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Letters to the Editor should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to dschneidman@facs.org, or via mail to Diane S. Schneidman, Editor-in-Chief, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

The American College of Surgeons Division of Education welcomes submissions to the following programs to be considered for presentation at Clinical Congress 2015, October 4–8, in Chicago, IL.

**Oral Presentations**
- **SCIENTIFIC FORUM***
  (15 Excellence in Research Awards were given in 2014)
- **SCIENTIFIC PAPERS***

**Poster Presentations**
- **SCIENTIFIC POSTER PRESENTATIONS**
  Ten posters are selected annually for the Posters of Exceptional Merit program

**Video Presentations**
- **VIDEO-BASED EDUCATION**

**Submission Information**
- Abstracts are to be submitted online only.
- Submission period begins after December 1, 2014.
- Deadline: 5:00 pm (CST), March 2, 2015.
- Late submissions are not permitted. There are no considerations made for “late-breaking abstracts.”
- Abstract specifications and requirements for each individual program will be posted on the ACS website at [http://abstracts.facs.org/](http://abstracts.facs.org/). Review the information carefully prior to submission.

*Accepted authors are encouraged to submit full manuscripts to JACS.*
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*Titles and locations current at the time articles were submitted for publication.

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Looking forward

by David B. Hoyt, MD, FACS

The military and surgery have long enjoyed a mutually beneficial relationship. Surgeons in combat areas have often uncovered new procedures and treatments, which they have brought back to the U.S. to improve civilian patient care. In the process, the troops fighting for our nation and patients throughout the world have benefited from the training that surgeons have received at U.S. medical centers prior to deployment to military hospitals. In an era of resident work-hour restrictions, an alarming increase in civilian mass casualty events, ongoing conflicts abroad, and rising demands for the efficient delivery of cost-effective, high-quality care, the need for a synergistic relationship between the American College of Surgeons (ACS) and the U.S. Department of Defense (DoD) Military Health System (MHS) has grown.

Thus, I am pleased to announce that the ACS and the MHS have entered into a strategic partnership designed to improve educational opportunities, systems-based practices, and research capabilities for both parties. This strategic alliance between the MHS and the ACS was solidified when Jonathan Woodson, MD, FACS, Assistant Secretary of Defense for Health Affairs, and I signed a charter at the 2014 Clinical Congress in San Francisco, CA. Officially known as the Military Health Service Strategic Partnership American College of Surgeons (MHSSPACS), the program launched in December 2014.

Origins of the MHSSPACS

The concept of the partnership originated a couple of years ago as a result of a conversation I had with U.S. Navy Captain Eric A. Elster, MD, FACS, chair and professor, Norman M. Rich Department of Surgery, Uniformed Services University of the Health Sciences (USUHS), Bethesda, MD; and retired U.S. Marine Corps Colonel Norman M. Rich, MD, FACS, DMCC, founding chair of the department and namesake of the department of surgery at USUHS. With several members of the College’s leadership—Julie L. Freischlag, MD, FACS, Past-Chair, ACS Board of Regents; A. Brent Eastman, MD, FACS, FRCS(Ed)(Hon), Past-President of the ACS; Michael F. Rotondo, MD, FACS, Past-Chair, ACS Committee on Trauma; and other surgeons—we agreed that the College and the military should collaborate on programs aimed at ensuring that the next generation of surgeons is prepared to provide optimal care to patients injured on and off the battlefield.

We reached out to Dr. Woodson to discuss the possibility of forming a strategic partnership. He agreed that maintaining and advancing clinical knowledge and skills are critical to the readiness of the MHS and that an affiliation with the ACS would positively affect care for patients who receive health care services through the MHS and the civilian health care system.

Under the charter, the MHS and the ACS have agreed to do the following:

- Share information related to the curriculum used to teach military surgical skills through expansion of the ACS Advanced Surgical Skills for Exposure in Trauma course and other programs
- Share information related to existing education offerings of importance to military and surgical communities that are interested in humanitarian and disaster response
- Share information related to validation of the military’s Optimal Resources handbook
- Share information related to potentially increasing the involvement of military surgeons in the ACS senior leadership program
- Share information related to review of the DoD Combat Casualty Care Research Program
- Share information on relevant research portfolios, including research conducted through the ACS National Trauma Data Bank® and Trauma Quality Improvement Program®
- Plan a presentation of an ACS military surgeon symposium at the 2015 ACS Clinical Congress
• Share information related to systems-based practice, including dissemination of surgical clinical practice guidelines and development of an optimal resources manual for surgical care

The College’s activities related to this strategic partnership will be coordinated by Executive Services and the ACS Division of Member Services. M. Margaret “Peggy” Knudson, MD, FACS, professor of surgery, division of general surgery, San Francisco General Hospital and Trauma Center, University of California, San Francisco, has been recruited to coordinate this effort. Dr. Knudson noted, “The past 13 years of war, the longest in our nation’s history, have yielded unprecedented advances in combat casualty care with the resultant lowest died of wounds rate ever recorded. Through this partnership, training and education platforms, research endeavors, quality improvement programs, and combat readiness and disaster preparedness efforts will be jointly shared, benefiting surgical patients in the U.S. and throughout the world in both civilian and combat arenas.”

...[T]he MHSSPACS is just the most recent addition to a long list of examples of cooperation between the ACS and the U.S. military.
Building on the past, preparing for the future

As noted previously, the MHSSPACS is just the most recent addition to a long list of examples of cooperation between the ACS and the U.S. military. President Woodrow Wilson (D) appointed ACS Founder Franklin H. Martin, MD, FACS, to the Advisory Commission of the Council of National Defense to prepare for the U.S. involvement in World War I and called upon the College to assist in organizing a field hospital for the American Expeditionary Force. The College’s involvement in the Great War led to significant advances in patient care. A shortage of splinting materials led to use of the plaster orthopaedic cast for treating fractures, and lessons learned during the war led to the successful management of open chest wounds and empyema.

In 1918, Sir Berkeley Moynihan, KCMG, CB, of the Royal College of Surgeons led a delegation to America to present the Great Mace to the ACS “in memory of mutual work and good fellowship in the Great War 1914–1918.” The Great Mace continues to be presented each year at the Convocation and is prominently displayed at the College’s headquarters to serve as a lasting reminder of this legacy.

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The College’s involvement in World War II dates back to the bombing of Pearl Harbor. When traveling to examine and treat patients injured during the attack, Isidor S. Ravdin, MD, FACS, took with him a supply of albumin that he used to successfully treat seven severely burned patients. In 1942 through 1944, the College replaced its sectional meetings with War Sessions throughout the U.S. and Canada to train the many physicians and surgeons entering the Army in the care of combat injuries. Furthermore, as Theater Commander for Surgery in the Mediterranean in World War II, Colonel Edward D. Churchill, MD, FACS, developed the use of delayed primary closure and early debridement of contaminated wounds and improved the air evacuation process for wounded soldiers.

In addition, Past-Director of the ACS, Paul Hawley, MD, FACS(Hon), has been credited with drawing the blueprint for the U.S. Department of Veterans Affairs’ health care system. More recently, Landstuhl Regional Medical Center, a military hospital operated in Germany by the U.S. Army and the DoD, became the only medical center outside of the U.S. to achieve Level II Trauma Center verification status from the College. In 2011, it was verified as a Level I center.

All of the individual surgeons involved in launching this initiative anticipate that the MHSSPACS will result in even greater advances for all trauma and surgical patients. If you would like to get involved in this program, please let me know. Together, we can do much to improve the quality of care and quality of life for all Americans.

If you have comments or suggestions about this or other issues, please send them to Dr. Hoyt at lookingforward@facs.org.
Highlights of the 2014 Clinical Congress
The 2014 Clinical Congress of the American College of Surgeons (ACS) in San Francisco, CA, 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 13,960, including 9,354 physicians; the remaining attendees were exhibitors, guests, spouses, and convention personnel.

Convocation
Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), surgeon-in-chief emeritus, Massachusetts General Hospital, and the W. Gerald Austen Distinguished Professor of Surgery, Harvard Medical School, Boston, MA, was installed as the 95th President of the ACS at the 2014 Convocation ceremonies October 26. Dr. Warshaw presented his Presidential Address, Achieving Our Personal Best—Back to the Future of the American College of Surgeons, to the College’s 1,640 Initiates and other attendees.

Two Vice-Presidents assumed office at the Convocation, as well: Jay L. Grosfeld, MD, FACS, FRCSI(Hon), FRCSEng(Hon), as First Vice-President; and Kenneth L. Mattox, MD, FACS, as Second Vice-President. Dr. Grosfeld is Lafayette F. Page professor emeritus of pediatric surgery, and past-chairman, department of surgery, Indiana University School of Medicine, Indianapolis.

Dr. Mattox 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.

In addition, Honorary Fellowship was conferred on six international surgeons: Pierre-Alain Clavien, MD, PhD, FACS, FRCSEng, FRCSEd, Zurich, Switzerland; Alberto Raul Ferreres, MD, PhD, MPH, FACS, Buenos Aires, Argentina; O. James Garden, BSc, MB, BCh, CBE, MD, FRCSEd, FRCPed, FRSE, Edinburgh, Scotland; Antoon (Toni) Lerut, MD, FACS, FACC, FRCSI(Hon), FRCSGlasg(Hon), AFC(Hon), ASA(Hon), Leuven, Belgium; Chung-Mau Lo, MB, BS, FACS, Hong Kong SAR, China; and Edgar Rodas, MD, FACS, Cuenca, Ecuador.

Named Lectures
Clinical Congress featured several Named Lectures, starting with the Martin Memorial Lecture, presented immediately after the Opening Ceremony on October 27. W. Marston Linehan, MD, chief, urologic surgery and urologic oncology branch, Center for Cancer Research, National Cancer Institute, Bethesda, MD, delivered the well-received lecture, Targeting the Genetic and Metabolic Basis of Cancer.

Other Named Lectures presented at the 2014 Clinical Congress were as follows:

- Valerie W. Rusch, MD, FACS, vice-chair for clinical research, department of surgery, and Miner Family Chair in Intrathoracic Cancers, Memorial Sloan Kettering Cancer Center, and professor of surgery, Weill...
CLINICAL CONGRESS HIGHLIGHTS

Cornell Medical College, NY, presented the John H. Gibbon, Jr., Lecture: Evolution in Lung Cancer Care: From Scalpels to Molecules.

- Dr. Ma tox presented the Charles G. Drake History of Surgery Lecture: Symbiotics and Serendipity in Aortic Trauma Management.

- Piero Anversa, MF, FAHA, CCNS, professor, anesthesia and medicine, Harvard Medical School, and director, Center for Regenerative Medicine, Brigham and Women’s Hospital, Boston, MA, presented the I. S. Ravdin Lecture in the Basic and Surgical Sciences: The Human Lung: A Self-Renewing Organ.

- David A. Rothenberger, MD, FACS, Jay Phillips Professor and Chair, department of surgery, and founder and co-director, emerging physician leaders program, University of Minnesota Medical School, Minneapolis, presented the Herand Abcarian Lecture: Surviving and Thriving As a Surgeon: What’s in Your Bag?

- Norman M. Rich, MD, FACS, DMCC, COL, MC, USA (Ret.), founding chair and namesake of the Norman M. Rich Department of Surgery, Uniformed Services University of the Health Sciences, Bethesda, MD, presented the Excelsior Surgical Society/Edward D. Churchill Lecture: Military Surgeons and Surgeons in the Military.

- C. William Schwab, MD, FACS, FRCS, professor of surgery, University of Pennsylvania Medical School, and trauma surgeon, Hospital of the University of Pennsylvania, Philadelphia, presented the Scudder Oration on Trauma: The Winds of War.

- Barbara L. Bass, MD, FACS, John F. and Carolyn Bookout Distinguished Endowed Chair of Surgery, Houston Methodist Hospital, TX; director, Methodist Institute for Technology, Innovation and Education, Houston; and professor of surgery, Weill Cornell Medical College of Cornell University, New York, NY, presented the Olga M. Jonasson Lecture: Our Lives As Surgeons: Finding a Sense of Place and Purpose.

- Meena N. Cherian, MD, lead, emergency and essential surgical care program, service delivery and safety department, Health Innovation Systems, World Health Organization, presented the Distinguished Lecture of the International Society of Surgery: Surgical Care in the Global Health Agenda.

- Steven Z. Pantilat, MD, FAAHPM, MHM, professor of clinical medicine, Alan M. Kates and John M. Burnard Endowed Chair in Palliative Care, director of the palliative care program and Palliative Care Leadership Center, and director of the Palliative Care Quality Network, University of California, San Francisco, presented the Ethics and Philosophy Lecture: Doctors Do Everything: Life and Death in the ICU.

- Carolyn C. Compton, MD, PhD, FCAP, chief medical officer of the National Biomarkers Development Alliance, member of the Biodesign Institute; chief medical officer of the Complex Adaptive Systems Initiative, and professor, life sciences, Arizona State University, Phoe-
nix; and professor, laboratory medicine and pathology, Mayo Clinic School of Medicine, Rochester, MN, presented the Commission on Cancer Oncology Lecture: Challenge, Convergence, Complexity, and Change in Cancer Care: Are We Ready?

Notable events
The ACS and the Department of Defense, Military Health System (MHS), signed an agreement at Clinical Congress. The partnership is meant to benefit both parties in the areas of education, systems-based practices, and research. (See related article, page 6.)

In light of the events preceding the start of Clinical Congress, a session on the Ebola virus was presented. Ebola: Pragmatic Information for Surgeons covered the pathogenesis, testing, treatment, transmission, and protective measures for the virus. The session featured Michele Barry, MD, FACP, professor of medicine at Stanford School of Medicine, CA; David B. Hoyt, MD, FACS, ACS Executive Director; Sherry M. Wren, MD, FACS, professor of surgery at Stanford School of Medicine, CA; and Gillian Lee Seton, MD, a general surgeon who provides care to patients in Monrovia, Liberia, and assistant professor of surgery at Loma Linda University, CA.

Holding its inaugural session at this year’s Clinical Congress was the ACS Surgical History Group (ACSSHG). The Panel Session, moderated by LaMar S. McGinnis, Jr., MD, FACS, Chair of the ACSSHG’s Executive Committee, was titled Factors Shaping Surgery during the 20th Century. The purpose of the ACSSHG is chiefly to promote and enhance the appreciation of American surgical history.

Awards and honors
Several surgeons were honored for their contributions to the ACS. Thomas R. Russell, MD, FACS, former Executive Director of the ACS, was posthumously awarded the Lifetime Achievement Award at the Convocation. The award is presented periodically “to an extraordinary individual for a lifetime of contributions to the art of medicine and surgery, and service to the ACS,” said Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), Immediate Past-President of the ACS. Dr. Russell’s wife, Nona, and his two daughters, Katie and Jackie, accepted the award.

J. Wayne Meredith, MD, FACS, the Richard T. Myers Professor and Chair, department of surgery, Wake Forest School of Medicine; surgeon-in-chief, Wake Forest Baptist Health; and medical director, Childress Institute of Pediatric Trauma, Wake Forest University Baptist Medical Center, Winston-Salem, NC, received the ACS Distinguished Service Award, the College’s highest honor, at the Convocation. The Board of Regents presented the award to Dr. Meredith in appreciation of “his continuous and devoted service” to the organization, as well as “his distinctive scientific contributions in cardiovascular physiology during resuscitation, trauma registries, and trauma systems.”

The Fellows Leadership Society (FLS) of the ACS Foundation presented the 2014 Distinguished Philanthropist Award to Patricia R. and W. Gerald Austen,
MD, FACS. The award was announced during the 26th annual FLS Benefactor Recognition Luncheon in recognition of Mrs. and Dr. Austen’s philanthropic contributions and service to the international and surgical communities.

Glen H. Tinkoff, MD, FACS, associate vice-chair, surgery for emergency surgical services, Christiana Hospital, Newark, DE, received the National Safety Council 2014 Surgeons’ Award for Service to Safety at the annual ACS Committee on Trauma (COT) Dinner. The award citation recognized Dr. Tinkoff’s “commitment to the advancement of care of injured patients in Texas through leadership in the organization of a regional trauma care system and outstanding trauma research.”

Harry S. Brown, MD, FACS, an ophthalmologist from Santa Barbara, CA, received the 2014 ACS/Pfizer Surgical Humanitarian Award for starting an international health care organization dedicated to restoring sight and preventing blindness in disadvantaged individuals. Additionally, three surgeons received the ACS/Pfizer Surgical Volunteerism Awards. Joseph V. Sakran, MD, MPH, FACS, a general surgeon from Boston, MA, received the Surgical Volunteerism Award for developing long-term interventions aimed at reducing the global burden of surgical disease, participating in numerous disaster relief efforts, and compiling medical supplies for communities of low- and middle-income countries. Robert D. Bach, MD, FACS, a general surgeon from North Haven, ME, received the Surgical Volunteerism Award for his decades of medical service to the impoverished and isolated population of northeastern Nicaragua. Scott A. Leckman, MD, FACS, a general surgeon from Salt Lake City, UT, received the Surgical Volunteerism Award for his efforts to provide free health care to low-income, uninsured patients in Salt Lake County.

The 2014 Owen Wangensteen Surgical Forum on Fundamental Surgical Problems was dedicated to Michael G. Sarr, MD, FACS, chair, division of general and gastroenterologic surgery, Mayo Clinic, Rochester, MN, in recognition of his exemplary leadership and mentorship of surgical residents.

Practicing surgeons, residents, and medical students were recognized for their contributions to advancing the art and science of surgery. Residents honored with the Surgical Forum Excellence in Research Awards included: Christa Grant, MD; Christopher Holley, MD; Bardiya Zangbar, MD; Johanna Riesel, MD; Mohamad Bydon, MD; Peter Adams, MD; Zeshan Maan, MB, BS, MS, MRCS; Elliott Wakeam, MD; Hyeyoun (Elise) Min; Jeniann Yi, MD; George Liao, MD; Ryan Spurrier, MD; Jeffrey Bassett, MD; and Jeffrey Carson, MD.

Carrie A. Sims, MD, MS, FACS, assistant professor of surgery, division of trauma, surgical critical care, and acute care surgery, University of Pennsylvania, Philadelphia, received the 10th Joan L. and Julius H. Jacobson II Promising Investigator Award. The award honors outstanding surgeons engaging in research, advancing the art and science of surgery, and demonstrating early promise of significant contributions to the practice of surgery.
The 12th annual ACS Resident Award for Exemplary Teaching was presented to Luise Ingeborg Maria Pernar, MD, a fifth-year resident in general surgery at the Brigham and Women’s Hospital in Boston, MA. The award is sponsored by the Division of Education to recognize excellence in teaching by a resident and to highlight the importance of teaching in residents’ daily lives. Dr. Pernar was selected by an independent review panel of the Committee on Resident Education.

The second annual Jameson L. Chassin, MD, FACS, Award for Professionalism in General Surgery was presented to Katie White Russell, MD, a chief resident in general surgery at the University of Utah and Affiliated Hospitals in Salt Lake City, Utah. The award recognizes a chief resident in general surgery who exemplifies the values of compassion, technical skill, and devotion to science and learning. The ACS established the award with gifts from the family, colleague, and friends of the late Jameson L. Chassin, MD, FACS, who was a skilled surgeon, teacher, and scholar in New York, NY. The award is administered by the ACS Division of Education. Dr. Russell was selected by an independent review panel of the Committee on Resident Education.

Craig S. Derkay, MD, FACS, Vice-Chair of the ACS Program Committee, and Audra A. Duncan, MD, FACS, ACS Program Committee member, awarded the Best Scientific Poster of Exceptional Merit award to Manu S. Sancheti, MD, for Risk Factors for 30-Day Mortality after Pulmonary Resection for Lung Cancer from the National Cancer Data Base: An Analysis of More than 200,000 Patients. The coauthors of this poster included the following: Theresa Gillespie, PhD; Dana Nickleach, MA; Yuan Liu; Kristin Higgins, MD; Suresh Ramalingam, MD; Joseph Lipscomb, PhD; and Felix G. Fernandez, MD, FACS, Emory University, Atlanta, GA.

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

- **First place**: Debi Thomas, University of Southern California, Los Angeles: Identifying Strains of Opportunistic Pathogens in Necrotizing Enterocolitis
- **Second place**: Steven Koprowski, Medical College of Wisconsin, Milwaukee: Curcumin-Mediated Notch 1 Signaling: A Potential Molecular Target in Cholangiocarcinoma
- **Third place**: Danny Mou, Emory University: Virus Induced CD28 Down-Regulation As a Driver of Costimulation Resistant Allograft Rejection
Jacobson Promising Investigator Awardee Dr. Sims (center, in red) with members of the Surgical Research Committee and past recipients.

Dr. Pernar, recipient of the Resident Award for Exemplary Teaching (second from left), pictured with (left to right): Ajit K. Sachdeva, MD, FACS, FRCSC, Director, Division of Education; Julie A. Freischlag, MD, FACS, Chair, Board of Regents; Michael J. Zinner, MD, FACS, Regent; Dr. Warshaw; Dr. Hoyt; Glenn T. Ault, MD, MSEd, FACS, Chair, Resident Award Program, Committee on Resident Education.

Dr. Russell, recipient of the Jameson L. Chassin, MD, FACS, Award for Professionalism in General Surgery (fifth from left), with (left to right): Mark T. Savarise, MD, FACS, professor of surgery, University of Utah School of Medicine (UUSOM), Salt Lake City; Courtney Scaife, MD, FACS, University of Utah and Affiliated Hospitals, Salt Lake City; Daniel J. Vargo, MD, FACS, Residency Program Director, UUSOM; Dr. Sachdeva, Dr. Freischlag; Dr. Hoyt; Dr. Warshaw; Clark J. Rasmussen, MD, FACS, Intermountain Medical Center, Salt Lake City, UT; Amalia Cochran, MD, FACS, associate professor of surgery, UUSOM; Leigh A. Neumayer, MD, MS, FACS, ACS Regent; and Raymond R. Price, MD, FACS, Intermountain Medical Center.
The following medical students were recognized for their Clinical and Educational Research posters:

• First place: Michelle Chua, Harvard University: Stratification of Recanalization for Patients with Endovascular Treatment of Intracranial Aneurysms

• Second place: Melina Deban, McGill University, Montreal, QC: McGill Simulation Complexity Score: Development of an Objective Complexity Scoring System for Virtual and Mannequin-based Simulations in Trauma

• Third place: Cynthia Miller, Massachusetts General Hospital: Immediate Implant Reconstruction Is Associated with a Reduced Risk of Lymphedema Compared to Mastectomy Alone: A Prospective Cohort Study

The International Relations Committee welcomed the International Guest Scholars for 2014 and other guests at a luncheon on October 28, including: Yoshifumi Baba, MD, PhD, Japan Exchange Fellow; Vivek Bindal, MB, BS, Baxiram S. and Kankuben B. Gellot Community Surgeons Travel Awardee; Fernando
CLINICAL CONGRESS HIGHLIGHTS

Bonilla, MD; Saud Majid Chaudhery, MB, BS, Dr. Pon Satitpunwaycha Community Surgeons Travel Awardee I; Roland S. Croner, MD, FACS, Murray F. Brennan Scholar; Eyo Effiong Ekpe, MB, BS; Jeffrey M. Farma, MD, FACS, 2014 Traveling Fellow to Germany; Luke Harper, MD; Alexander G. Heriot, MB, BChir, FRCSEd, FRCS, ANZ Exchange Fellow; Huang-Kai Kao, MD, Louis C. Argenta Scholar; Subodh Kumar, MB, BS, FACS, Dr. Abdol and Mrs. Joan Islami Scholar II; Nadja Lehwald, MD, PhD, Germany Exchange Fellow; Jiang-Tao Li, MD, Carlos Pellegrini Traveling Fellow; Haidar Mohammad Muhssein, MB, BCh, FACS, Dr. Pon Satitpunwaycha Community Surgeons Travel Awardee II; John T. Mulllen, MD, FACS, 2014 ACS Traveling Fellow to Germany; Ayodeji O. Oladele, MB, BCh, FWACS, Dr. Pon Satitpunwaycha Community Surgeons Travel Awardee III; Puthen Veetil Pradeep, MB, BS, FACS, Dr. Pon Satitpunwaycha Community Surgeons Travel Awardee IV; Eliza M. Raymundo, MD; Keishi Sugimachi, MD, Elias Hanna Scholar; Stephen Tabiri, MD; Mellika Tewari, MB, BS, MS; Dezso Tóth, MD, PhD; Ioannis K. Toupoulis, MD, Stavros Niarchos Foundation Scholar; Sterman Toussaint, MD, International Surgical Education Scholar; Benjamin W. Turney, MB, BChir, PhD, Dr. Abdol Islami and Mrs. Joan Mae Islami Scholar I; Carl Wahlgren, MD, PhD; and Wei Zhou, MD, PhD, FACS, 2014 Traveling Fellow to ANZ.

The Commission on Cancer (CoC) presented the State Chair Outstanding Performance Award to the following surgeons: Ned Zachary Carp, MD, FACS, Pennsylvania; Hisakazu Hoshi, MD, FACS, Iowa; and Valeri Moysaenko, MD, FACS, Ohio.

John M. McBee, MD, FACS, a general surgeon in Pendleton, OR, attended Clinical Congress as the recipient of the 2014 Nizar N. Oweida, MD, FACS, Scholarship (see Dr. McBee’s report on page 65). Additionally, Anees B. Chagpar, MD, MPH, FACS, director of the Breast Center-Smilow Cancer Hospital at Yale University, New Haven, CT, and recipient of the 2013 Claude H. Organ, MD, FACS, Traveling Fellowship, spoke before the ACS Scholarships Committee.

Lastly, the winners of the 2014 Resident and Associate Society (RAS) of the ACS essay contest spoke at the RAS Symposium. The theme of the essay contest was the Five-Year General Surgery Residency Program: Reform or Revolution? Jahan Mohebali, MD, third-year resident at Massachusetts General Hospital, Boston, was the first-place winner for the “reform” side. Edna Shenvi, MD, who has completed two years of residency at Brigham and Women's Hospital, Boston, MA, was the first-place winner for the “revolution” side.

Annual Business Meeting

The ACS Annual Business Meeting of Members convened on October 29 with Dr. Warshaw 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 ACS Professional Association political action committee (ACSPA-SurgeonsPAC) Board of Directors; Gary L. Timmerman, MD, FACS, Chair of the Board of Governors; and Dr. Hoyt.

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

J. David Richardson, MD, FACS, professor of surgery and vice-chairman, department of surgery, University of Louisville School of Medicine, KY, was elected President-Elect. Ronald V. Maier, MD, FACS, Jane and Donald D. Trunkey Endowed Chair in Trauma Surgery, and professor and vice-chairman of surgery, University of Washington School of Medicine, Seattle, was elected First Vice-President-Elect; Walter J. Pories, MD, FACS, founding chair, department of surgery; professor of surgery, biochemistry and kinesiology; and director, bariatric surgery research group, East Carolina University, Greenville, NC, was elected Second Vice-President-Elect.
The Board of Governors of the ACS reelected six members of the Board of Regents to additional three-year terms: James K. Elsey, MD, FACS, a general and vascular surgeon, Atlanta, GA; Gerald M. Fried, MD, FACS, FRCSC, FCAHS, a general surgeon, Montreal, QC; B. J. Hancock, MD, FACS, FRCSC, a pediatric surgeon, Winnipeg, MB; Lenworth M. Jacobs, Jr., MD, MPH, FACS, a general surgeon, Hartford, CT; Mark A. Malangoni, MD, FACS, a general surgeon, Philadelphia, PA; and Valerie W. Rusch, MD, FACS, a cardiothoracic surgeon, New York, NY.

The Board of Governors elected Fabrizio Michelassi, MD, FACS, a general surgeon, to serve as Chair of its Executive Committee; Karen J. Brasil, MD, FACS, a general surgeon, Portland, OR, as Vice-Chair; and James C. Denneny III, MD, FACS, otolaryngologist, Alexandria, VA, as Secretary. Newly elected to serve on the Executive Committee of the Board of Governors are Kevin Behrns, MD, FACS, a general surgeon, Gainesville, FL; Diana Farmer, MD, FACS, a pediatric surgeon, Davis, CA; and Steven C. Stain, MD, FACS, a general surgeon, Albany, NY. Governors-at-Large from throughout the world and Specialty Society Governors also were installed.

Clinical Congress 2015

Be sure to attend the 2015 Clinical Congress, October 4–8, in Chicago, IL. 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 2014
• Fellows honored for volunteerism, page 67

October 2014
• J. Wayne Meredith, MD, FACS, chosen as 2014 Distinguished Service Award recipient, page 50

November 2014
• Andrew L. Warshaw, MD, FACS, FRSCEd(Hon), installed as 95th President of the ACS, page 58
• Six outstanding surgeons conferred Honorary Fellowship in the ACS, page 60

December 2014
• Presidential Address: Achieving our personal best—Back to the future of the American College of Surgeons, page 9
• J. David Richardson, MD, FACS, next President-Elect of the ACS, page 53
• Regents reelected and new Board of Governors Executive Committee installed, page 56
• ACS presents Lifetime Achievement Award posthumously to Dr. Russell, page 57
The disruptive physician:
Addressing the issues

by Brian Santin, MD, FACS, and Krista Kaups, MD, FACS

HIGHLIGHTS

- Notes that 3 percent to 5 percent of all physicians display disruptive behaviors, and most of these individuals are not suffering from some sort of impairment
- Describes how disruptive physician behavior impedes optimal patient care and may compromise patient safety
- Recommends that each department or institution have a code of conduct in place that delineates behaviors that will not be tolerated
- Offers a step-by-step approach to addressing disruptive behaviors
Editor’s note: The following is the fourth in a series of excerpts from Being Well and Staying Competent: Challenges for the Surgeon, a guidebook issued in 2013 by the ACS Board of Governors’ Committee on Physician Competency and Health. The complete document is posted in the General Surgery community’s library in ACS Communities at http://bit.ly/1qD34QV (login required).

Most health care professionals have witnessed their colleagues engaging in disruptive behavior with coworkers, relatives, patients, and other acquaintances at one time or another. However, it is imperative to make the distinction between being disruptive and advocating on the behalf of a patient. For example, when a physician assumes a firm patient advocacy position in a conversation regarding the long-term care facility placement of an elderly patient, this may be an appropriate and effective behavior. Conversely, when a physician angrily demeans a nurse in a crowded hospital hallway or raises his or her voice, shouting profanities in a committee meeting, these actions are inappropriate and disruptive. When physicians exhibit this behavior in such a setting, it may be a signal that a more widespread issue within the health care system requires attention.1 Disruptive actions listed in the American Medical Association Code of Medical Ethics, adopted in 2009, include: “any abusive conduct, including sexual or other forms of harassment, or other forms of verbal or nonverbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.”2 Specifically mentioned are the following actions:2

- Physically threatening anyone [in the hospital]
- Making threatening or intimidating physical contact with another person
- Throwing things
- Threatening violence or retribution
- Sexual and other harassment
- Persistent inappropriate behavior, rising to the level of harassment

Specific inappropriate behaviors outlined in the code include, but are not limited to, the following: making belittling, sarcastic, or condescending statements; calling people names; using profanity; blatantly failing to respond to patient care needs or staff requests; and deliberately failing to return calls, pages, and messages.

Mounting pressures

As the complexity of medical care increases, the need for well-functioning partnerships between members of the medical team becomes more important. At the same time, the stresses, demands, and distractions for surgeons also continue to mount. As a result of the relatively high profile of physicians, disruptive behavior by these individuals is perceived to have a greater impact—and greater potential for disruption.

Despite physicians’ best efforts to work within “the system,” quite often surgeons are urgently contacted for an issue that ultimately does not qualify as an emergency. At other times, surgeons responding to a call arrive only to find that necessary preparations have not been made or equipment is not available for a procedure. Perhaps an important change in a patient’s condition went unrecognized, or the staff did not notify the physician of the change. Feelings of anger and frustration are understandable in these situations, but a physician must consider his or her response carefully.

Although little evidence is available to indicate that the frequency of disruptive conduct has increased in recent years, the issue is being increasingly studied, and physicians who display this behavior continue to be penalized. In 2008, The Joint Commission issued a Sentinel Event Alert, which stated, “Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.”3 For example, Joint Commission-accredited hospitals are mandated to have defined mechanisms in place for identifying and addressing disruptive behavior.
Although the overall prevalence of this type of conduct is unknown, large-scale studies suggest that disruptive behavior occurs frequently. In a 2002 survey of 675 nurses at 50 Veterans Affairs (VA) hospitals, 86 percent of the respondents reported witnessing disruptive physician behavior—a finding supported by the results of other studies.4 Most of these incidents involved nursing staff or other health care professionals. In 2011, another survey of more than 800 physicians found that disruptive behavior occurs in more than 70 percent of hospitals each month.7 More than 10 percent of the physicians surveyed reported that these behaviors occur weekly. Similarly, in 2009, more than 2,000 physician executives acknowledged encountering behavioral problems with physicians in their institution.6

It is important to note, however, that “a single episode of disruptive behavior does not render a physician a disruptive physician,” according to experts on the topic.7 Current research suggests that it is generally a small percentage of physicians who are responsible for the majority of the inappropriate behavior. Most reports describe 3 percent to 5 percent of physicians exhibiting disruptive behavior; unfortunately, it appears that surgeons are among those most often identified as disruptive (particularly general surgeons, neurosurgeons, cardiovascular surgeons, and orthopaedic surgeons).3 Another important clarification is that most disruptive physicians are not impaired or suffering from a substance abuse pathology, but are likely exhibiting longstanding behavior patterns. In fact, fewer than 10 percent of physician behavior issues are related to substance abuse.8,9

Effects of disruptive behavior
The consequences of disruptive behavior can be significant, and may even affect patient care. Furthermore, these behaviors often result in diminished morale and productivity and create work environment disturbances due to increased stress and turnover of health care employees.1 Collegiality is impaired by disruptive behavior, leading to a less efficient and less functional team. A colleague on the receiving end of inappropriate behavior may be less likely to question orders, express concerns regarding discrepancies in patient consents, or notify the physician of other patient-related issues, thereby increasing the potential for medical error.

As unimpeded communication becomes more difficult, patient safety is also compromised. In a survey conducted at 102 VA hospitals with 4,530 participants, 67 percent of respondents said they felt that disruptive behavior was linked to adverse events, 71 percent saw a link to errors, and 27 percent saw a link to patient mortality.7

Patient and family satisfaction deteriorates as a result of disruptive physician behavior.10,11 These occurrences may lead to complaints to the medical staff office, and multiple complaints may serve as an indicator of a disruptive physician. A review of complaints to state medical boards indicated that 36 percent of these reports were related to inappropriate physician behavior.12

Disruptive physician behavior also has economic consequences, including slowed patient throughput as a result of decreased efficiency, increased employee turnover leading to additional hiring and training expenditures, elevated costs for hospitals because of increased errors and adverse events, and an additional financial burden for physicians resulting from liability claims.13

How to address disruptive behavior
Because of the significant consequences associated with disruptive physician behavior, it is important that health care institutions and the profession address this problem. The following approach should provide a systematic and effective approach for reducing and deterring disruptive behavior.

Prevention. The first step in addressing disruptive behavior is prevention. Hospital systems should develop a clearly outlined approach for making all employees, including physicians, aware of what constitutes disruptive behavior, as well as the consequences of any transgressions. It is essential that health care professionals understand that the codes of conduct/standards apply to all patient care team members.

To address the issue of disruptive behaviors, most hospital systems have incorporated specific language in their medical staff bylaws. This behavior falls under the category of “professionalism,” requiring health care professionals to display a minimum standard of behav-
ior toward colleagues, employees, and patients. Any violation of the tenets of professionalism may serve as justification for taking action to address this behavior. The definition and expectations of professional behavior have some expected variance across health systems, but there are common components, including the following:

- Expected behaviors should be clearly defined
- Consequences for divergence from these behaviors should be delineated
- Repercussions should be in accordance with the severity of the incident
- Consequences for repeat behaviors should increase in a step-wise fashion
- Clear communication should occur and be documented after each and every reported incident

It is imperative to recognize that the individual displaying disruptive behavior(s) and the individual(s) on the receiving end of such behaviors may perceive these behaviors differently. Some physicians may claim that whether the behavior is positive or negative is in the eye of the beholder. Therefore, a code of conduct that is equally applied to all health care professionals is essential in order to establish a well-defined foundation to support any conduct-related conversation or disciplinary action. It also is essential to include due process in the code of conduct. Complaints should only be considered valid if a verification process is in place. In a report issued by the American Association for Physician Leadership (formerly the American College of Physician Executives), code of conduct bylaws should include an appeals process, along with an option for a fair hearing. For physicians, acknowledgment (and signing) of the code of conduct is frequently part of the credentialing process.

Identification. If a health care professional witnesses unwanted behaviors, they should identify and report the act in a timely and professional manner. Disruptive behaviors may be viewed as diminishing the strength of the health care team and, therefore, detrimental not only to other staffers and the physician involved, but, ultimately, to patient care. Identifying disruptive behavior is the cornerstone of promoting better patient care and encouraging long-lasting, meaningful relationships among all hospital staff. Most institutions recommend that reports of unfavorable physician behavior be directed at either the medical staff director/administrator or human resources. It is crucial that behavior standards are universally applied and that no perception of favoritism occur (that is, higher tolerance for inappropriate attitudes or actions exhibited by prominent or highly productive physicians). Identification of disruptive behavior must be done in accordance with defined criteria and must not be applied arbitrarily. Formal mechanisms, including detailed reporting, should be in place for documenting these events, alongside policies to protect those colleagues who are reporting them from retaliation; some individuals may otherwise be hesitant to report misconduct for fear of the repercussions.

Acknowledgement. Addressing disruptive behavior in a relaxed, informal setting with either the medical staff executive or in conjunction with a physician mentor is most likely to result in a desirable outcome. The degree and pattern of behavior may be a predictor for a positive outcome. For example, for a physician who has an unusual, uncharacteristic outburst, a private conversation with a colleague may be most appropriate. The physician with an ongoing pattern of unacceptable behavior may best be addressed by physicians in leadership—either within the department structure or via the institutional physician executive structure. Unfortunately, such a physician may have long-established behavior patterns and lack insight into his or her behavior. In these cases, changing
It is crucial that behavior standards are universally applied and that no perception of favoritism occur (that is, higher tolerance for inappropriate attitudes or actions exhibited by prominent or highly productive physicians).

the counterproductive and damaging behavior patterns is likely to require prolonged and intensive counseling. Physicians in this position generally must be mandated to enter counseling programs, as they are unlikely to seek assistance voluntarily.

In a structured format, the physician’s behaviors should be discussed and include specific documentation. The physician should have an opportunity to self-evaluate. Relevant cultural factors also should be addressed. A plan for future actions should be developed, agreed upon, and documented with stepwise progression up to and including dismissal from the medical staff, if the disruptive behaviors continue. Consequences of continued/repeated inappropriate behavior should also be explained to the physician. The conversation should be documented and the physician’s progress monitored. The ultimate goal of these actions is focused on two outcomes—improved patient care and a physician who embodies optimal behaviors and capabilities.

**Monitoring.** As part of the corrective plan, a monitoring program should be put in place. Established behavior patterns may be resolved incrementally, and while relapses are not uncommon, improved conduct is expected. If the behaviors persist, the agreed-upon penalties should be implemented. The monitoring period will vary, but it should extend at least six to 12 months to encourage the maintenance of appropriate behavior. Most state medical boards provide or contract with formal programs for the evaluation and rehabilitation of physicians who exhibit disruptive behavior, and these are available to hospitals as an option for resolution. These programs can be found on the website of the Federation of State Health Programs and the Federation of State Medical Boards (see sidebar, page 23). These programs provide the offending physician an opportunity to confidentially undergo rehabilitative counseling or behavior modification without jeopardizing his or her licensure.

**Conclusion**

In an era in which quality care and patient safety are high priorities, the surgical profession can no longer tolerate disruptive behavior in or out of the operating room. These behaviors should be addressed early on and in a stepwise fashion to reduce their impact and presence, to maintain the morale of other members of the health care delivery team, and to protect our patients’ well-being.

**REFERENCES**

COPING WITH PATIENT LOSS

Patient loss: Surgeons describe how they cope
by Devin Rose

Losing a patient is an experience that all surgeons are likely to face at some point in their careers. The circumstances surrounding these deaths differ—one patient’s life might have been in the process of ending for years due to a terminal illness, while another might suffer complications during what should be a routine procedure. These events can be devastating for everyone involved, and with that in mind, several Fellows of the American College of Surgeons (ACS) are sharing strategies they’ve learned that ease the difficulty of patient loss, as well as advice they would offer to people considering careers in surgery.

Telling the truth
Geoffrey P. Dunn, MD, FACS, general surgeon, department of surgery, and medical director, palliative care consultation service, University of Pittsburgh Medical Center (UPMC) Hamot, Erie, PA, said he has seen a change in the way that death is perceived in the surgical world. Dr. Dunn said that when he started his career 30 years ago, surgeons were not inclined to see death as a natural occurrence. The main question was, “Is my treatment of the patient working?” Recently, however, Dr. Dunn has noticed the focus shift from the single event of the death to improving the surgeon’s ability to anticipate it and to enhance the patient’s comfort level during this time. Dr. Dunn is the Editor-in-Chief of Surgical Palliative Care: A Resident’s Guide, published by the ACS, and in the introduction, he and one of the book’s Associate Editors write that over the last decade, palliative care has become recognized as an essential component of patient care.

When he began practicing at UPMC, Dr. Dunn learned how important it is to be completely honest with patients’ families because, many times, he knew the families and would often cross paths with them outside of the hospital. And as the son, grandson, and great-grandson of surgeons who practiced at the same institution, Dr. Dunn said he felt a great sense of responsibility to his patients and their loved ones. Recently, he treated a 102-year-old man on whom his grandfather also had operated.

Having that connection can be helpful, Dr. Dunn said, but it can also make it more painful if something happens to the patient. Even in those circumstances,
COPING WITH PATIENT LOSS

though, staying in touch with the patient’s family has helped him to cope. One of the first losses Dr. Dunn experienced was with a patient on whom his father had operated years before. After the funeral, the family invited him to dinner, where he heard them talk about the man’s life. He and the family kept in touch for years.

Dr. Dunn said he also became an early believer in the value of a condolence letter, which serves as a tribute to the patient and a source of comfort to the survivors. In those letters, he makes sure to recall qualities of the patient and offers a way to keep in touch.

“Death is not a final, defining point for the individual or the relationship that occurred around it,” Dr. Dunn said.

Developing a relationship with a patient’s family also helped Danielle Saunders Walsh, MD, FACS, get through the loss of a patient. Dr. Walsh, a pediatric surgeon who has been practicing for approximately 10 years, is an associate professor at Brody School of Medicine, East Carolina University, Greenville, NC.

Dr. Walsh said the death of every child affects her, regardless of how well she knows the family. “Children bring a different perspective in dealing with death. In general, we view them as innocent. We see it as a loss of an opportunity for someone to experience a full life,” she said.

One of her first experiences with loss occurred with a teenage patient who had a birth defect that had become increasingly problematic as the girl matured. No other physician whom Dr. Walsh consulted was able to help. The girl died suddenly while Dr. Walsh was performing a procedure.

Dr. Walsh said that losing this patient was extremely difficult, and she contemplated whether a career in surgery was right for her. “If this is so painful, why am I doing it?” she wondered. But at the funeral, the girl’s mother could tell she was hurting. “She said, ‘I hope you don’t give up,’” which reassured Dr. Walsh that she should continue in her chosen career.

Dr. Walsh said that in her experience, many conversations with patients and families would be easier if Americans could view death as a natural part of life—no matter how brief or lengthy that life may be. But we are not quite there yet as a society, she said, because people tend to think there is always more, medically, that can be done.

Patricia J. Numann, MD, FACS, FRCSEd(Hon), FRCSGlasg(Hon), is an ACS Past-President and Lloyd S. Rogers Professor of Surgery Emeritus, Upstate Medical University, Syracuse, NY, and State University of New York Distinguished Teaching Professor Emeritus. Dr. Numann said she has noticed that accepting the death of patients seems to be harder now than when she started her career as a surgeon. When she was a medical student in the 1960s at the State University of New York Upstate Medical University, there were no intensive care units, according to Dr. Numann. “A lot more people died. We didn’t have these extraordinary, heroic things that we could do for people.”

Dr. Numann said she was always reasonably comfortable talking about death. As a child, she would walk around Woodlawn Cemetery in the Bronx, NY, with her aunt, and they would look at the flowers on the graves. When she was a third-year medical student, Dr. Numann left school to help take care of her mother, who had pancreatic cancer and wanted to spend her remaining time at home. Dr. Numann’s mother died shortly after she returned to school. Her mother was, in a way, the first patient she lost.

From that experience, Dr. Numann began to see that some patients do tend to cling to life, waiting for certain events—babies to be born, graduations—before they pass away. It can be important to the process that they have something to look forward to, she said, and she always made it a habit to visit dying patients at home when she could. Many families want to know
that their loved ones are not alone when they are close to death. Dr. Numann said family members have asked her to sit with patients if they are not emotionally strong enough to do so.

Dr. Numann said she would always try to go to the family’s calling hours after the death of a patient in order to cope. Doing that shows families that “you did truly do your best, and you did truly care about the person,” she said. Dr. Numann added that many people don’t realize how much surgeons miss some of the patients they have treated. “[Some patients] become like part of your extended family,” she said, because, as part of a trusted relationship, they would get to know what was going on in each others’ lives.

**Conveying empathy**

Being involved with patients’ families also helped Frederick L. Greene, MD, FACS, medical director of cancer data services, Levine Cancer Institute and former chairman, department of surgery, Carolinas Medical Center, Charlotte, NC. Dr. Greene is also the host of *The Recovery Room*, a podcast featured on the ACS website that deals with medical topics.

Imparting difficult information was a big part of Dr. Greene’s job as a cancer surgeon, and he found the best approach was to communicate any bad news as early as possible.

“I think it’s important that you don’t wait until an event is over. For me, if I was going to operate on a high-risk patient, a lot [of learning to report bad news] has to do with communication with the family up front,” Dr. Greene said.

He cautioned to never impart difficult information in a public arena, like a hospital hallway. Instead, he suggested taking the family into a private area, such as a conference room, and making sure they sit down. Once the information has been presented, Dr. Greene said it is important to let the family be alone. The surgeon can also offer to contact another physician for a second or third opinion. Dr. Greene added that this can be difficult for some surgeons who want to believe that they can take care of their patients better than anyone else, but “you have to be the one opening the door for that conversation,” he said.

If a death occurs, the surgeon should ask how he or she can help the family with the grieving process. Dr. Greene said he has gone into the homes of families to explain autopsy results if such a conversation is necessary to determine how the patient died, or to discuss genetic risks for survivors.

Heena P. Santry, MD, FACS, assistant professor, University of Massachusetts Medical School, Worcester, MA, rarely has the opportunity to form lasting relationships with patients or their families. As a trauma and critical care surgeon, Dr. Santry said she is usually delivering bad news within hours of meeting the patient and oftentimes within minutes of meeting the family. In her four years of practice, Dr. Santry said she has developed a gut instinct concerning how to deal with the situations she encounters when she walks into the family waiting room.

Sometimes, Dr. Santry explained, she will give families a brief overview of what happened to the patient before giving them the news. Other times, people are so hysterical or nervous that she knows she needs to tell them right away, adjusting her word choices, body language, and intonation to the emotion of the situation.

There is not much time to train surgeons in their interpersonal communication skills, Dr. Santry said, and she has relied on mentors in developing her own style. It can be difficult to teach, so the best way for trainees to learn is to watch surgeons deliver difficult news over and over again, Dr. Santry said.

“The key is to develop a style that allows you to perceive the needs of the family you’re talking to while conveying the appropriate amount of empathy,” she noted.
Returning to the OR

Dr. Greene said that weekly morbidity and mortality conferences, which enable surgeons to come together and discuss surgical outcomes, have been helpful for him. Dr. Greene said the conferences, which were started by Ernest Amory Codman, MD, FACS, a founder of the College, are educational and provide a supportive atmosphere for surgeons at all stages in their careers. Even after analyzing outcomes, however, surgeons must remember that negative patient outcomes are still, unfortunately, a reality.

“Many people can’t cope with that,” he said. “I have seen surgeons who become devastated, and that’s why burnout occurs.”

For Dr. Dunn, it’s important to get in touch with peers and not become psychologically isolated after losing a patient. When that happens, he said, you tend to lose perspective. “You’ve got to have a place to put all the negative energy that can occur because of losses. Share your thoughts with someone you trust,” he said.

If another patient is waiting to be cared for, however, the doctors agreed that there is no time to express their sadness. Dr. Walsh said that learning to silo her emotions has been helpful to her after a patient dies, particularly if she must tend to another patient right away. “You have to put those emotions away in order to go take care of the next person who needs your help,” she said. To deal with those emotions outside of the operating room, Dr. Walsh said she turns to people she cares about who can provide the words and guidance necessary to help ease the pain.

Dr. Santry said there have been times when she has cried with the families of patients after a loss. But surgeons need to have a laser-like focus, she said. They have to be so fully engaged with the next patient that they simply have to shut down lingering feelings, if only temporarily.

Tyler G. Hughes, MD, FACS, ACS Governor and Chair, ACS Advisory Council for Rural Surgery, general surgeon, McPherson Hospital, KS, agreed that sharing the experience with someone else is helpful. For him, that means talking to another physician or someone other than his wife or friends.

“You have to find some objective way to see if you contributed, and be honest with yourself about it,” Dr. Hughes said. He added that it can be difficult to do that in McPherson, where the population is 13,000, and many people know each other.

Dr. Hughes cautioned against returning to surgery too quickly after a loss. The event might cloud your judgment, he said, and you don’t realize that you’re not listening to your current patient because your head is still back in the operating room with the last one. Surgeons of his generation were trained to be “bulletproof,” he said, but he’s learned that it’s not a sign of weakness to ask for help. It can also be comforting to know that every surgeon has most likely gone through the same thing.

“Never be too proud of your work,” Dr. Hughes said. “The easiest case can go south, and [you should] expect it to do so, because that’s going to happen one day. Know that every surgeon has been right there.”

No matter the circumstances that lead to the death of a patient, the surgeons agreed it’s always difficult for all involved. Some surgeons said it was important to keep in contact with the patient’s family because interaction with the family helped to show how much these physicians cared about the patient, while another surgeon found the reassurance she needed to continue practicing surgery from these personal exchanges. Many surgeons said it was important to talk to someone they trust after a loss, whether it be a family member or fellow physicians who help them see these situations objectively. No matter how sad they may feel, however, it’s essential for surgeons to be able to put their full focus on the next patient. ♦
The benefits of attending a 2015 ACS Surgical Coding Workshop

by Sarah Kurusz and Molly Peltzman, MA

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 commonly used by general surgeons. 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 benefiting from the workshops. Team attendance is strongly encouraged to ensure accurate, consistent, and complete coding. Registration discounts are offered when three or more team members enroll together. Furthermore, 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 beneficial to attend a workshop each year.

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 improve their 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 can learn how their colleagues are handling coding, billing, and practice management issues.

What will I learn?
Because the code set is updated annually, the topics discussed at an ACS coding workshop change from year to year. However, the focus of the first day of the workshop is on how to code correctly. Topics include selecting the right type of code and level of service in all situations, identifying evaluation and management (E/M) services that are part of the global payment and those that may be billed separately, and the transition to ICD-10 (see related article, page 31). These topics are addressed with an emphasis on their effects on surgical practices. 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 reimbursement for an operation performed with an assistant or co-surgeon. Other topics discussed include:

• The difference between CPT rules and Medicare rules and how this variance affects coding and billing
• Services included in the global surgical package
• Modifiers: how they are used and how they affect reimbursement

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• Coding for excisional breast biopsy or partial mastectomy

• How to initiate a successful appeal when receiving incorrect payment

• When and how to report E/M services for major and minor procedures, especially trauma

• 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

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 2015 ACS Surgical Coding Workshops take place?  
The workshops will take place on the following dates:

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
<th>Location</th>
<th>Phone</th>
<th>Room rates</th>
<th>Hotel cut-off dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago, IL</td>
<td>Apr. 23–24</td>
<td>Park Hyatt Chicago</td>
<td>888-421-1442</td>
<td>195</td>
<td>4/3/15</td>
</tr>
<tr>
<td>Nashville, TN</td>
<td>Aug. 13–14</td>
<td>Loews Vanderbilt Hotel</td>
<td>800-336-3335</td>
<td>176</td>
<td>7/22/15</td>
</tr>
<tr>
<td>Dallas, TX</td>
<td>Sept. 17–18</td>
<td>The Magnolia Hotel</td>
<td>888-915-1110</td>
<td>159</td>
<td>8/26/15</td>
</tr>
<tr>
<td>Chicago, IL</td>
<td>Nov. 12–13</td>
<td>Hyatt Chicago Magnificent Mile</td>
<td>888-591-1234</td>
<td>209</td>
<td>10/12/15</td>
</tr>
</tbody>
</table>

The dates and locations change each year; visit the ACS practice management Web page at www.facs.org/advocacy/practmanagement for the most current schedule.

How do I register?  
Register for the two-day workshop online at www.karenzupko.com/workshops/americancollegeofsurgeons/index.html or call 312-642-8310. The ACS offers a special price for members and their coding staff, but ACS membership is not a requirement for attendance. The member price is $650 for each course or $995 for both days. The non-member price is $750 per day or $1095 for both days. ACS Fellows and their staff should have their ACS member number available and enter it for each individual registering.

For hotel reservations, contact the hotel that is hosting the workshop using the number provided in the registration process, and then indicate that you are attending the ACS Surgical Coding Workshop for special pricing (see table, this page).

The ACS also offers special airfare discounts on United Airlines. 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.

The ACS file numbers are Agreement Code: 973454; ZCode: ZTEZ.

Additional 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), 9:00 am–6:00 pm EST. The Coding Hotline staff will answer five free coding questions per 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, 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.
ACS develops ICD-9 to ICD-10 crosswalk to assist in billing

In 2003, the Health Insurance Portability and Accountability Act identified the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) as the standard code set for reporting medical and surgical diagnoses and inpatient procedures. ICD is a diagnostic tool used for epidemiology, health management, and clinical purposes.* Currently, ICD-9-CM includes both diagnosis and procedural codes.

ICD-9 will be transitioning to the ICD 10th Revision (ICD-10), October 1. ICD-10 is expected to be an expanded code set, including additional information for ambulatory and managed care and injuries. It is expected to combine diagnosis and symptom codes to better define certain conditions, increase specificity through greater code length, and provide the ability to specify laterality.†

ICD-10 will consist of two parts: ICD-10-Clinical Modification (CM) and ICD-10-Procedure Coding System (PCS). Surgeons and other health care professionals will use ICD-10-CM to report medical diagnoses. Hospitals will use ICD-10-PCS to report inpatient procedures. For more information on the differences between ICD-10-CM and ICD-10-PCS, view the American College of Surgeons (ACS) ICD factsheet at www.facs.org/advocacy/prctmanagement/icd10/factsheet.

To assist surgeons with the transition to ICD-10, the ACS has developed an ICD-9-CM to ICD-10-CM crosswalk of the most frequently reported general surgery diagnosis codes. It can be used as tool to help determine what a particular ICD-9 code will be translated to in ICD-10. It may also be used as a resource to aid in the billing process. Accurate coding is the responsibility of the provider.

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ICD-10 CROSSWALK FOR GENERAL SURGERY

This crosswalk has been developed by the ACS and may be used as a basic guide for comparing a selection of frequently reported general surgery procedures between ICD-9 and ICD-10. Note that accurate coding is the responsibility of the provider. This crosswalk is intended only as a resource to assist in the billing process.

<table>
<thead>
<tr>
<th>ICD-9 (non-specified)</th>
<th>ICD-9</th>
<th>ICD-9 description</th>
<th>ICD-10</th>
<th>ICD-10 description</th>
</tr>
</thead>
<tbody>
<tr>
<td>569.0</td>
<td>Anal and rectal polyp</td>
<td>K62.0</td>
<td>Anal polyp</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>K62.1</td>
<td>Rectal polyp</td>
<td></td>
</tr>
<tr>
<td>569.1</td>
<td>Rectal prolapse</td>
<td>K62.2</td>
<td>Anal prolapse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>K62.3</td>
<td>Rectal prolapse</td>
<td></td>
</tr>
<tr>
<td>569.2</td>
<td>Stenosis of rectum and anus</td>
<td>K62.4</td>
<td>Stenosis of anus and rectum</td>
<td></td>
</tr>
<tr>
<td>569.3</td>
<td>Hemorrhage of anus and rectum</td>
<td>K62.5</td>
<td>Hemorrhage of anus and rectum</td>
<td></td>
</tr>
<tr>
<td>569.4</td>
<td>Other specified disorders of the rectum and anus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>569.41</td>
<td>Ulcer of anus and rectum</td>
<td>K62.6</td>
<td>Ulcer of anus and rectum</td>
<td></td>
</tr>
<tr>
<td>569.42</td>
<td>Anal or rectal pain</td>
<td>K62.89</td>
<td>Other specified diseases of anus and rectum</td>
<td></td>
</tr>
<tr>
<td>569.43</td>
<td>Anal sphincter tear (healed) (old)</td>
<td>K62.81</td>
<td>Anal sphincter tear (healed) (nontraumatic) (old)</td>
<td></td>
</tr>
<tr>
<td>569.44</td>
<td>Dysplasia of anus</td>
<td>K62.42</td>
<td>Dysplasia of anus</td>
<td></td>
</tr>
<tr>
<td>569.49</td>
<td>Other</td>
<td>K62.49</td>
<td>Other specified diseases of anus and rectum</td>
<td></td>
</tr>
<tr>
<td>569.5</td>
<td>Abscess of intestine</td>
<td>K63.0</td>
<td>Abscess of intestine</td>
<td></td>
</tr>
<tr>
<td>569.6</td>
<td>Colostomy and enterostomy complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>569.60</td>
<td>Colostomy and enterostomy complications, unspecified</td>
<td>K94.00</td>
<td>Colostomy complication, unspecified</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>K94.10</td>
<td>Enterostomy complication, unspecified</td>
<td></td>
</tr>
<tr>
<td>569.61</td>
<td>Infection of colostomy or enterostomy</td>
<td>K94.02</td>
<td>Colostomy infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>K94.12</td>
<td>Enterostomy infection</td>
<td></td>
</tr>
<tr>
<td>569.62</td>
<td>Mechanical complication of colostomy and enterostomy</td>
<td>K94.03</td>
<td>Colostomy malfunction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>K94.13</td>
<td>Enterostomy malfunction</td>
<td></td>
</tr>
<tr>
<td>569.69</td>
<td>Other complications</td>
<td>K94.09</td>
<td>Other complications of colostomy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>K94.19</td>
<td>Other complications of enterostomy</td>
<td></td>
</tr>
<tr>
<td>569.7</td>
<td>Complications of intestinal pouch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>569.71</td>
<td>Pouchitis</td>
<td>K91.850</td>
<td>Pouchitis</td>
<td></td>
</tr>
<tr>
<td>569.79</td>
<td>Other complications of intestinal pouch</td>
<td>K91.858</td>
<td>Other complications of intestinal pouch</td>
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</tr>
</tbody>
</table>

continued on next page
## ICD-10 CROSSWALK FOR GENERAL SURGERY (CONTINUED)

<table>
<thead>
<tr>
<th>ICD-9 (non-specified)</th>
<th>ICD-9</th>
<th>ICD-9 description</th>
<th>ICD-10</th>
<th>ICD-10 description</th>
</tr>
</thead>
<tbody>
<tr>
<td>553.0</td>
<td>Femoral hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>553.00</td>
<td>Unilateral or unspecified (not specific as recurrent)</td>
<td>K41.90</td>
<td>Unilateral femoral hernia, without obstruction or gangrene, not specified as recurrent</td>
<td></td>
</tr>
<tr>
<td>553.01</td>
<td>Unilateral or unspecified, recurrent</td>
<td>K41.91</td>
<td>Unilateral femoral hernia, without obstruction or gangrene, recurrent</td>
<td></td>
</tr>
<tr>
<td>553.02</td>
<td>Bilateral (not specified as recurrent)</td>
<td>K41.20</td>
<td>Bilateral femoral hernia, without obstruction or gangrene, not specified as recurrent</td>
<td></td>
</tr>
<tr>
<td>553.03</td>
<td>Bilateral, recurrent</td>
<td>K41.21</td>
<td>Bilateral femoral hernia, without obstruction or gangrene, recurrent</td>
<td></td>
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<tr>
<td>553.1</td>
<td>Umbilical hernia</td>
<td>K42.9</td>
<td>Umbilical hernia without obstruction or gangrene</td>
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</tr>
<tr>
<td>553.2</td>
<td>Ventral hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>553.20</td>
<td>Ventral (unspecified)</td>
<td>K43.9</td>
<td>Ventral hernia without obstruction or gangrene</td>
<td></td>
</tr>
<tr>
<td>553.21</td>
<td>Incisional</td>
<td>K43.2</td>
<td>Incisional hernia without obstruction or gangrene</td>
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<tr>
<td>553.29</td>
<td>Other</td>
<td>K43.9</td>
<td>Ventral hernia without obstruction or gangrene</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>K46.9</td>
<td>Unspecified abdominal hernia without obstruction or gangrene</td>
<td></td>
</tr>
<tr>
<td>553.3</td>
<td>Diaphragmatic hernia</td>
<td>K44.9</td>
<td>Diaphragmatic hernia without obstruction or gangrene</td>
<td></td>
</tr>
<tr>
<td>459.1</td>
<td>Postphlebitic syndrome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>459.10</td>
<td>Postphlebitic syndrome without complications</td>
<td>I87.009</td>
<td>Postthrombotic syndrome without complications of unspecified extremity</td>
<td></td>
</tr>
<tr>
<td>459.11</td>
<td>Postphlebitic syndrome with ulcer</td>
<td>I87.019</td>
<td>Postthrombotic syndrome with ulcer of unspecified lower extremity</td>
<td></td>
</tr>
<tr>
<td>459.12</td>
<td>Postphlebitic syndrome with inflammation</td>
<td>I87.029</td>
<td>Postthrombotic syndrome with inflammation of unspecified lower extremity</td>
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<tr>
<td>459.13</td>
<td>Postphlebitic syndrome with ulcer and inflammation</td>
<td>I87.039</td>
<td>Postthrombotic syndrome with ulcer and inflammation of unspecified lower extremity</td>
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</tr>
<tr>
<td>459.19</td>
<td>Postphlebitic syndrome with other complications</td>
<td>I87.039</td>
<td>Postthrombotic syndrome with ulcer and inflammation of unspecified lower extremity</td>
<td></td>
</tr>
</tbody>
</table>
ICD-10 will consist of two parts: ICD-10-Clinical Modification (CM) and ICD-10-Procedure Coding System (PCS). Surgeons and other health care professionals will use ICD-10-CM to report medical diagnoses.

codes using the website www.icd10data.com. The three ICD-9 family codes used in the ACS crosswalk include:

- 569 (other orders of the intestine)
- 553 (other hernia of abdominal cavity without mention of obstruction or gangrene)
- 459 (other disorders of the circulatory system)

The figure on pages 32 and 33 illustrates the crosswalk.

Resources

The crosswalk can be found online at www.facs.org/advocacy/practmanagement/icd10. Surgeons should continue to monitor the ACS ICD-10 website leading up to the October 1 transition for more ICD-9 to ICD-10 coding examples and other important information.

For additional ICD-10 resources, visit the following sites:

- The American Health Information Management Association ICD-10 website, www.ahima.org/topics/icd10
- The American Hospital Association Central Office ICD-10 website, www.ahacentraloffice.org/codes/ICD10.shtml
- Online tool for converting ICD-9 codes to ICD-10, www.icd10data.com
The Joint Commission recognized 1,224 hospitals for outstanding accountability measure performance in November 2014 as part of its Top Performer on Key Quality Measures program. The hospitals represented 36.9 percent of all Joint Commission-accredited hospitals that reported accountability measure data for 2013 and included general, children’s, psychiatric, surgical and cardiac specialty, and critical access hospitals.*

To become a Top Performer, hospitals must have achieved the following:

- A cumulative performance of 95 percent or above across all reported accountability measures
- A performance of 95 percent or above on each reported accountability measure that had at least 30 denominator cases
- Had at least one core measure set that had a composite rate of 95 percent or above, and within that measure set, all applicable individual accountability measures had a performance rate of 95 percent or above†

Surgical care measure set
Since 2005, The Joint Commission has collected accountability measure data for surgical care. The surgical care measure set includes individual accountability measures for seven types of operations—coronary artery bypass graft (CABG), cardiac (other than CABG), colon, hip joint replacement surgery, hysterectomy surgery, knee joint replacement surgery, and vascular surgery. The three specific accountability measures are as follows:

- Surgical patients receive a prophylactic antibiotic within one hour prior to surgical incision
- Surgical patients receive appropriate prophylactic antibiotic selection
- Prophylactic antibiotics are discontinued within 24 hours of the operation’s end time

Additional accountability measures within the surgical care measure set not specific to one of the seven surgical operations are available for further information.

As the performance of hospitals using surgical care accountability measures continues to improve, demonstrating the nationwide implementation of evidence-based quality improvement processes for surgery, more patients will receive the correct surgical care treatment, in the correct way, at the correct time.

procedures identified earlier include the following:

- Surgical patients on beta-blocker therapy prior to arrival receive a beta-blocker during the perioperative period
- Cardiac surgery patients have controlled postoperative blood glucose
- Surgical patients receive appropriate hair removal
- Surgical patients receive venous thromboembolism prophylaxis within a time period of 24 hours before to 24 hours after an operation
- Urinary catheter is removed on postoperative day one or postoperative day two with day of surgery being day zero.

Since 2005, the average number of hospitals reporting accountability measure data for the surgical care measure set was 1,979, ranging from 258 to 2,766 hospitals. In 2009, the national average for Joint Commission-accredited hospitals submitting data for surgical care accountability measures was 95.8 percent. Today, that figure has increased to 98.7 percent.*

With more hospitals submitting data, the health care community is able to better gauge progress in quality improvement. As the performance of hospitals using surgical care accountability measures continues to improve, demonstrating the nationwide implementation of evidence-based quality improvement processes for surgery, more patients will receive the correct surgical care treatment, in the correct way, at the correct time.

There is still a long way to go in the development and tracking of accountability measures and other quality metrics. The Joint Commission encourages surgeons and hospitals to continue to strive for excellence in patient care and to share their solutions and challenges to help shorten the path to further quality improvement.

Joint Commission-accredited hospitals have access to the Core Measure Solution Exchange, a database of success stories from accredited hospitals that have attained excellent performance on core measures, including accountability measures. The database is available at www.jointcommission.org/core_measure_solution_exchange/ and includes several surgical care solutions.

For more information on the Top Performer program, visit www.jointcommission.org/accreditation/top_performers.aspx.
2014 Pediatric Report: How severe is it?

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

The 2014 Pediatric Report of the National Trauma Data Bank® (NTDB®) is an updated analysis of the largest aggregation of U.S./Canadian trauma registry data ever assembled. In total, the NTDB now contains more than 6 million records. The 2014 Annual Report is based on 814,663 records submitted by 758 facilities from the single admission year of 2013. The 2014 Pediatric Report is based on 141,067 records from the single admission year of 2013. The NTDB classifies pediatric patients in this report as patients that are younger than 20 years of age.

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

More than half (58.9 percent) of the 756 facilities that submitted data for the 2014 Pediatric Report are not affiliated with a pediatric hospital. The remaining 311 facilities (41.1 percent) are associated with a children’s hospital. Another 32 facilities are further characterized as pediatric-only, including 26 pediatric Level I and six pediatric Level II trauma centers. In total, 65 percent of the reporting facilities have a pediatric ward, and 33 percent have a pediatric intensive care unit. Almost three-fourths (74 percent) of the facilities transfer severely injured patients to other medical centers (see Figures 1 and 2, page 38).

Developing better data
Many dedicated members of the ACS COT, including those surgeons who serve on the Pediatric Surgery Subspecialty group, along with dedicated individuals caring for pediatric patients at trauma centers around the country, have contributed to the early development of the NTDB and its rapid growth in recent years.

The NTDB 2014 Pediatric Report is available on the ACS website at www.facs.org/trauma/ntdb/index.html. In addition, information regarding how to obtain NTDB data for more detailed study is available at www.ntdb.org.
Building on these achievements, the goals in the coming years include improving data quality, updating analytic methods, and developing processes that allow users to draw more useful comparisons from hospital to hospital. The results of these efforts will be reflected in future NTDB reports to participating hospitals, as well as in annual pediatric reports.

Throughout the year, we will be highlighting these and other trauma data through brief reports published monthly in the Bulletin. The 2014 NTDB Pediatric Report is available on the ACS website at www.facs.org/trauma/ntdb/index.html.

In addition, information is available on the NTDB Web page about how to obtain NTDB data for more detailed study. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB at mneal@facs.org.
Editor’s note: The following comments were received regarding recent articles published in the Bulletin.

Letters should be sent with the writer’s name, address, e-mail address, and daytime telephone number via e-mail to dschneidman@facs.org, or via mail to Diane Schneidman, Editor-in-Chief, Bulletin, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611.

Letters may be edited for length or clarity. Permission to publish letters is assumed unless the author indicates otherwise.

Google Glass liability risks
I am writing in response to the letter by Thomas R. McLean, MD, JD, FACS, published in the September 2014 Bulletin (Bull Am Coll Surg. 2014;99[9]:66). Although I retired from urology before the development of Google Glass, the majority of my procedures were performed endoscopically with a camera. All these procedures were recorded electronically and stored in a way that protected patient confidentiality. Although they were never required in court, fortunately (no medical liability experience), I reviewed the tapes as a learning tool for new camera-assisted procedures, such as laparoscopy, laser procedures, and so on. If one is required to go to court, a video copy of the procedure reveals far more than an operative report, and if the procedure was done properly, then any complication may be more readily understood as such rather than as gross negligence.

Jerry Frankel, MD, FACS
Plano, TX

gloving technique
I am writing with regard to the cover of the November 2014 Bulletin (Bull Am Coll Surg. 2014;99[11]). When we are teaching sterile techniques worldwide, why show incorrect donning or removing surgical gloves? The correct application should avoid the thumb contamination, both in putting on and taking off surgical gloves. This is basic sterile technique, which all health care professionals should follow.

Alan S. Rapperport, MD, FACS
Coral Gables, FL

Electronic health record
I found it interesting, perhaps telling, that “The e-volution of the 21st century surgeon” (Bull Am Coll Surg. 2014;99[8]:42-48) made no mention of the electronic health record. It is distressing to me that surgeons in our community who are eager to adopt advanced surgical hardware and techniques are the same ones who are refusing to learn and use electronic medical record systems.

Name withheld upon request
Oregon Fellow of the ACS
In memoriam:
Renowned trauma surgeon and former COT Chair, Erwin Thal, MD, FACS

Erwin R. Thal, MD, FACS, 78, a world-renowned trauma surgeon, and a dedicated Fellow of the American College of Surgeons (ACS) for more than 43 years, died of heart failure December 13 at William P. Clements Jr. University Hospital, University of Texas, Dallas. Dr. Thal chaired the ACS Committee on Trauma (1986–1990), served as President of the ACS North Texas Chapter (1990–1991), and as a member of the ACS Board of Governors (1998–2004).

He led the surgical emergency department of Parkland Health and Hospital System, Dallas (1970–1994), and was appointed medical director of Parkland’s day surgery unit in 1995. He chaired the surgical postgraduate course for the department (1981–2001) and was coordinator of surgical continuing medical education (1993–2002).

Dr. Thal received his undergraduate degree from The Ohio State University (OSU), Columbus, in 1958 and his doctor of medicine degree from the OSU College of Medicine in 1962.

Dr. Thal completed his general surgery residency at Parkland Hospital in 1969, interrupted by two years of service in the U.S. Air Force (USAF) as a flight medical officer. He was awarded the USAF Commendation Medal for Meritorious Service.

After completing his residency, Dr. Thal joined the faculty at the University of Texas Southwestern Medical School (UTSMS), Dallas, as an instructor of surgery and was promoted to professor in 1982. From 1988 until his death, Dr. Thal served as the director of the UTSMS’ Willed Body Program. Dr. Thal was also a researcher who studied lead poisoning from retained bullet wounds and techniques to explore the abdominal cavities of trauma patients.

In the course of a 21-year relationship with the Dallas Fire Department, Dr. Thal developed the basic emergency management technician and advanced paramedic course for the metropolitan area. He was the recipient of many honors throughout his career, including an honorary fire chief appointment in 1985, a place on the Giants of Parkland Surgery wall, the 2000 Minnie Stevens Piper Professor award given to outstanding Texas college professors, an honorary fellowship in the Royal Australasian College of Surgeons in 2009, and numerous Excellence in Teaching Awards from UTSMS.

An avid OSU alumni who flew back for every Buckeyes home football game over the past 25 years, Dr. Thal often told friends and family members that he wanted the OSU marching band to play at his funeral. After one of his friends extended that invitation to the OSU band, 10 brass players traveled to Dallas from Columbus to perform three songs at the funeral of the lifelong fan. The Thal family covered the band members’ travel and other expenses.

Dr. Thal’s survivors include his son, James G. Thal, and his wife Rhonda; daughter Barbara Potts and her husband Steven W. Potts; daughter-in-law Kathy D. Thal; and seven grandchildren. His wife of 37 years, Carolyn, and his son, Jeffrey, preceded him in death.
AMA House of Delegates takes action on spectrum of issues

by John H. Armstrong, MD, FACS, and Jon H. Sutton, MBA

The American Medical Association (AMA) House of Delegates (HOD) met November 7–11, 2014, in Dallas, TX, and considered 96 resolutions and 33 reports, many of which were of interest to surgeons. Hot-button issues included Medicaid physician payment, maintenance of certification, and Ebola readiness.

Opening session
The HOD opened with a variety of speeches and presentations from leaders in the health care arena. Following is a snapshot of speaker remarks at the opening session.

Robert A. McDonald, Secretary of the U.S. Department of Veterans Affairs (VA) sought help with recruiting physicians for the VA system and sharing positive messages about the VA. “VA cannot accomplish its mission as a standalone system,” Mr. McDonald said. “We’re part of a larger community facing the same challenges you [in non-federal medicine] face.”

James L. Madara, MD, AMA executive vice-president and chief executive officer, shared an overview of the AMA’s three focus areas: improving health outcomes, accelerating change in medical education, and professional satisfaction and practice sustainability. “Working together, we can lead the way to improving health outcomes for our patients—attacking the enormous burdens of chronic disease. Working together, we can ensure the next generation of physicians is trained by 21st century standards. And working together, we will shape a more satisfying and sustainable practice environment for physicians,” Dr. Madara said.

American Medical Political Action Committee (AMPAC) chair John W. Poole, MD, FACS, added, “If you are in medicine, you are in politics.” AMPAC raised $2.76 million in the 2014 election cycle, up 11 percent from the previous cycle.

Reports and resolutions
The following items of business cover a range of issues and reflect the advocacy focus of the Interim Meeting.

Reference Committee on Constitution and Bylaws
• Council on Ethical and Judicial Affairs (CEJA) Report 1, Physician Exercise of Conscience, was adopted. The report examines the implications for patients and physicians when conflict arises between a physician’s professional commitments and personal moral beliefs, and offers guidance to resolve these conflicts.

• CEJA Report 3, Modernized Code of Medical Ethics, proposed an updated Code of Medical Ethics that has been a work in progress since 2008. Given the scale of the project, however, the update was referred back to CEJA for further refinement.

Reference Committee B (Legislation)
• Substitute Resolution 208, Stark Law and Physician Compensation, was referred to the Board of Trustees, who will review use of Stark Law regulations by hospitals to unfairly and arbitrarily cap or control physician compensation.

• Resolution 213, Cannabis—Expanded AMA Advocacy, was adopted. As a result, the AMA will initiate an aggressive campaign to educate the media and legislators regarding the scientifically established health effects of chronic cannabis use and the potential public health, social, and economic consequences of expanded use; urge legislatures to delay initiating full legalization of any cannabis product until the U.S. Food and Drug Administration (FDA) and Drug Enforcement Administration has completed further research; and increase efforts to educate the press,
legislators, and the public regarding “public health” versus “criminal justice” approaches to cannabis. In addition, the AMA will encourage model legislation that would require placing the following warning on all cannabis products not approved by the FDA: “Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States.”

Reference Committee F (Governance)

- Resolution 601, Employee Association and Collective Bargaining for Physicians, was adopted. The AMA will study and report back on physician unionization in the U.S.

Reference Committee J (Advocacy for Medical Service)

- Council on Medical Service Report 7, Medicaid Primary Care Payment Increases, was adopted as amended with a proposal from the American College of Surgeons (ACS) and neurosurgery delegations. The initial report recommended extension of primary care payment increases beyond 2014 and with the inclusion of obstetricians/gynecologists as qualifying specialists for these payment increases. The ACS delegation worked in the Reference Committee and on the floor of the HOD to emphasize that any payment increases for one group must “not negatively impact payment for any other physicians,” with which the HOD agreed.

Reference Committee K (Advocacy for Medical Education and Public Health)

- Substitute Resolution 920, Principles on Maintenance of Certification (MOC), consolidated four separate resolutions and amended the AMA’s Principles on MOC to include the following:
  - MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
  - The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, and intent to maintain or change practice.
  - MOC should be used as a tool for continuous improvement.
  - The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, or network participation or employment.
  - Physicians in active practice should be well-represented on specialty boards developing MOC.
  - MOC activities and measurement should be relevant to clinical practice.
  - The MOC process should not be cost-prohibitive or present barriers to patient care.

The AMA will also encourage specialty boards to consider alternative approaches for MOC, work with the American Board of Medical Specialties to
eliminate practice performance assessment modules (as currently written) from the requirements of MOC, and prepare a yearly report regarding the MOC process.

A concern about potential conflict of interest by specialty boards, which simultaneously develop MOC standards and design and deliver MOC curricula that generate financial profits, was referred to the Board of Trustees.

• Substitute Resolution 925, AMA Role in Addressing Ebola, consolidated four resolutions by broadening the context. The AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola; improved public health infrastructure and surveillance in affected countries; and all health care workers and volunteers, U.S. Public Health Service, and U.S. military members responding to the Ebola epidemic and other epidemics and pandemics in affected countries. The AMA also reaffirms that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science and encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.

Complete actions on all items of business of the HOD are available on the November 2014 HOD Web page at www.ama-assn.org/sub/meeting/index.html.

Surgical Caucus
The Surgical Caucus of the AMA brings together surgeons, anesthesiologists, and emergency physicians for focused discussions about relevant AMA resolutions through the lens of surgical interventions. The caucus held a one-hour continuing medical education program, From the Front Lines to the States: Continuum of Care for Soldiers/Veterans, which was well-timed to coincide with Veterans Day. Raj Ambay, MD, FACS, a plastic surgeon from Tampa, FL, and Allen Morey, MD, FACS, a urologic trauma and reconstruction surgeon from Dallas, TX, offered insights from their care of wounded troops in Iraq and Afghanistan. In addition, Chandramouli Pattabiramen Iyer, MD, MS, MCh, an anesthesiologist from the VA Medical Center in Dallas, joined the panel to discuss his experiences in treating wounded soldiers at home and abroad.

Next HOD meeting
The Annual Meeting of the AMA HOD will take place June 6–10, 2015, in Chicago, IL. The delegation is open to comments and feedback on issues before the HOD, as well as suggestions for resolutions. These may be directed to jsutton@facs.org.

In addition to addressing the volume of business conducted by the HOD, the ACS Delegation is preparing for the re-election campaign of Patricia L. Turner, MD, FACS, Director, ACS Division of Member Services, for the AMA Council on Medical Education. First elected in 2011, Dr. Turner has diligently worked to represent surgery’s perspective in dealing with many complicated medical education issues, and has been a key participant in the development of the Initiative to Transform Medical Education, a project of the Council on Medical Education, of which Dr. Turner is a member. Richard B. Reiling, MD, FACS, who previously served as the ACS Representative in the AMA HOD, was also a member of the Council.

♦
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For additional dates, locations, registration fees, and to register, visit www.facs.org/advocacy/practmanagement/workshops or call 312-642-8310.
Report on ACSPA/ACS activities, October 2014

by Fabrizio Michelassi, MD, FACS

The Board of Directors of the American College of Surgeons Professional Association (ACSPA) and the Board of Regents of the American College of Surgeons (ACS) met during the 2014 Clinical Congress in San Francisco, CA. Following is a report of the their discussions and actions.

ACSPA

As of the October meeting, the American College of Surgeons Professional Association’s political action committee (ACSPA-SurgeonsPAC) had raised $467,990 in both personal and corporate funds from 1,531 American College of Surgeons (ACS) members and staff, with an average contribution of $306. Of this amount, $421,475 is personal (hard) dollars and $46,515 is corporate (soft) dollars.

In the 2014 election cycle, the PAC contributed $1,053,500 to 151 candidates, leadership PACs, and party committees. Of this amount, 60 percent was given to Republicans and 40 percent to Democrats.

The ACSPA-SurgeonsPAC has been making an increased effort to encourage ACS members to deliver SurgeonsPAC checks to their legislators’ in-district offices as a step toward developing long-term relationships with key elected officials. In the six months preceding the Clinical Congress, more than 30 PAC checks were delivered to members of Congress and congressional candidates.

ACS

Division of Advocacy and Health Policy

The College’s top-ranking advocacy and health policy initiatives include the following:

• Medicare physician payment
• Medical liability reform
• Workforce/graduate medical education
• Quality
• Trauma
• Cancer

In September 2014, leadership from the ACS, American Medical Association (AMA), American College of Physicians, American Academy of Family Physicians, and American Osteopathic Association met with senior congressional leadership to explain why Congress should repeal the sustainable growth rate (SGR) formula used to calculate physician reimbursement. Patrick V. Bailey, MD, FACS, Medical Director of Advocacy, ACS Division of Advocacy and Health Policy, represented the College.

The 96-hour rule

The Centers for Medicare & Medicaid Services (CMS) recently indicated it would begin enforcing a long-forgotten regulation requiring that physicians who admit patients to critical access hospitals (CAHs) certify that each patient can reasonably be expected to be discharged or transferred within 96 hours.

Previously, CAHs operated under a similar but separate condition of participation that required patient stays to be under 96 hours on average. As a result of CMS’ action, surgeons will be unable to admit patients for procedures routinely performed in CAHs, and many patients will be forced to travel further from home for treatment. To address the issue, Rep. Adrian Smith (R-NE) and Sens. Pat Roberts (R-KS) and Jon Tester (D-MT) have introduced legislation—the Critical Access Hospital Relief Act (H.R. 3991/S. 2037)—to eliminate the certification requirement and maintain the 96-hour average stay requirement. The College has endorsed the bill.

21st century cures

The House is reviewing the nation’s response to scientific and technological advances. Late last year, the House held listening sessions with support and participation from research institutions, consumer groups, the National Institutes of Health, and pharmaceutical and biotech organizations.

Workforce

The Affordable Care Act authorized funding for loan repayments for pediatric subspecialists, including pediatric surgeons, who agree to practice in workforce shortage areas for at least two years. The College sent a letter to appropriators asking that $5 million be allocated to the program. Unfortunately, monies
for the program were omitted from the omnibus appropriations bill that funded the government for the remainder of the fiscal year (FY). The College also signed on to a coalition letter to the Office of Management and Budget asking the Administration to request that $5 million be appropriated to the Health Resources and Services Administration to fund the program. Program authorization is set to expire after the current fiscal year; Rep. Joe Courtney (D-CT) has recently introduced legislation that would extend this authorization through FY 2018. The ACS supports this legislation.

Misvalued physician service codes
The most recent one-year SGR patch included the misvalued services provision that was part of the larger SGR Repeal Act. The legislation allows the Secretary of the Department of Health and Human Services (HHS) to revise payments for potentially misvalued codes within the physician fee schedule based on information collected from providers, as follows:

• The policy applies to the fee schedule for the years 2017–2020.
• The target for value reduction is 0.5 percent of the estimated amount of total fee schedule expenditures for the given year.
• If the total relative value unit for an identified misvalued code is scheduled to be reduced by 20 percent or more due to the reevaluation, the adjustment must be phased in over two years.

The College has long opposed this provision, noting that the AMA Relative Value Scale Update Committee and CMS have been working for a number of years to revalue all codes; this work is expected to continue through 2016.

Open payments
CMS recently announced that physicians and teaching hospitals may register in the CMS Enterprise Portal to request access to the Physician Payments Sunshine Act (PPSA) open payments system in July. Although the PPSA does not require physicians to take action, nor does it impose any penalties on physicians, registration is required for physicians and teaching hospitals to review and dispute reported information.

National Quality Forum
Clifford Y. Ko, MD, MS, MSHS, FACS, Director, ACS Division of Research and Optimal Patient Care, serves as the ACS representative on the National Quality Forum (NQF) Surgery Standing Committee, which identifies and endorses performance measures for a number of surgical disciplines, including cardiac, thoracic, vascular, orthopaedic, neurosurgery, urologic, and general surgery. The ACS continues to have representation on the NQF Measure Applications Partnership (MAP), a public-private partnership convened by the NQF for providing input to HHS on selecting performance measures for public reporting, performance-based payment, and other programs. Eric Whitacre, MD, FACS, a breast surgeon in Tucson, AZ, serves as a technical expert to the NQF MAP Clinician Workgroup.

State Affairs
Surgeons have become more active in sending letters to their state legislators through the Surgery State Legislative Action Center. Typically, 15 to 20 letters are sent when an action alert e-mail goes out to surgeons in a particular state. In 2014, however, a large number of letters were sent, including the following:

• New York surgeons made clear their support for truth in advertising legislation by sending 163 letters, supported changes in payment for out-of-network coverage with 127 letters, and opposed some liability-related legislation with 287 letters.
• Louisiana surgeons sent 208 letters supporting coverage for bariatric surgery and sent 148 letters opposing expansion of scope of practice for optometrists.
• California surgeons helped to defeat optometric scope-of-practice expansion legislation by sending 133 letters.

AMA House of Delegates
The College sent five delegates to the annual meeting of the
AMA House of Delegates (HOD) meeting, June 7–11, 2014, in Chicago, IL: John H. Armstrong, MD, FACS; Jacob Moalem, MD, FACS; Leigh Neumayer, MD, FACS; Richard Reiling, MD, FACS; and Patricia L. Turner, MD, FACS. Assisting the delegation was Timothy Kresowik, MD, FACS, a vascular surgeon from Iowa, and Kenneth Louis, MD, FACS, a neurosurgeon from Florida. With this meeting, Dr. Reiling completed his 22-year tenure as a member of the ACS delegation. He chaired the delegation from 2006 through 2010 and was the first Fellow to be elected to an AMA Council as a nominee of the College. The delegation recognized his leadership, and he was on the list of retiring delegates presented to the HOD.

Chapter Lobby Day Grants 2015
Chapters were asked to apply for lobby day grants in 2015. Under the program, chapters may receive up to $5,000, with the expectation that the chapters provide a 50 percent match. In 2014, 17 states received a grant. As of the October board meeting, the Health Policy and Advocacy Group (HPAG) confirmed that the following chapters would be receiving grants for 2015:

- Alabama
- Brooklyn/Long Island
- California
- Connecticut
- Florida
- Georgia

Other states expecting to conduct lobby days in 2015 are Louisiana, North Carolina, Ohio, Oregon, Texas, and Washington.

Cancer programs
The Commission on Cancer (CoC) has accredited a total of 1,507 cancer programs in the U.S. and Puerto Rico. Annually, these centers treat 71 percent of all newly diagnosed cancer patients. The CoC conducted 433 cancer program surveys in 2013–2014, and 27 new cancer programs joined the accreditation program. The CoC presented Outstanding Achievement Awards to 79 cancer programs, and eight new physician and nonphysician surveyors were recruited and participated in initial training.

CoC’s Best Practices Repository was reformatted, and additional content was approved by the Standards Advisory Group for Excellence. In addition, the site for CoC Accreditation was launched for distribution of certificates and Outstanding Achievement Award trophies and the purchase of related promotional materials. Furthermore, in 2013, more than 1,000 individuals registered on the CAnswer Forum site, and more than 2,000 questions were submitted. Most inquiries focused on cancer registry coding guidelines.

The National Cancer Data Base’s (NCDB) Cancer Program Practice Profile Reports have been expanded to include two new sets of quality measures. Three breast measures were released in March 2014. Three additional measures will be included along with the 2012 data release, two for non-small cell lung and one for gastric, bringing the total released measures to 12. Multiple societies are collaborating to develop and harmonize additional measures to be evaluated by the Quality Integration Committee, and, if approved, implemented through an NCDB reporting tool.

Interest in the NCDB Participant User File (PUF) program grew in 2014; 227 applications (up from 178 the previous year) were reviewed for technical feasibility of research aims. Researchers using PUF data have generated 19 breast, 15 colorectal, nine esophagogastric, one melanoma, three ovarian, three pancreas, one sarcoma, two thyroid, and four bladder papers/presentations.

The number of programs participating in the Rapid Quality Reporting System (RQRS) grew in 2013–2014 from 54 percent of CoC-accredited programs/networks to 71 percent currently.

The Prospective Payment System (PPS)-exempt contract, received in October 2012, completed its second year.
The 11 members of the Alliance of Dedicated Cancer Centers (ADCC) submitted data to the RQRS system. Quarterly data files containing quality measure rates for three measures (two for breast cancer, one for colon) are generated and submitted to CMS for public reporting. CMS hosted a meeting in June 2014 with representatives of the facilities and contractors to discuss progress to date. The ACS received notice of renewal for the second option year of the contract in September 2014.

The CoC’s second Annual Advocacy Committee Planning Meeting took place in San Francisco, CA, on October 25, 2014. The CoC has been actively engaged in several legislative and regulatory policy issues this quarter, including support of the AMA resolutions on genetic testing and biomedical research legislation.

The College’s Clinical Research Program (ACS CRP) Cancer Care Standards Development Committee has submitted the manuscript, Operative Standards in Cancer Surgery, to the publisher. Production began in September 2014, with a targeted publication date of February 2015. All 23 CoC-accredited institutions have volunteered to pilot-test the data collection tool and electronic interface; pilot-testing began in September 2014.

In addition, the ProvenCare Lung Cancer Collaborative leadership met to discuss the expansion of the collaborative to include medical and radiation oncology. Data elements for these specialties have been developed and will be finalized through conference calls in October 2014. The expanded program, Phase III, is set to launch in early 2015, in which nine institutions are participating.

Content development for the American Joint Committee on Cancer (AJCC) Cancer Staging System 8th Edition began in October 2014. The infrastructure is now in place to support more than 500 volunteers, 18 expert panels, five cores, and the editorial board. The AJCC continues to administer the Collaborative Stage Data Collection System (CS) through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). Collaborative Stage CS Version 02.05 was released in November 2013.

Two new educational presentations were developed specifically for the registrar community to assist in the transition from CS to directly coded AJCC Staging. This transition will take place January 1, 2016. The CDC has provided funding for the development of educational offerings. The initial two presentations were made available for the state registrar meetings, and over the coming year an additional 12 presentations will be rolled out as part of a comprehensive curriculum from registrars to reinforce their knowledge of AJCC staging.

The National Accreditation Program for Breast Centers (NAPBC) has now accredited more than 560 breast centers in the U.S. Reaccreditation rates for 2014 and 2015 remain at 99 percent. Approximately 20 percent of centers request to be surveyed with their CoC program. A small team of cross-trained surveyors perform these collaborative surveys. Efforts are under way to validate NAPBC-accredited centers that are affiliated with a CoC program.

The CoC collected video testimonials from Survey Savvy attendees. The videos have been completed, are being used at trade shows, and will be posted to the College’s YouTube channel.

Division of Education

The Committee on Residency Training (“Fix the Five”) has met regularly and has identified seven principal areas of focus:

- Organizational commitment
- Transitions during surgery residency
- Structured curricula, assessment, proficiency-based training and advancement
- Appropriate autonomy for residents
- Environment of residency education, including duty hours, fiscal resources, and support systems
• Faculty development and support; identification and dissemination of best practices

• End product of surgery residency training

The committee will continue its deliberations and plans to support innovative pilot projects that will help to transform surgical education and training. Best practices from experiences across the country will be widely shared.

The ACS Clinical Congress remains the premier annual surgical meeting and provides a broad range of outstanding education and training opportunities for surgeons, surgery residents, medical students, and members of surgical teams. In 2007, a strategic planning process that involved two retreats of the Program Committee resulted in transformational changes in the Clinical Congress program, including the introduction of tracks composed of blocks with uniform start and end times, addition of Meet-the-Expert Luncheons and Town Hall Meetings, and expansion of the range of Skills Courses.

In preparation for the retreats, a number of task forces were appointed and charged with the responsibility of critically reviewing various components of the Clinical Congress program and developing recommendations for further enhancements. The retreats were extremely productive and resulted in several recommendations that will help to take the Clinical Congress program to another level.

The Board approved the establishment of an ACS Academy of Master Surgeon Educators. This Academy will play a critical role in providing recognition for Master Surgeon Educators, advancing the science and practice of leading-edge surgical education and training; fostering the exchange of creative ideas and collaboration; supporting faculty development and recognition; and underscoring the importance of surgical education and training in the changing health care environment. This Academy will complement the new Education and Training Campaign that the College launched at Clinical Congress 2014, as well as activities of the Committee on Residency Training, the Transition to Practice Program, and other education and training activities.

**Division of Member Services**

As of September 1, 2014, the College comprised 78,361 members—36,864 of whom are dues-paying Fellows. A total of 1,676 applications for Fellowship were evaluated in 2014 by the College’s credentials committees. Of these applicants, 1,640 surgeons from the U.S., Canada, and 61 other countries, having been determined to have met all requirements for Fellowship, were approved by the Board of Regents, and were granted Initiate status.

The Board of Regents accepted resignations from 16 ACS Fellows. In addition, the College is surveying all dues-paying Fellows and Associate Fellows; a separate version of the instrument will be deployed to recently lapsed members. The two surveys are intended to determine how the College could be of greater value to members.

To further boost retention and recruitment of members, in January the College launched a Young Surgeons Marketing Campaign—Realize the Potential of Your Profession. A Show Your Pride campaign also has been launched to reinforce use of the FACS insignia and encourage pride in Fellowship. Specialty-by-specialty recruitment strategies are being employed, along with efforts to increase membership and international outreach.

Other retention and recruitment activities are as follows:

• Following the 2013 Clinical Congress, each new Fellow received a welcome letter from ACS Executive Director David B. Hoyt, MD, FACS, along with their membership ID card and instructions on how to update their electronic profile and download FACS artwork. Additionally, they received the new member benefits brochure and a complimentary FACS pen.

• In December 2014, all Fellows received a personalized e-mail or letter thanking them for their...
membership in the College and informing them about how to contact their current Governor and Advisory Council chair to voice their concerns about issues affecting their geographic location or specialty.

- In January 2014, the new member benefits brochures were mailed to all International Fellows, Associate Fellows, Residents, and Medical Student members, and have been made available in hard copy or via e-mail to any surgeon leader, chapter, or program of the ACS.

To engage members at all levels of the College’s leadership structure, the ACS is evaluating the committee nomination and member engagement processes, conducting a member and non-member survey, coordinating the ACS response, deploying the Leadership Guide as a reference tool for members, and providing opportunities for members to become more involved in College committees and leadership positions.

This division is also responsible for managing the College’s governance and internal structures. It is responsible for reviewing the current membership application and related processes to improve efficiencies, centralizing scholarship and fellowship offerings within the Division, creating a Maintenance of Certification (MOC) calendar, conducting chapter-by-chapter needs assessment, completing the redesign of the role of the Advisory Councils, and more fully engaging leadership in personal interaction with members.

After an evaluation of their role and function, a workgroup has recommended a restructuring of the 13 Advisory Councils; the evaluation results have been shared with each council.

The Advisory Council for Rural Surgery, in conjunction with the Mithoefer Center for Rural Surgery, sponsored the Rural Surgery Symposium in May 2014 in Chicago. The symposium drew 54 attendees and faculty and focused on advocacy, economics, and patient care issues.

The Advisory Councils are developing a list of reasons to join the College.

The College now has 106 chapters: 67 domestic and 39 international. The newest domestic chapter to be approved was Guam, led by ACS Governor Ricardo Eusebio, MD, FACS.

Currently, 274 individuals serve on the ACS Board of Governors.

The newest chapter and specialty society Governors are from Guam, Nigeria, and the American Hepato-Pancreato-Biliary Association.

The Board of Governors welcomed 33 Governors-at-Large and 13 specialty society Governors at Clinical Congress 2014.

The Resident and Associate Society (RAS) has reached out to specialty surgeons in several ways: jointly sponsoring a “meet and greet” with the Advisory Council for Pediatric Surgery following the Pediatric Surgery Forum at the Clinical Congress; distributing informational materials at the American Society of Plastic Surgery’s Chief Resident Day session; and developing a plan to engage thoracic surgical trainees via the Joint Committee on Thoracic Surgical Education.

The Young Fellows Association’s (YFA) Mentorship Program, now in its third year, has paired 22 young Fellows with ACS leaders to encourage young surgeons’ career-long involvement in the College. Plans are under way to expand this program.

Other YFA activities are as follows:

- During the 2014 Clinical Congress, the YFA sponsored two Town Halls Meetings, one Meet-the-Expert Luncheon, and three Panel Sessions.

- New this year is a multi-purpose video offering positive and light-hearted commentary from family members about the realities of life with a surgeon, and about the effect that surgeons have on their families. New Initiates viewed the 10-minute video during the Convocation robing at Clinical Congress 2014. The YFA intends to add to this project and post these videos on the YFA Web page and in the ACS Communities.
• The YFA held its first essay contest and reviewed seven submissions on the topic, The Promise of a Profession Lies within Us. The winning essay was published in the October 2014 issue of the Bulletin.

• The Young Surgeons Marketing Campaign is a major initiative intended to build broad awareness and understanding of the benefits of ACS membership.

Research and Optimal Patient Care
A total of 561 hospitals currently participate in the ACS National Surgical Quality Improvement Program (ACS NSQIP®), 500 of which are Adult ACS NSQIP sites. The Essentials option has the highest enrollment of all the adult participation options with 255 sites; the Procedure Targeted option, with 191 hospitals, has the highest level of growth.

The Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) continues to grow and evolve since the unification of the ACS Bariatric Surgery Center Network and the American Society for Metabolic and Bariatric Surgery (ASMBS) Bariatric Surgery Center of Excellence. Of the 751 centers that participate in the MBSAQIP, 627 are fully accredited, 46 are data collection centers, and 78 are applying for accreditation. Expanding the accreditation options to include varying levels and surgical volume expectations—Comprehensive, Band, Low Acuity, and Comprehensive with Adolescent Qualifications—allows more centers to participate in MBSAQIP.

The soon-to-be-launched Decreasing Readmissions through Opportunities Provided (DROP) quality improvement initiative will enroll 75 MBSAQIP participating centers nationwide in an effort to reduce 30-day postoperative readmissions by 20 percent through the use of prescriptive patient intervention bundles. The MBSAQIP may then use program data to inform meaningful changes in the clinical care of patients, as well as examine resource utilization and cost containment in metabolic and bariatric surgery.

The MBSAQIP continues to expand its market presence by participating at national meetings. MBSAQIP staff attended the ASMBS’s First Annual National Obesity Collaborative Care Summit in September 2014 in Chicago. More than 40 thought leaders and health care providers representing more than 20 societies, including two payors, attended the summit, allowing participants to network for future collaboration in providing and coordinating care to the obese population. This meeting will continue annually in pursuit of the development of standards and guidelines for the multidisciplinary care of obese patients.

The MBSAQIP planned a significant presence at the annual ObesityWeek meeting, which the ASMBS and The Obesity Society sponsor to attract professionals who treat obesity and obesity-related illnesses. The MBSAQIP exhibit booth and staff at the meeting will offer attendees on-site access to clinical and statistical support. Staff will also participate in three distinct presentations and panel discussions presenting a review of the MBSAQIP, national initiatives, and the role of bariatric coordinators and data collectors. The expanded presence of the MBSAQIP at ObesityWeek helps to advance collaboration between the ACS and ASMBS.

Development of the ACS Quality Manual is under way. Quality Manual author groups submitted draft manuscripts mid-summer of 2014, which are under review.

The College celebrated the 10th anniversary of the Joan L. and Julius H. Jacobson II Promising Investigator Award at the 2014 Clinical Congress. Various events and sessions held during the Clinical Congress recognized Dr. and Mrs. Jacobson, as well as all the recipients over the past decade. Carrie A. Sims, MD, FACS, a general surgeon from Pennsylvania, was honored as the 10th recipient of the Jacobson Promising Investigator Award.

The ACS and the Armstrong Institute for Patient Safety and Quality piloted a one-day surgeon leadership course at the 2014
Clinical Congress. Surgeons participated in this course, which featured national quality improvement (QI) leaders. The course’s primary goal is to introduce QI and data review, present engagement strategies and QI models, and discuss strategies for overcoming barriers. First steps for initiating quality improvement in a surgical practice or hospital will be emphasized. Participant feedback will shape subsequent course development, and attendees will receive 6 AMA PRA Category 1 Credits™ upon completion.

The Outcomes Research Course, sponsored by the Surgical Research Committee, took place December 4–6, 2014, at ACS headquarters in Chicago. Thirteen faculty members led a combination of didactic lectures, work-in-progress sessions, and breakouts that allowed participants to select modules appropriate to their skill level and professional interests.

The ACS Clinical Scholars in Residence Program is a two-year on-site fellowship in applied surgical outcomes research, health services research, and health policy, offering surgery residents a unique opportunity to work with the College. Clinical scholars become embedded with the ongoing QI initiatives in the various programs. The application process for 2016–2018 appointments began January 1 and runs through April 1, 2015.

**American College of Surgeons Foundation**

As of October 2014, the 1913 Legacy Campaign had met 46 percent of its $5 million goal. Throughout the Campaign, the Foundation sought industry support in collaboration with volunteers and ACS leadership. Top prospects were engaged through presentations, visits, and proposals, with participation by Dr. Hoyt, program staff, volunteers, and a campaign consultant.

**Journal of the American College of Surgeons**

Over the last five years, the number of submissions of original scientific manuscripts to the *Journal of the American College of Surgeons (JACS)* has increased by 49 percent. The increase in scientific papers *JACS* receives will positively affect the journal’s impact factor. In 2013, measuring citations from 2011 and 2012, *JACS'* impact factor was 4.5, ranking ninth out of 202 surgery journals.

In addition to the 300-plus Surgical Forum abstracts published in the September supplement in print and online, approximately 600 abstracts from the 2014 Clinical Congress, including Scientific Papers and Scientific Poster Presentations, were published online and can be accessed through the *JACS* mobile app.

More than 3,500 Fellows per year earned MOC credit from *JACS*’ CME program in 2013–2014, a 3.8 percent increase from 2012–2013. The *JACS* Twitter feed, @JAmCollSurg, has promoted featured articles, coverage of *JACS* articles in the news media, and important articles that generate buzz on Twitter. Since Lillian Kao, MD, FACS, joined *JACS* as Social Media Editor, the number of surgeon-followers for *JACS* has more than doubled, and she has facilitated conversations about *JACS* content. *JACS* articles are being picked up by national media as a result of *JACS* collaboration with the ACS Public Information team.

**Thanks**

Finally, the College expresses its appreciation to the 2013–2014 Officers: Layton F. Rikkers, MD, FACS, First Vice-President; John T. Preskitt, MD, FACS, Second Vice-President; and Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), President. The College also thanks Gary L. Timmerman, MD, FACS, and Lorrie A. Langdale, MD, FACS, for their service as Chair and Secretary, respectively, of the Board of Governors. ♦
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Metro Philadelphia Chapter holds mock oral exam
On September 27, 2014, the Metropolitan Philadelphia Chapter of the American College of Surgeons (ACS) hosted its sixth annual mock oral board examination at the Annenberg Center for Medical Education, Lankenau Medical Center, Wynnewood, PA. This year’s event was the most widely attended to date. The 58 attendees included Fellows, residents, and recent graduates of eight general surgery residency programs and two fellowship programs in the Philadelphia area. This event was made possible through the voluntary participation of more than 60 faculty surgeons who donated their weekend time to assist younger surgeons preparing for the certifying examination. A seventh annual mock oral board will take place in fall 2015.

Dr. Pellegrini special guest at Congress of the JSS and Japan Chapter meeting
Carlos A. Pellegrini, MD, FACS, FRCSI(Hon), then-President of the ACS, attended the Annual Congress of the Japan Surgical Society (JSS) last year in Kyoto. As a special guest speaker, Dr. Pellegrini delivered a lecture, Ensuring Quality in Surgical Practice. He also spoke at the Japan Chapter’s annual business meeting, held in conjunction with the Congress of the JSS; the topic of the talk was Education and Training of Surgeons in a Modern Society.

Massachusetts Chapter meeting offers a range of events
The Massachusetts Chapter of the ACS (MCACS) held its 61st Annual Meeting December 6, 2014, at the Albert Sherman Conference Center, University of Massachusetts Memorial Medical Center, Worcester. A
total of 117 health care professionals, including 56 surgery residents, attended the meeting, which opened with a breakfast symposium featuring two debates hosted by the Society for Surgery of the Alimentary Tract. The day’s activities included a poster session and a Resident Research Paper Competition moderated by Jacqueline J. Wu, MD, FACS, a general surgeon at Berkshire Medical Center, Pittsfield, MA, and assistant professor of surgery, University of Massachusetts; and Heena P. Santry, MD, FACS, a general surgeon and assistant professor of surgery, University of Massachusetts.

The chapter meeting featured the fourth annual Resident Top Gun Competition, in which surgical residents from each of the state’s 10 general surgery training programs were invited to showcase their laparoscopic skills. The winning team was from Lahey Clinic, Burlington, MA, and included Andrew Gagnon, MD; Victor Kim, MD; and Kristian Stensland, MD. A Lahey team has won the competition three out of the four years it has been held.

The winner of the second Joseph E. Murray Basic Science Oral Presentation Award was Beatrice Dionigi, MD, a general surgery resident at Boston Children’s Hospital. The award is given in memory of Joseph E. Murray, MD, FACS, who died in 2012. Dr. Murray, who hailed from Massachusetts, conducted the world’s first successful organ transplant and received the Nobel Prize in Physiology/Medicine in 1990.

Members of the MCACS looks forward to its 62nd Annual Meeting, which is scheduled to take place December 5 in Boston.

Dr. Warshaw special guest speaker at ACS South Korea Chapter meeting
Andrew L. Warshaw, MD, FACS, FRCSEd(Hon), ACS President, was the special guest speaker at the Annual Meeting of the Korean Surgical Society November 27–29, 2014, in Seoul, South Korea. Dr. Warshaw gave a presentation titled Making Appropriate Decisions for Surgical Care. While in Seoul, Dr. Warshaw attended the ACS South Korea Chapter meeting, at which he
provided an update on College activities. The chapter meeting was moderated by Hyuck Sang Lee, MD, PhD, FACS, former ACS Governor for South Korea. Other presenters at the meeting included Hang-Seok Chang, MD, PhD, FACS, Chapter Secretary; Choong Bai Kim, MD, FACS, Chapter President; and Sun-Whe Kim, MD, PhD, FACS, current ACS Governor for South Korea.

New Jersey Chapter meeting attendance tops 200
The ACS New Jersey Chapter held its 63rd annual Clinical Symposium December 6, 2014, at the Renaissance Woodbridge Hotel & Conference Center, Iselin, NJ. Michael J. Spedick, MD, FACS, New Jersey Chapter President-Elect, moderated the program, which more than 200 surgeons attended. A variety of speakers from different geographic regions spoke on a spectrum of surgical specialty topics. Margaret Dunn, MD, FACS, ACS Regent, presented an overview of recent College activities.

Harry Agis, MD, FACS, a general surgeon from Morristown, NJ, presented certificates and gifts to the five 2014 Resident/Fellow manuscript winners. More than 25 papers were submitted for the competition. Ronald Chamberlain, MD, FACS, chairman and surgeon-in-chief, department of surgery, St. Barnabas Medical Center, Livingston, NJ, hosted the well-attended chapter Resident Jeopardy competition.

Ronald G. Tompkins, MD, FACS, gave the Sheen Award Recipient Lecture for 2014, titled Genomics of Injury—The Glue Grant Experience. Dr. Tompkins is the Sumner M. Redstone Professor of Surgery, Harvard Medical School, and chief of staff emeritus, Shriners Hospitals for Children, Boston, MA. He also is founding director, The Institute for Bioengineering and Biotechnology, division of surgery, Massachusetts General Hospital (MGH), Boston. The institute is a new center for research and innovation that builds upon the MGH burn division’s collaborative track record and expertise in securing more than $200 million in federal, foundational, and industrial support for basic research and clinical programs.

In addition, Fred Weber, MD, JD, FACS, outgoing President of the New Jersey Chapter, offered a last presidential address on the topic of the College motto: Omnibus per artem fidemque prodesse. Dr. Weber highlighted in his speech that the designation of FACS when used after a surgeon’s name guarantees that patients will receive quality care.

Lebanon Chapter welcomes new members, celebrates 50th anniversary
The ACS Lebanon Chapter hosted a Gala Dinner December 13, 2014, to celebrate the chapter’s 50th anniversary. More than 90 attendees, including Fellows and guests, participated in the festivities. As part of the evening’s activities, 19 Fellows who were admitted to the College over the last three years were welcomed as Lebanon Chapter members and received ACS Lebanon Chapter pins. Chapter President Ghassan Nawfal, MD, FACS, gave a presentation on strategic planning for the Lebanon Chapter and announced the location of the 2015 Surgical Congress, which will take place June 25–27 in Beirut. Lebanon Chapter membership currently includes 120 Fellows, 10 Associates, and 73 Resident members.

ACS Executive Director offers keynote speech at Missouri Chapter meeting
ACS Executive Director David B. Hoyt, MD, FACS, gave the keynote address, 100 Years of Inspiring Quality at the American College of Surgeons, at the Missouri Chapter annual meeting May 30–June 1, 2014, Lake of the Ozarks, MO. Dr. Hoyt also delivered the Committee on Trauma report.

continued on page 58
Lebanon Chapter Council, from left: Rola Dakroub, MD, FACS, Councilor; Muhammad Younis, MD, FACS, Secretary; Tarek Birjawi, MD, FACS, President-Elect; Ghassan Nawfal, MD, MBA, FACS, President; Ziad Zakaria, MD, FACS, Treasurer; Ashraf Hamdan, MD, FACS, Councilor; Jamal Hoballah, MD, MBA, FACS, ACS Governor for Lebanon; and Antoine Kachi, MD, FACS, Councilor.

More than 90 guests attended the 50th Anniversary Gala of the Lebanon Chapter of the ACS in downtown Beirut.

Missouri Chapter, from left: Mark Wakefield, MD, FACS, Past-President; John Kirby, MD, FACS, Vice-President; Paul Dale, MD, FACS, President-Elect; Dr. Hoyt; Julie Margenthaler, MD, FACS, President; Joseph Corrado, MD, FACS, Past-President and Past ACS Governor; and Brent Sorenson, MD, FACS, Secretary.

Pictured are new Fellows, Associate Fellows, and Residents attending a Panama Chapter reception at the 2014 Clinical Congress. Front row, second from right is Rafael Andrade-Alegre, MD, FACS, President of the ACS Panama Chapter and coordinator of the chapter meeting in San Francisco.
ACS Panama Chapter welcomes new Fellows at Clinical Congress

The Panama Chapter met at Neptune’s Waterfront Grill & Bar in San Francisco, CA, during the 2014 ACS Clinical Congress. The purpose of the impromptu meeting was to celebrate the initiation of 11 new Fellows from Panama. Associate Fellows and Resident Members of the chapter also attended the dinner gathering. Though predominantly a social event to promote friendship among chapter members, the group did discuss some administrative issues, offered suggestions for better communication between chapter members, and specified to those new members the rights and duties of Fellowship.

Pauline Chen, MD, FACS, delivers keynote address at Southwestern Pennsylvania Chapter event


Dr. Chen’s moving presentation was titled Choosing between Technology and Palliation. As a transplant surgeon, and one who treats terminally ill patients, Dr. Chen spoke on the care of the dying by physicians who often consider a patient’s death as a sign of imperfect care and, thus, a personal failure.

Also at the chapter event were outstanding senior students, selected by local hospital program directors to attend the meeting so that they could also hear Dr. Chen’s presentation. After her keynote presentation, Dr. Chen stayed to spend time and answer questions one-on-one with members of the audience.

Dr. Chen is the recipient of numerous awards, including the University of California, Los Angeles, Outstanding Physician of the Year Award and the George Longstreth Humanness Award at Yale University, New Haven, CT, for exemplifying empathy, kindness, and care in an age of advancing technology.

Wisconsin Chapter Meeting

From left: Shanu Kothari, MD, FACS, Past-President of the Wisconsin Surgical Society, a Chapter of the ACS, and Paul Severson, MD, FACS, Beaumont Lecturer, attending the chapter annual meeting November 14–15 in Kohler, WI. Dr. Warshaw also attended the event and represented the College.

Connecticut Chapter annual meeting

Residents from Stamford Hospital, CT, were winners of the surgical skills resident competition held at the Connecticut Chapter annual meeting November 7, 2014. From left (all pictured are affiliated with Stamford Hospital): Michael Stone, MD, FACS, chairman, department of surgery; Heather Player, MD, postgraduate year-four (PGY-4) general surgery resident; Kevin Dwyer, MD, FACS, vice-chair, department of surgery, director, surgical residency program, and director, trauma and surgical critical care; John Calhoun, MD, PGY-1; Kristina Ziegler, MD, PGY-3; and Jennifer Bishop, MD.
Disciplinary actions taken

The Board of Regents of the American College of Surgeons (ACS) took the following disciplinary action at its June 6, 2014, meeting:

• Frank S. Cohen, MD, a general surgeon from New York, NY, was expelled from the College. This action was taken following disciplinary action by the New York State Board for Professional Medical Conduct based on a determination that he had ordered excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient.

The ACS Board of Regents took the following disciplinary actions at its October 25, 2014, meeting in San Francisco, CA:

• Michael F. E. Jones, MD, an otorhinolaryngologist from Sioux City, IA, was expelled from the College. This action was taken following disciplinary actions by the Iowa, Arizona, and California Boards of Medicine following charges that he violated appropriate professional boundaries and had engaged in inappropriate prescribing.

• Mike Lynn Schmit, MD, FACS, a general surgeon from Bismarck, ND, was placed on probation until such time as he has a full and unrestricted license to practice medicine, until he has full and unrestricted surgical privileges in an accredited hospital or outpatient facility, and until his practice pattern has been reviewed and approved by the ACS Central Judiciary Committee. This action was taken following disciplinary action by the North Dakota Board of Medical Examiners involving violation of a Physicians Health Program agreement and charges that he had engaged in a sexual relationship with a patient.

DEFINITION OF TERMS

Following are the disciplinary actions that may be imposed for violations of the principles of the College.

• **Admonition**: A written notification, warning, or serious rebuke.

• **Censure**: A written judgment, condemning the Fellow or Member’s actions as wrong. This is a firm reprimand.

• **Probation**: A punitive action for a stated period of time, during which the Member: (a) loses the rights to hold office and to participate as a leader in College programs; (b) retains other privileges and obligations of membership; (c) will be reconsidered by the Central Judiciary Committee periodically and at the end of the stated term.

• **Suspension**: A severe punitive action for a period of time, during which the Fellow or Member, according to the membership status: (a) loses the rights to attend and vote at College meetings, to hold office, and to participate as a leader, speaker, or panelist in College programs; (b) is subject to the removal of the Member’s name from the public listing and mailing list of the College; (c) surrenders his or her Fellowship certificate to the College, and no longer explicitly or implicitly claims to be a Fellow of the American College of Surgeons; (d) pays the visitor’s registration fee when attending College programs; (e) is not subject to the payment of annual dues. When the suspension is lifted, the Fellow or Member is returned to full privileges and obligations of Fellowship.

• **Expulsion**: The certificate of Fellowship and all other indicia of Fellowship or membership previously issued by the College must be forthwith returned to the College. The surgeon thereafter shall not explicitly or implicitly claim to be a Fellow or Member of the American College of Surgeons and may not participate as a leader, speaker, or panelist in College programs.
Registration now open for 2015 Leadership & Advocacy Summit

Registration is now open for the American College of Surgeons (ACS) 2015 Leadership & Advocacy Summit, April 18–21, at the JW Marriott in Washington, DC. The annual Summit is a dual meeting that offers ACS members, volunteer leaders, and advocates comprehensive and specialized educational sessions focused on effective surgeon leadership as well as interactive advocacy training and coordinated visits to congressional offices. The fourth annual Summit will begin with a reception Saturday, April 18.

The Leadership Summit, which convenes April 19, will examine the skills required of surgeon leaders and feature specialized educational sessions with expert speakers who will describe the tools needed for effective leadership at all career levels. Chapter success stories and breakout sessions to identify strategies for development and enhancement of ACS chapters also are planned.

The Advocacy Summit will commence that evening. Retired U.S. Army General Stanley McChrystal will serve as the keynote speaker at the dinner meeting and will provide insights into successful leadership. On Monday, April 20, speakers will discuss the political environment in Washington, DC, and across the country, as well as the status of health care issues. Monday also will feature a luncheon sponsored by the ACS Professional Association political action committee (ACSPA-SurgeonsPAC), including a talk by Washington Post political reporter Chris Cillizza. Monday evening, the ACSPA-SurgeonsPAC will host a fundraising event and raffle.

On Tuesday morning, attendees will apply what they have learned at the Summit in face-to-face meetings with their senators and representatives and/or congressional staff. This portion of the program provides an opportunity to rally surgery’s collective grassroots advocacy voice on such issues as physician payment, professional liability, and physician workforce issues.

For more information or to register for the 2015 Leadership & Advocacy Summit, go to the ACS website at www.facs.org/advocacy/participate/summit. The hotel reservation deadline is March 12.

Correction

The location of Halifax was incorrect in the December 2014 Bulletin article, “Presidential Address: Achieving our personal best—Back to the Future of the American College of Surgeons.” Halifax is in Nova Scotia. The editors regret the error.
Study examines effects of duty-hour reforms on surgical patients

The duty-hour reforms that the Accreditation Council for Graduate Medical Education imposed in 2011, which limit resident work hours to 80 per week, have had no significant effect on the outcomes for general surgery patients, according to a study in the December 10 issue of the Journal of the American Medical Association (JAMA).

Ravi Rajaram, MD, ACS Clinical Scholar in Residence and a fourth-year resident in general surgery at Northwestern Medicine, Chicago, IL, conducted the study to determine the effects of the controversial 2011 ACGME duty-hour reforms. Karl Bilimoria, MD, MS, FACS, Faculty Scholar at the American College of Surgeons (ACS); director, Surgical Outcomes and Quality Improvement Center, and vice-chair for quality, department of surgery, Feinberg School of Medicine, Northwestern University, was the senior author of the study. ACS Executive Director David B. Hoyt, MD, FACS, and Clifford Y. Ko, MD, MS, MSHS, FACS, Director of the ACS Division of Research and Optimal Patient Care and the ACS National Surgical Quality Improvement Program (ACS NSQIP®), were co-authors. The authors used data from ACS NSQIP.

The study examined general surgery patient outcomes two years before (academic years 2009–2010) and after (academic years 2012–2013) the 2011 duty-hour reform, and no difference in outcomes was observed for any of the postoperative complications studied. General surgery resident performance on the annual in-training written board and oral board examinations was assessed for this same period. Similarly, the reforms had no observable impact on exam performance.

The prospective Flexibility In duty hour Requirements for Surgical Trainees Trial (FIRST Trial), sponsored by the ACS, the American Board of Surgery, and the ACGME, will provide further evidence to guide surgical residency duty-hour policies. View more information about the FIRST Trial at www.thefirsttrial.org/. Dr. Bilimoria noted that certain duty-hour restrictions offer no benefits to patient care and have the unintended consequence of hurting patient safety, resident education, and the physician-patient relationship. The authors also noted that increased handoffs, trainees feeling unprepared to practice, and concern regarding residents developing a shift-work mentality engendered by these duty-hour policies suggest the need for revision or reconsideration of the duty-hour reform.


Jacobson Promising Investigator Award deadline extended to March 27

The application deadline for the 2015 Joan L. and Julius H. Jacobson II Promising Investigator Award has been extended to March 27, 2015. The award recognizes outstanding surgeons who engage in research, advance the art and science of surgery, and demonstrate early promise of significant contribution to the practice of surgery and the safety of surgical patients. Visit www.facs.org/quality-programs/about/cqi/jacobson to view details and selection criteria for the award.
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"[Eric L.] Wan [study co-author and intramural research training award fellow at the National Institutes of Health] would like to see their program expand. ‘One could dream that every hospital has a program like this and forms community partnerships that are both local and global, so that these supplies don’t become labeled as waste and instead become labeled as a resource that can be shared,’ he said.

“The study was released Monday at the annual meeting of the American College of Surgeons in San Francisco. Data and conclusions presented at meetings are usually considered preliminary until published in a peer-reviewed medical journal.”

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**Checklist can improve surgical patient handoff**
*FierceHealthcare*, October 29, 2014

“The protocol during the shift change encourages physicians to discuss the sickest patients first, according to Nicole Tapia, MD, a fourth-year resident at Baylor College of Medicine in Houston, who presented her preliminary findings this week at the American College of Surgeons 2014 Clinical Congress. The protocol then calls for doctors to discuss new admissions, changes to current patients, and finally to review tasks.”

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**Universal helmet laws may help save young motorcyclists**

“After accounting for all injuries together, the researchers said that young riders in states with universal helmet laws were 2.5 times less likely to suffer a traumatic head injury than those in states with age restrictions.

“The study was released Tuesday at the annual meeting of the American College of Surgeons in San Francisco. The data and conclusions of research presented at meetings are usually considered preliminary until published in a peer-reviewed medical journal.”

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**U.S. medical supplies donated annually to developing countries**
*Voice of America*, October 30, 2014

“Sometimes they are used for emergency surgery, and sometimes they are not used for emergency surgery,” [Eric L. Wan, a study coauthor, and post-baccalaureate..."
Intramural Research Training Award Fellow at the National Institutes of Health] said. ‘So our goal is that in the end, we save and improve lives.’

‘Details of the SHARE program were presented at the annual meeting of the Clinical Congress of the American College of Surgeons in San Francisco.’

Child’s appendix more likely to rupture in regions short of surgeons

U.S. News & World Report, October 31, 2014

‘Young appendicitis patients with limited access to general surgeons likely have to wait longer to be transferred and start receiving care, according to the authors of the study presented this week at an American College of Surgeons meeting in San Francisco.’

American College of Surgeons names Warshaw as new president, and other executive moves

Modern Healthcare, November 8, 2014

‘Dr. Andrew Warshaw [MD, FACS] has begun his one-year term as [P]resident of the American College of Surgeons, a 79,000-member professional association based in Chicago.

'[Dr.] Warshaw, 75, is surgeon-in-chief emeritus at Massachusetts General Hospital in Boston and the W. Gerald Austen Distinguished Professor of Surgery at Harvard Medical School, where he has been a professor since 1987. He also is director of the Andrew L. Warshaw Institute for Pancreatic Cancer Research at Massachusetts General. His clinical interests have centered on diseases of the pancreas and gastrointestinal tract with a focus on surgical oncology.’

Medical errors drop with doc handoff program

FierceHealthcare, November 6, 2014

‘Medical errors are now the third leading cause of death in the United States and may be as high as 400,000 deaths a year. The [New England Journal of Medicine] study echoes the findings of another study presented last month at the American College of Surgeons 2014 Clinical Congress, which examined the use of a surgical checklist to improve communication and reduce potential errors during patient handoffs. The protocol during the shift change encourages physicians to discuss the sickest patients first.’
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*Practicing surgeons may earn CME credit and claim self-assessment credit*
It was a great honor to be selected as the Nizar N. Oweida, MD, FACS, Scholar for 2014. This award funded my attendance at the October 2014 Clinical Congress of the American College of Surgeons (ACS) in San Francisco, CA. The meeting was a fantastic experience and provided clarity of purpose to me as a rural general surgeon in Pendleton, OR. In addition to attending excellent Panel Sessions and Postgraduate Skills-Oriented Courses, I spoke with numerous other surgeons and clinical experts about special challenges we face as general surgeons in the rural setting. Having the opportunity to interact with other surgeons was as important to me as the informative courses.

Postgraduate Courses
Funding from the Oweida Scholarship afforded me the opportunity to register in advance for four Postgraduate Courses. On October 25, for example, I attended the Rural Surgeons Skills Course, during which the speakers provided an excellent review of upper gastrointestinal (GI) bleeding control, esophageal and pediatric airway obstruction, and other topics. This Skills Course provided me with the opportunity to become more familiar with the use of enteric stents, argon plasma coagulators, and several new devices for treating hemorrhoids, polyps, and mucosal defects.

On October 26, I attended the Emergency General Surgery Update, a Didactic Postgraduate Course. The thorough and up-to-date review of difficult conditions, including perforated esophagus, diverticulitis, necrotizing pancreatitis, acute hernia, and C. difficile colitis, was very valuable. These problems do occur in my rural practice, so this review and additional information was extremely helpful.

Interaction with ACS leadership
On October 27, I was honored to be a participant in the Opening Ceremony of the Clinical Congress. Beforehand, I had the opportunity to meet some of the ACS leadership, including ACS Executive Director David B. Hoyt; Immediate Past-President Carlos A. Pellegrini, MD, FACS, FRCSI(Hon); Second Vice-President Kenneth L. Mattox, MD, FACS—a distinct privilege in itself. I also enjoyed visiting with several residents who had received basic science research scholarships. It was interesting to hear about their research and intended career paths in academic surgery. After the Opening Ceremony, I visited with Edgar Rodas, MD, FACS, a general surgeon who was accorded Honorary ACS Fellowship at the Clinical Congress Convocation, and learned about the mobile hospital he has developed to deliver surgical care to patients in rural Ecuador.

I then attended a variety of Panel Sessions throughout the day, including Desperate Situations in Rural Surgery, which provided perspective on my approach to such problems as ruptured aortic aneurisms and other serious conditions.
The ACS Clinical Congress was a superior educational and interactive event. I am extremely grateful to the Scholarships Committee for awarding me this high honor and am indebted to the late Dr. Oweida and his family for funding this great experience for rural surgeons such as myself.

The Optimal Fluid Resuscitation session was another valuable session, particularly because it included a discussion on endpoints of resuscitation.

In the afternoon, I attended the Scholarships Committee meeting and listened to the excellent advanced basic science presentations delivered by surgical residents and faculty in academic programs. It was humbling to learn about the time and effort these surgeons and trainees have dedicated to scientific research. I felt especially privileged to present an overview of my clinical practice and community to this academic group. I emphasized that I am an eventual end user of their research findings and will benefit immensely from their research efforts. My presentation was warmly received, and I much appreciated their respect for rural surgical practice.

That evening, my wife and I attended the Rural Surgeons dinner at a local Italian restaurant. It was truly inspiring to meet so many rural surgeons and to be able to match the faces to the names of those surgeons who post on the ACS rural listserv and the online Rural Community. It was a great privilege to meet ACS Governor Tyler G. Hughes, MD, FACS, and Philip R. Caropreso, MD, FACS, Chair and Vice-Chair, respectively, of the Advisory Council for Rural Surgery, both of whom have such dedication to the cause of rural surgery. The evening was enlightening and enjoyable.

**Further educational opportunities**

On October 28, I spent most of the day in the Didactic portion of the Laparoscopic Colectomy Postgraduate Course. I also attended the Panel Session titled Is Private Practice Dead? I was relieved to learn that I wasn’t extinct after all!

I left the cadaver skills lab at the impressive University of California, San Francisco, facility a bit early to attend the Rural Surgeons Open Forum, where I was presented the Oweida Scholarship and certificate by Dr. Pellegrini. The Open Forum discussion and audience participation provided enlightening information relevant to several rural surgery issues of concern, including the training of rural surgeons. This session clarified that the ACS values rural surgeons and is working to help solve some of the problems unique to practicing rural general surgeons.

On October 29, I attended a comprehensive Postgraduate Course on Surgical Critical Care. The instructors provided an extensive review of newer concepts for every organ system; much of the information presented was new to me.

This experience is particularly useful to me, as I am without formal intensivist support.

The final half-day of the Clinical Congress, I attended Ten Hot Topics in General Surgery—a fast-paced interactive session covering many interesting topics, all relevant to my practice. In particular, blood component therapy in resuscitation and neoadjuvant therapy in breast cancer were both very helpful. The discussion at a Panel Session, Gastroesophageal Junction Surgery, also was pertinent to my practice.

The ACS Clinical Congress was a superior educational and interactive event. I am extremely grateful to the Scholarships Committee for awarding me this high honor and am indebted to the late Dr. Oweida and his family for funding this great experience for rural surgeons such as myself. I have already implemented some of what I learned at the Clinical Congress in my own practice, including use of the suction cap for endoscopic explantation of impacted food from the esophagus and restraint in fluid resuscitation of seriously injured trauma patients. This experience has given me a renewed enthusiasm and higher level of expertise in patient care as I continue to practice rural surgery in Pendleton.
International ACS NSQIP Scholarships and International Surgical Education Scholarships deadlines approaching

The application deadlines for two prestigious international scholarships are rapidly approaching. Applications for the 2015 American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP®) Scholarships are due February 16, 2015 and applications for the International Surgical Education Scholarships are due May 1, 2015.

**ACS NSQIP Scholarships**
The ACS Quality Programs and International Relations Committee awarded three International ACS NSQIP Scholarships in 2014. Two will be awarded in 2015. These scholarships enable international surgeons who are interested in surgical quality improvement to attend the annual ACS NSQIP National Conference. The 2014 awardees—Abhinav A. Sonkar, MB, BS, FACS, a general surgeon and associate professor of surgery, Chaptrapat Shahuji Maharaj Medical University, Lucknow, India; Arkadiusz P. Wysocki, MB, BS, a general surgeon in Brisbane, Australia; and Zafar Nazir, MB, BS, FACS, a pediatric surgeon and associate professor of surgery, The Aga Khan University of Karachi, Pakistan—attended the ACS NSQIP National Conference in San Diego, CA, and then visited several ACS NSQIP-approved surgery centers tailored to their specialty interests.

The next application deadline for the 2015 International ACS NSQIP Scholarships is February 16. The National Conference will take place in July in Chicago, IL. For details about the scholarship and the application requirements, go to www.facs.org/member-services/scholarships/international/isnsqip or contact Kate Early, International Liaison, ACS Division of Member Services, at scholarships@facs.org.

**International Surgical Education Scholars**
Two International Surgical Education Scholars were selected to attend the 2014 ACS Clinical Congress in San Francisco, CA. This program is cosponsored by the ACS Division of Education and the International Relations Committee. Rajeev Kumar, MB, BS, a urological surgeon in New Delhi, India, and Sterman Toussaint, MD, a general surgeon in St. Marc, Haiti, attended the Surgical Education: Principles and Practices course and other sessions at Clinical Congress and gave brief public addresses about their work before going on to visit several ACS-approved centers for surgical education.

The next application deadline for the 2015 International Surgical Education Scholarships is May 1 for attendance at the 2015 Clinical Congress in Chicago, IL. The requirements will be published shortly. ♦
Calendar of events

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

**FEBRUARY**

Puerto Rico Chapter
February 19–21
San Juan, PR
Contact: Marcos Perez-Brayfield, mperezb1@yahoo.com, www.acspuertoricochapter.org

North Texas Chapter
February 20–21
Dallas, TX
Contact: Carrie Steffen, carrie@stefenmanagement.com, www.ntexas.org

Oklahoma Chapter
February 26–27
Tulsa, OK
Contact: Jennifer Starkey, jennifer@executive-office.org, www.okfacs.org

South Texas Chapter
February 26–28
Houston, TX
Contact: Janna Pecquet, janna@southtexasacs.org, www.southtexasacs.org

**METROPOLITAN WASHINGTON, DC, CHAPTER**

Metropolitan Washington, DC, Chapter
March 7
Washington, DC
Contact: Jennifer Starkey, jennifer@executive-office.org, www.dcfacs.org

Alaska Chapter
March 14
Anchorage, AK
Contact: Danny Robinette, ddrabinette@gmail.com

Peru Chapter
March 25–27
Lima, Peru
Contact: Jaime Herrera-Matta, juanjaimhepe@yahoo.com

**EGYPT CHAPTER**

Egypt Chapter
April 29–May 2
Cairo, Egypt
Contact: Mohey Elbanna, moheyelbanna@yahoo.com, www.egyptacs.net

**MARCH**

Maryland Chapter
March 6
Towson, MD
Contact: Jennifer Starkey, jennifer@executive-office.org, www.marylandfacs.org

**INDIANA CHAPTER**

Indiana Chapter
April 17–18
Indianapolis, IN
Contact: Carolyn Downing, cdowing@ismanet.org, www.infacs.org

**ACSi LEADERSHIP & ADVOCACY SUMMIT**

ACSi Leadership & Advocacy Summit
April 18–21
Washington, DC
Contact: Donna Tieberg, dtieberg@facs.org, www.facs.org

**MAY**

North Dakota Chapter & South Dakota Chapter
May 1–2
West Fargo, ND
Contact: Terry Marks, tmarks@sdmsa.org

Virginia Chapter
May 1–3
Richmond, VA
Contact: Susan McConnell, smcconnell@ramdocs.org, www.virginiaacs.org

**FUTURE CLINICAL CONGRESSES**

2015
October 4–8
Chicago, IL

2016
October 16–20
Washington, DC

2017
October 22–26
San Diego, CA