Register for 2011 In-depth Review by Jan. 11 and save!

The General Surgery In-depth Review Seminar on Trauma and Breast Surgery will be held Feb. 11–12, 2011, at the Orlando World Center Marriott Resort in Orlando, Fla. Register by Jan. 11 and qualify for the seminar’s early registration rate, which will save ACOS members $100 and resident members $50 off the full registration fee.

Preceding the In-depth Review Seminar, the ACOS will host an optional Ultrasound Workshop that will include a half day of hands-on instruction with ultrasound equipment. Register early for this event since space is limited to 40 attendees.

You may register for the seminar and workshop using one of these options:
- Register securely online through the ACOS website at www.facos.org.
- Print out and mail the online registration form to ACOS, 123 North Henry Street, Alexandria, VA 22314-2903; or
- Fax the registration form and your credit card information (Visa or MasterCard accepted) to 703-684-3280.

A block of rooms has been reserved for the In-depth Review at the Orlando World Center Marriott Resort at a group rate of $179 for single or double occupancy. This hotel rate will be available until Jan. 3, 2011, or until the room block is full. To make your reservation, call 800-228-9290 and mention that you are participating in the ACOS In-depth Review Seminar.

If you need additional information about the In-depth Review Seminar, visit the ACOS website at www.facos.org or call 800-888-1312, ext. 107.

WASHINGTON WATCH:
Federal legislative and regulatory update

**Virginia federal court finds individual mandate provision in PPACA unconstitutional**

A federal district court in Virginia ruled on Dec. 13 that the provision in the health reform legislation—Patient Protection and Affordable Care Act (PPACA)—that requires individuals to purchase healthcare insurance is unconstitutional. However, the court stopped short of striking down the entire PPACA. Four other federal district court decisions have upheld the law’s constitutionality, and a number of other cases still are pending. The government has announced that it will appeal the Virginia federal court’s decision to the 4th Circuit Court of Appeals, where a three-judge panel picked at random will hear the appeal. Whatever the outcome, the 4th Circuit Court’s decision likely will be appealed, making the challenge a Supreme Court contender along with nearly two dozen other challenges to the health reform law.

**Repeal of health reform bill top priority for Congress?**

House and Senate Republican leaders, including many incoming committee chairs, have said that repealing the historic health reform bill (PPACA) will be their top priority for the 112th Congress. And, the day after Democrats sustained huge losses at the voting polls, both President Obama and Senate Majority Leader Harry Reid signalled that they are open to tweaking the healthcare law but not substantially dismantling it.

However, due to the cost of repealing many of these policies or programs, and facing the challenge of potential Obama vetoes, Republicans likely will have little choice but to whittle away at pieces of the reform law such as shaving educational programs, mandated studies, and reports. Still, it is likely that Republicans will introduce and try to pass a bill quickly to make good on their pledge to kill health reform, even if this means it goes nowhere in a Democratically-controlled Senate or is vetoed by the president.

Among the targets of a Republican-led House will be a bevy of unpopular health reform law mandates that includes the Independent Payment Advisory Board, the Community Living Assistance Services and Support Act (CLASS) Act, the hundreds of millions of dollars allocated for comparative effectiveness research, and the $2 billion Prevention and Public Health Fund, as well as reductions in payments to Medicare Advantage plans. The individual mandate, under which people must buy insurance or pay a penalty, also may be targeted by denying IRS funding for enforcement implementation.

Another potential target is the medical loss ratio requirement of the PPACA in order to continue to keep the agents and brokers in business who advise people about health insurance plans. The medical loss ratio requirement requires large group plans to spend at least 85 percent of premiums on medical claims or quality improvements, and small group and individual plans to spend at least 80 percent. If plans do not spend that much

*See WASHINGTON WATCH, page 2*
WASHINGTON WATCH:
Congress passes physician payment cut fix;

From WASHINGTON WATCH, page 1

beginning in 2011, they must refund the difference to policyholders beginning in 2012.

House Republicans also are likely to try to shut off appropriations funding for various reform projects. This past May, the Congressional Budget Office reported that funding the health reform law’s requirements would cost roughly $115 billion over the next 10 years. Republicans will attempt to ensure that this funding is not included in the annual appropriations bills.

Republicans also are likely to try to employ various esoteric procedural mechanisms to repeal reform measures or block implementing regulations.

Finally, another implication of the 2010 elections is that the new crop of Republican governors may impede the implementation of health reform’s major provisions at the state level. States have tremendous responsibilities under the law, including expanding the Medicaid program and setting up insurance exchanges. The exchanges are health insurance marketplaces that must be up and running by the time the new healthcare law is fully implemented in 2014. States just now are beginning to figure out how to assemble their exchanges.

In addition, there are many other less-publicized provisions that states can take advantage of based on their existing efforts and preferences, such as medical education, workforce development, payment reform, data collection, and quality improvement.

Congress passes one-year fix to Medicare physician payment cuts

The House and Senate approved legislation (H.R. 4994) that would maintain Medicare physician payment at current 2010 levels through Dec. 31, 2011. The measure cleared the Senate on Dec. 8 by unanimous consent; the House vote the next day was 409 to 2. President Obama signed the bill on Dec. 15. The legislation prevents the impending Medicare E-prescribing penalties to be applied to physicians in some cases. The provision is vague enough to allow the FTC from applying the Red Flags Rule to physicians. While an improvement on the original legislation, the language of the amendment’s (FTC) Red Flags Rule that requires “creditor” in the 2008 Federal Trade Commission’s (FTC) Red Flags Rule that requires

Congress passes Red Flags relief bill

Earlier in December, Congress passed the Red Flag Program Clarification Act of 2010 (S. 3987), which narrows the definition of “creditor” in the 2008 Federal Trade Commission’s (FTC) Red Flags Rule that requires

Medicare E-prescribing penalties to be implemented based on 2011 conduct

Although the law provides that Medicare e-prescribing penalties do not take effect until 2012, the CMS has announced that it will determine whether to apply a penalty in 2012 based on a physician’s compliance with the e-prescribing standard during the first
half of 2011. Specifically, the CMS states that to avoid the 2012 penalty of 1 percent on Medicare payments, a physician must report the e-prescribing G Code (G8553) on claims at least 10 times from January to June 2011 in connection with specified office visit codes. This CMS decision caught the medical community by surprise since generally it had been assumed that physicians had until 2012 to meet the e-prescribing rules.

### Implementation of PECOS enrollment for ordering physicians delayed

CMS announced that it will delay implementation of the requirement that physicians who order services (e.g., imaging, lab tests) be enrolled in the Medicare online Provider Enrollment, Chain, and Ownership System (PECOS) system. The deadline for PECOS enrollment is Jan. 3, 2011; however, because of backlogs of enrollment applications being processed by the Medicare Administrative Contractors, the CMS has postponed turning on the claims denial edits indefinitely. Once the edits are effective, the CMS will deny claims for services ordered by physicians who are not enrolled through PECOS.

### Financial incentives can improve quality

Offering providers financial incentives for improving patient care increases quality of care and reduces growth in Medicare expenditures, according to the results from three demonstration projects released by the CMS on Dec. 9, 2010.

The Physician Group Practice (PGP) demonstration project continued to show improvement in the preventive and chronic care delivery processes and to generate shareable savings for the Medicare program. All 10 of the provider groups in the demo hit performance goals on at least 29 of the 32 measures reported in this fourth year of the five-year project, while three hit their goals on all 32, including Geisinger Clinic in Danville, Pa., Marshfield Clinic in Marshfield, Wis., and Park Nicollet Health Services in St. Louis Park, Minn. Marshfield Clinic reported that it saved the Medicare program more than $83 million over those four years.

The Medicare Care Management demonstration project showed that more than 500 small and solo physician practices were rewarded for providing high-quality care, based on their performance on 26 quality measures, in the delivery of preventive care and care using health information technology for patients with chronic illnesses. According to the CMS, 26 percent of practices were able to submit at least some of the measures from a certified electronic health record.

The Hospital Quality Incentive demonstration project, sponsored by Medicare in partnership with Premier Healthcare Alliance, continued to show improvement among participating hospitals; 212 hospitals in the program will be awarded a total of $12 million for top performance, top improvements, and overall attainment in six clinical areas—heart attack, coronary bypass graft, heart failure, pneumonia, hip and knee replacements, and the Surgical Care Improvement Project (SCIP). Through the first five years of the demo project, the CMS has awarded more than $48 million to top performers. Hospitals were scored on more than 30 care measures and showed an average of 18 percent improvement overall.

CMS Administrator Donald Berwick, M.D., acknowledges that the progress so far is “just a start” but indicates that these CMS demos confirm the agency’s decision to focus on pay-for-performance reimbursement models. He further indicated that the CMS would continue to test new payment models. The CMS currently is working to transition the PGP demonstration project into the accountable care organization shared savings program called for in the PPACA.

Author Rebecca L. Burke, Of Counsel to the law firm of POWERS PYLES SUTTER & VERVILLE PC (PPSV) in Washington, D.C., is part of the PPSV team retained by the ACOS as government affairs consultants.

### CHS permits AOA board-certified physicians to apply for staff appointments and privileges

The Carolinas HealthCare System (CHS)—the third-largest public hospital system in the nation, with a network of 32 hospitals—has opened the door for AOA board-certified physicians to apply for medical staff appointments and clinical privileges at CHS facilities.

The medical staff at the Carolinas Medical Center (CMC) in Charlotte, N.C.—CHS’s flagship facility and one of North Carolina’s largest hospitals—and all other CHS facilities were considering a revision to their medical staff bylaws that would permit AOA board-certified physicians to apply for medical staff appointments and clinical privileges at their facilities.

CHS and CMC medical and administrative staff participated in an Aug. 30, 2010, conference call with leaders of the AOA and ACOS, which provided CMC staff with information about osteopathic surgical residency programs, the current standards for surgical residency training, surgical training program model curricula, and AOA board certification. On Dec. 14, 2010, the CHS Board of Commissioners approved an amendment to the CMC medical staff bylaws that will permit AOA board-certified physicians to apply to CMC for medical staff appointments and clinical privileges. The CHS board approved the same amendment to the medical staff bylaws of the other CHS facilities earlier. The bylaw changes for all CHS facilities are in effect.

Serving as the regional referral center for western North Carolina and northern South Carolina, the CMC is one of only five facilities in North Carolina designated as an Academic Medical Center teaching hospital and a Level I trauma center.

The following ACOS members participated in the Aug. 30 conference call: Gregory Heath Smith, D.O., FACOS, Residency Evaluation and Standards Committee (RESC) chair; James H. McQuiston, D.O., FACOS, then ACOS president-elect and former RESC chair; and Albert H. Olimencia-Yurvati, D.O., FACOS, chair of the American Osteopathic Board of Surgery.
New members encouraged to open ‘doors of opportunity’

The ACOS is here to assist you with your new endeavors, and it will open doors of opportunity,” said Marc E. Rosen, D.O., FACOS, pictured above delivering his charge to the new members who were inducted into the College during the Annual Ceremonial Conclave on Oct. 24 in San Francisco.

He encouraged the new members to consider the following opportunities:

- **Leadership**—Use the leadership, organizational, and management skills that you gained in your surgical residency to serve as a program director, committee chair, discipline officer, governor, or president of the College, said Dr. Rosen.

- **Political advocacy**—At this critical time for our nation’s healthcare delivery system, join ACOS’s efforts to educate Washington on issues that are important to physicians, he continued.

- **Education and mentorship**—Get involved in the training of new physicians, and share your experiences with them to make future generations better, said Dr. Rosen.

- **Assessment**—Assist the ACOS in the evaluation of residents by writing in-service test questions, serving as a training program site inspector, or helping to build simulator labs.

- **Advancement**—Get involved in efforts to improve patient care by developing new equipment or techniques such as robots, training simulators, or telemedicine, he said.

- **Fundraising**—Contribute to the ACOS Trust Fund, which helps to provide the resources needed for the College’s programs to succeed and grow, said Dr. Rosen.

- **Collaboration**—Join with your ACOS colleagues in conducting medical research projects, and invite each other to lecture or assist in conducting labs.

“Use your individual talents to keep our organization current and strong. We are looking for your ideas and wisdom,” Dr. Rosen concluded. “You are in the position to make a difference through participation, through which we will grow as an organization and we will grow as surgeons.”

---

**New Members**

The following members were inducted into the College during the 2010 Annual Ceremonial Conclave on Oct. 24 in San Francisco:

- Johan Aerts, D.O.
- Juhi Asad, D.O.
- Bradford K. Bickley, D.O.
- Adam J. Braze, D.O.
- Nathan R. Brought, D.O.
- Antonino S. Cammarata, D.O.
- Sean A. Castellucci, D.O.
- Louis E. Costa, D.O.
- Adair Frierson De Berry-Carilide, D.O.
- Brian P. DeFade, D.O.
- Seema P. Dhorajia, D.O.
- Nguyen Trong Do, D.O.
- Danielle M. Duchini, D.O.
- Roger C. Ernest, D.O.
- Thomas H. Erter, D.O.
- Michael W. Fountain, D.O.
- Alok D. Gandhi, D.O.
- Jeffrey R. Gerken, D.O.
- Toni M. Green, D.O.
- Jeffrey L. Greski, D.O.
- Scott T. Hartnett, D.O.
- John F. Hua, D.O.
- Daniel S. Hurton, D.O.
- Mollie M. James, D.O.
- Eric A. Kvistin, D.O.
- Brian M. Koper, D.O.
- Gustavo A. Lopes, D.O.
- Craig Lum, D.O.
- James M. MacNutt, D.O.
- Todd P. Mangione, D.O.
- Eric D. Martin, D.O.
- Jason J. McAllaster, D.O.
- Christine N. McGinn, D.O.
- Adnan Mohammadhboy, D.O.
- Troy A. Moritz, D.O.
- John T. Morris, D.O.
- William J. Myers, D.O.
- Richard Nguyen, D.O.
- Sean A. Nie, D.O.
- Cynthia L. Nydick, D.O.
- Alan M. Parks, D.O.
- Neil N. Patel, D.O.
- Nirav S. Patel, D.O.
- Tamy E. Perg, D.O.
- Lina M. Price, D.O.
- Kevin P. Purgiel, D.O.
- Douglas A. Rex, D.O.
- John B. Roach Jr., D.O.
- Jacob E. Roberts, D.O.
- Semone B. Roehlin, D.O.
- Roy L. Sandau, D.O.
- Bradford J. Scanlan, D.O.
- Christopher Schaefer, D.O.
- Tendara A. Schellman, D.O.
- Tina K. Schuster, D.O.
- James R. Scott, D.O.
- Clint G. Semrau, D.O.
- Eric T. Sevensma, D.O.
- Lawrence R. Sirota, D.O.
- David M. Skeehan, D.O.
- David M. Spire, D.O.
- Michael J. Stumpf, D.O.
- Alireza N. Tehrani, D.O.
- David A. Terry, D.O.
- Kelly M. Van Fossen, D.O.
- Ed V. Wehling, D.O.
- Michael A. White, D.O.
- Jacob C. Yannetta, D.O.
- William B. Zimmerman, D.O.

---

**New Fellows**

The title of Fellow of the American College of Osteopathic Surgeons (FACOS) was conferred on the following members at the 2010 Ceremonial Conclave:

- Juhi Asad, D.O.
- M. Lisa Arzbery, D.O.
- Lloyd J. Beaudry, D.O.
- Gordon A. Brown, D.O.
- J. Bracken Burns Jr., D.O.
- Stuart J. Chow, D.O.
- Craig N. Czyz, D.O.
- Dino A. DeLaurentis, D.O.
- Arthur J. DeMarino, D.O.
- Jeffrey G. DePaton, D.O.
- Mark A. Drake, D.O.
- Alok D. Gandhi, D.O.
- Rick A. Gemma, D.O.
- Clarisa C. Hamner, D.O.
- Michael P. Heid, D.O.
- Ronald A. Hyde, D.O.
- Steven P. Kerner, D.O.
- David R. Lawrence, D.O.
- Lisa J. Learn, D.O.
- Michael McCann, D.O.
- William J. Meis, D.O.
- Janie L. Orinton-Myers, D.O.
- Chad Michael Robbins, D.O.
- Tina K. Schuster, D.O.
- Armando C. Sciuillo, D.O.
- Nikhil L. Shah, D.O.
- Casey J. Thomas, D.O.
- Carlos A. Valladares, D.O.
- Darrel Mark Warner, D.O.
- Michael A. White, D.O.
- Dennis A. Whitney, D.O.
- William B. Zimmerman, D.O.
- Vincent J. Zizza III, D.O.
Resident award winners recognized during 2010 ACA

The College recognized the winners of the 2010 scientific exhibit and poster competition and the 2010 recipients of the Robert C. Erwin Literary Award and the Resident Achievement Award during the 2010 Annual Clinical Assembly of Osteopathic Surgeons in San Francisco.

This year’s award winners are pictured above from left to right:


BACK ROW: Melissa Dakkak, MS; Lauren N. Eisenberg, D.O.

AOA approval of ACOS revised standards
The American Osteopathic Association Council on Postdoctoral Training (AOA COPT), which reviews all postdoctoral training policies and procedures for osteopathic training programs, approved in November the ACOS revised and reformatted standards and the companion crosswalks to be used for pre-site visit reviews and AOA/ACOS scheduled site visits. The new standards and crosswalks are expected to be implemented in July 2011, after approval by the AOA Bureau of Osteopathic Education and the AOA Board of Trustees. The revised standards are available in the “Education” section of the ACOS website at www.facos.org.

Revised Program Director’s Annual Resident Evaluation Report for Surgery
The AOA Basic Documents for Postdoctoral Training requires training program directors to complete the resident annual reports and a final resident assessment on AOA forms.

The AOA COPT approved a resolution that would allow specialty affiliates, including the ACOS, to use substitute forms; the resolution will be forwarded to the AOA Bureau of Osteopathic Education and the AOA Board of Trustees for final approval. The substitute forms must integrate the AOA Core Competencies and related elements with associated questions, and they must be submitted to the COPT for approval. The ACOS has incorporated the elements of the AOA’s Core Competency Compliance Program into its Program Director’s Annual Resident Evaluation Report for Surgery. The revised form will be distributed to residency programs and posted on the ACOS website early in 2011.

Annual forms must be signed by the resident and maintained in the resident file at the institution. The Program Complete form must be forwarded to the Osteopathic Postdoctoral Training Institution (OPTI) and maintained in the resident file.

Board Pass Rate Data
The AOA COPT has drafted a resolution to post the board certification pass rate for each training program in the “Opportunities” section of the AOA website for public review. The posting would automatically display the five-year rolling average pass rate or, at the program director’s discretion, the three-year rolling average pass rate. The resolution will go to the AOA Bureau of Osteopathic Education in December and AOA Board of Trustees in January for approval.

AOA duty-hours policy
In December 2008, the Institute of Medicine released recommendations based on a study of resident duty hours, which has spurred much discussion in the medical education community.


Likewise, the AOA duty-hours policy was amended and approved to include the following changes: a reduced time allowance beyond the 24-hour duty limit; a written report by residents for hours spent beyond 24 hours; a specified amount of resident time off beyond 12 to 24 hours of duty; allowance of additional time for emergency department trainees; and provision of facilities for rest for residents too fatigued to drive. The revised AOA policy also addresses the instruction of faculty in recognizing early fatigue and sleep deprivation in residents. The proposed changes, which will be submitted to the AOA Bureau of Osteopathic Education in December and the AOA Board of Trustees in January for approval, are posted on the AOA website.

See OGME CORNER, page 8
Other Legislative and Regulatory Issues Affecting Surgeons

ACOs and Medicare Shared Savings Program

The ACOS and 16 other surgical organizations submitted feedback on Dec. 3 to the Centers for Medicare & Medicaid Services (CMS) in response to the agency’s request for information concerning accountable care organizations (ACOs) and the Medicare Shared Savings Program. The organizations strongly believe that a new delivery system must focus on promoting quality care and improving patient access, and ultimately provide cost-efficient care. They discussed:

- Policies or standards to ensure that groups of solo and small-practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by the Center for Medicare and Medicaid Innovation.
- The process of attributing beneficiaries to an ACO to ensure that expenditures and savings achieved by the ACO are appropriately calculated and that quality performance is accurately measured.
- Assessment of beneficiary and caregiver experience of care as part of the CMS assessment of ACO performance.
- Development of patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program.
- Quality performance standards for determining ACO performance in the Medicare Shared Savings Program.

Inaction on defensive medicine solutions

The Health Coalition on Liability and Access (HCLA), of which ACOS is a member, issued a Dec. 3 press release expressing disappointment that the National Commission on Fiscal Responsibility and Reform failed to recommend substantive medical liability reforms to reduce the national deficit. “Comprehensive medical liability reform must be a priority for the new Congress,” said HCLA Chair Mike Stinson. “Reform not only will help reduce the cost of defensive medicine and our skyrocketing deficits, but it will preserve access to quality care for all Americans.”

Red Flag Program Clarification Act

The ACOS and 26 other national medical organizations joined in a Dec. 6 letter to House leaders urging House approval of the Red Flag Program Clarification Act of 2010 (S. 3987) prior to the Dec. 31, 2010, enforcement deadline for the Red Flags Rule that was effective on Jan. 1, 2008. Approved by the Senate on Nov. 30, 2010, S. 3987 narrows the definition of “creditor” for purposes of implementing the Red Flags Rule, i.e., federal guidelines for use by financial institutions and creditors in establishing policies and procedures to mitigate identity theft risks.

The Red Flags Rule defines a “creditor” as any person who sells a product or service for which a consumer can pay later. This definition concerned the medical organizations. The Federal Trade Commission (FTC) delayed enforcement of the rule several times since 2008 to allow covered entities time to comply with the regulation, but there was little progress in establishing an equitable definition of “creditor.” As a result, several organizations sought relief from the regulation through the courts.

The FTC requested that Congress approve legislation that would clarify which entities should be covered as “creditors.” S. 3987, as approved by the Senate, meets the FTC request and the concerns of the medical organizations. The House unanimously passed S. 3987 on Dec. 10, and President Obama signed it into law on Dec. 18.

Medicare e-prescribing penalty program

The ACOS joined 103 other national and state medical organizations in a Dec. 9 letter to Health and Human Services (HHS) Secretary Kathleen Sebelius, urging that the CMS be required to revise its policy that uses e-prescribing activity during the first six months of 2011 as the basis for imposing e-prescribing penalties on physicians in 2012 (entire 2011 calendar year for 2013). Although the organizations strongly oppose basing the 2012 and 2013 e-prescribing penalties on e-prescribing activity that occurs during 2011, they urged, at the minimum, the following immediate actions:

- That the CMS extend the reporting period so that physicians can report the e-prescribing G-code (G8553) at least 10 times for applicable Medicare office visits and services during the first 10 (not six) months of 2011 (Jan. 1 – Oct. 31) to avoid penalties in 2012; and
- That the CMS add more exception categories consistent with recommendations made by commenters in response to the proposed rule so that more physicians will be eligible for an exemption from e-prescribing penalties in 2012.

Retroactive Medicare payment increases

The ACOS and 107 other national and state medical organizations joined in a Dec. 9 letter to the HHS to urge that the CMS immediately reimburse physicians for retroactive Medicare payment increases they did not receive as required by the Patient Protection and Affordable Care Act (PPACA).

The PPACA implemented six provisions that called for the CMS to reimburse physicians retroactively to Jan. 1, 2010: (1) extend the 1.0 work geographic practice cost index (GPCI) floor that expired on Dec. 31, 2009; (2) raise practice expense GPCIs in low-cost areas by reflecting only half the geographic wage and rent-cost differences in their calculation; (3) extend the 5 percent add-on payment for specified psychiatry services; (4) increase payments for bone density tests; (5) extend the therapy cap exception that expired on April 1; and (6) extend a provision allowing independent labs to bill for the technical component of physician pathology services.

Incentive program for general surgeons

The CMS has established a five-year Medicare incentive payment program for major surgical procedures furnished by general surgeons in health professional shortage areas (HPSAs). The program will begin on Jan. 1, 2011. For major surgical procedures furnished in HPSAs that are not included on the list of zip codes eligible for automatic payment, practitioners must submit claims with an “AQ” modifier to avoid penalties. The CMS will make the 10 percent incentive payment to general surgeons on a quarterly basis, in addition to payments that otherwise would be made for the major surgical procedures.

The list of zip codes eligible for automatic incentive payment is available online at http://www.cms.gov/HPSA/PhysicianBonuses/01_Overview.asp. For more information, also go to http://www.cms.gov/MLNMattersArticles/downloads/MM7146.PDF.
OGME Corner

From OGME CORNER, page 5


General Surgery In-service Examination

The General Surgery In-service Examination will be administered electronically to all general surgery residents on Saturday, Jan. 8, 2011. The purpose of the exam is to assist program directors in the evaluation of a resident’s level of knowledge relative to other residents’ knowledge at the same level of training, to identify a resident’s areas of weakness, and to track a resident’s progress. Exam results also are used by the Residency Evaluation and Standards Committee (RESC) as an indicator in evaluating the strengths and weaknesses of each residency program.

This is the second year the exam will be administered online. Examination results will be distributed to program directors in March.

Annual resident reports

The RESC’s next meeting will be held Feb. 4–5, 2011, in Alexandria, Va. All annual resident reports to be reviewed by the RESC at its February meeting must be received at the ACOS office by Wednesday, Jan. 5, 2011.

RESC review of the annual resident report is a benefit of ACOS membership; nonmembers must pay a $250 review fee. New residents should contact their program director about ACOS membership or visit the ACOS website at www.facos.org for membership information or applications.

Future Programs

Feb. 10–12, 2011
2011 General Surgery
In-depth Review Seminar
Orlando World Center Marriott Resort
Orlando, Fla.

March 27–29, 2011
Joint Surgical Advocacy
Conference (JSAC)
J. W. Marriott Hotel, Washington, D.C.
(Online registration for the JSAC will open in January. Go to http://facs.org/ahp/jsac2011.html.)

Sept. 15–18, 2011
2011 Annual Clinical Assembly
of Osteopathic Surgeons
Atlanta Hilton, Atlanta, Ga.

Call 800-888-1312 or visit the ACOS website at www.facos.org for more information about these and other upcoming educational programs.

Classifieds

Classified advertising is available to ACOS members at the rate of $50 per column inch; the cost to nonmembers is $75 per column inch. Classified advertising or professional notices should be sent to:

Advertisements are accepted by ACOS News when they conform to the College’s ethical standards. ACOS News does not verify the accuracy of claims made in advertisements, and acceptance does not imply endorsement by the College. The ACOS assumes no liability for errors or missing ads beyond a refund for any amounts paid.