio State University, Columbus. The theme of this year’s essay contest was Treating the Difficult Patient.

Annual Business Meeting
The ACS Annual Business Meeting of the Members convened on October 3 with Dr. Eastman presiding and the following officials presenting reports: J. David Richardson, MD, FACS, Chair of the Board of Regents and Chair of the American College of Surgeons Professional Association’s Board of Directors; Lena M. Napolitano, MD, FACS, Chair of the Board of Governors; and David B. Hoyt, MD, FACS, ACS Executive Director.

The election of the ACS President-Elect, Vice-Presidents-Elect, Regents, and Governors also took place during the Annual Business Meeting.

Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), was named President-Elect. Layton “Bing” Rikkers, MD, FACS, was named First Vice-President-Elect; John T. Preskitt, MD, FACS, was named Second Vice-President-Elect.

Julie A. Freischlag, MD, FACS, was elected Chair of the Board of Regents. Mark C. Weissler, MD, FACS, was elected Vice-Chair.

The following six surgeons were elected to the Board: John L.D. Atkinson, MD, FACS; Henri R. Ford, MD, FACS; Enrique Hernandez, MD, FACS; L. Scott Levin, MD, FACS; Beth H. Sutton, MD, FACS; and Steven D. Wexner, MD, FACS.

Reelected to additional three-year terms on the Board of Regents were: Raymond F. Morgan, MD, FACS; Dr. Neumayer; and Marshall Z. Schwartz, MD, FACS.

The Board of Governors reelected Dr. Napolitano as Chair of its Executive Committee; Gary L. Timmerman, MD, FACS, as Vice-Chair; and William G. Cioffi, Jr., MD, FACS, as Secretary. Also reelected to the Executive Committee of the Board of Governors were Lorrie A. Langdale, MD, FACS, and Sherry M. Wren, MD, FACS. Governors-at-Large from throughout the world and Specialty Society Governors also were installed.

Clinical Congress 2013
Be sure to attend the 2013 Clinical Congress October 6–10 in Washington, DC. This meeting will mark the conclusion of the College’s Centennial celebration. Details regarding the educational program, registration, housing, and transportation will be posted at www.facs.org.
To help commemorate the American College of Surgeons’ (ACS) Centennial, the Bulletin of the American College of Surgeons is reprinting articles centered on the issues and developments that have defined the character and integrity of the organization throughout its 100-year history. This month, the Bulletin is reprinting an article from the July 1926 issue titled “American College of Surgeons Dedication and Inauguration of the John B. Murphy Memorial.”

The Murphy Memorial, which still stands at 50 E. Erie Street, Chicago, IL, was built in honor of John B. Murphy, MD, FACS, one of the more prominent founders of the ACS. Soon after his death in August 1916, a group of Dr. Murphy’s friends formed an association to solicit funds for erection of a suitable memorial to be built in honor of his distinguished service to humanity and to the art and science of surgery. In addition to members of the College, a large group of diverse leaders in industry, business, banking, and real estate contributed to the purchase of the property on which the building was constructed over the course of three years—1923 to 1926.

Since then, the College has used the facility for meetings and as office space for College staff. The building underwent a restoration several years ago and is now used for a variety of events sponsored by the College and other groups and individuals.

The following reprint summarizes the remarks made at the memorial’s dedication, the events leading up to the completion of the building, and construction and design of the building.
AMERICAN COLLEGE OF SURGEONS

DEDICATION AND INAUGURATION OF THE JOHN B. MURPHY MEMORIAL

THE completion of the Murphy Memorial marks an epoch in the history of the American College of Surgeons. Two evenings, June 10 and 11, were occupied with its dedication and inauguration. The first evening was under the supervision of the John B. Murphy Memorial Association, with Mr. Leroy A. Goddard, the president of the association, as presiding officer. The ceremony was begun by a procession to the platform of officers of the Murphy Memorial Association and the American College of Surgeons, and distinguished guests, preceded by the bearer of the Mace, symbol of authority of the College. Following the playing of the national anthem, the invocation was pronounced by the Reverend William H. Agnew, S.J., president of Loyola University, as follows:

"Almighty and Everlasting God, Omnipotent Author and Benignant Owner of the universe, recognizable as such with scientific certainty by the human intellect that fairly views the world and honestly traces back phenomena to their adequate and ultimate origins, we are assembled here this evening to dedicate to the service of humanity a new instrumentality of mercy and enlightenment in memory of one who always believed in Thee, and worked always in Thy Holy Name. Grant that those who are to administer this noble institute may always reckon themselves as the stewards and dispensers of Thy bounty and the responsible agents of Thy mercy. Grant that those who will study and labor within these walls for the betterment of human kind may always be mindful of Thy warning and Thy charge: 'Whosoever you do to the least of my brethren, you do to me.' Likewise we pray Thee, give to those who will write and deliberate within these halls the gifts of wisdom, sure knowledge, honesty and loyalty; wisdom, knowledge, honesty and loyalty that will make them the beneficent dispensers of truth, and the safe guides of genuine research, and that will save them from the blasphe-

mous stupidity of invoking the very evidences of Thy handiwork in disproof of Thy existence and in destruction of man's highest dignity and supremest hope, which are that we are Thy children and the heirs of an eternal destiny. Amen."

The John B. Murphy Memorial building was formally presented to the American College of Surgeons by the president of the Murphy Memorial Association and was accepted in behalf of the College by its president, Dr. Rudolph Matas.1

Because of the fame of Doctor Murphy and the recognition of the importance of the work being carried on by the College, of which Doctor Murphy was a founder and Regent, the civic and educational organizations in the city of Chicago were represented, and there were present to participate in the ceremony many famous surgeons of the United States and Canada. To those who cooperated in making possible the Murphy Memorial, the presiding officer expressed the appreciation of the Memorial Association as follows:

"Before introducing the speaker of the evening I desire to give expression of our appreciation to the many units that have co-operated with us for the success of these exercises. We have here representatives from the following educational institutions: Northwestern University, University of Wisconsin, University of Illinois, Notre Dame University, University of Michigan, University of Chicago, and St. Ignatius College. Doctor Murphy was directly associated with or received honors from all these institutions. We are honored by representatives from the State, County and City Governments. We appreciate especially the presence of so many of the County Commissioners, and several of the members of the Mayor's cabinet. In this connection I mention also with much pleasure the following clubs of Chicago: Chicago, Chicago Woman's, City, Fortnightly, Industrial, Kiwanis, Rotary, and the Union League. The last named Club appointed fifty-three

1Addresses appear in full in following pages.
delegates, and its president, Harry Eugene Kelly, is attorney for the Chicago Medical Society. The Chicago Association of Commerce, one of our most influential supporters, appointed thirty-four delegates. Its president, Mr. William R. Dawes, one of the busiest of business men, is here heading this delegation. It has a companion in the Illinois Manufacturers Association, whose long time secretary and successful pusher, Mr. John M. Glenn, is here with its representatives. Mr. Glenn has proved one of the most useful members of the executive board of our association. I mention also the presence of representatives from the Chicago Bar Association and the Ohio Society. Time will not permit more than the mere mention, though just as important and just as fully appreciated, that we are favored with delegates from ten medical societies and from all the leading hospitals in Chicago."

In introducing Dr. William J. Mayo, the principal speaker of the evening, the President said:

"I know it is a delight to you all to have this opportunity to listen to one of the most interesting men of this period, and one whose name and reputation are internationally known. Many of us heard the splendid address that he delivered at the laying of the cornerstone of this building. He has graciously favored us again with his presence. I present our neighbor from the West, the distinguished surgeon, Dr. William J. Mayo, of Rochester, Minnesota."

Dr. Mayo spoke on "The John B. Murphy Memorial, the Athenaeum of Surgery."

The ceremony was brought to a close by the playing of the "Star Spangled Banner," and an informal reception for the audience, among whom were the daughters of Doctor Murphy.

THE inauguration of the Memorial by the American College of Surgeons took place on the second evening, Friday, June 11, with the president of the College, Dr. Rudolph Matas, as the presiding officer. A formal procession of the officers of the Memorial Association and the College, distinguished guests, and Fellows of the College in the academic gown and cap, headed by the Mace bearer in the uniform of the United States Army, opened the meeting. The orchestra rendered the national anthem, whereupon the following invocation was pronounced by the Reverend Duncan H. Browne, S.T.D., rector of St. James Church:

1 Addresses appear in full in following pages.

"In Thy presence, our Father, we stand tonight to dedicate this temple to the pursuits of scientific research in medicine and surgery. The building bears the name of one who gave himself without stint to the service of mankind—John Benjamia Murphy—devoted husband and father—faithful friend—loyal and patriotic citizen—a teacher with a keen insight into the truth—a skillful minister to the relief of the diseases and ailments of human kind.

"May this building ever stand as the symbol of all that is best and noblest in the practice and profession of medicine and surgery! May it inspire to break down prejudice and ignorance by the clear rays of truth and knowledge. May its ideal to serve God and minister to the needs of humanity ever remain the foundation stone upon which it is built and its ideals maintained. In that light shall we see light. In so dedicating this temple of light we bespeak the divine guidance and the blessing of Him who taught that inasmuch as we do it unto those least we do it unto Him—our Lord and our Saviour Jesus Christ. Amen."

The President's introductory remarks follow:

"The Fellows of the American College of Surgeons who represent the thought and aspirations of the surgeons of America, have assembled here tonight to voice, through the utterances of their most distinguished leaders, the sentiments of gratitude that animate the College in accepting the noble edifice that the relatives, friends, and admiring colleagues of Doctor Murphy have dedicated to his memory and to the service of surgery.

"In grateful recognition of the generous motives that have prompted the John B. Murphy Memorial Association to transfer this monumental testimonial of their love and admiration for the great surgeon, whose name it bears, to the permanent care and custody of the American College of Surgeons, the College will now celebrate the first public session held under its auspices in this memorial hall. Availing themselves of this memorable opportunity, the speakers who will address you will confirm their faith in the purposes and ideals of the College and renew fidelity to its pledges and to the fulfillment of its obligations.

"Doctor Murphy's life and labors in their relation to the American College of Surgeons and to the progress of the science and art of surgery as developed in America, have been
THE JOHN B. MURPHY MEMORIAL

John B. Murphy Memorial.
told in a way that is too fresh in your memory of last evening's proceedings to require, at this moment, more than an added word to emphasize the service that he rendered in exalting and glorifying surgery by his teachings and example. It is in the prosecution of his high aims and ideals through the instrumentality of this priceless possession that the College will render the most faithful tribute to his memory.

"It is to the further expansion of the altruistic purposes of this organization in serving the highest interests of humanity through the ever growing, ever changing, ever advancing, and ever conquering forces of modern scientific medicine, that the proceedings of this session will be formally consecrated.

"In calling for the first number on the program we are happy to recall that there is no one in our guild who lived closer to the thoughts of the great master and who sympathized more respondingly to the noble spirit that animated him, or who promoted and gave form to his aspirations and ideals, than the friend and colleague whose genius for organization and leadership has given life and movement to the great enterprise that we now visualize in the mission and functions of the American College of Surgeons. To renew the pleasure that it gives us to acknowledge the unpayable debt that we owe to the originator and organizer of our association, I am now happy to present the Commanding General of our Army as the best fitted to initiate the proceedings of the evening,—Dr. Franklin H. Martin."

Dr. Martin spoke on "John Benjamin Murphy—Citizen and Surgeon."

Dr. George W. Crile, of Cleveland, whose subject was "The American College of Surgeons" was introduced by the President, who said:

"Throughout the fourteen years that have elapsed since the foundation of the American College of Surgeons, a great surgeon and a great personality in American surgery has stood by the helm of this institution and brought to bear upon its administration all the light that his gifted intelligence and the incalculable wealth of his scientific knowledge could give to the guidance and support of its aims and functions. I have the honor to present to you one of the greatest assets of the American College of Surgeons and one of the outstanding, most original and prolific contributors to the progress and prestige of American surgery—Dr. George W. Crile."

At this stage, the proceedings were agreeably interrupted by the entrance of Dr. Charles H. Mayo whose presence on the platform was the signal for a general outburst of applause. After responding in fitting terms to the warm welcome accorded him, Dr. Mayo proceeded, in behalf of the College, to present to Mr. Walter E. Carr, a specially designed and engraved testimonial in parchment, attesting to the thanks and grateful appreciation of the College for his invaluable service in financing and erecting the Murphy Memorial. Mr. Carr did not spare time, thought, or labor in completing his task but worked with zeal and enthusiasm solely for the love of the cause and without thought of pecuniary compensation. Dr. Mayo's remarks follow:

"My present task is a most agreeable one. While we are here assembled to dedicate this beautiful memorial building, erected to the memory of that great surgeon and teacher, John B. Murphy, for the advancement of medical science, it is most fitting that we, at this time, acknowledge the work of Mr. Walter E. Carr in making our vision come true. The members of the Board of Regents, now that the construction details are over, appreciate the magnitude of the work and the importance of the detail which was the burden of Mr. Carr rather than the Board. We have appreciated his contagious optimism and enthusiasm at all times no matter how arduous were his duties.

"I now present to Mr. Carr on behalf of the members of the Board of Regents this record of their appreciation which states:

TO WALTER E. CARR
in recognition of his unselfish devotion, his persistent endeavor, and his unselfish service in aiding and establishing the monumental

JOHN B. MURPHY MEMORIAL BUILDING
which commemorates one of the world's greatest surgeons, the Board of Regents of the American College of Surgeons has delegated us to express the thanks of the College, and has authorized us to place upon the walls of the Murphy Memorial a tablet attesting for all time this appreciation. In Witness Whereof, we have caused the Common Seal of the American College of Surgeons to be hereunto affixed this tenth day of June, Nineteen Hundred and Twenty-six.

(signed) RUDOLPH MATAS, President
(signed) FRANKLIN H. MARTIN, Director-General

In responding, Mr. Carr said:

"I can assure you it is not necessary for me to state that I am taken entirely by surprise, but I most deeply appreciate the great
THE JOHN B. MURPHY MEMORIAL

honor that has been conferred upon me. And in your own more than kind words, Dr. Mayo, you have not lived up to your reputation for conservatism, but have readily exaggerated whatever it may have been my good fortune to have accomplished in connection with the work to which you have referred. To be associated in any way with the very distinguished men who comprise the Board of Regents of the American College of Surgeons is an honor, a very unusual honor, and most especially for a business man. So far as the work is concerned, it was not difficult, but was a pleasure throughout on account of the object—a memorial to Dr. John B. Murphy, and on account of the dignity of the work of the American College of Surgeons.”

“Surgeons of America” was the title of the presentation by Dr. W. W. Chipman, of Montreal, president-elect of the College, whose introduction by the President follows:

“One of the greatest aims of the American College of Surgeons has been to promote international relations and to foster the spirit of brotherhood among the men of our profession. From the very beginning of this institution it recognized no frontiers between the Dominion of Canada and the United States. The deeply rooted sympathies of race, language, and tradition have inseparably interlocked the professional interests of the Canadian profession and our own, and have fused these into a common mold. Ever since our foundation, the surgeons of Canada and of this country have moved together as a solid phalanx in the most perfect unity of purpose, sentiment, and action. Our administrative and executive offices are shared alike in a common Fellowship, and we glory in the achievements of the great Canadian leaders who have contributed so largely, so freely and so effectively, to the cause of our organization. Of this number, no one is better fitted to represent the loyalty and the service of the Canadian profession in aiding this College to the attainment of its mission than the distinguished leader, now our president-elect, whom I have the honor to present—Dr. Walter W. Chipman, of Montreal.”

In presenting the last speaker of the evening, the President said:

“If there is merit in a life of service devoted to the unalloyed love of his profession and to the promotion of every movement that could tend to elevate and dignify it by the force of example, I know of none greater than the life and labors of the distinguished gentleman who is here as the representative of the medical culture of the greatest metropolis of the world. Thrice president of the New York Academy of Medicine, one of the ablest, most eloquent, and most inspiring masters of that center of medical learning—a plumed knight of our profession and one of the best loved members of our guild—Dr. George David Stewart, of New York.”

Dr. Stewart spoke on “Three Decades in Surgery.”

With the playing of the “Star Spangled Banner” and an informal reception, the ceremonies drew to a close.

DESCRIPTION OF THE MURPHY MEMORIAL BUILDING

The John B. Murphy Memorial Building is a monumental structure built of fireproof materials, faced with Bedford stone. It follows in design the French Renaissance period of architectural development and the exterior design was inspired by the Memorial Building in Paris. The building is set back somewhat from the street to set off the beautiful architectural motifs of the façade in the best way. The façade is featured by a pair of exceptionally designed and modeled bronze doors by Tiffany, presented by Mr. Edward L. Doheny as a tribute to Dr. Norman Bridge, who was a lifelong friend and a man of high repute in the medical profession. The bronze doors contain panels setting forth historic incidents and lives marking the various great steps of advancement in the history of medicine. These panels represent: Æsculapius, the god of medicine; Pasteur, a founder of scientific medicine; Osler, a great clinician; Lister, the father of modern surgery; McDowell, an American pathfinder in surgery; Gorgias, a world sanitarian. These bronze doors are at the top of an imposing flight of double stairs leading to the main floor of the building.

The main floor is taken up with the Memorial Hall. This auditorium is also French Renaissance in architectural treatment and is exceptionally impressive in its proportions with its high vaulted and ornamented ceiling. The color scheme of the room is ivory accented with gold. Blue is used in the draperies, floor covering and upholstering. An outstanding feature in the auditorium is the memorial stained glass window, directly opposite the main entrance and back of the platform, donated by Mr. C. H. Matthiessen, and executed by the Willet Company, of Philadelphia. This

Addresses appear in full in following pages.
THE JOHN B. MURPHY MEMORIAL

stained glass window ties in beautifully with the color scheme of the room and has the feature of the seal of the American College of Surgeons. Below the stained glass window, the stage is largely treated with carved walnut paneling of exceptional merit and incorporates the seats for the Board of Regents and their president. A pipe organ is now being installed in the Memorial Hall. The interior of this room has been designed with the thought in mind to arrange as many spaces as possible for the installation of memorial paintings, tablets, busts, statues, etc., and still in no way to interfere with the impressive architectural treatment of the room. The main floor and balcony seat about 1,000 people. This auditorium is flanked on the south and west by a very impressively treated foyer carried out in the same architectural style as the auditorium, with numerous wall spaces and alcoves provided for memorial treatments.

The building contains on the ground floor a lecture hall with necessary foyers, having seating capacity of about 250. This assembly room and the larger auditorium will be open to gatherings of medical and other scientific societies. There is an additional room which is available for the beginning of the Clinical Research Department and Medical Museum of the American College of Surgeons.

The top floor of the building contains accommodations for literary research work with adequate library stack space and reading rooms.

SUMMARY

A brief review of the Murphy Memorial, from its inception to its completion, is given herewith:

The death of John B. Murphy on August 11, 1916, created among laymen and the medical profession a spontaneous demand that a suitable memorial be erected to commemorate his distinguished services to humanity and to the science and art of surgery. This demand was so imperative that a number of Dr. Murphy's friends considered it desirable to incorporate an association that could legally investigate the many plans suggested and crystallize these efforts in a way to obtain dignified and permanent results. Among the many plans for a memorial that fulfilled the ideals of the incorporators of the Association, one was paramount, namely that the memorial take the form of the John B. Murphy Memorial of the American College of Surgeons, as Dr. Murphy was a founder and the first chief of the editorial staff of Surgery, Gynecology and Obstetrics, now the official journal of the College; an organ-izer of the Clinical Congress of Surgeons of North America; and a founder and member of the Board of Regents of the American College of Surgeons, and in the activities of each of these organizations he was actively and earnestly interested. It was realized that such an affiliation assured permanency and that the memorial would become a living power for the advancement of surgery along scientific and moral lines and in form and use present an appeal to the people of Chicago and the continent that would satisfy them that their monument would perform a service that would be of benefit for all time to all people.

The entrance of our country into the great War scattered the incorporators and caused a temporary cessation of the activities of the Association. In the early months of 1920 the plan of providing a memorial was revived and the Association was reorganized as follows:

Officers: Leroy A. Goddard, president; Charles H. Wacker, treasurer; W. A. Evans, secretary.
Board of Directors: Walter E. Carr; W. A. Evans; Leroy A. Goddard; Edward N. Hurley; James E. Keeffe, and Franklin H. Martin.
Building Committee: Albert J. Ochsner, chairman; Franklin H. Martin; Edward N. Hurley; W. A. Evans, and Walter E. Carr.
Executive Board: Edward Hines, chairman; Norman Bridge; Walter E. Carr; Edward F. Carry; Edward I. Cudahy; Charles G. Dawes; W. A. Evans; Samuel M. Felton; John M. Glenn; Leroy A. Goddard; John F. Golden; Edward N. Hurley; Samuel Insull; James E. Keeffe; Franklin H. Martin; William J. Mayo; John J. Mitchell; Fred W. Upham; William Wrigley, Jr.

The moneys for the erection of the Memorial, contributed by physicians and surgeons and friends of Dr. Murphy, were assembled by the John B. Murphy Memorial Association. The construction of the building was begun, and the cornerstone laid, with appropriate ceremony, on October 23, 1923. The dedication and inauguration, which marked the completion of the building, occurred on June 10 and 11, 1926.

Those who lived with Dr. Murphy—his contemporaries, his friends—appreciated him and sought to demonstrate their love by erecting to his memory a monument which, in the words of Dr. W. J. Mayo uttered at the laying of the cornerstone: "is a fitting monument to the greatest surgeon of his day, John B. Murphy, one of the founders of the College, who gave unspARINGly of his strength and talents to aid in the establishment of the organization, and whose noble spirit will always sanctify this ground."
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The importance of surgical workforce maps

by Thomas Ricketts III, PhD, MPH; Chantay Moye; and Dana Halvorson

The Association of American Medical Colleges’ Center for Workforce Studies estimates that the U.S. will face a shortage of 46,000 surgeons and medical specialists in the next decade. For example, New Jersey, the third wealthiest state in the U.S. according to the U.S. Census Bureau’s report on median household income for 2011, is projected to have at least 3,000 fewer physicians than will be needed by 2020 to adequately serve the state’s health care needs. Unfortunately, other states are facing the same predicament.

In the mid-2000s, national policymakers debated how to better define and overcome these emerging shortages, and the American College of Surgeons (ACS) sought to have a voice in these discussions. As a result, the College established the Health Policy Research Institute (ACS HPRI) at the University of North Carolina (UNC) Cecil G. Sheps Center for Health Services Research in Chapel Hill.

Under the direction of George F. Sheldon, MD, FACS, and Thomas C. Ricketts III, MPH, PhD, the ACS HPRI developed resources aimed at creating a clearer understanding of where disparities in access to surgeons and surgical care are most prevalent.

Over the last two years, the ACS HPRI has steadily relocated to the College’s Washington Office. Dr. Ricketts is now a formal consultant to the College’s Division of Advocacy and Health Policy (DAHP), and UNC now functions as a Health Policy Collaborating Center. These important workforce research activities at UNC continue through the direction of Dr. Ricketts and Erin Fraher, MPP, PhD, at UNC and Don E. Detmer, MD, FACS, Medical Director of the DAHP.

Earlier this year, the ACS HPRI released updated surgical workforce maps that illustrate the distribution of general surgeons and surgeon specialists per 100,000 population across the nation in 2006 and 2011. The maps track the number of surgeons in each county in 2011 and the change in surgeons per population between 2006 and 2011. The data and maps include all 3,107 counties in the U.S.

In 2012, the HPRI released an updated version of the U.S. Atlas of the Surgery Workforce which is an interactive, Web-based data system that displays surgery and population data on customizable maps available at www.acshpri.org/atlas/. The Atlas details demographic and health access indicators by county and state, and reveals where surgeon and physician shortages threaten patient access to timely, safe, high-quality, affordable health care.

This column provides answers to questions surgeons may have concerning the...
The overall picture is one of change that mirrors general economic trends.

The central focus of the ACS HPRI and the relevance of surgical workforce maps to policymakers, providers, and patients.

**What is the ACS HPRI and its purpose?**
The College established the HPRI in 2008 to study and report on issues related to the state of the surgical profession, the surgical workforce, and the volume of surgical procedures in the U.S. The HPRI provides expert advice, data analysis, and original research for surgical associations and boards, policymakers, and the health services research community.

**What kind of surgical workforce data can I expect to find in these maps?**
The maps display data for surgeons in the specialties in one category and general surgeons in another. Subspecialties will be added in the near future. The specific maps include:
- Surgeons per 100,000 population, 2006 and 2011
- Percent change in surgeons per 100,000 population, 2006 and 2011
- General surgeons per 100,000 population, 2006 and 2011
- Percent change in general surgeons per 100,000 population, 2006 and 2011
- Counties that lost all general surgeons between 2006 and 2011
- Counties that saw a decline of 10 percent or greater in general surgeons to population ratio, 2006–2011
- Counties that saw an increase in general surgeons to population ratio, 2006–2011
- Counties that lost all surgeons between 2006 and 2011
- Counties that saw a decline of 10 percent or greater in surgeons to population ratio, 2006–2011
- Counties that saw an increase in surgeons to population ratio, 2006–2011

**Selected HPRI surgical workforce maps are updated every year, but trend data are gathered every five years. Given the quantity and quality of existing data and trends, is more immediate data collection needed?**
Acquiring data can be costly, and researchers must consider the amount of time required to prepare the data for analysis. HPRI researchers have captured complete workforce data files from 1981 to 2011 and have completed detailed trend analyses for each file. These trend analyses, in turn, will require additional in-depth review, adding to the cost of the research.

HPRI reviews annual numbers for comparisons of national and state-level numbers. HPRI releases in-depth data in five-year increments as researchers have found this schedule to be the most practical for interpreting data.

**The ACS HPRI U.S. Atlas of the Surgical Workforce shows state-by-state data. What are the benefits of presenting the information in this manner?**
The state-by-state data provide a sense of variation. It is important that surgeon advocates be able to demonstrate these differences because states control essential policies that affect medical and surgical practice, including tort laws, payments under Medicaid, and funding for medical education and residency training. As Figure 1 on page 51 shows, the current Atlas allows surgeons and policymakers to view the U.S. distribution of total surgeons, general surgeons, surgical subspecialists, total physicians, and primary care physicians at the state level. The state-level maps are also the gateway to county-level maps for each state. By clicking on the individual state, the user is taken to a...
county-level map with options for displaying various data. In addition, the Atlas shows the supply and geographic distribution of institutions and individuals providing surgical services so that health care professionals, policymakers, and patients are able to anticipate changes in distribution and to identify places with limited access to surgical services. New Atlas data will be available by the end of this year.

Which areas are most at risk of decreasing health care coverage, and what factors are contributing to the shortage of surgeons in these particular areas?

As Figure 2 on page 52 demonstrates, counties located in the middle of the country have been experiencing significant surgeon shortages in recent years. The swath of rural counties in the middle of the nation, running from North Dakota to Texas, experienced the greatest shortages in 2006, and not much changed in 2011. Some of these states have seen a decrease in their population and/or their employment rate is falling. Physicians and surgeons are responding to the economic realities and choosing to leave or to start practices in other areas. The overall picture is one of change that mirrors general economic trends. There is also a mixed pattern of contraction or expansion of supply across the nation that tends to show a concentration of surgeons in counties with large cities.

The maps indicate that the East Coast has more counties with higher densities of surgeons. What’s the explanation for this trend?

As Figure 2 indicates, the Northeast traditionally had a higher physician supply. There were several reasons for this trend, including a strong economy, more training centers and hospitals, and more practice opportunities. However, a net shift from the Northeast and Midwest to the South and West is occurring, which may not be as apparent in the county-by-county maps. This shift follows the overall pattern of migration of the U.S. population to the Sun Belt as states in that region strengthen their economies and expand practice opportunities and training programs.

Has the HPRI uncovered any inconsistencies in the distribution of surgeons?

One could point to the mixed pattern of gains and losses in Minnesota, Iowa, and Virginia as examples of inconsistencies that may reflect small, regional patterns of...
FIGURE 2. SURGEONS PER 100,000 POPULATION, 2006 AND 2011

Produced By: American College of Surgeons Health Policy Research Institute, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Source: AMA Physician Masterfile, 2008. Data include non-federal, non-resident, clinically active physicians less than 80 years old reporting a primary specialty classified by the ACS HPRI as surgery.

Produced By: American College of Surgeons Health Policy Research Institute, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Source: AMA Physician Masterfile, 2011. Data include non-federal, non-resident, clinically active physicians less than 80 years old reporting a primary specialty classified by the ACS HPRI as surgery.
Surgical maps allow legislators to see where surgeon shortages exist, and this information can be used to craft policies that address such disparities.

How can surgeons best use the information in these maps?
Are they more beneficial for policymaking, wage negotiation, advocating, or some other purpose?

The maps may provide a general impression of where the surgical workforce situation is getting better or worse. These maps are important for policymaking, wage negotiation, advocating for better health care facilities, and deploying resources to reduce patient mortality. The maps can help surgeons shape the questions they may wish to ask regarding practical realities and the quality of life in the practice locations they are considering. In addition, the maps can help patients determine where surgical access might be more readily available.

How could the maps be used to shape policy at both the federal and state level relative to existing and proposed legislation?

If trends point to state-level policies that may drive surgeons away from a particular state, then those policies require reexamination. There are substantial differences in the conditions surgeons face from state to state, and surgeons will react to negative factors by changing their practice location. Both state and federal legislators have an obligation to examine their policy choices and their impact on access to quality health care. Surgical maps allow legislators to see where surgeon shortages exist, and this information can be used to craft policies that address such disparities.

Dr. Ricketts and the staff at HPRI are available to answer questions concerning the maps highlighted in this article and how best to analyze and display geographic data. Dr. Ricketts can be reached at tom_ricketts@unc.edu, or contact Katie Gaul, HPRI Research Associate, at k_gaul@unc.edu. Visit www.acshpri.org/maps.html to access the maps.

REFERENCES
College leaders answer the question, “Why is rural surgery an important issue now?”

by Mark W. Puls, MD, FACS

Perhaps rural surgery is the “canary in the coal mine” for general surgery. If there aren’t enough replacements for rural surgeons, how long will it be before there aren’t enough replacements for general surgeons?

The American College of Surgeons (ACS) is a scientific and educational association dedicated to improving the quality of care for the surgical patient. The College is involved in many activities, such as surgical education, cancer programs, trauma care, volunteerism, political advocacy, and so on. Recently the College’s Board of Regents chose to place new emphasis on the issue of rural surgery, and with the Board’s support, an Advisory Council for Rural Surgery was formed in June 2012. It is the first new Advisory Council that the ACS has established since 1988.

Considering the fact that the practice of rural surgery has been a part of the profession since the advent of surgery, what motivated the ACS leadership to start focusing attention on this important issue now?

Rural roots

In an effort to determine why the practice of rural surgery has become a top priority for the College, I interviewed the current ACS President, A. Brent Eastman, MD, FACS; Immediate Past-President Patricia Numann, MD, FACS; and the Past-Chair of the Board of Regents J. David Richardson, MD, FACS.

It quickly became apparent that all three of these College leaders had personal ties to rural America and rural surgery. Dr. Eastman grew up in Evanston, WY, a town with a population of approximately 3,000. At age eight, he developed nausea, vomiting, and abdominal pain. An appendectomy was performed, but his symptoms persisted, and the appendix was found to be normal. He was referred to a surgeon in Ogden, UT, who ordered an intravenous pyelogram, which showed bilateral ureteral obstruction due to an anomalous renal artery. Two urologists performed a ureteropyeloplasty, which Dr. Eastman said, “Really saved my life, because I was destined for chronic pyelonephritis.”

Dr. Numann grew up in upstate New York, in the town of Denver, which had a population of 82. Her family was poor. “Much of our medical care was really
The leadership in the ACS has in recent years increased our efforts to facilitate two-way communication with our Fellowship and hear from the ‘surgeons in the trenches.’

—Dr. Eastman

Given to us by those doctors who never seemed to make an issue of it in any way,” she said. “We always received good care.”

As a surgical resident, Dr. Numann was driving home late on Christmas Eve. When she was about 10 miles from home, she fell asleep at the wheel, and “went through three guard rails and a tree.” After extricating herself from the car and waking up the family at a nearby residence, she was taken to the local hospital. She had an extensive scalp laceration, and her hematocrit was found to be 17 percent. She is very appreciative of the care she received from the rural surgeon and the rural hospital.

Dr. Richardson also has a rural background and, in fact, was born in a one-room house in the small town of Morehead, KY. At the age of 10, he developed acute appendicitis with perforation. “I had to go to Lexington, which was nearly a two-hour ride in my dad’s truck, and it was not pleasant. That left an impression on me,” recalled Dr. Richardson, which may explain why access to surgical care has always been an important issue to him.

Although having three College leaders with ties to rural surgery likely helped to draw attention to the issue, there are other reasons why the College is placing greater emphasis on this topic. One reason is the change that has occurred within the College leadership and the Board of Regents. According to Dr. Eastman, “The leadership in the ACS has in recent years increased our efforts to facilitate two-way communication with our Fellowship and hear from the ‘surgeons in the trenches.’”

Dr. Numann added that the composition of the Board of Regents has changed and that the Regents “understand because they have been the workers in the field. They have walked the walk. I think it’s making a difference, and it’s going to make the College more relevant to everyone.”

Access issues

The College has always been concerned about access to surgical care and that is an issue of particular concern in rural America. An estimated 59 million citizens live in rural America. One-third of the land mass of America is defined as rural. Although 24 percent of Americans live in small rural communities, only 10 percent of general surgeons practice in those communities. Trauma literature has shown that a higher density of surgeons is associated with a significant reduction in deaths from motor vehicle crashes. The lack of proximity to a trauma center or to the appropriate level of care results in a higher death rate for motor vehicle traffic accident victims, and the death rates are higher in areas that have a lower number of surgeons per county.

Given that access to high-quality surgical care is “part of the overall mission of the ACS,” according to Dr. Numann, it should be no surprise that improving the availability of surgical care in rural areas has become a priority for the College. As Dr. Richardson said, “We have to refocus our efforts to really make sure that quality care is available for all of our people. It’s a matter of getting a good surgeon out to where the people are.”

Workforce shortages

The College is particularly aware of the shortage of general surgeons and its impact on rural surgery. Although the number of general surgery residents completing residency each year has remained constant, the U.S. population continues to rise. The number of residents choosing to specialize is also growing. Due to these two factors, the overall number of general surgeons per 100,000 population has decreased by 25.91 percent between 1981 and 2005. Fewer general surgeons are practicing in rural areas relative to urban areas. Lynge and colleagues have shown that there are 4.67 general surgeons per 100,000 population in rural areas, compared with 6.53 general surgeons per 100,000 population in urban areas. Critical access hospitals, which serve as the sole support for many rural areas, are having difficulty recruiting general surgeons. Of the 1,294 critical access hospitals, 365 (28.2 percent) have facilities with operating
rooms, but do not have a general surgeon residing in that county. Furthermore, the current rural surgical workforce is aging. General surgeons in small or isolated rural areas are more likely than their urban counterparts to be 50 years of age or older. In a survey of hospital administrators from 111 rural hospitals, one-third reported that they are actively recruiting a general surgeon, and one in 10 hospitals reported that they would be forced to close if they did not recruit general surgeons.

Surgical training and education

From its origin, the College has always been concerned about surgical training and education. This issue also affects rural surgery. All three surgeons interviewed for this column expressed concern that the Halsted model of surgical training may no longer be the best model. And according to Frank R. Lewis, MD, FACS, executive director, American Board of Surgery, the failure rate for the oral exam of the American Board of Surgery has increased from 16 percent in 2006 to 27 percent in 2012 (personal communication with Dr. Lewis, November 14, 2012).

Residents choose to specialize for many reasons. One reason may be that the current model for residency training may not adequately train residents to practice in a broad-based general surgical practice. In a survey of general surgery residents, 27.5 percent reported being concerned that they would not feel confident performing surgical procedures by themselves before they completed training.

The College’s leadership is concerned about surgical education issues. “The College actually was founded to look at the quality of the hospitals that residents were trained in to be sure that they had sufficient services to support the proper training of surgical residents. Isn’t it ironic that here we are 100 years later, and maybe we need to look at that again,” said Dr. Numann.

“For the American College of Surgeons to be relevant to the people practicing in the rural environment, the ACS needs to be involved from the beginning in setting standards for training and continuing education to support our rural surgeons,” Dr. Eastman added.

As the data cited previously in this article clearly demonstrate, rural surgery is an endangered area of general surgery. Approximately 1,000 general surgery residents complete their training annually. About 80 percent of these residents will go on to complete a fellowship, and if all of these residents then specialize, only 200 new general surgeons will enter the workforce each year, which leaves just four new general surgeons per state annually.

Perhaps rural surgery is the “canary in the coal mine” for general surgery. If there aren’t enough replacements for rural surgeons, how long will it be before there aren’t enough replacements for general surgeons?

Establishing the Advisory Council

As Chair of the Board of Regents, Dr. Richardson invited two rural surgeons, Tyler Hughes, MD, FACS, and Philip Caropreso, MD, FACS, to address the Board of Regents in February 2012. Dr. Hughes practices in McPherson, KS, and is on call every other night. Dr. Caropreso has practiced general surgery for 36 years, and works in Keokuk, IA. Dr. Caropreso is trying to retire but is having difficulty finding a surgeon to replace him. During the meeting, both surgeons described
why they chose to practice rural surgery and made it clear that they derive great personal satisfaction from that decision. They also described challenges related to rural surgery, including workforce issues, such as an aging surgeon population, burnout, call issues, fatigue, difficulty with recruitment and retention, and training issues. Drs. Hughes and Caropreso warned of the possible extinction of rural surgery if these issues are not addressed.

“I think it would be no understatement to say that to me it was one of the most compelling things I’ve ever listened to in my life. I think we all felt that way,” recalled Dr. Richardson.

Dr. Eastman described the presentation as a “seminal moment,” provoking the Board to convene a business meeting on the issue of rural surgery. Drs. Eastman, Numann, and Richardson all stated that this meeting was very brief due to the unanimous support for rural surgery. The Board of Regents agreed that action needed to be taken immediately to support rural surgery and recommended the formation of an Advisory Council for Rural Surgery. By the June 2012 meeting, the membership and leadership of the Advisory Council on Rural Surgery was in place. Dr. Eastman said, “I don’t think that I’ve ever seen anything in my time as a Regent for nine years, or as President–Elect, or now as President, move through the machinery of governance of the Board of Regents as fast. I think that spoke to [the] leadership [of] David Richardson, and I think that it spoke to a strong, well-presented message from the rural surgeons that provided the reasons why the College should be interested in this [issue].”

The leadership of the College has always been concerned about the issues of access to quality surgical care, surgical education, and surgical workforce issues, including those specific to rural surgery. Through leaders with personal ties to rural America and rural surgery, this topic became a top priority for ACS leadership, particularly as the result of an excellent presentation given to the Board of Regents. This presentation crystallized and personalized the issues involving rural surgery, and made it clear that rural surgery is a modern-day concern, particularly for members of the College. The real key in the events leading up to the formation of this Advisory Council is the rapid response of the leadership of the College. They not only heard the message, but they chose to act accordingly, responding to the needs of both Fellows and patients. With the help of the ACS, rural surgeons will continue to be able to, in the words of the College’s motto, “serve all with skill and fidelity.”

—Dr. Richardson

REFERENCES

Is medicine still a good profession?
Reflections of a retired surgeon

by Paul H. Jordan, Jr., MD, FACS

Editor's note: The following is the first submission to a new column titled “From residency to retirement” that will be published periodically in the Bulletin. The column is intended to provide an opportunity for surgeons at every stage of their career to share their thoughts regarding the practice and profession of surgery.

If you are interested in contributing to this new column, contact Diane Schneidman, Editor-in-Chief, Bulletin of the American College of Surgeons, at dschneidman@facs.org.

The June 2012 issue of the Bulletin featured a news story indicating that 90 percent of 5,000 physicians who participated in a study conducted by The Doctor’s Company were unwilling to recommend health care as profession.’ This appalling statistic, compared with the mindset that existed when I graduated from medical school 68 years ago, made me stop to reflect on my own experiences and on the question, “Is medicine still a good profession?”

Some colleagues of my generation have also expressed the view that we practiced medicine during its golden era. They say that—considering the problems that exist today—they too would be reluctant to recommend medicine as a profession to a family member.

It’s true that major changes have occurred in medicine in the last six or seven decades, and some of them have been undesirable. However, I really believe that when one considers the amazing advancements that have occurred, it is apparent that every generation of surgeons is part of a golden era. Anyone who wants to serve other people, or who has an interest in understanding how the human body functions or in unraveling its mysteries, should be encouraged to pursue this field. As an additional advantage, no profession surpasses medicine for the caliber of people with whom we work and socialize.

Outside influences
Surgery has certainly undergone many changes and many more surely will come. Some will be bad, and some will be good. One negative change that comes to mind is the loss of pride in our work. Unfortunately, some of the restrictions that have been forced upon surgeons in recent years have led to a deterioration of the physician-patient relationship that really makes the practice of medicine special.

Examples of these constraining forces include increased supervision by institutional review boards (IRBs) and expanded use of patient consent forms. The latter are certainly essential and beneficial, and, on the whole, IRBs are desirable but sometimes create unnecessary roadblocks.

Likewise, peer review of manuscripts submitted to medical and surgical journals is often helpful, but some authors have been the victim of overzealous reviewers. Along this line, I am reminded of the work performed by Edward R. Woodward, MD, demonstrating that a hormone release from the gastric antrum was under pH control. All of the best surgical journals rejected the paper. It was finally
Is there any reason, other than administrative disenchantment, why surgeons should discourage young people from considering a career in medicine?

Arguably, this study was among the most important to originate in the laboratory of Lester Dragstedt, MD, FACS, in the mid-1940s. However, its publication was delayed several years because some surgical reviewers happened to disagree with the findings. My point is that no rule or well-intentioned safeguard is perfect, but, on the whole, most provide some benefit.

In spite of these challenges, my generation feels that we practiced medicine during its best days. Of course, retired physicians of every generation probably think they practiced in the golden era of medicine. But consider the next generation and the unbelievable tools they have at their disposal. Aren’t these surgeons likely to think they practiced during the golden age when they retire?

The shoulders of giants

Is there any reason, other than administrative disenchantment, why surgeons should discourage young people from considering a career in medicine? The answer, in my opinion, is that there is not. If an individual has the desire to help mankind and contribute to society and has an inquisitiveness to learn or discover how the human body functions, he or

she should be encouraged to consider the field of medicine.

Above and beyond the factors that motivate medical students, this profession provides role models and friendships that are as strong as they are in any profession. I have been privileged to associate with people who are the kindest, smartest, and most noble individuals. And, if ever the metaphor “dwarves standing on the shoulders of giants can see further” could be applied to a profession, it would certainly be relevant to the field of medicine.

Personal odyssey

Some individuals who inspired me—a few of the giants on whose shoulders I have had the opportunity to stand—are addressed in the following section.

I matriculated at the University of Chicago, IL, which began to develop its own medical faculty in 1925. Dallas B. Pemister, MD, FACS, FRCSE(Hon), a prominent surgeon at Presbyterian Hospital in Chicago, was named the first chief of surgery. One of the unique features of the school was that the faculty was full time. Although full-time faculties eventually became the pattern at medical schools throughout the U.S., the only other medical school that purportedly had full-time faculty then was Johns Hopkins University.

The surgical faculty was composed almost entirely of general surgeons. Dr. Pemister had a strong interest in orthopaedics. He first described aseptic necrosis of bone and developed the first classification of bone tumors. He collaborated with Alfred Blalock, MD, FACS, at Vanderbilt University, Nashville, TN, on the study of hemorrhagic shock and was instrumental in establishing the first blood bank in the U.S. at Cook County Hospital in Chicago.

At this time, Dr. Dragstedt was head of physiology at Northwestern University, also in Chicago. Dr. Pemister asked him to design the dog lab in the new school and eventually offered Dr. Dragstedt a position on the surgical faculty. Dr. Dragstedt replied that he was not a surgeon, he was a physiologist. Dr. Pemister allegedly responded by saying that it was easier for him to make a surgeon out of a physiologist than a physiologist out of a surgeon. With that, Dr. Dragstedt was sent to Europe to visit and work in many of the famous surgery clinics before returning to the University of Chicago to join the surgical faculty.

Hilger Perry Jenkins, MD, FACS, also a general surgeon, had an interest in plastic surgery and eventually became the chair of that department. An interesting story relates to Dr. Jenkins conducting the live surgical television programs at the Clinical Congress. In 1955, Robert Zollinger, MD, FACS, called Dr. Jenkins and said he would like to present a woman who had

...if ever the metaphor “dwarves standing on the shoulders of giants can see further” could be applied to a profession, it would certainly be relevant to the field of medicine.

undergone multiple operations for a duodenal ulcer. Dr. Jenkins said that would be an interesting case to present but to look for a pancreatic tumor. Sure enough, this patient had the first described Zollinger-Ellison tumor. Dr. Zollinger subsequently gave Dr. Jenkins credit for his advice.

Then there was Charles B. Huggins, MD, FACS, also a general surgeon, who became chair of urology at the University of Chicago and subsequently won the Nobel Prize for his work on the hormonal relationship to carcinoma of the prostate. You can begin to appreciate the development of specialization that was bound to occur in medicine and surgery when you consider the explosive development of new devices and techniques.

By this time, Hitler had become very aggressive. Japan had attacked Pearl Harbor, and the U.S. responded with a declaration of war. As a result, the University of Chicago campus was filled with all types of scientists, including the nuclear physicists who initiated the first successful chain reaction that led to the atomic bomb. This growth led to a housing shortage, and the faculty was asked to open their homes to students. Dr. and Mrs. Phemister had a beautiful three-story home on University Avenue, and I was privileged to live on the third floor next to Dr. Phemister’s library, of which he was very proud. When he brought a guest to see his library, they would pass my door and Dr. Phemister would say, “Shush, Paul is studying.” I never figured out whether he knew something I did not, or whether he was suggesting in a gentle way that I might try a little harder.

There was no question that because of living with the Phemisters until I graduated, and because of the close friendships I formed with other students who chose surgical careers—including George Nardi, MD, FACS; Robert Jamplis, MD, FACS; and Henry McWhorter, MD, FACS—I, too, decided to go into surgery, and so began my golden era.

It is my sincere hope that I have been a role model to medical students and residents. I have often encouraged young people to consider a MD-PhD program, which provides greater opportunities for professional growth in the future. Young people usually do not know whether research is of interest until they have had an opportunity to discover its excitement.

A good profession
If you want to evaluate your legacy in medicine, you might consider, as one guide, the last paragraph in the autobiography of Loyal Davis, MD, FACS. Dr. Davis was the first neurosurgeon to practice in Chicago. He was profoundly instrumental in the development of the American College of Surgeons and ardently advocated for the College to take a strong stand against fee-splitting—one of the scourges of medicine and surgery. In his autobiography, titled A Surgeon’s Odyssey, Dr. Davis wrote, “I should like to believe that I have contributed to the happiness, future, success, and well-being of my family, professional colleagues, students and patients. If these are the thoughts of an old man, I accept the accusation. But if at some time in the future my relatives, my contemporaries, and my young friends in surgery speak with each other about my failings, my virtues, and my accomplishments, I shall have made it.”

Medicine, indeed, was a good profession, and so long as young physicians have the shoulders of giants on which to stand, it will continue to be a good profession for dedicated individuals. ◆

Borderline resectable pancreatic cancer: Pushing the technical limits of surgery

by Matthew H.G. Katz MD, FACS; Syed Ahmad MD, FACS; and Heidi Nelson MD, FACS

Tumor involvement of the major mesenteric vasculature historically has represented a contraindication to the surgical treatment of pancreatic cancer. Unfortunately, most patients with this disease present with primary tumors that abut or encase the superior mesenteric artery, superior mesenteric vein (SMV)/portal vein (PV), or hepatic artery. Therefore, only approximately one-third of patients with localized pancreatic cancers have been considered eligible for surgical therapy.

Studies show that resection is potentially curative for patients with primary tumors that can be resected to negative margins, up to 27 percent of whom can expect to live five years or longer.1 For patients with unresectable tumors, cure is impossible. Most of these individuals will die within 18 months of diagnosis.

However, over the last two decades two clinical observations have increasingly blurred the distinction between resectable and unresectable pancreatic cancers. First, surgeons have recognized that resection and reconstruction of the SMV/PV and the hepatic artery can be performed safely and effectively concurrent with a pancreatoduodenectomy in well-selected patients and may lead to an improvement in survival over nonsurgical management. Second, multidisciplinary teams have recognized that, when administered in the preoperative setting, chemotherapy and chemoradiation can exert cytotoxic effects on the primary tumor, enabling surgical oncologists to effectively select patients with favorable tumor biology for the major operations to follow.

Multimodality therapy, including surgical resection, now represents a potential route to long-term survival for a group of patients with so-called “borderline resectable” cancers. These cancers include localized tumors that are technically resectable but at high risk for margin-positive resection due to their close anatomic relationship with the major mesenteric vasculature. A typical treatment schema for patients with borderline resectable disease is shown in Figure 1, page 62. Both systemic chemotherapy and chemoradiation are administered first. Patients who are found to have progressive disease on restaging studies receive palliative care, and surgical treatment is no longer considered an option. Patients who have stable disease following completion of preoperative therapy are brought to the operating room (OR) for resection. This approach allows complete resection to be performed in a highly enriched population most likely to benefit from it.
and therefore leads to potential cure in patients previously considered unresectable.2

Multi-institutional trials needed
Although this treatment strategy is rational and its use has been accepted by consensus, no multi-institutional trial has been performed to study it.3 Indeed, only one multi-institutional prospective trial has been conducted specifically to study patients with borderline resectable pancreatic cancer, and that trial closed prematurely almost a decade ago largely due to an absence of a well-defined study population and therapeutic and surgical standards.4 Since then, standardization of preoperative assessment and staging, surgical decision making and technique, and integration of drug therapy and chemoradiation has not been accomplished for this group.5 For these reasons, patients with borderline resectable cancer are still often either treated as inoperable, and are therefore denied a chance at cure, or are brought to the OR for massive operations that are unlikely to be of long-term benefit.

The critical need for prospective evaluation of novel therapeutic strategies for patients with borderline resectable cancer is clear. The Alliance for Clinical Trials in Oncology (Alliance), in cooperation with the Southwest Oncology Group, the Eastern Cooperative Oncology Group, and the Radiation Therapy Oncology Group recently obtained the approval of the National Cancer Institute to conduct a feasibility study of preoperative chemotherapy and chemoradiation for this challenging group of patients. This study will be the first involving national and multi-institutional cooperation to look at neoadjuvant therapy for patients with advanced pancreatic cancer.

Study design
Adult patients with biopsy-proven adenocarcinoma of the pancreatic head, a serum CA 19-9 level < 1000 U/ml in the absence of jaundice, and no evidence of metastatic cancer are considered to have borderline resectable disease and are eligible for this study if their primary tumor meets any one or more of the following radiographic criteria:

- An interface between the primary tumor and SMV/PV exists that measures 180° or greater of the circumference of the vessel wall
- Short segment occlusion of the SMV/PV exists with normal vein above and below the level of obstruction that is amenable to resection and venous reconstruction
- Short segment interface (of any degree) between tumor and hepatic artery exists with normal artery proximal and distal to the interface that is amenable to resection and arterial reconstruction
- An interface between the tumor and superior mesenteric artery exists that measures less than 180° of the circumference of the vessel wall

Following central confirmation of the initial staging studies in a pre-registration phase, enrolled patients will be treated with FOLFIRINOX and capecitabine-based.

**FIGURE 1. TREATMENT SCHEMA FOR PATIENTS WITH BORDERLINE RESECTABLE PANCREATIC CANCER**

![Treatment Schema Diagram](image)
chemoradiation (see Figure 2, this page). Patients who maintain their performance status and exhibit no radiographic evidence for tumor progression at completion of therapy will be brought to the OR for planned resection. The primary end points of this initial single-arm pilot study will be to achieve the following: rapidly determine the feasibility of multi-institutional study of borderline resectable pancreatic cancer, develop a standardized clinical and research infrastructure specific to this disease stage that is necessary to study it, and define a new standard of care therapy for patients in whom such a standard does not currently exist to which novel regimens will subsequently be compared. Following rapid completion of this initial feasibility trial, a larger clinical study that includes a robust translational science program will be performed to evaluate this group of patients.

It is anticipated that surgeons will play a critical role in the success of this trial and their active participation is encouraged. For additional information, contact Dr. Katz at mhgkatz@mdanderson.org.

FIGURE 2.
TREATMENT SCHEMA FOR ALLIANCE TRIAL A0201101

REFERENCES
Surgeons and other health care professionals seeking to improve the safety and quality of health care are turning to new methods to achieve highly reliable care that is free from defects. One such method is simulation, a topic that was presented at the 2012 Fifth International High Reliability Conference in May 2012, conducted by Strategic Reliability LLC and hosted by The Joint Commission. A technique rather than a technology, simulation provides an interactive, immersive method to amplify or re-create the experiences that occur in the health care environment. Simulation may include verbal exercises, role-playing, storytelling, and computer-aided simulations featuring virtual patients, patient actors, computerized mannequins, and so forth.

David M. Gaba, MD, has been a pioneer in health care simulation, beginning in the 1980s with his work in mannequin-based simulation and continuing today in his role as associate dean for immersive and simulation-based learning and director of the Center for Immersive and Simulation-based Learning at Stanford University School of Medicine, CA. During his presentation at the conference, Dr. Gaba stated that health care presents different challenges than other industries of intrinsic hazard, such as aviation or nuclear power. Noting that physicians and health care workers do not design or build patients, let alone receive an instruction manual, he acknowledged that the alternatives to providing medical care are often untenable, regardless of risk.

Dr. Gaba noted that the decentralized nature of health care in both daily operations and business structure—for example, an estimated 22 million surgical procedures with anesthesia occur annually at approximately 6,000 hospitals owned by more than 1,000 entities—is another factor that separates the health care industry from other high-risk professions.

According to Dr. Gaba, simulation provides a comprehensive, continuous, and integrated way for individuals, teams, and work units to strive for the perfection and mindfulness that characterizes high-reliability organizations. Recognizing that identifying and addressing system problems requires more than training, simulation scenarios are designed to elicit behaviors likely to occur in real cases. Thus simulation offers direct education and hands-on training, as well as a method for performance assessment and evidence regarding human factors and teamwork. Furthermore, Dr. Gaba said that shifting the focus to optimal communication and teamwork behaviors that are fundamental to health care simulation exercises may also prompt cultural change, thus improving quality and risk-management efforts.

For more information regarding high reliability and simulation, including the 2012 Fifth International High Reliability Conference and Dr. Gaba’s presentation and podcast related to simulation, go to http://www.jointcommission.org/highreliability.aspx.
The 2012 Annual Report of the National Trauma Data Bank (NTDB®) is an updated analysis of the largest aggregation of U.S. and Canadian trauma registry data ever assembled. In total, the NTDB now contains more than 5 million records. The 2012 Annual Report is based on 773,299 records with valid trauma diagnoses that 744 facilities submitted for the single admission year of 2011. These facilities include 228 Level I trauma centers, 251 Level II trauma centers, and 210 Level III or IV trauma centers; 31 are Level I or Level II pediatric-only centers.

For the fourth year, the report contains an expanded section on facility information. This section includes the usual information on hospital characteristics, such as bed size and trauma level, as well as registry inclusion criteria for participating hospitals. A few of the inclusion criteria highlighted include minimum length of stay, hip fractures, and death on arrival. This information allows the reader to consider differences in case mix across hospitals while reading the report.

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

Generating more meaningful data

Each year the requirements for data submission have become more stringent. This effort to improve the quality and reliability of the data started in earnest with the introduction of the National Trauma Data Standard (NTDS) in 2007, which was applied initially to the first single admission year Annual Report of 2008. Along with this effort to improve data quality over the past five years, the number of participating U.S. hospitals has increased more than 70 percent. In the 2008 Annual Report, the total number of participating facilities was 435. This year’s report includes 744 facilities (see figure, page 66).

Many dedicated individuals who serve on the ACS COT and at trauma centers throughout the nation have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, the goals in the coming years include improving data quality, updating analytic methods, and developing.

The NTDB Annual Report 2012 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.
Each year the requirements for data submission have become more stringent. This effort to improve the quality and reliability of the data started in earnest with the introduction of the National Trauma Data Standard (NTDS) in 2007, which was applied initially to the first single admission year Annual Report of 2008.

The results of these efforts will be reflected in future NTDB reports for participating hospitals, as well as in the Annual Reports. Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The NTDB Annual Report 2012 is available on the ACS website as a PDF file and a PowerPoint presentation at www.ntdb.org. In addition, information regarding how to obtain other NTDB data for more detailed study is available on the website.

If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

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NUMBER OF PARTICIPATING FACILITIES

![Graph showing the number of participating facilities from 2008 to 2012.]

- 435 in 2008
- 567 in 2009
- 682 in 2010
- 697 in 2011
- 744 in 2012
ACS in the news

**Editor’s note:** The work of the American College of Surgeons (ACS) is often reported in broadcast, online, print, and social media throughout the world. Beginning with this issue, the Bulletin periodically will direct your attention to some recent major news stories that mention key ACS activities and initiatives. Following are brief summaries of and excerpts from the stories. To access the news items in their entirety, visit the online ACS Newsroom at [http://www.facs.org/newsroom/acs-in-the-news.html](http://www.facs.org/newsroom/acs-in-the-news.html).

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**Combine trauma, emergency surgery to save thousands**

Fierce HealthCare, November 9, 2012

“Hospitals looking to improve surgical care quality while lowering the cost of emergency surgical care should take a page from Loma Linda University Medical Center. The California hospital found success with an acute care surgery model that combined trauma and emergency general surgery into one 12-hour in-house shift service, according to research in the November issue of the *Journal of the American College of Surgeons.*”

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**After the diagnosis: Do you travel for treatment?**

*Columbus Dispatch,* October 28, 2012

“Patients with certain cancers are apt to do better at a cancer center that has significant experience with that kind of cancer, said Dr. David P. Winchester, medical director of the American College of Surgeons’ Commission on Cancer.

‘Esophagus, liver, pancreas and bladder are good examples of locations of tumors that require a team that’s experienced in managing those complex cancers,’ Winchester said. Often, he said, treatment of such cancers results in a high rate of post-operative complications, so an experienced rescue team should be on hand.”

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**“Need Surgery? You Might Have to Get Healthier First”**


A program that Thomas Varghese, MD, FACS, has championed to help patients get in better physical shape prior to a surgical procedure was profiled by *Wall Street Journal* columnist, Laura Landro. “Mr. Rice’s surgeon, Thomas Varghese, is medical director of a program in Washington state, Strong for Surgery, which has joined with partners including the American College of Surgeons to provide preoperative checklists focusing on risk factors that can be modified before surgery.”

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**Weekend Web: New Trauma App**

*NBC Chicago,* October 7, 2012

The ACS Committee on Trauma’s new Advanced Trauma Life Support® ATLS® app was featured as a technology advance on the October 7 edition of the show “Weekend Web” on the Chicago NBC-TV affiliate. Karen Brasel, MD, FACS, and Will Chapleau, RN, EMT-(P), explained some of the app’s new applications for delivering trauma care content to mobile devices.
The work of the American College of Surgeons (ACS) is often reported in broadcast, online, print, and social media throughout the world.

**Surgeons Report Progress Against Dangerous Hospital Infection**
*ABC News Online,* October 4, 2012

“[I]n findings presented...at the 2012 Annual American College of Surgeons Clinical Congress in Chicago, surgeons report success using a medicine called intestinal alkaline phosphate (IAP) to prevent C. difficile infections in tests on mice.”

**Rural Colon Cancer Patients Fare Worse**
*HealthDay News,* October 3, 2012

“Colon cancer patients in rural areas of the United States are more likely to die than those in cities,’ a new study reports. The study also found that rural patients with colon cancer tend to be diagnosed at a later stage and are less likely to receive chemotherapy or thorough surgical treatment. The study was presented at the American College of Surgeons Annual Clinical Congress in Chicago.”

**Smallpox virus may help treat deadly form of breast cancer**
*Daily Mail (U.K.)*, October 2, 2012

“A relative of the small pox virus may be an effective weapon against one of the deadliest forms of breast cancer, researchers say. Laboratory tests showed that more than 90 per cent of triple negative breast cancer (TNBC) cells treated with the vaccinia virus were destroyed within four days.... The findings were presented at the American College of Surgeons Annual Clinical Congress in Chicago.”

**Surgeons issued guidelines for seniors’ care**
*Modern Physician,* September 28, 2012

“Prompted by statistical findings that the growing population of seniors in the U.S. is aging increasingly with complex and advanced medical conditions, the American College of Surgeons and the American Geriatrics Society developed a set of 13 guidelines to steer the preoperative care of surgical patients age 65 and older.”

**Follow the ACS Centennial celebration online**

The American College of Surgeons (ACS) launched its Centennial celebration during the 2012 Clinical Congress in Chicago, IL, with special sessions, exhibits, and commemorative publications that pay tribute to the College’s 100-year commitment to quality surgical care. The ACS has developed a Web page dedicated to the Centennial, including a link to an interactive timeline titled 100 Years of Surgical Quality Improvement. The Centennial site can be accessed at http://www.facs.org/centennial/index.html.
Dr. Leonard Weireter appointed to NQF panel

Leonard J. Weireter, Jr., MD, FACS, a general surgeon and a member of the American College of Surgeons (ACS) Board of Governors, has been appointed to the National Quality Forum’s (NQF’s) Regionalized Emergency Medical Care Services Measure Topic Prioritization expert panel. The panel provides guidance for measure development to the U.S. Department of Health and Human Services’ Office of the Assistant Secretary for Preparedness and Response.

More specifically, the NQF is focused on prioritized areas of emergency department (ED) crowding, including boarding and diversion, emergency preparedness, and surge capacity. The panel is charged with developing a report that will tie together the concepts of ED crowding, preparedness, and regionalization, and will examine how these issues are measured and reported at the facility and regional level. In addition, the panel is responsible for shaping future measure development efforts in this area and laying the groundwork for a potential measure endorsement project. Go to http://www.qualityforum.org/Projects/n-r/Regionalized_Emergency_Medical_Services/Regionalized_Emergency_Medical_Care_Services_(REMCS).aspx for details.

Dr. Weireter is the Arthur and Marie Kirk Family Professor of Surgery at Eastern Virginia Medical School, Norfolk, VA. Dr. Weireter currently serves as Governor of the Virginia ACS Chapter. He previously served as President of the Virginia Chapter (2004–2005). He is also current chair of the ACS Committee on Trauma Ad Hoc Committee for Disaster and Mass Casualty Management. Dr. Weireter is the Regional Chief of the ACS Health Policy Advisory Council in Virginia, Maryland, Central Pennsylvania, and West Virginia.

Dr. Frank Opelka appointed chair of PCPI

Frank G. Opelka, MD, FACS, Associate Medical Director of the American College of Surgeons Division of Advocacy and Health Policy, was recently appointed chair of the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (PCPI). The ACS nominated Dr. Opelka for the post. The PCPI is a national, physician-led program that serves to align patient-centered care, performance measurement, and quality improvement. The consortium is a leader in developing, testing, and implementing evidence-based performance measures for use at the point of care.

Dr. Opelka has served as a member of the PCPI Executive Committee for the last five years and is a recognized national leader in surgical quality improvement, patient safety, public reporting, and health care delivery system redesign. He founded the Surgical Quality Alliance and serves on many national coalitions and committees, including the National Quality Forum’s National Priority Partnership and the Measures Application Partnership.

Dr. Opelka is a colon and rectal surgeon and currently serves as the executive vice-president for health care and medical education redesign at the Louisiana State University System, New Orleans. Dr. Opelka is a former member of the ACS General Surgery Coding and Reimbursement Committee (2001–2011), a former Chair of the Committee on Patient Safety and Quality Improvement (2006–2010), and a former Liaison to the ACS Program Committee (2006–2009).

NEWS

ACS staffer receives NAEMT Lifetime Achievement Award

Will Chapleau, EMT-P, RN, TNS, the American College of Surgeons (ACS) Director of Performance Improvement, is the 2012 recipient of the Rocco V. Morando Lifetime Achievement Award. The award’s sponsors, the National Registry of Emergency Medical Technicians (NREMT) and the National Association of Emergency Medical Technicians (NAEMT), presented the honor to Mr. Chapleau last year at the NAEMT’s General Membership Meeting. Mr. Chapleau previously served as Manager of the ACS Advanced Trauma Life Support® (ATLS®) program.

Before joining the ACS, Mr. Chapleau worked as a paramedic for 36 years and a trauma nurse specialist for 23 years. He worked for 20 years as a firefighter paramedic for the Chicago Heights, IL, fire department and served as chief of the department for six years.

An emergency medical services (EMS) educator for 28 years, Mr. Chapleau has published four EMS textbooks and contributed to numerous other texts for several trauma educational programs, including ATLS, Prehospital Trauma Life Support, and Advanced Trauma Care For Nurses. He also has written frequently for EMS and trauma journals and has lectured on EMS and trauma topics in more than 50 countries.

In addition, he served as a director on the boards of NAEMT, the National Association of EMS Educators, and the Society of Trauma Nurses.

The Rocco V. Morando Lifetime Achievement Award is the most prestigious honor awarded by the NREMT and the NAEMT, and is named after one of its founding members. To learn more about NAEMT and to view a press release on Mr. Chapleau’s receipt of the award, go to http://www.naemt.org.

SRGS Rural Surgery Single Issue

Nonsubscribers can earn CME credit for this special issue.

This issue of Selected Readings in General Surgery immerses itself in topics of interest to rural surgeons. These include the characteristics of rural practice, challenges in recruitment and retention, and a selective review of common clinical problems encountered in rural practice: trauma care, cutaneous surgery, endoscopy, gynecology, laparoscopic surgery, and urology.

To order: Purchase online at www.facs.org/srgs/subscribe/individuals.html. Scroll to the bottom and select “SRGS Rural Surgery Single Issue with CME.”

If you are an ACS member or have an ACS username, please log in to the e-store using your existing username and password BEFORE you place your order.

An order form is available at www.facs.org/srgs/rural.html

Order by phone at 800-631-0033
Call for nominations for ACS Board of Regents

The 2013 Nominating Committee of the Board of Governors (NCBG) will select nominees for pending vacancies on the Board of Regents that will need to be filled during the 2013 Clinical Congress. The NCBG uses the following guidelines when reviewing the names of candidates for potential nomination to the Board of Regents.

- Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship along with an unquestioned devotion to the highest principles of surgical practice.
- Nominees must have demonstrated leadership qualities that might be reflected in service and active participation on ACS committees or in other components of the College.
- The Nominating Committee members recognize the importance of representing all individuals who practice surgery.
- Geography, surgical specialty balance, and academic or community practice are other factors taken into consideration.
- The College encourages consideration of women and other under-represented minorities.

Individuals who are no longer in active, surgical practice should not be nominated for election or reelection to the Board of Regents.

All surgical specialties will be considered; however, ophthalmic surgery will be given priority consideration.

All nominations must include a letter of recommendation, a personal statement from the candidate detailing their ACS service, and the name of one reference. Surgical specialty societies, ACS advisory councils, ACS chapters, and other entities that are nominating as such, must provide a description of their selection process and the total list of applicants reviewed. Any attempt to contact members of the NCBG by a candidate or on behalf of a candidate will be viewed in a negative manner and possibly result in disqualification of the candidate. Applications submitted without the requested information will not be considered.

The deadline for submitting nominations is Thursday, February 28, 2013. Submit nominations to officerandbrnominations@facs.org

Should you have any questions, contact 312-202-5360.

For information only, the current members of the Board of Regents who will be considered for re-election are the following (all MD, FACS): Margaret Dunn, Howard Snyder, and Michael Zinner.

Stay current by using new ACS member e-mail forwarding benefit

The American College of Surgeons (ACS) is offering a new member benefit that maintains a permanent address for all e-mail communications from the College. The benefit ensures that all e-mail from the ACS is promptly sent to your current e-mail account and that the College can reach you for years to come, even if your employment changes—for example, if you retire or move on from a residency or fellowship program.

Go to http://efacs.org/emailforward to register for the benefit. Registration for this service is quick, easy, and free. If you have questions about the new service, contact the ACS Division of Member Services at ms@facs.org.
Call for nominations for ACS Board of Governors

Help the American College of Surgeons (ACS) keep pace in a changing health care environment and meet the goals of its Inspiring Quality: Highest Standards, Better Outcomes initiative by nominating your brightest, most engaged, responsible, and forthright members to three-year terms on the ACS Board of Governors (B/G). Nominations for the 2013 process must be submitted to your local chapter/surgical specialty society by February 28, 2013. The B/G is the representative body of the ACS. The membership at-large nominates two-thirds of the Governors, who are elected during an Annual Meeting of the Fellows at the ACS Clinical Congress. Certain surgical societies, chapters, and federal medical services may nominate Governors up to a level of one-third of the Board of Governors.

The Governors act as a liaison between the Board of Regents and ACS Fellows and as a clearinghouse for the Regents on general assigned subjects and local problems. Governors must attend Convocations and other formal meetings of the Fellows and the Governors. The Governors’ work includes assisting in establishing chapters of the College, serving as ex officio members of the governing group of the chapter and of the local Committee on Applicants, aiding in selecting personnel of committees organized within their areas, and helping to investigate special cases of Fellowship applicants.

A Board of Governors’ Ad Hoc Committee explored the role and responsibilities of Governors and the selection criteria for nominating members to the Board of Governors who can meaningfully represent their communities. An inclusive, transparent B/G depends on members who can actively serve as a link to the local community and a resource for the ACS. For more information, go to http://www.facs.org/about/governors/candidates.html. If you have questions, contact 312-202-5360.

Call for nominations for ACS Officers-Elect

The 2013 Nominating Committee of the Fellows (NCF) will select nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The NCF will use the following guidelines when considering potential candidates:

• Nominees must be loyal members of the College who have demonstrated outstanding integrity and medical statesmanship, along with an unquestioned devotion to the highest principles of surgical practice.

• Nominees must have demonstrated leadership qualities that might be reflected by service and active participation on ACS committees or in other components of the College.

• Members of the Nominating Committee recognize the importance of achieving representation of all who practice surgery.

The College encourages consideration of women and other under-represented minorities. All nominations must include a letter of recommendation, a personal statement from the candidate detailing ACS service, and the name of one individual who can serve as a reference. In addition, nominating entities, such as surgical specialty societies, ACS Advisory Councils, and ACS chapters, must provide a description of their selection process and the total list of applicants reviewed. Any attempt to contact members of the NCF by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification. Applications submitted without the requested information will not be considered.

The deadline for submitting nominations is Thursday, February 28, 2013. Submit nominations to officerandbrnominations@facs.org. If you have questions, contact 312-202-5360.
Jim Henry, Incorporated would like to extend a heartfelt congratulations and gratitude to every American College of Surgeons Member and Fellow, on the occasion of the College’s Centennial Celebration. For 60 years, Jim Henry has served the College with responsive, hands-on customer service and outstanding quality awards and recognition. As we celebrate our own 75th anniversary in business, we look forward to many more years of successful partnership with the American College of Surgeons.
The American College of Surgeons (ACS) and New York Presbyterian/Weill Cornell Medical Center, New York City, NY, hosted the 10th Inspiring Quality forum November 16, 2012. The forum, which highlighted programs such as the ACS National Surgical Quality Improvement Program (ACS NSQIP®), drew more than 160 attendees from nearly 40 hospitals, medical schools, and other health care organizations in the state—a record attendance for the Inspiring Quality tour.

ACS Governor Fabrizio Michelassi, MD, FACS, Lewis Atterbury Stimson Professor and chairman, department of surgery, surgeon-in-chief, New York Presbyterian/Weill Cornell Medical Center, moderated. The program featured a diverse panel of health care leaders who spoke on the importance of a data-driven approach to quality improvement.

"The New York medical community has pioneered public reporting and the use of meaningful data to improve outcomes," said Dr. Michelassi. "We, perhaps better than anyone, know the benefits and challenges of public reporting, and this forum is an important vehicle to continue those discussions and demonstrate how outcomes-based programs like ACS NSQIP are driving effective quality improvement here in New York and across the country."

"Regulators are realizing that we need a more robust quality measurement system in this country based on clinical, not administrative, data and focused on measuring outcomes," added Clifford Y. Ko, MD, MS, FACS, Director, ACS Division of Research and Optimal Patient Care. "ACS NSQIP is working closely with the Centers for Medicare & Medicaid Services (CMS) to evolve our hospital quality measurement in this direction, which is good for our patients, for surgeons and hospitals, and for our nation’s health care system."

"We are at a critical time when it comes to advocating for the right kind of quality improvement, especially as CMS moves toward public reporting based on clinical data and outcome measures in the coming years and ties these measures to value-based purchasing programs," said David Hoyt, MD, FACS, ACS Executive Director. "The challenge now is taking action on what we know already works. Hospitals now have good reputational and financial reasons to participate in programs like ACS NSQIP and help communicate that quality improvement is not just quality improvement for compliance sake—it is quality improvement to help hospitals achieve better outcomes that ultimately lower costs."

Panelists noted that provisions in the Affordable Care Act will add to the focus government agencies place on outcomes and costs. As Steven J. Corwin, MD, CEO, New York Presbyterian Hospital, noted, “Hospital administrators and clinicians need to measure meaningful outcomes and use real-time data to ensure we deliver the type of improvement valued most by regulators.”

Foster C. Gesten, MD, FACP, Medical Director, Office of Quality and Patient Safety, New York State Department of Health, added, “Public reporting of health outcomes by providers is here to stay, with increasing expectations by payors and the public of transparency and accountability. This is taking place during a time in which ever-rising health care expenditures, public and private, are being scrutinized for value. Clinicians, including the surgical community, by virtue of its history and its expertise, can lead and contribute to this movement by helping to create a system of performance measurement that first helps providers improve care quality and safety for their patients, but is also responsive to these wider set of expectations by the public.”

“Our hospital uses a unique management dashboard, which provides quality data on mortality, 30-day readmissions, surgical site infections, and length-of-stay rates,” reported H. Leon Pachter, MD, FACS, George D. Stewart Professor and Chair, department of surgery, New York University School of Medicine. “This has been a useful tool to objectively determine trends, verify data, and provide feedback to surgeons, including how they fare among their colleagues.”
“The data we have collected through ACS NSQIP has been a catalyst for change at our multi-specialty hospital,” added Steven C. Stain, MD, FACS, Henry and Sally Schaffer Chair, department of surgery, Albany Medical Center; professor and chair, department of surgery, Albany Medical College. “As a result of seeing the risk-adjusted data, we have implemented new hospital processes and protocols to address the areas we’ve identified as needing improvement.”

Panelists noted that quality improvement is an ongoing, evolving process. “Quality improvement is not self-sustaining, and therefore hospitals need continuous feedback in order to move the needle,” said Jeffrey H. Peters, MD, FACS, professor of surgery and chair, department of surgery, University of Rochester Medical Center. “Having adequate staffing levels, technology, checklists, etc., continuously validated through the accreditation process, are key to implementing quality improvement successfully.”

Experienced hospital clinicians must play a proactive role in performance improvement activities, said Pierre F. Saldinger, MD, FACS, chair, department of surgery, surgeon-in-chief, New York Hospital-Queens. “I’ve practiced in three other cities before coming to New York and it is my experience that regardless of geography, hospitals have the most success with programs like ACS NSQIP when they involve experienced clinicians who proactively seek out performance results in advance of issues, rather than reactively make changes if the data are disappointing,” he said.

Outcome measurement needs to be taught in medical schools, added Laurie H. Glimcher, MD, Stephen & Suzanne Weiss Dean, Weill Cornell Medical College, and provost for medical affairs, Cornell University. “Integrating the system-based approaches used in successful quality improvement programs into the medical school curriculum is critical to equip our future generation of physicians with an understanding of how the right process can improve outcomes.”

To view the archived forum video and follow updates on upcoming tour locations, visit InspiringQuality.FACS.org or the College’s YouTube channel at http://www.youtube.com/AmCollegeofSurgeons.
• Office Coding and Profitable Practice Operations  **(THURSDAY)**

**NEW CASES for 2013!**

Vein and thoracic surgical cases are featured this year — along with bariatric, breast, GI, skin cancer and trauma. Learn to apply modifiers correctly. Understand how to reduce delays and appeals.

Real case examples illustrate key documentation and coding principles — not vague theory. The workbook will serve as a useful, readable reference.

You’ll learn how to stay out of the auditor crosshairs for your evaluation and management coding.

Coding isn’t like riding a bicycle — once you’ve mastered cycling, you’ve got it down. Codes change, rules change, payers change — it’s a dynamic art.

These two workshops in combination will sharpen your ability to run your practice profitably and compliantly. Read signed reviews by workshop alums on our website.

* Earn CME credits!

**OUR INSTRUCTORS**

Mary LeGrand, RN, MA, CCS-P, CPC, consultant with more than three decades of nursing and administrative experience, including leadership positions on several national boards

Betsy Nicoletti, MS, CPC, author, speaker and consultant with over two decades engaged in coding education, billing, and accounts receivable management

To register visit www.karenzupko.com or call 312-642-8310

99% of the 2012 attendees would recommend the American College of Surgeons and KarenZupko & Associates workshops to a colleague!!

“Excellent course. The speaker was exceptional!! She was able to simplify the complicated areas for me, a new surgeon in practice.”

David J. Dupree, MD, Dr. Chaagaes and Dupree, Shrewsbury, NJ

“I think the course was well presented and formatted. There was a lot of good information that will be useful for everyone.”

Sandra Kenning, RN, Kearney Clinic, Kearney, NE

“As usual, excellent presentation. I will attend again.”

Mitzi Edge, Administrator, The Breast Center, PC, Marietta, GA
2013 International Guest Scholars and Community Surgeons Travel Awardees selected

Twelve International Guest Scholarships for 2013 were approved by the American College of Surgeons (ACS) Board of Regents during the 2012 Clinical Congress. This scholarship program enables talented young academic surgeons from countries other than the U.S. or Canada to attend and participate in the activities of the Clinical Congress and then tour surgical institutions in North America specifically tailored to their interests. The program is administered by the ACS International Relations Committee. The requirements for applicants for the 2014 International Guest Scholarships will appear in a future edition of the Bulletin, and are posted on the College’s website at www.facs.org/memberservices/igs.html.

The 2013 International Guest Scholars are: Amos Olufemi Adeleye, MB, BS, FWACS, Ibadan, Nigeria; Rajiv Agarwal, MB, BS, MS, Lucknow, India (Louis C. Argenta Scholar); Marco del Chiaro, MD, PhD, Stockholm, Sweden (Dr. Abdol and Mrs. Joan Islami Scholar I); Walid Faraj, MB, BS, Beirut, Lebanon; Julie Riina Howle, BSc, MB, BS, FRACS, Sydney, Australia (Murray F. Brennan Scholar); Mariano Norese, MD, Buenos Aires, Argentina, Maria Eliza Medina Raymundo, MD, Quezon City, Philippines; Sohei Sato, MD, PhD, Ashiya, Japan (Dr. Abdol and Mrs. Joan Islami Scholar II); Georgios Tsoulfas, MD, FACS, Thessaloniki, Greece (Stavros Niarchos Foundation Scholar); Jorge H. Ulloa, MD, Bogota, Colombia; Christopher John Wakeman, MB, ChB, MMed (Sci), Christchurch, New Zealand; and George Kwok Chu Wong, MB, ChB, Hong Kong, China (Elias Hanna Scholar).

The more recently created Community Surgeons Travel Awards program also enables international surgeons to attend Clinical Congress. This program permits a broader age range for applicants and does not require an academic or research background. In 2013, applicants from African nations will receive preference.

The 2013 Community Surgeons Travel Awardees are: Adesoji Oludotun Ademuyiwa, MB, BS, FWACS, FMCS, Lagos, Nigeria (Baxiram S. and Kankuben B. Gelot Awardee); and Linda Carolyn Chokotho, MB, BS, FCS, Blantyre, Malawi.

Requirements for the year 2014 have been posted on the ACS website at http://www.facs.org/memberservices/community-travel.html. For the 2014 Community Surgeons Travel Awards, preference will be given to applicants from Southeast Asian nations.
International ACS NSQIP® Scholarships now accepting applications for 2013

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) offers international scholarships for two surgeons from countries other than the U.S. or Canada who demonstrate strong interest in surgical quality improvement. The scholarships, in the amount of $10,000 each, provide the Scholars with an opportunity to attend the 2013 ACS NSQIP National Conference July 13–16, in San Diego, CA, where they will meet with program leadership and surgeon champions from ACS NSQIP participating hospitals. Following the conference, the candidate is encouraged to visit one to two hospitals that meet the candidate’s specific clinical interests. These hospitals should also have strong quality programs.

The scholarship requirements are:

• Applicants must be medical school graduates.

• Applicants must submit their applications from their intended permanent institution.

• Applications will be accepted for processing only when the applicants have been in surgical practice, teaching, or research for a minimum of one year at their intended permanent location, following completion of all formal training (including fellowships and scholarships).

• Applicants must be under 55 years of age at the time of application.

• Applicants must have demonstrated a commitment to surgical quality improvement.

• Applicants must submit a fully completed application form provided by the College on its website. The application and accompanying materials must be typewritten and in English. Submission of a curriculum vitae only is not acceptable.

• Applicants must provide information regarding their work setting, including their hospital and patients, as well as their participation in quality improvement activities in this setting. They must also indicate their career goals and describe how they will transfer their newly acquired knowledge to their current workplace.

• Applicants must submit letters of recommendation from three colleagues, including one letter from the chair of the department of their hospital or where they hold an academic appointment, or an ACS Fellow who resides in their country. The letter from the chair or the Fellow letter must include a specific statement detailing the nature and extent of the quality improvement involvement of the applicant. Letters of recommendation should be submitted separately by the recommenders.

In order to qualify for consideration, applicants must fulfill all requirements. The formal International ACS NSQIP Scholar application appears on the ACS Scholarships Web page at http://www.facs.org/memberservices/isnsqip.html.

Supporting materials and questions should be directed to: Administrator, International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, USA; or kearly@facs.org; or fax: 312-202-5021.
SCHOLARSHIPS

The scholarships...provide the Scholars with an opportunity to attend the 2013 ACS NSQIP National Conference...where they will meet with program leadership and surgeon champions from ACS NSQIP participating hospitals.

• Applicants are required to submit a curriculum vitae of no more than 10 pages.

The International ACS NSQIP Scholarships must be used in the year for which they are designated. They cannot be postponed.

Applicants who are awarded scholarships will submit a full written report of their experiences provided through the scholarships upon completion of their scholarships.

An unsuccessful applicant may reapply only twice and only by completing and submitting a current application form provided by the College, together with new supporting documentation.

The scholarships provide successful applicants with the privilege of participating in the ACS NSQIP National Conference. The College will assist in arranging hotel accommodations in the conference city.

More information regarding the ACS NSQIP can be found at http://www.acsnsqip.org.

In order to qualify for consideration by the selection committee, applicants must fulfill all requirements. The formal International ACS NSQIP Scholar application appears on the ACS Scholarships Web page at http://www.facs.org/memberservices/insnsqip.html. Supporting materials and questions should be directed to: Administrator, International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, USA; or kearly@facs.org; or fax: 312-202-5021.

Completed applications for the International ACS NSQIP Scholarships for the year 2013 and all of the supporting documentation must be received by the International Liaison Section before February 15, 2013, in order for an applicant to receive consideration by the Selection Committee. All applicants will be notified of the Selection Committee’s decision by April 30, 2013. ♦
Calendar of events*

**JANUARY 2013**

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

**Southern California Chapter**
**January 18–20**
Four Seasons Biltmore Santa Barbara, CA
Contact: C. James Dowden, jdowden@prodigy.net

**FEBRUARY 2013**

**Mexico, Federal District**
**February 4–5**
American British Cowdray Medical Center, Mexico City
Contact: Jose Octavio Ruiz, MD, FACS, joctavioruiz@aol.com; or Jorge Cervantes, MD, FACS, jcervantes@abchospital.com

**North Texas Chapter**
**February 15–16**
Cityplace Conference Center, Dallas, TX
Contact: Nonie Lowry, nonie@lp-etc.com

**Peru Chapter**
**February 20–22**
Lima Sheraton Hotel and Convention Center, Lima, Peru
Contact: Danilo Bambaren Gastelumendi, MD, FACS, dabambaren@yahoo.com

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

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

**Idaho, Montana, and Wyoming Chapter**
**February 21–24**
Sun Valley Resort, Sun Valley, ID
Contact: Shanna Hardman, shanna.hardman@hcahealthcare.com

**Lebanon Chapter**
**February 25**
TBD, Beirut
Contact: Mohamad Tarek Berjawi, dr_berjawi@hotmail.com

**Oklahoma Chapter**
**February 28–March 1**
Renaissance Hotel Oklahoma City, OK
Contact: Jennifer Starkey, jennifer@executive-office.org

**Trauma, Critical Care, and Acute Care Surgery**
**March 19–21**
Caesars Palace, Las Vegas, NV
Contact: Mary Allen, redstart@aol.com

**APRIL 2013**

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

**Chile Chapter**
**April 14–17**
Hotel Sheraton Convention Center, Santiago, Chile
Contact: Ivan Alcoholad, MD, FACS, ialcoholado@alemana.cl

**MARCH 2013**

**Medical Disaster Response**
**March 18**
Caesars Palace, Las Vegas, NV
Contact: Mary Allen, redstart@aol.com

**FUTURE CLINICAL CONGRESSES**

<table>
<thead>
<tr>
<th>Year</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>October 6–10</td>
<td>Washington, DC</td>
</tr>
<tr>
<td>2014</td>
<td>October 26–30</td>
<td>San Francisco, CA</td>
</tr>
<tr>
<td>2015</td>
<td>October 4–8</td>
<td>Chicago, IL</td>
</tr>
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*Dates and locations subject to change.*