Dealing with surgical complications
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continued on next page
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A t press time, the nation was both reflecting on the 50-year anniversary of the assassination of U.S. President John F. Kennedy and preparing for the holiday season. These two contrasting events reminded me that over the last 50 years, all Americans, particularly surgeons, have borne witness to many profound changes in our society and our profession—some more positive than others.

**a fateful day**
I was a 14-year-old high school freshman the day President Kennedy was assassinated. Like most young people of the time, I felt a connection to the youthful president and his wife, and his steadfast efforts to deal with the difficult issues of the day were inspiring.

The early 1960s were a precarious time in U.S. history. The climate of confrontation with communism, the vulnerability of the world to nuclear destruction as evidenced in the proliferation of bomb shelters both in people’s homes and at schools, and the rising awareness of racial inequities created a strong sense of fear among many Americans.

During his short time in office, however, President Kennedy generated a feeling of optimism and confidence about the future. He took on the Cold War with strength and resolve, established the Peace Corps, and shared his vision of excellence and innovation in science, space exploration, medicine, human rights, and racial and gender equality. And, with his beautiful and intelligent wife and children, the Kennedy White House emanated a touch of class and vigor.

His assassination in November 1963 seemingly put an end to much of the national enthusiasm, and the country’s mood took a rather dark turn. The war in Vietnam escalated over the coming years, and, in response, the size, number, and volatility of anti-war protests grew. Although Kennedy’s successor, Lyndon B. Johnson, signed the Civil Rights Act, frustrations over ongoing racial disparities erupted into inner-city riots. In the 1970s, the revelations in the Pentagon Papers followed by Watergate during the Nixon Administration left many Americans feeling betrayed and distrustful of politicians.

**Looking forward**

Even during those tumultuous days in the nation’s history, however, much progress occurred, particularly in medicine.
To overcome these challenges, we must call upon not only our ingenuity, but also our past experience and collective wisdom.

**Progress Continues**

Even during those tumultuous days in the nation’s history, however, much progress occurred, particularly in medicine. Technological and scientific advances in angiography, ultrasound, magnetic resonance imaging, computed tomography, and so on have led to more accurate and speedier diagnoses. Innovative surgical techniques, including endovascular, laparoscopic, and robot-assisted procedures, have led to safer operations with shorter recovery times.

Furthermore, in the last 50 years, we have witnessed the development of acute care and trauma systems, multidisciplinary teams for cancer care, the rise of transplant surgery, and advances in every surgical specialty. As a result, many more critically injured and ill patients have a far greater chance of leading long and productive lives.

Outside of surgery, the nation and the rest of the world have benefitted from other technological innovations—many of which have evolved directly or indirectly through the fulfillment of President Kennedy’s vision of landing on the moon and exploring the rest of the galaxy. Examples include computerization and electronic and digital communication. Indeed, 50 years ago, few among us would have imagined the swift and wide-ranging effects of modern technology on nearly every aspect of our day-to-day existence.

**Continued Uncertainty**

Nonetheless, numerous issues continue to confront the world, many of which cannot be resolved with technology alone. To overcome these challenges, we must call upon not only our ingenuity, but also our past experience and collective wisdom.

Examples of high-priority issues in surgery include access to and ongoing disparities in health care, outside interference with the surgical practice environment, and economic concerns. Many surgeons also have concerns regarding how they will be evaluated professionally as the nation moves toward a value-based health care system. Who will decide whether they are providing quality care and how they will be paid? What new regulatory burdens will they face in their efforts to provide accountable, reliable, transparent, patient-centered care? Will their efforts to maintain certification and licensure detract from their time in the operating room and consulting with patients?

Unquestionably, our profession faces many challenges, and, yes, we live in a time of great uncertainty. But as I look back on the last 50 years and recall walking home from school on a cold, rainy November afternoon in Hudson, OH, I am reminded that these difficulties are relatively small, albeit significant, in comparison with what the nation was experiencing at that moment.

**Looking Forward**

The American College of Surgeons (ACS) is working hard to help its members meet these evolving demands and to ensure that surgeons are involved in setting the standards for the profession. In the process, we would be wise to draw on the values, inspiration, and leadership that President Kennedy demonstrated during his brief time in office. We must look to the future not with fear and cynicism, but with a commitment to continuing to make progress in the delivery of quality care and to building on the legacy of those innovators who came before us. And as we begin 2014, to paraphrase President Kennedy, I would ask each of you to ask not what your profession can do for you, but what you can do for your profession.

I look forward to working with all of you and am committed to ensuring that the ACS will continue to meet your expectations and the needs of your patients. Thank you for the privilege of serving as one of the leaders of this organization, and happy New Year.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Annual RAS-ACS essay contest:

Dealing with surgical complications
Surgeons, both in training and in practice, face potential complications with nearly every decision made or action taken. We each cope with these events in slightly different ways but share common experiences: the feeling of guilt or shame when facing a patient or family member after an adverse event; analyzing our actions in an effort to improve; seeking the advice of a colleague or mentor; and ultimately coming to peace with ourselves so that we may provide quality care to the next patient who needs us to be at our best. In this issue of the Bulletin, members of the Resident and Associate Society of the American College of Surgeons (RAS-ACS) share their experiences with and perceptions on the subject of complications.

Each year, the Communications Committee of the RAS-ACS selects a topic of broad interest to young surgeons and solicits brief essays from interested members on the subject. Essays are judged by a panel of Communications Committee members, and in addition to publication in the Bulletin, the author of the winning essay receives a $500 prize.

This year’s topic, How Surgeons Deal with Complications, generated a robust response from the RAS-ACS membership, and we were pleased to select the essay written by Elisha Brownson, MD, from the Boston University Medical Center, MA, as our winner. Although Dr. Brownson’s essay stood out from the rest, all of the thought pieces that follow are excellent and worthy discourses and share universal themes on this emotional topic. I anticipate that most readers will empathize with the authors and will learn from these selections from the next generation of surgeons. ♦

How surgeons deal with complications:
Introductory remarks

by Robert D. Winfield, MD
Snap.
In an instant, the whole procedure changed. I had been called to assist another co-resident in removing a port-a-cath at the bedside. It had been difficult, and despite retrieving the port, the tunneled line was proving to be more of a struggle to remove. It was my hands that came to assist, that applied stronger tension, and that snapped the catheter. It was my complication.

My thoughts flashed back to the consent form that the patient had signed. The risks of the procedure include: bleeding (not expected to be more than a tablespoon), infection (we are removing the port due to suspected infection), damage to nearby structures...

Did we even mention retained foreign body?
In a calm voice, I asked my co-resident to get our chief resident to the bedside and get the nurse to put the patient on telemetry. There we were, with an awake patient and a catheter that I could not retrieve.

Surgeons must often face complications in a much more overt way than our medical colleagues. And, unlike a hospital-acquired pneumonia, which often can be attributed to several factors with shared responsibility among numerous providers, surgical complications can often fall into the operator’s hands. Our hands, which we have trained to heal, are also held accountable for their actions.

I returned to our workroom feeling a mixture of embarrassment, regret, and disappointment in myself. My chief’s response surprised me. She said that this problem was a sign that I was operating because, in the end, we cannot operate without encountering complications. We must reconcile this fact within ourselves to move forward, while at the same time proceeding with great care and detail so that we do not advance recklessly to the operating room. It is this awareness that our colleagues and attendings attempt to reproduce at the podium of our morbidity and mortality conferences, but often we are our own greatest critic in this process.

The sterile field was taken down. My gown, gloves, and mask were removed. Are you all done now? We invited the patient’s wife back to the room so the attending surgeon and I could explain our findings and the plan going forward. It is a challenge, in a field wrought with pride and confidence, to expose our failures to patients and their families. But this humility carries forward with us and shapes us. Every surgeon has those poignant faces or names engraved in their memory, and they stay with us for the duration of our career.

The patient was wheeled off to interventional radiology. Thankfully, retrieval of his catheter was resolved promptly and without further complications. The next day, I apprehensively walked into the patient’s room to round. Deep breath. Move forward. Another day in residency. These were the thoughts that were running through my head that morning.

I am a surgeon in training and as my responsibilities grow, I understand more intimately the unique challenges of our field. I have learned from this patient and have found that our complications spur us on to strive for better care in the future. ◆
I am nearing the end of preparing the gastric conduit for an esophageal replacement during a long and complicated esophagectomy. I staple the left gastric pedicle along the lesser curvature. The orientation of the stomach does not look right. It dawns on me that, yes, I did the unthinkable. I stapled the right gastroepiploic pedicle—the blood supply for the gastric conduit. Her stomach is now unusable.

As much as I wanted to mentally kick myself and retreat from the world and the gravity of my error, I still had a patient with an open abdomen who needed an esophagectomy and an alternative replacement. In such situations, there is no time to retreat, rationalize, and ponder; there is only time to humbly admit the mistake and find a solution. In the face of a serious error, the surgeon needs to respond by accepting that he or she has made a mistake—without excuse, defense, or rationalization—and quickly return to caring for the patient. In this particular situation, the solution was to create a pedicled segment of jejunum to serve as an interposition between the proximal esophagus and remnant distal stomach.

Once the error has been physically resolved to the best of the surgeon’s ability, he or she should proceed as follows:

• Be transparent with the patient, your colleagues, and yourself. Transparency is essential not only because the patient and family have the right to know the truth about the complication, but also because discussing complications with your colleagues serves as a foundation for lessons in how to prevent and compensate for such errors.

• Create a moment of pause the next time you encounter a situation similar to the one that led to the error. I will forever remember stapling the right gastroepiploic pedicle to the gastric conduit, and from that incident forward, both my assistant and I have checked, double-checked, and triple-checked the orientation of the stomach and the anatomy before dividing what we believe is the left gastric pedicle. This simple tactic, “the pause”, serves as an effective checkpoint to prevent errors.

• Reflect on the error. One of my mentors likes to keep a “little black book” in which he writes down lessons and thoughts for improvement after every case. He calls these entries his “black book thoughts.” As surgeons, we all need to have a means of reflecting on and, importantly, documenting our black book thoughts for posterity. This process allows us to accept what we have done, be transparent with ourselves, reflect on errors, develop error-prevention strategies, and ultimately forgive ourselves.

• Forgive yourself. It is impossible to be an effective clinician and surgeon working with the weight of regret and the fear of repeating mistakes. Our prior errors should live with, but not hinder, us. We must be able to forgive ourselves so that we can continue to do the right thing and take care of our future patients. It is a chance to heal not only the patient, but also ourselves. ♦

acknowledgement
The author would like to acknowledge Sara S. Kim, MD, a first-year general surgery resident at the University of North Carolina-Chapel Hill, for her assistance with this essay.
We don’t like to think about the fact that surgeons make mistakes. Yet, a significant proportion of our patients suffer complications either on the wards or in the operating room, and some of these problems are direct consequences of our mistakes.

The emotional reactions of surgeons to adverse events can be categorized into different phases:

1. The kick, during which feelings of failure emerge
2. The fall, in which a sense of chaos prevails
3. The recovery, when we try to learn from our mistakes
4. The long-term impact, which involves integrating what we have learned into our practice*

But how do we integrate these lessons into our everyday lives?

I remember it as if it happened yesterday. It was the first week of my fellowship, and I was assigned a non-complex case with a resident. I was nervous because it was one of my first few independent cases, but, at the same time, I was excited to be able to prove to others that, “I can do it.”

We planned to resect a pancreatic cyst that had previously been internally drained to a Roux-en-Y. At some point in the case, I felt the complex portion was over. We had identified the anatomy of the Roux limb, and we simply had to take it down. I thought this step was the routine part of the operation and resorted to “automatic mode.” Little did I know, but I was actually taking down and resecting the normal duodenum of the patient and not the Roux-en-Y. As a result, we had to perform a much larger operation with an end-to-end anastomosis to the second portion of the duodenum, which led to several postoperative complications.

Many thoughts were going through my mind. A couple of these bothered me tremendously: one was that my patient had just suffered a major complication that was avoidable, and the other was that my credibility and identity as a good surgeon-in-training were in jeopardy.

This error marked the beginning of my training as a fellow, and I was unsettled for a long time. Talking about and discussing this operative complication with residents, fellows, and junior and senior staff helped me to deal with these emotions—not only talking about the technical aspects of the operation, but also how to prevent something like this from happening again.

Through this experience, I learned the concept of “slowing down when you should.” My mistake was definitely attributable to a failure to slow down and be mindful at a crucial moment during the operation. By talking about this surgical error, I was able to dig into this problem—to look at it head-on and not shy away from it.

Talking about our reactions to cases involving surgical complications should not leave us feeling embarrassed or denigrated. Rather, expressing our feelings regarding these situations should allow us to achieve an understanding of two crucial and conflicting realities—our desire for perfection as we strive for our best and our imperfection on this real, lifelong journey.

His eyes became sunken and retreated backwards. His face grew pale. Within seconds, a lifeless corpse replaced the spirit of a once vivacious, living being. My mind was paralyzed, but my instincts remained engaged. Without delay, I initiated chest compressions, glaring intently at the monitor and hoping that the asynchronous beats would somehow reorganize into a familiar rhythm again; but they did not. Instead, the tracing flattened. This man and his soul had drifted away, and there was no way I could call him back. He was gone forever, and in the recesses of my mind, I felt I was in some way responsible.

In medicine, a “complication” refers to the unfavorable evolution of a disease, condition, therapy, or procedure. By and large, complications are unintended, and, particularly in surgery, they frequently occur with little or no advance notice. Occasionally, complications arise without any true reason as to how or why they occurred. What is clear, however, is that the costs associated with most complications are high—sometimes conferring unnecessary morbidity and premature mortality, which is every surgeon’s nightmare.

Much interest is frequently placed on understanding how to avoid the varying types of complications, but little is ever spoken regarding how to conduct oneself when, indeed, confronted with the reality of an undesirable surgery-related event. This notion has emerged as being critically important to us as surgeons, given that we are now judged not only by the scope and adeptness of our surgical skill, but also on the bases of the short- and long-term complication rates associated with the care we provide.

Invariably, we will all face complications. Even those whom we hail as masters and experts of our craft can recall complications that have haunted their clinical practice. To this point, there are few situations in which specific complications are essentially unavoidable; they just happen. Yet, irrespective of the context, we must recognize that in almost every situation—regardless of the setting—rests an opportunity for the surgeon to be inquisitive, to be transparent, to be introspective, and to learn from the moment at hand.

In whatever way we choose to address our complications, either in our clinical practice or on the basis of consultation, we must challenge ourselves to be responsive in identifying sentinel causality. We must demonstrate equipoise between self-assessment and constructive peer censure. We must continue to recognize the inherent frailties of the human experience and work toward shifting from a culture of blame and duplicity to one of accountability and trust. Finally, we must be dedicated to delivering responsible, patient-centered care in a safe, collegial environment that includes equitable treatment and full disclosure to all patients and families alike. These tenets may represent the way forward in our specialty and inarguably will define how well we are able to truly advance our profession beyond the veil of complications.
The family gathers in the waiting area, holding hands, exchanging stories. The surgeon appears. He’s done this operation many times before, he assures them. The family offers reassurance to the patient as well. Hugs are exchanged, along with a final kiss from his wife of 50 years. Off rolls a husband, a father, a grandfather—entrusting his life to a man he’s spoken with for less than 30 minutes.

In the operating room, lines are in place and checklists are completed. The team has done this routine many times before. The belly is opened; everyone knows the process from here. The surgeon’s hand reaches in, but something feels different than the images displayed on the monitor. What seemed small before has now grown and is near the major vascular structures. The surgeon ponders the next move, constantly assessing the risk of proceeding. To resect is to cure; to not resect is failure. Heal by steel it is, and they press on.

The dissection is tedious, the exposure difficult. Frustration mounts as the lighting just never seems quite right. Red flags are all around, but to not resect is failure. Then the bleeding starts. The open cavity fills torrentially. The patient’s blood pressure drops, while the heart rate rises. The head of the table is now a flurry of activity. Sponges are used in an attempt to quell the crimson surge but to no avail. The monitor alarms. The pulse is absent. Compressions begin, but this chapter is closed. No more morning strolls with his wife. No more weekends manning the grill with his son during football season. No more pushing his granddaughter on the backyard swing.

The family gathers in the consultation room. Once jovial, they now sit in silence, waiting, hoping. On the other side of the restricted area, the surgeon changes his soiled scrubs. His mind races. What if he had just improved the exposure? He rinses the blood splatter from his neck. What if he hadn’t pushed forward?

The door opens, the surgeon removes his cap. He did all he could. The tumor was large. There was bleeding. His heart could not take the stress. He’s passed. Tears flow as everyone gathered huddles together in a consoling embrace. There are no dry eyes except for the surgeon. He weeps within—weeps for what he’s done.

His peers will offer solace—the tumor was large, the tissue quality was poor. His heart was already in suboptimal condition. Inside he knows this outcome was avoidable. Knows his pride put this man in danger. Knows the void now created in this family. Knows these feelings will trouble him for days, weeks, months, years.

But there isn’t time to ponder these consequences. The next case is on the table. ◆

Consequences

by G. Paul Wright, MD
As a surgeon, when complications happen, I tend to take them very personally. I see these technical or clinical errors as damning evaluations of my own effort, work, and worth. I think all surgeons have this mentality to some extent—the belief that their value and ability as a physician is tied to their patients’ outcomes.

This belief, of course, is foolish because clinical outcomes are dependent on many factors outside of the surgeon’s control, such as patient follow-up, comorbidities, and so on. However, as “captains of the ship,” surgeons inherently believe that the outcomes are in our control. When the outcomes go wrong, the effects on our self-worth can be devastating.

After my first complication, I found myself in a semi-depressive state, wondering whether I was cut out to be a surgeon. As one of my patients showed me, however, this was borne out of an error in how I viewed the surgeon-patient relationship.

I received my education after inadvertently ligating the common bile duct on a patient. The patient remained in the hospital for months, and for the first few days after the complication, I became a mute, walking the halls in a zombie-like daze of regret and self-anger.

My attending paged me a few days later and asked me to meet him in the patient’s room. As I entered with my head held low, not wanting to make eye contact with the patient whom I had injured, the patient put his hand on my shoulder and told me, “Doc, you’re my surgeon. We can’t take this on together if you’ve already given up.”

We talked for about 15 minutes that day—the patient, my attending, and I. We talked about the patient’s kids, about the championship football game of his son that he would miss while in the hospital, and about how the patient needed to quit smoking. A small amount of time was devoted to explaining what the next steps in his care would be, the challenges ahead, and what each of us needed to do. Sitting there, huddled together, it felt like a discussion on a team bus headed for a big game. Teammates talking about our personal lives, but also focused on what needed to be done to achieve a positive outcome.

When mistakes occur, retreating into seclusion and self-blame are common reactions. For surgeons, this reaction is borne of the theory that they are ultimately in control of the patient’s care and outcomes. However, we are not.

Surgeons have a complex relationship with their patients, one marked by the common goal of a positive outcome. When successes happen, we should celebrate together. And when failures occur, we should grieve and rebound together as well. This is a unique method of dealing with errors as surgeons that we all should embrace.
Preoperative telemedicine evaluation of surgical mission patients: should we use it routinely?

by Rifat Latifi, MD, FACS; Francisco Mora, MD; Flamur Bektlesi; and Renato Rivera, MD, FACS
As most surgeons know, medical care is insufficient or nonexistent in many regions of the world. The lack of access to surgical care accounts for a high number of disability-adjusted life years (DALYs), defined as years of healthy life lost. DALYs have been launched by the World Bank and by the World Health Organization (WHO) as a measure of the global burden of disease. WHO estimates that 2 billion people have no access to basic surgical care and that surgery could be used to cure 11 percent of the global burden of disease.

Surgical humanitarian missions, including those outreach efforts arranged through the American College of Surgeons’ Operation Giving Back program, have become a viable method of providing surgical care to patients in underserved areas. Many other organizations around the world facilitate such missions as well, which typically involve a broad spectrum of surgical disciplines.

Preoperative evaluation of surgical mission patients is a complex, time-consuming, and often chaotic process. Typically, these evaluations require intense work by the operating team on the day of arrival at the mission site. On-site screening, unfortunately, precludes many patients from receiving surgical treatment due to the identification of last-minute medical issues, such as comorbidities or the lack of necessary test results. Many of these patients wait for years to obtain surgical care only to be told they are inappropriate candidates for the surgical care that will be provided through the mission. It is unclear how many patients are disqualified from participation during on-site screening worldwide for any of the aforementioned reasons, but it is likely that the number is considerable.

**The Mission**

For the last seven years, the Association of Filipino Physicians of Southern Illinois has organized a team of surgeons, anesthesiologists, nurses, and other health care professionals to deliver surgical care in Tagbilaran, the capital city of the island province of Bohol.

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**HIGHLIGHTS**

- Reports that on-site preoperative evaluation of global surgery patients is a complex, time-consuming, and often chaotic process and that telemedicine could be used to expedite the delivery of lifesaving care
- Describes how the authors reviewed patient information and radiologic studies using sAFT before embarking on a surgical mission in the Philippines, followed by in-person follow-up
- Authors found a 98 percent correlation rate between sAFT and in-person preoperative evaluations
- Demonstrates that low-cost telemedicine is a viable and secure tool for preoperative evaluation of surgical mission patients, and its routine use should be encouraged
To assess the applicability of telemedicine in advance of short-term surgical missions, our team conducted a study comparing the use of store-and-forward telemedicine (SAFT) with in-person, on-site preoperative evaluations of surgical mission patients.
In five patients (less than 5 percent), the remote surgeon required more information or better images (see Table 2, page 21) to render an opinion. Of those five patients, during the on-site in-person evaluation, the surgical team found that two had a lipoma, two had an inguinal hernia, and one patient had a breast mass. Figure 3, page 22, is a photo of one of these conditions, a mass on the patient’s flank that turned out to be a lipoma.

The remote surgeon, using SAFT, preliminarily decided against an operation in five (less than 5 percent) of the patients: two had severe hyperthyroidism and required medical therapy before surgery; one had been misdiagnosed by the local medical team as having an inguinal hernia but, per SAFT, did not; one had a lipoma that did not require removal; and one patient had a breast tumor that appeared suspicious for cancer that required further evaluation and staging (see Table 3, page 22).

The correlation rate between SAFT and in-person preoperative evaluations was 98 percent. Only two operations preliminarily arranged based on the SAFT evaluations were canceled after an in-person on-site consult, both due to a lack of indication for surgery. Overall, preoperative telemedicine evaluation decreased the on-site screening time significantly over what it would have been, as compared with previous missions.

effective evaluation method
Several studies have shown that telemedicine is a safe and reliable method for evaluating surgical patients preoperatively and postoperatively. However, the infrastructure for using low-cost telemedicine technologies has yet to become ubiquitous worldwide. Most studies have used one of the two main techniques: SAFT or live teleconsultation. For the most part, live telemedicine consultation
requires advanced infrastructure and technology, but low bandwidth telemedicine for intraoperative consultations in the jungles of Ecuador has been reported.\(^9\)\(^{12}\) Subsequently, Merrell and colleagues in Richmond, VA, used remote screening to evaluate 51 patients in Kenya using e-mails and attachments containing patient data and images. In this study, 33 patients (65 percent) were deemed poor candidates for operative care for various reasons. The rest of the patients underwent successful surgical procedures.\(^10\) Although a large number of patients were considered non-candidates for surgical services, the real number of patients that typically are disqualified from receiving care on surgical missions has never been reported.

In our study, the number of patients who did not receive operative care was much lower; however, this high acceptance rate may reflect careful patient selection by the Gift of Life Foundation for the Philippines and past experience. Other studies have reported good results in the use of preoperative screening using telemedicine for patients treated in the Amazon basin.\(^11\)

Like many other reports, this study demonstrated that the use of SAFT immediately before such missions is safe and reliable. We were unable to render an opinion in advance of our surgical mission via SAFT only for a small number of patients. Additional information that was unobtainable remotely (for example, from maneuvers during in-person physical examinations) was required. The development of standardized SAFT

### TABLE 1. PATIENTS EVALUATED VIA SAFT

<table>
<thead>
<tr>
<th>Condition</th>
<th>number of patients</th>
<th>saFT diagnosis and opinion rendered</th>
<th>Confirmation by in-person evaluation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thyroid mass (mostly, giant goiter)</td>
<td>52</td>
<td>52</td>
<td>100%</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>14</td>
<td>12</td>
<td>86</td>
</tr>
<tr>
<td>Gallbladder disease</td>
<td>7</td>
<td>7</td>
<td>100</td>
</tr>
<tr>
<td>Superficial soft-tissue tumor</td>
<td>7</td>
<td>5</td>
<td>86</td>
</tr>
<tr>
<td>Breast tumor</td>
<td>9</td>
<td>8</td>
<td>89</td>
</tr>
<tr>
<td>Parotid mass</td>
<td>4</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>93</td>
<td>88</td>
<td>95</td>
</tr>
</tbody>
</table>

### TABLE 2. CONDITIONS UNABLE TO RENDER AN OPINION VIA SAFT

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipoma</td>
<td>2</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>2</td>
</tr>
<tr>
<td>Breast mass</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
</tr>
</tbody>
</table>
techniques for surgical mission and additional live telemedicine consultation protocols may be a solution to this problem. Some studies have established guidelines for capturing radiologic images for telemedicine patients.\textsuperscript{13,14}

**Future applications**

Similar studies are needed to assess the quality of other imaging methods for telemedicine patients with superficial soft-tissue tumors and hernias, to name just two conditions. Videos showing surgical mission patients’ pathology tests and physical examinations also are needed.

The authors believe that videos obtained by smartphones or other video equipment would help to remotely identify such conditions as thyroid lobe goiter with greater precision (differentiating, for example, between involvement by one lobe versus both lobes), especially in patients with a bilateral giant goiter, as depicted in Figure 4, this page. Sometimes, massive goiters are difficult to evaluate even in an anesthetized patient on the operating table.

Although involvement of surgery residents and surgical fellows may be admirable in these missions, training a local nurse or physician—someone who lives year-round in the underserved area—to perform preoperative evaluations and forward the data and images to the mission’s surgical team is advisable. Having a local nurse or physician participate in this meaningful manner would strengthen the on-site surgical mission and aid in the development of sustainable health care teams. Perhaps most importantly, this local involvement would facilitate long-term postoperative follow-up care for all surgical mission patients.

### TABLE 3.
**Patients Deemed Non-Operative Candidates Via Saft**

<table>
<thead>
<tr>
<th>SaFT Diagnosis</th>
<th>n</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goiter</td>
<td>2</td>
<td>Severe hyperthyroidism; medical therapy required</td>
</tr>
<tr>
<td>Inguinal hernia</td>
<td>1</td>
<td>Misdiagnosis by local team; no indication for surgery</td>
</tr>
<tr>
<td>Lipoma</td>
<td>1</td>
<td>No indication for excision</td>
</tr>
<tr>
<td>Breast tumor</td>
<td>1</td>
<td>Further evaluation and staging required</td>
</tr>
</tbody>
</table>

### Figure 3.
**Flank Mass, Undiagnosable Via Saft**

![Flank Mass, Undiagnosable Via Saft](image)

### Figure 4.
**Bilateral Giant Goiter**

![Bilateral Giant Goiter](image)
Like many other reports, this study demonstrated that the use of SAFT immediately before such missions is safe and reliable.

**Summary**

Low-cost telemedicine is a viable and secure tool for preoperative evaluation of surgical mission patients. It increases efficiency and optimizes the use of existing resources. More specifically, it helps ensure an accurate assessment of patients before the surgical team arrives, reduces on-site prescreening time, and decreases the number of surgical candidates on the waiting list. Routine use of telemedicine in surgical missions most likely would reduce preoperative times and the number of operations canceled at the last minute. Moreover, it may be effectively used for long-term follow-up care, including the management of any postoperative complications.

**Acknowledgments**

The authors thank all the members of Borja Family Hospital in Tagbilaran, Philippines, and all members of Bohol Operation Giving Back 2013 for their support and assistance with this project, as well as the Medweb team for their generous technical support, and Ronald Merrell, MD, FACS, professor, Virginia Commonwealth University, Richmond, VA, for his valuable editorial comments and review of the manuscript.

**Editor’s Note**

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**References**


A recurring character on The Tonight Show with Johnny Carson was Carnac the Magnificent. A “mystic from the East,” Carnac would divine the answers to unknown questions that were contained in a “hermetically sealed envelope.” State Affairs staff in the American College of Surgeons (ACS) Division of Advocacy and Health Policy would like to have this mystical ability to predict what is likely to happen in the state legislatures in 2014, but, unfortunately, there is no crystal ball or Carnac available to help divine the future of state legislation. However, it is possible to make some educated guesses about 2014, especially after a look back at what happened in 2013.

where the action is
Advocacy at the state level has become much more important in recent years because that is where all the action seems to be taking place. The 16-day federal government shutdown in October 2013 reflects the end result of hyper-partisanship, and impedes good governance. However, at the state level, legislators get bills passed, with or without partisanship. States must, by law, have balanced budgets, so spending plans that the majority party introduces are acted upon, as are other initiatives near and dear to the majority’s heart.

It is also at the state level where medical licensure and insurance markets are regulated, and where Medicaid payment is determined. Public health issues are often addressed at the state level, as are banking and health care systems overall (trauma center/system approval, hospital/ambulatory surgery center licensure, and so on). Medical liability reform, while often discussed and attempted at the federal level, actually gets enacted at the state level—with varying degrees of success. And certainly there can be a hodgepodge of health care-related issues relating to trauma, cancer, bariatric surgery, quality and patient safety, and medical education.

Legislative schedules are typically limited, with most state legislatures meeting for two to three months between January and July. Then legislators adjourn and return home, providing plenty of opportunities for in-district visits with their constituents.

Brief look back
A detailed review of state legislatures in 2013 was published in the December 2013 issue of the Bulletin (pages 31–35), but for the sake of more accurately assessing the issues likely to top the state legislatures’ agendas in 2014, it’s worthwhile to briefly look back at 2013. Following are some of the issues debated heavily in the state legislatures last year.
Advocacy at the state level has become much more important in recent years because that is where all the action seems to be taking place.

Medical liability reform. A number of states saw legislative and judicial activity related to medical liability reform.* Legislators in Arkansas looked at potential constitutional amendments to implement caps on noneconomic damages and other reforms similar to those in the groundbreaking Medical Injury Compensation Reform Act (MICRA). Meanwhile, efforts were under way in California, the birthplace of MICRA, to attack the statute at the ballot box. The Supreme Courts in New Jersey and in Oklahoma issued rulings, and other states passed disclosure, apology, and offer laws (Oregon); clarified existing medical liability reform laws (Michigan); and introduced and enacted the concept of provider shields relating to public/private payor guidelines used as evidence in medical liability lawsuits (Georgia).

Provider shields create a barrier between physicians and public or private payor guidelines that could be used as evidence in medical liability lawsuits. Evidence related to the public and private payor guidelines is inadmissible in court and may not be used to demonstrate negligence or failure to follow a standard of care.

Injury prevention. Legislators at the state level saw the usual mix of youth concussion education, firearm safety, and distracted driving bills introduced and, in some cases, enacted by their legislatures. For the past few years, it has been popular in the states to address use of handheld communication devices and texting while driving.

Scope of practice. Many bills are introduced every year at the state level, which would expand the scope of practice for nonphysician health care practitioners.

Advanced practice nurses, optometrists, dentists, podiatrists, and other practitioners regularly go to their legislators to see what they can achieve with varying degrees of success. One point worth noting with respect to scope issues is that they generally result in legislators’ friends fighting over some aspect of the issue, and legislators typically prefer to avoid such conflicts.

Cancer/trauma. Many states sought to require insurance companies to provide for additional imaging in those cases where dense breast tissue is detected. In addition, after multiple attempts, Texas succeeded in enacting the Uniform Emergency Volunteer Health Practitioners Act.†

r inging in the new year
Some significant issues are likely to be considered in the states this year. A few examples of what to watch for are as follows:

• As mentioned previously, MICRA is once again under attack in California. An initiative, should it receive the required number of signatures, will be on the November 2014 ballot, which would not only increase the cap on noneconomic damages from $250,000 to approximately $1.1 million, but would impose mandatory random drug testing and other dictates on physicians. A summary description of this initiative (13-001) is available at the California Secretary of State’s Web page.‡

Campaign efforts to defeat or pass this ballot initiative are going to be very expensive—in the hundreds of millions of dollars. Surgeons, ACS chapters, and the entire California medical community will be hearing from those organizations that oppose the initiative and will want and need to be engaged.

• With the implementation of the Affordable Care Act (ACA), legislators in some states may be taking another look at the essential benefits package to determine what procedures should be covered. Now would be a good

With the implementation of the Affordable Care Act (ACA), legislators in some states may be taking another look at the essential benefits package to determine what procedures should be covered.

time for surgeons to advocate for coverage of procedures they believe should be included in the benefits package. Other ACA-related issues may include transparency of fee schedules for providers, Medicaid expansion and improving Medicaid payment, participation in networks included in insurance plans purchased through the exchanges, and so on.

• As mentioned earlier, provider shield legislation was passed in 2013 for the first time in Georgia. This legislation was drafted in response to a joint effort by the medical and the trial attorney communities. While Georgia is the first state to do this, it is likely to catch fire in other state legislatures, so surgeons and ACS chapters should pay close attention in their states and look for advocacy opportunities should provider shield or other liability reform legislation be introduced.

• Many scope-of-practice bills are expected to be introduced this year. In particular, advanced practice nurses (APNs) have been very active at the grassroots level for the last year or so, educating state legislators about their desire to practice independently and why they think they should be allowed to do so. A counterbalance to this movement—not just for APNs, but really any non-physician provider group seeking independent practice—is a law that Texas passed in 2013 that creates a team-based, physician-led collaborative model of practice. It would not be surprising to see the Texas model bill popping up all over the country, especially in those states where scope-of-practice battles rage on year after year.

• At least eight states passed breast imaging laws in 2013, and many more will be considered in the state legislatures in 2014. These bills mandate that coverage be provided for an additional imaging test when dense breast tissue is found.

• The few remaining states that have yet to adopt youth concussion education and prevention laws will likely be considering such legislation. In light of recent national coverage of brain injury in professional football players, this issue has gotten a second wind and certainly generated considerable concern among the parents of children who want to play football or other sports where concussions are a possibility.

• Now that many state budgets are in slightly better shape, 2014 may be the year to start looking at not only trauma system development, but also funding for these systems. Possible models would include raising the fee on the issuance of driver’s licenses or vehicle registrations with those additional funds directed to the trauma system. Another possibility would be an increase in the tobacco tax.

• With 2014 being an election year, state legislators will be looking to introduce the kind of legislation they can get passed to bolster the likelihood of re-election. With this in mind, now might be a good time for surgeons to contact their state legislators and suggest that they introduce and pass bills that would be good for the profession, for patients, and for the state.

This summary lists just a few legislative and policy trends to watch for at the state level. Certainly, many other issues will arise, and ACS State Affairs staff would like to hear from surgeons and chapters when they do. Send correspondence to stateaffairs@facs.org. Likewise, when the College issues a grassroots advocacy request for action, surgeons and chapters need to participate. Typically a five-minute visit to the Surgery State Legislative Action Center to send a prewritten letter to a state legislator is all that is required. The ACS Surgery State Legislative Action Center is available at http://www.facs.org/sslac/index.html. It’s easy to do but can make a world of difference in the outcome of a piece of legislation in the states. ♦
Highlights of the 2013 Clinical Congress
The 2013 Clinical Congress of the American College of Surgeons (ACS) provided surgeons, medical students, surgical residents, and other members of the operating room team with the opportunity to immerse themselves in a variety of educational experiences and to interact with their peers. Total registration for this year’s meeting was 13,367, including 8,857 physicians; the remaining registrants were exhibitors, guests, spouses, and convention personnel.

Centennial celebration concludes
Over the course of the last year, ACS Fellows have been commemorating the 100th anniversary of the founding of the College. Adding to the excitement of the 2013 conference were activities marking the conclusion of the Centennial celebration. Once again, a special exhibit, 100 Years of Inspiring Quality—An Interactive Timeline, was on display at the meeting with new features added to spotlight the lessons learned from the ACS Inspiring Quality Tour and other developments in 2012–2013.

The ACS leadership also hosted an evening of coffee, cordials, and conversation. During this social event, College leaders conducted a Centennial cake-cutting ceremony. The ACS International Relations Committee and Operation Giving Back also presented a Centenary International Reception in honor of the College’s milestone anniversary.
In a related activity, a new Surgical History Group held an organizational breakfast under the leadership of former ACS President LaMar S. McGinnis, Jr., MD, FACS. The primary focus of the new group will be the preservation of College’s historical resources. Furthermore, the ACS Foundation announced the official launch of the 1913 Legacy Campaign fundraising initiative. The campaign will secure gifts to advance programming that is critical to the College, while also recognizing the Centennial and looking forward to the next 100 years.

Convocation
Although considerable attention was directed toward the ACS Centennial, the underlying focus was the future of the organization as exemplified by the theme of the 2013 Clinical Congress—“The Next 100 Years.”

Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), The Henry N. Harkins Professor and Chair, department of surgery, University of Washington Medicine, Seattle, was installed as the 94th President of the ACS during the 2013 Convocation ceremonies on October 6. Dr. Pellegrini presented his Presidential Address, The Surgeon of the Future: Anchoring Innovation and Science with Moral Values, to the College’s 1,622 Initiates.

Two Vice-Presidents assumed office during the Convocation as well: Layton “Bing” Rikkers, MD, FACS, as First Vice-President, and John T. Preskitt, MD, FACS, as Second Vice-President. Dr. Rikkers is professor emeritus at the University of Wisconsin-Madison and Editor-in-Chief of Surgery News. Dr. Preskitt is a surgical oncologist at Baylor University Medical Center, Dallas, TX.

In addition, Honorary Fellowship was conferred on six international surgeons: Markus W. Büchler, MD, of Heidelberg, Germany; R.J. (Bill) Heald, CBE, MChir, FRCS(Ed)(Eng), Basingstoke, Hampshire, UK; J. Octavio Ruiz Speare, MD, MSc, FACS, Mexico City, Mexico; Prinya Sakiyalak, MD, FACS, FRCS(T), Bangkok, Thailand; Norman S. Williams, MS, FMedSci, PRCS(Eng), London, UK; and Cheng-Har Yip, MB, BS, FRCS(Glas)(Eng), Kuala Lumpur, Malaysia.

Named Lectures
As always, Clinical Congress featured several Named Lectures, starting with the Martin Memorial Lecture, presented immediately after the Opening Ceremony on October 7. In honor of the conclusion of the College’s Centennial celebration, historian David McCullough, recipient of two Pulitzer Prizes and two National Book Awards, delivered the well-received lecture, Something New, Something Old with Renewed Force: The Role of History and Innovation in Medicine.
Other Named Lectures presented at the 2013 Clinical Congress were as follows:

- **Pauline W. Chen, MD, FACS**, a transplant surgeon and *New York Times* columnist presented the Olga M. Jonasson Lecture: Conduct Unbecoming

- **Robert H. Bartlett, MD, FACS**, professor emeritus of surgery at the University of Michigan, Ann Arbor, presented the John H. Gibbon, Jr., Lecture: Extracorporeal Life Support: Gibbon Fulfilled

- **Peter W. Carmel, MD, D. Med Sci, FACS**, chair emeritus, department of neurological surgery, and professor of neurological surgery, New Jersey Medical School at Rutgers University, Newark, presented the Charles G. Drake History of Surgery Lecture: Neurosurgical Contributions to Anesthesiology in the Early 20th Century

- **Roy A. J. Spence, OBE, JP, MD, LLD(Hon), FRCS(Edin)(I), FRCS(Eng, Glas)(Hon)**, professor of surgery at Queen’s University of Belfast and the University of Ulster, Northern Ireland, gave the I.S. Ravdin Lecture in the Basic and Surgical Sciences: Reflections of a Surgeon in Troubled Times

- **Ian C. Lavery, MD, FACS**, staff surgeon, department of colon and rectal surgery, the Cleveland Clinical, OH, presented the Herand Abcarian Lecture: How Health Care Reform Will Impact the Practice of Surgery

- **Mark A. Talamini, MD, FACS**, professor and chairman, department of surgery, Stony Brook University
School of Medicine, Stony Brook, NY, presented the Excelsior Surgical Society/Edward D. Churchill Lecture: Surgery and Technology: A Complicated Partnership

• **Ronald V. Maier, MD, FACS**, the Jane and Donald D. Trunkey Endowed Chair in Trauma Surgery and professor and vice-chair, department of surgery, University of Washington, Harborview Medical Center, Seattle, presented the Scudder Oration on Trauma: A Century of Evolution in Trauma Resuscitation.

• **Norman S. Williams, MS, FMedSci, PRCS**, President of the Royal College of Surgeons, London, UK, gave the Distinguished Lecture of the International Society of Surgery: Attempts to Innovate in Coloproctology and Beyond.

• **Bruce L. Gewertz, MD, FACS**, the H. and S. Nichols Distinguished Chair in Surgery; surgeon-in-chief; chair, department of surgery; vice-president of interventional services; and vice-dean of academic affairs, Cedars-Sinai Medical Center, Los Angeles, CA, presented the Ethics and Philosophy Lecture: Sustaining Fulfillment in Work and Life.

• **Glenn D. Steele, Jr., MD, FACS**, president and chief executive officer, Geisinger Health System, Danville, PA, gave the Commission on Cancer Oncology Lecture: Re-engineering of Care: Surgical Leadership.

### Awards and Honors

Several surgeons were honored for their contributions to the ACS. **Barbara Lee Bass, MD, FACS**, the John F. and Carolyn Bookout Distinguished Endowed Chair and chair of the department of surgery at Houston Methodist Hospital, TX, received the ACS Distinguished Service Award, the College’s highest honor, during the Convocation. The Board of Regents presented the award to Dr. Bass in appreciation of her exceptional service to the organization for more than “20 years in noteworthy leadership roles,” as well as “her outstanding clinical and academic contributions to the field of surgery.”

The Fellows Leadership Society (FLS) of the ACS Foundation presented the 2013 Distinguished Philanthropist Award to **Elias S. Hanna, MD, FACS**. The award was announced during the 25th annual FLS Benefactor Recognition Luncheon in recognition of Dr. Hanna’s philanthropic contributions and service to the international community.

Other awards were presented to surgeons for their commitment to trauma care. **John M. Templeton, Jr., MD, FACS**, a retired pediatric surgeon in Bryn Mawr, PA, received the National Safety Council (NSC) 2012...
Surgeons’ Award for Service to Safety at the annual ACS Committee on Trauma (COT) Dinner on October 7. The award recognizes Dr. Templeton’s “zeal for the care of injured children, his longstanding interest in injury prevention, and his generous philanthropic support of young investigators in the field of injury prevention.”

Ronald M. Stewart, MD, FACS, professor and chair, department of surgery, University of Texas Health Science Center, San Antonio, received the National Safety Council 2013 Award for Service to Safety during the COT Dinner. Dr. Stewart was recognized “for his commitment to the advancement of the care of injured patients in Texas through leadership in the organization of a regional trauma care system and outstanding trauma research.” In addition, the COT presented its Meritorious Achievement Award to Ricardo G. Sonneborn, MD, FACS, a retired general surgeon in Santiago, Chile.

Donald R. Laub, Sr., MD, FACS, a plastic and reconstructive surgeon, Redwood City, CA, received the 2013 ACS/Pfizer Surgical Humanitarian Award for his lifetime of service to patients in developing countries and for his development of a much-emulated model for providing surgical outreach around the world. Three surgeons received the ACS/Pfizer Surgical Volunteerism Award. Ingida Asfaw, MD, FACS, a cardiothoracic surgeon and clinical associate professor of surgery at Wayne State University School of Medicine, Detroit, MI, and chief of staff at St. Joseph Mercy Oakland-Trinity Health, Pontiac, received the Surgical Volunteerism Award for international outreach for his commitment to improving medical and surgical care in Ethiopia. Jerone T. Landström, MD, FACS, a general surgeon and Navy reservist, Tamuning, Guam, received the Surgical Volunteerism Award for military outreach in recognition of his contributions in the Federated States of Micronesia, Guam, the Philippines, and Afghanistan. Katrina B. Mitchell, MD, a general surgery resident at Weill Cornell Medical College, New York, NY, received the Surgical Volunteerism Award for outreach during residency for her contributions to improving surgical care and education in Tanzania.

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery. The 2013 Owen Wangensteen Surgical Forum on Fundamental Surgical Problems was dedicated to Kirby I. Bland, MD, FACS, professor and chairman, department of surgery, University of Alabama, Birmingham, for his contributions to the science of surgical research, as well as for his years dedicated to mentoring surgical residents.

Residents honored with the Surgical Forum Excellence in Research Awards included: Elizabeth M. Pontarelli, MD; David A. Kleiman, MD; Mahesh Thirunavukarasu, PhD; Sulaiman R. Hamarneh, MD; Viraj Pandit, MD; Allison F. Linden, MD, MPH; Colleen Rivard, MD; Jesse D. Vrecenak, MD; Reid A. Maclellan, MD; Nicole M. Tapia, MD; Nicholas J. Dedy, MD; Scott K. Sherman, MD; Juan Rodolfo Mella, MD, MPH; E. Will Kirby, MD; and Jonathan R. Thompson, MD.
Adil H. Haider, MB, BS, MPH, FACS, assistant professor, department of surgery, Johns Hopkins Medical School, Baltimore, MD, received the ninth Joan L. and Julius H. Jacobson II Promising Investigator Award. The award honors outstanding surgeons engaged in research, advancing the art and science of surgery, and demonstrating early promise of significant contributions to the practice of surgery and patient safety.

The eleventh annual ACS Resident Award for Exemplary Teaching was presented to Jacob A. Quick, MD, chief resident in general surgery at the University of Missouri, Columbia. The award is sponsored by the ACS Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives. Dr. Quick was selected by an independent review panel of the Committee on Resident Education.

The inaugural Jameson L. Chassin, MD, FACS, Award for Professionalism in General Surgery was presented to Justin P. Fox, MD, MHS, a chief resident in general surgery at the Wright State University School of Medicine in Dayton, OH. The award recognizes a chief resident in general surgery who exemplifies the values of compassion, technical skill, and devotion to science and learning. The award is
administered by the ACS Division of Education and will now be granted on an annual basis. The ACS established the new award with gifts from the Chassin family, colleagues, and friends of the late Jameson L. Chassin, MD, FACS, who was a skilled surgeon, teacher, and scholar in New York City. Dr. Fox was selected by an independent review panel of the Committee on Resident Education.

Valerie W. Rusch, MD, FACS, Chair of the ACS Program Committee; Quan-Yang Duh, MD, FACS, Vice-Chair of the Program Committee; and Mary T. Hawn, MD, FACS, presented Best Scientific Poster Presentation Awards to Junior Investigator Winner Elizabeth A. Phillips, MD, Boston, MA, for the poster Does a Surgical Career Affect a Woman’s Childbearing? A Report on Pregnancy and Fertility Trends Amongst Female Surgeons, and to Senior Investigator Winner T. Bruce Ferguson, Jr., MD, FACS, Greenville, NC, for Image-Guided Surgery: The Impact of Intraoperative Imaging on Risk-Adjusted Quality Outcomes.

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

- **First place**: Alison A. Smith, Tulane University, New Orleans, LA, for The Use of Paracrine Factors from Reprogrammed Mesenchymal Stem Cells to Treat Biofilm-Infected Wounds in Vivo

- **Second place**: Ryan J. Ellis, National Institutes of Health, Bethesda, MD, for Genome-Wide Methylation Patterns in Papillary Thyroid Cancer Are Distinct Based on Histologic Subtype and Tumor Genotype

- **Third place**: Scott T. Robinson, Emory University School of Medicine, Atlanta, GA, for A Novel Platelet Lysate Scaffold Promotes Human Mesenchymal Stem Cell Growth and Invasion
The following medical students were recognized for their Clinical and Educational Research posters:

- **First place**: Barbara J. Williams, University of California-Irvine School of Medicine, for Intravenous Infusion of Bendavia during Renal Revascularization Attenuates Cardiac Injury and Dysfunction in Swine Renovascular Hypertension

- **Second place**: Michael T. Onwugbufor, Children’s National Medical Center, Washington, DC, for Myocardial Cytochrome Oxidase Activity Increases with Age and Hypoxemia in Patients with Congenital Heart Disease

- **Third place**: Jamie E. Anderson, University of California-San Diego, for Cockcroft-Gault Equation Estimates of Nephron Mass and Need Can Predict Improved Outcomes in Expanded Criteria Donor Kidney Transplantation

The International Relations Committee welcomed the International Guest Scholars for 2013 and other guests at a luncheon October 8, including: Jensen T-C Poon, MB, BS, FRCS(Ed), FACS, Carlos Pellegrini Traveling Fellow; Stephen Ridley Smith, FRACS, ANZ Exchange Fellow; Walid Faraj, MB, BS, FACS; Georgios Tsoufas, MD, FACS, Stavros Niarchos Foundation Scholar; George Kwok Chu Wong, MB, ChB, FACS, Elias Hanna Scholar; Carlos Pastor, MD; Philip M. Mshelbwala, MB, BS, FWACS; Christopher John Wakeman, MB, ChB, MMed(Sci); Giuseppe R. Nigri, MD, PhD, FACS; Marco Del Chiaro, MD, PhD, Dr. Abdol and Mrs. Joan Islami Scholar I; Linda Carolyn Chokotho, MB, BS; Jorge H. Ulloa, MD, FACS; Sohei Satoi, MD, PhD, FACS, Dr. Abdol and Mrs. Joan Islami Scholar II; Anneke T. Schroen, MD, MPH, FACS, ACS Traveling Fellow to Germany; Shinji Itoh, MD, PhD, Japan Exchange Fellow; Matthias Heuer, MD, PhD, German Exchange Fellow; Adesoji Oludotun Ademuyiwa, MB, BS, Baxiram S. and Kankuben B. Gelot Scholar; Julie Rina Howle, MB, BS, FRACS, Murray F. Brennan Scholar; Mariano Norese, MD; Amos Olufemi Adeleye, MB, BS, FWACS; and Rajiv Agarwal, MB, BS, MS, Louis C. Argenta Scholar.

The Commission on Cancer presented the State Chair Outstanding Performance Award to the following surgeons: Allen Silbergleit, MD, FACS, Michigan; Patrick Jackson, MD, FACS, District of Columbia; and William Dooley, MD, FACS, Oklahoma.

Amy E. Tan, MD, FACS, a general surgeon in Blue Hill, ME, attended the Clinical Congress as the recipient of the 2013 Nizar N. Oweida Scholarship. Additionally, Anees B. Chagpar, MD, MPH, FACS, director of the Breast Center-Smilow Cancer Hospital at Yale University, New Haven, CT, recipient of the 2013 International Scholars and Travelers 2013.
Claude Organ Traveling Fellowship, spoke before the ACS Scholarships Committee.

Lastly, the Resident and Associate Society (RAS) of the ACS presented a $500 award to the winner of the 2013 RAS essay contest—Elisha G. Brownson, MD, a surgical resident at Boston Medical Center, MA. The theme of this year’s essay contest was How Surgeons Deal with Complications. This year’s essays are published in this issue of the Bulletin beginning on page 11.

**annual Business meeting**

The ACS Annual Business Meeting of Members convened October 9 with Dr. Pellegrini presiding and the following officials presenting reports: Julie A. Freischlag, MD, FACS, Chair of the Board of Regents; Robert R. Bahnson, MD, FACS, Chair of the American College of Surgeons Professional Association political action committee (ACSPA-SurgeonsPAC) Board of Directors; Lena M. Napolitano, MD, FACS, Chair of the Board of Governors; and David B. Hoyt, MD, FACS, ACS Executive Director.

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

Andrew L. Warshaw, MD, FACS, surgeon-in-chief emeritus, Massachusetts General Hospital, and the W. Gerald Austen Professor of Surgery at Harvard Medical School, Boston, MA, was elected President-Elect. Jay L. Grosfeld, MD, FACS, Lafayette F. Page Professor Emeritus of Pediatric Surgery, Indiana University School of Medicine, Indianapolis, was elected First Vice-President-Elect; Kenneth L. Mattox, MD, FACS, Distinguished Service Professor, Michael E. DeBakey Department of Surgery, Baylor College of Medicine; and chief of staff and chief of surgery, Ben Taub General Hospital, Houston, TX, was elected Second Vice-President-Elect.

The Board of Governors of the ACS elected one new member of the Board of Regents: James Gigantelli, MD, FACS, professor of ophthalmology and assistant dean of government relations at the University of Nebraska Medical Center, Omaha. Reelected to additional three-year terms on the Board of Regents were: Margaret M. Dunn, MD, FACS, a general surgeon, Dayton, OH; Howard M. Snyder III, MD, FACS, a urological surgeon, Philadelphia, PA; and Michael J. Zinner, MD, FACS, a general surgeon, Boston. Dr. Freischlag, the William Stewart Halsted Professor, chair of the department of surgery, and surgeon-in-chief at Johns Hopkins Hospital in Baltimore, MD, will continue to serve as Chair of the Board of Regents. Mark C. Weissler, MD, FACS, Joseph P. Riddle Distinguished Professor at the University of North Carolina, Chapel Hill, will continue to serve as Vice-Chair.

The Board of Governors elected Gary L. Timmerman, MD, FACS, a general surgeon, Sioux Falls, SD, to serve as Chair of its Executive Committee;
Fabrizio Michelassi, MD, FACS, a general surgeon, New York, NY, as Vice-Chair; and Lorrie Langdale, MD, FACS, a general surgeon, Seattle, WA, as Secretary. Newly elected to serve on the Executive Committee of the Board of Governors are Karen Brasel, MD, FACS, a general surgeon, Milwaukee, WI, and Joseph H. Tepas III, MD, FACS, a pediatric surgeon, Jacksonville, FL. In addition, James C. Denneny III, MD, FACS, an otolaryngology surgeon, Columbia, MO, and Sherry M. Wren, MD, FACS, a general surgeon, Palo Alto, CA, have been reelected to the Board of Governors’ Executive Committee. Governors-at-Large from throughout the world and Specialty Society Governors also were installed.

Clinical Congress 2014
Be sure to attend the 2014 Clinical Congress October 26-30 in San Francisco, CA. Details regarding the educational program, registration, housing, and transportation will be posted at www.facs.org.

For More Information
This article contains information that is discussed in greater depth in previous issues of the Bulletin. The following is a list of where these articles can be found.

September 2013
• Barbara Lee Bass, MD, FACS, selected to receive 2013 Distinguished Service Award, page 58
• Fellows honored for volunteerism, page 68

November 2013
• Carlos A. Pellegrini, MD, FACS, installed as 94th ACS President, page 46
• Six prominent surgeons accorded Honorary Fellowship in the ACS, page 48

December 2013
• Presidential Address: The surgeon of the future: Anchoring innovation and science with moral values, page 8
• Andrew L. Warshaw, MD, FACS, is President-elect of the College, page 54
• New ACS Regents and Governors elected, page 57

Dr. Warshaw (left) and Dr. Pellegrini at the Annual Business Meeting of Members.
**Officers/Officers-Elect**

**Carlos a. pellegrini**  
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General surgery  
The Henry N. Harkins Professor and Chair, department of surgery, university of Washington, seattle  
Seattle, WA

**Layton F. r ikkers**  
*First vice-president*  
General surgery  
Professor emeritus, university of Wisconsin-Madison; and editor-in-Chief, Surgery News  
Madison, WI

**John t. preskitt**  
*Second vice-president*  
General surgery  
Clinical professor of surgery, Texas A&M Health science Center Baylor campus; director of surgical oncology, Baylor sammons Cancer Center  
Dallas, TX

**Edward e. Cornwell iii**  
*Secretary*  
General surgery  
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Washington, DC

**William g. Cioffi, Jr.**  
*Treasurer*  
General surgery  
J. Murray Beardsley Professor and chairman, Alpert Medical school of Brown university; and surgeon-in-chief, the Rhode Island Hospital and the Miriam Hospital  
Providence, RI

**Andrew l. warshaw**  
*President-elect*  
General surgery  
W. Gerald Austen Professor of surgery, Harvard Medical school; and senior consultant, international and regional clinical relations, Massachusetts General Hospital and Partners HealthCare  
Boston, MA

**Jay l. grosfeld**  
*First vice-president-elect*  
Pediatric surgery  
Lafayette F. Page Professor emeritus of Pediatric surgery, Indiana university school of Medicine, Indianapolis  
Indianapolis, IN

**Kenneth l. Mattox**  
*Second vice-president-elect*  
General surgery  
Distinguished service Professor, Michael e. DeBakey Department of surgery, Baylor College of Medicine; and chief of staff and chief of surgery, Ben Taub General Hospital  
Houston, TX
Board of Regents

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Chair  
Vascular surgery  
William Stewart Halsted Professor and surgeon-in-chief, The Johns Hopkins Hospital  
Baltimore, MD

John l.d. atkinson  
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Rochester, MN

James k. elsey  
General and vascular surgery  
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Atlanta, GA

Mark C. weissler  
vice-Chair  
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Board of Regents/
Board of Governors’ Executive Committee

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lorrie Langdale
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General surgery
Professor of surgery, university of Washington; chief, general surgery and director siCu, va-puget sound Health Care system Seattle, WA
Statement on advance directives by patients: “Do Not Resuscitate” in the operating room

It is generally expected that the surgeon will assume primary responsibility for advising patients regarding risks, benefits, and alternatives when discussing a potential operation. This policy focuses on patients who accept a surgeon’s recommendation to have surgery and who already have in place an advance directive, specifically, a “Do Not Resuscitate” (DNR) order. The best approach for these patients is a policy of “required reconsideration” of the existing DNR orders. Required reconsideration means that the patient or designated surrogate and the physicians who will be responsible for the patient’s care should, when possible, discuss the new intraoperative and perioperative risks associated with the surgical procedure, the patient’s treatment goals, and an approach for potentially life-threatening problems consistent with the patient’s values and preferences.

Some patients with DNR status become candidates for surgical procedures that may provide them with significant benefit, even though the procedure may not change the natural history of the underlying disease. Examples include procedures to treat intestinal obstruction in individuals with advanced malignancy and surgical procedures such as amputation to alleviate pain or prevent progression of underlying illness.

When such patients who have DNR orders in place undergo surgical procedures and the accompanying sedation or anesthesia, they are subjected to new and potentially correctable risks of cardiopulmonary arrest. Furthermore, many of the therapeutic actions employed in resuscitation (for example, intubation, mechanical ventilation, and administration of vasoactive drugs) are also an integral part of routine anesthesia management, and it is appropriate that the patient be so informed.

Policies that lead either to the automatic enforcement of all DNR orders or to disregarding or automatically cancelling such orders do not sufficiently support a patient’s right to self-determination. An institutional policy of automatic cancellation of DNR status in cases where a surgical procedure is to be carried out removes the patient or the patient’s duly authorized representative from appropriate participation in decision making. Automatic enforcement of DNR orders without discussion and clarification may not adequately inform patients or their authorized representatives about the new risks associated with surgery and anesthesia and may lead to inappropriate perioperative and anesthetic management.

The required reconsideration discussion should occur as early as practical after a decision is made to have surgery. This discussion may result in the patient agreeing to suspend the DNR order
The required reconsideration discussion should occur as early as practical after a decision is made to have surgery.

during surgery and the perioperative period, retaining the original DNR order, or modifying the DNR order. Required reconsideration works best when the patient has decision-making capacity and when time is available for a conversation. However, even in urgent situations or when the patient lacks decision-making capacity, the surgeon can usually discuss the situation with the patient’s designated surrogate. In emergency situations, it may be impossible or impractical for the surgeon to speak with the patient or the patient’s duly authorized representative prior to the patient’s approaching demise, when irreversible damage occurs, or similar circumstances. In such situations, the surgeon must use his or her best judgment as to what the patient would wish.

Once a decision is reached on the patient’s DNR status as a result of the required reconsideration conversation, the surgeon must continue his or her leadership role in the following areas: (1) documenting and conveying the patient’s advance directive and DNR status to the members of the operating room team; (2) helping the operating room team members understand and interpret the patient’s advance directive; and (3) if necessary, finding an alternate team member to replace an individual who has an ethical or professional conflict with the patient’s advance directive instructions.6

State law and institutional policies may also impact DNR orders and must be taken into account in determining the appropriate course of action. ♦

References
The benefits of attending a 2014 ACS Surgical Coding Workshop

Editor’s note: This column is an updated version of an article that was published in the March 2013 Bulletin. This revised column was prepared by the regulatory and Quality staff in the ACS Division of Advocacy and Health Policy.

Each year the American College of Surgeons (ACS) hosts a series of two-day workshops on the application of changes to the Current Procedural Terminology (CPT)* code set with an emphasis on codes that general surgeons commonly use. Instructors from the practice management consulting firm KarenZupko & Associates deliver practical explanations for each change, using real case examples and educational materials developed by the American Medical Association (AMA).

who should attend an ACS Surgical Coding workshop?
Surgeons, administrators, managers, coders, and reimbursement staff all report benefitting from the workshops. Team attendance is strongly encouraged to ensure accurate, complete, and consistent coding. Registration discounts are offered when three or more team members are enrolled at the same time. Moreover, if the physician is an ACS member, team members or practice employees may attend the workshop at the ACS member rate.

how often does coding change? should I plan to attend a workshop each year?
Codes change frequently. In fact, the AMA updates the CPT code set annually. Moreover, improvements in coding constructs, additions of new technology, and changes to coding and reimbursement rules and payment policies make it necessary to attend a workshop annually.

what are the advantages of attending an ACS Surgical Coding workshop?
When accurate coding is aligned with a clear understanding of payment policy rules, practices will begin to improve profit margins. Attending an ACS coding workshop increases participants’ knowledge of coding principles and helps them develop the skills needed to decrease coding errors and reduce the risk of an audit. The workshop also comprises information regarding the new codes for the year and audit trends and allows participants to practice accurate coding.

Additionally, attendees have the opportunity to share their different coding and practice management ideas, knowledge, experiences, and backgrounds with the group. Attendees also learn how their colleagues are handling coding, billing, and practice management issues.

what will I learn?
The topics discussed at an ACS coding workshop change annually due to the addition, deletion, and revision of the CPT code set. However, the focus of the first day of the workshop is on how to code correctly. Topics may include coding accurately for evaluation and management (E/M) services, reducing the risk of an audit, and new Medicare rules, regulations, and policies. These topics are addressed with an emphasis on their effects on surgical practices. Additionally, the instructors discuss how to appropriately apply coding and modifier guidelines to accurately report multiple procedure combinations.

The Centers for Medicare & Medicaid Services’ Physician Quality Reporting Initiative, Electronic Health Record, Electronic Prescribing Incentive Programs, and the Physician Value-Based Payment Modifier, all of which are updated annually, also are addressed.

The second day of the workshop is dedicated to surgical case coding. The instructor discusses the information that should be included in an operative note if a surgeon is seeking...
ADDitionNAL ACs Coding resourCes

to assist surgeons in their efforts to address coding questions, the ACs also offers the following resources:

- the Coding Hotline (1-800-227-7911), hours of operation 7:00 am–4:00 pm Mountain time. the Coding Hotline staff will answer five free coding questions a year for each Fellow of the ACs. For additional information on the ACs Coding Hotline, visit www.facs.org/ahp/coding/secoding.html.
- Coding and Practice Management Corner (previously socioeconomic tips), a column in the Bulletin, provides tips on a range of reimbursement-related issues. the topics change monthly and in past years have included coding for hernia and other complex abdominal repairs, debridement, and sentinel lymph node mapping and its relation to biopsy. these and other articles are available at www.facs.org/ahp/pubs/tips/index.html.

reimbursement for an operation performed with an assistant or co-surgeon. Other topics discussed include:

- Coding for excisional breast biopsy or partial mastectomy
- Coding for component separation release
- When and how to report E/M services for major and minor procedures, especially trauma
- The use of modifier 58 in wound care, lesion excision, and breast and colon surgery
- Services included in the global surgical package
- The difference between returning a patient to the operating room to treat a surgical complication and a staged procedure
- Procedures correctly documented and reported that are unrelated to surgeries done previously in the global period
- How to initiate a successful appeal when paid incorrectly

Can I earn Cme for attending a workshop?
Physician attendees are eligible to receive continuing medical education (CME) credits through the ACS. Physicians are eligible for 6.5 CME credits for each day of attendance. In addition, nonphysician attendees who are members of the American Academy of Professional Coders are eligible for 6.5 continuing education units for each day of attendance.

when and where will the 2014 aCs surgical Coding workshops take place?

- February 6–7, Las Vegas, NV
- April 10–11, Chicago, IL
- May 15–16, Washington, DC
- August 21–22, Nashville, TN

The dates and location change each year; visit the ACS practice management Web page at www.facs.org/ahp/workshops/index.html for the most current dates and locations.

New in 2014, the ACS is offering a one-day Comprehensive Breast Coding Workshop, which will be presented February 21 in Orlando, FL. The workshop will provide instruction on how to incorporate the 2014 CPT breast biopsy and imaging coding changes, identify required documentation to accurately incorporate ICD-10 verbiage into office notes and pre- and postoperative diagnosis in operative notes, use appropriate modifiers to ensure accurate claim submission, and more.

how do i register?
The ACS offers a special price for members and their coding staffs. ACS Fellows and their staff should be sure to have their ACS member number available and enter it for each person registering. ACS membership is not a requirement for attendance. Register for the two-day workshop online at www.karenzupko.com/workshops/americancollegeofsurgeons/index.html or call 312-642-8310.

For hotel reservations, contact the hotel that is hosting the workshop using the number provided during the registration process, and then indicate that you are attending the ACS Surgical Coding Workshop for special pricing.

The ACS also offers special airfare discounts on United. Contact an ACS Travel Counselor at 800-456-4147 or ACSTravel@facs.org, or contact United Airlines by phone at 800-521-4041 or online at www.united.com. When booking individual travel, be sure to indicate the name of the meeting and refer to the ACS file numbers provided for any applicable discounts.

editor’s note
Accurate coding is the responsibility of the provider. This article is intended only as a resource to assist in the billing process.

JAN 2014 Bulletin American College of Surgeons
Students need exposure to the joys of rural surgery

by Robert A. Swendiman

I want you to know that Dr. Tate is a good man. He did my gallbladder 15 years ago, his daddy did my C-section, and his daddy birthed me. You understand? He’s a good man.”

The patient, who I will call “Rose,” a spunky North Carolinian in her mid-70s, was referring to William C. Tate III, MD, FACS, a general surgeon in the town of Linville, NC. It was in my first week as a fourth-year medical student on a sub-internship in rural surgery. Rose’s eyes twinkled through her bifocals as she reminded me again how lucky I was to be working at the Tate Clinic. Today, her daughter had driven her to this small practice for a biopsy of a suspicious lesion on her left arm.

Dr. Tate knocked and then unceremoniously walked into the exam room. He greeted Rose with a kiss on her cheek and a warm hug. The visit began with an update on his mother’s health, followed by discussion of the renovations going on at the local church. It was a good few minutes before the conversation turned to medicine. I reported a quick history and physical exam to Dr. Tate, and a biopsy was done. Rose left with another hug from Dr. Tate and some more advice for me.

“You remember that Bill Tate is a good man, you hear?” She grinned at Dr. Tate as she shook her finger at me.

My four weeks as a sub-intern in rural surgery were inspiring. Dr. Tate’s grandfather came to Linville in 1910 as the town’s first general surgeon. Later, his son took over the practice, and now his grandson runs the clinic with his partner, Thomas Matthews Haizlip, Jr., MD, FACS. As general surgeons in the truest sense, they have served the citizens of western North Carolina expertly. I had the opportunity to first-assist on a range of cases, including amputations, hemi-colectomies, skin grafts, cholecystectomies, and endoscopies. More importantly, for those four weeks, I felt like part of the town. I saw how their kindness, humanity, and investment in the community have positively affected patients’ lives.

opportunity leads to inspiration
But what spurred my interest in rural surgery? It certainly was not my upbringing. I was born and raised in the Washington, DC, metropolitan area and have spent most of my adult life in the suburbs of Chapel Hill, NC. However, in the last two years, I have taken a 180-degree turn. I completed my third year of medical school in a program that emphasizes rural care in western North Carolina. I am currently finishing my master’s thesis on the effects of federal and state policies on a rural hospital system in the region. As a general surgery applicant, I have sought out residency programs that have an academic and clinical focus on rural disparities.

I would not have followed this trajectory had it not been for the opportunity to learn in a rural environment with engaging mentors. During my first two years at the University of North Carolina (UNC) School of Medicine, I was assigned to five “community weeks” in a pediatrics office in the northwest corner of the state. This experience was my first foray into medicine outside the academic and urban environments. I immediately appreciated how invested the physicians were in the community. They knew their patients on a personal level. Thus, I chose to complete my entire third year in Asheville, NC, where I trained under a group of superb mentors.

Almost everyone reading this column likely has had at least one mentor in surgery. Somewhere
More than 80 percent of general surgery residents are now pursuing fellowship training, which is negatively correlated with a career in rural practice.

As someone who is still in training, I do not have a silver bullet to fix these issues. However, I do believe, rural surgeons and medical schools can take a few actions right away. These suggestions stem from my own experience and current evidence on rural care.

- Become a mentor. Rural surgeons should become closely involved with local and state medical schools, taking students under their wings. Without caring clinicians like Dr. Tate, I would never have heard Rose’s story regarding how important his practice was to her and her family.
- Expose students earlier to rural care. It is nearly impossible to recruit general surgeons to rural areas if they have not had exposure to the field. For this reason, undergraduate medical education students should have the opportunity to serve in rural communities. They should have clerkships in the third and fourth years that require them to move beyond academic wards and into new environments. Schools should offer sub-internships at rural clinics and encourage students to participate. If medical students never experience the joy of being part of a close-knit community, how can we expect them to join one after residency?
- Recruit more students from rural backgrounds. The statistics suggest that my story would be an exception. Most physicians who work in underserved rural areas are from similar backgrounds. Medical schools must emphasize recruitment of students from these communities to increase the number of physicians who will choose to return to underserved rural areas. At UNC, efforts are already under way to attract students from rural areas.

These recommendations can be implemented easily, and they would make a significant difference in the career choices of medical students and residents. However, all stakeholders must make a concerted effort, starting from the ground up. Caring for patients in a small community is an honor and a life-changing experience, but no one will know it without living it first.

**ReferNCes**

Surgeons as employees: Is the lining always golden?

When I recently queried third-year medical students at the University of Florida College of Medicine, Gainesville, FL, about their plans for practice after finishing their residencies, 75 percent of them indicated that they plan to work for some form of a health conglomerate. The idea of proceeding into one of the many private practice models of the past is not part of their mindset. In other words, they plan to be employees of the “system.”

The allure of hospital employment
In a 2008 article titled “Medicine in a vortex,” published in the Bulletin of the American College of Surgeons, I outlined the likely reasons for these students’ decisions.* Basically, physicians entering the workforce today enjoy the lifestyle employee status affords and, for the time being, have an income initially better than that of a junior partner in a private practice. Work hours are more predictable, and the employed physician is protected from the perils of private practice, primarily the cost of medical liability insurance and oppressive night call.

Even employed trauma surgeons have a satisfactory lifestyle. They are usually on call no more than once every four days, and their inpatient demands are limited because typically one of the members of the trauma group is designated as having responsibility for inpatients, usually a week at a time. When on the inpatient service, night call is not a responsibility. So at worst, night call is once every three days and patients are admitted to the team member who is responsible for inpatients that week. Because the service usually includes acute care surgery, surgical specialists, such as surgical oncologists and laparoscopic surgeons, have no acute care or trauma responsibilities.

Much has been written about the pros and cons of this system. I will limit my comments to the potential pitfalls for employed physicians.

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Financial incentives for hospitals
In an editorial published in General Surgery News, “Health care delivery: Its origin and its dilemma. Who is in charge in the USA?,” I concluded that the answer is hospitals.† The reason is quite simple: our reimbursement for medical care collects primarily on the hospital side of the profession from both private and government insurers. Many hospitals are flush with money, and salaries of hospital administrators can reach well above the $1 million mark. All of this money comes from the delivery of health care services or from the investment of prior money obtained from the provision of patient care. So, for now, hospital systems have the financial resources to recruit physicians as employees and with what may turn out to be inflated salaries.

Trauma centers are proliferating, at least throughout Florida, and especially in for-profit hospital systems. Why this sudden interest in trauma center development? The obvious and true answer is to provide better care to the injured patient. The other reason, however, is income to the hospital. Trauma patients often have multiple medical problems, each of which is attached to a billable Current Procedural Terminology (CPT) code. Medicare, as an example, uses a computer program that groups these CPT codes into diagnostic-related groups (DRGs) from which reimbursement is determined. The CPT codes associated with trauma care fall into multiple DRGs, thereby generating a potential surplus of income. This phenomenon I have termed “legal unbundling” of reimbursement.

In the early days of trauma centers, the criteria to be a Level I center were strict and the term “trauma center” was applied only to Level I centers. Level II centers now are advertised as trauma centers or trauma hospitals and are accepted as such by the public, by various triage services, and by payors. Therefore, in my opinion, the rush to become a “trauma center” is for reimbursement purposes along with the ability to provide better care to the trauma patient. Fortunately, there has been a proliferation of trauma fellowships to staff some these new centers.

What would happen if reimbursement changed? For example, what if my legal unbundling were to disappear and patient reimbursement was based on the entire hospital event rather than on multiple CPT codes? Would the financial incentive for having a trauma center take precedence over providing care for the trauma patient? Would the trauma center disappear along with the elimination of its associated expense?

Hospital systems are in a rush to form meaningful financial relationships with freestanding facilities. This event is occurring in metropolitan and rural areas of the country. For rural hospitals, the advantage is telemedicine, especially for the evaluation of radiographs by subspecialty radiologists in the “mother” institution. The attachment of the name of the mother institution to the small hospitals is seen as a way to stimulate retired patients who have a second home in desirable

remote areas to seek follow-up care in a facility associated with the mother hospital rather than returning to their primary residence. It also allows for establishment of large specialty groups so that a specialist has time to travel to the rural area on a scheduled basis.

**a surplus of surgeons?**
For metropolitan and surrounding areas economy of scale makes financial sense and has led to the amalgamation of several hospitals into a single functional unit. Eventually, as in many businesses, one system is incorporated (bought out) by a larger system. The simple result of this process is that there are often two employees for only a single job—and somebody, unfortunately, has to go. If this somebody is a surgeon, radiologist, or any other specialist, where will he or she go?

The simple result of this process is that there are often two employees for only a single job—and somebody, unfortunately, has to go. If this somebody is a surgeon, radiologist, or any other specialist, where will he or she go? If this somebody is a surgeon, radiologist, or any other specialist, where will he or she go? I suppose that if the U.S. population continues to rise and if the Affordable Care Act creates many more “paying” patients, such a dilemma is unlikely to occur.

The thought process driving medical education today is the possibility of having a deficit of 20,000 physicians in the year 2020. Consequently, states are rushing to increase the physician pipeline by establishing new medical schools and/or increasing the student body size of existing ones. New osteopathic schools are opening, and the number of American students studying abroad continues to increase. When a void is recognized in a free society, there typically is a rush to fill the void, which often results in a plethora of individuals seeking to seal the gap. So what was once recognized as a need has now become a surplus. We are several years from realizing such an event, but I believe one is on the horizon.

The bottom line is that employee status is almost always at the discretion of the employer. On the expense side of the ledger, often the most costly items are employee salaries and benefits. These costs are not fixed and may be subject to reduction at the employer’s discretion. As employees, surgeons will need to do their best to ensure that they are largely indispensable and their salaries are safe from dramatic reductions.

Most young physicians live at the end of their income stream and carry a large personal debt service. I advise them to do their best to avoid becoming a victim of the system. Do not totally rely on quality measures to ensure your continued employment. Many of these quality measures are not yet “drilled down” to identify the best surgeon who cares for the patients with the highest severity index scores. Do not totally rely on disease protocols to protect your quality of clinical practice. Many protocols are devised to take the best surgeons and the worst surgeons and create a median of clinical care among them. Such a system could result in your being a victim of “downsizing” for reasons other than quality of care. Political connections and personality are just a couple of other reasons. ♦

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Patient-centered outcomes research: Is this really something new?

by Caprice Greenberg, MD, MPH, FACS; George J. Chang, MD, FACS; and Heidi Nelson MD, FACS

We all are familiar with the traditional government funding agencies that sponsor research, including the National Institutes of Health, the U.S. Department of Defense, and the many and varied private foundations, such as the Susan G. Komen Breast Cancer Foundation, but few of us are familiar with the new Patient-Centered Outcomes Research Institute (PCORI). Two authors of this column—Dr. Chang and Dr. Greenberg of the Cancer Care Delivery Research Committee of the Alliance/American College of Surgeons Clinical Research Program (ACS CRP)—were recently awarded PCORI grants. This column is intended to inform Bulletin readers of this new institute, the research it will support, and the projects that are getting under way.

PCORI is an independent, not-for-profit research funding institution authorized by Congress as part of the Affordable Care Act of 2010. It is funded through a trust that receives monies from the U.S. Treasury and fees assessed on private and public health plans. PCORI is charged with funding clinical comparative effectiveness research (CER) to provide information on best evidence that will help patients and their providers make better informed decisions about their care, including cancer care. The CER priorities of PCORI are distinguished from prior initiatives such as the American Recovery and Reinvestment Act of 2009 by an emphasis on stakeholder engagement to help researchers design research questions and measure outcomes that are most relevant to them. More information regarding PCORI is available at www.pcori.org.

alliance/aCs Cr p awards approved
PCORI approved two awards sponsored by the Alliance/ACS CRP to fund CER aimed at answering questions most important to patients and their caregivers. The newly approved awards will fund studies on posttreatment surveillance:

- Posttreatment Surveillance in Breast Cancer: Bringing CER to the Alliance (Dr. Greenberg)
- Patient-Centered, Risk-Stratified Surveillance after Curative Resection of Colorectal Cancer (Dr. Chang)

Dr. Greenberg’s study seeks to develop a new approach to surveillance following breast cancer treatment that will be more patient-centered and effective than the existing one-size-fits-all approach and will consider individual risk factors. The project has three primary goals: (1) use existing data from clinical trials sponsored by one of the leading cancer cooperative groups to evaluate how risk of recurrence and side effects of treatment vary based on patient and cancer characteristics; (2) use existing data to evaluate the effectiveness of the latest imaging technology for improving survival in patients previously treated for breast cancer; and (3) engage cancer survivors, providers, and health outcomes researchers in the development of an improved patient-centered approach to guide posttreatment care, as well as identify the highest-priority strategies for prospective randomized trials.

Dr. Chang’s study will address a critical question that patients often raise: “Based on my individual tumor characteristics, conditions, and preferences, what is the best way to monitor me?” By tailoring the strategy for monitoring to the individual...
PCORI approved two awards sponsored by the Alliance/ACS CRP to fund CER aimed at answering questions most important to patients and their caregivers.

colorectal cancer survivors—taking into account their risk for recurrence, eligibility for salvage treatment, and personal preferences—the study seeks to improve the cancer care experience for patients and identify strategies to improve the effectiveness of cancer monitoring and reduce the burden on patients and the health care system.

**new approach**
These studies represent an important new approach to research—one in which patients and providers together identify the most pressing research questions. As part of previous work with the Agency for Healthcare Research and Quality’s Developing Evidence to Inform Decisions about Effectiveness Cancer Consortium, stakeholders were engaged to identify the highest priority topic for CER in cancer care. Posttreatment surveillance was identified for a variety of reasons, including the number of patients and practitioners facing this decision every day, the uncertainty about the optimal approach, and the applicability across cancer sites. By designing parallel studies in colon and breast cancer, we hope to take a more efficient approach to research by sharing resources and experience.

Furthermore, a major challenge exists in translating knowledge generated by research into clinical practice. By addressing the cancer care delivery research question that is the most relevant to patients and their providers and refining the study design based on stakeholder input we hope to improve the relevance of both the research question and the study outcomes to maximize the potential for incorporation into daily practice. The major goal of these projects is to improve the effectiveness of posttreatment surveillance in real-world practice, and the Alliance/ACS CRP provides the ideal setting to conduct this work.

Both observational studies will use data from the National Cancer Data Base as well as legacy data from Alliance clinical trials and other databases and will engage cancer survivors, health care providers, and researchers to guide the development of an improved approach to surveillance that recognizes individual patient risk factors and allows for design of future prospective studies. The knowledge gained through these studies will provide important new tools to guide patients and their clinicians in making individualized decisions regarding cancer surveillance.

**additional studies**
The studies are two of 71 projects totaling more than $114 million approved for funding in PCORI’s latest round of awards. All were selected through a highly competitive review process in which scientists, patients, caregivers, and other stakeholders helped to evaluate more than 570 proposals that responded to five PCORI funding announcements.

Proposals were evaluated on the basis of scientific merit, how well they engage patients and other stakeholders, their methodological rigor, and how well they fit within PCORI’s national research priorities. All awards were approved pending completion of a business and programmatic review by PCORI staff and issuance of a formal award contract.

Over the next few years, we can anticipate a continued increase in the support and focus on health services research, including patient-centered outcomes, comparative effectiveness, and cancer care delivery research. The Cancer Care Delivery Research Committee of the ACS CRP aims to develop a program to support investigators in their pursuit of studies in this important area. These two initial PCORI projects will play an important role in launching this initiative.
The Joint Commission has issued a *Sentinel Event Alert* urging hospitals and ambulatory surgery centers to take a fresh look at how to avoid leaving items such as sponges, towels, and instruments in a patient’s body after surgery. The unintended retention of foreign objects (URFOs)—also called retained surgical items (RSIs)—after invasive procedures can cause death, and surviving patients may sustain both physical and emotional harm, depending on the type of object and the length of time it is retained.

The Joint Commission has received more than 770 voluntary reports of URFOs in the past seven years. These cases resulted in 16 deaths, and approximately 95 percent of these incidents resulted in additional care and/or an extended hospital stay. There may be an extended time frame between occurrence and detection of an URFO, although these objects are most commonly detected immediately after the procedure, by X ray, during routine follow-up visits, or from a patient’s report of pain or discomfort. Beyond the human toll, studies have shown that objects left behind after surgery may cost as much as $200,000 per case in medical and liability payments.

“Leaving a foreign object behind after surgery is a well-known problem, but one that can be prevented,” said Ana Pujols McKee, MD, executive vice-president and chief medical officer of The Joint Commission. “It’s critical to establish and comply with policies and procedures to make sure all surgical items are identified and accounted for, as well to ensure that there is open communication by all members of the surgical team about any concerns.”

Some actions recommended in The Joint Commission Alert include:

- Creating a highly reliable and standardized counting system to ensure all surgical items are identified and accounted for
- Developing and implementing evidence-based, organization-wide, standardized policy and procedures for the prevention of URFOs through a collaborative process promoting consistency in practice to achieve zero defects
- Establishing procedures for counting of items, wound opening and closure, and when intraoperative radiographs should be performed
- Researching the potential of using assistive technologies (such as barcoding and radio frequency identification systems) to supplement manual counting procedures and methodical wound exploration
- Encouraging effective communication during each surgical procedure, including team briefings and debriefings, to allow the opportunity for any team member to express concerns regarding the safety of the patient, including the potential for an URFO
- Completing appropriate documentation, which should
“Leaving a foreign object behind after surgery is a well-known problem, but one that can be prevented,” said Ana Pujols McKee, MD, executive vice-president and chief medical officer of The Joint Commission. “It’s critical to establish and comply with policies and procedures to make sure all surgical items are identified and accounted for, as well to ensure that there is open communication by all members of the surgical team about any concerns.”

include the results of counts of surgical items, instruments, and URFOs (such as needle or device fragments deemed safer to remain than remove) and actions taken if count discrepancies occur. Tracking discrepant counts is important to understanding practical problems

Although URFOs may occur in previously healthy patients during elective operations, one study shows common risk factors that can lead to foreign objects left behind include obesity, urgent procedures, patients requiring more than one surgical procedure, multiple surgical teams, and multiple staff turnovers during the procedure.* Occurrence of an URFO was nine times more likely when an operation was performed on an emergency basis and four times more likely when the procedure changed unexpectedly.†

The Alert states that objects most commonly left behind after a procedure are soft goods, such as sponges and towels; small miscellaneous items, such as broken parts of instruments and stapler components; and needles or other sharps. The cases studied by The Joint Commission showed the most common root causes of URFOs are:

- Absence of policies and procedures
- Failure to comply with existing policies and procedures
- Problems with hierarchy and intimidation in the surgical team
- Failure in communication with physicians
- Failure of staff to communicate relevant patient information
- Inadequate or incomplete staff education

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 medical device alarms, 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 others.

For a complete list and text of past issues of Sentinel Event Alert, visit The Joint Commission website at http://www.jointcommission.org/sentinel_event.aspx.


A SERIES OF REPORTS

The warning about objects left behind after surgery is part of a series of Joint Commission Alerts. 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 medical device alarms, 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 others.

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Annual Report 2013: Where did they go?

by Richard J. Fantus, MD, FACS, and Michael L. Nance, MD, FACS

The 2013 Annual Report of the National Trauma Data Bank® (NTDB®) is an updated analysis of the largest aggregation of U.S. and Canadian trauma registry data ever assembled. The NTDB now contains more than 5 million records. The 2013 Annual Report is based on 833,311 records with valid trauma diagnoses from the single admission year of 2012. The data were submitted by 805 facilities, including 235 Level I trauma centers, 267 Level II trauma centers, and 240 Level III or IV trauma centers; 33 are Level I or Level II pediatric-only centers.

Continuous quality improvements

Each year the requirements for data submission quality have increased. This data quality improvement effort started in earnest with the introduction of the National Trauma Data Standard (NTDS) in 2007, which was the basis of the first single admission year Annual Report of 2008. Along with this increase in data quality, over the past six years the number of records submitted by the nation’s hospitals has escalated more than 165 percent. In the 2008 Annual Report, the first using the NTDS, 506,452 records were submitted. This year’s report includes 833,311 records.

This year, to capture a better picture of deaths listed in the NTDB, any patients who have been recorded as “discharged to hospice” have been counted as deaths, which brings the total to 34,622 deaths. When taking a closer look at the emergency department disposition for all comers, the overwhelming majority are admitted to the general surgical floor (see the figure on page 56).

The mission of the American College of Surgeons (ACS) Committee on Trauma (COT) is to develop and implement meaningful programs for trauma care. In keeping with this mission, the NTDB is committed to being the principal national repository for trauma center registry data. The purpose of this report is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. It has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation.
Many dedicated individuals who serve on the ACS COT and at trauma centers around the country have contributed to the early development of the NTDB and its rapid growth in recent years. Building on these achievements, the goals in the coming years include improving data quality, updating analytic methods, and enabling more useful inter-hospital comparisons. These efforts will be reflected in future NTDB reports to participating hospitals as well as in the Annual Reports.

Throughout the year, we will be highlighting these data through brief reports in the Bulletin. The National Trauma Data Bank Annual Report 2013 is available on the ACS website as a PDF file and a PowerPoint presentation at www.ntdb.org. In addition, information about how to obtain NTDB data for more detailed study is available on the website. To learn more about submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.

Many dedicated individuals who serve on the ACS COT and at trauma centers around the country have contributed to the early development of the NTDB and its rapid growth in recent years.
Ronald M. Stewart, MD, FACS, to head Committee on Trauma

The Board of Regents of the American College of Surgeons (ACS) recently appointed Ronald M. Stewart, MD, FACS, to serve as the next Chair of the ACS Committee on Trauma (COT). Dr. Stewart is professor and chair of the department of surgery at the University of Texas (UT) Health Science Center, San Antonio.

Dr. Stewart will take office in March after the COT’s 2014 Annual Meeting, when he will become the 19th Chair of the committee, succeeding Michael F. Rotondo, MD, FACS, of Rochester, NY.

“We congratulate Dr. Stewart and look forward to his leadership and direction as the COT enters its 92nd year of work to improve the care of injured patients,” Dr. Rotondo said of the appointment.

Dr. Stewart received his medical degree and completed his surgical residency at the UT Health Science Center. He completed a two-year trauma and surgical critical care fellowship at the University of Tennessee Health Science Center in Memphis and then served as the director of trauma at University Hospital in San Antonio.

In May 2000, then Texas Gov. George W. Bush appointed Dr. Stewart to the Governor’s Emergency Medical Services and Trauma Advisory Council. He was the recipient of the 2013 National Safety Council Surgeons’ Award for Service to Safety (see p. 32) and the ACS Arthur Ellenberger Award for Excellence in State Advocacy.

Dr. Stewart also served as Chair of the South Texas Chapter of the ACS COT and later as the ACS COT Region 6 Chief (Texas, New Mexico, Louisiana, and Arkansas). In addition, he is the Southern Surgical Association’s representative to the ACS Board of Governors.

Nominations for Jacobson Promising Investigator Award accepted through February 28

The American College of Surgeons (ACS) Surgical Research Committee is accepting nominations until February 28 for the 10th Joan L. and Julius H. Jacobson II Promising Investigator Award, to be conferred in 2014. This award recognizes outstanding surgeons who engage in research, advance the art and science of surgery, and demonstrate early promise of significant contribution to surgical practice and the safety of surgical patients.

Surgeons who are at the “tipping point” of their research careers with a track record indicative of early promise and potential will receive special consideration for the award. Well-established surgeon-scientists are ineligible. To be considered for the award in 2014, submissions must be received by the February 28 deadline.

For details on award criteria and nomination procedures, visit the Jacobson Promising Investigator Award website at http://www.facs.org/cqi/src/jacobson.html. For additional information, contact Carla Manosalvas at jacobsonpia@facs.org or 312-202-5319.
Building a global perspective at International Surgical Leaders forum

The American College of Surgeons (ACS) recently hosted an International Surgical Leaders forum. Representatives from Australia, Canada, France, Hong Kong, Ireland, Japan, Latin America, Lebanon, Malaysia, Mexico, the Philippines, the U.K., and the U.S. gathered at the ACS Washington Office to discuss possible ways to improve surgical care throughout the world and to share novel ideas, approaches, and resources on best practices in global surgery.

Following an evening of networking and connecting with colleagues over dinner, Program Moderator A. Brent Eastman, MD, FACS, then-ACS President, began the day-long meeting by providing an overview and expectations of the forum. The objective of the meeting was to begin a dialogue on how each organization is affected by the critical challenges surrounding issues such as access to health care, rural surgery, education and training, and internationalism. The idea, said Dr. Eastman, is to collaboratively establish best practices that will directly increase quality of care—a goal that he said has been at the top of his agenda throughout his career and tenure as ACS President.

Quoting Dr. Martin Luther King, Jr., Dr. Eastman said, “Every nation must now develop an overriding loyalty to mankind as a whole in order to preserve the best in their individual societies.” He said the forum was an opportunity for the international surgical community to work toward fulfilling that vision by developing a set of actionable items that will serve the best interests of patients around the world.

David B. Hoyt, MD, FACS, ACS Executive Director and Co-Moderator of the program, said the College welcomes opportunities to work with international organizations. “We are all [nationally and internationally] feeling the evolution of health care today. There are financial pressures, quality, and accountability pressures,” said Dr. Hoyt.

He noted that in 2011, the College launched the ACS Inspiring Quality Tour to help inform policymakers and the public about the benefits of various ACS quality improvement programs,
Networking with colleagues over dinner on the rooftop terrace of the ACS Washington office. Dr. Hoyt at the podium.

Presidential medallions from the international surgical societies represented at the meeting.

such as the ACS National Surgical Quality Improvement Program (ACS NSQIP®), the Commission on Cancer, the National Accreditation Program for Breast Centers, the ACS Committee on Trauma (COT), and the ACS Bariatric Surgery Center Network.

Dr. Hoyt said that because quality is of concern to surgeons throughout the world and health care systems share many of the same challenges, this forum may serve as a defining moment in improving the patient experience, quality of care across all populations, and ultimately reduce costs worldwide.

ACS efforts internationally
Patricia L. Turner, MD, FACS, Director of the ACS Division of Member Services, described the College’s organizational structure and said the divisions, committees, and governance bodies work together to advance the practice of surgery nationally and internationally.

One ACS program that has had a profound impact internationally is the Advanced Trauma Life Support® (ATLS®) course, Dr. Turner said. ATLS courses have been presented in approximately 50 countries to more than 1 million health care professionals. Other examples of the College’s international activities include the educational programs developed in collaboration with numerous international institutions and the several scholarships that allow for an exchange between U.S. and international surgical scholars.

revitalized IRC
To help bolster the College’s global reach, the International Relations Committee (IRC) met several times with ACS leaders who examined how the many ACS programs are interwoven to form an international blanket.

Stephen A. Deane, MD, MB, BS, FACS, FRACS, FRCS, Chair of the IRC, offered an international perspective on the process of growing the surgical profession from the viewpoint of someone who trained both in Australia and in North America. He noted that it is important to understand the differences in training, certification, and practice that exist in different countries to move forward with a renewed vision for the IRC and international interactions.

As part of the effort to revitalize the IRC, the committee has developed a revised mission statement, which the Board of Regents has approved: “To develop relationships and partnerships between the College, international surgeons, and international surgical and other health care organizations to address issues of surgical practice, education, research, advocacy, and leadership with the aim of achieving and safeguarding appropriately high standards of clinical care, access, safety, and quality improvement for surgery worldwide.”

The IRC now comprises approximately 30 members—one-third domestic, one-third international, and one-third naturalized members—as well as members of the ACS Young Fellows Association and Residents and Associates Society. The IRC construct is designed to break down silos and bridge the gap between it and other ACS programs.
“We have redefined our plan, and we can work toward meeting our promises. The difference between the way we do things now and the way we did them in the past is that we have realistic, deliverable goals,” said Carlos A. Pellegrini, MD, FACS, then President-Elect of the ACS.

The international attendees and the ACS leaders at the meeting agreed to compare interests and concerns through a survey, which the Division of Member Services has completed. A broader group of international surgeons met during the 2013 Clinical Congress. Another survey will be undertaken with the goal of creating a matrix or database of activities and opportunities in which the surgical societies might become involved.

The following international surgical societies were represented at the meeting:

- Academy of Medicine of Malaysia—College of surgeons
- ACS international relations Committee
- College of surgeons of Hong Kong
- Federation of Latin American surgeons
- Japan surgical society
- Philippine College of surgeons
- Royal Australasian College of surgeons
- Royal College of surgeons of Canada
- Royal College of surgeon of edinburgh
- Royal College of surgeons of england
- Royal College of surgeons of Glasgow
- Royal College of surgeons in ireland
- West African College of surgeons

or GANiZAt ioNs Wit H For uM r ePr eseNtAt ives
The American College of Surgeons (ACS) hosted the ACS Surgical Health Care Quality Forum, Arizona, the 14th stop on the Inspiring Quality (iQ) Tour, on November 8. A panel of health care leaders from several Arizona institutions discussed the promise of quality improvement programs in increasing the value of health care.

“Amidst the national dialogue surrounding patient access to health insurance, surgeons and health care providers must continue to focus their efforts on ensuring the delivery of patient care is the highest quality possible,” said Forum host Steven B. Johnson, MD, FACS, FCCM. Dr. Johnson is professor and chairman, department of surgery, University of Arizona-Phoenix College of Medicine; program director, Phoenix Integrated Surgical Residency Program, Banner Good Samaritan Medical Center; and President of the Arizona Chapter of the ACS.

Forum speakers underscored the critical role that quality data measurement and reporting may have on the future of health care delivery. They pointed to the ACS National Surgical Quality Improvement Program (ACS NSQIP®) as a model that provides surgeons with reliable data to help pinpoint areas for improvement. ACS NSQIP is unique in that it uses risk- and procedure mix-adjusted data that are taken from the patient’s medical chart, not insurance claims, and are based on 30-day patient outcomes.

“We know through published data and countless anecdotes that quality improvement programs, like ACS NSQIP, improve patient care and save valuable health care dollars,” said David B. Hoyt, MD, FACS, ACS Executive Director. “As the Centers for Medicare & Medicaid Services and others start tying clinical data and outcome measures to value-based purchasing, hospitals have a reputational and financial incentive to participate in these tried-and-true programs.”

Arizona State Rep. Heather Carter (R), PhD, RN-BC, Chair of the Arizona House Health Committee, and clinical associate professor, Mary Lou Fulton Teachers College, Arizona State University (ASU), Phoenix, delivered the keynote address.

“The recent Medicaid Restoration Program implemented in Arizona is an important example of how we have upheld the will of the Arizona voters who have twice voted to ensure our residents...
“Clinical excellence and quality improvement programs not only result in improved patient outcomes but are essential for health systems and hospitals today.”

–Dr. Hensing

have access to high-quality health care,” Representative Carter said. “Implementing this program was the most fiscally responsible decision for our great state and helps stop the out-of-control rising costs of uncompensated care.”

“Clinical excellence and quality improvement programs not only result in improved patient outcomes but are essential for health systems and hospitals today. These efforts result in a reduction in waste, patient care complications, liability exposure, and unsatisfied patients, all positively impacting a hospital’s economic survival,” added John A. Hensing, MD, FACP, executive vice-president and chief medical officer, Banner Health.

“The Affordable Care Act includes many provisions aimed at improving health care quality and lowering costs. It is helpful to understand and recognize the specific aspects of the law that will impact the quality of health care, such as the creation of accountable care organizations and certain changes to Medicare,” said Leila F. Barraza, JD, MPH, deputy director, Network for Public Health Law—Western Region, fellow, Public Health Law and Policy Program, and adjunct professor of law, Sandra Day O’Connor College of Law, ASU.

Stuart D. Flynn, MD, dean, University of Arizona College of Medicine-Phoenix, noted that, “For many years, medical schools did not emphasize the importance of quality improvement to residents. We now realize how important it is to engrain concepts of quality assurance and health care economics into students so that they can understand the crucial role these issues will have in their future careers.”

“In order for organizations to improve care, they need access to the right data. Clinical, risk-adjusted outcomes data give physicians critical insights into their performance, allowing them to improve their work and ultimately the care they provide,” said Nirav Y. Patel, MD, FACS, vice-chairman for quality and patient safety, department of surgery, Banner Good Samaritan Medical Center.

Video of the Arizona forum is available at InspiringQuality.facs.org and on the College’s YouTube channel. ♦
Nominations for 2014 volunteerism and humanitarian awards due February 28

The American College of Surgeons (ACS), in association with Pfizer, Inc., is accepting nominations for the 2014 Surgical Volunteerism Award(s) and Surgical Humanitarian Award. All nominations must be received by Friday, February 28.

The ACS/Pfizer Surgical Volunteerism Award—offered in four potential categories each year—is given in recognition of surgeons who are committed to giving back to society by making significant contributions to surgical care through organized volunteer activities. The awards for Domestic, International, and Military Outreach are intended for ACS Fellows in active surgical practice whose volunteer activities go above and beyond the usual professional commitments or retired Fellows who have been involved in volunteerism during their active practice and into retirement. Resident Members and Associate Fellows (ACS Members) who have been involved in significant surgical volunteer activities during their postgraduate surgical training are eligible for the Resident award. Surgeons of all specialties are eligible for each of these awards.

For the purposes of these awards, “volunteerism” is defined as professional work in which one’s time or talents are donated for charitable clinical, educational, or other worthwhile activities related to surgery. Volunteerism in this case does not refer to uncompensated care provided as a matter of necessity in most clinical practices. Instead, volunteerism should be characterized by prospective, planned surgical care to underserved patients with no anticipation of reimbursement or economic gain.

The ACS/Pfizer Surgical Humanitarian Award is given in recognition of an ACS Fellow whose career has been dedicated to ensuring the provision of surgical care to underserved populations without expectation of commensurate reimbursement. This award is intended for surgeons who have dedicated a significant portion of their surgical careers to full-time or near full-time humanitarian efforts rather than routine surgical practice. Examples include a career dedicated to missionary surgery, the founding and ongoing operations of a charitable organization dedicated to providing surgical care to the underserved, or a retirement characterized by surgical volunteer outreach. Having received compensation for this work does not preclude a nominee from consideration and, in fact, may be expected based on the extent of the professional obligation.

Nominations will be evaluated by the ACS Board of Governors Surgical Volunteerism and Humanitarian Awards Workgroup, with final approval of award winners by the Executive Committee of the Board of Governors.

Potential nominees should make note of the following conditions:

• Self-nominations are permissible but require at least one outside letter of support

• Renomination of previous nominees is acceptable but requires an updated application

• Supplemental materials should be kept to a minimum and will not be returned

The nomination website will open January 6, 2014, for electronic submissions and may be accessed through the “Announcements” section of the Operation Giving Back (OGB) website at http://www.operationgivingback.facs.org/. Contact OGB at ogb@facs.org with any questions. ✉
ACS and other specialty surgical organizations release *Physicians as Assistants at Surgery* report

The American College of Surgeons (ACS) and 15 other specialty surgical organizations have jointly compiled and released the seventh edition of *Physicians as Assistants at Surgery*, a report that provides guidance on how often an operation might require the use of a physician as an assistant. This report reflects the most recent clinical practices, and often serves as a resource for the Centers for Medicare & Medicaid Services and other payors.

Using the American Medical Association’s (AMA) Current Procedural Terminology (CPT) codes from the 2012 and 2013 coding manuals, each participating organization reviewed codes applicable to their specialty that are classified as “Surgery” in CPT. CPT is the most frequently used physician medical nomenclature for reporting medical services and procedures to private and public health insurance payors. Participants indicated the frequency of an operation requiring the use of a physician as an assistant at surgery: (1) almost always; (2) almost never; or (3) some of the time.

The newly released report adds 107 CPT codes that were introduced since the last report was issued in 2011. In addition, the report revises 74 codes that had been previously included. Historically, the report is conducted approximately every other year. However, to more accurately reflect new and updated CPT codes and to help improve the quality of care for the surgical patient, updates to the *Physicians as Assistants at Surgery* report now will be conducted annually, and a full review of all surgical CPT codes will be released every five years.

“The frequency of updating the report is becoming increasingly important,” said Mark Savarise, MD, FACS, ACS alternate advisor for the AMA CPT editorial panel. “Medicare and third-party payors are attracted to the report because it provides a comprehensive clinical review of surgical procedures to bring an informed opinion from surgeons in the field about the frequency with which a physician’s services as an assistant at surgery are needed.”

The College maintains that a physician who serves as an assistant in an operation should be a trained individual who can participate in and actively assist the surgeon in completing the operation safely. When a surgeon is unavailable to serve as an assistant, a qualified surgical resident or other qualified health care professional, such as a registered nurse or a physician’s assistant with experience in assisting during a procedure, may be used, according to the ACS *Statements on Principles*.

Dr. Mattox receives AMA award for citizenship and community service

The American Medical Association (AMA) awarded Kenneth L. Mattox, MD, FACS, the 2013 Benjamin Rush Award for Citizenship and Community Service November 16, during the opening session of the 2013 Interim Meeting of the AMA House of Delegates in National Harbor, MD. Dr. Mattox, Second Vice-President-Elect of the American College of Surgeons, is Distinguished Service Professor, Michael E. DeBakey Department of Surgery, Baylor College of Medicine; and chief of staff and chief of surgery, Ben Taub General Hospital, Houston, TX. The Benjamin Rush Award annually recognizes a physician who has exceeded professional responsibilities and contributed significantly to public service.

Dr. Mattox provided exemplary service in the medical response to several natural disasters, including the 2001 tropical storm Allison and Hurricanes Katrina and Rita in 2005. As part of the Katrina Joint Unified Command, Dr. Mattox helped form an “evacuation city” to house, treat, clothe, and feed more than 27,000 evacuees from New Orleans, LA, in only 18 hours.

Dr. Mattox is a past-president of the American Association for the Surgery of Trauma, past-president of the Harris County Medical Society in Texas, and was the Texas representative to the AMA House of Delegates from 2004 to 2006. He developed the internationally known Ben Taub Hospital Emergency Center and its trauma center and currently serves as board chair of the John P. McGovern Museum of Health & Medical Science, Houston. View an AMA press release announcing the award at http://www.ama-assn.org/ama/pub/news/news/2013/2013-11-18-houston-surgeon-receives-award-for-citizenship.page.

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

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→ Review your transcript for accuracy and authorize transfer of credits
→ Have your ABS 13-digit authorization number ready

Log into the member Web portal at www.eFACS.org to get started.
Members in the news

Joseph B. Cofer, MD, FACS, a general surgeon and program director, department of surgery, and professor of surgery, University of Tennessee College of Medicine, Chattanooga, President of the American College of Surgeons (ACS) Tennessee Chapter, and chair of the American Board of Surgery, was named a 2014 recipient of the Accreditation Council for Graduate Medical Education's J. Palmer Courage to Teach Award. The award honors program directors who find innovative ways to teach residents and remain committed to providing quality patient care.

Stephen R. T. Evans, MD, FACS, has been elected 2014–2015 vice-chair of the American Board of Surgery (ABS) and will serve as chair in 2015–2016. Dr. Evans is executive vice-president for medical affairs and chief medical officer at MedStar Health and professor of surgery at Georgetown University, Washington, DC. He is a former President of the ACS Metropolitan Washington, DC, Chapter and, in 2009, was elected as an ABS director representing the American Medical Association.

David Rothenberger, MD, FACS, on October 1, 2013, has been appointed head of the department of surgery at the University of Minnesota (UMN), Minneapolis. He previously held the John P. Delaney Chair of Clinical Surgical Oncology and was deputy chairman of the department of surgery (2006–2013) at UMN. Dr. Rothenberger, an internationally known surgical leader, is past-president of the American Society of Colon and Rectal Surgeons, the American Board of Colon and Rectal Surgery, and the Research Foundation of the American Society of Colon and Rectal Surgeons. Dr. Rothenberger is founder and co-director of the UMN Medical School Emerging Physician Leaders Program, which fosters collaboration and develops skills among faculty from all departments.

Arthur J. Vayer, Jr., MD, FACS, recently was installed as vice-speaker of the Medical Society of Virginia (MSV) during the organization’s annual meeting at The Homestead Resort in Hot Springs, VA. Dr. Vayer, a MSV member since 2006 and a general surgeon at Stafford Surgical, Sentara Medical Group, also worked at Robert Cohen, MD, PC, Riverside Gloucester Surgery Associates and in private practice. Dr. Vayer serves as an MSV delegate and associate director, an officer with the Prince William County Medical Society, a committee member at Potomac Hospital, Woodridge, and chairs the performance evaluation committee at Sentara Northern Virginia Medical Center. ♦
Call for nominations for ACS Officers-Elect

The 2014 Nominating Committee of the Fellows (NCF) will select nominees for the three Officer-Elect positions of the American College of Surgeons (ACS): President-Elect, First Vice-President-Elect, and Second Vice-President-Elect. The NCF will use the following guidelines when considering potential candidates:

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

All nominations must include:

- A letter of recommendation
- A personal statement from the candidate detailing ACS service (for President-Elect position only)
- A current curriculum vitae
- The name of one individual who can serve as a reference

In addition, nominating entities, such as surgical specialty societies, ACS Advisory Councils, and ACS chapters, must provide a description of their selection process and the total list of applicants reviewed. Any attempt to contact members of the NCF by a candidate or on behalf of a candidate will be viewed negatively and may result in disqualification. Applications submitted without the requested information will not be considered.

The deadline for submitting nominations is Friday, February 28, 2014. Please submit nominations to officerandbrnominations@facs.org. If you have questions, call Betty Sanders, ACS Senior Administrator, Board of Governors, at 312-202-5360.

Call for nominations for ACS Board of Governors

Help the American College of Surgeons (ACS) keep pace in a changing health care environment and meet the goals of its Inspiring Quality: Highest Standards, Better Outcomes Initiative by nominating your chapter’s brightest, most engaged, responsible, and forthright members to serve a three-year term on the ACS Board of Governors. Nominations for 2014 appointments must be submitted to your local ACS chapter or surgical specialty society by Friday, February 28, 2014.

The Board of Governors is the representative body of the ACS. The membership at-large nominates two-thirds of the Governors, who are elected during the Annual Meeting of Members at the ACS Clinical Congress. Certain surgical specialty societies, ACS chapters, and federal medical services nominate one-third of the Board of Governors.

The Governors shall act as a liaison between the Board of Regents and the Fellows, and serve as a clearinghouse for the Regents on general assigned subjects and local problems.

A Governor’s duties include:

- Actively participate in a minimum of one Board of Governors Workgroup
- Attend the spring Leadership Summit (spring meeting attendance is not required for international governors)
- Participate in Board of Governors’ meetings, Convocation, and the Annual Meeting of Members at the Clinical Congress
- Complete an Annual Survey
- Attend chapter or specialty society meetings
- Assist in establishing an ACS chapter and serve on the Chapter governing board
- Participate in local Committee on Applicants meetings and interviews
- Provide reports to the ACS chapter or specialty society and the Board of Governors Communications Pillar
- Promote ACS Fellowship in state and specialty society
- Welcome new Fellows into the ACS

An inclusive, transparent Board of Governors depends upon members who can actively serve as a link to their local community and as a resource for the ACS. For more information, go to http://www.facs.org/about/governors/candidates.html. If you have questions, call Betty Sanders, ACS Senior Administrator, Board of Governors, at 312-202-5360.
American College of Surgeons Professional Association (ACSPA)

As of October 1, 2013, the American College of Surgeons Professional Association’s political action committee (ACSPA-SurgeonsPAC) had raised $475,000 from 1,607 members of the College and staff ($295 average contribution).

Contributions for 2013 among ACSPA’s leaders are:

- 25 of 25 Officers and Regents in the U.S. (100 percent) contributed $17,300
- 121 of 213 Governors in the U.S. (57 percent) contributed $63,574
- 15 of 15 members of the College’s Health Policy and Advocacy Group (100 percent) contributed $16,699
- 17 of 17 PAC Board members (100 percent) contributed $33,200
- Eight of nine ACS Legislative Committee members (89 percent) contributed $5,250
- 10 of 14 General Surgery Coding and Reimbursement Committee members (71 percent) contributed $10,300

- 114 of 228 Committee on Trauma members (50 percent) contributed $47,351
- 19 of 65 Commission on Cancer members (29 percent) contributed $9,920

This June, ACSPA-SurgeonsPAC Board Members Patrick Bailey, MD, FACS; Clarence Watridge, MD, FACS; and Michael Sutherland, MD, FACS, attended the 2013 Physician PAC Forum in Louisville, KY. This year’s forum focused on engaging residents in the SurgeonsPAC, hosting in-district fundraisers for members of Congress, integrating SurgeonsPAC and grassroots strategies, disbursing the funds in a strategic way, and other topics.

So far in the 2014 election cycle, the ACSPA-SurgeonsPAC has contributed $218,000 to 83 candidates, leadership PACs, and party committees. Of this amount, 61 percent went to Republicans and 39 percent to Democrats.

American College of Surgeons (ACS)

Division of Member Services

The Division of Member Services continues to evaluate, refine, and create programs in support of College leaders and members. This year the Division
is embarking on initiatives that the ACS anticipates will result in an enhanced member experience. These efforts include:

- Develop an overarching strategy to expand international efforts
- Redesign the Advisory Councils
- Fully implement the Board of Governors’ redesign
- Conduct a needs assessment
- Develop strategic plan for ACS chapters
- Coordinate and centralize scholarships and fellowships
- Implement a young surgeon marketing and recruitment campaign
- Conduct a member and non-member survey

The ACS currently has 36,135 active, dues-paying Fellows. At the 2013 Clinical Congress, 1,622 initiates were inducted into the College, representing one of the largest classes of initiates in the last decade. These new Fellows represent the U.S. and its territories, Canada, and 55 other nations.

**Board of governors**

The annual Board of Governors survey was distributed in August and included questions pertaining to surgeon employment practices. Governors were asked to provide information regarding their constituents’ views on issues pertinent to their practices. More than 195 Governors responded to the survey, and their responses were presented to the Board of Regents for consideration. The top five issues of concern to the Fellows of the College in 2013 as reported by the Governors are:

- Health care reform and its impact on practice
- Professional liability/tort reform, risk management/patient safety
- Medical education/graduate medical education
- Physician reimbursement/Medicare/Medicaid
- Competency measurement for the practicing surgeon/newly trained surgeons

Also discussed were the Centers for Medicare & Medicaid Services’ (CMS) plans to change how Medicare pays physicians with a focus on recent proposed rules and the College’s response, as well as what Congress and multi-stakeholder groups are doing to address the development of a value-based health care system.

**Advisory Councils**

The role and function of the Advisory Councils are being evaluated, and a workgroup of volunteer leaders from the Advisory Council Chairs has been formed to restructure the councils using a process similar to that employed by the Board of Governors. The goal of this effort is to improve communication among the Advisory Councils, Governors, and Regents, members, and specialty societies.

The Advisory Council for Rural Surgery, chaired by Tyler Hughes, MD, FACS, continues to develop its primary initiatives, has established a rural surgery presence at the Clinical Congress, and is conducting preliminary work on a set of rural surgery standards and guidelines. This year, the Clinical Congress Program Planner included a wrapper with program information targeted to the rural surgeon. Plans for 2014 include a Rural Surgery Symposium in May and creation of an ACS Rural Surgery Ambassador Program. The Sixth Rural
Surgery Symposium will take place at the College’s headquarters in May 2014. The one-and-one-half-day program will include presentations on advocacy, practice issues, and clinical practice. Clinical practice topics that will be addressed include critical care, pancreatitis, cancer care, management of large skin lesions, and palliative care. The Rural Surgeon Ambassador Program will consist of council members speaking to chapters, medical students, and residents on issues in rural surgery. Council members have already been guests of chapters in Georgia, Ohio, and Maine.

**Chapters**

The ACS is working to provide support to its domestic and international chapters to facilitate incremental improvement and re-energize each of them. Currently, Chapter Services staff assists with tasks related to bylaws, governance, strategies for growth of membership, and best practices in general, to revitalize and move chapters forward. Several international chapters are at various stages of being admitted to the College, with surgeons in the Middle East, Eastern Europe, and South America showing particular interest. Three more chapters have been approved for providing continuing medical education (CME) credit via the ACS, which brings the total to 36 domestic chapters.

In January, a chapter listserv was created to promote sharing of ideas and to encourage discussion between the chapters. A chapter mentor program, with stronger chapter administrators assisting and offering guidance to those that may need help in specific areas, is planned for 2014. An expanded Winter Learning Event for chapter leaders took place at the College in December 2012, which included discussion of best practices, social networking for chapters, implementation of Young Fellows Association (YFA) and Resident and Associate Society (RAS) initiatives at the chapter level, and other topics regarding how chapters can be of greater value to their members.

A new chapter survey is being disseminated to assess performance and identify the attributes of a high-functioning chapter, along with another study to uncover the perspectives of the chapter membership. This latter survey is intended to cull crucial information from multiple sources to more accurately assess chapter “health.” The resultant dashboard will offer performance indicators rating chapter performance in various areas, and will allow chapters to identify areas for improvement. These data will be shared with individual chapters and best practice resources will be designed and developed to assist chapters more broadly.

**RAS-ACS**

RAS-ACS continues to move forward with several key initiatives, including development of a Surgical Jeopardy toolkit for domestic and international surgical societies and chapters.

Maintaining a strong social media presence is a vital part of RAS outreach. The RAS-ACS Facebook page now has more than 1,200 followers, spanning 20 countries and 19 languages.

The RAS-ACS introduced new programs at the 2013 Clinical Congress, including Focus on RAS: A RAS Leadership Session. A networking lunch for all Resident and Associate Members of the ACS was followed by the Governing Board meeting. Immediate Past-President of the ACS, A. Brent Eastman, MD, FACS, delivered the keynote address, focusing on the importance of RAS membership and involvement of residents within the greater College structure.

The RAS-ACS sponsored two essay competitions in 2013, providing winners with awards and presentation opportunities and continues to coordinate and publish content relative to members in the Bulletin. Because the ACS actively incorporates Resident Members
into the committee structure, RAS has been able to support a well-integrated liaison program. The selection committee identified and filled more than 20 positions on ACS committees, Advisory Councils, and Board of Governor work groups this year.

**yFa**
The YFA serves as a clearinghouse and point of entry for young Fellows who want to actively participate in the College but may be uncertain where or how to get started. The YFA also seeks to increase awareness of ACS programs/educational products that are available to this demographic and to connect young Fellows with their local/state chapters and leaders with special emphasis on those chapters without an identified YFA liaison. Another goal this year was to improve outreach to international young Fellows.

**operation giving Back (oGB)**
A new Board of Governors Workgroup has been created to oversee selection of the ACS Surgical Humanitarian and Volunteerism Awards. The 2013 Humanitarian and Volunteerism award recipients included Donald R. Laub, Sr., MD, FACS, Humanitarian Award; Ingida Asfaw, MD, FACS, International Volunteer Outreach; Jerone T. Landström, MD, FACS, Military Volunteer Outreach; and Katrina B. Mitchell, MD, Resident Volunteer Outreach.

To date, more than $39,000 in humanitarian donations of Advanced Trauma Life Support® (ATLS®) materials have been facilitated through the OGB to health care professionals in 20 countries, including Afghanistan, the Dominican Republic, Ecuador, Ethiopia, Gabon, Haiti, Liberia, Kenya, Malawi, Mexico, Nepal, Nicaragua, Pakistan, Peru, the Philippines, Sierra Leone, Thailand, Uganda, Vietnam, and Zimbabwe.

In the past 12 months, 38,162 visitors from 185 countries completed 111,530 page views of the OGB website. A total of 207 volunteer opportunities currently are published on OGB; 62 were newly created or updated in the last year. Additionally, more than 2,000 surgeons have completed demographic profiles in “My Giving Back.”

OGB has been collaborating on global surgery advocacy efforts internally with the International Relations Committee and externally with the Royal Australasian College of Surgeons, the Royal College of Surgeons of England-affiliated group the International Collaboration on Essential Surgery, and the Alliance for Surgery and Anesthesia Presence.

**divisio n of advoCaCy and health poliCy**

**medicare physician payment**
Under current law, Medicare physician payments will be cut by approximately 24.4 percent on January 1, 2014. For the last two years, the ACS has lobbied for physician payment reform, urging Congress to address the long-term implications of a broken physician payment system and its incompatibility with the provision of care.

Before adjourning for the August congressional recess, the House Committee on Energy and Commerce unanimously approved the Medicare Patient Access and Quality Improvement Act. The bipartisan legislation would permanently repeal the Medicare sustainable growth rate (SGR) formula and create a new physician payment system. The Committee’s approval of this legislation represents several months of collaboration with the House Committee on Ways and Means, as well as input from key stakeholders, including the College and the broader physician community. Several beneficial provisions are included in the Energy and Commerce legislation, including full repeal of the SGR, and the ACS stresses the importance of moving legislation forward in 2014. Although the ACS supports the overall effort to move payment reform through the House and
Senate, the College will continue to lobby for improvements to all payment reform plans.

In written correspondence and congressional testimony, the College encouraged Congress to implement its Value-Based Update (VBU) proposal. The College also expressed strong support of efforts to find more innovative models of physician payment and asserted that any new payment system should be based on the complementary objectives of improving outcomes, quality, safety, and efficiency while simultaneously reducing the growth in health care spending.

**ehr**

Rep. Diane Black, RN (R-TN), reintroduced legislation that addresses several concerns with respect to the current Electronic Health Record (EHR) Incentive Program. Specifically, H.R. 1331, the Electronic Health Record Improvement Act, would create a hardship exemption from penalties for noncompliance for small practices and physicians in and near retirement, shorten the gap between the performance period and application of the penalty, expand options for participation in the Incentive Program, improve quality measures by using specialty-led registries, and establish an appeals process before application of penalties. Twenty-one other medical organizations joined the ACS in sending a letter of support for the legislation.

The EHR Incentive Programs provide a financial incentive for the meaningful use of certified EHR technology to achieve health and efficiency goals. There are three stages of meaningful use, with increased requirements each year. The last year eligible providers (EPs) qualified for the full incentive amount of $44,000 was 2012. The maximum for 2013 was $39,000. Details on the EHR Incentive Program are posted at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/, along with educational materials and resources.

**workforce**

In August, the Council on Graduate Medical Education (COGME) released its 21st report, “Improving Value in Graduate Medical Education.” In the report, COGME recommends an increase in Graduate Medical Education (GME) funding for high-priority specialties, such as general surgery, family medicine, geriatrics, general internal medicine, certain pediatric subspecialties, and psychiatry. COGME acknowledges the many challenges facing GME, such as poor geographic distribution of physicians in relation to population needs and increasing specialization while primary care remains under-resourced. According to COGME this misdistribution can be attributed partly to the fact that many teaching hospitals have not recognized the need for greater emphasis on primary care training and that curriculum is often inadequate in the areas of population health, care coordination, team-based practice, and other aspects of new systems of care. To address these and other challenges, COGME recommends that the GME system be reformed to improve the value the public receives for its investment by increasing partnerships among training programs, teaching hospitals, accreditation organizations, state and federal governments, and other stakeholders. This recommendation is based on the assumption that greater value in GME means better targeting of public GME money and more effective training models.

The Affordable Care Act authorized funding for loan repayments for pediatric subspecialists, including pediatric surgeons, who agree to practice in shortage areas for at least two years. The College signed a letter to the Deputy Director for Management with the Office of Management and Budget (OMB) thanking the Obama Administration for their previous support of the Pediatric Subspecialty Loan Repayment Program and asking
that $5 million in funding once again be included within the Health Resources and Services Administration (HRSA) budget. The $5 million in funding was included in the President’s budget plan; however, the money has yet to be appropriated by Congress. The ACS and other stakeholders sent a letter to House and Senate appropriators urging them to include the $5 million for the program in the fiscal year (FY) 2014 appropriations bill. The Senate for the first time included $5 million for this program in its Labor, Health and Human Services, and Education appropriations bill. The ACS will continue to push for the funds to be appropriated. The authorization of this program is set to expire after next year, and Rep. Joe Courtney (D-CT) has recently introduced legislation that would extend this authorization through FY 2018. The ACS sent a letter of support in August and signed a coalition letter of support in August.

### pQr's

The ACS continues to provide Physician Quality Reporting System (PQRS) educational materials and resources to Fellows and office staff through the website, meetings, and publications. Columns in the April and September 2013 issues of the Bulletin provide information on PQRS requirements and compliance. The PQRS section of the website is continually updated with new information, including updated 2013 PQRS flow sheets for various surgical procedures and details on how to report measures via claims, registries, and EHR. The ACS staff continues to represent the surgical community at meetings regarding the future of PQRS and possible changes to the program.

### division of Research and Optimal patient Care (DROP)

#### aCS nsQIP

Approximately 497 sites participate in ACS National Surgical Quality Improvement Program (NSQIP®); 60 additional sites are in the enrollment process, and another 53 hospitals are pursuing the Pediatric option. The Essentials option is the most popular adult participation option with ACS NSQIP Procedure Targeted the second most common option.

The Eighth Annual ACS NSQIP National Conference took place in July 2013 in San Diego, CA. With more than 1,000 attendees, it was the largest annual ACS NSQIP conference to date. The focus of the conference was on promoting quality improvement through data analysis and collaboration. Next year’s conference will take place July 26–29 in New York, NY.

While ACS NSQIP is recognized for its high-quality data, this information must be actionable and used to improve the quality of surgical care. In the coming months, ACS NSQIP will have an increased focus on assisting hospitals in their quality improvement efforts. An illustration of this emphasis on improving quality was demonstrated at the national conference with the release of the new ACS NSQIP Surgical Risk Calculator. Based on data from more than 1.4 million operations, the Surgical Risk Calculator is designed to help physicians provide patients with accurate estimations of postoperative complications. Covering more than 1,500 unique surgical procedures across multiple specialties, this instrument is a revolutionary new decision support tool. The calculator has been publically released in an effort to improve the processes of informed consent and shared decision making with patients. The release of the calculator has led to moderate press coverage for the ACS and its role in quality of care. Additionally, CMS, through the PQRS, may soon provide a financial incentive for surgeons to calculate the risk of operations using the Surgical Risk Calculator and to discuss these patient-specific risks with patients before a surgical procedure. The risk calculator can be

Collaboration continues to play a critical role in the success of ACS NSQIP and the quality improvement initiatives at participating hospitals. Two ACS NSQIP collaboratives were recently honored with national awards based on their leadership in quality improvement, and each cited ACS NSQIP results as key quality achievements. The Tennessee Surgical Quality Collaborative and the Florida Surgical Care Initiative both noted significant reductions in complications and their resulting cost savings in their award nomination entries.

The spirit of collaboration is also responsible for the development of another ACS NSQIP quality improvement resource. Presented to all attendees at the last ACS NSQIP conference, the fourth edition of ACS NSQIP’s Best Practices Case Studies provides information on the experiences and expertise of hospitals that have successfully implemented quality improvement programs at their institutions. The guide also provides insight into the methods and tools used for implementing initiatives in quality improvement. The latest edition of the Best Practices Case Studies included entries from the Cleveland (OH) Clinic, Tampa (FL) General Hospital, Mayo Clinic Rochester (MN) Methodist Hospital, and Sheikh Khalifa Medical City, Abu Dhabi. The international entry to the Best Practices Case Studies is noteworthy, as there continues to be significant growth and interest in ACS NSQIP among international hospitals. Currently, 36 international sites are enrolled in ACS NSQIP and another 12 sites are in the application process.

This was the second year that the International ACS NSQIP Scholarship Award was presented. The scholarship is presented to two surgeons from countries other than the U.S. or Canada who demonstrate a strong interest in surgical quality improvement. Recipients in 2013 were Ping Lan, PhD, MD, FACS, of the Sixth Affiliated Hospital of Sun Yat-Sen University in Guangzhou, China, and Manuel Francisco Roxas, MD, FPCS, FACS, of the Medical City in Pasig City, Philippines. As part of their scholarship, Drs. Lan and Roxas attended the ACS NSQIP National Conference and visited participating hospitals to learn how to implement surgical quality improvement methods at their home institutions. Both surgeons submitted formal reports recounting their scholarship experience and effusively praised the conference and the knowledge gained from their hospital visits.

ACS NSQIP continues to develop tools to help hospitals achieve improved surgical care and outcomes. Additionally, ACS NSQIP is evaluating the incorporation of financial aspects of care into the program to provide information not only on the quality of care, but also costs. Such “value” reporting will likely be commensurate with the priorities of the overall health care movement at the broad policy level and the individual hospital level.

**mBSaQIP**

A total of 725 U.S. bariatric surgery centers participate in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), 634 of which are fully accredited; the remaining 91 are provisionally approved. An additional 28 initial applications are under review.

The Committee for Metabolic and Bariatric Surgery, the overarching advisory committee for the MBSAQIP, works closely with the American Society for Metabolic and Bariatric Surgery (ASMBS) leadership via its Executive Council to ensure multi-membership representation from both the ACS and the ASMBS. Due to the collective work of both the ACS and the ASMBS leadership, work is under way to develop a critically important quality improvement initiative aimed at reducing acute hospital readmissions related to bariatric surgery.
The Standards Subcommittee has collected feedback from the second public comment period and has voted to approve the MBSAQIP standards. At press time the Standards Subcommittee’s goal is to release and implement these standards in January 2014 with associated training and educational activities.

CoC
A total of 1,507 cancer centers in the U.S. and Puerto Rico are accredited by the Commission on Cancer (CoC). These institutions treat 71 percent of all newly diagnosed cancer patients annually. In the last year, 27 new cancer programs joined the accreditation program, and 79 cancer programs received the Outstanding Achievement Award.

CoC leadership and external constituents developed an initial framework for health care system standards that will form the basis for an accreditation model. An October 2013 meeting was held with staff from two leading health care systems to complete the initial draft, and pilot site visits are targeted for the first quarter of 2014. Release of a system accreditation manual is targeted for later in 2014.

A cross-functional pediatric workgroup will be established to evaluate existing pediatric standards and develop an enhanced set of standard and pediatric performance measures with an eye toward providing more value to program participants and adding new participants in this category.

The Cancer Quality Improvement Program (CQIP) has a new annual cancer program report under development. CQIP 2013 was released to more than 1,500 CoC-accredited hospitals in November 2013. The CQIP 2013 report is based on cases diagnosed in 2011 and includes more than 100 data points for each cancer diagnosed in patients treated in CoC-accredited facilities. The CoC plans to update and expand this report annually for its programs to use to improve compliance with quality measures, outcomes, and the overall care for cancer patients.

nap BC
National Accreditation Program for Breast Centers (NAPBC) accreditation has now been awarded to more than 500 U.S. breast centers, with another 223 centers currently working toward accreditation or reaccreditation.

As part of the NAPBC International Committee exploration toward developing an international arm of the NAPBC, a survey was sent to 918 physicians in 43 countries representing 184 breast centers to inquire whether they would be interested in learning more about breast center accreditation and participating in a quality-based breast accreditation program. The same survey was sent to all International Fellows of the ACS. The results overwhelmingly supported the development of a global breast accreditation. Therefore, the NAPBC identified three pilot sites (Montreal, QC; London, UK; and Dubai, UAE) and developed a questionnaire based on the current American-based standards and asked how they would satisfy the standards. This questionnaire will be sent to each international program and a catalog of responses will be built to capture geographic differences and help guide international surveyors in the future.
2014 International ACS NSQIP Scholarship applications due February 14

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) and the ACS International Relations Committee co-sponsor International ACS NSQIP Scholarships for two surgeons from countries other than the U.S. or Canada who demonstrate a strong interest in surgical quality improvement. Completed applications for the 2014 scholarships and all of the supporting documentation must be received by the International Liaison Section no later than February 14.

The scholarships of $10,000 each provide the recipients with an opportunity to attend the 2014 ACS NSQIP National Conference July 26–29 in New York, NY, and meet with program leadership and surgeon champions from ACS NSQIP participating hospitals. Following the ACS NSQIP conference, the candidate is encouraged to visit one to two hospitals reflecting the candidate’s specific clinical interests. These hospitals should also have strong quality programs.

The scholarship requirements are as follows:

• Applicants must be graduates of schools of medicine.

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

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

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

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

• Applicants must submit a fully completed application form provided by the College on its website. The application and accompanying materials must be typewritten and in English. Submission of a curriculum vitae only is unacceptable.

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

• Applicants must submit letters of recommendation from three of their colleagues. One letter must be from the chair of the department of their hospital or in the program in which they hold academic appointment or from an ACS Fellow residing in their country. The chair’s or the Fellow’s letter should include a specific statement detailing the nature and extent of the applicant’s quality improvement activities. Letters of recommendation should be submitted separately by the references.

• Applicants must submit a curriculum vitae of no more than 10 pages.

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

Applicants who are awarded scholarships will submit a full written report of the experiences provided through the scholarships upon completion of their scholarships.
The scholarships of $10,000 each provide the recipients with an opportunity to attend the 2014 ACS NSQIP National Conference July 26–29 in New York, NY, and meet with program leadership and surgeon champions from ACS NSQIP participating hospitals.

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

The scholarships provide successful applicants with the privilege of participating in the ACS NSQIP National Conference. Assistance will be provided in arranging hotel accommodations during the conference.

More information regarding the ACS National Surgical Quality Improvement Program can be found at http://www.acsnsqip.org.

To qualify for consideration by the selection committee, applicants must fulfill all requirements. The formal International ACS NSQIP Scholar application appears on the ACS Scholarships Web page at http://www.facs.org/memberservices/research.html.

Supporting materials and questions should be sent to the International Liaison, Kate Early, via e-mail at nearly@facs.org.

All submissions must be received by the February 14 deadline for the selection committee to consider each application. All applicants will be notified of the selection committee’s decision by April 30. ◆
2013 Traveling Fellow reports on trip to Australia and New Zealand

by Nancy Baxter, MD, FACS

It was a great honor to have been selected the 2013 American College of Surgeons (ACS) Traveling Fellow to Australia and New Zealand (ANZ). The fellowship allowed me to travel across the world to visit spectacular places, learn from colleagues, and reconnect with old friends. This truly was a trip of a lifetime. The opportunity to visit surgeons in their practices in two countries, to learn about their training, their approach to patient care, and their health care system showed me that while we can learn a great deal from these differences, our worries, struggles, and successes are similar.

Well before my visit, the Australians went out of their way to welcome me and help with planning. My experience started at the 2012 ACS Clinical Congress where I received a warm greeting from Ian Civil, MB, ChB, FACS, PRACS, a general and trauma surgeon at Auckland City Hospital, and president of the Royal Australasian College of Surgeons. He put me in contact with Ian Bisit, MD, FRACS, associate professor of surgery at the University of Auckland and head of the department of surgery and consultant colorectal surgeon at Auckland City Hospital, and Mattias Soop, MD, PhD, department of surgery, University of Auckland, and Mattias Soop, MD, PhD, department of surgery, University of Auckland, and consultant colorectal surgeon at Auckland City Hospital, and Mattias Soop, MD, PhD, department of surgery, University of Auckland, and consultant colorectal surgeon at Auckland City Hospital, and Mattias Soop, MD, PhD, department of surgery, University of Auckland, and Mattias Soop, MD, PhD, department of surgery, University of Auckland, and consultant colorectal surgeon at Auckland City Hospital, and Mattias Soop, MD, PhD, department of surgery, University of Auckland. Dr. Civil advised me on specifics of the trip, including top places to visit.

Just before my visit “Down Under” I was greeted at the American Society of Colorectal Surgeons annual meeting by Bruce Waxman, MB, BS, FACS, head of colorectal surgery, Monash Health in Melbourne Australia, and Frank Frizelle, MB, ChB, MMedSc, FACS, academic head of the department of surgery at the University of Otago in Christchurch. I was pleased to share Minnesota connections with Bruce and Frank, and meeting them before my travels reassured me that I would have a terrific trip.

 Auckland

After traveling from Toronto via Vancouver to Auckland, I arrived at the North Island at 5:00 am. Fortunately, I was able to check into my hotel and get some sleep. With lingering jetlag, I found myself falling asleep at the dinner table on a number of occasions; thankfully, my hosts were understanding.

In Auckland, I attended the RACS Annual Scientific Congress, May 6–10, at the Crowne Plaza Convention Centre. The convention center is attached to the Sky Tower, the tallest building in New Zealand. The Scientific Congress is a well-organized and well-attended meeting of surgeons of all specialties in Australasia.
The meeting is organized according to specialty tracks. Dr. Soop organized a phenomenal colorectal surgery program in which I was pleased to participate.

On the first full day of the conference, I was involved in a master class—a group session of approximately 80 attendees. The topic was Research: How to Publish Your Research in a Good Journal. My presentation was titled How to Design Good Studies—a subject that is tough to tackle in 20 minutes, but my efforts were warmly received.

Later in the week I presented the ACS Lecture as part of the colorectal program titled Quality Control in Colonoscopy: How to Avoid Missing Tumors. During the talk I highlighted other surgeons’ and my research into the effectiveness of and quality measures in colonoscopy.

In preparation for the talk, I learned a great deal about the status of colorectal screening in Australia and New Zealand and what each country is doing in terms of colonoscopy quality assurance. Matt had invited a number of prominent colorectal surgeons to the meeting, and I was lucky to have the opportunity to network with Torbjörn Holm, MD, a colorectal surgeon at the Karolinska Institute, Stockholm, Sweden, and Thomas Read, MD, FACS, a colorectal surgeon in Burlington, MA. I also had the opportunity to attend the Women in Surgery Symposium, coordinated by Eva Juhasz, BHB, MB, ChB, FRACS, a colorectal surgeon in Brightside, NZ, who, unfortunately was unable to attend. The symposium focused on Past and Present Inspirations in Surgery, with presentations by several international visitors, including myself and the following: Lillian Kao, MD, FACS, associate professor of surgery and critical care, University of Texas Medical School, Houston, and a faculty member for the university’s Center for Clinical Research and Evidence-Based Medicine; Monica Bertagniolli, MD, FACS, a general surgeon, at the department of surgery, Brigham & Women’s Hospital, Boston, MA. It was great to network not only with women from Australasia, but also with leaders of the ACS. My presentation was on International Perspectives in Women in Surgery.

I also attended the lunch meeting of the ANZ Chapter of the ACS. I was fortunate to hear A. Brent Eastman, MD, FACS, then-President of the ACS, give an inspirational talk highlighting the benefits of international networks and collaborations. He emphasized the importance of building links between Australasian surgeons and the ACS and made me feel very proud to represent the College.

I attended a number of wonderful social events where I met international colleagues. I attended the welcome reception on May 6, the colorectal section dinner on May 8, at the Auckland Art Gallery hosted by Dr. Soop, and on the final evening of the meeting, I attended a lovely gala dinner held at the Langham Hotel.

In addition, a number of high-spirited surgeons from the Association of Academic Surgery attend the RACS meeting annually to help lead the course, Developing a Career in Academic Surgery, with the Academic Section of RACS. I shared an adventure with these surgeons, or, more precisely, watched an adventure unfold. Carlton Barnett, MD, FACS, a general surgeon,
Denver Health Medical Center/University of Colorado, and Justin Dimick, MD, FACS, a general surgeon, University of Michigan, Ann Arbor, took the plunge from the top of Sky Tower mentioned previously and lived to tell the tale. Only in New Zealand.

On May 10, I visited Auckland City Hospital, where I toured the facility with Arend Merrie, MB, ChB, PhD, FRACS, a general surgeon and director of general surgical training, Auckland Hospital, and Julian Hayes, MB, ChB, FRACS, a general and a colorectal surgeon at Auckland City Hospital. I presented grand rounds to the colorectal surgery group. My talk, How Effective Is Colonoscopy for the Prevention of Colorectal Cancer Mortality?, was well-received, and the surgeons in attendance offered thoughtful comments.

I was very impressed by the health care system and the focus of the hospital on population health. Most notable were the perioperative smoking cessation programs implemented on site and the quality metrics in place for smoking cessation at the institution. Patients are motivated to stop smoking around the time of surgery, and the institution provides organized, systematic help to these patients, which is likely to result in increased rates of smoking cessation, improved surgical outcomes, and more lives saved. Since I have returned from my trip I have already taken steps to see if a similar program might be implemented on a provincial level through Cancer Care Ontario. The Auckland City Hospital staff was welcoming, and Dr. Merrie provided further insights into the health care system and practice of colorectal surgery in New Zealand.

Queenstown
I then flew from Auckland to Queenstown on the South Island. The view of the amazing mountains and farming stations is breathtaking. Queenstown is the home of unparalleled outdoor adventure touring. I was fortunate to have two travel companions, Richard Hanney, MB, BS, FRACS, University of Sydney; and Dr. Kao. Queenstown is also the home of bungee jumping. Lillian and I watched Richard jump off a bridge, and who could blame him? His friends Carlton and Justin had just jumped off a building.

I traveled to Christchurch where I received a warm welcome from Frank Frizelle MB, ChB, MMedSc, FACS, a colorectal surgeon and department head, department of surgery, University of Otago, Christchurch, and his wife Marguerite Crooks, DMD. They opened their home to me and provided me with an opportunity to visit the Christchurch Hospital, the major tertiary referral center in the South Island and affiliated with the University of Otago. During my two-day visit I was able to observe in the operating room, attend multidisciplinary tumor rounds and teaching rounds, and meet the general surgical trainees. Chris Wakeman, BSc, MB, ChB, MMedSci, FRACS, a colorectal surgeon at Christchurch Colorectal, NZ, and Tim Eglinton, MB, ChB, MMedSc, FRACS, a consultant colorectal surgeon at the hospital, helped with my visit.

Christchurch suffered a massive earthquake on February 22, 2011, which caused widespread damage to this beautiful Victorian city. The response of the team at
Christchurch Hospital to this natural disaster and their participation in the recovery was inspiring. I promised to return in 10 years to see the city rebuilt. I shared a wonderful meal with the faculty and was encouraged to enjoy the magnificent local oysters. We drank some terrific wine from the vineyards of New Zealand native Murray Brennan, MD, FACS, the Benno C. Schmidt Chair in Clinical Oncology and director of the center for international programs at Memorial Sloan-Kettering Cancer Center, New York, NY.

I then traveled up the east coast of the South Island to Kaikoura and fulfilled a lifelong dream of swimming with wild dolphins. New Zealand is a magical place with wonderful people in a spectacular setting. I will be back.

**melbourne**

I then left New Zealand and flew to Melbourne, Australia, where my stay was brief but engaging. This wonderful Victorian city has become a foodie’s paradise, and I was able to reconnect with several friends and colleagues in medical oncology whom I knew from their fellowship days at Princess Margaret Hospital in Toronto. With their help I had two stops arranged. First I visited St. Vincent’s Hospital where I was hosted by Rodney Woods, MB, BS, FRACS, director of colorectal surgery; and Jamie Keck, MB, BS, FRACS, director of anorectal physiology. I attended two multidisciplinary rounds, as well as tumor board and inflammatory bowel disease rounds. St. Vincent’s Hospital is a major force in Australia for the management of inflammatory bowel disease (IBD). I had heard about this program and the rounds throughout New Zealand and Australia. Based on the same principles as tumor boards, they facilitate multidisciplinary management of complex IBD patients, enabling real-time communication between gastroenterologists, surgeons, radiologists, pathologists, and nurses. I hope to institute these principles at my hospital where we see a large number of IBD patients.

Next, I visited the Peter MacCallum Cancer Centre and met my host, Sandy Herriot, MA, MB, BChir, MD, FRCS, a colorectal surgeon, department of surgical oncology, Peter MacCallum Cancer Centre, Melbourne; department of colorectal surgery, St. Vincent’s; and honorary senior lecturer, University of Melbourne. I presented at grand rounds and toured the facilities, which include an extensive tumor bank and offer opportunities for translational research.

**newcastle**

I then flew to Newcastle, Australia, where I had been invited by Stephen Deane, MB, BS, FACS, FRACS, FRCSC, a general surgeon with the John Hunter Hospital, to visit the hospital and the University of Newcastle. He and Stephen Smith, MB, BS, BSc, FRACS, a colorectal surgeon, John Hunter Hospital and the University of Newcastle, who were the visitors from Australasia to the 2013 ACS Clinical Congress, coordinated the arrangements for my visit. I received a wonderful welcome in Newcastle, and my hosts ensured an enjoyable stay.
In preparation for the talk, I learned a great deal about the status of colorectal screening in Australia and New Zealand and what each country is doing in terms of colonoscopy quality assurance.

We started with a dinner with the surgeons in the colorectal service at John Hunter, including Dr. Smith, Brian Draganic, FRACS, conjoint senior lecturer, University of Newcastle, and Peter Pockney, MB, BCh, colorectal surgeon, division of surgery, and senior lecturer, John Hunter, and their spouses. These surgeons are committed to excellence in patient care and research, but they also have built a wonderful, collegial team.

On May 22, I attended the morning training meeting with registrars (residents and fellows). Later that day, I rounded with Dr. Smith at the John Hunter Hospital and was amazed at the amount of clinical research performed there. This colorectal unit has achieved the goal of enrolling all patients in a clinical study. This feat shows the dedication of the unit’s surgeons, nurses, and patients to research and continuous quality improvement. Having learned of this inspiring achievement, I now am committed to getting more patients enrolled in clinical studies.

At city-wide rounds for the Newcastle Gut Club, I delivered two presentations during two-well-attended meetings of gastroenterologists and general surgeons, one in the evening on colonoscopy effectiveness for prevention of colorectal cancer mortality, and one the next morning, where I presented my research in cancer survivorship to the general surgery faculty and residents at the John Hunter Hospital.

Later that day, I took a scenic train ride to Sydney. It is a wonderful place where the people are friendly, the sun is almost always shining, and the most fabulous beach you have ever seen is just a ferry ride away. Michael Solomon, MB, BCh, BAO, MSc, FRACS, a colorectal surgeon at Concord Repatriation General Hospital and Royal Prince Alfred Hospital in Sydney, met me at my hotel and drove me to the Royal Prince Albert Hospital. Professor Solomon and I have been friends since he completed his colorectal surgery fellowship and master of science degree in clinical epidemiology at the University of Toronto. We began the tour of the hospital with a visit to the clinical research training unit that he initiated, the Surgical Outcomes Research Centre. Professor Solomon developed and led a master’s of surgery program that provides training and expertise in clinical epidemiology to surgeons throughout Australia.

Next, we participated in ward rounds. Professor Solomon’s clinical work is remarkable. He is pushing the field of radical surgery for locally aggressive primary and recurrent pelvic cancers forward and is one of the world leaders in pelvic exenteration. He is a wonderful and inspiring individual. I would encourage anyone interested in additional training in this area to seek him out. My professional visits ended with a wonderful dinner off Sydney Harbour. I was able to stay an extra day and visit friends. I was fortunate to catch the Sydney Light Festival. The Opera House is an amazing building that, when lit up, becomes a work of art.

**inspiring experience**

My experience as the ANZ Traveling Fellow was an incredible adventure. I interacted with and learned from wonderful surgeons who have a passion for quality patient care. The trip made me look at my practice in different ways and has inspired me to try to achieve more and do better in the future. I made new friendships, reconnected with dear friends from the past, and developed potential collaborations for future research.

I am truly grateful to all the surgeons who made my trip such a wonderful experience and to the ACS for selecting me to serve as the 2013 ANZ Traveling Fellow. ✦
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- Free access to the College coding consultation hotline, career opportunities, and resume posting
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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

JANUARY
southern California Chapter
January 17–19
Santa Barbara, CA
Contact: Jim Dowden, jdownen@prodigy.net, http://www.socalsurgeons.org/

Louisiana Chapter
January 17–19
New Orleans, LA
Contact: Janna Pecquet, janna@laacs.org, http://www.laacs.org/

south Florida Chapter
January 27
Fort Lauderdale, FL
Contact: Bill Bouck, bill@bouckmgmt.com, http://www.sfc-acs.org/

FEBRUARY
puerto rico Chapter
February 20–22
San Juan, Puerto Rico
Contact: Aixa Velez, genteinc@gmail.com

north Texas Chapter
February 21–22
Dallas, TX
Contact: Nonie Lowry, events@lp-etc.com, http://www.ntexas.org/

sOUTHERN CALIFORNIA Chapter
February 20–22
Austin, TX
Contact: Janna Pecquet, janna@southtexasacs.org, http://www.southtexasacs.org/

MARCH
metropolitan Washington, D.C., Chapter
March 8
Washington, DC
Contact: Jennifer Starkey, Jennifer@acschapters.com, http://www.dcfacs.org/

7th Annual Consortium Meeting of the ACS-Accredited Education Institutes
March 21–March 22
Chicago, IL
Contact: Catherine Wojcik, cwojcik@facs.org

FEBRUARY
puerto rico Chapter
February 20–22
San Juan, Puerto Rico
Contact: Aixa Velez, genteinc@gmail.com

north Texas Chapter
February 21–22
Dallas, TX
Contact: Nonie Lowry, events@lp-etc.com, http://www.ntexas.org/

SFUCTIONS CLINICAL CONGRESSES
2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL

Trauma, Critical Care, and acute Care Surgery
March 31–April 2
Las Vegas, NV
Contact: Mary Allen, redstart@aol.com

APRIL
Japan Chapter
April 3
Kyoto, Japan
Contact: Kazuhiko Yoshida, MD, FACS, kaz-yoshida@jikei.ac.jp

minnesota Chapter
April 14
Minneapolis, MN
Contact: Nonie Lowry, nonie@lp-etc.com, www.mnsurgicalsoociety.org

North Dakota and South Dakota Chapter
April 25–April 26
Sioux Falls, SD
Contact: Terry Marks, tmarks@sdsma.org

FUTURE CLINICAL CONGRESSES
2014
October 26–30
San Francisco, CA

2015
October 4–8
Chicago, IL