The future of robotics:

A dilemma for general surgeons

CLINICAL CONGRESS 2013
PRELIMINARY PROGRAM INSIDE
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For more than a decade, surgeons and other physicians have sought passage of Medicare payment reform and called upon Congress to repeal the flawed sustainable growth rate (SGR) formula used to calculate reimbursement. Unfortunately, these efforts have yielded little more than short-term fixes that have allowed the problem to grow and fester. This year, however, members of the U.S. House Ways and Means Health and Energy and Commerce Committees have demonstrated a true commitment to addressing the complex problems facing Medicare’s payment system and, at press time, were finalizing the details of a joint proposal to enact meaningful, long-term improvements.

The American College of Surgeons (ACS) applauds their efforts to develop this joint proposal and is pleased to be playing a proactive role in helping Congress to shape the new payment system. Working together, it is anticipated that Congress, physician groups, and other stakeholders will develop a pathway to reforms that will ensure that Medicare beneficiaries and ultimately all Americans have access to quality health care now and in the future.

**Thought leadership**

The College has a longstanding history of helping to educate members of Congress on how health care policy affects patient care. In recent years, we have been delivering a message that clearly resonates on Capitol Hill: quality improvement programs may be used to achieve the “Triple Aim” of enhancing the health care experience, improving the health of populations, and reducing costs.

In July 2012, ACS leaders testified at two different congressional meetings dedicated to developing an alternative payment methodology to the SGR. First, Frank G. Opelka, MD, FACS, Associate Medical Director of the ACS Division of Advocacy and Health Policy, represented the College at a Senate Finance Committee roundtable, during which representatives from a range of physician organizations offered their suggestions for addressing the payment problem. About a week later, I spoke at a House Energy and Commerce Health Subcommittee hearing, describing the College’s experience with quality programs and the framework for the ACS’ Value-Based Unit (VBU) to replace the SGR.

At press time, the College has responded to three requests for input on the House committees’ joint proposal. On February 25, the College wrote to Dave Camp (R-MI), Chair of the Ways and Means Committee, and Fred Upton (R-MI), Chair of the Energy and Commerce Committee, to offer feedback on the first draft of

In recent years, we have been delivering a message that clearly resonates on Capitol Hill: quality improvement programs may be used to achieve the “Triple Aim” of enhancing the health care experience, improving the health of populations, and reducing costs.
A core feature of the College’s VBU is the establishment of Clinical Affinity Groups (CAGs). In concept, CAGs would be groups of physicians who treat specific medical conditions, diseases, or patient populations.

the plan. Also at their invitation, the ACS commented on the committees’ second draft in an April 25 letter, and on May 7, the ACS testified at a House Ways and Means Health Subcommittee hearing on developing a viable Medicare physician payment policy.

In each of these instances, the College asserted that any new payment system must be based on the complementary objectives of improving outcomes, quality, safety, and efficiency while simultaneously reducing the growth in health care spending. The ACS maintains that our VBU provides a feasible model for achieving these ends and could be readily adapted to the three-phase implementation timeline suggested in the committees’ joint proposal.

VBU and committee plan
It is still too early to delve into specifics of the joint proposal or the VBU, but the College’s views on some key elements are as follows:

• The College has endorsed the proposal’s call for immediate repeal of the SGR and elimination of the 24.4 percent across-the-board cut slated for 2014, as well as any future SGR cuts.

• The College supports an initial five-year period of payment stability during which longer-term reforms could be developed, tested, and incrementally implemented. If Medicare payment is to move toward a value-based system, it is imperative that the payment models and quality measures that will support this paradigm be properly aligned, which may take some time.

• The ACS supports tying a base rate of payment with a variable rate that would be adjusted for performance as measured through overall physician participation in quality improvement programs, including the Physician Quality Reporting System, the Electronic Health Record and e-Prescribing Incentive Programs, the ACS National Surgical Quality Improvement Program, and so on.

• A core feature of the College’s VBU is the establishment of Clinical Affinity Groups (CAGs). In concept, CAGs would be groups of physicians who treat specific medical conditions, diseases, or patient populations. Examples include cancer care, surgery, cardiac care, digestive diseases, rural health care, and so on. The purpose of the CAGs would be to encourage the delivery of team-based, coordinated care, which the College has found yields more favorable patient outcomes.

• The ACS maintains that physicians should be able to participate in a number of alternate payment models, including CAGs, accountable care organizations, and bundling projects.

• To encourage physicians to be good stewards of the health care commons, the College supports the provision of payment incentives for efficient use of health care resources.

Much work ahead
The joint congressional committee proposal and the ACS’ VBU plan are the results of many years of examining the challenges confronting the physician payment system. The College’s leadership is extremely proud and pleased to have the opportunity to share with Congress the lessons we have learned through 100 years of promoting high-quality patient care and to play a leading role in developing a value-based health care system.

It is important to remember, however, that passage of payment reform legislation will be just the beginning of a transformative process. The College looks forward to continuing to apply its experience, knowledge, and programs in the creation of a truly sustainable system that will appropriately reimburse surgeons and other physicians who provide quality care to the American people.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
The future of robotics:

A dilemma for general surgeons

by F. Dean Griffen, MD, FACS, and Jane G. Sugar, MD
Many general surgeons are adding robotics to their scope of practice, but most are taking a wait-and-see approach for several reasons. For some surgeons, the technology is simply inaccessible. Others think the currently unfavorable cost/benefit equation makes the expense of adding robotics wasteful, if not ridiculous. But many physicians are watchfully waiting, seeking more clarity in the face of current uncertainty. Emblematic of these differing perspectives are two recent quotes from noteworthy surgeons: In February 2013, Pier Cristoforo Giulianotti, MD, FACS, chief of minimally invasive, general, and robotic surgery at the University of Illinois at Chicago, said, “In my opinion, there is no way back from robotic surgery.”1 Meanwhile, in March 2013, James Breeden, MD, FACS, president of the American Congress of Obstetricians and Gynecologists, wrote, “Robotic surgery is not the only or the best minimally invasive approach for hysterectomy.”2

It is no wonder that questions and concerns remain: Will robotics enhance the ability of general surgeons to broaden their scope of practice, make the practice of surgery more fulfilling, and add value to the services provided? To address these questions and to assist general surgeons in making decisions about the value of robotic technology for themselves and their patients, this article offers some perspective on what the future may hold. In addition, this article addresses the pathway for safely introducing robotics into practice as it applies to both practicing surgeons and residents in training.

**Benefits and challenges**

There is considerable evidence that the enthusiasm for robotics is escalating among general surgeons. According to the marketing division of Intuitive Surgical, the company that markets the da Vinci surgical system, general surgeons are among the surgeons most commonly completing the clinical pathway required for credentialing. (Personal communication between Frank Grillo, vice-president, marketing and business development, Intuitive Surgical, Inc., and Dr. Griffen, May 9, 2013.) Now well up
Will robotics enhance the ability of general surgeons to broaden their scope of practice, make the practice of surgery more fulfilling, and add value to the services provided?

The learning curve for laparoscopy is long and painstaking. Because of the technical advantages, the learning curve for robotics is much shorter for most surgeons. Researchers have found that suturing was statistically more precise and easier with robotics for residents performing sutured anastomosis on porcine intestine than with laparoscopy. Statistical significance was reached in another study using a live porcine model. Medical students with no experience placed gastro-gastric sutures and tied knots more precisely, faster, and with less operator workload using robotic assistance compared with laparoscopy alone. Marked improvement in the robotically assisted arm was noted with just three repetitions, whereas no improvement in the laparoscopy arm was seen. This finding indicated that the learning curve for robotically assisted suturing and knot tying was shorter.

Tasked with collecting data regarding general surgeons’ acceptance of robotics, a researcher interviewed a young, qualified, but relatively inexperienced surgeon who preferred robotic-assisted to laparoscopic multi-port cholecystectomy. When asked why, according to...
journalist Deborah Fowler, the student responded, “Because it is easier.” (Personal communication with Dr. Griffen, December 2012.) For a young surgeon still mired in the laparoscopic learning curve, it may even be safer.

For multi-port cholecystectomy performed by a seasoned laparoscopic surgeon, it is almost impossible to envision any way to improve any outcome measure. In essence, for multi-port cholecystectomy, robotics decreases the value of care by increasing costs without improving quality. However, the progression from easier to more precise to safer cannot be so easily dismissed when considering the performance of procedures that are more technically demanding. As surgeons progress through the learning curve and become increasingly skilled in robotics, it is logical to theorize that ease and precision will lead to better outcomes. It is also likely that the scope of minimally invasive surgery will broaden to include more complex procedures. This trend is exemplified by the performance of robotic prostatectomy, which has become the surgical option of choice, whereas many urologists found laparoscopic prostatectomy so challenging that few had the capability to safely pursue it.

The future of robotic surgery can be determined only by probing the possibilities. To ignore the potential for extending the boundaries and safety of surgical care with robotic technology seems unwise. As a paradigm, there were many naysayers during the advent of laparoscopic surgery; time has proven them wrong.

**Policies and standards**

L. D. Britt, MD, MPH, FACS, a Past-President of the American College of Surgeons (ACS), plays a leadership role in numerous organizations that set the policies for general surgery training. According to Dr. Britt, “While our discipline needs to continue ‘to push the edge of the envelope’ with respect to embracing advanced technology, it is equally imperative that any innovation (including robotic surgery) has a documented proven benefit based on evidence/outcome analysis. As the stewards of our resources, we must also promote cost effectiveness.” (Personal communication with Dr. Griffen, January 2013.) These requirements are clearly stated in an ACS Committee on Emerging Surgical Technologies and Education (CESTE) policy dating back to 1995 titled Statement on Issues to be Considered Before New
Surgical Technology Is Applied to the Care of Patients. Dr. Britt points out that although the College’s leaders are supportive of pursuing robotic technology, they are concerned that, thus far, little data are available to justify it. Even so, there is some optimism that important applications for robotics will evolve that will expand the scope of general surgery beyond current boundaries. At this time, developing final policy regarding these issues is premature.

Training and credentialing
Several reports address robotic surgery and resident training. In preparation for participating in robotic cases at the surgeon’s console, residents should be required to spend a specified amount of time in a robotic simulator and achieve a defined degree of proficiency. Also, residents should complete the surgeon’s didactic training modules on the Intuitive Surgical website (www.intuitivesurgical.com). At Louisiana State University Medical Center (LSUHealth), Shreveport, the senior author requires residents to spend a minimum of four hours in a robotic simulator and successfully complete the Web-based didactic course. Residents then must attain experience and proficiency with the patient console. Then, they may participate in the tandem surgeon’s console and begin their proctored/mentored operative experience dissecting first a non-inflamed gallbladder from its fossa. From there, residents are allowed to progress at varying rates depending on their abilities. Ideally, residents and attending surgeons should have access to dual (tandem) surgeon’s consoles, making it easy to safely share surgeons’ responsibilities. Residents who are unable to competently operate using the dual consoles will have their training in robotics slowed to ensure patient safety.

The requirements for acquiring credentials in robotic surgery after completion of residency have varied among hospitals. CESTE has promulgated clear guidelines in the ACS Statement on Emerging Surgical Technologies and the Evaluation of Credentials, and surgeons in active practice and newly trained surgeons should strictly follow the guidelines set forth in this statement. Certainly, residents will be required to document their training and experience with a letter of acknowledgment from the chair of their department. With this requirement in mind, residents are encouraged to log their robot-assisted cases separately; otherwise, they will be hard to find later given that robotic-assisted and purely laparoscopic cases currently share the same codes. Temporary privileges with proctoring prior to becoming fully credentialed must follow. For those surgeons who completed their residencies before the robotic era, a credentialing pathway is available and should be followed in every instance. This pathway meets the criteria that the CESTE set in its Statement on Approval of Courses in New Skills. This training includes Web-based didactics, simulation, a pig lab with assessment of knowledge and skill, and temporary privileges and proctoring. Successful completion of these requirements leads to full privileges.

Introducing a new technology into a surgeon’s repertoire also requires choosing easier cases performed on ideal patients. Even though the cost/quality equation for value appears unfavorable, this is likely the place for robotically assisted multi-port cholecystectomy for surgeons in private practice, academics, and residency. Serving as a bridge toward skills needed for more complex procedures, multi-port cholecystectomy may be justifiable on a cost/value basis after all.

Even though robotics makes it easier to perform technical tasks, the safe application of the other aspects of the technology is daunting. Beyond the basic requirements for credentials, the complexity that robots bring to the operating room environment is unparalleled. These complexities compel a significant moral and professional commitment to put safety first. An article in the August 2010 Bulletin of the American College of Surgeons clarifies the surgeon’s obligation to make the environment safe. In a different report written years before robotics became more commonly used in surgery, many of the same points are made in a generic sense, with added emphasis on team training by surgeons, institutions, and device manufacturers.
Even though robotics makes it easier to perform technical tasks, the safe application of the other aspects of the technology is daunting.

complex robotic environment maximizes the importance of the team concept. Only with diligent attention to all of these issues that take surgeons beyond the relative security of the user-friendly surgeons’ console will the benefits of robotically assisted laparoscopy be safely realized.

The dilemma
For some general surgeons, making the decision to pursue robotics is difficult, and the decision may vary with the nature of each surgeon’s practice. For surgeons that embraced laparoscopy belatedly, the consequences were sometimes damaging. Given the much shorter learning curve, a wait-and-see approach to robotic training should have fewer adverse effects. However, several factors are influencing the early pursuit of robotics, including:

- Many surgeons have already trained in robotics and are probing the possibilities.
- Hospitals are marketing robotics as evidence that they are state-of-the-art facilities.
- Residents trained in robotics are applying for robotics credentials in gradually increasing numbers.
- The number of surgeons in the training pipeline is increasing.
- As of December 2012, financial analysts are advising investors to buy/hold stock in Intuitive Surgical, concluding that the need for additional robots will be ongoing as more surgeons enter this territory.21

Many of the wait-and-see general surgeons are thinking that the added cost for robotically assisted laparoscopy will forestall a robotic era and mitigate the need to pursue robotics. Thus far, payors are only monitoring the situation; for the most part, they pay surgeons and facilities the same for procedures, with

REFERENCES
little concern for the methods used. For example, the Current Procedural Terminology (CPT) billing code for robotically assisted laparoscopic cholecystectomy is the same as that for laparoscopic cholecystectomy without robotic assistance (CPT code 47562). Hospitals continue to absorb extra cost, hoping to offset it with the presumed advantage it affords for market share. It is questionable whether this policy will continue as volume swells with general surgery cases.

In this era of health care reform and limited funding, robotics in surgery is correctly under intense scrutiny. Thus far, the cost/quality equation for value often has been at odds with additional investment of the health care dollar in robotic technology. The apparent waste incurred pursuing a flight to the moon led to a giant step forward in technology that proved to be of tremendous value in other areas. Is this a paradigm for robotic surgery, thus justifying the cost, expecting benefits with experience over time? Surgeons must contribute meaningfully to the debate, helping to guide industry, government, and payors in a path that best serves the safe, efficient, value-based care of their patients.

General surgeons not yet committed to robotics should stay well-informed with regard to this technology. As such, some surgeons are likely to find robotically assisted laparoscopy to be an important part of their practice, while others will not. For example, a young surgeon practicing in a small rural hospital without robotic capability can, with good reason, opt to hone laparoscopic skills and await further developments. On the other hand, a skilled, advanced laparoscopist working in a larger facility with robotic capabilities already in place should seriously consider the alternative approach. From the authors’ perspective, those surgeons who are in a position to embrace robotic training will find increasing meaningful use for the technology, which will enhance the value of the care they provide and the scope of practice they enjoy. ♦

REFERENCES (CONTINUED)

Who is behind the surgical drape?

Understanding the role of anesthesiologist assistants

by Caitlin Burley

Author’s note: For several years, I worked for the American College of Surgeons’ (ACS) Division of Advocacy and Health Policy in Washington, DC, as the Quality Associate. Working with the ACS members provided an eye-opening view of what clinicians face on a daily basis—both the challenges and rewards of offering high-quality patient care. After almost four years in that position, I sought to put my interest in high-quality patient care and my premedicine educational background to use by becoming a health care professional. My time with the ACS specifically had sparked an interest in the care of surgical patients, and one surgeon in particular offered to help me discover firsthand the responsibilities that surgical professionals fulfill. Rahul Shah, MD, FACS, FAAP, pediatric otolaryngologist and medical director of perioperative services at Children’s National Medical Center, Washington, DC, offered to allow me to shadow him in the operating room (OR). Needless to say, I was hooked.

Though my day with Dr. Shah was spent observing surgeons performing operations, I was drawn to the other side of the surgical drape. I found fascinating the challenges and unknowns presented with each patient, the constant vigilance, and the complexities of physiology and pharmacology involved in anesthesia. With that, I left the ACS in May 2011 to earn a master’s degree in anesthesiology and become an anesthesiologist assistant (AA).

As the completion of my graduate training draws near and I embark on this new career, I identify myself with anesthesia during the surgical “time-out” rather than as a representative of the ACS, as I did so many times in the past. Many surgeons have asked about the letters after my name: “AA-C—what does that mean? Who are you? What is your training?” This article is intended to educate surgeons about the role and training of the AAs who may be behind the drapes caring for their patients in the OR.

HIGHLIGHTS

• Describes the emergence of AAs as important contributors to quality surgical patient care
• Summarizes the history of the profession
• Explains how AAs are trained
• Discusses scope of practice for AAs
• Considers how AA services affect patient care
• Presents suggestions on how the ACS and surgeons can support AAs as important members of the operating room team
Whereas AAs increase access to the operative care for surgeons and their patients, they also increase the quality of anesthesia care provided to the surgical patient by functioning under the ACT model.

**History of the profession**

In response to the shortage of qualified anesthesia professionals in the mid-1960s, anesthesiologists Joachim S. Gravenstein, MD; John E. Steinhaus, MD; and Perry P. Volpitto, MD, performed a workforce analysis of all the qualities required to deliver safe, effective anesthesia care, including responsibility, education, and technical skill. The results of their investigation led to the creation of a new mid-level anesthesia provider, the “anesthesiologist assistant.”1 The AA would be a nonphysician health care professional with a premedical undergraduate background who would be trained in a graduate-level anesthesiology program.2 The AA would practice in an anesthesia care team (ACT) model, in which an anesthesiologist concurrently supervises up to four nonphysician providers, working together to provide quality anesthesia care to the surgical patient. Dr. Gravenstein and the coauthors described their vision for ending the anesthesia shortage as follows: "Responsibility and immediate care of the patient must remain within the province of the anesthesiologist; consequently, personnel could not work independently but only under the immediate direction of an anesthesiologist. An advantage in manpower for the anesthesiologist would result, as he could provide attention to several patients with the proper employment of the anesthesia team, described above."

**AA education and training**

As a result of their vision, the first AA program opened at Emory University, Atlanta, GA, in 1969. To date, nine AA programs that have been accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) exist in the U.S.:

- Emory University
- Case Western Reserve University, Cleveland, OH
- South University, Savannah, GA
- Nova Southeastern University, Ft. Lauderdale, FL
- University of Missouri–Kansas City
- Nova Southeastern University, Tampa, FL
- Case Western Reserve University, Houston, TX
- Case Western Reserve University, Washington, DC
- University of Colorado School of Medicine, Aurora, CO

A new program will soon matriculate its first classes at Quinnipiac University, Hamden, CT. These programs are all affiliated with a university that has a medical school, and each has a board-certified, licensed anesthesiologist serving as medical director.3

According to Shane Angus, AA-C, program director of the newest school at Case Western Reserve University-DC, “The process of opening a new AA program in our nation’s capital involved meticulous planning in order to meet the high criteria for accreditation. Having high AA program credentialing requirements serves the growing surgical patient population by ensuring the graduation of exceptionally skilled AAs.” (Personal communication with the author, May 29, 2013.)

Competitive applicants must have a bachelor’s degree, all of the premedical coursework required by the typical American medical school, and must have taken either the Medical College Admissions Test or the Graduate Records Admission Test. The programs, which range from 24 to 28 months, include specialized didactic and clinical instruction in anesthesia-related courses. Students graduate with a master’s degree and more than 2,000 hours of clinical experience.4

According to Gina Scarboro, AA-C, chair of the Association of Anesthesiologist Assistant Program Directors, “The curriculum covered in an AA educational program is extremely rigorous. In the first year, students attend classes, participate in clinical education, and train using high-fidelity patient simulators. Unlike other graduate health care training, AA students participate in clinical rotations early in their curriculum, which leads to a tight temporal coupling between classroom instruction of the scientific concepts of anesthesia and their direct application in the operating room. Another unique aspect of AA education is the didactic instructional focus on

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anesthesia systems of delivery (machines) as well as instrumentation and monitoring that adds value to the anesthesiologist assistant’s role in the anesthesia care team.” (Personal communication with the author, April 26, 2013.)

The National Commission for Certification of Anesthesiologist Assistants, in collaboration with the National Board of Medical Examiners, administers a written certification examination for AAs. To maintain certification, AAs need to register for 40 hours of continuing medical education every two years and successfully complete a continued demonstration of qualifications examination every six years. AAs use the designation AA-C to indicate that they are currently certified.

Scope of practice
As members of the ACT, AAs work under the medical direction of an anesthesiologist. AAs are trained in all aspects of anesthesia care, including but not limited to:

• Performing preoperative anesthetic evaluations
• Establishing noninvasive and invasive monitoring
• Applying and interpreting advanced monitoring techniques
• Administering medication and delivering continuous anesthesia care during the perioperative period
• Securing the airway, applying advanced life support practices
• Performing and managing regional anesthetic techniques

The specific responsibilities of AAs vary from practice to practice, as directed by the anesthesiologist.

AAs are either licensed by specific state statute or practice under provisions of the medical practice act that allow a licensed physician to delegate specific duties to a qualified practitioner. Howard Odom, MD, chair of the American Society of Anesthesiologists (ASA) Committee on AA Education and Practice, said, “Since defining the profession in the late 1960s, anesthesiologists have actively engaged in educating, advocating for practice, and employing AAs as our specialty-specific mid-level practitioner. Whether under delegation or statutory licensure, AAs have contributed to safe anesthesia care for more than 40 years under the medical direction of anesthesiologists.” (Personal communication with the author, April 29, 2013.)

AAs currently practice in 17 states and the District of Columbia (see table, this page). Additionally, the federal government recognizes AAs, allowing them to practice at all Veterans Affairs hospitals under the TRICARE insurance program, which serves uniformed service members, retired military personnel, and their families. AAs practice in various surgical settings, including ambulatory surgery centers; however, according to the American Medical Association, “AAs are most commonly employed in larger facilities that perform procedures such as cardiac surgery, neurosurgery, transplant surgery, and trauma care, given the training in extensive patient monitoring devices and complex patients and procedures emphasized in AA educational programs.”

Improved access and outcomes
In 2010, the RAND Corporation released a study that cited a shortage of 3,800 anesthesiologists and 1,282 nurse anesthetists as of 2007. This national shortage of anesthesia providers has increased due to various factors, including the growing number of procedures requiring anesthesia services, the rising number of surgeries required by the elderly population, and the rapid expansion of sites where surgery is performed. Furthermore, the shortage of anesthesia services is projected to continue until 2020. ASA past-president Mark Warner, MD, reflected on this disturbing shortage in a 2011 Physician’s Weekly article. “The projected

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*Delegatory authority (other states in list have licensure)
shortage of anesthesiologists suggests that the U.S. will soon face a gap in anesthesia services that will be just as important to Americans’ health as the projected physician gap for primary care services,” Dr. Warner wrote. “As more and more patients are projected to become older and sicker, healthcare facilities will need more anesthesiologists to provide the full scope of care that patients will need before, during, and after their surgeries and procedures.”10

With this alarming anesthesia professional shortage, operations may be delayed due to lack of qualified personnel, or, even worse, exhausted providers may be forced to care for surgical patients. The shortage of anesthesiology professionals limits access to high-quality care and has an unnecessarily deleterious effect on patient safety. According to James Mesrobian, MD, chair of the ASA committee on practice management, “Anesthesiologist assistants fill the need for more midlevel providers in anesthesia services, particularly in rural areas where anesthesiologists are in short supply.”11

Whereas AAs increase access to the operative care for surgeons and their patients, they also increase the quality of anesthesia care provided to the surgical patient by functioning under the ACT model. Under this system, anesthesiologists medically direct two or more mid-level anesthesia providers at the same time. The shared skills, knowledge, and vigilance of the team allow for the ultimate collaboration to provide the most appropriate and high-quality care for the surgical patient. “I have worked with AAs for almost a decade and they provide outstanding care to patients as a member of the perioperative services team,” said Dr. Shah. (Personal communication with the author, April 27, 2013.) “They play an invaluable role in a niche position that will always provide value in the OR. In the era of health care reform, the role of the AA will continue to be important, if not expand.”

The “observation synergism” of multiple providers in the ACT is further supported by the ability to rapidly respond during a crisis, leading to improved patient outcomes.12 In fact, “improved patient outcomes associated with care provided by anesthesia care teams and hybrid practices have been confirmed by a study of hospital characteristics and mortality after elective surgery.”13 An additional study also supports the premise that the physician-directed ACT model provides higher-quality patient care: “Both 30-day mortality rate and mortality rate after complications (failure-to-rescue) were lower when anesthesiologists directed anesthesia care. These results suggest that surgical outcomes in Medicare patients are associated with anesthesiologist direction, and may provide insight regarding potential approaches for improving surgical outcomes.”14

“With the ACT, the patient is assured that, with the anesthesiologist plus the AA, there are two anesthesia providers,” explained Rob Wagner, AA-C, MMSc, RRT, associate chair of the health science department and assistant professor at the AA program at Nova Southeastern University, Orlando, FL.15 “With the anesthesiologist and surgeon, there are two medical doctors. It is the highest standard of patient care.”15

AAs are the only anesthesia professionals who work exclusively in the ACT model. The unique dedication to this optimal mode of patient care is evident in the mission statement of the American Academy of Anesthesiologist Assistants (AAAA), which supports excellence through education, advocacy, and promotion of the ACT.16 “AAs are the sole nonphysician mid-level anesthesia providers that ensure an anesthesiologist-led delivery of safe anesthesia care,” said Saral Patel, AA-C, president of the AAAA. (Personal communication with the author, April 26, 2013.) “The AAAA promotes quality values during the delivery of anesthesia patient care, including teamwork, leadership, communication, professionalism, and mentorship.”

Anesthesiologists may supervise AAs in ratios defined in state law or board guidelines. The Centers for Medicare & Medicaid Services’ (CMS) requirements call for assigning up to four anesthetists to one an-
“The use of AAs in the anesthesia care team delivery system not only improves access for our surgeons, but also provides a value-driven team approach to patient care.”

—Dr. Hoyt

**REFERENCES**


Support from anesthesiologists

The ASA has been a strong advocate for the AA profession since its inception. Not only does the ASA participate in the training, education, accreditation, and certification of AAs, but it also is one of the biggest proponents of the expansion of AAs in the workforce. In the March 2003 *ASA NEWSLETTER*, David C. Mackey, MD, clinical associate professor of anesthesiology, University of Florida College of Medicine, Gainesville, said, “The national emergence of the AA is long overdue. It is time to work with well-trained physician extenders who want to work with us and who are committed to the anesthesia care team concept.”

Most recently, at the 2011 American Medical Association House of Delegates meeting in Chicago, “ASA unambiguously defined its position in full support of promoting the practice of AAs.” John M. Zerwas, MD, president of the ASA, member of the Texas House of Representatives, and past-president of Greater Houston Anesthesiology, has seen the implementation of AAs within the ACT model in Houston. “In both the hospital and ambulatory surgical setting, AAs have proven to be valuable, highly qualified members of the anesthesia care team in Texas.”

The ASA, together with the AAAA, continues to support the growth of AA practice. Shared efforts include introduction of new state statutes that will enable AAs to practice in more states. “Anesthesiologists have always been and will continue to be medical leaders in innovation when it comes to patient safety, and AAs are proud to be part of the solution,” said Claire Chandler, AA-C, immediate past-president of the AAAA. (Personal communication with the author, April 21, 2013.) “It is uncommon to witness such a global bipartisan effort between physicians...
and advanced non-physician providers to promote the common goal of patient safety. This cooperative model is the future of quality health care.”

**How surgeons can support AAs**

The ACS has shown support for AA expansion in recent letters to state legislatures for AA licensing measures. “The ACS supports high-quality perioperative care of the surgical patient,” according to David B. Hoyt, MD, FACS, ACS Executive Director. “The use of AAs in the anesthesia care team delivery system not only improves access for our surgeons, but also provides a value-driven team approach to patient care.” (Personal communication with the author, April 30, 2013.)

It is the hope of all of us who have chosen to serve as AAs that surgeons will continue to advocate for and support our efforts to provide high-quality anesthesia care to surgical patients. Surgeons can help bring AAs to their institutions by contacting their local ACS chapter and encouraging their leaders to write letters of support for AAs.

For more information about AAs, visit the AAAA website at www.anesthetist.org.

**REFERENCES (CONTINUED)**

100 years of surgical education: The past, present, and future

Until the 19th century, the most common and well-established method of training surgeons—if any training was pursued at all—was through apprenticeships. Length of training and the starting age of the apprentice could vary, but a typical apprenticeship in the mid-16th century lasted five to seven years and would start around the age of 12 or 13. Further training, in the form of a journeyman ship, was available under the tutelage of the same master or a different one but was not required for the practice of surgery. In the most basic form of this model, the student learns surgery through direct observation and then by imitating the actions of a skilled mentor, both in the operating theater and in the clinical environment.

As surgery slowly evolved from a trade into a profession, the apprenticeship model remained the standard of surgical education. Still, there were no principles or guidelines for what knowledge or skills were to be taught, who should be trained, when training should start, or how long training should last. The end of the 19th century and beginning of the 20th marked the first major shift from the apprenticeship training...
TABLE 1.

HALSTED’S PRINCIPALS OF SURGICAL TRAINING

| The resident must have intense and repetitive opportunities to take care of surgical patients under the supervision of a skilled surgical teacher. |
| The resident must acquire an understanding of the scientific basis of surgical disease. |
| The resident must acquire skills in patient management and technical operations of increasing complexity with graded enhanced responsibility and independence. |

model to more formalized and structured education. The method used to train surgical residents in the U.S. for the last century is, in large part, due to the influence of William S. Halsted, MD, FACS.2

Halsted model

Until nearly the turn of the 20th century, direct patient contact was considered beyond the abilities of medical students, but Sir William Osler, MD, firmly believed in the value of learning from patients. In the early 1890s, Dr. Osler introduced the concept of clinical clerkships to the Board of Trustees at the Johns Hopkins School of Medicine, Baltimore, MD.3 Dr. Osler also incorporated bedside rounds into all of his student classes, a rare practice in the U.S. at that time.

At this point, Dr. Halsted moved to Baltimore and was appointed the first chief of the department of surgery at Johns Hopkins Hospital. His two years in Europe, in particular his observance of the significant differences in European and North American surgical training, had a profound influence on his future career. He was impressed by the formal training of German surgeons with close integration of basic sciences into the curriculum. By embracing Dr. Osler’s concept of bedside rounds and the German curriculum, he fathered the Halstedian training model (see Table 1, this page). In 1904, Dr. Halsted delivered a landmark lecture at Yale University, New Haven, CT, on the training of surgeons, whereby trainees received increasing responsibility with each advancing year.4

The Council on Medical Education conducted a survey, led by Abraham Flexner, on medical education in U.S. and Canada. His findings were published in 1910 as the Flexner report, which triggered much-needed reforms in the standards, organization, and curriculum of North American medical schools.5 During the same year, the first national postgraduate surgical meeting, the Clinical Congress of Surgeons of North America, convened. This meeting led to the formation of the American College of Surgeons (ACS) in 1913.

Since its inception, the ACS has been a formidable force in advancing graduate surgical education. One of the founding objectives of the ACS was to improve training opportunities for surgeons. Surgical training has been propelled further through the College’s activities over the course of the last century, beginning with the establishment of qualifications for Fellowship.

Transformation during the 20th century

This Halstedian training model produced several leaders in the field of surgery who went on to establish training programs at various distinguished institutions. The deepening understanding of the educational process during this period led to significant developments, which became the foundation for surgical education in the 21st century. The Council on Medical Education and the American Medical Association (AMA) became among the first professional organizations to set standards for graduate medical education (GME), and in 1927, the ACS published the *Fundamental Requirements for Graduate Training in Surgery* as its own surgical education standards.6

In 1937, the AMA, the ACS, and the American Board of Surgery (ABS) formed a Committee on Graduate Training in Surgery to investigate, analyze, and evaluate the opportunities for the training of surgeons in hospitals in the U.S. and Canada. The committee’s findings led to the guidelines set forth in 1940 in the ACS’ *Manual of Graduate Training in Surgery*, prepared by Assistant Director Harold Earnheart, MD, FACS, which contains and explains the Minimum Standard for Graduate Training in Surgery. The ACS published
a list of 200 hospitals in the U.S. and Canada that met the standard and were approved for graduate training in surgery. This directory was the first to identify graduate training programs available to assist in the selection of a training institution that will best prepare residents for surgical practice. It included detailed descriptions of the provisions for basic science study, supervision, and opportunities for practical experience, enabling residents to locate the program best-suited to the individual’s needs.

This Committee on Graduate Training in Surgery was the basis for the establishment of the Residency Review Committee in Surgery (RRCS) in 1950, the first official RRC among all specialties. As result of the RRCS’ formation, the responsibility for the certification examination process and for accreditation of training programs was divided between the ABS and RRCS, respectively. The formation of the RRCS also led to the establishment of organizational bodies to oversee and control the training process. To ensure coordination between all organizational bodies, the Coordinating Council of Medical Education was established in 1972. This council subsequently created a Liaison Committee for GME in the same year, which was the forerunner to the independent accrediting organization now known as the Accreditation Council for Graduate Medical Education (ACGME), established in 1982.

Since its establishment, the ACGME introduced several landmark changes in graduate surgical education. For example, in 1999, the ACGME defined six core competencies that residents must achieve and master during their training (Table 2, page 23). The accreditation model used by the ACGME shifted from a focus on process measures to one that focuses on evaluation of outcomes. Another ACGME regulation that has had a major impact on the training of surgery residents is the restriction on resident work hours mandated in 2003 that was further modified in 2011. Residency programs had to substantially restructure their education and service activities to comply with this regulation.

The development of minimally invasive surgery over the last few decades has been remarkable. Minimally invasive surgery has become an integral part of operative management in virtually every realm of surgery, including urologic, gynecologic, and thoracic specialties. Technological advances in surgery ranging from laparoscopic instruments, to stapling devices, to endoscopic technology, brought new challenges for operating room (OR) nurses, surgical residents, and surgeons alike. Consequently, surgical trainees are responsible for a significant amount of technical knowledge and training for the safe and effective use of this vast array of instruments.

The American Surgical Association (ASA), in partnership with the ACS, ABS, and RRCS, appointed a Blue Ribbon Committee on Surgical Education in June 2002. After two years of deliberations, the committee proposed several far-reaching recommendations. For medical students who are interested in surgery, the committee suggested implementing a standardized, national curriculum for residency education in surgery. This recommendation resulted in the development of the Surgical Council on Resident Education (SCORE), a voluntary consortium of six organizations with the responsibility for monitoring resident education in surgery and improving the training of surgeons (see Table 3, this page). SCORE’s mission is to improve the education of general surgery residents in the U.S. through the development of a standardized national curriculum. With the current shift in data acquisition and the revolution in information

| TABLE 3. |
| SCORE FOUNDING ORGANIZATIONS |
| American Board of Surgery |
| American College of Surgeons |
| American Surgical Association |
| Association of Program Directors in Surgery |
| Association for Surgical Education |
| Residency Review Committee for Surgery of the Accreditation Council for Graduate Medical Education |
technology, SCORE created an online General Surgery Resident Curriculum portal to deliver educational content aligned with the standard curriculum to general surgery residents and residency programs.13

**Current status of surgical training**

In 2011, in the U.S., 1,756 individuals applied for a total of 1,108 positions, meaning that the total number of applicants per position was 1.6 and indicating that surgery remains a highly competitive and desirable field.14 A long-held misconception was that female medical students found surgical training unappealing. However, from 2000 to 2006 the number of women entering medical school increased from 43 to 46 percent and the number of women entering general surgery residencies also increased from 32 to 40 percent during the same period.15

Training occurs in a variety of settings including university, university-affiliated, military facilities, and community hospitals in rural, suburban, and urban locations, each with varying strengths, patient populations, and exposures. Under current ABS and RRCS standards, surgical residency consists of 60 months of training in an accredited program. At least 54 months are devoted to clinical training, 42 of which center on various categories deemed essential to training. Surgical residents are expected to log their cases into the ACGME resident case log system. Graduating residents must log 750 major operative cases, with at least 150 major cases performed during the chief resident year.16

Many traditional components and philosophies of surgical training continue to apply today. The concept that surgery and medicine are founded on scientific knowledge and the overarching principle of apprenticeship with progressive transfer of patient care responsibilities and graded autonomy in the OR is still the building block of residencies. The morbidity and mortality conference, a cornerstone of surgical education since the inception of formal surgical training programs, continues to be a vital component of training programs today. The current landscape of surgical residency education also includes protected education time for didactic lectures and journal clubs to develop the tools to critically analyze and appraise. Feedback is incorporated into all training programs and is a critical component to assessing and improving resident skills.

The ACS Division of Education developed the *ACS Fundamentals of Surgery Curriculum*, a highly interactive, case-based, online curriculum that addresses the essential content areas that all surgical residents should master in the early years of training. There has also been a recent push to include more competency-based assessments beyond the traditional ABS In-Training Examination and ABS qualifying and certifying examinations as part of progressive surgical education reform efforts.17 Through a collaborative arrangement with the Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), the ACS Division of Education has been involved in dissemination of the *Fundamentals of Laparoscopic Surgery (FLS)* Program, both nationally and internationally. Subsequently, ABS included *FLS* in its requirements for initial certification in 2010.

Historically, surgical training programs have emphasized a broad-based curriculum intended to train residents to pursue a variety of career paths, and most graduates entered general surgery practice without additional subspecialty training. However, an increasing number of surgery residents are pursuing fellowship training. Since 1992, the proportion of general surgeons pursuing fellowship training increased from more than 55 percent to more than 80 percent.18 Hence, the Blue Ribbon Committee also proposed a new structure for resident education, which includes a core basic education program leading to pathways for further specialization and subspecialization in surgery. A number of new approaches, including early specialization programs, are being evaluated and introduced.19

**21st century training**

The first decades of the 21st century are bringing new challenges to the surface. With the ever-expanding range of diseases that are treated surgically and the development of new therapies, residents are expected to learn more in a limited period of time. In light of the work-hour restrictions and increasing demand for documentation and other “service-related duties,” less time is available for learning or education.20 The Blue Ribbon Committee recommended that changes be made in surgery residency programs to emphasize...
education above service activities that are of little or no educational value. To counter this, many hospitals have increased the number of advanced clinical practitioners to help improve the balance between service and education for surgical residents.

An active effort is under way to develop new approaches to surgical training and evaluation. There is now more emphasis on increasing the efficiency of the learning process. OR time is too valuable to permit acquisition of basic technical skills. Deconstructing complex operative tasks into component skills became fundamental to current surgical training paradigms. Simulators, inanimate skills training stations, and animate models have all provided opportunities to acquire familiarity with instruments, improve dexterity, and have offered surgeons the chance to become knowledgeable about surgical management, techniques, and potential complications. In fact, these developments have been validated by an increasing body of data demonstrating transference of these skills to the OR. Residents would thus be trained in the laboratory until pre-set criteria have been met and only then would be allowed to participate in the performance of procedures in the OR. Competence-based advancement, rather than time served, would become the standard in surgical training. The RRCs has mandated that residents perform 35 upper endoscopies and 50 colonoscopies before completion of general surgery residency training. SAGES has established a Fundamentals of Endoscopic Surgery (FES) task force to create a comprehensive program for the training and evaluation of basic flexible endoscopic skills. The FES task force recently introduced valid and reliable tools to assess clinical endoscopic skills for both upper endoscopy and colonoscopy.

The impact of robotics on surgical training is enormous (see related article on page 9). Computer-integrated surgery using robotics can provide additional information that is less available to surgeons through human senses. For example, the robotic visualization can overlay a reconstructed computed tomography scan of a tumor on the operating site. Robots with intelligent sensors can address humans’ physiological limitations, such as poor vision or hand tremor. Even the best surgeons can use intelligent assistance to improve performance. State-of-the-art virtual reality simulators

REFERENCES


continued on next page
that are currently in development hold enormous potential in improving learning and efficiency. Simulators will allow for alteration in an operation for educational purposes. It will be possible to repeat steps, demonstrate anatomical anomalies, and to repeat tasks when failure occurs—all without putting patients at risk.

It is not only the introduction of simulation for skills training, but also the structured objective assessment of skills performance with benchmark metrics, that has enabled simulation to transform surgical education from subjective judgment to objective measurement of performance. National efforts are under way to develop standardized, simulation-based surgical skills curricula for surgical trainees. The ACS Division of Education is spearheading efforts to design and implement three national simulation-based surgical skills curricula in collaboration with the Association of Program Directors in Surgery and the Association for Surgical Education. The ACGME and American Board of Medical Specialties are engaged in a project called Milestones, in which the RRC will evaluate training programs based on the ability of residents to successfully achieve specialty-specific goals. A surgery working group is engaged in this project, and the ABS is also independently evaluating individual resident achievements.

Overall, this era of surgical education is characterized by rapid and dynamic changes in knowledge, understanding of surgical disease, new procedures, and technologies. Furthermore, public demand for greater accountability and patient safety, with greater scrutiny in institutions where training occurs and heightened requirements for oversight in training programs, is increasing. Novel educational and training paradigms will be necessary to navigate the current waters, meet the challenges of the 21st century, and ensure the production of professional, capable, competent, and versatile surgeons.

REFERENCES (CONTINUED)

For many years, the Federation of State Medical Boards (FSMB) has been actively pursuing the development of a maintenance of licensure (MOL) program. Numerous committee and stakeholder meetings have centered on the concept and how the state medical boards can take it from the theoretical to the implementation level. Because licensure is critical to surgical practice, it is important that surgeons have some understanding of how changes in licensing are likely to affect them in the coming years, or at least what they may have to do to maintain licensure.

Many physicians may not yet know what MOL is or why it is necessary, as they may have heard or read only generalities about the topic. With that in mind, this article presents a more in-depth overview of MOL.

**Describing MOL**

Simply stated, MOL is a process by which licensed physicians periodically provide, as a condition of license renewal, evidence that they are actively participating in a program of continuous professional development. This activity should be relevant to areas of practice, measured against objective data sources, and aimed at improving performance over time.*

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According to the FSMB, the rationale for developing and implementing a MOL system is an outgrowth of the health care system’s evolving emphasis on improving patient safety and quality outcomes. Continuous quality improvement has become a staple of policymakers, especially with the adoption of health system reform. In addition, state medical boards have long recognized their responsibility to protect the public and promote quality health care by ensuring that only qualified individuals receive a license to practice medicine and deliver health care.†

Status of MOL
In 2010, the FSMB House of Delegates adopted a framework for MOL. Under this paradigm, physicians would periodically provide evidence of participation in professional development and lifelong learning activities based on the general competencies model: medical knowledge, patient care, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice.

Three major components of effective lifelong learning are included in this framework:

• Reflective self-assessment through which physicians participate in an ongoing process of self-evaluation and practice assessment with subsequent successful completion of tailored educational or improvement activities

• Assessment of knowledge and skills, which calls for physicians to demonstrate the knowledge, skills, and abilities necessary to provide safe, effective patient care within the framework of the general competencies as they apply to their individual practice

• Performance in practice, meaning physicians should demonstrate accountability for their performance using a variety of methods that incorporate reference data to evaluate their practices and guide improvement*

The FSMB adopted five guiding principles to further assist in the development of MOL. Based on these guidelines, MOL should do the following:

• Support physicians’ commitment to lifelong learning and facilitate improvement in physician practice.

• Demonstrate administrative feasibility and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.

• Avoid compromising patient care or creating barriers to physician practice.

• Offer flexible support for physician compliance with MOL requirements and provide options for meeting requirements.

• Balance transparency with privacy protections.‡

Every time a new program or process affecting physicians is discussed, legitimate concerns are expressed regarding compliance, such as whether the new system will create additional practice burdens, and so on. To address some of these concerns, the FSMB came up with a list of explanatory comments to reassure physicians that MOL is not intended to impose an additional level of regulatory bureaucracy, which includes the following:

• MOL is being constructed in a way that is carefully integrated and coordinated with activities of other organizations. The FSMB is working closely with the American Board of Medical Specialties, which ad-

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One early critique of MOL was that it would result in a significant increase in regulatory burdens, especially for physicians already working hard to keep up with MOC requirements.

ministers the Maintenance of Certification (MOC) program for physicians; however, MOC will not be required as a part of the future MOL system. Similarly, Osteopathic Continuous Certification (OCC) will not be required for MOL. The three systems are independent. The FSMB is recommending, however, that physicians engaged in MOC or OCC be recognized as being in “substantial compliance” with the three MOL components: reflective self-assessment, assessment of knowledge and skills, and performance in practice.

•MOL is being constructed in a way that minimizes additional burdens for physicians. It will not mandate a high-stakes examination as a part of its structure. For physicians who are not board-certified in a medical or surgical specialty and, therefore, not engaged in MOC or OCC, the FSMB will help identify activities that could satisfy MOL.

•MOL is being constructed in a way that takes into account the wide variation in clinical activity among physicians. Licensed physicians in the U.S. include professors, executives of health care organizations, policymakers, and other individuals who are part of a broad spectrum of professional niches. In recognition of the diversity in physicians’ professional endeavors, the FSMB is working with health care organizations to create a system that fairly evaluates and assesses the activities of all licensed physicians. Many kinds of professional activities outside of clinical practice may be acceptable for MOL and are being evaluated.‡

These assurances are very important to physicians. One early critique of MOL was that it would result in a significant increase in regulatory burdens, especially for physicians already working hard to keep up with MOC requirements. Ultimately, it will come down to how state medical boards choose to implement MOL, and at this stage of the process, it seems these boards have little interest in further complicating the licensure process by imposing additional burdens on licensees or on themselves.

Going forward
It will be a while before an MOL system is implemented. The FSMB is currently working with a few state medical boards on MOL pilot projects, and the results will be critical in determining how to roll out the program. One suggestion calls for MOL to be implemented in phases based on the major components of lifelong learning as previously described, starting with reflective self-assessment, then adding assessment of knowledge and skills, and finally including performance in practice, which may be the most difficult of the three to demonstrate and evaluate.

In the meantime, the FSMB has posted a useful MOL resource Web page at http://www.fsmb.org/mol.html. The site provides fact sheets, federation reports, and other items and will provide updates over time on MOL implementation.

Of particular interest to surgeons may be FSMB Board Report 11-3: Report of the MOL Implementation Group, which can be accessed at http://www.fsmb.org/pdf/BD_RPT_1103_%20MOL.pdf. In Attachment B of the report is a suggested toolbox for implementation of MOL along with a description of the professional development programs and activities for the three major components of lifelong learning, such as continuing medical education, participation in registries, use of self-assessment tools, and so on. With access to these resources, along with the FSMB’s sensitivity to realistic development of MOL requirements and processes, implementation should have limited impact on the practicing surgeon.

Centennial reprint:

ACS launches program for surgeons to assess their knowledge

The American College of Surgeons (ACS) was established largely to provide surgeons with the ongoing educational programming needed to provide patients with safe, high-quality care. These efforts originated with presentation of the annual Clinical Congress and publication of Surgery, Gynecology & Obstetrics, now known as the Journal of the American College of Surgeons. Since then, the ACS has continually expanded the range and scope of learning opportunities available to its Fellows.

In 1971, the ACS launched the Surgical Education and Self-Assessment Program® (SESAP®) under the auspices of the Committee on Continuing Education and in cooperation with the National Board of Medical Examiners. This month’s Centennial reprint describes the rationale for developing SESAP and explains how surgeons can use it to evaluate their own knowledge or as an educational tool.

The authors note that SESAP was developed in response to growing public demands for assurances that patients have access to quality care and the possibility of new requirements for re-licensure and recertification—challenges that the profession and the ACS have continued to address these last 40-plus years. Each edition of SESAP has responded to surgeons’ evolving needs. Today, many surgeons and surgical residents use SESAP to prepare for board examinations and to help fulfill Maintenance of Certification Part 2 requirements. At press time, the 15th edition of this important educational program was under development and scheduled for release at the 2013 Clinical Congress.
A unique opportunity
to evaluate your surgical knowledge

The Surgical Education and Self-Assessment Program

WILLIAM S. BLAKEMORE, MD, FACS, Philadelphia
and
JAMES V. MALONEY, JR., MD, FACS, Los Angeles

IT IS GENERALLY CONCEIVED that the “half life” of medical knowledge is between five and ten years. At the end of that period, approachable medical information currently in use will be demonstrated to be incomplete or incorrect, or will have been superseded by new information. It is for this reason that a major portion of a physician’s effort is devoted to a continuing program of self-education throughout his professional career. The acquisition and expansion of his knowledge is accomplished through reading of scholarly journals, attendance at regional and national medical meetings, participation in study and journal clubs, and the taking of formal postgraduate courses offered by universities and professional societies. There is no other profession whose members can be more appropriately considered “life-long students”.

With the increased affluence and sophistication of society, the consumer is progressively more concerned with assuring himself, through governmental regulation, of the quality and dependability of the goods and services he purchases. This is particularly true where his safety and welfare are concerned. Regulations governing public transportation, public utilities, and building codes are examples of how society regulates itself to provide this assurance. It is interesting that the regulation of the professions has been largely through a one-time certification and licensure which is presumed to attest to the individual’s competence throughout his career. An exception to this generalization are the regulations governing the competence and continuing education of commercial pilots. In this field, the federal government continuously determines, by a program of recertification and re-licensure throughout the pilot’s career, that he is physically and technically competent. The report of the Millis Commission recommended that consideration be given to a program which would assure the medical consumer that his physician maintains his professional competence. Considerable interest in implementing this recommendation has been demonstrated at both the state and federal governmental levels.

It is recognized that a specialist in medicine, as represented by Fellows of the ACS, cannot and need not know the complete body of medical knowledge. Within each individual’s needs is a requirement unique to his activities and best judged by himself. There is a need for assessment of knowledge; and some community planners have suggested re-licensure or recertification. Regardless of the future requirements, there is little possibility of any surgeon being deprived of the opportunity to practice his skills at a time when medical manpower...
does not meet the demands of such patients. Some assistance is offered to the practicing surgeon in determining his knowledge, both broad and specialized, in surgery as compiled by a broadly based peer group of clinical surgeons. Forty-four specialists were chosen in these fields—chosen broadly to cover general surgery which comprises 50 percent of the membership of the College, and other specialties, including obstetrics and gynecology, orthopedics and urology which make up more than half of the remainder.

It is actually quite anomalous that a profession so intimately responsible for human health and welfare should be essentially free of the concept of re-certification and re-licensure at the present time. This freedom from obligatory postgraduate education is a tribute to a profession whose members have, on a voluntary basis, so conscientiously continued their educational efforts following certification and licensure.

Minimum vs. ideal standards

It is historically true that regulation of professional activities by governmental fiat establishes only minimum standards. In a profession where human health and welfare are the principal objectives, we are concerned with a uniform rather than minimal level of excellence. To this end, the College has always considered one of its primary missions to be education. The dissemination of knowledge to the Fellowship is accomplished through the scientific programs of the Clinical Congress, formal postgraduate courses, programs of the sectional and chapter meetings, and through the official publications of the College.

An admitted deficiency of the program of the College, as well as of other professional societies, is the inability of the individual practitioner to identify those areas of weakness in his medical knowledge requiring remedial educational activity. How does the surgeon know if his knowledge of the most recent advances in cardiovascular physiology is sufficient? Is he aware of recent advances in other surgical specialties which might affect the care of patients in his own specialty? In order to achieve maximum benefit of his educational effort, it is necessary for the physician to identify precisely those areas of medical knowledge in which he has failed to keep up with his peers.

Many surgeons have no continuing program of well-organized study and some do not regularly attend scientific meetings or clinical courses, or by selective reading keep abreast of new technics and knowledge. The effectiveness of such activities can only be more sharply
focused for the surgeon who evaluates his own information aided by the selection of what others in his, or a closely related, specialty believe to be useful knowledge.

Recognition of this defect in postgraduate medical education has led to the concept of the voluntary self-assessment examination. Several professional societies have already developed examinations which are voluntary, self-administered, and permit the physician to evaluate his own medical knowledge. Each physician should be able to determine his need for specific knowledge in special areas. The questions, with a bibliography for reference reading are designed to cover basic material and are thought to be of value to all surgeons. Obviously practical limitations restrict the scope so that all the ambiguities cannot be eliminated nor can all the areas be completely covered, but the breadth of the material and the depth of the inter-related knowledge surveyed should compensate for these inevitable omissions.

Some questions will be answered correctly by most and others by only a few surgeons in an attempt to give a better measurement of basic and new knowledge in special areas.

**SESAP-Surgical Education and Self-Assessment Program**

Under the auspices of the Committee on Continuing Education, the College, in cooperation with the National Board of Medical Examiners, is developing a self-assessment examination for the general surgeon and surgical specialist. Nationally recognized leaders in the fields of general and specialty surgery have generously donated their time to the construction of the program. It consists of 750 clinically-oriented objective questions covering the broad field of surgery, and is better described as an “educational and self-assessment exercise” than as an “examination”. The questions emphasize new information which may have been developed since the practicing surgeon completed his residency five, ten, or more years ago. The evaluation covers both body of surgical knowledge which is essential to all surgeons, whether generalists or specialists. No attempt is made to examine in depth the individual specialty areas.

The seven categories of the program are:

1. Cardiovascular and respiratory.
2. Musculoskeletal and neurosurgery.
3. Skin, breast, and burns.
5. Genitourinary and gynecology.
7. Head, neck, ear, nose, throat, and ophthalmology.

*June 1971 Bulletin*
In addition, questions on cancer and trauma are distributed throughout the seven categories, and will be evaluated separately. Thus, the program will assess the surgeon’s knowledge in nine areas.

SESAP and the specialist

The typical surgical specialist has little difficulty in keeping abreast of new discoveries in his own field because of the nature of the literature he reads and the meetings he attends. In contrast, he has little opportunity to learn of new advances in other specialties which might affect the clinical management of patients in his own specialty. There is a certain body of knowledge which must be possessed by all surgeons if they are to administer competent clinical care. Thus, the ophthalmologist who employs general anesthesia must be aware of the recently discovered occurrence of high output renal failure following methoxyflurane anesthesia, or he would be unable to recognize the syndrome when he encounters it in one of his patients. The urologist must be aware of the recent advances in the use of steroids for the treatment of cerebral edema, since anesthetic accidents and patients with cerebral trauma are not uncommon in his specialty. The general surgeon should be thoroughly familiar with the use of the new positive inotropic agents if he is to achieve the high rate of resuscitation from circulatory collapse which is accomplished by the thoracic surgeon.

SESAP is not an in-depth assessment of knowledge in the specialty fields. Such a detailed evaluation might be the subject of a future program by the College or, more likely, by the individual specialty groups.

Scoring

Since this is not an examination, but a self-assessment, there is no passing or failing score. Rather, the effort is to provide the individual surgeon an evaluation of his knowledge in nine specific areas of knowledge. The evaluation will be made, both in relation to the entire group participating in the program, and in relation to those in the individual’s own specialty. It is quite likely that urologists would do relatively poorly in Category 11 (skin, breast, and burns) when compared to the entire group, since half of the members of the College are general surgeons and would be quite familiar with new knowledge in this field. On the other hand, a urologist who does poorly in Category 3, when compared to other urologists, might consider himself too isolated in his specialty practice and in need of broader educational exposure to better practice his own specialty.

It is expected that the surgical knowledge of those participating in the program will vary according to a normal frequency distribution curve, i.e., the greatest number of surgeons will achieve similar scores, a few will be outstandingly high, and a few very low. The most meaningful way of reporting the results of the self-assessment will, therefore, be in terms of the surgeon’s performance in relation to the performance of his peers. The decile rating system will be employed.

Those who score high and close to the mean of the group will feel that their knowledge in a specific categorical area is such that they are capable of providing good clinical care. Those who score in the lowest 10 to 20 percent of their peers in their own specialty may well interpret this as reflecting a need for additional education effort in a specific area of knowledge. It is anticipated that the College will provide at its future Clinical Congresses and sectional meetings, and perhaps in conjunction with universities, remedial postgraduate courses for those seeking to correct deficiencies demonstrated by the self-assessment program.

All answers to the objective type questions will be indicated on a special answer sheet which can be machine-scored. The availability of modern computer techniques makes it possible to provide the individual surgeon with a
personal critique of his own knowledge. The computer carries stored comments, both laudatory and critical, as well as recommendations for remedial education for all possible levels of performance in the evaluation. Thus, after the individual's entire examination has been corrected, and after the performance of all of the individual's surgical peers has been determined, a very personal evaluation of the surgeon's knowledge is automatically printed out by computer. A typical report, reproduced in part, might look like the following:

YOUR EVALUATION NUMBER IS:
YOUR SPECIALTY IS:
YOUR RAW SCORE IS:
YOUR PERFORMANCE IN RELATION TO YOUR FELLOW SPECIALISTS IS:
1. CARDIOVASCULAR AND RESPIRATORY
2. MUSCULOSKELETAL AND NEUROSURGERY
3. SKIN, BREAST AND BURNS
4. GASTROINTESTINAL
5. GENITOURINARY AND GYNECOLOGY
6. METABOLISM, SHOCK AND ENDOCRINE
7. HEAD, NECK, EAR, NOSE, THROAT AND OPHTHALMOLOGY
8. CANCER
9. TRAUMA

CONGRATULATIONS ON YOUR PERFORMANCE IN CATEGORY 1, YOUR KNOWLEDGE OF GASTROINTESTINAL SURGERY IS OUTSTANDING IN COMPARISON WITH YOUR SPECIALTY PEERS. THE EVALUATION OF YOUR KNOWLEDGE IN THE FIELD OF METABOLISM, SHOCK AND ENDOCRINE SURGERY SUGGESTS THE NEED FOR REMEDIAL POSTGRADUATE EDUCATION.
may, by appropriate study, compensate for the deficiencies in his knowledge. On the other hand, he may elect to take an “open book” examination. When he comes to questions to which he does not know the answer, he may use the reference material to seek the correct answer before marking the answer sheet. Since the purpose of SESAP is education, not examination, the surgeon will, with either option have accomplished the objective of the program.

Those who use reference material or consultation with colleagues to answer questions will be asked to so indicate at the end of the examination. The examination results of these individuals will then be eliminated by the computer before computing the performance of individuals in various specialty groups. Thus, those who use the program for self-evaluation can be assured that they will be compared only with others who also answered the questions on a “closed book” basis.

Evaluating clinical competence

Those who are knowledgeable in the field of testing in medical education are fully aware of the limitations in attempting to obtain reliable measures of competence. Clinical competence is a combination of 1) knowledge, 2) clinical experience, 3) technical skill, and 4) a certain intangible characteristic of the human mind related to pattern recognition and the decision-making process. Clinical experience, technical skill, and the intangible qualities of the human mind are not readily measurable. It is quite possible that a group of surgical residents might perform better than a group of highly competent surgical practitioners. Although the overall clinical competence of the surgical residents may be inferior, their surgical knowledge may be superior. SESAP might indicate that the surgical practitioners, although having great clinical competence, are not keeping up with the latest advances in surgery. Because of this deficient knowledge, they are not providing the high level of clinical care to their patients which their clinical experience and technical skill make them capable of.

The Surgical Education and Self-Assessment Program is a test of knowledge, not of clinical competence. However, given two surgeons with equal clinical experience, technical skill, and clinical manner, the one who performs better on an test of surgical knowledge can be expected to provide better clinical care to his patients.

The committees have functioned under the belief that each man has his own profile of special knowledge and the need for such knowledge to fit his experience and requirements for the practice of clinical surgery is best known to himself. To each physician electing to take the program goes a recognition of his dedication to insure better care by determining his profile of clinical knowledge.

Confidentiality

Since lay individuals could not be expected to understand the foregoing differences between a test of knowledge and a test of clinical competence, it is essential that there be absolute confidentiality in the handling of the self-assessment program. The National Board of Medical Examiners has an unblemished record for maintaining confidentiality in the handling of its testing program over a period of decades. Even greater protection of the confidentiality of SESAP will be provided by the use of a bonded agency. The National Board of Medical Examiners will have only the answer sheets and grades coded only by an identification number. Only the bonded agency will have both the identification number and the individual surgeon’s name and address. The bonded agency will serve to correlate the assessment results provided by the National Board of Medical Examiners with the name and address of the surgeon. The evaluation scores on the individual surgeon will not be available to the American College of Surgeons or to the National Board of Medical Examiners.

Collated scores for both specialty groups and for categorical areas of knowledge will be available to the College to enable it to prepare the postgraduate educational courses which would be of greatest benefit to those participating in the program.

Mechanics of the program

The program is open to all doctors of medicine, including residents in training. Requests for a prospectus and application should be directed to SESAP, American College of Surgeons, 55 E. Erie Street, Chicago Illinois 60611 (editor’s note: A postage paid card for this purpose can be found between pages 2 and 3.) A prospectus and application will be sent by mail. The application is returned with a check directly to the bonded agency. The cost for the program is $55.00 for Fellows, members of the Candidate Group, and residents, and $60.00 for nonfellows.
Included with the application are two mailing labels which will be filled out by the surgeon. One of these will be used to direct the question books and answer sheets back to the surgeon. The second mailing label will be retained by the bonded agency to be used in returning the results of the evaluation and critique to the surgeon. Since the surgeon himself makes out these labels, he can be certain to direct the report on the evaluation to himself personally in such a way that absolute confidentiality is maintained.

The answer sheets must be returned to the bonded agency by a specified date early in 1972. They will then be evaluated by computer and the scoring and critique returned to the individual some weeks later.

It is anticipated that between ten and 25 hours will be necessary to complete the evaluation. Therefore, a minimum period of six weeks will be permitted for completion of the examination before the deadline date. Since scoring is on the basis of comparison with peer specialists, it is apparent that the scoring of all examinations must be done simultaneously. When scoring and critique are completed, the results will be returned by the National Board of Medical Examiners to the bonded agency which will use the second mailing label to return the results to the individual surgeon.

The National Board of Medical Examiners

The College is desirous of having the highest level of professional knowledge in the testing field available for this program. The testing of medical knowledge is a unique science which has reached a high level of development in the last several decades. Fellows of the College are fortunate to have the participation of the National Board of Medical Examiners in the program. The NBME has had years of experience in administering tests of knowledge. Its staff is composed of physicians, medical educators, psychometricians, and editors, with the back-up of the appropriate computer technology. The reputation of the NBME will give assurance to the Fellows of the absolute confidentiality of the self-assessment program.

All Fellows of the College and other interested physicians are urged to take advantage of this unique opportunity to evaluate their surgical knowledge.

SURGICAL EDUCATION AND SELF-ASSESSMENT PROGRAM

The following nationally recognized surgeons have contributed generously of their time to make this program possible:

Curtis P. Atre, MD, Charleston
Arthur E. Bakke, MD, St. Louis
Edward J. Beattie, Jr., MD, New York
Ronald B. Berggren, MD, Columbus
William S. Blackmon, MD, Philadelphia
Donald F. Bratton, MD, Los Angeles
Allan D. Callow, MD, Boston
Marion S. DeWomo, MD, Columbus
Charles Eckert, MD, Alhamb
F. Henry Ellis, Jr., MD, Boston
Eric W. Fonkalsrud, MD, Los Angeles
William Frayer, MD, Philadelphia
Robert J. Freeark, MD, Maywood
Lyle A. French, MD, Minneapolis
John Grayhack, MD, Chicago
J. Alex Haller, MD, Baltimore
J. Hartwell Harrison, MD, Boston
Lucius D. Hill, MD, Seattle
Edward S. Judd, MD, Rochester, Minn.
Maurice J. Jurkiewicz, MD, Gainesville
Thomas W. Langfitt, MD, Philadelphia
James V. Maloney, Jr., MD, Los Angeles (Chairman)

Theodore R. Miller, MD, New York
J. G. Moore, MD, Los Angeles
C. Barber Mueller, MD, Hamilton, Ont.
John J. Murphy, MD, Philadelphia
Thomas F. Nealon, Jr., MD, New York
William S. Paone, MD, Columbus
Erle E. Peacock, Jr., MD, Tucson
Leonard F. Peltier, MD, Kansas City
John Raaf, MD, Portland
George P. Rosemond, MD, Philadelphia
Henry P. Royster, MD, Bryn Mawr
Carl P. Schlicke, MD, Salt Lake City
Charles R. Smart, MD, Salt Lake City
Marvin E. Steinberg, MD, Philadelphia
Robert B. Sweet, MD, Ann Arbor
Alan P. Thal, MD, Kansas City
Howard M. Tovell, MD, New York
Edward E. Wallach, MD, Philadelphia
Paul H. Ward, MD, Los Angeles
Ashbel C. Williams, MD, Jacksonville
Harry Wollman, MD, Philadelphia
Robert Zollinger, Jr., MD, Cleveland

*Indicates membership on the Standing Committee on Continuing Education.

NATIONAL BOARD OF MEDICAL EXAMINERS

The staff of the National Board of Medical Examiners participating actively in this program are:

John P. Hubbard, MD, Director
Francis E. Rosato, MD, Coordinator for SESAP
Ernest Rosato, MD
Alfred R. Smutko, MD
Charles F. Schumacher, PhD
Barbara Eason, EdD
Muriel Stangier, BA
CLINICAL CONGRESS 2013
PRELIMINARY PROGRAM

THE NEXT 100 YEARS
Inspiring Quality

OCTOBER 6–10, 2013 | WASHINGTON, DC
WALTER E. WASHINGTON CONVENTION CENTER

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

100 years
DEAR COLLEAGUES,

I invite you to attend the American College of Surgeons 2013 Annual Clinical Congress, scheduled for October 6–10, in Washington, DC. This year’s Clinical Congress will continue our celebration of the 100-year anniversary of the founding of the American College of Surgeons. In 2013, as at the time of our founding, the Congress will offer high-quality educational programs designed to educate and train surgeons and improve the health and safety of surgical patients.

The Program Committee, chaired by Valerie W. Rusch, MD, FACS, and the Division of Education, under the leadership of Ajit K. Sachdeva, MD, FACS, FRCSC, have put together an outstanding Scientific Program. Our President, A. Brent Eastman, MD, FACS, has chosen the President’s theme of “The Next 100 Years.”

The educational program includes a wide array of timely and important topics that are essential to delivery of surgical care of the highest quality. Included in the program are diverse Panel Sessions presented by experts from across the surgical specialties and nonsurgical disciplines and Named Lectures delivered by top leaders in their fields. The Didactic and Skills-Oriented Postgraduate Courses will focus on important domains and will help attendees advance their knowledge and acquire new skills. Experiential, hands-on learning will be used to achieve the objectives of these courses.

The Scientific Program for the Clinical Congress will also include presentations on innovative research and surgical practices presented in the Scientific Paper and Surgical Forum Sessions, as well as the Scientific Poster Presentations. The Video-Based Education Presentations will highlight interesting surgical procedures from around the world. These sessions will be complemented by intimate, topic-specific Meet-the-Expert Luncheons and interactive Town Hall Meetings. In addition to the valuable educational sessions, activities focusing on our profession will be highlighted.

Attendees will be able to obtain certificates of verification following their participation in Postgraduate Courses and additional certificates will be provided for participation in specific sessions to help meet various regulatory mandates. Many of our courses will have self-assessment continuing medical education credits this year, which are vital in the Maintenance of Certification process.

The Clinical Congress Program has been arranged in thematic tracks that address content of interest to all surgical specialties, as well as specialty-based tracks that address the learning needs of various specialty groups. The stimulating educational content, which includes special opportunities to address regulatory requirements and interact with experts, and the ability to reconnect with professional colleagues make the 2013 Clinical Congress an essential meeting for all practicing surgeons, surgery residents, and members of surgical teams. On behalf of the American College of Surgeons, I look forward to welcoming you to Washington, DC, for the 2013 Annual Clinical Congress.

With best regards,
Julie A. Freischlag, MD, FACS
Chair, Board of Regents

Registration is open: http://www.facs.org/clincon2013/registration/
WHAT’S NEW IN 2013?

The Next 100 Years
- Centennial celebration
- Ten Hot Topics in General Surgery
- Looking Back and Moving Forward: 100 Years of Surgical Research
- Subject-Oriented Symposium II: 100 Years of Surgery
- Surgical Heroes of the Next 100 Years: Will They Be Different?
- What’s New in Advocacy and Health Policy: Top 10 Advances in the Past Year
- Meet-the-Expert Luncheons featuring timely topics
- Subject-Oriented Symposium IV: ACS Video Atlas Showcase
- Tracks for Rural Surgery and Informatics
- Self-assessment credit available for select panel sessions

New Postgraduate Courses offered:
- Non-technical Skills for Surgeons in the Operating Room: Behaviors in High-Performing Teams
- Measure Twice, Cut Once! Optimizing Surgical Systems of Care
- MOC Review: Essentials for Surgical Specialties
- Minimally Invasive Colorectal Surgery Skills Course
- Ultrasound for Pediatric Surgeons
- Emergency Airways

CANCELLATION OF SESSIONS
The American College of Surgeons (ACS) reserves the right to cancel any of the scientific sessions listed in this Program Planner. The information in this Program Planner is preliminary. Check the College’s website at www.facs.org/clincon2013 for updates.

GOAL
The Clinical Congress is designed to provide individuals with a wide range of learning opportunities, activities, and experiences that will match their educational and professional development needs.

OBJECTIVE
By the conclusion of the Clinical Congress, participants should gain and be able to apply the knowledge needed to improve their current practice, research, and care of surgical patients.

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

CME CREDIT
The American College of Surgeons designates this live activity for a maximum of 30 “AMA PRA Category 1 Credits”. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

“An additional 17 AMA PRA Category 1 Credits” can also be earned through completion of Meet-the-Expert Luncheons and weekend Postgraduate (PG) and Skills-Oriented (SC) Courses.

SELF-ASSESSMENT CREDIT
Of the 30 AMA PRA Category 1 Credits indicated above, a maximum of 24 credits meet the requirements for Self-Assessment. All non-ticketed sessions providing Self-Assessment Credit are indicated in this advance program and successful completion of a posttest for each session is required in order to earn Self-Assessment Credit. In addition, Self-Assessment Credit is available for most ticketed PG and SC Courses.

Further information regarding posttests and how to claim Self-Assessment Credit will be available in the final Program Book at the meeting.

CME CERTIFICATES
On-site claiming of CME credit for nonticketed sessions (PS, NL, SF, VE, SP) will be available at the My CME Connection booth located in the Walter E. Washington Convention Center, October 7–10, 2013.

CME credit specific to patient safety, trauma, and ethics will be reflected on the certificate for general sessions through the online claiming system. Physicians are responsible for claiming CME credit for the Clinical Congress. Claims for CME credit for this event will be accepted until March 31, 2014.

SCIENTIFIC POSTER PRESENTATIONS AND TECHNICAL EXHIBITS
The Scientific Poster Presentations is a forum of more than 300 posters showcasing timely, innovative information and findings on original scientific research, surgical procedures, practices, and approaches. The Scientific Poster Presentations will be located in the Walter E. Washington Convention Center. Hours are 9:00 am to 4:30 pm, Monday through Wednesday.

The Technical Exhibition comprises more than 225 companies displaying their products and services. The exhibition provides an excellent opportunity to explore the surgical marketplace by comparing products firsthand and planning purchases.

The Technical Exhibit hours are 9:00 am to 4:30 pm, Monday through Wednesday. The exhibits are located in the Walter E. Washington Convention Center, Halls A and B.

FRIENDS OF BILL W.
Friends of Bill W. will meet Monday, October 7, through Wednesday, October 9, 7:00 to 8:30 pm at the Marriott Wardman Park Hotel.

Clinical Congress News
The official newspaper of the annual meeting, the Clinical Congress News, will be distributed at the Marriott Wardman Park Hotel and Walter E. Washington Convention Center each morning during Clinical Congress.

CONVOCATION
Sunday, October 6
6:00–8:00 pm, Walter E. Washington Convention Center, Ballroom AB

Conferral of Fellowship and Response on Behalf of New Fellows, Granting of Honorary Fellowships, Presentation of the Distinguished Service Award, Installation of Officers, and Presidential Address.

All Initiates of the ACS must register for the Clinical Congress if they wish to participate in the Convocation. Confirmed ACS Initiates will be bestowed with Fellowship in the College during the ceremony regardless of their attendance at the event and may begin using the FACS designation upon the conclusion of the ceremony.

Family members of Initiates are not required to register for the Clinical Congress program to attend the Convocation Ceremony.

OPENING CEREMONY
Monday, October 7
8:30–9:00 am, Walter E. Washington Convention Center, Ballroom AB

The Canadian and American national anthems are presented, along with a short video highlighting the new President’s theme for the year. The President presides and introduces the College Officers and Regents, Honorary Fellows, Past-Presidents, the recipient of the Distinguished Philanthropist Award, special invited guests from national and international health care organizations, the Resident Research Scholars, the International Guest Scholars, and the Franklin Martin, C. James Carrico, and Louis C. Argenta Faculty Research Fellows. The Martin Memorial Lecture, sponsored by the American Urological Association, follows immediately.

ANNUAL BUSINESS MEETING OF MEMBERS
Wednesday, October 9
4:15–5:15 pm, Walter E. Washington Convention Center

- Reports from the Chair of the Board of Regents, the Chair of the Board of Governors, the Executive Director, and the American College of Surgeons Professional Association-Surgeons PAC Board Chair
- Presentation of the Resident Award for Exemplary Teaching and the Joan L. and Julius H. Jacobson II Promising Investigator Award
- Reports of the Nominating Committee of the Board of Governors and the Nominating Committee of the Fellows, and introduction of the President-Elect
Key to Session/Course Codes

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<th>ME</th>
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<td>NL</td>
<td>Named Lecture</td>
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**SATURDAY, OCTOBER 5**

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<td>8:15 – 9:00</td>
<td>SC01 Humanitarian Surgery: Surgical Skills Training for the International Volunteer Surgeon</td>
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<td>9:15 – 11:00</td>
<td>SF01 Alimentary Tract I</td>
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<td>11:30 – 12:00</td>
<td>SC03 Ultrasound for Pediatric Surgeons</td>
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<td>12:30 – 14:30</td>
<td>SC05 Flexible Endoscopy for General Surgeons</td>
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<td>14:30 – 16:00</td>
<td>PG16-1 Endocrine Surgery Review Course</td>
<td>GEN, SA</td>
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<td>16:00 – 17:00</td>
<td>SC02 Bedside Procedures in the Surgical ICU: What, Why, and How</td>
<td>GEN, TRA, PS</td>
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<td>17:00 – 18:00</td>
<td>PG17 Basic Office Coding and Profitable Practice Operations</td>
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**SUNDAY, OCTOBER 6**

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<td>9:00 – 10:00</td>
<td>SC04 Flexible Endoscopy for General Surgeons</td>
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<tr>
<td>10:00 – 11:00</td>
<td>SC05 Ultrasound for Pediatric Surgeons</td>
<td>PED</td>
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<td>11:00 – 12:00</td>
<td>SC06 Rapid Ultrasound</td>
<td>TRA, RES/MED</td>
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<tr>
<td>12:00 – 13:00</td>
<td>SC07 Thyroid and Parathyroid Surgery</td>
<td>GEN-OTO, SA</td>
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<tr>
<td>13:00 – 14:00</td>
<td>SC08 Intra-Operative Decisions in Endocrine Surgery</td>
<td>GEN-OTO, SA</td>
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<tr>
<td>14:00 – 15:00</td>
<td>SC09 Advanced Colonoscopy Skills Course</td>
<td>GEN-OTO, SA</td>
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<tr>
<td>15:00 – 16:00</td>
<td>SC10 Medical Student Program, Session 1</td>
<td>RES/MED, SA</td>
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<tr>
<td>16:00 – 17:00</td>
<td>SC11 Advanced Colonoscopy Skills Course</td>
<td>GEN-OTO, SA</td>
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**MONDAY, OCTOBER 7**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:00 – 9:00</td>
<td>NL01 Opening Ceremony/Special Lecture</td>
<td>URO</td>
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<tr>
<td>9:00 – 10:00</td>
<td>NL02 John H. Gibbon, Jr., Lecture</td>
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<tr>
<td>10:00 – 11:00</td>
<td>PS100 Acute Cholecystitis: What to Do When the Patient Is Too Sick?</td>
<td>GEN, SA</td>
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<tr>
<td>11:00 – 12:00</td>
<td>PS101 Abdominal Wall Reconstruction in an Infected Field</td>
<td>GEN</td>
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<tr>
<td>12:00 – 13:00</td>
<td>PS102 Abdominal Wall Repair: The New Paradigm</td>
<td>GEN-ONC, W, SA</td>
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<tr>
<td>13:00 – 14:00</td>
<td>PS103 “What Do You Mean, I Might Need an Operation? I Feel Fine…” Endocrine Incidentalomas—Work-Up and Management</td>
<td>GEN, W, SA</td>
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<tr>
<td>14:00 – 15:00</td>
<td>PS104 The Toughest Trauma Case I Ever Had</td>
<td>GEN-TRA, W, SA</td>
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<tr>
<td>15:00 – 16:00</td>
<td>PS105 Management of Hereditary Colon Cancer Syndromes</td>
<td>CRS-ONC, W, SA</td>
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<td>16:00 – 17:00</td>
<td>SF01 Image-Navigated Laparoscopic Inguinal and Ventral Hernia Repair</td>
<td>GEN-HUM, INT</td>
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<tr>
<td>17:00 – 18:00</td>
<td>SF02 Image-Navigated Laparoscopic Inguinal and Ventral Hernia Repair</td>
<td>GEN-HUM, INT</td>
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$ Indicates that additional fees and registration apply
W Indicates a Webcast session (Webcast package available for purchase)
SA Self-Assessment Credits available
PS Patient Safety Credits available
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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>7:00–7:45</td>
<td>TH01</td>
<td>Who Will Be Available to Take General Surgical Calls in 2015?</td>
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<tr>
<td>7:00–7:45</td>
<td>TH02</td>
<td>What Are the Current Issues in Board Certification and MOC?</td>
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<td>7:00–7:45</td>
<td>TH03</td>
<td>Surgeons As Health Policy Advocates</td>
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<tr>
<td>8:00–9:00</td>
<td>NL05</td>
<td>Heran Abcarian Lecture</td>
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<td>8:00–9:30</td>
<td>PS200</td>
<td>Severe Acute Pancreatitis: Evolving Management Strategies</td>
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<td>8:00–9:30</td>
<td>PS201</td>
<td>Managing Thoracic Trauma: The Debate Continues</td>
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<td>8:00–9:30</td>
<td>PS202</td>
<td>Case-Based Discussion of the Management of Pediatric Trauma Brain Injury</td>
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<td>8:00–9:30</td>
<td>PS203</td>
<td>Diversity in Surgery: Does It Matter?</td>
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<td>8:00–9:30</td>
<td>PS204</td>
<td>Can Your New Partner Operate? Mentoring Your New Partner</td>
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<td>8:00–9:30</td>
<td>PS205</td>
<td>High-Risk Breast Patients: Assessment, Genetics, and Atypical Lesions</td>
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<tr>
<td>8:00–9:30</td>
<td>PS206</td>
<td>Innovation and Invention in Surgery</td>
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<td>8:00–11:15</td>
<td>PS207</td>
<td>Spectacular Cases</td>
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<tr>
<td>8:00–11:15</td>
<td>SF12</td>
<td>Cardiothoracic Surgery I</td>
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<td>8:00–11:15</td>
<td>SF13</td>
<td>Critical Care I</td>
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<td>8:00–11:15</td>
<td>SF14</td>
<td>Plastic and Maxillofacial Surgery I</td>
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<tr>
<td>8:00–11:15</td>
<td>SF210</td>
<td>100 Years of Rural Surgery: Challenges, Great Lessons</td>
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<td>8:00–11:15</td>
<td>SF212</td>
<td>Don't Get Burned: A Refresher</td>
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<td>8:00–11:15</td>
<td>SF213</td>
<td>A Wild Night on Acute Care Surgery Call: Challenging Cases, Great Lessons</td>
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<tr>
<td>8:00–11:15</td>
<td>SF214</td>
<td>100 Years of Rural Surgery: Past Accomplishments, Future Challenges</td>
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<tr>
<td>8:00–11:15</td>
<td>SF215</td>
<td>Quality, Outcomes, and Costs II</td>
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<td>8:00–11:15</td>
<td>SF216</td>
<td>Surgical Oncology/Endocrine II</td>
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<td>8:00–11:15</td>
<td>SF217</td>
<td>Transplantation and Tissue Engineering</td>
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<td>8:00–11:15</td>
<td>SF218</td>
<td>Otolaryngology–Head and Neck Surgery</td>
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<td>8:00–11:15</td>
<td>SF219</td>
<td>General Surgery Review Course</td>
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<td>8:00–11:15</td>
<td>SF220</td>
<td>Measure Twice, Cut Once! Optimizing Surgical Systems of Care</td>
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<td>8:00–11:15</td>
<td>SF221</td>
<td>Practical Applications of Ultrasonography in the ICU</td>
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<td>SF222</td>
<td>Minimally Invasive Colorectal Surgery Skills Course</td>
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<td>8:00–11:15</td>
<td>SF223</td>
<td>Breast Cancer: Current Treatment Paradigms</td>
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<td>8:00–11:15</td>
<td>SF224</td>
<td>Emergency Airways</td>
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<td>9:45–11:15</td>
<td>NL06</td>
<td>Excelsior Surgical Society/Edward D. Churchill Lecture</td>
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<td>9:45–11:15</td>
<td>PS208</td>
<td>A Wild Night on Acute Care Surgery Call: Challenging Cases, Great Lessons</td>
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<td>9:45–11:15</td>
<td>PS209</td>
<td>Don't Get Burned: A Refresher</td>
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<td>PS210</td>
<td>100 Years of Rural Surgery: Past Accomplishments, Future Challenges</td>
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<tr>
<td>9:45–11:15</td>
<td>PS211</td>
<td>Are CT Scans Killing Patients?</td>
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<td>9:45–11:15</td>
<td>PS212</td>
<td>Piece of the Action or Run the Trial: Managing Conflict of Interest in Research and Innovation</td>
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<td>9:45–11:15</td>
<td>PS213</td>
<td>Management of Polytrauma Patients with CNS Injury</td>
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<td>9:45–11:15</td>
<td>PS214</td>
<td>Personalized Therapy of Surgical Diseases</td>
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<tr>
<td>11:30–</td>
<td>PP</td>
<td>Posters of Exceptional Merit Presentation</td>
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<tr>
<td>11:30–</td>
<td>ME201</td>
<td>How to Mentor a Newly Trained Partner</td>
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<tr>
<td>11:30–</td>
<td>ME202</td>
<td>Who Says Yes and Who Says No: The Role of the Surgeon in Palliative Care</td>
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<tr>
<td>11:30–</td>
<td>ME203</td>
<td>New Concepts in Breast Cancer</td>
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<td>11:30–</td>
<td>ME204</td>
<td>Treatment of Early Low Rectal Cancer: Chemoradiation Therapy, Transanal Resection, or Coloanal?</td>
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<td>11:30–</td>
<td>ME205</td>
<td>Barrett’s Esophagus</td>
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<tr>
<td>Time</td>
<td>Session Code</td>
<td>Title</td>
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<td>11:30–12:00</td>
<td>ME206</td>
<td>Diverticulitis: Time to Operate? Is This the Question</td>
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<td>11:30–12:00</td>
<td>ME207</td>
<td>Mesh for Hernia Repair: The Good, the Bad, and the Ugly</td>
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<td>11:30–12:00</td>
<td>ME208</td>
<td>The Difficult Gallbladder: Tricks of the Trade</td>
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<td>11:30–12:00</td>
<td>ME209</td>
<td>Crohn’s Disease: Basic Principles to Steer You Away from Trouble</td>
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<td>11:30–12:00</td>
<td>ME210</td>
<td>Developing a Robotic Surgery Program in Urology</td>
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<td>11:30–12:30</td>
<td>ME211</td>
<td>Management of GERD in the Obese Patient</td>
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<td>11:30–12:30</td>
<td>ME212</td>
<td>Necrotizing Fasciitis</td>
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<td>12:45–2:15</td>
<td>PS218</td>
<td>Advances in Periocular and Orbital Surgery: The Past 25 Years</td>
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<td>12:45–2:15</td>
<td>PS217</td>
<td>Lung Cancer and the Pulmonary Resection Patient: Screening, Preparation, Techniques, and Outcomes</td>
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<td>12:45–2:15</td>
<td>PS219</td>
<td>From the Battlefield to the Home Front: Translating Military Experience into Civilian Practice</td>
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<td>12:45–2:15</td>
<td>VE09</td>
<td>Obstetrics and Gynecology</td>
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<td>12:45–2:15</td>
<td>VE10</td>
<td>Complex Conditions Managed by Laparoscopy</td>
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<td>12:45–2:15</td>
<td>VE11</td>
<td>Controversial Cases in General Surgery</td>
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<td>12:45–2:15</td>
<td>VE12</td>
<td>Subject-Oriented Symposium II: 100 Years of Medical Student Program</td>
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<td>12:45–4:00</td>
<td>VE13</td>
<td>Highlights from International Sessions</td>
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<td>1:00–5:00</td>
<td>PS221</td>
<td>APDS Panels: Improving General Surgery Residency Training</td>
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<td>1:00–5:00</td>
<td>PS222</td>
<td>Medical Student Program, Session III</td>
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<td>2:30–3:30</td>
<td>NL08</td>
<td>Olga M. Jonasson Lecture</td>
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<td>2:30–4:00</td>
<td>PS222</td>
<td>Managing Emergencies in Crohn’s Disease</td>
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<td>2:30–4:00</td>
<td>PS223</td>
<td>Implementing Social Media Applications into Your Continuing Professional Development</td>
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<td>2:30–4:00</td>
<td>PS224</td>
<td>She’s Pregnant: Things the General Surgeon Should Know</td>
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<td>2:30–4:00</td>
<td>PS225</td>
<td>Hot Topics in Thyroid Cancer</td>
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<td>2:30–4:00</td>
<td>PS226</td>
<td>Ingested, Inserted, and Impaled Foreign Bodies: Strategies for Successful Management</td>
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<td>2:30–4:00</td>
<td>PS227</td>
<td>Long-Term Outcomes of Combat Wound Care</td>
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<td>Orthopaedic Surgery</td>
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<td>2:30–4:00</td>
<td>VE14</td>
<td>Urology</td>
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<td>2:30–5:45</td>
<td>PS228</td>
<td>Ethics Colloquium: End-of-Life Issues for Surgical Patients</td>
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<td>2:30–5:45</td>
<td>SF19</td>
<td>Alimentary Tract II</td>
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<td>2:30–5:45</td>
<td>SF20</td>
<td>Biomarkers and Genetic Determinants of Disease and Outcomes</td>
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<td>2:30–5:45</td>
<td>SF21</td>
<td>Pediatric Surgery II</td>
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<td>2:30–5:45</td>
<td>VE15</td>
<td>General Surgery II</td>
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<td>4:15–5:45</td>
<td>PS229</td>
<td>Intestinal Stomas: Prevention and Management of Complications</td>
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<td>4:15–5:45</td>
<td>PS231</td>
<td>Perioperative Care in the Surgical ICU: Challenging Scenarios for the Surgeon and Intensivist</td>
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<td>4:15–5:45</td>
<td>PS232</td>
<td>Improving Outcomes through ACS NSQIP*</td>
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<td>4:15–5:45</td>
<td>PS233</td>
<td>Incorporating Palliative Care in Cancer Management</td>
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<td>4:15–5:45</td>
<td>PS235</td>
<td>Surgical Heroes of the Next 100 Years: Will They Be Different?</td>
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<td>4:15–5:45</td>
<td>SF22</td>
<td>Urology and Reproductive Surgery II (Robotic)</td>
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<td>6:30–8:30</td>
<td>VE16</td>
<td>Best Videos from the Past</td>
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<td>7:00–7:45</td>
<td>TH04</td>
<td>Robotic Surgery for General Surgeons</td>
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<tr>
<td>7:00–7:45</td>
<td>TH05</td>
<td>Rural Surgery: What Are the Challenges?</td>
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<td>7:00–7:45</td>
<td>TH06</td>
<td>Medical Liability Reform 2013: Thinking Outside of the Box to Achieve Tort Reform</td>
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<td>8:00–9:00</td>
<td>NL09</td>
<td>Distinguished Lecture of the International Society of Surgery</td>
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<td>PS300</td>
<td>Barrett’s Esophagus: Management Options</td>
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<td>8:00–9:30</td>
<td>PS301</td>
<td>Colorectal Emergencies for Noncolorectal Surgeons</td>
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<td>8:00–9:30</td>
<td>PS302</td>
<td>Intestinal Failure: Evolution of Therapy in the Era of Intestinal Transplantation</td>
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<td>8:00–9:30</td>
<td>PS303</td>
<td>Civilian and Military Injuries to Kidney, Ureter, and Bladder</td>
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<td>8:00–9:30</td>
<td>PS304</td>
<td>Redirection and Reentry: Flexibility for a Surgical Career</td>
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<td>8:00–9:30</td>
<td>PS331</td>
<td>Lessons Learned from the Boston Marathon Bombing</td>
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<td>8:00–11:15</td>
<td>PS305</td>
<td>Surgical Jeopardy</td>
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<td>SF22</td>
<td>Alimentary Tract III</td>
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<tr>
<td>8:00–11:15</td>
<td>SF24</td>
<td>Critical Care II</td>
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<td>8:00–11:15</td>
<td>SF25</td>
<td>Progenitor Cells and Cell-Based Therapies</td>
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<td>8:00–11:15</td>
<td>SF26</td>
<td>Surgical Education I</td>
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<tr>
<td>8:00–11:15</td>
<td>VE17</td>
<td>General Surgery III</td>
</tr>
<tr>
<td>8:00–11:15</td>
<td>VE18</td>
<td>Pediatric Surgery</td>
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<tr>
<td>8:00–3:30</td>
<td>PG26</td>
<td>Update in Surgical Critical Care</td>
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<tr>
<td>8:15–5:45</td>
<td>SC14</td>
<td>Advanced Skills Training for Rural Surgeons</td>
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<tr>
<td>8:30–4:00</td>
<td>PG27</td>
<td>Nontechnical Skills for Surgeons (NOTSS) in the Operating Room: Behaviors in High-performing Teams</td>
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<td>8:30–5:00</td>
<td>SC15</td>
<td>Basic Breast Ultrasound</td>
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9:00–4:30 PG28 Review of the Essentials of Vascular Surgery VAS SA
9:45–10:45 NL10 Ethics and Philosophy Lecture ETH
9:45–11:15 PS306 Anastomotic Leak: Prevention and Management CRS SA
9:45–11:15 PS307 Developing, Implementing, and Evaluating Trauma Care Systems: Experiences from Low- and Middle-Income Countries INT-TRA
9:45–11:15 PS308 Metabolic Surgery: The Science, the Patient, and the Future GEN
9:45–11:15 PS310 Mass-Casualty Shootings: Saving the Victims GEN, TRA
9:45–11:15 PS311 Regenerative Medicine in Practice Now: Cell Therapies and Artificial Organs BTR
9:45–11:15 PS328 A Century of Canadian Contributions to the ACS and Surgical Science CEN-EDU SA
9:45–11:15 VE19 Subject-Oriented Symposium III: Managing Abdominal Disasters GEN-TRA
11:30–12:30 ME301 Hemorrhoids CRS
11:30–12:30 ME302 Recurrent Esophageal Symptoms after Nissen Fundoplication OTO
11:30–12:30 ME303 Radiological Workup and the Breast GEN-ONC
11:30–12:30 ME304 Laparoscopic Colectomy: Tips and Tricks CRS GEN
11:30–12:30 ME305 Critical Issues in Laparoscopic Ventral Hernia Repair GEN
11:30–12:30 ME306 Rectal Cancer—Advanced CRS
11:30–12:30 ME307 Preparing for ABS Recertification: Don't Sweat It…or Maybe… EDU-GEN
11:30–12:30 ME308 Management of the Axilla in Breast Cancer 2013 ONC
11:30–12:30 ME309 How to Create Your Own Bundled Payment for Surgical Reimbursement GEN-HP
11:30–12:30 ME310 Thyroid Surgery: Tips for Staying Out of Trouble OTO
11:30–12:30 ME311 The Role of Surgeons in Reducing Never Events GEN
11:30–12:30 ME312 Clostridium Difficile Colitis: Is It Getting Out of Hand? CRS-GEN
12:45–1:45 NL11 Commission on Cancer Oncology Lecture ONC
12:45–2:15 PS312 Bariatric Surgical Complications: I Don’t Do Bariatric Surgery—But You Are the Only Surgeon on Call! GEN
12:45–2:15 PS314 Innovative Technologies for the Treatment of Incontinence and Prolapse GEN
12:45–2:15 PS315 Controversies in Men’s Health: PSA and Testosterone URO
12:45–2:15 PS316 Nonsurgical Education: Is It Worth Going Back to School? EDU-RES/MED VAS SA
12:45–2:15 PS317 Challenges in Management of Patients with Aneurysms EDU-RES/MED VAS SA
12:45–2:15 VE20 Movie Classics from the Past GEN
12:45–2:15 VE21 Trauma GEN-TRA
12:45–4:00 PS318 The College’s International Scholars and Travelers 2013 HUM-INT
12:45–4:00 VE22 Subject-Oriented Symposium IV: ACS Video Atlas Showcase GEN
2:30–4:00 PS319 Quality Colorectal Cancer Care: What You Should Know CRS-ONC
2:30–4:00 PS320 Looking Back and Moving Forward: 100 Years of Surgical Research CEN-GEN
2:30–4:00 PS321 Gunshot Wounds to the Face: Contemporary Management OTO-PLA-TRA
2:30–4:00 PS322 State of the Art in Head and Neck Trauma, Adult and Pediatric OTO-PED-TRA
2:30–4:00 PS323 Neoadjuvant Therapy: Finding the New Normal in Cancer Treatment ONC
2:30–4:00 PS324 Contemporary Approaches to Dialysis Access VAS
2:30–4:00 VE23 Vascular Surgery VAS
2:30–5:45 VE24 Hepatobiliary Surgery GEN
2:30–5:45 SF27 Cardiotoracic Surgery II CTS
2:30–5:45 SF28 Plastic and Maxillofacial Surgery II PLA
2:30–5:45 SF29 Quality, Outcomes, and Costs III EDU-HP
2:30–5:45 SF30 Vascular Surgery II VAS
4:15–5:45 PS326 Risk and Opportunity of Employed Physicians in an Integrated Health System GEN
4:15–5:45 PS327 Advancing the Surgeon's Role in Cancer Prevention and Clinical Trials ONC
4:15–5:45 PS330 Negotiating for Success EDU-HP
4:15–5:45 SF31 Geriatric Surgery GER
4:15–5:45 SF32 Patient Safety EDU

THURSDAY, OCTOBER 10

7:00–7:45 TH07 ACS-CRP Defining Cancer Surgical Guidelines and Reporting HP-ONC
7:00–7:45 TH08 Choosing a Surgical Discipline EDU-RES/MED
7:00–7:45 TH09 Ethics in Advertising: What Is the Surgeon's Responsibility? ETH
8:00–9:30 PS400 Ten Hot Topics in General Surgery GEN SA
8:00–9:30 PS401 The Geriatric Surgery Patient: Issues in Perioperative and End of Life ETH-GER
8:00–9:30 PS402 Simulation Training in the ICU TRA
8:00–9:30 PS403 Outpatient Venous Procedures VAS
8:00–9:30 PS404 How to Bring Biologic Therapies and Devices to Clinical Use INFO
8:00–11:15 SF33 Critical Care III GEN-TRA
8:00–11:15 SF34 Innovative Clinical Technology INFO
8:00–11:15 SF35 Plastic and Maxillofacial Surgery III PLA
8:00–11:15 SF36 Surgical Education II EDU-RES/MED
8:00–11:15 VE25 Bariatric Surgery GEN
9:45–11:15 PS405 What's New in Advocacy and Health Policy: Top 10 Advances in the Past Year HP
9:45–11:15 PS406 Trauma Care Around the World: Differences, Similarities, Controversies INT-TRA
9:45–11:15 PS407 Current Options in Management of Hepatoma ITEDU-RES/MED
9:45–11:15 PS408 It Pays for Your Patients to Quit Smoking before Surgery Outcomes, Interventions, and Reimbursement GEN
### POSTGRADUATE COURSES

**REGISTER ONLINE FOR THESE POSTGRADUATE DIDACTIC AND SKILLS-ORIENTED COURSES**

<table>
<thead>
<tr>
<th>COURSE CODE</th>
<th>COURSE TITLE</th>
<th>FELLOW</th>
<th>NON-FELLOW</th>
<th>RAS</th>
<th>NON-RAS</th>
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<tbody>
<tr>
<td>SC01</td>
<td>Humanitarian Surgery: Surgical Skills Training for the International Volunteer Surgeon</td>
<td>$715</td>
<td>$825</td>
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<td>SC02</td>
<td>Bedside Procedures in the Surgical ICU: What, Why, and How</td>
<td>$475</td>
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<td>SC03*</td>
<td>Ultrasound for Pediatrics</td>
<td>$650</td>
<td>$750</td>
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<td>SC04A</td>
<td>Flexible Endoscopy for the General Surgeon (LECTURE)</td>
<td>$350</td>
<td>$405</td>
<td>$175</td>
<td>$205</td>
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<td>SC04B</td>
<td>Flexible Endoscopy for the General Surgeon (LECTURE AND LAB)</td>
<td>$975</td>
<td>$1,125</td>
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<td>SC05</td>
<td>Surgical Education: Principles and Practice</td>
<td>$425</td>
<td>$490</td>
<td>$215</td>
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<td>SC06*</td>
<td>FAST Ultrasound</td>
<td>$690</td>
<td>$795</td>
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<td>SC07*</td>
<td>Thyroid and Parathyroid Ultrasound</td>
<td>$900</td>
<td>$1,040</td>
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<td>SC08A</td>
<td>Intra-Operative Decisions in Laparoscopic Inguinal and Ventral Hernia Repair (LECTURE)</td>
<td>$320</td>
<td>$370</td>
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<tr>
<td>SC08B</td>
<td>Intra-Operative Decisions in Laparoscopic Inguinal and Ventral Hernia Repair (LECTURE AND LAB)</td>
<td>$990</td>
<td>$1,135</td>
<td>$495</td>
<td>$570</td>
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<td>SC09</td>
<td>Advanced Colonoscopy Skills Course: Polypectomy and Beyond</td>
<td>$690</td>
<td>$795</td>
<td>$345</td>
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<tr>
<td>SC10</td>
<td>Measure Twice, Cut Once! Optimizing Surgical Systems of Care</td>
<td>$495</td>
<td>$570</td>
<td>$245</td>
<td>$285</td>
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<tr>
<td>SC11A</td>
<td>Minimally Invasive Colorectal Surgery Skills Course (LECTURE)</td>
<td>$475</td>
<td>$545</td>
<td>$240</td>
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<td>SC11B</td>
<td>Minimally Invasive Colorectal Surgery Skills Course (LECTURE AND LAB)</td>
<td>$1,500</td>
<td>$1,725</td>
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<td>SC12*</td>
<td>Practical Applications of Ultrasound in the ICU: ECHO and Thoracic</td>
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<td>SC13</td>
<td>Emergency Airways</td>
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<td>SC14</td>
<td>Advanced Skills Training for the Rural Surgeon</td>
<td>$850</td>
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<td>SC15*</td>
<td>Basic Breast Ultrasound</td>
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<td>PG16</td>
<td>Endocrine Surgery Review Course</td>
<td>$700</td>
<td>$805</td>
<td>$350</td>
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<tr>
<td>PG17</td>
<td>Basic Office Coding and Profitable Practice Operations</td>
<td>$475</td>
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<td>PG18</td>
<td>Management of Benign Anorectal Disease</td>
<td>$500</td>
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<tr>
<td>PG19</td>
<td>Mastering General Surgery Coding (Advanced)</td>
<td>$475</td>
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<td>PG20</td>
<td>Endoscopic and Minimally Invasive Surgical Approaches for Managing Benign and Malignant Esophageal Disease</td>
<td>$500</td>
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<tr>
<td>PG21</td>
<td>General Surgery Review Course</td>
<td>$950</td>
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<td>PG22</td>
<td>Robotic Surgery for Gastrointestinal Operations: Program Planning, Approaches, and Applications</td>
<td>$475</td>
<td>$545</td>
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<tr>
<td>PG23</td>
<td>Trauma Update 2013</td>
<td>$500</td>
<td>$575</td>
<td>$250</td>
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<tr>
<td>PG24</td>
<td>Breast Cancer: Current Treatment Paradigms</td>
<td>$500</td>
<td>$575</td>
<td>$250</td>
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<tr>
<td>PG25</td>
<td>MOC Review: Essentials for Surgical Specialties</td>
<td>$375</td>
<td>$375</td>
<td>$190</td>
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<tr>
<td>PG26</td>
<td>Update in Surgical Critical Care</td>
<td>$500</td>
<td>$575</td>
<td>$250</td>
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<tr>
<td>PG27</td>
<td>Nontechnical Skills for Surgeons (NOTSS) in the Operating Room: Behaviors in High-performing Teams</td>
<td>$425</td>
<td>$490</td>
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<tr>
<td>PG28</td>
<td>Review of the Essentials of Vascular Surgery</td>
<td>$475</td>
<td>$545</td>
<td>$240</td>
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<tr>
<td>PG17 &amp; PG19</td>
<td>Coding Course Bundle</td>
<td>$850</td>
<td>$980</td>
<td>$425</td>
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</tbody>
</table>

*Requires a prerequisite to attend.*
Converse with experts on selected topics over an informal lunch. There will be no formal presentations or A/V provided during these luncheons. Case-based discussions will be encouraged. Cost for each luncheon is $45. The luncheons will be from 1:15 to 2:15 pm on Monday and from 11:30 am to 12:30 pm on Tuesday and Wednesday.

### Meet-the-Expert Luncheons

#### Monday, October 7, 1:15–2:15 PM

| ME101 | Burning Issues in Surgical Ethics: Collaborations with Industry and Potential Conflicts of Interest | Facilitated by: Peter Angelos, MD, PhD, FACS, Chicago, IL |
| ME102 | Sportsman Hernia: Is It Real? | Facilitated by: L. Michael Brunt, MD, FACS, St. Louis, MO |
| ME103 | ERCP: How to Incorporate into a General Surgery Practice | Facilitated by: Jeffrey L. Ponsky, MD, FACS, Cleveland, OH |
| ME104 | Retroperitoneal Adrenalectomy | Facilitated by: Nancy D. Perrier, MD, FACS, Houston, TX |
| ME105 | Advancing the Use of Ultrasound in Acute Care Surgery | Facilitated by: Grace S. Rozyczki, MD, FACS, Atlanta, GA |
| ME106 | Personalized Medicine for Breast Cancer | Facilitated by: Ingrid M. Meszoely, MD, FACS, Nashville, TN |
| ME107 | Pilonidal Disease | Facilitated by: Herand Abcarian, MD, FACS, Chicago, IL |
| ME108 | How to Get Your Research Published | Facilitated by: Keith D. Lillemeoe, MD, FACS, Boston, MA |
| ME109 | I Got Sued: Now What? | Facilitated by: Terrell C. Hicks, MD, FACS, New Orleans, LA |
| ME110 | Anal Neoplasia | Facilitated by: Rocco Ricciardi, MD, MPH, FACS, FASCRS, Burlington, MA |
| ME111 | Parathyroid Disease | Facilitated by: Herbert Chen, MD, FACS, Madison, WI |
| ME112 | Nonoperative Management of Solid Organ Injuries | Facilitated by: Daniel L. Dent, MD, FACS, San Antonio, TX |

#### Tuesday, October 8, 11:30 AM–12:30 PM

| ME201 | How to Mentor a Newly Trained Partner | Facilitated by: Barbara L. Bass, MD, FACS, Houston, TX |
| ME202 | Who Says Yes and Who Says No: The Role of the Surgeon in Palliative Care | Facilitated by: Bridget N. Fahy, MD, FACS, Houston, TX |
| ME203 | New Concepts in Breast Cancer | Facilitated by: Hiram S. Cody, MD, FACS, New York, NY |
| ME204 | Treatment of Early Low Rectal Cancer: Chemoradiation Therapy, Transanal Resection, or Coloanal? | Facilitated by: Philip B. Paty, MD, FACS, New York, NY |
| ME205 | Barrett’s Esophagus | Facilitated by: Blair A. Jobe, MD, FACS, Pittsburgh, PA |
| ME206 | Diverticulitis: To Operate or Not to Operate? This Is the Question | Facilitated by: James W. Fleshman, MD, FACS, Dallas, TX |
| ME207 | Mesh for Hernia Repair: The Good, the Bad, and the Ugly | Facilitated by: Brent D. Matthews, MD, FACS, St. Louis, MO |
| ME208 | The Difficult Gallbladder: Tricks of the Trade | Facilitated by: Nathaniel J. Soper, MD, FACS, Chicago, IL |
| ME209 | Crohn’s Disease: Basic Principles to Steer You Away from Trouble | Facilitated by: Alessandro Fichera, MD, FACS, FASCRS, Seattle, WA |
| ME210 | Developing a Robotic Surgery Program in Urology | Facilitated by: David Lee, MD, FACS, Philadelphia, PA |
| ME211 | Management of GERD in the Obese Patient | Facilitated by: Jon C. Gould, MD, FACS, Milwaukee, WI |
| ME212 | Necrotizing Fasciitis | Facilitated by: Gerald B. Demarest, MD, FACS, Albuquerque, NM |
| ME213 | Pediatric Urologic Surgery | Facilitated by: David A. Bloom, MD, FACS, Ann Arbor, MI |

#### Wednesday, October 9, 11:30 AM–12:30 PM

| ME301 | Hemorrhoids | Facilitated by: Richard J. Yarger, MD, FACS, Price, UT |
| ME302 | Recurrent Esophageal Symptoms after Nissen Fundoplication | Facilitated by: S. Scott Davis, Jr., MD, FACS, Atlanta, GA |
| ME303 | Radiological Workup and the Breast | Facilitated by: Lisa A. Newman, MD, MPH, FACS, Ann Arbor, MI |
| ME304 | Laparoscopic Colectomy: Tips and Tricks | Facilitated by: Peter W. Marcello, MD, FACS, FASCRS, Burlington, MA |
| ME305 | Critical Issues in Laparoscopic Ventral Hernia Repair | Facilitated by: Karl A. LeBlanc, MD, FACS, Baton Rouge, LA |
| ME306 | Rectal Cancer—Advanced | Facilitated by: George J. Chang, MD, FACS, Houston, TX |
| ME307 | Preparing for ABS Recertification: Don’t Sweat It...or Maybe... | Facilitated by: Thomas H. Cogbill, MD, FACS, La Crosse, WI |
| ME308 | Management of the Axilla in Breast Cancer in 2013 | Facilitated by: Eric B. Whitacre, MD, FACS, Tucson, AZ |
| ME309 | How to Create Your Own Bundled Payment for Surgical Reimbursement | Facilitated by: Robert R. Lorenz, MD, FACS, Cleveland, OH |
| ME310 | Thyroid Surgery: Tips for Staying Out of Trouble | Facilitated by: David J. Terris, MD, FACS, Augusta, GA |
| ME311 | The Role of Surgeons in Reducing Never Events | Facilitated by: T. Forcht Dagi, MD, MPH, FACS, Newton Centre, MA |
| ME312 | Clostridium Difficile Colitis: Is It Getting Out of Hand? | Facilitated by: John C. Alverdy, MD, FACS, Chicago, IL |
Please note: These are non-CME designated sessions unless otherwise indicated.

**SUNDAY, OCTOBER 6**

**Medical Student Program**
**Day I: 11:30 am–5:45 pm**

The Division of Education invites students from all four years of medical school to attend Clinical Congress and to participate in this program designed specifically for those considering a career in surgery. Programming is varied from day to day, and students are welcome to attend all or selected portions of this three-day program. The program is free to ACS Medical Student members who register in advance. Nonmembers will be charged a nominal registration fee.

Topics include optimizing each year in medical school to prepare for a surgical residency, choosing the surgical discipline that best suits one’s personality, and navigating the residency application process and interviewing successfully.

Speakers include College leaders and surgical educators at both the medical student and resident levels. Students are able to hone their interviewing skills through an interactive session with surgeons as well as network with specialty surgeons, surgical residents, residency program directors, and others.

Also incorporated in this program is the Medical Student Program Poster Session, during which 40 medical students present their research in one of three areas: clinical, basic science, or educational research. Resident and surgeon volunteers critique these presentations, and winners are formally recognized during the program.

Students enrolled in a U.S., Canadian, or international allopathic or osteopathic medical school are invited to attend this comprehensive program. For regularly updated information about the Medical Student Program and the Medical Student Program Poster Session, visit www.facs.org/clincon2013/special/medicalstudent.html. For additional information, contact Ms. Krashina Hudson at khudson@facs.org or 312-202-5335.

**Resident and Associate Society Symposium**

**3:00–5:30 pm**

**Patient Rankings: Should Patient Feedback Affect Our Pay and Delivery of Care?**

The RAS Symposium will feature a debate between leaders in surgery on the timely topic of patient rankings and their use in day-to-day practice. There has been an explosion in online websites that post patient feedback after surgeon encounters. Survey instruments such as Hospital Consumer Assessment of Healthcare Providers and Systems request patient feedback on multiple aspects of hospitalizations and physician-patient interactions and will soon be tied to pay as part of health reform. This debate will focus on the role of patient rankings in improving care and whether existing methods for obtaining patient feedback (online, surveys, and so on) should be tied to surgeon payment.

This session will be followed by audience questions and interaction. For additional information, e-mail RAS@facs.org.

Refer to the registration section of the ACS website at www.facs.org/clincon2013/registration.

**MONDAY, OCTOBER 7**

**Surgery Resident Program**

**Starting Surgical Practice:**

**Essentials for Success**

**10:00 am–4:15 pm**

The Division of Education invites surgery residents from all postgraduate year levels to participate in a special program designed to assist them with essential nonclinical issues they face during residency training and the transition to their posttraining career. Topics will include job hunting tips, managing professional liability risk, negotiating a first contract, attaining a successful work/life balance, and more. Additionally, an interactive session will be offered during which residents may explore different types of practice settings. Speakers will include not only leaders from surgery, but also a certified financial planner, an attorney with extensive professional liability experience, and an expert in physician career development.

For additional information, contact Ms. Cherylnn Sherman at 312-202-5424 or csherman@facs.org or go to www.facs.org/education/essentials6ills.html. Register online for this special program at www.facs.org/clincon2013/registration.

**Medical Student Program**

**Day II: 12:30–5:45 pm**

For a full description of this program, refer to the Sunday schedule. Note that programming is varied from day to day, and students are welcome to attend all or selected portions of this three-day program.

For regularly updated information about the Medical Student Program and the Medical Student Program Poster Session, visit www.facs.org/clincon2013/special/medicalstudent.html.

**PS127 4:15–5:45 pm**

**TRACK: CEN**

**Symposium on the Legacy of Frank H. Netter, MD**

**MODERATOR:** Basil A. Pruitt, Jr., MD, FACS, San Antonio, TX

Francine Mary Netter, the daughter of Dr. Frank Netter and author of *Medicine’s Michelangelo, The Life and Art of Frank H. Netter, MD* (Quinnipiac University Press, Sept. 2013), will provide a personal introduction to the man and his career. William C. DeVries, MD, FACS, cardiothoracic surgeon known for implanting the first total artificial heart, and Basil A. Pruitt, Jr., MD, FACS, critical care surgeon revered for his care of the burn patient, will reflect on their experiences working with Dr. Netter.

**SPONSORED BY THE PROGRAM COMMITTEE**

*CME designated for 1.5 hours

**Cardiothoracic Surgery in the Future: Technology Overview for Residents and Medical Students**

**3:30–9:00 pm**

**Fee:** $25 (includes dinner)

**COURSE DIRECTORS:**

Thomas E. MacGillivray, MD, FACS, Boston, MA

James I. Fann, MD, FACS, Stanford, CA

This course will introduce surgery residents and medical students to conventional and complex procedure that cardiothoracic surgeons perform today and provide information about upcoming new technologies and the six-year integrated cardiothoracic surgery training program. The primary focus of the session will be hands-on experience with specific cardiothoracic surgical procedures. Participants will experience and have the opportunity to perform these surgical procedures using synthetic and tissue-based simulation models. The program will be taught by cardiothoracic surgeons who are leaders in their respective fields of cardiac and general thoracic surgery. (A buffet dinner will be available at 5:30 pm.)

**SPONSORED BY THE AMERICAN COLLEGE OF SURGEONS AND THE SOCIETY OF THORACIC SURGEONS**

Refer to the registration section of the ACS website at www.facs.org/clincon2013/registration.
TUESDAY, OCTOBER 8

Town Hall Meetings
7:00–7:45 am

TH01 Who Will Be Available to Take General Surgery Calls in 2015?
TRACK: GEN
SPONSORED BY: THE ADVISORY COUNCIL FOR GENERAL SURGERY

TH02 What Are the Current Issues in Board Certification and MOC?
TRACK: URO
SPONSORED BY: THE ADVISORY COUNCIL FOR UROLOGY

TH03 Surgeons as Health Policy Advocates
TRACK: HP
SPONSORED BY: THE ADVISORY COUNCIL FOR OPHTHALMIC SURGERY

Posters of Exceptional Merit
Presentation
11:30 am–12:30 pm

All attendees are invited to join in a lunchtime tour and discussion of the Posters of Exceptional Merit facilitated by Program Committee Chair, Valerie W. Rusch, MD, FACS. More than 300 posters will be on display at the Clinical Congress, but only a select few are designated Posters of Exceptional Merit. Come hear the authors of these distinguished works present their innovative research and answer questions prior to the judges awarding one poster the title of Best Scientific Poster.

Medical Student Program
Day III: 1:00–5:45 pm

For a full description of this program, refer to the Sunday schedule. Note that programming is varied from day to day, and students are welcome to attend all or selected portions of this three-day program.

For regularly updated information about the Medical Student Program and the Medical Student Program Poster Session, visit facs.org/clincon2013/special/medicalstudent.html.

Chapter Best Practices
2:30–4:00 pm

Back by popular demand, this year’s best practices session will include a segment on how to develop an effective chapter meeting/event. A second segment will offer advice on how best to use the Chapter Checklist in order to build excellence. For chapters large and small! New to the session this year is a Town Hall Meeting that will allow attendees to learn about issues that affect chapters. Come prepared to participate!

The following will be presented:
- Running an Effective Chapter Meeting
- Utilizing the Chapter Checklist As a Tool to Achieve Success!
- Chapter Services Town Hall
For more information contact Donna Tieberg at dtieberg@facs.org or 312-202-5361.

2013 Excellence in Research Awards Distribution/Surgical Forum Dedication
Orthopaedic Surgery
2:30–4:00 pm

Prior to the scientific presentations, the Committee for the Forum on Fundamental Surgical Problems will distribute 15 awards for excellence in research, and the 64th volume of the Owen H. Wangensteen Surgical Forum will be dedicated to Kirby I. Bland, MD, FACS, Birmingham, AL. Introduction will be made by Mary T. Hawn, MD, FACS, Birmingham, AL, with following remarks from Dr. Bland. Surgical residents and their mentors are encouraged to attend the awards distribution/dedication.

Rural Surgeons Open Forum and Oweida Scholarship Presentation
4:15–5:45 pm

The session opens with the introduction of the 2013 Nizar N. Oweida Scholarship recipient, Amy E. Tan, MD, FACS, a general surgeon practicing in Blue Hill, ME.

The Advisory Council for Rural Surgery (ACRS) sponsors this open forum to enable direct communication between rural surgeons and the ACRS. Following an introduction of the Advisory Council, brief presentations will highlight several initiatives the ACRS is currently addressing.

This open forum is for all surgeons who believe that rural general surgeons are valuable to both the College and health care in America.

WEDNESDAY, OCTOBER 9

Town Hall Meetings
7:00–7:45 am

TH04 Robotic Surgery for General Surgeons
TRACK: INFO
SPONSORED BY: THE ADVISORY COUNCIL FOR GENERAL SURGERY

TH05 Rural Surgery: What Are the Challenges?
TRACK: HP
SPONSORED BY: THE ADVISORY COUNCIL FOR RURAL SURGERY

TH06 Medical Liability Reform 2013: Thinking Outside of the Box to Achieve Tort Reform
TRACK: HP
SPONSORED BY: THE ADVISORY COUNCIL FOR OTOLARYNGOLOGY–HEAD AND NECK SURGERY

PS331 Lessons Learned from the Boston Marathon Bombing
8:00 – 9:30 am

This session will discuss the April 15, 2013, Boston Marathon bombing as an example of a civilian mass-casualty event. The exercises leading up to the event and the Committee on Trauma’s certification of five adult Level 1 trauma centers in Boston helped save the life of every victim who made it to the hospitals. Lessons learned from this experience will be shared.

TH07 ACS-CRP Defining Cancer Surgical Guidelines and Reporting
TRACK: EDU, RES/MED
SPONSORED BY: THE ACS-CRP EDUCATION COMMITTEE

TH08 Choosing a Surgical Discipline
TRACK: EDU

SPONSORED BY: THE COMMITTEE FOR THE FORUM ON FUNDAMENTAL SURGICAL PROBLEMS

TH09 Ethics in Advertising: What Is the Surgeon’s Responsibility?
TRACK: ETH

SPONSORED BY: THE COMMITTEE ON ETHICS
AIR TRANSPORTATION
The ACS has arranged special meeting discounts on United Airlines. These special discounts are available by booking with United directly, through a travel agent, or online.

United Airlines
800-426-1122
7:00 am–9:00 pm CST; Monday–Friday
8:00 am–6:00 pm CST; Saturday–Sunday

ACS Z Code: ZNEQ
Agreement Code: 725614

Purchase your ticket online at united.com and receive a discount off the lowest applicable fares. When booking online, please enter ZNEQ725614 to receive your discount.

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

CAR RENTAL
Avis is designated as the official car rental company for the 2013 Clinical Congress. Special meeting rates and discounts are available on a wide selection of GM and other fine cars. To receive these special rates, be sure to mention your Avis Worldwide Discount (AWD) number when you call.

Avis Reservations
800-331-1600
avis.com
AWD Number: B169699

CHILD POLICY
The ACS policy regarding children is as follows:
- Under 12—not permitted on Social Program tours
- Under 16—not permitted on exhibit floor or in scientific sessions
- 16 and over—must have a badge to enter exhibit area or meeting rooms
- This policy includes infants in strollers or arms.

CAMP ACS
The American College of Surgeons is once again partnering with ACCENT on Children’s Arrangements, Inc. to provide an exciting on-site children’s program in Washington, DC. ACCENT has prepared a program with activities such as arts and crafts and active games designed to entertain your children while you are attending meetings and sessions. The camp, which is offered to all children ages six months through 17 years, will be located at the Renaissance Washington, DC, hotel located one block from the Washington Convention Center. For more information on Camp ACS, please visit our website at www.facs.org/clincon2013/social/campacs.html.

VISA INFORMATION
International Fellows, guest physicians, and meeting attendees: The process of obtaining a visa to attend meetings in the U.S. takes much longer. You are strongly urged to apply for a visa as early as possible, preferably at least 60 days before the start of the meeting. For detailed information regarding obtaining a visa, visit http://travel.state.gov/visa/ temp/types/types_1262.html. For information regarding the Visa Waiver Program (VWP), visit http://travel.state.gov/visa/ temp/without/without_1990.html.

You may request a letter from the College welcoming you to the meeting when you register online. You may also obtain a letter from the College welcoming you to the meeting when you go to www.facs.org/clincon2013/attendees/visa.html.

SHUTTLE BUS SERVICE
Complimentary shuttle bus service will be provided for all registrants at regular intervals between the Walter E. Washington Convention Center and most designated ACS Clinical Congress hotels. For a list of hotels on the shuttle route, refer to the Housing Information. Schedules and routes will be available at the Convention Center and participating hotels.

LOST AND FOUND
Lost-and-found areas will be located in the ACS Convention Office at the Marriott Wardman Park and in the Convention and Exhibit Office at the Walter E. Washington Convention Center. Persons looking for or finding lost items should contact one of these offices.

HELP AND INFORMATION CENTER
Portable Help and Information kiosks will be located throughout the Walter E. Washington Convention Center and will be available during registration hours. Assistance with general information, travel, housing, and local information will be available.

NURSING MOTHERS’ ROOM
A nursing mothers’ room will be located in the Hall A Show office available during the meeting.

AFFILIATE GROUP FUNCTIONS
Groups planning a social function or business meeting to be held in conjunction with the Clinical Congress are required to obtain approval, and if events are to be held at one of the participating venues/hotels need to secure event space through the ACS. For more information and to request function space, visit http://web2.facs.org/meetings/events for the online request form or contact Marisa Villalba, Senior Meeting Planner, ACS Convention and Meetings, at mvillalba@facs.org. Space assignments are made on a first-come, first-processed basis.

PRAYER ROOM
A prayer room located in the Hall B Show Office will be available during the meeting and open during registration hours.
Registration is open to all physicians and individuals in the health care field and includes a name badge, Program Book, and entrance to the exhibits and all sessions,* other than Postgraduate Courses and Meet-the-Expert Luncheons. To review the full registration policies and submit your 2013 Clinical Congress registration, visit our website at www.facs.org/clincon2013/registration.

* The following sessions are included with your Clinical Congress registration and are not ticketed. Registering for these sessions does not guarantee seating at the course. Seating is provided on a first-come, first-served basis until the meeting room is full.

- Named Lectures
- Panel Sessions
- Surgical Forum
- Scientific Poster Presentations
- Scientific Papers
- Town Hall Meetings
- Video-Based Sessions

REGISTRATION AND MEMBERSHIP QUESTIONS

Should you have any questions regarding Clinical Congress registration, contact Registration Services.

Phone registrations are not accepted.

E-mail: registration@facs.org | Phone: 312-202-5244 | Fax: 312-202-5003

Should you have any questions regarding your ACS membership prior to registering for the Clinical Congress, please contact Member Services at the appropriate number below.

Fellow Dues and Status: 877-277-0036
Associate Fellow, Resident, Medical Student, and Affiliate Members: 800-293-4029

For information on becoming a member of the College and to download an application, please visit www.facs.org/memberservices/documents.html. You may also contact Cynthia Hicks, Credentials Section, Division of Member Services, at 800-293-9623 or at chicks@facs.org.

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Commercial representatives may obtain the commercial registration form by e-mailing a request to registration@facs.org.

*The Marriott Wardman Park registration location will handle advance registration only. If you require onsite registration, ticket changes or purchases, visit on-site registration at the Walter E. Washington Convention Center during the times listed above.

~Retired Fellows fall under the ACS Fellow registration category for the Clinical Congress. Applicable registration fees apply.

*Nomembers who pay the applicable registration fees will have their membership application fees waived if they apply for membership by December 31, 2013. The American College of Surgeons is pleased to offer discounted registration fees for residents and medical students. Submit a letter verifying your educational status with the completed registration form to expedite processing. Residents should obtain a letter from their program director; students should contact their department chairs.

†Residents and Medical Student Membership

The College has membership opportunities for medical students and residents. Medical students must be attending a U.S., Canadian, or international allopathic or osteopathic medical school. There is a one-time fee of $20, which covers all four years of medical school. Membership will expire upon graduation from medical school.

Residents enrolled in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME) or surgeons in surgical research or fellowship programs acceptable to the American College of Surgeons are eligible for Resident Membership. The application fee of $20 is waived for first-year residents. Annual dues thereafter are also $20. Nonmember medical students and residents that register for this meeting and meet the appropriate membership category requirements will be contacted to affirm their membership status.
**GUEST REGISTRATION**

Guests may register for the Clinical Congress by paying the applicable registration fee. All Guest registrants must be accompanied by a Scientific Program registrant of another category. Guest registration is meant for nonmedical attendees only. Guests are not eligible for CME credits or Certificate of Attendance, nor may they attend Postgraduate Courses or Meet-the-Expert Luncheons.

The guest registration fee entitles you to attend scientific sessions, view the technical and scientific exhibits, purchase tour tickets, and use the shuttle bus service.

**TOURS AND EVENTS**

Important Note: All tours will depart from and return to the Renaissance Washington, DC. Please meet in the lobby of the hotel unless otherwise indicated. We recommend that you arrive at least 15 minutes prior to the scheduled tour time and wear comfortable walking shoes for all tours. Unless otherwise indicated, all lunches and dinners referred to are included in the price of the tour. Tours will be held rain or shine, unless otherwise notified. Children under 12 years of age are not permitted on tours. All children ages 12 and older must be accompanied by an adult.

Visit our website at [www.facs.org/clincon2013/](http://www.facs.org/clincon2013/) for a complete description of all Tours and Events.

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### Sunday, October 6

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<tr>
<th>DAY</th>
<th>ST01</th>
<th>12:00 noon–4:00 pm</th>
<th>The Secret Garden</th>
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<tr>
<td></td>
<td>ST02</td>
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<td>Welcome to Washington: Washington Highlights Tour</td>
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<td></td>
<td>ST03</td>
<td>10:00 am–2:00 pm</td>
<td>Arlington National Cemetery</td>
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<td></td>
<td>ST04</td>
<td>10:00 am–3:00 pm</td>
<td>Magic of Mount Vernon (lunch on own)</td>
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<td></td>
<td>ST05</td>
<td>10:00 am–3:00 pm</td>
<td>Smithsonian Exploration with Boxed Lunch</td>
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<td></td>
<td>ST06</td>
<td>11:00 am–3:00 pm</td>
<td>Behind-The-Scenes Tour at the Newseum (lunch on own)</td>
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<td></td>
<td>ST07</td>
<td>1:00–5:00 pm</td>
<td>Georgetown and Shopping</td>
<td>$40</td>
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<tr>
<td></td>
<td>ST08</td>
<td>2:00–3:30 pm</td>
<td>Estate Planning &amp; Tax Issues for Surgeons and Their Spouses</td>
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<td></td>
<td>ST09</td>
<td>6:00–10:00 pm</td>
<td>Exclusive After Hours Tour at Mount Vernon and Dinner</td>
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<td></td>
<td>ST10</td>
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### Monday, October 7

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<th>DAY</th>
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<th>Step Back in Time: Historic Alexandria with Lunch at Gadsby’s Tavern</th>
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<td>Capital Collection Tour</td>
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<td>Women in Washington with Boxed Lunch</td>
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<td></td>
<td>ST16</td>
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<td>Welcome to Washington: Washington Highlights Tour</td>
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### Wednesday, October 9

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<td>Lincoln Assassination Tour</td>
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<td></td>
<td>ST21</td>
<td>10:00 am–1:00 pm</td>
<td>Art on the Avenue</td>
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</table>
Support the ACS by booking your room through Travel Planners at one of the official Clinical Congress hotels!

To obtain the necessary amount of meeting and exhibit space at the convention center and the hotels, the ACS must commit to a minimum number of guest rooms. If that commitment is not met, the ACS will incur significant financial penalties and have difficulty obtaining sufficient meeting space in the future. This situation can have a major impact on the programs that the ACS is able to offer. You can help the ACS avoid penalties by booking your reservation through the official housing company.

**SUITE RAFFLE**
To thank you for booking your reservation through Travel Planners in the official housing block, you will be entered in a raffle to win an upgrade to a one-bedroom suite for your entire hotel stay, valid for reservations booked for October 6–10, 2013. Your reservation must be made by September 10, 2013, in order to qualify for the raffle. The winner will be notified via e-mail on September 11, 2013.

**APPLYING FOR HOTEL ACCOMMODATIONS**
The following housing procedures apply to all general registrants of the Clinical Congress. If you are a Regent, Officer, Past-Officer, Advisory Council Chair, Governor, Recipient of the Distinguished Service Award, Special Invited Guest, or Standing Committee Chair and are applying for the Marriott Wardman Park, please use the special housing application sent to you.

**HOUSING PROCEDURES**
The ACS has appointed Travel Planners to coordinate housing for the 2013 Annual Clinical Congress. Reservation requests will be processed on a first-come, first-served basis and must be received by September 10, 2013. Requests received after this deadline or after the room blocks are filled are subject to space and rate availability. Housing requests can be made using ONE of the following options:

**GO ONLINE** to [fas.org/clincon2013/hotel](http://fas.org/clincon2013/hotel) to submit your Clinical Congress hotel reservation. A credit card is needed to guarantee your reservation at the time of booking. The online reservation service is available 24 hours a day, seven days a week!

**CALL** Travel Planners at 888-810-4455 or 212-532-1660 (international attendees) between the hours of 9:00 am and 7:00 pm ET, Monday through Friday. A credit card is needed to guarantee your reservation at time of booking.

**FAX** your completed Clinical Congress Hotel Reservation Form (which can be found on the website at [fas.org/clincon2013/hotel](http://fas.org/clincon2013/hotel)) to 212-532-1556. A credit card is needed to guarantee your reservation.

**MAIL** your completed Hotel Reservation Form (which can be found on the website at [fas.org/clincon2013/hotel](http://fas.org/clincon2013/hotel)) with credit card guarantee to: Travel Planners/ACS Housing Bureau 381 Park Ave. South, 3rd Floor, New York, NY 10016

Note: If you would like a housing form mailed to you, contact Beth Faubel at 312-202-5033 or bfaubel@facs.org.

Reservations received after the housing deadline of September 10, 2013, or after the room blocks are filled are subject to space and rate availability. Please do not send your request directly to the ACS office; doing so will only delay the processing of your request. If you do not receive acknowledgement within 72 hours, contact Travel Planners via e-mail at acs@tphousing.com or at the numbers indicated. Verify your acknowledgment for accuracy. It is the only acknowledgment you will receive.

**DEPOSIT POLICIES**
Reservations made via the Web, telephone, fax, or mail will require a credit card (American Express, VISA, or MasterCard) for guarantee purposes only. The credit card will guarantee your room for late arrival for the day of scheduled arrival only. Credit cards will not be charged at the time the reservation is made. Credit cards will only be charged directly by the hotel if your reservation is not cancelled at least 72 hours prior to arrival or in accordance with your hotel’s cancellation policy as noted on your reservation confirmation.

**CHANGES AND CANCELLATIONS**
Do not call or write the ACS office to change or cancel your reservation. Changes to and/or cancellation of your reservation should be made with the ACS/Travel Planners Housing Bureau until October 1, 2013, at 7:00 pm ET. Beginning October 2, 2013, you must contact the hotel directly to make any changes. Ask for a confirmation number when canceling or changing your reservation directly with the hotel.

Your credit card will not be charged unless you cancel your reservation less than 72 hours in advance of arrival date or in accordance with your hotel’s cancellation policy as noted on your reservation confirmation.
Bundled payment

In April, the American College of Surgeons (ACS) released *Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches*—a resource for members of the College. Developed by contributors from the ACS General Surgery Coding and Reimbursement Committee (GSCRC), the purpose of the primer is to inform Fellows about the concept of bundled payment and the effect this approach to reimbursement could have on surgical patients. Unlike the traditional fee-for-service model, under a bundled payment approach to surgery the surgeon, other physicians, the hospital, and possibly other health care providers and facilities share one fee for a surgical procedure or for treating a medical condition.

This column describes topics addressed in the primer, namely, existing bundled payment programs, issues to consider when developing a bundle or when determining whether to participate in a bundled payment program, and the GSCRC Surgical Bundled Care Project.

### Which bundled payment programs are addressed in the primer?

The primer addresses three congressionally mandated initiatives: the Acute Care Episode Demonstration, the Medicare Bundled Payments for Care Improvement Initiative, and the National Pilot Program on Payment Bundling. The primer also describes two leading private-sector bundled payment programs: Geisinger Health Plan’s ProvenCare program and the BlueCross BlueShield of Massachusetts Alternative Quality Contract. Also analyzed in the primer is the unique case of transplant surgery, where bundled payment has been the industry standard for more than 20 years.

### Does the primer provide guidance on issues to consider when developing a bundle or when determining whether to participate in a bundled payment program?

Yes. The primer addresses various topics to consider in the development of a bundle or when deciding whether to participate in a bundled payment program, including whether to center the bundle on a condition or a procedure, how to select the condition or procedure to bundle, costs included in the bundle, timeframe covered, data needed to create the bundle, incorporation of quality measures, and administration.

The primer also considers concepts of attribution, gain-sharing, and risk adjustment as they relate to bundled payment. In addition, the primer highlights key differences between bundled payment and the accountable care organizations approach. Although both forms of payment seek to facilitate coordinated, integrated, and efficient care, differences exist in the focus, operation, and distribution of payment in both models.

### What is the GSCRC Surgical Bundled Care Project?

An addendum to the primer provides a detailed description of the GSCRC Surgical Bundled Care Project, which was formed to develop a process for creating clinically coherent bundled payment models and analyzing the potential opportunities and barriers for surgery. The GSCRC workgroup involved with the project developed criteria for selecting surgical procedures for bundled payment, contemplated various timeframes for bundles, requested and used Medicare data sets, and developed a methodology for analyzing the data. The addendum explains this entire process and the findings related to the two condition-specific procedure bundles that the GSCRC chose to examine: colon resection for cancer and mastectomy for cancer.

*Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches* may be accessed on the ACS members-only website using your ACS-issued username and password at this link: [http://efacs.org/portal/page/portal/ACS_Content/Advocacy](http://efacs.org/portal/page/portal/ACS_Content/Advocacy).
Rural surgical practice requires new training model, offers great opportunities

by David C. Borgstrom, MD, FACS

Surgical care for rural America is at a crossroads. The average age of a rural general surgeon is 55 and increasing. The rural population is growing and aging as well. More than 50 million Americans live in rural America, hours from major metropolitan medical centers.*† These people want and deserve optimal care in their communities.

Fiscal uncertainty is everywhere, including in rural America. Financial viability is razor-thin for many health care systems. It is a well-recognized fact that surgical services are critical to the financial viability of rural hospitals and quite often to the communities they serve because the hospital and schools are typically the largest employers in these towns. They provide stable, high-paying jobs for an educated workforce.

The good news is there is an increasing interest among medical students in developing the skill set necessary for providing surgical care in rural America. These students are tech-savvy, have clarity of long-term vision, and are interested in diverse training opportunities. Further, an increasing number of opportunities for that training are now available.

The American College of Surgeons’ (ACS) Advisory Council for Rural Surgery (ACRS) is developing a repository of opportunities for training to optimize the skill set of a surgeon to competently and safely enter practice in rural America. Practicing surgery in a rural setting requires a more diverse skill set than is needed to practice in urban areas because small communities are often unable to support surgical specialists, such as otolaryngologists, plastic surgeons, urologists, or even obstetrician-gynecologists (OB-GYNs). Rural surgeons need to be capable of providing emergency care for specialty surgical problems as well as for general surgery conditions. Fortunately, several types of educational opportunities are available for residents to develop these added skills. Although this column by no means provides a comprehensive list of all available programs, it does help to begin a conversation about different program types that are available.

Rural surgery rotation
One rural training model is a rural surgery rotation. Many general surgery programs offer residents the opportunity to do a rural surgery rotation, either as an elective or as a required component of training. Residents spend anywhere from one to three months away from the primary urban teaching center in a community setting where they get concentrated focus on general surgical experience and on a variety of subspecialty cases as well. In many of these settings, endoscopy experience is emphasized. These opportunities are available at East Carolina University, Greenville, NC; East Tennessee University, Johnson City; University of Nebraska, Lincoln; University of Tennessee at Knoxville; and University of Tennessee at Chattanooga, as well as other programs.

Dedicated track
Another model of training is a dedicated rural surgery track. One example of this model is a program available at the University of North Dakota, Grand Forks. This program includes

The ACS Advisory Council for Rural Surgery is developing a repository of opportunities for training to optimize the skill set of a surgeon to competently and safely enter practice in rural America.

Immersion approach
Another model for rural training is an immersion approach. At Oregon Health Sciences University, Portland, and the University of Utah, Salt Lake City, residents have the opportunity to spend an entire year in a rural community in lieu of the usual year of research in the middle of residency. The residents spend the year immersed in the community, where they work alongside surgical subspecialists, have their own morbidity and mortality conferences and journal clubs, and participate in local educational opportunities and county medical societies. Typically, these residents have a high volume of operative experience, including endoscopy.

Several programs in the U.S. have a more broadly defined general surgical experience intrinsic to their general surgery residency. Gundersen Lutheran Medical Center in La Crosse, WI, and Bassett Medical Center in Cooperstown, NY, are programs in smaller communities that have no competing fellowships or subspecialty residents. The lack of competing learners allows for a much broader collaborative experience with subspecialty faculty throughout the entirety of the surgical training program. Dedicated rural electives are available in both, as well as subspecialty-specific rotations. These programs provide great opportunity for collaboration in subspecialty operative and perioperative care opportunities throughout the entirety of the five-year residency program.

Fellowships
Fellowship opportunities are also available, such as the program at The Mithoefer Center for Rural Surgery in Cooperstown, which has pioneered a flexible fellowship experience that allows a surgeon in practice or at the completion of his or her residency to spend additional time in a focused experience—for example, endoscopy—to better develop the skill set necessary to go into practice in rural America. These programs have typically been collaborative efforts with the ultimate site chosen as a stepping stone to develop the specific skills needed to succeed in the new location.

The ACS has recently developed a Transition to Practice Program in General Surgery. This program is intended for residents finishing their general surgery training who would like additional experience in practice development, subspecialty exposure, and rural surgical care. To date, the ACS Transition to Practice Program in General Surgery is offered at the following institutions: Eastern Virginia Medical School, Norfolk; Gundersen Lutheran Health System; Mercer University School of Medicine, Macon, GA; Ohio State University, Columbus; University of Louisville, KY; and the University of Tennessee at Chattanooga.

The interest level in providing opportunities for young surgeons to undergo the training necessary to provide optimal care to surgical patients in rural America is on the rise. At the same time, medical students, residents, and surgeons in-practice are often looking for a change in practice type. Exciting opportunities to introduce young surgeons to the joys of rural surgery are emerging all over the country, and rural general surgeons are in great demand.

The ACRS and ACS as a whole are committed to promoting and enhancing these opportunities. The advisory council recognizes that the list of programs that will provide appropriate training in this field is far from comprehensive and is making further efforts to develop a more detailed list of programs offering this educational opportunity. Directors of programs not mentioned in this article who would like to submit information to the ACRS about their training models should send details to Karen Deveney at deveneyk@ohsu.edu.
Retired surgeon satisfies desire to serve patients through primary care

by George W. Hartzell, Jr., MD, FACS

When are you going to retire? What will you do after you retire?
Surgeons typically start getting these questions around the time of their 60th birthday. Because I felt that I had only become really good at my work in my 50s, I did not feel rushed to end the experience. My response was usually a shrug and an, “I haven’t given it much thought.”

As I approached the age of 65, however, it became apparent that I should give the matter some consideration. I was working with a group of three other general surgeons in a community hospital that was affiliated with a medical school, and the combination of teaching and patient care led to a very satisfying career.

I was continuing to work a full schedule. Getting up at 3:00 am, even though it was only every fourth night, was losing its charm, and I found that my feet hurt after a long day in the operating room. I could not help noticing that it was taking me five minutes longer to do a routine hernia repair—not much of a change, but it caused me to wonder how long it would be before my performance would come under the scrutiny of those in power.

A substitute position
When I reached the age of 66, I decided that I should retire and pursue an entirely different line of work. I enrolled in the Pennsylvania Guest Teacher program and worked as an elementary school (kindergarten through fifth grade) substitute teacher for the next eight years. At first, I was called three or four days a week and found the challenge enjoyable most of the time.

In 2008, because of the economic crunch, a large number of certified teachers returned to the workforce, and I was called only once or twice a week. Being a clinical associate professor of surgery does not count as certification for teaching elementary school. As I sat around the house, reading the classics, playing the piano, and trying not to annoy my wife, I realized that I missed the physician-patient relationship, and that maybe I could return to a less physically demanding type of practice.

Career path
As a medical student at the University of Pennsylvania, PA, I wanted to be a family physician, but the surgeons lured me away.

I.S. Ravdin, MD, FACS, was fond of telling his students that a surgeon is “an internist and something more,” and during my rotating internship I found the intelligence and commitment of the surgical residents impressive. Thus inspired, in the 1960s, I endured the physical and emotional trauma of a surgical residency in an academic institution, namely the University of Pennsylvania, where Jonathan E. Rhoads, MD, FACS, was Chairman. I anticipated that, when I emerged, I would be able to provide a special type of care to my patients.

Following residency, I joined two excellent general surgeons in Pottstown, PA, performing general surgery of the old-fashioned kind. No subspecialists practiced in this town, so the surgeons in my practice performed thoracic, vascular, and pediatric cases and also took care of all but the most complicated fractures. Practicing in this location was exciting, but it offered no academic opportunities or conferences, except for the occasional mortality and morbidity meeting. My only form of “education” at this time was the frantic reading before performing an internal fixation of a fracture, and of
As I sat around the house, reading the classics, playing the piano, and trying not to annoy my wife, I realized that I missed the physician-patient relationship, and that maybe I could return to a less physically demanding type of practice.

course on-the-job training with my excellent associates.

After two years, it was time for a change, and I accepted an offer in Allentown, PA, where I would be doing a more limited scope of surgery and could participate in a teaching program that had been around since 1934. I joined a busy private practice, and the change worked well for me. Medical school affiliations provided opportunities for teaching, and working with residents was a great source of satisfaction. This combination of teaching, learning, training, and patient care was ideal for me, and it was a way of life for 35 years.

When I retired, I converted my active Pennsylvania license to the “retired active” category, which requires the licensee to pay the same biennial fee as surgeons in active practice, but without the requirements for liability insurance or continuing medical education (CME) credits. With this license, I could prescribe medicine for myself and for my wife but could no longer provide services to other patients. To convert back to an active license, I would obtain liability insurance, do CME, and pay a $5 fee.

Re-education
When I decided to return to medicine, however, the fact that I had been out of action for eight years was a problem, which was not made easier by the fact that I wanted to do primary care. I would need the help of a program provided by the Pennsylvania Medical Society to re-qualify. First, I needed a cognitive screen with a psychologist, which required an hour of testing to see if I had any cognitive impairment. After I passed this test, I was required to take a course in family medicine. I completed this assignment with a 60-hour review course available on DVDs provided by Temple University, Philadelphia, PA, with a pretest and a posttest. Upon completion of these studies, I was required to take the National Board of Medical Examiners Module in Family Medicine, a two-hour test comprising 100 multiple-choice questions and given in a closed room with an outside monitor, to whom I had to surrender my iPhone.

After several weeks, I was informed that I had passed and was instructed to proceed with a four- to six-week preceptorship with a family practice group. An excellent group of family physicians, who, incidentally, had been some of my referring physicians, helped me out here, teaching me quite a bit, and I was finally ready for the last step, which was to spend a day with a teacher in the family practice residency. My evaluation was satisfactory, and I was deemed safe to get my active license back and go to work.

I had started this process in June, and it was the second week in December when I started waiting for the final ruling from the Pennsylvania State Board of Medicine. Fortunately, I was approved, and my new certificate arrived in the mail. The story does not end here. I needed a job, and I needed to be certified by the health insurance companies so that payment could be rendered for my services.

Reborn as primary care physician
A local internal medicine group offered me a part-time job to replace a retiring partner, and the process of getting insurance company approval began. I had to rejoin the active hospital staff, which meant making and submitting copies of all the certificates that had previously hung on my office walls, including evidence that I was board certified. Because I was certified in surgery, I came on staff as a nonoperating member of the department of surgery with special permission to do primary care.

Several more weeks went by before all the necessary approvals came through, and I was finally ready to start work on March 3, 2010. In all, it had taken 10 months...
Primary care physicians are expected to know everything about everything, and I still have a lot to learn.

to complete the process of getting back into the fold.

I am now working three days a week in a group with two other physicians and a physician’s assistant, doing adult internal medicine as a primary care physician. Because I am seeing only 10 to 12 patients a day, I have time to listen to them, and I have time to work with electronic health records, which takes about 10 extra minutes per visit.

Primary care physicians are expected to know everything about everything, and I still have a lot to learn. I find myself relying on reference sources, with my smartphone always at the ready with the appropriate applications. I explain to patients that, as a surgeon, I was familiar with about 14 drugs, and I am now expected to be knowledgeable in the use of 1,400. Patients actually seem to appreciate that I am looking up information, and I do not believe that I lose face by using an external source of wisdom in their presence.

Professional satisfaction

Two-and-one-half years into this new career, I am happy with my choice to be reborn in another form. I am now 78 years old but feel much younger, probably because of the reactivation of neurons related to medicine that had been in a resting state for eight years. I hope to continue in this mode for another three or four years.

Is internal medicine as satisfying as general surgery? It is satisfying but in a different way. Relationships with patients are longer, and results are determined by many factors that are often out of my control. Genetic factors are out of my hands, and it can be difficult to get patients to cooperate in matters of weight loss, diet, smoking, alcohol, prescription medication use, and other lifestyle choices.

I feel that my original choice of general surgery was a good one for me, providing gratification of a kind that is inaccessible to me as a primary care physician. Based on my experience, I would continue to encourage any undecided young physician to take the path that leads to general surgery.

Advice for the retiring general surgeon

What advice would I give to a general surgeon who is about to retire? I would tell him or her that a license to practice medicine is more than a piece of paper, and the decision to let it lapse is an important one. In the words of Joni Mitchell, “You don’t know what you’ve got ’til it’s gone.” It is a good idea to find some way, through part-time work, volunteering, or teaching, to maintain active licensure until such time as ill health or old age dictate the end of the line.

Most of my difficulty in being restored to medical usefulness was caused by my eight years of pursuing activities that were not related to medicine. A surgeon who wants to move into primary care will need some re-education, but it is unlikely that it will be necessary to go through the 10-month exercise that I underwent. Anyone with the appropriate desire should be able to accomplish the new goal. ♦
Quality of health care in the U.S. has come under increased scrutiny, given its rising costs—now accounting for nearly 20 percent of the gross domestic product—and passage of the Affordable Care Act, which expands access to care for a greater number of Americans.1,2 However, assessing the quality of surgical care remains difficult and largely unstandardized.

The American College of Surgeons (ACS) has had a longstanding goal of improving care of the surgical patient and has helped promulgate a validated, outcomes-based program to measure quality via the ACS National Surgical Quality Improvement Program (ACS NSQIP®). The data disseminated through ACS NSQIP allow hospitals and other stakeholders to conduct risk-adjusted assessments of complication rates and surgical outcomes across a variety of surgical specialties.3

Beyond assessing complications after surgery, the ACS is in the process of developing surgical standards and checklists based on available evidence and results of clinical trials. For example, the results from the Clinical Outcomes of Surgical Therapy Study Group trial comparing laparoscopic and open colectomy for adenocarcinoma of the colon suggested that a lymph node count of 12 or higher could serve as a marker of surgical quality.4 Similarly, results from two American College of Surgeons Oncology Group trials (Z0010 and Z0011) have informed us regarding the need and type of node dissection required in women with breast cancer.5,6

**The critical role of lymphadenectomy**

Within urologic surgery, lymphadenectomy plays a critical role in a variety of malignancies, including cancer of the prostate, bladder, and testis. Although the primary benefit is in providing accurate staging information to inform prognosis and direct early adjuvant therapy, lymphadenectomy has a proven therapeutic benefit in men with testicular cancer both before and after systemic chemotherapy, as well as squamous cell carcinoma of the penis. An area of ongoing controversy is the role, benefit, and extent of lymph node dissection in patients with urothelial carcinoma of the bladder. Pelvic lymphadenectomy has been an integral component of radical cystectomy for invasive urothelial carcinoma of the bladder for decades. Up to 25 percent of patients with muscle-invasive disease who undergo an operation will harbor nodal metastases, which negatively impacts cancer-specific survival. Nevertheless, approximately one-third of patients with positive lymph nodes will be free of disease five years after the operation, suggesting that adequate removal of local and regional disease may have a positive therapeutic impact.

**Limitations**

The traditional limits of a standard pelvic lymph node dissection include removal of all tissue between the bladder and pelvic sidewall and along the external and internal iliac artery and vein, cranially to the bifurcation of the common iliac vessels and laterally to the genitofemoral nerve. The caudal limit is the crossing of the circumflex iliac vein over the external iliac artery and the node of Cloquet. The most common location of involved lymph nodes is in the obturator fossa or along the internal iliac artery; however, mapping studies have suggested that nodal metastases are frequently identified in the presacral and retroperitoneal regions. Thus, some surgeons have advocated for extended lymphadenectomy at the time of cystectomy to include tissue along and between the common iliac arteries, and even up the distal aorta and vena cava to the...
takeoff of the inferior mesenteric artery (see photo, this page).

Several reports suggest that removal of at least 10 lymph nodes represents a minimal quality standard, while other researchers have proposed that 12 to 18 nodes represents an adequate lymph node yield.7 It should be noted, however, that these data are based on retrospective studies, expert opinions, or analysis of large administrative datasets. The optimal lymphadenectomy technique more likely is defined by anatomic boundaries rather than lymph node number, which is dependent on factors such as method of pathologic examination and number of individual specimens submitted for analysis. Current evidence suggests significant variation in practice patterns of lymphadenectomy at the time of cystectomy with respect to boundaries and even whether or not any lymph nodes are removed.8

**NCI-supported clinical trial**

Given the uncertainty surrounding the benefit of more extended lymphadenectomy and the absence of adequate studies, the Southwest Oncology Group initiated a trial (NCT01224665) to determine whether extending the limits of lymphadenectomy at the time of radical cystectomy to include the common iliac and presacral nodes improves progression-free and overall survival; the Alliance for Clinical Trials in Oncology and the Eastern Cooperative Oncology Group both have endorsed the National Cancer Institute (NCI)-supported trial. The German Association of Urogenital Oncology recently completed a similar randomized trial of standard and extended node dissection for bladder cancer (NCT01215071).

Patients with T2-T4a urothelial carcinoma of the bladder undergoing radical cystectomy are eligible to participate in the trial, and they may have received neoadjuvant systemic chemotherapy. An important aspect of the trial is the standardization of surgery and rigorous credentialing of surgeons, as documented by operative and pathology reports and intraoperative images demonstrating appropriate lymphadenectomy. The trial is limited to patients undergoing open surgery and not laparoscopic or robotic-assisted cystectomy. All operations performed in conjunction with the study will undergo a central surgical review, assessing both arms of the study—standard versus extended lymph-node dissection.

The primary goal of the study is to evaluate disease-free survival in patients who undergo the procedure, with secondary objectives of comparing overall survival and perioperative variables, such as operative time, 90-day morbidity and mortality.
The primary goal of the study is to evaluate disease-free survival in patients who undergo the procedure, with secondary objectives of comparing overall survival and perioperative variables, such as operative time, 90-day morbidity and mortality, and length of hospitalization.

and length of hospitalization. Pathologic features, such as lymph node counts and lymph node density (number of positive lymph nodes/total number of lymph nodes examined), also are included in the analysis. Formalin-fixed, paraffin-embedded blocks of the primary tumor will be collected for correlative studies with planned analysis for biomarkers associated with metastasis and epithelial-mesenchymal transformation, and blood will be collected to assay for circulating tumor cells. The target accrual for the trial is 620 patients over five years.

Implications
This trial will test the ability of urologic surgeons to complete an important trial addressing surgical technique. The results will have clinical implications and will determine what type of lymph node dissection should be the standard of care going forward.

It is possible that the removal of additional lymph nodes may have only a small but beneficial therapeutic impact in patients with bladder cancer. It is important to note that neoadjuvant platinum-based combination chemotherapy for invasive bladder cancer yields a 5 percent absolute improvement in survival at five years; however, this significant difference was consistent in two large U.S. and European randomized trials and represents a current standard of care.9

REFERENCES
Medical device alarms pose safety issues for hospitals

The constant beeping of alarms and an overabundance of information transmitted by medical devices, such as ventilators, blood pressure monitors, and electrocardiogram machines, is creating “alarm fatigue,” which puts hospital patients at serious risk, according to a Sentinel Event Alert that The Joint Commission issued in April. Although medical device safety is part of life safety code activities in hospitals and ambulatory surgery centers, clinicians play a critical role in addressing alarm safety. Specifically, the issue of medical device alarms is of interest for surgeons because their patients’ outcomes are often dependent on postoperative care and safety, including proper monitoring of intravenous (IV) pumps and other devices that track vital signs.

**Alarming number of problems**
Information from a U.S. Food and Drug Administration (FDA) database shows that more than 560 patients died over the course of a four-year period due to alarm-related problems, and The Joint Commission’s Sentinel Event database includes reports of 80 alarm-related deaths and 13 serious alarm-related injuries during a similar period. (Because reporting requirements and programs vary, and may overlap, it can be challenging to determine a clear picture of the scope of the problem.)

Patient deaths related to monitoring device alarms have also been the focus of national media attention and special reports by the Association for the Advancement of Medical Instrumentation (AAMI) and ECRI Institute. The Joint Commission, the AAMI, ECRI Institute, and the American College of Clinical Engineering also brought together patient safety and health care experts at a 2011 summit to seek solutions to problems associated with medical device alarms.

Alarms are intended to alert caregivers of potential problems but may compromise patient safety if they are not properly managed. Many patient care areas have numerous alarms, and the barrage of warning noises can have a desensitizing effect on nurses, technicians, and other caregivers. As a result, these individuals may ignore alarms or even disable them.

Other related issues include too many medical devices with alarms or individual alarms that are difficult to hear. Preset or default settings also may cause problems because the device sounds a warning even when no caregiver action or decision is required. Rather than calling attention to a patient’s needs, these settings may distract caregivers.

**Confronting the issue**
Alarm fatigue issues vary greatly among hospitals and even within different units in a single hospital. Although there are many variables, the Alert makes it clear that in order to reduce risks related to alarms on medical devices, a series of actions still needs to occur related to people, processes, and technology.

“Alarm fatigue and management of alarms are important safety issues that we must confront,” says Ana McKee, MD, executive vice-president and chief medical officer, The Joint Commission. “The recommendations in this Alert offer hospitals a framework on which to assess their individual circumstances and develop a systematic, coordinated approach to alarms. By making alarm safety a priority, lives can be saved.”

The Joint Commission Alert recommends that health care organizations take the following actions, which correspond with recommendations made by both the AAMI and the ECRI Institute:

- Ensure that there is a process for safe alarm management and response in areas that the
Alarms are intended to alert caregivers of potential problems but may compromise patient safety if they are not properly managed.

organization has identified as high-risk.

• Prepare an inventory of alarm-equipped medical devices used in high-risk areas and for high-risk clinical conditions, and identify the default alarm settings and the limits appropriate for each care area.

• Establish guidelines for alarm settings on alarm-equipped medical devices used in high-risk areas and for high-risk clinical conditions; include identification of situations when alarm signals are not clinically necessary.

• Establish guidelines for tailoring alarm settings and limits for individual patients. The guidelines should address situations in which limits may be modified to minimize alarm signals and the extent to which alarms may be modified.

• Inspect, check, and maintain alarm-equipped medical devices to provide for accurate and appropriate alarm settings, proper operation, and detectability. Base the frequency of these activities on such criteria as the manufacturers’ recommendations, risk levels, and current experience.

The Joint Commission Alert also recommends that all clinical care team members receive training and education in safe alarm management and response in high-risk areas. In addition, health care institutions should consider methods for reducing nuisance alarm signals and for determining whether critical alarm signals can actually be heard in patient care areas. Based on input from patient care providers, health care engineers, risk managers, and information technology professionals, organizations should also establish policies and processes for alarm safety that include the regular review of trends and patterns that reveal improvement opportunities. Finally, the Alert urges organizations to share information about alarm-related incidents, prevention strategies, and lessons learned with organizations such as the AAMI, the ECRI, the FDA, and The Joint Commission.

Beyond issuing the Alert, The Joint Commission is considering the development of a National Patient Safety Goal to help health care facilities address this issue. A field review of the proposed goal composed of voluntary feedback from health care providers and other stakeholders occurred in February, and public comments are now under review. The Joint Commission already has numerous accreditation standards in place related to alarm safety. The standards address such issues as leadership, the environment of care, provision of care, and staff training and education.

The warning about medical device alarms is part of a series of Alerts that The Joint Commission has issued. Much of the information and guidance provided in these Alerts is drawn from The Joint Commission’s Sentinel Event database, one of the nation’s most comprehensive voluntary reporting systems for serious adverse events in health care. The database includes detailed information about both adverse events and their underlying causes. Previous Alerts have addressed risks associated with the use of opioids, health care worker fatigue, diagnostic imaging risks, violence in health care facilities, maternal deaths, health care technology, anticoagulants, wrong-site surgery, medication mix-ups, health care-associated infections, and patient suicides, among other topics.

The complete list and text of past issues of the Sentinel Event Alert can be found on The Joint Commission website, www.jointcommission.org. A podcast featuring a Joint Commission standards expert discussing medical alarm devices is also available on The Joint Commission website.
As the crow flies

When it comes to trauma care, time is of the essence. Transportation of the injured patient from the scene of the medical emergency to definitive care may take on several forms. Using a method of transport that would significantly reduce travel time to the trauma center resulting in earlier care is an example of one of the underlying tenets of the American College of Surgeons’ Advanced Trauma Life Support® course, which describes the concept of the “golden hour.” The golden hour is the time period after an injury occurs during which a patient should be assessed and resuscitated to ensure a positive outcome.

Geographic disparities exist throughout the U.S. with respect to access to trauma care. Some regions, such as large urban areas, may have an ample number of trauma centers that can be accessed using only a ground transportation model. Patients injured in suburban, rural, and wilderness areas may be several hundred miles away from the closest medical care.

**Obstacles to timely transport**
When looking at a map, the shortest distance between two points is a straight line. Because the earth is a sphere, however, this straight line is, in fact, a geodesic short line, and the reality is that roads and highways often are less than direct. Natural resources (including lakes, rivers, valleys, and mountains) as well as manmade structures may cause roads to meander and take odd turns along the way from one point to the next. Additionally, the timeliness of ground transportation may be dependent on several factors. Roadways may become impassable due to natural disasters, or ground transport times may increase significantly due to heavy vehicular traffic during the normal morning or evening commute.

**Helicopter transport**
Helicopter transports from the scene to definitive care address several of the impediments to timely care that may exist with conventional ground transport. To examine the occurrence of scene-to-trauma center helicopter transports in the National Trauma Data Bank® (NTDB®) research dataset for 2012, admissions medical records were searched using the fields “transport mode” (the mode of transport delivering the patient to your hospital) and “other transport mode” (all other modes of transport used during patient care event prior to arrival at your hospital, except the mode...
delivering the patient to the hospital). Transport mode field value of “helicopter ambulance” and another transport mode field value of “not applicable” (used to indicate that a patient had a single mode of transport and therefore this field does not apply to the patient) were selected. A total of 34,507 records were found; 31,058 records contained a hospital discharge status, including 21,512 patients discharged to home, 4,526 to acute care/rehab, and 2,997 sent to skilled nursing facilities; 2,023 died. These patients were 70.3 percent male, on average 38.8 years of age, had an average hospital length of stay of 7.9 days, an intensive care unit length of stay of 6.8 days, an average injury severity score of 15.6, and were on the ventilator for an average of 6.8 days. Of the 17,570 tested for alcohol, almost one-third were positive.

Air medical transport does have some consequences. It is costly, and several recent unfortunate incidents involving downed medical helicopters have occurred. Recent studies are starting to look at the value of helicopter transport to see if this higher-cost mode of transport results in improved outcomes. So far, it appears that in order to preserve the golden hour, the best way to get from point A to point B is “as the crow flies.” For certain situations, this direct route can be best accomplished with a helicopter ambulance.

Throughout the year, we will be highlighting data through brief reports in the Bulletin. 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. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Acknowledgement
Statistical support for this article has been provided by Chrystal Caden-Price, data analyst, NTDB.
He goal of this portion of the meeting is to renew our pledge to each other as leaders,” said David B. Hoyt, MD, FACS, Executive Director of the American College of Surgeons (ACS) in his opening remarks at the second annual Leadership Conference, which took place April 13–14 at the Mandarin Oriental Hotel in Washington, DC. “We each have a role in the leadership of this organization. Today’s activities are intended to start a conversation to move this organization forward,” added Dr. Hoyt.

The 2013 Leadership Conference—part of a dual meeting with the Advocacy Summit—drew a total of 308 attendees from all levels of the ACS leadership, including Regents, Governors, Advisory Council members, chapter leaders, and others.

A “recommitment to ACS leadership goals” was a central message of this year’s conference, according to Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services. Part of this re-energized focus included the unveiling of a new and expanded list of ACS Board of Governors (B/G) duties presented to conference attendees by Lena M. Napolitano, MD, FACS, Chair of the B/G. The ultimate goal of these new responsibilities—which include required attendance at future Leadership Conference and Advocacy Summit meetings—is to enhance “bi-directional communication between the Board of Governors and their constituents,” explained Dr. Napolitano.

This year’s conference also included a new, interactive component designed to foster relationship-building among like-minded colleagues. Participants convened by geographic location, allowing them to identify areas for synergy and unified effort and to discuss common challenges and potential solutions. A representative from each breakout session presented the findings to the group-at-large. Common themes to emerge from these breakout sessions included a need for increased communication among chapter members, enhanced member engagement, and a desire for professional development training.

Other conference sessions covered a wide spectrum of topics tethered to the meeting’s leadership theme, including presentations on the following: defining roles and responsibilities, a review of ACS infrastructure, enhancing member involvement, and best practices for chapter leaders and executives.

**Roles and responsibilities**
The first session, titled Roles and Responsibilities, included four presentations by Fellows representing the Regents, Governors, chapters, and Advisory Council chairs with the
goal of defining the functions of the individuals in these roles.

Julie A. Freischlag, MD, FACS, Chair of the Board of Regents, outlined the “Top 10 Things a Regent Should Do,” including “attend the Regents’ meetings, prepare for and talk at the Regent meetings, and communicate to your group about the ACS.” She encouraged attendees to develop the ability to learn from others who are Regents, Governors, members of Advisory Boards. “As surgeons we like to talk, but we have to learn to listen,” advised Dr. Freischlag. “All of these people—both younger surgeons and senior surgeons—have valuable information to share.”

Dr. Napolitano’s presentation provided an overview of the enhanced duties of the B/G. “The Governors act as a liaison between the Board of Regents and the Fellows and as a clearinghouse for the Regents on general assigned subjects and on local problems,” she said, quoting the College Bylaws on the duties of the Governor. The B/G’s updated duties incorporate both new and existing responsibilities including:

- Provide bi-directional communication between B/G and constituents
- Participate in B/G pillars and work groups
- Attend B/G meetings: Annual Clinical Congress and Leadership Conference
- Complete annual survey featuring new questions
- Compile annual survey results from constituents and Fellows
- Participate in Clinical Congress Convocation
- Attend Annual Business Meeting of members
- Attend chapter or specialty society meetings
- Provide a report to chapter or specialty society, and provide electronic copy to B/G Executive Committee and the Communications Committee
- Participate in local committee on applicants meetings and interviews
- Promote ACS Fellowship in state or specialty society
- Engage new Initiates

“This new and expanded list of duties will enhance the communication of the B/G over the next several years,” explained Dr. Napolitano. “Our mission is to bring the voice of the Fellows forward so that the Regents can make important decisions.”

Dr. Napolitano urged Governors to promote ACS efforts in the Accredited Educational Institutes program, ACS National Surgical Quality Improvement Program (ACS NSQIP®), and in advocacy efforts, in particular, and she underscored the fact that “Governors are expected to oversee and assist with ACS membership recruitment efforts at the local level.”

In his presentation on the roles and responsibilities of chapter leaders, John P. Rioux, MD, FACS, Chair of the Board of Governors’ National Chapter Workgroup, outlined the key duties of the chapter president, vice-president, secretary, and treasurer. In particular, Dr. Rioux underscored the importance of developing an overall strategic plan, a task traditionally led by the Chapter President. “Plan a strategic planning meeting if one has not already taken place,” he advised. “Develop an operational plan, assign tasks with established timelines, and develop measures of success necessary to fully implement...
“This new and expanded list of duties will enhance the communication of the B/G over the next several years,” explained Dr. Napolitano. “Our mission is to bring the voice of the Fellows forward so that the Regents can make important decisions.”

Dr. Napolitano

Once the plan has been determined, “the vice-president takes an active role in implementing the strategic plan using the communication tools you developed as secretary,” he said.

Dr. Rioux also emphasized chapter council diversity as a key factor in developing a successful, sustainable chapter. “Populate the council with a diverse spectrum of individuals. A variety of views will better allow you to implement the chapter’s strategic plan.”

The final presentation on the topic of ACS leadership roles was an overview of ACS Advisory Councils for the Surgical Specialties, presented by E. Christopher Ellison, MD, FACS, Chair, Advisory Council for General Surgery, and Chair, Advisory Council Chairs. “Since the founding of the College, surgical specialties have been closely integrated into all College activities,” observed Dr. Ellison in his opening remarks. “This is not surprising as the College was conceived by a specialist in gynecology, Dr. Franklin H. Martin.”

The ACS Advisory Councils for Surgical Specialties are responsible for the following activities, according to Dr. Ellison:

- Serve as a liaison for communicating information to and from surgical societies and the Regents
- Advise the Regents on policy matters relating to their specialties
- Nominate Fellows from the surgical specialties to serve on College committees and other organizations
- Provide specialty input into the development of general and specialty sessions for the annual Clinical Congress meeting

Dr. Ellison also proposed a review of the committees and structures of the Advisory Councils to better and more efficiently align with the mission of the College.

**Review of ACS Infrastructure**

The Leadership Conference’s second block of meetings featured presentations by ACS staff members and others on key areas of the College. “This next section of the agenda is a review of the infrastructure of the American College of Surgeons and highlights the offerings of each division,” explained Dr. Turner. “These presentations are also intended to point out where you, as leaders in your respective roles, can integrate with these programs. It is our expectation that [these overviews] will present opportunities for increased involvement [with the College] and will also highlight opportunities to support the rank-and-file surgeons whom you represent.”

Ajit K. Sachdeva, MD, FACS, FRGSC, Director, ACS Division of Education, underscored the division’s “special focus on the two ends of residency training—the transition from medical school to surgery residency and the transition from training to independent surgical practice.”

The College’s efforts to enhance the transition from medical school to surgery residency include the development of a publication titled *Successfully Navigating the First Year of Surgical Residency*, which lists the critical cognitive, clinical, and technical skills necessary for students’ first year of residency training.

In an effort to assist with the transition from training to independent surgical practice, the Division of Education has introduced the new ACS Transition to Practice Program in General Surgery initiative, which helps residents with the following:
“The RAS/YFA is the pipeline for future leaders. If you’re a chair or a program director, encourage or fund participation of your trainees,” suggested Dr. Turner, underscoring the fact that interacting with young surgeons is a golden opportunity for member involvement.

The program is being rolled out at several facilities in regions currently underserved by general surgery trainees in an effort to address the shortage of general surgeons in those areas. The following institutions have committed to begin pilot testing the ACS Transition to Practice Program in General Surgery:

- University of Tennessee College of Medicine, Chattanooga
- Eastern Virginia Medical School, Norfolk
- Gundersen Lutheran Health System, La Crosse, WI
- Mercer University School of Medicine/Medical Center of Central Georgia, Macon
- Ohio State University (OSU) Wexner Medical Center, Columbus
- University of Louisville School of Medicine, KY
- University of Kentucky College of Medicine, Lexington

In his concluding remarks, Dr. Sachdeva unveiled a new tagline for the ACS Division of Education: “Blended Surgical Education and Training for Life,” which exemplifies the department’s ongoing mission to “promote excellence and expertise in surgery through innovative education, training, verification, validation, and accreditation,” noted Dr. Sachdeva.

Highlighting the numerous roles and responsibilities of the Member Services Division, Dr. Turner touched on everything from the application process to member recruitment and retention to nominating committees and scholarships and fellowships. All of these areas, as well as the Advisory Councils, the Young Fellows/Residents and Associates, and Operation Giving Back, fall under the aegis of Member Services, and each provides an opportunity for enhanced member engagement, noted Dr. Turner.

“The RAS/YFA is the pipeline for future leaders. If you’re a chair or a program director, encourage or fund participation of your trainees,” suggested Dr. Turner, underscoring the fact that interacting with young surgeons is a golden opportunity for member involvement. “If you’re a part of a chapter which does not currently invite or engage residents, please consider doing so—that may be where your future partners are first integrated into the fabric of the community of surgeons. Many of our most robust chapters with the most engaging meetings incorporate a resident research day or other opportunity to engage surgeons early in their careers.”

“Interview new Fellows with the Committees on Applicants in your local area,” she added. “Reach out to new Fellows and welcome them.”

Dr. Turner also urged conference attendees to complete their member profiles and to encourage their constituents to do the same. It is her goal to implement “substantive use of existing member data to drive marketing and increase value to our Fellows.” Thousands of patients use the College’s “find-a-surgeon” feature on the website, added Dr. Turner in a post-conference interview, “So, updating one’s profile is a smart business decision as well.”

In his presentation, Christian Shalgian, Director, Division of Advocacy and Health Policy, outlined legislative and regulatory
issues that are a priority for the College this year, including Medicare physician payment, quality care initiatives, graduate medical education and workforce challenges, and medical liability reform. Mr. Shalgian called 2013 “the year of less spending” and cited sequestration cuts, less government funding, and budget reductions as examples of this year’s overall economic climate.

“The current system is broken and $138 billion in debt has been created,” noted Mr. Shalgian in reference to the current Medicare physician payment fee schedule. “The first step is eliminating the current system and eliminating the debt. The second step is determining what replaces the current, broken system.” Mr. Shalgian said the sustainable growth rate (SGR) formula, which is used to calculate physician payment, could be replaced with the Value-Based Update, a proposal developed by the ACS that better reflects accurate health care costs and would factor in the quality of care physicians deliver based on measures that are meaningful to both patients and surgeons.

“The College is seen as a group that brings solutions to the table,” added Shalgian, referring to the VBU proposal. “The ACS has developed the framework for this proposal, and now we need to add data and modeling,” he said. Specifically, the College has partnered with researchers from Brigham and Women’s Hospital, Boston, MA, and Brandeis University, Waltham, MA, to gain a better understanding of how this methodology may be used to ensure that payment updates are more closely aligned with factors that surgeons can control rather than being anchored to the spending and resource use of all Medicare Part B providers.

The remainder of Mr. Shalgian’s presentation highlighted strategies for strong advocacy. In particular, he championed grassroots actions as straightforward means of connecting with policymakers on Capitol Hill. “I am often surprised to learn that some really accomplished surgeons are intimidated by the thought of calling Capitol Hill,” observed Mr. Shalgian. “They shouldn’t be. These offices keep track of who is calling and what they are calling about, so it’s important not to worry about who is specifically answering the call. Just make the call.”

Mr. Shalgian also unveiled a new grassroots initiative titled ACS–SurgeonsVoice, which he described as an “ongoing, organized program of recruiting, educating, and motivating members to use their political power to advocate and influence.” The program’s mission, according to Mr. Shalgian, will be to develop a “united surgical voice influencing policy” with participants at all levels including residents, Fellows, and leadership.

Following Mr. Shalgian’s presentation, Dr. Hoyt provided an overview of the ACS Inspiring Quality initiative and ACS NSQIP. “Not only do we have the opportunity to make a difference right now and the professional responsibility to make it happen—I also believe that we really are at a crossroads,” observed Dr. Hoyt in his opening remarks. “What we decide to do in the next few years may have profound effects on the future of our profession. Putting our imprimatur on quality in a very public and recognizable way strikes me as one of the important things we can do not just for our patients and our future Fellows, but for our societal commitment as surgeons.”

He outlined four “guiding principles of continuous quality improvement,” including the following: standards (validated by research and
“Surgery is increasingly subspecialized and if we want to remain the umbrella organization and maintain membership, we must remain inclusive and cater to a variety of needs.”

—Dr. Weissler

Dr. Hoyt’s presentation also included the official release of a new, limited-edition book titled *Inspiring Quality Tour: Lessons Learned in the Pursuit of Quality Surgical Health Care*, which summarizes the findings of an 18-month effort to generate a national dialogue about surgical quality and patient safety through a series of ACS Surgical Health Care Quality Forums held throughout the country.

“Failure to take action—whether that failure is born of fear of reprisals or simply apathy born of decades of administrative battles—is actually more pernicious than public ridicule. My message to you today is that we are at a critical time right now when it comes to advocating for the right kind of quality improvement,” Dr. Hoyt said.

The final presentation in the ACS infrastructure session was led by Dr. Napolitano, and provided an overview of the B/G committee reorganization. In particular, she summarized the goals of the board’s five pillars—Member Services, Education, Advocacy/Health Policy, Quality-Research/Optimal Patient Care, and Communication—which are modeled after the Divisions of the College. Workgroups representing each of the pillars are being led by members of the Board of Governors’ Executive Committee to whom the chairs of the workgroups will report.

The Board of Governor “Leads” for each pillar are as follows:

- **Member Services Pillar**: Lead: Fabrizio Michelassi, MD, FACS
- **Education Pillar**: Lead: Lorrie Langdale, MD, FACS
- **Advocacy and Health Policy Pillar**: Lead: Jim Denneny, MD, FACS
- **Quality-Research/Optimal Patient Care Pillar**: Lead: Sherry Wren, MD, FACS
- **Communication Pillar**: Lead: Gary Timmerman, MD, FACS

Dr. Napolitano said the goal of the pillars is to allow for closer “alignment and interaction with College activities and divisions.”

**Challenges in leadership**

The conference’s third session, Challenges in Leadership, included presentations by Mark C. Weissler, MD, FACS, Vice-Chair, Board of Regents; Gary L. Timmerman, MD, FACS, Vice-Chair Board of Governors; and Mary E. Fallat, MD, FACS, Chair, Advisory Council for Pediatric Surgery.

Dr. Weissler opened the session by underscoring the importance of setting goals. It can “sometimes be difficult for a professional organization to maintain a focus, because it is not like a business where goals can be easier to define, goals such as maintaining profit and the creation of new products,” observed Dr. Weissler. “The core purpose of the ACS is to maintain the professional core of surgery in North America,” said Dr. Weissler. He noted that surgery in North America is not only about open abdominal general surgery, but rather, it is about T&As [tonsillectomy and adenoidectomy], cataracts, joint replacements, and sinus surgery. “If we really advocate for the surgical patient we must realize that this is truly who they are,” he said. “Surgery is increasingly subspecialized and if we want to remain the umbrella organization and maintain membership, we must remain inclusive and cater to a variety of needs.” He encouraged attendees to be “visionary versus reactionary. Have a vision for where you want to end up in the future, have a plan for 10 or 20 years from now for what surgery will look like in America.”
In his presentation, Dr. Timmerman championed the new B/G pillar structure, noting that it is designed to “reduce duplication of effort” and provide a unique opportunity for “Governors to contribute to the ACS organization.”

Dr. Timmerman also outlined the qualities of a strong leader. “The best leaders are the best listeners, are humble servants, and [engage in] volunteerism,” said Dr. Timmerman. “Attempt to do something outside your comfort zone,” he added. “It is important to try something new and to use all your resources—no matter who they are, where they are from, or what you may think they have to offer.”

Closing out the session, Dr. Fallat described specific challenges surgeons typically face, particularly those in leadership positions, including “volume of information, time constraints, ability to absorb content, and ability to extract what is important for all surgeons, as well as what is important for the specialty.”

Dr. Fallat discussed the alignment of ACS pillars with pediatric surgery, including the Advocacy and Health Policy Pillar, and she explained how advocacy issues for children can be both similar and different from adult advocacy issues.

**Improving involvement**
The fourth and final session of the Leadership Conference addressed the concept of enhanced member engagement from two perspectives—young surgeons and chapter leaders—and included presentations by S. Rob Todd, MD, FACS, Chair, Member Services Workgroup, Young Fellows Association; Steven L. Chen, MD, FACS, Chair, Education Workgroup, Young Fellows Association; and David W. Dexter, MD, FACS, member, ACS Northwest Pennsylvania Chapter.

Dr. Todd described the advantages of membership in the College for young Fellows, such as the development of leadership skills and the opportunity to convey concerns of young Fellows to ACS leadership, and for ACS leaders, including mentoring future organization leaders and enlisting assistance in activities, particularly at the chapter level.

“We surveyed interested young Fellows from previous meetings representing all surgical specialties,” said Dr. Todd. “Fifty percent of those surveyed are involved in their local chapter, but 82 percent want to be even more involved in the ACS.” He said approximately a dozen local/regional chapters lack a YFA representative and urged young Fellows to get more involved for themselves and the future of the profession.

Dr. Chen highlighted the ACS YFA Mentorship Program as an example of enhanced engagement among young physicians and established surgeons. “Many young Fellows are interested in being more involved in the ACS. Yet, many young Fellows are not sure how to access College leadership,” he added, noting that “many young Fellows lack local mentors that have ACS ties.” Dr. Chen encouraged attendees to apply to become either a mentor or mentee, as both roles can lead to increased involvement with the College. Since the program
launched in July 2011, “All but one mentor said they plan to be in touch with their mentee after the program is over,” according to Dr. Chen. “Five mentors felt this improved their own view of young Fellows and their own knowledge of what the ACS has to offer,” he said.

In a presentation titled Best Practices for Your Chapter and Your Members, Dr. Dexter described strategies for stimulating chapter growth and member engagement, including developing a plan for the future, achieving financial stability, providing self-assessment continuing medical education for members’ Maintenance of Certification, and getting residents involved in chapter activities. Successful chapters, he said, “sustain membership, involve and recruit young surgeons, are marked by member enthusiasm, feature strong administrative leadership, and promote ACS programs.”

Several factors are affecting chapters’ financial sustainability, according to Dr. Dexter, including an aging membership, decreases in enrollment, increasing costs, decreasing vendor support, mergers and consolidation of vendors, and others. He urged attendees to “take financial control of your chapter” by increasing recruitment efforts, eliminating non-essential spending, promoting a fixed location for annual chapter meetings, and seeking sponsorships for events.

Breakout sessions
The Conference concluded with a new, interactive component designed to boost communication among colleagues. Attendees were organized by state or region into separate meeting rooms with the aim of answering three discussion questions. Attendees later reconvened in the main conference room, where a representative from each breakout session presented a brief report.

Participants addressed the following questions in their breakout sessions:

• What one ACS initiative or event can be planned in your area over the next 12 months that will support or enhance the practice, patient care, financial well-being, or engagement of your local surgeons?

• Of what accomplishment by your local community of surgeons are you most proud?

• What topics would you like to see covered at the Leadership Conference next year?

Several common goals emerged from the breakout session reports including:

• Increased communication among chapter members

• More member engagement

• Professional development training

• Leadership skills training

• Bringing the ACS Quality Forum tour to states that have not hosted a forum up to this point

Member Services staff are compiling the information presented in the breakout session reports and will be providing a summary of these presentations later this year.

The next ACS Leadership Conference and Advocacy Summit will take place March 29 to April 1, 2014, in Washington, DC. ♦
The American College of Surgeons (ACS) hosted its second annual Advocacy Summit, April 14–16, in Washington, DC. Presented in conjunction with the ACS Leadership Conference, the Advocacy Summit is an opportunity to rally surgery’s collective grassroots advocacy voice. More than 200 surgeons spent one day learning about such vital topics as reforming the Medicare physician payment system, protecting the surgical workforce, and funding graduate medical education (GME). Attendees also heard from advocacy and health care experts regarding how the current political climate affects Congress’ ability to pass legislation.

The meeting culminated on the second day of the summit with 186 surgeons heading to Capitol Hill to advocate for their profession by meeting with their representatives and senators. These surgeons have begun building relationships with key policymakers in Washington, which will serve surgeons and their patients well in the future.

**Understanding the issues**

Prior to attending the Summit, I felt a sense of hopelessness as if my hands were tied. I felt like a warrior fighting alone. Today, after hearing about the relevant issues, I feel like we are going to be able to fix things.

—Laura Schwartz, MD, FACS, pediatric neurosurgeon, New Jersey Pediatric Neurosurgical Associates, Hackensack, NJ

The nation’s health care system is undergoing a time of unprecedented change. There is enormous pressure to gain control of increasing health care costs, particularly as the baby boomers age and thereby increase the demand for services. The ACS Young Fellows Association (YFA) sponsored a panel at the Summit that discussed the future of health care. Moderated by Scott Coates, MD, FACS, Vice-Chair, YFA Member Services Work Group, the panel featured speakers Gail Wilensky, PhD, senior fellow, Project HOPE, Millwood, VA; Harold Miller, executive director, Center for Healthcare Quality and Payment Reform, Pittsburgh, PA; and Frank G. Opelka, MD, FACS, Associate Medical Director, ACS Division of Advocacy and Health Policy.

Dr. Wilensky, who is married to a physician, said she sympathizes with surgeons’ frustrations with the direction in which the health care system is moving. Dr. Wilensky discussed physician payments, the cost of health care, and spending—topics that have gained traction over the last several years. Spending “has gotten out of hand,” said Dr. Wilensky, and she is skeptical as to whether programs such as accountable care organizations (ACOs)—designed to provide more coordinated, high-quality care to Medicare patients—are the answer to physician payment woes. However, bundled payments that encourage efficiency could play a part in helping to lower health care costs, she said. Bundled payments cover services delivered by two or more providers during a single episode of care or over a specific period of time.*

Mr. Miller, however, said there is a “win-win-win” solution to accountable care that may benefit surgeons and patients while reducing Medicare spending. Under this model, health care professionals

*To better understand bundled payment options, the ACS released *The Surgeons and Bundled Payment Models: A Primer for Understanding Alternative Physician Payment Approaches* at the Summit. This resource summarizes the concept of bundled payment and the effect bundled payment policies could have on surgical practices. To access the primer, go to the Members-only website, [http://efacs.org/portal/page/portal/ACS_Content/Advocacy](http://efacs.org/portal/page/portal/ACS_Content/Advocacy).
As a leader on physician issues, the ACS seeks out partnerships with other critical stakeholders to encourage development of a fair payment system, address possible solutions to the workforce shortages, and advocate for medical liability reform and increased GME funding.

would choose to participate in a flexible, alternative payment and delivery model that best fits their practices and that delivers high-quality, efficient care.

He provided this example: In Lansing, MI, in 1987, an orthopaedic surgeon and Ingham Medical Center offered a fixed total price for surgical services for shoulder and knee problems. Included in the charge was a two-year warranty for subsequent services needed, such as repeat visits, imaging, re-hospitalization, and additional surgery. Using this approach, the health insurer paid 40 percent less than if the services had each been charged separately, the surgeon received more than 80 percent more in payment than otherwise, and the hospital received 13 percent more despite fewer re-hospitalizations. Mr. Miller attributed this result to the reduction in unnecessary auxiliary services such as radiography and physical therapy, in length of stay, and in complications and readmissions.

The College believes it has a solution as well, called the Value Based Update (VBU), noted Dr. Opelka.† The VBU calls for replacing the sustainable growth rate (SGR) formula used to calculate physician payment with a system that improves outcomes, quality, safety, and efficiency while reducing the growth in health care spending. Dr. Opelka explained how the VBU would work, highlighting that it would combine the College’s century of experience in quality measurement to improve patient care and reduce costs. This system shifts the emphasis from cost of care provided to the value of care provided, Dr. Opelka noted.

Atul Grover, MD, chief public policy officer, Association of American Medical Colleges, Washington, DC; Doug Henley, MD, chief executive officer, and executive vice president, American Academy of Family Physicians, Washington, DC; and Samuel Finlayson, MD, MPH, Kessler Director, Center for Surgery and Public Health, Brigham and Women’s Hospital, Boston, MA, discussed present and future physician workforce issues. The three presenters offered vastly different viewpoints. Among other topics, Dr. Grover discussed what drives physicians to choose certain specialties and practice locations, deficit reduction plans, and incentives for surgeons to practice in rural areas. Dr. Henley provided data on what he believes are probable causes of the current workforce shortage and suggested possible solutions, including appropriately valuing and compensating primary care physicians to address the income gap between primary care and other specialties and reforming GME. Dr. Finlayson, offering a different perspective, believes that increasing the number of surgeons is an “unwise response to the workforce crisis” and that “addressing geographic and specialty distribution is the main challenge.”

As a leader on physician issues, the ACS seeks out partnerships with other critical stakeholders to encourage development of a fair payment system, address possible solutions to the workforce shortages, and advocate for medical liability reform and increased GME funding. Advocacy Summit attendees heard from three groups that have a significant stake in the health care system, including the business sector, insurers, and pharmaceutical and device manufacturers.

Maria Ghazal, vice-president and counsel of Business Roundtable, Washington, DC, an organization that represents the interests of many of the nation’s largest companies and employers, extended an invitation to work with the College on many issues, including the use of state insurance exchanges. Greg Gierer, vice-president of policy, America’s Health Insurance Plans, Washington, DC, agreed

†An overview of the ACS VBU project can be accessed using the following link, http://www.facs.org/ahp/news/2013/may.html#Summit_Overview.
that collaborations through multi-stakeholder groups are effective in addressing elements of health care reform, particularly cost-containment. Mr. Gierer discussed health care cost and how insurers are leading changes in the marketplace through collaboration with providers and possible means of providing care to vulnerable populations through effective public-private cooperation. Lastly, Harlan F. Weisman, MD, chairman and chief executive officer of Coronado Biosciences, Inc., Burlington, MA, talked about the need to regain the country’s status as the world leader in the development of pharmaceutical research and advancement.

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**The price of politics**

Bob Woodward, Pulitzer Prize-winning journalist for The Washington Post and author of The Price of Politics, opened the Summit on Sunday evening as the keynote dinner speaker. Mr. Woodward gave a behind-the-scenes look at government, politics, and the role of an investigative journalist. The book, based on 10 months of reporting, is a documented examination of how President Barack Obama and high-profile Republican and Democratic leaders in the
Congressional “Asks”: Medicare Physician Payment

House and Senate

- The ACS has drafted a proposal to reform the physician payment system using the VBU.
- The VBU focuses on delivering improved, high-quality care and resultant cost reductions. The ACS believes that its VBU proposal will produce shared savings across the delivery system that, when attributed appropriately, would allow for a stable baseline for all physicians without the need to cut payment rates.
- The critical component of the VBU is the Clinical Affinity Group (CAG), a team of physicians and providers who provide care for a specific condition, disease, or patient population. CAGs are the core of this proposal and might include categories such as cancer care, trauma care, surgery, cardiac care, frail elderly/end of life, digestive diseases, women’s health, rural and primary care/chronic care.
- Each CAG, which can be designed to account for regional variations in the provision of care to be captured and reflected in each physician’s reimbursements, will have its own patient-oriented, outcomes-based, risk-adjusted quality measures intended to foster continuous improvement and help lower costs.

House

The ACS submitted comments on the House Ways and Means and Energy and Commerce Committees’ joint SGR proposal:

- The ACS supports the permanent repeal of the SGR formula and a stable five-year period of statutory updates that would complement the development of new payment models needed to improve the quality of care and slow the growth in health care spending.
- The ACS is concerned that the application of budget neutrality to relative rankings will undermine overall reform efforts with tournament model reimbursement. Robbing Peter to pay Paul undercuts our combined goal of a more collaborative and coordinated health care delivery system.
- The ACS does not support an across-the-board cut to all physicians (10 to 15 percent) from the current baseline as a starting point in the period of stability. Presumably, only those providers deemed “top performers” would be eligible for incentive payments to recoup the 10 to 15 percent cut—in essence, a freeze at the current rate.

U.S. Congress attempted to restore the American economy and improve the federal government’s fiscal condition. He focused many of his comments on political investigative reporting, providing examples of events that have had a profound impact on today’s political climate, including President Bill Clinton’s impeachment, Vice-President Al Gore’s unsuccessful run for president, and President Obama’s fight to bring together both major parties in Congress. Mr. Woodward discussed his disappointment with the present-day media’s fact-finding methods, asking, “Why isn’t the media doing more?” Reporters have turned to e-mails, Facebook, Twitter, and the like to find people to interview and to gather information, said Mr. Woodward. Widely regarded for his preeminent investigative reporting on the Watergate scandal that led to numerous government investigations and the resignation of President Richard Nixon, Mr. Woodward argued that reporters must get back to the basics. They must get in the field, investigate, and uncover the important stories. To fully understand and report on the key issues of the
Mr. Woodward discussed his disappointment with the present-day media’s fact-finding methods, asking, “Why isn’t the media doing more?”

presidential and congressional campaigns, the state of the American economy, and how events transpire, a reporter must be in the trenches giving verbatim accounts of political events, meetings, and exchanges, Mr. Woodward said.

**Technology-driven campaigns**

Mike Allen, chief White House correspondent for *Politico* and author of the *Politico Playbook* was the featured speaker at the Summit’s political luncheon. Mr. Allen is recognized for successfully using grassroots outreach to uncover political developments and engage the American people. *Time* magazine named Mr. Allen as having one of the top 140 Twitter feeds shaping the day’s debate. He talks mostly centered on President Obama’s second election bid and how, unlike past U.S. presidents, the president’s reelection campaign was successful largely because of its effective use of technology-driven communications.

Regardless of a candidate’s political leanings, a campaign must be broad and optimistically open to change, explained Mr. Allen. He added that the Obama reelection campaign has proven the advantages of having a digital strategy and the confidence to explore the wide range of methods that appeal to various demographics. The Obama campaign used Facebook, Twitter, website advertising, video programs, and visits to neighborhoods, seeking out places such as local barbershops and beauty salons to engage voters.

**Training to be an effective advocate**

Christopher Kush, grassroots expert and chief executive officers of Soapbox Consulting, Washington, DC, sought to galvanize participants and help them navigate their day on Capitol Hill.

“Securing a legislative meeting is not always an easy task, and if you’re fortunate to get on the calendar [of a member of Congress], ensure that you are prepared,” said Mr. Kush, adding that it is “important to know the new members of Congress—who is on key committees for issues on which you advocate because those relationships help to get bills [introduced].”

“Hook, line, and sinker” is a three-phase method Mr. Kush suggests advocates use when meeting with a member of Congress. He says ultimately an advocate has three minutes for introductions (hook), five minutes to tell the story (line), and five minutes to make the request and discuss it (sinker).

In preparation for Lobby Day, participants were provided with individualized legislative meeting schedules, educational literature, and a pocket card that listed the critical health care talking points, or “Congressional Asks” (see sidebar, page 78).


“Advocating on Capitol Hill can be intimidating, and one hopes that in situations like this there’s someone to help show you the way—to help you understand the important issues. This meeting does that,” said Kyle Kalkwarf, MD, a Summit participant and resident at the University of Arkansas for Medical Science, Little Rock. Matthew Steliga, MD, FACS, agreed, stating,

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9The 140 Best Twitter Feeds of 2011: Mike Allen. [http://www.time.com/time/specials/packages/article/0,28804,2058946_2059032_2059024,00.html](http://www.time.com/time/specials/packages/article/0,28804,2058946_2059032_2059024,00.html).
“The experience has been invaluable. The meeting has provided real information on how advocacy in action really works. I’m impressed.” Dr. Steliga is an assistant professor at the University of Arkansas for Medical Sciences in Little Rock, AR.

Grassroots and the ACSPA-SurgeonsPAC

In advance of Lobby Day, several members of Congress provided insight into issues on which they are searching for bipartisan solutions, such as medical liability reforms and reimbursement. Legislators who spoke included Reps. Kevin Brady (R-TX), Chair, House Ways and Means Health Subcommittee; Larry Bucshon, MD, FACS (R-IN); and Ami Bera, MD (D-CA).

“Get involved and stay involved,” was the collaborating message among many presenters. Jeff Carroll, chief of staff for Rep. Frank Pallone (D-NJ), gave a presentation titled Winning in Advocacy: Why Grassroots and Messaging Matter, in which he emphasized the influence political action committees (PACs), such as the American College of Surgeons Professional Association (ACSPA)-SurgeonsPAC, can have. “Access comes through PAC donations,” said Mr. Carroll. “It’s important to encourage members to give to the PAC. PAC donations help build trust and get you in the door to create effective relationships.”

Mr. Carroll also discussed the importance of grassroots efforts, and which methods work best, pointing out that “a lot of members of Congress pay attention to social media—and the College should, too.” Mr. Carroll added that face-to-face meetings will also continue to be an effective means of communicating messages to Congress. Meetings allow advocates to talk about issues that matter to them.

An essential part of the Summit was the opportunity for participants to meet and mingle with members of Congress. PAC contributors participated in a wine-tasting fundraiser and reception hosted by the ACSPA-SurgeonsPAC at the National Museum for Women in the Arts. Guests contributed more than $56,000 to the ACSPA-SurgeonsPAC at that event, which 11 members of Congress, many with medical backgrounds, attended:

- Rep. Dan Benishek, MD, FACS (R-MI)
- Rep. Diane Black, RN (R-TN)
- Rep. Michael Burgess, MD (R-TX)
- Rep. Lois Capps, RN (D-CA)
- Rep. Phil Gingrey, MD (R-GA)
- Rep. Andy Harris, MD (R-MD)
- Rep. Joe Heck, MD (R-NV)
- Sen. Johnny Isakson (R-GA)
- Rep. Leonard Lance (R-NJ)
- Rep. Phil Roe, MD (R-TN)
- Rep. Tom Price, MD, FACS (R-GA)

The 2014 Leadership Conference and Advocacy Summit will take place March 29–April 1 in Washington, DC. ◆
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NOTE: 2013 Webcasts will be available for viewing from December 15, 2013; access expires December 31, 2014.
AJCC names Mahul B. Amin, MD, FCAP, Editor-in-Chief of staging manual

The Executive Committee of the American Joint Committee on Cancer (AJCC) named Mahul B. Amin, MD, FCAP, Editor-in-Chief of the upcoming eighth edition of the AJCC Cancer Staging Manual. Dr. Amin is chairman and professor of the department of pathology and laboratory medicine at Cedars-Sinai Medical Center, Los Angeles, CA. Programs of the AJCC, established in 1959, are administered by the American College of Surgeons (ACS).

The AJCC Cancer Staging Manual provides physicians and health care professionals around the world with a tool to facilitate the uniform description and reporting of cancer. The manual presents evidence-based criteria for the staging of cancer for a number of anatomic disease sites, which includes the rationale and rules for staging; the definitions of tumor, lymph node involvement, and metastasis; stage groupings; and histologic grade.

Dr. Amin is a nationally and internationally recognized expert in tumors of the genitourinary tract including prostate, urinary bladder, kidney, and testis. He earned his medical degree from G.S. Medical College and King Edward Memorial Hospital in Bombay, India. He served on the executive committee of the AJCC from 2003 to 2011.

“He brings a multidisciplinary approach to the editor-in-chief position, in addition to a molecular-based medical perspective of cancer staging. These approaches are important since, for this latest edition, we’re stabilizing anatomic staging and expanding the focus on personalized medicine using molecular markers,” David P. Winchester, MD, FACS, Medical Director of the ACS Cancer Programs, said.

The eighth edition of the Cancer Staging Manual—which is expected to be published in late 2015 for patients diagnosed with cancer after January 2016—will incorporate advances made in cancer research, staging, diagnosis, and treatment since the seventh edition was published in October 2009. More than 500 cancer experts from around the world will collaborate on the manual, covering more than 60 primary disease sites.

“There have been enormous advances in cancer diagnosis, staging, and treatment since the results of the Human Cancer Genome Project were first announced more than a decade ago,” Dr. Amin said. “As a result, we can better predict the level of cancer risk and tailor a more personalized treatment program for the patient. For the eighth edition, we will incorporate these newer precision medicine paradigms, as appropriate, into the more traditional anatomic extent of disease premise of the AJCC staging classification.”

Correction

The article “ACS Board of Regents approves ACS Foundation Officers,” on page 59 of the May 2013 Bulletin, included inaccurate information regarding the past experience of Foundation Chair Amilu Stewart, MD, FACS. Dr. Stewart is a former associate clinical professor of surgery at the University of Colorado Health Sciences Center, Denver. The editors regret the error.
You’re a Fellow of the American College of Surgeons. Proudly display this honor by using the FACS designation on your business card, lab coat, website, and letterhead.

To download electronic files of the FACS artwork, go online to efacs.org and click on the “FACS Artwork” Quick Link in the lower left corner.

Questions? Contact ms@facs.org and include your Fellowship ID number in your note.
The American College of Surgeons (ACS) hosted the ACS Surgical Health Care Quality Forum Connecticut on April 26, in partnership with the ACS Connecticut Chapter and the Connecticut State Medical Society. In this 13th forum, surgeons, hospitals, health plans, physicians, and government leaders shared best practices for improving patient care, achieving better outcomes, and curbing rising health care costs. The Connecticut Forum highlighted the efforts of the Connecticut Surgical Quality Collaborative (CtSQC), a statewide group of 20 hospitals that meets regularly to share quality outcomes including successes and best practices. The CtSQC announced that six more hospitals are joining this effort, including Hartford Hospital, The Hospital of Central Connecticut, New Britain and Southington; Windham Hospital, Willimantic; MidState Medical Center, Meriden; Lawrence + Memorial Hospital, Pawcatuck; and John Dempsey Hospital at the UConn Health Center, Farmington. Many CtSQC hospitals also use the ACS National Surgical Quality Improvement Program (ACS NSQIP®) to improve outcomes in key areas of surgical care and provide the best possible value to patients, hospitals, and health plans. “Our collaborative is a unique forum to get hospitals at the table, not as competitors, but as health care providers with a common goal to improve patient care,” said forum host Scott J. Ellner, DO, MPH, FACS, director of surgical quality, Saint Francis Hospital and Medical Center, assistant professor of surgery, University of Connecticut School of Medicine, and Co-Chair, ACS Connecticut Chapter Committee on Patient Safety. “We now have more than two-thirds of the hospitals in the state participating, sharing practical and candid information with each other,
“We now have more than two-thirds of the hospitals in the state participating, sharing practical and candid information with each other, and that’s something we all can be really proud of. As a result of this effort, patients will get better care and our health care system will improve—everyone wins.”

—Dr. Ellner

and that’s something we all can be really proud of. As a result of this effort, patients will get better care and our health care system will improve—everyone wins.”

“Connecticut is the perfect example of what the College aspires to drive forward with these forums and the Inspiring Quality initiative—encouraging collaboration to share tangible examples of quality improvement and therefore provide a platform for action,” said ACS Executive Director David B. Hoyt, MD, FACS.

The Connecticut forum featured diverse opinions on high-quality health care and the impact of health care reform, including:

• Kevin J. Counihan, chief executive officer, Access Health CT: “Premium rate increases are among the greatest threats to the sustainability of health reform and enhanced access to health insurance.”

• Andrew Baskin, MD, national medical director, quality and provider performance, Aetna: “Quality improvement is more than just one single event or provider—it requires partnerships throughout the spectrum of care.”

• Colleen Desai, MSN, RN, CEN, trauma program manager, Saint Francis Hospital and Medical Center; president-elect, Connecticut Emergency Nurses Association: “At Saint Francis, we rely on quality programs like ACS NSQIP and the ACS Trauma Quality Improvement Program (TQIP) to tell us exactly how we’re doing in key areas so we know what we need to improve on.”

• Alison L. Hong, MD, director, quality and patient safety, Connecticut Hospital Association: “Connecticut hospitals are recognized as leaders by the Centers for Medicare & Medicaid Services for their participation in Partnership for Patients, an initiative to prevent harm and reduce readmissions.”

• Kathleen LaVorgna, MD, FACS, private practice surgeon, Norwalk Hospital; president, ACS Connecticut Chapter: “Participation in the state collaborative allows us to compare our quality issues with other hospitals in our state, and by sharing our experiences, we learn from each other and the quality movement becomes not just a concept to discuss, but a real collaborative project based on science and clinical results.”

• Kevin P. Lembo, Comptroller, State of Connecticut: “Through the Health Enhancement Program, we are bringing patients closer to primary care—proving that quality care and management result in better outcomes for both the patient and the plan.”

• Rocco Orlando III, MD, FACS, senior vice-president and chief medical officer, Hartford HealthCare: “Our leaders drive our culture by linking our values to our performance. Across our health system, we set goals collectively and collaboratively—building dashboards and objective metrics to assess our progress.”

• Donna Laliberte O’Shea, MD, market medical director, Connecticut, UnitedHealthcare: “Transparency will continue to play a larger role as we examine both how to define quality and how to provide higher-quality care.”

To view the archived Connecticut forum video and follow additional updates, visit InspiringQuality.facs.org or the College’s YouTube channel at http://www.youtube.com/AmCollegeofSurgeons.
Three Clinical Scholars-in-Residence will begin two-year programs in July at the American College of Surgeons (ACS) headquarters in Chicago, IL, as the three-year tenure of Ryan P. Merkow, MD, MS, ended June 30.

The three incoming Clinical Scholars will focus on advancing ACS quality improvement programs and performing related outcomes research. In addition, the scholars will pursue a master’s degree in health services and outcomes research at Northwestern University’s Feinberg School of Medicine, Chicago, IL.

**Dr. Merkow’s accomplishments**
As an ACS Clinical Scholar-in-Residence for the last three years, Dr. Merkow worked on a number of programmatic initiatives, including the College’s National Surgical Quality Improvement Program’s (ACS NSQIP®) Oncology section, the National Quality Forum (NQF)-endorsed colon surgery 30-day outcome measure, and the introduction of Procedure-Targeted ACS NSQIP. He has developed an expertise in risk-adjustment methodology and has helped to mentor the junior Clinical Scholars. He also worked to provide ACS NSQIP hospitals with comparative data for reoperation, length of stay, and readmission.

As a researcher, Dr. Merkow focused on surgical oncology and evaluated the appropriateness of surgical readmission as a quality measure. The Society of Surgical Oncology (SSO) recognized Dr. Merkow’s research at its 2012 annual meeting, awarding him the Harvey Baker Traveling Fellow award in 2012; he was a finalist for the same award in 2013. In addition, his abstract titled Effect of Cancer-Specific Variables on Risk-Adjusted Hospital Comparisons for ACS NSQIP Short-Term Outcomes was recognized as the best abstract at the SSO meeting.

Dr. Merkow completed his medical education at the University of Colorado, Denver, where he also completed his first three years of general surgery residency. He will complete his final two years of general surgery training at the University of Chicago Pritzker School of Medicine and then go on to a surgical oncology fellowship.

**Incoming Clinical Scholars**
Clinical Scholar Elliot Asare, MD, a graduate of Howard University College of Medicine, Washington, DC, and third-year general surgery resident at the Medical College of Wisconsin Affiliated Hospitals, Milwaukee, will focus his research on cancer staging in conjunction with the American Joint Committee on Cancer (AJCC). The AJCC has started to assemble the eighth edition of the *Cancer Staging Manual*, which contains standards that help the cancer patient management team determine the correct...
The three incoming Clinical Scholars will focus on advancing ACS quality improvement programs and performing related outcomes research.

stage for cancer patients and the most appropriate care plan.

In addition, as a Clinical Scholar, Dr. Asare will interact with College-based peers and mentors, and will conduct outcomes research with the National Cancer Data Base (NCDB). Dr. Asare is planning a career as an academic surgical oncologist and to return eventually to his native country of Ghana to establish a cancer center, including a cancer registry. Genentech, Inc., and the Medical College of Wisconsin are funding Dr. Asare’s Scholar-in-Residence award.

Clinical Scholar Ravi Rajaram, MD, is a third-year general surgery resident at Northwestern’s Feinberg School of Medicine, focusing his research on outcomes and quality improvement around thoracic and foregut surgical oncology. A graduate of Vanderbilt University School of Medicine, Nashville, TN, Dr. Rajaram will work with College scholars and mentors on projects involving surgical quality.

Dr. Rajaram is working toward a career in academic thoracic surgical oncology. Merck & Co. and the department of surgery and the Center for Healthcare Studies at Northwestern University are funding this program.

Sanjay Mohanty, MD, will join the ACS as the James C. Thompson/American Geriatrics Society Clinical Scholar. Dr. Mohanty earned his medical degree from the Indiana University School of Medicine, Indianapolis, and completed two years of general surgery residency at Henry Ford Hospital in Detroit, MI. During his fellowship, Dr. Mohanty will focus on developing guidelines for the care of geriatric surgical patients and geriatric-related health services and outcomes research. Dr. Mohanty is shaping his career around academic surgical oncology. The American Geriatrics Society is supporting Dr. Mohanty’s fellowship.

The ACS Clinical Scholars-in-Residence work to improve the ACS quality improvement programs and harness the ACS registry data to devise studies for enhancing the quality of patient care. The program prepares a surgical resident for a career in academic surgery through a practice research and health policy experience. ♦

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JUL 2013 BULLETIN American College of Surgeons
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Information on becoming a member of the College and an application form are available online at [www.facs.org/memberservices/documents.html](http://www.facs.org/memberservices/documents.html) or contact Cynthia Hicks, Credentials Section, Division of Member Services, at 800-293-9623 or chicks@facs.org.
House hearing focuses on quality’s role in SGR reform

American Medical News, May 20, 2013

“The American College of Surgeons has advocated for a value-based overhaul of the payment system, said David Hoyt, MD, the College’s executive director. Payment updates would be based on improving quality and patient safety. ‘We have learned measuring quality improves patient care, increases the value of health care services and reduces cost,’ Dr. Hoyt said. ‘The savings gained are the direct result of improving quality outcomes.’”

Surgeon-Driven Quality Effort Slashes Complications, Costs

HealthLeaders Media online, May 10, 2013

“The National Surgical Quality Improvement Project, a growing effort run by the American College of Surgeons since 2004, reports that 83% of program participants have been able to decrease their surgical complication rates by a statistically significant level.”

New Partnership Aims to Improve Palliative Care for Cancer Patients

Oncology Times, April 25, 2013

“[Dr. Amy] Abernethy—a medical oncologist specializing in melanoma as well as health services research and delivery in patient-centered cancer care including pain, symptom management, and palliative care—is focused on oncology. Ultimately, though, she wants to use the ASCO-AAHPM project to create models for others specialties as well.... She also explained that the American College of Surgeons’ Commission on Cancer’s mandate that distress screening be part of cancer care for accreditation has opened the door for other psychosocial services.”

Noisy Operating Rooms May Jeopardize Patient Safety

HealthDay/Philly.com (Philadelphia Inquirer), May 15, 2013

“Background noise in the operating-room—such as the sounds of surgical equipment, chatter or music—can affect surgeons’ ability to understand what is being said to them and might result in a breakdown of communication among surgical team members, according to a new study published...in the May issue of the Journal of the American College of Surgeons.”
Media around the world, including social media, frequently report on the work of the American College of Surgeons.

Tourniquets credited in Boston with saving lives
*Omaha World-Herald,* April 21, 2013

“...American College of Surgeons and the FBI met early this month with law enforcement and trauma care specialists to develop strategies to improve the survival of victims of mass shootings. One of the group’s conclusions was that life-threatening bleeding from extremity wounds is best controlled initially through the use of tourniquets.”

Death and injuries in Boston evoke war’s hard lessons
*USA Today,* April 16, 2013

“A committee of medical experts from the military, first responders, the FBI and the American College of Surgeons met this month in Hartford, Conn. Citing the Sandy Hook massacre that killed 20 children and six adults, the panel drafted recommendations for improving survival rates in horrific events. [See June Bulletin for complete report.]

‘Active shooter/mass casualty events are a reality of modern life,’ the recommendations say, adding that current practices used by civilian first responders such as police ambulance personnel do not ‘maximize victim survival.’

The panel’s paper points to methods used by the military to keep gravely wounded victims alive, particularly when there is a potential for massive blood loss. Tourniquets were reportedly used at the scene in Boston, and [George] Velmahos [MD, FACS] said a surgeon on his staff treated the wounded in Iraq and Afghanistan.”

CMS Mulls Use of Specialty Registries for Quality Data
*HealthLeaders Media,* April 16, 2013

“We think that if CMS allows registries to serve as physician quality reporting efforts, the agency should make sure the data is accurate and rigorously collected,” says Clifford Ko, MD, [FACS,] director of the American College of Surgeons National Surgical Quality Improvement Program or NSQIP, which now has 700 hospitals participating in a variety of outcomes registries for surgery.”

People with certain cancers enrolled in clinical trials survive longer
*Reuters Health/Chicago Tribune,* March 3, 2013

“Researchers found a 26 percent decrease in the risk of death for cancer patients enrolled in clinical trials, according to research published in the *Journal of the American College of Surgeons.* The study did not report how many people died.” ◆
Introducing SESAP® 15

The newly expanded edition will debut at the 2013 Clinical Congress

For more than 42 years, the Surgical Education and Self-Assessment Program (SESAP®) has been a premier resource for practicing surgeons who want to evaluate and maintain clinical competence, as well as expand clinical knowledge and provide the best surgical care.

SESAP® 15 features more content than previous editions, including more than 800 questions and critiques. Earn up to 90 continuing medical education (CME) credits that can be used for self-assessment purposes and, for the first time ever, claim CME credit as each category in general surgery is completed:

- Head and Neck
- Breast
- Alimentary Tract
- Abdomen
- Vascular System
- Endocrine
- Trauma
- Perioperative Care
- Surgical Critical Care
- The Immunocompromised Patient
- Problems in Related Specialties
- Oncology
- Skin/Soft Tissue
- Anesthesia/Pain Management
- Legal/Ethics

A variety of print and electronic formats will be available to ensure that the expanded content and new method of claiming CME credit can be used to help fulfill Maintenance of Certification, Part 2 requirements.

To learn more about this exceptional program, developed by the American College of Surgeons Division of Education, visit facs.org/education/sesap.
Calendar of events*

*Dates and locations subject to change. For more information on College events, visit http://www.facs.org/cmecalendar/index.html or http://web2.facs.org/ChapterMeetings.cfm

**JULY**

2013 ACS NSQIP National Conference
July 13–15
San Diego, CA
Contact: Whitney Watson, wwatson@facs.org, http://www.acsnsqipconference.org

South Carolina and North Carolina Chapters
July 12–14
Asheville, NC
Contact: Jennifer Starkey, jennifer@acsschapters.org, http://www.ncfacs.org/

Tennessee Chapter
July 26–28
Nashville, TN
Contact: Wanda McKnight, wanda@tnacs.org, http://www.tnacs.org/

**AUGUST**

2013 ACS Comprehensive General Surgery Review Course
August 8–August 11
Chicago, IL
Contact: Ulrike Langenscheidt, ulangenscheidt@facs.org, www.facs.org.

**SEPTEMBER**

Saudi Arabia Chapter
September 6
No other information provided at this time.

Kansas Chapter
September 7–8
Overland Park, KS
Contact: Gary Caruthers, gcaruthers@kmsonline.org, http://www.kansaschapteracs.org/

Kentucky Chapter
September 10
Louisville, KY
Contact: Linda Silvestri, lsilv2@email.uky.edu

New Mexico Chapter
September 13–14
Albuquerque, NM
Contact: Gloria A. Chavez, GChavez@nmms.org

Arkansas Chapter
September 21
Little Rock, AR
Contact: Linda Clayton, lindac92@comcast.net

**OCTOBER**

ACS Clinical Congress
October 6–10
Washington, DC
www.facs.org

**NOVEMBER**

Connecticut Chapter
November 1
Farmington, CT
Contact: Chris Tasik, info@CTACS.org, http://ctacs.org/

Wisconsin Surgical Society–a Chapter of the ACS
November 8
Kohler, WI
Contact: Terry Estness, wisurgical@att.net, http://www.wisurgicalsociety.com/

Keystone Chapter
November 8
Danville, PA
Contact: Lauren Ramsey, lramsey@pamedsoc.org, http://www.keystonesurgeons.org/

Arizona Chapter
November 9–10
Phoenix, AZ
Contact: Joni L. Bowers, Jonib@azmed.org, http://www.azacs.org/

**FUTURE CLINICAL CONGRESSES**

2013
October 6–10
Washington, DC

2014
October 26–30
San Francisco, CA